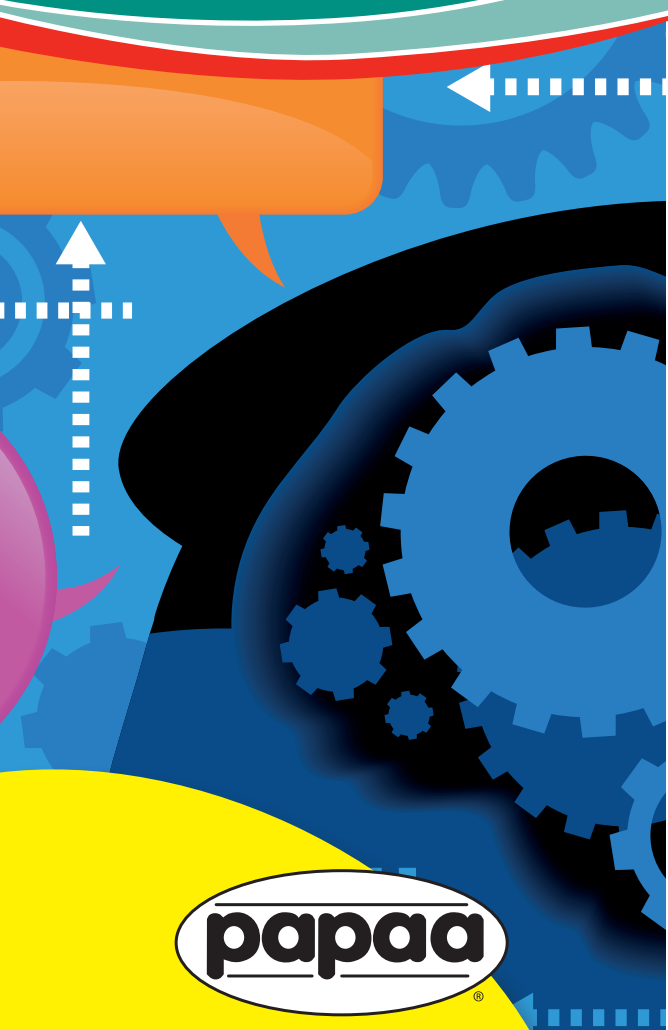
Psoriatic Arthritis: *An introduction*



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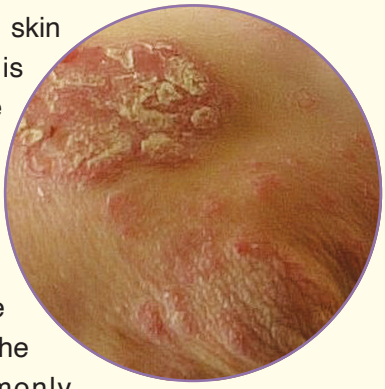
A positive approach to psoriasis and psoriatic arthritis

What are the aims of this leaflet?

This leaflet has been written to provide you with a basic introduction to psoriatic arthritis. It is not intended to provide a full comprehensive explanation. You will find throughout the text references to other materials that we produce.

About psoriasis and psoriatic arthritis

Psoriasis (sor-i'ah-sis) is a long-term (chronic) scaling disease of the skin which affects around 1 in 50 people, which is about 1.3 million, or around 2% of the UK population. It usually appears as red, raised, scaly patches, known as plaques. In people with skin of colour, the redness is less pronounced. The plaques therefore may appear darker, brown or as purple patches with grey scales. Any part of the skin surface may be involved, but the plaques most commonly appear on the elbows, knees and scalp. They can be itchy, but are not usually painful. Psoriasis is not contagious; you cannot catch it from another person.

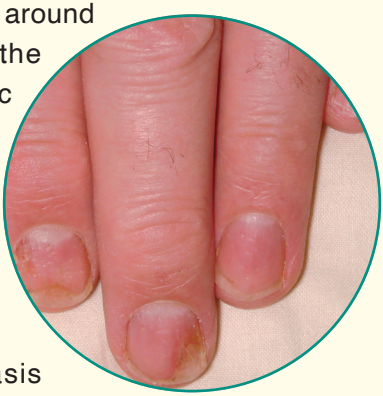


For those that have psoriasis, around 1 in 4 may develop an associated psoriatic arthritis (PsA), which is about 325,000 people, or around 0.5% of the UK population. Psoriatic arthritis causes pain and swelling in the joints and tendons, accompanied by stiffness particularly in the mornings or after a period of rest.

There does not seem to be any consistent robust link between the severity of the psoriasis affecting the

skin and the severity of psoriatic arthritis. For more detailed information on each condition, please see our leaflets ***What is Psoriasis?*** and ***What is Psoriatic Arthritis?***

Nail changes



Nail changes occur in around 4 out of 5 people (the majority) with psoriatic arthritis compared to 1 in 2 (half) of those with psoriasis alone. Nail disease can occur in both the finger and toe nails.

People with psoriasis or psoriatic arthritis commonly notice changes to their nails.

These include:

- Onycholysis (lifting of the nail from the nail bed)
- Pitting (nails develop dents and pits)
- Hyperkeratosis (thickening of the nail)
- Salmon patch (brown discoloration of the nail often with onycholysis)
- Nail plate crumbling (brittle nails that easily break)

People with psoriatic arthritis with severe nail changes often have more arthritic joints, especially those joints in the vicinity of the affected nail. See our ***Nail Psoriasis*** leaflet for more information.

Lethargy and fatigue

If you have psoriatic arthritis it is very common to feel lethargic and fatigued, which may be an early symptom or sign of the inflammatory activity associated with both psoriasis and psoriatic arthritis. See our ***Psoriatic Fatigue: Why do I feel so tired?*** leaflet for more information.

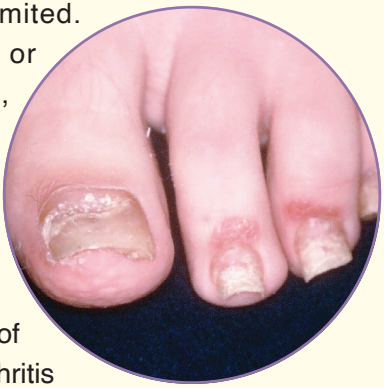
Types of psoriatic arthritis

The condition has the potential to affect any joint, tendon or ligament in the human body.

There are 5 types of psoriatic arthritis:

- Asymmetric (one side of the body)
- Symmetric (matching left and right pairs of joints)
- Distal (tips of fingers and toes)
- Spondyloarthritis (affecting the spine and pelvis)
- Arthritis mutilans (very rare, causing severe destruction of fingers and toes)

The most commonly affected sites are the hands, feet, neck and knees, with movement in these areas becoming severely limited. Sometimes just one or two joints (oligoarthritis), such as a knee or ankle are a problem. Often several joints (polyarthritis), both large and small are involved. About a third of people with psoriatic arthritis

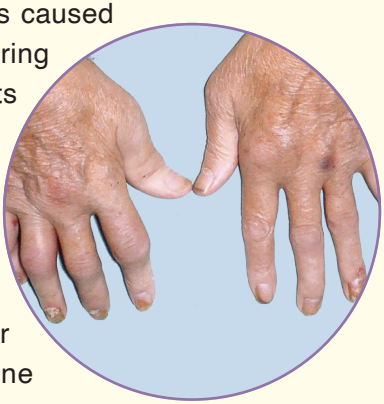


also have spondyloarthritis, which can result in a stiff, painful or reduced motion of the spine (neck or back) or pelvis (especially tailbone and buttock area).

Getting a diagnosis

Given that there are no specific tests for psoriatic arthritis, an experienced healthcare professional will assess for swollen and tender joints, and a certain pattern of involvement typically seen in psoriatic arthritis. The skin and nail changes that are seen in psoriasis will also provide a clue towards the diagnosis as will any family history. Factors such as the symptoms mentioned above, full medical history, blood tests, ultrasound scanning, MRI scans and x-rays may also be included in a diagnostic decision-making process.

Typically, psoriatic arthritis can be recognised by the finding of a sausage-like swelling of a finger or toe, called dactylitis. This is caused by inflammation occurring simultaneously in joints and tendons. Painful heels and other bony prominence can also occur and this is caused by inflammation where ligaments or tendons attach to bone (enthesitis).

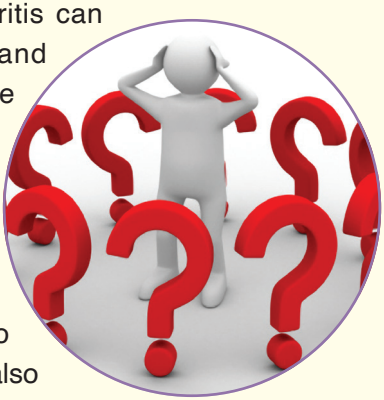


If you've been diagnosed with psoriasis, you should have check-ups at least once a year to monitor your condition. This should include careful consideration of any changes that may have occurred to your joints. Make sure you let your doctor know if you're experiencing any such problems, which you feel may appear to match the symptoms of psoriatic arthritis.

If you haven't been diagnosed with psoriasis, but experience persistent pain, swelling or stiffness in your joints or any of the symptoms listed, you should make an appointment with your GP. You may be referred to a specialist doctor called a rheumatologist and, in some instances, these specialists will have a particular interest in psoriatic arthritis.

Living with psoriatic arthritis

Being diagnosed with a long-term chronic condition such as psoriatic arthritis can be both reassuring and worrying at the same time. Learning more about all aspects and the management of the condition, may provide the information that will help you to cope successfully and also understand the complexity of the diagnosis. See our ***Psoriatic Lifestyle and Nutrition*** leaflet for more information.



Genetics

Genetic factors play a role, with several genes being identified that are linked to psoriatic arthritis. This multi-genetic presentation means that people with the condition may unknowingly have a genetically linked relative with either psoriasis or psoriatic

arthritis, and occasionally uveitis (inflammatory eye disease) or inflammatory bowel disease (Chrohn's disease or ulcerative colitis). It is not fully understood why those who have psoriatic linked genetics develop the condition, but it is thought that when exposed to some sort of trigger, for example a virus, trauma, toxin, changes in hormones etc. the condition can appear. Research is ongoing to understand how genetics determine who will develop the condition, and whether a person could get mild or severe disease.

Psychosocial burden

Many people report that the psychosocial burden of psoriatic arthritis has a negative effect on their mental health and quality of life. This includes sleep disorders, lethargy, fatigue, low-level stress, anxiety, depression, including mood and behavioural changes, poor body image, low self-esteem, and reduced ability to work and carry out daily tasks.

Psychological factors including personality structure, cognition (thought or reasoning) and attention to pain, are now seen as important factors which should be considered by those treating people with psoriatic arthritis. See our ***Psychological aspects of psoriasis*** leaflet for more information.

Treatments

There are now many treatment options available to people with psoriatic arthritis. Some options will have to meet certain criteria before being offered, but there are many to be tried and tailor-made to your individual needs. These include mild painkillers, steroid injections, non-steroidal anti-inflammatory drugs (NSAIDs), synthetic disease modifying anti-rheumatic drugs

(sDMARD), biologic agents (bDMARD) and targeted synthetic agents (tsDMARD). Other interventions may also be included in your treatment plan, such as an assessment of your mental health, quality of life, and overall lifestyle choices. It should be noted that it may take a few months, to see whether the selected treatment plan will be beneficial or if an alternative therapy to supress the symptoms is required. See our ***Treatments for Psoriatic Arthritis: An overview*** and ***Psoriatic Lifestyle and Nutrition*** leaflets for more information.

Progression

Psoriatic arthritis tends to remain symptomatic once it has started. It rarely disappears on its own accord. It is therefore important to seek specialist rheumatology help and consider starting a disease modifying anti-rheumatic drugs (DMARD). There is no cure for psoriatic arthritis, but it often can be calmed or suppressed, such that it is not or barely noticeable.

Prognosis

If psoriatic arthritis is diagnosed early and correctly with a good treatment plan provided by your rheumatologist the prognosis and outlook is good.

For those where diagnosis has been delayed and the condition has progressed there are still options that can be taken to reduce further impact. See ***Psoriatic Arthritis: When to Treat*** and ***Psoriatic Arthritis treatments: An overview*** for more information.

Monitoring

Once a psoriatic arthritis diagnosis has been established and a treatment plan has been agreed, it may take some time for your symptoms to subside. Your healthcare provider may wish to change or adjust any plan until your condition is stable, this may take some time as some people will not necessarily get any benefit from the first treatment offered. Ongoing monitoring will be needed, particularly where some treatments will require blood tests to assess the risks and benefits.

Associated conditions

Apart from the skin, nails and joints, there is an increased risk of cardiovascular disease. There are many, well-known, risk factors for heart disease in the general population including diabetes, obesity, high blood pressure (hypertension), and increased low-density lipoprotein (LDL), often known as bad cholesterol. It appears that this risk is increased in people with psoriasis and psoriatic arthritis, and considered part of psoriatic disease.

See our leaflet ***Psoriasis and the Heart*** for more information.

Inflammatory bowel disease (IBD), including ulcerative colitis (UC), and Crohn's Disease (CD) are interlinked with psoriatic disease. The occurrence of IBD is higher in those with psoriasis than would be seen in the general population.

A persistent (days or weeks) painful and red eye caused by inflammation around the pupil of the eye, is called uveitis, and is seen more commonly in people with psoriatic arthritis.

Anaemia (not enough red blood cells) may also be found, but this is the result of long-term inflammation and is not a specific feature of psoriatic arthritis.

In conclusion

Psoriatic arthritis is a much more complex condition than it may appear at first sight. Research into the understanding of what makes psoriatic arthritis different to other types of arthritis is ongoing. It will lead to not only a better understanding of the psoriatic condition, but also how to manage and successfully treat the symptoms associated with living with psoriatic arthritis.

Useful contacts

For information about health matters in general and how to access services in the UK, the following websites provide national and local information.

- NHS UK: www.nhs.uk
- NHS England: www.england.nhs.uk
- NHS Scotland: www.scot.nhs.uk
- Health in Wales: www.wales.nhs.uk
- HSCNI Services (Northern Ireland): http://online. hscni.net

These are the official sites for the National Health Service and provide links and signposting services to recognised organisations and charities.

About this information

This material was produced by PAPAA. Please be aware that research and development of treatments is ongoing. For the latest information or any amendments to this material, visit our website: www. papaa.org the site contains information on treatments and includes patient experiences and case histories.

Following consultation and feedback received this leaflet replaces ***Psoriatic Arthritis: Did you know?*** The current text has been written by the PAPAA editorial team with input from our lay reviewers and peer reviewed by Dr Deepak Jadon, consultant rheumatologist at Cambridge University Hospitals, March 2023

Quality and accuracy

To learn more about how this material was developed and produced and the criteria we use to deliver quality support and information, go to our website and read the PAPAA Pledge: www.papaa.org/pledge

If you have any views or comments about this information or any of the material PAPAA produces you can contact us via the details on the back page or online at www.papaa.org/user-feedback

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The charity for people with psoriasis and psoriatic arthritis

PAPAA is independently funded and is a principal source of information and educational material for people with psoriasis and psoriatic arthritis in the UK.

PAPAA supports both patients and professionals by providing material that can be trusted (evidence-based), which has been approved and contains no bias or agendas.

PAPAA provides positive advice that enables people to be involved, as they move through their healthcare journey, in an informed way which is appropriate for their needs and any changing circumstances.

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