NHS
Central London
Clinical Commissioning Group

Psoriasis

General points

- Mild to moderate psoriasis can usually be managed in primary care
- Prior to referral basic treatment should be tried as outlined below
- Psoriasis may worsen (sometimes months after) the introduction of some drugs e.g. B blockers, NSAIDs, ACE inhibitors
- Remember it is an independent risk factor for cardiovascular disease / cancer / anxiety and depression
- Adherence to treatment is low and only just over 50% even in clinical trials – try to consider cosmetic acceptability, side effect profiles, formulation and practicalities of application

Treatment

Generous emollients for all – may be all that's required for mild disease

CHRONIC PLAQUE PSORIASIS

Topical treatment options are: vitamin D analogues +/- steroid, tar, dithranol and tazarotene (a retinoid)

There isn't a large difference in the effectiveness of each though tolerability varies between individuals

Treat in a stepwise approach

Step 1 – emollients

Step 2 – Dovonex gel or Dovonex cutaneous foam (*Enstilar*)

- Expect gradual improvement over 12 weeks
- Can be used long term or intermittently
- Most patients will achieve flattening and partial clearance of plaques
- If irritating then calcitriol / tacalcitol are better tolerated
- Can be used on face and flexures

Step 3 – Dovobet gel (calcipotriol + betamethasone) for up to a month or intermittent treatment e.g. weekends only to maintain remission

Step 4 – consider referral – see criteria below

Tar preparations

Refined tar products are less smelly or messy than old unrefined preparations. May stain clothes or irritate. Expect slow response over 6 – 12 weeks.

- Alphosyl cream
- Exorex lotion

Apply away from flexures twice daily.

Dithranol preparations

Can be used as 'short contact therapy' at home, away from face flexures and genitals.

Start with the lowest strength, applied daily to plaques for 15–30 minutes only, then wash off. Increase through strengths weekly unless irritancy occurs.

Prescribe a range of strengths:

e.g.

• Dithrocream 0.1%

• Dithrocream 0.25%

• Dithrocream 0.5%

• Dithrocream 1.0%

• Dithrocream 2.0%

as this counts as one prescription item.

GUTTATE PSORIASIS

= numerous small lesions mostly on trunk of children / young adults. Often self-limiting over 3-6 months

Treatment

Treat with emollients plus trials of tar preparations, Vitamin D analogues or moderate potency steroid e.g. Eumovate

If severe, refer early for phototherapy

SCALP PSORIASIS

Generally requires combination of keratolytic and anti-inflammatory agents. Initially:

- tar based shampoo, e.g. Polytar, Alphosyl or Capasal plus
- Calcipotriol (eg *Dovonex gel Applicator*)
- If very itchy a topical steroid could be substituted eg Dovobet gel + Etrivex shampoo

In more severe cases use keratolytic e.g. Cocois ointment massaged in and left overnight, washed out in the morning with tar based shampoo

plus topical potent steroid e.g.

- Betacap or
- Diprosalic (= Betamethasone + Salicylic Acid)

Apply once daily for up to 2 weeks

FLEXURAL PSORIASIS

Characterised by smooth well-demarcated areas in axillae, groins, inframammary folds and natal cleft. May occur alone or with chronic plaques elsewhere.

Use mild to moderate potency steroids combined with antibiotic/antifungals e.g.

- Trimovate cream

  Apply once to twice daily. Often only partial response achievable

- Non irritant Vit D analogue eg Silkis cream

NAILS

There is no effective treatment for psoriatic nail disease. Except for potent medication such as methotrexate and Infliximab used in severe painful disease.

Exclude fungal infection with mycology samples

Referral criteria

1. Extensive/severe or disabling psoriasis.

2. Failure to respond to adequate treatment or rapid relapse post treatment.

3. Extensive acute guttate psoriasis.

4. Unstable and generalised pustular psoriasis.

5. For patient education by nurse practitioner on how to apply topical treatment

Note: Severe psoriatic patients often have higher cardiovascular comorbidity e.g. increased BP, cholesterol.

Smoking and obesity should be addressed and treated as it will impact on their general health as well as ability to treat psoriasis with 2nd line agents

References

Psoriasis and its management – clinical review BMJ 2006;333:380