Psoriasis

Psoriasis – Primary Care Treatment Pathway

What is Psoriasis?

Psoriasis is a chronic, relapsing, inflammatory condition affecting the skin, scalp, nails, flexures and joints, with cardiovascular and psychological co-morbidities[1]

It is not contagious and there is often a family history

Psoriasis typically manifests with sharply demarcated dull red plaques with silvery scales, which shed easily

It can be well controlled and treatment aims are to minimise skin manifestations, co-morbidities and improve quality of life

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Reviewed by the Psoriasis Association

Triggers and Exacerbating Factors

Stress

Smoking, alcohol and obesity

Skin injury/surgery

Infections – Streptococci, HIV

Drugs (oral), such as lithium, beta-blockers,terbinafine and antimalarials such as hydroxychloroquine

Assessment

An holistic approach is essential

Examine the skin:

Body

Special sites – scalp and nail involvement and specifically ask about genital areas

Joints – be alert to signs of inflammatory arthritis including tendonitis and heel pain

Cardio-metabolic risk (e.g. modified Q-risk)

Cardiovascular risk assessment, smoking and alcohol consumption

Explore wellbeing (e.g "how are you coping?")

Management

Explore expectations and discuss treatment options initially using topical therapies

Emphasise benefits of lifestyle changes and provide support

Arrange follow up and consider primary healthcare team's role in review of psoriasis and management of co-morbidities

DLQI – https://www.cardiff.ac.uk/medicine/resources/quality-of-life-questionnaires/dermatology-life-quality-index

Psoriasis Epidemiology Screening Tool (PEST) http://www.bad.org.uk/shared/get-file.ashx?id=1655&itemtype=document

Lifestyle Directed Advice

Lifestyle change, reducing obesity, smoking and alcohol and managing psychological co-morbidities have been shown to improve psoriasis severity. Provide advice on managing stress, smoking and alcohol, diet and physical exercise. Utilise local resources where available.

Natural sunlight can improve psoriasis in some. However, sun-beds and exposing oneself to excessive periods in the sun is not recommended, especially in patients with very fair complexions, as this risks skin cancer and burning

Skin Directed Treatment

We strongly advocate the use of emollients both as soap substitutes and leave on preparations for all patients, alongside active topical therapies. Emollients soften scale, relieve itch and reduce discomfort and should be prescribed in large quantities, (500g/week for an adult, 250-500g/week for a child). When choosing an emollient, patient preference is crucial for adherence

Active topical treatments should be used daily during a flare. During remissions, improvement should be sustained by using less frequent active topical treatment (apply twice weekly, on Monday and Friday, or Saturday and Sunday)

Immediate referral if:

- Erythroderma (more than 90% skin coverage)
- Severe worsening psoriasis and systemically unwell patient
- Generalised pustular psoriasis

Routine/urgent referral if:

- Poor response to treatment
- Severe psoriasis or widespread psoriasis (more than 10% body surface area)
- Psychological distress

Secondary Care

Treatments available in Secondary Care:

- Phototherapy, especially for new guttate psoriasis or hand and foot psoriasis
- Systemic oral therapies e.g. methotrexate, ciclosporin, apremilast, Skilarence® and actiretin
- Injectable biologics

Other Information

Assessing psychological distress with DLQI score

Assessing psoriatic arthritis with PEST score

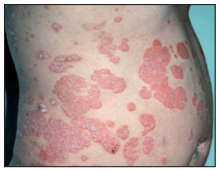
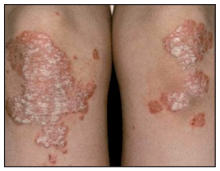
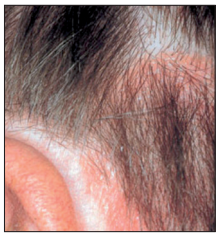
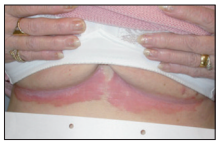
Reduce costs of multiple prescriptions by advising a pre-payment certificate

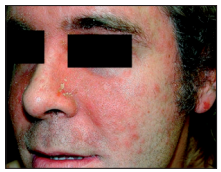
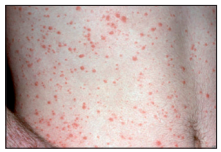
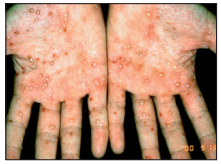
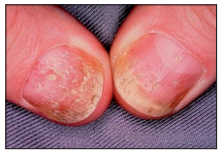
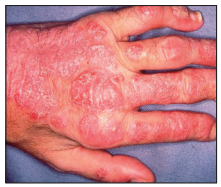
Further information for patients can be found at **www.pcds.org.uk** and **www.psoriasis-association.org.uk**

Psoriasis

Psoriasis – Clinical Features and Treatment

PCDS PRIMARY CARE DERMATOLOGY SOCIETY

Trunk & Limbs  	**Clinical Features** Well defined symmetrical small and large scaly plaques, predominantly on extensor surfaces but can be generalised	**Treatment** Calcipotriol/Betamethasone (Dovobet®, Enstilar®) combination product should be used first line, once daily until lesions flatten. This treatment protocol differs from NICE guidance but is more patient-centred and clinically effective using once daily dosage If the response is sub-optimal at 8-12 weeks: 1. Review adherence 2. Very thick scale can act as a barrier to topical therapies and consider using a salicylic acid preparation to descale (e.g. Diprosalic® ointment once or twice daily) or occluding thick plaques with a greasy emollient or Sebco® shampoo overnight under Clingfilm® wrap 3. Consider using a tar product such as Exorex® lotion, or see the PCDS website for using therapies such as Dithranol® During remissions improvement should be sustained with emollients and by using less frequent active topical treatment (twice weekly application)
Scalp Psoriasis 	**Clinical Features** Much more common than appreciated and easier felt than seen May be patchy Socially embarrassing Typically extends just beyond the hairline, best seen on nape of neck	**Treatment** Treatments can be messy and this can be a difficult site to treat, so it is important to manage your patient's expectations and provide clear explanations 1. Descale if necessary with coconut oil or if more severe, Sebco Ointment® – massaged onto the scalp generously and ideally left over night. Wash out with Capasal® or Alphosyl 2-in-1® shampoo. Continue to use until the scale becomes much thinner 2. Treat ongoing inflammation with potent topical steroids such as Synalar Gel® or Diprosalic® scalp application applied at night. Dovobet Gel® or Enstilar foam® could be used 3. Maintenance therapy: Once or twice weekly tar-based shampoo such as Capasal® or Alphosyl®, with once or twice weekly potent topical steroids. If the scale thickens then revert to Sebco® ointment in short bursts
Flexures & Genetalia 	**Clinical Features** Erythematous patches, shiny red,and lack scale. Commonly mistaken for candidiasis	**Treatment** Mild or moderate topical steroid, such as Daktacort®, 1% hydrocortisone, or eumovate® once daily. For thicker plaques consider a short course of Trimovate® for a week to gain control, then wean down to a moderate or mild topical steroid. Once the skin is under control, use the steroid twice weekly to keep under control A topical vitamin D preparation such as Silkis® or Curatoderm® can be used opposite end of the day, to the topical steroid, and continued daily whilst using the steroid twice a week, to keep control. For flexures, topical calcineurin inhibitors can be used instead of topical steroid or vitamin D analogs, but we would advise avoid using these agents in uncirmcumised male patients unless directed by secondary care

Face 	**Clinical Features** An uncommon and distressing site sometimes with plaques but more often similar to that seen in seborrhoeic dermatitis	**Treatment** **Eumovate Ointment** – many would use this initially, for a week and follow on with any of • Protopic 0.1% ointment – once or twice a day and reducing with response • Silkis ointment – can cause irritation so introduce gradually (initially twice a week then build up to daily) • Daktocort® cream once or twice a day for more seborrhoeic types
Guttate Psoriasis 	**Clinical Features** Rapid onset of very small 'raindrop like' plaques, mostly on torso and limbs, usually following a streptococcal infection May lack scale initially An important differential is secondary syphilis	**Treatment** Refer to secondary care for light therapy. In the interim, consider treating with tar lotion (Exorex lotion®) 2-3 times a day, or using topical steroids such as eumovate®, Diprosalic® ointment, Dovobet® or Enstilar® foam for itchy patches In cases of recurrent guttate psoriasis with proven streptococcal infections, consider the early use of antibiotics and/or referral for tonsillectomy
Palmoplantar Pustular 	**Clinical Features** **Very resistant and difficult to treat. Creamy sterile pustules mature into brown macules**	**Treatment** This is more likely in smokers: strongly advise stopping smoking Dermovate Ointment at night under polythene occlusion (e.g. Clingfilm®) A moisturiser of choice to be used through the day Early referral important for hand and foot PUVA/ Acitretin
Nails 	**Clinical Features** **In about 50% of patients pitting, hyperkeratosis and onycholysis** **NB.** Look for arthritis and co-existing fungal infection. Terbinafine may aggravate psoriasis	**Treatment** Practical tips – keep nails short, use nail buffers Nail varnish and gel safe to use Trickle potent topical steroid scalp application or apply Dovobet gel if nails are onycholytic
Psoriatic Arthritis 	**Clinical Features** Inflammatory polyarthritis, spondylarthritis, synovitis, dactylitis and tendonitis	**Treatment** Psoriatic arthritis is under-recognised and it is very important it is diagnosed and referred early to Rheumatology because of the risk of permanent joint destruction and functional damage Refer to the PCDS website for more information **www.pcds.org.uk/clinical-guidance/psoriatic-arthropathy**

Please note this guidance is the view of the contributors and reflects evidence as well as experience