Guidelines for the management of patients with Psoriasis

Contents: use ctrl and click to follow the chapter links

<table>
<thead>
<tr>
<th>Assessment, Referral Criteria and offering topical treatment</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Psoriasis – Trunk and limb</td>
<td>2</td>
</tr>
<tr>
<td>Adult Psoriasis – Face, flexures &amp; genitals</td>
<td>2</td>
</tr>
<tr>
<td>Adult Psoriasis – Scalp +/- scaling</td>
<td>3</td>
</tr>
<tr>
<td>Children and young people - Trunk and limb</td>
<td>4</td>
</tr>
<tr>
<td>Children and young people - Face, flexures &amp; genitals</td>
<td>4</td>
</tr>
<tr>
<td>Children and young people - Scalp +/- scaling</td>
<td>4</td>
</tr>
<tr>
<td>Safe use of topical corticosteroids and finger tip unit guide</td>
<td>5</td>
</tr>
<tr>
<td>Preferred Prescribing List</td>
<td>6</td>
</tr>
<tr>
<td>Practical guidance, links and references</td>
<td>7</td>
</tr>
</tbody>
</table>

Acknowledgement: This document was developed by clinicians of NHS Lambeth CCG, NHS Southwark CCG, Departments of Dermatology and Pharmacy GSTFT & KCH
Guidelines for the management of patients with Psoriasis

For people with any type of psoriasis — NICE Pathway

- assess severity & impact of their psoriasis; ask about scalp, genital, natal cleft, nail involvement (Psoriasis disability index)
- clarify previous treatment history
- assess co-existing psoriatic arthritis & depression: treat and refer as needed
- assess comorbidities and lifestyle risk factors and offer advice/support e.g. obesity, type 2 diabetes, smoking (refer for smoking cessation advice), harmful drinking (NICE CG24)
- discuss the risks and benefits of treatment options with the patient (and their carers)
- discuss the importance of persistence with treatment for optimising outcomes.

Offer patients with psoriasis (their families or carers) support and information. Discuss:

- what aspects of daily living are affected by their psoriasis
- how they are coping with their skin condition and any treatments that they are using
- the impact of their skin condition on their family/carers
- their diagnosis, possible triggers eg stress, infection, medication (anti-malarials, lithium, B Blockers, NSAIDs, stopping corticosteroids) and lifestyle risk factors
- their treatment options and when to seek review
- when and how to use prescribed treatments safely and effectively (eg how to apply topical treatments, how to minimise the risk of side effects)
- what further advice/support they need (eg PILDs, support groups, information about pre-payment certificates from community pharmacist, advice from nurse specialist)

Referral criteria for dermatology specialist advice1,2

- Patients with generalised pustular psoriasis or erythroderma: Telephone for same-day specialist (hospital) assessment and treatment2.
- For acute guttate psoriasis (small, red, and scaly teardrop-shaped spots appear on the arms, legs, and middle of the body) request Urgent OP review via Choose & Book. Refer routinely if there is:
  - diagnostic uncertainty or
  - severe/very severe psoriasis (defined by the Physician’s Global Assessment as clear, nearly clear, mild, moderate, severe or very severe psoriasis) or
  - extensive psoriasis for example more than 10% of the body surface area affected or
  - any type of psoriasis which cannot be controlled with topical therapy or
  - nail disease which has a major functional or cosmetic impact or
  - any type of psoriasis having a major impact on a patient’s physical, psychological or social wellbeing.

Refer children <12 and young people 12-18 with any type of psoriasis; initiate treatment according to this guideline and refer to specialist.

1. Offering topical therapy: Refer to BNF/BNFc for prescribing information and NICE pathway

Take into account patient preference, cosmetic acceptability, practical aspects of application and the site(s) and extent of psoriasis to be treated; discuss the variety of formulations1,2,3,4 available and depending on the patient’s preference offer:

- cream, lotion or gel for widespread psoriasis
- lotion, solution or gel for the scalp or hair-bearing areas
- ointment to treat areas with thick adherent scale

People with psoriasis that is extensive (eg. more than 10% of body surface area affected) or at least ‘moderate’ on the static Physician’s Global Assessment will usually need more than topical treatment for disease control and should be considered for specialist referral.

Review patients within 4 weeks (2 weeks in children under age of 12)2 of starting or changing treatments. Assess effectiveness of the intervention(s), check toxicity and tolerability. Check adherence & ensure patient has sufficient quantity of topical treatments1,2.

2. Maintenance treatment: where psoriasis is responding to topical treatment, discuss:

- the importance of continuing treatment until a satisfactory outcome is achieved (eg clear or nearly clear) or up to the recommended maximum treatment period for corticosteroids
- that relapse occurs in most people after treatment is stopped
- using topical treatments when needed to maintain satisfactory disease control

Aim for a 4 week break between treatment courses of potent or very potent corticosteroids:

- Consider non-steroid-based topical treatments (eg vitamin D, Vitamin D analogues or coal tar) to maintain psoriasis disease control during this period.
- Offer a supply of their topical treatment to keep at home for self-management

3. Using corticosteroids safely: Continuous use of potent/very potent corticosteroids causes:

- Irreversible skin atrophy and striae. Psoriasis can become unstable
- Systemic side effects when applied continuously to extensive psoriasis (eg more than 10% of body surface area affected).

Explain the risks of these side effects and discuss how to avoid them:

- Do not use potent or very potent corticosteroids on the face, flexures or genitals.
- Do not use very potent corticosteroids continuously at any site for longer than 4 weeks. Do not use potent corticosteroids continuously at any site for longer than 8 weeks.

Offer a Finger tip unit (FTU) patient information leaflet about using topical corticosteroids. Consider only affected skin when calculating FTUs

Offer a review at least annually1,2 to those using potent or very potent corticosteroid (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

Approved by: NHS Lambeth Borough Prescribing Committee Date approved: 24/03/2014 and NHS Southwark Medicines Management Committee. Date approved: 25/02/2014. Review date: 31/03/2016.

Refer queries to: lamcgg.medicinesmanagement@nhs.net or 0203 049 4197 (Lambeth). soucgg.medicines-management@nhs.net or 0207 525 3253 (Southwark).
Guidelines for the management of patients with Psoriasis

Trunk and Limb

Involve patient in decision making process
Discuss choice of preparations and demonstrate use. Emphasise the importance of adherence to, and persisting with, treatment. When improvement occurs, stop treatment. NB relapse occurs in most cases so give patient treatments for self-management at home.

Emollients
Use regularly throughout treatment and when skin is clear. Offer a range of emollients from the preferred list. The best emollient is the one the patient will use.

Offer a potent corticosteroid applied once daily plus vitamin D or a vitamin D analogue applied once daily (applied separately, one in the morning and the other in the evening) for up to 4 weeks as initial treatment.
- Betamethasone Valerate 0.1% Ointment or
- Betamethasone dipropionate 0.05% & salicylic acid 3% Ointment (Diprosalic) if scaling

If there is little or no improvement at 4 weeks, discuss the next treatment option with the patient.

Offer vitamin D or a vitamin D analogue applied twice daily
- Calcipotriol ointment or if this causes irritation
- Calcitriol Ointment

No clearance/near clearance or no satisfactory control after 8 weeks
Check treatment adherence

Offer either a twice daily potent corticosteroid or a coal tar preparation
- Beclometasone valerate 0.1% applied twice daily for up to 4 weeks or,
- Exorex lotion/Carbo-Dome/Psoriderm applied once or twice daily

OR if twice daily potent corticosteroid or coal tar cannot be used or a once daily preparation aids adherence of a combination product offer
- Calcipotriol monohydrate 50micrograms/g and betamethasone dipropionate 0.05% ointment once daily for 4 weeks

No Improvement
Check treatment adherence

Refer to specialist for consideration of Phototherapy or

Further Topical or Systemic treatment

ADULTS: Assess extent & severity
Refer for specialist review if > 10% body surface area involved

Face, flexures and genitals

Involve patient in decision making process
Discuss choice of preparations and demonstrate use. Emphasise the importance of adherence to, and persisting with, treatment. When improvement occurs, stop treatment. NB relapse occurs in most cases so give patient treatments for self-management at home.

Emollients
Use regularly throughout treatment and when skin is clear. Offer a range of emollients from the preferred list. The best emollient is the one the patient will use.

Offer a short-term mild to moderate corticosteroid applied once or twice daily for a maximum of 2 weeks.
- Hydrocortisone 1% cream or ointment
- Clobetasone butyrate 0.05% cream or ointment

Do not use potent or very potent topical steroids

If the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is serious risk of local corticosteroid-induced side effects, offer a calcineurin inhibitor* applied twice daily for up to 4 weeks.
- Tacrolimus 0.1% ointment or
- Pimecrolimus 1% cream

These should be initiated by healthcare professionals with expertise in treating psoriasis. Advise use of sunscreens.

(*Calcineurin inhibitors are not licensed for this indication; but this use is recommended in NICE 2012 Psoriasis guidelines CG153, prescribers following this local guidance, take full responsibility for the decision. The patients (or their parent or carer) informed consent, should be documented. See the GMC Good practice in prescribing medicines – guidance for doctors for further information)

No clearance/near clearance or no satisfactory control after 8 - 12 weeks. Check treatment adherence

Refer to specialist for consideration of Phototherapy or

Further Topical or Systemic treatment

Approved by: NHS Lambeth Borough Prescribing Committee Date approved: 24/03/2014 and NHS Southwark Medicines Management Committee. Date approved: 25/02/2014. Review date: 31/03/2016.
Refers to: lamccg.medicinesmanagement@nhs.net or 0203 049 4197 (Lambeth). souccg.medicines-management@nhs.net or 0207 525 3253 (Southwark).
Guidelines for the management of patients with Psoriasis

**ADULTS**

**SCALP +/- scaling**
Assess severity and impact

*Involve patient in decision making process*
Discuss choice of preparations. Demonstrate how to use. Emphasise the importance of adherence to, and persisting with, treatment. Give patient supply of treatments for self-management at home.

Offer a potent corticosteroid applied once daily for up to 4 weeks as initial treatment
- Beclomethasone Valerate 0.1 % Preparation

Consider a different formulation of the potent corticosteroid (as per table below) eg
- Betacap
- Betamousse
and/or topical agents to remove adherent scale before application of the potent corticosteroid.
- Sebco® scalp ointment *(To remove or reduce scale before using other topical treatments. Patient may use if scale returns).*
- Consider use of Hydromol ointment OR Dermol 600 rubbed into scalp which can be left overnight and washed out in the morning as an alternative

Offer a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily for up to 4 weeks or vitamin D or a vitamin D analogue applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis).
- Betamethasone dipropionate 0.05% and calcipotriol 50 microgram/g gel or
- Calcipotriol cutaneous solution *(if skin irritation occurs consider Tacalcitol lotion)* or Calcitriol ointment

Consider referral to a specialist for additional support with topical applications and/or advice on other treatment options.
Offer a very potent corticosteroid applied once to twice daily for 2 week. *Check BNF/SPC for dosing requirements for individual corticosteroids* or Coal tar applied once or twice daily
- NB risk of side effects. Careful monitoring required and for short term use ONLY

<table>
<thead>
<tr>
<th>Very potent corticosteroid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clobetasol Propionate 0.05% scalp application (Dermovate)</td>
</tr>
<tr>
<td>Clobetasol Propionate 0.05% foam (Clarelux)</td>
</tr>
<tr>
<td>Short contact (15minutes) Clobetasol Propionate 0.05% shampoo (Etrivex)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coal tar preparation for a couple of hours &amp; washed out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psoriderm cream or</td>
</tr>
<tr>
<td>Sebco / Cocos ointment</td>
</tr>
<tr>
<td>Exorex lotion</td>
</tr>
</tbody>
</table>

NB: Suitable shampoos can be used as adjuncts to other treatment e.g. Capasal, Aphosyl 2 in 1 and T/Gel
Guidelines for the management of patients with Psoriasis

**CHILDREN AND YOUNG PEOPLE**

Refer all children and young people with a new diagnosis of psoriasis for a specialist opinion.

**Involves patient/Parents/Carers in decision making process**

Discuss choice of preparations. Demonstrate how to use. Emphasise the importance of adherence to, and persisting with, treatment. When improvement occurs, stop treatment. NB relapse occurs in most cases therefore give a supply of treatments for self-management at home.

**Trunk and Limb:**

- **Assess extent & severity**

**Face, flexures and genitals:**

- **Assess extent & severity**

**Scalp +/- scaling:**

- **Assess severity**

Offer a short-term mild or moderate potency corticosteroid applied once or twice daily.

- Hydrocortisone 1% cream
- Clobetasone Butyrate 0.05% ointment

Consider either:

- Calcipotriol applied once daily (only for those over 6 years of age) or
- Betamethasone valerate 0.1% applied once daily or
- Mometasone 0.1% Ointment applied once daily
- Both corticosteroids only to be used for those over 1 year of age

Consider a different formulation of the potent corticosteroid

- Beclometasone Valerate 0.1% preparation eg scalp application

Check adherence

Or for those children with mild to moderate scalp psoriasis and who cannot use topical steroids offer a topical vitamin D or a vitamin D analogue applied once daily

- Calcipotriol scalp solution (if skin irritation occurs consider offering Tacalcitol lotion)

Offer a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily

- e.g. Betamethasone dipropionate 0.05% and calcipotriol 50microgram/g gel

Or for those children with mild to moderate scalp psoriasis and who cannot use topical steroids offer a topical vitamin D or a vitamin D analogue applied once daily e.g. Calcipotriol scalp solution (if skin irritation occurs consider offering Tacalcitol lotion)

Offer coal tar applied once or twice daily for a couple of hours before washing out

- Sebco / Cocos
- Psoriderm cream
- Exorex lotion

Refer to a specialist for additional support with topical applications and/or advice on other treatment options.

Discuss choice of preparations. Demonstrate how to use. Emphasise the importance of adherence to, and persisting with, treatment. When improvement occurs, stop treatment. NB relapse occurs in most cases therefore give a supply of treatments for self-management at home.

No satisfactory control. Check treatment adherence

Please refer to the BNF for children for information on licensed use, appropriate dosing and duration of treatment. Follow link to Nice Psoriasis Pathway for advice about assessment. Follow link to PCDS

No clearance, near clearance or no satisfactory control. Check adherence

Involve patient/Parents/Carers in decision making process

Discuss choice of preparations. Demonstrate how to use. Emphasise the importance of adherence to, and persisting with, treatment. When improvement occurs, stop treatment. NB relapse occurs in most cases therefore give a supply of treatments for self-management at home.

Emollients

Use regularly throughout treatment and when skin is clear. Offer a range of emollients from formulary. The most effective emollient is the one that the patient will use happily.

No control with topical therapy

Refer to specialist for consideration of further topical therapy, systemic treatment or phototherapy according to site of psoriasis.

1 Please refer to the BNF for children for information on licensed use, appropriate dosing and duration of treatment. Follow link to Nice Psoriasis Pathway for advice about assessment. Follow link to PCDS

2 Please note use is unlicensed in children

Approved by: NHS Lambeth Borough Prescribing Committee Date approved: 24/03/2014 and NHS Southwark Medicines Management Committee. Date approved: 25/02/2014. Review date: 31/03/2016.

Refer queries to: lamccg.medicinesmanagement@nhs.net or 0203 049 4197 (Lambeth). souccg.medicines-management@nhs.net or 0207 525 3253 (Southwark).
Guidelines for the management of patients with Psoriasis

APPENDIX 1  Safe use of topical corticosteroids and Finger Tip Unit (FTU) Guide

Continuous use of topical corticosteroids may result in permanent skin damage and other adverse effects, causing:

- irreversible skin atrophy and striae
- psoriasis to become unstable
- systemic side effects when applied continuously to extensive psoriasis (for example more than 10% of body surface area affected).

It is important that patients and their families / carers are educated on the risks of overuse of topical corticosteroids and discuss how to avoid them:

- Very potent topical corticosteroids should not be used continuously at any site for longer than 4 weeks
- Potent topical corticosteroids should not be used continuously at any site for longer than 8 weeks
- Do not use very potent corticosteroids in children and young people
- A break of at least 4 weeks should be observed between courses of topical corticosteroid
- Offer an annual review to assess for adverse effects in (1) children using any topical corticosteroids on a regular basis and (2) for adults using potent or very potent topical corticosteroids either as short courses or intermittent use.

Topical corticosteroids should always be used for the least amount of time necessary to control symptoms, and should be applied thinly, avoiding normal skin. The quantity to be applied is specified by the amount of cream/ointment squeezed out of the tube nozzle in a line from the tip of an adult finger to the crease of the first joint (~2.5cm); equivalent to 0.5g of cream/ointment. As a guide, one Finger Tip Unit is enough to cover the palms of both hands. Various areas of the skin may be affected differently – ensure that potency of treatment is tailored according to the severity of each affected part.

Number of fingertip dosage units recommended for a single application are listed below (this guide indicates how much is required to cover the entire area specified. Smaller areas will need correspondingly lower amounts of cream/ointment). [NB the patient.co.uk patient information leaflet repeats this information]

<table>
<thead>
<tr>
<th>Age</th>
<th>Face &amp; neck</th>
<th>Arm &amp; hand</th>
<th>Leg &amp; foot</th>
<th>Trunk (front)</th>
<th>Trunk (back) including buttocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6 mths</td>
<td>1</td>
<td>1</td>
<td>1.5</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>1-2 yrs</td>
<td>1.5</td>
<td>1.5</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3-5 yrs</td>
<td>1.5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>2</td>
<td>2.5</td>
<td>4.5</td>
<td>3.5</td>
<td>5</td>
</tr>
<tr>
<td>Adults</td>
<td>2.5</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Table to show number of adult fingertip units (FTU) per body parts for children and adults

Corticosteroid formulations

- Always apply thinly in accordance with fingertip unit guide
- Apply once daily
- Topical corticosteroid treatment for flares should be started as soon as signs and symptoms appear
- Continue for +/- 48 hours after symptoms subside. Always check for and reinforce avoidance of trigger factors (e.g. soap)
- Ointment preparations are always to be preferred when available, use cream if ointment is unacceptable to the patient
- They can be applied twice weekly to prevent flares but if they are need daily to prevent flares, consider topical calcineurin inhibitors (see TCI algorithm). Twice weekly use to prevent flares must be monitored and appropriate

Prescribing and dispensing: best practice recommendations

- When prescribing or dispensing topical corticosteroids, the potency of the preparation should be specified on the prescription and the dispensing label.\(^1,3\) This aids both patient and healthcare professional education and also medicines reconciliation processes when patient care is transferred to another setting

Remember: Always educate patient about the use of products
### Guidelines for the management of patients with Psoriasis

**APPENDIX 2**

<table>
<thead>
<tr>
<th>Preferred prescribing list (Costs BNF 66, Dec 2013 Drug Tariff)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emollients</strong>&lt;br&gt;Any emollient recommended in the <a href="#">Lambeth and Southwark Emollient Prescribing Guidelines</a>&lt;br&gt;Salicylic acid in Aqueous cream 2% (JFC approved special – skin that is not dry)&lt;br&gt;Salicylic acid in WSP ointment 2% (JFC approved special – drier skin)</td>
<td>Emollient creams with 10% Urea are helpful for hands and feet e.g. Aquadrate&lt;br&gt;Hydromol ointment or Dermol or Hydromol bath emollients rubbed into a warm wet scalp and left on for several hours may help lift scale For scaling unresponsive to Sebco</td>
</tr>
<tr>
<td><strong>Emollients with salicylic acid</strong>&lt;br&gt;Salicylic acid in Aqueous cream 2% (JFC approved special – skin that is not dry)&lt;br&gt;Salicylic acid in WSP ointment 2% (JFC approved special – drier skin)</td>
<td></td>
</tr>
<tr>
<td><strong>Mild corticosteroid</strong>&lt;br&gt;Hydrocortisone 1% cream (30g = £2.26)&lt;br&gt;Hydrocortisone 1% ointment (30g = £2.28)</td>
<td>Initially once daily as per NICE pathway&lt;br&gt;Educate about Fingertip Units</td>
</tr>
<tr>
<td><strong>Moderate corticosteroid</strong>&lt;br&gt;Clobetasone butyrate 0.05% cream (30g = £1.86)&lt;br&gt;Clobetasone butyrate 0.05% ointment (30g = £1.86)</td>
<td>Initially once daily as per NICE pathway, Educate about Fingertip Units&lt;br&gt;Maximum 1-2 weeks per month for face/flexures</td>
</tr>
<tr>
<td><strong>Potent corticosteroid</strong>&lt;br&gt;Betamethasone valerate 0.1% cream (30g = £2.47)&lt;br&gt;Betamethasone valerate 0.1% ointment (30g = £2.47)&lt;br&gt;Mometasone furoate 0.1% cream (30g = £4.34)&lt;br&gt;Mometasone furoate 0.1% ointment (30g = £3.79)&lt;br&gt;With salicylic acid for scaling:&lt;br&gt;Betamethasone dipropionate 0.05% &amp; salicylic acid 3% ointment (Diprosalic – 30g = £3.18)&lt;br&gt;Shampoos:&lt;br&gt;Betamethasone valerate 0.1% scalp application <em>aqueous</em> (Betacap – 100mL = £3.75)&lt;br&gt;Betamethasone valerate 0.1% scalp application <em>alcohol</em> (Betamousse – 100g = £9.75)&lt;br&gt;Gels and other scalp formulations:&lt;br&gt;Betamethasone dipropionate 0.05% scalp lotion (Diprosone – 30mL = £2.73)&lt;br&gt;Mometasone 0.1% scalp lotion alcohol (Elocon – 30mL = £4.36)&lt;br&gt;Fluocinolone acetonide 0.025% gel (Synalar – 100g = £11.75)&lt;br&gt;Betamethasone 0.1% ointment or Mometasone furoate 0.1% ointment - Alternative for localised patch&lt;br&gt;Scalp applications with salicylic acid for scaling:&lt;br&gt;Betamethasone dipropionate 0.05% &amp; salicylic acid 2% scalp application (Diprosalic – 100mL = £10.10)</td>
<td>Initially once daily as per NICE pathway&lt;br&gt;Review after 1 month of treatment and if prescribed as prn ‘repeat’ at least annually&lt;br&gt;Maximum 8 weeks continuously&lt;br&gt;According to patient need&lt;br&gt;Educate about Fingertip Units</td>
</tr>
<tr>
<td><strong>Very Potent Corticosteroids (Adults)</strong>&lt;br&gt;Shampoos:&lt;br&gt;Clobetasol propionate 0.05% shampoo (Etrivex – 125mL = £14.32)&lt;br&gt;Gels and other scalp applications:&lt;br&gt;Clobetasol propionate 0.05% foam for scalp <em>alcohol</em> (Clarelux – 100g = £11.06)&lt;br&gt;Clobetasol propionate 0.05% scalp application alcohol (Dermovate – 100mL = £10.42)</td>
<td>Initially once daily as per NICE pathway&lt;br&gt;Once daily to dry scalp for 15 minutes, wash out; max 2 weeks; alcohol-based so may sting. Part hair and rub into scalp Review after 1 month of treatment and if prescribed as prn ‘repeat’ at least annually&lt;br&gt;Educate about Fingertip Units</td>
</tr>
<tr>
<td><strong>Vitamin D and vitamin D analogues</strong>&lt;br&gt;Calcipotriol 50mcg/g ointment (30g = £5.78)&lt;br&gt;Others (less irritant):&lt;br&gt;Calcitriol 3microgram/g ointment (100g = £16.34); Tacalcitol 4microgram/g ointment (30g = £13.40)&lt;br&gt;Calcipotriol 50microgram/mL scalp solution (60mL = £37.32) Tacalcitol 4microgram/mL lotion (30mL - £12.73)</td>
<td>Not in pregnancy&lt;br&gt;Refer to SPC/BNF for maximum daily quantities&lt;br&gt;NB: Calcipotriol, Calcitriol and Tacalcitol are not licensed for use in children</td>
</tr>
</tbody>
</table>
Guidelines for the management of patients with Psoriasis

| Combined calcipotriol + betamethasone dipropionate gel | Betamethasone dipropionate 0.05% + calcipotriol monohydrate 50microgram/g ointment or gel (60g = £61.55) Betamethasone dipropionate 0.05% + calcipotriol monohydrate 50microgram/g gel (60g =£33.08, 2x 60g = £61.43) - for scalp | Only prescribe a combination product where a twice-daily regimen of steroid and vitamin D analogue cannot be tolerated Does not need to be washed out daily. Add shampoo to DRY scalp before washing hair otherwise it becomes ‘gooey’ and is difficult to wash out |
| Calcinurin inhibitors | Pimecrolimus 1% cream (30g = £19.69) Tacrolimus 0.1% ointment (30g = £19.44) (Calcinurin inhibitors are not licensed for this indication; but this use is recommended in NICE 2012 Psoriasis guidelines CG153, prescribers following this local guidance, take full responsibility for the decision. The patients (or their parent or carer) informed consent, should be documented. See the GMC Good practice in prescribing medicines – guidance for doctors for further information) | For face/flexures/genitals Apply 15-30 minutes after emollients; may cause transient burning sensation after application for the first few days of treatment. Do not use near cold sores; Use sunscreens also on exposed sites if sunny. |
| Coal Tar preparations | Coal Tar Solution 5% in an emollient basis (Exorex – 100ml = £8.11) Coal tar 6% and Lecithin 0.4% cream (Psoriderm – 225ml = £9.42) | Not in pregnancy; Exorex lotion pleasant and easy to use; Psoriderm cream is thicker and smells more of tar. |
| | Scalp Shampoos: | Coal Tar 6% and Lecithin 0.4% Scalp Lotion (Psoriderm - 250ml £4.74) Coal Tar 1%, Coconut Oil 1% and Salicylic acid 0.5% Shampoo (Capasal - 250ml =£ 4.69) Alcoholic coal tar extract 5% shampoo (Alphosyl 2 in 1 - 250ml (£3.59) Coal tar extract 2% shampoo (T/Gel (fragrance) 250ml = £5.12) | Coal Tar preparations should not be applied to the genital region |
| | If very scaly: | Coal tar solution 12%, Salicylic acid 2%, precipitated sulphur 4% in a coconut oil emollient basis Scalp ointment (Sebco - 40g = £4.54; 100g = £8.11) Can stain very blond hair |
| | Coal tar solution 12%, Salicylic acid 2%, precipitated sulphur 4% in a coconut oil emollient basis Scalp ointment (Cocois - 40g - £6.22; 100g = £11.69) | If very inflamed: Part hair and rub into scalp; leave on for as long as possible, ideally overnight; Use old pillow/ pillowcase as can stain Warn that old hair will be lost (attached to scale) but generally regrows. |
| Oral retinoids | Acitretin | Specialist Medicine – Secondary care initiation and Prescribing Only Teratogenicity remains a risk for 2 years after stopping. |

Practical guidance and links


Guideline on quantities for topical application of steroids: [http://www.patient.co.uk/health/fingertip-units-for-topical-steroids](http://www.patient.co.uk/health/fingertip-units-for-topical-steroids)

British Association of Dermatologists - Clinical advice on use of:
- topical corticosteroids [http://www.bad.org.uk/site/1117/default.aspx](http://www.bad.org.uk/site/1117/default.aspx)
- topical vitamin D and tazarotene [http://www.bad.org.uk/site/1116/default.aspx](http://www.bad.org.uk/site/1116/default.aspx)
- topical coal tars [http://www.bad.org.uk/site/1114/default.aspx](http://www.bad.org.uk/site/1114/default.aspx)
- general background and advice (including links to specific advice above): [http://www.bad.org.uk/site/1110/default.aspx](http://www.bad.org.uk/site/1110/default.aspx)

Primary Care Dermatology Society
Overview on diagnosis and management with useful images; links to further detail on specific sub-types of psoriasis [http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview](http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview)

References


Approved by: NHS Lambeth Borough Prescribing Committee Date approved: 24/03/2014 and NHS Southwark Medicines Management Committee. Date approved: 25/02/2014. Review date: 31/03/2016.

Refer queries to: lamccg.medicinesmanagement@nhs.net or 0203 049 4197 (Lambeth), souccg.medicines-management@nhs.net or 0207 525 3253 (Southwark).