Psoriasis – Primary Care Topical Treatment Pathway

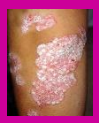
NHS Oxfordshire Clinical Commissioning Group

Emollients

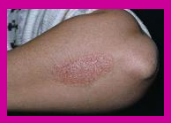
Help reduce scaling and associated itch. Choose one in line with OCCG Emollient Guidelines and formulary http://www.oxfordshireformulary.nhs.uk/ (may be non-prescription*)

Trunk/limbs

- Try a potent topical steroid e.g. betamethasone 0.05% & vitamin D preparation e.g. calcipotriol applied separately od for up to 4 weeks
- If unsatisfactory control, consider:
  - coal tar preparation e.g. Exorex lotion* bd-tds for thin or widespread plaques
  - potent topical steroid od for 4 weeks for thick plaques (N.B. psoriasis may flare on stopping)
  - vitamin D preparation applied bd for up to 4 weeks (N.B. this can be irritant)



Thick plaque psoriasis



Thin plaque psoriasis

- **If the patient does not respond to the above, cannot use twice daily treatments, or if once daily treatment would improve adherence, offer Enstilar foam od for 4 weeks, then as needed, as this is more effective, better tolerated and may avoid the need for a referral to dermatology**
- Patients are likely to need to use treatment intermittently on an ongoing basis so do not stop prescribing effective treatments after initial 4 weeks

Scalp

- A common mistake is to use anti-inflammatory treatment without first ensuring scaling is treated, enabling anti-inflammatories to reach scalp
- **Treating scale**: Preparations to remove thick adherent scale e.g. Sebco ointment*, Cocois ointment*, can be left overnight to allow extra time for the treatment to work, then washed off in the morning. A comb can be used to ease off and gently remove some of the scale. This treatment will need to be used on an ongoing basis depending on the degree of scalp scaling.
- Tar based shampoos e.g. Capasal*, T-gel* & anti-fungal shampoos e.g. Nizoral* may reduce mild scaling and itch/irritation but will not treat thick adherent scale. These should generally be used once-twice weekly.
- **Treating redness/inflammation**: Try a potent or very potent topical steroid e.g. Diprosalic, Dermovate as a scalp application od for 4 weeks, then as needed on an ongoing basis
- If unsatisfactory control of inflammation with above, consider a different formulation e.g. Etrivex shampoo (this can be massaged into dry hair, left for 15-20 minutes, then washed off) AND/OR offer a combined product containing calcipotriol & betamethasone dipropionate e.g. Enstilar foam, initially daily for 4 weeks, then as needed on an ongoing basis

Flexures/genitals

- Try a mild-moderately potent topical steroid e.g. Eumovate or topical steroid/antimicrobial combined product e.g. Daktacort ointment, Trimovate cream od for 2-3 weeks initially, then as required
- If unsatisfactory control, could consider Protopic (0.03%, 0.1%) preparations (off-label use) bd for 2-3 weeks then od until psoriasis clears (warn may sting on first few applications; no risk of skin atrophy)
- Vitamin D analogues may irritate flexural/genital skin but Silkis (calcitriol) ointment is better tolerated and can be tried od for up to 4 weeks initially
- Vulval psoriasis not responding to e.g. Trimovate can be treated with a potent topical steroid e.g. Elocon or Lotriderm for up to 4 weeks initially

Hands/Feet

- Ensure fungal infection is excluded (perform skin scrapings)
- Emollients are important in reducing hyperkeratosis: consider urea-based emollients (imuDERM, Balneum cream) for thick scale; advise using an emollient as a soap substitute, especially for hands
- Try a potent-very potent topical steroid e.g. Diprosalic, Dermovate ointment od for up to 4 weeks, then as needed
- Occlusion e.g. cotton gloves or clingfilm can be applied over treatments
- If unsatisfactory control, refer promptly to Dermatology for consideration of hand and foot PUVA or systemic treatment

Face

- Try a mild-moderately potent topical steroid e.g. hydrocortisone, Eumovate or topical steroid/antimicrobial combined product e.g. Daktacort ointment (particularly if seborrhoeic pattern) od for 2 weeks initially, then as needed
- If unsatisfactory control, could consider Protopic (0.03%, 0.1%) preparations (off-label use) bd for 2 weeks then od until psoriasis clears (warn may sting on first few applications; no risk of skin atrophy)

Guttate

- Teardrop like small plaques, often widespread, typically 7-10 days after streptococcal respiratory tract infection
- Widespread nature can make application of topical treatments difficult/impossible, but potent topical steroids or tar based preparations e.g. Exorex lotion can be tried
- UVB phototherapy is effective so refer early to Dermatology if widespread involvement

Nails

- Typically pitting, hyperkeratosis, onycholysis Difficult to manage with topical treatments . Often bothers patients significantly
- Keep nails short, can use nail varnish/gel to strengthen/protect nails
- Can try potent topical steroid e.g. Betnovate scalp application under nail od for 2-4 weeks

Patients will likely need to use treatments intermittently on an ongoing basis – don't stop prescribing effective treatments after 4 wks
Important to check adherence to treatment/barriers to using treatments

Reference: NICE Clinical Guideline [CG153] Psoriasis: assessment and management. Published October 2012; last updated September 2017 https://www.nice.org.uk/guidance/cg153. ***consider in line with OCCG Clinical Commissioning Policy 088d on Over the Counter Medicines.**

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Approved by APCO March 2017