Dermatology intersects with just about every other medical specialty out there, but perhaps the greatest synergy is seen with rheumatology, given the numerous skin manifestations that occur with rheumatic diseases, including psoriatic arthritis, rheumatoid arthritis, lupus erythematosus, and others, as well as a growing list of shared therapies including biologics and now biosimilars.

Despite these commonalities, not all dermatologists feel wholly comfortable caring for non-cutaneous diseases, and the same can be said about some rheumatologists when it comes to the treatment of skin manifestations of rheumatic disease.

Still, the obvious overlap is siring a combined-specialty all of its own: rheumatic dermatology or dermatology-rheumatology. Many US academic medical centers are combining dermatologic and rheumatologic care for the management of psoriatic arthritis (PsA) and other inter-related skin and musculoskeletal diseases, and a team of researchers called the Psoriasis and Psoriatic Arthritis Clinic Multicenter Advancement Network (PPACMAN) is currently studying the impact, strengths, barriers, and challenges to creating such novel combined clinics elsewhere. All of these efforts are enhanced by technology, such as electronic health records and telemedicine, that makes information sharing between specialists more seamless.

BUILDING BRIDGES, WITHOUT STEPPING ON EACH OTHER’S FEET

Some joint dermatology-rheumatology clinics have already started to identify and develop best practices that may work in real-word settings.

“We can do so much more than recommending a topical corticosteroid and sun protection to these patients who really could benefit from our expertise.”

—David F. Fiorentino MD, PhD

David F. Fiorentino MD, PhD, a Professor in the Department of Dermatology and the Department of Immunology and Rheumatology at Stanford University in Stanford, CA, has been running a joint rheumatology/dermatology clinic since 2004, together with rheumatologist Lorinda Chung, MD, MS. He is also President of the Rheumatologic Dermatology Society (RDS), originally known as North American Rheumatologic Dermatology Society (NARDS).

At the clinic, “We physically see every patient together and bill them separately. We write our own notes,” he says, admitting that such an arrangement is not always practical.

“We are able to learn from each other in clinic, so that now what the other specialty pays attention to or what medications they use are not as much of a mysterious black box,” he says.

“The rheumatologist and dermatologist need to work together as a team in the care of the patient,” he says. “This will mean consistent communication and willingness to
teach the treating specialist about critical dermatologic issues that might impact care, or vice versa.”

For the dermatologist, it would be important to advise the rheumatologist about the potential systemic significance of various skin findings and possible therapeutic options for their skin disease, he says. “Especially in patients that have skin-predominant issues, I find there is often misunderstanding regarding their diagnosis or systemic risks—this is a critically important role of the dermatologist,” he says.

In addition, creating strong local relationships with rheumatologists is essential when it comes to earning trust and developing a mutual understanding. “If the treating dermatologist shows interest not only in the skin but in their entire systemic disease, this goes a long way in indicating to the treating rheumatologist that they are committed to providing complete care for the patient.”

Some of Dr. Fiorentino’s closest relationships with rheumatologists began with honest questions about things he had little expertise in, and in turn, came a willingness to educate them on the importance of skin diseases, he recalls.

These efforts will go a long way toward building strong relationships with fellow providers, he says. “We can do so much more than recommend a topical corticosteroid and sun protection to these patients who really could benefit from our expertise,” he says.

**A RHEUMATOLOGIST’S PERSPECTIVE**

“There are a number of rheumatic diseases that have cutaneous manifestations including lupus, dermatomyositis, scleroderma, rheumatoid arthritis, but the most common one is the connection between psoriasis and psoriatic arthritis,” says Duke University rheumatologist David Pisetsky, MD.

Up to 30 percent of people with psoriasis develop psoriatic arthritis, according to the National Psoriasis Foundation.

It may seem like a slam-dunk diagnosis if a psoriasis patient starts complaining about joint aches and pains, but it’s not always PsA, he says. “Psoriasis may also travel with osteoarthritis (OA), due to shared risk factors such as excess weight or be a function of advancing age,” he says. Another possible diagnosis could be ankylosing spondylitis (AS), he says. “Inflammatory diseases tend to cluster, so if someone with psoriasis complains of back pain, ankylosing spondylitis is a possible cause,” Dr. Pisetsky says.

“Dermatologists need to recognize the different types of arthritis and try to identify particular complaints that are inflammatory as opposed to something else,” he says.

For these reasons, there should be cooperative care. He agrees with Dr. Fiorentino about the importance of cultivating relationships across silos. “Dermatologists should build relationships with a rheumatologist so if they are a treating a woman with psoriasis and she says her knees hurt, they can run things by the rheumatologist before jumping to a diagnostic conclusion.”

Treatments vary based on the differential diagnosis, he says. “If it is OA, NSAIDS may help, or if perhaps it is undertreated PsA, adding on a DMARD may make a difference, opposed to switching biologics, which are working so well on the skin,” he says.

Some dermatologists, such as Jerry Bagel, MD, Director of the Psoriasis Treatment Center of Central New Jersey, are comfortable in making a diagnosis of PsA in a patient who has psoriasis. Dr. Bagel says making the differential diagnosis starts with asking the right questions based on the CASPAR (classification criteria for psoriatic arthritis) criteria. This includes asking about fatigue and the nail pitting that occurs in 80 percent of people with PsA, but just 30 percent of those with psoriasis. Other symptoms that may tip the scale in favor of a PsA diagnosis include symptoms of enthesitis, current dactylitis or history of dactylitis recorded by a rheumatologist, juxta-articular new bone formation, and/or rheumatoid factor negativity.

“Since the arthritic component of psoriasis occurs after the onset of psoriasis by years in about 80 percent of cases, dermatologists are in a sentinel position to help make the diagnosis or, at the least, ask the appropriate questions about stiffness in fingers and toes, fatigue, evidence of dactylitis, enthesitis, and joint swelling.”

Dr. Bagel agrees with Drs. Pisetsky and Fiorentino that there is room for communication between the two specialties. “There are cases when psoriasis may clear up with treatment, but the arthritis doesn’t improve, and if we don’t want to take
the patient off of the therapy that is working so well for their skin, but aren’t sure what to add, I would refer or reach out to a rheumatologist to discuss the options,” he says.

By contrast, “If the joints are doing well, but the psoriasis is not, it may be time to refer to a dermatologist to augment treatment with phototherapy or another modality with proven efficacy for skin clearing,” he says.

Bruce E. Strober, MD, PhD, a professor of dermatology, Chair and Director of Clinical Trials of the Department of Dermatology at UConn Health in Farmington, CT, breaks it down like this: “First [we] choose a systemic therapy to treat moderate to severe psoriasis with arthritis that might cover both aspects of psoriatic disease,” adding that choices are now numerous and growing.

“Rheumatologists should educate on which biologics and oral systemics they believe are best for the joints, and which are second-line drugs,” he suggests.

“If there is minimal to no arthritis improvement, yet with skin clearing well, then refer to rheumatology,” he says. “If skin and joints respond well, continue management in dermatology.”

That said, minimal psoriasis managed well by a topical, for example, with significant arthritis, should be referred to rheumatology immediately, Dr. Strober says.

LEARNING BY DOING

Some of the work being done at the RDS aims to make these visions more of a reality. For example, RDS residents and fellows from both specialties rotate through the clinic where they learn the critical questions to ask patients, the right tests to order and what to look for on a physical exam.

What’s more, the RDS aims to offer any trainees (medical students, residents, fellows) with an interest in rheumatic dermatology a structured context to network and find mentors. “At each annual meeting I would estimate that we have 10 medical students and maybe equally as many post-doctoral trainees (rheumatology fellows and dermatology residents) and a larger number of young, new faculty with an interest in the field,” Dr. Fiorentino says. (The next RDS meeting will be held at the American College of Rheumatology meeting in San Diego, on November 4.)

In addition to providing mentorship, the RDS provides accurate patient and physician information, as well as an infrastructure to assemble clinical or translational research groups.

“Our goal is to let patients know that there is an entire group of people out there who might have primarily skin disease with their rheumatic condition—and so we try to provide a realistic picture of systemic risk as well as skin-focused tips regarding management of their disease,” he says.

At the end of the day, these efforts to remove silos do improve patient care. “As a dermatologist, there is much more that you can do than simply ‘treating skin’ when managing a patient with rheumatic skin disease,” Dr. Fiorentino says. “Thinking about how skin informs systemic risk and how treatment options for skin need to be integrated into the treatment of the entire patient makes taking care of these patients so much more rewarding.”

With the advent of electronic health records (EHR) and the promise of interoperability between systems, much of this communication can take place virtually by sending a dermatologist a photo of a skin issue that could be a drug rash, a cutaneous lupus lesion, or a psoriasis plaque for evaluation via the EHR. This sharing of information will also cut back on the repeat testing and allow all providers a big-picture look at the patient’s health history.

“Finally, of course, it is easiest for the patient, because their care is more coordinated and there is effective communication between the treating providers,” says Dr. Fiorentino.

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**PSORIATIC ARTHRITIS BY-THE-NUMBERS**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>people with psoriasis develop psoriatic arthritis</td>
</tr>
<tr>
<td>80%</td>
<td>people with PsA report fatigue and the nail pitting</td>
</tr>
<tr>
<td>30%</td>
<td>people with PsO report fatigue and the nail pitting</td>
</tr>
<tr>
<td>80%</td>
<td>PsA cases: arthritic component of psoriasis occurs after the onset of psoriasis by years</td>
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