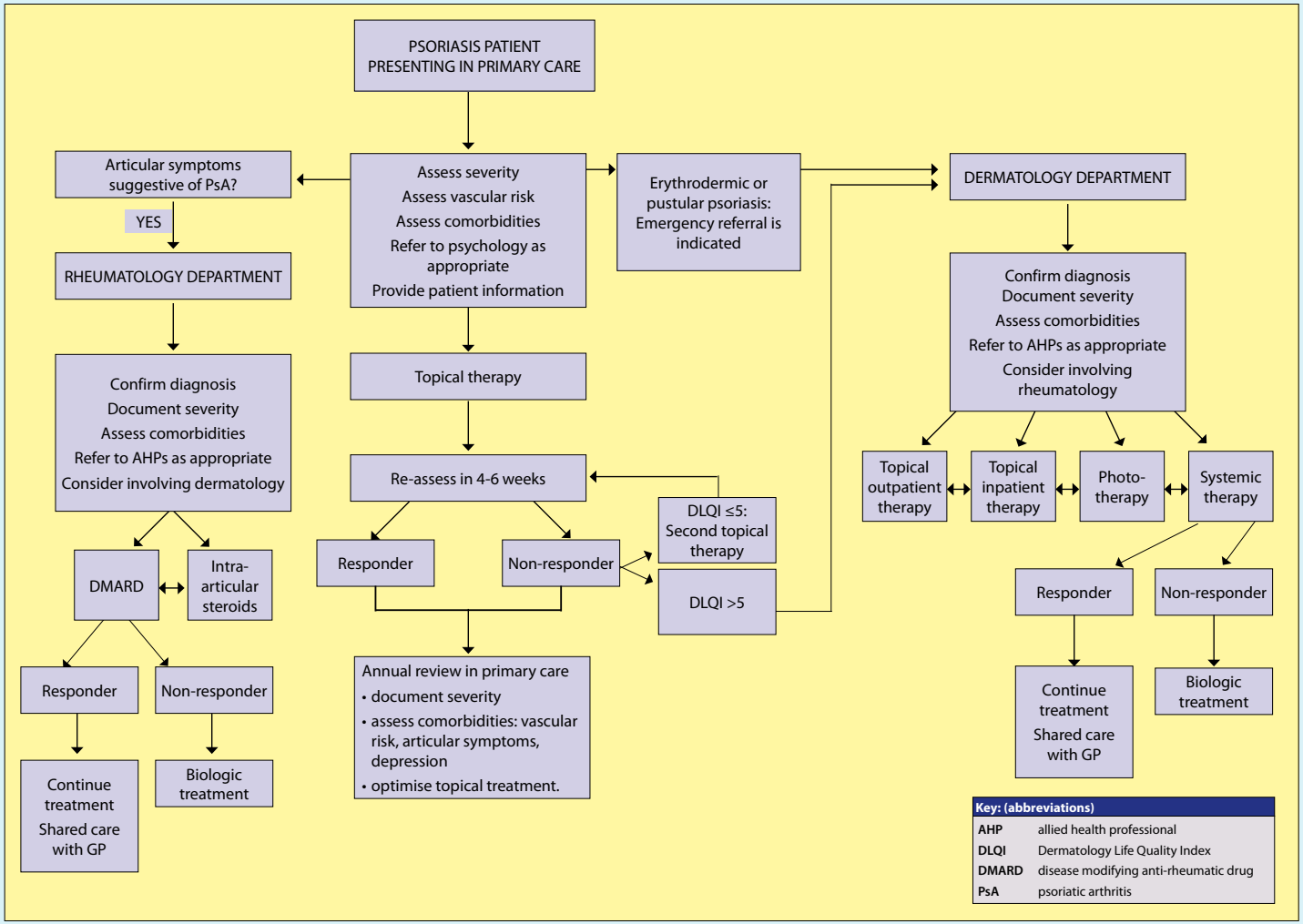
PSORIASIS AND PSORIATIC ARTHRITIS CARE PATHWAY



Key: (abbreviations)

AHP	allied health professional
DLQI	Dermatology Life Quality Index
DMARD	disease modifying anti-rheumatic drug
PsA	psoriatic arthritis

ONLINE RESOURCES

Psoriasis Area and Severity Index (PASI) **Calculator**
http://pasi.corti.li/

British Association of Dermatologists Biologic Interventions Register (BADBIR) www.badbir.org

Psoriasis Association
www.psoriasis-association.org.uk

Psoriasis and Psoriatic Arthritis Alliance (PAPAA)
www.papaa.org

Psoriasis Scotland Arthritis Link Volunteers (PSALV)
www.psoriasisscotland.org.uk

This Quick Reference Guide provides a summary of the main recommendations in **SIGN 121 Diagnosis and management of psoriasis and psoriatic arthritis in adults.**

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

Healthcare Improvement Scotland

SIGN
Scottish Intercollegiate Guidelines Network

121 Diagnosis and management of psoriasis and psoriatic arthritis in adults

Quick Reference Guide

October 2010

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DIAGNOSIS, ASSESSMENT AND REFERRAL

Diagnose **chronic plaque psoriasis** (psoriasis vulgaris) on the basis of well demarcated bright red plaques covered by adherent silvery white scales affecting any body site, often symmetrically, especially the scalp and extensor surfaces of limbs. The differential diagnosis includes eczema, tinea, lichen planus, and lupus erythematosus.

Diagnose **guttate psoriasis** on the basis of the development, over a period of 1-7 days, of multiple small papules of psoriasis over wide areas of the body. The differential diagnosis includes pityriasis rosea, viral exanthems and drug eruptions.

Generalised pustular psoriasis is rare and is characterised by the development of multiple sterile non-follicular pustules within plaques of psoriasis or on red tender skin. This may occur acutely and be associated with fever. The differential diagnosis includes pyogenic infection, vasculitis and drug eruptions.

D	**Patients with erythrodermic or generalised pustular psoriasis must receive emergency referral to dermatology.**
D	**Healthcare professionals who treat patients with psoriasis should be aware of the association between psoriasis and psoriatic arthritis.**
B	**All patients suspected as having psoriatic arthritis should be assessed by a rheumatologist so that an early diagnosis can be made and joint damage can be reduced.**
D	**Patients in primary care who do not respond to topical therapy and who score 6 or above on the DLQI should be offered referral to dermatology.**
D	**Assessment of patients with psoriasis or psoriatic arthritis should include psychosocial measures, with referral to mental health services as appropriate.**
☑	Referral for rheumatology opinion is appropriate in psoriasis if joint swelling or dactylitis is present, or when spinal pain with significant early morning stiffness is present.
☑	Patients with psoriasis or psoriatic arthritis should have an annual review with their GP involving the following: ▪ documentation of severity using DLQI ▪ screening for depression ▪ assessment of vascular risk (in patients with severe disease) ▪ assessment of articular symptoms ▪ optimisation of topical therapy ▪ consideration for referral to secondary care.

TREATMENT IN PRIMARY CARE

D	**Active involvement of patients in managing their care should be encouraged.**
D	**All patients with psoriasis or psoriatic arthritis should be encouraged to adopt a healthy lifestyle, including:** ▪ **regular exercise** ▪ **weight management, aiming for BMI 18.5-24.9** ▪ **moderation of alcohol consumption** ▪ **cessation of smoking.**
☑	Regular emollient use may be considered to reduce fall of scales and help with other symptoms, including itch.
A	**Short term intermittent use of a potent topical corticosteroid or a combined potent corticosteroid plus calcipotriol ointment is recommended to gain rapid improvement in plaque psoriasis.**
D	**Potent to very potent topical corticosteroids are not recommended for regular use over prolonged periods because of concern over long term adverse effects.**
A	**For long term topical treatment of plaque psoriasis a vitamin D analogue is recommended.**
B	**If a vitamin D analogue is ineffective or not tolerated then consider coal tar** *(solution, cream or lotion)***, tazarotene gel, or short contact dithranol** *(30 minute exposure in patients with a small number of relatively large plaques of psoriasis)***.**
B	**Short term intermittent use of potent topical corticosteroids or a combination of a potent corticosteroid and a vitamin D analogue is recommended in scalp psoriasis.**
☑	For patients with thick scaling of the scalp, initial treatment with overnight application of salicylic acid, tar preparations, or oil preparations (eg olive oil, coconut oil) to remove thick scale is recommended.
B	**Moderate potency topical corticosteroids are recommended for short term use in facial and flexural psoriasis.**
B	**If moderate potency topical corticosteroids are ineffective in facial and flexural psoriasis, then vitamin D analogues or tacrolimus ointment are recommended for intermittent use.**
D	**Patients should be offered a follow-up appointment within six weeks of initiating or changing topical therapy to assess treatment efficacy and acceptability.**
D	**To improve adherence, the number of treatments per day should be kept to a minimum.**
☑	For guttate psoriasis consider early referral for consideration of phototherapy in those who do not respond to topical therapy.

PSORIATIC ARTHRITIS IN SECONDARY CARE

☑	Dermatology and rheumatology departments should work closely together to manage patients with severe joint and skin disease.
☑	In patients with psoriasis and psoriatic arthritis, monotherapy that addresses both skin and joint disease should be used in preference to multiple therapies.
A	**Leflunomide is recommended for the treatment of active peripheral psoriatic arthritis.**
C	**Sulfasalazine may be considered as an alternative in the treatment of peripheral psoriatic arthritis.**
C	**Methotrexate may be considered in the treatment of psoriatic arthritis, especially when associated with significant cutaneous psoriasis.**
A	**Adalimumab, etanercept or infliximab are recommended for treatment of active psoriatic arthritis in patients who have failed to respond to, are intolerant of, or have had contraindications to, at least two disease-modifying therapies.**
D	**Nurse-led triage clinics should be considered for psoriatic arthritis.**

PSORIASIS IN SECONDARY CARE

B	**Patients with psoriasis who do not respond to topical therapy should be offered NBUVB phototherapy.**
B	**Three times weekly NBUVB phototherapy is recommended where practicable.**
B	**Patients with severe or refractory psoriasis should be considered for systemic therapy with ciclosporin, methotrexate or acitretin, following discussion of benefits and risks with patients.**
D	**Inpatient treatment on a dermatology ward should be available for patients with severe psoriasis.**
A	**Patients with severe psoriasis who fail to respond to, or have a contraindication to, or are intolerant of phototherapy and systemic therapies including ciclosporin and methotrexate, should be offered biologic therapy unless they have contraindications or are at increased risk of hazards from these therapies.**
☑	Patients on biologic therapies should be offered the opportunity to join the BADBIR long term safety register.
C	**Nurse-led clinics for psoriasis should be considered for delivery of services such as follow up of specialist caseload, re-access for patients with recurrent disease, and monitoring of systemic therapies.**