

**Psoriasis Lecture notes from HIGP meeting on 20<sup>th</sup> January 2010**  
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Psoriasis is a commonly encountered problem in general practice affecting 1.5% of the UK population. There are several phenotypes with chronic plaque being the most prevalent. It can affect joints and complications such as the potentially life-threatening erythroderma can occur. There is also thought to be an increased cardiovascular risk in these patients.

Treatments of psoriasis include topical agents (such as emollients, topical steroids and coal tar, phototherapy and systemic treatments (such as disease-modifying agents).

Emollients are used to soften the hyperkeratic surfaces of plaques, soothe, smooth and hydrate the skin. The most effective emollients such as 50/50 (liquid and white soft paraffin) may be limited by their greasiness which can lead to poor compliance.

Topical steroids are widely used and are cosmetically acceptable. Examples include (in order of potency) Hydrocortisone, Eumovate, Betnovate/ Elocon and Dermovate. It is advised to use steroids for up to 6/52 at a time and then reduce potency and have a break. This is thought to both reduce the risk of rebound psoriasis and the risk of skin atrophy.

Topical vitamin D analogues such as calcipotriol and calcitriol act by inhibiting epidermal cell proliferation. They should be avoided by those with calcium metabolism disorders. Examples include Silkis, Dovonex and Dovobet (with betamethasone). These can be used in combination with the tars but not with salicylic acids.

Coal tar is used for its anti-inflammatory properties however use is limited by its unpleasant smell and messy application. Examples include Exorex, Psoriderm, Sebco/ Cociois (with salicylic acid) and Alphosyl HC (with hydrocortisone).

Salicylic acid acts as a keratolytic agent useful for scaly plaques. They also enhance the penetration of other agents.

Dithranol is often used for short periods of contact because of being a skin irritant. It also stains clothing. It is useful for localised areas of plaque. Examples include Dithrocream and Dithranol.

**Regimes to try**

1. 6/52 Dovobet od
2. 6/52 Dovonex on weekdays and Dovobet on weekends
3. 6-12/52 of Silkis on weekdays and Dovobet on weekends

## **Specific types of Psoriasis**

### Unstable Psoriasis:

- Appears very red and inflamed
- Avoid Vitamin D analogues
- Use steroids e.g. elocon
- See pt after 2/52 as may need dermatology referral.

### Flexural Psoriasis:

- Use milder steroids as area is naturally occluded e.g. Fucibet / Silkis combination.

### Genitals:

- Short course of potent steroids

### Under breasts:

- Candida infection is common.
- Use a mild steroids e.g. trimovate bd for a short course

### Scalp:

- If very scaly use Sebco and leave overnight. Wash off with Tar based shampoo.
- Otherwise can use a steroid like Betnovate scalp application or dithranol.

### Nails:

- Dovonex under nails for 3/12

### Guttate:

- Can use 30g Silkis a day to cover body.
- Think of doing a throat swab.

### **When to refer:**

- If the diagnosis is in doubt.
- The patient has failed to respond to standard topical treatments.
- There is severe disease or systemic involvement.

### Fungal infection:

- Ringworm (can look similar to psoriasis but) tends to be just scaly at the periphery,

### **Patient information website:**

- <http://www.psoriasis-association.org.uk/firstline.html>

**Photos:**

□ Dermnet.com



**HIGP Group wishes to thank Dr Iman Velji for preparing the lecture notes.**