

PSORIASIS

Patient Information Fact Sheet

What is psoriasis?

Psoriasis is a skin condition that can cause sufferers much distress as a result of its unsightly appearance. It is thought to affect around 1–5% of the population worldwide and has a tendency to run in families. The condition is less common in sunny climates and in pigmented skins. It can appear at any time but often develops in the teens or 20s or later in life, in the 50s and 60s. Psoriasis can affect various areas of the body but in around 50% of people, it affects the scalp. The condition is unpredictable and symptoms may occur at irregular intervals. However, most people have mild, persistent symptoms for much of the time. Psoriasis is not infectious.

What are the symptoms of psoriasis?

In people with psoriasis, cells in the outer layer of the skin (the epidermis) are replaced at a faster rate than normal and there is inflammation in the epidermis and the layer of skin below (the dermis). This results in patches of psoriasis that often stand out from the skin; these raised patches are referred to as plaques. Plaques are often red and can be rounded in appearance. The surface of the affected skin is rough and scaly and can look silvery or shiny. Although the skin cells in these patches grow at a quicker rate than in normal skin, this rapid growth is thought to be a symptom of psoriasis rather than a cause. Psoriasis does not cause ill health in any other way and many sufferers are generally very healthy. In some cases, psoriasis plaques may not cause the sufferer any problems while in others they may cause mild itching. It is not usually painful and the main complaint is of its appearance.

Plaque psoriasis (psoriasis vulgaris) is the most common type of psoriasis. The parts of the body most commonly affected are the knees, lower back, elbows, shoulders and scalp. The face, hands and feet are rarely affected. Less common forms of the disease include guttate psoriasis (small spots), generalized psoriasis (all over the body), psoriasis of the nails, or pustular psoriasis.

What causes psoriasis?

Psoriasis is often an inherited condition but can also occur in people with no family history of the disease. If a parent has the condition it may be passed on to a child but this is not necessarily the case. For this reason, psoriasis is not considered to be a genetically inherited condition. Currently, there is no definite explanation for what causes psoriasis although it has been suggested that there are certain triggers that may cause it to develop, including injury, sunburn, HIV, beta-hemolytic streptococcal infection, emotional stress, alcohol and certain drugs. It is not an infectious condition but, occasionally, the skin may become infected and need treatment. There does not appear to be any connection between diet and psoriasis.



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How is psoriasis treated?

Natural sunlight seems to be of benefit in many psoriasis sufferers. However, the greater the exposure to sun, the greater the risk of developing skin cancer, so the amount of exposure to sunlight needs to be monitored carefully such that the risks do not outweigh the benefits. Sun lamps also have the potential to be harmful to skin and should be used only under the direction of your doctor.

Professional treatment may be available in the form of **PUVA**. This treatment involves the administration of a compound known as a psoralen, such as **methoxsalen** (either orally by mouth [8-MOP, Oxsoralen-Ultra] or applied topically to the skin [Oxsoralen]) followed two hours later by exposure to long-wave ultraviolet light (UVA) for 15 to 30 minutes. This treatment is repeated two or three times a week and in most people the psoriasis is cleared in four to six weeks. Although this treatment has been popular in the past, there are still risks associated with the future development of skin cancer and its use needs to be carefully supervised.

There are many topical products available for treating psoriasis: **Anthralin** (Zithranol-RR) is available as a cream and is sometimes used in combination with another medication such as **salicylic acid** (Drithro-Creme). Anthralin is known to be a potential skin irritant. The irritant potential of anthralin is directly related to the strength being used, the time of contact, and each patient's individual tolerance. Where the response to anthralin treatment has not previously been established, treatment is usually started using a short contact time (5–15 minutes) for at least 1 week. When a short contact time is used initially, it can be increased stepwise to 30 minutes before removing the cream by washing or showering. The optimal period of contact will vary according to the patient's response to treatment. Apply sparingly to the psoriatic lesions avoiding normal skin and rub gently and carefully into the skin. Avoid applying an excessive quantity which may cause unnecessary soiling and staining of the clothing and/or bed linen. At the end of each period of treatment, rinse the skin thoroughly with cool to lukewarm water before washing with soap. The margins of the lesions may gradually become stained purple/brown as treatment progresses, but this will disappear after cessation of treatment.

Tar products such as **coal tar** (Scytera) may be used on areas where anthralin is unsuitable as they tend to be less irritating. Although the smell, color and staining properties of coal tar make it undesirable, it does not have any significant side effects and the effects are usually long-lasting.

Topical corticosteroids (eg, creams, gels and ointments) are useful for treating small areas of psoriasis but long-term use, particularly in large doses, is not advisable because of the potential side effects. Topical corticosteroids are often prescribed as first-line treatment



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because they are so easy to use. Once-daily application is usually sufficient. Examples of topical steroids include **betamethasone** (Diprolene, Luxiq), **clobetasol propionate** (Clobex, Olux, Temovate), **hydrocortisone** (Hytone) and **mometasone** (Elocon).

Acitretin (Soriatane) is a retinoid that may be given in severe psoriasis. Acitretin must not be used by women who are pregnant, or who intend to become pregnant during therapy or at any time for at least 3 years following discontinuation of therapy. Acitretin also must not be used by women who may not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation of treatment. Acitretin should be prescribed only by dermatologists who have special competence in the diagnosis and treatment of severe psoriasis, are experienced in the use of systemic retinoids, and understand the risk of teratogenicity. Because of Acitretin's potential to cause birth defects in unborn children, prescribers and patients must adhere to a strict program to educate women of childbearing potential and their healthcare providers about the serious risks associated with acitretin and to help prevent pregnancies from occurring with the use of this drug.

Tazarotene (Tazorac) is a topical retinoid used in the treatment of mild to moderate psoriasis. The gel is applied once daily and can be used to treat up to 10% of total body surface area. **Vitamin D analogues** such as **calcipotriene** (Dovonex) or **calcitriol** (Vectical) prevent the increased growth of skin cells seen in psoriasis plaques. The advantages of these products are that they do not smell and do not stain clothing. Taclonex combines calcipotriol and the corticosteroid **betamethasone**; it is available as an ointment or suspension and can be used to treat psoriasis on areas of the body or the scalp, for up to four weeks.

Cyclosporine (Neoral) may be prescribed for severe psoriasis when other treatments have not worked. It is only used under strict medical supervision. **Methotrexate** (Trexall) is another powerful drug and is usually given as tablets. As it can have other potentially serious effects on bone marrow, its use must be carefully monitored and it will only be given in severe cases.

Adalimumab (Humira), **etanercept** (Enbrel), **infliximab** (Remicade) and **ustekinumab** (Stelara) are relatively new drugs administered by injection that can be used for moderate to severe chronic plaque psoriasis in patients who have failed to respond to, or who are intolerant of, or cannot take other systemic treatments, including cyclosporine, methotrexate and PUVA.

Further information

National Psoriasis Foundation: www.psoriasis.org

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