

Roadblocks Perceived by Canadian Dermatologists for Referring Patients with Suspected Psoriatic Arthritis

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Introduction

- There is a high prevalence of undiagnosed psoriatic arthritis (PsA) in psoriasis patients seen in dermatology clinics.
- The awareness of the prevalence of PsA, the consequences of delayed diagnosis and strategies for screening of psoriasis patients for PsA among Canadian dermatologists is unknown.
- The recently published Canadian Guidelines for Management of Plaque Psoriasis recommends that psoriasis patients be referred to a rheumatologist if they experience arthritis or arthralgia. However, since more than 50% of patients with psoriasis have rheumatic symptoms, this recommendation may lead to many inappropriate referrals.
- We hypothesize that knowledge level, attitude and confidence in being able to refer appropriately impacts the ability of dermatologists to refer patients who may have PsA to a rheumatologist.**

Aim

To define their current awareness of, and practices relating to, the diagnosis and referral of PsA.

Methods

- An advisory group that is multidisciplinary in scope and includes dermatologists, rheumatologists and patients to define the priority actions/interventions/barriers that educational tools will need to target was established.
- Questions for structured interviews and focus groups with practicing dermatologists were developed based on recommendations from the advisory group.
- Dermatologists from across Canada at different stages of their career were recruited via electronic mail.
- Initially, to map key structural influences and stakeholder perspectives on identifying PsA in patients with psoriasis, the interviewer (research associate) inquired about confidence, barriers and attitudes towards referral and assessment of PsA from 8 dermatologists.
- Two focus group with a total of 12 dermatologists were facilitated by the research associate to elicit information on knowledge, barriers to screening for PsA and suggestions for facilitating the screening process.
- The interviews and focus groups were recorded, transcribed, and analyzed by 2 experts and key themes identified.

Results

- An **advisory group** consisting of four patients, two dermatologists and one rheumatologist was established to assist the research team consisting of two rheumatologists, 2 dermatologists, 2 methodologists and 2 research associates.

Results (2)

- The following questions for the **interview** were developed:
 - To begin, can you tell me what you know about PsA and other comorbidities associated with psoriasis?
 - How common is PsA in your patients/clinic?
 - What would normally be a 'red flag' for you that might indicate a patient could have PsA and should be further investigated?
 - If you do suspect PsA, what would your next step be in managing that patient? [Probes: What are some screening strategies for identifying PsA? If referral is the next step, do you continue to be involved in that patient's ongoing management of PsA? What do you think your role is regarding PsA?]
 - When you think about your own experience and practice, how confident are you in your ability to identify possible PsA in your patients?
 - How important do you think it might be to identify PsA early? [Probes: Why do you think this is important? What are the consequences if not identified early – to patients? To the healthcare system?]
 - What are your thoughts on whether PsA is appropriately identified in patients with psoriasis? [Probes: In your own clinic or practice? In dermatology clinics across Canada?]
 - What do you think the barriers might be to the early identification of PsA in patients with psoriasis [probe- time spent per patient, access to specialist?]
 - Is there anything that might help dermatologists in the early identification of patients with PsA? [Probes: practice guidelines (are you aware of any guidelines), web apps, paper tools for office, etc.?]
 - Do you think the diagnosis of PsA should only be made only by a Rheumatologist? [Probe: Is confirmation required by a Rheumatologist?] What is your threshold for referral?
 - What treatment strategies are you aware of that will benefit both skin and joints in patients with psoriasis? [Probes: Psoriasis patients with joint pain – use a drug that benefits arthritis and skin assuming the patient has PsA. (no formal diagnosis)]
 - Would you be confident to treat/manage PsA?
 - Do you assess for other comorbidities (probe- do you refer your patient back to his/her family physicians for further evaluation?)
 - Is there anything else you want to say about PsA in practice?
- The questions for **focus groups** with dermatologists were developed based on the results of the interviews with dermatologists.
- 8 interviews and 2 focus groups** involving a total of **20 dermatologists** in community practice (10 males, mean years in practice 18.4) were conducted and data saturation reached.
- The following **themes** were identified:
 - Self-perceived knowledge** of psoriasis and associated co-morbidities was fairly high, with a mean of 7.1 across focus groups (range 5-9). Across the eight interviews, the mean was higher, at 8.5 (range 7-10).
 - The **number of patients** with psoriasis seen was quite variable, 30-50 weekly on average. Of these, the percentage with PsA or suspected PsA ranged from 5%-50%.
 - Comorbidities**, including PsA, diabetes, obesity, heart disease, depression, metabolic syndrome, and hypertension were consistently mentioned.

Results (3)

- Themes** (continued)
 - Red flags for PsA:**
 - A number of red flags were noted as potentially indicating PsA, most notably morning stiffness and joint pain. Fewer mentioned nail lesions and swelling of the hands.
 - There was recognition that while asking about arthritic symptoms and examination of the joints were red flags for PsA, dermatologists were more likely to do this on first consultation.
 - Importance of identifying PsA early:** All dermatologists recognized the importance of identifying PsA early, both for the patient and for the broader healthcare system.
 - Comfort with identifying PsA- Dermatologist's role:**
 - Most dermatologists felt they had adequate knowledge of PsA and generally know for which red flags to look.
 - However, there was a notable divide between their perceived role in screening for PsA and in making the diagnosis.
 - A minority of respondents felt comfortable managing patients' PsA if it was mild and there was significant skin disease, with or without confirmation of diagnosis by a rheumatologist.
 - Co-management of patients with PsA:**
 - The **severity of a patient's psoriasis and arthritis** appeared to affect dermatologists' perception of their role in patient management.
 - Generally, if arthritis is perceived to be mild, and skin disease to be moderate to severe, dermatologists perceive an ongoing role in patient management.
 - Other aspects of the healthcare system also affected dermatologists' perception of their role in patient management, including the nature of the local healthcare context, access to rheumatology specialists, and the role of primary care in managing patients.

Conclusions

- This qualitative study shows that **dermatologists have high self-perceived knowledge** of psoriasis, PsA and its associated comorbidities.
- Dermatologists **recognize the importance of identifying PsA early**.
- However, the **nature of the local healthcare context** and **access to rheumatologists** are significant roadblocks to appropriate referral.

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