Guidelines for the Management of Adult Psoriasis in Primary Care

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:

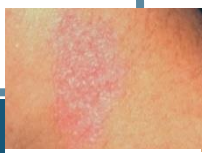
- Age of onset, triggers, personal or family history of psoriasis or inflammatory bowel disease
- Severity and impact assessment (mild/moderate/severe)
- Assess comorbidities and lifestyle cardiovascular risk factors (e.g. smoking, alcohol, diabetes)
- Joint involvement (is a Rheumatology referral also required?)
- Consider Quality of life assessment

Examine:

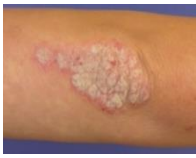
- Distribution, severity, morphology - dry skin, redness, scale, fissuring
- Review special sites: nail, scalp, post auricular, genitals, palms & soles

Exclude:

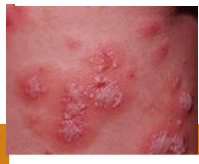
- Symptoms or signs suggestive of generalised pustular psoriasis or erythrodermic psoriasis
  - Contact dermatology on-call (bleep 8440 through SGH switchboard) for advice & referral



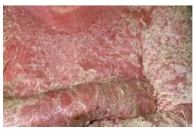
Moderate Psoriasis



Severe Psoriasis



Generalised Pustular Psoriasis



Erythrodermic Psoriasis

Step 2: General considerations in management of Psoriasis

- **Regular, liberal use of emollient & bath oil** of patient's choice *(as per local formulary)* (recommend 250-500g of emollient applied per week). Bathe with bath oil pat skin dry and apply thick layer of emollient. Emollients can also be used as soap substitute and if very dry skin, 2-3 hourly.
- **Reducing Staph aureus load** (using emollients with antimicrobials)
- 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 of Psoriasis

Mild to Moderate	Moderate to Severe	Scalp psoriasis	Face, flexures and groin psoriasis
For acute flares of trunk and limbs: Topical moderately potent corticosteroid ointment (e.g. clobetasone butyrate) • OD for up to 4 weeks **AND/OR** Topical vitamin D analogue • OD for up to 4 weeks **AND/OR** Short contact therapy coal tar **OR** Dithranol preparation **OR** topical retinoid (tazarotene) After 4 weeks flare up, followed by maintenance therapy when flare resolved: • Vitamin D analogue* **OR** • 3/7 of a topical potent steroid (e.g. betamethasone) *can cause irritation if used in severe disease	For acute flares of trunk and limbs: Topical potent corticosteroid (e.g. betamethasone) • OD for up to 4 weeks **AND/OR** Topical vitamin D analogue • OD for up to 8 weeks **IF ABOVE FAILS:** Use vitamin D analogue alone applied BD for 8-12 weeks (if no effect with initial treatment) **OR** Combined vitamin D analogue & potent corticosteroid (e.g. dovobet) for up to 4 weeks **IF ABOVE FAILS:** Topical potent steroid (e.g. mometasone) OD for up to 4 weeks **IF ABOVE FAILS:** **REFER** and prescribe a potent steroid ointment BD (e.g. mometasone)	1. Betamethasone scalp application for up to 4 weeks (e.g. Betacap) 2. Add in topical agent to remove adherent scale (e.g. salicylic acid or olive oil overnight soaks) for further 4 weeks **If step 1 and 2 ineffective:** Topical Sebco or **Cocois ointment** (coal tar & salicylic acid) alternate with BETACAP (betamethasone scalp application) **If still ineffective:** *Combine calcipitrol and betamethasone (e.g. Dovobet gel) OD for up to 2 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)
** Failure of appropriate topical treatment after 2- 3 months
** Diagnostic uncertainty

Reference: http://cks.nice.org.uk/psoriasis#!topicsummary

Images courtesy of dermnet