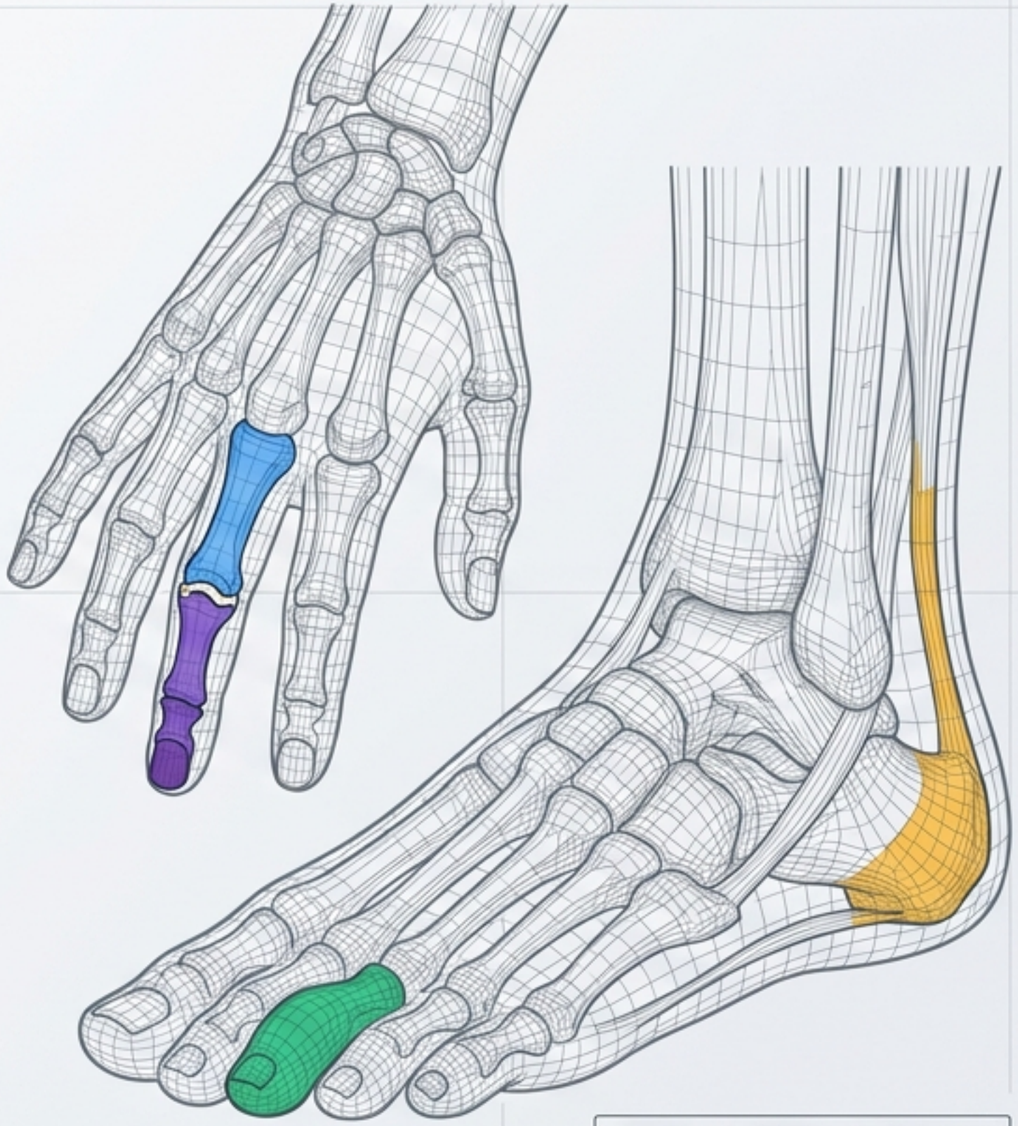
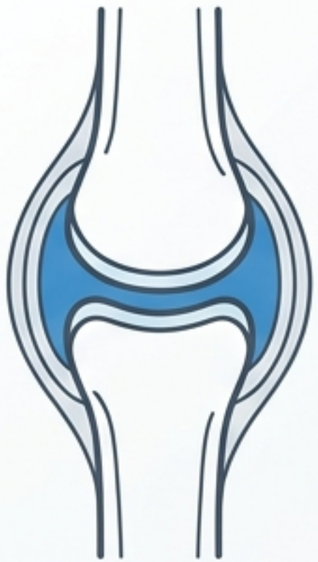
Psoriatic Arthritis: The Clinical Blueprint

Rapid diagnostic criteria, domain-based assessment, and targeted PBS treatment pathways.

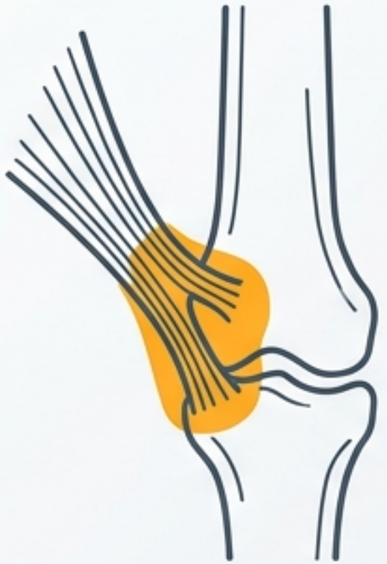


Clinical Guideline Reference

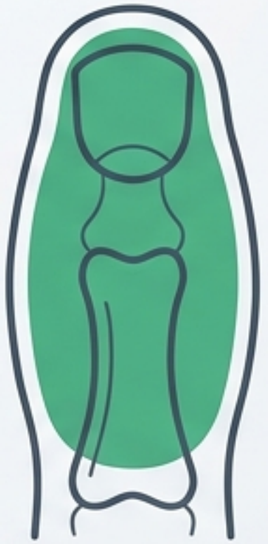
Derived from Med2Date 2026



Peripheral Arthritis



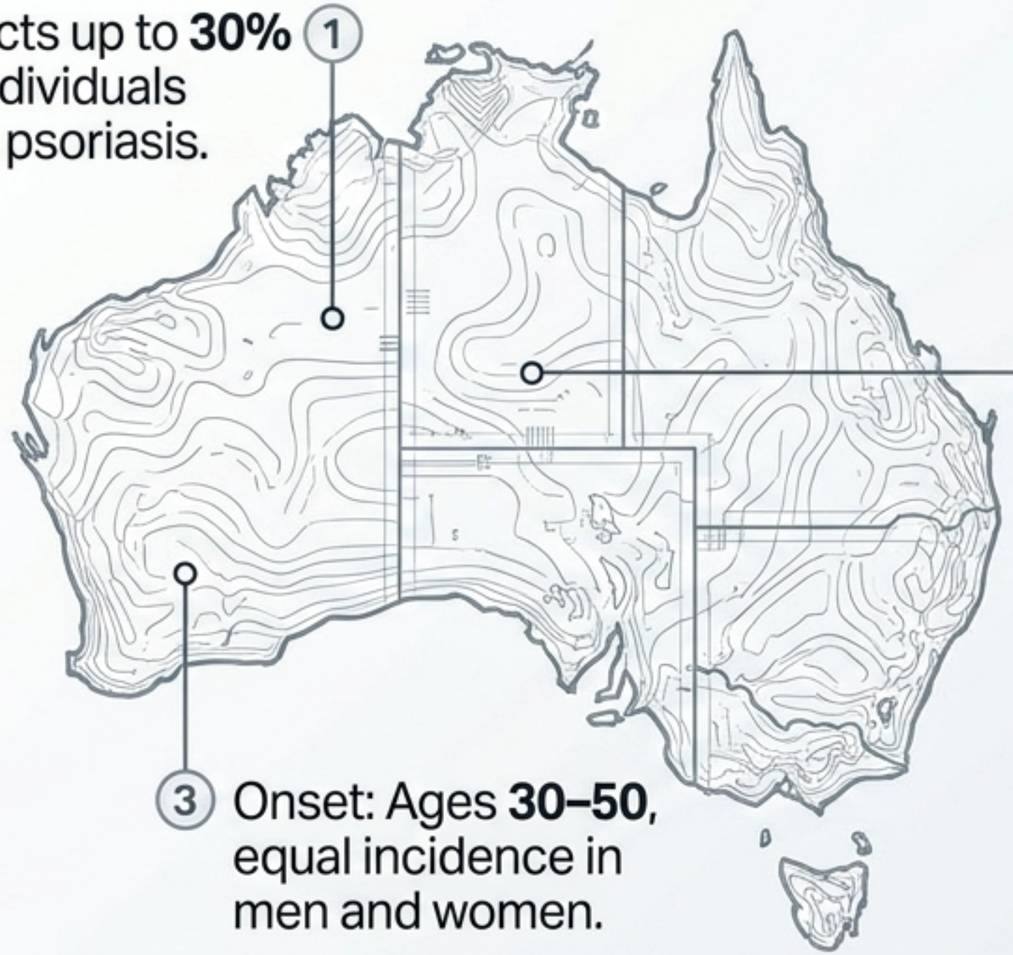
Enthesitis



Dactylitis

Skin & Nails

A Multi-Domain Disease: PsA is not a single presentation, but a combination of four distinct clinical domains. Treatment escalation is dictated by which domains are active.



Clinical Takeaway: The disease burden—impacting quality of life, physical function, and work productivity—is equal to rheumatoid arthritis. Early pattern recognition is critical.

Phase 1: The Triggers

Genetic Susceptibility
(HLA-B27 & HLA alleles)

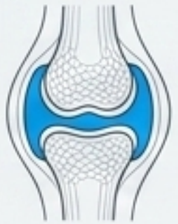
Environmental Triggers

Phase 2: The Mechanism

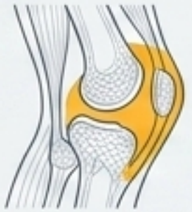
Immune Dysregulation

Activation of Th1, Th17, and IL-23 Pathways

Phase 3: Tissue Impact

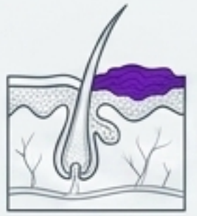


Joint Space
(Synovitis)



Enthesis
(Insertion Point)

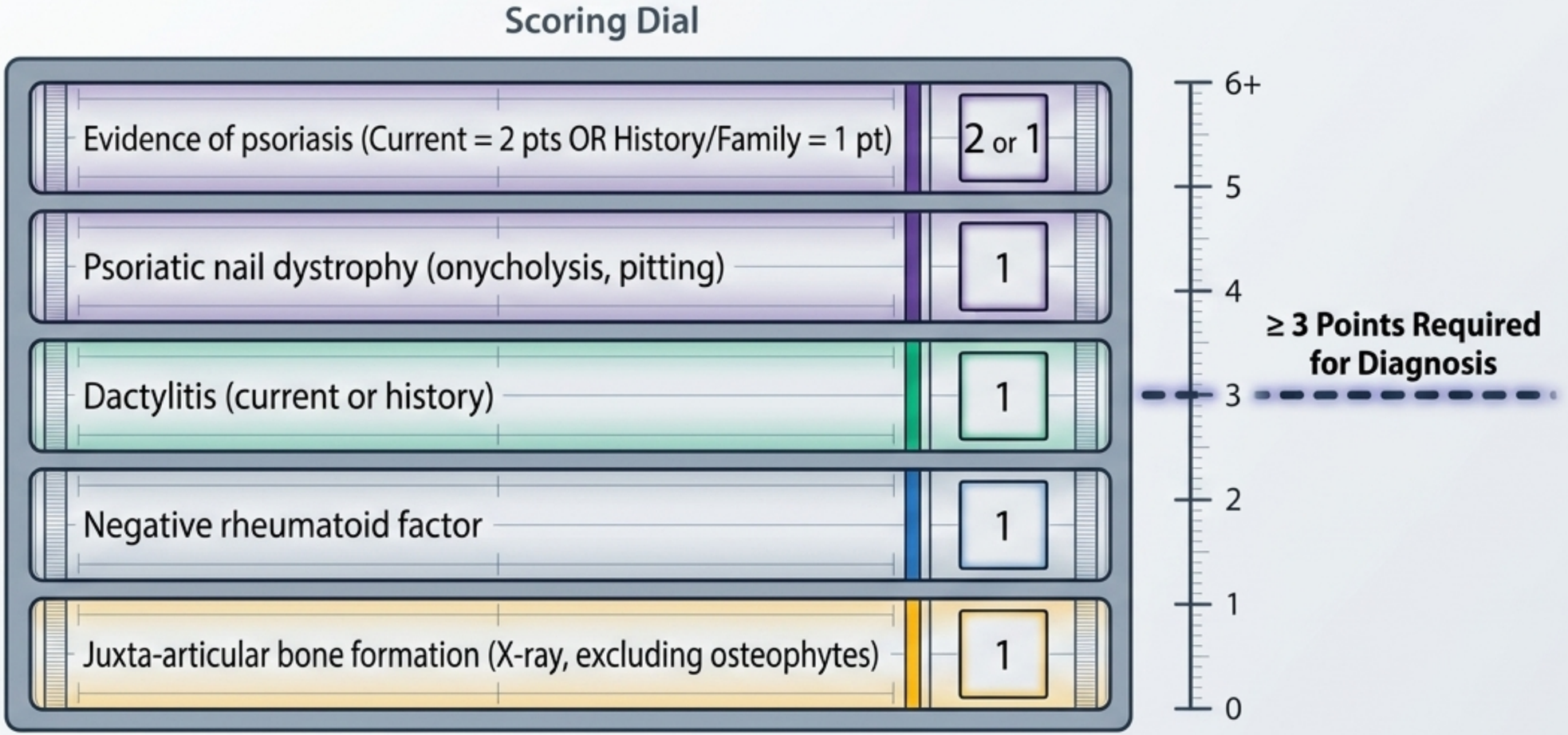
Soft Tissue
(Dactylitis)



Epidermis
(Plaques/Nails)

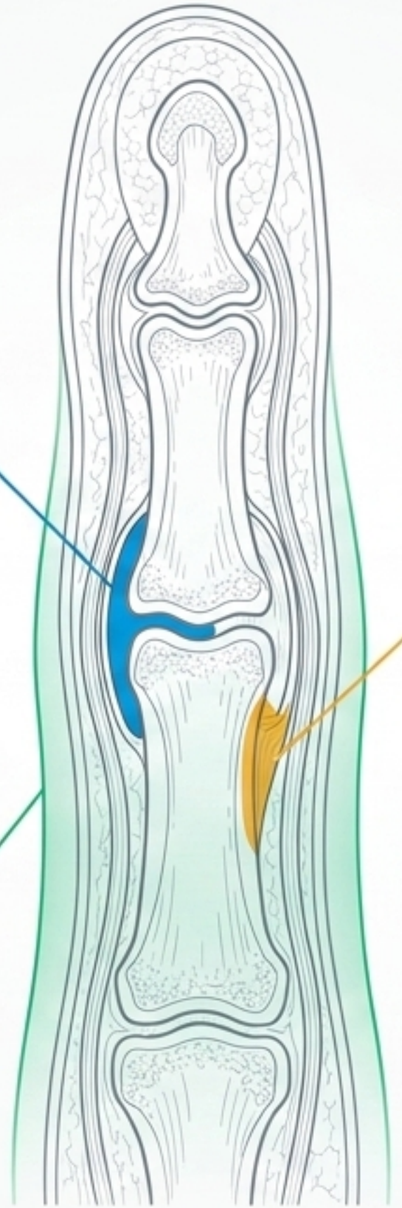
The identical immune error targets distinct anatomical structures, driving multi-domain inflammation.

CASPAR Classification Criteria for Psoriatic Arthritis



Diagnostic Threshold: Inflammatory articular disease must be present to apply criteria. Specificity ~99%, Sensitivity ~91%.

The Anatomy of Inflammation



1

Synovitis

Clinical Blue

Inflammation confined to the synovial membrane.

2

Enthesitis

Medical Amber

Inflammation at the insertion point of tendons or ligaments into bone.

3

Dactylitis

Emerald Green

Diffuse inflammation of the entire digit (The Sausage Digit).

Peripheral Arthritis

Asymmetric Oligoarticular	Symmetric Polyarthritis	DIP Predominant	Arthritis Mutilans
70% frequency. Key feature: ≤4 joints, often large joints (knee/ankle) + DIP.	Key differentiator: Resembles rheumatoid arthritis, but with fewer joints and concurrent DIP involvement.	Key hallmark: Classic pattern strongly linked to severe nail disease.	5% frequency. Severe osteolysis (‘pencil-in-cup’ deformity, telescoping digits).

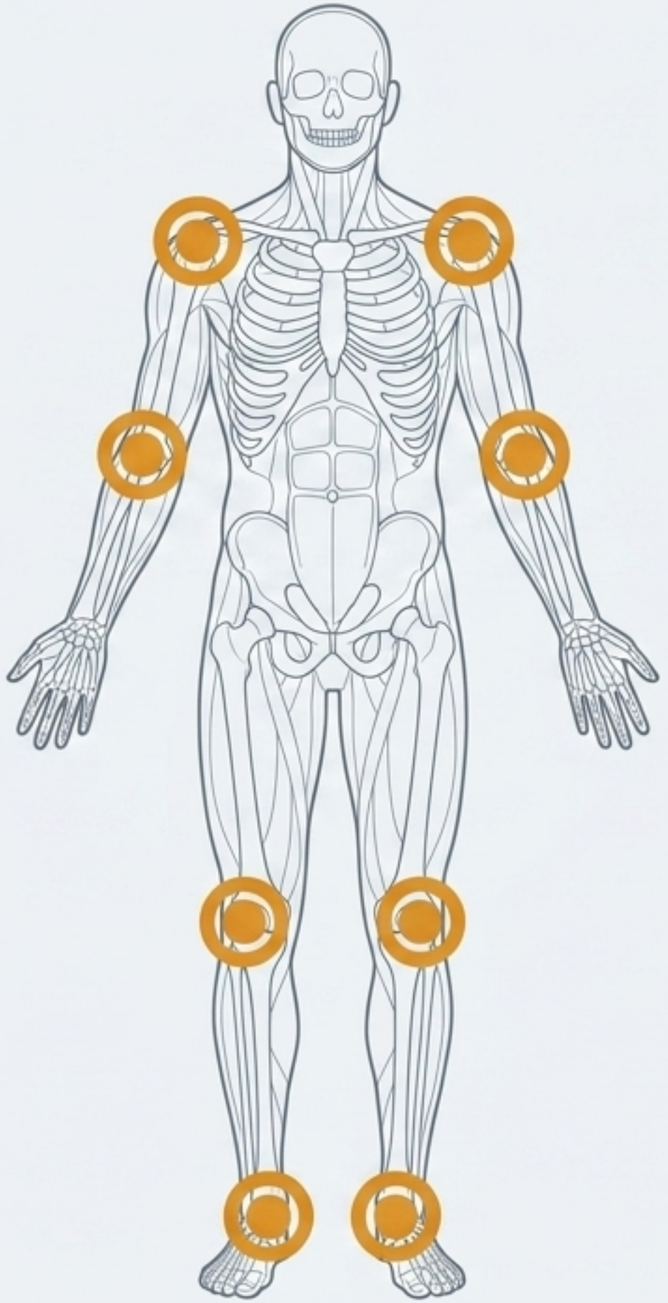
Baseline Requirements: 68/66 joint count, patient global VAS, HAQ-DI, and hands/feet X-rays to detect erosions/new bone formation.

Enthesitis

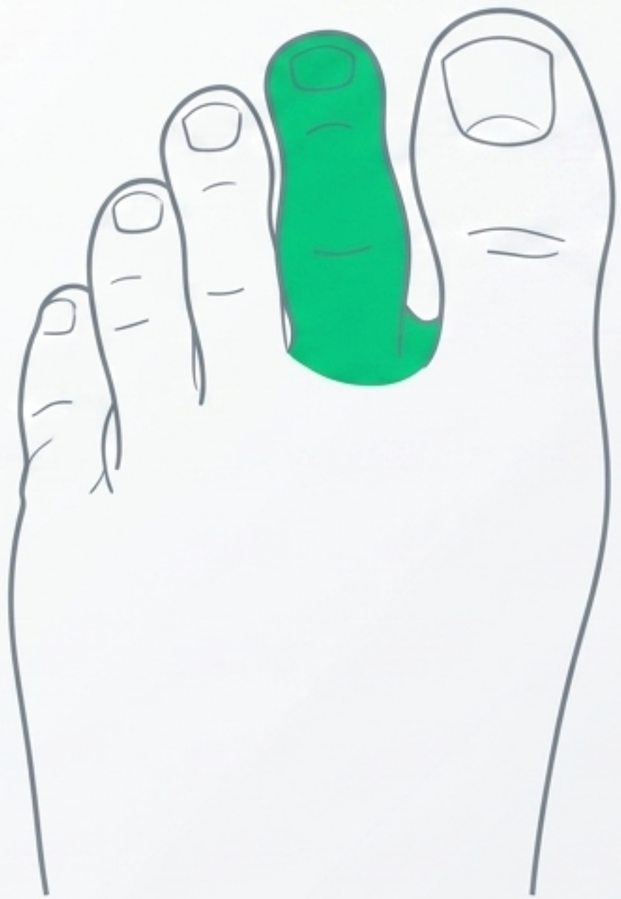
Palpation Targets:
- Achilles tendon & plantar fascia (calcaneus)
- Lateral epicondyles
- Medial femoral condyles
- Supraspinatus insertion

Monitoring Metrics:
Leeds Enthesitis Index (LEI) or MASES.

The Clinical Pivot: Pathognomonic feature. Often responds poorly to conventional csDMARDs (methotrexate). Predominant enthesitis favours early escalation to bDMARDs (TNFi or IL-17i).



Dactylitis



Clinical Profile

Present in up to 50% of patients. Involves joint, tendon sheath, and soft tissue simultaneously.

Prognostic Value

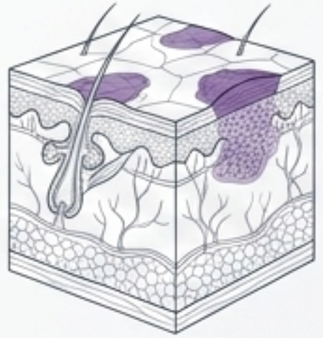
High risk of radiographic progression. Strong predictor of severe disease phenotype.

Management Escalation

Similar to enthesitis, the presence of dactylitis is a poor prognostic factor often requiring earlier escalation to bDMARDs than peripheral arthritis alone.

Skin & Nails

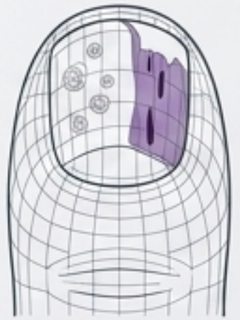
Skin Disease



Plaque psoriasis is the most common presentation.

However, the severity of cutaneous lesions does not correlate with the severity of underlying joint disease.

Nail Disease

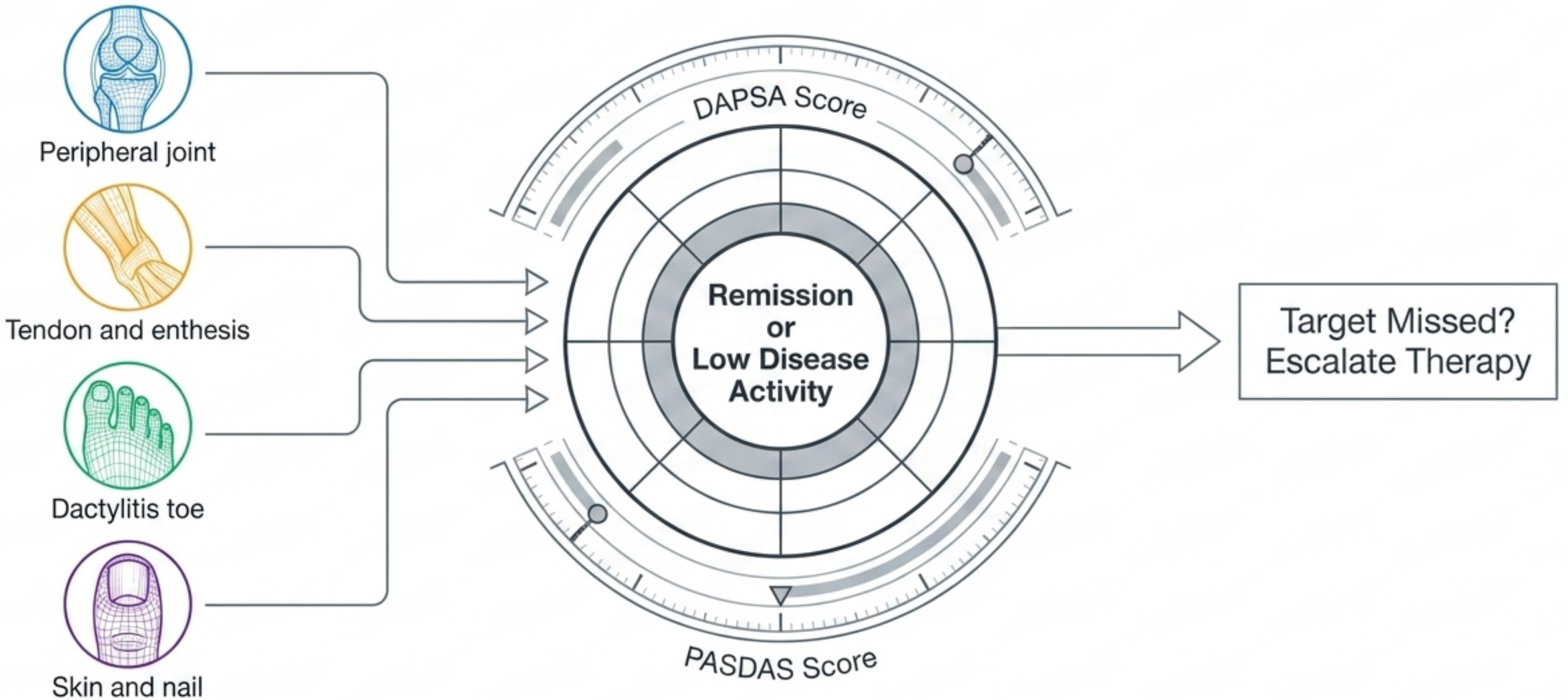


Key manifestations: Pitting, onycholysis, subungual hyperkeratosis, splinter haemorrhages.

Strong clinical link: Present in ~80% of PsA patients (compared to only ~40% with cutaneous psoriasis alone)

Management Integration: Topical therapies alone are insufficient for significant PsA. Utilize MBS Item 110 (GP Management Plan) to structure chronic, multi-disciplinary integration with dermatology.

The Treat-to-Target Convergence



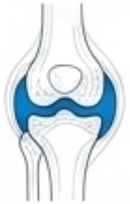
The overarching logic: We don't just treat symptoms;
we measure, treat, and adjust dynamically until the disease is quiet.

Pharmacological Escalation Pathway

Step 1: First-Line (Peripheral Focus)

csDMARDs

Methotrexate [PBS-listed], Sulfasalazine, Leflunomide



Clinical Assessment

Step 2: Biologic Escalation (bDMARDs)

TNFi

IL-17i

IL-23i

Selection based on specific domain severity and PBS Authority criteria.

Step 3: Oral Targeted Alternatives

JAK inhibitors

(For bDMARD-inadequate response)

Target Met: Continue Therapy

Advanced Therapeutics Selection Matrix

Class	Example Agents	Key Strengths	PBS / Safety Notes
TNFi (First-line biologic)	Adalimumab (Humira, 40mg SC q2w) & Etanercept (Enbrel, 50mg SC wkly)	Broadly effective across domains.	PBS: Authority Req after 1x csDMARD fail.
IL-17i	Secukinumab (Cosentyx, 150-300mg SC)	Highly effective for skin, enthesitis, arthritis. First-line or post-TNFi.	PBS: Authority Req.
IL-23i	Guselkumab (Tremfya, 100mg SC)	Robust for severe psoriasis. Used post-TNFi or IL-17i.	PBS: Authority Req.
JAKi (Oral)	Tofacitinib (Xeljanz, 5mg PO bd)	Targeted oral option.	**PBS**: Post-TNFi fail. Increased VTE, MACE, and malignancy risk (>65yrs/smokers).

Pharmacological Safety Guardrails

Pre-Initiation Screening

Mandatory checks for Latent TB (IGRA) and Hepatitis B serology are required before starting any b/tsDMARD. All agents increase the risk of serious infection.

Absolute Contraindication

Live vaccines are strictly contraindicated for patients actively managed on biologic DMARDs or JAK inhibitors.

Comorbidity Screening

High prevalence of baseline cardiovascular risk, metabolic syndrome, and depression in PsA.

Requires concurrent, proactive management alongside joint therapy.

Aboriginal & Torres Strait Islander Health Integration

Care Matrix		
	Identified Barriers	**Targeted Clinical Actions**
Systemic	Long public clinic wait times (especially in rural/remote areas).	◆ Utilize Telehealth (MBS 91801, 91802). ◆ Ensure PBS safety net arrangements. ◆ Implement proactive recall systems.
Cultural	Historical healthcare racism driving avoidance. Distrust of injectable medications. Variable health literacy barriers.	◆ Partner with ACCHOs & Aboriginal Health Workers. ◆ Utilize plain language and visual aids. ◆ Engage professional interpreters (do not use family members).

Clinical Note: Autoimmune conditions are likely under-diagnosed. The high comorbid burden (CVD, Diabetes) requires aggressive, holistic screening.

The Blueprint for Practice

1. Recognize the Patterns

Utilize CASPAR criteria and identify the dominant clinical domains early in the diagnostic pathway.

2. Define the Target

Establish absolute remission or low disease activity goals utilizing validated tools like DAPSA and PASDAS.

3. Escalate with Precision

Bypass standard csDMARDs early if enthesitis or dactylitis dominate. Leverage the PBS authority pathways for targeted bDMARDs.

4. Manage the Whole Patient

Integrate cardiovascular, metabolic, and culturally safe care models for optimal, long-term outcomes.