Bedfordshire Psoriasis Summary Guidance - ADULTS

NICE Quality Standards (NICE CKS, November 2017)
Statement 1. People with psoriasis are offered an assessment of disease severity at diagnosis and when response to treatment is assessed.
Statement 2. People with psoriasis are offered an assessment of the impact of the disease on physical, psychological and social wellbeing at diagnosis and when response to treatment is assessed.
Statement 3. People with psoriasis are referred for assessment by a dermatology specialist if indicated.
Statement 4. Adults with severe psoriasis are offered a cardiovascular risk assessment at diagnosis and at least once every 5 years.
Statement 5. People with psoriasis having treatment are offered an annual assessment for psoriatic arthritis.
Statement 6. Systemic therapy for psoriasis poses a risk of adverse events, for which careful monitoring is needed. It is essential that monitoring is in accordance with national drug guidelines to minimise this risk. Where shared care arrangements are in place, it is important that the roles and responsibilities of healthcare professionals involved in monitoring people with psoriasis receiving systemic therapy are clearly outlined in a formalised local agreement.

NHS Bedfordshire Clinical Commissioning Group

Offer emollients daily (1st line)

Lifestyle advice: smoking cessation, weight loss, alcohol consumption within recommended limits, managing stress, Mediterranean diet

Topical Drug Treatment Line	TRUNK & LIMBS OR GUTTATE	FACE, FLEXURES AND GENITALIA	SCALP
2nd Line	Potent topical corticosteroid ONCE daily plus topical Vitamin D preparation ONCE daily (apply separately, corticosteroid in AM and Vitamin D in PM or vice versa) for up to 4 weeks	Short term mild or moderate potent topical corticosteroid ONCE or TWICE daily for maximum of 2 weeks. Review at 4 weeks, if good response, consider repeating 1-2 week courses with treatment break of 4 weeks	Coal tar shampoo in combination with potent topical corticosteroid ONCE daily OR Vitamin D preparation ONCE daily (if steroid not tolerated or mild/moderate psoriasis)
	If ineffective after maximum 8 weeks	If ineffective or not tolerated	If ineffective after 4 weeks
3rd Line	Topical Vitamin D preparation TWICE daily	Topical Calcineurin inhibitor A (tacrolimus or pimecrolimus) TWICE daily for up to 4 weeks Tacrolimus or pimecrolimus should only be prescribed by GPs with a Specialist Interest in Dermatology	Consider alternative formulation of potent steroid e.g. mousse or shampoo AND/OR topical agent to remove scale prior to applying steroid e.g. salicylic acid, emollient
	If ineffective after maximum 8-12 weeks		If ineffective after a further 4 weeks
4th Line	Alternate Potent topical corticosteroid ONCE daily for 4 weeks **or** Coal tar ONCE or TWICE daily		Corticoteroid plus Vitamin D preparation ONCE daily for up to 4 weeks **or** Vitamin D/ Vitamin D analogue ONCE daily for 8 weeks – if cannot tolerate steroids or mild/moderate psoriasis
			If ineffective after treatment duration
5th Line	Combined topical preparation: Potent corticosteroid plus Vitamin D ONCE daily up to 4 weeks		Very potent corticosteroid ONCE daily for 2 weeks **or** Coal tar ONCE or TWICE daily

***Refer to Specialist Dermatology Service**

IMMEDIATE REFERRAL:
Generalised erthodermic or generalized pustular psoriasis

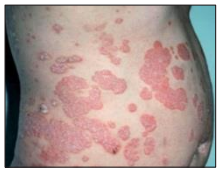
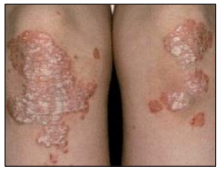
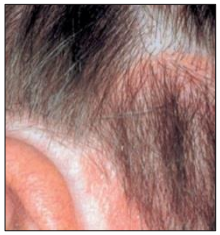
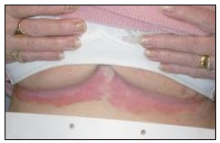
URGENT REFERRAL:
Acute unstable psoriasis

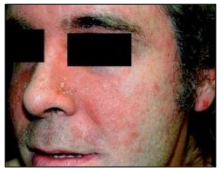
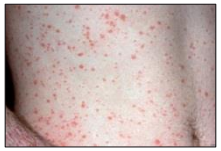
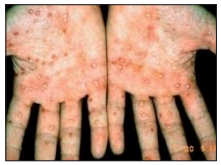
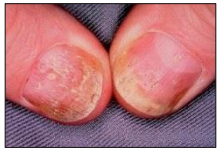
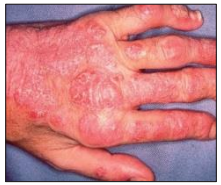
General Principles

- Examine skin
- Explore wellbeing
- Review exacerbating drugs (B-blockers, NSAIDSs, lithium, chloroquine, mepacrine)
- Holisitic approach
- Nail psoriasis: no effective topical treatment. Consider referral if severe and has major functional/cosmetic impact.
- **Pharmaceutical specials are not recommended**

***When to Refer:**

- If severe/extensive (>10% body surface area) – May require phototherapy/systemic treatment.
- If adverse reactions to topical treatments
- Consider early referral in guttate psoriasis for systemic treatment
- If failure of appropriate topical treatment
- Moderate-severe nail psoriasis
- Sever psychological morbidity, refer to Psychiatry

Trunk & Limbs	Clinical Features	Treatment
 	Well defined symmetrical small and large scaly plaques, predominantly on extensor surfaces but can be generalised	Apply emollient daily Ointments for thick scales Lotions, creams for widespread scaling Topical corticosteroids Ensure 4 week break between courses of potent steroid. Coal tar preparations can be used during these breaks Vitamin D / vitamin D analogue Local adverse effects itching, erythema, skin burning reduce with time
Scalp Psoriasis 	Clinical Features Much more common than appreciated and easier felt than seen May be patchy Socially embarrassing Typically extends just beyond the hairline, best seen on nape of neck	Treatment Treatments can be messy and this can be a difficult site to treat, so it is important to manage your patient's expectations and provide clear explanations Descale if necessary with coconut oil massaged into the scalp generously and ideally left over night. Wash out with Capasal® shampoo (self-care). • Potent corticosteroid once daily • Lotions, gels, foams are more suitable than ointments and creams for hairy areas as they are less sticky. • If ineffective after 4 weeks try: • An alternative formulation of steroid • Use a descaling agent prior to steroid application if not already • If ineffective after further 4 weeks • Vitamin D or analogue (if cannot tolerate steroid) • Topical steroid plus topical vitamin D preparation once daily for up to 4 weeks • 'Treatment breaks' between courses of steroids may be required
Flexures & Genitalia 	Clinical Features Erythematous patches, shiny red and lack scale. Commonly mistaken for candidiasis.	Treatment A short-term mild- or moderately-potent topical corticosteroid preparation (applied once or twice daily) for up to two weeks • Topical tacrolimus or pimecrolimus twice daily for up to 4 weeks • Topical tacrolimus or pimecrolimus should only be prescribed by GP's with a Specialist Interest in Dermatology. If not effective refer to specialist dermatology service

Face	Clinical Features	Treatment
	An uncommon and distressing site sometimes with plaques but more often similar to that seen in seborrhoeic dermatitis	A short-term mild- or moderately-potent topical corticosteroid preparation (applied once or twice daily) for up to two weeks Topical tacrolimus or pimercolimus twice daily for up to 4 weeks Topical tacrolimus or pimecrolimus should only be prescribed by GPs with a Specialist Interest in Dermatology. If not effective refer to specialist dermatology service
Guttate Psoriasis 	Clinical Features Rapid onset of very small 'raindrop like' plaques, mostly on torso and limbs, usually following a streptococcal infection May lack scale initially An important differential is secondary syphilis	Treatment Refer to secondary care for light therapy and in the interim consider treating with tar lotion (Exorex lotion®) 2-3 times a day There is insufficient evidence for the routine use of antibiotics however in cases of recurrent guttate psoriasis with proven streptococcal infections, consider the early use of antibiotics and/or referral for tonsillectomy
Palmoplantar Pustular 	Clinical Features Very resistant and difficult to treat. Creamy sterile pustules mature into brown macules	Treatment Stop smoking Dermovate Ointment at night under polythene occlusion (e.g. Patches of Clingfilm®) A moisturiser of choice to be used through the day Early referral important for hand and foot PUVA/ Acitretin
Nails 	Clinical Features In about 50% of patients pitting, hyperkeratosis and onycholysis NB. Look for arthritis and co-existing fungal infection. Terbinafine may aggravate psoriasis	Treatment Practical tips – keep nails short if nail disease is mild and is not causing discomfort or distress: no treatment is needed and nail varnish can be used to disguise pitting, avoid abrasive acetone based nail varnish removers. If nail disease severe refer to dermatology specialist service.
Psoriatic Arthritis 	Clinical Features Inflammatory polyarthritis, spondylarthritis, synovitis, dactylitis and tendonitis	Treatment Psoriatic arthritis is under-recognised and it is very important it is diagnosed and referred early to Rheumatology because of the risk of permanent and radiological damage

Refer to the NICE website www.nice.org.uk and the PCDS website for more information www.pcds.org.uk/clinical-guidance/psoriatic-arthropathy

STEROIDS (Creams/ Ointment)	**Mild**	Hydrocortisone 1% (cream/ ointment)	**Children:** Any area up to twice a day **Adults**: Any area up to twice a day
	Moderate	Clobetasone butyrate 0.05% (cream/ointment) (Eumovate®)	**Children:** Up to twice a day. Face and flexures for severe flares max 3-5 days then reduce potency. Adults: all areas max twice a day
		Betamethasone valerate 0.025% (cream/ointment)	**Children:** Up to twice a day. Avoid face and flexures. Adults: all areas max twice a day
	Potent*	Betamethasone valerate 0.1% (cream/ointment)	**Children: Age <12 months:** specialist initiation only **Age>12 months**: Short term use up to 14 days in areas like axilla and groin. Only if inadequate response to moderate steroid. **Adults**: body, limbs, feet and hands ONLY up to twice a day for max 7-14 days then reduce strength
		Mometasone furoate 0.1% (cream/ointment) [Elocon®]	**Children:** Only use if inadequate response to moderate steroid and when recommended by specialist in <12 months age. Use least amount possible once a day for no more than 5 days. **Adults:** Thin film of cream or ointment should be applied to affected areas once daily. If used on face, then max 5 days
	Very Potent*	Clobetasol proprionate 0.05% (cream/ointment)	**Children:** Never use without specialist advice. **Adults:** Never for face. Only for those unresponsive to potent steroids for a short course especially on hands or feet

Key prescribing messages for steroids:

Ointments should be used in the first instance if cosmetically acceptable.
Creams contain more water and therefore may contain more preservatives – but they may be more cosmetically acceptable
*There should be a four week gap between courses of potent/very potent steroid treatments
Refer to relevant product SPC (www.medicines.org.uk) for further information on side effects and excipients.