Psoriasis - Primary care Topical Treatment Pathway

**TREATMENT**
Assess pre/post Rx on Dermatology Life Quality Index (DLQI), [http://www.dermatology.org.uk/quality qualidade.html]

- Discuss treatment options
- Explain method of application
- Reinforce the need for compliance
- For wet, weeping skin employ a cream
- For dry skin use an ointment
- Ensure appropriate quantities are prescribed

**EDUCATION**
- Educate the patient about psoriasis and agree treatment options
- Provide information leaflets / online addresses, as required

**EMOLLIENTS**
- Essential part of the management of psoriasis
- Ointments are more effective than creams, but less well tolerated  
- Light creams (e.g. Aquamax®creams, ZeroDouble® gel) are better suited during the day. Find an emollient that patients are likely to use regularly and prescribe sufficient quantities.
- Employ a soap substitute (e.g. Aquamax® cream) or for clinically significant infected skin employ an emollient containing an antimicrobial agent (e.g. Dermol® cream)

**TOPICAL THERAPIES**

- **Topicals**
  - Calcipotriol, Calcitriol – USE TWICE DAILY (alternate with a topical corticosteroid or use a co-formulation e.g. Enstilar®, to increase adherence)
  - Enstilar® foam - useful for scalp and non-scarp psoriasis
  - Tacalcitol - APPLY ONCE DAILY AT NIGHTIME
- **Tar preparations**
  - Dithrocream - short contact,
  - Exorex®
  - Alphosyl®
  - T-gel®
  - Tar preparations e.g. Alphosyl 2 in 1®, Capasal®, T-gel®, Psoriderm® valuable
  - Dithranol e.g. Dithranol ointment BP - Specialist nurse input advised
  - Vitamin A derivatives e.g. Tazarotene gel - APPLY ONCE DAILY (irritation of skin may occur and could require the use of a topical corticosteroid)
- **Vitamin D analogues**
  - Calcipotriol, Calcitriol - USE TWICE DAILY (alternate with a topical corticosteroid or use a co-formulation e.g. Enstilar®, to increase adherence)
  - Enstilar® foam - useful for scalp and non-scarp psoriasis
  - Tacalcitol - APPLY ONCE DAILY AT NIGHTIME

**HAND AND FEET**

- Consider diagnostic differential (scraping to exclude Tinea)
- Emollients and soap substitutes
- Avoid products that contain known irritants.
- Emollients and soap substitutes
- Consider differential diagnosis

**SCALP**

- Shampoos, Long term management
  - Massage into scalp for 5mins then wash out (for dandruff)
  - Scalp for 5mins then wash out
- Emollients – use oil/coconut or creams ( Aquamax® cream, Epmac®, T-gel®)
- Topical applications for flare ups
  - Enstilar® foam, alternatives Betcap® or Enliven® short contact steroid shampoo
  - Sebcox® or Coci® for thick crust, apply for at least 2 hours or overnight (some patients cannot tolerate for more than a few hours)

**TRUNK AND LIMBS**

- **(Mild to Moderate)**
  - Enstilar® foam OD, Calcipotriol (Dovonex®) OD, Tacalcitol (Curatoderm®) OD, Calcitriol (Silkis®) OD, Enstilar® foam OD-TDS, Dithrocream - short contact, Tazarotene (Zoric®)
- **Mild topical steroids**
  - Hydrocortisone 1%
  - Hydrocortisone 1% / miconazole nitrate 2% (Daktacort®) or clotrimazole 1% (Canesten®) for co-existent yeast infection. Stop steroid once controlled
- **SEVERE**
  - Enstilar® foam BD, Diprobase or Audavate® (betametha- cream / ointment) BD for 2 weeks only then reduce to OD and add in Dovonex® OD for 4 weeks then stop steroid and continue with Dovonex® BD.
- **Alternative to Dovonex® is Curatoderm® OD or Silkis® BD**

**FLEXURES AND GENITALIA**

- Moisnturisers and ointment substitutes – Aquamax® cream useful
- Mild topical steroids
- Hydrocortisone 1%
- Hydrocortisone 1% / miconazole nitrate 2% (Daktacort®) or clotrimazole 1% (Canesten®) for co-existent yeast infection. Stop steroid once controlled
- - intermittent use only
- Moderate topical steroid
- -Clobavate® (clobetasone) cream (2nd line)
- - Tacalcitol (Curatoderm®) or tacalcitol (Silkis®) or tacrolimus (Protopic®) (off label use)

**FACE**

- Uncommon site for psoriasis
- - Emollients - use light creams avoid ointments as risk of folliculitis
- - Vitamin D analogues calcitriol (Silkis®) or tacrolimus (Curatoderm®)
- - 1% hydrocortisone or clobetasone butyrate (Clobavate®) or Betamethasone 0.025% (Clobavate®) or Calcipotriol cream applied over affected areas will improve symptoms and signs.
- - Tar preparations e.g. Enstilar® can be applied to a large area.
- - Phototherapy, refer early for widespread cases

**GUTTATE PSORIASIS**

- Typically triggered 7 – 10 days after streptococcal URTI
- MILD emollients until spontaneous resolution in 2-3 months
- Topical steroids
- Clobetasone butyrate (Clobavate®) or Betamethasone 0.025% (Clobavate®) or Calcipotriol cream applied over affected areas will improve symptoms and signs.
- Phototherapy, refer early for widespread cases

**PATIENT REVIEW**

Initial treatment period 4-8 weeks, then review as required. Important to check compliance and amounts of treatment used.

**IF NO IMPROVEMENT:**
- Change topical treatments as per protocol
- Try treatments for a further 6 weeks with review

**IF STILL NO IMPROVEMENT-REFER TO TRIAGE SERVICE**

- Referral Criteria
  - Moderate-severe psoriasis at onset
  - Failure to respond adequately to topical treatments
  - Generalised purpuric psoriasis (not hand and foot purpuric psoriasis) needs admission, call on duty dermatologist

**REFERRAL TO SECONDARY CARE:**

- Erythema
- Extensive > 20% body surface area involved / severe disabling psoriasis / PPP on both hands and feet
- Failure to respond to topical therapies or had systemic treatment in the past
- Unstable/ rapidly extending psoriasis

References

1) [https://www.medicinescomplete.com/mcs/bnf/current/9/197779-abb/index.htm?valid=1#search&text=t=1499197779-abb]

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