Clinical Insights on Management of Comorbidities in the Psoriasis Patient

As psoriasis is associated with an increasing number of comorbidities, clinicians discuss their approach to management focused on the whole patient.

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IN WHICH PSORIASIS PATIENTS DO YOU ASSESS ANXIETY AND DEPRESSION? HOW DO YOU DO THIS? WHAT SORTS OF INTERVENTIONS ARE YOU WILLING TO PROVIDE OR RECOMMEND?

Dr. Yamauchi: We assess all patients with psoriasis for anxiety and depression. We use a questionnaire to assess how psoriasis is impacting the quality of patients’ lives. These questions include asking whether psoriasis impacts your job or school performance, social encounters, dating, and intimacy. If a person has a difficult time coping with psoriasis, then we refer them to a therapist who has experience dealing with psoriasis patients.

Dr. Schlesinger: The assessment of anxiety and depression is not a part of our routine practice. We also do not prescribe medications to treat these conditions. During our routine review of systems and health history, the presence or absence of anxiety and/or depression is determined and the patient is referred to an appropriate healthcare provider for treatment.

Dr. Schlam: I generally assess for these things when the patient has a large amount of body surface area involvement and is extremely self-conscious about it. I have very rarely, on occasion, prescribed antidepressants, however, with today’s biologics and innovative therapies we can often drastically improve the patient’s psoriasis. This is frequently the underlying cause of the patient’s depression and thus eliminates the need for psychological treatment. If necessary, I do feel more comfortable referring the patient to a mental health professional than treating them myself.

Dr. Wu: I assess those who express to me that they are depressed. One patient I saw last month was telling me that her psoriasis was clear with etanercept, but she just got tired of using it. She expressed to me that she had some family problems, and that contributed to her not wanting to take the etanercept, even though it kept her clear. I referred her to her PCP to evaluate for depression.

Dr. Johnson: I often ask patients about their mood but am not trained to deal with these sorts of concerns, so if I suspect an issue, then I refer back to PCP.

HOW DO YOU CONCEPTUALIZE THE DEPRESSION/PSORIASIS CONNECTION? HOW DOES THIS CONCEPTION INFLUENCE YOUR APPROACH TO PATIENTS?

Dr. Schlesinger: The connection between psoriasis disease activity and mental health is understood in our practice. We see the improvement in our patients’ disposition when successful treatment is instituted. Being familiar with the connection between psoriasis and mental health at least allows
us to make the appropriate referral and entertain a discussion that may help the patient get the care they need.

**Dr. Yamauchi:** Because psoriasis is such a visible skin condition, people afflicted with this condition are often stigmatized and discriminated against. Having psoriasis makes people feel withdrawn and socially isolated. Many patients with psoriasis take anti-depressants. Many people each year commit suicide due to their psoriasis. People state they'd rather lose a kidney than have psoriasis.

**Dr. Johnson:** I am more likely to prescribe systemic/more aggressive treatment because of this connection.

**Dr. Wu:** If I feel it is necessary, I refer to PCP to evaluate further.

**IN WHICH PSORIASIS PATIENTS DO YOU ASSESS CARDIAC RISK FACTORS? HOW DO YOU DO THIS? DO YOU RECOMMEND ANY INTERVENTIONS?**

**Dr. Wu:** All Kaiser Permanente patients are assessed for cardiac risk factors. All patients automatically have their blood pressure and weight checked. Some systemic therapies may increase lipids, so I routinely check lipid panels in these patients.

I refer to PCP to evaluate further or to manage these other cardiometabolic diseases.

**Dr. Schlam:** I assess cardiac risk in those patients who are obese or have other comorbidities (hypertension, etc.). I refer to an internist if warranted.

**Dr. Johnson:** We have questions about cardiac risks on our psoriasis history sheet and consent forms that we use for all patients with psoriasis that we treat with a systemic agent.

**Dr. Schlesinger:** Cardiac risk factor assessment is not a part of our routine practice. However, physical exam signs, such as the presence of edema and vascular compromise, are assessed as part of our routine exam. Red flags would be the presence of leg swelling, stasis changes, and the symptoms of shortness of breath, if present. Our main intervention is to suggest that the patient see their primary care doctor to evaluate and treat potential disease.

**Dr. Yamauchi:** Studies have shown that the younger a person develops psoriasis (in their 20s) and the more severe it is, the likelihood of developing a heart attack is greater than someone who has mild psoriasis or develops psoriasis at a later age.

Psoriasis is linked to metabolic syndrome—obesity, hypertension, insulin-resistant diabetes, hyperlipidemia, and reduction of HDL cholesterol. If a patient has these components, they are at risk for heart attacks and strokes. If they are not being seen by a primary care physician or cardiologist, then we refer the patient to one.

**DO YOU DISCUSS DIABETES RISKS WITH PSORIASIS PATIENTS?**

**Dr. Yamauchi:** Yes, we discuss the association of diabetes with psoriasis as well as other components of metabolic syndrome.

**Dr. Schlam:** Rarely, unless the patient has been taking oral prednisone and has a history of glucose intolerance.

**Dr. Schlesinger:** The increased risk of type II diabetes mellitus with obesity is brought up during our lifestyle discussions. Patients are encouraged to lead a healthy lifestyle to help avoid the development of diabetes. They are also encouraged to have appropriate screening labs by their primary care doctor or by us if labs are drawn as part of high risk drug monitoring or as part of a research protocol.

**DO YOU ASSESS JOINT INVOLVEMENT AND POSSIBLE PSORIATIC ARTHRITIS? HOW DO YOU ASSESS INVOLVEMENT RELIABLY?**

**Dr. Schlesinger:** All psoriasis patients are questioned about joint pain. A history is taken as to which joints are involved, the presence or absence of morning stiffness, and an attempt to determine the likelihood the patient has psoriatic arthritis is undertaken.

An abbreviated joint-specific physical exam is undertaken at the first visit and at follow-up visits based on the history. Specifically, I am looking for overt signs of psoriatic arthritis such as tenderness, joint swelling, and the classic “sausage digit” appearance. Also, the presence or absence of nail involvement is evaluated. Joints suspected of having at least moderate involvement may be radiographed. Treatment is guided based on the presence or absence of psoriatic arthritis. In some cases, ESR and CRP are followed as a measure of treatment success.

**Dr. Johnson:** We use history to assess joint involvement. It is also on our questionnaire. We use this information to help pick which systemic agent to utilize.

**Dr. Wu:** I ask all patients about joint pains, morning stiff-
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—Dr. Schlam

Dr. Yamauchi: We assess all patients with psoriasis for psoriatic arthritis. We ask for the classic signs and symptoms, such as morning stiffness, pain and tenderness in their joints, difficulty grasping objects, back pain, enthesitis, and fatigue. We look for the presence of dactylitis, and nail changes due to psoriasis. We refer to a rheumatologist to order more lab testing and x-rays.

Dr. Schlam: I evaluate all patients. If it is localized, I often refer to rule out osteoarthritis, however, when arthritis exists with psoriasis it is an important factor in determining biologic therapy.

DO YOU EDUCATE PATIENTS ABOUT OBESITY AND HEALTHY BMI? DO YOU DISCUSS EXERCISE AND NUTRITION? WHAT ABOUT OTHER LIFESTYLE ISSUES?

Dr. Yamauchi: We tell patients if they are overweight to diet and exercise to lose weight. By doing so, this will reduce their cardiovascular risk factors and may help improve their psoriasis.

Dr. Wu: I always encourage smokers to stop smoking. I tell them that smoking is known to worsen psoriasis.

Nurses ask all patients if they are exercising regularly.

Dr. Johnson: We mention obesity and discuss the association with psoriasis.

Dr. Schlesinger: All patients having office visits are weighed and a BMI is calculated in accordance with meaningful use guidelines. A limited discussion of the relationship of obesity to psoriasis is undertaken and the patient is encouraged to lead a healthy lifestyle that includes an appropriate amount of exercise and proper nutrition. The patient is encouraged to seek advice from their primary care physician before embarking on a new nutrition and physical activity program. Often, patients with severe psoriasis and obesity improve in terms of both when successful treatment is implemented.

Dr. Yamauchi: In addition, if patients consume too much alcohol or smoke, we encourage to try to wean off of them. We also recommend doing activities to minimize stress, such as yoga, meditation, taking up a fun hobby, working out, etc.

Dr. Schlam: When the patient is overweight, I discuss diet and BMI. I try to touch on all of these topics in my initial consultation with psoriasis patients as they are all somewhat pertinent to the patient’s care.

Dr. Schlesinger: Since tobacco use is assessed during the meaningful use data collection process, we have that information to use in our discussions when the patient provides it.

GIVEN THE NUMBER OF FACTORS THAT MAY BE ADDRESSED WITH THE PSORIASIS PATIENT, HOW DO YOU FIND TIME? WHAT ROLE DOES SUPPORT STAFF PLAY?

Dr. Johnson: I have a brief three to five minute discussion to address comorbidities of psoriasis and the importance of treating the whole person. I then give each patient a psoriasis questionnaire and consent packet that restates this information in more detail.

Dr. Yamauchi: Since we treat a lot of psoriasis patients, we are efficient in taking a history, performing the physical exam, and coming out with a treatment plan on the first visit for a new psoriasis patient. Our staff are well trained in doing prior authorizations, educating patients on the nature of psoriasis, and having a great conversation with the patient.

Dr. Schlesinger: Finding time is the hard part, but a limited discussion can be undertaken in the course of an office visit. We employ a full time nurse who is our research coordinator. She sees many of the psoriasis patients in follow-up and is able to engage in a more thorough discussion during her visits. We have also used physician extenders on and off over time to accomplish similar goals.

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