Psoriasis is one of the commonest, chronic dermatoses and affects ~2% of the UK population [1]. The cutaneous manifestations of psoriasis are protean, ranging from chronic plaque, psoriasis vulgaris to rarer pustular variants and acute guttate lesions characteristically occurring in childhood [2]. It is widely accepted that the epidermal keratinocyte hyperproliferation present in plaques of psoriasis is mediated by T cells [2]—a process occurring within a setting of genetic predisposition and strong association with HLA-Cw6. Evidence for the T-cell mediation of psoriasis comes from both fundamental research demonstrating an influx of activated T cells into the epidermis in early evolving lesions of psoriasis and the ability of supernatants from T cells grown out of psoriatic lesions to induce epidermal keratinocyte proliferation. Further evidence for the integral role of T cells in psoriasis is evinced by the efficacy of relatively selective immunosuppressive drugs such as cyclosporin [3] and FK506 [4], and highly selective T-cell-mediated approaches such as anti-CD4 monoclonal antibodies [5] and interleukin-2 fusion toxin, in its treatment [6]. Although our knowledge of the immunopathogenesis of psoriasis is rapidly expanding, there is still considerable uncertainty regarding the disease processes leading to psoriatic arthritis.

Psoriatic arthritis has always been difficult to define as it lacks specific serological markers. It is best described as an inflammatory arthritis associated with psoriasis, but occurring in the absence of positive rheumatoid factor and rheumatoid nodules [7]. Psoriatic arthritis probably occurs in 5–8% [8] of patients with psoriasis, although some estimates are as high as 30%. Various clinical forms of psoriatic arthritis exist: the classical arthritis associated with distal interphalangeal joint involvement; symmetrical peripheral arthritis; asymmetrical pauciarticular small joint involvement with dactylitis (sausage digits); ankylosing spondylitis with or without peripheral arthritis and a severe mutilating arthritis known as arthritis mutilans with sacroiliitis [7]. Cutaneous lesions of psoriasis pre-date the arthritis in 75% of cases, although in 10% of patients the arthritis occurs first [7] thereby making diagnosis particularly difficult.

Treatment of cutaneous psoriasis is dictated both by the extent and subtype of disease. In essence, limited disease is controlled by topical preparations including dithranol, coal tar, corticosteroids and vitamin D3 analogues. More extensive disease necessitates the use of systemic therapies including psoralsens plus ultraviolet A radiation (PUVA), UVB, acitretin, methotrexate and cyclosporin. The most severe cases, <20% of patients with psoriasis, are more likely to have concomitant psoriatic arthritis. Unfortunately, psoriatic arthritis may be treated by rheumatologists without discussion with their dermatological colleagues. Such isolated decision making may lead to dermatological difficulties not readily appreciated by rheumatologists.

Although pharmacological treatment of psoriatic arthritis often has beneficial effects for cutaneous psoriasis, it may be detrimental. Non-steroidal anti-inflammatory drugs (NSAIDs) such as naproxen and indomethacin can substantially reduce the discomfort of axial disease in psoriatic arthritis. However, the ability of NSAIDs, including aspirin, to inhibit the cyclooxygenase pathway may redirect products of the inflammatory arachidonic acid cascade into the lipoxygenase pathway, thereby increasing leukotriene load and a consequent flare of skin lesions [9, 10]. Gold salts administered for the treatment of psoriatic arthritis may also exacerbate psoriasis [11].

Methotrexate in low doses, as used by rheumatologists and dermatologists alike, produces some divergence in opinion as to monitoring of side-effects [12, 13]. It appears that patients with psoriasis are more at risk of the hepatotoxic effects of methotrexate and to minimize this risk it is recommended that liver biopsy should be performed after each cumulative 1.5 g of methotrexate [14]. Rheumatologists mostly use methotrexate for treating patients with rheumatoid arthritis, a group of patients who, by comparison with those with psoriatic arthritis, seem to have a much lower risk of methotrexate-induced hepatotoxicity [13]. It is a misconception that this low-risk profile can be extrapolated to patients with psoriatic arthritis as it appears that psoriasis per se, or in addition to alcohol intake, predisposes to the development of hepatic fibrosis in 6–7% of patients even before the commencement of methotrexate treatment [14]. Thus, the use of methotrexate for treating psoriatic arthritis should be mandated by the same rules that determine its use in the treatment of psoriasis.

Rheumatologists’ use of systemic corticosteroids for the treatment of psoriatic arthritis probably produces the most difficulty for dermatologists responsible for the management of the cutaneous lesions. Systemic corticosteroids are contraindicated in the treatment of psoriasis and are only advisable in discrete circumstances, and not for chronic use. Understandably, by virtue of their immunosuppressive effects, systemically administered corticosteroids can markedly improve psoriasis, but their withdrawal may result in a rebound worsening of psoriasis, sometimes producing a generalized pustular (Von Zumbusch) form of the disease [15]. Generalized pustular psoriasis was a relatively rare occurrence in the first half of this century, but has become commoner, most likely
attributable to the use of systemic corticosteroids [15] and perhaps the use of fluorinated, very potent topical corticosteroids. Chronic use of low-dose systemic corticosteroids undoubtedly destabilizes psoriasis and produces resistance to control by other effective therapies such as cyclosporin or methotrexate. Disease-modifying therapies including sulphasalazine (also beneficial for psoriasis), methotrexate, PUVA and cyclosporin are preferable alternatives to the use of long-term, low-dose corticosteroids for the treatment of psoriatic arthritis. Our North West of England regional psoriasis service caters for many psoriasis patients whose disease severity is great enough to require systemic treatment. Those of our patients whose psoriasis is least amenable to control by traditional systemic therapies are frequently those treated concurrently with low-dose systemic corticosteroids prescribed by rheumatologists. To prevent such problems, a paradigm for the management of patients with severe psoriasis and concomitant arthritis should be multidisciplinary clinics involving both dermatologists and rheumatologists. This approach would facilitate transfer of knowledge between the two specialties not just for a concerted approach to the management of psoriasis, but also for research into disease pathogenesis.

C. E. M. Griffiths
Section of Dermatology, Department of Medicine, University of Manchester School of Medicine, Manchester
Correspondence to: C. E. M. Griffiths, Section of Dermatology, Department of Medicine, Clinical Sciences Building, Hope Hospital, Salford M6 8HD.

REFERENCES

THE EXPANDING ROLE OF THE NURSE IN RHEUMATOLOGY

Specialist nurses were first utilized in rheumatology in the late 1970s as clinical metrologists [1] to take clinical measurements during clinical drugs trials [2]. However, the supportive, educational approach provided by these nurses was much valued by patients who began to request nursing consultations [3]. This led to a system which allowed cross-referral between the rheumatologist and nurse, and so the first nursing clinics began to evolve. A descriptive evaluation by patients consulting the nurse showed a highly favourable response in terms of acceptability and satisfaction with the care they received [4]. During the next decade, there was an upsurge in the number of nurses specializing in this and other clinical areas [5]. This growth has continued and, by 1992, 96% of health authorities funded at least one diabetes nurse specialist [6] and, today, many rheumatology teams include a nurse specialist or nurse practitioner [7].

As the number of specialist nurses has increased, the role itself has expanded. In addition to being an expert in her chosen clinical area and managing a case load, many specialist nurses are expected to: provide a service which complements that of the rheumatologist; act as an educator to both patients and colleagues; advance nursing practice; undertake extended clinical procedures; carry out research into clinical practice. In addition, she must also act as a role model, a leader, a patient advocate and agent of change [8]. The list appears to be infinite, so much so that some authors have expressed fears that without clarification of their role, specialist nurses may become overwhelmed and fail to fulfil any part of it effectively [9].
Castledine [10] attempted to identify the core components of the role of the specialist nurse as early as 1982, but little research has been carried out to determine the role in clinical rheumatology. One study has been carried out which provided a profile of rheumatology nurses and their key duties [11]. It showed a degree of uniformity in that the majority (96%) of the 51 respondents considered counselling and patient and staff education as one of their major responsibilities. Drug monitoring, including phlebotomy and interpretation of results, was carried out by 86% (43). Seven nurses undertook extended clinical procedures, including i.v. drug administration (14%) and intra-articular joint injections (12%). Most nurses (78%) ran an independent out-patient clinic and 19 (38%) were able to admit patients to rheumatology wards without the prior consent of the medical staff. However, in addition to the similarities, the study also highlighted the differences. For instance, one researcher has pointed out that 22% of the nurses in the study had little autonomy and were not holding independent clinics; 62% could not refer patients for admission [12]. He has called for a more vigorous approach to the evaluation of the role to be combined with effective mechanisms to minimize geographical variations in nursing practice.

Although the specialist nurse must tailor her role according to the needs of her patients and local service requirements, there is clearly a need for some standardization; patients and personnel working within the health care system need to know what to expect of a specialist nurse. In response to this need, the Royal College of Nursing Rheumatology Nursing Forum has recently set up a working party to identify the core elements and skills required by nurses to fulfil the role effectively.

Despite the present shortcomings, there is no doubt that specialist nurses are contributing to improvements in patient care. Research from a nurse-led rheumatology clinic showed significant improvement in levels of patients’ pain, morning stiffness, psychological status, knowledge and satisfaction when compared to a similar group cared for by a consultant [13].

With an ever-increasing out-patient workload such as that described by Kirwan [14], and the reduction in the working hours of junior doctors, the employment of specialist nurses can contribute to the improved utilization of limited resources. Many specialist nurses working in rheumatology welcome the challenge of innovation and are advancing their practice by accepting greater responsibilities; the nurse-led clinics in Leeds and the nurse-led ward at St Helens in Merseyside are examples. Innovation has been encouraged by the introduction of the Scope of Professional Practice in 1992 [15] which represents a marked change in philosophy by the United Kingdom Central Council (UKCC), and the nursing and midwifery professions [16]. This has, in effect, given nurses the freedom to carry out advanced roles which improve their service to their patients, provided the task is within their professional competence. The acceptance by nurses of delegated technical tasks has caused some anxiety in nursing circles [17]. The fear is that in order to make way for technical activities, nurses may delegate their nurturing nursing skills to unqualified nursing assistants, thereby devaluing the essence of nursing and leading to fragmentation of care which would be detrimental to patients. However, this will not happen if role development is patient led and nurses themselves set the agenda for change.

As rheumatology nursing develops and extends its boundaries, nurses must be willing to accept full accountability for their actions and be competent to carry out their extended roles [18]. Advanced roles require further education. The UKCC’s paper Standards for Education and Practice Following Registration, states that for a nurse to practise as a specialist she must be educated to at least first degree level [19]. Unfortunately, in the UK at the present time, there is no standard preparation for specialist nurses. A proposal which has considerable merit is to establish a core curriculum suitable for all specialist nurses which would be followed by a specialist module.

In rheumatology, there is a lamentable paucity of nursing education programmes at all levels, and research into rheumatology nursing outcomes is scarce and uncoordinated. However, this situation is hardly surprising as rheumatology lacks an academic centre which focuses on rheumatology nursing and nurses. Perhaps the solution is for nurses to emulate the medical profession and clamour for the inauguration of the world’s first Chair of Rheumatology Nursing!

J. Hill
Chapel Allerton Hospital, Chapeltown Road, Leeds LS7 4SA

REFERENCES