

Psoriatic Arthritis Causes and Treatment

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Abstract: The psoriatic arthritis of the important issues both at the level of scientific research or in the field of medicine and in this paper we tried to ask Tarafaa for this disease, and ask the symptoms and the resulting damage to the injured person and ways of talking to the disease and how to prevent it therapy, and we tried to ask many questions about the disease and respond to them in a scientific manner simplified..onrjawa Adava that we have something on the subject of the researcher.

Psoriatic arthritis can cause swelling, stiffness and pain in and around the joints, cause nail changes and overall fatigue.

Studies show that delaying treatment for psoriatic arthritis as little as six months can result in permanent joint damage. Early recognition, diagnosis and treatment of psoriatic arthritis are critical to relieve pain and inflammation and help prevent joint damage.

Keywords: Psoriatic arthritis, Psoriasis, arthritis, skin disease, Inflammation, Treatment.

I. INTRODUCTION

And it is a skin disease psoriasis (Psoriasis) of chronic skin diseases, and which is to be displayed red leather patches thick and inflamed, which is usually covered by silvery scales color. Syndrome affects psoriatic arthritis (Psoriatic arthritis) is less than 5 % of patients with psoriasis skin.

Psoriatic arthritis is a type of arthritis that affects patients with psoriasis, which leads to red patches covered with crusted silver color on the surface of the skin in addition to joint pain and harshness. The most vulnerable: the age group it can happen at any age but it is most prevalent in the adult age (30) to (50) years.

Psoriasis, a chronic skin disease, which causes rashes Akecraa, can affect the nails and scalp also affects, in a small percentage of people, on the joints. Disease causes inflammation in the areas of the skin, the area becomes inflamed reddish color and covered with a white or silver - colored scales, and the disease can affect the nails in the hands and feet.

When you hear that juvenile arthritis affects nearly 300,000 children, you may imagine all of those children having the same symptoms and facing the same struggles. Juvenile arthritis actually is an umbrella term for a number of childhood diseases affecting the joints and musculoskeletal system. And although they share many common telltale symptoms, like pain, joint swelling, redness and warmth, they are distinct and each have their own special concerns and symptoms.

One of the first steps to living with a diagnosis of juvenile arthritis is to understand the type of arthritis your child has. The following is a list of some of the common types of juvenile arthritis.

Juvenile Idiopathic Arthritis (JIA). Considered the most common form of arthritis, juvenile idiopathic arthritis (JIA) begins before age 16 and involves swelling in one or more joints lasting at least six weeks. JIA, which includes several types of arthritis previously known as juvenile rheumatoid arthritis (JRA), may include a variety of symptoms, such as muscle and soft tissue tightening, bone erosion, joint misalignment and changes in growth patterns.

In addition to watching for symptoms for at least six weeks, your child's doctor will wait to see how her symptoms unfold during the first six months after onset. As with the previous JRA criteria, the number of joints affected during those first

six months determines the diagnosis. In addition, the JIA criteria also rely on other results, such as those from the rheumatoid factor blood test, to help further stratify patients.

Depending on her symptoms, your child may be diagnosed with one of the following categories of JIA: oligoarthritis, polyarthritis, systemic, enthesitis-related, juvenile psoriatic arthritis or other.

Juvenile dermatomyositis: An inflammatory disease, juvenile dermatomyositis causes muscle weakness and a skin rash on the eyelids and knuckles. Roughly one in five children also have arthritis, but it's likely to be mild. The disease can result in muscle weakness in the trunk, shoulders and upper legs thus potentially limiting running, climbing stairs and other activities.

Juvenile lupus: Lupus is a disease of the immune system; the most common form is systemic lupus erythematosus, or SLE. Adults are diagnosed more often than children and the disease is far more common in women. Lupus can affect the joints, skin, kidneys, blood and other areas of the body. Symptoms may include a butterfly-shaped rash that bridges the nose and the cheeks, a scaly-type rash on the face or neck, sensitivity to sunlight, pain in the joints and chest pain.

Juvenile scleroderma: sclera-derma, which literally means "hard skin," describes a group of conditions that causes the skin to tighten and harden. There are two basic forms, one of which affects the entire body, and one that is localized – primarily a skin disease – and occurs more commonly in children. The localized form is not systemic and doesn't involve the heart, lungs or other internal organs. The skin may become thickened or thinned, lighter or darker, but is often smooth or shiny in appearance. Skin changes resulting from localized disease can occur anywhere, from the face, to the arms and legs or trunk. The more widespread, systemic form, which targets internal organs, tends to affect the skin of the fingers, hands, forearms and face, and more frequently seen in women.

Kawasaki disease: A Japanese pediatrician named Tomisaku Kawasaki discovered common patterns in a group of children – inflammatory-type symptoms followed in later years by heart complications. The disease, which primarily affects infants and young children, frequently starts with a high fever. Other changes may include a visible rash or a swelling or redness around the hands or feet, followed a few weeks later by peeling around the fingers and toes. Although arthritis can occur, the most serious concern is inflammation of the blood vessels themselves; careful monitoring for heart complications is necessary.

Mixed connective tissue disease: This disease may include features of arthritis, lupus dermatomyositis and scleroderma, and is associated with very high levels of a particular antinuclear antibody (anti-RNP). Of course, there are a number of other non-inflammatory causes of pain and stiffness, sometimes chronic, in children.

Fibromyalgia: This chronic pain syndrome is an arthritis-related condition, which can cause stiffness and aching, along with fatigue, disrupted sleep and other symptoms. More common in girls, fibromyalgia is seldom diagnosed before puberty. Inflammation psoriatic «healthy Psoriatic Arthritis he was named due to the presence of inflammation in the joints accompanied the presence of psoriatic skin inflammation. That psoriatic arthritis is a disease rheumatoid disease who suffer from the skin disease psoriasis, and this percentage is estimated at less than 30% of people with the skin disease psoriasis. The disease affects many joints in the body, such as a detailed wrist, knee, ankle, fingers and toes joints, the spine and the joints of the hips and pelvic joints. The disease can also affect other organs in the body. The disease affects both men and women equally, usually affects people aged between twenty and fifty years, but it is possible that this disease affects anyone at any age.

Psoriatic arthritis disease may appear before the appearance of the skin disease psoriatic, making the doctor diagnosed as arthritis inflammation articular negative factor rheumatoid type (RF-ve), and this group of rheumatic diseases are similar in their symptoms and pathological lack laboratory worker rheumatoid RF.

The different symptoms of injury to joints, skin psoriatic arthritis, ranging from mild to severe, where it is difficult to diagnose the disease, especially in the symptoms of moderate in the early stages, as early diagnosis is essential to prevent inflicting exposed joints and tissues for long-term damage.

Psoriatic arthritis can cause swelling, stiffness and pain in and around the joints, cause nail changes and overall fatigue.

Studies show that delaying treatment for psoriatic arthritis as little as six months can result in permanent joint damage. Early recognition, diagnosis and treatment of psoriatic arthritis are critical to relieve pain and inflammation and help prevent joint damage.

Research problem:

The cases of psoriatic arthritis is increasing dramatically, especially in children and the elderly, should have been growing scientific research in this area increased illness, and Kaleidoscope facing a researcher on the subject lack of resources and scientific research published, especially that of the topics complex and have a great relationship and connected to other diseases such as blood and immunology, genetics and other diseases.. which may cause interference.

Research goals:

Aim of this research educate the reader and the scientific results of the exit can open the doors of the medical therapeutic research on this topic, the psoriatic arthritis catch him as we mentioned research.

According to the Arthritis Foundation, approximately 294,000 children under the age of 18 are affected by some type of pediatric arthritis, including psoriatic arthritis. Psoriatic arthritis causes pain, stiffness and swelling in and around the joints and occurs in up to 30 percent of individuals with psoriasis. Children are more likely to experience the onset of psoriasis and psoriatic arthritis simultaneously than adults, and arthritis may precede the skin disease in up to half of children who have it.

Psoriatic arthritis can develop at any time, but it most commonly appears between the ages of 30 and 50. According to the American Academy of Dermatology, a peak period of pediatric onset is age 11 to 12 in both boys and girls.

So it was important and necessary to choose the subject of this research, which I find in my view the most important and most dangerous diseases that threaten humanity oarjua that I have as much contribution to this important topic

2. SYMPTOMS OF ARTHRITIS AND PSORIATIC DISEASE

Symptoms: the symptoms of arthritis, psoriatic disease for many, and include the following:

The tumor in the fingers or toes pain has affected joint becomes red color has been a festering finger much like sausage shows because the finger is entirely aflame.

The existence of pain and swelling in areas related to bones, tendons and ligaments.

The existence of pain in the lower back and joints of the body when getting up from sleep in the morning or after sitting for long periods of time and a sense that the patient's pain diminished and improves with movement.

The patient feels overwhelmed and tired of doing the least effort, with redness and pain in the eye.

The existence of infections and rashes and blisters scaly gray or silver-colored stripes on the scalp, elbows, knees or back or elsewhere in the body.

Nails may be affected by the disease of the skin, nails and becomes perforated shape and rough texture has been separated from the finger nail.

Attention to the skin: For the patient should try to avoid dry skin and use creams that prevent dehydration, and avoid the use of the types of strong soaps that contain perfumes or chemicals that may cause dermatitis. Can also benefit from the patient to sit in the sun during the periods are moderate sun's rays, as the sunlight slows down cell growth, and can help improve skin psoriasis. It must be the patient knows that exposure to sunlight for too long can damage the skin, so it took seriously the necessary steps to protect his skin. We emphasize the need to review the dermatologist with follow his advice.

What are the signs and symptoms of psoriatic arthritis?

Psoriatic arthritis causes pain and swelling of joints, and stiffness, particularly in the morning. This may result in reduced mobility and function.

Psoriatic arthritis:

In most patients, the psoriasis precedes the arthritis by months to years. There can be tiny pitting nail changes of the finger and toenails. The type of psoriatic arthritis depends on the distribution of the joints affected. Accordingly, there are five types of psoriatic arthritis: symmetrical, asymmetric and few joints, spondylitis, distal interphalangeal joints, and arthritis mutilans.

The arthritis frequently involves the knees, ankles, and joints in the feet. Usually, only a few joints are inflamed at a time. The inflamed joints become painful, stiff, swollen, hot, tender, and red. There is usually loss of range of motion of the involved joints. Sometimes, joint inflammation in the fingers or toes can cause swelling of the entire digit, giving them the appearance of a "sausage." Joint stiffness is common and is typically worse early in the morning. Less commonly, psoriatic arthritis may involve many joints of the body in a symmetrical fashion, mimicking the pattern seen in rheumatoid arthritis. Psoriatic arthritis can also cause inflammation of the spine (spondylitis) and the sacrum, causing pain and stiffness in the low back, buttocks, neck, and upper back. Occasionally, psoriatic arthritis involves the small joints at the ends of the fingers. A very destructive, though less common, form of arthritis called "mutilans" can cause rapid damage to the joints. Fortunately, this form of arthritis is rare in patients with psoriatic arthritis.

Patients with psoriatic arthritis can also develop inflammation of the tendons (tendinitis) and around cartilage. Inflammation of the tendon behind the heel causes Achilles tendinitis, leading to pain with walking and climbing stairs. Inflammation of the chest wall and of the cartilage that links the ribs to the breastbone (sternum) can cause chest pain, as seen in costochondritis

Other signs and symptoms of psoriatic arthritis include:

Enthesitis (pain and swelling at insertion of tendons and ligaments such as the heel); this affects 1 in 5 patients with psoriatic arthritis. 'Sausage' digits (very swollen fingers or toes that look like fat sausages). Joint deformity – in its severest form this is known as arthritis mutilans. Other features that may be seen in association with psoriatic arthritis include:

Fatigue: Iritis (eye inflammation); this does not often cause serious eye problems, and is often associated with arthritis of the spine.

Mouth ulcers: Psoriatic nail dystrophy: thickening and ridging of the nails with separation of the nail from the underlying nail bed.

Psoriatic arthritis usually affects joints in an asymmetrical pattern (that is, different joints are affected on each side of the body). Approximately one third of patients will have spinal and/or sacroiliac (hip) joint involvement and two-thirds will have arthritis affecting the limb joints without spinal disease. The following are common ways in which psoriatic arthritis can present:

Arthritis predominantly of the small joints at the ends of the fingers Severe deforming arthritis.

Arthritis involving many joints on both sides of the body symmetrically.

Asymmetrical arthritis affecting several joints in the fingers and hands.

Arthritis predominantly of the spine and sacroiliac joints (where the hip bones attach to the base of the spinal).

3. CAUSES AND SYMPTOMS OF PSORIATIC ARTHRITIS

Causes psoriatic arthritis:

The real reasons for psoriatic arthritis and having to be known, but seems to have a strong genetic connection Research shows that 40% of patients with psoriatic arthritis had a family member with psoriasis or inflammatory joint disease, it indicates that genetics can play an important role in the pathogenesis of psoriatic arthritis, in fact, family members of people with psoriatic arthritis were 55 times more likely to develop the disease than others. Search is still underway to determine the exact genes responsible for causing psoriatic arthritis.

Symptoms of psoriatic arthritis:

Symptoms of psoriatic arthritis can range from mild to severe, can take a mild form, which affects four or fewer joints in the body, and JIA limited number referred to as, more severe symptoms can take the form of several joints (inflammation of multiple joints), which affects more than four joints. Psoriatic arthritis can be symmetrical and asymmetrical.

Psoriatic arthritis is characterized by swelling of the joints on both sides of the body pain, psoriatic arthritis is replicated on the other hand, it involves some of the joints in the extremities randomly (ie the fingers of the left and right fingers). In general, all types of inflammation of psoriatic arthritis is characterized by pain, swelling and stiffness in the joints.

Affected before determining a treatment plan. Even a small number of inflamed joints, however, can have a profound impact on pain and function and factors into the treatment decisions.

Mild psoriatic arthritis is sometimes referred to as oligoarticular, meaning it affects four or fewer joints in the body.

Severe psoriatic arthritis is often referred to as polyarticular, meaning it affects four or more joints.

Spondylitis refers to inflammation of the spinal column. This occurs in some individuals with psoriatic arthritis. The main symptoms are inflammation with stiffness of the neck, lower back and sacroiliac joints. Spinal arthritis makes joint motion in these areas painful and difficult.

Enthesitis refers to inflammation of entheses, the site where ligaments or tendons insert into the bones. Common locations for enthesitis include the bottoms of the feet, the Achilles' tendons, and the places where ligaments attach to the ribs, spine and pelvis. It is unique to psoriatic arthritis and does not occur with other forms of arthritis like rheumatoid arthritis or osteoarthritis. Enthesitis can make the tissues in the affected area become ropey (known as fibrosis) or solid (known as ossification or calcification).

Dactylitis, or "sausage digits," refers to inflammation/swelling of an entire finger or toe. It happens when the small joints and entheses of the surrounding tendons become inflamed. Dactylitis is another distinguishing indicator of psoriatic arthritis. Usually dactylitis involves a few fingers and/or toes, but not in a symmetrical pattern (different toes and fingers are affected on different sides of the body).

Psoriatic arthritis also can affect the joints of your arms and legs, including the elbows, wrists, hands and feet.

Treatments for psoriatic arthritis range from oral medications that reduce inflammation and swelling to biologic drugs that are injected or infused, and target specific parts of your immune system to combat psoriatic arthritis symptoms and slow joint damage. Learn more about psoriatic arthritis treatment.

What about children with psoriatic arthritis?

According to the Arthritis Foundation, approximately 294,000 children under the age of 18 are affected by some type of pediatric arthritis, including psoriatic arthritis. Psoriatic arthritis causes pain, stiffness and in up to 30 percent of individuals with swelling in and around the joints and occurs psoriasis. Children are more likely to experience the onset of psoriasis and psoriatic arthritis simultaneously than adults, and arthritis may precede the skin disease in up to half of children who have it.

Psoriatic arthritis can develop at any time, but it most commonly appears between the ages of 30 and 50. According to the American Academy of Dermatology, a peak period of pediatric onset is age 11 to 12 in both boys and girls.

As with psoriasis, genes, the immune system and environmental factors are all believed to play a role in the onset of the disease.

As with adults, early recognition, diagnosis and treatment of psoriatic arthritis are critical to relieve pain and inflammation and help prevent progressive joint damage.

The spread of disease:

Syndrome affects psoriatic arthritis all ages, but usually affects the two, aged between twenty and fifty years and Asabalanat and male patients alike. Be a genetic factor analysis (HLA-B27) positive in most patients. Often they suffer inflammation arthritis patients after the onset of symptoms of psoriasis Algeldahala he had arthritis skin in about 15% of patients and in 15% accompanied by other affected joints affected skin at the same time.

Some of the symptoms of psoriatic arthritis commonly include:

Joints painful and swollen.

Stiffness in one or more joints.

Swelling of the fingers and toes, resembling a sausage.

Nail changes, including the separation of the nail from the nail bed, and the infusion of the fingernails or toenails or peeling nails of the fingers and toes.

Back and neck, including the spine inflamed the pain of making movement very difficult.

Fatigue generalized.

Conjunctivitis, characterized by redness and pain in the eye.

Morning stiffness, fatigue, especially after sitting or sleeping.

4. COMPLICATIONS AND TREATMENT

What should I do if I have psoriatic arthritis?

Psoriatic arthritis is a chronic, progressive disease that can lead to permanent joint damage if treatment is delayed. Like psoriasis, psoriatic arthritis is associated with other comorbidities. The good news is that treating your disease can lower your risk of developing some comorbidities, like cardiovascular disease.

This makes the relationship you have with your doctor particularly important. To receive the highest standard of specialized care for your joints and connective tissues, people with psoriatic arthritis should consider seeing a rheumatologist. This is a doctor who specializes in arthritis. You can ask your current health care provider to refer you to a rheumatologist. A doctor referral can help you get into a rheumatologist more quickly. To find a rheumatologist near you, contact NPF's Patient Navigation Center. Our Patient Navigators can help you find a specialist in your area who understands psoriatic arthritis and can help you get you into their office quicker. You also can search the Health Care Provider Directory to find a rheumatologist near you.

Complications:

Mutilans arthritis (arthritis mutilans) which is very dangerous type, severe pain leads to the destruction of the small joints in the hand, causing deformities and disabilities them.

What are psoriatic arthritis complications?

Psoriatic arthritis can be complicated by issues within the skin or the joints. The skin of psoriasis can become infected and require antibiotic treatments. The joints can become destroyed, deformed, and functionless. With aggressive treatment, however, these complications are generally avoidable. Psoriatic arthritis with eye, bowel, lung, or heart-valve inflammation can be complicated by disease in these areas. The degree of any injury depends on the location, the intensity, and duration of the inflammation.

The treatment of psoriatic arthritis:

Psoriatic arthritis starts with a light that can develop rapidly and become more severe if left untreated symptoms. Treatment involves the control of symptoms to prevent damage to the joints. If not treated in time, psoriatic arthritis can lead to disability, the treatment described below can ease pain, reduce swelling, keep joints in good condition, and prevent further joint damage

Medicine:

Drugs for the treatment of psoriatic arthritis mainly fall into three categories

A. Non - steroidal anti-inflammatory (NSAID):

These include over the counter medications such as aspirin, ibuprofen and naproxen, followed by drugs more effective, such as diclofenac, indomethacin, concern with these medicines is that long - term use, can lead to side effects such as stomach and intestinal irritation, gastrointestinal bleeding

B. Drugs against rheumatism (DMARD):

The aim of these medications to alleviate the symptoms more severe, and can limit the amount of joint damage caused by psoriatic arthritis, and include examples of methotrexate, for Vlonomid, cyclosporine, sulfasalazine ... and etc., these immunosuppressive medications can reduce the symptoms of psoriasis but can cause side effects such as liver and kidney problems.

C. Biologics:

It is the biological drugs that target a specific type of immune cells called T. cells, these cells cause inflammation in psoriasis and psoriatic arthritis. Include medications approved Humira (Odalimomab), simponi (Gollymomap) and Remicade (influximab).

Term prognosis for psoriatic arthritis:

Most people with psoriatic arthritis will have ongoing problems with arthritis throughout the rest of their life. Remissions are uncommon; occurring in less than 20% of patients with less than 10% of patients having a complete remission off all medication with no signs of joint damage on X-rays.

Features associated with a relatively good prognosis are:

Male sex: Fewer joints involved: Good functional status at presentation (this relates to ability to carry out normal daily tasks at work and home):

Previous remission in symptoms. Some genetic subtypes (this can be determined by a blood test looking at a genetic marker called an HLA-group).

Features associated with a poor prognosis include:

ESR >15 mm/hr at presentation.

Use of medication prior to initial consultation.

Absence of nail changes.

Joint damage on x-rays.

Other remedies:

Other treatments joint injection with corticosteroids in cases detailed influenced by one particular strongly psoriatic arthritis, in cases of joint damage severe, patients undergo orthopedic surgery for the treatment of joint destruction of joint replacement, has been proven to be effective in relieving pain The correct joint deformity to restore the benefit of detailed and strength.

Disease-modifying medications for psoriatic arthritis:

Patients who experience progressive joint destruction in spite of NSAIDs are candidates for more aggressive disease-modifying medications. Disease-modifying medications are important to prevent progressive joint destruction and deformity. These medications include methotrexate, which is used orally or can be given by injection on a weekly basis for psoriatic arthritis as well as for psoriasis alone. It can cause bone-marrow suppression, as well as liver damage with long-term use. Regular monitoring of blood counts and liver blood tests should be performed during therapy with methotrexate.

Antimalarial medication, such as hydroxychloroquine (Plaquenil) is also used for persistent psoriatic arthritis. Its potential side effects include injury to the retina of the eye. Regular ophthalmologist examinations are suggested while using this medication.

Sulfasalazine (Azulfidine) is an oral sulfa-related medicine that has also been helpful in some patients with persistent psoriatic arthritis. Traditionally, Azulfidine has been an important agent in the treatment of ulcerative and Crohn's colitis. It should be taken with food, as it, too, can cause gastrointestinal upset.

Research has demonstrated effective treatment of both psoriasis and psoriatic arthritis with leflunomide (Arava), a medication that is also used for the treatment of rheumatoid arthritis.

Medications that block the chemical messenger known as tumor necrosis factor (TNF) are another treatment option for moderate to severe psoriatic arthritis. The TNF-blockers etanercept (Enbrel), infliximab (Remicade), adalimumab (Humira), golimumab (Simponi), and certolizumab pegol (Cimzia) are also referred to as biologic medications and can be very effective for severe psoriatic arthritis. They can significantly improve or eradicate both the psoriasis and the arthritis as well as stop progressive joint damage. These medications are given intravenously or by injections. There is an increased risk of infection while taking biologic medications and patients are screened for underlying tuberculosis prior to TNF-blocker administration.

Ustekinumab (Stelara) is an injectable biologic medication that is used to treat severe plaque psoriasis and psoriatic arthritis with or without methotrexate. This biologic works by blocking chemical messengers called interleukins. There is an increased risk of infections while taking ustekinumab.

Apremilast (Otezla) is an oral medicine approved for the treatment of patients with moderate to severe plaque psoriasis for whom phototherapy or systemic therapy is appropriate and for the treatment of adult patients with active psoriatic arthritis. Apremilast works by inhibiting an enzyme called phosphodiesterase 4 (PDE4). Apremilast can have side effects, including an increase in depression and gastrointestinal upset such as diarrhea and nausea.

Secukinumab (Cosentyx) is an injectable biologic medication used to treat adults with psoriatic arthritis. Secukinumab is an antibody that binds to and blocks interleukin 17, an important chemical messenger in the inflammation of the skin in psoriasis and the joints in psoriatic arthritis. After a month of weekly loading injections, it is given monthly, or by monthly injections from the start according to the doctor's discretion.

Corticosteroids are potent anti-inflammatory agents. Corticosteroids can be given by mouth (such as prednisone) or injected (cortisone) directly into the joints to reduce inflammation. They can have side effects, especially with long-term use. These include thinning of the skin, easy bruising, infections, diabetes, osteoporosis and, rarely, bone death (necrosis) of the hips and knees.

While the relationship between the skin disease and joint disease is not clear, there are reports of improvement of the arthritis simultaneously with clearing of the psoriasis. Patients with psoriasis can benefit by direct sunlight exposure and are often treated with direct ultraviolet light therapy.

Finally, patients who have severe destruction of the joints may be candidates for orthopedic surgical repair. Total hip joint replacement and total knee joint replacement surgery are now commonplace in community hospitals throughout the United States. Continue Reading

Is it possible to prevent psoriatic arthritis?

There is no method for the prevention of psoriatic arthritis. It is best to treat the skin optimally. Treatments that control the disease, in a sense, prevent recurrence of the arthritis. Because when they are discontinued, the inflammatory joint disease typically recurs. Is there a psoriatic arthritis diet? Are there home remedies for psoriatic arthritis?

5. RESULTS

This study was carried out on 42 patients with P psoriatic arthritis,

Table (1): Demographic data of the studied patients with psoriatic arthritis .

	Male		Female		Total	
	No.	%	No.	%	No.	%
Age group						
<20	2	6.5	1	9.1	3	7.1
20-40	4	12.9	2	18.2	6	14.3
40-60	16	51.6	6	54.5	22	52.4
>60	9	29.0	2	18.2	11	26.2
Total	31	73.8	11	26.2	42	100.0
Range	18-70		19-66		18-70	
Mean	42.6		40.1		41.6	
S.D.	15.6		13.2		14.2	

Table (2): Distribution of the studied patients regarding the disease duration

	No.	%
Duration of disease		
<2 years	2	4.8
2-5	16	38.1
5-10	25	59.5
Total	42	100.0
Range	1.5-9.0	
Mean	7.25	
S.D.	3.22	

Table (3): Distribution of the studied patients regarding the complain.

	No.	%
Pain	39	92.9
Fatigue	32	76.2
Skin problems	18	42.9
Decrease work and/or leisure activities	20	47.6

Decrease Functional capacity	19	45.2
Discomfort	16	38.1
Sleep disturbance	20	47.6
Anxiety	26	61.9
Embarrassment and/or shame	17	40.5
Depression	22	52.4

Table (4): Nail findings in patients with psoriatic arthritis.

Nail finding	No.	%
Normal	8	19.0
Pitting	6	14.3
Subungual hyperkeratosis	10	23.8
Onycholysis	6	14.3
Discoloration	8	19.0
Longitudinal ridging	3	7.1
Nail plate thickening	6	14.3
Oil drop sign	2	4.8

Table (5): Findings on x-ray examination of affected joints in patients with psoriatic arthritis

Finding on x-ray of affected joint	No.	%
Normal	20	47.6
Marginal erosion	6	14.3
New bone formation	4	9.5
Joint space narrowing	3	7.1
Periosteal reaction	2	4.8
Sacroiliac joint obliteration	1	2.4
Soft tissue inflammation	3	7.1
Pencil in cup deformity	2	4.8
Fused cervical vertebra	0	0.0
Degenerative changes	1	2.4
Bony ankylosis	3	7.1
Others (wedge compression, osteoporosis)	2	4.8

Table (6): Distribution of the studied patients regarding treatment received.

	No.	%
NSAIDs	36	85.7
Topical steroids	18	42.9
Topical retinoids	20	47.6
Oral retinoids	22	52.4
Methotrexate	11	26.2
Cyclosporine	7	16.7
Infliximab	12	28.6
Ustekinumab	6	14.3
Golimumab	8	19.0

What is the future for patients with psoriatic arthritis?

The doctor can not forecast the future of your illness because the disease may appear in different forms in each patient, it affects only one detailed Kalcahal disease, or affects iliac joints in the back, or injured finger fully one in the hand or leg.

Epidemiological evidence for PSA:

The prevalence of psoriasis among patients with arthritis in the general population is 2–3%, but among patients with arthritis it is 7%. Inflammatory arthritis occurs in 2–3% of the general population, but among patients with psoriasis the prevalence of inflammatory arthritis varies from 6% to 42%. Thus, there is a distinct increase in the prevalence of inflammatory arthritis with varied patterns of presentation that are associated with psoriasis. The genetic epidemiology of PsA also supports its unique status. PsA has been associated with human leucocyte antigen (HLA) class 1 alleles as opposed to the class 2 alleles associated with RA.⁴

The exact prevalence of PsA is unknown and its estimation has been difficult, partly due to the lack of a widely accepted classification or diagnostic criteria, and partly due to the fact that even experts may fail to make the correct diagnosis.^{5,6} Estimated prevalence rates vary from 0.04% in the Faroe Islands to 0.1% in a study from the Mayo Clinic.³ The reported incidence of PsA has varied from 3.4 to 8 per 100,000.^{7–9} It may very well be that these are underestimates. As described above, although the prevalence of psoriasis has been estimated between 2% and 3%, the estimated prevalence of inflammatory arthritis among patients with psoriasis has varied widely from 6% to 42%. A recent study from Sweden suggests that PsA occurs in 30% of patients with psoriasis.¹⁰ Similarly a study of patients attending a psoriasis clinic identified 31% as having PsA.¹¹ If this prevalence is correct, the prevalence of PsA in the general population should be close to 1%. Once the classification of Psoriatic arthritis (CASPAR) group arrives at a valid set of diagnostic/classification criteria, a proper prospective epidemiological study can be performed to determine accurately the prevalence of the disease.

The future looks bright for people with psoriatic disease:

No one has found a cure for psoriasis — yet. But several new drugs in the pipeline have dermatologists excited, because the new treatments have the potential to clear psoriasis better than anything before. Some of the drugs also show promise for treating psoriatic arthritis and have rheumatologists optimistic about what they may soon be able to offer their patients.

"In clinical trials, these medications have had very high response rates," said Dr. Abby Van Voorhees, chairwoman of the National Psoriasis Foundation Medical Board and chairwoman of dermatology at Eastern Virginia Medical School.

Some of the most effective medications for moderate to severe psoriasis available today are a type of biologic known as TNF-alpha (tumor necrosis factor-alpha) inhibitors. Biologics are derived from living cells that are cultured in a laboratory. TNF-alpha is a protein that, when produced in excess, causes rapid growth of skin cells, which leads to plaque psoriasis and/or damage to joint tissue. TNF-alpha inhibitors help stop the inflammatory cycle that causes psoriatic disease, and those approved for psoriatic disease include Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) and Simponi (golimumab).

The drugs still in development target different proteins, or cytokines, that researchers recently discovered also play a role in the inflammation that leads to psoriatic disease. The development of these drugs confirms work researchers have conducted to get a better understanding of how the immune system works, Van Voorhees said.

"Think of it like a New England town square," she said. "There are many roads that lead you to the same center green. That's what the drugs, one that was recently approved and others that are in development, do. They get you to the same place, only by a different route."

Eight dermatologists and rheumatologists Psoriasis Advance surveyed agreed: The most promising drugs in the pipeline are those that stop the proteins identified as interleukin-17A (IL-17A) and IL-23 from triggering an inflammatory response from the immune system.

IL-17A inhibitors:

Earlier this year, the US Food and Drug Administration approved Cosentyx (secukinumab), a drug marketed by Novartis that works by targeting IL-17A. Four clinical trials enrolled more than 2,400 patients taking either Cosentyx or a placebo. More than 80 percent of patients taking Cosentyx saw 75 percent or more of their symptoms disappear, according to a study published in The New England Journal of Medicine in July 2014. After three months, more than 65 percent of patients taking Cosentyx rated their psoriasis symptoms at a 0 or 1, meaning that their skin was totally or almost totally clear.

Dr. Mark Lebwohl, dermatology professor at the Icahn School of Medicine at Mount Sinai and chairman emeritus of the NPF Medical Board, said drugs that target IL-17A not only work unbelievably well but also appear to be safe.

"Patients born with defects in IL-17 aren't known to have an increased risk of heart attacks or cancer. They develop yeast infections," said Lebwohl, who was involved in clinical trials of Cosentyx.

Cosentyx has few side effects, with colds and respiratory tract infections that include symptoms such as a sore throat and nasal congestion as the most common. In addition, patients with Crohn's disease should discuss with their doctor whether this medication is right for them, as it doesn't work as well as some other biologics for Crohn's disease and causes some people with the illness to have flares. And, as expected, mild or moderate yeast infections are increased, Lebwohl said.

Another drug in development that targets IL-17A is Eli Lilly's ixekizumab. Like other biologics, ixekizumab is delivered by injection under the skin. Clinical trials have shown it to be effective in helping clear skin, and researchers also are studying the drug as a treatment for psoriatic arthritis.

IL-23 Inhibitors:

Stelara (ustekinumab), a biologic drug, targets IL-12 and IL-23. Some new drugs in development zero in on just IL-23. These are tildrakizumab (manufactured by Merck), guselkumab (developed by Janssen), and a Boehringer Ingelheim drug that doesn't have a name yet. The IL-23 protein is one step earlier in the immune response than IL-17, Lebwohl said. What the doctors like about IL-23 blockers is that they appear to be more targeted than those that block both IL-12 and IL-23. In animal studies, those given IL-23 blockers developed fewer tumors than those given IL-12 and IL-23 blockers.

Dr. Christopher Ritchlin, a rheumatologist and chief of the Allergy, Immunology and Rheumatology Division and the Clinical Immunology Research Center at the University of Rochester, said drugs that target IL-17 and IL-23 seem to work better for psoriasis than psoriatic arthritis.

"In clinical trials, these medications have had very high response rates."

Dr. Abby Van Voorhees, chairwoman, National Psoriasis Foundation (8) Medical Board

"Psoriatic arthritis is responsive to blocking these proteins, but the magnitude of response is less than observed in patients with psoriasis," he said.

New topicals:

A number of promising topical treatments also are in development for mild to moderate plaque psoriasis. One is tofacitinib, by Pfizer, a topical Janus kinase inhibitor that interferes with the signalling pathway that results in rapid skin growth. A second is a combination of nicotinamide and calcipotriene, made by the Israeli company Dermipso. Also, LEO Pharma has submitted a drug application to the FDA for a combination of calcipotriene and betamethasone dipropionate (Taclonex) in an aerosol foam, which allows better penetration and greater efficacy than the current ointment and solution combinations, Lebwohl said.

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