Treatment of Psoriasis

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Conflicts of Interest

- Advisor to Abbott
- Previously advisor to Leo, Valeant
- Sponsorship from many drug companies

Treatments Available

- Topical Preparations
- UVB/PUVA
- Conventional systemic drugs
- Biologics

Choice of Treatment

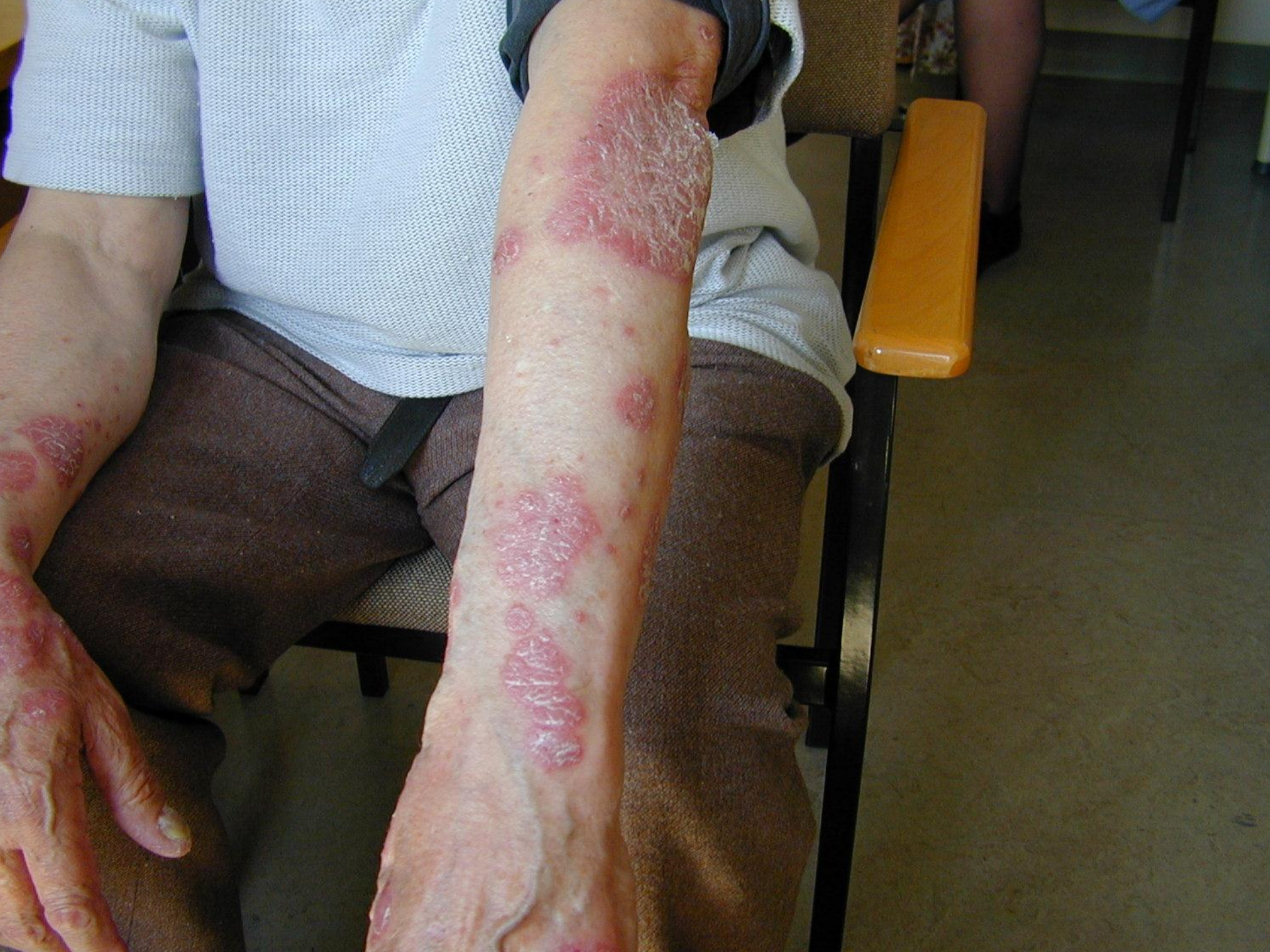
- Localised CPP = localised treatment
- Widespread CPP/poor quality of life = UVB/systemic treatment +/- topical
- Inflammatory Ps = UVB/systemic treatment +/- topical
- Co-morbidity eg arthritis = systemic treatment

Factors Influencing Choice of Topical Treatment

- Site
- Extent
- Inflammation
- Patient Choice

Patient 1

- Psoriasis for 10 years
- Not itchy
- Gradually more extensive
- Affects extensor forearms, lower legs, few plaques elsewhere
- About 5% BSA affected

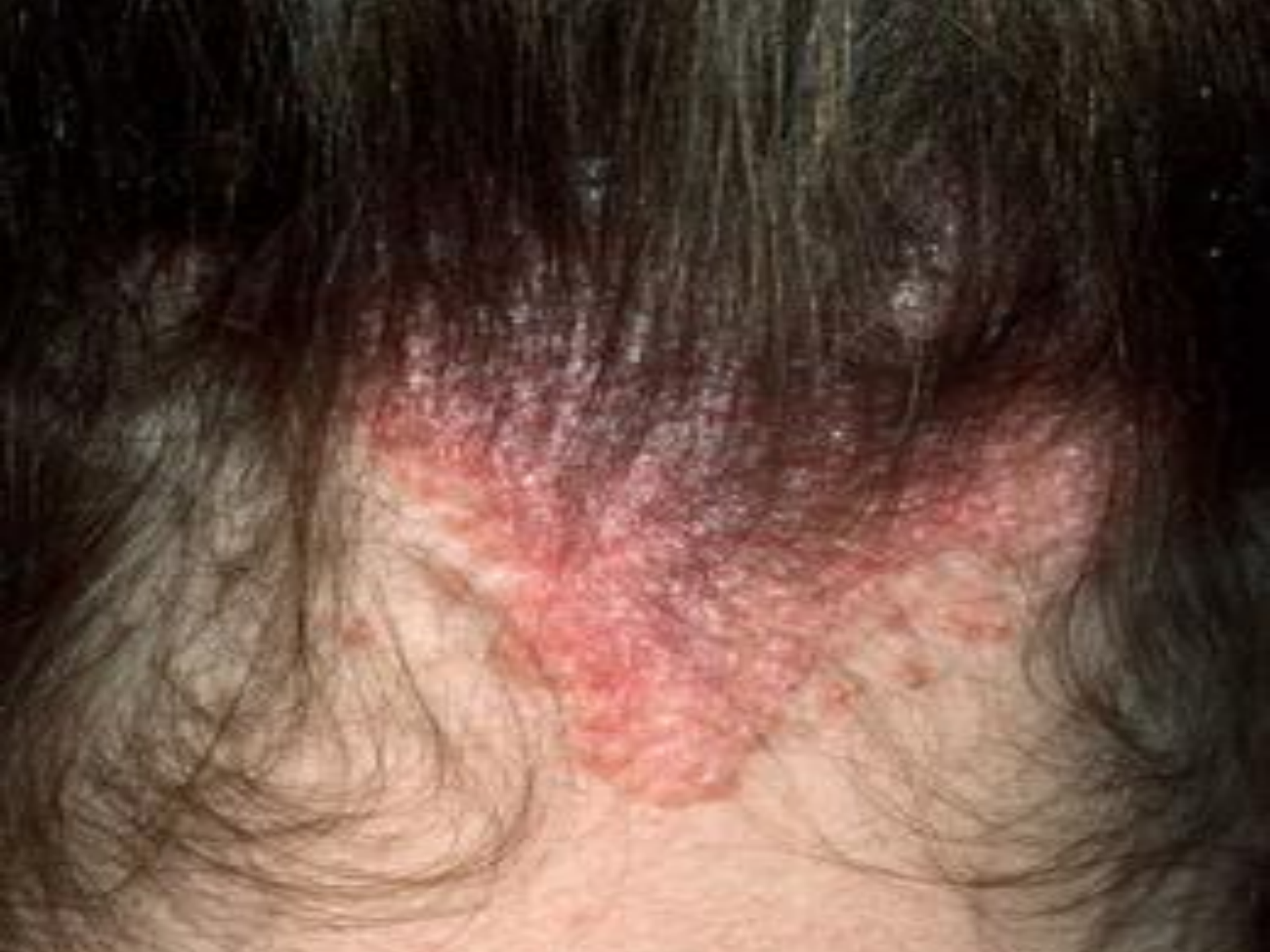


Chronic Plaque Psoriasis

- Emollients
- Calcipotriol (prefer ointment)
- Calcipotriol plus topical steroid (Daivobet)
- Tar (5% Liquor Picis Carbonis in WSP/Emulsifying ointment/Cetomacrogol)
- Tar plus topical steroid (5%LPC 25% Beta in …)
- (Dithranol)

Patient 2

- Severe scalp psoriasis
- Itchy
- Intractable
- +/- psoriasis elsewhere

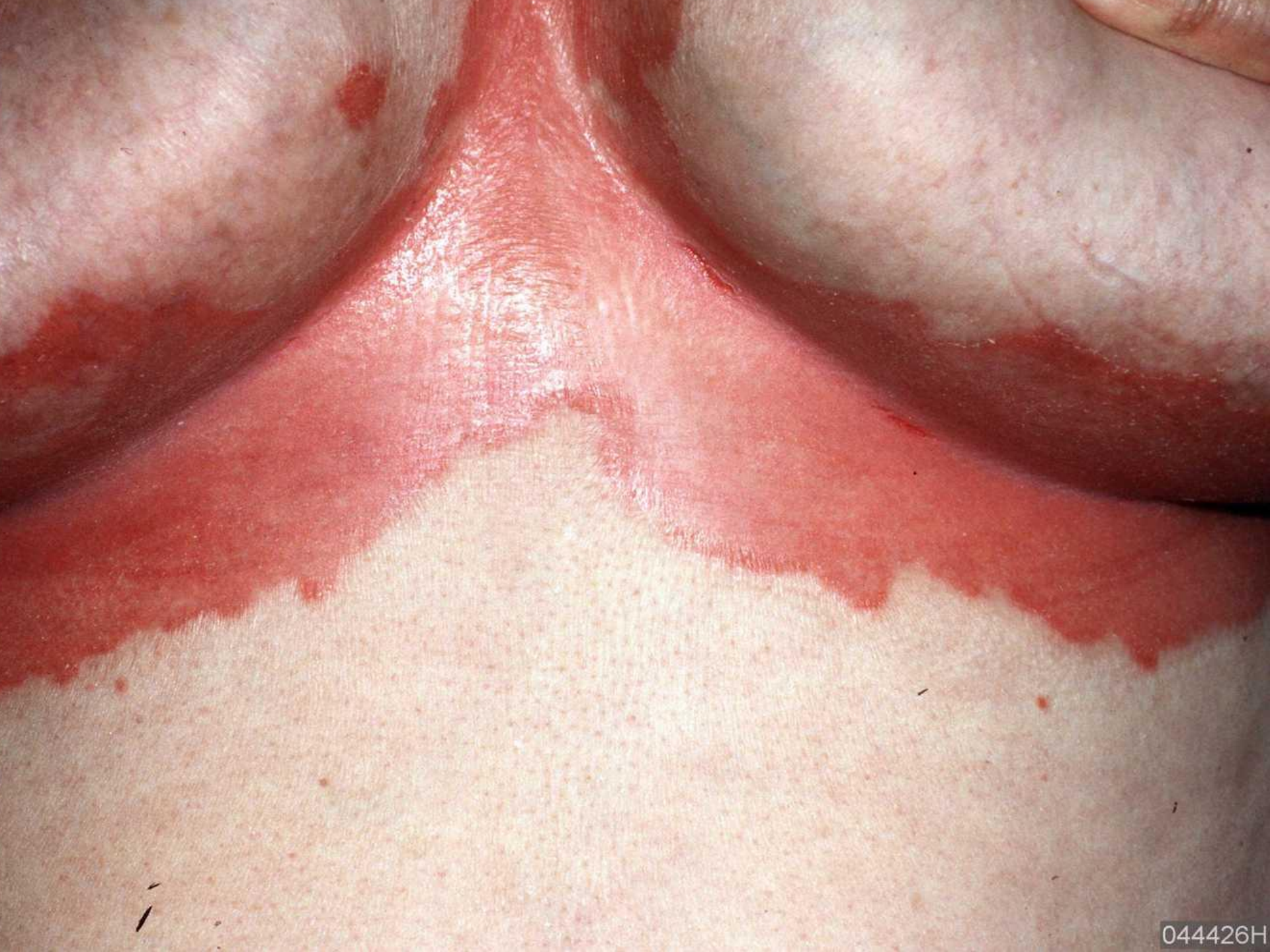


Scalp Psoriasis

- Coco-Scalp at night, cover with shower cap, old sheets etc
- Wash hair in morning with tar shampoo
- Apply topical steroid lotion
- Repeat daily for 2 weeks
- Intermittent use thereafter
- Daivonex Scalp Solution
- (Topical tacrolimus)

Patient 3

- Severe flexural psoriasis
- Facial Psoriasis
- Itchy
- Sore
- Embarrassing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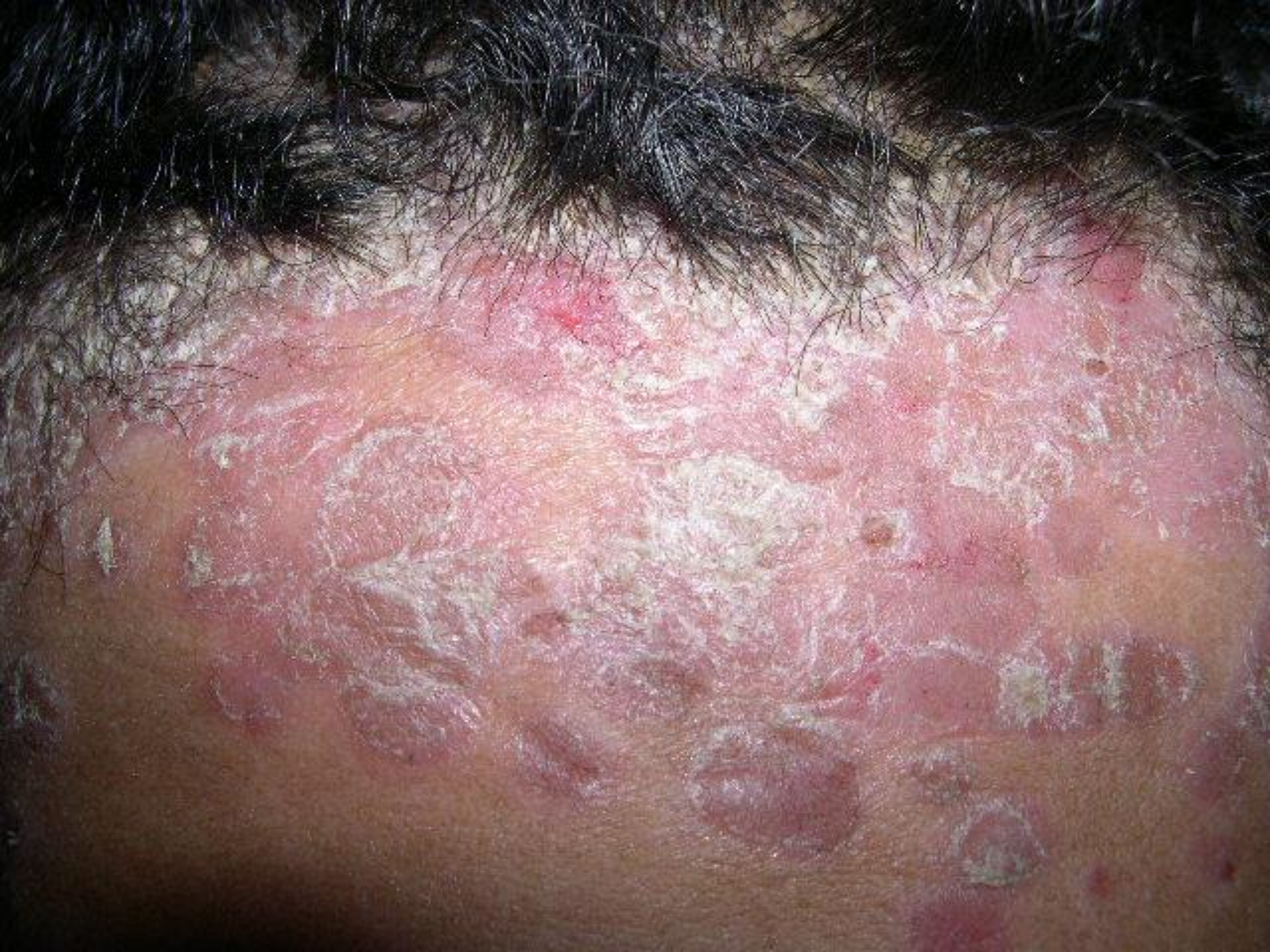


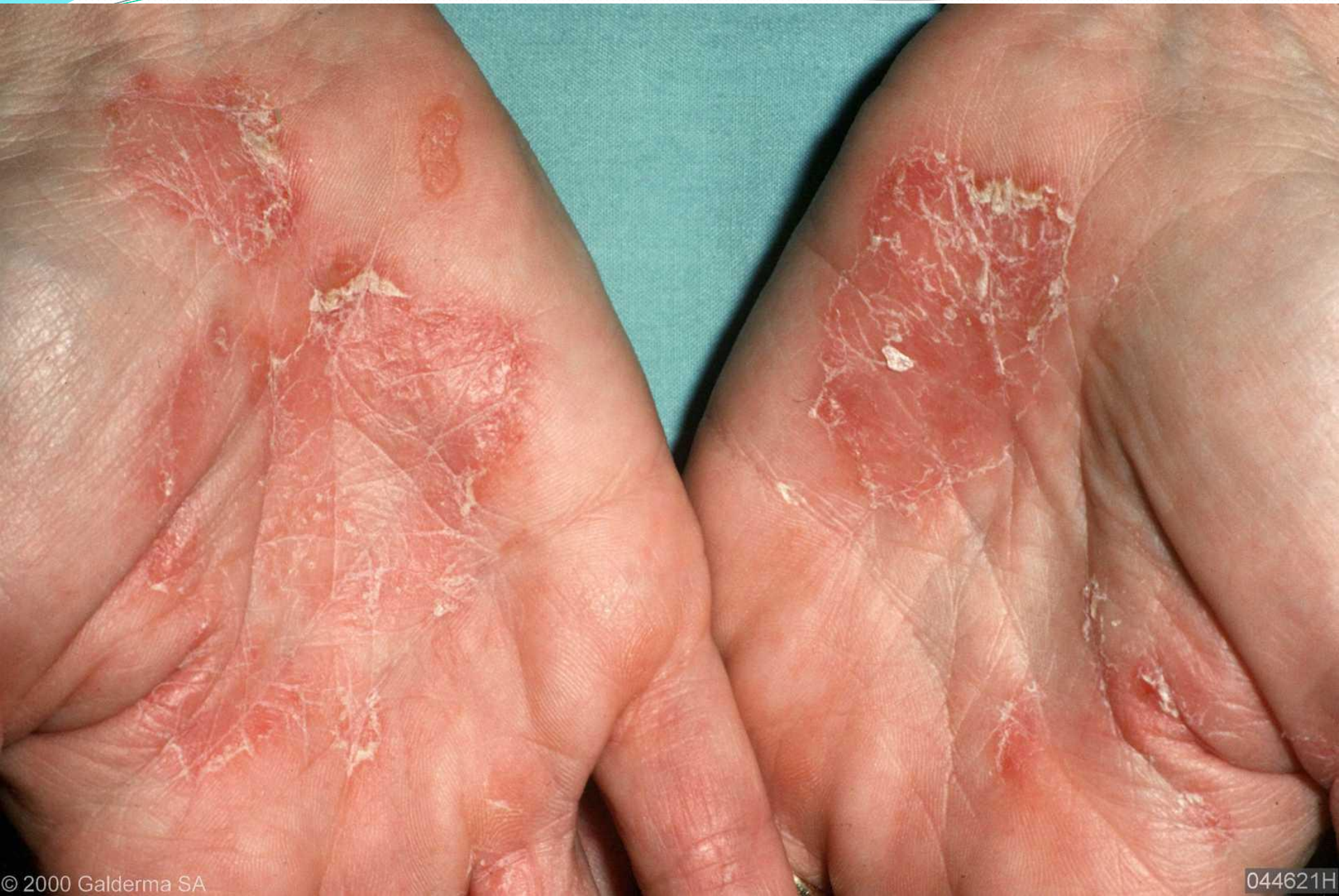
Flexural/Facial Psoriasis

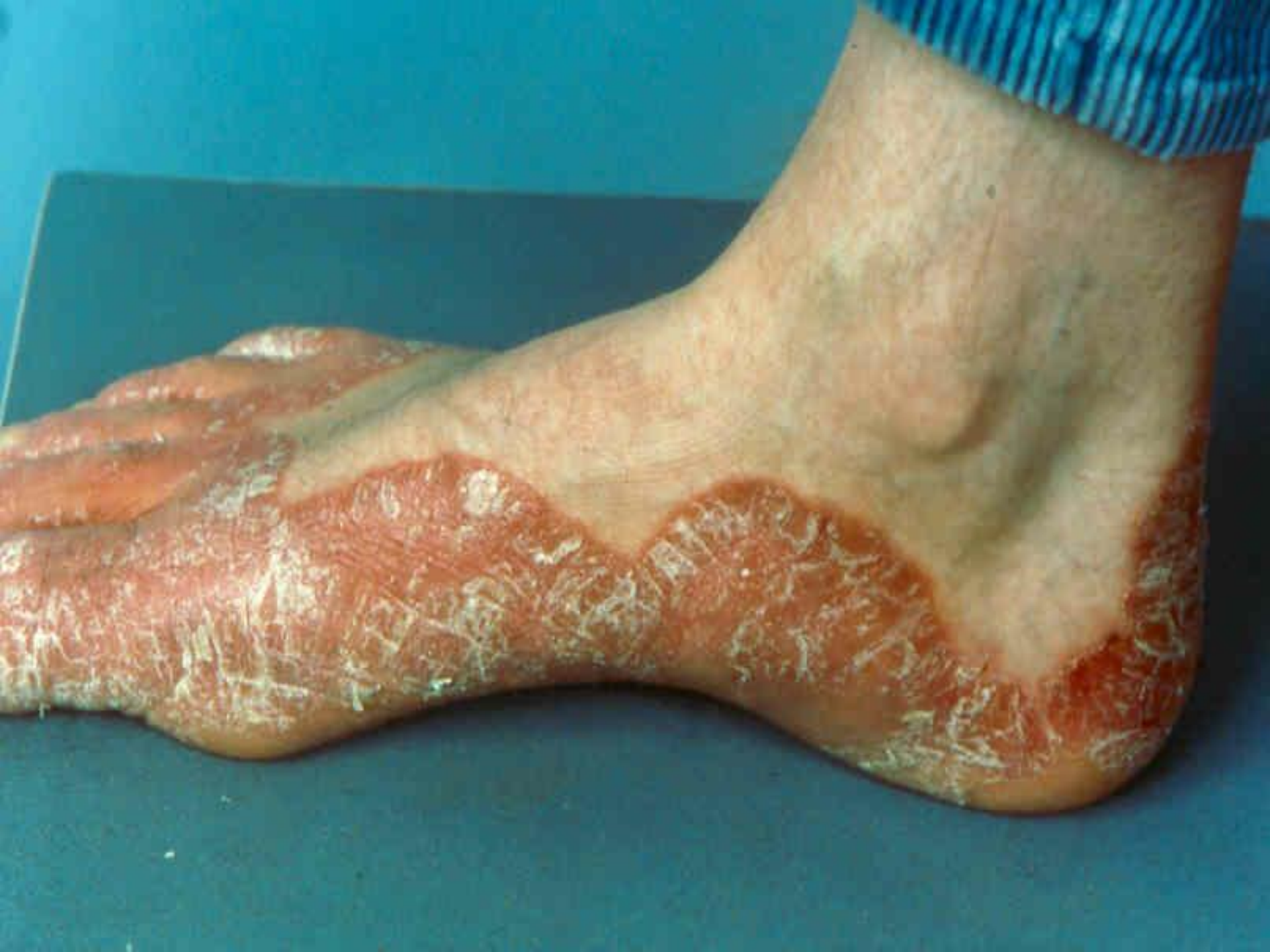
- Moderate potency topical steroid eg Eumovate cream
- Stronger steroid sometimes eg. Locoid Lipocream
- HC usually too weak
- +/- topical antibiotic/imidazole
- (Tacrolimus/Pimecrolimus)
- Calcipotriol often too irritant
- Tar

Patient 4

- Psoriasis on palms and soles
- Not itchy
- Not pustular
- Manual job

Hand and Foot Psoriasis



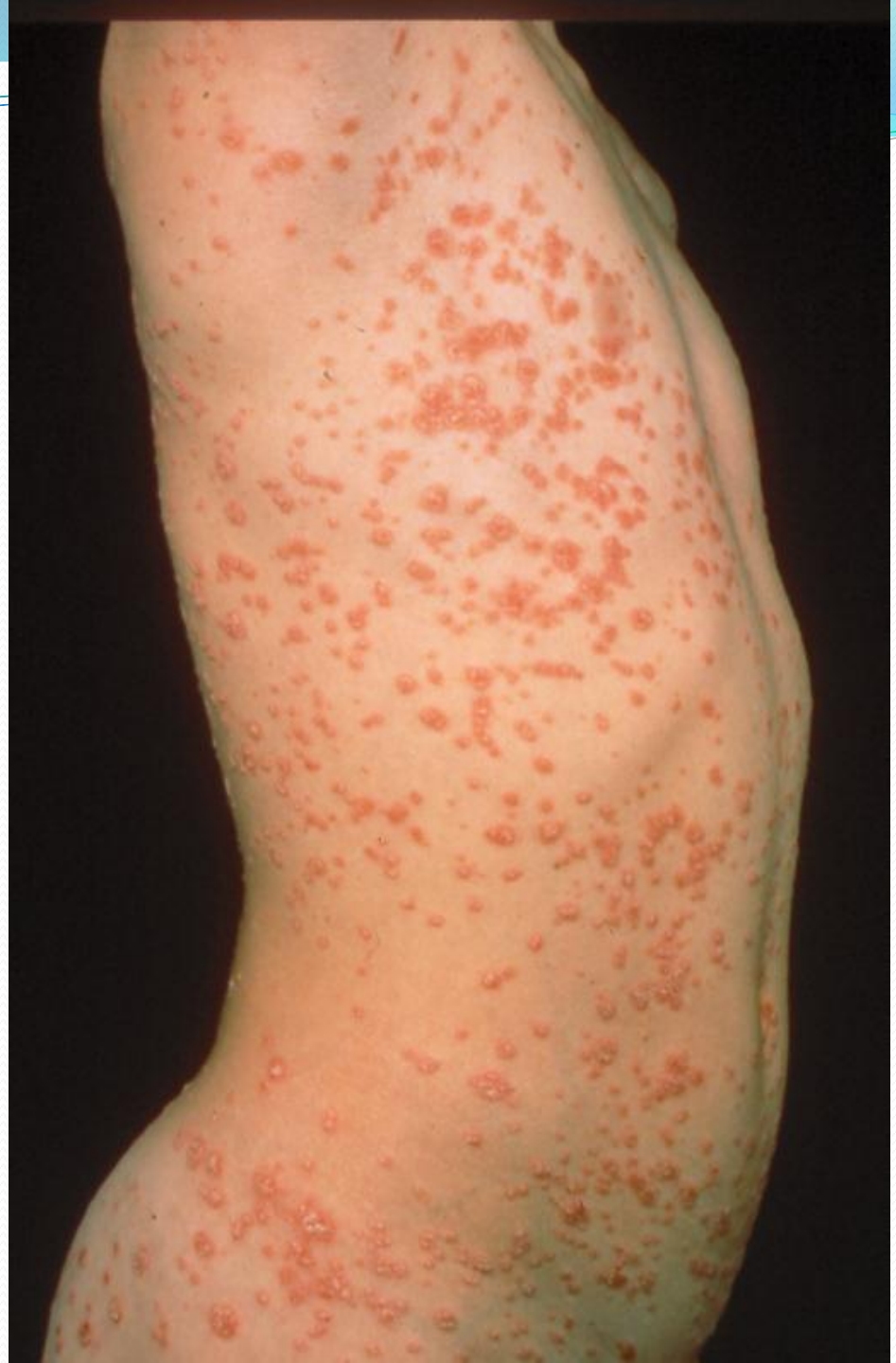


Palmo-plantar psoriasis

- Dermol ointment +/- Salicylic acid (3-5%)
- Daivonex/Dermol combination
- Tar
- PUVA
- Systemic treatment

Patient 5

- Child aged 10
- Acute onset of small psoriatic papules 2 weeks after streptococcal sore throat



Guttate Psoriasis

- Emollients
- Mild tar preparation
- UVB
- Avoid potent steroids etc

Which Patients to Refer

- Failure of Topical Treatment
- Concern about use of topical steroids
- Diagnostic uncertainty
- Guttate Ps
- Extensive CPP
- Poor Quality of Life
- Erythrodermic Ps
- Generalised Pustular Psoriasis

Phototherapy

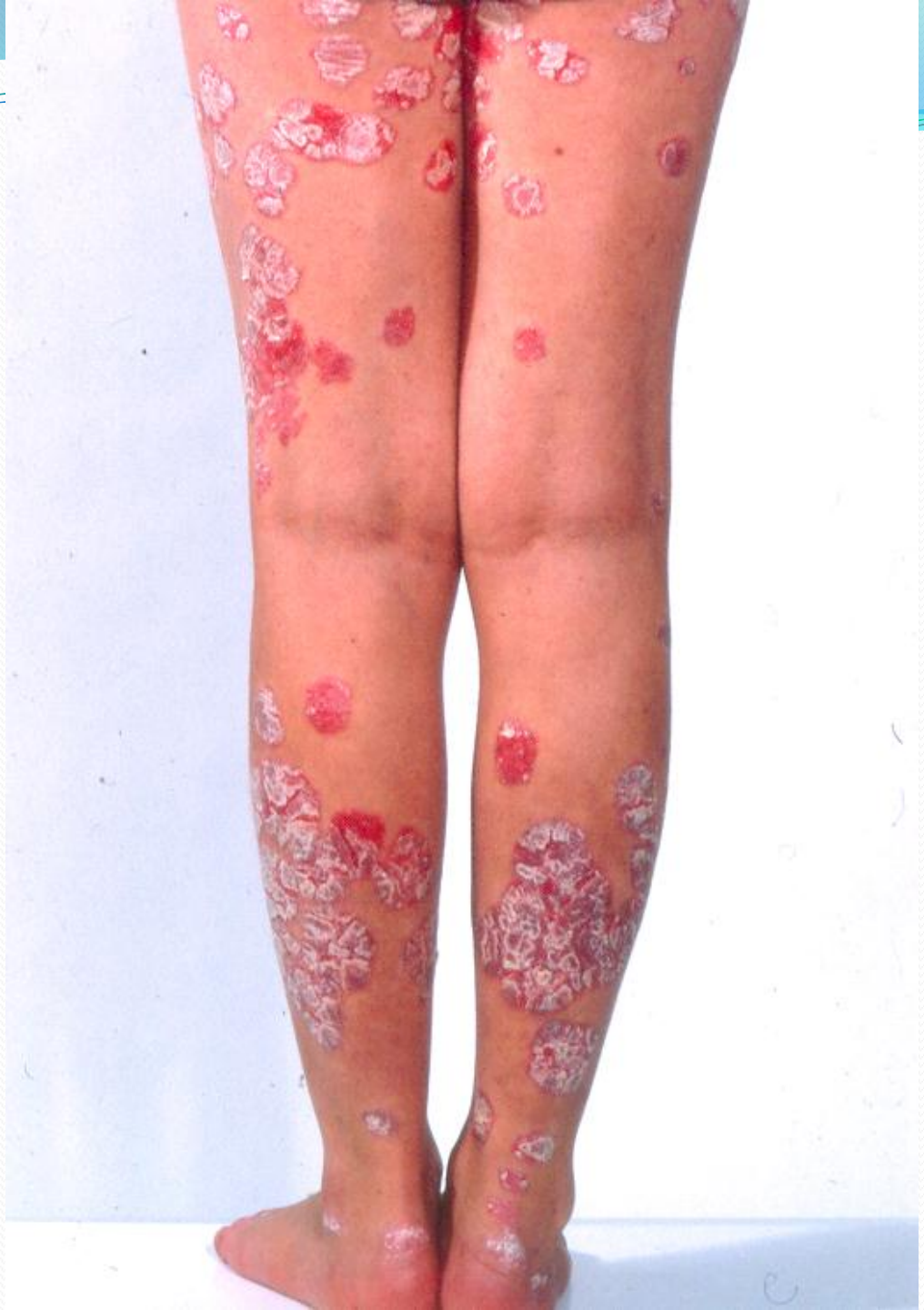
- Broadband UVB
- Narrowband UVB
- PUVA (Psoralen + UVA)

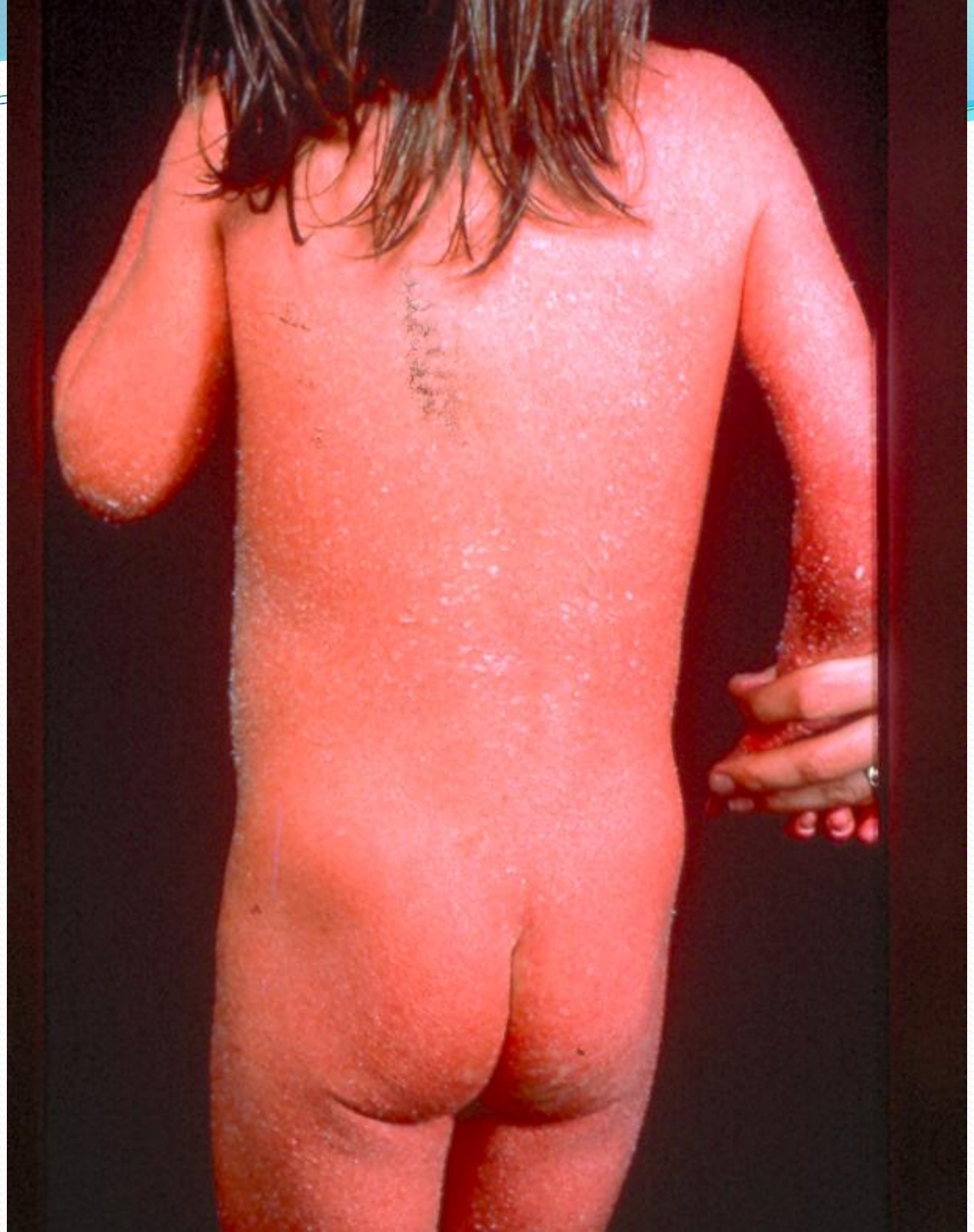
Phototherapy

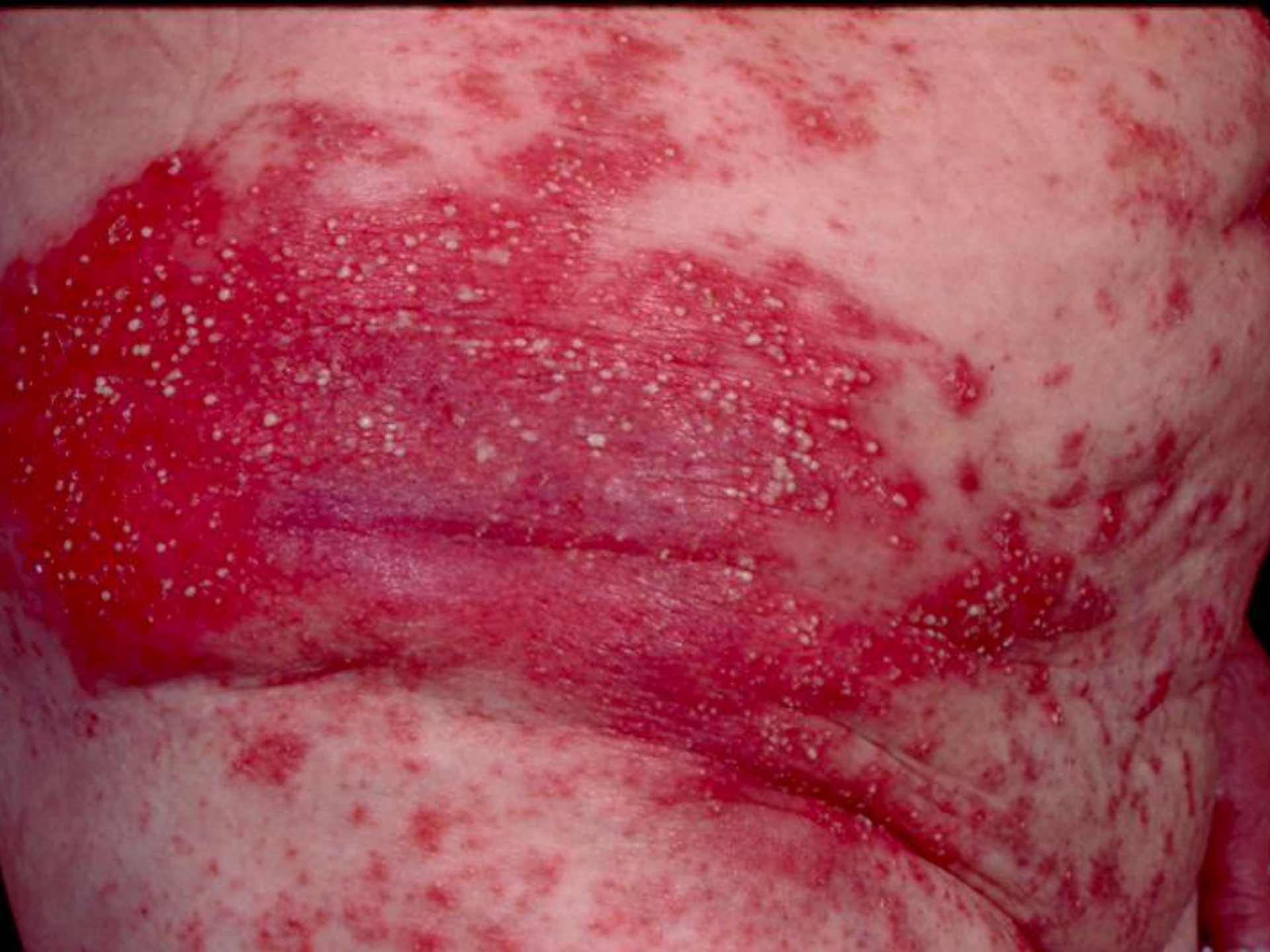
- >10%BSA,
- Ideal for quick responders who get prolonged remission
- nUVB effective approx 60-80%
- Efficacy PUVA vs nUVB 84% vs 65%
- Remission at 6/12 68% vs 35%
- Lifetime maximum 250 treatment sessions

Criteria for Systemic Treatment

- Severe Psoriasis
  - PASI Score >10, >10% BSA, severe localised psoriasis
- Poor Quality of Life (DLQI >10)
- Poor response to topical treatment
- Poor response/rapid relapse after UV
- Erythrodermic/GPP







Systemic Drugs

- Methotrexate
- Cyclosporin
- Acitretin
- Hydroxyurea, Azathioprine, Mycophenolate
- Biologics

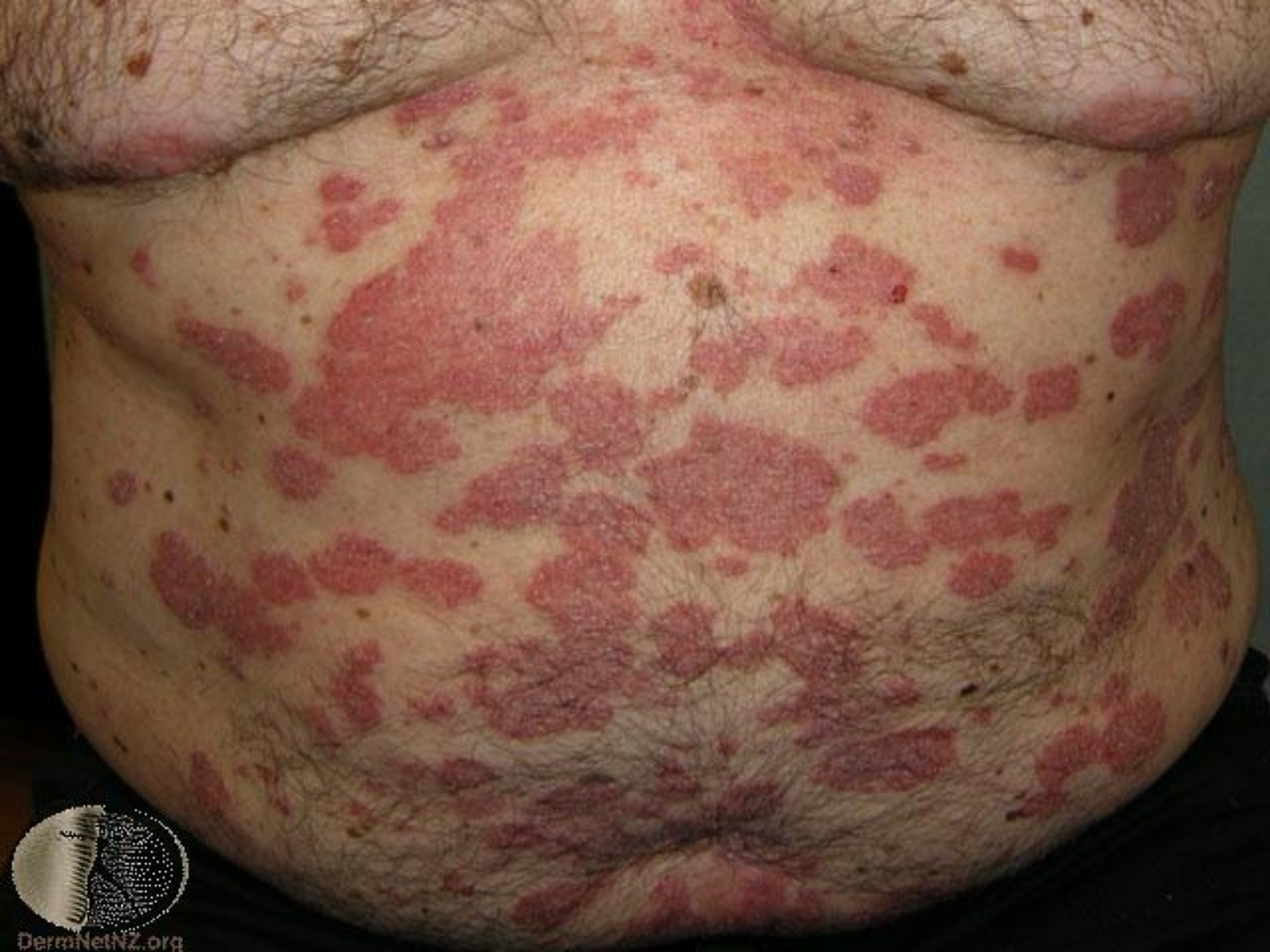
Methotrexate vs Cyclosporin

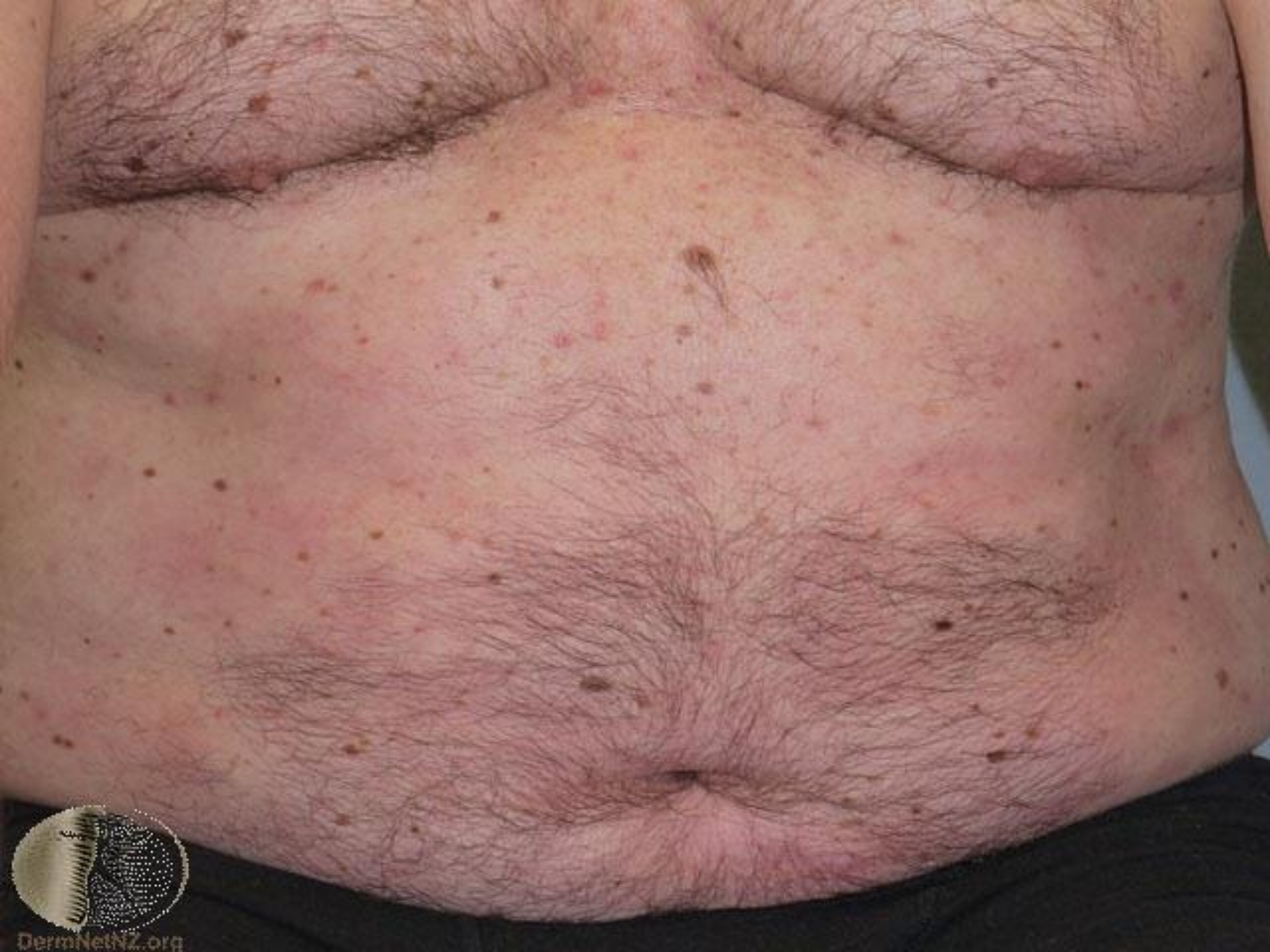
- No RCTs of MTX
- Multiple small CyA trials
- Two head to head studies indicate:
- Similar efficacy
- 60 – 80% achieve PASI 75 at 16 weeks

Biological Response Modifiers

- Adalimumab
  - Adalimumab is a recombinant monoclonal antibody containing only human peptides. It works by directly binding to TNF molecules in the blood and diseased tissue.
  - 71% (40mg alt weeks) of patients achieved PASI 75 by 16 weeks.

- Etanercept
  - Etanercept is genetically engineered TNF receptor fusion protein.
  - 48% (50 mg biweekly) of patients achieving PASI 75 by 12 weeks.


DermNetNZ.org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Biologics vs Conventional Systemic Drugs

- One RCT comparing efficacy of adalimumab (40 mg every other week) vs. methotrexate (7.5 mg initial dose weekly, increasing to a maximum of 25 mg weekly as tolerated)

- 80% of patients achieving PASI 75 by week 16 compared with surprisingly low methotrexate (36%) and high placebo (19%) response rates

Published Guidelines

- British Association of Dermatologists and Primary Care Dermatology Society Guidelines
  - Recommendations for Initial Management of Psoriasis
    - www.bad.org.uk/Portals/_Bad/Guidelines/Clinical%20Guidelines/BAD-PCDS%20Psoriasis%20reviewed%202010.pdf

    or
    - www.bad.org.uk Clinical Guidelines

- Canterbury Health Pathways

CANTERBURY HealthPathways

Psoriasis

About psoriasis

Assessment

1. Clinical assessment:
   - Normally presents as unsightly and/or itchy patches over body especially extensor surfaces of limbs.
   - Often involves scalp, trunk, may involve nails.
   - Can be mistaken for fungal dermatoses in the groin genital and perianal regions.
   - May be associated with psoriatic arthropathy.
   - May be exacerbated by lithium, anti-malarials, or steroid withdrawal.
2. Consider differential diagnosis.

Management

While psoriasis is treatable, there is no cure and it is not responsive to special diets.

1. General measures.
2. Soap substitutes.
3. Plaques on body - use calcipotriol 50 mcg/g cream/ointment (Daivonex)
4. Psoriasis on face and flexures
5. Scalp psoriasis
6. Nail psoriasis, limited treatment is available. Exclude fungal infection. Refer if disabling.
7. Other treatments which may be useful.

Note: Sunbeds emit the wrong frequency of UVA light to be helpful and increase the risk of skin cancer.