

# PSORIATIC ARTHRITIS



**NATIONAL  
PSORIASIS  
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# PSORIATIC ARTHRITIS

## WHAT IS PSORIASIS?

Psoriasis is a noncontagious, lifelong skin disease that has been diagnosed in more than 4.5 million adults in the United States. The most common form, plaque [pronounced plak] psoriasis, appears as raised, red lesions covered with a silvery white buildup of dead skin cells, called scale.

About 10 percent to 30 percent of people with psoriasis also develop psoriatic [sore-ee-AA-tic] arthritis, which causes pain, stiffness and swelling in and around the joints. The hands, feet, wrists, ankles, knees and lower back are most often affected by this type of arthritis.



*Three percent to 10 percent of the body affected by psoriasis is considered to be a moderate case. More than 10 percent is considered severe. The palm of the hand equals 1 percent of the skin. However, the severity of psoriasis is also measured by how psoriasis affects a person's quality of life. Psoriasis can have a serious impact even if it involves a small area, such as the palms of the hands or soles of the feet.*

To learn more about the types of psoriasis, contact the National Psoriasis Foundation and request *Specific Forms of Psoriasis*.

Psoriatic arthritis, a chronic inflammatory disease of the joints and connective tissue, was first described in 1818 by a French physician, Baron Jean Louis Alibert, but it was not until the 1950s that it was classified as distinct from other arthritic diseases.

Psoriatic arthritis is associated with psoriasis on the skin. Approximately 10 percent to 30 percent of people with psoriasis develop psoriatic arthritis, although it often may go undiagnosed, particularly in its milder forms. It can develop at any time, but for most people it appears between the ages of 30 and 50. Psoriatic arthritis seems to affect men at a slightly higher percentage than women.

Both genetic and environmental factors seem to be associated with the development of psoriatic arthritis. The immune system plays an important role.

Prompt diagnosis and treatment can relieve pain and inflammation and possibly help prevent progressive joint involvement and damage. Without treatment, psoriatic arthritis can potentially be disabling and crippling.

## THE DIAGNOSIS OF PSORIATIC ARTHRITIS

Psoriatic arthritis can develop slowly with mild symptoms, or it can develop quickly and be severe. Early recognition, diagnosis and treatment of psoriatic arthritis can help prevent or limit extensive joint damage that occurs in later stages of the disease.

Generally, one or more of the following symptoms appears:

- Generalized fatigue
- Tenderness, pain and swelling over tendons

- Swollen fingers and toes
- Stiffness, pain, throbbing, swelling and tenderness in one or more joints
- A reduced range of motion
- Morning stiffness and tiredness
- Nail changes—for example, the nail separates from the nail bed and/or becomes pitted and mimics fungus infections
- Redness and pain of the eye, such as conjunctivitis

The disease can develop in a joint after an injury and may mimic a cartilage tear. The diagnosis of psoriatic arthritis may sometimes be made only after repeated episodes. Muscle or joint pain can occur without joint inflammation (swelling). Tendonitis and bursitis (see shaded box on next page) may be prominent features. Swelling of the fingers and toes can suggest a “sausage-like” appearance, known as dactylitis. Psoriatic arthritis usually affects the distal joints (those closest to the nail) in fingers or toes. The lower back, wrists, knees or ankles also may be affected. (See a list of the five types of psoriatic arthritis on page 18.)

In 85 percent of patients, skin disease precedes joint disease. Therefore, it is important to tell your dermatologist if you have any aches and pains.

#### Tests to confirm the diagnosis

A person with psoriatic arthritis symptoms should talk to a doctor about diagnosis and treatment. Primary-care doctors or dermatologists can treat psoriatic arthritis, but psoriatic arthritis patients should consider seeing a rheumatologist, a doctor who specializes in arthritis.

#### OTHER COMMON ARTHRITIC DISEASES

- **Bursitis:** Inflammation of a bursa, a small sac of fluid that cushions and lubricates an area between tendon and bone or around a joint
- **Gout:** Disease caused by deposits of uric acid crystals in the joints; characterized by pain, swelling, redness, heat and stiffness in a joint or joints
- **Reactive arthritis:** Form of arthritis that, in addition to joints, can affect the eyes; typically is triggered by an infection
- **Rheumatoid arthritis:** Inflammation of membranes or tissues lining the joints; over time, the inflammation may destroy the joints
- **Tendonitis:** Inflammation of a tendon, a ropelike fiber that connects muscle to bone

There is no definitive test for psoriatic arthritis. The diagnosis is made mostly on a clinical basis and by a process of elimination. Medical history, physical examination, blood tests, MRIs and X-rays of the joints that have symptoms may be used to diagnose psoriatic arthritis. It is important to communicate your history of psoriasis to your doctor.

The symptoms of psoriatic arthritis are similar to those of three other arthritic diseases: rheumatoid arthritis, gout and reactive arthritis (see above). Rheumatoid arthritis generally involves joints symmetrically distributed on both sides of the body, and it may produce bumps under the skin that are not present in psoriatic arthritis. However, some forms of psoriatic arthritis look very similar. The simultaneous presence

of psoriasis on the skin and nail changes supports a diagnosis of psoriatic arthritis.

A certain antibody, called a rheumatoid factor, is normally present in rheumatoid arthritis. The rheumatoid factor is not usually found in the blood of psoriatic arthritis patients. A blood test for that antibody may help distinguish between the two diseases. A person can have rheumatoid arthritis *and* psoriatic arthritis, but that is rare. Many of the treatments for psoriatic arthritis and rheumatoid arthritis overlap.

Likewise, it is possible to have gout along with psoriasis and psoriatic arthritis. If you have an excruciatingly painful attack in a joint, particularly in the big toe, you may want to have a test for gout. Fluid drawn from the affected joint is examined to resolve the diagnosis of gout or psoriatic arthritis. Psoriatic arthritis patients are commonly misdiagnosed as having gout, because they often have elevated serum uric acid levels, which also can be caused by taking low-dose aspirin or by increased skin cell turnover. It is important to distinguish between the two forms of arthritis, because they may be treated with different medications.

In the very early stages of the disease, X-rays usually do not reveal signs of arthritis and may not help in making a diagnosis. In the later stages, X-rays may show changes that are characteristic of psoriatic arthritis but not found with other types of arthritis, such as the “pencil in cup” phenomenon where the end of the bone gets whittled down to a sharp point. However, most of the changes occur in the later stages of the disease.

## APPROACH TO TREATMENT

Treatment for psoriatic arthritis can relieve pain, reduce swelling, help keep joints working properly and

possibly prevent further tissue damage. Doctors will recommend treatments based on the type of psoriatic arthritis, its severity and an individual’s reaction to treatment.

Early diagnosis and treatment can help slow the disease and preserve function and range of motion. Some early indicators of severe disease include onset at a young age, having many joints involved and spinal involvement. A National Institutes of Health study reported that psoriasis skin flares may aggravate psoriatic arthritis. Good control of the skin may be valuable in the management of psoriatic arthritis.

### “LOCALIZED” MILD PSORIATIC ARTHRITIS (ONE OR TWO JOINTS)

Generally, localized psoriatic arthritis is mild and affects only one or two joints. A person may experience long periods with no symptoms. Psoriatic arthritis of this nature generally causes less deformity and long-term disability.

### “GENERALIZED” DISABLING PSORIATIC ARTHRITIS

In contrast, a portion of people who have three or more affected joints may have a higher risk of joint destruction and disability. When it is not relieved by anti-inflammatory drugs, more potent medications may be required. Some cases may require surgery and rehabilitation.

## TREATMENTS

Drugs for the treatment of psoriatic arthritis can be divided into several categories:

- Nonsteroidal anti-inflammatory drugs (NSAIDs), including over-the-counter

medications such as aspirin and ibuprofen as well as prescription products, help to decrease inflammation, joint pain and stiffness.

- Disease-modifying antirheumatic drugs (DMARDs) may relieve more severe symptoms and attempt to slow or stop joint and tissue damage and progression of psoriatic arthritis.
- Biologics, such as Enbrel, Humira and Remicade, are also considered DMARDs. They are highly selective agents that target specific internal events in the body that cause psoriasis and psoriatic arthritis.

The following treatments are not listed in any order of importance. Each case must be evaluated individually.

#### Aspirin and NSAIDs

Aspirin can help reduce pain, swelling and stiffness.

Prescription and nonprescription NSAIDs are effective for many people with psoriatic arthritis in controlling swelling, pain and morning stiffness, and in improving range of motion to joints. They can help reduce the limitations to daily activities often caused by arthritis.

A partial list includes:

- Clinoril (sulindac)
- Daypro (oxaprozin)
- Feldene (piroxicam)
- Indocin (indomethacin)
- Lodine (etodolac)
- Meclomen (meclofenamate)
- Mobic (meloxicam)

- Motrin, Advil (ibuprofen)
- Aleve, Anaprox, Naprelan, Naprosyn (naproxen sodium)
- Orudis (ketoprofen)
- Relafen (nabumetone)
- Tolectin (tolmetin sodium)
- Voltaren, Arthrotec (diclofenac)

Which NSAID you use is a decision to be made between you and your doctor. Ask for a discussion of side effects. NSAIDs and aspirin generally do not significantly alter psoriasis skin lesions. NSAIDs or aspirin can be sufficient treatment for many people over time. Acetaminophen (Tylenol) may be added for pain relief; however, Tylenol does not relieve inflammation. A doctor considers stronger medications when NSAIDs and aspirin fail to work and progression of the disease is evident.

#### COX-2 inhibitors

Some NSAIDs, when taken in high doses or over long periods of time, carry a risk of causing stomach problems, including ulcers and gastrointestinal bleeding. The risk depends on the strength of the NSAID and how long it is taken. Many people with psoriatic arthritis do not have problems with NSAID side effects.

NSAIDs called COX-2 inhibitors have proven to be less problematic for the stomach than other NSAIDs. The COX-2 inhibitor Celebrex has been approved for treating the symptoms of rheumatoid arthritis and osteoarthritis.

COX-2 inhibitors are not necessarily more effective at relieving pain and inflammation than regular NSAIDs. They are more expensive and have their own risks.

People with psoriatic arthritis who are interested in trying a COX-2 inhibitor should talk to their doctor.

In spring 2005, the U.S. Food and Drug Administration (FDA) announced new label requirements for both prescription and non-prescription NSAIDs, including Celebrex. In 2004, Vioxx was voluntarily removed from the market by its manufacturer, following concerns about its risk-versus-benefit profile. Bextra, another COX-2, was also voluntarily removed.

### DMARDs

#### **Antimalarials**

Antimalarial treatment, commonly used with success in rheumatoid arthritis, has sometimes been used to treat psoriatic arthritis.

Antimalarials are usually given as a pill once a day. It may take many months before seeing benefits. Side effects include vision changes (blurring, halos around lights, sensitivity to light), headache, dizziness, nausea and vomiting. Individuals taking an antimalarial should have eye examinations periodically. The most commonly prescribed antimalarial is Plaquenil.

Some antimalarials can cause skin psoriasis to get worse in some individuals. Talk to your doctor about the available antimalarial treatments and alternatives.

#### **Biologics**

##### *Enbrel*

The FDA approved the use of Enbrel (also known by its generic name etanercept) for patients with moderate to severe psoriatic arthritis in January 2002. Enbrel was originally approved for rheumatoid arthritis in 1998. Enbrel was FDA-approved in April 2004 for treating psoriasis.

Studies have also shown that Enbrel reduced the progression of joint damage for two years among psoriatic arthritis patients using the treatment.

Treatment with Enbrel consists of once- or twice-weekly, subcutaneous (under the skin) self-injections. The recommended dose for adult patients with psoriatic arthritis is 50 milligrams (mg) per week.

Enbrel works by suppressing a specific cellular “messenger” called tumor necrosis factor-alpha (TNF-alpha) that is involved in triggering inflammation.

For more information, request the Psoriasis Foundation educational booklet *Biologic Medications for Psoriasis & Psoriatic Arthritis* and the *Enbrel Biologic Fact Sheet*.

##### *Humira*

Humira (also known by its generic name adalimumab) is a biologic medication approved by the FDA in October 2005 to treat psoriatic arthritis. It is also approved to treat rheumatoid arthritis. It is being studied for the treatment of psoriasis, and some doctors are already prescribing it “off label” for this disease—a common and accepted medical practice.

Treatment of psoriatic arthritis with Humira consists of 40 mg, subcutaneous self-injections every other week.

Similar to Enbrel, Humira works by suppressing TNF-alpha.

For more information, request the Psoriasis Foundation educational booklet *Biologic Medications for Psoriasis & Psoriatic Arthritis* or the *Humira Biologic Fact Sheet*.

### ***Remicade***

Remicade (also known by its generic name infliximab) is a biologic medication approved in May 2005 by the FDA to treat psoriatic arthritis. Remicade is also approved for ankylosing spondylitis, ulcerative colitis, rheumatoid arthritis and Crohn's disease. It is being studied for the treatment of psoriasis, and some doctors are already prescribing it "off-label" for this disease.

Treatment of psoriatic arthritis with Remicade calls for patients to receive 5 mg per kilogram (kg) in three infusions in a doctor's office during the first six weeks of treatment. During an infusion, the patient sits in a chair or lies on an examination table and the medication is administered by IV in the course of about two hours. After the first three treatments, patients continue to receive Remicade infusions at regular intervals of eight weeks.

Similar to Enbrel and Humira, Remicade is an anti-TNF-alpha drug.

For more information, request the Psoriasis Foundation educational booklet *Biologic Medications for Psoriasis & Psoriatic Arthritis* or the *Remicade Biologic Fact Sheet*.

### **Corticosteroids**

Steroid medications taken orally (by mouth) are not generally recommended for long-term treatment of psoriatic arthritis, although in some circumstances they may be needed for relief of acute, severe joint inflammation and swelling. For the most part, large doses of steroids should be avoided because of the potential of making psoriasis lesions worse after the steroid treatment is discontinued.

Occasionally, severe forms of psoriasis, such as pustular psoriasis, may be provoked by the use of systemic steroids. However, selective low-dose steroid injections to inflamed joints, tendons and the area around joints can improve range of motion.

### **Cyclosporine**

Cyclosporine is an immunosuppressive drug that is FDA-approved for treating psoriasis, and it may produce improvement in psoriatic arthritis. Periodic blood tests are required due to the possibility of kidney damage. For more information, request the Psoriasis Foundation educational booklet *Systemic Medications: Internal Drugs for Moderate to Severe Psoriasis*.

### **Gold (chrysotherapy)**

Both injection of gold salts and administration of gold capsules by mouth have been reported to be effective in treating arthritis affecting the limbs, but not for treating arthritis of the spine. This treatment also has been reported to be beneficial for rheumatoid arthritis. Its use has declined somewhat in recent years as new treatments have been developed.

### **Imuran**

Imuran is an immunosuppressive drug approved for use in arthritis. It has potent anti-inflammatory effects. Skin lesions may respond to the treatment as well. Blood tests must be performed periodically.

### **Methotrexate**

Methotrexate, an immunosuppressive drug, is FDA-approved for treating psoriasis, and is used widely and successfully for treating psoriatic arthritis and rheumatoid arthritis. It can be effective at relieving the symptoms associated with psoriatic arthritis, and it may help prevent joint destruction.

Methotrexate usually is well tolerated in low doses. However, it potentially has a number of side effects and the long-term potential of damaging the liver. With careful management and dosage, the drug can be used safely for years by certain individuals. A person taking methotrexate should follow a doctor's instructions carefully. For more information, request the Psoriasis Foundation educational booklet *Systemic Medications: Internal Drugs for Moderate to Severe Psoriasis*.

### **PUVA**

PUVA is an acronym for psoralen (a light-sensitizing medication) combined with exposure to ultraviolet light A. It may improve psoriatic arthritis. Generally it is used in combination with other medications. It is not helpful in treating psoriatic arthritis of the spine.

PUVA is FDA-approved for the treatment of moderate to severe cases of psoriasis. It has few short-term side effects, but it has the long-term potential to increase the risk of skin cancers. For more information, request the Psoriasis Foundation educational booklet *Phototherapy: Light Treatment for Psoriasis*.

### **Retinoids**

Soriatane, a systemic retinoid FDA-approved for severe skin psoriasis, may be effective for some psoriatic arthritis patients. Oral retinoids carry the risk of birth defects in women of child-bearing potential, and the rare possibility of producing skeletal side effects with long-term use. For more information, request the Psoriasis Foundation educational booklet *Systemic Medications: Internal Drugs for Moderate to Severe Psoriasis*.

### **Sulfasalazine**

Sulfasalazine, a sulfa drug developed to treat inflammatory bowel diseases, is sometimes used for

psoriatic arthritis. Approximately one-third of psoriatic arthritis patients respond rapidly to this treatment (usually within four to eight weeks).

Sulfasalazine is a tablet given in evenly divided doses over a 24-hour period of time. Use of sulfasalazine is not recommended in patients with sulfa allergies, people with intestinal or urinary obstructions and individuals suffering from porphyria, a metabolism disease. A doctor may require regular blood tests while a patient is on sulfasalazine to monitor cell counts and liver enzymes. Possible side effects include nausea, rash, headache, abdominal pain, vomiting, fever and dizziness.

### **Development of new treatments**

People with psoriatic arthritis who are interested in trying one of these medications should talk to their doctor; a rheumatologist or dermatologist is most likely to be familiar with them. Some of these drugs may be very expensive, and insurance companies may not cover them because the FDA has not specifically approved them for psoriatic arthritis.

### **Arava**

Arava is a rheumatoid arthritis drug that has been prescribed off-label for the treatment of psoriatic arthritis. Arava, which comes in a pill, is beneficial to some people with psoriatic arthritis, according to recent medical studies.

### **Other treatment options**

#### **Diet and climate**

Manipulating the diet has not been found to be useful for psoriatic arthritis. However, a warm, stable climate may have some influence on the disease symptoms.

Various dietary supplements have been reported to help some people with arthritis. For more information

on glucosamine, chondroitin, methylsulfonylmethane (MSM) and S-adenosylmethionine (SAM-e), request the Psoriasis Foundation educational booklet *Alternative Approaches*.

### **Exercise**

Exercise is essential to preserve strength and maintain range of motion. Isometric exercise is often prescribed because it appears to be less damaging to inflamed joints. A range of motion program should be coupled with a stretching program.

Pain lasting for two hours after exercise is a sign of overdoing it or of choosing the wrong exercise. Stretching exercises are part of the treatment, and are especially useful for spinal arthritis.

### **Rehabilitation**

Physical therapy and rehabilitation are used to maximize the function of an arthritic joint. Rehabilitation interventions frequently involve general aerobic conditioning to help maintain cardiovascular fitness, proper positioning of joints to assist with mobility and coping strategies to help individuals continue or return to work.

### **Splints**

In addition to exercise and local pain therapy, a splint may be used to support a joint in a position to improve function and relieve pain and swelling.

### **Surgery**

Surgery can help people whose joint destruction limits motion and function despite medical treatment.

### **Other tips**

Heat, cold and rest are used to relieve pain. Immobilizing an inflamed swollen area while using

cold packs can reduce the swelling and improve range of motion. Follow your doctor's directions.

Osteoporosis, the progressive deterioration of bone density, may occur with arthritis—especially with psoriatic spondylitis (inflammation of the spine)—and fractures from minor trauma may occur. Prolonged use of corticosteroids and inactivity can potentially induce osteoporosis. Calcium supplements along with vitamin D help prevent it in affected individuals. In addition, calcitonin and biphosphonates (prescription drugs that affect calcium metabolism and bone formation) may be used. Avoid prolonged bed rest unless directed by a doctor.

### **HELP FOR FEET**

Foot and ankle arthritis is common in psoriatic arthritis. It can cause a great deal of pain. “Sausage” toes are swollen, painful and do not fit into standard shoes. A shoe with a high toe box or an extra-depth shoe can provide relief. Shoe inserts, heel cups and/or pads also may be used in shoes to relieve pain from heel spurs and arthritis in other areas of the foot. A podiatrist, a doctor who specializes in the feet, may be able to provide additional help for people with psoriatic arthritis of the feet and ankles.

### **OTHER RESOURCES**

More information on psoriatic arthritis of the spinal column (spondylitis) is available from the Spondylitis Association of America. Call 800.777.8189 or visit [www.spondylitis.org](http://www.spondylitis.org)

The Arthritis Foundation offers exercise programs and self-help manuals. Call 800.568.4045 or visit [www.arthritis.org](http://www.arthritis.org) Information on local programs can be obtained by contacting a local Arthritis Foundation chapter.

## THE FIVE TYPES OF PSORIATIC ARTHRITIS

**Symmetric arthritis** is much like rheumatoid arthritis but generally milder with less deformity. It usually affects multiple symmetric pairs of joints (occurs in the same joints on both sides of the body) and can be disabling.

**Asymmetric arthritis** can involve a few or many joints and does not occur in the same joints on both sides of the body. It can affect any joint, such as the knee, hip, ankle or wrist. The hands and feet may have enlarged “sausage” digits. The joints may also be warm, tender and red. Individuals may experience periodic joint pain which is usually responsive to medical therapy. This form is generally mild, although some people might develop disabling disease.

**Distal interphalangeal predominant (DIP)** although the “classic” type, occurs in only about 5 percent of people with psoriatic arthritis. Primarily, it involves the distal joints of the fingers and toes (the joint closest to the nail). Sometimes it is confused with osteoarthritis, but nail changes are usually prominent.

**Spondylitis** is inflammation of the the spinal column. In about 5 percent of individuals with psoriatic arthritis, spondylitis is the predominant symptom. Inflammation with stiffness of the neck, lower back, sacroiliac or spinal vertebrae are common symptoms in a larger number of patients, making motion painful and difficult. Peripheral disease can be present in the hands, arms, hips, legs and feet.

**Arthritis mutilans** is a severe, deforming and destructive arthritis that affects fewer than 5 percent of people with psoriatic arthritis. It principally affects the small joints of the hands and feet, though there is frequently associated neck or lower back pain.

## STAY INFORMED AND INVOLVED. TAKE ACTION.

The National Psoriasis Foundation is committed to improving the lives of people with psoriasis and psoriatic arthritis. Join the Psoriasis Foundation to make a difference in the lives of millions of people with these diseases. Donate today!

Call **800.723.9166**

Visit **[www.psoriasis.org](http://www.psoriasis.org)**

E-mail **[getinfo@psoriasis.org](mailto:getinfo@psoriasis.org)**

### The following educational materials are available from the National Psoriasis Foundation:

- Alternative Approaches
- Biologic Medications for Psoriasis & Psoriatic Arthritis
- Conception, Pregnancy & Psoriasis
- Genital Psoriasis
- Phototherapy: Light Treatment for Psoriasis
- Psoriasis: How It Makes You Feel
- Psoriasis Research: Progress & Promise
- Psoriasis on Specific Skin Sites
- Psoriatic Arthritis
- Scalp Psoriasis
- Specific Forms of Psoriasis
- Steroids
- Sun & Water Therapy
- Systemic Medications: Internal Drugs for Moderate to Severe Psoriasis
- Topical Treatments for Psoriasis
- You & Your Doctor: Things to Consider
- Your Diet & Psoriasis

*More updated information may be available at*  
**[www.psoriasis.org](http://www.psoriasis.org)**

# PSORIATIC ARTHRITIS

## MISSION STATEMENT

Our mission is to improve the quality of life of people who have psoriasis and psoriatic arthritis. Through education and advocacy, we promote awareness and understanding, ensure access to treatment, and support research that will lead to effective management and, ultimately, a cure.

The National Psoriasis Foundation, a charitable 501(c)(3) organization, depends on your tax-deductible donations to support more than 5 million people affected by psoriasis and/or psoriatic arthritis. The Psoriasis Foundation is governed by a volunteer Board of Trustees and is advised on medical issues by a volunteer Medical Board. For more information, or to obtain a copy of the Foundation's Annual Report, call 800.723.9166.

National Psoriasis Foundation educational materials are reviewed by members of our Medical Board and are not intended to replace the counsel of a physician. The Psoriasis Foundation does not endorse any medications, products or treatments for psoriasis or psoriatic arthritis and advises you to consult a physician before initiating any treatment.

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