What is psoriasis?

Psoriasis is a common and usually long-term (chronic) condition that can appear at any age, although most commonly arises between the ages of 15–25 and 50–60 years old. There are several types of psoriasis that can affect your skin, scalp, and nails in different ways.

Psoriasis can also affect the joints (psoriatic arthritis), mental health, and in moderate to severe psoriasis, increases the risk of heart disease and stroke. Uncommonly, psoriasis can be associated with inflammatory bowel disease (Crohn's disease and ulcerative colitis) and inflammation of the eye (uveitis).

What does psoriasis look and feel like?

In some people psoriasis can be itchy.

The most common type of psoriasis is **chronic plaque psoriasis**, with well-defined (i.e. easy to draw around) slightly raised pink-red plaques with silvery-white scales. In skin of colour the plaques can be darker than the surrounding skin, and the scales grey. Many people have just a few plaques that are several centimetres in diameter **(large plaque psoriasis),** usually present on the knees, elbows, trunk, scalp, ears and between the buttocks. Some people have many plaques covering large areas of their body. A variation is the presence of many smaller scaly plaques (**small plaque psoriasis**).

Genital involvement is not uncommon and must be brought to the attention of your health professional as treatment can help.

Nails can be involved, and sometimes this is the only sign of psoriasis. Nail changes include small indentations (pitting) of the surface, separation of the nail plate from the nail bed (onycholysis), pink areas of discolouration under the nail, thickening and yellowing of the nails, and complete nail destruction.

Other types of psoriasis include:

- **Flexural psoriasis** – sore, red, shiny patches of skin in the body folds (armpits, groin and under the breasts). This can be part of chronic plaque psoriasis, or be the only feature

- **Guttate psoriasis** – this is sometimes confused with small plaque psoriasis, although its' appearance and behaviour differ. It is often caused by a bacterial throat infection (Streptococcus), presenting with very many small drop-like lesions over the trunk and limbs. The lesions are raised, and initially there may be little scale. The lesions usually fade over a few months but can recur. Some

people with guttate psoriasis go on to develop other types of psoriasis

- **Hand and foot psoriasis** – can present in 3 ways. It can be part of chronic plaque psoriasis, or present with thickened scaly plaques on the palms and heels/soles (hyperkeratotic psoriasis), or arise as many painful small brown and yellow spots on the soles and sometimes the palms (palmoplantar pustulosis)

- **Generalised pustular psoriasis** – a rare type of psoriasis where the plaques on the trunk and limbs are studded with tiny yellow pus-filled spots. It can be localised (affecting a small area) or generalised (affecting most of the body) and can flare rapidly, requiring hospital admission

- **Erythrodermic psoriasis** – a rare form of psoriasis that affects nearly all the skin and sometimes require hospital admission

Psoriasis in children

Psoriasis can present less commonly in children; it **may have a different appearance**, and sometimes the diagnosis only becomes clear over time. Clues to the diagnosis include any two of the following:

- Scale and redness in the scalp involving the hairline
- Redness and scale inside the opening of the ear canal (external auditory meatus)
- Persistent well-demarcated (can easily draw around) patches/plaques anywhere on the body
- Persistent skin changes in the umbilicus
- Scaly plaques on the outside of the elbows and/or knees
- A well-demarcated persistent rash in the napkin area involving the skin folds
- Family history of psoriasis

What causes psoriasis?

Both inherited (genetic) and environmental factors play a role.

People with psoriasis have an increased production of skin cells. Skin cells are normally made and replaced every 3-4 weeks, but in psoriasis this process only takes about 3-7 days. The resulting build-up of skin cells is what creates the scaly plaques associated with psoriasis.

Although the process is not fully understood, inflammatory cytokines play a vital role in the behaviour of psoriasis – these are small proteins produced by nearly every cell to regulate and influence the body's immune response.

Psoriasis can run in families, so if you have a family member affected then you are more likely to have psoriasis, although the exact role genetics plays in causing psoriasis is unclear.

What else may also contribute to psoriasis?

In many cases, psoriasis may become worse because of certain triggers, including:

- **Stress** is strongly associated with psoriasis
- Moderate-large amounts of **alcohol** consumption may aggravate psoriasis and make it more difficult to treat
- **Obesity and smoking** are associated with a poorer response to treatment. Smoking is also associated with palmoplantar pustular psoriasis
- **Pregnancy** – if psoriasis alters it is more likely to improve in pregnancy but get worse after delivery (postpartum)
- **Medications** – a wide range of drugs are known to affect psoriasis. The most notable associations include lithium and certain anti-malarials such as hydroxychloroquine. Beta-blockers and non-steroidal anti-inflammatory pain killers (NSAIDs) such as ibuprofen occasionally make psoriasis worse
- **Infection** – streptococcal infection can trigger guttate psoriasis. HIV infection can cause severe psoriasis and/or psoriasis that is hard to control. In such cases, always ask for an HIV test, HIV infection can be successfully treated if diagnosed early
- **Skin injury** – psoriasis may occur at sites of previous trauma to the skin (this is called the 'Köebner phenomenon')
- In moderation, **sunlight** often improves psoriasis, although in a few people it can make it worse
- Psoriasis is **not contagious** (i.e. it cannot be spread from person to person)

Things you can do to help yourself

- Given that psoriasis can affect the body in many ways, **self-care** should be an essential part of your daily life. It involves taking responsibility for your own health and wellbeing, with support from those involved in your care. Self-care includes staying fit, **maintaining good physical and mental health**, limiting alcohol intake, stopping smoking, preventing illness or accidents, and caring more effectively for minor illnesses and long-term conditions. **People with long-term conditions can benefit enormously from self-care** - they can live longer; have less pain, anxiety, depression, and fatigue; have a better quality of life; and be more active and independent

- **Avoid soaps** and anything else that can irritate the skin. An emollient cream (moisturiser) can be used to wash the skin instead, although care must be taken

as these will make the shower/bath slippery and are best avoided in the bath or shower if you have poor balance and/or are more at risk of breaking a bone

- Applying an **emollient regularly** can make the skin more comfortable and reduce the amount of scale

- Careful and moderate exposure to **sunlight** help most people with psoriasis – **however**, **regular sunlight (or sunbed) exposure should NOT be used** to control your psoriasis as this will damage your skin (causing more wrinkles) and increase your risk of skin cancer. If you are using sunlight/sunbeds regularly you must inform your health professional who can refer you if needed for effective and safer treatment

- See your **pharmacist** and ask about treatments for the skin and scalp that can be purchased without a prescription. If you pay for your prescriptions, ask about a pre-payment certificate

Make an appointment at your GP surgery

Although there is no cure for psoriasis, there is much that can be done to improve and manage most cases of psoriasis, so if you need help make an appointment at your GP surgery.

Treatment options provided by your health professional are primarily **topical treatments (applied directly to the skin and scalp)**.

For information on **specific treatments** refer to the ***Best Practice Concise Guidelines*** or the **A-Z list of Clinical Conditions** from the homepage of www.pcds.org.uk.

Unfortunately, **nail psoriasis** is more difficult to treat, however, should the nails be severely affected, then you can be referred to a specialist as there may be suitable stronger treatment options.

It's important to continue to **use your treatment as prescribed**.

Because psoriasis is usually a long-term condition, you may be in regular contact with your healthcare team, and if you have moderate-severe psoriasis you will need a '**cardiovascular**' check-up at least once a year to help reduce your risk of associated heart disease and stroke.

Psoriasis affecting the joints

Some people with psoriasis develop **psoriatic arthritis**, which causes inflammation in your joints and/or spine, with pain, swelling, redness (erythema), warmth, and

prominent morning stiffness (lasting morning than an hour) as well as prolonged stiffness after rest. It can also cause painful heels.

If you think that you have inflammatory arthritis it is important to let a **health professional know as soon as possible** – the longer it is left untreated the more the joints may be irreversibly damaged.

Your mental health

Psoriasis can have a significant psychological impact and may affect many areas of daily life including work and personal relationships. If the psoriasis is affecting your mental health, you should discuss this with a health professional.

Referral to a specialist

The following groups of people may need to be referred to a specialist, who will usually be a Dermatologist, or in cases of psoriatic arthritis, a Rheumatologist:

- Where the diagnosis is unclear
- Moderate-severe psoriasis of the skin or scalp not responding adequately to treatment
- More severe cases of nail psoriasis

You may be given a choice of where to be referred. It is usually better to choose **somewhere closer to home** as some of the prescribed treatments will need frequent follow-up appointments for monitoring, especially in the initial stages of treatment.

What will happen when you are referred?

The appointment may be face-to-face (the person attends the clinic), or a video call (teledermatology).

Treatment options include alternative topical treatments (creams, ointments, gels), a course of light treatment (phototherapy), oral medications (tablets) including some that lessen the immune reaction in your skin (immunosuppressive drugs), and injections.

Please take to your appointment a list of the treatments that you are currently using (and have used) for your psoriasis, as the specialist may not otherwise know.

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Can psoriasis be cured?

Unfortunately, there is no cure for psoriasis and complete clearance may not always be possible. However, there are many effective treatments available to control your psoriasis. Spontaneous clearance of psoriasis is uncommon.

Other helpful resources for psoriasis

- The Psoriasis Association at https://www.psoriasis-association.org.uk/

CAUTION: this leaflet mentions 'emollients' (moisturisers). When emollient products come into contact with dressings, clothing, bed linen or hair, there is a danger that a naked flame or cigarette smoking could cause these to catch fire. To reduce the fire risk, patients using skincare or haircare products are advised to be incredibly careful near naked flames to reduce the risk of clothing, hair or bedding catching fire. Cigarette smoking (and being close to people who are smoking) should be avoided.

Helping with other skin conditions

If you, a family member, or friend have an undiagnosed skin condition; or you want to learn more about how to treat skin conditions, please visit www.pcds.org.uk – if you click the purple tile near the top of the homepage that reads ***Take a Tour*** you can learn how best to use this website.

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