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Clinical science

Similar rates of new psoriatic arthritis diagnoses in a dedicated psoriatic disease triage clinic, regardless of referral route

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Abstract

Objectives: To describe the findings from a dedicated psoriatic disease (PsD) triage clinic, including new PsA diagnosis rates, the characteristics of psoriasis (PsO) patients referred by general practitioners (GPs) *vs* dermatologists and the utility of the Psoriasis Epidemiology Screening Tool (PEST).

Methods: A single-centre, cross-sectional study of consecutive PsO patients with arthralgia referred by either GPs or dermatologists to the PsD Triage Clinic underwent clinical, laboratory and imaging evaluations as appropriate. Patient characteristics were compared by referral route and by PEST scores using a Wilcoxon signed-rank test for continuous variables and a chi-squared test for categorical variables.

Results: Of 158 patients [mean age 49 years (S.D. 14), 63% female], 28% were diagnosed with PsA, with similar rates across referral sources. Dermatology-referred patients had more metabolic comorbidities and more DMARD exposure ($P < 0.05$), whereas GP-referred patients were more often female and had a family history of PsA ($P < 0.05$). Overall, PEST demonstrated limited sensitivity (56.8%) and specificity (41.4%) for PsA. Patients with a PEST score ≥3 were older, had higher BMI and more entheseal tenderness than those with a PEST score <3.

Conclusions: A PsD triage clinic facilitated early PsA diagnosis in nearly one-third of referred patients, irrespective of GP or dermatology clinic referral routes.

Lay Summary

What does this mean for patients?

Psoriatic arthritis (PsA) is an inflammatory joint condition that affects up to 3 in 10 people with psoriasis (PsO). If left untreated, it can lead to permanent joint damage and disability. Early diagnosis is key to preventing this. Our study looked at a special clinic in Leeds where people with PsO and joint pain (arthralgia) were referred by either their GP or dermatologist for expert assessment. We found that nearly one in three people referred to the clinic were newly diagnosed with PsA, and this was true whether they were referred from primary care (GP) or secondary care (dermatology). This suggests that having a dedicated triage clinic helps ensure early identification and timely treatment of PsA. We also looked at the usefulness of a screening questionnaire called the Psoriasis Epidemiology Screening Tool and found that it did not reliably identify PsA in this setting. This highlights the importance of thorough clinical assessment by a specialist. For patients, this research supports the value of integrated services where dermatologists, GPs and rheumatologists work together. It shows that patients with PsO and joint symptoms can benefit from prompt referral to a dedicated clinic, regardless of where the referral comes from.

Keywords: psoriatic arthritis, screening, psoriasis, arthralgia, PEST, triage clinic, referral route.

Key messages

- A psoriatic disease triage clinic diagnosed PsA in nearly one-third of referred psoriasis patients with arthralgia.
- GP- and dermatology-referred psoriasis patients had distinct characteristics, but PsA diagnosis rates were similar.
- The Psoriasis Epidemiology Screening Tool (PEST) had limited sensitivity and specificity for detecting PsA.

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Introduction

Psoriatic arthritis (PsA) is a chronic peripheral and/or axial inflammatory joint disease that occurs in 20–30% of people with psoriasis (PsO) [1]. Early diagnosis of PsA is crucial for optimizing long-term outcomes [2]. The prevalence of PsA among PsO patients in secondary care settings has been reported to be as high as 30% [3, 4], whereas lower rates (4–18%) have been observed in primary care settings [5, 6].

Optimizing the referral process for suspected PsA through collaboration between general practitioners (GPs), dermatologists and rheumatologists is key to ensuring prompt assessment and timely diagnosis. However, identifying individuals with early PsA among PsO patients remains challenging due to the heterogeneous clinical presentation, typically negative inflammatory markers and the variable performance of screening tools [7]. Thus, consensus regarding the best screening strategy is yet to be reached.

Several PsA screening questionnaires have been developed, including the Psoriasis Epidemiology Screening Tool (PEST) [8]. Like other screening questionnaires for PsA, the PEST has demonstrated low specificity in subsequent independent study populations, with most false positives attributed to OA [9]. Musculoskeletal ultrasound (MSK-US) has also been proposed as a potential screening tool for PsA in PsO patients, with data suggesting that power Doppler can help differentiate PsA from PsO alone, aiding in early diagnosis [10]. Screening with MSK-US has been shown to significantly improve the accuracy of PsA diagnosis among PsO patients [11, 12].

Combined dermatology–rheumatology clinics have been advocated to improve quality of care by increasing awareness of psoriatic disease, enhancing education for both patients and physicians and enabling comprehensive and timely interdisciplinary evaluation and management [13, 14]. The Leeds Combined Psoriatic Service, part of the Leeds Specialist Spondyloarthritis Service, has a 20-year history of providing integrated, multispecialty and multidisciplinary care [15]. A dedicated psoriatic disease (PsD) triage clinic operates as part of this service, led by rheumatology specialists in PsA with access to diagnostic imaging, with the aim to facilitate prompt diagnosis of PsA in individuals with PsO and musculoskeletal symptoms.

The aims of this study were to describe the findings of a first point of contact PsD triage clinic, including diagnostic outcomes and the prevalence of newly diagnosed PsA; to compare the characteristics of PsO patients referred by GPs and by secondary care dermatologists; and to assess the value of the PEST screening tool in the referral pathway.

Methods

Patients and settings

This cross-sectional study included consecutive PsO patients with arthralgia referred to the Leeds Rheumatologic PsD Triage Clinic with clinical suspicion of PsA from November 2017 to October 2024. The clinic is part of the Leeds Combined Psoriatic Service, a secondary and tertiary regional and national referral centre for PsD with parallel rheumatology and dermatology clinics running weekly for nearly 2 decades, also serving as a research hub. Referrals to this monthly triage clinic are made either by GPs or by dermatologists working in secondary care. While the PEST score may be used in both settings, there is no structured referral algorithm or mandatory screening criteria for access to the triage clinic. In most cases, PEST scores for GP-referred patients were calculated retrospectively using information from referral letters or electronic health records. Secondary-care dermatologists routinely assess the PEST score in clinic, but there is no pre-specified cut-off score to trigger referral; some patients were referred with a PEST score ≥3, while others with lower scores were referred based on clinical judgment or suspicion. Patients with known PsA were excluded. Data were extracted from electronic health records as part of a service evaluation process, registered with the Leeds Teaching Hospitals NHS Trust clinical audit database (ref: SE0353). No ethical approval was required.

Clinical assessment

Patients were assessed by a single rheumatologist expert in PsA (J.E.F.), who performed comprehensive clinical, laboratory and imaging evaluations. Recorded data included the following demographic and clinical characteristics: age, sex, family history, weight, BMI, smoking status, comorbidities, PsO duration, PsO phenotype (including nail involvement), Psoriasis Area and Severity Index (PASI) and treatments ever given for skin [topicals, ultraviolet B (UVB) phototherapy, conventional synthetic DMARDs (csDMARDs), biologic DMARDs (bDMARDs)]. The reason for referral, PEST score, presence of morning stiffness and features of inflammatory back pain were retrieved. The physical examination variables included 78 tender joint counts, 76 swollen joint counts, tender entheses count and presence of dactylitis. Blood tests were performed for CRP, HLA-B27, urate, RF and anti-CCP antibodies.

Imaging investigations were performed as clinically indicated and not as part of a predefined protocol. US scans were performed within 1 week of the clinical evaluation by an experienced MSK sonographer (J.E.F.), using a Logiq E9 machine (GE Healthcare, Chicago, IL, USA) with 6–15 and 8–18 MHz linear transducers. Power Doppler was assessed using a pulse repetition frequency of 1.5 kHz and a wall filter level of 108 Hz and gain was adjusted until background signal was removed. Patients were asked not to change their medications between the clinical and sonographic evaluation and were instructed to stop anti-inflammatory medications during this time.

The results of available imaging were systematically recorded for the following variables: X-rays of peripheral and axial joints were analysed for erosions, new bone formation and degenerative changes; US findings included synovitis, enthesitis, tenosynovitis, erosions, degenerative changes and new bone formation; and axial MRI results were analysed for the presence of acute or chronic evidence of inflammatory changes, e.g. sacroiliitis.

The diagnoses of PsA and other rheumatology conditions were made on clinical grounds utilizing all available test results.

Statistical analysis

Descriptive statistics were used for demographic, clinical and imaging variables. Continuous variables were reported as mean (S.D.) or median with interquartile range (IQR), while categorical variables were presented as frequencies and percentages. Patient characteristics were compared using a Wilcoxon signed-rank test for continuous data and

chi-squared test for categorical variables. Sensitivity and specificity were calculated for the PEST score, using the rheumatologist's assessment as the gold standard. *P*-values <0.05 were considered statistically significant. All statistical analyses were performed using RStudio/R version 4.3.0 (R Foundation for Statistical Computing, Vienna, Austria).

Results

Demographics and clinical characteristics

A total of 158 patients were included in our cohort. The mean age was 49 years (S.D. 14) and 100 (63%) were female. Fifty-eight patients (37%) were referred to the PsD Triage Clinic by their GPs and 100 (63%) by dermatology. The median duration of PsO was 14 years (IQR 6–25.5), the median PASI was 5.3 (IQR 1.6–10), 72% of patients had scalp involvement and 60% had nail involvement. After the first evaluation in the PsD Triage Clinic, 44 (28%) patients were diagnosed with PsA, 94 (59%) with OA and 7 (4%) with gout. Thirteen patients had non-specific arthralgia. Among the 44 patients diagnosed with PsA, 25 (57%) had an oligoarticular pattern, 12 (27%) had polyarticular involvement and 7 (16%) had predominantly axial disease.

Patients' characteristics analysed by referral route

Analysing the cohort by referral route (Table 1), patients referred by GPs were more likely to be female [47 (81%) *vs* 53 (53%), $P < 0.01$] and have a family history of PsA [6 (10%) *vs* 2 (2%), $P = 0.03$], while those referred by dermatology had higher median PEST scores (3 *vs* 2, $P < 0.01$). Notably, 29/58 (50%) and 95/100 (95%) of the GP-referred and dermatology-referred patients, respectively, had all the PEST score components available. Although BMI, PASI scores, PsO phenotype and disease duration were similar across groups, patients referred by dermatology had more metabolic comorbidities and greater exposure to csDMARDs and bDMARDs ($P < 0.05$). Physical examination findings, as well as laboratory tests and imaging findings, were similar across groups. The PsA diagnosis rate was similar irrespective of referral route (28%). Of the 44 patients diagnosed with PsA, 13 (30%) were ever treated with biologics.

Patients' characteristics analysed by PEST scores

When compared according to PEST score (Table 2), patients with a PEST score ≥3 were older, had a higher BMI and had more cardiovascular comorbidities compared with those with a PEST score <3 ($P < 0.05$). Patients with a PEST score <3 were more likely to be referred with back pain, have features of inflammatory back pain and exhibit inflammatory findings on spinal and SI joint MRI, but had less psoriatic nail disease and entheseal tenderness ($P < 0.05$). Other imaging and laboratory findings were similar between the groups. The PsA diagnosis rate (≈30%) was similar across groups (Table 2).

Table 1. Comparison of clinical characteristics and diagnoses by referral route.

Characteristics	GP referral ($n = 58$)	Dermatology referral ($n = 100$)	Total ($N = 158$)	*P*-value
Age, years, mean (S.D.)	48.44 (12.88)	49.29 (14.53)	48.98 (13.91)	0.76
Female, *n* (%)	47 (81)	53 (53)	100 (63)	**<0.01**
Family history, *n* (%)				
Psoriasis	24 (41)	36 (36)	60 (38)	0.62
PsA	6 (10)	2 (2)	8 (5)	**0.03**
Uveitis	1 (2)	1 (1)	2 (1)	0.72
IBD	3 (5)	7 (7)	10 (6)	0.60
PEST score, median (IQR)[a]	2 (1–2)	3 (2–4)	3 (2–4)	**<0.01**
BMI, median (IQR)	29.91 (25.24–35)	30 (26–33.04)	30 (26–34)	0.98
Comorbidities, *n* (%)				
DM	3 (5)	20 (20)	23 (15)	**0.01**
IHD	4 (7)	6 (6)	10 (6)	0.82
NAFLD	6 (10)	19 (19)	25 (16)	0.15
HTN	13 (22)	36 (36)	49 (31)	0.08
Dyslipidaemia	7 (12)	37 (37)	44 (28)	**<0.01**
Uveitis	0 (0)	1 (1)	1 (1)	0.44
IBD	3 (5)	5 (5)	8 (5)	0.96
Psoriasis duration, years, median (IQR)	14 (6.75–25)	15 (6–29)	14 (6–25.5)	0.40
PASI, median (IQR)[b]	5.4 (0.3–10)	5.15 (1.85–10)	5.3 (1.55–10)	0.76
Scalp involvement, *n* (%)	42 (72)	71 (71)	113 (72)	0.85
Nail involvement, *n* (%)	32 (55)	63 (63)	95 (60)	0.33
Psoriasis treatment ever, *n* (%)				
Topicals	45 (78)	94 (94)	139 (88)	**<0.01**
UVB	16 (28)	58 (58)	74 (47)	**<0.01**
csDMARDs	17 (29)	63 (63)	80 (51)	**<0.01**
bDMARDs	7 (12)	35 (35)	42 (27)	**<0.01**
TJC, median (IQR)	1 (0–3)	1 (0–3)	1 (0–3)	0.70
Tender entheses count, median (IQR)	0 (0–1)	0 (0–1)	0 (0–1)	0.36
Overall diagnosis, *n* (%)				
Degenerative disease	32 (55)	62 (62)	94 (59)	0.36
PsA diagnosis	16 (28)	28 (28)	44 (28)	0.96
Gout	3 (5)	4 (4)	7 (4)	0.96

Statistically significant results are in bold.
[a] $n = 29$ for GP referral, $n = 95$ for dermatology referral.
[b] $n = 21$ for GP referral, $n = 90$ for dermatology referral.
DM: diabetes mellitus; IHD: ischaemic heart disease; NAFLD: non-alcoholic fatty liver disease; HTN: hypertension.

Table 2. Comparison of demographic, clinical and imaging characteristics by PEST score

Characteristics	PEST score <3 ($n = 52$)[a]	PEST score ≥3 ($n = 72$)[a]	*P*-value
Age, years, mean (S.D.)	45.24 (14.66)	50.68 (14.09)	**0.04**
Female, *n* (%)	33 (63)	40 (56)	0.38
BMI, median (IQR)	27 (24.39–30.95)	31 (27–33)	**0.02**
Cardiovascular comorbidity, *n* (%)	18 (35)	43 (60)	**<0.01**
Reason for referral, *n* (%)			
Peripheral joint pain	25 (48)	45 (63)	**<0.01**
Back pain	9 (17)	1 (1)	
Peripheral joint pain and back pain	18 (35)	26 (36)	
Psoriasis duration, years, median (IQR)	13 (5.5–21)	15 (8–30)	0.32
PASI, median (IQR)	5.6 (1.6–10)	5.2 (1.5–10)	0.84
Psoriasis nail involvement, *n* (%)	25 (48)	54 (75)	**<0.01**
Morning stiffness, *n* (%)	20 (38)	16 (22)	0.08
TJC, median (IQR)	1 (0–3)	2 (0–3)	0.68
SJC, median (IQR)	0 (0–0.5)	0 (0–1)	0.37
Dactylitis, *n* (%)	2 (4)	9 (13)	0.10
Tender entheses count, median (IQR)	0 (0–1)	0 (0–2)	**0.04**
Inflammatory back pain, *n* (%)	15 (29)	10 (14)	**0.04**
Laboratory tests			
Elevated CRP	7 (13)	7 (10)	0.50
Positive HLA-B27	2 (4)	1 (1)	0.21
Elevated urate	9 (17)	18 (25)	0.42
X-ray, *n* (%)			
Peripheral degenerative	16 (31)	33 (46)	0.35
Axial degenerative	14 (27)	27 (38)	0.37
MSK-US, *n* (%)			
Synovitis	9 (17)	8 (11)	0.17
Enthesitis	4 (8)	11 (15)	0.27
MRI spine/SI joints inflammatory, *n* (%)	6 (12)	3 (4)	**0.04**
PsA diagnosis, *n* (%)	16 (31)	21 (29)	0.85

Statistically significant results are in bold.
[a] PEST score not available for 34 patients. For most GP referrals, the PEST score was calculated in the PsD Triage Clinic.
Cardiovascular comorbidity: diabetes mellitus or ischaemic heart disease or non-alcoholic fatty liver disease or hypertension or dyslipidaemia; CRP: normal value <5 mg/dl.

Overall, PEST score sensitivity and specificity for PsA diagnosis were 56.8% and 41.4%, respectively.

In a separate analysis of patients who underwent imaging to aid clinical diagnosis ($N = 107$), 48/107 (45%) had findings suggestive of current or previous inflammation, while 59/107 (55%) had normal MSK-US and/or MRI (Supplementary Table S1, available at *Rheumatology Advances in Practice* online). The median PEST score was similar between patients with and without imaging findings [median 3 (IQR 2–3) *vs* 3 (2–4), $P = 0.11$, respectively].

Discussion

The ideal referral algorithm for patients with PsO and arthralgia to rheumatology is debatable and there is great variation between different centres. This study describes the PsD Triage Clinic, embedded within the Leeds Combined Psoriatic Service, aiming to facilitate early diagnosis and care for PsA. Our results demonstrate that almost one-third of patients with PsO and arthralgia referred to the PsD Triage Clinic received a new diagnosis of PsA. Given that untreated or delayed PsA diagnosis may result in irreversible joint damage and disability [2], this clinic provides a clear and efficient referral pathway for suspected PsA from both primary and secondary care referrals.

In this cohort, 37% were referred with suspected PsA by their GPs and 63% by a consultant dermatologist; 28% of patients were newly diagnosed with PsA in the PsD Triage Clinic, irrespective of referral route. Similarly, others have reported that 24–29% of PsO patients attending secondary care dermatology clinics had undiagnosed PsA, highlighting the importance of improving screening and referral processes [4, 16]. However, the undiagnosed PsA rate of 28% in our study is higher than previously reported in primary care settings [5, 6]. We believe this may reflect the structured triage process in our service and increased PsA awareness among GPs in our region. Of note, in our cohort, patients referred by GPs were more likely to be female and have a family history of PsA. In contrast, patients referred by dermatology had greater exposure to treatments than those referred by GPs, suggesting that some cases of arthritis might have been masked or even intercepted by DMARDs prescribed for skin disease in dermatology-referred patients. This could partly explain both the diagnostic equivalence in PsA detection across referral routes and the unexpectedly similar PASI scores between referral groups, with dermatology-referred patients achieving better skin scores following DMARD treatment. For example, a previous (2013) secondary care–based study reported that csDMARDs and bDMARDs were used in 7% of cases each [9], whereas in the current study, 51% and 27% were ever treated with csDMARDs and bDMARDs, respectively. This suggests that secondary care patients may have had more severe PsO and the proportion of PsA could have been even higher in this group without treatment. Furthermore, the fact that 13/44 (30%) patients diagnosed with PsA were treated with biologics is of interest. Although biologics strongly reduce PsA risk, new-onset PsA diagnosis has been reported in 8–12% of patients under

biologic therapy [17, 18]. These data align with our study results, emphasizing the importance of ongoing routine screening for PsA in PsO, even in patients treated with biologics.

In our cohort, patients referred by dermatology had more cardiovascular comorbidities than those referred by their GPs. Indeed, more than one-third had hypertension or dyslipidaemia, and 20% had diabetes mellitus, similar to previous reports in specialized centres [14]. The difference between the groups, however, may reflect the impact of more severe prior active skin disease in dermatology-referred patients on the accrual of cardiovascular comorbidities. Interestingly, BMI and disease duration were similar between these groups.

Different algorithms for optimizing referrals for suspected PsA have been suggested [19, 20]. PsA accounts for ≈20% of patient referrals to early arthritis clinics, and it has been shown that such rapid-access clinics achieve good clinical outcomes in most patients [21]. Moreover, the benefits of combined dermatology–rheumatology clinics, which aim to accelerate early diagnosis and improve the quality of care for PsD, have been described [13, 14, 22, 23]. The Leeds Combined Psoriatic Service exemplifies collaboration between dermatologists and rheumatologists with a special interest in early diagnosis of PsA [15]. Recently, a significant burden of undiagnosed and undertreated PsO in the Leeds community was reported [24], underscoring the crucial role of improving access and referral routes to rheumatology for suspected PsA in our area. In parallel, a pilot Psoriasis Rapid Access Clinic set up in Salford, North West England, reported 39 patients assessed by a combined specialist dermatology and health psychology team [25]. However, no rheumatologic assessment was reported despite 18% having a PEST score ≥3. Our results underscore the need for a dedicated PsD triage clinic in large referral centres in a real-world setting, with accessible rheumatologic evaluation.

The PEST score was initially introduced as a screening questionnaire for primary care settings [8] but was later shown to perform in both primary and secondary care settings [5, 9]. In the current study, 58% of patients with an available PEST score had a positive result of ≥3. These patients were older, had more entheseal tenderness, a higher BMI and more cardiovascular comorbidities compared with those with a PEST score <3. In accordance with our results, others have reported an association of higher PEST scores with greater BMI and cardiovascular comorbidities [26, 27]. Moreover, in a recently published study evaluating the cross-sectional and longitudinal performance of the PEST in PsO patients followed for up to 5 years, older age and body weight >90 kg were associated with an increased likelihood of becoming PEST positive over time [28]. As a component of the PEST, psoriatic nail disease was more prevalent among patients with higher PEST scores.

In the current study, the PsA diagnosis rate (≈30%) was similar in patients with a PEST score ≥3 *vs* those with a PEST score <3, with the sensitivity and specificity of PEST for PsA diagnosis at 56.8% and 41.4%, respectively. Other studies have reported widely variable sensitivity (27–92%) and specificity (37–98%) of the PEST score depending on the population studied [4, 8, 9, 12, 29–35]. Across the studies using the PEST, most false positives were attributed to OA [9, 35]. In line with these data, in the current study, 63% of patients with a PEST score ≥3 were diagnosed with OA (while only 29% were diagnosed with PsA). Patients with a PEST score <3 were more likely to be referred with back pain and to have axial PsA. It has been suggested that the PEST has lower sensitivity for identifying non-polyarticular (oligoarticular, spinal and entheseal) disease [4, 9]. Moreover, it has been suggested that in academic, specialized and secondary care settings, where patients are already screened with questionnaires, the remaining undiagnosed PsA is characterized by a lower perceived disease burden, fewer active PsA features and lower yield of the PEST [16, 35]. We hypothesize a possible explanation to the relatively low sensitivity and specificity of the PEST in the current study is similar, with raised awareness of PsA in primary and secondary care in Leeds, meaning that unidentified PsA has a different, more subtle phenotype, consisting mostly of non-polyarticular disease.

It has been suggested that integrating MSK-US into referral algorithms for suspected PsA could improve screening and enhance diagnostic accuracy [20]. US may differentiate PsA from PsO alone by detecting early power Doppler changes at the enthesis [10]. In addition, it has been reported that MSK-US may reduce the false positive rate in referrals from dermatology to rheumatology [11, 12, 36]. A recent German study demonstrated that MSK-US conducted by previously trained dermatologists led to more precise PsA detection, increasing specificity to 90% [11]. Hence the authors concluded that MSK-US used by dermatologists may potentially decrease referral rates to rheumatology [11]. Similarly, Sarabia *et al.* [12] compared the performance of different triage modalities for PsO patients with MSK symptoms and found that the addition of MSK-US improved the performance of screening questionnaires. Nevertheless, it should be kept in mind that the routine use of MSK-US is associated with added time and cost and requires a skilled sonographer who may not be available in every triage setting. Moreover, if the sonographer is a rheumatologist, sometimes the diagnosis is clear on clinical grounds, making MSK-US redundant. An alternative strategy currently being explored is the use of a focused MSK examination by referring clinicians, which may increase specificity while requiring less specialized training than MSK-US [37]. Future triage pathways could benefit from integrating screening questionnaires such as the PEST with either MSK-US or structured joint examination by referring clinicians, depending on available resources. Validation of such combined approaches in real-world settings will be essential to improving early PsA detection.

There are several limitations to this study. First, the cross-sectional design reflected assessment for PsA at a single time point, whereas a longitudinal assessment might have provided more information regarding the transition from PsO to PsA over time. Second, imaging was not systematically performed for all patients, and MSK-US was conducted by the same unblinded assessor who performed the clinical evaluation, which may introduce confirmation bias. Moreover, as imaging was performed based on clinical judgement, this introduces potential selection bias related to disease severity and phenotype. Third, PEST scores were missing in a substantial proportion of GP referrals, although retrospective calculation from electronic health records allowed recovery of some data. No imputation was performed due to sample size, and comparisons based on the PEST score were limited to patients with complete scores. Fourth, the lack of a control group of patients reviewed in an early arthritis clinic prevented a comparison of waiting times. Fifth, the time from the onset of MSK symptoms and the time from referral to

assessment in the PsD triage clinic were not systematically collected. Furthermore, the observational design and inclusion based on clinician suspicion of PsA introduces additional potential for referral and confirmation bias, as only patients referred by GPs or dermatologists were assessed.

Strengths include the fact that the PsD Triage Clinic is part of a tertiary referral centre, allowing analysis of a heterogeneous population of PsO patients referred from both primary and secondary care, thus representing the real-world PsO + arthralgia population. Patients were referred for rheumatologic assessment based on clinical suspicion of PsA by a dermatologist or GP. While this still reflects a degree of selection bias—as these patients are engaged with healthcare services—it differs from studies that relied solely on patient self-assessment questionnaires, which are more susceptible to self-selection bias and may capture a less clinically validated population [5, 6, 8, 9, 12, 32]. Additionally, clinical diagnosis of PsO and PsA was confirmed by an experienced consultant rheumatologist and not health record based, avoiding misclassification.

In conclusion, nearly one-third of patients with PsO and arthralgia referred to the PsD Triage Clinic by a GP or dermatology were newly diagnosed with PsA, underscoring the benefits of integrated cross-specialty clinical services for the prompt identification of PsA. Further larger, longitudinal studies are needed to evaluate the optimal triage strategy to improve outcomes cost-effectively.

Supplementary material

Supplementary material is available at *Rheumatology Advances in Practice* online.

Data availability

The data that support the findings of this study are available upon request from the corresponding author.

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