Psoriasis

Psoriasis – Primary Care Treatment Pathway

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What is Psoriasis?

Psoriasis is a chronic, relapsing, inflammatory condition affecting the skin, scalp, nails, flexures 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 salmon red plaques with silvery scales. In skin of colour, plaques may be violaceous or hyperpigmented and scale more greyish

It can be excellently controlled. The aims of treatments are to minimise skin manifestations, co-morbidities, and improve quality of life

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

Examine the skin, hands and feet, and check scalp & nails, and specifically ask about, and assess if appropriate, genital sites (patients often downplay involvement).

Screen for joint involvement. Use the PEST tool (QR code for PEST)

Screen for cardio-metabolic risks (use QRISK 3 or equivalent) and ask about smoking and alcohol consumption

Explore wellbeing (e.g. "how are you coping?") and use DLQI for a baseline score (QR code for DLQI)

PEST

DLQI

Management

Explore expectations and discuss topical therapy treatment options

Emphasise benefits of lifestyle modifications and provide support

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

Use DLQI to monitor treatment response

Lifestyle Directed Advice

Lifestyle modifications, 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 or prone to burning, as this risks skin cancer

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 (admit to hospital) 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 or DLQI remains higher than 10 despite treatment
- Refer to Rheumatology if psoriatic arthritis is suspected (PEST >3)

Secondary Care

Treatments available in Secondary Care:

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

Other Information

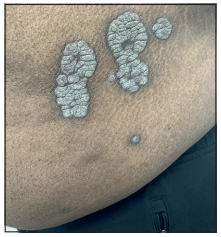
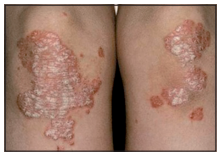
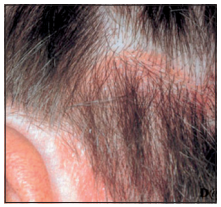
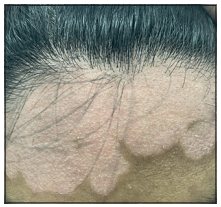
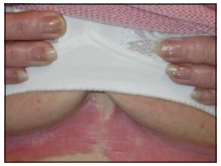
Reduce costs of multiple prescriptions by advising a pre-payment certificate

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

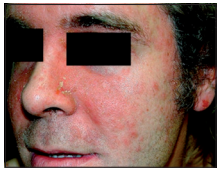
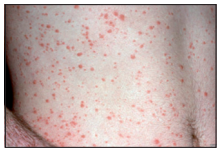
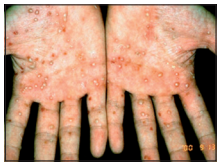
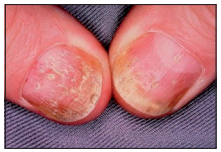
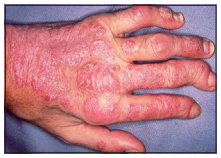
Psoriasis

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** A calcipotriol/betamethasone combination should be used first line, once daily, until plaques 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 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, 4. 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 Sebco Ointment® – massaged onto the scalp generously and ideally left over night. Wash out with Capasal® or Dercos-DS® shampoo. Continue to use until the scale becomes much thinner 2. Ongoing inflammation should be treated with a calcipitriol/betamethasone combination daily. Review at 4 weeks and once controlled, consider twice weekly application for maintenance. Alternatives are Synalar Gel® if not particularly scaly, or Diprosalic® scalp application if scale remains problematic 3. Maintenance therapy: Once or twice weekly tar-based shampoo such as Capasal® or Dercos-DS®, with once or twice weekly potent topical steroids. If the scale thickens then revert to Sebco® ointment in short bursts
Flexures & Genitalia 	**Clinical Features** Erythematous patches, shiny red,and lack scale. Commonly mistaken for candidiasis	**Treatment** • Mild or moderate topical steroid, such as 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 mild or moderate topical steroid. Once the skin is under control, use the steroid twice weekly to keep under control • A topical vitamin D 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

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

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 • Tacrolimus 0.1% (or pimecrolimus, if cream preferred) – once or twice a day and reduce to twice a week when controlled) • Silkis® ointment – can cause irritation so introduce gradually (initially twice a week then build up to daily)
Guttate Psoriasis 	**Clinical Features** • Rapid onset of 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, a calcipitriol/betamethesaone combination 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** Pitting, hyperkeratosis and onycholysis **NB.** Look for arthritis and co-existing fungal infection. Oral Terbinafine may aggravate psoriasis	**Treatment** • Practical tips – keep nails short, use nail buffers. Nail varnish and gel safe to use • Use Enstilar® foam, sprayed on the palm, and fingertips rubbed in the mousse to get under the onycholytic nails and around nail folds for 2-3 minutes. Repeat for other hand, and can be performed for toenails (exclude fungal nail disease). Perform daily for at least 3 months before assessing response. Continue if helping
Psoriatic Arthritis 	**Clinical Features** Inflammatory polyarthritis, spondylarthritis, synovitis, dactylitis and tendonitis	**Treatment** Psoriatic arthritis is under-recognised and it is important that, if suspected, refer 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**

Calcipitriol/betamethasone combination products are available as ointments and gel (Dovobet® ointment and gel), foam (Enstilar® foam), and cream (Wynzora® cream). Choose the formulation that the patient will comply with, e.g. foam, gel or cream for scalp; foam, or cream for nails; and any formulation for trunk and limb psoriasis. For specific advice on scalp application and Enstilar, see manufacturer website for instructions on how to wash out. Total usage of any formulation should not exceed more than 30% body surface area or more than 15g a day