Comorbidities in PsA
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Disclosures

- Consulting/Advisory Boards: Abbvie, Amgen, BMS, Celgene, Corrona, Gilead, Janssen, Lilly, Novartis, Pfizer, UCB
- Grants: Pfizer to Penn, Novartis to Penn, Amgen to Forward/NDB
- Royalties: Novartis to my husband
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Overview

- Review of key comorbidities in rheumatic disease
- Updates on management of CV disease
- Screening for comorbidities

Treating the Whole Patient

- Physical therapy
- Diet
- Exercise and muscle balance
- Sleep
  - Sleep physician or Sleep psychologist
- Fatigue
- Emotional wellbeing
- Family and Friends
- MSK Disease
- Dermatologist
- Skin and Nail Disease
- Specialty Pharmacist
- Treatment Burden
- Concomitant Conditions
  - Primary Care
  - Screening for CVD, Diabetes, osteoporosis, IBD, Uveitis, Skin Cancer, etc
- Work
  - Therapy, Psychiatry, Occupational therapy
Common comorbidities in PsA

- Cardiovascular disease
- Metabolic disease
- Mental health
- Bone disease
- Extra-articular manifestations
- Drug-related outcomes

Photo by Unknown author is licensed under CC BY-NC.
Approach to Mental Health in Practice

- Inform patients about depression/anxiety
- Ask about signs and symptoms of anxiety and depression
- Refer patients with symptoms for further assessment and management
- Treat disease as this can help improve depression and anxiety

Fibromyalgia/Central Sensitization
The circle

Stress → Sleep → Central Sensitization → Fatigue → Pain → Biomechanics

Cardiovascular Disease

<table>
<thead>
<tr>
<th>Condition</th>
<th>HR (95%CI)</th>
<th>Fully Adjusted Model*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsA: No DMARD</td>
<td>1.46 (1.14-1.86)</td>
<td>1.36 (1.04-1.77)</td>
</tr>
<tr>
<td>PsA: DMARD</td>
<td>1.35 (1.02-1.78)</td>
<td>1.36 (1.01-1.84)</td>
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<tr>
<td>RA: No DMARD</td>
<td>1.36 (1.21-1.53)</td>
<td>1.33 (1.27-1.51)</td>
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<tr>
<td>RA: DMARD</td>
<td>2.02 (1.82-2.24)</td>
<td>1.96 (1.75-2.19)</td>
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<tr>
<td>Psoriasis: No DMARD</td>
<td>1.18 (1.09-1.28)</td>
<td>1.07 (0.98-1.17)</td>
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<tr>
<td>Severe Psoriasis (DMARD)</td>
<td>1.36 (1.09-1.70)</td>
<td>1.31 (1.03-1.65)</td>
</tr>
</tbody>
</table>

*Fully adjusted model includes: age, sex, hypertension, diabetes, hyperlipidemia, and smoking status (never, past, current).
Increased risk for diabetes in PsA

![Graph showing diabetes incidence with age at cohort entry](image)

*Adjusted for age, sex, calendar time, BMI, alcohol and smoking status


Management of Cardiovascular Risk

**Table 3. Risk-Enhancing Factors for Clinician–Patient Risk Discussion**

<table>
<thead>
<tr>
<th>Risk-Enhancing Factors</th>
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<tr>
<td>Family history of premature ASCVD (males, age &lt;55 y; females, age &lt;65 y)</td>
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<tr>
<td>Primary hypercholesterolemia (LDL-C &gt;160–189 mg/dL; [4.1–4.8 mmol/L]; non-HDL-C &gt;190–219 mg/dL; [4.9–5.6 mmol/L])</td>
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<td>Metabolic syndrome (increased waist circumference [by ethnically appropriate cutpoints], elevated triglycerides &gt;150 mg/dL, nonfasting), elevated blood pressure, elevated glucose, and low HDL-C (&lt;40 mg/dL in men; &lt;50 mg/dL in women) are factors; a tally of 3 makes the diagnosis)</td>
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<td>Chronic kidney disease (eGFR 15–59 mL/min/1.73 m² with or without albuminuria; not treated with dialysis or kidney transplantation)</td>
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<td>Chronic inflammatory conditions, such as psoriasis, RA, lupus, or HIV/AIDS</td>
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<td>History of premature menopause (before age 40 y) and history of pregnancy-associated conditions that increase later ASCVD risk, such as preeclampsia</td>
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<td>High-risk race/ethnicity (eg, South Asian ancestry)</td>
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<td>Lipid biomarkers: associated with increased ASCVD risk</td>
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<tr>
<td>Persistently elevated* primary hypertriglyceridemia (≥175 mg/dL, nonfasting)</td>
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<td>If measured:</td>
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<tr>
<td>Elevated high-sensitivity C-reactive protein (≥2.0 mg/L)</td>
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<tr>
<td>Elevated Lp(a): A relative indication for its measurement is family history of premature ASCVD. An Lp(a) ≥50 mg/dL, or ≥125 nmol/L constitutes a risk-enhancing factor, especially at higher levels of Lp(a).</td>
</tr>
<tr>
<td>Elevated apolipoprotein B (≥130 mg/dL): A relative indication for its measurement would be triglyceride ≥200 mg/dL. A level ≥130 mg/dL corresponds to an LDL-C &gt;160 mg/dL, and constitutes a risk-enhancing factor</td>
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<td>ABI (≤0.9)</td>
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</table>
Management of CV Risk

Arnett et al. JACC 2019.

Statin therapy guidelines (2018)

- Adults with clinical ASCVD (CAD, PAD, TIA, CVA)
- Adults age 40 to 75 with diabetes
- Adults of any age with LDL above 190
- Adults age 40 to 75 with LDL between 70-189, and 10-yr ASCVD risk is 7.5 percent or higher

Reiter-Brennan Cleveland Clinic, 2020, 87(4), p231
Obesity is associated with poor response to therapy

Weight loss is important in PsA
## Comorbidities and Treatment Selection

### Table: Comorbidities and Treatment Selection

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>NSAIDs</th>
<th>Glucocort</th>
<th>HCQ</th>
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<th>LEFL</th>
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<td>Cardiovascular Disease</td>
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### Sources:

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**Psoriasisdecisionaid.com**

Funded by Pfizer
IGLC grant

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**Psoriasis & Psoriatic Arthritis**

**What is Psoriasis?**
Psoriasis is a chronic autoimmune condition that causes the rapid buildup of skin cells. This buildup of cells causes scaling on the skin's surface. Inflammation and redness around the scales is often common. Typical psoriatic scales are whitish-silver and develop in thick, red patches.

**Words to Know**

- Treatmentic (ty)
- Psoriatic (ic)
- Drug (s)

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**Psoriasis & Psoriatic Arthritis**

**What is Psoriatic Arthritis?**
Psoriatic arthritis is a form of arthritis that affects some people who have psoriasis. Most people develop psoriasis first and are later diagnosed with psoriatic arthritis, but the joint problems can sometimes begin before skin lesions appear.

**Words to Know**

- Disease (s)
- Arthritis (ic)
- Joint (s)

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**Psoriasis & Psoriatic Arthritis**

**What is Inflammatory?**

- Disease (s)
- Arthritis (ic)
- Joint (s)

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**Psoriasis & Psoriatic Arthritis**

**What is Rheumatoid?**

- Disease (s)
- Arthritis (ic)
- Joint (s)

---

**Psoriasis & Psoriatic Arthritis**

**What is RHEUMATOID?**

- Disease (s)
- Arthritis (ic)
- Joint (s)

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**Psoriasis & Psoriatic Arthritis**

**What is RHEUMATOID?**

- Disease (s)
- Arthritis (ic)
- Joint (s)
Conclusions

- Address the whole patient
- Identify comorbidities
- Communicate with PCPs and patients