

## The Evolution and Impact of Combined Dermatology-Rheumatology Clinics in Psoriatic Care

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### DESCRIPTION

The rise of combined dermatology-rheumatology clinics represents a significant evolution in the care of patients with psoriatic disease. Traditionally, dermatologists and rheumatologists have worked in separate silos, each managing their respective manifestations of the disease skin and joints. However, psoriatic disease is a multifaceted condition that does not adhere to such boundaries. Recognising the overlapping yet distinct expertise of these two specialties, combined clinics have emerged as a practical and innovative solution that prioritizes holistic patient care, improves outcomes and fosters interprofessional collaboration.

One of the clearest advantages of combined clinics is the improved ability to establish a timely and accurate diagnosis of Psoriatic Arthritis (PsA). For many patients, psoriasis precedes the onset of joint symptoms by several years. This positions dermatologists as the first medical professionals to encounter patients who may later develop PsA. In traditional care models, the delay between suspicion and confirmation of PsA often results in progression of joint damage and reduced quality of life. Combined clinics effectively bridge this gap. Rheumatologists can assess musculoskeletal symptoms in real time, confirm the presence of inflammatory arthritis and initiate appropriate investigations without delay. This real-time, co-managed diagnostic process reduces fragmentation of care and provides patients with a cohesive understanding of their condition.

### Joint clinics enhance treatment precision in psoriatic disease

Another substantial benefit of combined clinics is their role in optimizing treatment. As new systemic therapies have become available, the landscape of psoriatic disease management has grown increasingly complex. Certain biologics may work better for skin manifestations, while others are more effective in controlling joint inflammation. Without cross-specialty dialogue, patients may remain on suboptimal regimens for longer than necessary. In combined clinics, dermatologists and rheumatologists

can jointly assess treatment response and make timely adjustments. The German prospective study and the Cleveland Clinic experience both demonstrate this effect, with a notable increase in treatment changes and greater use of biologics following joint consultations. This responsiveness to patient needs reflects a higher standard of care one that tailor's therapy not just to symptoms but to the whole patient.

Patient-reported outcomes also reflect the positive impact of combined care. In a healthcare climate where patient satisfaction and quality of life metrics increasingly influence policy and reimbursement, this cannot be understated. Clinics in Italy and Germany reported improvements across multiple validated tools, such as the Dermatology Life Quality Index (DLQI) and the Psoriatic Arthritis Impact of Disease questionnaire. These gains extend beyond symptom relief; they speak to patients feeling seen, heard and respected in their healthcare journey. The value of this therapeutic alliance cannot be quantified easily, but its presence is evident in the data.

Beyond clinical outcomes, these integrated clinics offer rich educational opportunities. Trainees both dermatologists and rheumatologists benefit immensely from seeing patients together and learning how each specialty approaches diagnosis and treatment. The feedback from the Singapore clinic, where nearly all surveyed trainees found the experience beneficial, supports the notion that combined clinics serve as incubators for the next generation of collaborative practitioners. This model not only enhances competency but also builds a culture of mutual respect and shared learning between disciplines. In a world where medicine is becoming ever more specialized, these experiences are vital in maintaining a patient-centred, integrative approach to care.

### Implementing combined clinics: models and challenges

Of course, the implementation of such clinics is not without challenges. Clinic structure, resource allocation and scheduling logistics all play significant roles in determining success. Two

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primary models have emerged: the parallel model, where patients see each specialist separately but under coordinated care; and the face-to-face model, where both specialists see the patient together during the same consultation. While both have merit, the latter offers greater immediacy and cohesion in decision-making. However, it is also more resource-intensive and may be difficult to sustain in busy healthcare systems with workforce constraints. Identifying scalable, adaptable models for broader implementation remains a work in progress.

## CONCLUSION

In conclusion, combined dermatology-rheumatology clinics are a paradigm shift in the management of psoriatic disease. They

represent a move away from fragmented, specialty-driven care toward a more holistic, patient-focused model. The benefits improved diagnostic accuracy, optimised treatment regimens, enhanced patient satisfaction and enriched training experiences are compelling. While structural and operational challenges exist, the core principle remains clear: patients with complex, multisystem diseases deserve coordinated, comprehensive care. Combined clinics deliver just that and should be viewed not as an innovation of the few, but as a blueprint for the future.