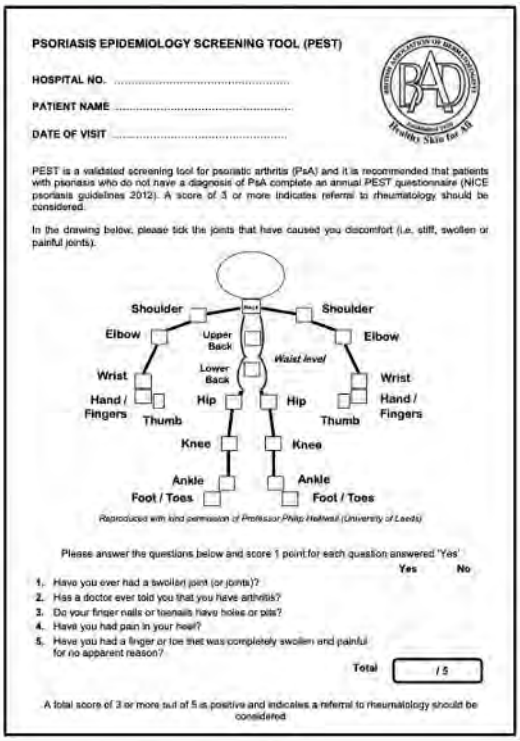
Psoriatic arthritis screening

In a recent study funded by the Psoriasis and Psoriatic Arthritis Alliance, research pharmacist Dr Rod Tucker examined whether the new breed of clinical pharmacists working within general practices could be used to help identify patients with psoriatic arthritis (PsA).

The chronic and progressive nature of PsA highlights the need for regularly screening of patients with psoriasis to help identify potential sufferers so that they can be promptly referred to a rheumatologist for further assessment. According to NICE, PsA affects up to 30% of those with psoriasis and its psoriasis guideline recommends that healthcare professionals "offer an annual assessment for psoriatic arthritis to people with any type of psoriasis" and that "as soon as psoriatic arthritis is suspected, refer the person to a rheumatologist for assessment and advice about planning their care".



PSORIASIS EPIDEMIOLOGY SCREENING TOOL (PEST)

HOSPITAL NO. .....

PATIENT NAME .....

DATE OF VISIT .....

PEST is a validated screening tool for psoriatic arthritis (PsA) and it is recommended that patients with psoriasis who do not have a diagnosis of PsA complete an annual PEST questionnaire (NICE psoriasis guidelines 2012). A score of 3 or more indicates referral to rheumatology should be considered.

In the drawing below, please tick the joints that have caused you discomfort (i.e. stiff, swollen or painful joints).

Shoulder, Shoulder, Elbow, Upper Back, Elbow, Waist level, Wrist, Lower Back, Wrist, Hand / Fingers, Hip, Hip, Hand / Fingers, Thumb, Thumb, Knee, Knee, Ankle, Ankle, Foot / Toes, Foot / Toes

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Please answer the questions below and score 1 point for each question answered 'Yes'

	Yes	No
1. Have you ever had a swollen joint (or joints)?		
2. Has a doctor ever told you that you have arthritis?		
3. Do your finger nails or toenails have holes or pits?		
4. Have you had pain in your heel?		
5. Have you had a finger or toe that was completely swollen and painful for no apparent reason?		
Total	/ 5	

A total score of 3 or more out of 5 is positive and indicates a referral to rheumatology should be considered

In primary care, the Psoriasis Epidemiological Screening tool (PEST) represents a means of identifying those who may have PsA. The tool asks patients five simple yes/no questions about swollen joints and heel pain. Where at least three of these questions are answered in the affirmative, patients should be referred to a rheumatologist.

However, a recognised limitation of PEST is the inability to identify patients with axial (i.e. spinal) PsA. Consequently, an additional inflammatory back pain tool (IBP) can be used in conjunction with PEST for those with inflammatory back pain (which can be due to axial PsA).

Although performing a screening programme would appear straightforward, a major barrier in primary care is that joint pain is extremely common. For example, in one study in over 15,000 individuals, 54% reported multiple-site joint pain. Consequently, if a patient with psoriasis complains of joint stiffness and pain, unless their GP is aware of PsA, it is more likely that he/she will provide symptomatic relief with a prescription for painkillers rather than trying to establish the underlying cause.

A further concern in primary care is that a screening programme might lead to additional GP appointments and since many GPs already feel under pressure, they are unlikely to be supportive of such an initiative.

The study

One potential solution to avoiding the potential increased GP workload from screening would be to make use of the increasing number of practice-based clinical pharmacists working in general practice to support GPs. Their role is predominately medicine management, which involves reviewing current medicines.

Although it would be easy enough for the pharmacists to undertake a screening programme, what about patient referral? This is usually done via GPs, who would normally want to see and examine the patient to confirm the suspicion of PsA. This would obviously increase their workload. A solution was for the practice pharmacist to agree a referral template letter with the GP.

After all, according to the NICE guideline, once PsA was suspected, as would be the case from a screening programme, then referral to a rheumatologist is warranted. It therefore doesn't really matter whether the patient was seen by the GP because the index of suspicion for PsA would already be raised.

For the study, a total of five GP practices agreed to participate in the research and in each case,

I contacted the lead GP to discuss the project to ensure their support as well as speaking with the clinical pharmacist and the practice manager.

Each practice performed a search of its patient database using criteria kindly developed by one of the practice's IT staff. Identified patients were sent an information leaflet describing the nature of the study and a consent form (required for NHS ethics approval) together with a copy of the PEST and IBP tools, which they were asked to complete and return to the practice.

The predefined referral criteria were a PEST and IBP after discussion with the specialist rheumatologist who sat on the NICE psoriasis guideline group. The clinical pharmacist reviewed the returned forms and arranged for any relevant blood tests (as dictated by local referral policies) to be done, prior to referral. The local rheumatology departments were also contacted to inform them about the study – primarily to inform them of a potential surge in referrals!

The results

In total, 276 eligible patients were identified, with a response received from 184 (66%). Interestingly, the mean sample PEST score was 2.12 and the IBP score was 1.61, which were substantially lower than the referral criteria. In fact, only 18 patients met the predefined referral criteria (i.e. PEST and IBP) and, of these patients, a total of nine were currently prescribed analgesics for "joint pain".

Unfortunately, and despite several requests, only 13 patients attended their rheumatology appointment, from which only a single patient was diagnosed with PsA. Other diagnoses included osteoarthritis but, in some cases, while PsA was ruled out, no specific diagnosis was given on the letter sent to the practice.

Conclusion

In a sample of 184 primary care psoriasis patients, only 18 met the criteria for referral to a rheumatologist with only one being subsequently diagnosed with PsA. Nevertheless, since five patients did not attend their outpatient appointments, additional cases may have been missed.

An important recommendation from the study was that clinical pharmacists should perhaps refocus their efforts away from general screening and concentrate more on performing annual medicine reviews in those with psoriasis. In addition, they could provide educational support, alerting patients to the main symptoms of PsA and undertaking screening among those displaying symptoms to ensure a more targeted approach so that referrals become more appropriate.

Study lead
Dr Rod Tucker