NICE guidance indicates that health professionals should regularly assess people with psoriasis, and know when to refer them on to specialist care

The assessment and management of psoriasis

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Psoriasis is a common inflammatory skin condition that affects approximately 1.3-2.2% of the UK population (Parisi et al, 2012). Up to 13% of this group may also develop psoriatic arthritis (Ibrahim et al, 2009a). Recent studies have found people with psoriasis have an increased risk of cardiovascular disease, diabetes and depression, especially those with severe disease (Ahlehoff, 2011; Kurd et al, 2010; Qureshi et al, 2009).

The National Institute for Health and Clinical Excellence published its first clinical guideline on the assessment and management of psoriasis last year (NICE, 2012). In most cases, psoriasis is managed in primary care, with specialist referral being needed at some point for up to 60% of people (Schofield et al, 2009). The new guideline makes recommendations for the holistic assessment of affected patients.

Psoriasis is a long-term condition and self-management requires the support of clinicians as a single point of contact to help patients (and families/carers) access information and advice about the condition and services at each stage of the care pathway. Clinicians should be trained and competent to offer support and advice about the use of topical treatments.

Assessment

When seeing a patient with psoriasis in primary care, the following assessments should be undertaken as standard:
> Disease severity;

BOX 1. INDICATIONS FOR SPECIALIST REFERRAL

Adults
- Diagnostic uncertainty
- Any type of psoriasis that is severe or extensive, for example if it affects more than 10% of the body surface area
- Any type of psoriasis that cannot be controlled with topical therapy
- Acute guttate psoriasis requiring phototherapy
- Nail disease with a major functional or cosmetic impact

Children and young people
- Any type of psoriasis
- Generalised pustular psoriasis or erythroderma: this is a red flag symptom and requires same-day assessment
- Suspected psoriatic arthritis: referral to rheumatologist is required

- Any type of psoriasis with a major impact on physical, psychological or social wellbeing

Psoriasis is linked to other conditions
Presence of psoriatic arthritis;  
Impact on physical, psychological and social wellbeing;  
Cardiovascular risk factors (in severe disease).

This holistic assessment will help determine whether the patient should be referred to a specialist (Box 1).

Various assessment tools are recommended. Disease severity can be estimated by both patient and clinician using a static global assessment score (clear, nearly clear, mild, moderate, severe or very severe). The clinician can estimate the body surface area (BSA) affected and should record if nails, high-impact sites and difficult-to-treat sites (for example the face, scalp, palms, soles, flexures and genitals) are affected. Any systemic upset, such as fever and malaise, should be noted and acted upon as these are common in unstable forms of psoriasis, such as erythroderma or generalised pustular disease. Specialists will use a psoriasis area and severity index (PASI) score to measure severity objectively.

Assessment for psoriatic arthritis should be undertaken annually and referred to a rheumatologist made promptly if suspected. The validated Psoriasis Epidemiology Screening Tool (PEST) questionnaire (Table 1) can be used; however, it does not detect axial arthritis or inflammatory back pain. Adults with severe psoriasis (>10% BSA) should be offered a cardiovascular risk assessment using a validated risk estimation tool; this should be repeated every five years or more frequently if indicated. All patients should be offered advice on healthy lifestyles.

The impact of psoriasis on physical, psychological and social wellbeing should be assessed by asking about a range of matters including:

- The aspects of daily living affected by psoriasis;  
- How the patient is coping;  
- Further advice or support is needed;  
- If psoriasis affects mood or causes distress.

If depression is suspected, information, advice and support should be offered in line with NICE guidance (2009; 2005). A dermatology-specific questionnaire can be used to gauge the impact on quality of life (Lewis-Jones and Finlay, 1995; Finlay and Khan, 1994).

**Treatment**

Topical therapy is the first-line treatment for psoriasis. Second-line treatments, for example phototherapy or systemic drug therapy, such as methotrexate, must be specialist-led. Treatment algorithms have been developed based on clinical and cost-effectiveness analyses and are available to download from the NICE website (tinyurl.com/NICEpathways-Psoriasis).

Different sites require different topical therapies as some are more susceptible to side-effects. The face, flexures and genitals are particularly vulnerable to steroid atrophy, so corticosteroids should only be used for short-term treatment of psoriasis at these sites (1–2 weeks per month). All adult patients should be reviewed four weeks (for children, two weeks) after starting a new topical therapy to evaluate tolerability, toxicity and initial response.

Psoriasis lesions should be responding to treatment within four weeks but may require a further 2–4 weeks to clear fully. If there is no response after four weeks, treatment should be changed following the appropriate treatment algorithm. Prescribers need a good knowledge of the different strengths of topical corticosteroids and ensure patients are fully informed about their safe use (Box 2).

**Conclusion**

All clinicians assessing and treating psoriasis should reflect on their knowledge and skills to ensure they are delivering the care NICE sets out. Forthcoming quality standards and tools will provide support.