Camden Adult Psoriasis Pathway

NHS Camden Clinical Commissioning Group

Patient information

The Psoriasis Association

The Psoriasis and Psoriatic Arthritis Alliance

The Psoriasis Patient information leaflet

Patient leaflet and Video

Patient presents with suspected psoriasis

Does the patient have
- a history of systemic upset? e.g shivers, hypothermia, tachycardia
- erythroderma or generalised pustular psoriasis

Yes → Contact on call Dermatology

NO ↓

Assess severity and Impact of their psoriasis :

- Ask about scalp, genital, natal cleft, nail involvement and assess degree of body surface area (BSA) affected- 1 adults hand =1% BSA
- Dermatology Quality of Life Index-DLQI
- Consider and manage exacerbating factors (alcohol, stress, infection, B-blockers, NSAIDS, lithium, chloroquine, mepacrine)
- Assess smoking, body mass index (BMI), exercise
- Cardiovascular disease (at least every 5 years) – venous thromboembolic risk – diabetic risk
- Assess for associated stress, anxiety and/or depression
- Psoriasis epidemiology screening tool (PEST tool) -undertake annually- **screen for psoriatic arthritis**
- Assess for axial arthritis or inflammatory back pain. Positive if 4/5

  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

Offer and encourage use of emollients throughout even when skin clear. 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
- cream to treat areas that are prone to maceration

* Available as a pump

Ointments (very greasy)	**Ointments (greasy)**	**Creams**	**Gels**
1st choice: White Soft Paraffin: Liquid Paraffin, NPF (50%:50%)	1st choice: Emulsifying Ointment or Zeroderm® ointment 2nd choice: Hydrous ointment BP (oily cream) or Hydromol® ointment 3rd Choice: Diprobase® Ointment or Cetraben® ointment	1st choice: *Epimax® cream, ZeroAQs® cream, Cetomacrogol (Formula A) cream, Aquamax® cream, 2nd choice: *Oilatum® cream or *Zerobase® cream 3rd choice: *Cetraben® cream or *Ultrabase cream.	1st choice – *Zerodouble® gel

MILD- almost clear or <10% body surface area and low impact

MODERATE

SEVERE/EXTENSIVE ->10% body surface area

Low Impact DLQI Score (<10)

High impact DLQI score (≥10)

Commence topical therapies see below
Review patients within 4 weeks of starting or changing treatments

Refer to dermatology
If no improvement after trying 2 different therapies, adverse reaction to topicals or severe psychological morbidity

Refer to dermatology

Pathway updated by Clinical Cabinet and CMMC August 2018
Reference – NICE CG153/PCDS/STP consultants
Review due August 2021
Queries- camden.pathways@nhs.net

Please refer to the Summary of Product Characteristics (SPC) of any drug considered. This pathway has been developed from published guidance in collaboration with local dermatologists. This guidance is to assist GPs in decision making and is not intended to replace clinical judgement.

Management of Psoriasis –Topical therapies

Encourage use of emollients throughout, even when skin in clear.

Trunk/limb

1st line: Vitamin D analogue
Calcipotriol ointment (Dovonex®) (avoid face/flexures) twice daily

2nd line: Coal tar preparation eg Psoriderm® daily/twice daily

3rd line: Topical steroids
If a topical steroid is needed (eg particularly itchy or painful plaques) a potent topical steroid can be tried for 2 weeks followed by 2 weeks of a moderately potent steroid then stop. Recommence treatment with vitamin D analogue or coal tar.

Review effectiveness after 4 weeks

Palms and soles
(Exclude fungal infection)
1st line: Topical steroids
Potent or very potent steroid for 4 weeks
Emollients under occlusion may be helpful

This pathway should be used in conjunction with the Camden psoriasis guidelines

Flexural/genital/breast

Treat any coexistent yeast infection:
1st line: Topical clotrimazole or terbinafine.
If a combined anti-yeast/ steroid preparation is required: clotrimazole 1% / hydrocortisone 1%

1st line: Mild to moderate steroid Daily/twice daily for a maximum of 1 - 2 weeks

2nd line: Calcitriol (Silkis®) twice daily

3rd line: Tacrolimus 0.1% (Protopic®)* or pimecrolimus cream (Elidel®)*
Twice daily for max 4 weeks

Review effectiveness after 4 weeks

NOTE: Risk of reactivation of warts/herpes simplex virus (HSV) in the genital area with topical tacrolimus and pimecrolimus

Guttate

Send throat swab and assess + treat any streptococcal infection

1st line: Moderate steroid (for localised areas of psoriasis only)

2nd line: Coal tar preparation eg Psoriderm® (if steroid not tolerated)

Refer to dermatology for phototherapy

Face

1st line: Mild steroid
Daily or twice daily for 2-4 weeks

2nd line: Tacrolimus 0.1% (Protopic®)* or Pimecrolimus (Elidel®)*
Twice daily for max 4 weeks

Scalp

Responds best to a combination of treatments- Suitable shampoos can be used as adjuncts to other treatment e.g. Capasal®, Aphosyl 2 in 1® and anti-yeast shampoo e.g. ketoconazole or benzalkonium chloride. Anti-yeast shampoo should be used 3 x week for 4 weeks and weekly thereafter

Thick scale -Sebco® scalp ointment (or olive/coconut /arachis oil) left overnight and washed off in the morning with Capasal® shampoo

1st line: Tar preparation (should not be used alone for severe psoriasis)
eg Polytar® liquid or Aphosyl 2 in 1®

2nd line: Calcipotriol scalp application (for mild to moderate psoriasis only) twice daily

3rd line: Topical steroids (inflammatory scalp psoriasis)
eg betamethasone scalp application daily for 2 -4 weeks
Reserve topical steroid preparations for short term use eg 2-4 wks and then continue with calcipotriol scalp application.

Nails

Treat any coexistent fungal infection if confirmed on clippings.
Avoid terbinafine as exacerbates psoriasis

No effective topical treatment.

Refer to dermatology for moderate or severe nail psoriasis

Advice for GP when prescribing topical therapies

- Be aware that the face, flexures and genitals are particularly vulnerable to steroid atrophy so do not use potent/very potent steroids on these sites.
- Explain the risks to people undergoing this treatment (and their families or carers where appropriate) and how to minimise them. Continuous use of potent/ very potent steroids causes irreversible skin atrophy and striae and psoriasis can become unstable. Systemic side effects can occur when applied continuously to extensive psoriasis (eg>10% of body surface area affected).
- There should be a **4 week gap between courses of potent/very potent steroid treatments**
- Consider non-steroid-based topical treatments (e.g. vitamin D, Vitamin D analogues or coal tar) to maintain psoriasis disease control during this period.
- Offer a fingertip unit (FTU) patient information leaflet about using topical steroids. See Camden Prescribing Recommendations for side effect information and fingertip unit guide
- **Maintenance**: Continue treatment until satisfactory outcome- clear or nearly clear or up to max recommended treatment period. Relapse is common after stopping treatment. Use topical treatment when needed to maintain control particularly using non-steroid based treatments.
- Review annually those using potent or very potent steroids (either as monotherapy or in combined preparations (not recommended locally)) to assess for the presence of steroid atrophy and other adverse effects.

STEROIDS – Ointment/Cream		
Use ointments 1st line if cosmetically acceptable. Creams contain more water and so may contain more potentially irritating preservatives.	**Mild**	Hydrocortisone 1% (cream /ointment)
	Moderate	Clobetasone butyrate 0.05% (cream/ointment) eg Eumovate® Betamethasone valerate 0.025% (cream/ointment)
	Potent Do not use for>8wks	Mometasone furoate 0.1% (cream/ointment) eg Elocon® Betamethasane valerate 0.1% (cream/ointment) e.g. Betnovate® Betamethasone dipropionate 0.05% (cream/ointment) e.g. Diprosone®
	Very potent Do not use for>4wks	Clobetasol proprionate 0.05% (cream/ointment)

VITAMIN D & ANALOGUES	1st line: Calcipotriol 50mcg/gram ointment or calcitriol 3mcg/gram ointment (less irritating)

***Calcineurin inhibitors (topical tacrolimus/pimecrolimus)** - should only be initiated on advice of a specialist or GP with specialist interest/experienced in managing psoriasis. Calcineurin inhibitors are not licensed for psoriaisis; but use is recommended in NICE 2012 Psoriasis guidelines CG153, prescribers following this local guidance, take full responsibility for the decision. The patient's informed consent should be documented as per GMC prescribing guidance. Advise use of sunscreen