Psoriasis

Psoriasis – Primary Care Treatment Pathway

What is Psoriasis?

Psoriasis is a chronic, relapsing, inflammatory condition affecting the skin, scalp, nails 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; including lithium 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)

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

Lifestyle Directed Advice

Providing advice on managing stress, smoking, alcohol and obesity (in accordance with local resources), physical activity and Mediterranean diet

Safe natural sunlight exposure depending on individual risks and benefits. Patients are especially vulnerable to suboptimal lifestyles due to the cardiovascular and metabolic risk and a negative impact on psoriasis itself. A dietary plan and physical exercise has been shown to reduce psoriasis severity

Obesity, excess alcohol, smoking also are associated with worsening psoriasis

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, (e.g. a 70kg adult is likely to need at least 500g/month). 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, for example, weekend therapy

Immediate referral if:

- Erythroderma
- Unstable or pustular

Routine/urgent referral if:

- Poor response to treatment
- Severe
- Psychological distress

Secondary Care

Treatments available in Secondary Care:

- Phototherapy
- Systemic therapy e.g. Methotrexate, Cyclosporin
- Apremilast
- Biologics (TNF and interleukin blockers)

Other Information

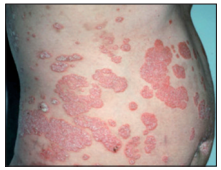
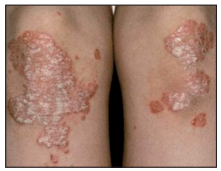
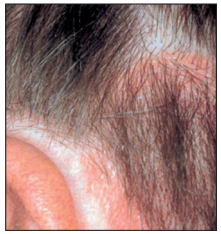
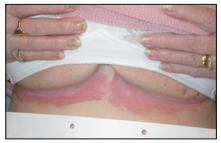
DLQI, PEST

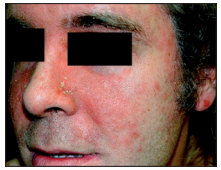
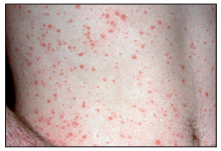
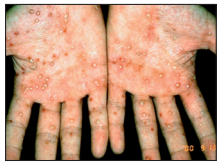
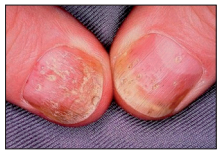
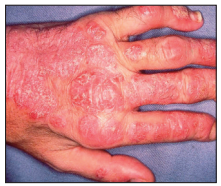
Advice re: prepayment season ticket

Further information for patients can be found at www.pcds.org.uk and

www.psoriasis-association.org.uk

Psoriasis – Clinical Features and Treatment

Trunk & Limbs	Clinical Features	Treatment
 	Well defined symmetrical small and large scaly plaques, predominantly on extensor surfaces but can be generalised	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 daily) 3. Consider other therapies such as tar products (e.g. Exorex Lotion®), Tazarotene (Zorac®) or Dithranol (e.g. Micanol®). See www.pcds.org.uk for more details During remissions improvement should be sustained with emollients and by using less frequent active topical treatment, for example, weekend therapy
Scalp Psoriasis	**Clinical Features**	**Treatment**
	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	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® 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® could be used 3. Maintenance therapy: • Once or twice weekly tar based shampoo such as Capasal® Alphosyl® or Polytar® • Once to twice weekly potent topical steroids as above or more frequently if needed • If the scale thickens then revert to Sebco ointment
Flexures & Genetalia	**Clinical Features**	**Treatment**
	Erythematous patches, shiny red,and lack scale. Commonly mistaken for candidiasis	Eumovate cream or Ointment Daktacort Silkis

Face	Clinical Features	Treatment
	An uncommon and distressing site sometimes with plaques but more often similar to that seen in seborrhoeic dermatitis	**Eumovate Ointment** – many would use this initially and follow on with any of • Protopic 0.1% ointment – twice a day (off-license) and reducing with response • Silkis ointment – can cause irritation so introduce gradually (initially twice a week) • Dactocort cream twice a day for more seborrhoeic types
Guttate Psoriasis	**Clinical Features**	**Treatment**
	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	Refer to secondary care for light therapy and in the interim consider treating with tar lotion (Exorex lotion®) 2-3 times a day There is insufficient evidence for the routine use of antibiotics however 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**	**Treatment**
	**Very resistant and difficult to treat. Creamy sterile pustules mature into brown macules**	Stop smoking Dermovate Ointment at night under polythene occlusion (e.g. Patches of Clingfilm®) A moisturiser of choice to be used through the day Early referral important for hand and foot PUVA/ Acitretin
Nails	**Clinical Features**	**Treatment**
	**In about 50% of patients pitting, hyperkeratosis and onycholysis** **NB.** Look for arthritis and co-existing fungal infection. Terbinafine may aggravate psoriasis	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 under the onycholytic nail
Psoriatic Arthritis	**Clinical Features**	**Treatment**
	Inflammatory polyarthritis, spondylarthritis, synovitis, dactylitis and tendonitis	Psoriatic arthritis is under-recognised and it is very important it is diagnosed and referred early to Rheumatology because of the risk of permanent and radiological damage Refer to the PCDS website for more information www.pcds.org.uk/clinical-guidance/psoriatic-arthropathy

Please note this guidance is the views of the contributors and does not consider costs of treatments