Psoriasis - Primary care Topical Treatment Pathway

TREATMENT
Assess pre/post Rx on Dermatology Life Quality Index (DLQI), http://www.dermatology.org.uk/quality/dlqiq.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 (e.g. Zeroderm® ointment, 50:50 Petroleum Jelly). Useful for dry elbow and knees, they best suited to nighttime use.
- Light creams (e.g. Zerobase®, Zeroderm®) 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
- Vitamin D analogues e.g. Calcipotriol, Calcitriol - USE TWICE DAILY (alternate with a topical corticosteroid or use a co-formulation e.g. Dovobet®, to increase adherence)
- Tacrolimus (Protopic®) BD - Specialist nurse input advised
- Vitamin A derivatives e.g. Tazarote (tazarote gel - APPLY ONCE DAILY (imitation of skin may occur and could require the use of a topical corticosteroid)
- Dithranol e.g. Dithranol ointment BP - Specialist nurse input advised

HAND AND FEET
- Consider differential diagnosis (scraping to exclude Tinea)
- Emollients and soap substitutes: Avoid products that contain known irritants
- For Palmoplantar pustulosis use Ointments are more effective than creams, but less well tolerated (e.g. Zeroderm® ointment, 50:50 Petroleum Jelly). Useful for dry elbow and knees, they best suited to nighttime use.
- Light creams (e.g. Zerobase®, Zeroderm®) are better suited during the day. Find an emollient that patients are likely to use regularly and prescribe sufficient quantities.
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SCALP
- Shampoo, Long term management - massage into scalp for 5mins then wash out (tar based polytar, capasal®, T-gel®)
- Emollients - use oil/coconut or creams (aquamax® cream, zerobase®)
- Apply overnight as necessary (1-2 x per week if very dry)
- Topical applications for flare ups
- Dovobet® gel, alternatives Betacap® or Entrix® short contact steroid shampoo
- Sebco® or Cocox® 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)
- Dovobet® gel OD, Calcipotriol (Dovonex®) OD, Tacrolimus (Curataderm®) OD
- Calcipotriol (Curataderm®) OD, Calcitriol (Silkis®) OD, Eroxor® Lotion BD-TDS, Dithrocream® short contact, Tazarote (Tinset®)
- (Mild topical steroids)
- Hydrocortisone 1%, Hydrocortisone 1%/miconazole nitrate 2% (Daktorol®) or Hydrocortisone 1%/ clotrimazole 1% (Canesten®) for co-existing yeast infection. Step steroid once controlled
- - intermittent use only
- (Moderate topical steroid)
- Clobetasone butyrate (Clobavate®) alternative
- (Strong topical steroid)
- - Calcitriol cream applied all over affected areas will improve symptoms and signs.
- - For dry skin use an ointment
- - For wet, weeping skin employ a cream

FLEXURES AND GENITALIA
- Moisturisers and soap substitutes - Aquamax® cream useful
- Mild topical steroids
- Hydrocortisone 1%
- Hydrocortisone 1%/miconazole nitrate 2% (Daktorol®)
- Hydrocortisone 1%/ clotrimazole 1% (Canesten®) for co-existing yeast infection. Step steroid once controlled
- - intermittent use only
- - Moderate topical steroid
- Clobetasone butyrate (Clobavate®)
- - Alternative to Dovonex® is Curataderm® OD or Silkis® BD

FACE
- Uncommon site for psoriasis
- Emollients - use light creams avoid ointments risk of folliculitis
- Vitamin D analogues calcitriol (Silkis®) or tacrolimus (Curataderm®)
- -1% hydrocortisone or clorobetasone butyrate (Clobavate®) can be used although risk of atrophy, alternative is 0.03 - 0.1% tacrolimus (Protopic®) (off label use)

GUTTATE PSORIASIS
- Typically triggered 7 – 10 days after streptococcal URTI
- MILD emollients until spontaneous resolution in 2-3 months
- Topical steroids - Clorobetasone butyrate (Clobavate®) or Betamethasone 0.025% (Aubacter®)
- - Calcium pantothenate
- - Calcipotriol cream applied over affected areas
- - For dry skin use an ointment
- - For wet, weeping skin employ a cream

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 pustular psoriasis (not hand and foot pustular psoriasis) needs admission, call on duty dermatologist

REFERRAL TO SECONDARY CARE:
- Erythroderma
- - 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/browse/current/YPFP7779-elidel.htm?valid=1&search=true&text=f1=1499F7779-elidel
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