Psoriatic arthritis

This booklet provides information and answers to your questions about this condition.
Psoriatic arthritis is a condition that causes painful inflammation of the joints and is often linked with the skin condition psoriasis. In this booklet we’ll explain what the condition is, how it’s treated and where you can find out more about living with psoriatic arthritis.

At the back of this booklet you’ll find a brief glossary of medical words – we’ve underlined these when they’re first used in the booklet.
What’s inside?

3 Psoriatic arthritis at a glance
4 What is psoriatic arthritis?
4 What are the symptoms of psoriatic arthritis?
6 What causes psoriatic arthritis?
6 What is the outlook?
6 How is psoriatic arthritis diagnosed?
8 What treatments are there for psoriatic arthritis?
  – Drugs
    – Non-steroidal anti-inflammatory drugs (NSAIDs)
    – Disease-modifying anti-rheumatic drugs (DMARDs)
    – Steroid treatments
  – Treatments for the skin
  – Surgery
12 Self-help and daily living
  – Exercise
  – Diet and nutrition
  – Complementary medicine
  – Work and benefits
  – Sex and pregnancy
  – Living with psoriatic arthritis
15 Research and new developments
16 Glossary
17 Where can I find out more?
20 We’re here to help
Psoriatic arthritis usually affects adults but occasionally children can develop the condition. It can be treated with drugs and exercise, and a sensible diet can help to ease symptoms.

About 1 in 3 people who have psoriatic arthritis will have pain and stiffness in their neck or back.
What is psoriatic arthritis?
Psoriatic arthritis can cause painful inflammation in any of the body’s joints, including those of the neck and back, and is often associated with a scaly skin condition called psoriasis.

What are the symptoms of psoriatic arthritis?
Symptoms of psoriatic arthritis can include:
- a red, scaly skin rash (psoriasis)
- stiff, painful joints, including the neck or back
- sausage-like swelling of fingers or toes
- thickening, discoloration and pitting of the nails
- pain and swelling at the back of the heel
- eye inflammation (less frequent).

How is it diagnosed?
Your doctor will examine you and ask if there’s a family history of psoriasis. You may also have blood tests to rule out other conditions, and x-rays can sometimes help to confirm the diagnosis.

What treatments are there?
You may be given some of the following treatments, depending on your symptoms:
- non-steroidal anti-inflammatory drugs (NSAIDs) to relieve symptoms
- disease-modifying anti-rheumatic drugs (DMARDs) that act on the causes of inflammation
- steroid injections
- ointments, tablets or light therapy for skin symptoms
- exercise and physiotherapy to keep the joints mobile
- surgery to repair damaged tendons or replace badly damaged joints, but this is rarely needed.

How can I help myself?
Maintaining a healthy weight reduces strain on the joints. Keeping active will help, but you’ll need to find the right balance between rest and exercise.
What is psoriatic arthritis?
Psoriatic arthritis causes inflammation in and around the joints. It usually affects people who already have psoriasis, a skin condition that causes a red, scaly rash, especially on the elbows, knees, back, buttocks and scalp. However, some people develop the arthritic symptoms before the psoriasis, while others will never develop the skin condition.
Psoriasis can affect people of any age, both male and female, but psoriatic arthritis usually only affects adults. People with psoriasis may also have other types of arthritis, such as osteoarthritis or rheumatoid arthritis, but these aren’t linked to the psoriasis.

See Arthritis Research UK booklets Osteoarthritis; Rheumatoid arthritis.

What are the symptoms of psoriatic arthritis?
Figure 1 shows some of the common symptoms of psoriatic arthritis. Symptoms can include:
• pain and stiffness in and around the body’s joints

swelling of fingers or toes (dactylitis), caused by inflammation occurring simultaneously in joints and tendons

- buttock pain, a stiff back or a stiff neck, which is caused by inflammation in the spine (spondylitis)

- pain and swelling in the heels, caused by inflammation where the Achilles tendon attaches to the bone

- pain in other areas where tendons attach to bone (enthesitis), such as the knee, hip bones and chest

- pitting, discoloration and thickening of the nails.

There are 78 major joints in the body and psoriatic arthritis can affect any one of these, although some joints are more likely to be affected than others (see Figure 2). About 1 in 3 people who have psoriatic arthritis will have pain and stiffness in their neck or back.
Does psoriatic arthritis affect other parts of the body?
It’s unusual for major organs of the body to be affected. However, if you have psoriatic arthritis you may be more likely to develop an itchy, red eye. This may be caused by inflammation of the membrane that covers the front of the eye and the inside of the eyelid (conjunctivitis) or around the pupil (iritis/uveitis).

People with psoriasis and psoriatic arthritis may also have a slightly greater risk than other people of developing heart disease, so it’s important to tackle anything that could add to this risk, such as smoking, high alcohol intake, being overweight or blood pressure problems.

Psoriatic arthritis doesn’t usually affect other major organs such as the kidneys, liver or lungs.

What causes psoriatic arthritis?
The arthritis and the skin condition are both caused by inflammation. The processes of inflammation are very similar in the skin and the joints. We don’t yet know exactly what triggers the inflammation in psoriatic arthritis, although a particular combination of genes makes some people more likely than others to develop psoriasis and psoriatic arthritis.

Research suggests that something – perhaps an infection – acts as a trigger in people who are already susceptible to this type of arthritis because of the genes they’ve inherited from their parents. No specific infection has yet been found, and it may be that a variety of infections can trigger the disease, for example bacteria that live in patches of psoriasis. Sometimes the arthritis can follow an accident or injury, particularly if it affects a single joint.

What is the outlook?
Psoriatic arthritis can vary a great deal between different people so it’s not possible to offer specific advice on what you should expect. About a third of people with psoriatic arthritis will have a mild form of the disease that remains very stable over time. Others will have more severe symptoms that require long-term treatment.

Psoriatic arthritis will usually have some effect on your quality of life. However, it’s less likely than rheumatoid arthritis to result in serious disability.

How is psoriatic arthritis diagnosed?
It’s important that psoriatic arthritis is diagnosed early so treatment can be started as soon as possible. There’s no specific test for psoriatic arthritis, but the diagnosis is based on your symptoms and a physical examination. Your doctor will check for psoriasis and may ask if there’s a history of psoriasis in your family.
It can be difficult to distinguish between psoriatic arthritis and rheumatoid arthritis. If several joints are affected, your doctor will consider features such as the pattern of arthritis – that is, which joints are affected. Your doctor may want to take a blood test for rheumatoid factor to help rule out rheumatoid arthritis. X-rays of the back, hands and feet can also be helpful, as psoriatic arthritis can affect the bones and joints in these areas in a distinctive way.

What treatments are there for psoriatic arthritis?
A team of health professionals are likely to be involved in your treatment. Your doctor (either your GP or a specialist) will usually be responsible for your care, although a nurse may also be involved in monitoring your condition and treatments.

You may also see:
- a physiotherapist, who can advise on exercises to help maintain your mobility
- an occupational therapist, who can advise on protecting your joints from further damage, for example, by using splints (see Figure 3) or altering the way you perform tasks to reduce the strain on your joints
- a podiatrist, who can assess your footcare needs and offer advice on special footwear.

See Arthritis Research UK booklets
Feet, footwear and arthritis; Meet the rheumatology team; Occupational therapy and arthritis; Physiotherapy and arthritis.

Figure 3
A wrist splint
Psoriatic arthritis

Drugs

**For the arthritis**

- anti-inflammatory drugs (NSAIDs) e.g. ibuprofen, indometacin, naproxen
- steroid injections
- disease-modifying drugs (DMARDs) e.g. methotrexate, sulfasalazine
- biological therapies e.g. adalimumab, infliximab

**For the psoriasis**

- ointments
- retinoid tablets
- ultraviolet light therapy
- DMARDs and biological therapies used for arthritis sometimes also help the psoriasis

Non-steroidal anti-inflammatory drugs (NSAIDs)

Anti-inflammatory drugs act by blocking the inflammation that occurs in the lining of your joints. They can be very effective in controlling pain and stiffness. Usually you’ll find your symptoms improve within hours of taking these drugs but the effect will only last for a few hours, so the tablets have to be taken regularly.

Some people find that NSAIDs work well at first but become less effective after a few weeks. In this situation, it sometimes helps to try a different NSAID. There are about 20 available, including ibuprofen, diclofenac, indometacin and naproxen.
Like all drugs, NSAIDs can sometimes have side-effects, but your doctor will take precautions to reduce the risk of these, for example, by prescribing the lowest effective dose for the shortest possible period of time.

NSAIDs can cause digestive problems (stomach upsets, indigestion or damage to the lining of the stomach) so in most cases NSAIDs will be prescribed along with a drug called a **proton pump inhibitor (PPI)**, which will help to protect the stomach.

NSAIDs also carry an increased risk of heart attack or stroke. Although the increased risk is small, your doctor will be cautious about prescribing NSAIDs if there are other factors that may increase your overall risk, for example, smoking, circulation problems, high blood pressure, high cholesterol or diabetes.

**See Arthritis Research UK drug leaflet** *Non-steroidal anti-inflammatory drugs.*

**Disease-modifying anti-rheumatic drugs (DMARDs)**

Disease-modifying drugs help by tackling the causes of inflammation. They change the way the disease progresses and hopefully will stop your arthritis from getting worse. It may be several weeks before DMARDs start to have an effect on your joints, so you should keep taking them even if they don’t seem to be working. Sometimes these drugs are given by injection.

DMARDs are normally used as a second-line treatment, and the decision to use them will depend on a number of factors, including the effects of the anti-inflammatory drugs, how active the arthritis is and the likelihood of further joint damage.

Examples of disease-modifying drugs include:

- methotrexate
- sulfasalazine
- hydroxychloroquine
- ciclosporin.

Biological therapies are a newer group of drugs that may be used if other DMARDs aren’t working well enough. These are given either by injection or through a drip into a vein.

Biological therapies used for treating psoriatic arthritis include:

- adalimumab
- etanercept
- infliximab.

When taking almost all DMARDs you’ll need to have a regular blood tests and in some cases a urine test. The tests allow your doctor to monitor the effects of the drug on your condition but also to check for possible side-effects, including problems with the liver, kidneys or blood count.

Anti-inflammatory drugs can be taken along with DMARDs, and sometimes more than one DMARD is needed.
Psoriatic arthritis

Steroid treatments
Steroid tablets aren’t generally used for psoriatic arthritis. However, steroid injections are often recommended for joints that are particularly troublesome or when ligaments and tendons become inflamed.

Treatments for the skin
Skin treatment is usually with ointments. There are five main types:

- tar-based ointments
- dithranol-based ointments (it’s very important not to let these come into contact with normal skin)
- steroid-based creams and lotions
- vitamin D-like ointments such as calcipotriol and tacalcitol
- vitamin A-like (retinoid) gels such as tazarotene.
If the creams and ointments don’t help the psoriasis your doctor may suggest:

• light therapy, involving short spells of exposure to high-intensity ultraviolet light carried out in hospital
• retinoid tablets.

Many of the DMARDs used for psoriatic arthritis will also help the skin condition. Similarly, some of the treatments for the skin may help the arthritis.

Treatments for nail psoriasis are usually less effective than the skin treatments. Many people use nail varnish to make the marks less noticeable.

**Surgery**

People with psoriatic arthritis don’t often need surgery. Very occasionally a damaged tendon may need surgical repair. And sometimes, after many years of disease, a joint that has been damaged by inflammation is best treated with joint replacement surgery.

If the psoriasis is bad in the skin around the affected joint, your surgeon may recommend a course of antibiotic tablets to help prevent infection. Sometimes psoriasis can appear along the scar left by the operation, but this can be treated in the usual way.

See Arthritis Research UK booklets

*Hip replacement; Knee replacement; Shoulder and elbow joint replacement.*

---

**Self-help and daily living**

There are some things you can do in your daily life that may help relieve your symptoms.

**Exercise**

Inflammation can lead to muscle weakness and stiffness in the joints. Exercise is important to prevent this and to keep your joints working properly. However, inflammation can also make you feel unusually tired so you may find you need to take more rests than usual.

Your doctor or a physiotherapist will be able to advise on suitable forms of exercise depending on which joints are most affected. However, you’ll need to find out for yourself the right balance between rest and exercise.

See Arthritis Research UK booklets

*Fatigue and arthritis; Keep moving; Looking after your joints when you have arthritis.*
Diet and nutrition
No specific diets have been found to be very effective for psoriatic arthritis, although some people find that fish body oils (not fish liver oils) from salt-water fish reduce the need for anti-inflammatory drugs.

Being overweight will put extra strain on your joints, particularly the leg and back joints. It’s also important to control your weight because of the increased risk of heart disease. We recommend a healthy, balanced diet with plenty of fresh vegetables and fruit.

See Arthritis Research UK booklet
    Diet and arthritis.

Complementary medicine
There’s no scientific evidence that suggests any form of complementary medicine helps to ease the symptoms of psoriatic arthritis. Generally speaking, complementary and alternative therapies are relatively well tolerated, but you should always discuss it with your doctor if you want to try them.

There are some risks associated with specific therapies, but in many cases the risks associated with them are more to do with the therapist than the therapy. This is why it’s important to go to a legally registered therapist, or one who has a set ethical code and is fully insured.

If you decide to try therapies or supplements you should be critical of what they’re doing for you, and base your decision to continue on whether you notice any improvement.

See Arthritis Research UK booklet
    Complementary and alternative medicine for arthritis.

Work and benefits
People with arthritis are likely to have some difficulties with work, but help is available. Work assessment and, if necessary, retraining can be arranged by a Disability Employment Adviser. You can contact an adviser through your local Jobcentre Plus office.
The Employment Medical Advisory Service can also help by providing equipment to make it easier for you to do your job. Benefits are available if you’re unable to work or have mobility problems. A health or social worker or your local Citizens Advice Bureau will be able to advise you on which benefits you may be able to claim.

See Arthritis Research UK booklets
Everyday living and arthritis;
Work and arthritis.

Sex and pregnancy
Sex can sometimes be painful, particularly for a woman whose hips are affected. Experimenting with different positions will usually provide a solution.

Psoriatic arthritis won’t affect your chances of having children or a successful pregnancy. The arthritis often improves during the pregnancy, although your symptoms may return after the baby is born.

Some of the drug treatments given for psoriatic arthritis should be avoided when trying to start a family. For instance, sulfasalazine can cause a low sperm count (this isn’t permanent) and you shouldn’t try for a baby if you or your partner are on methotrexate or have been using it in recent months. If you’re thinking about starting a family, you should discuss your drug treatment with your doctor well in advance so that your medications can be changed if necessary.

Both psoriasis and psoriatic arthritis do tend to run in families to some extent. If there’s a history of psoriasis or psoriatic arthritis in your family, then your children may be more likely than most to get psoriatic arthritis, but the risk of passing it on directly is still low.

See Arthritis Research UK booklets
Pregnancy and arthritis;
Sex and arthritis.

Living with psoriatic arthritis
Any long-term condition can affect your moods, emotions and confidence, and it can have an impact on your work, social life and relationships.

Talk things over with a friend, relative or your doctor if you do find your condition is getting you down. You can also contact support groups if you want to meet other people with psoriatic arthritis.

Research and new developments
Scientists are working to find the exact causes of psoriatic arthritis. It’s now possible to scan human genetic material to look for genes that increase the likelihood of psoriasis and psoriatic arthritis. This is likely to bring completely new developments in the next few years. In addition, new magnetic resonance imaging (MRI) techniques are now telling us more about the sites of inflammation in the disease, which will lead to better targeted therapies.
Glossary

Disease-modifying anti-rheumatic drugs (DMARDs) – drugs used in rheumatoid arthritis and some other rheumatic diseases to suppress the disease and reduce inflammation. Unlike painkillers and non-steroidal anti-inflammatory drugs (NSAIDs), DMARDs treat the disease itself rather than just reducing the pain and stiffness caused by the disease. Examples of DMARDs are methotrexate, sulfasalazine, gold, infliximab, etanercept and adalimumab.

Enthesitis – inflammation of the sites (entheses) where tendons or ligaments attach to bone.

Inflammation – a normal reaction to injury or infection of living tissues. The flow of blood increases, resulting in heat and redness in the affected tissues, and fluid and cells leak into the tissue, causing swelling.

Ligaments – tough, fibrous bands anchoring the bones on either side of a joint and holding the joint together. In the spine, they’re attached to the vertebrae and restrict spinal movements, therefore giving stability to the back.

Magnetic resonance imaging (MRI) – a type of scan that uses high-frequency radio waves in a strong magnetic field to build up pictures of the inside of the body. It works by detecting water molecules in the body’s tissue that give out a characteristic signal in the magnetic field. An MRI scan can show up soft-tissue structures as well as bones.

Non-steroidal anti-inflammatory drugs (NSAIDs) – a large family of drugs prescribed for different kinds of arthritis that reduce inflammation and control pain, swelling and stiffness. Common examples include ibuprofen, naproxen and diclofenac.

Occupational therapist – a therapist who helps you to get on with your daily activities (e.g. dressing, eating, bathing) by giving practical advice on aids, appliances and altering your technique.

Osteoarthritis – the most common form of arthritis (mainly affecting the joints in the fingers, knees, hips), causing cartilage thinning and bony overgrowths (osteophytes) and resulting in pain, swelling and stiffness.

Physiotherapist – a therapist who helps to keep your joints and muscles moving, helps ease pain and keeps you mobile.

Podiatrist – a trained foot specialist. The terms podiatrist and chiropodist mean the same thing, although podiatrist tends to be preferred by the profession. NHS podiatrists and chiropodists are state-registered, having followed a 3-year university-based training programme. The podiatrist or chiropodist can deal with many of the foot problems caused by arthritis.

Proton pump inhibitor (PPI) – a drug that acts on an enzyme in the cells of the stomach to reduce the secretion of gastric acid. They’re often prescribed along with non-steroidal anti-inflammatory drugs (NSAIDs) to reduce side-effects from the NSAIDs.
Rheumatoid arthritis – an inflammatory disease affecting the joints, particularly the lining of the joint. It most commonly starts in the smaller joints in a symmetrical pattern – that is, for example, in both hands or both wrists at once.

Rheumatoid factor – a blood protein produced by a reaction in the immune system. About 80% of people with rheumatoid arthritis test positive for this protein. However, the presence of rheumatoid factor can’t definitely confirm the diagnosis.

Tendon – a strong, fibrous band or cord that anchors muscle to bone.

Where can I find out more?
If you’ve found this information useful you might be interested in these other titles from our range:

Conditions
• Osteoarthritis
• Rheumatoid arthritis

Therapies
• Meet the rheumatology team
• Occupational therapy
• Physiotherapy and arthritis

Surgeries
• Hip replacement
• Knee replacement
• Shoulder and elbow joint replacement

Self-help and daily living
• Complementary and alternative medicine for arthritis
• Diet and arthritis
• Everyday living and arthritis
• Fatigue and arthritis
• Feet, footwear and arthritis
• Keep moving
• Looking after your joints when you have arthritis
• Pregnancy and arthritis
• Sex and arthritis
• Work and arthritis

Drug leaflets
• Adalimumab
• Ciclosporin
• Etanercept
• Hydroxychloroquine
• Infliximab
• Methotrexate
• Non-steroidal anti-inflammatory drugs
• Sufalsalazine

You can download all of our booklets and leaflets from our website or order them by contacting:

Arthritis Research UK
PO Box 177
Chesterfield
Derbyshire S41 7TQ
Phone: 0300 790 0400
www.arthritisresearchuk.org
Related organisations

The following organisations may be able to provide additional advice and information:

**Arthritis Care**
18 Stephenson Way
London NW1 2HD
Phone: 020 7380 6500
Helpline: 0808 800 4050
www.arthritiscare.org.uk

**Citizens Advice Bureau**
Myddelton House,
115–123 Pentonville Road,
London, N1 9LZ
Phone: 020 7833 2181 (admin only – no advice available on this number)
To find your local office, see the telephone directory under ‘Citizens Advice Bureau’ or the Yellow Pages under ‘Counselling and Advice’.
www.citizensadvice.org.uk

**Benefit Enquiry Line**
2nd Floor
Red Rose House
Lancaster Road, Preston
Lancashire PR1 1HB
Phone: 0800 882 200
www.direct.gov.uk

**Psoriasis Scotland Arthritis Link Volunteers (PSALV)**
54 Bellevue Road
Edinburgh EH7 4DE
Phone: 0131 556 4117
webplus.psoriasisscotland.org.uk

**Psoriasis and Psoriatic Arthritis Alliance (PAPAA)**
PO Box 111
St Albans
Hertfordshire AL2 3JQ
Phone: 01923 672837
www.papaa.org.uk

The Scottish Intercollegiate Guidelines Network (SIGN) recently published new guidelines for the diagnosis and management of psoriasis and psoriatic arthritis in adults. You can view these guidelines at www.sign.ac.uk/guidelines/fulltext/121/index.html
Notes
We’re here to help

Arthritis Research UK is the charity leading the fight against arthritis. We’re the UK’s fourth largest medical research charity and fund scientific and medical research into all types of arthritis and musculoskeletal conditions. We’re working to take the pain away for sufferers with all forms of arthritis and helping people to remain active. We’ll do this by funding high-quality research, providing information and campaigning.

Everything we do is underpinned by research.

We publish over 60 information booklets which help people affected by arthritis to understand more about the condition, its treatment, therapies and how to help themselves.

We also produce a range of separate leaflets on many of the drugs used for arthritis and related conditions. We recommend that you read the relevant leaflet for more detailed information about your medication.

Please also let us know if you’d like to receive our quarterly magazine, Arthritis Today, which keeps you up to date with current research and education news, highlighting key projects that we’re funding and giving insight into the latest treatment and self-help available.

We often feature case studies and have regular columns for questions and answers, as well as readers’ hints and tips for managing arthritis.

Tell us what you think of our booklet

Please send your views to: feedback@arthritisresearchuk.org or write to us at: Arthritis Research UK, PO Box 177, Chesterfield, Derbyshire S41 7TQ.

A team of people contributed to this booklet. The original text was written by Dr Philip Helliwell, who has expertise in the subject. An Arthritis Research UK editor revised the text to make it easy to read, and a non-medical panel, including interested societies, checked it for understanding. An Arthritis Research UK medical advisor, Prof. Anisur Rahman, is responsible for the overall content.
Get involved

You can help to take the pain away from millions of people in the UK by:

- Volunteering
- Supporting our campaigns
- Taking part in a fundraising event
- Making a donation
- Asking your company to support us
- Buying gifts from our catalogue

To get more actively involved, please call us 0300 790 0400 or e-mail us at enquiries@arthritisresearchuk.org

Or go to: www.arthritisresearchuk.org

Providing answers today and tomorrow