Transcript Details
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Overcoming Obstacles to Psoriatic Arthritis Treatment

Announcer:
This is ReachMD. Welcome to this special series, *Beyond Skin Deep: Impacts of Psoriatic Arthritis,* sponsored by Lilly.

Mr. Nacinovich:
Patients with untreated psoriatic arthritis become susceptible to a range of negative impacts to quality of life, such as physical disabilities, chronic pain, psychosocial stresses, and even increased risk of heart disease. For these reasons and more, it's essential that we address the barriers keeping patients from receiving treatments that minimize these inflammatory changes. Understanding those barriers and what we can do to overcome them will be the focus of today's discussion.

Coming to you from the ReachMD studios, this is *Beyond Skin Deep: Impacts of Psoriatic Arthritis*. I'm Mario Nacinovich, and joining me is Dr. Robin Dore, Clinical Professor of Medicine at the David Geffen School of Medicine at UCLA in Los Angeles, California.

Welcome to the program, Dr. Dore.

Dr. Dore:
Thank you very much.

Mr. Nacinovich:
To start off, let's get a better idea of the signs and symptoms that patients with psoriatic arthritis can present with. And I'm especially interested in less common presentations that can go under the diagnostic radar for a long time if one doesn't know what to look for.

Dr. Dore:
As suggested by the name psoriatic arthritis, these patients tend to have both arthritis and skin disease, but they don't necessarily have to occur at the same time. The joints that are involved can typically be the hands and feet, but some patients will only present with back pain, and at times this can delay the diagnosis because the primary care clinician might think that this patient has mechanical back pain and not realize that it's a manifestation of their psoriatic arthritis. And the patients themselves certainly don't realize that there is a relationship between what's going on in their skin and other parts of their body, and that can be a significant problem because what's going on in their skin is a reflection of increased level of inflammation, which, as you said, can be associated with an increased risk of heart disease, morbidity and mortality.

Another less common presentation actually is chronic plantar fasciitis, and I get referrals from podiatrists where patients just have recalcitrant plantar fasciitis and they were not aware that the patient had any psoriasis, but when I'm examining the patient, they might have a little bit in their inner ear canal, and they might have a little bit of scalp in their umbilicus area, and then some of the patients only have nail involvement so that there might be back pain; and again, the primary care clinician might not put two and two together that they are related.

Mr. Nacinovich:
Now, beyond the recognition issues that come into play here, are there other diagnostic barriers that can delay or even misdiagnose patients indefinitely?

Dr. Dore:
There's no question about that, because in rheumatology, what we always look at are things like the sedimentation rate and an elevated C-reactive protein, and what we see in these patients with psoriatic arthritis, only about up to 40% can have an elevated sedimentation rate. And when we're looking at an elevated C-reactive protein that's a better indicator of age-related inflammation, we see that that is

only seen in about 52% compared to 14% of normal controls, so the 2 labs that we use to suggest inflammation can frequently be normal in these patients. There's also a genetic marker, the HLA-B27, that we use when we're looking at the seronegative spondyloarthropathies, and that's only present in 17–34% of these patients, so it really takes a trained historian to really go through and get the history of inflammatory joints or inflammatory back pain.

Mr. Nacinovich:
But to clarify, even if patients remain undiagnosed or misdiagnosed, does symptom management alone make a sizable impact for them?

Dr. Dore:
It might make a difference to them cosmetically, and I have many patients with psoriatic arthritis who are much more interested in getting their psoriasis under control rather than their joint pain, but as a rheumatologist I'm very concerned that they can have irreversible joint damage based on x-rays, or they can end up with, what you had already mentioned, with increased vascular disease. These patients have an increased incidence of type 2 diabetes and heart disease, so we don't just want to treat the symptoms. We want to make certain that we get the inflammation control, whether it's in their skin, their joints, their back or in other parts of their body.

Mr. Nacinovich:
And staying on the topic of symptom management, Dr. Dore, what are some methods you've adopted to get ahead of patients' symptoms, whether they be rheumatologic or dermatologic?

Dr. Dore:
That can certainly be tricky. What I tend to use is the RAPID3, which uses patient-reported outcomes. These are things that the patients might not think about but talk about, like their sleep, so I can determine if, perhaps, the pain is keeping them awake at night. And we know if patients who have inflammation have problems with their sleep. To try to proactively discuss these symptoms that they're having that could have an impact on their risk of inflammatory disorders. The RAPID3 also looks at their ability to function, so this is something that the patients fill out while they're waiting to see me. They can fill it out online on my patient portal so when they come in for the visit, I can see that, "Oh, they're having these other symptoms that they haven't told me about before, and I need to delve further into that."

Mr. Nacinovich:
For those just tuning in, you're listening to ReachMD, and this is *Beyond Skin Deep: Impacts of Psoriatic Arthritis*. I'm Mario Nacinovich, and today I'm speaking with Dr. Robin Dore about addressing barriers to treatment for patients with psoriatic arthritis.

So, Dr. Dore, let's dig deeper into the therapeutic space and understand some of the issues that crop up for patients when initiating and maintaining treatments, respectively. Starting with the initiation phases, what kinds of obstacles do you and your patients most commonly encounter?

Dr. Dore:
The first obstacle is the patients don't understand why they can't just take an NSAID for their joint disease and something topical for their psoriasis. So again, I have to discuss with them the importance of getting the inflammation under control as well as controlling their comorbid conditions that we've already talked about, such as the diabetes and heart disease. Once we've sort of crossed that barrier, then the question is in talking to the patient: Do they prefer a pill? Do they prefer a self-injection? Do they prefer an infusion? And then taking what they prefer and working with their insurance companies. Unfortunately, at times, what the patient prefers is not what their insurance company wants, and so it's a matter of filling out prior authorization forms and trying to justify what the patient wants and what I feel is the best treatment for them.

Patients with just skin and joints, again, don't understand the severity of the condition, and so, when you are talking to them about medications that might increase their risk of infection or that we have to follow laboratory studies for some of these medications, they, are very hesitant to take something that has potentially some significant side effects without understanding the benefit that this poses to their overall quality of life.

In dealing with those prior authorizations, I have to be familiar with what the insurance company usually requires to really save my time and get the medication to the patient as quickly as possible. Before going to a small molecule and biologic therapy, most of the insurance companies require that a patient has failed methotrexate. Many patients are fearful of methotrexate and don't want to take it, so then I have to explain to the insurance company why this patient isn't a candidate for methotrexate, maybe because they are a woman of childbearing age, maybe they're overweight, as we typically see in these patients with psoriatic arthritis, and might have fatty liver so aren't candidates for methotrexate. Hopefully, this will take a week, but it can take up to a month, and it can be very frustrating for the patients, because once the patients make that decision that they are ready to start medicine, then they want to get on it right away, so it's really a discussion between myself, the patients, the insurance company, and then trying to get that medication to the

patient as quickly as possible.

The other problem is that the patients—especially if the skin is their primary driver, even though they have psoriatic arthritis— want to stop the medicine as soon as the skin is better, and so then we're having to talk to them about the importance of continuing on their medication as well.

Mr. Nacinovich:
Dr. Dore, you discussed some of the access barriers you've encountered that keep patients from receiving the treatments. Are there any best practices to counter those barriers?

Dr. Dore:
To begin with, again, it's really discussing with the patient what their insurance company requires and then knowing what those requirements are and having that discussion with the patient, and at that point the patient often can be their best advocate in talking with their insurer. One of my patients whose company is self-insured actually has an advocate that works with the patient to try to get the medicine from their insurance company as quickly as possible, and I would love if all my patients had advocates with their insurance so that it would be less work for me. It's time-consuming, but it's what we need to do in order to get the patient the best medication for them.

Mr. Nacinovich:
Let's shift to maintenance therapies and consider the issues of patient adherence and loss of follow-up, respectively. Are these common problems for patients with psoriatic arthritis?

Dr. Dore:
With psoriatic arthritis the symptoms can come and go, unlike some other types of arthritis. If their common presentation is inflammatory back pain, as soon as the back pain gets better or as soon as their psoriasis gets better, they want to stop their medicine. So there's a tremendous amount of patient education that has to happen during the visits in explaining to the patients that this is a chronic disease, it's inflammation throughout their body, and even once they are feeling better, the inflammation can still be present. So, if they do have an elevated sed rate or elevated C-reactive protein, I'm monitoring that to show them that we're keeping the inflammation under control with the medication.

What I wish we had was what we have in rheumatoid arthritis called a Vectra DA. That's a blood test that can monitor disease activity and help us in addition to what I find on examination and what the patient tells me if there's control of their disease. We don't have that yet for psoriatic arthritis. But that would be very helpful for the patient because it can give them a number. If the patients do have an elevated sedimentation rate or C-reactive protein, that's much easier because the patients, they like numbers. They know what their cholesterol is, and they know what their hemoglobin A1c is, and they like that number—if we can use that in treating these patients in order to improve their compliance and adherence.

Mr. Nacinovich:
Before we close, Dr. Dore, let's look ahead to some of the developments in the pipeline for treatments, outcome measures or standards of practice around psoriatic arthritis. Is there anything up-and-coming from any of those territories that you're excited about?

Dr. Dore:
The nice thing about practicing rheumatology now with regards to psoriatic arthritis is we're getting new medications all the time, and to the patient and to me, that's very exciting, because I have some patients who have had psoriatic arthritis for over 30 years, and so, many of them have run through the medications that are currently available on the market.

And then what we also see is that there are many other medicines in the pipeline and a couple even with a new mechanism of action. So, if we look at what's currently available for treating psoriatic arthritis, we have lots of medicines available, even a couple oral medicines. But most of my patients really prefer oral medicines, so if there's something that—if there are oral medicines that are coming up or if they prefer an injection where it's less frequent injections, those are things that we're seeing available as well. There are a couple medicines right now that are already approved for treating psoriasis but aren't yet approved for treating psoriatic arthritis, and so I'm really looking forward to those too because, again, an option for treating patients.

So you're looking at these new medicines—some were in phase 3, some were in phase 2—but I would anticipate that in the next year we should have 3 or 4 new medications and a couple even with new mechanism of action. In rheumatology, what we like to do is to use one class of drugs. If that isn't effective for treating the patient, then switch to a different class of medication, and we should have, as I mentioned, medicines with even new mechanisms of action to sort of give the patients hope.

Right now I have this guy who has psoriatic arthritis who's failed everything, just started him on a new medication that just came out, and his hope is that if this doesn't work, that there are still other medications coming out. These patients, because of the extent often of their

skin involvement, of their joint disease, can become really depressed because there's no hope, and so knowing that there are new medications on the market, new mechanisms of action, both pills and injection, really gives them some hope for the future and me as their treating rheumatologist as well.

Mr. Nacinovich:
Well, our primary focus may have been on the problems and barriers entrenched in this field, but you've definitely given us a lot to look forward to with improving our approach for these patients. I want to thank my guest, Dr. Robin Dore, for joining me to share her thoughts on how we can better address challenges in the management of psoriatic arthritis.

Dr. Dore, it was great having you on the program today.

Dr. Dore:
Thank you very much for asking me. I hope this information was helpful.

Announcer:
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