Issue 4 | July 2013

IRA e-bulletin

Newsletter For Health Professionals in Rheumatology

From the Editor's Desk
Latest Research
Expert Opinion
Conference Calendar
IRA Matters
News from EULAR 2013
Do You Know?

Expert Opinion

Is there any window of opportunity in PsA?

We do not know. However, it is safe to say that early diagnosis and treatment leads to better outcomes. Patients presenting to my clinic within 2 years of disease have less damage joint progression compared to those presenting to the clinic after 2 years. Short symptom duration was also an important predictor of favorable clinical outcome at the 5-year follow-up in a Swedish study of early PsA.

References

1. *Ann Rheum Dis.* 2011;70(12):2152–2154.

2. *Ann Rheum Dis.* 2013 Jan 25. [Epub ahead of print] PMID: 23355078.

Should all patients of PsA receive DMARDS? When and which DMARD to be started. Please elaborate.

When considering treatment, there are five domains of PsA that one should evaluate, such as peripheral arthritis, axial arthritis, enthesitis, dactylitis, and skin & nail disease. Although there is a lack of well-conducted clinical trials of DMARDs in PsA, there is a general consensus that methotrexate (especially in higher doses), leflunomide and sulfasalazine are effective. DMARDs like methotrexate are efficacious and effective for psoriasis. DMARDs may not be effective for axial disease and enthesitis. There is no clear evidence that DMARDs are effective in the treatment of dactylitis. However, lack of evidence of efficacy does not mean that there is evidence of lack of efficacy. Adequately powered and well-conducted clinical trials with appropriate PsA-specific outcomes measures are warranted. Depending on the domain affected, I aim to treat early with methotrexate or leflunomide.

References

1. *Ann Rheum Dis.* 2009;68(9):1387–1394.

2. *Ann Rheum Dis.* 2012;71(1):4–12.

Is it that true that no DMARDs slow or prevent radiographic damage in this disease?

There have been no trials that have addressed this specific question. However, achieving a state of minimal disease activity regardless of treatment leads to less damage progression.

What should be the minimum baseline work up done in these patients?

After a comprehensive clinical evaluation of all five domains, radiographic evaluation of affected joints, hands, feet, sacroiliac joints and spine is indicated. Tests for acute phase reactants and RF, liver and kidney functions tests, assessment of co-morbidities (especially metabolic syndrome) and hepatitis B and C serology are useful. If symptomatic, they should be evaluated for concomitant uveitis and inflammatory bowel disease.