



RHEUMATOLOGY NURSE PRACTICE

Accredited education for registered nurses and advanced practice providers

THE INTERSECTION OF DERMATOLOGY AND RHEUMATOLOGY

IN THE MANAGEMENT OF PSORIATIC ARTHRITIS

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Recognizing the difficulties that dermatology and rheumatology specialists face in collaborating on patient care in a clinical environment in which disciplinary silos are still the status quo, in this issue of *Rheumatology Nurse Practice*, we will review information about the prevalence of psoriatic arthritis (PsA) among patients with psoriasis, as well as tools that dermatologists can use to recognize PsA in their patients. We will also discuss various models that dermatology specialists, rheumatology specialists, and other clinicians can use to work together to improve outcomes for patients with PsA.

LEARNING OBJECTIVES

After participating in the activity, learners should be better able to:

- Explain the relationship between psoriasis and psoriatic arthritis (PsA)
- Discuss factors that should trigger a referral to rheumatology in patients diagnosed with psoriasis
- Analyze the clinical evidence supporting the use of multidisciplinary care among patients diagnosed with PsA
- Assess the viability of a multidisciplinary rheumatology-dermatology clinic in your practice setting

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THE INTERSECTION OF DERMATOLOGY AND RHEUMATOLOGY

IN THE MANAGEMENT OF PSORIATIC ARTHRITIS

More than 8 million individuals in the United States have psoriasis,¹ many of whom will go on to develop psoriatic arthritis (PsA).²⁻⁴ Because psoriasis typically occurs before the onset of PsA and 80% of patients with psoriasis report seeking care from a dermatologist,⁵ dermatology specialists play a critical role in either diagnosing or referring PsA in its early stages to help prevent irreversible joint damage.^{6,7} Once patients are diagnosed with PsA, rheumatology specialists typically become involved in their care.⁵ However, because PsA involves both skin and joint symptoms, many patients with PsA benefit from the continued involvement of a dermatology specialist.

With today's therapies and the proliferation of multidisciplinary, individualized care, experts now consider remission a reasonable treatment goal for many patients with PsA, especially if effective treatment is provided early in the course of disease.⁸ Clinical trial data suggest that patients who initiate therapy within 2 years of diagnosis experience greater improvements than those who begin therapy later.⁹

But crossing walls, even within the same medical facility, is not the easiest of tasks. So how can dermatology and rheumatology specialists work together to optimally diagnose and manage PsA, allowing patients to receive effective therapy as soon as possible?

Relationship between Psoriasis and PsA

Most patients with PsA develop psoriasis before the onset of arthritic symptoms, putting dermatologists on the frontline of PsA diagnosis. Estimates of the prevalence of PsA among patients with psoriasis have varied widely, ranging from 8% to 30% depending on the study.^{3,10,11} One systematic review suggested the prevalence of undiagnosed PsA among patients with psoriasis is roughly 15%.¹² This means that, currently, a considerable number of patients with PsA are experiencing diagnostic delays that will negatively impact their treatment outcomes.

PsA can develop at any time in patients with psoriasis. Roughly 60% of patients with PsA receive their PsA diagnosis within 10 years of being diagnosed with psoriasis.² Some researchers have interpreted this finding as meaning that the 10-year period after psoriasis onset is a high-risk time for developing PsA,² one in which clinicians should be especially alert for PsA symptoms. However, other studies have found that the incidence of PsA diagnosis is constant each year for patients with psoriasis.^{3,4} Thus, the longer a patient has been diagnosed with psoriasis, the more likely they are to have developed PsA. This observation suggests that dermatology specialists should never let down their guard when it comes to screening their patients with psoriasis for PsA symptoms.

Some evidence suggests that dermatologists can help patients with psoriasis decrease their chances of developing PsA by promoting weight loss. Research shows that any reduction in body mass index (BMI) is associated with a reduction in the risk of developing PsA.¹³ This may be because losing weight reduces patients' exposure to inflammatory molecules produced by adipose tissue, or it may be because weight loss ameliorates mechanical stress experienced by the joints.^{13,14} Because of the many health benefits of weight loss, dermatology specialists may want to consider discussing lifestyle changes that facilitate BMI reduction with patients who are overweight or obese.

It should be noted that 7% to 15% of patients develop PsA without first experiencing psoriasis,^{2,6} which means that prior skin involvement is not necessarily a precondition

for diagnosis. Because not all patients with PsA develop psoriasis first, healthcare providers who do not specialize in treating skin problems, such as primary care providers (PCPs), should also be prepared to diagnose this condition.

The Winding Route to PsA Diagnosis

Research shows that patients can take any number of routes to a diagnosis of PsA. In a survey of 100 rheumatologists, 41% said they typically make the diagnosis of PsA themselves.⁵ However, survey respondents reported that when patients with newly diagnosed psoriasis or PsA were referred to their clinics, 55% came from PCPs and 28% came from dermatologists. Thus, a variety of clinicians may make the initial PsA diagnosis.

Unfortunately, the current U.S. healthcare system results in many patients with PsA receiving a delayed diagnosis, preventing them from initiating treatment in a timely fashion. Indeed, in the same survey as noted in the previous paragraph, 25% of rheumatologists cited delayed referral as one of the greatest challenges in treating patients with PsA.⁵ Currently, the median time between the onset of PsA symptoms and a patient's diagnosis is 2.5 years.¹⁵ This is extremely concerning, as delays of just 6 to 12 months are associated with increasing levels of joint damage and worse functional outcomes.^{16,17}

Several factors likely contribute to the diagnostic delays experienced by patients with PsA.¹⁵ In some cases, patients with psoriasis may delay seeking treatment for their joint pain, unaware of the possibility of developing PsA. This is an issue for practicing dermatologists as well – in a survey of 101 dermatologists, only 57% reported discussing the possibility of developing joint disease with all of their patients with psoriasis.⁵ In other cases, difficulty in scheduling an appointment with a rheumatology specialist may contribute to diagnostic delay. However, the failure of clinicians, including dermatology specialists, to recognize PsA symptoms in a timely fashion is also likely an important contributor. This is not surprising, as PsA is a disease with extremely heterogeneous manifestations.¹⁸ Whereas rheumatology specialists have extensive training in recognizing PsA's signs and symptoms, other types of specialists do not and are more likely to miss diagnostic clues. Finally, many clinicians who do not specialize in rheumatology mistakenly may believe that PsA has a milder course than conditions such as rheumatoid arthritis (RA) and thus does not require aggressive treatment.¹⁹ This attitude may delay the urgency clinicians feel to make early and accurate PsA diagnoses.

Whatever the explanation, it is clear that many missed opportunities for early PsA diagnosis are occurring daily in medical offices throughout the United States. One study found that whereas patients with PsA who saw rheumatologists experienced a median delay from symptom onset to diagnosis of 1.0 years, those who saw dermatologists experienced a median delay of 2.6 years.²⁰

In another study, nearly 1,000 patients being seen in dermatology centers for psoriasis were evaluated by a rheumatologist for PsA; 41% of patients given a PsA diagnosis by one of the study's rheumatologists had never received a PsA diagnosis before.¹¹ Thus, dermatology specialists are uniquely positioned to reduce the diagnostic delay experienced by so many patients with PsA.

Strategies to Help Dermatologists Recognize PsA

Because PsA is so common among patients with psoriasis and its symptoms can be easy to miss, it is important for dermatology specialists to regularly screen all of their patients with psoriasis for PsA.³ Clinicians can start by talking to their patients with psoriasis about the possibility of developing PsA, what PsA symptoms they should be aware of, and the importance of early treatment for PsA, so that if patients do start to experience joint pain, they will know to seek help.²¹ Patients should also be encouraged to record information about skin and joint symptoms and share this information with their healthcare providers.^{21,22}

Several risk factors have been identified that may be able to help dermatology specialists identify patients with psoriasis who are at especially high risk for developing PsA. For example, a family history of PsA, especially in first-degree relatives, is a significant risk factor for PsA.⁷ Additionally, the presence of psoriasis in certain locations, such as the nails, scalp, and intergluteal cleft, are also associated with an increased risk of PsA.^{4,7} If such

risk factors are present, dermatology specialists can be especially alert for the onset of PsA symptoms.

In general, dermatology specialists should be alert to musculoskeletal inflammatory signs and symptoms in their patients with psoriasis.⁶ One approach to detecting PsA is to systematically ask patients about joint and back symptoms.²³ It can sometimes be challenging to differentiate between inflammatory arthritis symptoms, such as those present in patients with PsA, and non-inflammatory arthritis symptoms, such as those present in patients with osteoarthritis. Failure to distinguish between the two types of arthritis can contribute to diagnostic delays. For example, patients with PsA may mistakenly be sent to an orthopedist, wasting valuable time before effective treatment can start. Fortunately, there are some key differences that dermatologists can look for to make an informed decision about which type of arthritis is present in a given patient (see Table 1).

One complementary approach is to regularly use a screening tool designed to detect PsA symptoms (see Figure 1).⁶ These tools are ideally administered by dermatology specialists at the time when psoriasis is diagnosed and periodically thereafter (typically every 6 months to a year).⁶ Although these tools are useful, clinicians should be aware that their results may miss patients with early or subtle disease.⁶ Therefore, they are not a substitute for discussions with patients or for dermatology specialists' clinical judgment.

Serum laboratory tests can also be used to aid in screening for PsA. First-line tests include those for C-reactive protein, erythrocyte sedimentation rate, and rheumatoid

Table 1 Clinical characteristics of inflammatory vs non-inflammatory arthritis symptoms⁶

Inflammatory signs and symptoms	Non-inflammatory signs and symptoms
Morning joint stiffness >30 minutes	Morning joint stiffness <30 minutes
More intense when waking up and/or at night	More intense during the day
Improves with activity and exercise	Worsens with activity and exercise
May have rapid onset, can worsen in a matter of weeks	Usually develops slowly
Warm sensation at joint when touched	Grating sensation when joint moves
Tender joints, soft swelling	Joint enlargement hard and bony
Severity may go through cycles	Severity is usually continuous
Can affect any joint, entheses, or spine; can be symmetric or asymmetric	Most likely affects hands, feet, knees, hip, and spine

Figure 1

Self-Administered PsA Screening Tools

Psoriatic Arthritis Screening Evaluation (PASE)

- Patients complete 5 simple questions
- Can be taken online at www.psoriasis.org/psoriatic-arthritis-screening-test/
- Recommended that individuals with psoriasis complete every 6 months

Psoriasis Epidemiological Screening Trial (PEST) Questionnaire

- Patients complete 5 simple questions and mark affected joints on a drawing of the body
- Can be found at www.bad.org.uk/shared/get-file.ashx?id=1655&itemtype=document
- Recommended that individuals with psoriasis complete once a year

Early ARthritis Psoriatic (EARP) Questionnaire

- Patients complete 10 simple questions
- Can be found at www.researchgate.net/figure/The-EARP-questionnaire_tbl2_230643471

Psoriatic Arthritis Screening (SiPAS) Questionnaire

- Patients complete 5 simple questions
- Can be found at www.clinexprheumatol.org/abstract.asp?a=11911
- Recommended that individuals with psoriasis complete once a year

specialists have the opportunity to dramatically increase early diagnoses of PsA.

What Should Trigger a Referral to Rheumatology?

Currently, there is a lack of clear criteria for identifying those patients who should be referred to a rheumatology specialist for further evaluation.⁶ This can make the decision about when to refer challenging for dermatology specialists.

There is, however, some published guidance regarding circumstances that should spark a referral to a rheumatology specialist. A 2018 expert panel composed of dermatologists and rheumatologists agreed that a dermatologist may refer patients with psoriasis to a rheumatologist if the following conditions are met:⁶

- PsA is suspected based on clinical examination
- A validated screening questionnaire for PsA is positive, indicating follow-up is required
- Patients are known to have PsA and joint symptoms that are not adequately controlled
- Classification and assessment of disease activity and severity are required
- Intra-articular corticosteroid injections may be indicated

In addition, the European League Against Rheumatism (EULAR) recommends that rheumatology specialists be the main caregivers for patients with PsA.¹⁸ The EULAR guidelines explain that this is because rheumatology specialists are most familiar with the use of all types of disease-modifying antirheumatic drugs (DMARDs) used to treat PsA, including information regarding the evaluation of efficacy, risk, and the manner in which comorbidities affect treatment options for a given patient.

Not all patients with PsA, however, have easy access to a rheumatology specialist. In one survey of U.S. patients with PsA, 38% reported most often seeing a rheumatologist for psoriasis and PsA care, while 22% reported most often seeing a dermatologist, and 28% reported most often seeing a general medicine or primary care physician.⁵ A patient with PsA may not be managed by a rheumatologist for any number of reasons. In some cases, a patient may feel more comfortable continuing care with their dermatology specialist if they have already built a strong relationship with them, or they may feel that their skin symptoms are more troubling than their joint symptoms. Some patients may not even realize PsA is typically treated by rheumatology specialists, especially if they are not referred to one. Finally, many patients, especially those residing in rural areas or in the southern United States, may not live within close proximity of a rheumatology practice.²⁴

factor.⁶ Second-line tests include those for HLA-B27, uricemia, and anticitrullinated protein antibodies.⁶ Through judicious use of all of these tools, dermatology

The Need for Multidisciplinary Management of PsA patients

Because PsA involves both joint and skin symptoms, it seems obvious that input from both rheumatology and dermatology specialists should improve patient care. Indeed, the first overarching principle of the EULAR recommendations for the management of PsA is that PsA is a heterogeneous and potentially severe disease that may require multidisciplinary care. The third overarching principle states that, in the presence of clinically significant skin involvement, a rheumatologist and a dermatologist should collaborate in PsA diagnosis and management.¹⁸

Whether a clinician is selecting a patient's first PsA therapy or adjusting their treatment plan, it is important for them to assess disease activity in the various domains potentially affected by PsA, including skin, nails, peripheral arthritis, axial involvement, and enthesitis/dactylitis, and to let the domain with the highest level of activity drive treatment choices.²⁵ It is also important for healthcare providers to keep in mind that both skin and joint symptoms have a major impact on patients' quality of life, work productivity, ability to engage in daily activities, and emotional well-being.²⁶ Therefore, control of both skin and joint symptoms is critical. Just as some dermatology specialists may fail to recognize the symptoms of PsA, some rheumatology specialists may not appreciate that their patients with PsA are experiencing undertreated psoriasis, and they may thus fail to seek the expertise of a colleague in dermatology.²⁷ It is helpful for both types of specialists to understand which agents are most effective for joint signs and symptoms and which work better for skin signs and symptoms.²⁵

It is also important for clinicians to recognize that PsA care often extends beyond managing joint and skin symptoms.²¹ In fact, another overarching principle of the EULAR recommendations for the management of PsA is that, when managing patients with PsA, providers should take non-musculoskeletal manifestations into account, including those of the skin, eye (eg, uveitis), and gastrointestinal tract (eg, inflammatory bowel disease), as well as comorbidities such as metabolic syndrome, cardiovascular disease, and depression.¹⁸ Since caring for the whole patient requires ensuring that all of a patients' problems are addressed, it is important that both rheumatology and dermatology specialists are aware of the full spectrum of issues that patients with PsA are likely to experience.

Comorbidities are extremely common among patients with PsA. More than half of patients with PsA have at least 1 comorbidity, and research shows that having just a single comorbidity negatively impacts patient-reported outcomes related to function and pain.²⁸ Some of the most common comorbidities among patients with PsA include hypertension, obesity, hyperlipidemia, type 2 diabetes, cardiovascular disease, osteoporosis, sleep problems, and psychiatric disorders such as anxiety

and depression.^{22,23,29,30} For dermatology specialists, it is important to note that cardiovascular, metabolic, neurologic, liver, and gastrointestinal comorbidities are more common among patients with PsA than those with psoriasis.³¹ Therefore, screening for comorbidities is even more critical in this patient population.

Given the impact of non-skin and non-joint PsA symptoms and comorbidities on patients' health and quality of life, the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) recommends that providers take the following steps in their evaluation of patients with PsA:³²

- Strongly consider a cardiovascular risk assessment for their patients with PsA
- Measure fasting glucose or hemoglobin to screen for diabetes
- Ask about symptoms relevant to ophthalmic disease and inflammatory bowel disease and refer to specialists if needed
- Consider screening for depression

The relationship between PsA and comorbidities is complex, but emerging research suggests that improving management of PsA symptoms facilitates improved management of at least some comorbidities, and vice versa. For example, there is evidence that addressing obesity can improve PsA outcomes.²³ Conversely, managing PsA may improve cardiovascular outcomes. The risk of experiencing a major cardiovascular event is higher among patients with PsA who are *not* prescribed a DMARD than in the general population, but not higher among patients who *are* prescribed a DMARD.³³ Therefore, targeting all of the health problems of a patient with PsA is likely to have a synergistic effect on their overall well-being.

It is important to note that not all PsA comorbidities are physical. Patients with PsA may suffer from a number of psychiatric problems that may require treatment. Many individuals with PsA suffer from body image problems stemming from their condition.¹⁹ In addition, depression is more common among patients with PsA than among those with other health conditions, such as RA or diabetes mellitus.³⁴ Anxiety, in particular, appears to have an outsized influence on quality of life among patients with PsA, even more so than comorbidities such as cancer, cardiovascular disease, and pulmonary disease.³⁵

Several screening tools that are quick and easy to administer during office visits are available to help clinicians detect psychiatric problems. These include the Patient Health Questionnaire-9 for depression and the Goldberg Anxiety and Depression Scale-7 for anxiety.¹⁹ Once a psychiatric problem has been identified, a patient can be referred to an appropriate specialist for treatment.

Clinicians who treat PsA should be aware that a patient's unique disease manifestations and comorbidities will affect which treatments are appropriate for them. For example,

EULAR guidelines recommend tumor necrosis factor (TNF) inhibitors for uveitis and TNF or IL-12/23 inhibitors for inflammatory bowel disease in the absence of axial involvement.¹⁸ In addition, comorbidities may rule out some treatment options. Given the plethora of potential comorbidities, it can be difficult to keep track of how any one condition might affect treatment selection. Fortunately, the GRAPPA recommendations for PsA assessment and treatment provide a helpful reference chart (see *Rheumatology Nurse Practice*, Volume 5, Issue 5) detailing how various comorbidities affect PsA treatment options.³²

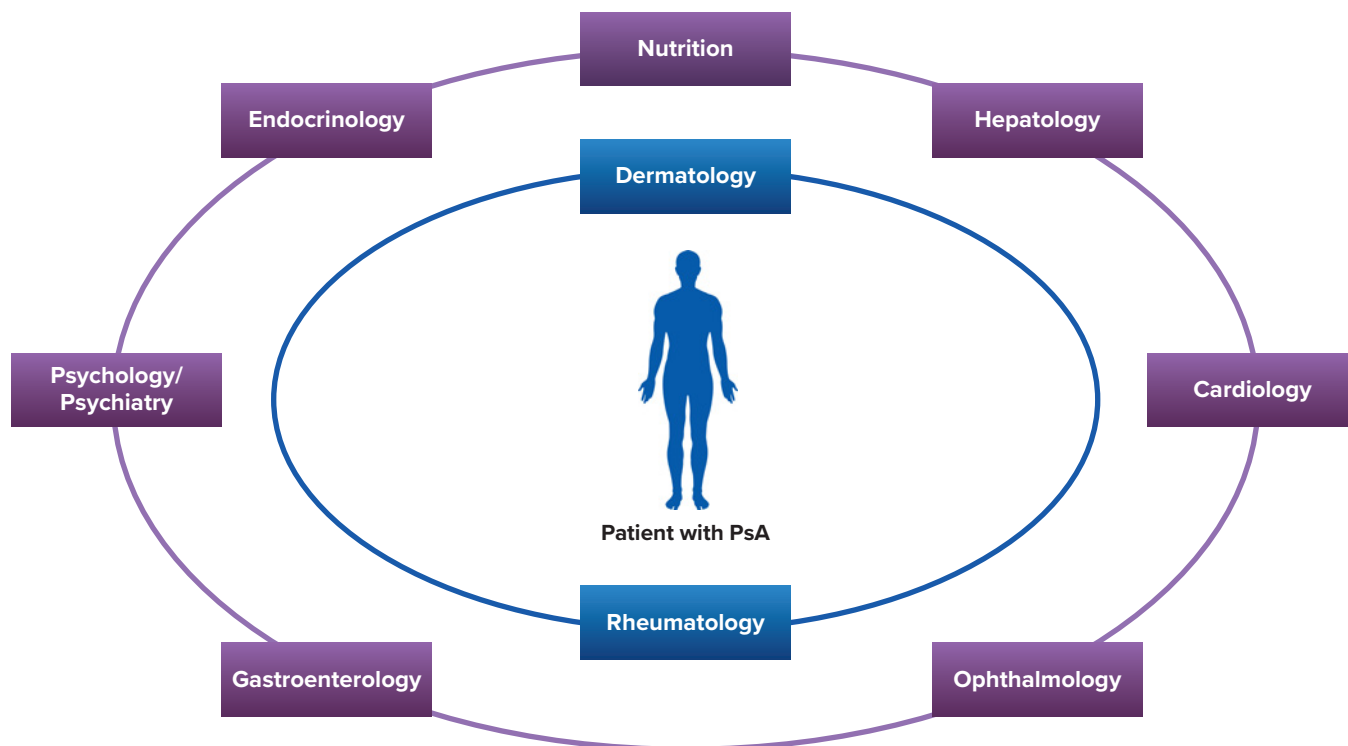
Given the various skin and joint manifestations of PsA, multidisciplinary care that, at a minimum, includes both rheumatology and dermatology specialists is optimal for most patients. When multiple healthcare providers are involved in a patient's care, it is critical that they communicate with one another about that individual's treatment. Otherwise, it may not be clear who is coordinating various parts of their care, such as managing comorbidities. Depending upon a patient's needs, any number of other provider types may also need to be involved in their care (see Figure 2). In this case, clear and effective communication and coordination between all clinicians involved, as well as the patient, becomes even more important—and challenging.

Models for Multidisciplinary Management of PsA Patients

As recognition of the need for PsA multidisciplinary care grows, different models are becoming increasingly common. In the United States alone, more than 30 multidisciplinary PsA care centers exist.³⁶ Clinicians can find information about where to locate such centers, or start their own, on the Psoriasis & Psoriatic Arthritis Clinics Multicenter Advancement Network website (see Figure 3).

One model of multidisciplinary management involves a rheumatology and dermatology specialist banding together to start a “combined clinic.” In this model, external providers can send patients with confirmed or suspected PsA to this collaborative unit. The combined clinic will then diagnose, treat, and stabilize the patient before sending them back to the clinician(s) who originally referred them.^{23,37,38} Typically, combined clinics meet anywhere from once a week to once a month.³⁶ This model of care can be very convenient for patients, as it offers them a one-stop shop for their PsA visits, and they can frequently discuss problems and solutions with both specialists at the same time.³⁹ The Center for Skin and Related Musculoskeletal Disease Clinic at Brigham and

Figure 2 Various specialties that may be involved in the multidisciplinary care of a patient with PsA



Women's Hospital in Boston is one example that utilizes this model of care.⁴⁰ At this center, one of the first of its kind, patients with PsA have been seen by both a rheumatologist and dermatologist since 2003.

Some PsA centers in the United States take the combined clinic model a step further, including not just dermatology and rheumatology specialists, but also psychiatrists, psychologists, and other types of specialists.³⁷ For example, the Center for Excellence for Psoriasis and Psoriatic Arthritis at Oregon Health Sciences University includes a collaboration between the institution's Dermatology and Arthritis & Rheumatic Disease divisions as well as specialists in disciplines such as hepatology, endocrinology, and cardiology who are affiliated with the Center.⁴¹

A word of caution—the combined clinic model of multidisciplinary care is not suited to all practices. It requires institutional support, and significant logistical concerns must be overcome. For example, dermatology specialists typically see patients at a much faster rate than rheumatology specialists. Therefore, when the two types of specialists see patients together, the dermatology specialist may see many fewer patients than usual.³⁹ Addressing this drawback for the dermatology specialist, perhaps by having a rotating pool of dermatology specialists or perhaps by offsetting their lower reimbursement rates in some way, is a critical part of making the combined clinic model succeed. Because of the challenges inherent in the combined clinic model, most of these centers are currently based in academic medical centers; however, the number of community practices engaging in combined care is increasing.³⁹

In many settings, it may be more practical for a rheumatology specialist and a dermatology specialist to see the same patient at different times. After the patient sees the specialists separately, they can then decide on the optimal management approach in tandem.²² This may involve the providers communicating in face-to-face or virtual meetings, or via email, letter, phone, or electronic medical record.³⁶

Finally, in the most common current form of multidisciplinary PsA care in the United States, a rheumatology specialist drives treatment decisions, consulting dermatology specialists and healthcare providers from other disciplines as needed. In this case, the rheumatology specialist creates their own trusted referral network to ensure that their patients can receive high-quality care in multiple domains. This informal network typically develops organically over time as patients move between providers. However, rheumatology specialists may need to make a special effort to fill holes in their network, asking respected colleagues about which adjunctive providers they trust and reaching out to clinicians who might make good referral partners. Professional membership organizations such as the Rheumatology Nurses Society can also be leveraged by reaching out to fellow members in your area to inquire about their current collaborating providers.

Figure 3

Resources Available from the Psoriasis & Psoriatic Arthritis Clinics Multicenter Advancement Network³⁶

- List of combined rheumatology/dermatology care PsA clinics in the United States and abroad
- Combined Clinic toolkit: a framework for providers in academic or private practice who are considering setting up or expanding a multidisciplinary PsA clinic
- Includes information about payment models and how combined clinics overcome common challenges
- Electronic medical record forms for dermatology and rheumatology specialists, designed for combined clinics
- Information about Psoriasis & Psoriatic Arthritis Clinics Multicenter Advancement Network meetings
- Psoriasis & Psoriatic Arthritis Clinics Multicenter Advancement Network newsletters and publications

Any practice interested in delivering multidisciplinary care for patients with PsA will need to figure out which model is best suited to their circumstances. Fortunately, there are many different approaches to choose from, as described in this section, and clinicians can pick and choose the strategies that will work best in their setting.

The Evidence in Favor of Multidisciplinary PsA Care

Because multidisciplinary care for PsA is a relatively recent phenomenon, data on whether this approach actually improves outcomes is still relatively scarce. However, the evidence thus far suggests that, relative to routine PsA care, multidisciplinary care results in improved skin and joint outcomes, as well as higher levels of patient satisfaction.⁴² It is also more likely to result in an escalation of care to systemic treatment (eg, oral or biologic therapies).²⁹

For example, the Psoriasis Rheumatology and Dermatology unit at Parc de Sabadell Taulí University Hospital in Spain has reported that, of the patients referred to them,

only approximately 20% do not require changes to their diagnosis or treatment plan.³⁸ In particular, many patients referred to the group are initiated on systemic therapy for the first time. Similarly, the Center for Skin and Related Musculoskeletal Disease Clinic at Brigham and Women's Hospital has reported a revised diagnosis for 46% of the cases referred to them.⁴⁰ Moreover, patients are five times more likely to receive a systemic medication for their PsA after referral to the combined clinic than before referral. These findings emphasize the meaningful differences in treatment that patients receive when they enter a center focused on multidisciplinary care.

The data reported in these studies from longstanding combined care centers are consistent with the experiences reported by providers who participate in combined care clinics. In a recent survey, healthcare providers who worked at combined dermatology/rheumatology clinics reported that the benefits of this model of care include improved communication between providers, enhanced training opportunities, and more prompt, accurate diagnosis.³⁹ In short, available research suggests that multidisciplinary care pays off for patients with PsA.

The Status of Multidisciplinary PsA Care Today: Still A Long Way to Go

The need for multidisciplinary care of PsA is widely recognized. Provision of this type of care is increasing, and growing evidence shows that it results in better outcomes for patients. Nevertheless, most providers who care for patients with PsA are still practicing within the siloes of their own specialty.³⁶ In a survey of 101 dermatologists and 100 rheumatologists, 73% of the rheumatologists and 30% of the dermatologists reported being solely responsible for prescribing decisions for their PsA patients.⁵ Only one-third of the dermatologists and rheumatologists indicated that they co-managed patients. When co-management did occur, it most frequently involved a rheumatologist primarily making prescribing decisions and a dermatologist monitoring skin symptoms—a relatively bare bones model of multidisciplinary care. Thus, although the promise of multidisciplinary PsA care is clear, it will take significant effort by a large number of healthcare providers to make it a reality for their patients.

Conclusion

Caring for patients with PsA is challenging. And while multidisciplinary care can alleviate some of the challenges that individual clinicians face when making PsA diagnoses and treatment decisions, not every rheumatology and dermatology specialist has access to a multidisciplinary PsA center that includes other specialists eager to take over aspects of their patients' care. However, every rheumatology specialist can work on establishing a preferred dermatology referral “partner” to complement their own care, someone with whom they have a personal relationship and whose clinical judgement they trust—and vice versa.^{23,27} The growth of multidisciplinary PsA care will proceed through the work of individual clinicians committed to providing optimal treatment for their patients. By working together, rheumatology and dermatology specialists, as well as colleagues from other disciplines, can improve outcomes for patients with PsA.



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Getting Off on the Right Foot with New Patients

by Carrie Beach, BSN, RN-BC



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Being a new patient showing up for the first appointment at a new practice can be an unnerving experience. Will I like my doctor? Will they understand me and take my issues seriously? Will they truly be interested in helping me get better? Whenever I have to see a new provider as a patient, I always rehearse what I am going to say in my head before the visit begins. I want to make sure to give my new provider all of the pertinent details without overwhelming them with my entire life history.

Let's face it—we all have new patients who overload us with more information than we need. It takes patience to listen nonjudgmentally. As a rheumatology nurse, I am typically the patient's initial point of contact before they see their new doctor. I always try my best to put myself in the shoes of the new patient and let them tell me whatever they are comfortable sharing. Some will give me their life history in 5 minutes while others will be much more reserved. Either approach—and anything in between—is fine. Our job is to listen with empathy—this is the first step toward building trust and rapport with a new patient.

Whenever I walk into the room with a new patient, I always start the conversation by introducing myself and asking, “So what brings you in today?” Even that can be a complicated question for some patients, who will laugh and

say, “Where do I even begin?” or “How much do you want to know?” Some patients know quite clearly why they have been referred to a rheumatology practice while others have no idea beyond, “Someone told me I should.” There are also some patients who will roll their eyes at this simple introductory question, having hoped to avoid going through their story one more time with one more healthcare provider.

Jane is a 56-year-old patient who came to our office for the first time in the middle of the COVID-19 pandemic. It was a few months after we had reopened our physical office for patient visits, with the obvious safety restrictions we all became used to. When I took Jane back to one of our exam rooms, I could sense that she was hesitant to open up to me. When I asked her the standard, “So what brings you in today?” question, she replied curtly, “I would have thought you would have read my chart so you would already know the answer to that.” Naturally, I had looked at Jane's chart before I met her, but a new patient's medical record doesn't always give us the full picture of what is going on with them. All I knew about Jane was that she had been referred to us by her primary care physician (PCP) because of “a rash.” We obviously were going to need a lot more information.

After our awkward beginning, I explained to Jane that yes, I had read her chart, but I wanted

to hear her story in her own words to make sure that what she was feeling was consistent with what I had read. Again, Jane appeared guarded, but she managed to explain to me that she had a history of psoriasis that had been diagnosed years ago and generally remained quiet without treatment. However, during the last year, she had developed a different sort of rash that had spread over most of her body. She also said she had developed significant pain and swelling in her hands.

Jane's PCP had initially referred her to a dermatologist, who told her that her rash appeared to be consistent with atopic dermatitis (ie, eczema) and prescribed a topical corticosteroid. When this didn't improve Jane's rash, she was started on dupilumab, a newer systemic agent. There was minimal improvement, but after a year on dupilumab, Jane remained frustrated that things had not gotten notably better.

Interestingly, Jane told me that she had never said anything to her dermatologist about the joint pain and swelling she was experiencing because she didn't think that this had anything to do with her rash. This is something we hear commonly. Thankfully, Jane's PCP had put the pieces together and referred her to our practice. Still, Jane initially refused to acknowledge the link between her rash and joint swelling. It was clearly going to take some hard work to convince her of the connection.

Once we made the preliminary diagnosis of psoriatic arthritis, we started Jane on infliximab infusions—a 5 mg/kg loading dose at weeks 0, 2, and 6, and then every 8 weeks thereafter. Her first follow-up visit to our office came after the third infusion. Jane's response wasn't as substantial as either of us had hoped. Her rash was only minimally improved, and she continued to have swelling in her knuckles and wrists. Jane was frustrated with her lack of progress and seemed skeptical of the guidance our office was providing. "How do I know what you are suggesting is any better than my dermatologist?" she asked me. "It doesn't seem to be doing much good."

At this initial follow-up, we pleaded with Jane to stay the course, explaining to her that infliximab frequently takes months to work and that we could either adjust her dose or switch medications if things didn't get better soon. A few weeks later, Jane called us in alarm to let us know that the psoriasis on her forehead was spreading and beginning to affect her vision. We immediately called in a dose pack of methylprednisolone and ordered an

increase of her next dose of infliximab to 6 mg/kg every 8 weeks. Unfortunately, we ran into some resistance from Jane's insurance company, which did not approve the new dosage, and as soon as we stopped the methylprednisolone, Jane's psoriasis returned, worsening specifically around her eyelids. While Jane naturally became frustrated by this chain of events, the fact that our practice kept advocating for her health allowed us to keep Jane motivated to try for something better.

Our next step was to switch Jane to golimumab, which was approved by her insurance company but also resulted in a minimal improvement. You can guess how Jane responded to the latest chapter in her saga. Sensing her frustration, I tried to get some more insight into Jane's day-to-day life to see what changes we might be able to make to her medication regimen. I was slowly beginning to unpeel the onion of Jane's life, gaining her trust little by little. She told me at this visit that she was an avid reader, and the recent exacerbations of psoriasis around her eyelids was making reading quite difficult and frustrating. We decided at this visit to add leflunomide to her regimen and again switched biologics, this time trying another mechanism of action with secukinumab injections. Importantly, I reinforced to Jane that she should call if she wasn't noticing improvement or just needed some reassurance that better days were ahead.

In the last 2 months, I've talked to Jane more than I had spoken to her in the previous year. She has been much more comfortable asking questions and accepting advice on how to best manage her symptoms. It appears that things are improving with the latest change to secukinumab. Things aren't yet perfect, but they are better.

Establishing trust with our patients, especially those who have been through the ringer of provider after provider, doesn't happen overnight. However, because of the chronic nature of rheumatic diseases and the likelihood that patients will be with our practices for an extended period of time, it's crucial that we develop strategies to break through some of the walls our patients set up. The initial visit is especially challenging, yet also particularly critical. Put yourself in the shoes of your patient, as someone searching for answers who has likely been disappointed multiple times during their healthcare journey. Listen to them and their story, no matter how much or little it may actually impact their overall plan of care. It's the best way to build trust and help our patients regain the lives they want.





Taking a Walk Down the Hall to Find Some Answers

by Joni Fontenot, RN

To the majority of the outside world, psoriasis is seen as a cosmetic nuisance, an unsightly skin condition that they are glad they don't have to deal with but not likely a major quality-of-life deterrent. But for a patient living with this chronic skin condition, the impact of psoriasis cuts far deeper than the appearance of the skin.

Psoriasis does not discriminate. While there are known genetic links and environmental triggers, there does not need to be a specific cause for the condition to develop in a given individual. In many patients, psoriasis will initially emerge as mild itching with no obvious indication that anything more serious is wrong. The nail involvement that may be a more significant clue is often overlooked by primary care physicians and certainly is not on the radar of the general public. It's typically not until silvery scales and bright red, well-demarcated plaques begin to appear that patients are sent to the dermatologist for further evaluation.¹

Psoriasis can present other challenges aside from skin issues. Patients with psoriasis are at increased risk for cardiovascular events, type 2 diabetes mellitus, metabolic syndrome, and lymphoma. Obesity can also worsen psoriasis.² This is something we are used to seeing in rheumatology and only reinforces the need for our overweight patients with PsA to exercise and embrace a healthy diet.

Within the walls of rheumatology, we typically don't see psoriasis patients until they develop joint symptoms, so we don't often hear about the early impact of the skin disease on patient quality of life. Certainly, in those patients for whom the disease progresses to psoriatic arthritis (PsA), we must become attuned to issues related to both the joints and skin, but we are generally more skilled at dealing with joint pain and swelling due to the general patient population that we treat.

To advance my own personal education, I walked down the hall recently to meet with members of the dermatology team at my institution to try to get a better sense of some of the issues they typically have to deal with in their newly-diagnosed psoriasis patients. Here are some of the highlights regarding what I learned:

1. There are several variants of psoriasis.

While the majority of patients will have plaque psoriasis (the indication that many of the biologics and small molecules that crossover into rheumatology are approved to treat), there are less common subtypes such as guttate, inverse, and pustulate psoriasis that all present and progress in a different fashion and require different management approaches.



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“I am lucky to work in a practice where dermatology is just down the hall, and it is easy to send patients back and forth to co-manage their care.”

- 2. When assessing patients with any skin condition, it is vital to do a full-body assessment from head to toe, front to back, and everywhere in between.**

Psoriasis sometimes “hides” in skin folds or under the hair. The nail beds are often one of the most obvious areas to look for signs of disease. Dermatologists look for pitting and thickening of the nail beds, which can sometimes be the only visible sign of early disease.

- 3. As with virtually any medical condition, getting an accurate diagnosis of psoriasis subtype is the first key step in determining an appropriate treatment regimen.**

Treatment then is typically based on the severity of the psoriasis (ie, the percentage of the body covered by rash) and the impact of the disease on the patient’s quality of life. Most patients will begin with topical corticosteroids as long as involvement excludes the scalp, genital area, and nail area. When there is moderate-to-severe scalp, genital, and/or nail involvement, oral biologics are often used as frontline therapy.

- 4. Patient preference is a key consideration when determining treatment as topical regimens require frequent and consistent application to be effective.**

Biologics, of course, have their own issues that we are well aware of in rheumatology (injection vs. infusion vs. oral, cost/insurance hurdles, etc.).

I am lucky to work in a practice where dermatology is just down the hall, and it is easy to send patients back and forth to co-manage their care. The rule of thumb for my dermatology colleagues is to send over any patient with psoriasis who develops joint stiffness and/or inflammation lasting >30 minutes to rheumatology for further evaluation. Conversely, we’ll often send patients with PsA over to dermatology to rule out atypical presentations such as drug eruptions (which often require a biopsy) in a patient who develops a new or atypical rash that appears unrelated to PsA.

In our center, we lead the management of the majority of patients with PsA. Taking the cue from our dermatology colleagues, our first step in any patient referred to us is to repeat that head-to-toe physical exam, looking both for any new rash as well as joint swelling/stiffness throughout the body. While this may sometimes seem redundant for our patient, this “double checking” ensures that nothing critical is missed and that we are able to set our patients on the right path of treatment.

Regardless of the pathway a patient with PsA takes to diagnosis, our job is to provide the best patient-centered care that is possible and to involve the patient in any decisions that will impact their health. Listening to the patient and the day-to-day challenges that they face can provide you with a wealth of information that will guide their treatment.



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Phoning a Friend in Time of Need

by April Johnson, MSN, APRN, CNP

There are times as a rheumatology nurse practitioner when I want to bang my head against the wall. A patient doesn't show up for a follow-up appointment for the second time in a row. Someone tells me that they stopped taking their medication "just because" and their disease is flaring badly. A letter from the insurance company arrives telling us that the medication our team feels a patient badly needs has not been approved.

Frustration is simply part of the job. But then so is creative problem solving, often with the help of one or more colleagues who are often only too happy to help us out of a jam.

Let me tell you about Joseph, a 47-year-old commercial pilot who has struggled with chronic plaque psoriasis for approximately 7 years. He initially was diagnosed and treated by a dermatologist, who put him on leflunomide and topical corticosteroids to help manage flares of his condition. After approximately 2 years of this regimen, Joseph discontinued use of the leflunomide due to unwanted side effects and a desire to start a family.

Five months before he arrived in our practice, Joseph woke up and noticed that his pointer finger was extremely tender and swollen. This was accompanied by gradually worsening

psoriasis and mild pain and tenderness in his knees and shoulders along with moderate morning stiffness in his back and hips that resolved with movement. While Joseph was unsure if these recent exacerbations were related to his psoriasis or another medical condition entirely, he scheduled an appointment with his primary care physician (PCP). Fortunately, his PCP was familiar with the association between psoriasis and joint issues—which as we've seen throughout this issue of *Rheumatology Nurse Practice* isn't always the case—and placed a referral to our clinic.

At his initial appointment with me, the most obvious physical manifestation was Joseph's plaque psoriasis, which covered most of his elbows, hands, knees, and trunk. As noted earlier, Joseph also had peripheral joint pain and swelling in several digits on both hands, his right knee, and left shoulder. While the swelling in his pointer finger had gone down, Joseph showed me pictures of it at its worst, confirming that it indeed "looked like a sausage." This was clearly a case of dactylitis. Joseph also had notable enthesitis in his left Achilles tendon.

Following the comprehensive physical examination, Joseph and I spoke at length about his overall level of pain, joint swelling,



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“So I did what I have done a few times over the years in similar situations – I did my best Who Wants to Be a Millionaire impression and decided to phone a friend.”

prolonged morning stiffness, and chronic fatigue. He also complained about some of the challenges he was facing on a daily basis both professionally and personally. As a pilot, Joseph is typically forced to sit for hours at a time and relegated to walking around in small spaces, which likely does not help his joint issues. Joseph also shared some cosmetic concerns with me surrounding his psoriasis and associated insecurities tied to his physical appearance (he was one of many psoriasis patients I have seen over the years who rarely wear any clothing that exposes his skin).

Next, we discussed Joseph’s short- and long-term treatment goals, along with potential nonpharmacologic and pharmacologic interventions. Joseph expressed an interest in treating his current joint issues as aggressively as possible, so we decided to start him on etanercept 50 mg weekly. Joseph is one of those patients with restrictive treatment options—the large commercial airline that employed him had its own formulary that primarily included drugs that have been available for several years or more—so we felt that etanercept would be more likely to be approved than some of the newer biologics available for the treatment of psoriatic arthritis (PsA). Fortunately, we were right, and etanercept was approved 2 weeks after Joseph came in to see us.

Joseph’s condition followed a relatively standard pathway for the next few years. His joint issues

improved, especially after we added weekly methotrexate 10 mg to his regimen, although his psoriasis remained a significant problem. Joseph was able to resume a normal workload in the cockpit without any major hiccups. I saw Joseph periodically for the next several years and discussed with him potential modifications to his treatment regimen that might have a positive impact on his psoriasis, but he stated that he was happy to have his joint pain and stiffness under control and didn’t want to do anything to throw things out of balance. Again, something we hear a lot.

A few months ago, however, Joseph’s priorities began to change. He and his wife were preparing to celebrate their 25th wedding anniversary and had arranged to renew their vows on the beach. Joseph emphasized to me how important it was to him to wear beach clothes during the ceremony, and that he wanted his skin to appear as clear as possible. To that point, we had only tried one TNF inhibitor along with other conventional DMARDs, which had led to partial relief of his symptoms. I suggested to Joseph that we try a biologic with a different mechanism of action to see if that would be more effective. He agreed to switch to secukinumab, an interleukin-17 inhibitor. Unfortunately, his restrictive insurance formulary was a roadblock and denied approving the switch without trying a second TNF inhibitor or ustekinumab, an IL-12/23 inhibitor. While ustekinumab is a reasonable

option in many cases, it can take up to 2 months in patients with PsA to see notable improvement, and I knew Joseph was under time pressure to see his psoriasis clear up.^{1,2}

So I did what I have done a few times over the years in similar situations—I did my best Who Wants to Be a Millionaire impression and decided to phone a friend. I had met a colleague in dermatology a few years ago at a professional event, and we had bonded over some of our shared professional experiences. From time to time, I called my friend in dermatology for assistance with patients who presented with unusual or nonspecific rashes associated with autoimmune disorders with which I was not familiar.

Knowing that secukinumab is also approved as a treatment for plaque psoriasis, I had Joseph schedule a dermatology appointment with my friend to see if that might be our avenue to success with his insurance provider. The strategy worked—this time the biologic was approved at a higher dosage than is typically offered for patients with PsA alone (300 mg per month vs. 150 mg per

month)—and Joseph quickly scheduled his first injection. Two months later, and 8 weeks before his wedding anniversary, Joseph came back to our office for his initial follow-up. His skin had improved by approximately 60 percent, and he was thrilled. Just before the big celebration a few weeks later, not only was his skin almost clear, but his joint pain had subsided substantially as well.

Joseph proudly showed me photos of the beach ceremony at his next visit to our office, which admittedly made me tear up a bit. As a nurse practitioner, I take great pride in advocating for my patients and trying to find creative solutions when roadblocks are put in front of me. It's important to remember that many of the biologics approved for the treatment of rheumatic disease also have indications for dermatology and gastroenterology conditions. Step therapy for one condition may be quite different than another, and our patients with comorbid issues may have more (and better) options in another specialist's office. I'm grateful that I was able to tap into my professional network and lean on my friend to help Joseph celebrate his special day.



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FROM THE OTHER SIDE OF THE FENCE

Dermatology's Perspective on Professional Collaboration for Psoriatic Arthritis Patients

Veronica Richardson, MSN, ANP-BC, DCNP



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As a dermatology nurse practitioner, psoriasis is one of the most common conditions that I encounter on a day-to-day basis. Psoriasis affects more than 8 million adults worldwide. Studies have shown that approximately 30% of patients with psoriasis will eventually develop psoriatic arthritis (PsA). Along with a myriad of comorbid conditions such as cardiovascular disease, liver disease, and depression, the impact of PsA on a patient's overall quality of life can be significant, especially among those with severe disease.¹ Given the multisystem impact of psoriatic disease, a collaborative, interdisciplinary approach to care that involves both dermatology and rheumatology teams is critical to provide our patients with the most holistic, comprehensive, and streamlined levels of care.^{2,3}

While this partnership may seem to have obvious benefits, in the majority of health systems throughout the United States, we continue to practice in silos. This compartmentalized level of care leads to delays both in diagnosis as well as treatment. This issue of *Rheumatology Nurse Practice* offers a look at a variety of potential collaborative settings, ranging from a formal, combined rheumatology-dermatology clinic to a very

informal, 1-on-1 relationship between providers. There are, of course, varying levels of logistical barriers and bureaucratic headaches depending upon the setup of the collaboration.

Let's start by looking at some of the primary pros and cons of a formal collaborative rheumatology-dermatology setup:^{2,4}

At my academic practice, we do not have a formal combined rheumatology-dermatology clinic, though our team certainly understands the importance of collaborating across walls for our patients with psoriatic disease. While we see our patients asynchronously, we have established a strong referral system with rheumatology that allows us to send over patients who require urgent evaluation for possible PsA. Our patients certainly appreciate that they don't have to wait months for a rheumatology referral once a member of our dermatology team suggests to them that they need one.

Of course, this model is not without its challenges. The most significant challenge I have faced with this model is access. Access is a two-way street. There always seem to be more patients that need to be seen than there are open scheduling slots for them. This may

Collaborative Care Models

PROS	CONS
Evidence suggests improved levels of patient outcomes, provider satisfaction, and patient satisfaction	Scheduling hurdles due to the need to manage schedules for multiple providers
“One-stop shop” that saves time for patients who require complex levels of care	Visits tend to be longer and limit the number of patients that can be seen
Providers are better prepared to recognize the nuances of specific disease over time	May not be fiscally efficient (fewer patients, insurance hurdles, financial burdens for patients)
Easier to screen and educate patients about potential comorbidities	

lead to frustration on the part of both the patient and provider, which then leads to delays and potentially disjointed care. This is especially true in an academic medical center like ours where most of the physician faculty have only one or two windows per week in which they see patients (the remaining time is spent attending to research and other non-clinical responsibilities). While our team of advanced practice providers can help to fill that gap, it does require the right education and training to be able to care for such a highly specialized group of patients. Personally, it took me several years practicing in dermatology before I felt comfortable in managing psoriatic patients independently. Our rheumatology department has recently added a nurse practitioner to help improve access for our PsA patients, which has been an incredibly helpful step in the right direction. Nonetheless, the number of dermatology providers in our department significantly outnumbers the number of rheumatology clinicians in our center specializing in the management of PsA, further accentuating the mismatch between supply and demand.

Our dermatology clinic is well versed in the link between psoriasis and joint disease, and we have developed a variety of best practices to make sure that we don't overlook patients whose disease may be accelerating.

For starters, we never let a psoriasis patient leave the exam room without asking them about joint issues. The vast majority of patients who develop PsA initially present with skin findings, and many simply don't associate joint pain and swelling with their psoriasis, so it's important that we reiterate this link to them at every visit. A positive report

of new or worsening joint symptoms triggers an automatic referral to rheumatology.

Second, we are strong proponents of educating our psoriasis patients about potential comorbidities of their disease. This will sometimes trigger a patient to tell us, “You know, I have been noticing that XYZ has happening recently.” If nothing else, it makes them more aware of self-monitoring for specific issues that are more common among psoriasis patients.

Third, we emphasize the importance of establishing care with a primary care provider (PCP) for those patients who do not have one they see on a regular basis. The PCP should be the one screening for common comorbidities such as hypertension, diabetes, hyperlipidemia, and cardiovascular disease at recommended intervals.

Last, but certainly not least, we screen all of our psoriasis patients for depression. Many studies have demonstrated the link between depression, anxiety, and suicidality among patients with psoriasis.

Let's look at how the process works for a specific patient in our practice.

In October 2020, I met Alexia for the first time. A 43-year-old female with single nail dystrophy, Alexia came to us after being referred by her PCP. She had been prescribed a topical antifungal 6 months before she came to us that failed to resolve her issues. Following a physical exam, my immediate suspicion was psoriatic nail disease based on Alexia's history and clinical presentation. Nail dystrophy is extremely common in patients

“The systemic, multisystem nature of psoriatic disease... warrants each of us to look at our respective practices to see where the gaps in care delivery exist and identify opportunities for professional collaboration.”

with PsA, with an overall prevalence of between 80-90%,¹ so I also asked Alexia about joint-related symptoms. It turns out that she had been struggling with persistent low back pain for approximately 3 years following the birth of her last child, along with morning stiffness that lasted for several hours every day. She told me it had gotten so bad that she needed to modify her seated position while breastfeeding simply to be able to withstand the pain. Certainly, this report raised my suspicion of a diagnosis of PsA even more.

With the exception of nail dystrophy on her right ring finger, there was nothing else abnormal about Alexia’s physical exam—not a silvery scale anywhere on her body. I sent a nail clipping to our dermatopathology department for evaluation and simultaneously reached out to a rheumatology colleague within our network for an urgent evaluation. He was able to see Alexia a few days later and quickly diagnosed her with axial PsA. Three months later, Alexia’s back pain had completely resolved thanks to the introduction of adalimumab,

and she told me she was feeling better than she had in years. This is obviously an optimal outcome, and there are many patients whose short-term progress is not as substantial as Alexia’s, but this nonetheless points to the importance of working together for all of our patients who may benefit from a collaborative approach.

There are undoubtedly challenges to finding the best collaborative model based on your own practice setting. There are many standalone dermatology clinics in the United States who are not fortunate enough to have a formal relationship with a rheumatology practice. These providers may need to seek out colleagues who are interested in working with members of their team. The systemic, multisystem nature of psoriatic disease and its comorbidities warrants each of us to look at our respective practices to see where the gaps in care delivery exist and identify opportunities for professional collaboration. Closing these gaps will help minimize delays in diagnosis and optimize outcomes for our patients.



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