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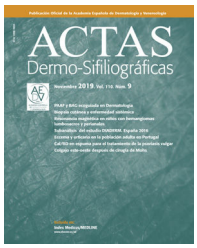

CASE AND RESEARCH LETTER

[Translated article] Ten-Year Experience in the Joint Dermatology–Rheumatology Approach to Patients With Psoriatic Arthritis

Diez años de experiencia en el abordaje conjunto, dermatología-reumatología, de los pacientes con artritis psoriásica

To the Editor,

Joint management of psoriatic arthritis (PsA) can be very effective in some patients, although there is limited evidence in the literature based on large series of clinical data.[1–9]

The aim of this article is to quantify the diagnostic and therapeutic changes experienced by patients due to their passage through the PAIDER clinic (Comprehensive Care Program for Dermatology and Rheumatology Patients) of a tertiary referral center specializing in the management of immunomediated diseases from June 29th, 2012 to July 4th, 2023. This study was approved by the center ethics committee. An episode was defined as the set of visits made by a patient until discharge. A complex patient was defined as one who exhibited psychiatric, cardiac, hepatic, or oncological disease, communication problems, or treatment-related issues. Statistical analysis was performed using SPSS 28 statistical software.

The sample consists of 970 episodes generated from 732 patients who attended the clinic on different occasions over the years. A total of 53.8% of these were women, and the mean age was 53.1 years. Disease duration, origin, reasons for consultation detailed by referring services, comorbidities, and the proportion of complex patients are shown in Tables 1 and 2.

The median number of visits per episode was 1, with a minimum of 0 (patient did not attend) and a maximum of 22 visits, interquartile range (IQR) = (1.0; 2.0).

Diagnostic changes showed an increase in favor of PsA. Among the patients' initial diagnoses, we found 381 (40.4%) with some type of PsA (axial, peripheral, or mixed) and 378 (40%) with psoriasis. Other diagnoses included rheumatoid arthritis (RA), ankylosing spondylitis (AS), SAPHO (synovitis, acne, pustulosis, hyperostosis, and osteitis), and hidradenitis suppurativa (HS). Patients with diagnoses of dactylitis, enthesitis, and/or mono-oligoarthritis were grouped under the same heading. Final diagnoses showed that 613 (65.2%) patients had some type of PsA (axial, peripheral, or mixed), 217 (23.1%) had psoriasis, and the rest showed other diagnoses (Table 1).

In 329 episodes of patients referred for dermatological evaluation, the diagnoses were psoriasis in 154 (46.8%), psoriatic onychopathy in 35 (10.6%), onychomycosis in 18 (5.5%), and others in 122 (37.1%). Of these, 187 (56.8%) served to confirm the suspicion of PsA. In 432 episodes of patients referred for rheumatological evaluation, the diagnoses were arthritis in 161 (37.3%), enthesitis in 39 (9%), dactylitis in 18 (4.2%), osteoarthritis in 93 (21.5%), crystalline arthritis in 20 (23.4%), and others in 101 (37.1%). Of these, 201 (46.5%) served to confirm the suspicion of PsA (Table 3).

Patients could present one or more diagnoses from the dermatologist or rheumatologist, in the same episode or successive episodes.

Changes in patient treatment occurred in 430 episodes (46.3%): treatment was initiated in 137 (14.7%), an additional treatment was added to the existing one in 102 (11%), a treatment change within the same therapeutic class was made in 93 (10%), a change of therapeutic class was made in 67 (7.2%), and treatment was stopped in 31 (3%).

As far as we know, this is the largest cohort of patients under joint follow-up in a dermatology–rheumatology clinic. The work describes that more than half experience a change in diagnosis and/or treatment. In our case, the number of new PsA cases increases among patients with an initial diagnosis of psoriasis and, to a lesser extent, with other musculoskeletal symptoms (oligoarthritis, dactylitis, enthesitis, etc.), likely because most of our patients first developed skin signs, as is common in the literature.[10]

Regarding treatment changes, our data show that these were performed in patients from rheumatology, indicating that the reason was mostly skin involvement. In addition, the approval processes for some drugs can take years of difference between specialties, often favoring dermatology,

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Table 1 Clinical and demographic characteristics of patients and initial and final diagnoses in the PAIDER clinic.

Clinical and demographic characteristics ($n = 970$)		
Age (mean, years)	53.1	
Female, n (%)	522	53.8
Male, n (%)	448	46.2
Mean disease duration – Dermatology (years)	16.8	
Mean disease duration – Rheumatology (years)	7.5	
Mean number of visits	2.2	
N (%)		
Referring department[a]		
Primary care	54	5.6
Dermatology	437	45.1
Rheumatology	434	44.7
Other specialties	45	4.6
Reason for referral	$n = 968$	
Diagnosis	430	44.4
Treatment	253	26.1
Both	285	29.4
Comorbidities	$n = 959$	53.1
Dyslipidemia	280	29.2
Diabetes mellitus	124	12.9
Hypertension	268	28
Hyperuricemia	105	11.1
Obesity (BMI > 30)	309	33.7
Smoking	249	26.3
Inflammatory bowel disease	39	18.9
Osteoporosis	99	18.7
Uveitis	32	3.5
Complexity	$n = 963$	54.3
Cardiac dysfunction	75	7.8
Hepatic dysfunction	178	18.5
Mental disorder	203	21.1
Neoplasm	78	8.1
Adverse effects	151	15.7
Paradoxical reaction	89	9.2
Communication problem	60	6.2

Diagnosis, *n* (%)	Initial	Final
Peripheral PsA	243 (25.7)	413 (43.9)
Axial PsA	45 (4.8)	79 (8.4)
Mixed PsA	93 (9.9)	121 (12.9)
Rheumatoid arthritis	24 (2.5)	27 (2.9)
Ankylosing spondylitis	48 (5.1)	24 (2.5)
SAPHO	11 (1.2)	12 (1.3)
Hidradenitis suppurativa	73 (0.3)	7 (0.7)
Dactylitis/enthesitis/mono-oligoarticular arthritis	99 (10.5)	41 (4.3)
Psoriasis	378 (40)	217 (23.1)

[a] Most referrals for diagnosis came from dermatology and rheumatology, while referrals for both reasons predominantly came from primary care and other specialties. Differences were statistically significant ($p < 0.001$).

which means that patients referred to these clinics may have a wider therapeutic arsenal available.

Limitations of this study include the fact that it is a single-center cohort, where patients from smaller hospitals may have been referred due to their complexity, which could lead to referral bias. However, this study includes a large sample size of consecutive patients, referred to a joint clinic and with prolonged follow-up. These results show that multidisciplinary care is associated with a change in diagnosis, fundamentally in favor of PsA and, linked to this, a change in treatment, with the aim of improving the prognosis of the disease.

Table 2 Reasons for consultation by referring service.

	Consultation for diagnosis, *n* (%)	Consultation for treatment, *n* (%)	Consultation for diagnosis and treatment, *n* (%)
Primary care	14 (25.9)	11 (20.4)	29 (53.7)
Dermatology	220 (50.3)	79 (18.1)	138 (31.6)
Rheumatology	191 (44.0)	152 (35.0)	91 (21.0)
Other hospital specialists	5 (11.6)	11 (25.5)	27 (62.7)

Data from 968 episodes.

Table 3 Dermatological and rheumatological diagnoses in the PAIDER clinic.

Dermatological disease in patients with arthritis *n* = 329, *n* (%)	
Psoriasis	154 (46.8)
Nail psoriasis	35 (10.6)
Onychomycosis	18 (5.5)
Others	122 (37.1)
Rheumatological disease in patients with psoriasis *n* = 432, *n* (%)	
Arthritis	161 (37.3)
Enthesitis	39 (9)
Dactylitis	18 (4.2)
Osteoarthritis	93 (21.5)
Gout	20 (23.4)
Others	101 (37.1)

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Conflicts of interest

A. López Ferrer has received payments or honoraria for educational events, support to attend meetings, and participation in advisory boards or consultancies from Abbvie, Almirall, Amgen, Boehringer Ingelheim, Bristol Myers Squibb Janssen, Eli Lilly, Leo Pharma, Novartis, UCB.

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