FIVE THINGS TO KNOW ABOUT ...

Psoriasis

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1

Psoriasis has a major impact on quality of life

Psoriasis is a chronic dermatosis that affects 2%–3% of the population.[1] Characteristic psoriatic lesions are well-circumscribed erythematous plaques with silvery-white scales, typically distributed over extensor surfaces, especially favouring the elbows and knees, as well as the scalp. Along with physical discomfort, psoriasis is associated with depression, sexual impairment, social stigmatization and reduced work productivity.[1]

2

The presence of arthritis and cardiovascular comorbidities should be considered in psoriasis

It is important to consider and potentially screen for comorbidities in patients with psoriasis. Up to 25% of patients with psoriasis will develop associated psoriatic arthritis, most commonly of the small joints of the hands and feet, and typically 10 years or more after the onset of skin disease.[2] A higher prevalence of metabolic syndrome, cardiovascular disease and stroke has been described.[2]

3

Guttate psoriasis can follow streptococcal pharyngitis

Guttate psoriasis is a form of psoriasis often observed in young people and typically noted following streptococcal pharyngitis. It is characterized by widespread small, red scaly papules (guttate means "resembling drops") rather than the typical larger lesions observed in plaque psoriasis. Whereas spontaneous resolution of guttate psoriasis is often observed within 12 weeks, 2%–30% of patients may progress to chronic plaque psoriasis.[3] Phototherapy and topical steroid preparations are often used to treat guttate psoriasis.[3]

4

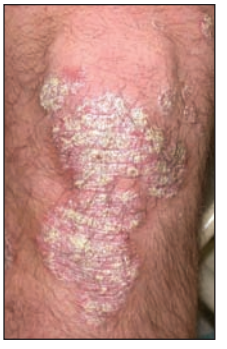
The choice of topical treatment for mild to moderate psoriasis should be targeted to the type and location of lesions

Common first-line topical treatments for mild to moderate psoriasis include topical steroids, the vitamin D derivative calcipotriol, and a combination of topical steroids and calcipotriol.[4] Topical immunomodulators tacrolimus and pimecrolimus can be used on sensitive body areas, such as the face, axillae and groin.[4] Tar and salicylic acid preparations are effective to reduce the thickness of hyperkeratotic plaques, and intralesional steroids may be used for stubborn localized psoriasis lesions.[4]

5

Widespread or severe psoriasis warrants referral to a dermatologist for phototherapy or systemic therapy

Phototherapy is an effective treatment, especially for widespread psoriasis. Systemic treatment options for psoriasis are divided into traditional therapies, such as methotrexate, acitretin and cyclosporine, and newer biologic therapies such as adalimumab, etanercept, infliximab and ustekinumab.[5] Although relatively new, the biologic medications can be very effective for both psoriasis and psoriatic arthritis.[5] Assessment and monitoring by a dermatologist is typically required for these therapies. There is a recently published evidence-based Canadian guideline for the management of plaque psoriasis.[4]



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