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. 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.

Contributors

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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

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# Psoriasis – Clinical Features and Treatment

<table>
<thead>
<tr>
<th><strong>Trunk &amp; Limbs</strong></th>
<th><strong>Clinical Features</strong></th>
<th><strong>Treatment</strong></th>
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<tbody>
<tr>
<td>Well defined symmetrical and large scaly plaques, predominantly on extensor surfaces but can be generalised</td>
<td>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:</td>
<td>1. Review adherence 2. Consider other therapies such as tar products (e.g. Exorex Lotion®), Tazarotene (Zorac®) or Dithranol (e.g. Micanol®). See <a href="http://www.pcds.org.uk">www.pcds.org.uk</a> for more details. During remissions improvement should be sustained with emollients and by using less frequent active topical treatment, for example, weekend therapy.</td>
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<tr>
<th><strong>Scalp Psoriasis</strong></th>
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<td>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</td>
<td>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 overnight. 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® Aphrosyl® 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</td>
<td>1. Stop smoking 2. Early referral important for hand and foot PUVA/Actretin 3. Nails: Practical tips – keep nails short, use nail buffers Nail varnish and gel safe to use Trickles potent topical steroid scalp application or apply Dovobet gel under the onycholytic nail</td>
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<th><strong>Flexures &amp; Genitalia</strong></th>
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<tr>
<td>Erythematous patches, shiny red, and lack scale. Commonly mistaken for candidiasis</td>
<td>Eumovate cream or Ointment Daktacort Silkis</td>
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