DORSET MEDICINES ADVISORY GROUP

THE MANAGEMENT OF PSORIASIS IN ADULTS

Psoriasis is a common, genetically determined, inflammatory and proliferative disorder of the skin, the most characteristic lesions consisting of chronic, sharply demarcated, dull-red, scaly plaques, particularly on the extensor prominences and in the scalp.

Self-care advice

Many people's psoriasis symptoms start or become worse because of a certain event, known as a trigger. Common triggers include:

- an injury to skin such as a cut, scrape, insect bite or sunburn (this is known as the Koebner response)
- drinking excessive amounts of alcohol
- smoking
- stress
- hormonal changes, particularly in women (for example during puberty and the menopause)
- certain medicines such as lithium, some antimalarial medicines, anti-inflammatory medicines including ibuprofen, ACE inhibitors (used to treat high blood pressure) and beta blockers (used to treat congestive heart failure)
- throat infections - in some people, usually children and young adults, a form of psoriasis called guttate psoriasis (which causes smaller pink patches, often without a lot of scaling) develops after a streptococcal throat infection, although most people who have streptococcal throat infections do not develop psoriasis
- other immune disorders, such as HIV, which cause psoriasis to flare up or to appear for the first time

Advice for patients can be found here

Management pathway

For people with any type of psoriasis assess:

- disease severity
- the impact of disease on physical, psychological and social wellbeing
- whether they have psoriatic arthritis
- the presence of comorbidities.
- Consider using the Dermatology quality of life assessment: **www.pcds.org.uk/p/quality-of-life**

Assess the severity and impact of any type of psoriasis:

- at first presentation
- before referral for specialist advice and at each referral point in the treatment pathway
- to evaluate the efficacy of interventions.

Assess the impact of any type of psoriasis on physical, psychological and social wellbeing by asking:

- what aspects of their daily living are affected by the person's psoriasis
- how the person is coping with their skin condition and any treatments they are using
- if they need further advice or support
- if their psoriasis has an impact on their mood
- if their psoriasis causes them distress (be aware the patient may have levels of distress and not be clinically depressed)
- if their condition has any impact on their family or carers.

Treatment Pathway

Step 1: general measures

- As with other chronic skin conditions time is needed by the GP or practice nurse to discuss the condition
- Provide a patient information leaflet (from British Association of Dermatologists (BAD))
- Patient support groups
- Advise on a pre-payment certificate where appropriate

Step 2: assess for related comorbidities

- Psoriatic arthritis recent studies suggest that the prevalence of psoriatic arthritis in patients with psoriasis may be up to 30%.
- Cardiovascular disease (CVD) ◦ there is a large amount of evidence pointing to an association between psoriasis and CVD. This is more apparent in cases of severe psoriasis
- It is important that healthcare professionals working with psoriasis patients including in cardiology, dermatology and general practice, need to target modifiable risk factors and have a lower threshold for investigating patients with cardiovascular symptoms

Step 3: emollients

- Reduce the amount of scale by prescribing copious emollients - these make the skin more comfortable. Several emollients are included in the Dorset formulary. There is no evidence that any one emollient is better than another.
- In general, ointments are preferred for use on dry skin, whereas creams and lotions can be used on less dry skin. Ointments may be poorly tolerated compared with creams; this may affect their acceptability, and hence adherence to their use.
- On first presentation, it may be useful to prescribe a trial of several emollients from the first line choices of the Dorset formulary (of small pack size), so that the person can make an informed choice as to which suits them best.
- The active treatments below should be used for psoriasis flare-ups until the plaques are controlled, with a treatment holiday between flare-ups when the use of regular emollients should still be encouraged.

Step 4: topical treatments - choice based on individual requirements

- Use Calcipotrol (or combination with betamethasone, Dovobet ® gel or Enstilar® foam) OD as first line to encourage a rapid improvement and hence compliance in chronic plaque psoriasis. Dovobet® gel can also be used on the scalp. The combinations are best avoided on areas of thin skin e.g. the face, flexures and the genitalia. Appropriate quantities (i.e. 120g) should be prescribed, and the patient should always be advised to shake the bottle well, before application. Usual duration of therapy-4 weeks; if necessary, treatment may be continued beyond 4 weeks or repeated, on the advice of a specialist
- Large thin plaques - it is preferable to use tar preparations e.g. Exorex ® lotion
- Dithranol preparations, such as the short contact dithranol regime, remain the most effective topical treatments but patient acceptability limits their use.
- In patients presenting with lesions that have thick scale it may be necessary to use de-scaling agents prior to commencing the treatments referred to above.

Step 5: second line treatments

- Patients with moderate-severe psoriasis at the onset, and those who fail to respond adequately to topical treatments such be referred for consideration of second line treatments, which include:
- **Phototherapy** - most patients receive narrow band UVB known as TL01 therapy. UVA therapy by way

of PUVA is sometimes used. There is a maximum dose of light therapy that a patient may receive in a life time to limit the risks of skin cancer

- **Ciclosporin** - acts quickly. It is an immunosuppressive agent and so is best used in younger patients who have not already received light therapy. The main risks are of hypertension and renal damage, which limit how long the treatment can be given for.
- **Methotrexate** - is still one of the most effective treatments and it can also help some patients with psoriatic arthritis. The main risks are liver damage and bone marrow suppression which can occur in the early stages of treatment - patients should be advised to report immediately for a FBC if they have a sore throat or other signs of infection. Methotrexate cannot be used in pregnancy (http://www.medicines.org.uk/emc/).
- **Acitretin** - It can be particularly useful in hyperkeratotic hand / foot psoriasis. Acitretin is highly teratogenic and pregnancy needs to be avoided while on acitretin and for two years after, for this reason it is generally avoided in women of child bearing age
- Other drugs – **fumaric esters** – not routinely commissioned, licensed alternative available (see below).

Step 6: apremilast, dimethyl fumarate and biologic agents

Responsibility for use of systemic therapy should be in specialist settings only with the choice of agent and dosing schedule tailored to the needs of the individual, with consideration of the cost-effectiveness of the agents where there remains a choice. NICE CG 153 suggests the following should be considered:

- the person's age
- disease phenotype, pattern of activity and previous treatment history
- disease severity and impact
- the presence of psoriatic arthritis (in consultation with a rheumatologist)
- conception plans
- comorbidities
- the person's views.

The **risks and benefits** of the selected treatment should be explained using absolute risks and natural frequencies when possible. Apremilast is subject to additional monitoring including mood and weight for patients who are underweight at the start of treatment.

Monitor people using systemic treatment for all types of psoriasis in accordance with national and local drug guidelines and policy see specific drug monitoring below. Offer people with psoriasis who are starting treatment with a systemic non-biological or biological drug the opportunity to participate in long-term safety registries (for example the British Association of Dermatologists Biologic Interventions Register)

Apremilast, dimethyl fumarate, Certolizumab, Deucravacitinib, Etanercept, Infliximab, Ixekizumab, Adalimumab, Secukinumab, Brodalumab, Guselkumab, Risankizumab, Tildrakizumab, Bimekizumab and Ustekinumab are all approved as first line options within their respective TAs. They differ in their mode of action, method of delivery and review criteria. Follow the links for more details.

Consider changing to an alternative drug in adults (i.e. rotating treatments if there is a loss of efficacy) or:

- the psoriasis does not respond adequately to a first drug as defined in NICE technology appraisals (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept, brodalumab, ixecizumab and secukinumab, 12-28 weeks for tildrakizumab, 24 weeks for deucravacitinib and 16 weeks for apremilast, adalimumab, certolizumab, guselkumab, risankizumab, bimekizumab and ustekinumab; primary failure) **or**
- the psoriasis initially responds adequately but subsequently loses this response, (secondary failure) **or**
- the first drug cannot be tolerated or becomes contraindicated.

For adults in whom there is an inadequate response to a second drug, the Dorset clinicians will consider the

options (which may include further biologic therapy) via their Dorset MDT discussions.

Local policy for patients with severe, localised disease:

For special populations of patients **with psoriasis** at high impact sites not meeting NICE criteria:
Biologic therapy (using the most suitable biologic from the available biologics/ biosimilar drugs including Anti TNFs , anti IL17 & and Anti IL23. Preference is to use a biosimilar as a first line unless contraindicated) may be considered in people with psoriasis where the PASI <10 if **all** the following criteria are fully met:

- **The psoriasis is severe at localised, high impact and difficult to treat sites such as the face, scalp, nails, palms, soles, flexures and genitals**
- **It cannot be controlled with topical therapy or optimised standard systemic therapy**
- **It has significant impact on physical, psychological or social wellbeing**
- **Associated with significant functional impairment and/or high levels of distress**

1. Measures of severe scalp disease must be confirmed by documenting ≥30% of scalp surface area affected and a PGA of severe. A Psoriasis Scalp Severity Index (PSSI) score of ≥20 (0-72 scale) may also be used although it is recognised that this is not currently widely used in clinical practice.
2. Measure of severe palm/sole disease or other high impact sites may utilise an adjusted PASI score to assist with assessing response from baseline. A NAPSI score may be used for severe nail disease or a ppPASI >20 for palmoplantar pustulosis.
3. Optimised standard systemic therapy includes ciclosporin and subcutaneous methotrexate to recommended doses as tolerated for at least 3 months. Consider acitretin in the context of palmoplantar disease. Long term ciclosporin cannot usually be used to control disease beyond one year
4. Significant impact as measured by a DLQI >10 and or/depression attributable to psoriasis

Successful response assessed by a 50% improvement in an appropriate disease score outlined by clinician and/or 5 point reduction in DLQI score at 16 weeks. Description of functional improvement, improvement in social wellbeing and reduction in measures of distress such as anxiety and depression will also be considered.

TNF antagonists or IL-23 agents may be considered (unlicensed) for patients with severe, disabling acral forms of pustular psoriasis, for example palmoplantar pustulosis or acropustulosis (acrodermatitis continua) of Hallopeau, which has failed to respond to standard systemic agents.
The biologics decision aid for psoriasis, available on the Dorset formulary, will assist with drug choice and adalimumab (best value biologic) will be considered first line.

(Adapted from South East London Prescribing Committee, Guideline for the use of biologics in special populations, within Psoriasis, Biologic drug treatment pathway, with thanks)

Management Pathway for Scalp Psoriasis

Shampoo: for long-term management

- Tar based preparations e.g. Capasal ® shampoo is useful when scale is present - massage into the scalp for five minutes to allow the shampoo to penetrate the scale and then wash out
- Some patients are not keen on the smell of tar based preparations and may wish to try an alternative such as Dermax ® shampoo

Topical applications: for flare-ups

- If the shampoo alone does not suffice add in a topical application
- Calcipitriol and betamethasone diproprionate gel should be considered first line as it has the benefit of combining a topical steroid with a vitamin D analogue, and is proven to be superior when compared to using either agent alone. Massage in to a dry scalp, with the bottle being well shaken before application, and wash out the following morning with shampoo. The gel can leave the scalp feeling greasy and so it is recommended that shampoo is massaged in to the treated areas of the scalp and left on for about five minutes before washing off
- There are a number of alternatives to the gel such as Betacap ® scalp application and Etrivex ® shampoo. It is best to avoid alcohol based solutions, which are not as well tolerated. Betacap® needs to be left on the scalp, whereas Etrivex® is a shampoo that needs to be massaged on to the scalp and left on for 20 minutes before washing out

Thick scale

- Some patients present with thick scale and this needs to be removed before commencing the topical applications referred to above
- Sebco ® scalp ointment is very effective at removing scale - massage into affected areas of the scalp for five minutes and leave on for at least two hours, or overnight, before washing out with shampoo (some patients cannot tolerate the treatment for more than a few hours)
- The treatment is messy and so if left on overnight patients should use an old pillowcase or towel, alternatively the scalp can be occluded with a shower cap. Sebco® may be need to be used for a few days until the scale diminishes, and then used PRN as the scale builds up
- Warn patients that hair loss may occur as the scale come away, but that this will recover

Hair margins

- Consider topical 1% Hydrocortisone or Eumovate ® BD

Severe scalp psoriasis

- Patients not responding adequately to treatment should for referred to a dermatologist for consideration of other treatments such as methotrexate and biologics within local policy.

Management of flexural psoriasis

Emollients

Topical steroids

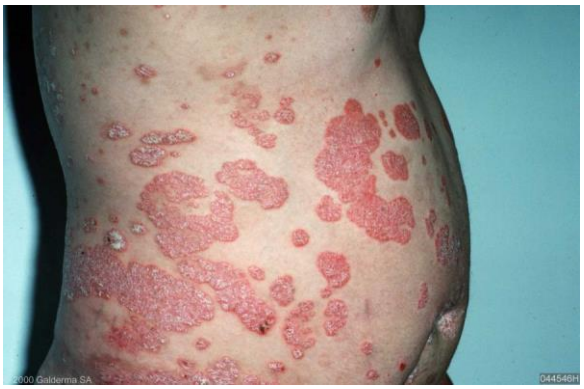
- The skin on flexural sites and the genitalia is relatively thin and so mild topical steroids such as Eumovate ® cream are preferred options
- In cases of co-existent yeast, a combination product such as Trimovate ® cream should be used. Stronger topical steroids need to be used with care and only for a few days at any one time
- Treatment with topical steroids should be discontinued once symptoms settle
- The overuse of topical steroids in body folds may cause striae and can result in long-term aggravation of psoriasis (tachyphylaxis)
- If there are concerns that too much topical steroid is being used it can be worth trying a **Vitamin-D compound** such as Silkis ® ointment. Another option is the **calcineurin inhibitors** Elidel ® (pimecrolimus) cream or Protopic ® (tacrolimus) ointment, although both are off-label in psoriasis
- The skin on the gluteal cleft is thicker than on the other sites and so more potent treatments can be used if needed

Types of Psoriasis

There are several different types of psoriasis. Many people have only one form of psoriasis at a time, although two different types can occur together. One type may change into another type or may become more severe.

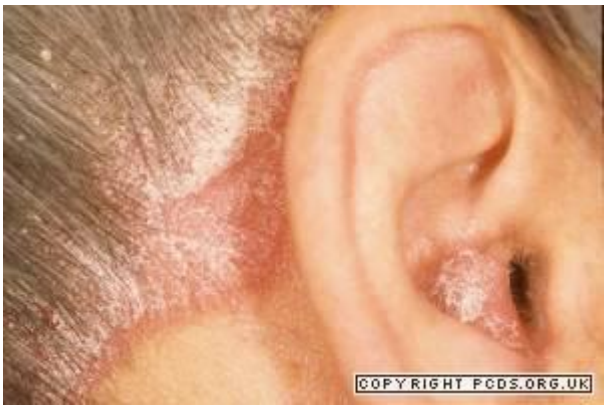
Plaque psoriasis

This is the most common form, accounting for about 90% of cases. Its symptoms are dry, red skin lesions, known as plaques, which are covered in silver scales. They normally appear on your elbows, knees, scalp and lower back but can appear anywhere on your body. The plaques can be itchy, sore or both. In severe cases, the skin around your joints may crack and bleed.



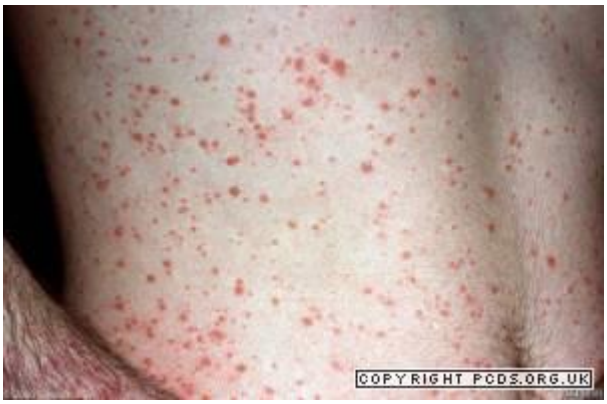
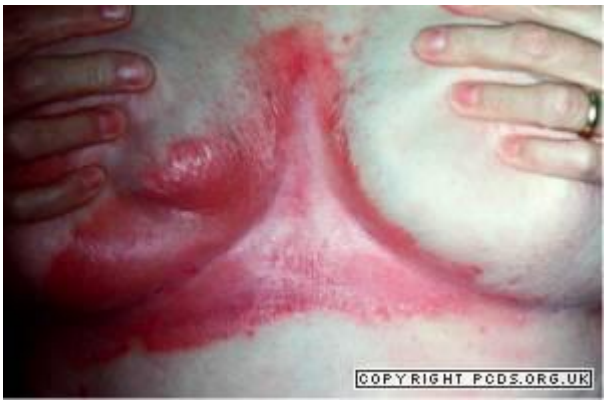
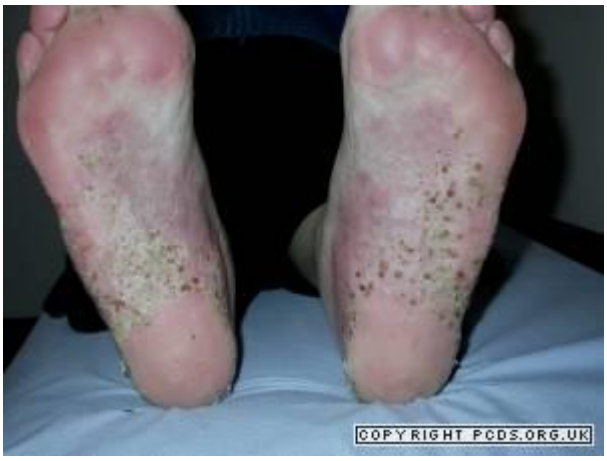
Scalp psoriasis

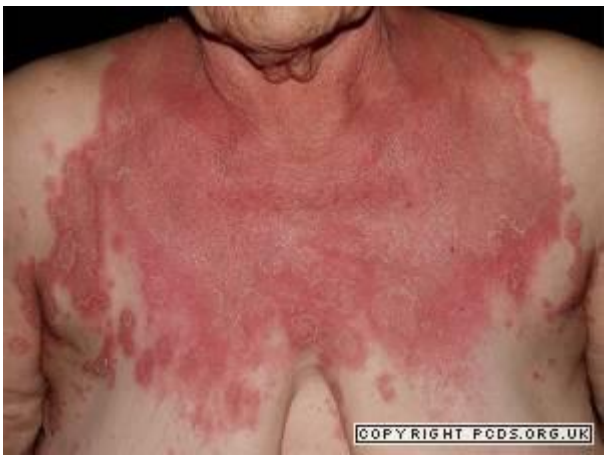
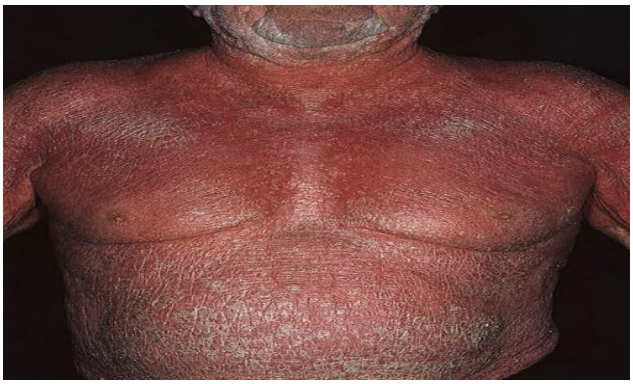
This can occur on parts of your scalp or on the whole scalp. It causes red patches of skin covered in thick silvery-white scales. Some people find scalp psoriasis extremely itchy, while others have no discomfort. In extreme cases it can cause hair loss, although this is usually only temporary.



Nail psoriasis

In about half of all people with psoriasis, the condition affects the nails. Psoriasis can cause your nails to develop tiny dents or pits, become discoloured or grow abnormally. Often nails can become loose and separate from your nail bed. In severe cases, your nails may crumble.

Guttate psoriasis Guttate psoriasis causes small (less than 1cm or 1/3 inch) drop-shaped sores on your chest, arms, legs and scalp. There is a good chance that guttate psoriasis will disappear completely after a few weeks, but some people go on to develop plaque psoriasis. This type of psoriasis sometimes occurs after a streptococcal throat infection and is more common among children and teenagers.	
Inverse (flexural) psoriasis This affects folds or creases in your skin, such as the armpits, groin, between the buttocks and under the breasts. It can cause large, smooth red patches in some or all of these areas. Inverse psoriasis is made worse by friction and sweating, so it can be particularly uncomfortable in hot weather**.**	
Pustular psoriasis Pustular psoriasis is a rarer type of psoriasis that causes pus-filled blisters (pustules) to appear on your skin. Different types of pustular psoriasis affect different parts of the body. **Palmoplantar pustular psoriasis** This causes pustules to appear on the palms of your hands and the soles of your feet. The pustules gradually develop into circular brown scaly spots, which then peel off. Pustules may reappear every few days or weeks.	

Generalised pustular psoriasis or von Zumbusch psoriasis This causes pustules on a wide area of skin, which develop very quickly. The pus consists of white blood cells and is not a sign of infection. The pustules may reappear every few days or weeks in cycles. During the start of these cycles, von Zumbusch psoriasis can cause fever, chills, weight loss and fatigue.	
Erythrodermic psoriasis Erythrodermic psoriasis is a rare form of psoriasis that affects nearly all the skin on the body. This can cause intense itching or burning. Erythrodermic psoriasis can cause your body to lose proteins and fluid. This can lead to further problems such as infection, dehydration, heart failure, hypothermia and malnutrition	

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Based on:

http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview

http://www.nice.org.uk/guidance/cg153

Etanercept, infliximab and adalimumab for the treatment of psoriatic arthritis nice guidance

Golimumab for the treatment of psoriatic arthritis nice guidance

Adalimumab for the treatment of adults with psoriasis nice guidance

Etanercept and efalizumab for the treatment of adults with psoriasis nice guidance

Infliximab for the treatment of adults with psoriasis nice guidance

Ustekinumab for the treatment of adults with moderate to severe psoriasis nice guidance

Secukinumab for the treatment of moderate to severe plaque psoriasis nice guidance

Apremilast for treating moderate to severe plaque psoriasis nice guidance

Ixekizumab for treating moderate to severe plaque psoriasis nice guidance

Brodalumab for treating moderate to severe plaque psoriasis nice guidance

Dimethylfumarate for treating moderate to severe plaque psoriasis nice guidance

Guselkumab for treating moderate to severe plaque psoriasis nice guidance

Tildrakizumab for treating moderate to severe plaque psoriasis nice guidance

Certolizumab pegol for treating moderate to severe plaque psoriasis nice guidance

Risankizumab for treating moderate to severe plaque psoriasis nice guidance

Bimekizumab for treating moderate to severe plaque psoriasis nice guidance

Deucravacitinib for treating moderate to severe plaque psoriasis nice guidance

Dermatology Quality of Life Index

Version 8

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