Treatment pathway for the management of psoriasis in adults

NHS
Mid Essex Locality

Psoriasis is characterized by scaly skin lesions, which can be in the form of patches, papules, or plaques with associated itchiness. The skin lesions of psoriasis are characterized by:

- Hyperproliferation of the epidermis.
- Dilatation and proliferation of blood vessels in the dermis.
- Accumulation of inflammatory cells, particularly neutrophils and T-lymphocytes.

Images of different types of psoriasis can be found here: http://www.dermnet.com/

For patients with any type of psoriasis:

- Assess severity & impact of their psoriasis (ask about scalp, genital, natal cleft, nail involvement):
  - at first presentation
  - before referral for specialist advice and at each referral point along treatment pathway
  - to evaluate the efficacy of interventions
- Assess impact of disease severity on physical, psychological and social well-being by asking:
  - if any aspects of daily living are affected by their psoriasis and how they are coping
  - if their mood is impacted
  - if their psoriasis causes them distress or impacting their family or carers
  - consider using the Dermatology quality of life assessment http://www.pcds.org.uk/p/quality-of-life
- Assess co-existing psoriatic arthritis
- Assess comorbidities for related co-morbidities e.g. cardiovascular disease. Evidence suggests an association between CVD and psoriasis. Modifiable risk factors need to be targeted and have a low threshold for investigating cardiac symptoms.
- Assess lifestyle risk factors and offer advice/ support – see self-care box.
- Discuss the risks and benefits of treatment options with the patient (and their carers).
- Discuss the importance of persistence with treatment for optimising outcomes.
- Clarify previous treatment history
- Provide patient information leaflet (British Association of Dermatologists BAD) http://www.bad.org.uk/shared/get-file.ashx?id=178&itemtype=document

Self-care advice

Psoriasis symptoms can start or become worse by the following triggers. Patients should be informed on the following triggers and advised to avoid them, where this is possible:

- drinking excessive amounts of alcohol
- smoking
- stress
- certain medicines such as lithium, some antimalarial medicines, anti-inflammatory medicines including ibuprofen, ACE inhibitors (used to treat high blood pressure) and beta blockers (used to treat congestive heart failure)
- hormonal changes, particularly in women (for example during puberty and the menopause)
- injury to skin such as a cut, scrape, insect bite or sunburn (this is known as the Koebner response)
- throat infections - in some people, usually children and young adults, a form of psoriasis called guttate psoriasis (which causes smaller pink patches, often without a lot of scaling) develops after a streptococcal throat infection, although most people who have streptococcal throat infections do not develop psoriasis
- other immune disorders, such as HIV, which cause psoriasis to flare up or to appear for the first time

Refer the person for dermatology specialist advice if:

- Diagnostic uncertainty exists.
- Psoriasis is extensive, for example more than 10% of the body surface area is affected.
- Psoriasis is severe as measured by the Physician's Global Assessment.
- Topical treatments have failed.
- The person cannot tolerate the treatment options available in primary care.
- There is a significant impact on physical, psychological or social well-being.
- Further information or education is needed (for example about application of topical treatments).

MILD TO MODERATE PSORIASIS

1st line - Topical treatments (see page 3 for treatment pathway of topical treatment)

Topical treatment options include:

1) Emollients to reduce scale and help with other symptoms including itch.
2) Topical corticosteroids are only suitable for treating localized psoriasis
   - A potent topical corticosteroid (applied once a day) plus a topical vitamin D preparation (applied once a day).
3) If scale is a particular problem, preparations containing salicylic acid may be useful, although evidence is lacking.

Review after 4 weeks. If there has been a good initial response, continue treatment until the skin is clear or nearly clear.

MODERATE TO SEVERE PSORIASIS

2nd line – Moderate to severe at onset and those who fail to respond adequately to topical treatments refer to dermatology for consideration of the following:

- Phototherapy for plaque or guttate-pattern psoriasis that cannot be controlled with topical treatments alone. Treatment with narrowband UVB phototherapy can be given 3 or 2 times a week depending on patient preference. Tell people receiving narrowband UVB that a response may be achieved more quickly with treatment 3 times a week.

- Under shared care agreements:
  - Ciclosporin – severe psoriasis
  - Methotrexate – severe psoriasis

- Acitretin – severe refractory psoriasis HOSPITAL PRESCRIBING ONLY

SEVERE PSORIASIS

Biologic therapies may only be initiated in severe psoriasis where patients have not responded or patients are intolerant of/have contraindications to standard systemic 2nd line therapy.
Individual prior approval required see High cost drugs proformas (LINK)

Severe psoriasis: NICE TA146 , TA103 , TA180 , TA350 , NICE TA 419
Adalimumab, Etanercept (Anti TNF)
Ustekinumab (Interleukin 12/23 inhibitor)
Secukinumab (Interleukin 17A inhibitor)
Apremilast (PDE4 inhibitor)

Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10

Very severe psoriasis NICE TA134 →
Infliximab (Anti TNF)

Psoriasis Area Severity Index (PASI) of 20 or more **and** a Dermatology Life Quality Index (DLQI) of more than 18.

Consider changing to an alternative biological drug in adults (i.e. rotating treatments if there is a loss of efficacy) where:

- the psoriasis does not respond adequately to a first biological drug as defined in NICE TA (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept and secukinumab, and 16 weeks for adalimumab, ustekinumab and apremilast; primary failure) or
- the psoriasis initially responds adequately but subsequently loses this response, (secondary failure) or
- the first biological drug cannot be tolerated or becomes contraindicated.

For adults in whom there is an inadequate response to a third biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy. Some patients may not be able to tolerate the biological agents.

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Trunk & limbs or guttate

1st line

Potent corticosteroid ONCE daily
PLUS
Vitamin D/vitamin D analogue ONCE daily
Apply separately – one AM and one PM for up to 4 weeks

If ineffective after max of 8 weeks

2nd line

Vitamin D/vitamin D analogue TWICE daily

If ineffective after max of 8 -12 weeks

3rd line

Potent steroid TWICE daily for 4 weeks
OR
Coal tar prep ONCE or TWICE daily

If not tolerated or OD application needed

4th line

Betamethasone 0.05% and calcipotriol 50mcg/g ONCE daily for up to 4 weeks.
1st line - Dovobet® ointment
2nd line – Enstilar® foam if ointment ineffective or not tolerated

Face, Flexures and genitals

Short term mild or moderate potency corticosteroid ONCE or TWICE daily for up to 2 weeks

If ineffective or continuous treatment is required and high risk of corticosteroid induced side effects

Calcineurin inhibitor A (tacrolimus or pimecrolimus) TWICE daily for up to 4 weeks ONLY
To be initiated by specialist or GP with special interest in dermatology

Scalp

Potent corticosteroid ONCE daily for up to 4 weeks

If ineffective after 4 weeks

Consider:
- alternative formulation of potent steroid e.g. mousse or shampoo
- topical agent to remove scale prior to applying steroid E.g. salicylic acid, emollient

If ineffective after a further 4 weeks

Betamethasone 0.05% and calcipotriol 50mcg/g (Dovobet®) gel ONCE daily up to 4 weeks
OR
Vit D/vit D analogue OD for 8 weeks – if cannot tolerate steroid and scalp psoriasis is mild/moderate

If ineffective after 8 weeks

Very Potent steroid TWICE daily for 2 weeks
OR
Coal tar ONCE or TWICE daily

When to refer to specialist:

- Unsatisfactory response to topical treatment
- Severe/extensive psoriasis which may require phototherapy or systemic therapy

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Topical preparations used for psoriasis

Topical corticosteroids	
Mild	Hydrocortisone 1% cream or ointment
Moderate	Clobetasone butyrate 0.05% Eumovate® cream or ointment
	Betamethasone valerate 0.025% cream or ointment
Potent	Betamethasone valerate 0.1% (cream/ointment)
	Mometasone furoate 0.1% cream/ointment (Elocon®)
	Betamethasone propionate 0.05% cream/ointment
	Hydrocortisone butyrate 0.1% cream/ointment (Locoid®)
Very potent	Clobetasol proprionate 0.05% (cream/ointment)

Topical scalp corticosteroids		
Potent	1st line	Betamethasone valerate 0.1% (Betnovate® scalp application)
	2nd line	Mometasone furoate 0.1% (Elocon® scalp lotion)
	3rd line	Hydrocortisone butyrate 0.1% (Locoid® scalp lotion)

Be aware that continuous use of potent or very potent corticosteroids may cause:
- irreversible skin atrophy and striae
- psoriasis to become unstable
- systemic side effects when applied continuously to extensive psoriasis (for example, more than 10% of body surface area affected).

Explain the risks of these side effects to people undergoing treatment (and their families or carers where appropriate) and discuss how to avoid them.

Advise not to apply potent corticosteroids for more than 8 weeks at any one site. Treatment with a corticosteroid may be restarted after a 4 week 'treatment break'. During this time vitamin D preparations may be continued.

Vitamin D and Vitamin D analogues	
1st line	Calcipotriol 50mcg/gram Generic – ointment & scalp solution Dovonex®- cream, ointment & scalp solution
2nd line	Calcitriol 3mcg/gram ointment (Silkis®)

Coal tar preparations		
1st line – large thin plaques	Coal tar 5% cutaneous emulsion	Exorex® lotion
Scalp – for thick scale	Coal tar solution 12% Salicylic acid 2% Sulphur 4% in coconut oil compound	Sebco® scalp ointment
	Coal tar 1% Salicylic acid 0.5%	Capasal® shampoo

Combination Betamethasone 0.05% and calcipotriol 50mcg/g	
1st line	Dovobet® ointment
2nd line	Enstilar® foam - if ointment ineffective or not tolerated Supply a maximum of 2 sprays for a 4 week treatment period.
Scalp/hairy skin	Dovobet® gel

Calcineurin inhibitor A – specialist/GPwSI initiation only	
Tacrolimus 0.03% and 0.1%	Ointment - Protopic®
Pimecrolimus 1%	Cream - Elidel®

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References	1. The management of psoriasis in adults. Dorset Medicines Advisory group. January 2016 http://www.dorsetccg.nhs.uk/Downloads/aboutus/medicines-management/Other%20Guidelines/Psoriasis%20management.pdf 2. Psoriasis summary Camden CCG June 2015 https://gps.camdenccg.nhs.uk/cdn/serve/pathway-downloads/1455269755-c7677f7d9a62df49a3cfa75b324f07e5.pdf 3. NICE Clinical Knowledge Summaries. Psoriasis. Last updated. Sept 2014 https://cks.nice.org.uk/psoriasis#!management 4. Prescqipp bulletin 76: Cost effective prescribing of emollients May 2015 https://www.prescqipp.info/resources/send/174-emollients/1951-bulletin-76-cost-effective-and-appropriate-prescribing-of-emollients
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Previous version	Summary of changes
Not applicable	New guidelines