Lancashire & South Cumbria Medicines Management Group

NHS

Guidelines for the Management of Psoriasis in Primary Care

Version 1.3 – May 2024

VERSION CONTROL		
Version	**Date**	**Amendments made**
Version 1	May 2017	New guideline. AG.
Version 1.1	July 2020	Minor amendments
Version 1.2	November 2020	Fast track option added to page 4 (T+L). AG.
Version 1.3	April 2024	Minor changes in line with relevant SPCs.

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INTRODUCTION

Psoriasis is a common, chronic inflammatory skin disease affecting 1.75% of the UK population; there are approximately 26,000 patients with psoriasis in the Lancashire area. Psoriasis vulgaris, or chronic plaque psoriasis, is the most common form of the disease, accounting for approximately 90% of cases. It is characterised by well-delineated red, scaly plaques. Plaques are usually distributed symmetrically, and occur most commonly on the extensor aspects of elbows, knees and scalp. Further complications following diagnosis of psoriasis include progression to psoriatic arthritis affecting up to 24% of psoriasis patients and increased risk of co-morbidities such as cardiovascular disease and diabetes mellitus.

A diagnosis of psoriasis is usually based on the clinical appearance. Once the severity and impact of psoriasis has been assessed the prescriber can formulate a clinical management plan in conjunction with the patient's needs and preferences. According to NICE Clinical Guideline 153 approximately 90% of psoriasis sufferers will be managed using topical therapy. Therefore, topical therapy is an appropriate first-line treatment along with practical advice and support in the application and use of the topical treatment. However, topical therapy alone may not provide satisfactory disease control and, given the number of topical treatments available, regular review is necessary to evaluate initial response, and, if appropriate, discuss the alternative options.

****Relapse occurs in most people after treatment is stopped, after initial treatment topical treatments can be used to maintain satisfactory disease control****

PURPOSE AND SUMMARY

This guideline comprises a flow chart outlining a stepwise approach to the management of psoriasis in adults and in children and young people. The guideline also includes relevant treatment review periods and referral criteria.

SCOPE

This guidance covers the principles of prescribing topical agents for psoriasis in the primary care setting.

CRITERIA FOR REFERRAL TO SPECIALIST DERMATOLOGY SERVICES

Children and young people with any type of psoriasis – see Child and Young People Psoriasis Topical Treatment Pathway – page 5

For all patient groups:

Generalised pustular psoriasis or erythroderma (**same day specialist assessment**)
There is diagnostic uncertainty
Severe or extensive psoriasis (more than 10% of body surface area affected)

> ***Please note:*** *The use of hand surface area (HSA) equating to 1% total body surface (TBSA) may result in an overestimate for adults (particularly women) and an underestimate for children. Palm surface area (PSA) equating to 0.5% TBSA appears to be suitable for adults. Patient variables including sex and BMI result in variation of HSA as a percentage of TBSA.*

Psoriasis uncontrolled with topical therapy
Psoriasis has major impact on a patient's physical, psychological or social wellbeing

Adult Psoriasis Topical Treatment Pathway

****Emollients should be applied regularly to reduce fall of scales at all steps in therapy and for all body areas (excluding scalp). Promote adherence to treatment****

	Trunk & Limbs	Face, Flexures & Genitals	Scalp
Step 1**	ONCE daily potent corticosteroid + ONCE daily vitamin D preparation (**betamethasone + calcipotriol**) Apply at **separate** times of the day **Review at 4 weeks*** **Discontinue if Ineffective after maximum of 8 weeks treatment**	ONCE or TWICE daily mild or moderate corticosteroid (**clobetasone or hydrocortisone**) (off-label use) applied for maximum of **2 weeks** **Discontinue if unsatisfactory response or continuous treatment required to maintain control**	ONCE daily potent corticosteroid (**betamethasone or fluocinolone**) for up to **4 weeks*** **Discontinue if Ineffective after maximum of 4 weeks treatment**
Step 2	Vitamin D preparation (**calcipotriol**) TWICE daily or (**tacalcitol**) ONCE daily **Discontinue if ineffective after a further 12 weeks treatment**	Calcineurin inhibitor (**tacrolimus or pimecrolimus**) TWICE daily (off-label use) for **up to 4 weeks** **To be initiated on the advice of a clinician with expertise in psoriasis e.g. GPwSI** **Continue to review for improvement as directed**	Consider using a different formulation of potent corticosteroid and/or a topical agent to remove adherent scales: **Betamethasone mousse or Betamethasone and salicylic acid** **Discontinue if Ineffective after maximum of 4 weeks treatment**
Step 3	Potent corticosteroid (**betamethasone or fluocinolone**) TWICE daily for **4 weeks *** **or** **Coal tar** containing preparations ONCE or TWICE daily for **4 weeks** * ₸ **Discontinue if the patient cannot tolerate or once daily is preferred to improve adherence**	**Clinicians have the option to fast track to Step 4 if there is a perceived clinical benefit**	Potent corticosteroid + vitamin D **combination preparation** (**betamethasone + calcipotriol**) ONCE daily for up to **4 weeks*** (TWICE weekly for maintenance) **Or** **Vitamin D only preparation for those that cannot tolerate further courses of steroid or with mild to moderate psoriasis for 8 weeks** **Discontinue if Ineffective after maximum specified interval**
Step 4	Potent corticosteroid + vitamin D **combination preparation** (**betamethasone + calcipotriol**) ONCE daily for up to **4 weeks*** **Discontinue if Ineffective after maximum of 4 weeks treatment**	Refer patients whose psoriasis is not controlled to the specialist dermatology service	TWICE daily very potent corticosteroid (**clobetasol or diflucortolone**) for **2 weeks*** **Or** ONCE or TWICE daily coal tar preparation (**coal tar lotion or coal tar and salicylic acid ointment**) for **4 weeks** **Discontinue if Ineffective after maximum specified interval**

* Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids. Consider topical treatments that are not steroid-based to maintain psoriasis disease control during this period **** Treatment should only be initiated in primary care if the patient does not fall within the criteria for referral to specialist dermatology services** – see page 3.

₸ Dithranol could be considered as an alternative to coal tar preparation at this stage of therapy for suitable patient groups.

Children and Young People Psoriasis Topical Treatment Pathway

Please note: Make referral at initial presentation of children and young people with any type of psoriasis to a dermatology specialist. Emollients should be applied regularly to reduce fall of scales at all steps in therapy and for all body areas (excluding scalp)

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Step 1

Trunk & Limbs

AGE >1 YEAR UP TO AGE 6
ONCE daily potent corticosteroid (**betamethasone or fluocinolone**)
Review at **2 weeks***
Discontinue if Ineffective after maximum of 4 weeks treatment

AGE > 6 YEARS
ONCE daily vitamin D preparation (**calcipotriol**)
Review at **2 weeks**

Discontinue if ineffective after maximum of 4 weeks treatment

Face, Flexures & Genitals

AGE > 1 YEAR
ONCE or TWICE daily mild or moderate corticosteroid (**clobetasone or hydrocortisone**)
(off-label use) applied for maximum of **2 weeks***

Discontinue if unsatisfactory response or continuous treatment required to maintain control

Scalp

AGE > 1 YEAR
ONCE daily potent corticosteroid (**betamethasone or fluocinolone**)
for up to **4 weeks***
Discontinue if Ineffective after maximum of 4 weeks treatment

Step 2

Defer further management until advised by the specialist dermatology service

AGE >1 UP TO AGE 6

AGE > 6 YEARS

Consider using a different formulation of potent corticosteroid and/or a topical agent to remove adherent scale:
Betamethasone mousse (unlicensed for use in those < 6 years) for up to 2 weeks* or betamethasone and salicylic acid for up to 5 days*
Discontinue if Ineffective after maximum specified interval

Step 3

Defer further management until advised by the specialist dermatology service

Suitable quantities of preparations to be prescribed for specific areas of the body

Area of Body	Creams and Ointments (Steroid)	Creams and Ointments (Non-Steroid)
Face and neck	15 to 30 g	15 to 30 g (**face only**)
Both hands	15 to 30 g	25 to 50 g
Scalp	15 to 30 g	50 to 100 g
Both arms	30 to 60 g	100 to 200 g
Both legs	100 g	100 to 200 g
Trunk	100 g	400 g
Groins and genitalia	15 to 30 g	15 to 25 g

Steroid: These amounts are usually suitable for an **adult** for a **single daily application for 2 weeks**

Please note: One fingertip unit (approximately 500 mg from a tube with a standard 5-mm diameter nozzle) is sufficient to cover an area that is twice that of the flat adult handprint (palm and fingers).

Non-Steroid: These amounts are usually suitable for an **adult** for **twice daily application for 1 week**

Maximum amounts of Vitamin D analogues to prescribe:
Calcipotriol - adults 100g weekly, 6–12 years max. 50 g weekly; over 12 years max. 75 g weekly.
Calcitriol - not more than 35% of body surface to be treated daily, max. 30 g daily.
Tacalcitol - max. 10 g ointment or 10 mL lotion daily (max. total tacalcitol 280 micrograms in any one week)

* Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids. Consider topical treatments that are not steroid-based to maintain psoriasis disease control during this period.

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