

Psoriasis Referral Guideline

Indications for Specialty Care Referral

- Large involvement of total surface area (greater than 10%).
- Patients with evidence of nail involvement and suspected psoriatic arthritis
- Lesions that are resistant to conventional therapy Patient is a candidate for UV light therapy.
- Patient is a candidate for systemic or biologic therapy

Criteria for Return to Primary Care

- Psoriasis has resolved and/or a suitable treatment plan has been established.

Diagnosis/Definition

Psoriasis is a papulosquamous disorder of unknown etiology that may affect the skin, scalp, nails and joints.

The most frequent form is psoriasis vulgaris, which manifests itself as chronic scaling papules and plaques largely located on the scalp, elbows, forearms, lumbosacral region, knees, hands and feet.

Psoriasis affects 1-3% of the population and has two peaks of onset, 20's and 50's.

The guttate form of psoriasis (erythematous tiny, drop-like psoriasis papules and small plaques) frequently follows, or is triggered by an upper respiratory infection, particularly Group A beta strep.

Psoriatic arthritis may be seen in 10-30% of patients and diagnosis is made using the CASPAR criteria: established inflammatory articular disease with three of the following: current psoriasis or a history of psoriasis, a family history of psoriasis (unless current or history of psoriasis is present), dactylitis, juxtaarticular new bone formation, rheumatoid factor negativity, and nail dystrophy. Enthesium (inflammation at sites of tendon, ligament, and joint fiber attachment to bone) is often seen.

Initial Diagnosis

Chronic, lingering plaques are a common presentation. Pruritus is reasonably common in the scalp and anogenital areas.

Document presence or absence of joint pain and inflammation if present.

Initial diagnosis is generally based on physical exam. Physical exam reveals papules and plaques, sharply margined with silvery-white scale. Color is usually "salmon pink" to

intense erythema. When limited to extremities, lesions are usually bilateral (though not necessarily symmetrical) and favor regions noted above.

Biopsy may be performed to confirm the diagnosis if MEB is considered or systemic medications are considered.

Management (see Psoriasis Treatment handout)

Instruct the patient never to rub or scratch the lesions as trauma may stimulate proliferative process (Koebner's phenomenon) and lead to pinpoint bleeding (Auspitz sign) may be seen if scale is lifted up off of the skin surface.

Topical Steroids – This class is the mainstay of therapy. Apply after attempting to loosen / lessen scales by soaking in water. Cream or ointment is preferred for non-hair bearing skin, with solutions, gels, lotion, or foam products best for hair-bearing sites.

“Chasing” any topical used with an emollient of choice (Eucerin, Vaseline Petroleum Jelly or other brands of petrolatum, Cetaphil or Moisturel Cream are examples) helps moisten affected site and reduces the amount of topical medication needed. Use of a plastic wrap - cover the area and leave on overnight – may be used in stubborn extremity sites until improved. **Beware the risks of steroid overdose, including striae, atrophy, telangiectasis formation and pigment changes, depending on the strength of the steroid and the location of the skin it is applied to**

Corticosteroid injection – for small plaques (<4.0 cm), triamcinolone acetonide (10mg/cc) aqueous suspension is injected into the lesion intradermally with small-gauge needle.

Vitamin D analogues (calcipotriene 0.005%; Dovonex) – Ointment and solution are good topical agents that are not associated with cutaneous atrophy. These are particularly useful in combination with the more potent topical steroids, with maintenance schedule of Dovonex daily on weekdays and the steroid on weekends. Apply to no more than 40% of body and not more than 100 g per week to avoid hypercalcemia risk.

Topical retinoid, Tazarotene cream or gel, (non-formulary) is another alternative to topical steroids or may be combined with fluocinonide 0.05% oint (lidex class II) topical corticosteroid. This formulation is stronger than Retin A, has promise, and may be obtained with a New Drug Request, TMOP, or off-post if the above options do not give desired outcome. It should be applied to the affected lesions at night.

Hydrocolloid dressing – Use is helpful and effective if left on for 24 to 48 hours. May use class I or II corticosteroid creams without occlusion in conjunction with this method. This method is uncommonly used.

Narrow-band UV phototherapy – With more than 10% involvement of total body surface area (TBSA), it may be used alone or in combination with topical or systemic medicine

treatments. Requires motivated patient with 2-3 treatments per week, appropriate TBSA involvement, and Dermatology consultation.

For the guttate form, test for Group A beta strep (throat culture and ASO titer), and initiate treatment for strep (Penicillin or suitable alternative). In many patients, the guttate psoriasis will resolve until the next strep infection.

Systemic and biologic medications: Methotrexate, cyclosporine, acitretin, etanercept, efalizumab and adalimumab are available and may be considered by the dermatologist after appropriate counseling.

See Care of Psoriasis Handout

Ongoing Management and Objectives

Patient should follow up at 2-4 week intervals initially until regression of lesions becomes apparent.