NHS
South West London

Management of Psoriasis in Adults

This guideline provides primary care clinicians with guidance on how to manage psoriasis in adults.

History and Examination

Focused history

- Age of onset
- Triggers, personal or family history of psoriasis or inflammatory bowel disease
- Severity and impact assessment (mild/moderate/severe). Consider Quality of life assessment
- Assess comorbidities and lifestyle cardiovascular risk factors (e.g., smoking, alcohol, diabetes)
- Undertake PEST score and consider Rheumatology referral https://www.pcds.org.uk/files/gallery/The_PEST_screening_questionnaire_updated_aug_2013_v5_1.pdf

Examine

- Distribution, severity, morphology - dry skin, redness, scale, fissuring
- Review special sites: nail, scalp, post auricular, genitals, palms & soles
- Images of patients with psoriasis can be found on The Primary Care Dermatology Society website.

Exclude

- Symptoms or signs suggestive of generalised pustular psoriasis or erythrodermic psoriasis, manage as a medical emergency.
  Contact dermatology on-call or emergency department for advice and emergency referral.
- Differential diagnoses: drug eruption or lichen planus.

General management considerations

- Psoriasis is associated with an increased risk of the metabolic syndrome, therefore advise a healthy lifestyle, treat cardiovascular risk (e.g., diabetes, smoking, BMI).
- The combination product calcipotriol 50micrograms/g with betamethasone 0.05% (Enstilar®) foam is often considered a first line option for chronic plaque psoriasis on the body and the scalp, patients should be advised to shake the can well before application and warned that the product is flammable.
  Other options include calcipotriol 50micrograms/g with betamethasone 0.05% (Dovobet®) gel, and calcipotriol 50micrograms/g with betamethasone 0.05% (Dovobet®) ointment. Appropriate quantities (i.e., 2 x 60g) should be prescribed.
- **Self-care: Olive oil**, in-line with the NHS England position on self-care, is recommended for patients to purchase. If patients are unable to purchase, then it can be prescribed in exceptional circumstances, clinicians should refer to the SWL Self Care Guidance.

Treatment

Trunk and limbs

- Combined topical preparation containing potent corticosteroid and vitamin D preparation e.g., calcipotriol 50micrograms/g with betamethasone 0.05% (Dovobet®) gel or calcipotriol 50micrograms/g with betamethasone 0.05% (Enstilar®) foam, daily for 4 weeks.
    - **Review at 4 weeks.**
- Poor response: Continue use of combined agent for further 4 weeks.
- Good response: 4 week treatment break before repeating treatment with vitamin D/topical steroid containing agent. During the break in steroid treatment, a vitamin D analogue may be used twice daily for maintenance e.g., Calcipotriol.
    - **Review at 8 weeks.**
- Check for steroid-induced atrophy.
- Poor response: Stop preparations containing steroid. Consider use of coal tar preparation e.g., Coal Tar 5% Lotion v/w (Exorex®) or Coal Tar 6% w/w Cream (Psoriderm®).
- Good response: consider use of topical vitamin D analogue twice daily for maintenance. Can use combined topical corticosteroid / vitamin D agent for future flares provided there is a 4 week break of treatment in between treatment cycles.
    - **Refer via the electronic Referral Service (eRS)** for Advice and Guidance if ongoing poor response after 8 weeks of treatment with calcipotriol 50micrograms/g with betamethasone 0.05% (Dovobet®) gel or 4 weeks of treatment with calcipotriol 50micrograms/g with betamethasone 0.05% (Enstilar®) Foam. See also manufacturers product information.

Scalp psoriasis

Signpost patient to British Association of Dermatologists (BAD) video for the treatment of scalp psoriasis. Treatment includes:

- Topical vitamin D analogue (e.g., calcipotriol scalp application) daily OR coal tar with salicylic acid & precipitated sulfur (Cocois®) ointment daily for mild disease.
- Add topical agent to remove adherent scale (e.g., olive oil overnight soaks).
- Add coal tar shampoo e.g., coal tar shampoo (Polytar®), coal tar with coconut oil and salicylic acid (Capasal®). Use daily reducing frequency to once or twice a week as condition improves.
    - **Review at 4 weeks.**
- Poor response: Consider Betamethasone valerate 0.1% scalp application daily for up to 4 weeks (e.g., betamethasone (as Valerate) 0.1% (Betacap®)) or clobetasol propionate shampoo or betamethasone (as valerate) 0.1% Cutaneous Foam (Bettamousse®) daily) or betamethasone (as dipropionate) 0.05% with salicylic acid 3% (Diprosalic®) ointment and topical agent to remove adherent scale.
- Good response: 4 week treatment break before repeating treatment with topical steroids
    - **Review at 8 weeks.**

- If still ineffective treat with combined calcipotriol and betamethasone (e.g., calcipotriol 50micrograms/g with betamethasone 0.05% (Dovobet®) gel) daily for 4 weeks.

Face, flexures and groin psoriasis

- Offer mild (hydrocortisone) or moderately potent (clobetasone butyrate 0.05%) topical corticosteroid ointment applied daily or twice daily for up to 2 weeks.
- If ineffective and / or requires ongoing treatment:
  - Consider referral to secondary care to discuss topical calcineurin inhibitors.
  - **Avoid** potent or very potent corticosteroids in these sites.

Referral

Refer to secondary care via eRS if any of the following apply:

- Extensive (>10% surface area) or recalcitrant psoriatic disease requiring phototherapy or systemic therapy.
- Difficult to treat areas (e.g., face, hands or genitalia, nails).
- Failure of appropriate topical treatment after 2 to 3 months.
- Diagnostic uncertainty.

General treatment measures

Topical Emollients

- Regular, liberal use of emollient (recommended quantities used in generalised eczema is 600g per week for an adult), emollients can also be used as soap substitute.
- Bathe with bath and shower preparations (patient to purchase), refer to the SWL bath and shower preparations position statement, pat the skin dry and apply thick layer of emollient.
- Prescribe emollients according to the dryness of the skin and individual preference / tolerance.
- Avoid emollients containing sodium lauryl sulphate (SLS) such as aqueous cream.
- Emollients containing antimicrobials (e.g., Dermol® 500) should only be used for infected eczema and stopped once infection resolves.
- Emollients may make the skin and surfaces slippery. Patients should be warned to take extra care when bathing / showering.
- Apply in one direction along the direction of hair growth.
- Pump dispensers, if available, may minimise the risk of bacterial contamination.
- Refer to SWL Joint Medicines Formulary for preferred emollients.
- Provide the patient with a psoriasis patient information leaflet.

Topical Corticosteroids

- Refer to the manufacturer's product information for further information, including use in pregnancy and breast feeding.
- MHRA advises that rare, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks

of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA guidance for further information, Topical corticosteroids: information on the risk of topical steroid withdrawal reactions.
- Avoid direct contact with eye (risk of cataracts and glaucoma).
- Advise patients to use enough to make the skin look shiny or to use fingertip units (see below).

Use of high cost drugs for the management of psoriasis, refer to SWL psoriasis drug pathway.

How much topical corticosteroid to apply and prescribe?

- Application Using fingertip guide
  Fingertip Unit (FTU) is the amount of cream or ointment that just covers the end of one adult finger from the tip to the crease of the first joint when squeezed from an ordinary tube nozzle. One FTU is enough to cover an area of skin the size of two adult hands with the fingers together (roughly 0.4 to 0.5g) (Topical Steroids | Eczema Treatment | Eczema.org).The National Eczema society have produced a factsheet on topical steroids, where a pictorial reference can be seen on page 6.

Number of fingertip unit (FTU) for different parts of an adult's body

- Face and neck
  - 2.5 FTU
- Trunk (front or back)
  - 7 FTU
- One arm
  - 3 FTU
- One hand (one side)
  - 0.5 FTU
- One leg
  - 6 FTU
- One foot
  - 2 FTU

Approximate amount needed for an adult (daily for 7 days (g))

- Face and neck
  - 8.75g
- Trunk (front or back)
  - 24.5g
- One arm
  - 10.5g
- One hand (one side)
  - 3.5g
- One leg
  - 21g
- One foot
  - 7g

Warning: Risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

The MHRA has warned of the risk of severe and fatal burns with all emollients, whether they contain paraffin or not. Advise patients who use these products not to smoke or go near naked flames (or be near people who are smoking or using naked flames), and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them. Patients' clothing and bedding should be changed regularly, preferably daily because emollients soak into fabric and can become a fire hazard. (See MHRA updates December 2018 and August 2020).

To the best of our knowledge, the information provided in this guideline is accurate and reliable as available at the time of issue. Always consult the Summary of Product Characteristics for full prescribing information.

References

- Psoriasis: assessment and management (nice.org.uk)
- Psoriasis | Treatment summaries | BNF | NICE
- Psoriasis: an overview and chronic plaque psoriasis
- Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients
- Emollients and risk of severe and fatal burns: new resources available

Document History

Version: V 1.0

Author: South West London Dermatology Clinical Network

Approved by: Integrated medicines optimisation committee (IMOC)

Approval date: October 2024

Review Date: 2 years from approval date or sooner where appropriate.