SPECIALIST
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SKIN HEALTH INSTITUTE

PSORIASIS PATIENT INFORMATION

OVERVIEW

Psoriasis is a common inflammatory disease, primarily manifesting in the skin that affects men and women equally and can appear at any age. Psoriasis is a chronic (long-term) condition for which there is no cure, but there are effective treatments. In Australia, approximately 2.5% of the population (about 450, 000 people) are affected by psoriasis.

SYMPTOMS

There are different types or patterns of psoriasis which may cause different symptoms. Most people only have one type of psoriasis at a time.

- **Chronic plaque psoriasis** (also called psoriasis vulgaris) is the most common type. Affected areas of skin appear raised, red or pinkish, and covered with a silver-white scale. It commonly affects the skin on the elbows, knees, scalp, behind the ears, torso, and the buttocks. The affected areas may be itchy or mildly uncomfortable.
- **Guttate psoriasis** is a less common type of psoriasis which is more frequently seen in children and young adults. It typically occurs after a throat infection with a type of bacteria known as Streptococci. It causes widespread small (~1cm), red, drop-like spots usually on the trunk, arms and thighs.
- **Pustular psoriasis** is uncommon and typically affects adults. There are small blisters containing sterile pus with surrounding red skin.
- Palmoplantar psoriasis affects the palms of the hands and soles of the feet, sometimes with a large amount of scaling. Some people develop painful cracks (fissures) in the skin.
- **Inverse psoriasis** (also called flexural or intertriginous psoriasis) affects the body folds, e.g. the armpits, groin, under the breasts, and between the buttocks. The areas may be raised, and are red, smooth, and shiny without any scale.
- **Erythrodermic psoriasis** is a rare, severe form involving almost the entire skin surface. This is considered a medical emergency and requires prompt treatment, sometimes in hospital.
- **Nail psoriasis** occurs in up to 55% of patients with psoriasis, and can make the nails look pitted, thickened, and/or discoloured. About 5% of patients will only have psoriasis in the nails without skin involvement.

The severity of psoriasis varies widely between people: for most it will be a mild annoyance needing occasional treatment, while a small group have severe disease requiring regular treatment. The appearance and severity of an individual's symptoms will also vary over time.

Around one third of people with psoriasis also develop psoriatic arthritis, a related disease which causes inflammation of the joints. Psoriatic arthritis is usually treated by a rheumatologist who works closely with a dermatologist or general practitioner.

Many people find the appearance of psoriasis embarrassing and this can have a significant impact on their mental health; rates of anxiety and depression are higher than in the general population.

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Psoriasis is associated with other health conditions that form part of the metabolic syndrome, including diabetes, obesity and high blood pressure.

HOW IT HAPPENS

Despite it being a relatively common condition, we do not know the exact cause of psoriasis. Psoriasis runs in families (30% of patients have a positive family history) and is thought to be due to a combination of environmental and genetic factors. A dysfunctional immune system with overactivity of some components is known to play an important role in driving the disease and many treatments work by suppressing different parts of the immune system.

Psoriasis is not contagious. It is not caused by dirty skin or poor hygiene.

While we do not know the cause of psoriasis, we do know there are several "triggers" that may make psoriasis worse:

- **Stress** can cause psoriasis to flare up for the first time or can aggravate existing psoriasis.
- **Damage to the skin** can cause psoriasis to appear in these areas (koebnerization). Examples include sunburn, cuts, and scratches.
- **Medications** can worsen psoriasis including lithium, antimalarial drugs, certain heart medications ('beta-blockers'), some anti-inflammatory drugs, and some blood pressure medications.
- **Infections** by bacteria and certain viruses can trigger psoriasis for the first time or aggravate existing disease.
- **Changes in hormones**, such as in pregnancy, can cause changes in psoriasis severity.
- **Smoking** increases the risk of developing psoriasis and the severity.

HOW IS IT DIAGNOSED?

In most people, a diagnosis of psoriasis can be made based on how the rash looks. A skin biopsy is rarely needed. Investigations may be needed to rule out other conditions (e.g. skin scrapings for fungal infections), or may be performed prior to instituting treatment (e.g. blood tests).

TREATMENTS

There is no cure for psoriasis, which means that we cannot give a single treatment to make it go away forever. However, there are many treatments that are highly effective, and most patients can achieve 'normal-looking' skin. Psoriasis does not scar, but can leave post-inflammatory pigmentation.

There are a variety of treatments for psoriasis which come in different forms. A GP or dermatologist will recommend the treatment that is best for you.

Treatment of psoriasis starts with avoiding the triggers (mentioned above) that can make it worse.

Topical treatments

'Topical treatments' means treatments applied directly to the skin:

- **Moisturisers (emollients)** help to reduce the build-up of scale and itch. They may also help increase the effectiveness of other topical treatments.
- **Steroid (cortisone)** creams, ointments, gels, lotions and shampoos come in a variety of strengths and help reduce inflammation, thickness, and scale.

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- **Vitamin D analogue**, combined with steroid, preparations are available as topical treatments in the form of gels, ointments and foam spray. Vitamin D analogue and steroid combination treatment is effective in reducing inflammation, thickness and scale.
- **Tar**-based soaps, bath oils, shampoos and creams can help reduce inflammation, itch and scale. Some may be mixed with a weak acid to help dissolve scale.

Phototherapy/Ultraviolet Therapy

Phototherapy or ultraviolet (UV) therapy mimics the beneficial effect of sunlight on psoriasis. There are two types:

- **Narrow band UVB** is the more commonly used form of phototherapy. Patients usually visit a treatment centre with a UV machine two to three times per week for a treatment course of two to three months.
- **Psoralen and UVA (PUVA)** combines psoralen (a treatment that makes the skin more sensitive to light) in either a tablet or bath form with UVA light. Availability is limited.

Oral treatments

There are also several treatments taken by mouth, which are mainly used when topical treatments have failed or when there is a large amount of skin affected:

- **Methotrexate** is the most commonly prescribed oral treatment for psoriasis. It is given weekly as a tablet and works by suppressing and modulating the immune system. It is also available as an injection. Methotrexate can be useful in both psoriasis of the skin and joints.
- **Acitretin** is a type of vitamin A, which works by slowing down how fast the skin replaces itself, which reduces thickness and scale. Acitretin is sometimes used in combination with phototherapy (ultraviolet light therapy). Acitretin can cause birth defects and hence is not used in women of child-bearing age.
- Cyclosporin is a medication which suppresses the immune system and is used for short periods of time for severe psoriasis.

Biologics

Biologics are the most recently developed treatments for psoriasis. These treatments are given as injections, which can be self-administered, at specified intervals.

Biologic treatments work by blocking specific pathways of the immune system in a targeted way. Biologic treatments are often very effective in treating psoriasis, however, they are not curative and are long-term, ongoing treatments.

Because they are newer treatments, some of the effects of long term treatment are still being studied, and they are only used where other treatments have failed. Medicare Australia has strict criteria that must be met before biologics can be prescribed by a dermatologist.

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