



PSORIASIS – AN OVERVIEW

What are the aims of this leaflet?

The British Association of Dermatologists offers three patient information leaflets on psoriasis. This leaflet has been written to provide you with an overview of psoriasis. It tells you what psoriasis is, what causes it, what can be done about it, and where you can find out more about it. The two other leaflets ([Topical treatments for psoriasis](#) and [Treatment of moderate and severe psoriasis](#)) give more details about the different types of treatment.

What is psoriasis?

Psoriasis is a common skin disease affecting 1 in 50 people. It occurs equally in men and women. It can appear at any age. Psoriasis is a long-term condition which may come and go throughout your lifetime. It is not infectious; therefore you cannot catch psoriasis from someone else. It does not scar the skin although sometimes it can cause a temporary increase or reduction in skin colour. Although psoriasis is a long-term condition there are many effective treatments available to keep it under good control.

Psoriasis can affect the nails and the joints as well as the skin. Psoriatic arthritis produces swelling and stiffness in the joints or stiffness in the lower back and should be managed by a rheumatologist who works closely with your dermatologist and/or your GP.

Psoriasis, particularly moderate to severe psoriasis, is associated with an increased risk of anxiety, depression and harmful use of alcohol. Moderate to severe psoriasis increases the risk of heart disease and stroke and treatment of psoriasis may reduce this risk. Psoriasis can also be associated with diabetes, obesity, venous thromboembolism, high cholesterol and high blood pressure. Psoriasis is also associated with inflammatory bowel disease and there is a small increased risk of skin cancer.

What causes psoriasis?

Both inherited and environmental factors play a role in the development of psoriasis

Skin affected by psoriasis is red and scaly. The outer layer of skin (the epidermis) contains skin cells which are continuously being replaced. This process normally takes between three and four weeks. In psoriasis, skin cells divide more quickly so that cells are both formed and shed in as little as three to four days.

Infections, stress, damage to the skin, alcohol, and sometimes intense sunlight may trigger flares of psoriasis. Certain medications such as beta blockers (used to treat high blood pressure and angina), lithium and some tablets used to treat malaria can also trigger flare-ups of psoriasis. Suddenly stopping some steroid tablets can also trigger or worsen psoriasis. Obesity and smoking are associated with a poor response to psoriasis treatments so exercise and being the correct weight can be beneficial.

Is psoriasis hereditary?

Yes, if you have a family member affected by psoriasis you are more likely to suffer from psoriasis. The way psoriasis is inherited is complex and not completely understood involving many genes.

What are the symptoms of psoriasis?

- Psoriasis may not have any associated symptoms, but it can be itchy and painful. Certain sites such as the scalp, lower legs and groin can be particularly itchy. If psoriasis affects the hands and feet, painful fissures (cracks) can develop and these can affect use of the hands and walking. Severe psoriasis on the body can also develop cracks which are painful and can bleed.
- Psoriasis can affect the nails and lifting away of the nail from the finger can be painful.
- Psoriatic arthritis produces pain, swelling and stiffness in one or more joints, particularly in the morning.

What does psoriasis look like?

The skin changes of psoriasis (often known as *plaques*) are well defined and slightly raised pink or red (can differ in colour depending on your skin colour) areas with silvery-white scales. Many people have just a few plaques but some individuals with moderate to severe psoriasis may have several plaques covering large areas of their body.

Several patterns of psoriasis are recognised:

- **Chronic plaque psoriasis** is the most common type of psoriasis. Plaques of psoriasis are usually present on the knees, elbows, trunk, scalp, behind ears and between the buttocks although other areas can be involved too.
- **Guttate psoriasis** consists of small plaques of psoriasis scattered over the trunk and limbs. It can be caused by a bacteria called Streptococcus which can cause throat infections.
- **Palmoplantar psoriasis** is psoriasis affecting the palms and soles. Psoriasis may appear at other sites too.
- **Pustular psoriasis** is rare type of psoriasis where the plaques on the trunk and limbs are studded with tiny yellow pus filled spots. It can be localised or generalised and can flare rapidly necessitating hospital admission for treatment.
- **Erythrodermic psoriasis** is an aggressive rare form of psoriasis which affects nearly all of the skin and can sometimes require hospital admission for treatment.

Nail psoriasis is present in about half of people with psoriasis. The features of nail psoriasis are:

- Pitting (indentations) and ridging of the surface of the nail;
- Salmon pink areas of discolouration under the nail;
- Separation of the nail plate from the nail bed; and
- Thickening and yellowing of the nails.
- Complete nail destruction.

How will psoriasis be diagnosed?

- Psoriasis is usually diagnosed on the appearance and distribution of the plaques. Skin biopsy is rarely used.
- Psoriatic arthritis is usually diagnosed by a rheumatologist, but your dermatologist or GP may ask you if you have any joint symptoms or ask you to complete a screening questionnaire.

How is psoriasis assessed?

Psoriasis should be assessed at diagnosis, before your first referral to a specialist, every time you see a specialist and to assess your response to treatment. Psoriasis may be assessed by your doctors using a variety of scores which measure the severity in your skin and joints, how psoriasis is affecting your mood and your activities of daily living and whether you are at risk of heart disease.

These scores include the PASI (Psoriatic Arthritis Severity Index – a score that measures the severity of joint symptoms in psoriasis) and DLQI (Dermatology Life Quality Index – a score that measures the impact of psoriasis on your daily activities)

Can psoriasis be cured?

There is no cure for psoriasis and complete clearance of skin lesions may not always be possible. There are several effective treatments available to control your psoriasis. Spontaneous clearance of psoriasis may occur in some people.

How can psoriasis be treated?

Treatment of psoriasis depends upon your individual circumstances. Treatment applied to the surface of your skin (topical treatment) is sufficient alone in most patients. For people with more extensive or difficult to treat psoriasis, ultraviolet light treatment (phototherapy), tablet treatment or injection treatment may be required.

1. *Topical treatments:*

- These include creams, ointments, gels, pastes and lotions. Topical treatments are dealt with in more detail in another of our leaflets ([Topical treatments for psoriasis](#)).

2. *Phototherapy:*

- Phototherapy is ultraviolet light delivered in a controlled way to treat psoriasis. A course of treatment usually takes about 8-10 weeks and will require treatment sessions two to three times a week. This usually means attending a Phototherapy Unit in a hospital.
- Two types of light are used: narrowband ultraviolet B light (nbUVB/TLO1) and ultraviolet A light (PUVA). The latter requires a sensitiser, known as a psoralen that can be taken as a tablet or added to a bath prior to treatment.

Further information on phototherapy is available in the following information leaflets: [Treatments for moderate and severe psoriasis](#) and [Phototherapy](#).

3. *Internal (systemic) treatments*

- Tablet options include [acitretin](#) (related to vitamin A), [ciclosporin](#) (suppresses the immune system), [methotrexate](#) (slows down the rate at which cells are dividing in psoriasis), and in some hospitals fumaric acid esters and apremilast.
- Injectable treatments for psoriasis include [etanercept](#), [adalimumab](#), [infliximab](#), [ustekinumab](#), [secukinumab](#), ixekizumab and guselkumab. Other new tablet and injected treatments are being developed in clinical studies at present.
- Blood tests may be recommended by your GP or dermatologist. If you are considering tablet or injection treatment for your psoriasis, then blood tests will be needed before and during treatment.

Further details of these treatments can be found in the Treatments for moderate and severe psoriasis and individual drug patient information leaflets.

What can I do to help?

- Discuss your psoriasis and how it affects your life with your GP or dermatologist and identify treatment goals.
- Manage your risk factors for heart disease and stroke with your GP.
- Adopt a healthy lifestyle: eat a balanced diet, try to lose weight if you are overweight and exercise regularly.
- Stop smoking if you smoke.
- If you drink excessive alcohol, reducing your intake might be helpful.
- Reduce stress, where possible.
- Take your medications as recommended by your GP or dermatologist.
- If you have pain in your joints discuss with your GP or dermatologist.

Where can I get more information about psoriasis?

NICE guidance on the assessment and management of psoriasis [CG153]:

<http://www.nice.org.uk/guidance/cg153/informationforpublic>

Links to patient support groups:

The Psoriasis Association

Dick Coles House

2 Queensbridge

Northampton, NN4 7BF

Tel: 0845 676 0076

Web: www.psoriasis-association.org.uk

Psoriasis and Psoriatic Arthritis Alliance (PAPAA)

3 Horseshoe Business Park

Lye Lane

Bricket Wood

St Albans

Hertfordshire

AL2 3TA

Tel: 01923 672837

Web: www.papaa.org

Psoriasis Scotland Arthritis Link Volunteers

54 Bellevue Road

Edinburgh, EH7 4DE

Tel: 0131 556 4117

Web: www.psoriasisScotland.org.uk

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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