Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Dermatology pre-referral guidelines – psoriasis

Fiona Stanley Hospital Dermatology

Disclaimer

These guidelines have been produced to guide clinical decision making for General Practitioners (GPs) and referring non-GP Specialists. They are not strict protocols. Clinical common-sense should be applied at all times. These clinical guidelines should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. Clinicians should also consider the local skill level available and their local area policies before following any guideline.

Introduction

Psoriasis is a chronic inflammatory skin condition characterised by well demarcated, red and scaly plaques. It affects 2-4% of the population and can start at any age, with onset peaks at 15-25 years and 50-60 years. About one-third of patients with psoriasis also have family members with psoriasis.

Clinical variants of psoriasis include:

- Chronic plaque psoriasis: the most common variant. Typically affects elbows, knees and lower back. Ranges from mild to extensive.
- Guttate psoriasis: sudden onset of widespread small psoriasis papules and plaques. Can be associated with streptococcal infection.
- Inverse (flexural) psoriasis: affects body folds and genitals. Smooth, well-defined patches.
- Scalp psoriasis: often the first or only site of psoriasis.
- Sebopsoriasis: overlap of seborrheic dermatitis and psoriasis with a predilection for the scalp, face, ears and chest.
- Palmoplantar psoriasis: affects the palms and/or soles causing keratoderma and painful fissuring.
- Nail psoriasis: presents with irregular pitting, yellowing, onycholysis and ridging. Associated with inflammatory arthritis.
- Erythrodermic psoriasis: rare. Acute or chronic. May or may not be preceded by another variant of psoriasis. Can be an emergency.

Pre-referral investigations

- Clinical examination is usually enough to diagnose psoriasis. If in doubt, a skin biopsy can be taken and sent for histopathology.
- Review medications and temporal history with commencement of medications and psoriasis. Many medications can trigger or exacerbate psoriasis, including lithium, beta-blockers, anti-malarials, non-steroidal anti-inflammatories, terbinafine, immunotherapy and others.
- In the case of guttate psoriasis, consider checking streptococcal serology and a throat swab for bacterial culture.

Pre-referral management

Patients with psoriasis who also display symptoms and signs of inflammatory arthritis should be referred to Rheumatology to assess for psoriatic arthritis.

General measures

- Minimise trauma to the skin – up to 75% of patients with psoriasis will develop psoriasis at the site of skin injury (known as the Koebner phenomenon).
- Gentle skin care measures will optimise barrier function of the skin and minimise scaling and irritation, i.e. avoid soap, use a soap-free wash, apply an emollient daily.
- Medicated shampoos can be used daily when scalp psoriasis is flaring (as per scalp seborrhoeic dermatitis), and then tapered to minimal effective dose (i.e. 1-2 times weekly) when controlled. They should be left in contact with the scalp for 3-5 minutes before rinsing off. These include: Nizoral Shampoo®, Dercos Shampoo®, T-Gel Shampoo®, Sebitar Scalp Treatment®.
- Gentle sun exposure can be helpful – up to 20 minutes sun on exposed skin in non-peak UVR times (i.e. UV index <3), up to three times per week.
- Obtain and maintain a healthy body weight – psoriasis is associated with the metabolic syndrome.
- Minimise alcohol intake and smoking.
- Minimise stress – up to 50% of patients with psoriasis will have worsening of their psoriasis with worry/stress.

Specific measures

- The following suggestions are not prescriptive but are a general guide for short term use. GP review is advised after four weeks to assess response to treatment.

Severity	Face / ears / neck / skin folds	Scalp	Body / arms / legs	Palms / soles
Mild	Hydrocortisone 1% ointment twice daily	Methylprednisolone aceponate 0.1% lotion, or Desonide 0.05% lotion once daily	Methylprednisolone aceponate 0.1% fatty ointment 1-2 times daily	Mometasone furoate 0.1% ointment 1-2 times daily
Moderate	Methylprednisolone aceponate 0.1% fatty ointment once daily	Mometasone furoate 0.1% lotion once daily	Mometasone furoate 0.1% ointment 1-2 times daily	Betamethasone dipropionate 0.05% ointment 1-2 times daily
Severe	Methylprednisolone aceponate 0.1% fatty ointment 1-2 times daily	Mometasone furoate 0.1% lotion once daily, or Calcipotriol 0.005% / Betamethasone Dipropionate 0.05% (Enstilar)* foam once daily	Betamethasone dipropionate 0.05% ointment 1-2 times daily, or Calcipotriol 0.005% / Betamethasone Dipropionate 0.05% foam or ointment once daily	Betamethasone dipropionate 0.05% ointment in optimised vehicle once daily, or Calcipotriol 0.005% / Betamethasone Dipropionate 0.05% ointment once daily

* PBS approved for chronic stable plaque type psoriasis vulgaris that is inadequately controlled by potent topical corticosteroid monotherapy.

Other treatments may be used at the hospital

- Phototherapy.
- Systemic agents: Methotrexate, Acitretin, Cyclosporin, Apremilast.
- Biologic therapy is reserved for severe psoriasis and/or psoriatic psoriasis that has failed to respond to conventional systemic therapy. There are many biologic agents currently available on the PBS - https://www.servicesaustralia.gov.au/psoriasis-severe-chronic-plaque-psoriasis?context=20

When to refer

If the diagnosis is unclear, or if there are ongoing signs or symptoms which remain problematic despite the above management, please refer to the Dermatology Department.

Essential information to include in your referral

- Duration of psoriasis.
- Affected sites.
- Estimation of body surface area involved – this may help us triage urgency of referral.
- Previous and current treatment, and how long this was used for.
- Associated psoriatic nail disease and psoriatic arthritis.
- Co-morbidities and current medications.
- Body Mass Index and cardiovascular disease risk factors.
- Family history of psoriasis and/or psoriatic arthritis.

References

1. Paller and Mancini – Hurwitz Clinical Pediatric Dermatology: A Textbook of Skin Disorders of Childhood and Adolescence (6th edution). Elsevier, 2022.

Useful patient resources

1. https://dermnetnz.org/topics/psoriasis - Dermnet NZ
2. https://www.dermcoll.edu.au/atoz/psoriasis/ - Australasian College of Dermatologists
3. https://pedsderm.net/site/assets/files/1028/spd_psoriasis_color_web_rev.pdf - Society of Pediatric Dermatology

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