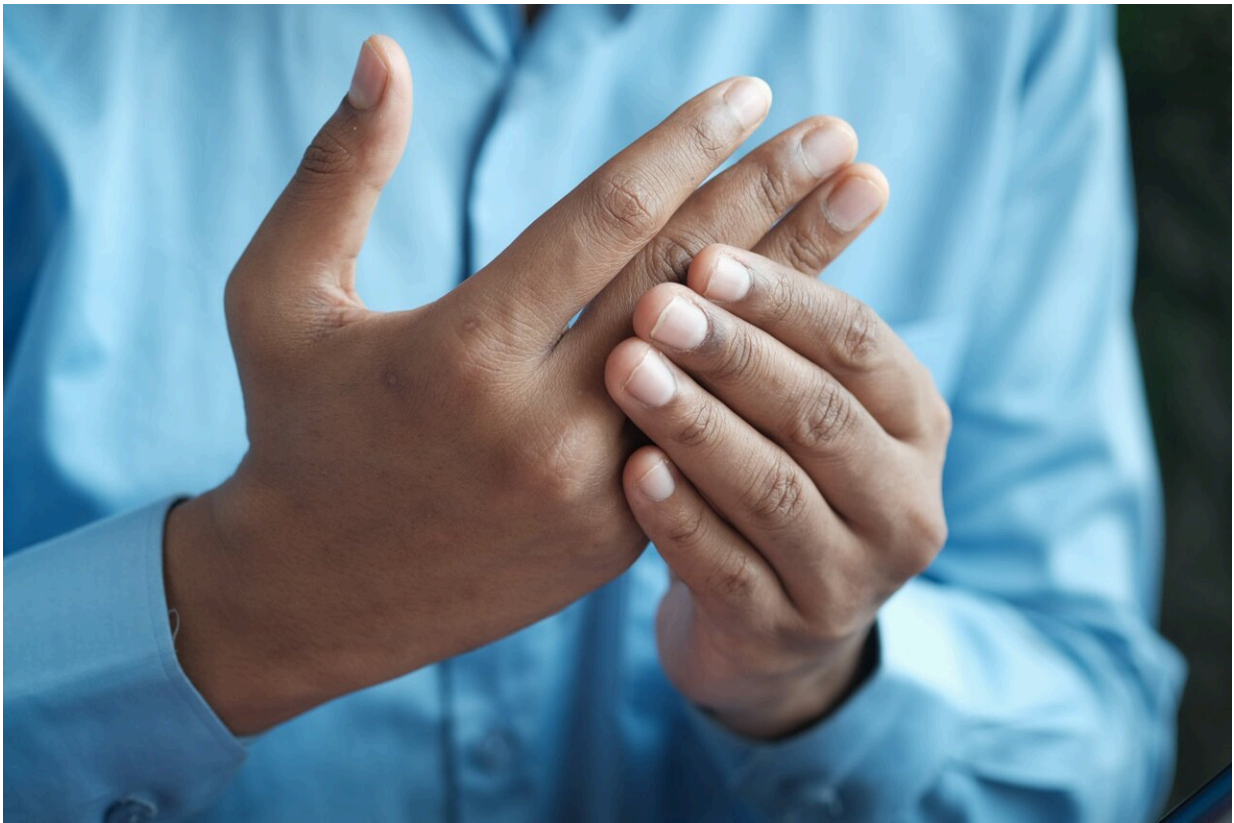


# Updated recommendations for psoriatic arthritis

March 25 2024

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Psoriatic arthritis (PsA) is an autoimmune inflammatory disease. It has both joint and non-joint symptoms and manifestations, which can vary from person to person. It is commonly associated with psoriasis that

affects the skin and nails but can also be linked to inflammation of the gut and eyes. PsA has also been linked to cardiovascular, psychological, and metabolic comorbidities—with a real impact on quality of life.

However, [treatment options](#) for this disease have grown rapidly in recent years, with both pharmacological and non-pharmacological treatments now available.

The EULAR recommendations for pharmacological management in PsA were first written in 2012 and updated in 2015 and 2019. Since that time, agents with new mechanisms have become available, and there is also a wealth of new long-term data for existing drugs.

The updated recommendations include seven overarching principles, three of which remain unchanged from the last publication, and three which have been reworded. The one new principle states that the choice of treatment should take into account safety considerations regarding individual modes of action in order to optimize the benefit–risk profile.

There are also 11 individual recommendations; Four remain unchanged from the previous version, six are modified, merged, or reworded, and one is new.

NSAIDs can be proposed as the first treatment but should not be given alone if there are signs the disease may be severe.

In people with peripheral arthritis (the vast majority of people with this disease), a quick start of conventional synthetic DMARDs is recommended—with a preference for methotrexate. If this strategy does not get people to their treatment target, then a bDMARD should be started, but there is no preference for which class to choose in this group of patients.

EULAR also proposes the possibility of using Janus kinase inhibitors after bDMARD failure or where bDMARDs are not appropriate. Aprelast can be proposed in specific cases.

In people with predominantly axial or enthesal disease, an algorithm is also proposed. Conventional synthetic DMARDs are not used for these people; axial disease responds well to tumor necrosis factor inhibitors (TNFi) or IL-17 inhibitors.

The mode of action chosen should reflect non-musculoskeletal manifestations, with specific recommendations for people with skin, gut, or eye involvement.

For example, in people with skin psoriasis, treatment should be directed to biological disease-modifying antirheumatic drugs (biologics or bDMARDs) that target interleukins, and there are now four classes to choose from: IL-12/23, IL-23p19, IL-17A, and IL-17A/ F inhibitors. People with uveitis should receive a monoclonal TNFi and people with [inflammatory bowel disease](#) should use a drug authorized for this disease (TNFi, IL-12/23 inhibitor, Janus kinase inhibitor, in some cases IL-23p19 inhibitor).

As well as treatment recommendations, the publication addresses topics such as drug switches and tapering for patients in sustained remission. EULAR hopes this practical and updated guidance will be useful to both health care professionals and their patients—and that it will support access to optimal care for people with PsA.

The work is [published](#) in the journal *Annals of the Rheumatic Diseases*.

**More information:** Laure Gossec et al, EULAR recommendations for

the management of psoriatic arthritis with pharmacological therapies: 2023 update, *Annals of the Rheumatic Diseases* (2024). [DOI: 10.1136/ard-2024-225531](https://doi.org/10.1136/ard-2024-225531)

Provided by European Alliance of Associations for Rheumatology, EULAR

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