

Madigan Army Medical Center

Referral Guidelines

Psoriasis

Diagnosis/Definition

Psoriasis is primarily thought of as an autoimmune disorder of the skin with a hereditary component. It has varying degrees of presentation and severity. The most frequent form is psoriasis vulgaris, which manifests itself as chronic scaling papules and plaques largely located on specific parts of the body: scalp, elbows, forearms, lumbo-sacral region, knees, hands and feet. The majority of psoriasis manifests itself earlier in life, often in late adolescence. The guttate form of psoriasis (erythematous tiny, drop-like psoriasis papules and small plaques) frequently follows, or is triggered by an upper respiratory infection, particularly Group A beta strep. Psoriatic arthritis can pre-date, co-exist or develop during the course of the disease and is usually manifested by asymmetric polyarticular joint pain and inflammation in the digits or toes.

Initial Diagnosis and Management

Chronic, lingering plaques are a common presentation. Pruritus is reasonably common (scalp and anogenital areas) and 10% of patients have associated joint pain +/- psoriatic arthritis. Initial diagnosis is generally based on physical exam. Physical exam reveals papules and plaques, sharply marginated with silvery-white scale. Color is usually “salmon pink” to intense erythema. When limited to extremities, lesions are usually bilateral (though not necessarily symmetrical) and favor regions noted above. Instruct the patient never to rub or scratch the lesions as trauma may stimulate proliferative process (Koebner’s phenomenon) and lead to pinpoint bleeding (Auspitz sign) may be seen if scale is lifted up off of the skin surface.

Topical Steroids – This class is a cost-effective mainstay of therapy. Apply after attempting to loosen / lessen scales by soaking in water. Cream or ointment is preferred for non-hair bearing skin, with solutions, gels, lotion, or foam products best for hair-bearing sites. “Chasing” any topical used with an emollient of choice (Eucerin, Vaseline Petroleum Jelly or other brands of petrolatum, Cetaphil or Moisturel Cream are examples) helps moisten affected site and reduces the amount of topical medication needed. Use of a plastic wrap - cover the area and leave on overnight – may be used in stubborn extremity sites until improved. **Beware the risks of steroid overdose, including striae, atrophy, telangiectasis formation and pigment changes, depending on the strength of the steroid and the location of the skin it is applied to.** Oral prednisone can also cause a worsening of the psoriasis and cause the entire skin surface to become inflamed, also known as erythroderma, so oral steroids are contraindicated in patients with psoriasis. Corticosteroid injection – for small plaques (<4.0 cm), triamcinolone acetonide (10mg/cc) aqueous suspension is injected into the lesion intradermally with small-gauge needle or a DermaJet.

Vitamin D analogues (calcipotriene 0.005%; Dovonex) – Cream and solution are good topical agents that are not associated with cutaneous atrophy. These are particularly useful in combination with the more potent topical steroids, with maintenance schedule of Dovonex daily on weekdays and the steroid on weekends. Apply to no more than 40% of body and not more than 100 g per week to avoid hypercalcemia risk.

Topical retinoid (Tazarotene cream or gel) – This is another alternative to topical steroids or may be combined with class II topical corticosteroids. This formulation is stronger than Retin-A. It should be

applied to the affected lesions at night. It is a Pregnancy Class X medication and should not be used by women who are pregnant.

UV phototherapy – With more than 10% involvement of total body surface area (TBSA), it may be used alone or in combination with topical or systemic medicine treatments. Requires motivated patient, appropriate TBSA involvement, and Dermatology consultation.

Biologic therapy- With more than 10% involvement of body surface area or disabling disease in the hands or feet, biologic therapy may be considered. This is a newer treatment and is being heavily advertised. If patients desire consideration for treatment, they should be referred to dermatology for further evaluation and counseling.

For the guttate form, test for Group A beta strep (throat culture and ASO titer), and initiate treatment for strep (Penicillin or suitable alternative). This wide-spread eruption responds quickly to UV light therapy and should be referred to dermatology. In many patients, the guttate psoriasis will resolve until the next strep infection.

Ongoing Management and Objectives

Patient should follow up at 2-4 week intervals initially until regression of lesions becomes apparent.

Indications for Specialty Care Referral

- Large involvement of total surface area (greater than 10%).
- Extensive involvement of hands or feet, limiting activities
- Lesions that are resistant to conventional therapy or that requires UV light therapy.

Criteria for Return to Primary Care

Psoriasis has resolved and/or a suitable treatment plan has been established.

Metabolic Disorder

Recently, research has confirmed that psoriasis patients are significantly at risk for metabolic disorder, and should be closely monitored by their PCPs for Cardiac disease, Diabetes, obesity, hypertriglyceridemia. These conditions may be leptin-mediated.

Pictures of [Psoriasis](#) from DermNet NZ - New Zealand Dermatological Society

Last Review for this Guideline: **October 2009**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator