ADDITIONAL RESOURCES
POSTTEST ANSWERS AND RATIONALE

POSTTEST QUESTION 1:

Jeremy is a 26-year-old white male who presents with a history of psoriasis involving his lower back, elbows, knees, lower legs and scalp for 4 years. He has been treating his psoriasis with topical steroids and calcipotriene. He also notes that his fingernails are "funky" and has been treating them with antifungals but has not had any improvement. He notes he suffered several injuries while deployed to Iraq and complains of stiffness in his back and feet, especially in the morning. He often wakes up at night to move around because his back gets sore. Other than that, Jeremy is healthy, a non-smoker, and has 1-2/beers per evening and recently started a job as a Fed-Ex driver. He is beginning to date but is self-conscious of his skin.

What initial assessments would you conduct on Jeremy?

A. Full body skin examination.
B. Full body skin examination and evaluation of the joints of the hands and feet.
C. Skin examination of hands/feet/back including the finger and toenails.
D. Full body skin examination, joint evaluation of the hands/feet, tendons of the Achilles, and evaluation of the finger and toenails.

Correct Answer: D.

Explanation:

It is important to conduct a full body skin examination to identify BSA. Higher BSA adds to severity and the greater the severity, the greater the risk of developing PsA. Also evaluate the joints of the hands and feet for swelling and dystrophic joint changes, especially of the DIPs and PIPs. Nail findings of onycholysis, nail pitting or oil spots are also associated with higher risk of PsA. Enthesitis is also part of PsA and the Achilles tendons are a common place to unveil this, and therefore, should be palpated. Axial disease is difficult to assess without radiography so a back joint examination is less useful. You can, however, ask about back pain and stiffness.

Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 2. Psoriatic arthritis: overview and guidelines of care for treatment with an emphasis on the biologics. *J Am Acad Dermatol.* 2008; 58:851-864.

POSTTEST QUESTION 2:

Your clinical examination of Jeremy reveals a BSA of 20%, and you find several DIPs of the fingers slightly disfigured and tender to palpation. Several fingernails have multiple pits and distal onycholysis. Most of his toenails are thickened distally with lifting of the nail plate. You perform a KOH scraping from the great toenails which is negative. A nail culture is negative for dermatophyte or yeast. Based on these clinical findings you suspect that John has severe psoriasis and early symptoms of PsA.

You decide the next course of action will be to:

A. Obtain a punch biopsy of the skin plaque to confirm a diagnosis of psoriasis.
B. Obtain a quantiferon gold test, Hep B panel and a CBC in anticipation of starting a TNF alpha blocker.
C. Obtain X-rays of his hands, feet and back to confirm a diagnosis of PsA.
D. Obtain a rheumatoid factor, an ANA and serum uric acid level to confirm a diagnosis of PsA.

Correct Answer: B.

Explanation:

Based on clinical findings and history, there is no need to do a punch biopsy to confirm psoriasis. There is no one X-ray or lab test to confirm a diagnosis of PsA. You could potentially refer him to Rheum to confirm the diagnosis. It is most prudent to initiate a TNF alpha blocker given his BSA of 20% (severe PsA). TNF alpha blockers are also appropriate first line therapy for PsA. TNF alpha blockers require TB and Hep B screening prior to initiating therapy.

Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 2. Psoriatic arthritis: overview and guidelines of care for treatment with an emphasis on the biologics. *J Am Acad Dermatol.* 2008; 58:851-864.

POSTTEST QUESTION 3:

Jeremy is initiated on a TNF alpha inhibitor and returns to your clinic in 3 months to assess response. Jeremy is thrilled that his skin is clearing nicely but he notes that his joints, while somewhat better, are still stiff in the morning and his back pain still awakens him at night.

Your next step would be to:

A. Add methotrexate 20mg once a week with folic acid 1mg daily.
B. Stop the TNF alpha inhibitor and switch to an IL-17 inhibitor.
C. Continue the TNF alpha inhibitor and refer to rheumatology.
D. Continue the TNF alpha inhibitor and refer back to primary care provider.

Correct Answer: C.

Explanation:

It might be reasonable to consider adding methotrexate. However, you would not start at such a high dose, but rather slowly titrate up, starting at 7.5mg or 10mg once a week with FA 1mg daily. It is too soon to consider switching therapy without a further work up of joint symptoms, especially since his skin is responding well. It is completely within the dermatology provider's purview to refer directly to rheumatology and should be done so to expedite evaluation for the patient's sake. Depending on your familiarity with your rheum's preference, you may consider ordering screening X-rays and labs, but it is usually not necessary. It is essential that you provide a thorough history of the patient's psoriasis symptom and treatment history in the rheumatology referral.

Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 2. Psoriatic arthritis: overview and guidelines of care for treatment with an emphasis on the biologics. *J Am Acad Dermatol.* 2008; 58:851-864.

POSTTEST QUESTION 4:

Types of arthritis include:

a. Asymmetric oligoarthritis—dactylitis.
b. Predominant DIP involvement—nail changes.
c. Arthritis mutilans—osteolysis of involved joints, "telescoping" of digits.
d. "Rheumatoid-like" disease—fusion of wrists.
e. Axial involvement—asymmetric sacroiliitis and "jug handle"-like syndesmophytes.
f. Enthesitis.

Which types of arthritis domains from listed below require biologics as first line of treatment according to the GRAPPA recommendations?

A. a, e, f
B. a, e
C. a ,b, c, d, e, f
D. a, b, e, f

Correct Answer: D.

Explanation:

Biologics are the first line therapy for patients with PsA who have dactylitis, nail disease, axial disease, and/or enthesitis.

Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 treatment recommendations for psoriatic arthritis. *Arthritis Rheumatol.* 2016;68(5):1060-1071.

NATIONAL PSORIASIS FOUNDATION WEB SITE

https://www.psoriasis.org/about-psoriatic-arthritis

INTERNATIONAL PSORIASIS COUNCIL WEB SITE

http://www.psoriasiscouncil.org/

GRAPPA WEB SITE

http://www.grappanetwork.org/

Easy Screening Tools for Dermatology Providers

There are 4 screening tools available.

EARP

Early **AR**thritis for **P**soriatic patients (most sensitive)

1

ToPAS II

Toronto **P**soriatic **A**rthritis **S**creen II (most specific)

2

PASE

Psoriatic **A**rthritis **S**creening and **E**valuation

3

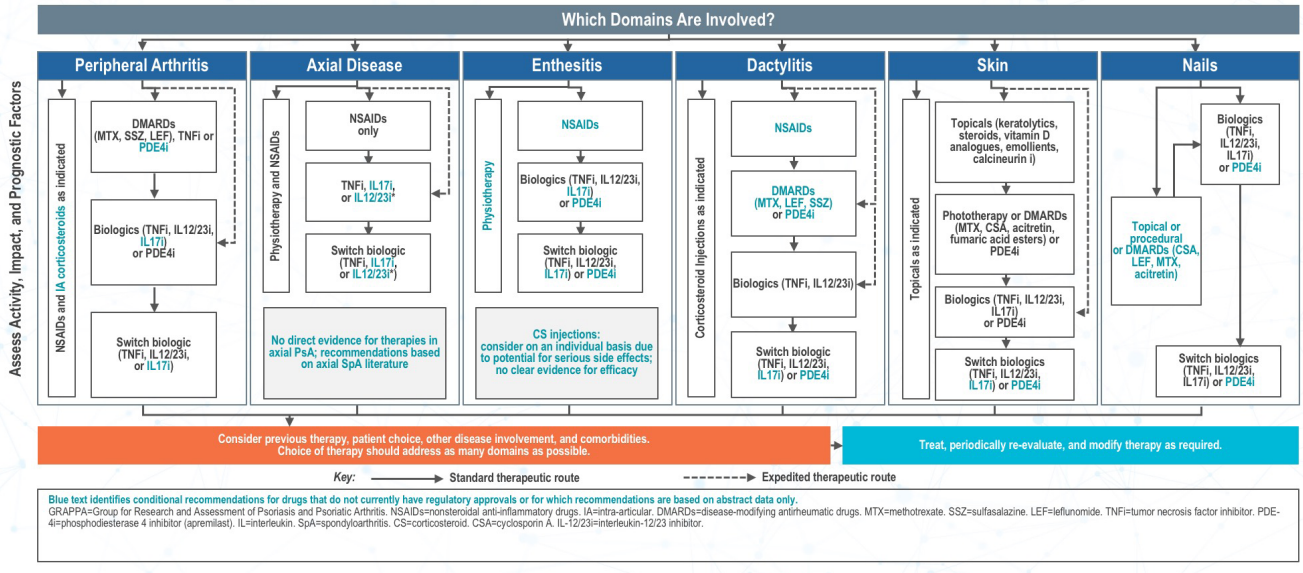
PEST

Psoriasis **E**pidemiology **S**creening **T**ool

4

Mishra S, et al. *Br J Dermatol*. 2017;176(3):765-770.

GRAPPA Treatment Schema for Active PsA



Blue text identifies conditional recommendations for drugs that do not currently have regulatory approvals or for which recommendations are based on abstract data only.
GRAPPA=Group for Research and Assessment of Psoriasis and Psoriatic Arthritis. NSAIDs=nonsteroidal anti-inflammatory drugs. IA=intra-articular. DMARDs=disease-modifying antirheumatic drugs. MTX=methotrexate. SSZ=sulfasalazine. LEF=leflunomide. TNFi=tumor necrosis factor inhibitor. PDE-4i=phosphodiesterase 4 inhibitor (apremilast). IL=interleukin. SpA=spondyloarthritis. CS=corticosteroid. CSA=cyclosporin A. IL-12/23i=interleukin-12/23 inhibitor.

Coates LC, et al. *Arthritis Rheumatol*. 2016;68:1060-1071.

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