Bedfordshire, Luton and Milton Keynes Health and Care Partnership

Management of **PLAQUE PSORIASIS** in Primary care

Patient information
- British Association of Dermatologists – www.bad.org.uk
- Psoriasis Association – www.psoriasis-association.org.uk
- Primary Care Dermatology Society – www.PCDS.org.uk

Prescribe **copious emollients** - these make the skin more comfortable and reduce the amount of scale-See Formulary for cost-effective choices

The active treatments below should be used for psoriasis flare-ups until the plaques are controlled, with a treatment holiday between flare-ups (aim for 4 weeks) when the use of regular emollients should be still be encouraged. All patients with psoriasis will require annual medication/skin review, joint and cardiovascular risk assessment.

SCALP—Adults

Initial treatment
For 4 weeks
1st line: Potent steroid [Betacap® scalp application]
If thick scales add a descaling agent e.g. salicylic acid [e.g. Diprosalic]
Check adherence and if treatment failed:
2nd line: Calcipotriol and betamethasone combination [generic ointment or gel, cream [Wynzora®] or Enstilar® Foam] daily*
If second line therapy fails after 8 weeks:
Offer a very potent corticosteroid applied up to twice daily for two weeks (Etrivex® shampoo) or refer to specialist.

Thick scales: Emollient ointment **OR** Coal Tar/ salicylic acid/precipitated sulfur combinations [Cocois® **OR** Sebco® ointment]

If steroid not suitable—Vitamin D alone—e.g. tacalcitol lotion

Maintenance: Emollients +/- Coal tar shampoo. Consider above steroid application twice weekly to sustain improvement.

*For patients with psoriasis on both scalp and body, a single prescription of Enstilar foam may improve compliance

FACE—Adults

Initial treatment
For 1-2 weeks max
Hydrocortisone 1% **OR** clobetasone 0.05%

If ineffective contact dermatology (via Advice & Guidance) for further treatment options e.g. off label topical Pimecrolimus (Elidel®) or tacrolimus [Protopic®) – (note that GPs with a special interest may initiate).

If fungal infection suspected: Daktacort®

Maintenance: Emollients, and/or vitamin D preparation twice weekly e.g. Silkis

FLEXURES/GENITALS— Adults

Initial treatment
For 2 weeks
Hydrocortisone 1% **OR** clobetasone 0.05% **OR** calcitriol ointment (Silkis®)

If fungal infection suspected: Daktacort® or Trimovate®

If ineffective contact dermatology (via Advice & Guidance) for further treatment options.

Maintenance: Emollients +/- calcitriol ointment (Silkis®)

TRUNK - Adults

Initial treatment
For 4 weeks
Calcipotriol + Betamethasone combination (e.g. cream [Wynzora] or foam (Enstilar®) or Calcipotriol + Betamethasone (e.g. generic ointment or gel)) daily

Thick plaques - Diprosalic® Ointment

Thin, widespread plaques on thin skin e.g. shins - Exorex® lotion

Maintenance: Emollient +/- calcipotriol ointment.

Consider above steroid application twice weekly to sustain improvement.

When to Refer:
Rheumatology – if symptoms are suggestive of psoriatic arthritis or PEST score > 3/5
The_PEST_screening_questionnaire_updated_aug_2013_v5_1.pdf (pcds.org.uk)

Acute medical team – Erythrodermic psoriasis
Dermatology outpatient – persistent symptoms, severe psoriasis

Medication review at 4 weeks with new topical treatment:
- Evaluate tolerability, toxicity and initial response to treatment
- Reinforce the importance of adherence when appropriate
- Reinforce the importance of a break between courses of potent/very potent corticosteroids
- If little or no improvement - discuss next treatment option
- If responding to topical treatment - discuss maintenance therapy / relapse / healthy lifestyle

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