NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

Dermatology

Psoriasis

General Points

- Well defined patches with silvery scales in chronic plaques.
- Mild to moderate psoriasis can usually be managed in primary care.
- Psoriasis may worsen (sometimes months after) the introduction of some drugs e.g. non-cardioselective B-blockers, NSAIDs, ACE inhibitors, lithium, antimalarials i.e. chloroquine based Rx. Alcohol excess can also exacerbate psoriasis.
- Remember it is an independent risk factor for cardiovascular disease, anxiety and depression.
- Adherence to treatment is low and only just over 50% even in clinical trials – try to consider cosmetic acceptability, side effect profiles, formulation and practicalities of application. Patient preference needs to be discussed and aims of treatment.
- There is often a positive family history. Generally improves with **gentle** sun exposure. It is common, affecting 1-2% of the population.
- **Note:** Severe psoriatic patients often have higher cardiovascular comorbidity e.g. increased BP, increased insulin resistance or cholesterol - consider screening for these and advise accordingly.
- Smoking, hypertension and obesity should be addressed and treated as it will impact on their general health as well as possibly ability to treat psoriasis with 2nd line treatments.

Exclude Red Flag Symptoms

- Erythroderma - development of generalised erythema with risk of heat and fluid loss.

Management

- See BNF for additional prescribing information.
- Generous emollients for all– may be all that's required for mild disease. Reduces flaking which can be one of the worst symptoms for patients. Use as soap substitutes and as leave-on emollients.
- **Chronic Plaque Psoriasis**
    - Topical treatment options are: vitamin D analogues +/- steroid, tar, dithranol.
    - There isn't a large difference in the effectiveness of each though tolerability and effectiveness varies between individuals. Effectiveness can also change over time.
    - Treat in a stepwise approach
      Step 1 – emollients
      Step 2 –calcipotriol (Dovonex)
      Expect gradual improvement over 12 weeks
      Can be used long term or intermittently
      Most patients will achieve flattening and partial clearance of plaques
      If irritating then calcitriol / tacalcitol are better tolerated
      Can be used on face and flexures if tolerated in these sites
      Step 3 - Dovobet gel (calcipotriol + betamethasone) –assess response after 2months; possibly intermittent treatment e.g. weekends only to maintain progress.

Also longer term Rx for up to 1 year may be required. Refer if needed most days at 1 year stage.

- Other treatments may suit some patients better:
  1. Tar preparations
  Refined tar products are less smelly and messy than old unrefined preparations. May stain baths, clothes or irritate. Expect slow response over 6 – 12 weeks.
  E.g. psoriderm, sebco (see prescribing information in scalp psoriasis below), exorex lotion.
  Apply away from flexures twice daily.
  2. Dithranol preparations
  Can be used as 'short contact therapy' at home, away from face, flexures and genitals.
  Start with the lowest strength, applied daily to plaques for 15–30 minutes only, then wash off. Increase through strengths weekly unless irritancy occurs. May stain towels, bath etc.
  Prescribe a range of strengths on same prescription:
  e.g.
  • Dithrocream 0.1%
  • Dithrocream 0.25%
  • Dithrocream 0.5%
  • Dithrocream 1.0%
  • Dithrocream 2.0%
  as this counts as one prescription item so only one prescription charge.

- **Guttate Psoriasis**
  - Numerous small lesions mostly on trunk of children / young adults. Often self limiting over 3-6 months. Often follows a Strep B throat infection-treat with penicillin if throat symptoms persist.
  - Treat with emollients plus trials of tar preparations, Vitamin D analogues or moderate potency steroid e.g. Eumovate
  - If severe, refer early for phototherapy-must be able to attend 3 times a week for 6-8 weeks.
- **Scalp Psoriasis**
  - Generally requires combination of keratolytic and anti-inflammatory agents.
  - Initially: tar based shampoo, e.g. Polytar, Alphosyl or Capasal plus-massage in to scalp and leave on for a few minutes; Calcipotriol scalp solution
  - If very itchy a topical steroid/combination Rx could be substituted e.g. Dovobet gel, clobetasol shampoo e.g. Etrivex (leave on for 15mins before rinsing off).
  - In more severe cases use keratolytic e.g. sebco scalp ointment (or Cocois ointment) massaged in and left for 1 hour (if tolerated and necessary use for 2-4hours and gradually extend contact time over 2 weeks up to overnight), washed out with tar based shampoo.
  - plus topical potent steroid if required e.g.
    Betacap or
    Diprosalic (= Betamethasone + Salicylic Acid)
  - Apply once daily for up to 2 weeks
- **Flexural Psoriasis**

  - Characterised by smooth “beefy red” well demarcated areas in axillae, groins, inframammary folds and natal cleft. May occur alone or with chronic plaques elsewhere.
  - Use mild to moderate potency steroids possibly combined with antibiotic/antifungals e.g. Trimovate cream, canesten HC or plain topical steroid
  - Apply once to twice daily. Often only partial response achievable
  - Nonirritant Vit D analogue e.g. Silkis cream
- **Nails**
  - There is no very effective treatment for psoriatic nail disease except for potent medication such as methotrexate and Infliximab used in severe painful disease.
  - Topical dovobet can be tried at the nail fold stroking it underneath the skin and at nail free edge. Also topical betamethasone eye/ear drops can be tried if onycholysis is present.
  - Exclude fungal infection with mycology samples
- **Pustular Psoriasis**
  - Sterile pustules on palms and soles. Pustules become brown when resolving.
  - Needs strong topical steroid to treat, often dermovate. Consider adding occlusion if necessary i.e. clingfilm around feet after application of dermovate, plastic gloves on hands. Occlusion increases the effectiveness considerably so watch for side effects.

Referral Information

Information to include in referral letter

- Extent and location of disease, treatments tried already and their effect, alcohol consumption, effect on quality of life.
- Relevant past medical/surgical history
- Current regular medication
- BMI/Smoking status

Investigations prior to referral

- Skin scrapings and nail clippings if diagnostic doubt.

Referral Criteria

- Extensive/severe or disabling psoriasis.
- Failure to respond to adequate treatment or rapid relapse post treatment. Trial of at least 3 different treatments for plaque (in addition to emollients) and scalp psoriasis before referral, each needs correct application and at least 8 weeks of Rx to achieve significant improvement.
- Extensive acute guttate psoriasis and willing to undergo phototherapy-see above.
- Unstable, generalized or uncontrolled pustular psoriasis.
- For patient education by nurse practitioner on how to apply topical treatment-specify in letter.
- Children

Patient information leaflets/ PDAs

- http://www.psoriasis-association.org.uk for patient information including section for young people.

- http://www.patient.co.uk/health/psoriasis for PIL

References

- Psoriasis and its management – clinical review BMJ 2006;333:380
- http://www.dermnetnz.org/topics/psoriasis/