

# Psoriasis

December 2017

## Plaque Psoriasis

### Before changing treatment:

1. Discuss whether there are any difficulties with application, cosmetic, acceptability or tolerability and where relevant offer an alternative formulation.
2. Discuss other reasons for non-adherence.

## Emollients<sup>1</sup>

### Emollients should be:

- Applied liberally and often.
- Used as a soap substitute.
- Put on 30 minutes before applying the specific topical psoriasis treatment prescribed.

Very mild psoriasis may respond to emollients alone.

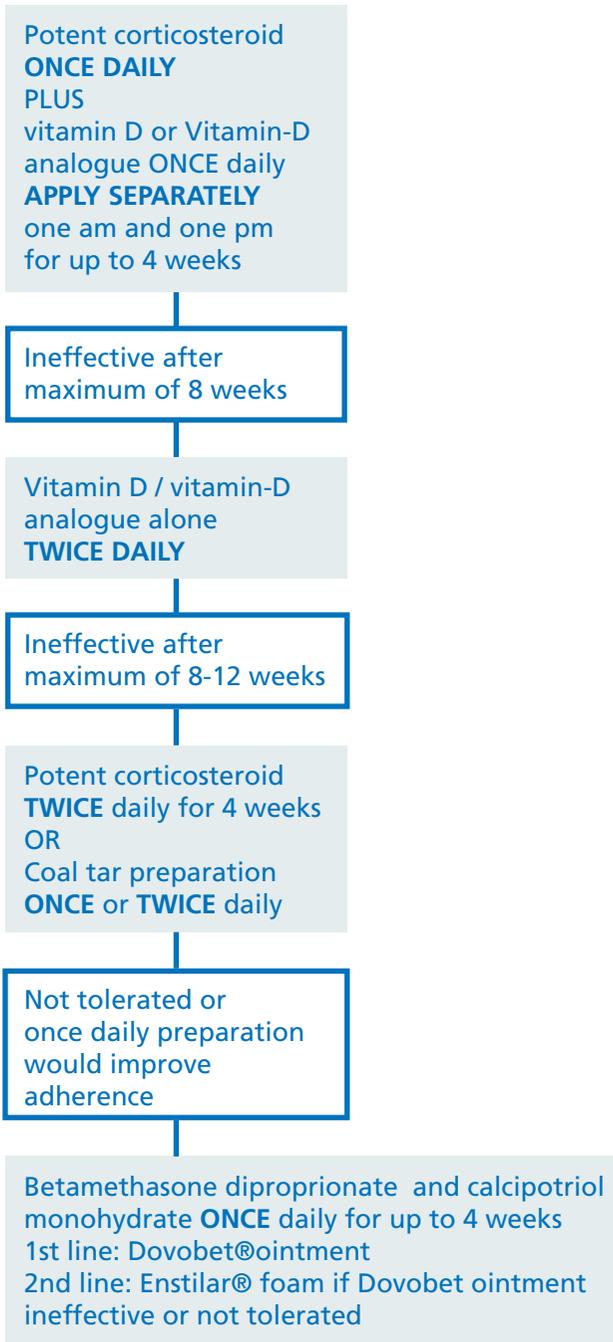
Emollient guidance is available on Area Prescribing Committee Website: <http://bit.ly/2EcyV5j>

## Active treatments

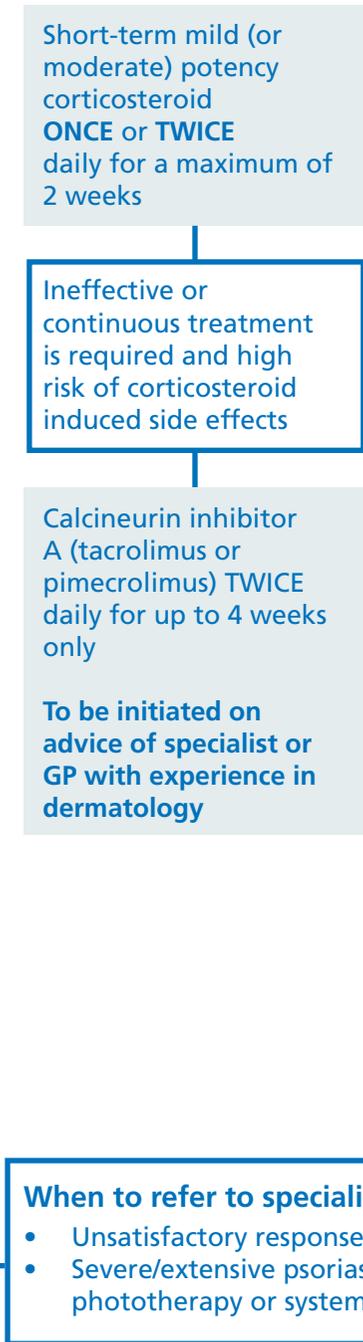
The active treatments below should be used for psoriasis flare-ups until the plaques are controlled, with a treatment holiday between flare-ups when the use of regular emollients should still be encouraged.<sup>2</sup>

**Treatment choice<sup>3</sup> – see flow chart on page 2 and product choice on page 3**

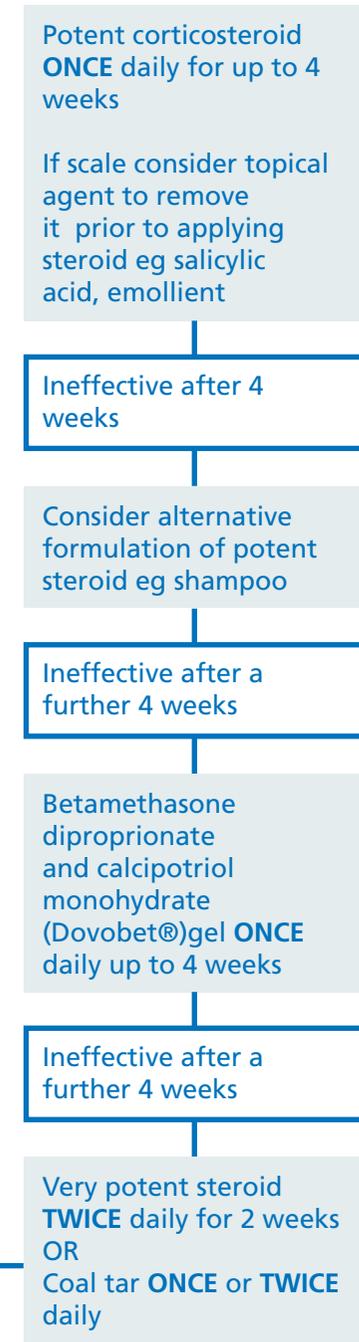
## Trunk and limbs



## Face, flexures and genitals



## Scalp



## Product choices & prescribing points

Vitamin D and Vitamin D analogues			
1 <sup>st</sup> line	Calcipotriol 50microgram per 1gram (Dovonex®)	Ointment	30g
2 <sup>nd</sup> line	Calcitriol 3microgram per 1 gram (Silkis®)	Ointment	100g
Combination Calcipotriol 50 microgram per gram and betamethasone 500 microgram per gram			
1 <sup>st</sup> line	Dovobet®	Ointment	30g
2 <sup>nd</sup> line	Enstilar®	Foam	60g
Scalp	Dovobet®	Gel	60g
Coal tar preparations			
1 <sup>st</sup> line large thin plaques	Coal tar 5% (Exorex®)	Emulsion	100ml, 250ml
Scalp for thick scale	Coal tar solution 12%, salicylic acid 2%, sulfur 4% in coconut oil compound	Sebco® scalp ointment	40g, 100g

**Emollients:** see separate guidance: <http://bit.ly/2EcyV5j>

**Topical corticosteroids:** see separate guidance for product choice

- Aim for a break of four weeks between courses of treatment with potent or very potent corticosteroids.
- Very potent corticosteroids should only be used in a specialist setting for a maximum of four weeks.
- Do not use potent or very potent corticosteroids for psoriasis affecting the face, flexures and genitals, or in children and young people.
- Do not use continuously at any site for longer than eight weeks for potent corticosteroids or four weeks for very potent corticosteroids.

Reviewing topical treatments<sup>3</sup>

Arrange a review appointment 4 weeks after starting a new topical treatment in adults and 2 weeks after starting a new topical treatment in children to:

- Evaluate tolerability, toxicity, and initial response to treatment
- Reinforce the importance of adherence when appropriate
- Reinforce the importance of a 4 week break between courses of potent/very potent corticosteroids.

If there is little or no improvement at this review, discuss the next treatment option with the person.

## Discuss with people whose psoriasis is responding to topical treatment (and their families or carers where appropriate):

- the importance of continuing treatment until a satisfactory outcome is achieved (for example clear or nearly clear) or up to the recommended maximum treatment period for corticosteroids
- that relapse occurs in most people after treatment is stopped
- that after the initial treatment period topical treatments can be used when needed to maintain satisfactory disease control.

Offer a review at least annually to **adults with psoriasis** who are using intermittent or short-term courses of a potent or very potent corticosteroid (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

Offer a review at least annually to **children and young people** with psoriasis who are using corticosteroids of any potency (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

## Nail Psoriasis<sup>4</sup>

- If nail disease is mild and is not causing discomfort or distress, no treatment is required. Nail varnish can be used to disguise pitting, but the person should avoid abrasive acetone-based nail varnish removers.
- If nail disease is severe, having a major functional impact refer to a dermatology specialist
- Nail disease responds poorly to topical treatment, and evidence to support treatment decisions is extremely limited.

## Guttate Psoriasis<sup>4</sup>

- If lesions are widespread (e.g. greater than 10% body surface area), refer urgently to a dermatologist for consideration of phototherapy.
- If lesions are not widespread:
  - Reassure the person that guttate psoriasis is self limiting and usually resolves within 3–4 months.
  - No treatment may be an option, if the person is not concerned about the appearance and it is not having an impact on their physical, psychological, or social well being.
  - If treatment is required, consider topical treatments as for trunk and limb psoriasis.( Note this is an off label use for some products)

## Pustular Psoriasis<sup>4</sup>

- Generalised pustular psoriasis is a medical emergency that requires same day referral and assessment.
- Localised (to hands and feet) pustular psoriasis – seek specialist advice regarding interim treatment while awaiting specialist appointment.( Note this is an off label use for some products)

## When to refer:

Refer children and young people with any type of psoriasis to a specialist at presentation.

Refer adults for dermatology specialist advice if:

1. The diagnosis is uncertain.
2. Extensive / severe or disabling psoriasis, for example if more than 10% of the body surface area is affected
3. Failure of first or second line topical treatment. Or rapid relapse post-treatment. (discuss adherence to treatment prior to referral)
4. Generalised pustular or erythrodermic psoriasis (as emergency)
5. Acute unstable psoriasis
6. Acute guttate psoriasis requiring phototherapy
7. Nail disease has a major functional impact
8. Severe psychological or social problems.

Refer to **Consultant clinic or GPSI** (unless severe enough to warrant second line systemic treatment)

Please document **past and current topical therapy and duration of use** in referral letter.

Refer patients with suspected psoriatic arthritis to a rheumatologist for assessment and advice about planning their care. Assessment for psoriatic arthritis should be offered annually to all patients with psoriasis.

## Patient leaflets

Available from: <http://www.bad.org.uk/healthcare-professionals/psoriasis>

## References

1. BAD: <http://www.bad.org.uk/healthcare-professionals/psoriasis>
2. PCDS: <http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview>
3. NICE: <https://www.nice.org.uk/guidance/cg153>
4. CKS: <https://cks.nice.org.uk/psoriasis>