Two peaks of onset.
- 35y (progressive and extensive)
OR
- 50y (usually milder)

- T-cell activation and infiltration into the epidermis.
- Autoimmune inflammatory response.
- Lot's of cytokines released.
- Dilation of blood vessels.
- Keratinocyte hyperproliferation leading to hyperplasia of epidermis.

Lifetime risk = 2-3%.
- 28% if one parent affected.
- 65% if two parents affected.

Psoriasis

References:
1. cks.nice.org.uk
2. Dermatology lecture, GP Scholar, Oct 2016
3. Dermatology consultant Alliance Federation Walsall, Mar 2018
4. Dermatology consultant Alliance Federation Walsall, Feb 2019
5. Dr Tewari dermatology consultant King's College NHS, LEO webinar Jan 2021
6. Dr George Moncleuf, webinar Feb 2021
7. Rheumatology consultant lecture, Nov 2016.
8. BMJ Webinar Sept 2017
9. Dr U Buhari GPwSI dermatology, Oct 2020
10 Rheumatology webinar Nov 2023

Symptoms

- Psoriasis is not as itchy as eczema.
- Thicked, silvery scalie plaque.
- Erythema.
- Itchy (myth that it's not a symptom).
- Umbilicus and behind the ears.
- Burning (if scalp).
- Nail pitting or onycholysis (lifting of the nails).
- Psoriatic arthritis (see separate algorithm)
- Depression (40% increase).

???what do these instructions refer to? Enstilar?

10 pumps = 0.05g = 2 palms surface.???

Investigations

- BP.
- Lipids.
- HbA1c.
- QRisk
- PHQ9

- PEST questionnaire annually.

Screen for psoriatic arthritis.
- If score 3/5, refer to rheumatology.

Management

- No cure !
- Aim is to control.
- 40% pt's do not use medication prescribed.
- Often need different treatment for different sites.
- Substantial variation between individuals in the effectiveness of specific treatments, hence, dermatologists use trial and error approach to find treatment for the pt.
- Finger tip = 0.5gram, covers 2 palms.

- Corticosteroids (topical or oral) makes psoriasis unstable, so should not be used long term (unlike in eczema).
- Use less than 100g per month otherwise will supress adrenals.
- On stopping may get severe rebound psoriasis (even with stopping topical is used on widespread areas).
- Use ointments as less skin thining, more moisturising, more potent than equivalent cream version.
- Only use creams for wet or weeping lesions or on face.

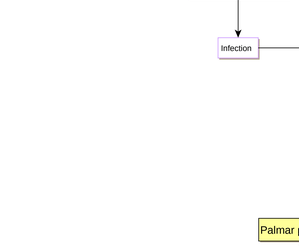
- Do not use dithromal in primary care, as risk of burning skin if not used properly.

- Zo care treatments include narrow band phototherapy for localised areas or whole body, Methotrexate, biologicals etc
- Pt's will not be allowed to try biologic unless fails other immunosuppressants.

- Weight loss improves psoriasis in trials.

- Blue Control by philips. No limit on use. Not UVB. Pt can buy and try. For limited areas.

- Warn about flammable nature of ointments.



Much more useful

Not particularly useful unless extensive

one palm surface is roughly 1%.
mild = ≤2%
moderate = 3-10%
severe = ≥ 11%

Psoriatic arthritis (PsA)

- 5-7% with psoriasis have PsA.
- 5 Types:
  - Assymetrical oligoarthritis (<6 joints) (70%).
  - Polyarthritis (may be symetric) (15%).
  - Axial (5%).
  - Predominant distal interphalangeal (5%)
  - Mutilans (5%).

Symptoms

- Psoriasis.
- Nail changes (80%).
- Dactylitis

- Do not need to have psoriasis to have psoriatic arthritis !
- But need to be scoring on the CASPAR criteria.

Investigations

- ESR/ CRP.
- RF.

- May be normal even in severe stage in up to 40% of pt's.

- CASPAR criteria.

CIASsification criteria for Psoriatic ARthritis

Management

- NSAIDs
- Refer to rheumatology.

- DMARDS.
- Biologicals.

Table. The CASPAR classification criteria for PsA

To be classified as having PsA, a patient must have inflammatory articular disease (joint, spine, entheseal) with ≥ 3 of the following 5 points:

Criterion	Description
1. Evidence of psoriasis (one of a, b, c):	
(a) Current psoriasis[a]	Psoriatic skin or scalp disease currently present, as judged by a rheumatologist or a dermatologist
(b) Personal history of psoriasis	A history of psoriasis obtained from patient or family physician, dermatologist, rheumatologist, or other qualified health care professional
(c) Family history of psoriasis	A history of psoriasis in a first- or second-degree relative by patient report
2. Psoriatic nail dystrophy	Typical psoriatic nail dystrophy, including onycholysis, pitting, and hyperkeratosis observed on current physical examination
3. Negative test result for RF	By any method except latex but preferably by ELISA or nephelometry, according to the local laboratory reference range
4. Dactylitis (one of a, b):	
(a) Current	Swelling of an entire digit
(b) History	A history of dactylitis recorded by a rheumatologist
5. Radiological evidence of juxta-articular new bone formation	Ill-defined ossification near joint margins (excluding osteophyte formation) on plain x-ray films of hand or foot

CASPAR, CIASsification criteria for Psoriatic ARthritis; PsA, psoriatic arthritis; RF, rheumatoid factor; ELISA, enzyme-linked immunosorbent assay.

[a] Current psoriasis scores 2; all other items score 1.

Plaque psoriasis

- Discoid eczema is more itchy.
- Tinea has central clearing and a very prominent edge.

differentials

Diprosalic

If very thick plaque, you must remove first, otherwise the other treatment will not work.

Emollient

- Use greasy emollient in the evening.
Should use spatula to get cream out, to avoid contamination from hands.

Enstilar foam OD 4/52 (for flare up)

- Same as Dovobet, but works much better.
- Dermatologist's use ≥ 15y on the body.
- Not for face or genital.
- Use this as a backup for flare up.
- Can be used twice weekly as maintenance.
Some dermatologist say do not use as maintenance as otherwise no where to go if fails.
- Once inflammation settled, step down to Dovonex.
- Advantage of combination product is compliance.
Rather than some recommendations to split the use of the steroid and vitamin D to morning and night.

- If larger areas of skin then you would not want to overload the body with such a potent steroid.
- So can switch to alternative regime.

Exorex lotion OD (coal tar)
AND
Betnovate RD

- Is well tolerated.
- Long term use is ok.

Dovonex (vitamin D) OD (for maintenance)

Use on < 30% BSA, 100g per week.

???unless your monitoring calcium, you would not want to use dovonex/dovobet on large areas.

what classifies as large???

Flexural psoriasis

- Lack scales.
- Sometimes only seen in these area's.

differentials

- Fungal infection is less well demarcated.
- Intertrigo i.e. contact dermatitis from sweat, urine faeces, which can get 2o infection with candida causing satellite lesions.
- Flexural eczema is less well defined.

Emollient

- Emollient as soap substitute.
- Cream or lotion
- e.g. Dermol lotion/cetraben lotion.

Steroid

- Clobetasone butyrate 0.05% (Eumovate) oint reducing dose.
- OD for 2/52
THEN
- Alternate days for 2/52
THEN
- Twice weekly for 2/52

- Can use alternative mod potency steroid:
- Betamethasone valerate 0.025% (Betnovate RD)
- Fluocinolone acetonide 0.001% (Synalar 1 in 4)

- If fails to control use 7-10/7 potent steroid ie Elocon or Betnovate oint.

- Protopic is very useful in these situations as no steroid thinning.

Need a 4/52 break after each course
Steroid can be restarted after this break
- To maintain control, vit D and steroids can be used PRN.

Protopic

signs of telangiectasia acts as steroid sparing option.

Silkis (vitmain D) oint OD

- This is used long term to maintain control.
It is Is less irritant than Dovonex.
- Contains a different form of vitamin D.

Infection

- If weeping flexures can be 2o infection with bacteria or fungus.
- Fungal = Lamasil or Daktacort. Use for 4/52.
- Trimovate/Timodine cream covers bacteria and fungal.

Scalp psoriasis

- Diff is seb dermatitis, which if left intreate can turn into pityriasis amiantacea.
- Can get scalp psoriasis and seb dermatitis on face = sebopsorisis.

- Seborrhoiec dermatitis has less scaling, less thick scaling, don't go beyoing hair line and no clear margin.
- Facial involvement.
- Remember dandruff is uninflammed seb dermatitis.
Dermatoscope = red dots and globules, twisted red loops and glomerular vessels. Whereas seb dermatitis = arborising vessels and atypical red vessels and absence of red dots and globules.

Severity

Mild = <50%

- Mild erythema.
- Mild scaling.
- Minimal thickness (barely detectable).
- Mild pruritus.

GPwSI regime

- Loyon solution (OTC):
- Emollient which deeply penetrates..
- Leave overnight, use shower cap.
- OD for 1/52.

THEN

- Alphosyl/Capasal shampoo.
- Enstilar OD for 4/52.
THEN
- Just Alphosyl/Capasal

Moderate = <50%

- Moderate erythema.
- Moderate scaling.
- Moderate thickness.
- Mild to moderate pruritus.

Severe = >50%

- Severe erythema.
- Severe scaling.
- Very thick.
- Hair loss and scarring.
- Moderate to severe pruritus.

GPwSI regime

- Sebco/Cocois:
- Leave overnight.
- Twice a week if busy lifestyle. But better to use OD for 2/52.
- Lifts scales and so allows other treatments to actually work.

- Etrivex shampoo (clobetasol):
- Apply dry scalp for 5 min OD for 1/12.

- Diprosalic scalp at night.
- AND
- Enstilar in morning.
- Continue both for 1/12.

- At 4 weeks review, if still persistent plaques:
- Sebco/cocois once a week
AND
- Capasal/Alphosyl/Ceanel shampoo
AND
- Enstilar OR Dovobet gel. OD for further 4/52.

maintenance

- Cocois ointment once a month.
- Shampoo regularly.
- If flare up, restart aggresively again to beginning of regime.

Thick scalp scales

- If thick scalp scales need to remove first, otherwise other treatment will not work.
- Once scales removed, then can treat the underlying inflammation with steroid.
- Coal tar (Sebco/Cocois) 2-3 x per week, or OD for 2/52 if severe.
- Then PRN if scales build up in the future.
- You need to lift off the thick scale first, then massage for 5 min.
- Leave for at least 2 hours or overnight. USe a shower cap or towel on pillow.
- Wash out with shampoo.
- Hair loss can occur as scales come away, but will recover.
- In morning use Alphosyl shampoo (is better tolerated than capsal), to wash out Sebco/Cocois.
Partner helping to apply, will work better than applying yourself

Emollient

Coconut oil or olive oil overnight.
Or Loyon solution.

Steroid

- The scalp skin is thick so do not worry about using potent steroid on scalp.

Dovobet:
- 4-5 nights per week, gradually reduce every 10/7.
- Apply to dry scalp.
- Apply in evening.
- Wash out in morning with shampoo.

Betacap:
- Apply to dry scalp.
- Apply at one end of the day and wash out the other end of the day.

Etrivex:
- If erythema is more prominent.
- Apply to dry scalp for 5-20min then wash out. For 1/12.

Maintenance

- Capasal:

- Dermax:
- Useful if cannot tolerate coal tar.

Hair margins

- Eumovate:
- Apply BD to margins.

Facial psoriasis

- Eumovate at scalp margin.
- Hydrocortisone around eye.
- Or is want to avoid steroid, use protopic.
- Daktacort in nasal seborrhoeic areas.

Guttate psoriasis

- If mild, no treatment as an option, as will usually go in 3-4/12.

- Exorex, can be applied even to normal skin, so do not have to puts tiny dots on just the affected skin i.e. makes it easier to apply.

- May benefit from erythromycin if started by an acute illness. Even if the acute illness was 6-8/52 ago and has fully resolved.

- Otherwise can also treat as per trunk and limbs.

???Erythomycin dose 500mg qds for 1 week???

Sebo-psoriasis

- Cross over between psoriasis in seborrhoeic dermatitis distribution.
- Daktacort BD for 7-10/7, repeat if needed.
OR
- Eumovate or ptotopic 0.1 nocte.???

Nail

- Very difficult to treat.
- Might need to go to sytemic quickly.

Lifestyle

- Nail must be kept short.
- No manicure involving cuticle.
- No prosthetics.
- Avoid abrasive acetone nail varnish remover.

No treatment

An option if mild and not bothered by appearance.
- Can disguise with nail varnish.

- Dermovate oint at nail bed.
- Dovonex scalp lotion underneath nails.

- Refer to dermatologist if fails.

Palmar plantar

- Well defined edge.
- Find other areas of psoriasis to make diagnosis confident.
- Is linked to smoking.

- Dermovate.
- Occlude with cling film and then wear cotton gloves.
- Use Diprosalic if scaling. Will sting if cracks.

Erythrodermic psoriasis

- Send to A&E.
- In hospital they use, bed rest, emollients, keep warm, betnovate RD.

Generalised pustular

- Send to A&E STAT.