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OPINION ARTICLE

Multidisciplinary Teams for Psoriatic Arthritis: On Aims and Approaches☆

Unidades multidisciplinarias de artritis psoriásica: sobre objetivos y modelos

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Early diagnosis and treatment of psoriatic arthritis (PsA) are critical for achieving optimal control of the disease and preventing progression to joint destruction, functional disability, and reduced quality-of-life.[1–3] The comorbidities associated with PsA, such as depression and cardiovascular events, should also be prevented, detected, and treated.[4] These are realistic objectives because we now have a better understanding of the disease, sensitive imaging techniques, such as ultrasound and magnetic resonance imaging, and effective treatments for all the manifestations of PsA.[5]

As skin disease usually precedes joint disease in this setting and about 30% of psoriasis patients will develop PsA, regular follow-up assessments are essential to ensure early detection of arthritis.[6,7] This is a challenge that can only be met by co-management of these patients by dermatologists and rheumatologists. Collaboration between a dermatologist and a rheumatologist makes possible more complete assessment of the overall cutaneous and musculoskeletal involvement and consequently leads to a more comprehensive therapeutic approach.[8]

Although different models of collaboration between the 2 specialties are possible and these will always be determined by the needs and unique circumstances of each center, we should not lose sight of the chief objective: early and comprehensive diagnosis and treatment of the patient with PsA.

In the United States, several pioneering units have already been set up in which patients with psoriatic disease are treated by a multidisciplinary team that includes not only dermatologists and rheumatologists, but also psychiatrists and psychologists.[9] These units also maintain close contact with gastroenterologists, cardiologists, ophthalmologists, and endocrinologists. These centers for psoriatic disease have clinical functions (inpatient and outpatient clinics) and also organize educational activities for residents, students, and other physicians and occasionally dermatology/rheumatology conferences. They also conduct clinical research (clinical trials) and keep longitudinal records of clinical, demographic, biological, and genetic data, as well as biological samples for research purposes. Since consensus between specialists, funding, and a premises are all prerequisites for setting up such centers, they may be difficult to start. Moreover, hard data is needed to confirm that this type of organizational structure obtains better clinical outcomes than other models, is cost-efficient, and generates new knowledge that can improve control of the disease.

Other collaborative units have a more pragmatic goal: to resolve diagnostic and therapeutic problems in patients with a confirmed or suspected diagnosis of PsA. In a multidisciplinary unit in Boston, patients are seen at a weekly clinic by a rheumatologist and a dermatologist. Once patients have been diagnosed, treated, and stabilized they are referred back to the outpatient clinician who originally sent them to the unit (a dermatologist in 43% of cases, a rheumatologist in 27%, and a family doctor in 23%).[8] A recently published

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retrospective study of 6 years of experience in that clinic provides data on the number of patients treated (510), the final diagnosis in each case (53% were diagnosed with PsA), comorbidities (hypertension 45%, hyperlipidemia 36%, and diabetes 19%), and the changes made in treatment (the proportion of patients on systemic therapy increased from 12% to 25%, and on biologic therapy from 16% to 37%). The total number of new patients treated grew steadily year on year. In total, 82% of patients were referred back to their physician after modification of their treatment had achieved stabilization of their condition. The authors concluded that these results represent preliminary evidence to support the usefulness of a multidisciplinary integrated care model for this subgroup of patients with more severe disease, and that it may serve as an example for other centers interested in co-management models. They also underscore the need for studies on the cost-effectiveness of this type of care model and the impact of multidisciplinary approaches on the efficiency of community health services and patient quality-of-life.

In this issue of ACTAS DERMO-SIFILIOGRÁFICAS, Luelmo et al.[10] report on 4 years of experience in a co-management program (dermatologist/rheumatologist) with monthly consultations at the Hospital de Parc Taulí (Sabadell, Barcelona). The program design included a preliminary project to define the criteria for referral to the unit agreed by consensus and to raise awareness among specialists from both departments (rheumatology and dermatology) about the usefulness of joint consultation. Once the preliminary project had been completed, a schedule of monthly joint clinics in the rheumatology department was drawn up. The report presents data for the period between 2009 and 2012. The model is similar to that used in the Boston unit,[8] although in this case the patients are referred only from the rheumatology and dermatology services of the hospital itself. The initiative is interesting because it is the first program in Spain to develop a co-management model to improve the care of patients with PsA and the management of their disease. We can also learn from the achievements and limitations of this model, and reflect on the fit between its objectives and the methods used.

In the 4-year period studied, the unit evaluated 180 patients; 63% were referred from rheumatology and 37% from dermatology. The main reasons for referral were suspected PsA (59%), which was confirmed in 66% of these cases, and specific problems relating to treatment (41%). Of the patients who attended the clinic during the study period, the diagnosis was revised in 32%, treatment was modified in 47%, and the original diagnosis and treatment were maintained in only 21%. In total, 24% of the patients were diagnosed with PsA for the first time, while 37% were diagnosed with noninflammatory arthritis (osteoarthritis and others). Of particular interest is the low diagnostic concordance the authors observed in the case of both the patients referred by rheumatologists and those sent by dermatologists. No information on comorbidities or outcomes is provided.

This article raises several questions, such as why the performance of the model over the 4 years not been evaluated with a view to remedying some of the obvious problems? For example, the low rate of referral by dermatologists appears to be a problem since an increase in referral from these specialists is crucial to the early diagnosis of PsA. Although the authors mention that early diagnosis was not the aim of the program, they later mention it as one of its achievements. To cite another example, since it was decided at the outset that the Psoriatic Arthritis Screening and Evaluation (PASE) questionnaire should be used as a screening tool, why has its use not been promoted more systematically (the authors report that is only used in 5% of cases). It is also surprising that this program has been able to continue to meet the demand for care with monthly joint clinics. What usually happens is that the steady growth in referrals leads to an increase in the frequency of the scheduled clinics.

Although the initial phase of this program included training for the 2 groups of specialists involved to raise awareness of the need for this type of multidisciplinary collaboration, the diagnostic concordance appears to be alarmingly low. The lack of concordance may be an indication that more training and work is needed to create greater awareness of PsA among rheumatologists and dermatologists or that the specialists responsible for the integrated unit should undertake the care of all the patients with this type of disease.

Concrete information on procedures and the patients' clinical and functional outcomes and comorbidities is also scant. The interest of this initiative should be appreciated and it is important to recognize the difficulties involved and the credit due to the participants for the effort they have made to implement a new model of care. At the same time, the satisfaction must also be qualified and the model must be analyzed critically in light of its goals and objectives in order to improve it and make it even more appropriate for the coordinated management of PsA.

There is no doubt that in our current health care system there are obstacles to a model involving ''super specialists'' who monopolize the management of a particular disease in a hospital, and that it is difficult to implement the administrative changes needed to organize the care and reception of patients from other departments to centers of reference devoted exclusively to the care of psoriatic disease. However, integrated care models for patients with PsA may be able to optimize control of the disease and achieve better clinical outcomes at a lower cost, although this has not yet been demonstrated.

In this context, it is interesting to describe the experience of another multidisciplinary unit: PAIDER (from the Spanish ''*programa de atención integral dermatología-reumatología*''), a coordinated care program involving dermatologists and rheumatologists in the Hospital de la Santa Creu i Sant Pau. PAIDER was set up in 2012 and only treats patients with a confirmed or suspected diagnosis of PsA. In addition to the enthusiasm of the members of the co-management team and the heads of the 2 departments involved, the willingness of all the dermatologists and rheumatologists to participate is also essential. This is facilitated by the presence of a core group within the hospital of several dermatologists and rheumatologists who devote a large percentage (or even all) of their time to the treatment of patients with moderate to severe psoriasis and PsA, respectively. Moreover, the existence of the program increases the training and capacity building of all of the specialists in the diagnosis and management of PsA, rendering the use of screening tools unnecessary within the hospital.

It is important to define patient flows and referral pathways from the outset, and very useful to create a

specific duplicate appointments system, since visits involving 2 specialists have to be included in the accounting of both departments. Patients can be referred from either department by way of a referral from the ''hierarchized'' specialists themselves, or they may be channeled directly from the primary care level as a result of an analysis of the primary care physician's referral report. In view of the prevalence of the disease and the need to achieve rapid referral flows, it was quickly realized that a weekly clinic would be necessary. In this model there are 2 types of consultation: those triggered by a request for a diagnosis or adjustment in treatment, which can be quickly resolved, after which the patient returns to the care of the referring specialist or to the normal care pathways of the rheumatology or dermatology department; and those involving patients who require follow-up to assess the results of tests, changes in treatment, or because the case is particularly complex (for example, paradoxical reactions to a biologic agent). In this model, preferential referral pathways have been established that send patients to practitioners who are specialists in the management of the major comorbidities of psoriasis (clinical psychologist, dietitian, internist). In this way, the PAIDER consultation has become the central axis in the integrated care of these patients.

There is no doubt that this model is beneficial to the patient in terms of quality of care, patient satisfaction with the process, shorter delays before referral (which may even prevent the progression of PsA by ensuring early diagnosis and treatment of the condition), and therapeutic management. However, the direct and indirect economic benefits and the benefits in terms of health outcomes are difficult to quantify.

Everything discussed in this article leads us to believe that, although there appears to be consensus on the desirability of establishing integrated dermatology/rheumatology units, further reflection is needed on the best model to follow. The objectives, methods, processes, and outcomes that will be evaluated must be clearly defined at the outset. Only thus can we continually improve the model through critical analysis of the procedures and ensure that its weaknesses are detected and corrected. The process of setting up such units may involve several stages before the ideal model for the particular situation is identified and defined. Fast track units dealing with diagnostic and therapeutic problems may represent the initial stage of a transition toward models of integrated care for patients with PsA and eventually for all the important comorbidities of psoriasis.

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