National Institute for Health and Clinical Excellence

Stakeholder comments proforma – engagement exercise for quality standard on Psoriasis

Please enter the name of your registered stakeholder organisation below. NICE is unable to respond to comments from non-registered organisations or individuals. We recommend that organisations register as a stakeholder on the NICE website or individuals contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.	
Stakeholder organisation:	British Association of Dermatologists
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Would you like to express an interest in being an endorsing partner for this quality standard? Yes	

Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Separately list each key area for quality improvement that has supporting evidence that you would want to see covered by this quality standard. ***EXAMPLE: Pulmonary rehabilitation for chronic obstructive***	*EXAMPLE: There is good evidence that appropriate and effective pulmonary rehabilitation can drive significant improvements in the quality of life and health status of people with COPD. Pulmonary rehabilitation is recommended within NICE guidance. Rehabilitation should be considered at all stages of disease progression when symptoms and disability are*	*EXAMPLE: The National Audit for COPD found that the number of areas offering pulmonary rehabilitation has increased in the last three years and although many people are offered referral, the quality of pulmonary rehabilitation and its availability is still limited in the UK.* *Individual programmes differ in the precise exercises used, are of different duration, involve variable amounts of home exercise and have different referral criteria.*	*EXAMPLE: Please see the Royal College of Physicians national COPD audit which highlights findings of data collection for quality indicators relating to pulmonary rehabilitation. http://www.rcplondon.ac.uk/resources/chronic-obstructive-pulmonary-disease-audit*

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pulmonary disease (COPD)	*present. The threshold for referral would usually be breathlessness equivalent to MRC dyspnoea grade 3, based on the NICE guideline.*		
1. Routine measurement of psoriasis severity – PASI score by dermatologists and an estimation of surface area affected and degree of inflammation (mild/moderate/severe) by general practitioners	The management of psoriasis is largely governed by the extent and severity of the disease. For example, people with < 3% body surface area (3 palms worth) of psoriasis can usually be managed with topical (cream) treatments whereas patients with > 10% surface area or PASI ≥ 10 may be eligible for a biologic treatment. Measurement of severity enables the response to treatments to be evaluated (e.g. PASI 75 (75% improvement in PASI score) indicated a good response to therapy. Progression from first-line treatments to second-line therapy, and referral to secondary care is determined by disease severity and response to treatment.	It is rare in primary care for an objective measurement of disease severity to be made, and even in secondary care measurement of severity such as using a PASI score may not be routine. Assessment of response to treatment allowing escalation of therapies if necessary, or referral to secondary care may not occur. People with psoriasis therefore may endure an unnecessarily high severity of disease which has a considerable life impact.	Please view guidelines for the management of psoriasis which include recommendations for treatment escalation and referral to secondary care. Psoriasis. The assessment and management of psoriasis NICE clinical guideline 153. http://Guidance.nice.org.uk/cg153 Diagnosis and management of psoriasis and psoriatic arthritis in adults. Oct 2010 www.sign.ac.uk British Association of Dermatologists' guidelines for biologic interventions for psoriasis 2009. Smith CH et al.Br J Dermatol. 2009 Nov;161(5):987-1019.
2. Routine measurement of impact of psoriasis or psychological co-morbidity using a	In keeping with other major long-term conditions, psoriasis has a considerable functional, psychological and social impact. Psoriasis is a highly visible,	The impact of psoriasis is under-recognised by patients and healthcare professionals. Patients with psoriasis are often alexithymic (unable to talk about their emotions), hence it is often difficult for health professionals to pick up on distress. The	Please view evidence on psychological impact of psoriasis, alexithymia in psoriasis and under-recognition of distress by healthcare professionals in people with psoriasis.

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validated tool, e.g. DLQI (Dermatology Life Quality Index) in secondary care and annual screening for anxiety and depression in primary and secondary care again using a validated tool such as HADS (Hospital Anxiety and Depression Score), Patient Health Questionnaire (PHQ-9)	disfiguring skin condition, which impacts relationships, employment, earning potential, quality of life and self-esteem. Unsurprisingly, a third of people with psoriasis experience major psychological distress (anxiety and/or depression), which is often missed by healthcare professionals.	routine use of validated measurement tools such as DLQI, HADS and PHQ-9 would ensure the impact of psoriasis is addressed and appropriate referrals made. Without these measures distress is often unrecognised and people do not receive appropriate interventions.	The contribution of perceptions of stigmatisation to disability in patients with psoriasis. Richards HLet al J Psychosom Res. 2001 Jan;50(1):11-5 Alexithymia in patients with psoriasis: clinical correlates and psychometric properties of the Toronto Alexithymia Scale-20. Richards HL, et al. J Psychosom Res. 2005 Detection of psychological distress in patients with psoriasis: low consensus between dermatologist and patient. Richards HL, et al Br J Dermatol. 2004 Dec;151(6):1227-33
3. Annual screening for psoriatic arthritis with a screening tool such as PEST (Psoriasis Epidemiology Screening Tool) questionnaire in secondary care, or asking about joint pain/swelling/stiffness in primary care	25-40% of people with psoriasis have co-existent psoriatic arthritis. Early treatment of psoriatic arthritis prevents permanent joint damage. Guidelines recommend immediate referral to a rheumatologist if psoriatic arthritis is suspected. Annual screening with a questionnaire such as PEST would identify people requiring referral to a rheumatologist.	Although annual screening for psoriatic arthritis, preferably using a questionnaire tool such as PEST questionnaire is recommended in guidelines, this is not routinely performed and many patients will have established arthritis and joint damage before treatment is instituted. Since psoriatic arthritis usually occurs after psoriasis (mean 10-year lag), even though patients may be asked about joint symptoms on an initial consultation, they may subsequently develop psoriatic arthritis and without annual screening this may be missed.	Please see evidence below for prevalence of psoriatic arthritis, evidence for benefits of early intervention and use of the PEST tool. The prevalence of psoriatic arthritis in people with psoriasis. Ibrahim G et al. Arthritis Rheum. 2009 Oct 15;61(10):1373-8. Do patients with psoriatic arthritis who present early fare better than those presenting later in the disease? Gladman DD et al

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			Ann Rheum Dis. 2011 Dec;70(12):2152-4 Evaluation of an existing screening tool for psoriatic arthritis in people with psoriasis and the development of a new instrument: the Psoriasis Epidemiology Screening Tool (PEST) questionnaire. Ibrahim GH, et al Clin Exp Rheumatol. 2009 May-Jun;27(3):469-74.
4. Screening for co-morbid conditions both in primary and secondary care – screening every 2 years for: • alcohol intake • smoking history • blood Pressure • Body Mass Index • waist circumference • pulse • fasting lipids • fasting glucose	Severe psoriasis is likely to be related to cardiovascular disease and all severities of psoriasis are associated with increased risk factors for cardiovascular disease. Risk factors include obesity, type 2 diabetes mellitus, metabolic syndrome, excess alcohol intake, smoking and hyperlipidaemia.	Assessing cardiovascular risk in patients with severe psoriasis and identifying risk factors in all patients with psoriasis enables preventative advice, healthy lifestyle information and support for behavioural change to be instituted. It also allows for interventions such as lipid lowering agents or anti-hypertensives to be introduced if necessary.	Please see references below for evidence of increased risk factors in patients with psoriasis and increased cardiovascular disease in severe psoriasis. Incidence of risk factors for myocardial infarction and other vascular diseases in patients with psoriasis. Kaye JA, Li L, Jick SS. Br J Dermatol. 2008 Sep;159(4):895-902 Prevalence of metabolic syndrome in patients with psoriasis: a population-based study in the United Kingdom. Langan SM et al J Invest Dermatol. 2012 Mar;132(3 Pt 1):556-62 Risk of myocardial infarction in patients with psoriasis.

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			Gelfand JM, et al JAMA. 2006 Oct 11;296(14):1735-41.
5. Commissioning of multi-disciplinary services to manage moderate-to-severe psoriasis, or mild psoriasis with significant co-morbidity such as severe distress.	Psoriasis is a complex systemic condition with multiple co-morbidities. People with psoriasis may require access to several different healthcare professionals, hence good communication between healthcare professionals, such as within a multi-disciplinary team, is essential to make appropriate management decisions. At present, the specialties involved with managing psoriasis (rheumatology, dermatology, psychology) are often under different management and income streams which can be a significant barrier to forming multi-disciplinary services. Combining or linking a patient pathway for patients with psoriasis and psoriatic arthritis may reduce duplication of tests etc. and number of hospital visits for patients.	At present, only a minority of patients attending supra-specialist (level 4, tertiary) centres have access to multi-disciplinary services. There are wide variations in access to specialist treatments (e.g. biologics), drug monitoring, specialist nurse support, psychological services and rheumatologists. The provision of psychological services within dermatology has reduced over the last 8 years, despite recommendations that it be increased. At present, only 4% of dermatology units have counselling available within departments. The commissioning of multi-disciplinary services, with clearly defined care pathways, will help ensure appropriate screening and monitoring of patients as well as adherence to guidelines. Care pathways can be patchy around the UK (e.g. methotrexate) and this is a major reason why certain drugs are not used optimally.	Please find evidence below for provision of dermatological services and psycho-dermatology services British Association of Dermatologists. Quality standards for dermatology: providing the right care for people with skin conditions. London: British Association of Dermatologists, 2011 Available from: http://www.bad.org.uk/Portals/_Bad/Quality%20Standards/Dermatology%20Standards%20FINAL%20-%20July%202011.pdf

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Closing date: 1 November at 5pm