SWL Guidelines for the Management of Adult Psoriasis

NHS South West London

Please provide the patient with psoriasis information leaflet by the British Association of Dermatologists. This can be found on their website: http://www.bad.org.uk/for-the-public/patient-information-leaflets

History and Examination and Exclude Additional Pathology

Focused history:

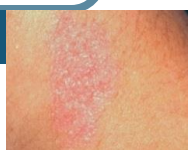
- Age of onset, triggers, personal or family history of psoriasis or inflammatory bowel disease
- Severity and impact assessment (mild/moderate/severe)
- Assess comorbidities and lifestyle cardiovascular risk factors (e.g. smoking, alcohol, diabetes)
- Joint involvement (PEST score; is a Rheumatology referral also required?: https://www.bad.org.uk/shared/get-file.ashx?id=1655&itemtype=document)
- Consider Quality of life assessment

Examine:

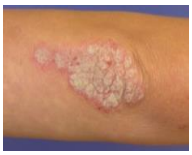
- Distribution, severity, morphology - dry skin, redness, scale, fissuring
- Review special sites: nail, scalp, post auricular, genitals, palms & soles

Exclude:

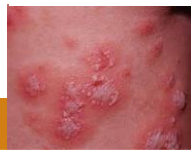
- Symptoms or signs suggestive of generalised pustular psoriasis or erythrodermic psoriasis
  - Contact dermatology on-call/ emergency department for advice & emergency referral



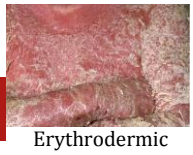
Moderate Psoriasis



Severe Psoriasis



Generalised Pustular Psoriasis



Erythrodermic Psoriasis

Images courtesy of dermnet

Step 2: General considerations in management of Psoriasis

- **Regular, liberal use of emollient** of patient's choice (recommended quantities used in generalised psoriasis being 250-500 g/week). Bathe with bath oil (patient to purchase OTC), pat skin dry and apply thick layer of emollient. Emollients can also be used as soap substitute
- Psoriasis is associated with increased risk of metabolic syndrome **– advise a healthy lifestyle and treat cardiovascular risk** (e.g. diabetes, smoking, BMI)

Step 3: Treatment

Trunk and limbs	Scalp psoriasis	Face, flexures and groin psoriasis
Combined topical preparation containing potent corticosteroid and vitamin D preparation e.g. Enstilar foam or Dovobet gel od for 4 weeks. Review at 4 weeks **Poor response**: Continue use of combined agent for further 4 weeks. **Good response**: consider use of topical vitamin D analogue bd for maintenance. 4 week treatment break before repeating treatment with topical steroid containing agent and assess regularly for steroid-induced atrophy. Review at 8 weeks Check for steroid-induced atrophy. **Poor response**: Stop preparations containing steroid. Consider use of coal tar preparation e.g Exorex or Psoriderm **OR** offer treatment with short contact Dithranol if educational support for self-use can be given. The Psoriasis Association leaflet on Dithranol may be helpful: https://www.psoriasis-association.org.uk/media/InformationSheets/Dithranol.pdf **Good response:** consider use of topical vitamin D analogue bd for maintenance. Can use combined steroid/ vitamin D agent for future flares provided there are 4 week breaks off treatment in between treatment cycles. **Refer if ongoing poor response after 2-3 months of treatment**	Signpost patient to video by BAD/ St John's Institute of dermatology: https://www.bad.org.uk/for-the-public/patient-information-videos 1. Betamethasone scalp application od for up to 4 weeks (e.g. Betacap) OR Topical vitamin D analogue (e.g. Calcipotriol scalp application) od OR Sebco or Cocois ointment od for mild disease 2. Add in topical agent to remove adherent scale (e.g. salicylic acid or olive oil overnight soaks). 3. Add in coal tar shampoo Review at 4 weeks **Poor response**: Consider different formulation of potent topical steroid e.g. shampoo or mousse od and topical agent to remove adherent scale **Good response**: 4 week treatment break before repeating treatment with topical steroids Review at 4 weeks *Combine calcipitrol and betamethasone (e.g. Dovobet gel) OD for 4 weeks **If still ineffective** Refer	Offer mild (hydrocortisone) or moderately potent (clobetasone butyrate) corticosteroid ointment applied OD or BD for up to 2 weeks max **If ineffective or require continuous control:** Consider referral to secondary care to discuss topical calcineurin inhibitors AVOID potent/ very potent corticosteroids in these sites

When to refer for all psoriasis

** Extensive (>10% surface area) or recalcitrant psoriatic disease requiring phototherapy or systemic therapy
** Difficult to treat areas (e.g. face, hands or genitalia, nails)
** Failure of appropriate topical treatment after 2- 3 months
** Diagnostic uncertainty