

Guidelines for the Management of Psoriasis in Primary Care

Version 1.1 – July 2020

VERSION CONTROL		
Version	Date	Amendments made
Version 1	May 2017	New guideline. AG.
Version 1.1	July 2020	Minor amendments

Page

2 Version Control

3 Introduction

3 Purpose and Summary

3 Criteria for Referral to Specialist Dermatology Services

4 Adult Psoriasis Topical Treatment Pathway

5 Children and Young People Psoriasis Topical Treatment Pathway

5 Suitable Quantities of Preparations to be Prescribed

6 Bibliography

INTRODUCTION

Psoriasis is a common, chronic inflammatory skin disease affecting 1.75% of the UK population; there are approximately 26,000 patients with psoriasis in the Lancashire area. Psoriasis vulgaris, or chronic plaque psoriasis, is the most common form of the disease, accounting for approximately 90% of cases. It is characterised by well-delineated red, scaly plaques. Plaques are usually distributed symmetrically, and occur most commonly on the extensor aspects of elbows, knees and scalp. Further complications following diagnosis of psoriasis include progression to psoriatic arthritis affecting up to 24% of psoriasis patients and increased risk of co-morbidities such as cardiovascular disease and diabetes mellitus.

A diagnosis of psoriasis is usually based on the clinical appearance. Once the severity and impact of psoriasis has been assessed the prescriber can formulate a clinical management plan in conjunction with the patient's needs and preferences. According to NICE Clinical Guideline 153 approximately 90% of psoriasis sufferers will be managed using topical therapy. Therefore, topical therapy is an appropriate first-line treatment along with practical advice and support in the application and use of the topical treatment. However, topical therapy alone may not provide satisfactory disease control and, given the number of topical treatments available, regular review is necessary to evaluate initial response, and, if appropriate, discuss the alternative options.

PURPOSE AND SUMMARY

This guideline comprises a flow chart outlining a stepwise approach to the management of psoriasis in adults and in children and young people. The guideline also includes relevant treatment review periods and referral criteria.

SCOPE

This guidance covers the principles of prescribing topical agents for psoriasis in the primary care setting.

CRITERIA FOR REFERRAL TO SPECIALIST DERMATOLOGY SERVICES

Children and young people with any type of psoriasis – see Child and Young People Psoriasis Topical Treatment Pathway – page 5

For all patient groups:

Generalised pustular psoriasis or erythroderma (**same day specialist assessment**)

There is diagnostic uncertainty

Severe or extensive psoriasis (more than 10% of body surface area affected)

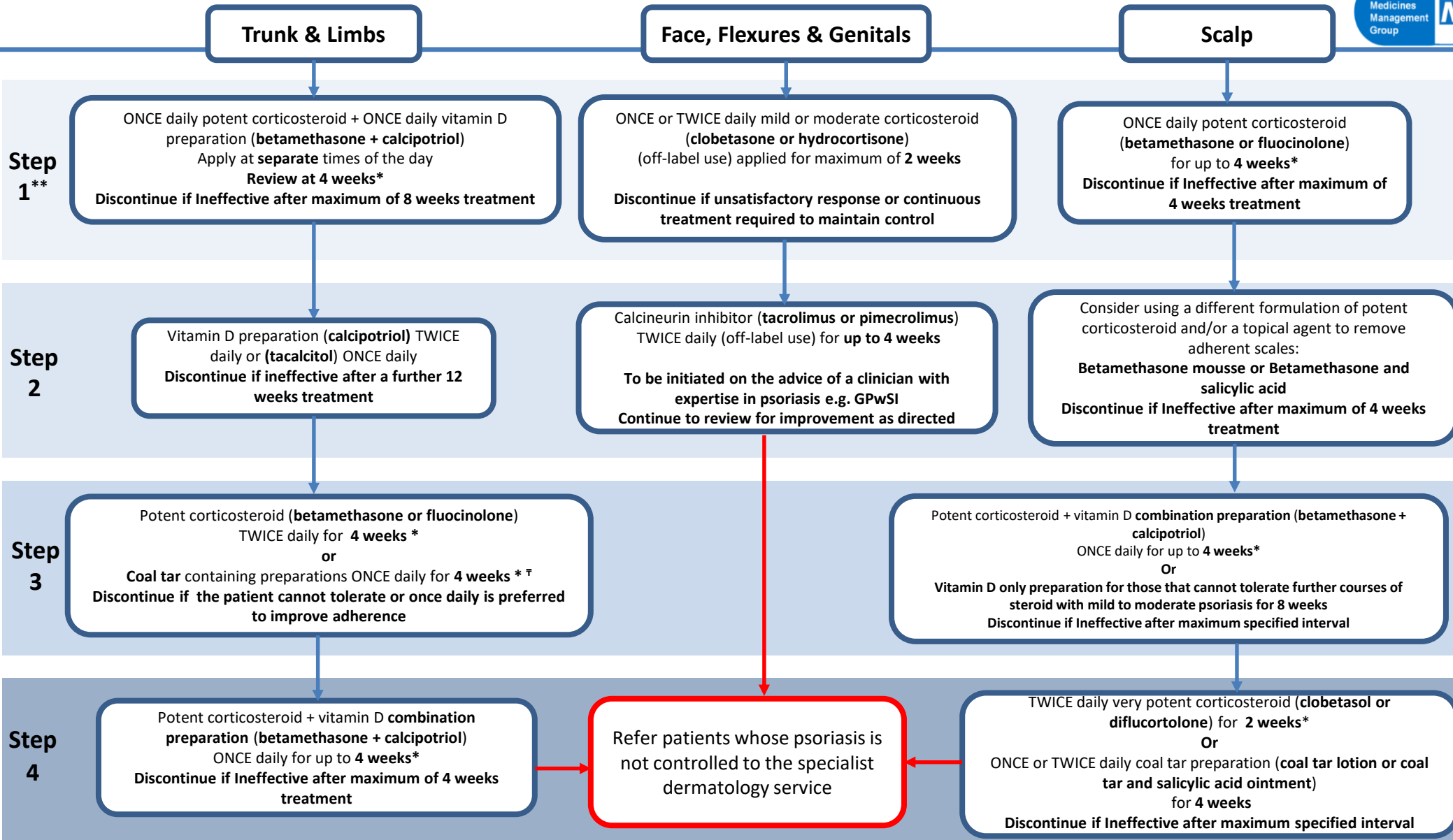
***Please note:** The use of hand surface area (HSA) equating to 1% total body surface (TBSA) may result in an overestimate for adults (particularly women) and an underestimate for children. Palm surface area (PSA) equating to 0.5% TBSA appears to be suitable for adults. Patient variables including sex and BMI result in variation of HSA as a percentage of TBSA.*

Psoriasis uncontrolled with topical therapy

Psoriasis has major impact on a patient's physical, psychological or social wellbeing

Adult Psoriasis Topical Treatment Pathway

Emollients should be applied regularly to reduce fall of scales at all steps in therapy and for all body areas (excluding scalp)

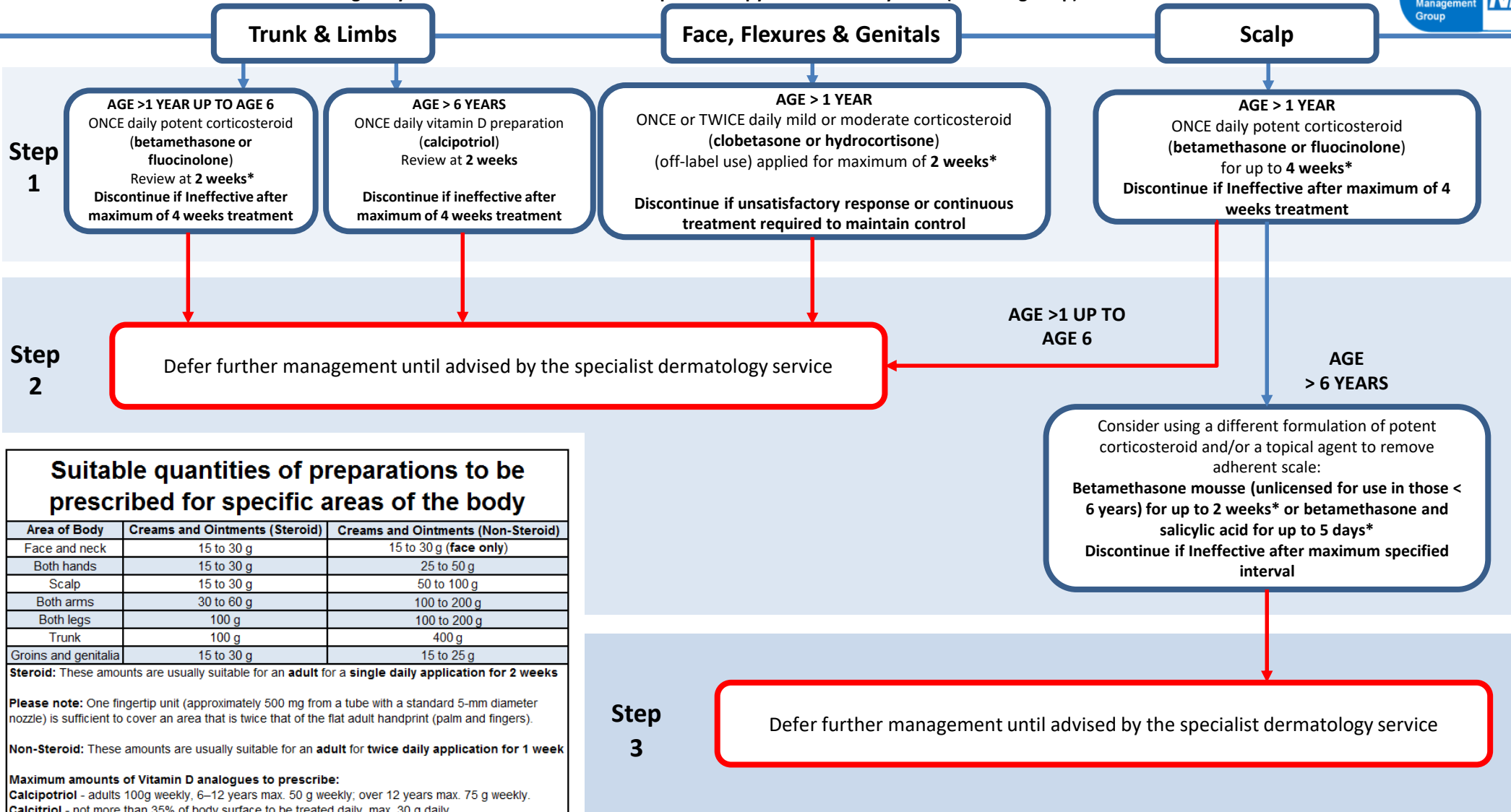


* Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids. Consider topical treatments that are not steroid-based to maintain psoriasis disease control during this period ** Treatment should only be initiated in primary care if the patient does not fall within the criteria for referral to specialist dermatology services – see page 3.

† Dithranol could be considered as an alternative to coal tar preparation at this stage of therapy for suitable patient groups.

Children and Young People Psoriasis Topical Treatment Pathway

Please note: Make referral at initial presentation of children and young people with any type of psoriasis to a dermatology specialist. Emollients should be applied regularly to reduce fall of scales at all steps in therapy and for all body areas (excluding scalp)



Suitable quantities of preparations to be prescribed for specific areas of the body

Area of Body	Creams and Ointments (Steroid)	Creams and Ointments (Non-Steroid)
Face and neck	15 to 30 g	15 to 30 g (face only)
Both hands	15 to 30 g	25 to 50 g
Scalp	15 to 30 g	50 to 100 g
Both arms	30 to 60 g	100 to 200 g
Both legs	100 g	100 to 200 g
Trunk	100 g	400 g
Groins and genitalia	15 to 30 g	15 to 25 g

Steroid: These amounts are usually suitable for an adult for a single daily application for 2 weeks

Please note: One fingertip unit (approximately 500 mg from a tube with a standard 5-mm diameter nozzle) is sufficient to cover an area that is twice that of the flat adult handprint (palm and fingers).

Non-Steroid: These amounts are usually suitable for an adult for twice daily application for 1 week

Maximum amounts of Vitamin D analogues to prescribe:
Calcipotriol - adults 100g weekly, 6–12 years max. 50 g weekly; over 12 years max. 75 g weekly.
Calcitriol - not more than 35% of body surface to be treated daily, max. 30 g daily.
Tacalcitol - max. 10 g ointment or 10 mL lotion daily (max. total tacalcitol 280 micrograms in any one week)

* Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids. Consider topical treatments that are not steroid-based to maintain psoriasis disease control during this period.

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