STANDARD TREATMENT WORKFLOW (STW)

Psoriasis

Binod K Khaitan[1], Deepika Pandhi[2], Ananta Khurana[3], Dipankar De[4], Rahul Mahajan[5], Renu George[6], Vishal Gupta[7]

[1]All India Institute of Medical Sciences, New Delhi; [2]University College of Medical Sciences, New Delhi; [3]Dr. Ram Manohar Lohia Hospital, New Delhi; [4]Postgraduate Institute of Medical Education and Research, Chandigarh; [5]Postgraduate Institute of Medical Education and Research, Chandigarh; [6] Christian Medical College, Vellore; [7]All India Institute of Medical Sciences, New Delhi

CORRESPONDING AUTHOR

Dr Binod K Khaitan, Department of Dermatology, All India Institute of Medical Sciences, New Delhi
Email: binodkhaitan@hotmail.com

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Standard Treatment Workflow (STW)

PSORIASIS

ICD-10-L40

***GENERAL PRINCIPLES OF MANAGEMENT**

- Establish the diagnosis
  - Usually clinical and by bed side tests (Auspitz sign, Grattage test)
  - If in doubt, refer to higher centre for evaluation & skin biopsy
- Assess for psoriatic arthritis and metabolic syndrome (obesity, dyslipidemia, diabetes, hypertension)
- Counsel about variable natural course of disease and expected treatment outcome, and lifestyle modifications (including weight reduction, avoidance of smoking and alcohol)
- Assess for requirement of systemic treatment, in addition to topical treatment
- Advise regular use of emollients/ moisturizers. Antihistamines if pruritic
- Avoid Methotrexate and Cyclosporine A in children scheduled for live vaccines
- Rule out tuberculosis, HIV, Hepatitis B and C infections before systemic immunosuppressive treatment
- Pregnancy test-prior to systemic therapy (Acitretin avoided in child bearing age group)
- Systemic steroids should not be given for the treatment of psoriasis, except for generalized pustular psoriasis of pregnancy
- If first-line treatment options fail or are contraindicated, refer to tertiary care center for combination. Baseline investigations to be carried out

These principles should be used only as a general guide to choose a treatment; final decision should be made on case-to-case basis

TREATMENT OVERVIEW

TOPICAL THERAPY (<5% BODY SURFACE AREA (BSA))

- Moisturizers like white soft paraffin
- Topical corticosteroids, Tacrolimus ointment, Tazarotene, Calcipotriol, Coal tar, Dithranol, Salicylic acid combinations

PHOTOTHERAPY (>5% BSA/ PALMOPLANTAR PSORIASIS)

- Narrow band UVB, Targeted phototherapy, Topical/systemic PUVA or Psoralens with sunlight (PUVAsol)

SYSTEMIC THERAPY (>5% BSA/ SEVERE RECALCITRANT DISEASE/ PALMOPLANTAR PSORIASIS/ ARTHRITIS)

- Methotrexate/ Cyclosporine A/ Retinoids-isotretinoin (may be preferred in adolescent girls), Acitretin/ oral antibiotics (guttate psoriasis)/ novel small molecules
- Resistant cases- Biologics

VARIANTS OF PSORIASIS

PLAQUE PSORIASIS | GUTTATE PSORIASIS | PALMOPLANTAR PSORIASIS | ERYTHRODERMIC PSORIASIS | PUSTULAR PSORIASIS

PLAQUE PSORIASIS

Erythematous plaques with silvery white scales

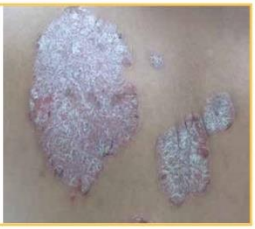
LIMITED PLAQUE PSORIARIS (< 5%)

PRIMARY/ SECONDARY LEVEL

- Face and flexures - 1% Hydrocortisone/ low potency steroid cream OD for 2 weeks
- Trunk and extremities - Betamethasone cream (or any other potent steroid, preferably with Salicylic acid 3-6%) OD for 2-4 weeks
- Other topical treatment as listed in treatment overview

TERTIARY LEVEL

- Continue with topical therapy
- If the patient does not respond in 6-8 weeks, try alternate topical agents and/ or systemic therapy or NB UV-B/ PUVA/ PUVAsol



GENERALIZED PLAQUE PSORIASIS

REFER TO GENERAL PRINCIPLES OF MANAGEMENT PREFERABLY TO BE MANAGED AT HIGHER CENTRE

- Systemic treatment- refer to treatment overview
- If these fail or are contraindicated, refer to tertiary level for combination or rotational therapy/ novel small molecules/ biologicals

- Continue emollients
- Avoid irritants & prolonged use of topical steroids

Scalp- Tar based shampoo and topical steroids +/- salicylic acid lotions

GUTTATE PSORIASIS

CLINICAL FEATURES

- Shower of numerous erythematous papules < 1 cm on the trunk and extremities
- Seen more commonly in younger patients

TREATMENT

REFER TO GENERAL PRINCIPLES OF MANAGEMENT*

Primary health centre/Level

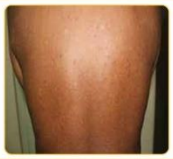
- Antibiotics for streptococcal infection

Secondary Level

- Same as primary level care
- Psoralen ultraviolet A Solar (PUVAsol)

Tertiary Level

- Same as primary level care
- Narrow band UVB
- Refractory cases- consider systemic treatments including novel small molecules



PALMOPLANTAR PSORIASIS

Chronic erythematous well defined plaques symmetrically on palms and soles, and occassional nail involvement to be differentiated from palmoplantar eczema

REFER TO GENERAL PRINCIPLES OF MANAGEMENT*

PRIMARY HEALTH CENTER

- Topical petrolatum at least twice daily
- Add antibiotics if signs of infection
- Potent steroid-salicylic acid combination Refer to higher center if not responding in 6-8 weeks

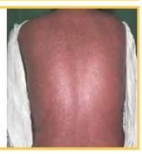
SECONDARY CARE HOSPITAL AND TERTIARY CARE HOSPITAL

- In addition to those treatment prescribed at primary care
- Tar based applications/ steroid-salicylic acid with occlusion (if very thick plaques) for 2-4 weeks
- Phototherapy- Hand and foot NB UV-B/ PUVA soaks
- Systemic therapy - refer to treatment overview

ERYTHRODERMIC PSORIASIS

CLINICAL FEATURES

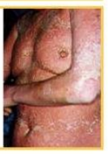
- Generalised erythema and scaling involving >90% of the BSA
- Triggered by withdrawal of systemic corticosteroids/ potent topical steroids or HIV infection
- Common D/D- dermatitis, drug reactions, pityriasis rubra pilaris, idiopathic erythroderma



PUSTULAR PSORIASIS

CLINICAL FEATURES

- Crops of localized or generalised sterile pustules and lakes of pus with surrounding erythema, often associated with fever
- In pregnancy- presents as impetigo herpetiformis,may lead to intrauterine growth retardation or still birth



GENERAL MANAGEMENT AT PRIMARY CARE

- Stabilize patient & treat secondary infection
- Maintain temperature/ fluid and electrolyte balance
- Admit if febrile & unstable vitals
- High protein diet
- Lab investigations: Complete Hemogram, Liver & Kidney Function test
- Refer to higher center for specific management

SPECIFIC MANAGEMENT

- Skin biopsy, if in doubt
- Methotrexate or Cyclosporine A
- Maintenance- Acitretin/ NbUVB/ PUVA
- If patient fails to respond, consider biologics

SPECIFIC MANAGEMENT

- Assess patient
- Take drug history (particularly Beta-lactams, Macrolides, Calcium channel blockers) to rule out acute generalized exanthematous pustulosis
- Generalized pustular psoriasis - admit the patient and follow general measures as for psoriatic erythroderma
- In addition to blood tests as listed previously, serum calcium (patients may have hypocalcemia) should also be estimated
- Acitretin/ Methotrexate/ Cyclosporine

PSORIASIS IS COMPLETELY TREATABLE BUT HAS A CHRONIC COURSE

This STW has been prepared by national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory, and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit the website of DHR for more information: (**stw.icmr.org.in**) for more information.
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