The management of psoriatic arthritis (PsA) begins with education. Each consultation provides an opportunity for the physician to counsel the patient and family about the disease and its clinical course that is unique to that individual. It is a chance for the patient and family to learn and adapt. There are also a variety of further ways for instruction to occur. In addition to regional educational symposia, there exists an international network of service organizations, focused on education and advocacy for patients with psoriasis and PsA, which are accessible by phone, mail, and the internet. Examples include the National Psoriasis Foundation and Arthritis Foundation in the USA, and a variety of similar organizations in other parts of the world.

There are numerous non-medication therapeutic approaches. Helping a patient cope with pain, physical dysfunction, and the embarrassment of skin lesions is achieved through counseling and understanding. It is helpful to encourage a balance of work, family, leisure, exercise, and rest. Proper sleep quality is important. Exercise that maintains muscle tone and flexibility, without stressing joints, can be taught. Physical and occupational therapists can manage specific physical therapies and provide assistive devices such as splints, orthotics, and walking aids. Interdisciplinary communication between healthcare providers is important.

Numerous medication approaches can be helpful to achieve the goals of reduction of pain and stiffness, improvement of function, energy, and quality of life, inhibition of disease progression in the joints, and amelioration or clearing of skin lesions. Treatment of skin diseases is discussed in Chapter 8, Treatment of Psoriasis. Most patients who develop PsA have already been working with a dermatologist and primary care provider for the treatment of the skin lesions of psoriasis, which usually precedes the development of PsA. This may have consisted of topical treatments or ultraviolet light. If the patient has been on systemic medications, such as methotrexate or a biologic, it is possible that this will have modified the initial appearance or severity of PsA. When pain in joints (arthritis) or at tendon or ligament insertion sites (enthesitis) begins, it is very common for the patient to try an over-the-counter remedy such as acetaminophen or a non-steroidal anti-inflammatory drug (NSAID). In some cases, if there are few joints involved and the disease is mild, this may prove to be adequate. On occasion, if one or two joints are inflamed out of proportion to others, intra-articular injection with a corticosteroid may be helpful to quiet the joint down. In patients with moderate-to-severe disease, including those who do not respond adequately to NSAID or injection therapy, it will be appropriate to use a disease-modifying antirheumatic drug (DMARD). Examples include the older drugs, which non-specifically diminish immunologic over-reactivity, such as methotrexate, sulfasalazine, and cyclosporine. Whereas a pattern of drug rotation has been a common approach in psoriasis treatment in order to avoid ‘wearing off’ of effect and avoiding toxicity, this is not an appropriate paradigm in arthritis management, where progressive joint destruction can occur without continuous therapy. There has been scant
controlled trial evidence for the efficacy of these medications in PsA (although there is substantial evidence in rheumatoid arthritis [RA]), but, nonetheless, they have been used widely, particularly methotrexate. The drawback of these medications in some patients is that they may not be fully successful, their efficacy may diminish over time, and, in some individuals, they may yield unacceptable side effects, such as the potential for hepatotoxicity with methotrexate.

An increased understanding of the specific cellular pathophysiology of the inflammatory immunologic conditions, such as RA and psoriasis, has led to the development of targeted treatments known as biologics. These are proteins biologically engineered to interact with specific cellular receptors or messengers to inhibit or downregulate overly reactive immune functions. When employed in chronic inflammatory conditions, they have proved highly efficacious in the majority of patients in both the joints and skin. Side effects do occur, such as the potential for increased infection, but with appropriate surveillance, they have so far proven to be relatively safe. Furthermore, for the first time in PsA, there is evidence that at least one class of these medications, the anti-tumor necrosis factor agents, can inhibit the progression of PsA as measured by X-ray changes over time. It is likely that this will be shown with other classes of biologics as well. This is a key goal for patients with more severe and advancing disease.

Coupled with the development of new therapeutic options has come an increased interest in developing and utilizing outcome measures in clinical trials that can accurately measure the efficacy of these medications. This is particularly important to know as we use health resources to pay for medications and monitor for adverse effects. In addition to measuring easily quantifiable benefits, such as reduction in tender and swollen joint count as well as skin lesions, it is important to measure less easily assessed benefits, such as a decrease in fatigue, improvement of quality of life, and socioeconomic benefits to the society of improved health in an individual. The measures used in PsA trials are described in the accompanying figures. International consortia of PsA and psoriasis researchers, such as the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA), are actively working on these measures. Other work of this group includes the development of long-term clinical registries to track disease natural history, the impacts of therapy, and treatment side effects.

At the present time, we have a growing number of therapeutic agents that can bring us closer to our goal of decreasing debilitating pain and stiffness, improving function and quality of life, improving skin disease, and inhibiting joint destruction. We have more tools that can be used either singularly or in combination to achieve optimal benefit at various stages of disease. Measuring benefit of these therapies is an evolving science. The accompanying figures detail these options. Combining use of these agents with increased understanding of the disease and increased public awareness through education provides great promise for the treatment of patients with PsA and psoriasis.