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Stakeholder Organisation:	Therapy & Guidelines sub-committee, British Association of Dermatologists
Name of commentator:	Jenny Hughes (Chair), Janet Mclelland, Deidre Buckley, Ibrahim Nasr, Tor Swale, Emilia Duarte Williams, Stephen Jones (president of BAD)

Order number *(For internal use only)*	**Document** Indicate if you are referring to the **Full** version or the **Appendices**	**Page Number** **Number only** (do not write the word ópage/pgô). Alternatively write **'general'** if your comment relates to the whole document.	**Line Number** **Number only** (do not write the word ólineô). See example in cell below	**Comments** **Please insert each new comment in a new row.** **Please do not paste other tables into this table, as your comments could get lost – type directly into this table.**
Example	Full	16	45	Our comments are as follows é é
Proformas that are not correctly submitted as detailed in the line above may be returned to you				
1	Full	General		The T& G committee generally felt this was a very thorough, well thought out and well written guideline, however, the main overall comment was that the extreme length of the guideline makes it unworkable. It is suggested that a much shorter summary version be made available, as otherwise we had concerns about whether it could ever practically be used. There were also comments about frequent typos and the need for proofreading. Some judicious editing might help, as the tone especially in the introductory sections is conversational and this adds more length. Some of the sections, e.g. the very detailed methodology/statistics, might be better served in the final version as an appendix.
2	Full	81-203		110 steps in the pathway of a patient with psoriasis are a lot to expect for any health professional managing this condition.
3	Full	204-357		Comments were that there is far too much emphasis on the use of topical corticosteroids. Opinions differ around the country over this matter and that there are already many caveats in the document over their use, but, the use of very potent topical corticosteroids is contraindicated in the management of chronic plaque psoriasis. Reliance on topical corticosteroids as sole therapy, except perhaps in flexures, should be greatly discouraged.

				Further comments were that the basis of managing any patient with psoriasis is to identify the specific problems that patient has in the context of any compounding factors and arriving at a joint decision on the best way forward. The didactic way of recommending treatments both topical and systemic in one particular order in these guidelines is not necessarily compatible with the needs of individuals. A better approach would be to highlight the pros and cons of each treatment and recommend that the clinician arrives at a joint decision with the patient as to the best way forward. For instance, in some patient it may be more appropriate to start with a tar or dithranol preparation rather than a topical steroid/vitamin D analogue. Likewise, depending on the individual patient and the distribution of disease, acitretin may be a more appropriate first-line systemic therapy than methotrexate. It would be difficult to state the "correct order" of treatments for the population of psoriasis patients as a whole ï it has to be bespoke and the guidelines should emphasise this.
4	Full	204	13	Irritation rather than burning.
5	full	273	8	Dithranol studies include only short contact dithranol, not treatment regimes, e.g. Ingrams using dithranol for a longer contact time.
6	full	292	17-21	Agree with these concerns as studies have a short-term (e.g. 4 weeks duration) to look at adverse reactions of skin atrophy etc., and this may take years to occur but if potent topical steroids are proposed as first-line treatment, this may become a significant problem.
7	full	343	10	Grammar; unacceptability of coal tar.
8	full	357	8.12	This may be the correct conclusion from published studies but does not individualise treatment for patients, e.g. in a patient with thick scale, a de-scaling agent should be used from the start. This does not come out in studies where the óstandardô patient is used.
9	full	367-481		Comments were that this is a reasonable section except that the suggestion that PUVA should not be tried on patients who fail with narrow-band UVB except in exceptional cases. With appropriate discussion with the patient PUVA is often tried as a next step. There is confusion in these recommendations between the number of treatments and the cumulative UV dose. It is now normally the number of treatments that is taken into account although both are recorded. The cumulative UVA dose depends on skin type/MPD testing. Twenty years ago recommended PUVA maximums were based on cumulative UVA dose but now numbers of treatments/exposures are used. Might be worth consulting the British Photodermatology Group on this. There are some papers in the literature comparing bath PUVA vs. oral PUVA (Collins P et al., BJD 1992; volume 127: 392-395) even if not the desired quality of evidence may be worth reviewing. We contend the mentioning of specific costs in relation to removing BCC and SCC in primary care, as these are likely to be inaccurate. SCC should not knowingly be removed in

				primary care according to NICE guidelines. Is the stated relative risk of relapse with PUVA vs. narrow-band UVB correct at 1.55? Surely the RR should be less than 1, as relapse is less likely with PUVA than narrow-band UVB ï has this been accidentally reversed? Lindelof and Goeckermann are spelt in a variable way in the text.
10	full	406		The word ñandò is missing from the first complete sentence after pigmentosum.
11	full	440		The word ñatò is missing from the 6th line at the bottom of the page beginning ñpatientsò.
12	full	558-631		This section is well written and there are no specific comments other than the content reflects what most dermatologists know and already do with their psoriasis patients treated with methotrexate.
13	full	632-682		There was an element of repetition regarding the mention of insufficient evidence and poor quality studies, however, the conclusion that it is cost effective to try a second biologic treatment when patients have failed on a first one was fair.