Primary Care Guide on the Clinical Features and Treatment According to Site of Psoriasis

Important note:
There should be a four week gap between courses of potent/very potent steroid treatments
First line treatment: Apply emollient daily

Clinical features	Treatment
TRUNK AND LIMBS	
Well defined symmetrical small and large scaly plaques, predominantly on extensor surfaces but can be generalised	**Dovobet®** (Calcipotriol/betamethasone) combination product should be used second line, once daily until lesions flatten. This treatment protocol differs from NICE guidance but is more patient centred and clinically effective using once daily dosage. The recommended treatment period is 4 weeks. If it is necessary to continue or restart treatment after 4 weeks, treatment should be continued after medical review and under regular medical supervision. Aim for a break of 4 weeks between courses of treatment with Dovobet®. Use vitamin D analogues (**Dovonex®** or **Silkis®**) in between courses. If the response is sub-optimal at 8–12 weeks: 1. review adherence 2. very thick scale can act as a barrier to topical therapies and consider using a salicylic acid preparation to descale e.g. **Diprosalic®** Ointment (0.065% w/w betamethasone dipropionate with 3.00% w/w salicylic acid ointment) once daily 3. consider other therapies such as tar products (e.g. 5% v/w coal tar solution - **Exorex®**), or **Dithranol** **During remissions** improvement should be sustained with non-steroid based products as needed to maintain control of psoriasis: **Dovonex®** Ointment (Calcipotriol ointment 50mcg/g) or **Silkis** Ointment (Calcipotriol ointment 3mcg/g)

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SCALP PSORIASIS	
• 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	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 1. Descale if necessary with **coconut oil**, or if more severe coal tar solution/salicylic acid/sulphur ointment (**Sebco®** Ointment) —massaged onto the scalp generously and ideally left over night. Wash out with tar-based shampoo (**Polytar®** or **Capasal®** shampoo). Continue to use until the scale becomes much thinner 2. Treat ongoing inflammation for 4 weeks with: ○ potent topical steroids such as topical **Betamethasone valerate** 0.1% scalp application applied at night ○ betamethasone dipropionate/calcipotriol monohydrate gel – **Dovobet® Gel** could be used 3. Maintenance therapy: ○ once or twice weekly tar based shampoo ○ once to twice weekly potent topical steroids as above or more frequently if needed ○ if the scale thickens then revert to coal tar solution/salicylic acid/sulphur ointment (**Sebco®** Ointment)
FLEXURES AND GENITALIA	
• Erythematous patches, shiny red, and lack scale. Commonly mistaken for candidiasis	• 0.05% w/w clobetasone butyrate (**Eumovate®**) cream or ointment once or twice daily for a maximum of 2 weeks • Calcitriol (**Silkis®** 3mcg/g) ointment

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FACE	
• An uncommon and distressing site sometimes with plaques but more often similar to that seen in seborrhoeic dermatitis	• 0.05% w/w clobetasone butyrate (**Eumovate®**) cream or ointment—many would use this initially for a maximum of 2 weeks. • Review at 4 weeks - if good response, consider repeating 1-2 week courses with treatment break of 4 weeks. Follow on with calcitriol ointment (**Silkis®** 3mcg/g)—can cause irritation so introduce gradually (initially twice a week) if ineffective or not tolerated, 0.1% tacrolimus monohydrate (**Protopic®**) ointment (initiated by GPwSPi in Dermatology)—twice a day (off-licence) and reducing with response. Use for up to 4 weeks.
GUTTATE PSORIASIS	
• 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 diagnosis is secondary syphilis	• 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	
• Very resistant and difficult to treat. Creamy sterile pustules mature into brown macules	• Stop smoking • A moisturiser of choice to be used through the day • Clobetasol propionate (**Dermovate®**) ointment at night under polythene occlusion (e.g. cling film) • Early referral to secondary care is important for hand and foot psoralen with **ultraviolet A light therapy/Acitretin**

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NAILS	
• In about 50% of patients pitting, hyperkeratosis and onycholysis • **NB**. Look for arthritis and co-existing fungal infection. Terbinafine may aggravate psoriasis	• Practical tips—keep nails short, use nail buffers • Nail varnish and gel safe to use • Trickle potent topical steroid scalp application or apply betamethasone dipropionate/calcipotriol monohydrate (**Dovobet®**) gel under the onycholytic nail
PSORIATIC ARTHRITIS	
• Inflammatory polyarthritis, spondylarthritis, synovitis, dactylitis, and tendonitis	• 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 PCDS website for more information: **www.pcds.org.uk/clinical-guidance/psoriatic-arthropathy**

Treatments available in secondary care:

- Phototherapy
- Systemic therapy e.g. methotrexate, ciclosporin
- Apremilast
- Biologics (TNF and interleukin blockers)

Further information for patients can be found at: www.pcds.org.uk **and** www.psoriasis-association.org.uk

References

1. Guidelines. Psoriasis treatment pathway guideline. Accessed via https://www.guidelines.co.uk/skin-and-wound-care/pcds-psoriasis-treatment-pathway-guideline/453660.article?_ga=2.249613647.814635913.1524484966-1667224246.1524484966 [23/04/18]

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