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Saturday, August 13, 2016

(Room 10)

7:00 - 8:00 Abbvie Breakfast Session

1. Joining the Dots in Psoriatic Arthritis; 2. Reaching for a Cure for Hep C

Joining the dots in psoriatic arthritis

Dr Daniel Ching, MB, FRCP, FRACP
Consultant Rheumatologist
Timaru

Double Whammy

abbvie

Disclosures

Advisory Boards and speaker at meetings: Abbott/Abbvie, Roche, Pfizer/Wyeth, MSD, Novartis, Quintiles CRO and Janssen.

Investigator in clinical trials for: Boehringer Ingelheim, MSD, UCB, Medi-Immune, Centocor, Roche, Abbott, Pfizer, Celgene, Lilly, Sanofi, Galapagos, GSK and Gilead.

Agenda

Learning Objectives

1. Review the presentation of PsA
2. The importance of early detection
3. When to refer and what to include

Presentation

- Epidemiology: delayed diagnosis
- Presentation: Skin, Nails & Joints
- Who to refer and what to include
- Treatment options
- Double Whammy program

Screening tool for PsA

Psoriatic Epidemiology Screening Test (PEST)

- Developed as a way of addressing brevity
- Entails five questions with a homunculus for patients to complete to indicate which joints are affected
- A score of ≥3 is indicative of PsA

	NO	YES
Have you ever had a swollen joint (or joints)?		
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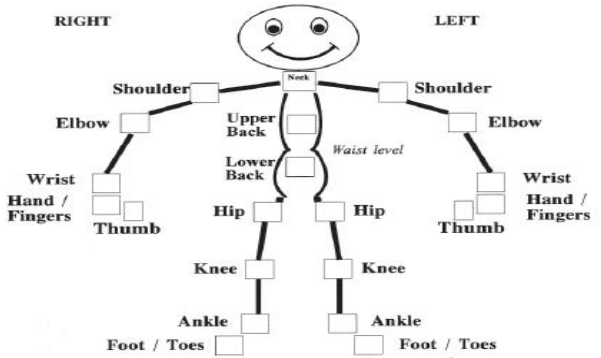


Reference: 1. Helliwell PS. *J Rheumatol* 2011;38:551–552.

Epidemiology of PsA

Snapshot of PsA

Psoriasis is estimated to affect about 2–4% of the population in western countries.[1]

Approximately 30% of people with plaque psoriasis may develop PsA[2]

Patient with moderate plaque psoriasis

Photo from Menter *et al.* 2008[3]

References: 1. Parisi R, *et al*. *J Invest Dermatol.* 2013;133:377–385. 2. Mease PJ, *et al*. *J Am Acad Dermatol.* 2013;69(5):729–735. 3. Menter A, *et al. J Am Acad Dermatol* 2008;58:106-15.

Prevalence of PsA

3 OUT OF 10 PATIENTS WITH CHRONIC PLAQUE PSORIASIS MAY DEVELOP PSORIATIC ARTHRITIS (PsA)[1]

41% (n=117) HAD NOT RECEIVED A PREVIOUS DIAGNOSIS OF PsA, SUGGESTING UNDERDIAGNOSIS OF THIS POTENTIALLY DEBILITATING DISORDER[1]

Patients diagnosed with PsA vs those who had Ps only:[1*]

- Significantly more body surface area (BSA) involvement (9.6% vs 7.7%; *p*=0.015)
- Longer psoriasis duration (21.7 vs 19.1 years; *p*=0.006)
- An increased awareness of the prevalence of PsA among patients with psoriasis is important for an appropriate diagnosis

*Multicenter noninterventional study investigating the prevalence of PsA in patients with plaque psoriasis presenting to dermatologists' offices.

Reference: 1. Mease PJ, *et al*. *J Am Acad Dermatol.* 2013;69(5):729–735.

Predictors of PsA

Nail disease[1,2]

- 46% in Ps vs 84% in PsA[1]

Psoriasis located at[2]

- Perianal
- Gluteal cleft
- Scalp and post-auricular area

Time since diagnosis of psoriasis[3]

Lifestyle factors[4]

- Obesity[5]
- Smoking[6]

References: 1. Gladmann DD, *et al. J Rheumatol* 1986;13:586–92. 2. Wilson FC, *et al. J Rheumatol* 2009; 36:3617. 3. Gottlieb A, *et al*. *J Am Acad Dermatol.* 2008;58(5):851–864. 4. Horreau *et al. J Eur Acad Dermatol Venereol*. 2013 Aug;27 Suppl 3:12–29. 5. Love TJ *et al. Ann Rheum Dis.* 2012 Aug;71(8):1273–1277. 6. Tillet W *et al. Ann Rheum Dis*. 2013 Aug;72(8):1358–1361.

Question

- The average delay in diagnosis of PsA is:

A. 1 year
B. 3 years
C. 5 years
D. 10 years

Answer = C: 5 years

Case Presentation No. 1

- Mrs TMM, 37-year old bank clerk

  Visit 1 – Complained of:

  - pain and swelling affecting sternoclavicular joint.
  - intermittent swelling affecting knees for 10 years which lasted 3-4 days per episode, averaging 3-4 episodes per year.

Examination

- Swelling and synovitis affecting left sternoclavicular joint. Other joints and spine were normal. (Thick, blonde hair, just been to hairdresser). No evidence of psoriasis in scalp, nails nor skin.

Visit 2 – Four months later:

- pain and swelling affecting both knees with a CRP of 60.
- HLA-B27 negative.

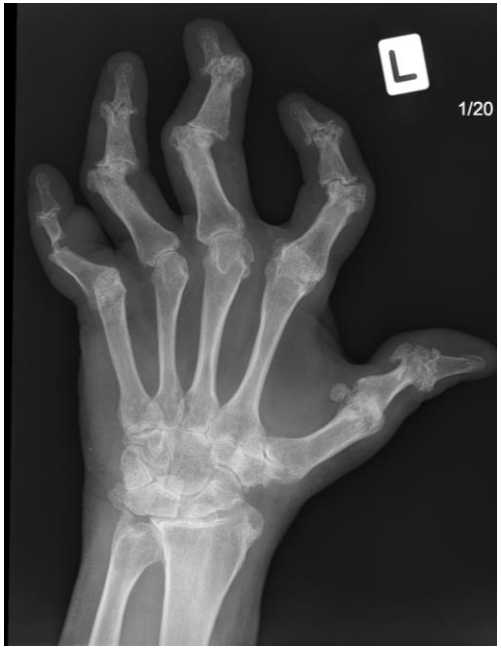
Examination

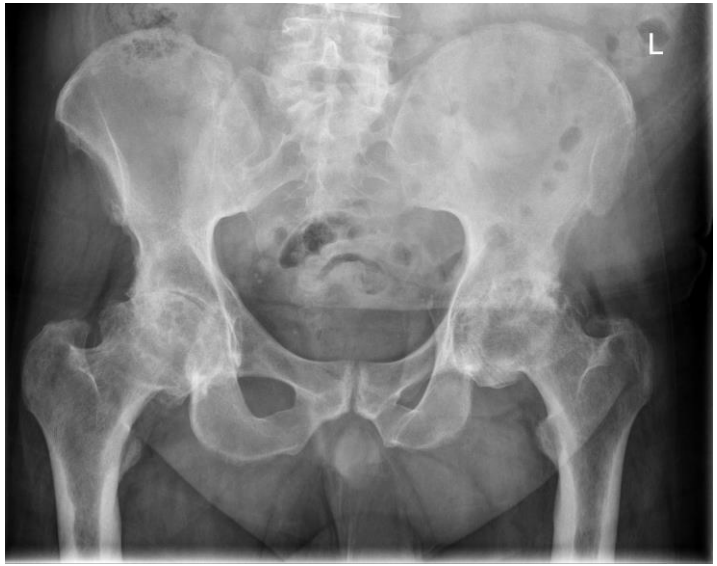
- Swelling and synovitis affecting left sternoclavicular joint and swelling affecting both knees with Baker’s cysts. Further examination revealed a patch of psoriasis over occipital area which she had attributed to ‘dandruff’ for a number of years which was intermittent.

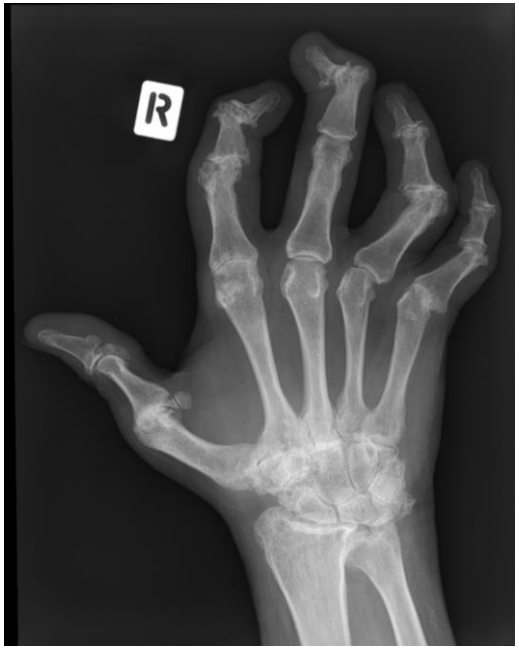
Diagnosis

- Psoriatic arthritis
- Psoriasis affecting occipital area of scalp

This is what we need to prevent







Need for early diagnosis: patients presenting late with PsA symptoms have worse joint damage[1]

Feature	Early PsA (n=436)	Late PsA (n=641)	*p*-Value
Mean number of actively inflamed joints	10.5	11.7	0.239
Mean number of damaged joints	3.5	9.2	0.0001*
Radiographic damage, %	39.2	65.9	0.0001*
Axial and peripheral disease,[a] %	24.2	35.1	0.02*
Mean PASI score	6.2	5.5	0.254

Early PsA = <2 years of diagnosis; late PsA = >2 years' disease duration

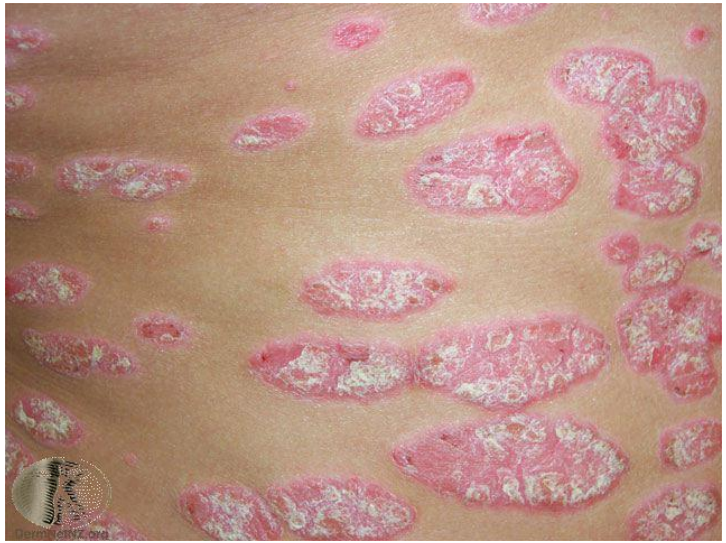
Delayed diagnosis of PsA (even as little as six months) is associated with worse long-term radiographic and physical function outcomes[2]

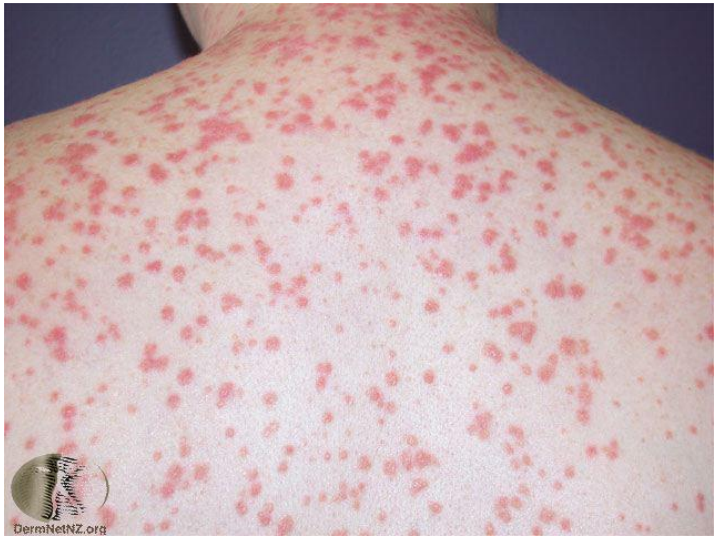
[a]Includes patients with both axial and peripheral disease. PASI=Psoriatic Arthritis Severity Index.

References: 1. Gladman DD, *et al. Ann Rheum Dis.* 2011;70(12):2152–2154. 2. Haroon M, *et al. Ann Rheum Dis.* 2014. [Epub ahead of print].

Presentation of PsA: Skin, Nails & Joints

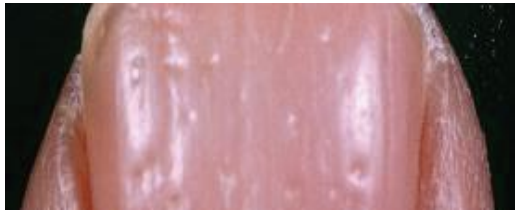
Psoriasis



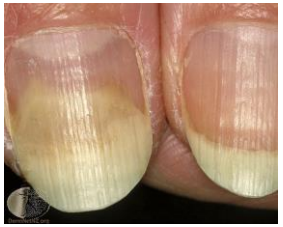


In 84% of patients with PsA, **skin disease** manifests before **joint disease**[1]

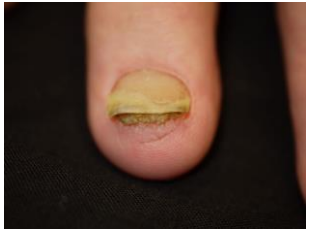
The Spectrum of Psoriatic Nail Changes



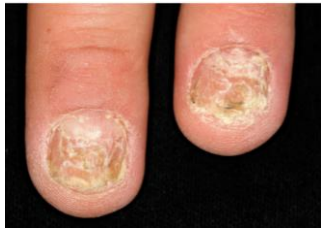
Pitting



Onycholysis



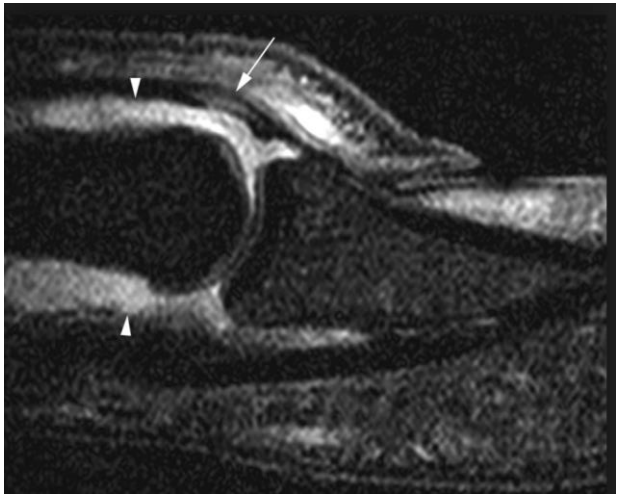
Subungual-hyperkeratosis



Dystrophy

Enthesitis, a hallmark feature of PsA[1]

- PsA characterised by ***osteitis, new bone formation, periostitis, spinal involvement and dactylitis***
- Inflammation of the enthesis, the epicentre
- Probably explains how skin relates to joints and nails in this disease



Reference: 1. McGonagle D. *J Eur Acad Dermatol Venereol* 2009;23 Suppl 1:9–13.

Question

- What pattern of joint involvement is most common on initial presentation of PsA?

A. Spondylitis
B. Symmetric polyarthritis
C. Asymmetric oligoarthritis
D. Distal interphalangeal predominant
E. Arthritis mutilans

Answer = C: Asymmetric oligoarthritis

PsA Presentation – Various manifestations

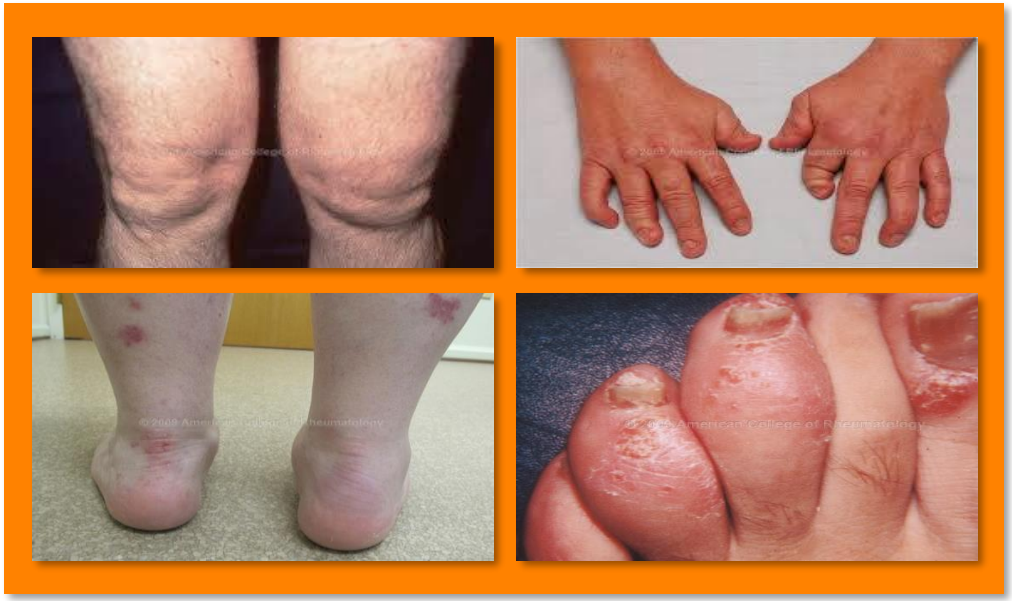
Oligo-articular[1,2]
- Most common

Poly-articular[2,3]
- RA like
- Mutilans

Spondylitis[2]
- AS like

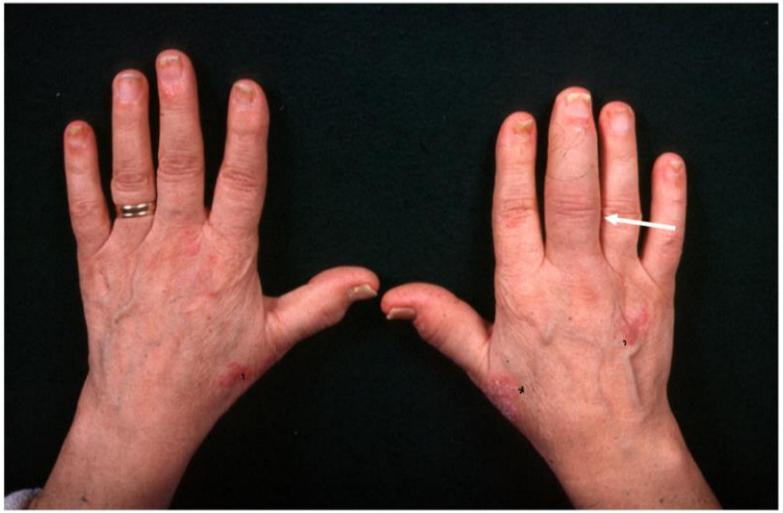
Enthesitis[1,2]

Dactylitis[2,4]
- Present in 16-48%
- Marker of severity of PsA

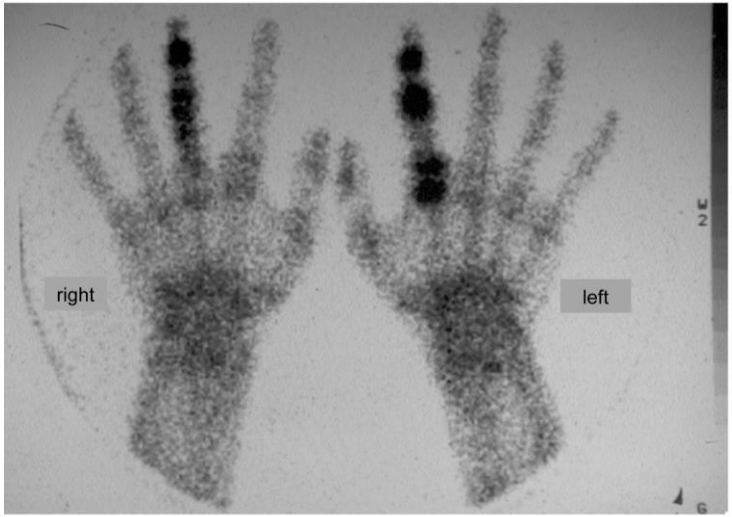


References: 1. Gottlieb AB. *Dermatol Nurs.* 2003;15(2):107–110. 2. Brockbank J & Gladman DD. *Exp Opin Invest Drugs.* 2000;9(7):1511–1522. 3. Gladman DD *et al. Q J Med* 1987;62(238):127–141. 4. Mease PJ. *Arth Care Res* 2011;63:S64–S85.

Dactylitis

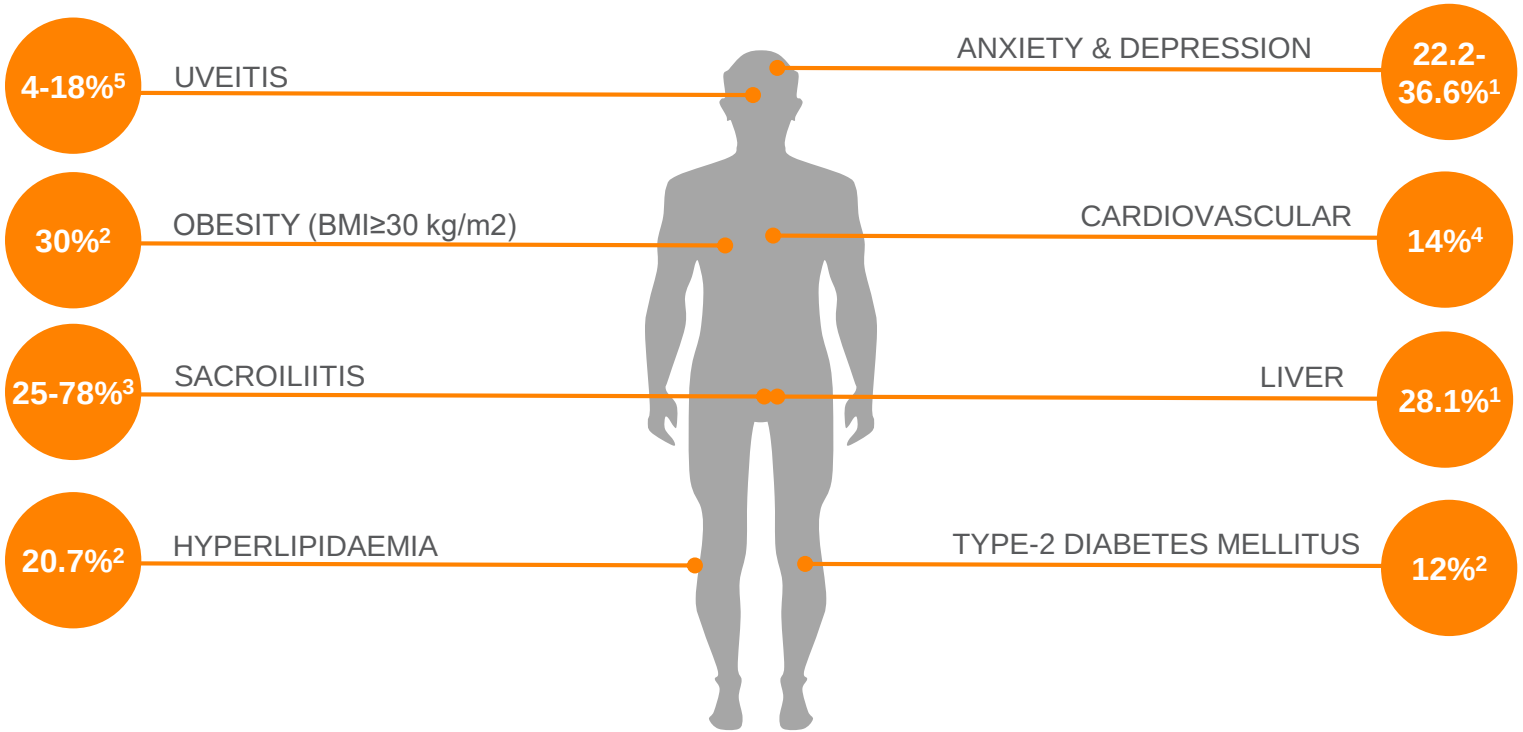


* Psoriasis plaque lesions



Digitum III (right hand) and Digitum II (left hand). Typical for Psoriatic Arthritis.

Co-morbidities in patients with PsA[1–4]

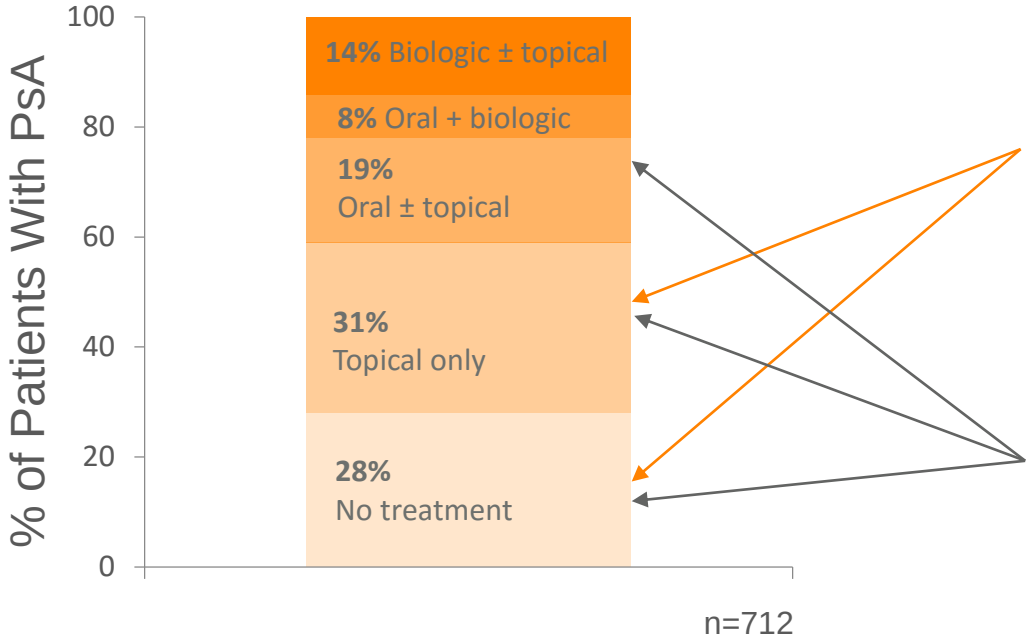


BMI, body mass index; IBD.

1. Ogdie A et al. Curr Opin Rheumatol. 2015;27:118–126. 2. Husted JA et al. Arthritis Care Res. 2011;63:1729–1735. 3. Mease PJ et al. Ann Rheum Dis. 2005;64(Suppl II):ii49–ii54. 4. Peluso R et al. Clin Rheumatol. 2015;34:745–753. 5. Dhir V and Aggarwal A. Clinic Rev Allerg Immunol. 2013;44:141-48.

Treatment

Pattern of treatment in PsA patients according to survey



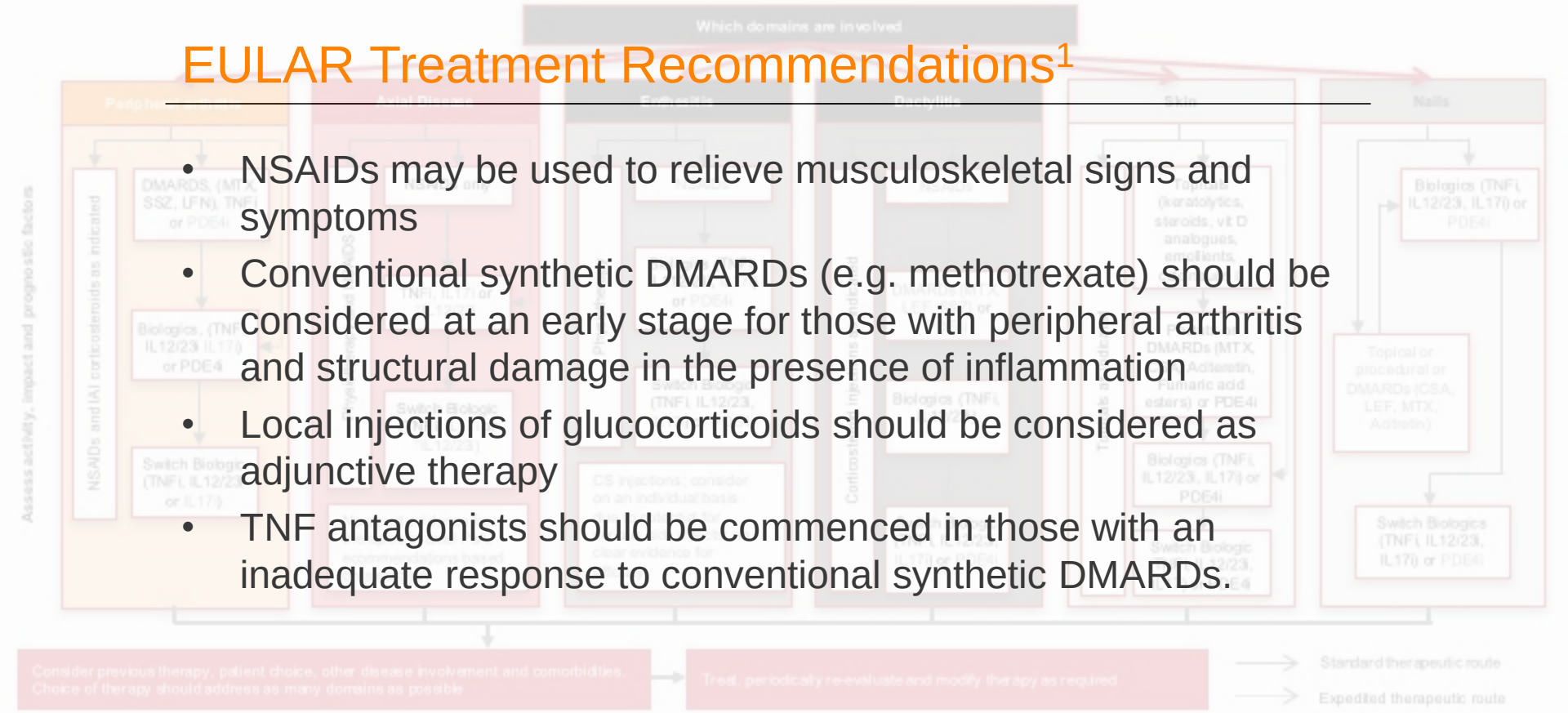
59% of patients with PsA were receiving no treatment or topical treatment

78% of patients with PsA are on a drug that may not inhibit irreversible joint damage

Results from a large, multinational, population-based (North America and Europe) survey of patients with PsA.
In the above chart, no notable difference in current treatment was observed between the 2 locations.
Reference: 1. Lebwohl MG*, et al. J Am Acad Dermatol*. 2014;70(5):871–881.

EULAR Treatment Recommendations[1]

- NSAIDs may be used to relieve musculoskeletal signs and symptoms
- Conventional synthetic DMARDs (e.g. methotrexate) should be considered at an early stage for those with peripheral arthritis and structural damage in the presence of inflammation
- Local injections of glucocorticoids should be considered as adjunctive therapy
- TNF antagonists should be commenced in those with an inadequate response to conventional synthetic DMARDs.



1. Gossec L et al. Ann Rheum Dis. 2015;0:1-12

Screening for PsA and when to refer

Screening tool for PsA

Psoriatic Epidemiology Screening Test (PEST)

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- Entails five questions with a homunculus for patients to complete to indicate which joints are affected
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	NO	YES
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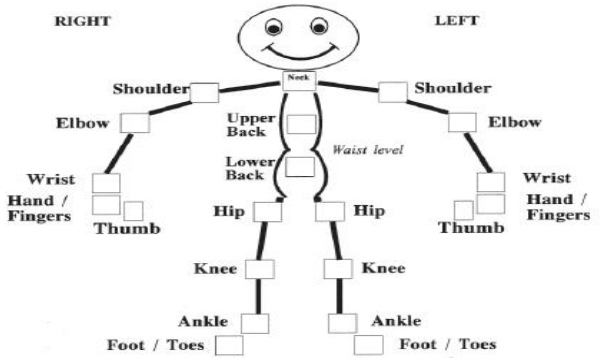

Reference: 1. Helliwell PS. *J Rheumatol* 2011;38:551–552.

The PEST questions

1) **Have you ever had a swollen joint (or joints) ?**
2) **Has a doctor ever told you that you have arthritis?**
3) **Do your fingernails or toenails have holes or pits?**
4) **Have you had pain in your heel?**
5) **Have you had a finger or toe that was completely swollen and painful for no apparent reason?**

Case Presentation No. 2

- Mrs DSN – 49-year old personal assistant

  Complained of:

  - pain of pain in hips and right knee

  Systemic Enquiry:

  - no history of psoriasis

Examination

- Pain over hips was in fact tenderness over both anterior superior iliac spines and posterior iliac crests. No evidence of enthesitis elsewhere.
- Tender and swollen right knee.
- Examination did not reveal any evidence of psoriasis affecting her scalp, skin or nails, but while examining her scalp, she recalled having psoriasis in her scalp at the age of 22 (27 years ago) which lasted two years.

Diagnosis

- Psoriatic arthritis with enthesitis and monoarthritis affecting right knee
- History of psoriasis affecting scalp

What is Double Whammy?

Did you know it takes an average of 5 years to receive a diagnosis of PsA following the onset of joint pain?[1]

Double Whammy

Supported by

ARTHRITIS NEW ZEALAND

A guide to the early identification of psoriatic arthritis (PsA)

The development of this educational booklet was funded by Abbvie

abbvie

First: red, scaly and itchy patches of skin.[1,2]

Now: swollen, stiff and painful joints.[1,2]

It's a double whammy!

Your skin symptoms and joint pain could have something in common: psoriatic arthritis.[1,2]

Complete a short symptom checker to find out more.

Take the symptom checker

About psoriatic arthritis

A long-term condition that attacks your skin on the outside and your joints on the inside.[1,2]

Learn more

Importance of early diagnosis

Learn more

References

1. American College of Rheumatology. Psoriatic arthritis. Available at: [illegible] Last accessed: June 2015.
2. Progeni D. 2013. Psoriatic arthritis. In: Firestein GS, et al. Kelley's Textbook of Rheumatology. Philadelphia: Elsevier; 1232–1248.
3. Gladman DD. Ann Rheum Dis. 2005;64 Suppl 2:ii14–17.

The Double Whammy initiative and this website are organised and funded by AbbVie Limited.

GBL/PSA/0615/0125

TAPS PP7859. NZ-HUMD-2015-23. Date of Preparation March 2016.

Summary

Psoriatic arthritis is the most common cause of undifferentiated inflammatory arthritis in a Rheumatology practice once gout and rheumatoid arthritis have been excluded (CRP and ESR are variable which can be normal, or slightly elevated, or grossly abnormal).

Summary

- PsA is variable and unpredictable, ranging from mild and nondestructive to a severe, debilitating, erosive arthropathy
- We can work together to improve outcomes by identifying patients earlier, as even short delays in diagnosis can lead to loss of function

  The mean delay in diagnosis is 5 years
- Skin, joints, other manifestations of the disease and comorbidities should be considered and managed when treating patients with PsA

References: 1. Gottlieb A, *et al. J Am Acad Dermatol* 2008;58:851–864. 2. Lee S, *et al. P & T* 2010; 35:680–689. 3. Gordon KB, Ruderman EM. *J Am Acad Dermatol.* 2006;54(3 suppl 2):S85–S91.

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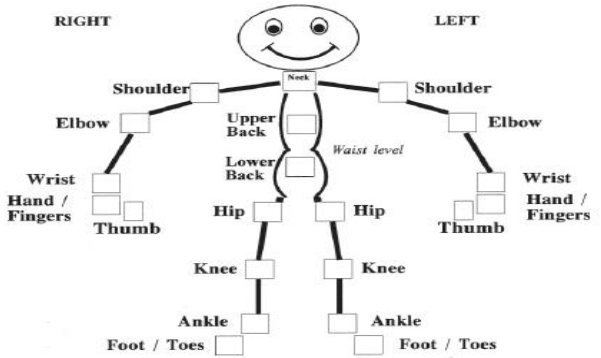
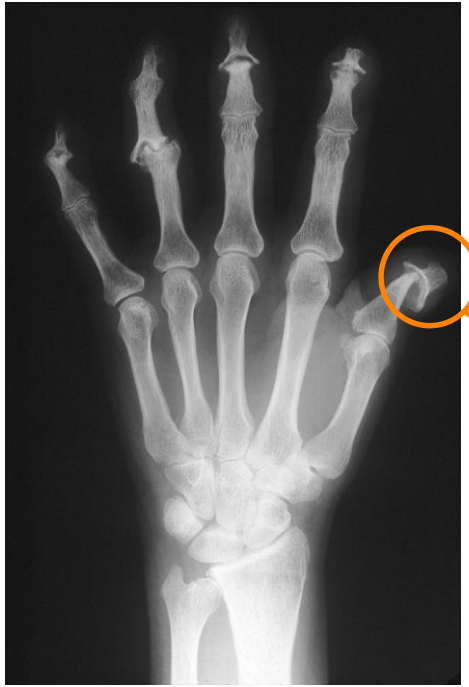


Reference: 1. Helliwell PS. *J Rheumatol* 2011;38:551–552.

Questions?

Thank you

Radiographic features of PsA[1]



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- Radiographic changes due to PsA, unlike those of RA, demonstrate characteristic bony proliferation and predominant distal interphalangeal (DIP) joint involvement

- Other radiographic features of PsA may include[1]
  - Osteolysis
  - **Pencil-in-cup** deformity
  - Spondylitis
  - Ankylosis
  - Spur formation

Reference: 1. Gottlieb A, *et al*. *J Am Acad Dermatol.* 2008;58(5):851–864.

The emotional impact of the psoriasis component of PsA

87%
experience
helplessness[1]

89%
experience
self-consciousness[1]

87%
experience
embarrassment[1]

Study Details

- National survey data were collected by the US National Psoriasis Foundation (NPF) via biannual surveys conducted from January 1, 2003 to December 31, 2011
- 5604 patients with psoriasis or psoriatic arthritis completed the survey

Reference: 1. Armstrong AW, *et al. PLoS One.* 2012;7(12):e52935.

Results: GRAPPA 2015 treatment schema

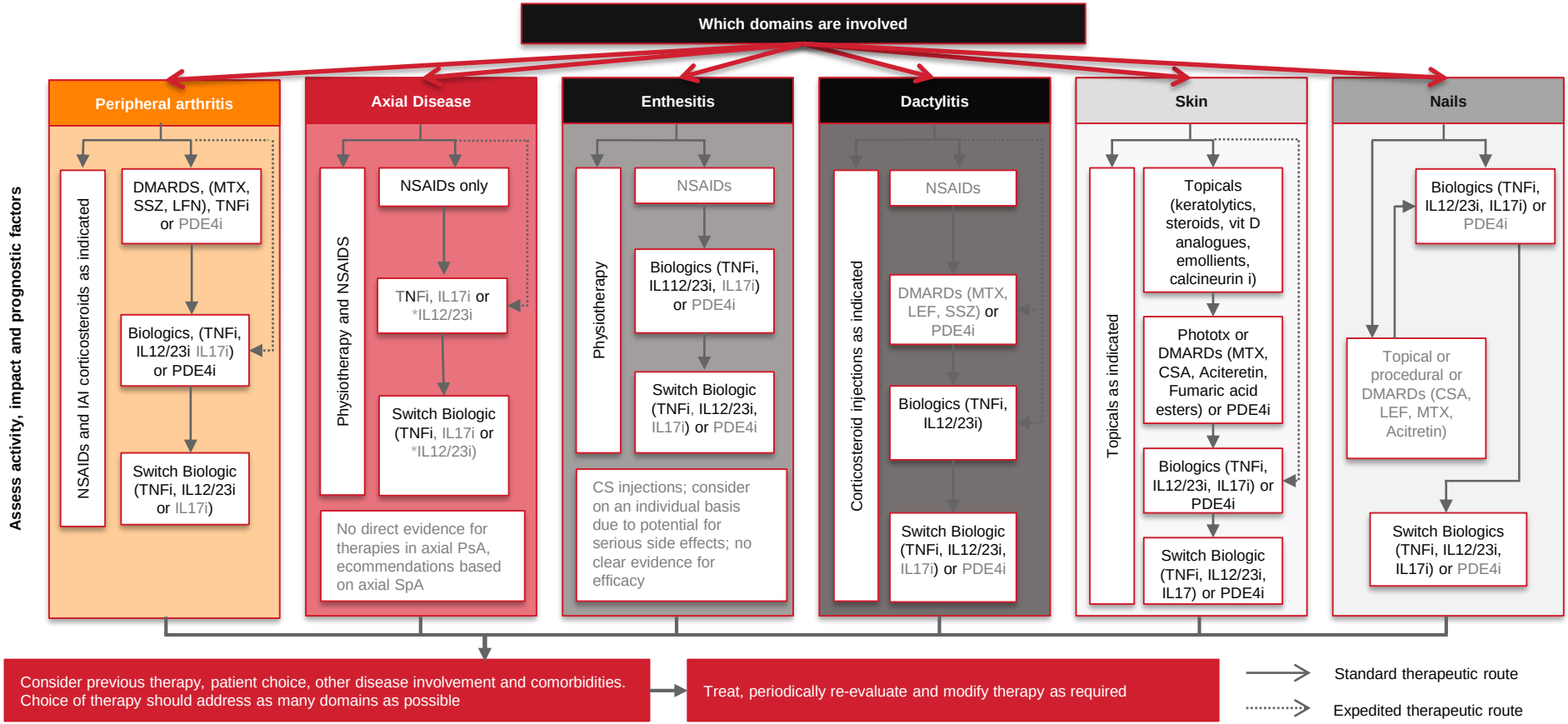

Figure 1: GRAPPA Treatment Schema for Active PsA. Grey text identifies conditional recommendations for drugs without current regulatory approvals or where recommendations are based on abstract data only.
DMARDs = disease modifying anti-rheumatic drugs, IL17i = interleukin 17 inhibitors, IL12/23i = interleukin 12/23 inhibitors, LEF = leflunomide, MTX = methotrexate, NSAIDs = nonsteroidal anti-inflammatory drugs, PDE4i = phosphodiesterase 4 inhibitor (apremilast), SSZ = sulfasalazine, TNFi = tumor necrosis factor inhibitor

Reference 1. Coates LC et al.
Arthritis & Rheumatology. 2016. DOI 10.1002/art.39573

Screening for PsA

Many screening tools/questionnaires:

- PEST, EARP, TOPAS, PASE, PASQ

Screening is sensitive in detection of PsA[1]

- >70% sensitivity in most screening tools

Reference: 1. Coates LC, *et al. Br J Dermatol.* 2013;168:802–807.