Psoriasis pathway

KEY:
- Questions for GP to ask
- Red flags
- Routine referral
- Audio-visual aids for patient and GP
- Public health intervention

New patient presents with suspected psoriasis

Pictures of psoriasis

Podcast on psoriasis

Does the patient definitely have psoriasis?

No → Other pathway

Yes

Does the patient have a history of systemic upset?
Eg shivers, subjective or objective fever or hypothermia, tachycardia
Is the patient erythrodermic or have pustular psoriasis?

Yes → **Contact on call dermatologist**

No

Make every contact count:
Smoking status
Alcohol consumption
BMI / physical inactivity /poor diet
Dangerous sun/UV exposure?
Psychological wellbeing
Life impact

- Smoker
- >14 units/wk♀ >21 units /wk♂
- BMI ≥30, <150 mins PA / wk
- Use of sunbeds, no sun protection
- Assessment of anxiety an d depression

Lifestyle advice pop up

Pictures to help distinguish severity

Pictures of guttate psoriasis

DLQI

HADS

Assess severity and impact:

Physician's global assessment (clear, almost clear, mild, moderate, severe and very severe)
Patient's global assessment (clear, almost clear, mild, moderate, severe and very severe)
Percentage of body surface area affected (1 adult hand area ≈1% BSA)
High impact sites: scalp, face, nails, hands, soles, flexures and genitals
What aspects of daily living are affected by the person's psoriasis (DLQI score)?
How is the patient coping with their psoriasis and the treatment they are using (DLQI score)?
Is their psoriasis causing distress or impacting mood (HADS)?
Is their psoriasis having an impact on family or carers?
Does the patient have guttate psoriasis?
Assess for psoriatic arthritis (assessment pathway)

Assessment **clear, almost clear or mild** and **<10%** body surface area and low impact → Commence topical therapies → **If no improvement in 6 weeks try alternative topical therapy and if no improvement in 6 weeks refer to dermatology triage**

Assessment **moderate**
- Low impact DLQI score (<10) → Commence topical therapies → **If no improvement in 6 weeks try alternative topical therapy and if no improvement in 6 weeks refer to dermatology triage**
- High impact DLQI score (≥10) → **Refer to dermatology triage**

Assessment as **severe or very severe or >10%** body surface area → **Refer to dermatology triage**

Guttate psoriasis → Commence topical therapies and **refer to dermatology triage service** (for phototherapy)

Assess for psoriatic arthritis

PEST form

Psoriasis Epidemiological Screening Tool (PEST)

Assess for axial arthritis or inflammatory back pain
Positive if patient answers 'yes' to at least 4 of the 5 statements below:
Back pain of **> 3 months' duration** is inflammatory if:
- Age at onset < 40 years
- Insidious onset
- Improvement with exercise
- No improvement with rest
- Pain at night (with improvement on getting up)

If PEST score ≥ 3 **or** positive for axial arthritis or inflammatory back pain → **Refer to rheumatology triage**

If PEST score ≤ 2 **and** negative of axial arthritis or inflammatory back pain → Repeat assessment on an annual basis

Assessment of comorbidities

Lifestyle advice/ signposting to prevention services

- •Cardiovascular risk
- •Alcohol-use
- •Obesity
- •Physical activity
- •Preventing type 2 diabetes
- •Smoking prevention and cessation

Present → Take action (NICE guidance and pathways)

Not present → Repeat assessments on a five yearly basis

NICE guideline CG153, Oct 2012 Page 9

Topical therapies

Chronic Plaque

Emollients
+
Tar Preparation
e.g. Exorex lotion
or
Vitamin D analogue
Calcipotriol ointment (Dovonex) (avoid face/flexures) or Calcitriol Ointment (Silkis) (less irritating)
or
Dithranol Preparation
Micanol or Dithrocream- large plaques/motivated patients. Gradual increase in concentration. Patients need to be warned about staining of clothes, bathroom etc.

4-6/52 to see improvement

Palms and soles
(Exclude fungal infection)
Potent steroid eg. Diprosalic
Or very potent steroid
Dermovate 4/52

Emollients under occlusion

Flexural/genital/breasts

Treat any coexistent fungal/candidal infection with Canesten HC and Dakacort

Eumovate cream
or
calcitriol (Silkis)
or
0.1% tacrolimus (Protopic)
or
pimecrolimus cream
(Elidel)

NB risk of reactivation of warts/HSV in the genital area with 0.1% tacrolimus ointment and pimecrolimus cream

4-6 weeks to see improvement

Guttate

Swab throat and send for C&S. Assess for and treat any streptococcal infection

Moderate steroid
e.g Eumovate
or
Coal tar prep e.g
Exorex Lotion

Refer for phototherapy if patient in agreement

Face

Emollients
+
Mild steroid e.g. 1% hydrocortisone ointment for two to four weeks
or
Pimecrolimus (Elidel)
or
0.1% Tacrolimus (Protopic)
or
Calcitriol (Silkis)

Scalp

Responds best to a combination of treatments

Use each once or twice a week (not on the same day)

Tar Shampoo e.g. Capasal, Polytar, Alphosyl, T-gel
+
Anti-yeast shampoo e.g. ketoconazole, Dermax
+
Calcipotriol scalp application

Reserve topical steroid preparations for short term use in particularly inflammatory scalp psoriasis only.

Thick scale – olive/coconut oil or Cocois/sebco left on overnight and washed off in the morning with capasal shampoo

Inflammatory scalp psoriasis– steroid preparation
e.g. Betamethasone or betamethasone/salicyclic acid combination scalp application for four weeks then calcipotriol scalp application

Nail

Treat any coexistent fungal infection if confirmed on clippings

Warning: oral terbinafine can exacerbate psoriasis. Consider itraconazole if oral therapy is indicated

Nail pits – Calcipotriol ointment to posterior nail fold

Onycholysis and sub-ungual hyperkeratosis – Calcipotriol scalp app. under free edge of nail plate
Betnovate scalp application can be used for up to 4 weeks

High impact site - consider dermatology triage referral and podiatry

Advice for GP when prescribing topical therapies
Discuss the variety of formulations available and, depending on the person's preference, use:

- cream, lotion or gel for widespread psoriasis
- lotion, solution or gel for the scalp or hair-bearing areas
- ointment to treat areas with thick adherent scale

Be aware that the face, flexures and genitals are particularly vulnerable to steroid atrophy and that corticosteroids should only be used for short-term treatment of psoriasis (1–2 weeks per month).
Explain the risks to people undergoing this treatment (and their families or carers where appropriate) and how to minimise them