

Managing Musculoskeletal Symptoms in Patients With Psoriasis: Who Should Be in the Driver's Seat?

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ABSTRACT. The Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) 2024 annual meeting included a lively debate regarding the optimal management of musculoskeletal (MSK) symptoms in patients with psoriasis (PsO) at risk of or with early psoriatic arthritis (PsA). Drs. Fabian Proft and Laura Savage presented comprehensive, evidence-based retrospective arguments from the perspectives of rheumatology and dermatology. Proft advocated for rheumatologists to lead PsA management by highlighting the specialized training that allows rheumatologists to identify inflammatory diseases and use advanced imaging techniques to differentiate PsA from mechanical MSK conditions. In contrast, Savage emphasized the pivotal role of dermatologists, who often serve as the first healthcare providers (HCPs) to encounter emergent PsA in their patients with PsO. Dermatologists are increasingly aware of the importance of early detection and timely intervention, as well as of the new data that support the concept of “treating to intercept” in patients at risk of transition from PsO to PsA. Both experts highlighted systemic barriers hindering collaborative care and underscored the necessity of patient-centered approaches that effectively address skin and joint manifestations. This article summarizes the insightful debate, reinforcing the importance of a multidisciplinary approach to optimize patient outcomes with PsA.

Key Indexing Terms: arthralgia, dermatology, GRAPPA, psoriasis, psoriatic arthritis, rheumatology

Introduction

Psoriatic arthritis (PsA) affects a significant proportion of patients with psoriasis (PsO), manifesting in a heterogeneous array of symptoms, including joint pain, swelling, stiffness, and fatigue, all of which can result in functional limitation, disability, and impaired quality of life. Detection and adequate treatment at an early disease stage are essential to prevent irreversible damage. These issues raise the question of which medical specialty should take the lead in the early identification and management of musculoskeletal (MSK) symptoms in patients with PsO. Since most patients at risk of developing psoriatic disease (PsD) will have antecedent PsO, dermatologists are in a prime position to recognize the early symptoms of PsA. However, rheumatologists have specialized training in diagnosing and treating PsA and its diverse manifestations. This debate seeks to determine whether the responsibility for early detection and managing MSK symptoms in PsA should rest primarily with 1 specialty or whether a collaborative approach would be more effective.

Arguments from the rheumatologist's perspective

Dr. Fabian Proft emphasized the need for rheumatologists to lead the management of PsA due to their expertise in recognizing and diagnosing inflammatory diseases. PsA is often complex and challenging to diagnose, due to symptoms that can overlap with mechanical MSK issues. Rheumatologists possess specialized training to differentiate between inflammatory and noninflammatory conditions, such as mechanical back pain or overuse injuries.

Proft noted that advanced diagnostic tools, such as MSK ultrasound and magnetic resonance imaging (MRI), are essential for identifying subclinical inflammation that may not be evident during a physical examination. For example, Achilles tendon pain may initially suggest an inflammatory origin. However, this pain could result from mechanical strain, as seen in athletes such as marathon runners, or from subclinical arthritis, which might only be diagnosed by inflammatory sensitive imaging. Accurate imaging interpretation is crucial in making the correct and early diagnosis of PsA to initiate early treatment interventions while also minimizing the risk of overmedication by preventing unnecessary intensification of treatment regimens.

Moreover, rheumatologists play a vital role in determining the most appropriate conventional or biologic treatment based on the specific domains of PsO that are most affected in each patient. Rheumatologists' expertise enables them to tailor therapeutic approaches that optimize disease control while minimizing potential side effects.¹

Proft further highlighted that rheumatologists are not only adept at managing arthritis but are also trained in internal

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medicine; therefore, rheumatologists are equipped to address common comorbidities prevalent in patients with PsO, such as hypertension, obesity, and cardiovascular disease, among others.² These comorbidities often exacerbate the severity of PsO and PsA, so a comprehensive approach is critical to enhance long-term patient outcomes. In conclusion, although dermatologists are essential collaborators in the treatment process, Proft asserted that rheumatologists should lead the care team to ensure a cohesive, multidisciplinary approach to patient management.

Arguments from the dermatologist's perspective

Dr. Laura Savage countered that PsO often precedes PsA by several years, with 70% of patients with PsA first experiencing PsO.³ This circumstance places dermatologists in a unique position to take the lead in the early stages of PsD care as these individuals' primary point of contact. Delays of more than 6 months in diagnosing PsA have been associated with increased disability and structural joint damage,⁴ so early detection and timely intervention are crucial. Savage argued that dermatologists typically see patients with PsO during this early phase and could therefore play a pivotal role in preventing the progression of PsA.

A key point Savage raised was the importance of recognizing cutaneous signs—such as nail pitting or scalp involvement—that may indicate a higher risk of developing PsA. She emphasized that dermatologists must be mindful of the subclinical manifestations of PsA, such as enthesitis, which first develop without clinical signs and are therefore absent on physical examination. Research demonstrates that up to 40% of patients with PsO may exhibit signs of subclinical PsA when using MSK ultrasound criteria for active synovitis or enthesitis to identify subclinical arthritis.⁵ Savage underscored the utility of screening questionnaires like the Psoriasis Epidemiology Screening Tool (PEST)⁶ and the Toronto Psoriatic Arthritis Screen (ToPAS)⁷ in identifying patients who warrant referral for rheumatologic evaluation. Although acknowledging that these tools have suboptimal specificity for PsA, she further argued that such tools remain helpful to remind both clinician and patient to report any emergent MSK symptoms or signs. Savage noted that the widespread adoption of these tools has strained rheumatology services by increasing referral numbers, particularly in healthcare systems experiencing staffing shortages, such as those in the United Kingdom.⁸ Therefore, dermatologists can and should choose treatments with efficacy across all domains of PsD in an attempt to reduce the progression to and severity of PsA.

Following this, Savage discussed recent studies indicating that biologics targeting interleukin (IL)-12/23,⁹ IL-17, and tumor necrosis factor^{10,11} may prevent or delay the onset of PsA in patients with PsO. She argued that dermatologists are better positioned to initiate these treatments to minimize the risk of progression to more severe joint disease, especially in patients exhibiting risk factors such as nail pitting, nail dystrophy, intergluteal involvement, scalp disease, severe PsO, and obesity.^{12,13} Considering these factors, Savage proposed that dermatologists adopt a more proactive role in managing early symptoms of PsA, particularly in healthcare systems with prolonged referral times to rheumatologists.

Challenges in collaborative care and systemic limitations

Both speakers acknowledged the systemic challenges that complicate collaborative care in managing inflammatory diseases. Proft underscored the necessity of early intervention by dermatologists while emphasizing that rheumatologists are vital for accurate diagnosis and long-term management of conditions such as PsO. Conversely, Savage pointed out that healthcare systems often impose barriers that inhibit seamless collaboration. These barriers include excessive wait times for rheumatology referrals and funding restrictions for setting up multidisciplinary clinics. For instance, patients in the UK may wait over 1 year to consult a rheumatologist, resulting in delayed diagnoses and poorer health outcomes.⁸

The discussion also addressed the limitations inherent in current diagnostic tools. Although imaging techniques are crucial in the diagnostic process, they are only sometimes conclusive. Proft noted that not all bone marrow edema detected through MRI indicate inflammatory disease. For example, back pain occurring after childbirth may appear inflammatory on imaging but could primarily stem from mechanical stress. This situation underscores the necessity for careful clinical judgment in interpreting imaging results to avoid the risks of overdiagnosis, as indicated in studies evaluating dermatologist-centered screening tools.¹⁴

Additionally, dermatologists may prioritize treatments to alleviate skin symptoms, which are often the most visible and distressing symptoms for patients. Proft, however, emphasized that addressing joint involvement is equally critical to prevent long-term disability, highlighting the imperative for a collaborative approach. Savage reinforced the significance of personalized treatment strategies, arguing that dermatologists are well positioned to tailor biologic therapies based on patients' individual needs and to consider evidence-based guidelines such as those from Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA)¹⁵ and European Alliance of Associations for Rheumatology (EULAR),¹⁶ which address all domains.

The role of the patient in decision making

Both speakers concurred that the patient must remain central to the care team but recognized that patient preferences and treatment goals frequently diverge from those of clinicians. For example, whereas clinicians may concentrate on controlling joint inflammation to avert future disability, patients often prioritize treatments that improve visible skin symptoms and alleviate social stigmatization. This discrepancy underscores the necessity of shared decision making in creating treatment plans that harmonize medical priorities with patient expectations.

Both Savage and Proft emphasized the critical role of patient education in fostering collaboration. By enhancing patients' understanding of the importance of skin and joint management, HCPs can empower patients to actively participate in their own care. This approach encourages adherence to treatment plans and improves long-term health outcomes.

A collaborative future

The debate concluded with mutual agreement on the necessity

of a collaborative approach in managing MSK symptoms among patients with PsO. Whereas rheumatologists contribute expertise in diagnosing and managing inflammatory arthritis, dermatologists are often the first to consult on patients with PsO, manage the risk of transition to PsA, and initiate timely interventions. Both specialties must collaborate closely to provide comprehensive care, minimize delay, educate each other, and optimize patient outcomes. The importance of multidisciplinary teamwork in treating complex diseases, such as PsO and PsA, cannot be overstated. This discussion highlights the necessity for robust collaboration between these specialties.¹⁷

The session emphasized the value of multidisciplinary care models, including combined clinics and virtual interdisciplinary teams, in facilitating collaboration. Ultimately, the speakers reiterated that the patient should be at the heart of the care team, with HCPs from both specialties working in tandem to address the entire spectrum of the disease.

Conclusion

In summary, effectively managing PsA requires a collaborative approach that harnesses the strengths of both dermatologists and rheumatologists. Dermatologists often serve as patients' initial point of contact, making them vital for early detection and intervention. However, rheumatologists possess specialized expertise in diagnosing and managing inflammatory conditions, which is crucial for ensuring optimal long-term outcomes for patients. This partnership highlights the necessity for precise diagnostic tools when managing the complexities of PsA and its associated comorbidities. Recognizing the contributions of both rheumatologists and dermatologists is essential for improving patient care in PsA.

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ETHICS AND PATIENT CONSENT

Institutional review board approval and patient consent were not required.

PEER REVIEW

As part of the supplement series GRAPPA 2024, this report was reviewed internally and approved by the Guest Editors for integrity, accuracy, and consistency with scientific and ethical standards.

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