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skin 'n' bones connection

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Dear Reader

One question that many people with psoriasis and psoriatic arthritis ask is: Can this condition be cured? Unfortunately, it can't at the moment, but some research is finding answers that may at least lead to more effective treatments. On page 3 there is a report on a study which is looking into genetic variants in psoriasis, which shows promise for the future.

On page 7, there is a report on a research trial, in which you could get involved. It is led by Dr Philip Helliwell at the University of Leeds, along with colleagues in Bradford, York, Newcastle, London and Bath.

Until there is a cure, the best way forward is to keep positive and manage your condition; on the centre pages (10 &11) there is an article that includes tips to get the most out of your psoriasis treatments.

Once again we are grateful to the contributors and various media outlets that provide us with the content for this magazine.

We also will continue to welcome articles and letters for inclusion. If you have access to the internet you might like to consider submitting an article for publication via our website: www.papaa.org

Managing editor

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Cover Photo:
DNA strand.

A team of researchers led by Professor Richard Trembath, Head of King's College London's Division of genetics and molecular medicine and director of the National Institute for Health Research (NIHR) Biomedical Research Centres (BRC), in collaboration with Professor Jonathan Barker, carried out a genome-wide association study of 2,622 patients with psoriasis and 5,667 healthy individuals from across the UK. The results were replicated with European studies involving more than 9,000 individuals. The study identified six regions of the genome newly associated with psoriasis, and found evidence for an interaction between two associated regions: HLA-C and ERAP1.

This is the first report of an interaction observed within a genome-wide association study into psoriasis. An interaction is when the risks for the disease occur at two independent regions, but when present together lead to a substantial increase in the chance of developing the disease.

Professor Richard Trembath, explained: 'We need to understand why psoriasis occurs and why individuals are more likely to develop the condition. Through our research, and other studies now coming through, the research community has identified genes that play a role in people's susceptibility to the condition.

'Our genetics studies in psoriasis are the largest worldwide, and because of their strong statistical power, have identified many new genetic loci linked to psoriasis. As a result we now have a much clearer view of what causes this chronic common distressing disease.

'The research work provides evidence of possible targets for future treatment strategies and this information is an important basis for further studies.'

This research is part of the Wellcome Trust Case Control Consortium 2 genome-wide association studies funded in 2008 into 13 different conditions: ankylosing spondylitis, Barrett's oesophagus and oesophageal adenocarcinoma, glaucoma, ischaemic stroke, multiple sclerosis, pre-eclampsia, Parkinson's disease, psychosis endophenotypes, psoriasis, schizophrenia, ulcerative colitis and visceral leishmaniasis.

About the researchers:

The comprehensive Biomedical Research Centre at Guy's and St Thomas' NHS Foundation Trust and King's College London, is one of five NIHR comprehensive BRC in the UK. With its strong focus on 'translational research' across seven research themes and a number of cross-cutting disciplines, it aims to take advances in basic medical research out of the laboratory and into the clinical setting to benefit patients at the earliest opportunity. Access to the uniquely diverse patient population of London and the southeast enables it to drive forward research into a wide range of diseases and medical conditions.

Website: **www.biomedicalresearchcentre.org**

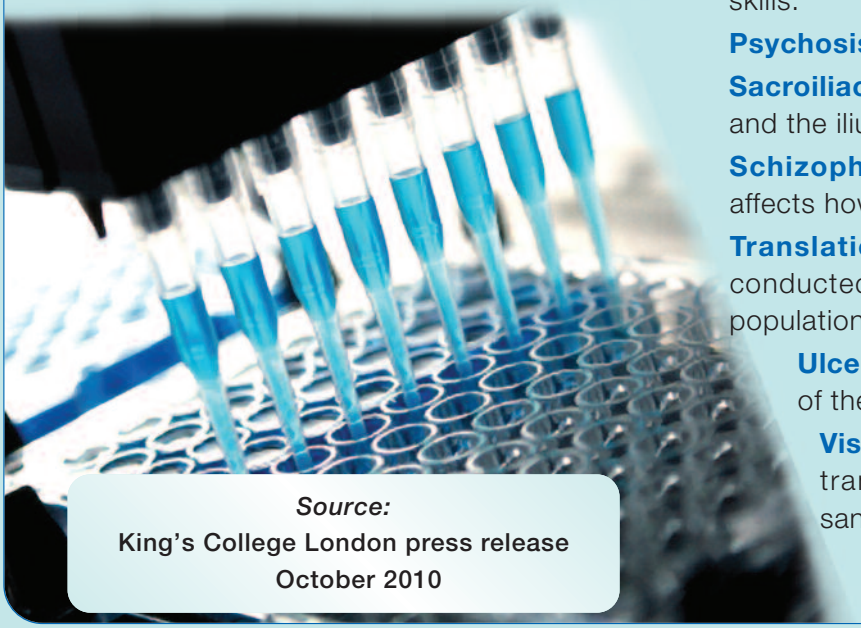
Genes link to psoriasis

King's College London is one of the top 25 universities in the world (2010 QS international world rankings), The Sunday Times University of the Year 2010/11 and the fourth oldest in England. A research-led university based in the heart of London, King's has nearly 23,000 students (of whom more than 8,600 are graduate students) from nearly 140 countries, and some 5,500 employees. King's is in the second phase of a £1 billion redevelopment programme which is transforming its estate.

Guy's and St Thomas' and King's College London are part of King's Health Partners Academic Health Sciences Centre (AHSC), a pioneering collaboration between King's College London, and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts.

King's Health Partners is one of only five AHSCs in the UK and brings together an unrivalled range and depth of clinical and research expertise, spanning both physical and mental health. Their combined strengths will drive improvements in care so that patients benefit from breakthroughs in medical science and receive leading edge treatment at the earliest possible opportunity.

For more information, visit:
www.kingshealthpartners.org



Source:
King's College London press release
October 2010

Glossary of terminology

Ankylosing spondylitis – inflammatory arthritis that affects back, hips and sacroiliac.

Barrett's oesophagus – acid reflux causes changes in the cells lining the lower part of the oesophagus.

Cross-cutting disciplines – more than one medical area.

DNA – deoxyribonucleic acid is a nucleic acid that contains the genetic instructions/code in the development of organisms.

Endophenotypes – a psychiatric concept to divide behavioural symptoms with genetic connections.

ERAP1 – name of the location of the gene associated with psoriasis within the genome.

Glaucoma – disease of the optic nerve.

HLA-C – name of the location of the gene associated with psoriasis within the genome.

Ischaemic stroke – blockage of the blood supply to part of the brain by a blood clot or fat leading to dysfunction of the brain tissue in that area.

Loci – the specific location of a gene genome – entire heredity information.

Multiple sclerosis – inflammatory disease of the brain and spinal cord.

Oesophageal adenocarcinoma – type of cancer of the esophogus.

Pre-eclampsia – a medical condition in which hypertension arises in pregnancy.

Parkinson's disease – a degenerative disorder of the central nervous system that impairs motor skills.

Psychosis – abnormal condition of the mind.

Sacroiliac joint – bony pelvis between the sacrum and the ilium of the pelvis.

Schizophrenia – a serious mental illness that affects how a person thinks, feels, and behaves.

Translational research – scientific research conducted with the view of being applied to the population and translated into medical practice.

Ulcerative colitis – a superficial inflammation of the large intestine, not caused by bacteria.

Visceral leishmaniasis – a deadly disease transmitted via the bite of an infected sand fly.

In the last issue of Skin 'n' Bones Connection we reported on the events being organised by the department of rheumatology at Portsmouth Hospitals NHS Trust.

The most recent ***day-to-day living well with arthritis and connective tissue diseases*** meeting took place in October. Nearly 600 delegates attending the event, the organisers were pleased that the work undertaken leading up to this meeting received such excellent patient feedback.

PAPAA had a stand and it was nice to say hello to some of our members.

The meeting aimed to raise the profile of self-management with local patients and members of the public through a variety of informal discussion break-out sessions and formal lectures and exhibition stands. The speakers from the rheumatology department, primary, secondary and social care also provided the opportunity to celebrate advancements in the medical, nursing and therapy management to support people in a practical manner.

What did some of the delegates say about this conference?

"One of the best and most relevant patient conferences I have ever attended."

"An excellent day. Every speaker gave an excellent, valuable insight into arthritis. I was most impressed and I look forward to future events."

"An excellent and informative event with a balanced and informative and occasional entertaining programme."

"I welcomed the opportunity to talk with other patients with arthritis for the first time. It was also reassuring for my husband to talk to other partners and carers to share ideas."

"This really was the best conference yet – well done indeed to you all. Every aspect of the conference works so well and it is beginning to get a networking feel about it, giving some of us the one and only chance each year to meet up".

This and other feedback was extremely positive from conference participants and a full conference report highlights all feedback received in relation subjects covered. Many also commented on the quality of the presentations and workshops. The majority of participants reported that they had learnt something new and 97% said they would attend future events.

These patient and public conferences/events organised by the department in partnership with local and national support groups over the past four years have grown from strength to strength. In 2010 over 1,600 patients received information through these educational events.

Each year the department of rheumatology has ensured that as many patients and members of the public as possible have the opportunity to attend a varied programme of events and conferences. For patients who have rare diseases, the department has hosted a number of evening events and the larger conferences have tackled more common conditions such as osteoarthritis, inflammatory arthritis and connective tissue diseases.

Planned for 2011

17th June 2011 - Love Your Bones 5 – Osteoporosis Update

18th June 2011 - Ankylosing Spondylitis Conference – Living Well with Connective Tissue Diseases

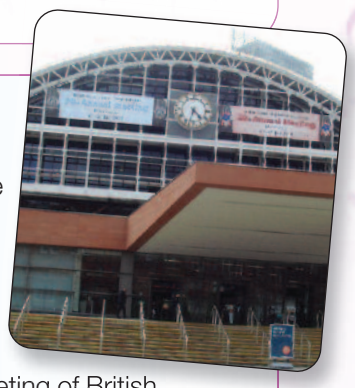
With thanks to Colin Beevor, Matron of Musculoskeletal Outpatient Services at Queen Alexandra Hospital, Portsmouth and Royal Haslar Hospital (Naval) Gosport for supplying this article.

The British Association of Dermatologists AGM

In July PAPAA attended the British Association of Dermatologists (BAD) annual meeting and were provided with free stand space to promote the organisation and our work.

The annual meeting is aimed at professionals and is attended by dermatologists, nurses, general practitioners and other allied healthcare professionals.

This year the event was held in Manchester Central, and gave us an opportunity to meet many of the professionals whom we supply with free patient information.

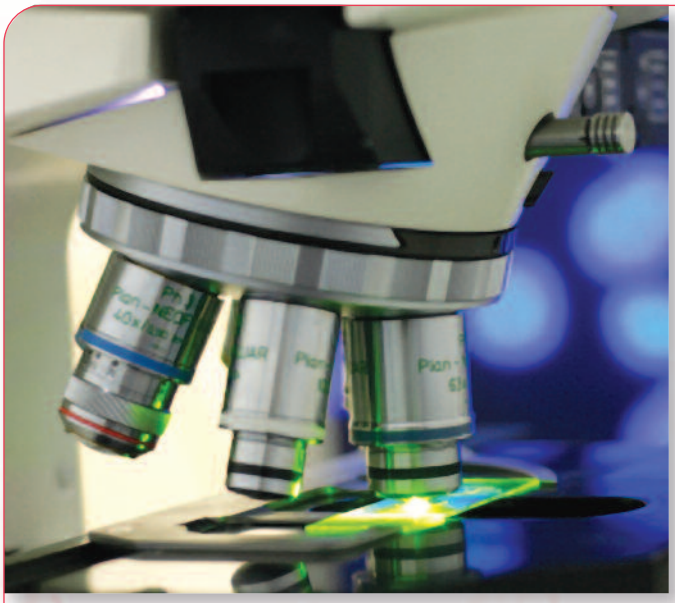


It was pleasing for us to receive such a warm reception and to be able to get some welcome feedback regarding our material and approach to patient support.

Next BAD AGM 91st Annual Meeting of British Association of Dermatologists ICC London ExCeL 5-7 July 2011.

For more information contact:
BAD Conference & Event Services
Telephone: 020 7391 6357
Email: conference@bad.org.uk

Psoriasis 'hotspots' identified



Scientists at the University of Michigan Health System and their collaborators have found four new DNA 'hotspots' that may one day help guide new treatments for psoriasis.

Using cutting-edge methods to peer into the hidden genetic underpinnings of the disease, the research, published in Nature Genetics, further maps the as-yet-unknown territories of psoriasis and psoriatic arthritis.

"The findings could lead to new drug targets and tailored treatments for the skin disease," says Dr James T Elder, the Kirk D Wuepper Professor of Molecular Genetic Dermatology and lead investigator on the study, which included researchers from the department of dermatology and school of public health.

"This is a hot topic in genetics these days", Elder says. "Even when you add up all the genes that have been found around the world so far, they only account for about 40% of the genetic liability to psoriasis. The question among geneticists continues to be: "Where is the dark matter?"

The new research builds on past work by the team, whose discoveries have helped to unveil the hereditary factors of the disease and provided scientists with a better understanding of psoriasis' relationship to other autoimmune diseases, such as Crohn's disease, rheumatoid arthritis and lupus.

So far, research worldwide has linked 25 genes to psoriasis, which has a strong hereditary component. Including the new discoveries, Elder's team was involved in finding more than half of them. Two of the four new 'hotspots' were strongly linked to psoriatic arthritis.

Once a full catalogue of psoriasis genes has been identified, scientists hope to generate a psoriasis gene profile that can predict one's risk of developing the disease and pave the way for innovative treatments.

Current treatments, including different types of immunosuppressive agents, aren't always effective and can cause serious side effects.

The researchers have suggested that the discover of these 'hotspots' may aid in developing new therapies.

Reference:

Nature Genetics, published online 17 October 2010

Source:

News story from the University of Michigan

www.med.umich.edu

www.nature.com/ng/index.html

Tight control in psoriatic arthritis (TICOPA) *RECRUITS NEEDED*

What is the objective of the project?

The objective is to establish the best treatment for psoriatic arthritis (PsA). Improving the treatment for everyone who is diagnosed with this condition in future.

Psoriatic arthritis is a form of inflammatory arthritis, associated with the skin disease psoriasis, causes joint pain and swelling and then joint damage and disability over time.

We think that in PsA, the situation is similar to that found in rheumatoid arthritis (RA), where inflammation of the joint and adjacent bone causes the damage and destruction.

In this study, people with newly diagnosed PsA will be followed for one year. Half will be treated using standard hospital care. The other half will be reviewed monthly in a specialist clinic ('tight control') and will be treated intensively, aiming to further reduce the inflammation in their joints.

After 12 months we will assess whether this 'tight control' treatment can improve clinical outcomes and reduce the damage to the joints and prevent long-term disability. It is expected that joint damage will be reduced in those patients treated intensively, therefore preventing disability. The therapeutic trial will provide direct evidence to support the use of early and intensive treatment in PsA to ensure that people are treated optimally.

The trial is led by Dr Philip Helliwelll at the University of Leeds. Recruiting centres will be based in the clinics in Leeds, Bradford and York, but other centres in Newcastle, London (St Bartholomews and King's) and Bath are shortly to start recruitment as well. People with early PsA (less than two years) who have not yet received treatment will be eligible.

Contact:
For further information contact Dr Helliwell's Leeds office number: 0113 392 3064.

About the author:

Philip Helliwell is currently senior lecturer in rheumatology at the University of Leeds, in the UK, and honorary consultant rheumatologist for the Bradford Hospitals NHS Trust.

Previous appointments include: Member of NHS R&D Research Committee on Physical and Complex Disabilities; Member of the Executive Council, Centre for Biomechanics and Medical Engineering; Treasurer and Member of Executive Committee, Society for Back Pain Research; Member of Education Committee, Arthritis Research Campaign; and Editor for the ARC Patient Information Leaflets and Convener Publications Working Group. His main research interest is in clinical features and classification of psoriatic arthritis. He was a founding member of the GRAPPA* group in 2003 and served on the executive committee until 2008. He was the principal investigator of the CASPAR study and is now leading the GRAPPA composite measure exercise in preparation for OMERACT** 2010.

Between 1997 and 2000, Dr Helliwell was a member of the Heberden Committee, at the British Society for Rheumatology where he was involved in research, training and educational matters. He was also a member of council at the British Society for Rheumatology.

Dr Helliwell is also a referee for Medical Research Council (MRC), Engineering and Physical Sciences Research Council (EPSRC), Arthritis Research UK and several European and North American Journals.

***GRAPPA** – *Group for Research and Assessment of Psoriasis and Psoriatic Arthritis*
****OMERACT** – *Outcome Measures in Rheumatoid Arthritis Clinical Trials.*

Obesity risks in psoriatic arthritis

Among persons with psoriasis, those who reported being obese at age 18 were found to have an increased risk of developing psoriatic arthritis, according to a report in the July issue of Archives of Dermatology.

According to background information in the article, "obesity has emerged as a significant risk factor for psoriasis," and "psoriatic arthritis, affecting 6% to 42% of people with psoriasis." Additionally, "psoriatic arthritis shares some clinical features with rheumatoid arthritis, both leading to joint destruction and significant morbidity."

Dr Razieh Soltani-Arabshahi, of the University of Utah School of Medicine, Salt Lake City, and colleagues studied a volunteer sample of patients with dermatologist-diagnosed psoriasis enrolled in the Utah Psoriasis Initiative from November 2002 to October 2008. Of the 943 participants, 50.2% were women and psoriatic arthritis was present in 26.5% of participants with psoriasis (250 persons).

The study found that body mass index (BMI) at age 18 was predictive of psoriatic arthritis. Other predictors included younger age at psoriasis onset, being female and having larger body surface areas affected with psoriasis. Additionally, the findings show "the obese group having an earlier onset of psoriatic arthritis, followed by the overweight group and finally the normal BMI group." 20% of the overweight or obese group developed psoriatic arthritis by age 35 years while 20% of those individuals in the normal BMI group developed psoriatic arthritis by age 48.

The authors concluded that their findings "support a growing concept that patients more prone to psoriatic arthritis might benefit from more frequent and meticulous screening measures for early detection and treatment of psoriatic arthritis, i.e. before the development of irreversible joint destruction."

Body Mass Index (BMI) calculator available at:
www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx

Source:
Arch Derm. 2010;146[7]:721-726.
www.jamamedia.org
July 2010

Golf star talks about his psoriatic arthritis

American golf star Phil Mickelson announced in August that he had been diagnosed with psoriatic arthritis, which in his case it came on quite suddenly, leaving him nearly crippled earlier in the summer.

"Every joint in my body started to hurt to where I couldn't move," he told a press conference, reported the New York Times. "I would just lay down and couldn't roll over."

Mickelson said the psoriatic arthritis quickly spread from his ankle, finger and wrist to his hips, elbows and shoulders.

Mickelson is currently undergoing treatment, which he hopes will halt the progression.

Born in 1970, Mickelson has won four major championships and a total of 38 events on the Professional Golf Association (PGA) Tour. He has reached a career-high world ranking of 2nd in multiple years. He is nicknamed 'Lefty' for his left-handed swing, even though he is otherwise right-handed.

Hotelier talks about psoriasis

Another public figure to speak about psoriasis earlier this year was hotelier, writer and television presenter Ruth Watson, probably best known as the former presenter of Hotel Inspector on Channel Five. In a report in the Daily Mail earlier this year Ruth is quoted as saying "…my face is the only place I don't have psoriasis …"

She is further quoted as saying: "…I use the concealer particularly for the driving shots, when you see my hands up close…"

"…It's not that I'm embarrassed – it's a part of me - but I don't want it to distract people from the programme. I'd like them to be enjoying the story, rather than staring at the screen and wondering what's wrong with my hands…

In a positive approach Ruth said: ' …don't see living with psoriasis as a battle, accept that it's part of your life but don't let it define you. Learn to live with it, like you would a slightly difficult pet dog…"

If you've a positive story to share or have learned to live with your condition and would like to share your experience, why not write it down and send it us for publication?

Making the most of your skin treatment

So you've got psoriasis and you've had it for a long time; it's another day of flaky, sore and cracked skin. So what to do? Leave it – you know you shouldn't, but can you face another day of applying that awful lotion? It's winter and it's cold and you don't have enough time and of course tomorrow will be exactly the same. So what the hell, just ignore it, but then you feel guilty as you know you *should* do something. If this sounds familiar then you are not alone. Psoriasis is a relentless condition which saps the spirits of the most dedicated of individuals.

In Issue 31 of Skin 'n' Bones Connection we looked at topical treatments and this article is aimed at helping you to maximise the benefits and maybe helping you when using treatments on a daily basis.

Generously dot the skin with the preferred moisturiser and smear in a downward motion following the natural hair fall. Avoid applying in an enthusiastic, circular motion as this may irritate the skin and block up the hair follicles.

Common soap substitu are aqueous cream and emulsifying ointment. To impr consistency of emulsifying oin add to hot water and whisk, forms a smooth white cream. I is sore and cracked apply to t affected area before immersing water to prevent the stinging sensation.

Look at gadgets to help apply creams.

Allow yourself time.

Bathing should be used as a moisturising event. Use both a bath oil additive and a separate soap substitute. Baths should not be too hot.

Pat the skin dry. Do not rub the skin hard. Skin may look redder following bathing - this is normal.

Freshly bathed skin is at its most receptive for applying topical steroids, if prescribed. Otherwise, immediate application of an emollient captures the increased water content of the skin and delays the drying out process.

Emollients come in a wide range and the severity of your skin condition will determine the type of moisturiser to use.

Dry, cracked and scaly skin needs the occlusiveness and oiliness of an ointment such as 50% liquid paraffin in 50% white soft paraffin or grease based emollients. Skin that is less dry may require a lighter emollient. Your dermatologist can advise you.

To ensure the texture of the skin stays waxy and pliable, emollients should be reapplied before the skin feels dry and rough again. Apply liberally.

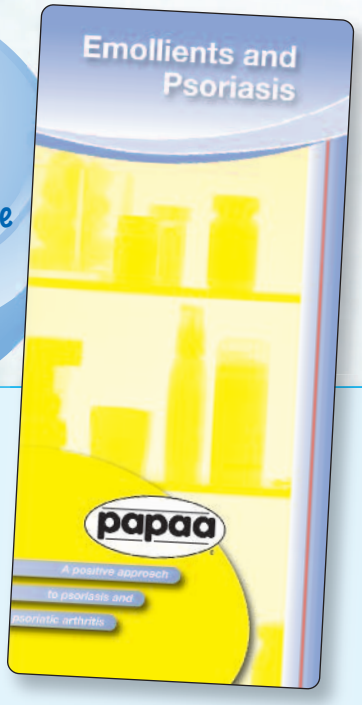
Adopt a relaxed approach to your bath-time treatments

Seek advice to get the best out of your treatment – it can be trial and error.

Make it an enjoyable time-out pampering experience

Always read the label and patient information supplied with your treatments.

Topical steroids should be applied to freshly bathed skin or 30 minutes after moisturisers have been applied. Allowing the moisturiser to soak into the skin improves the efficacy of the steroids.



Further information:

A leaflet called Emollients and Psoriasis is available free to download or in hard copy. Visit our main website or online shop to order a copy. Alternatively contact us and we'll be pleased to send you a copy in the post.

Websites: www.papaa.org or www.psoriasis-shop.org
Telephone: 01923 672837
Email: info@papaa.org

Following local pilot projects in 1998, NHS Direct became available nation-wide from 2000. NHS Direct has 33 sites across England linked into a single virtual contact centre.

In September 350 members of staff from NHS Direct celebrated 10 years of service to patients.

Staff were brought together with colleagues from contact centres in the surrounding area to mark the occasion and received thanks for their long service.

In 2000 the average number of calls dealt with a day was around 8,000. In comparison, NHS Direct handled around 27,000 calls a day last year. This includes calls to its helpline and commissioned services delivered by NHS Direct locally and nationally.

Long-serving staff have seen a number of advances in technology, as most of the work 10 years ago was done on paper, which has now been replaced by computers. Staff have provided health information and advice through a number of major health events including foot and mouth disease, SARS virus, bird flu, swine flu, and the polonium incident in London.

Nick Chapman, chief executive of NHS Direct, said: "I would like to offer my congratulations to all our long-serving members of staff, and also say thank you for their continuing hard work and commitment. Over a constantly changing 10 years, we have always managed to deliver an effective, safe and reliable service which is popular with patients. This would not be possible if it wasn't for the dedication and experience of our staff."

NHS Direct's telephone number is 0845 4647 and will continue to be available until the new NHS 111 number is rolled out nationally (see article on page 13).

www.nhsdirect.nhs.uk

Source:
NHS Direct news release
September 2010

A new three-digit number programme – 111 – will make it easier for patients to access non-emergency NHS healthcare wherever they are, 24 hours a day.

The new service, launched in August in County Durham and Darlington, marks the first step towards a national roll-out programme and is the beginning of a significant White Paper commitment to make care more accessible by introducing a single telephone number for every kind of non-emergency healthcare.

The 111 service is free to call and is staffed by a team of fully trained call advisers, supported by nurses, who are on hand to assess callers' needs and ensure they receive the right service as quickly as possible. It guides patients to a locally available service or provides appropriate advice and information 24 hours a day, 365 days a year.

The number can be used when you need help fast if a situation is not life threatening, or when you do not know who to call. This will be particularly useful outside of GP surgery hours and for people who are away from home.

When someone calls 111, they will be assessed straight away. If it is an emergency, an ambulance will be despatched immediately without the need for any further assessment. For any other health problems, the NHS 111 call advisers will be able to direct people to the service that is best able to meet their individual needs. For minor illnesses and injuries, the 111 service will be able to provide immediate medical advice.

Visiting the very first operational 111 call centre in the Northeast to talk to staff and patients about how the service is working, health secretary Andrew Lansley said:

"It is essential that we improve access to, and understanding about, urgent care services, which includes out-of-hours care. At present, too many people are confused about who to contact and how to do so.

"By putting in place one easily memorable 111 number for all urgent inquiries to run alongside the emergency 999 number we will simplify NHS services for patients. 111 will be free to call and available 24/7, putting patients in touch with the right NHS service, first time.

"I am delighted that people in County Durham and Darlington are to be the first to benefit from this new service. Later this year we will launch the service in Nottingham City, Lincolnshire and Luton. Ahead of national roll-out, this will help us understand what model works best for patients and delivers value for money."

Yasmin Chaudhry, chief executive of NHS County Durham and Darlington said:

"The NHS 111 service will make it easier for the public to access urgent healthcare and will drive improvements in the way in which the NHS delivers that care. We want to make sure the right care is delivered in the right way for patients as well as ensuring NHS resources are used in the best way.

"By better understanding what people really need from different local services, 111 will help improve efficiency across the whole healthcare system by reducing unnecessary waste and making sure people get access to the right service, first time."

Further pilots are planned for the East Midlands in Nottingham City and Lincolnshire and the East of England in Luton. Both regions have been chosen to test different ways of delivering the 111 service using various NHS providers that include the Ambulance Trust, an out-of-hours service and NHS Direct.

www.dh.gov.uk

Source:
Department of Health press release
23 August 2010

Study suggests glucosamine no better than placebo for osteoarthritis

The British Medical Journal has published online the results of a study into the effectiveness of glucosamine, chondroitin or placebos on patients with osteoarthritis of hip or knee. The study looked at published trials and used the data to see how effective these supplements were in relieving symptoms.

Glucosamine and chondroitin are widely advertised and sold as treatments for osteoarthritis and other arthritic conditions. Taken as supplements, glucosamine, which is found naturally in the joints, is claimed to stimulate the production of connective tissue to help prevent the bones rubbing. Chondroitin is claimed to stimulate the production of cartilage and combined together with glucosamine helps to maintain healthy joints.

In the study the main area that was looked at was the intensity of pain, with a secondary outcome of joint space. The study looked at trials which included more than 200 patients and which used glucosamine or chondroitin and their combination with placebos or as direct head-to-head trials.

The ten trials, which had a total of 3803 patients, showed that compared with placebos, glucosamine and chondroitin or in combination do not reduce pain or have any impact on the space within a joint.

Professor Peter Juni, head of division at the Institute of Social Preventive Medicine, University of Bern in Switzerland and one of the study authors, told the BBC Radio 4 Today programme that: "… these supplements show no benefit for osteoarthritis in the hip or knee…" although he did add "… although they don't benefit a patient, they won't cause any harm, so if a patient feels better, then there is no reason to stop taking these supplements, even though they are probably wasting their money."

One recommendation from the report was that health authorities and insurers should no longer pay for these supplements and new prescriptions should be discouraged.

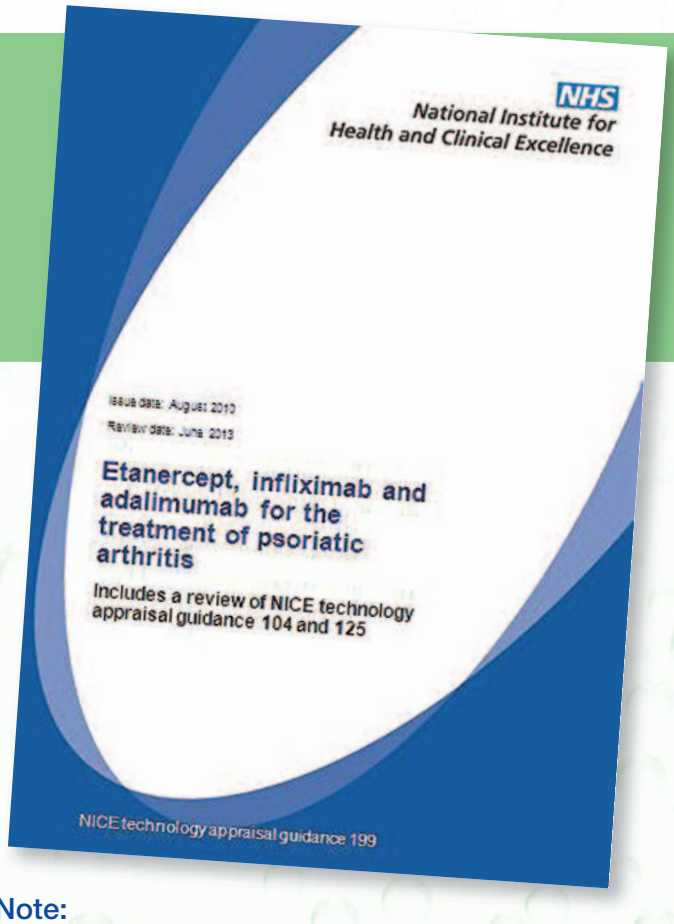
If you are currently taking either of these supplements, you may wish to speak to your healthcare provider about how to proceed.

A full version of the study is available free online at: **www.bmj.com**

Sources:
British Medical Journal (BMJ)
British Broadcasting Corporation (BBC)

University of Berne, Switzerland

NICE final guidance recommends improved access to psoriatic arthritis treatments



Three treatments for psoriatic arthritis are recommended in final guidance published by the National Institute of Health and Clinical Excellence (NICE) in August 2010.

Etanercept, infliximab and adalimumab are all recommended for the treatment of active and progressive psoriatic arthritis, based on specific criteria: The person has peripheral arthritis with three or more tender joints and three or more swollen joints, and the psoriatic arthritis has not responded to adequate trials of at least two standard disease-modifying anti-rheumatic drugs (DMARDs), administered either individually or in combination.

Treatment choice should be started with the least expensive drug (taking into account drug administration costs, required dose and product price per dose), and considering the administration requirements of individual patients.

The appraisal updates and combines the existing NICE guidance on these drugs, originally published in 2006 and 2007.

When the draft guidance was issued for consultation in June this year, Dr Carole Longson, director of the NICE Health Technology Evaluation Centre, said: "We're pleased to propose improved access to treatments for psoriatic arthritis in this final draft guidance. Following the helpful responses to our public consultation on the first draft guidance, we now intend to recommend a wider range of treatment options for people with psoriatic arthritis."

Reference:

NICE technology appraisal guidance 199
Etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis (includes a review of NICE technology appraisal guidance 104 and 125)
Issue date: August 2010

Note:

- Etanercept brand name is Enbrel, manufactured by Wyeth Pharmaceuticals.
- Infliximab brand name is Remicade, manufactured by Schering-Plough Ltd.
- Adalimumab brand name is Humira, manufactured by Abbott.
- Golimumab brand name is Simponi, manufactured by MSD for the treatment of psoriatic arthritis, is currently being appraised by NICE with the Final Appraisal Document (FAD) expected to be issued in February 2011.

These medications are all prescription only (POM) and can only be prescribed by a doctor in a hospital setting. You should always discuss with your healthcare provider about your suitability for any new medication that is available. As they will be in the best position to understand your particular medical needs and circumstances.

Source:
NICE press office website
Accessed 26 August 2010

Letters

Q Dear PAPAA,

Whilst visiting the USA, I heard about a doctor who claimed that dental toxicity due to mercury in amalgam fillings was the cause of many unexplained diseases and conditions.

I have always suffered with scalp psoriasis until recently and after having some routine dental work and a tooth removed, the scalp psoriasis has completely disappeared.

This all fits in with the doctor's theory and I wonder if any of your readers have had any similar experiences?

SL

Q Dear PAPAA,

I am a 35 year old single parent with 2 boys and have recently been diagnosed with psoriatic arthritis. I know absolutely nothing about it, other than the pain it causes.

As you can image I have so many questions that I would like answers to and am grateful to have found PAPAA.

I do not have psoriasis but several members of my family do. Does that mean that I will get this at some point in my future?

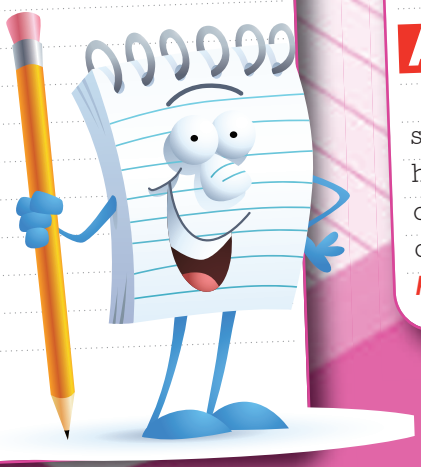
I do hope you can help, thank you for taking the time to read this letter

GD

A Dear GD,

It doesn't follow that because you have psoriatic arthritis you will automatically get psoriasis. Likewise, having psoriasis also doesn't automatically mean you would develop psoriatic arthritis, although having a relative with either condition does increase your chances. It is known that both conditions are genetic in origin therefore hereditary.

PAPAA



Q Dear PAPAA,

I was diagnosed as having psoriatic arthritis at my second visit to the clinic in June. I have psoriasis in my hair at the back of my head – not too much fortunately, but the painful bones came on very suddenly and the pain seemed to travel through my joints with pain going from shoulders, back, lower back, legs, feet and toes and fingers ending up with my hands, wrists and fingers, now being the most painful, and toes and feet occasionally hurting.

Fortunately I am able to go to work – I'm a typist – but feel as though I am not nearly as energetic and lively as I was. I feel very languid and unfit. Is this a common complaint with this illness?

MR

A Dear MR,

Yes, fatigue is a commonly reported problem associated with psoriatic arthritis, most commonly inflammation associated with arthritis, medications and of course inactivity can all cause fatigue.

PAPAA

Q Dear PAPAA,

My dentist thinks my gum problems might be psoriasis related; can you shed some light on this?

CS

A Dear CS,

Some of the treatments used for psoriasis – specifically ciclosporine – can cause gum hypertrophy (abnormal enlargement of an organ or structure). It is not known that psoriasis per se causes or is associated with gum disease.

PAPAA

Please note: letters and emails have been edited and names withheld for privacy

Q: *At what age do you normally develop psoriatic arthritis?*

A: Psoriatic arthritis can develop at any age. Although it is uncommon to develop in children although some cases have been diagnosed. It is usual for the condition to develop during teenage years. Men are slightly less likely to be affected than women, where there may be an increased incidence following pregnancy or the menopause.

Q: *Can psoriasis be passed onto your baby when pregnant?*

A: Psoriasis is a multi-genetic disease and therefore your unborn baby may not necessarily inherit the condition. It is estimated that if one parent has psoriasis there is a 15% chance that a child will develop the condition. If both parents have psoriasis this increases to above 75%.

It is worth remembering that as with all medications, some psoriasis medications may have adverse affects on a developing baby in the womb so you should discuss any concerns you have with your healthcare provider.

Q: *Can you recommend any make-up I can use on my face to cover my psoriasis?*

A: The British Red Cross Society's cosmetic camouflage service was set up to help people cope with disfiguring marks and skin blemishes. Approximately 5,000 or more referrals each year are primarily for dermatological conditions. Initially those with birthmarks were most numerous, and those with vitiligo, but increasingly in recent years practitioners have received referrals from those with other conditions – rosaccea, acne and psoriasis. When a referral is received an appointment will be arranged at a convenient clinic. In the course of a consultation, which may last between 45 and 60 minutes, the cosmetic camouflage practitioner will colour-match the special creams to the client's skin colour. The aim is a satisfactory match, either to the client's single colour or a simple mix of two or three colours.

The client will be involved throughout and shown how to match the creams him/herself, before being instructed in how to apply and set the creams. Properly applied, the creams can be made waterproof. Before finishing the consultation, the client will be given a note which can be passed to their medical advisor as the creams used by British Red Cross practitioners are all available on prescription.

Q: *. How can I remove my psoriasis scales?*

A: If the scales are superficial you will find the best way to clear them is by using an emollient. This is helpful for several reasons. Cosmetically, the plaques look better and are easier for dressing, etc. Scale removal also allows easier application, and possibly enhanced penetration, of other topical treatments. The best emollient is the one you prefer, because then you will use it more frequently and gain more benefits.

Q: *What is Koebner's phenomenon?*

A: Koebner's phenomenon or Koebnerisation is named after the German dermatologist Heinrich Koebner, who found that skin in people with psoriasis which had became traumatised following an injury often developed a psoriatic lesion in the area, but where psoriasis had not previously been seen; including cuts, bruises, burns, bumps, vaccinations, tattoos and other skin conditions.

Stronger measures required

British Medical Association (BMA) Scotland demands stronger measures to protect patient confidentiality.

The BMA in September called for tougher safeguards to protect patient confidentiality for electronic patient records. The calls come as MSPs prepare to debate the Health Committee report on clinical portal technology[1] and telehealth.

Dr Alan McDevitt, deputy chairman of the BMA's Scottish General Practitioners Committee and lead on IT issues, said:

"The ease with which patient information can now be shared challenges us to come up with new ways of protecting information they have shared with us. With the growing use of electronic patient records, it is essential that we know who has looked at which records and when, so we can ensure only appropriate access.

"Although BMA Scotland is broadly supportive of the clinical portal technology project, we do have concerns relating to patient confidentiality and how access to the system will be managed. If portals are to be accessible from computers anywhere within the NHS then it is our view that username and password access does not offer sufficient security of data.

"We are concerned that it may be commonplace for usernames and passwords to be shared between medical staff. This can often occur because staff do not receive access to systems promptly enough or are unable to reset their access out of hours. While this is already an issue of concern, the risk of misuse in an environment where clinical portals display much more data about many more people, is considerably greater. An identity and access system[2] is required to ensure that access is granted promptly to those who need it (after secure identity checks), that they can reset access at all times and that access is stopped when they leave or change roles.

"The BMA strongly believes that introducing tighter controls will be far more effective at limiting inappropriate access to electronic patient records than using retrospective audit in isolation."

References:

1. The clinical portal technology project will allow patients and clinicians to electronically view relevant patient information through clinical portals. Patient information accessible through clinical portals will be viewed by other NHS clinical systems and possibly non-NHS databases such as child protection systems.

2. Identity and access management is a broad area that deals with identifying individuals in a system (such as a country, a network or an organisation) and controlling access to the resources in that system by placing restrictions on the established identities.

About the BMA

The BMA is the doctors' professional organisation established to look after the professional and personal needs of its members. The BMA represents doctors in all branches of medicine all over the UK.

Source
BMA Scotland press release
September 2010

New SIGN guideline is 'missing link' for improved care for patients with psoriasis and psoriatic arthritis.

The guideline calls for more joined-up care between dermatologists and rheumatologists.

The authors of a groundbreaking guideline on psoriasis and psoriatic arthritis recently published believe that it is the 'missing link' that will bring about improved diagnosis and treatment by GPs in primary care.

The guideline also emphasises that greater co-ordination in the care delivered by dermatologists and rheumatologists can result in much improved outcomes for patients.

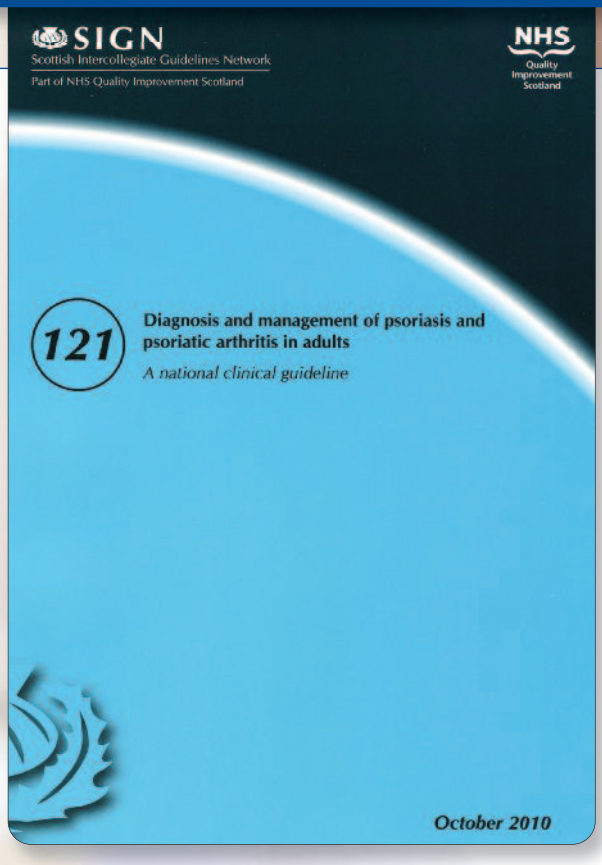
The guideline from the Scottish Intercollegiate Guidelines Network (SIGN), part of NHS Quality Improvement Scotland (NHS QIS), is the first of its kind internationally to draw together the best available evidence on diagnosing and treating psoriasis and psoriatic arthritis, recognising the need to see the relationship between both conditions and treat them in a co-ordinated fashion.

Key recommendations contained within the guideline include the following:

- **Patients should have an annual review with their GP**
- **Patients should have access to appropriate multidisciplinary care**
- **Assessment of patients should include psychosocial measures, with referral to psychological services as appropriate**
- **Active involvement of patients in managing their care should be encouraged.**

The guideline includes information on the following areas:

- **Diagnosis, assessment and monitoring**
- **Treatment in primary care (GPs)**
- **Treatment in secondary care (hospital setting)**
- **Pharmacological and biological therapy**
- **Patient information.**



Dr David Burden, consultant dermatologist at Glasgow's Western Infirmary and chair of the guideline development group, said: "This guideline can be the missing link for GPs to improve their knowledge of psoriasis and psoriatic arthritis, and to improve the care that these patients receive. Improved knowledge and co-ordinated treatment are key to managing a condition that can have a significant effect on people's quality of life."

About SIGN:

SIGN (Scottish Intercollegiate Guidelines Network) develops national clinical guidelines aimed at reducing variations in clinical practice and in outcomes for patients. Founded in 1993, SIGN became part of the national clinical effectiveness body, NHS Quality Improvement Scotland, on 1 January 2005.

Reference:

Scottish Intercollegiate Guidelines Network (SIGN). Diagnosis and management of psoriasis and psoriatic arthritis in adults. Edinburgh: SIGN; 2010. (SIGN publication no. 121) – cited 12 Oct 2010.

Source
SIGN media release
October 2010

Market Place

Here are a few items that have been brought to our attention by our readers. These are for your interest and in no way are we endorsing or recommending these products.

We've been sent some interesting items for this edition, so thank you if you have provided suggestions.

Having trouble applying your creams and lotion to your scalp? This seven-panelled mirror might be the answer. Rated highly by the channel Five Gadget Show and available from **The Verdict**, the product is portable or can be wall mounted using suction cups, adhesive pads or the screws provided. Battery-operated lights are located at the top and base of mirror.

Product Code 159 8069 Price: £39.95

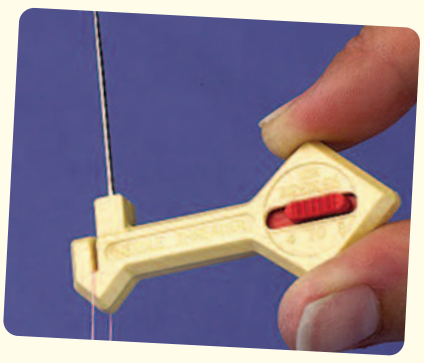
Finding it difficult to get your pillow in the right place? **The Side Sleeper Pillow** helps make sleeping on your side more comfortable and less painful. Invented and patented by chiropractor Dr Larry Cole, a leading researcher into the effect of sleep on the musculoskeletal system. Side-sleeping on a conventional pillow causes your head to tilt forward, placing pressure on your neck and shoulders, while sleeping on your back curves your vertebrae and restricts your airway.

The product is made from hypo-allergenic hollow fibre with machine washable zipped polycotton cover. Available from numerous outlets including **The Verdict** and **Viva**

Product Code 158 7968 Price: £29.95

No matter how small the eye of your needle is, the new **Needle Threader** will thread it for you. A real must for every sewing kit!

Simple to use - just hold the Threader in one hand and insert the needle, then the thread. Available from **Renwoods**.



Product Code 107 0777 Price: £6.95

Available from **Essentials by Post,** this product makes garden paths, steps and driveways safer in the ice and snow without shovelling, sweeping or laying salt. Simply roll out this non-slip carpet over the snow or slippery ice and walk to your door in safety.

Made from woven coir and treated with latex rubber, it grips even icy surfaces. Reusable year after year.

Product Code 9438 Price: £9.99

This **clever button helper device,** also available from **Renwoods**, allows anyone with any form of hand disability, such as arthritis, to fasten a button using only one hand. Simply slip the wire hook through the buttonhole and over the button, and then pull the button back through the hole.

Economical solutions for faster, pain-free dressing.

Product Code 132 9931 Price: £6.95

Getting the best prices online:

Price comparison sites - enter a search phrase 'compare prices' into a search engine and then access the sites directly.

Remember to check availability of products, cost of delivery and most of all whether the site is secured for eCommerce transactions.

- **www.dealtime.co.uk**
- **www.comparestoreprices.co.uk**
- **www.kelkoo.co.uk**
- **www.google.co.uk/products**

Secure sites will have a certificate on the site, such as **GoDaddy, DigiCert, VeriSign, Thawte** and **Comodo**. These certificates will allow you to check site validity, if you are suspicious.

Contact details for the above products:

The Verdict	
0844 482 2802	www.expertverdict.co.uk
Viva Direct	
0844 482 2803	www.vivadirect.co.uk
Renwoods	
0844 482 1555	www.renwoods.com
Essentials by Post	
0844 854 6666	www.essentialsbypost.co.uk

If you come across products or items that you have found useful or you think others will find of interest please let us know. There may be similar products on the market made by other manufacturers that are as useful so keep your eyes open