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 topical treatment algorithm – ADULTS

Emollients help reduce scaling and associated itch. Choose one in line with West Essex Emollient Guidelines and formulary website link

Trunk and limbs

Offer a potent topical steroid e.g. betamethasone 0.05% & vitamin D preparation e.g. calcipotriol applied separately ONCE daily (one in the morning and the other in the evening) for up to 4 weeks[1]#

If unsatisfactory control, consider:

- Review adherence
- 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)
- Coal tar preparation e.g. Exorex lotion* for thin or widespread plaques

If the patient does not respond to the above, cannot use twice daily treatments and once daily treatment would improve adherence, offer calcipotriol/betamethasone (Dovobet®ointment or gel, Enstilar® foam) combination product daily for 4 weeks#

If ineffective after ↓ maximum of 8 weeks treatment

Offer vitamin D or a vitamin D analogue alone applied twice daily

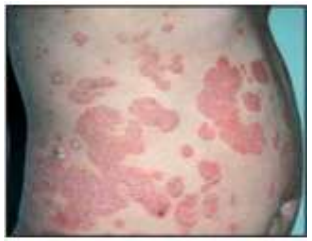
If ineffective after ↓ 8 to 12 weeks treatment

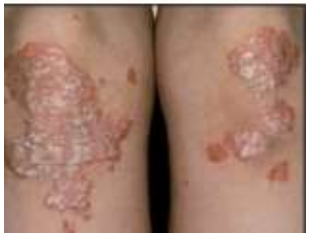
Offer either a potent corticosteroid applied twice daily for up to 4 weeks# or a coal tar preparation applied once or twice daily.

↓

If these cannot be used or require once daily product to aid adherence betamethasone 0.05% & calcipotriol applied ONCE daily for up to 4 weeks# (Dovobet®ointment or gel, Enstilar® foam)

Patients are likely to need to use treatment intermittently on an ongoing basis so do not stop prescribing effective treatments after initial 4 weeks. During remissions improvement should be sustained with emollients and by using less frequent active topical treatment, for example, weekend therapy. Dithranol cream is an alternative therapy.





Well defined symmetrical small and large scaly plaques, predominantly on extensor surfaces but can be generalised

REFER adults not controlled on topical treatment to secondary care for further treatment options (phototherapy and/or systemic treatment)

1). Psoriasis: assessment and management NICE CG 153 Oct 2012

Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids. Consider non-steroid based products (coal tar, vit D/ vit D analogues) as needed to maintain control of psoriasis during this period.

Scalp

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 A common mistake is to use anti-inflammatory treatment without first ensuring scaling is treated, enabling anti-inflammatories to reach scalp

Treating scale: Preparations to remove thick adherent scale e.g. Sebco® ointment, Cocois® ointment, shampoo off after one hour or can be left overnight to allow extra time for the treatment to work, then washed off in the morning. Continue to use until the scale becomes much thinner. A comb can be used to ease off and gently remove some of the scale. This treatment will need to be used on an ongoing basis depending on the degree of scalp scaling.
Tar based shampoos e.g. Capasal® or may reduce mild scaling and itch/irritation but will not treat thick adherent scale. These should generally be used once-twice weekly.

Treating redness/inflammation: Try a potent steroid e.g. betamethasone or mometasone scalp application, Synalar Gel®as a scalp application daily for 4 weeks, then as needed on an ongoing basis.

If ineffective after ↓ 4 weeks consider

A different formulation e.g. Bettamousse®

If ineffective after ↓ 4 weeks consider

A combined product containing calcipotriol & betamethasone e.g. Enstilar® foam or Dovobet Gel®, initially daily for 4 weeks#, then as needed on an ongoing basis or vitamin D or a vitamin D analogue alone applied ONCE daily for 8 weeks (only if cannot use steroids and mild/moderate psoriasis)

If ineffective after ↓ treatment duration consider

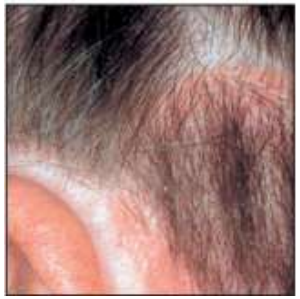
Very potent corticosteroid, Etrivex® shampoo, Dermovate® scalp application TWICE daily for 2 weeks# or coal tar ONCE or TWICE daily or referral to a specialist for support and advice

Treat ongoing inflammation with:

- Potent topical steroids such as Synalar Gel ® or Diprosalic® scalp application applied at night
- Dovobet® Gel

Maintenance therapy:

- Once or twice weekly tar based shampoo such as T-gel®, Capasal®, Alphosyl® or Polytar®
- Once to twice weekly potent topical steroids as above or more frequently if needed



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

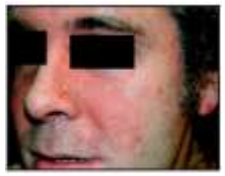
Face, flexures and genitals

Offer a short-term mild or moderate potency corticosteroid applied ONCE or TWICE daily (for a maximum of 2 weeks#)

If ineffective or continuous treatment and serious risk of steroid-induced required to maintain control local side-effects consider

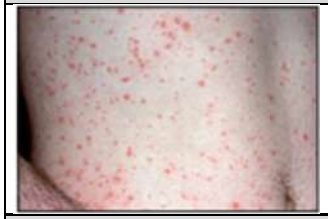
Calcineurin inhibitor* tacrolimus or pimecrolimus, TWICE daily for up to 4 weeks
Calcineurin inhibitors should be initiated by healthcare professionals with expertise in treating psoriasis

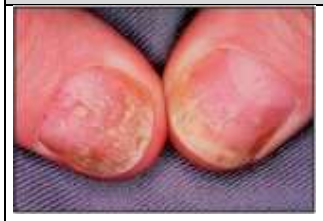
REFER adults not controlled on topical treatments to secondary care for further treatment options (phototherapy and/or systemic treatment)

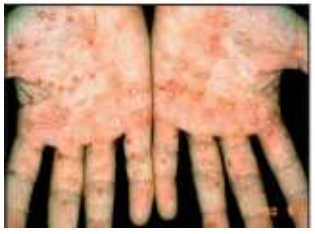
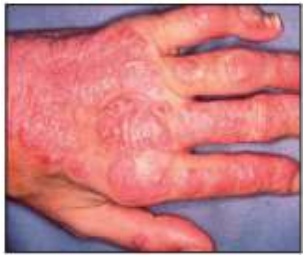


An uncommon and distressing site sometimes with plaques but more often similar to that seen in seborrhoeic dermatitis

Erythematous patches, shiny red and lack scale.
Commonly mistaken for candidiasis

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

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

Palmoplantar Pustula	Clinical features	Treatment	Psoriatic arthritis	Clinical features	Treatment
	Very resistant and difficult to treat. Creamy sterile pustules mature into brown macules	Stop smoking Potent corticosteroid 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		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