Managing PsA with pharmacological therapies

This is the lay version of the 2019 update of the EULAR recommendations for the management of psoriatic arthritis using pharmacological medicines. The original publication can be downloaded from the EULAR website: www.eular.org.

Gossec L, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update. Ann Rheum Dis 2020;79:700–712. doi:10.1136/annrheumdis-2020-217159

Introduction

EULAR recommendations give advice to doctors, nurses and patients about the best way to treat and manage diseases. EULAR has updated its recommendations on the management of people with psoriatic arthritis (sometimes shortened to PsA). Psoriatic arthritis is a condition where the joints become stiff, painful and damaged due to the immune system attacking the body's own tissues and causing inflammation. It is often associated with a skin condition called psoriasis.

Doctors, nurses, other health professionals and patients worked together to develop this advice. The patients in the team ensured that the patient point of view was included. The authors looked at the evidence on drug treatments for people with psoriatic arthritis. There are separate recommendations for non-pharmacological options for the disease.

What do we already know?

The day-to-day management of people with psoriatic arthritis includes several pharmacological (drug) options. Psoriatic arthritis can present differently in different people, and so the most appropriate drug for each person will depend on their own particular symptoms with respect to the affected joints or other parts of the body.

These recommendations include information on several different types of groups of drugs that are used to treat psoriatic arthritis. The main groups are listed below.

- Non-steroidal anti-inflammatory drugs (also called NSAIDs): these drugs only relieve symptoms.
- Disease modifying anti-rheumatic drugs (often shortened to DMARDs) aim to change the course of the disease by reducing inflammation. These drugs can prevent flares and disease worsening. They can also help to improve function and stop the progression of joint damage. DMARDs include:
    - Conventional synthetic disease modifying anti-rheumatic drugs (shortened to csDMARDs): these are the traditional DMARDs and include methotrexate, which has been used effectively for more than 50 years.
    - Biologic disease modifying anti-rheumatic drugs (also called bDMARDs, biologics or biologicals). These are injectable drugs (most are used subcutaneously) that target the inflammatory process. These types of drugs have been available for up to 20 years.
    - Targeted synthetic disease modifying anti-rheumatic drugs (shortened to tsDMARDs): these are oral drugs that target the inflammatory process.

EULAR recommendations on the pharmacological management of psoriatic arthritis were last updated in 2015, and have now been updated again based on new evidence, and to include new treatments that have become available since the last version.

What do the recommendations say?

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In total, there are 6 overarching principles and 12 recommendations. The main principles remain mostly unchanged from the 2015 recommendations, and talk about the diverse nature of psoriatic arthritis and the different musculoskeletal and non-musculoskeletal manifestations. They also stress the need for collaborative management and shared decision-making. Of the 12 recommendations, 3 are new, 1 remains unchanged but has been renumbered, and the rest have been modified or rephrased.

Each recommendation is based on the best current knowledge and studies of scientific evidence or expert opinion. The more stars a recommendation has the stronger the evidence is. However, recommendations with limited scientific evidence may be important, because the experts can have a strong opinion even when the published evidence may be lacking.

One star (*) means it is a recommendation with limited scientific evidence.

Two stars (**) means it is a recommendation with some scientific evidence.

Three stars (***) means it is a recommendation with quite a lot of scientific evidence.

Four stars (****) means it is a recommendation supported with a lot of scientific evidence.

- **Your treatment goal should be remission or low disease activity; this is achieved with check-ups and adjusting treatment if needed.****
  The goal of your treatment should be remission or low disease activity. Remission means that the disease is well-controlled, there is no longer any inflammation such as swollen joints and no signs of inflammation in blood tests. However, there may still be some symptoms even in remission. Low disease activity means that your levels of inflammation are very low. Your doctor can help you to achieve these goals by keeping a close eye on your disease by examining you and asking for tests as needed. Your doctor may also adjust your treatment up or down as needed.

- **Non-steroidal anti-inflammatory drugs may be used to relieve pain in your joints and entheses or spine.****
  NSAIDs can help to reduce pain and improve mobility (movement) in your joints, but do not stop joint damage. These drugs will not help the skin psoriasis.

- **Glucocorticoid injections should be considered; low doses of glucocorticoid pills can sometimes be used.****
  Glucocorticoid (steroid) injections in affected joints or near tendons can provide symptom relief for people with psoriatic arthritis. Steroids taken by other means (e.g. as tablets) are not usually recommended but may be used with caution at the lowest possible dose.

- **People with many swollen joints should be quickly treated with a csDMARD – preferably methotrexate if their skin is also affected.*****
  People with polyarticular disease should receive a csDMARD either first-line or after a short course of NSAIDs. The recommendations say that csDMARDs should be started quickly – ideally within 2 weeks, depending on the severity of symptoms – and continued for at least 3 months. The csDMARD can be stopped or switched if there is less than 50% improvement within 3 months, or if the treatment target is not reached within 6 months. Methotrexate works well on both joints and skin psoriasis, which is why it is recommended especially if your skin is involved.

- **People with few swollen joints will also benefit from csDMARDs, especially if there is joint damage visible on X-rays, inflammation on blood tests, or disease affecting the nails or leading to swollen fingers.****
  You may receive a csDMARD even if you have only a few swollen joints. This will depend on other

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factors that can affect how your disease will progress – for example, if you have joint damage, high levels of inflammation, or swollen fingers and nail damage. Currently methotrexate is proposed as the first choice.

- **A bDMARD should be prescribed for people with swollen joints who have not responded to at least one csDMARD; if you have a lot of psoriasis as well an IL-17 or IL-12/23-inhibitor may be preferred.*****
  If you have tried csDMARDs but not seen any improvement, you might be prescribed a bDMARD. The recommendations do not distinguish between the different types of bDMARDs available, so you may receive a TNF inhibitor, IL-12/23 or IL-17 inhibitor, depending on your symptoms and profile. The only exception is if you have extensive skin disease, when an IL-17 or IL-12/23 inhibitor may be a better choice for you. Usually, methotrexate is given with the bDMARD.

- **A JAKi may be considered if you have swollen joints and have not responded to at least one csDMARD and at least one bDMARD, or for people who cannot take bDMARDs.*****
  For people who have tried csDMARDs and bDMARDs without any success, or for whom a bDMARD is not a good solution, JAK inhibitors can be used. This includes people who cannot tolerate injections or who have a strong preference for an oral drug.

- **If you cannot take a bDMARD or JAKi, a PDE4i may be considered for mild disease that has not responded to least one csDMARD.*****
  PDE4 inhibitors can be proposed when csDMARD therapy has failed and bDMARDs and JAKi are not appropriate. This option might be suitable for you if you have mild disease in four joints or fewer, you have lower disease activity and/or limited skin involvement.

- **A bDMARD should be considered for people with enthesitis who have not got better with NSAIDs or steroid injections.*****
  In people whose symptom of psoriatic arthritis is mostly enthesitis (tendon pain and inflammation), NSAIDs and steroid injections are the first-line treatment. If this does not work well for you then a bDMARD may be used without trying a csDMARD first. There is no preference for which type of bDMARD to use.

- **A bDMARD should be considered for people whose disease is mostly in their lower back and who do not get relief from NSAIDs. A TNFi is the usual choice, but IL-17 inhibitors can be used if you have psoriasis as well.*****
  If you have axial psoriatic arthritis, and if NSAIDs do not work well enough, a bDMARD may be proposed. If you have extensive skin involvement then an IL-17 inhibitor is preferred over a TNF inhibitor. But if you also suffer from inflammatory bowel disease or uveitis, a TNF inhibitor (monoclonal antibody) would be preferred.

- **People who do not respond to or get side effects from a bDMARD can be switched to a different bDMARD or a tsDMARD; this includes one switch within the same class of medicine.****
  It is possible to switch drugs within a class if a first option does not work. However, the recommendations also say it is logical to change class after a second failure, and try a drug that works in a different way.

- **In people in sustained remission, cautious tapering of DMARDs may be considered.****
  This is a new recommendation. Reducing the dose of DMARDs may be possible in some people

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who have stayed in complete remission for at least 6 months. This should be done very carefully and only after discussion between you and your doctor. The intention is not to completely stop treatment but rather to find the smallest effective dose, either through dose reduction or increasing the time between doses.

Summary

Overall, the recommendations highlight that there are many different treatments available for psoriatic arthritis. Some are more beneficial for specific symptoms than others. If you have psoriatic arthritis these recommendations will give you some guidance on what to expect from your rheumatologist and what drug treatments you may be offered.

Recommendations with just one or two stars are based mainly on expert opinion and not backed up by studies. These may be as important as those with three or four stars.

If you have any questions or concerns about your disease or your medication, you should speak to a health professional involved in your care.

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