



# PSORIASIS

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Psoriasis is a common skin condition with systemic considerations. The skin component is variable among patients, but the most common type, plaque psoriasis, consists of raised lesions covered with a variable amount of silvery scales most commonly seen on the elbows, knees, scalp, and trunk. Other types of psoriasis are guttate, inverse, pustular, scalp, erythrodermic, and psoriatic inflammatory arthritis.

Guttate psoriasis consists of drop-like lesions, usually with a sudden onset and commonly seen after a streptococcal pharyngitis infection and more commonly seen in children and young adults. This type may come and go and does not necessarily mean that a patient will develop ongoing, chronic plaque-type psoriasis.

Inverse psoriasis is a type of psoriasis where the scaly plaques develop in skin fold areas like the axillae, groin and buttock creases and the folds under the breasts. Because of the heat and skin-on-skin friction at these sites, the scales tend to be rubbed off and all that remains is shiny red smooth areas that look like scalded skin.

Erythrodermic psoriasis very often occurs after a stressful event in the body as a whole, such as an infection, fever, or other significant illness. Patients with this type of psoriasis report that the skin becomes bright red all over, with or without significant scaling. Nail changes including loss of nails may be seen with this type of psoriasis. Fevers and chills may accompany this form of psoriasis. With significant involvement of the skin, patients with erythrodermic psoriasis may need to be treated in a burn unit because of loss of fluid, electrolytes, protein, and disruption of normal body hemostasis functions.

Three types of pustular psoriasis exist: von Zumbusch, palmoplantar pustulosis, and acropustulosis (acrodermatitis continua of Hallopeau). Pustular psoriasis of von Zumbusch appears as a distinctive acute form of psoriasis that develops after a significant fever and manifests itself with crops of sterile pustules over the trunk and extremities. These pustules develop in clusters on top of bright red skin. These clusters of pustules usually coalesce into larger areas as the disease progresses. Patients tend to have waxing and waning of the fever with pustules developing throughout the flare. The face, as with most types of psoriasis, is usually spared. Palmoplantar pustulosis develops as multiple sterile pustules on the palms and soles that eventually turn brown, peel and crust over with repeated episodes occurring. Smoking can aggravate all types of psoriasis, but palmoplantar pustulosis is particularly common among smokers. Acropustulosis is manifested by skin lesions at the end of the fingers and toes starting after an injury to the skin or infection. These lesions can be quite painful and may cause deformity of the nails. With severe causes the inflammation can be severe enough to cause boney changes.

Some patients will develop only scalp involvement and this type of psoriasis can often be misdiagnosed as **seborrhea** (cradle cap) or **tinea** (fungal/ringworm). Generally there is a family history of psoriasis that can help with the diagnosis, and the scale of scalp psoriasis is usually more white/silvery than the waxy, off-white/yellowish scale of seborrhea.

Because psoriasis is a systemic inflammatory condition, some patients may develop psoriatic arthritis, with or without skin lesions. There is usually asymmetrical joint involvement and patients may have only a few joints (oligoarthritis) involved.

Psoriasis is often considered a skin condition, but in fact is a systemic disease resulting from a malfunction of the immune system, more specifically, over active/stimulated T-cells, a type of white blood cell involved in inflammatory activities. These overactive T cells trigger other immune responses that cause increased blood flow and inflammation in the areas of involvement with resultant increases in skin growth. The increased growth of skin cells cannot be sloughed off in a timely manner and an increased thickness (plaque) of skin develops. This cycle repeats itself (unless treatments intervene) and continued scale and plaques develop.

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Psoriasis is controllable, but not curable. Many things can trigger the onset and continuation of psoriasis:

- Bacterial and viral infections
- Stress: emotional or frictional on the skin surface inducing new areas of psoriasis and aggravating existing plaques
- Medications: beta-blockers, lithium, antimalarial medications, prednisone and other oral steroids
- Injury to the skin: intentional such as with surgery, or unintentional such as a cut or scrape
- Dry skin: may lead to scratching of the skin
- Too little sunlight and even too much sunlight causing a sunburn
- Alcohol
- Nicotine: smoking and smokeless tobacco products

Patients with weakened immune systems (AIDS, cancer chemotherapy patients, and patients with autoimmune disease such as rheumatoid arthritis) may have more severe bouts of psoriasis.

Treatment of psoriasis depends on the severity of involvement (the severity may be clinically very mild, but in the eyes of the patient the 'heart break' of psoriasis may be significant, thus changing the therapy indicated for a particular patient) and what treatment have been employed in the past. The goal of therapy is to control the symptoms as well as to prevent infections secondary to the disruption of the normal skin barrier functions.

Three basic therapeutic options exist for the treatment of psoriasis: topical, systemic, and phototherapy. Topical treatments include moisturizers, topical steroids, non-steroid topical treatments, "peeling" agents such as salicylic acids or lactic acids, and dandruff shampoos. These products can be used individually or in combinations.

**Moisturization** of the skin alone may help a percentage of patients without the addition of anything else. Thicker, emollient creams are much more effective as moisturizers than lotion and in fact, some lotions, because of their water to oil ratio, may actually increase dryness of the skin (due to the evaporation of the water from the skin and the lesser amount of oils left behind.) There are many moisturizing creams on the market; the best one for you is the one you decide you are going to use...and you use it multiple times a day.

Topical 'medicinal' treatments include **topical steroids** in various formulations and strengths. The choice of formulation (cream, lotion, gel, liquid, shampoo, ointment) and strength is best determined with input from your dermatologist based on what has or has not worked in the past and what body site is being treated. Some stronger steroid products are inappropriate for your face and/or crease areas. One product's percentage strength listed on your tube or jar does not necessary indicate a stronger or weaker product when compared to another product's percentage strength. In other words, a betamethasone product with a strength of 0.05% is not weaker than a hydrocortisone product of 1%. There is no correlation strength to strength between two different entities.

Topical steroids are only one of many topical treatments for psoriasis. Coal tar products (OTC and Rx) have been used for years to turn down/turn off psoriasis. They can be used in the bath as a soak or direct applied to the skin and left on for a variable amount of time. Short contact therapy (SCT) with anthralin may work but has been used less and less because of more effective products, and anthralin can stain clothes and skin.

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Salicylic and lactic acid containing topical products are used to reduce the thickness of scales and are often combined in a compounded product with topical steroids and/or emollient OTC moisturizer creams.

Vitamin-D analog containing ointments (**calcipotriene and calcitriol**) can be used as stand-alone products or in combination with topical steroids (pre-made ready to use by the manufacturer or as individual products applied at different times of the day/week). These products tend to take longer for results to be noticed by the patient, so a minimum trial period of 2-3 months may be necessary before changing to something else.

**Tazarotene** is a topical retinoid that is used both for acne and psoriasis. This product may cause irritation and dryness of the skin. Combining it with topical steroids and/or emollient moisturizers may reduce the irritation.

Systemic therapies include oral and injectable products. **Methotrexate** is one of the older oral products used for psoriasis. It works by inhibiting an enzyme involved in rapid cell growth. Methotrexate can be taken orally or by injection and patients using this medication need to be monitored regularly with blood work and possibly a liver biopsy, especially with accumulated doses over months/years of therapy. Avoidance of alcohol is required while on this medicine. **Acitretin** is another oral medicine for the treatment of psoriasis. This medicine needs regular monitoring, too, both for blood counts, liver enzymes, and triglyceride and cholesterol levels. Avoidance in pregnant and pregnant-potential-aged patients is a must as this drug causes severe birth defects. Significant sensitivity to UV exposure may also be a problem with this medication.

In some psoriasis patients, because their activity is triggered by infections, chronic antibiotic use has been utilized as an adjunctive therapy.

**Cyclosporine** which works to slow the growth of skin cells by suppressing the immune system directly has been used for psoriasis treatment, but is limited to a maximum of 9-12 months. Regular monitoring of therapy is required. This is also true for the use of **mycophenolate mofetil** (CellCept®).

The newer "biological" injectable medicines are being used more and more often for the treatment of psoriasis. There are several to choose from and in consultation with your dermatologist, the most appropriate product for you and your condition can be used. These include: **adalimumab** (Humira®), **etanercept** (Enbrel®), **infliximab** (Remicade®), and **ustekinumab** (Stelara®). Some of these products are self-administered and some require SQ or IV administration by your physician or staff.

Phototherapy is a treatment for psoriasis that involves careful exposure of your skin to ultraviolet light.

Both **UVA** and **UVB** therapies are used and both require monitoring and care when using. Phototherapy may be used alone or in combination with topical and/or oral therapies. UVA therapy as a stand-alone treatment is not effective for psoriasis (one of the reasons why a trip to the tanning booth is not appropriate for psoriasis treatment), but combining it with oral (or bath-applied) psoralens which makes the skin more sensitive to UVA light, is used and commonly called PUVA treatment. This type of treatment is undertaken at your physician's office or a treatment center. UVB light therapy can be used at home with purchased UVB light 'box' and monitored with regular interaction with your dermatologist or administered at your dermatologist's office.

Potential complications from psoriasis include arthritis, pain, itchiness which can sometimes be severe and may lead to secondary skin infections, side effects from your treatment medicines, psychiatric or depression episodes because of your condition and

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even skin cancer from UV treatments. All of these can be discussed, and very often controlled, with ongoing evaluations and discussions with your dermatologist.

Some home-use tips include the use of non-drying, non-harsh soaps (sometimes anti-bacterial, deodorant soaps may be too drying for your skin) and when bathing, use cleansers in "strategic" areas only... armpits, groin, hands, and face and where you see dirt. It is not always necessary to lather the entire body every time you bathe. Regular, emollient cream/moisturizer applications to the trunk and extremities—more frequently in the often times drier winter months than the more humid summer months will aid in the prevention of dry skin with the subsequent tendency to scratch and potential flare your psoriasis. Mild UV exposure (even on a cloudy day) may help, but be careful not to sunburn as this can actually flare some psoriasis patients. Anti-stress and relaxation techniques may be a part of overall general well-being and may actually lessen your potential to flare.

For more information:

The National Psoriasis Foundation

1.800.723.9166

[www.psoriasis.org](http://www.psoriasis.org)

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