



ARTHRITIS FOUNDATION

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PSORIATIC ARTHRITIS

This information leaflet is published by the Arthritis Foundation
as part of our continuing education
programme for all people with arthritis.



The Bone and Joint Decade is a global campaign to improve the quality of life for people with musculoskeletal conditions and to advance understanding treatment of those conditions through research, prevention and education.

What is in this booklet?

This booklet aims to answer questions commonly asked by people who have psoriatic arthritis. Each section deals with a different question. A brief answer (in italics) is followed by a more detailed explanation.

What is psoriatic arthritis?

Psoriatic arthritis causes inflammation in and around the joints, usually in people who already have the skin condition psoriasis. Sometimes, however, the arthritis develops before the psoriasis.

There are 78 major joints in the body and psoriatic arthritis can affect any one of these. However, certain joints are more likely to be affected - these are shown in Figure 1. Different patterns are found. Sometimes it affects just one or two joints such as a knee or ankle, but often several joints, both large and small and on both sides of the body, are involved. About a third of people with psoriatic arthritis also have a painful, stiff back caused by inflammation in the spine. This is called spondylitis.

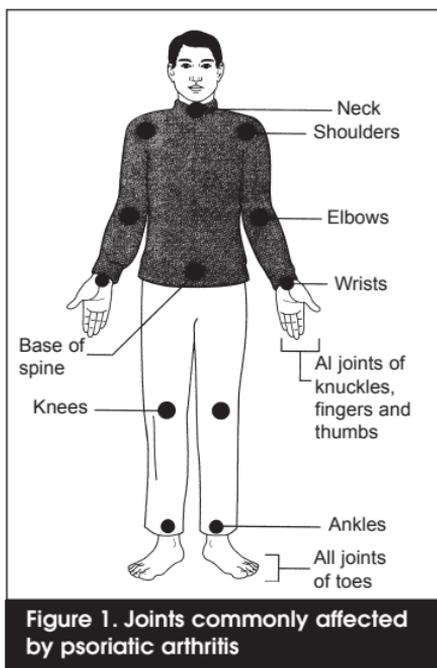


Figure 1. Joints commonly affected by psoriatic arthritis

Psoriasis can affect the nails with pitting, discoloration and thickening. Sometimes the joint at the end of the finger or toe can also be inflamed. There can be a sausage-like swelling of a finger or toe with psoriatic arthritis. This is called dactylitis and is caused by inflammation occurring simultaneously in joints and tendons. Painful heels can be caused by inflammation where gristle attaches to bone. Some of the symptoms of psoriatic arthritis are shown in Figure 2.

Psoriatic arthritis usually affects adults but occasionally children can develop the disease.

How does the doctor diagnose psoriatic arthritis?

Psoriatic arthritis is diagnosed based on your symptoms and on what your doctor finds when s/he examines you. There is no specific test for psoriatic arthritis.

Most doctors would check for psoriasis, or a history of psoriasis in a close relative, together with arthritis and inflammation in at least one joint. It can be difficult to distinguish between psoriatic arthritis and rheumatoid arthritis. If several joints are affected doctors will consider features such as the pattern of arthritis (which joints are affected) and other symptoms (see 'What is psoriatic arthritis?') to distinguish between the two conditions. Blood tests for rheumatoid factor, if negative, may also help to rule out rheumatoid arthritis.

Can psoriatic arthritis attack other organs of the body?

Usually, apart from the skin, nails and joints, no other major organs are affected.

People with psoriatic arthritis may be more likely to develop an itchy, red eye due to conjunctivitis, and some people may occasionally develop a painful, red eye caused by inflammation around the pupil of the eye. This is called iritis or uveitis. Some people may also develop anaemia (a shortage of red blood cells). Although this is not a specific feature of psoriatic arthritis it can sometimes happen as a result of long-term inflammation.

How common is psoriatic arthritis?

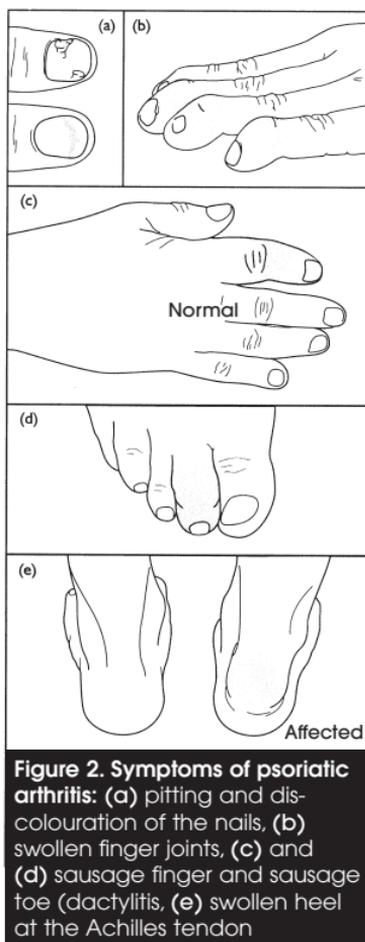
Psoriatic arthritis is not common. About 1 in 50 people have psoriasis, and of these about 1 in 14 will develop psoriatic arthritis.

People with psoriasis may also have other forms of arthritis, such as osteoarthritis or rheumatoid arthritis, but these are not linked to the psoriasis and are not dealt with in this booklet (see Arthritis Foundation booklets 'Osteoarthritis' and 'Rheumatoid Arthritis').

What is the cause?

At present, the exact cause is unknown..

A particular combination of genes make some people more likely to get psoriasis and psoriatic arthritis. Current research suggests that something (perhaps an infection) acts as a trigger in people who are susceptible to this type of arthritis because of their genetic make-up. No specific infection has been found and it may be that a variety of infections (including bacteria that live in patches of psoriasis) can trigger the disease.



Will my children develop psoriatic arthritis?

Your children will be more likely than the next person to get psoriatic arthritis but the risk is still low.

Both psoriasis and psoriatic arthritis occur more frequently in some families than in others. Sometimes other diseases such as inflammation of the bowel (Crohn's disease and ulcerative

colitis), stiffening of the spine (ankylosing spondylitis) and severe eye inflammation (iritis or uveitis) also run in the same family. The link is genetic but the risk of passing it on is low.

What links the skin and the joints in psoriatic arthritis?

The link is probably genetic but fortunately many treatments help the skin and the joints at the same time.

Some people find that when their psoriasis is bad their arthritis is also bad and as one improves, so does the other. It is possible that bacteria in the skin disease trigger the inflammation in the joints (see 'What is the cause?'). Most people develop psoriasis before the arthritis but about 1 in 10 develop the arthritis first.

Who can help?

Treatment is given by a team of health workers (usually a rheumatology team) including doctors, nurses, physiotherapists, occupational therapists and podiatrists.

The doctor (either your GP or a specialist) will normally be the first to diagnose your condition, and will probably also be the person who refers you to other members of the team and starts treatment with drugs. The other members of the health team play an important role in helping you to understand the disease, as well as monitoring the condition and providing treatment within their own specialist areas. Their advice and treatments are invaluable because tablets are not the only way of treating psoriatic arthritis. Although the roles of the rheumatology team members overlap, a general guide to their specialist areas is shown below:

The nurse practitioner will provide information and guidance about your disease and the drugs you take but will also give advice and information relating to your home and personal situation.

The physiotherapist will assist you with physical therapies (use of heat, cold, and other therapies to help your joints) and will advise on helpful exercises. It is important to maintain the mobility of your joints as well as maintaining the strength in your muscles. Exercise therapy is particularly important in people with spinal inflammation (spondylitis).

The occupational therapist has an important role in advising you on how to protect your joints from further damage and s\he may give you splints to wear - particularly on your wrists

and hands (see Figure 3). S/he will also assess whether equipment is needed to help you cope at home.

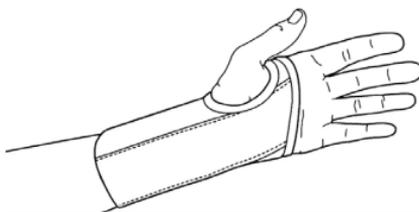


Figure 3. A wrist splint

The podiatrist (foot specialist) will assess your need for regular foot care and whether specially made insoles will help you. S/he will also advise on footwear and where you can buy appropriate shoes.

The hospital pharmacist will probably offer extra advice on the tablets prescribed. Many of the tablets used for psoriatic arthritis are also used in other forms of arthritis, particularly rheumatoid arthritis. This is because in both conditions the joints become inflamed and the tablets are used to control this inflammation. Information about the main types of tablets used is shown below.

What are anti-inflammatory drugs?

Anti-inflammatory drugs act by blocking the effects of the inflammation which occurs in the lining of your joints.

They can be very effective in controlling the pain and stiffness of arthritis. Usually you will feel a benefit within hours of taking these drugs but the effect will only last for a few hours, so the tablets have to be taken at regular intervals for the benefit to continue. Some people find that these tablets are of little help, while others find that they help at first but the benefit begins to wear off after a few weeks. In this situation it sometimes helps to try a different anti-inflammatory drug

Examples of anti-inflammatory drugs

Diclofenac, ibuprofen, indometacin, naproxen, nabumetone, piroxicam

The main side-effect of the anti-inflammatory drugs is indigestion and, in some cases, the drugs can cause a stomach ulcer. For this reason doctors recommend taking these tablets with or after food. You must tell a health professional (preferably a member or the rheumatology team) if you get indigestion while taking these drugs as something can be done to help.

What are disease-modifying drugs?

Disease-modifying drugs help by attacking the causes of the inflammation in the lining of the joints.

These drugs act quite differently from anti-inflammatory drugs and hopefully will stop your arthritis from getting worse. Unlike anti-inflammatory drugs it may be several weeks before they start to have an effect on your joints. Therefore it is important to keep going with these tablets even if you think they aren't doing any good. Sometimes these drugs are given by injection because a suitable tablet is not available.

Disease-modifying drugs are normally used as a 'second-line' treatment and the decision to use them will depend on a number of factors including the effects of the anti-inflammatory drugs, the activity of the arthritis and the likelihood of further joint damage. Your doctor will discuss these factors with you before starting treatment.

Examples of disease-modifying drugs

Older drugs: *chloroquine/hydroxychloroquine, ciclosporin, gold, methotrexate, penicillamine, sulfasalazine*

Newer drugs: *adalimumab, anakinra, etanercept, infliximab*

Anti-inflammatory drugs can be taken along with disease-modifying drugs. In fact, it is sometimes necessary to give more than one disease-modifying drug, so you could end up taking several tablets a day. Not surprisingly some people feel sick after all these tablets but there are ways of preventing this - you could try taking your tablet with a meal (unless your doctor advises you not to).

The side-effects of disease-modifying drugs are more complex than with anti-inflammatory drugs. With almost all disease-modifying drugs you will need to have a regular blood test and, in some cases, a urine test. The blood test allows your doctor to monitor the effects of the drug on your disease, also to check that the drug is not causing problems with your blood count (the number of blood cells) or affecting your liver and kidneys. To help this monitoring a 'shared-care' card is provided which is used to keep details of the drugs, their doses, and the results of blood tests. You should carry this card at all times.

Will I need steroid treatments?

Steroids are often recommended as an injection to the inflamed joint or where the tendon attaches to the bone.

In general, steroid tablets (such as prednisolone) are not used for psoriatic arthritis. However, small injections of steroid are often recommended for joints which are particularly troublesome and for the painful bony sites where ligaments and tendons become inflamed.

What treatments will be used for the skin?

Treatment is usually with ointments but if these don't help you may need tablet treatment and light therapy.

Ointments and creams can be of five types:

- tar-based ointment and creams (it may not be obvious that they contain tar)
- dithranol-based ointments and creams (These can burn normal skin, so it is important to follow the instructions carefully.)
- steroid-based ointments, creams and lotions
- vitamin D-like such as calcipotriol and tacalcitol
- vitamin A-like (retinoid) gels such as tazarotene.

If the creams and ointments do not help the psoriasis your doctor may suggest light therapy and/or tablets such as retinoids (which are similar to vitamin A). Light therapy involves being exposed to high intensity ultraviolet light for short periods and has to be carried out in a hospital.

Many of the disease-modifying drugs used for psoriatic arthritis will also help the skin disease. Similarly, some of the treatments for psoriasis may help the arthritis. For this reason dermatologists will often work together in treating you.

Treatments for nail psoriasis are usually less effective than the skin treatments. Nail blemishes are often very noticeable to the person who suffers from them but fortunately much less so to other people. Some people use nail varnish to make the marks less noticeable.

How much rest and exercise should I take?

It is hard to generalize on this question - no two people are the same. Inflammation can cause generalized tiredness and you may find you need to take more rests than usual. On the other hand, it is very important to keep exercising the joints.

Inflammation can lead to muscle weakness and stiffness in the joints. Exercise is important to help prevent this and keep the joints functioning properly. You will need to find the right balance for yourself but remember not to neglect either rest or exercise when you are trying to help your disease.

Chronic pain can get you down and may cause stress, anxiety and depression. Counselling can help, and so can relaxation techniques - these can be taught by a physiotherapist. Stress is not the cause of psoriatic arthritis but can make it feel worse - so it will help if you can find ways of reducing and dealing with stress.

Are any special diets recommended?

Many diets have been suggested for psoriatic arthritis but none have been found to be very effective.

A number of books recommend different diets for people with arthritis. However, some books contradict each other. Some may even recommend stopping your tablets in order to try the diet. Don't do this without discussing it with your doctor. Sometimes the diet can reduce the need to take tablets but unfortunately this is rare. Fish oils from marine (sea water) fish may reduce the amount of anti-inflammatory drugs needed to control joint inflammation and may therefore be worth a try.

If you are overweight, you need to follow a weight-reducing diet because extra weight will add to the strain on your leg joints and back.

For more information, see Arthritis Foundation booklets '*Diet and Arthritis*' and '*Complementary Therapies and Arthritis*'.

Should I give up work?

The answer to this question depends on your arthritis, your age and your job.

People who work - both in physical jobs and in offices - will

have difficulties if they develop arthritis, but the problem may not be as serious as it first appears.

Will this disease affect my sex life or my chances of having children?

Your chances of having children will not be affected. Painful joints can be a problem and interfere with your sex life but there are ways round this.

Psoriatic arthritis will not in itself affect your chances of having children or a successful pregnancy. For a woman who becomes pregnant, the arthritis often improves during the pregnancy. However, the arthritis may worsen again after the child has been born. It is worth remembering that looking after small babies is hard work and even harder if you have painful joints. Would-be mothers with psoriatic arthritis should therefore try to arrange plenty of help with childcare.

Some of the drug treatment given for psoriatic arthritis should be avoided when trying to start a family. For instance, sulfasalazine can cause a low sperm count (this is not permanent) and you should not try for a baby if you or your partner are on methotrexate or have been using it in recent months. **If you are considering starting a family you should discuss your drug treatment with your doctor.**

Sexual intercourse may be painful, particularly for a woman whose hips are affected. Using different positions can help. It may help to discuss this with a member of the rheumatology team.

Will I need an operation?

Operations are sometimes necessary to repair damaged tendons and, more rarely, to replace worn-out joints.

Operations are not often needed in psoriatic arthritis. Very occasionally a tendon may become damaged and need surgical repair. Sometimes, after many years of disease, a joint worn out by inflammation is best treated by a replacement with an artificial joint. There is no reason why this should be any more difficult in psoriatic arthritis than in any other type of arthritis. However, if the psoriasis is bad in the skin around the affected joint some surgeons like to give a course of antibiotic tablets to help prevent infection. Sometimes psoriasis can occur along the scar of the operation, but this can be treated in the usual way.

What will the future hold for me?

Psoriatic arthritis can vary from a simple condition to a long-term problem requiring complicated treatment.

Everyone is different. Therefore it is impossible to offer specific advice on what you should expect. Most people with this condition will be on long-term treatment with anti-inflammatory and disease-modifying drugs. Generally, people with psoriatic arthritis are less disabled than people with rheumatoid arthritis, but their overall quality of life may be equally affected.

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