

**Chronic Plaque Psoriasis:** a common, genetically determined, inflammatory and proliferative skin disorder. Lesions typically consist of chronic, sharply demarcated, dull-red, scaly plaques.

**Patient Assessment - Document:**

- Disease severity
- Duration and presence of symptoms
- Co-morbidities (arthritis, metabolic associations, alcohol intake, psychosocial impact etc)
- Whole skin examination requires documentation of all sites involved including high-impact and difficult to treat sites
- %BSA
- Degree of scale, inflammation
- Presence of systemic upset such as fever and malaise (unstable psoriasis)

- RED FLAGS**– emergency referrals to on-call dermatology service at SRFT for:
- Erythrodermic patients
  - Generalised pustular psoriasis

**Refer directly to secondary care dermatology for:**

- Acute guttate psoriasis needing phototherapy
- Nail psoriasis affecting Quality of Life or function

**Treatment:**

- Discuss options and assess practicalities of options
- Prescribe appropriate quantities
- Address CVS, psychological, rheumatological co-morbidities

**Education for self-care**

Use PILS to support information on diagnosis, actions and expectations of treatment, exacerbating lifestyle factors

**ALL PATIENTS MUST BE PRESCRIBED EMOLLIENT TREATMENT AS FIRST LINE**

**Palmoplantar:**  
Potent topical steroid ointment under gloves once daily for 4 weeks only

**Trunk & Limbs**

- <10% BSA
- Potent topical steroid ointment morning + vitamin D analogue evening up to 8 weeks

**Scalp**

- **Mild** (fine scaling): tar based shampoo
- **Moderate** (palpable plaques): descale if needed. Potent corticosteroid applied once daily (up to 4 weeks)
- **Severe:** descale with salicylic acid preparation/emollients or oils (1 week) then potent corticosteroid applied once daily (up to 4 weeks)

**Flexural Genitalia/ Face/ Hairline**  
Initial mild potency topical steroid (max twice daily) or if not irritated vitamin D analogues

<10% BSA and satisfactory control not achieved

Vitamin D analogue twice daily 8 weeks

<10% BSA and satisfactory control not achieved

Potent topical steroid twice daily for 4 weeks  
OR coal tar preparation max twice daily

If above not tolerated or concerns around adherence

Combination product potent topical steroid + vitamin D analogue treatment once daily for 4 weeks only

If satisfactory response not achieved try:

- Different formulation (mousse/gel/lotion)
- Vitamin D analogues or combination steroid + vitamin D analogue preparation

If no improvement:

- Increase to moderate potency topical steroid for no more than 2 weeks (max twice daily) then step down to mild as response achieved.
- Maintenance therapy requires specialist recommendation (calcineurin inhibitors)

**Refer to local provider when:**

- Psoriasis is severe/extensive (>10% BSA affected)
- Condition cannot be controlled with topical therapy
- Condition is having a major impact on a person's physical, psychological or social wellbeing
- Children and young people affected (<18y)
- Psoriatic arthritis is suspected
- Diagnosis is uncertain

**Monitoring Tips:**

- **Review adults 4 weeks after initiating treatment**
- As a precaution avoid vitamin D analogues in female patients if trying to conceive/pregnant
- If T+L combined with flexures/face agent: vitamin D analogue (expect a minimum of 8 weeks to see maximum effect)
- Hypercalcaemia can occur with high dose of topical vitamin D analogues
- Vitamin D analogues and coal tar preparations increase photosensitivity therefore counsel patients to avoid excessive exposure to sunlight/sun lamps at outset of treatment
- The least potent effective topical steroid should be chosen. Potent topical steroids should not be used continuously at any site for longer than 8 weeks
- Very potent topical steroids are not recommended for chronic plaque psoriasis and can only be prescribed under the supervision of a specialist