The relationship between joint, scalp, and nail psoriasis: The Florence experience

(Poster reference number 4636)

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Psoriasis is a chronic inflammatory skin disease with a prevalence ranging between 1% and 3% in the worldwide population. Plaque type psoriasis is the most common form, affecting approximately 80% to 90% of patients. The scalp is most commonly involved with a frequency that ranges from 50% to 80%; on the other hand, about 50% of psoriatic patients have nail involvement. Recent studies have shown that these two frequent affected sites can be a reliable predicting factor of psoriatic arthritis (PsA) development. It should be noticed that to date, no recent and proper epidemiologic studies have been conducted with respect to the incidence and prevalence of scalp and nail psoriasis and to their relationship with PsA. We carried on a retrospective study in order to support the available data regarding the prevalence of nail, scalp and joint involvement in psoriatic outpatients. Four hundred and eighty-two outpatients (58% males) attending our psoriatic clinic between September 2009 and November 2010 were analyzed. All subjects were examined by a dermatologist who registered demographic, family, and personal history of psoriasis, biometric, and other relevant data on a case report form. To confirm the diagnosis of PsA, all patients with joint involvement underwent a rheumatologic evaluation. Four hundred fifty-one psoriatic patients were included in the study: 172 patients (38.1%) had nail involvement, 147 (32.5%) had scalp lesions, and 40 patients (8.8%) received a diagnosis of PsA. Specifically, 55% of patients affected by PsA had nail involvement, 32.5% had scalp involvement and 20% showed all three sites involved. In our study, the prevalence of PsA is lower than that reported in literature, but we observed a very strong correlation between the involvement of nails (in more than half of patients) and scalp (in about one third of patients) and PsA. So, our study points out that it is very important to carefully examine these sites in all psoriatic patients, because they could represent predicting factors for the development of a future arthropathy.

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The risk of incident depression and anxiety in patients with psoriasis: A population-based cohort study

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Background: An association between psoriasis and psychiatric morbidity has been explored. However, no studies have been reported regarding the psychiatric morbidity risk in Asian psoriasis populations.

Objectives: The aim of this study was to estimate the risk of incident depression and anxiety after adjusting age, gender and severity in new-onset psoriasis patients compared with the psoriasis-free subjects.

Methods: We conducted a retrospective cohort study on the Taiwan National Health Insurance research data. The study included 7079 patients with new-onset psoriasis and 7079 corresponding subjects without psoriasis. Psoriasis patients who received a systemic treatment consistent with extensive disease were classified as severe (N = 862) and those who did not receive systemic therapies were classified as mild (N = 6217). All enrolled subjects were followed-up until the end of 2008. We identified the first-time diagnosis of depression and anxiety based on ICD-9-CM codes and corresponding therapies. After excluding the subjects with history of depression or anxiety, the analyses were adjusted for age, gender, and person−time using a Cox proportional hazards model.

Results: Among the psoriasis patients, 301 had incident depression, and 534 had incident anxiety. The 4-year cumulative incidence rates among psoriasis patients were as follows: depression: 4.4%; and anxiety: 8.6%. The adjusted hazard ratios (HRs) were increased among patients with psoriasis versus the comparison cohort for incident depression (HR, 1.67; 95% CI, 1.37-2.03), and anxiety (HR, 1.39; 95% CI, 1.22-1.59). The HRs of depression and anxiety were higher in severe compared with mild psoriasis (depression: 1.88 vs 1.63; anxiety: 1.55 vs 1.37). Older or female patients with psoriasis had elevated HRs of interested outcomes compared with younger or male patients with psoriasis.

Conclusion: In this large population-based cohort study the risk of incident depression and anxiety were increased for patients with psoriasis as compared with a psoriasis-free comparison group. The risk increased with age and psoriasis severity. It is important for clinicians to evaluate patients with psoriasis for these conditions to improve outcomes. Future investigation should determine the mechanisms by which psoriasis or its treatment is associated with psychiatric outcomes as well as approaches for prevention.

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Topical treatment habits in psoriasis patients receiving adalimumab

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Objective: Biologics are used increasingly to treat moderate to severe psoriasis. The effects of combining topicals and moisturizers with biologics are still unclear. Here we evaluated the topical treatment habits (corticosteroids and vitamin D derivatives) and moisturizer use of 97 Swiss patients (65 males, 32 females) receiving adalimumab.

Methods: During telephone contact with patients having opted for home delivery of adalimumab, the pharmacist asked patients about their topical treatment habits and psoriasis activity in the form of a short cross-sectional survey.

Results: Forty-seven patients (48.5%) were free of psoriatic lesions at an average of 13 months after starting a monotherapy with adalimumab, and 8 (17%) thereof still used topical treatment. In contrast, 38 (76%) of the 50 patients with remaining psoriatic lesions used topicals. More than three quarters of patients indicated that the perceived efficacy of additional topical therapy was ≥ 5 on a VAS scale (0-10). The use of moisturizers, however, did not correlate with disease activity.

Conclusion: Topical treatment use by patients treated with adalimumab is associated with remaining disease activity. 83% of patients without residual plaques, or 40% of all adalimumab patients, are able to stop topical treatment completely.

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Tumor necrosis factor blocker treatment patterns after discontinuation within the first year of therapy initiation in psoriatic arthritis patients in a real-world managed care setting

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Background: Clinical guidelines and published literature do not offer specific recommendations for treatment options after discontinuing a tumor necrosis factor (TNF) blocker for psoriasis (PsO). Some clinical trials have tested the efficacy of switching among TNF blockers, but rates of TNF-blocker use after discontinuation in a real-world setting are not well characterized.

Objective: To estimate the rate of and time to restart the initial TNF blocker or switch to another biologic within the first year of therapy initiation among PsA patients discontinuing etanercept (ETN), adalimumab (ADA), or infliximab (INF) in a real-world managed care setting.

Methods: MarketScan Commercial Database was used to identify biologic-naïve adult (18-64 years) PsA patients with ≥ 1 claim for ETN, ADA, or INF between 11/1/2005 and 6/30/2009. Patients were required to have 1 year of follow-up after the date of the initial TNF blocker claim (index date) and 6 months continuous enrollment prior to index (pre-index period). Patients diagnosed with rheumatoid arthritis, psoriasis, ankylosing spondylitis, juvenile idiopathic arthritis, Crohn disease, or ulcerative colitis in the preindex period were excluded. Discontinuation from index therapy was defined as either a >45 day gap in therapy or switch to another biologic. Time to restart or switch was measured in days from index date of initial TNF blocker therapy.

Results: Overall, 567 etanercept, 426 adalimumab, and 133 infliximab PsA patients were included. Patient characteristics were similar between the treatment groups with a mean age (SD) of 48 (10) years and 50% male. Restart rates for the initial TNF blocker therapy after discontinuation were 30% for ETN, 17% for ADA, and 17% for INF. Mean (SD) time to restart was 230 (81) days for ETN, 232 (85) days for ADA, and 263 (75) days for INF. Switch to any non-index biologic occurred in 12% of ETN, 13% of ADA, and 11% of INF patients. Of the patients who switched, the majority (83%) switched to one of the other TNF-blockers (ETN, ADA, or INF) with a mean time to switch between 133 to 214 days.

Conclusion: Among biologic-naïve PsA patients in a managed care setting, 17% to 30% of patients restart the initial TNF blocker therapy and approximately 11% to 13% switch to another biologic. The majority of patients discontinued and restarted therapy within 230 to 263 days, whereas switching to another TNF blocker therapy occurred around 133 to 214 days from initiation of index therapy.

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