Herefordshire and Worcestershire Medicines and Prescribing Committee

NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Psoriasis

Plaque Psoriasis

Before changing treatment:

1. Discuss whether there are any difficulties with application, cosmetic, acceptability or tolerability and where relevant offer an alternative formulation.
2. Discuss other reasons for non-adherence.

Emollients[1]

Emollients should be:

- Applied liberally and often
- Used as a soap substitute
- Put on 30 minutes before applying the specific topical psoriasis treatment prescribed

Very mild psoriasis may respond to emollients alone.
Emollient guidance is available on H&W CCG website, see under Clinical & Medicines Commissioning

Active treatments

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.[2]

Treatment choice[3] – see flow chart on page 2 and product choice on page 3

Trunk and limbs

Potent corticosteroid **ONCE DAILY**
PLUS
vitamin D or Vitamin-D analogue ONCE daily
APPLY SEPARATELY
one am and one pm
for up to 4 weeks

Ineffective after maximum of 8 weeks

Vitamin D / vitamin-D analogue alone
TWICE DAILY

Ineffective after maximum of 8-12 weeks

Potent corticosteroid **TWICE** daily for up to 4 weeks
OR
Coal tar preparation **ONCE** or **TWICE** daily

Not tolerated or once daily preparation would improve adherence

Betamethasone diproprionate and calcipotriol monohydrate **ONCE** daily for up to 4 weeks
1st line: Dovobet® ointment
2nd line: Enstilar® foam if Dovobet® ointment ineffective or not tolerated

Face, flexures and genitals

Short-term mild (or moderate) potency corticosteroid
ONCE or **TWICE**
daily for a maximum of 2 weeks

Ineffective or continuous treatment is required and high risk of corticosteroid induced side effects

Calcineurin inhibitor A (tacrolimus or pimecrolimus) TWICE daily for up to 4 weeks only

To be initiated on advice of specialist or GP with experience in dermatology

Scalp

Potent corticosteroid **ONCE** daily for up to 4 weeks

If scale consider topical agent to remove it prior to applying steroid eg salicylic acid, emollient

Ineffective after 4 weeks

Consider alternative formulation of potent steroid eg shampoo

Ineffective after a further 4 weeks

Betamethasone diproprionate and calcipotriol monohydrate (Dovobet®) gel **ONCE** daily up to 4 weeks

Ineffective after a further 4 weeks

Very potent steroid **TWICE** daily for 2 weeks
OR
Coal tar **ONCE** or **TWICE** daily

When to refer to specialist:

- Unsatisfactory response to topical treatment
- Severe/extensive psoriasis which may require phototherapy or systemic therapy

Product choices & prescribing points

Vitamin D and Vitamin D analogues			
1st line	Calcipotriol 50 microgram per 1 gram (Dovonex®)	Ointment	30g
2nd line	Calcitriol 3 microgram per 1 gram (Silkis®)	Ointment	100g
Combination Calcipotriol 50 microgram per gram and betamethasone 500 microgram per gram			
1st line	Dovobet®	Ointment	30g
2nd line	Enstilar®	Foam	60g
Scalp	Dovobet®	Gel	60g
Coal tar preparations			
1st line large thin plaques	Coal tar 5% (Exorex®)	Emulsion	100ml, 250ml
Scalp for thick scale	Coal tar solution 12%, salicylic acid 2%, sulfur 4% in coconut oil compound	Sebco® scalp ointment	40g, 100g

Emollients: see separate guidance

Topical corticosteroids: see separate guidance **for product choice**

- Aim for a break of four weeks between courses of treatment with potent or very potent corticosteroids.
- Very potent corticosteroids should only be used in a specialist setting for a maximum of four weeks.
- Do not use potent or very potent corticosteroids for psoriasis affecting the face, flexures and genitals, or in children and young people.
- Do not use continuously at any site for longer than eight weeks for potent corticosteroids or four weeks for very potent corticosteroids.
- Capasal Shampoo (coal tar based) to use in conjunction with the topical steroids for the scalp.

Reviewing topical treatments[3]

Arrange a review appointment 4 weeks after starting a new topical treatment in adults and 2 weeks after starting a new topical treatment in children to:

- Evaluate tolerability, toxicity, and initial response to treatment.
- Reinforce the importance of adherence when appropriate.
- Reinforce the importance of a 4 week break between courses of potent/very potent corticosteroids.

If there is little or no improvement at this review, discuss the next treatment option with the person.

Discuss with people whose psoriasis is responding to topical treatment (and their families or carers where appropriate):

- The importance of continuing treatment until a satisfactory outcome is achieved (for example clear or nearly clear) or up to the recommended maximum treatment period for corticosteroids.
- That relapse occurs in most people after treatment is stopped.
- That after the initial treatment period topical treatments can be used when needed to maintain satisfactory disease control.

Offer a review at least annually to **adults with psoriasis** who are using intermittent or short-term courses of a potent or very potent corticosteroid (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

Offer a review at least annually to **children and young people** with psoriasis who are using corticosteroids of any potency (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

Nail Psoriasis[4]

- If nail disease is mild and is not causing discomfort or distress, no treatment is required. Nail varnish can be used to disguise pitting, but the person should avoid abrasive acetone-based nail varnish removers.
- If nail disease is severe, having a major functional impact refer to a dermatology specialist.
- Nail disease responds poorly to topical treatment, and evidence to support treatment decisions is extremely limited.

Guttate Psoriasis[4]

- If lesions are widespread (e.g. greater than 10% body surface area), refer urgently to a dermatologist for consideration of phototherapy.
- Reassure the person that guttate psoriasis is self limiting and usually resolves within 3–4 months.
- If lesions are not widespread
  - No treatment may be an option, if the person is not concerned about the appearance and it is not having an impact on their physical, psychological, or social well being.
  - If treatment is required, consider topical treatments as for trunk and limb psoriasis. (Note this is an off label use for some products)

Pustular Psoriasis[4]

- Generalised pustular psoriasis is a medical emergency that requires same day referral and assessment.
- Localised (to hands and feet) pustular psoriasis:
  - Arrange for referral to a dermatologist, the urgency depending on clinical judgement, for specialist assessment and management.
  - Consider seeking specialist dermatology advice whilst awaiting specialist assessment, regarding interim treatment options that may be initiated in primary care.

When to refer[3]:

Refer children and young people with any type of psoriasis to a specialist at presentation.

Refer adults for dermatology specialist advice if:

1. The diagnosis is uncertain.
2. Extensive / severe or disabling psoriasis, for example if more than 10% of the body surface area is affected.
3. Failure of first or second line topical treatment. Or rapid relapse post-treatment. (discuss adherence to treatment prior to referral).
4. Generalised pustular or erythrodermic psoriasis (as emergency).
5. Acute unstable psoriasis.
6. Acute guttate psoriasis requiring phototherapy.
7. Nail disease has a major functional impact.
8. Severe psychological or social problems.

Refer to **Consultant clinic or GPSI** (unless severe enough to warrant second line systemic treatment).

Please document **past and current topical therapy and duration of use** in referral letter.

Refer patients with suspected psoriatic arthritis to a rheumatologist for assessment and advice about planning their care. Assessment for psoriatic arthritis should be offered annually to all patients with psoriasis.

Patient leaflets

Available here.

References

1. BAD: *http://www.bad.org.uk/healthcare-professionals/psoriasis*
2. PCDS: Psoriasis: an overview and chronic plaque psoriasis. September 2019. Accessed at: *http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview*
3. NICE Clinical Guideline 153: Psoriasis: assessment and management. October 2012. Accessed at: *https://www.nice.org.uk/guidance/cg153*
4. NICE CKS. Psoriasis. March 2018. Accessed at: *https://cks.nice.org.uk/psoriasis*