TEXT DR WONG SU-NI

Psoriasis: More than a cosmetic nuisance

What can you do to make a difference?

Psoriasis is a common inflammatory skin condition estimated to affect 0.5% to 3% of populations worldwide. In Singapore, the estimated prevalence is about 2%.

Psoriasis is often described in older textbooks as being non-pruritic, with the implication, in many doctors' minds, that it is a mere cosmetic nuisance. In reality, most patients locally experience itching at the affected skin, particularly in warmer weather. Although the itch may not be comparable to that in scabies or eczema, the skin lesions are more chronic and persistent, and lead to greater disturbances in quality of life, analogous to chronic pain syndromes. In addition, thick psoriatic plaques over the joints (e.g. fingers and knees) tend to fissure when the joint is fully flexed, leading to pain and disability. Up to 35% of affected individuals may also develop enthesitis or psoriatic arthritis, which may lead to destruction of the joints if not treated adequately early. Psoriasis is more than a cosmetic nuisance.

Most patients with a rash for the first time will initially present to a general practitioner or family physician. There is much that can be done at the primary care level – accurate diagnosis, searching for aggravating factors and attempting to minimise them, eliciting joint symptoms and early referral to a rheumatologist when indicated, initiation of first-line therapy, counselling and emotional support for newly-diagnosed psoriasis patients, and referral to self-help groups or related websites for support and empowerment. Certainly, patients with more extensive or severe psoriasis, or those not responding to topical therapy, may warrant a referral to a dermatologist for further treatment options such as phototherapy or systemic agents.

Diagnosis of psoriasis

Diagnosis of psoriasis is clinical in most cases. Chronic plaque psoriasis, the most common form, accounts for about 95% of psoriasis seen locally. The classical appearance of well-defined salmon-pink plaques surmounted by silvery white scales with a predilection for extensor surfaces, lower back and scalp, especially in the presence of nail changes (such as pitting and onycholysis) is sufficient for the diagnosis of psoriasis (Figure 1). Occasionally, partially treated psoriasis may become annular and mimic tinea corporis, warranting a fungal scrape.

It is helpful at diagnosis to ascertain if there is a family history of psoriasis – this is present in about 30% of patients. Patients find it easier to accept the diagnosis if they are not the first in the family. If there is no family history, then we need to explain that psoriasis is multi-factorial – genes confer susceptibility and several susceptibility genes are probably required, which are inherited from either or both parents, but environmental factors are important in the development of psoriasis in a genetically susceptible individual.

Aggravating factors of psoriasis

A medication history is important as β-blockers and anti-malarials may cause a psoriasiform drug eruption

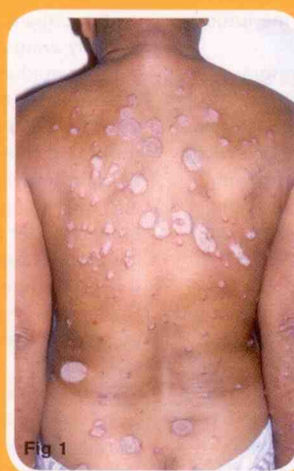

Fig 1

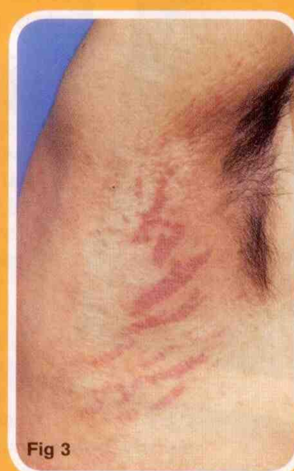

Fig 3

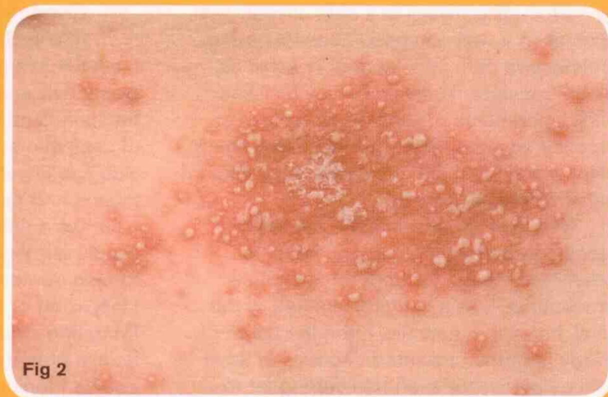

Fig 2

Fig 1: Typical well-defined pink plaques surmounted by silvery white scales on the back and extensor aspects of the forearms and elbows.
Fig 2: If chronic plaque psoriasis becomes very red, inflamed or painful, look out for tiny pustules like these, which herald an unstable form of psoriasis. These patients should be referred urgently.
Fig 3: Steroid-induced skin atrophy and striae are most commonly seen in the flexures, where occlusion increases the penetration of the topical steroids.

or aggravate psoriasis. Other common aggravating factors should be elicited and minimised where possible, e.g. streptococcal throat infection; stress; lack of sleep; warm environmental conditions; and skin trauma such as scratching, cuts or sunburn. In high-risk individuals with severe psoriasis, HIV testing is recommended as HIV infection is associated with more florid and therapy-resistant psoriasis, which responds to phototherapy or systemic agents and anti-retroviral therapy.

Initiation of first-line therapy

Topical therapies are usually first-line therapy. Topical coal tar is a safe, time-honoured treatment generally available over-the-counter, but takes persuasion to use. Calcipotriol or calcitriol ointment, both vitamin D analogues, are newer alternatives without the problem of steroid-induced skin atrophy. Topical steroids should be used judiciously, not only because of the risk of steroid-induced skin atrophy when used for long periods, but also because of systemic absorption when used in large quantities over long periods of time, as is often the case in psoriasis. It is safer to keep to mid-potency steroids, in combination therapy with coal tar or vitamin D analogues, and refer to a dermatologist if this does not lead to sufficient control. Systemic steroids are not recommended in psoriasis as rebound phenomenon may occur on cessation, leading to unstable forms of psoriasis such as pustular psoriasis (Figure 2) or erythrodermic psoriasis.

For psoriatic arthritis, intermittent use of non-steroidal anti-inflammatory drugs (NSAIDs) are useful as first-line therapy, but if the patient needs more than three weeks of NSAIDs on a continual basis, referral to a rheumatologist should be considered.

Counselling

Counselling is an integral part of the practice of medicine, and may need to be done in stages over several consultations. We need to explain the diagnosis yet not overwhelm the patient at the first instance, reassure that effective treatments are available for control, yet not raise false expectations of cure. Patients are often worried about passing the disease on to their loved ones, and their loved ones may shun them for fear of catching the disease – it may be necessary to meet up with the latter to reassure them of the non-infective nature of psoriasis, and enlist their support for the patient. The effect of psoriasis or the treatment on the patient's quality of life needs to be assessed on an ongoing basis, with adjustments to treatment and social intervention as necessary.

Patients need to know that psoriasis is characterised by periods of flare alternating with periods of remission. The aim of therapy is to induce remission or as near remission as possible, then maintain it as long as one can. Individuals respond differently to therapy, and we may need to try them on several different formulations or dosing regimens before finding one that suits them best. After remission is achieved, a basic skincare regimen consisting of mild soap substitutes or coal tar soap with regular use of cream moisturisers is still recommended.

When to refer

If the diagnosis is in doubt, the dermatologist may be able to assist, and, if necessary, perform a skin biopsy. Severe unstable forms of psoriasis such as pustular psoriasis and erythrodermic psoriasis are best referred urgently to a dermatologist. Chronic plaque psoriasis that is getting more extensive (>5-8 % of body surface area) despite optimisation of topical therapy and environmental factors, may require more specialised therapy such as phototherapy or systemic immunosuppressive or immune-modulating agents (e.g. methotrexate, cyclosporin, acitretin and the biologics), which are best administered by a dermatologist familiar with their use.

After-care

Experienced patients who have attained control of their psoriasis on a topical regimen may be referred back to their family physicians for maintenance therapy. They may be given different strengths of topical therapy, stepping up on their own to stronger concentrations during flares and stepping down again when better. It is important to monitor for signs of excessive use of topical steroids such as striae (Figure 3), skin atrophy, localised hirsutism, and even cushingoid facies, and to encourage stepping-down or cessation of topical steroids whenever possible. Long-term use of moisturisers should also be encouraged.

As the course of psoriasis is a dynamic one, fluctuating from week to week, or even day-to-day, you may sometimes feel that the patient looks worse than the previous visit but if he or she continues to be content with the existing creams and is certain that the mild flare will settle, they are often right. However, if the progression is relentless despite use of stronger creams, or the skin looks very red and inflamed, do consider referring the patient back to the original dermatologist, who would have a record of previous successful step-up therapies. MG

Dr Wong Su-Ni is a consultant dermatologist and chief of the Psoriasis Unit at National Skin Centre, Singapore.

Useful information for patients

The Psoriasis Association of Singapore is a self-help group that meets monthly and can provide emotional support and practical suggestions for affected individuals. Interested parties should contact Psoriasis Association of Singapore, c/o National Skin Centre, 1 Mandalay Rd, Singapore 308205 for further details. Useful and reliable websites for patients who want to find out more about their skin condition and treatment options available include the official websites of American Academy of Dermatology, National Psoriasis Foundation and The Psoriasis Association.

Useful resources for doctors

If you would like to keep abreast of latest developments in psoriasis, you may consider visiting:

- **http://www.serono4psoriasis.net/Login.aspx?p=/InformationExchange_2.aspx&tp=4&id=927 which highlights latest scientific literature involving psoriasis.**
- **www.psoriasis.org/home, the official web-site of the National Psoriasis Foundation in the US, or**
- **www.psoriasis-association.org.uk., the official website of The Psoriasis Association based in the UK.**
- **Clinical guidelines are available on http://www.bad.org.uk/healthcare/guidelines/ and patient information leaflets may be obtained at http://www.bad.org.uk/public/leaflets/.**