MANAGEMENT OF PSORIASIS IN PRIMARY CARE

Dr. M. Rustin, Consultant Dermatologist

THE ROYAL FREE HAMPSTEAD NHS TRUST
Royal Free Hospital
GRAY'S INN DIVISION

RELEVANT HISTORY

1. Possible Triggers - Streptococcal Throat Infections, Stress
2. Medical History - Presence or absence of arthritis
3. Drug History - Beta Blockers, Antimalarials, Lithium

CHRONIC PLAQUE PSORIASIS

TREATMENT

1. Assess practicalities of treatment
2. Assess motivation to use treatment
3. Explain method of application
4. Explain need for compliance and expected time of response *(at least 6 weeks)*
5. Calculate amount of topical therapy needed to treat extent of disease.

TOPICAL STEROIDS IN PSORIASIS FOR LIMITED PERIODS ONLY

ACCEPTABLE USES

1. Flexural psoriasis including hairline
2. Areas of inflammation/fissuring
3. Guttate psoriasis
4. Nail onycholysis

PROBLEMS WITH STEROIDS

1. Prolonged use leads to skin atrophy/ absorption if used over large areas
2. Rebound of psoriasis post-steroid use
3. Unstable psoriasis/progression to pustular disease.
4. Tachyphylaxsis

WITHDRAWAL

1. Patient should be weaned off steroids by changing to a dilute version and/or utilising emollients in place of the steroid for *2 weeks* before commencing new therapy
2. Reason for therapy change should be explained to the patient.

1. Encourage emollients - bath oil/topical emollients or aqueous cream. plus
2. Vitamin D Analogues (Calcipotriol <100gm/week - no limit on course length) (Tacalcitol <30gm/ week).
3. Short contact Dithranol.
4. Topical Retinoids (Tazarotene).
5. Potent topical steroids +or- Salicylic Acid (6%) if thick scales. (Elbows, knees,palms and soles).
6. Very thick plaques - overnight application of coal tar, Salicylic Acid (6%) with emollients, coconut oil preparations.

PATIENT REVIEW

1. Initial treatment period for *at least 6 weeks*
2. Check compliance (amounts of treatment used and treatment technique)
3. Check expectations compared with results
4. Assess need for nursing support
5. Consider need for regular review
6. Assess need for referral

PATIENT EDUCATION

1. Advice at consultation e.g. genetics, pathogenesis
2. Leaflets
3. Support agencies (Psoriasis Association), Milton House, 7 Milton St., Northampton, NN2 7JG. 01604 711129)
4. Nursing support - treatment techniques

CONTINUING TREATMENT

Partial response (soreness, erythema, fissuring)

1. Alternate a moderately potent/potent steroid with Vit. D Analogues & topical retinoids, for limited period - steroid alone.
2. Continue emollients

FULL RESPONSE

1. Continue treatment

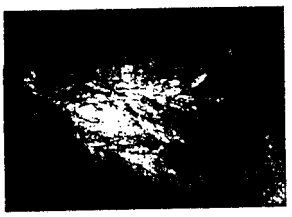
FAILED RESPONSE

1. Consider tar/dithranol preparations with emollients
2. If patient unable to comply at home refer to hospital treatment.

CRITERIA FOR REFERRAL TO DERMATOLOGIST

1. Erythrodermic Psoriasis
2. Unstable/generalised pustular
3. Extensive/severe or disabling psoriasis
4. Failure to respond or early relapse post topical therapies
5. Difficulty with diagnosis
6. Disfiguring nail disease
7. Patient request for specialist opinion

SCALP PSORIASIS



MILD

CALCIPOTRIOL SCALP SOLUTION
+ or -
COAL TAR SHAMPOO

MODERATE

CALCIPOTRIOL SCALP SOLUTION
+ or -
COAL TAR AND SALICYLIC ACID SHAMPOO

THICK SCALING

at night

COAL TAR AND SALICYLIC ACID SHAMPOO + or -
COAL TAR, SALICYLIC ACID AND COCONUT OIL OINTMENT LEFT ON FOR ONE HOUR OR OVERNIGHT UNDER OCCLUSION WITH SHOWER CAP

in morning

COAL TAR AND SALICYLIC ACID SHAMPOO + CALCIPOTRIOL SCALP SOLUTION + or -
POTENT TOPICAL STEROIDS

FLEXURAL PSORIASIS

USE VITAMIN D ANALOGUE CREAM (CALCIPOTRIOL OR TACALCITOL) AND /OR MODERATELY POTENT STEROID/ANTIYEAST.

FACIAL PSORIASIS

1. VIT D. ANALOGUES (CALCIPOTRIOL OR TACALCITOL)
2. EMOLLIENT (+MILD OR MODERATE STEROIDS OR TAR/STEROID COMBINATIONS).

PSORIATIC NAIL DYSTROPHY

VIT. D ANALOGUE CREAM OR CALCIPOTRIOL SCALP SOLUTION AND/OR POTENT STEROIDS.

ADVICE

1. KEEP NAILS SHORT AND REFRAIN FROM CLEANING UNDER.
2. TAKE NAIL CLIPPINGS TO EXCLUDE FUNGAL INFECTION.
3. IF GROSS SUB-UNGUAL HYPERKERATOSIS - CONSIDER SUB-UNGUAL INJECTION OF STEROID. (Not a G.P. Procedure).

GUTTATE PSORIASIS

1. VITAMIN D ANALOGUE
2. TOPICAL POTENT STEROIDS
3. SYSTEMIC ANTIBIOTICS IF POSITIVE THROAT SWAB.
4. PHOTOTHERAPY IF NOT RESPONDING.

PSORIATIC ARTHROPATHY

REFER TO RHEUMATOLOGIST