Recommendations for the initial management of psoriasis

• British Association of Dermatologists & Primary Care Dermatology Society •

- Psoriasis affects 1–2% of the population of the United Kingdom; there is often a positive family history. Most cases are mild
- The degree of psychological and social disability that accompanies psoriasis is commonly underestimated by the medical profession and this can result in suboptimal care
- There is no cure for psoriasis, although there are effective suppressive treatments aimed at inducing a remission or making the amount of psoriasis tolerable to the patient
- For the majority of patients, psoriasis follows a chronic course, interspersed with periods of remission. Relapses are difficult to predict
- The physician should make the patient aware of the possible therapeutic options, including the simplest available therapies and the option that treatment may not be necessary
- The patient's perception of his or her disability will often dictate the need for treatment
- To be able to advise the patient on suitable therapies, the physician needs to know the sites, extent and severity of the psoriasis
- Treatment may depend on the patient's age, sex, occupation, personality, general health, understanding and resources
- Most patients with mild or moderate plaque psoriasis can be treated in primary care using topical therapies
- If the decision is made to refer (see 'referral') treatment should usually be initiated while awaiting a clinic appointment
- Most patients with uncomplicated psoriasis will only require referral in the instance of treatment failure

Clinical features

- The diagnosis of psoriasis is clinical, and laboratory investigations are unhelpful
- There are several forms of psoriasis, and the type affecting an individual may change over time. The sites and extent of involvement can range from trivial to almost total coverage
- Psoriasis can change from stable plaques to an unstable form, typified by eruptive inflammatory lesions that are easily irritated by topical treatment
- Drugs thought to precipitate or worsen psoriasis include β-adrenoceptor blocking drugs and NSAIDs. Oral administration of lithium, chloroquine or mepacrine may be associated with severe deterioration of psoriasis. Alcohol may worsen psoriasis and may interfere with treatment in various ways
- Assessment of severity should include the patient's own perception of disability, the need for treatment, and an objective assessment of the extent and severity of the disease
  - the total area of involvement is a factor in assessing severity, but is difficult to estimate accurately
- Management should take the patient's views into account. It is helpful to record the patient's views of the most upsetting aspect of his or her psoriasis. Management strategies can then be directed appropriately within therapeutic limitations based on the risk:benefit ratio

Initial presentation

- Basic information about psoriasis and its management should be provided

- To help patients come to terms with what is, for many, a lifelong condition, great efforts should be made to improve communication during consultations and to educate patients

- Patients should have a plan of management, including the therapeutic options for the treatment of their psoriasis at each site involved, and verbal and written information on the probable benefits, and possible side-effects, of each therapy, enabling them to make an informed decision about the treatment

- Ideally, practical demonstrations of the application of treatment should be offered by appropriately trained members of a primary healthcare team

- Points to discuss at initial presentation:
  - explanation of psoriasis, including reassurance that it is neither infectious nor malignant
  - treatment options (including no active treatment)
  - the probable benefit the patient can expect from treatment
  - techniques of application of any topical treatment (especially important with dithranol and scalp preparations)
  - an introduction to patient support groups may be helpful, e.g. the Psoriasis Association (7 Milton Street, Northampton NN2 7JG ☎ – 01604 711129) and the Psoriatic Arthropathy Alliance (PO Box 111, St Albans, Herts AL2 3JQ ☎ – 0870 770 3212)

Treatment of chronic plaque psoriasis

- Emollients should be used to soften scaling and reduce any irritation

- For **localised plaque psoriasis**, e.g. on the elbows or knees, one or more of the following topical preparations can be tried. The sequence of choice will vary according to the extent and pattern of psoriasis, and patient preference:
  - a tar-based cream, or a tar/corticosteroid mixture (most are relatively mild; stronger tar preparations tend to be messy)
  - a moderate potency topical corticosteroid (e.g. 0.05% clobetasone butyrate); stronger agents can be used on palms and soles or on the scalp
    - use of topical steroids may lead to rebound exacerbation when treatment is discontinued
  - a vitamin D analogue (e.g. calcipotriol, calcitriol or tacalcitol – the latter two tend to be less irritant and are more suitable for face or flexures, but should still be used with caution)
  - calcipotriol with betamethasone dipropionate as a combination product (note that long term data regarding relapse rates is not yet established)
  - a vitamin A analogue (tazarotene)
  - a dithranol preparation, usually used as a short-contact treatment (these are effective but more difficult to use, especially if there are many small lesions)

- For more **widespread plaque psoriasis**, e.g. on the trunk or the limbs, the same treatments may be appropriate. However, dithranol is often impracticable to apply to multiple small lesions and will irritate flexures. Topical corticosteroids may be inappropriate for use in widespread psoriasis, particularly more potent agents if used on a long-term basis. Application of treatment by appropriately trained nurses may overcome these problems in some cases

- For **scalp psoriasis** a tar-based shampoo should be tried first; this can be combined with the use of either a 2–5% salicylic acid preparation, a coconut oil/tar/salicylic acid combination ointment, a potent topical corticosteroid preparation (e.g. 0.1% betamethasone valerate), calcipotriol scalp application, or more than one of these
  - it is important to use a keratolytic agent (e.g. 5% salicylic acid in aqueous cream)

first when there is significant scaling, or other treatments will fail. Keratolytic creams should be applied for a few hours or overnight. A different treatment for day- and night-time is a useful approach

- In **palm and sole psoriasis**, as for the scalp, both hyperkeratosis and inflammation are usually present and may require separate treatments. Hyperkeratosis usually needs to be treated with a keratolytic agent. Topical steroids (usually potent, due to the thick skin at this site), tars and vitamin D analogues may all be useful

- In general, milder agents are used for **flexures**. These include low potency topical steroids, mild tar preparations, and tacalcitol or calcitriol (not calcipotriol, this is usually irritant in flexures)

- In **facial psoriasis**, use mild agents: emollients, mild corticosteroids, calcitriol, tacalcitol, mild tars

Referral

- Those patients with extensive disease who need secondary care treatments such as systemic treatment or phototherapy will normally be under the supervision of a consultant dermatologist because of the potential adverse effects of these approaches

- The dermatologist will also be involved in the care of difficult cases where the site or unresponsiveness of the rash are important factors

- Indications for consultant referral:
  - diagnostic uncertainty
  - request for further counselling and/or education including demonstration of topical treatment
  - failure of appropriately used topical treatment for a reasonable time (e.g. 2–3 months)
  - extensive disease, if unresponsive to initial therapy or difficult to self-manage
  - need for increasing amounts or potencies of topical corticosteroids
  - involvement of sites which are difficult to treat, e.g. face, palms and soles, genitalia, if unresponsive to initial therapy
  - need for systemic therapy, phototherapy (e.g. guttate psoriasis), day treatment or inpatient admission
  - generalised erythrodermic or generalised pustular psoriasis (emergency referral is indicated); acute unstable psoriasis (urgent referral may be justified)
  - adverse reactions to topical treatment
  - occupational disability or excessive time off work or school

- Content of the referral letter
  - the reason for referral and what is hoped to be gained from the consultation
    - the consultant should try to address these issues in reply
  - the patient's present therapy, if any, its duration, and quantity being used
  - information on previous therapy, including responses or side-effects
    - a treatment could be mistakenly recorded as ineffective when the real problem was under-treatment or incorrect use of the prescribed treatment, or discontinued as unsuitable when transient side-effects could have been overcome had more advice been given
  - any relevant background information, including the patient's general health and current medication
  - the patient's home circumstances; important because the patient's ability to apply topical therapies at affected sites may be compromised, affecting treatment choice

full guideline available from…
British Association of Dermatologists, http://www.bad.org.uk/

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