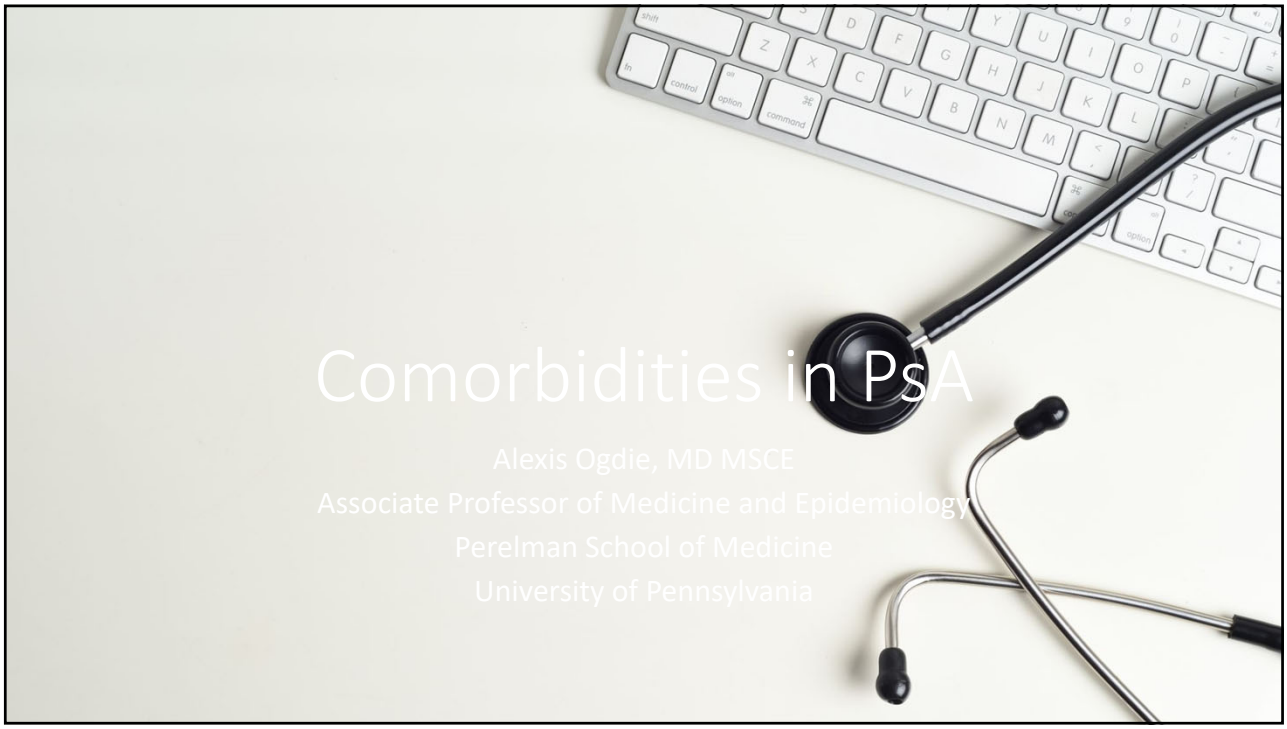

Comorbidities in PsA

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1

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- Consulting/Advisory Boards: Abbvie, Amgen, BMS, Celgene, Corrona, Gilead, Janssen, Lilly, Novartis, Pfizer, UCB
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- Royalties: Novartis to my husband
- Other Funding: NIAMS, Rheumatology Research Foundation, National Psoriasis Foundation, University of Pennsylvania

2

Overview

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

3

Treating the Whole Patient

Nutritionist
Diet

MSK Disease

Dermatologist
Skin and Nail Disease

Physical therapy
Exercise and muscle balance

Specialty Pharmacist
Treatment Burden

Concomitant Conditions
Primary Care
Screening for CVD, Diabetes, osteoporosis, IBD, Uveitis, Skin Cancer, etc

Sleep
Sleep physician or Sleep psychologist

Fatigue

Work

Emotional wellbeing

Family and Friends

Therapy, Psychiatry, Occupational therapy

4

Common comorbidities in PsA

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

5

6

Approach to Mental Health in Practice

Inform patients about depression/anxiety

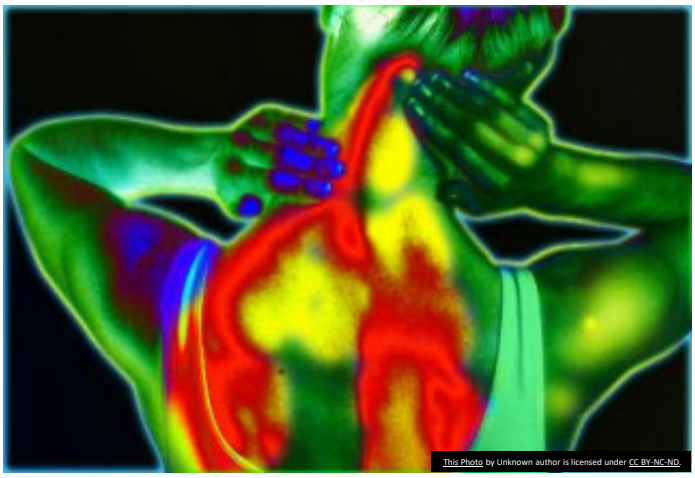
Ask about signs and symptoms of anxiety and depression

Refer patients with symptoms for further assessment and management

Treat disease as this can help improve depression and anxiety

7

Fibromyalgia/Central Sensitization



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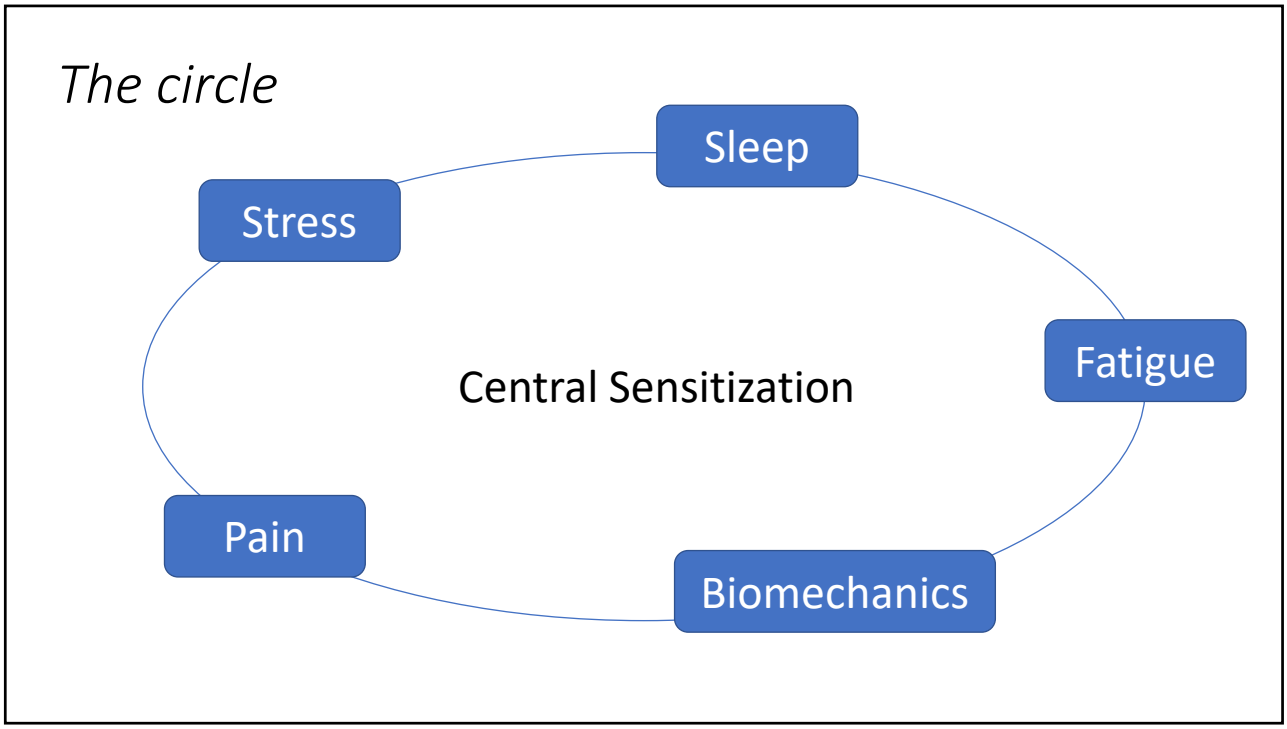
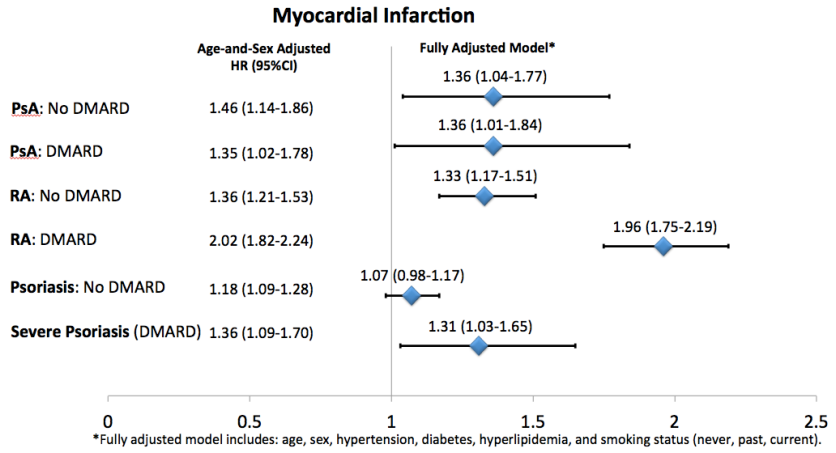


9

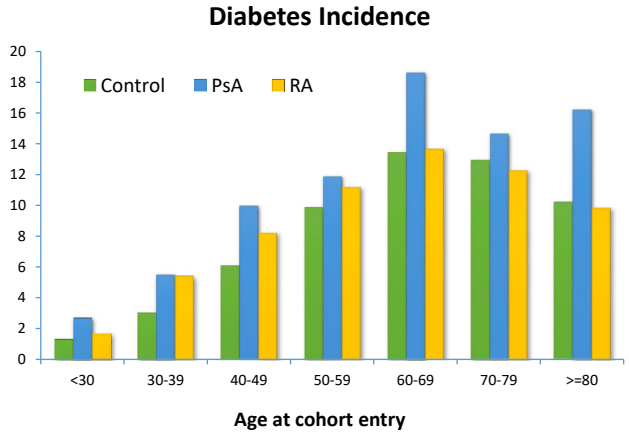
Cardiovascular Disease

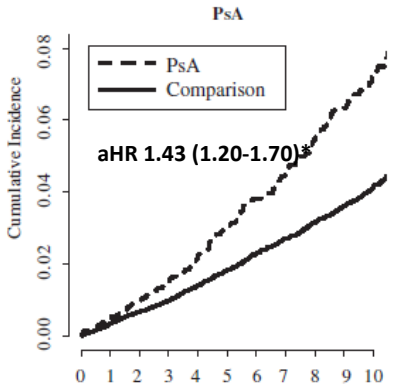


Ogdie A, et al. Ann Rheum Dis. 2015

10

Increased risk for diabetes in PsA





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

Dubreuil M. Rheumatology (Oxford) 2014; Jafri K, et al. Arthritis Care Res 2017

11

Management of Cardiovascular Risk

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

Risk-Enhancing Factors
Family history of premature ASCVD (males, age <55 y; females, age <65 y)
Primary hypercholesterolemia (LDL-C 160–189 mg/dL [4.1–4.8 mmol/L]; non–HDL-C 190–219 mg/dL [4.9–5.6 mmol/L])*
Metabolic syndrome (increased waist circumference [by ethnically appropriate cutpoints], elevated triglycerides [>150 mg/dL, nonfasting], elevated blood pressure, elevated glucose, and low HDL-C [<40 mg/dL in men; <50 mg/dL in women] are factors; a tally of 3 makes the diagnosis)
Chronic kidney disease (eGFR 15–59 mL/min/1.73 m^2 with or without albuminuria; not treated with dialysis or kidney transplantation)
Chronic inflammatory conditions, such as psoriasis, RA, lupus, or HIV/AIDS
History of premature menopause (before age 40 y) and history of pregnancy-associated conditions that increase later ASCVD risk, such as preeclampsia
High-risk race/ethnicity (eg, South Asian ancestry)
Lipids/biomarkers: associated with increased ASCVD risk
Persistently elevated* primary hypertriglyceridemia (≥175 mg/dL, nonfasting);
If measured:
Elevated high-sensitivity C-reactive protein (≥2.0 mg/L)
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).
Elevated apoB (≥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 >160 mg/dL and constitutes a risk-enhancing factor
ABI (<0.9)

12

Management of CV Risk

Arnett et al. JACC 2019.

Recommendations for Assessment of Cardiovascular Risk
Referenced studies that support recommendations are summarized in Online Data Supplement 3.

COR	LOE	Recommendations
I	B-NR	1. For adults 40 to 75 years of age, clinicians should routinely assess traditional cardiovascular risk factors and calculate 10-year risk of ASCVD by using the pooled cohort equations (PCE).[S2.2-1,S2.2-2]
IIa	B-NR	2. For adults 20 to 39 years of age, it is reasonable to assess traditional ASCVD risk factors at least every 4 to 6 years.[S2.2-1–S2.2-3]
IIa	B-NR	3. In adults at borderline risk (5% to <7.5% 10-year ASCVD risk) or intermediate risk (≥7.5% to <20% 10-year ASCVD risk), it is reasonable to use additional risk-enhancing factors to guide decisions about preventive interventions (eg, statin therapy).[S2.2-4–S2.2-14]
IIa	B-NR	4. In adults at intermediate risk (≥7.5% to <20% 10-year ASCVD risk) or selected adults at borderline risk (5% to <7.5% 10-year ASCVD risk), if risk-based decisions for preventive interventions (eg, statin therapy) remain uncertain, it is reasonable to measure a coronary artery calcium score to guide clinician–patient risk discussion.[S2.2-15–S2.2-31]

13

Statin therapy guidelines (2018)

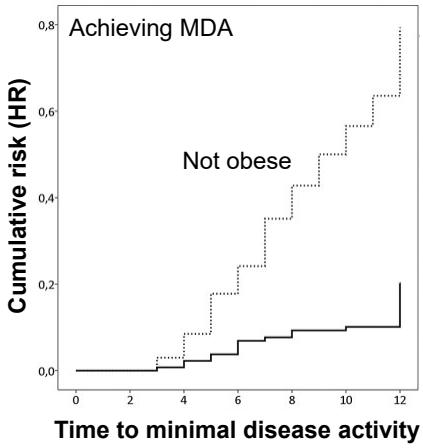
- Adults with clinical ASCVD (CAD, PAD, TIA, CVA)
- Adults age 40 to 75 with diabetes
- Adults of any age with LDL above 190
- Adults age 40 to 75 with LDL between 70-189, and 10-yr ASCVD risk is 7.5 percent or higher

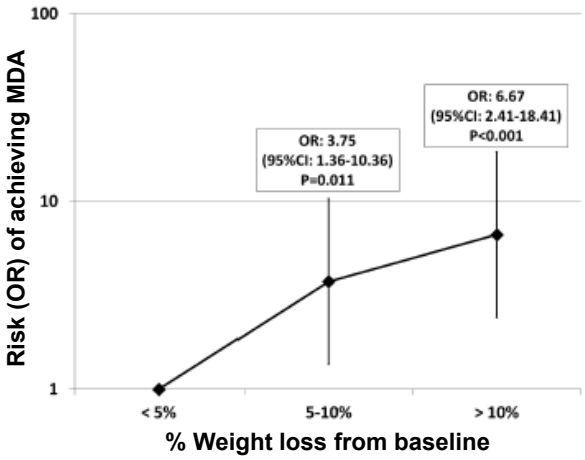
Reiter-Brennan Cleveland Clinic, 2020, 87(4), p231

14

15

Weight loss is important in PsA





16

Comorbidity	NSAIDs	Glucocort	HCQ	SS	MTX	LEFL	CYC	ETA	D	INFX	CER	GOL	UST	APR	SEC
Cardiovascular Disease	*	?											?		
Congestive Heart Failure								?	?	?	?	?			
Obesity					*										
Metabolic Syndrome		*			*										
Diabetes		*			*										
Inflammatory Bowel Disease	?														*
Uveitis		P						?	P	P					
Osteoporosis		*													
Malignancy								*	*	*	*	*	?		
Fatty Liver Disease	*			*	*	*									
Chronic HBV or HCV	*				*	*		**/P	**	**	**	**	?		
HIV								**	**	**	**	**	?		
Chronic Kidney Disease	*				*	?	**								
Depression														*	

Comorbidities Affect Treatment Selection
Coates et al. Arthritis & Rheumatology. 2016

17

18

Conclusions

Address the whole patient

Identify comorbidities

Communicate with PCPs and patients

19