PSORIATIC**ARTHRITIS:**

Understanding Patient Perspectives and Providing Patient-Centered Care

ADDITIONAL RESOURCES

SUMMARY OF GRADE RECOMMENDATIONS FOR PSA THERAPIES BY DISEASE DOMAIN

Indication	Recommended (Strong)	Recommended (Conditional)	Not Recommended
Peripheral arthritis, DMARD-naive	DMARDs (MTX, SSZ, LEF), TNFi	NSAIDs, oral CS, IA CS, *PDE-4i*	IL-12/23i, IL-17i (lack of evidence)
Peripheral arthritis, inadequate response to DMARDs	TNFi, IL-12/23i, PDE-4i	NSAIDs, oral CS, IA CS, *IL-17i*	
Peripheral arthritis, inadequate response to biologic treatment	TNFi	NSAIDs, oral CS, IA CS, IL-12/23i, *IL-17i*, PDE-4i	
Axial PsA, biologic-naive*	NSAIDs, physiotherapy, simple analgesia, TNFi	*IL-17i*, SI joint CS injections, bisphosphonates, [*IL-12/23i*]	DMARDs, IL-6i, CD20i (not recommended–strong evidence)
Axial PsA, inadequate response to biologic treatment*	Physiotherapy, simple analgesia	NSAIDs, TNFi, IL-12/23i, *IL-17i*	
Enthesitis	TNFi, IL-12/23i	NSAIDs, physiotherapy, CS injections (with extreme caution since injecting CS in weight-bearing entheseal sites can lead to rupture of entheses), *PDE-4i, IL-17i*	DMARDs (lack of evidence)
Dactylitis	TNFi (infliximab, adalimumab, golimumab, CZP)	CS injections, DMARDs (MTX, SSZ, LEF), TNFi (etan), IL-12/23i, *IL-17i, PDE-4i*	
Psoriasis (plaque)	Topical therapies, phototherapy, DMARDs (MTX, LEF, CSA), TNFi, IL-12/23i, IL-17i, PDE-4i		
Nail psoriasis	TNFi, IL-12/23i	Topical therapies, procedural therapies, DMARDs (CSA, LEF, acitretin, MTX), IL-17i, *PDE-4i*	

Italicized text signifies conditional recommendations for drugs without current regulatory approvals or for which recommendations are based on data published in abstract form only; italicized text in brackets signifies conditional recommendations based only on data from a small, open-label, proof-of-concept trial, published in abstract form only. GRADE=Grading of Recommendations, Assessment, Development, and Evaluation. PsA=psoriatic arthritis. DMARD=disease-modifying antirheumatic drug. MTX=methotrexate. S SZ=sulfasalazine. LEF=leflunomide. TNFi=tumor necrosis factor inhibitor. NSAIDs=nonsteroidal anti-inflammatory drugs. CS=corticosteroids. IA=intra-articular. PDE-4i=phosphodiesterase 4 inhibitor (apremilast). IL-12/23i=interleukin-12/23 inhibitor. IL-17i= interleukin-17 inhibitor. SI=sacroiliac. IL-6i=interleukin-6 inhibitor. CD20i=B-lymphocyte antigen CD20 inhibitor. CZP=certolizumab pegol. etan=etanercept. CSA=cyclosporin A. *Based on ankylosing spondylitis literature.

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

A Decision Aid for RA Patients Considering Methotrexate

Instructions: This decision aid gives you information about rheumatoid arthritis (RA), an overview about Methotrexate (MTX) and some questions to help you think through the decision, "should I take MTX?" Reviewing this decision aid should help you feel more aware of what is important to you and be more confident with your decision.

In RA your body's natural defense system is over active. This causes widespread inflammation (including the joint linings). This can lead to joint swelling, damage, and deformity which, over time, reduces your physical abilities. RA typically cannot be cured and needs treatment for years. The main goals are to reduce joint pain and swelling and slow or prevent joint damage.

1. What is the Decision?

You have 5 options to choose from:

Decision Options

- No treatment
- Continue current treatment
- Begin methotrexate now
- Ask doctor about other options
- Defer choice for now

2. Information on MTX

- MTX has been used to treat RA since 1976.
- MTX is considered a disease modifying drug (DMARD).
- It is taken once a week as pills or injection in the skin.
- It can be taken alone or with anti-inflammatory medications (NSAIDs), prednisone and biologic DMARDs.
- It is generic and typically costs about $40.00 per month.
- MTX works slowly. After starting MTX, RA symptoms begin to improve after about 3-6 weeks with the full benefits by 6 months.
- To reduce side effects, 1 mg of folic acid is taken daily.

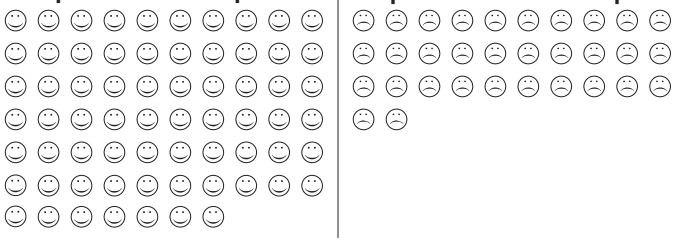
3. Chance of Improving RA

If 100 RA patients start taking MTX

100

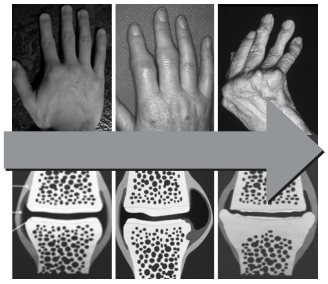
65 RA patients will improve

35 RA patients will not improve



4. Slowing Joint Damage

10 Year Progression without Treatment



Effect of Treatment

Treatment Program	Slows pace of new joint damage.
No DMARD	0%
Methotrexate	85%

5. Methotrexate quiets the overactive immune system in RA. This can also reduce your ability to fight infections. This can increase your chance of getting a new serious infection like pneumonia. If you have a chronic infection, this can worsen while taking MTX. Thus, it is not safe to take MTX if you have hepatitis B or C, HIV, an open skin ulcer. You can safely take most vaccines i.e. flu shots, pneumonia or zoster/shingles when taking MTX.

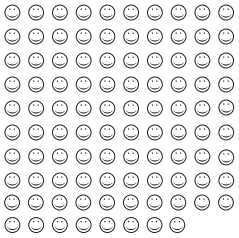
6. Chance of Serious Infection

If 100 RA patients take MTX for 1 year

100

98 RA patients will not have a serious infection

2 RA patients will have a serious infection



Serious infections need treatment in the hospital.

7. Other Possible Harms

- **Inconvenience:** Monitoring includes: a baseline chest x-ray, blood tests every 4 -12 weeks & regular checks with your doctor.
- **Nausea:** feel a little tired or queasy the day you take MTX.
- **Liver scarring**: About 1 in 1000 people who take MTX for 5 years will develop serious liver scarring. However if regular monitoring blood tests are done and are normal the chance of a serious liver problem is very small.
- **Lung Scarring:** Around 1-2 % of people who take MTX develop a chronic hacky cough or asthma like reaction which could be a symptom of lung scarring. If this occurs, report this to your doctor promptly to check if it is safe to continue MTX.
- **Conception:** MTX is harmful to the fetus and can cause either miscarriage or serious deformities. You must use birth control.
- **Cancer:** It does not appear that MTX increases cancer risk.

8. Sorting It Out

This is a good time to think back to what you know about your options and what is most important to you.

- Start by reading the summary lists of possible benefits and harms (box 9).
- Then, think about which of these are most likely to occur and are most important to you.
- Rate each feature (box 10) and then review your answers.

As you move towards a decision, you may want to list some of the pro's and con's of your options in the table in box 11.

9. Summary: Benefits & Harms

Possible Benefits

- Less pain, stiffness, swelling and fatigue
- Improve physical function
- Reduce progression of joint damage
- Prevent complications of RA
- Use less prednisone (steroids)

Possible Harms

- Fatigue or nausea the day you take it
- Serious infection like pneumonia
- Irritation or scarring of the liver
- Lung scarring
- Miscarriage or fetal damage

10. What Matters Most to Me

The table below lists some of the benefits and risks of therapy. With a pen, rate how much each of these matter to you if they were to occur.

	Most Important	Somewhat Important	Less Important
Improve pain and function			
Reduce joint damage			
Take less prednisone			
Infections			
Liver scarring			
Lung scarring			
Other side effect			
Inconvenience of treatment and monitoring			
Cost			

11. Moving Towards a Decision

Some people find that listing the pros and cons makes the decision clearer. Make notes in the table below.

Pros	My top options	Cons
	Continue current medications	
	Start methotrexate now	
	Think about other options	
	Defer choice for now	

12. Reflecting on your Decision

As you work towards making a decision about taking MTX, consider whether these statements are true for you:

- I know the options.
- I am informed about the benefits and harms of treatment.
- The doctor gave me a chance to be involved in the decision.
- I will have the support I need to get, take and monitor the safety of the new medicine.

If most or all of these statements are true for you, then you are on your way to a good decision.

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To learn more about methotrexate, scan the QR code or visit "patient decision aids" at www.mi-arthritis.com

DECISION AIDS AND OTHER TOOLS

Patient Decision Aids
West Michigan Rheumatology PLLC. Patient Decision Aids. Available at http://mi-arthritis.com/patient-decision-aids/.

Methotrexate Decision Aid
Martin RW. Adapted from Methotrexate Patient Decision Aid. Michigan State University Rheumatoid Arthritis Shared Decision Making Initiative. http://www.mi-arthritis.com/patient-decision-aids/methotrexate.html

Martin RW, Enck RD, Tellinghuisen DJ, Eggebeen AT, Birmingham JD, Head AJ. Comparison of the effects of a pharmaceutical industry decision guide and decision aids on patient choice to intensify therapy in rheumatoid arthritis. *Med Decis Making.* In press: March 2017.

American Academy of Dermatology Guidelines
Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2008;58(5):826-850.

National Psoriasis Foundation: Treat-to-Target
Armstrong AW, Siegel MP, Bagel J, et al. From the Medical Board of the National Psoriasis Foundation: Treatment targets for plaque psoriasis. *J Am Acad Dermatol.* 2017;76(2):290-298. doi: 10.1016/j.jaad.2016.10.017. PubMed PMID: 27908543.

Psoriatic Arthritis Screening Tools and Comparisons
Coates LC, Aslam T, Al Balushi F, et al. Comparison of three screening tools to detect psoriatic arthritis in patients with psoriasis (CONTEST study). *Br J Dermatol.* 2013;168(4):802-807.
Erratum in: *Br J Dermatol.* 2013;168(6):1376. Burden-The, E [corrected to Burden-Teh, Esther].
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POSTTEST QUESTIONS ON PSORIASIS WITH EXPLANATIONS

1. According to the American Academy of Dermatology psoriasis treatment guidelines, presence of which of the following is the first consideration in the treatment algorithm for psoriasis?

A. Cardiovascular comorbidities
B. Obesity
C. Psoriatic arthritis
D. Psoriasis severity
E. Tuberculosis

Correct answer: C. Psoriatic arthritis

Explanation: The 2008 AAD recommendation for treating psoriasis states that the first consideration in the treatment algorithm for psoriasis is to assess whether the patient has psoriatic arthritis. The presence or absence of psoriatic arthritis is the first branch in the decision tree. If psoriatic arthritis is present, the treatment will be mainly driven by psoriatic arthritis regardless of the degree of psoriasis involvement. That is, if the patient has active psoriatic arthritis and little or no psoriasis, the treatment of both psoriatic arthritis and psoriasis will be driven by psoriatic arthritis.

If the patient has no psoriatic arthritis involvement, then the degree of skin involvement becomes central to treatment selection. If psoriasis involves limited skin, it is usually treated with topical therapies or targeted phototherapy; more extensive psoriasis is treated with ultraviolet light therapy, oral systemic medications, or biologic therapies.

While cardiovascular comorbidities and obesities are important factors to consider, they are not the first assessment that will impact treatment options. Tuberculosis is important to monitor, especially in the setting of biologic use. However, the presence of tuberculosis is not the first assessment in the treatment algorithm for psoriasis.

2. According to the National Psoriasis Foundation (NPF) treat-to-target consensus, what is the target response that clinicians and patients should aim for three months after starting a new therapy and during maintenance therapy?

A. BSA ≤1%
B. BSA ≤3%
C. PASI 75
D. PASI 90
E. PASI 100

Correct answer: A. BSA ≤1%

Explanation: The NPF recommends that dermatology providers and patients work toward a target response of 1% or less body surface area involvement 3 months after initiation of a new treatment and that such response be maintained at 1% or less body surface area thereafter. In clinical practice, the clinician and the patient can use these treatment targets to monitor disease progression and evaluate patient response to treatment. If treatment goals are met at defined time intervals, the patient's disease state is thought to have satisfied the current, established US treatment targets for plaque psoriasis.

If the treatment goals are not met at defined time intervals, this provides opportunities for the clinician and patient to reevaluate the disease state and the existing treatment regimen. Not meeting the treatment target should prompt discussions between the provider and the patient about treatment options based on benefit-risk assessment. These discussions need to account for the multitude of clinical, socioeconomic, and behavioral factors that influence treatment outcomes and may necessitate treatment reevaluations. Clinicians and patients should discuss all relevant treatment options in order to maximize the likelihood of meeting treatment targets; the management options may include but are not limited to treatment escalation with the same treatment, combination therapies with other agents, or switching treatments. These discussions also need to take into account a continual assessment of patient satisfaction.

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GENERIC/TRADE NAME IDENTIFICATION GUIDE FOR DRUGS MENTIONED IN ACTIVITY

GENERIC NAME	TRADE NAME*
acitretin	Soriatane
adalimumab	HUMIRA
apremilast	Otezla
calcipotriene and betamethasone dipropionate	Taclonex
certolizumab	Cimzia
clobetasol cream	Temovate, Temovate E
clobetasol shampoo	Clobex
cyclosporine A	Neoral, Sandimmune, Restasis, Gengraf
etanercept	Enbrel
golimumab	Simponi

hydrocortisone cream	Ala-cort, Cortef Acetate, Dermacort, Hytone, Locoid, MiCort-HC, Pandel, Proctocort, U-cort, Westcort
infliximab	Remicade
ixekizumab	Taltz
leflunomide	Arava
methotrexate	Rasuvo, Trexall
naproxen	Aleve, Anaprox, Naprelan, Naprosyn, Ec-Naprosyn
secukinumab	Cosentyx
sulfasalazine	Azulfidine
triamcinolone cream	Aristocort, Aristocort A, Kenalog, Triacet, Triacort, Triderm
ustekinumab	Stelara

**Trade names are used for identification purposes only and do not imply endorsement.*