Psoriasis

Psoriasis is a common skin condition affecting 1 or 2 in every 100 people. It has a tendency to run in families. It can start at any age but it most commonly starts between the ages of 15 and 25. The severity of psoriasis varies greatly between people. In some, it can be mild with a few small patches of psoriasis being barely noticeable. In others there may be a rash over many parts of the body. Psoriasis tends to come and go throughout life. A 'flare-up' can occur at any time. The frequency of flare-ups varies between people. It is not uncommon to have long spells without the rash. However, in some people the flare-ups may be frequent.

What causes Psoriasis?

The exact cause is not known. Normal skin is made up of layers of skin cells. The top layer of cells are gradually shed (they fall off). New cells are constantly being made underneath to replace the shed top layer. It normally takes about 28 days for a bottom cell to reach the top and to be shed. People with psoriasis have a faster turnover of skin cells. It is not clear why this occurs. More skin cells are made which leads to a build up of cells on the top layer. These form the 'flaky plaques' on the skin or severe dandruff of the scalp described below. There is also a slight change of the blood supply of the skin. This may lead to a tendency to cause inflammation. This is why the skin underneath a patch of psoriasis (psoriasis plaque) is usually red.

Aggravating factors

There is no apparent reason for most flare-ups of psoriasis. However, some people have found that their psoriasis is more likely to flare up in certain situations. These include the following:

- *Stress* - it is impossible to measure stress or prove that it can cause flare-ups of psoriasis. However, it is commonly felt that stress does contribute on some occasions.
- *Infections* - - psorisasis may flare up with feverish illnesses. In particular, a sore throat caused by a bacteria (germ) is a cause of guttate psoriasis (see below).
- *Injury* - psoriasis plaques sometimes form over skin injuries or scars.
- *Medicines and drugs* - such as beta-blockers (propranolol, atenolol etc), chloroquine, lithium, anti-inflammatory pain killers (ibuprofen, naproxen, diclofenac, etc), and alcohol may sometimes contribute to a flare-up of psoriasis.

Types of psoriasis

Plaque psoriasis is the most common form. The rash is made up of areas on the skin called plaques. Each plaque usually looks red with overlying flaky white scales that feel rough. There is usually a sharp border between the edge of a plaque and normal skin. The most common areas affected are the front of the elbows and knees, the scalp and the lower back. However, plaques may appear anywhere on the skin. It is not common on the face. The extent of the rash varies between people and can vary from time to time in an individual. Many people just have a few small plaques when their psoriasis flares up. Others may have a more widespread rash with large plaques. Sometimes small plaques near each other merge to form large plaques.

Scalp psoriasis can occur alone or in combination with psoriasis in other parts of the body. It looks like severe dandruff.

Guttate ('drop') psoriasis typically occurs following an infection with a sore throat. The plaques of psoriasis are a lot smaller than usual (less than 1 cm) but are widespread over the whole body. It normally lasts a few weeks then fades away. It may never return but there is a higher than normal chance of developing common plaque psoriasis at a later time.

Nail psoriasis occurs in about half the people with plaque psoriasis. It may also occur alone without the skin rash. There are pinhead sized pits in the nail. Sometimes the nail separates from the nail bed. There is no effective treatment for the

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nail problems of psoriasis.

Other kinds of psoriasis such as pustular psoriasis or 'erythroderma' are uncommon.

Other problems of psoriasis

Psoriasis is sometimes itchy but does not usually cause much discomfort. It is not infectious. About 1 in 10 people with psoriasis also develop inflammation and pains in some joints (arthritis). This is called psoriatic arthropathy. The cause of this is not clear.

Cream and ointment treatments for psoriasis

There is no total cure for psoriasis. Treatment aims to clear the rash or to make it tolerable. Treatment may clear the rash and it may stay away for long periods. However, psoriasis tends to recur. Therefore treatments may be needed 'on and off' throughout life.

There are a variety of creams and ointments used to treat psoriasis. There is no 'best buy' that suits everybody. The treatment advised may depend on the severity and the type of psoriasis. Also, one treatment may work well in one person but not in another. It is not unusual to try a different treatment if the first one does not work so well. Treatments have to be applied regularly to clear the psoriasis. They also have to be applied correctly for best results. Make sure you know exactly how to use whatever treatment is prescribed. Do not be afraid to ask a doctor or nurse if you are unsure. Some people may not want treatment if the rash is not too bad or not in a noticeable place. The following are options if treatment is required.

Moisturisers (Emollients) are not 'active' treatments but help to soften hard skin and plaques. They may reduce scaling and itch. A variety of moisturiser creams and oitments are available. A mosturiser may be all that is required for very mild psoriasis. It can also be used in addition to any other treatment and as often as needed to keep the skin supple and moist.

Vitamin D based creams such as calcipotriol (dovonex) are popular and usually effective for plaque ('common') psoriasis. They are easy to use, are less messy and have less of a smell than coal tar or dithranol creams and ointments (below). They can cause irritation in some people and should not be used on the face. There is also a scalp preparation of calcipotriol.

Coal tar preparations have been used successfully for psoriasis over many years. They are thought to work by reducing the turnover of the skin cells. There are a variety of different preparations containing tar. Traditional tar preparations are messy to use but more modern formulas are more pleasant. Tar based shampoos are popular for scalp psoriasis. Tar should not be used on the face or on any broken or sore skin.

Dithranol has been used for many years for psoriasis. For most people a daily application of dithranol to a psoriasis plaque will eventually cause it to go. However, this can take time and dithranol may irritate healthy skin. Therefore it needs to be carefully applied to the psoriasis plaques only. Starting with low strength and moving onto stronger preparations over a few weeks can reduce skin irritation. There are various types of dithranol preparations. 'Short contact therapy' is quite popular. This involves putting a higher strength dithranol on the plaques of psoriasis for 15-60 minutes each day and then washing it off. Dithranol may stain skin, hair, clothes, bedding, baths etc.

Steroid creams or ointments can be useful, particularly for thick plaques. They work by reducing inflammation. They are sometimes prescribed for short periods for areas of skin with thick plaques. Ideally they should not be used for more than 4-6 weeks at a time. This is because the skin may become used to or 'tolerant' to steroids if used longer. Side effects with long term use may also occur. They are easy to use and may be a good treatment for difficult areas such as the scalp and face. Steroid lotions are useful for flare-ups of scalp psoriasis.

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Salicylic acid is sometimes combined with other treatments such as coal tar or steroid creams. It tends to loosen and 'lift' the scales of psoriasis on the body or the scalp.

Combinations of the above treatments may sometimes be advised if the psoriasis is not helped by one treatment alone. Sometimes treatments are 'rotated'. For example, a steroid ointment may be used for up to 6 weeks and then replaced with dithranol cream for a while. Scalp treatments often contain a combination of ingredients such as a steroid, coal tar and salicylic acid.

Other treatments

Treatment may have to be given at hospital for severe psoriasis. PUVA (Psoralen and Ultra violet light in the A band) is the most frequently used. This involves taking tablets (Psoralen) which enhances the effects of sunlight and attending for regular special light treatment sessions.

Sometimes people with severe psoriasis are given intense courses of treatment using the creams or ointments described above but in stronger strengths and with special dressings. There are also some drugs that are used for severe psoriasis. They are only prescribed by a specialist and are usually monitored carefully as there is some risk of serious side effects. Medication for arthritis may be required for people with psoriasis who develop psoriatic arthropathy (described above).

For further information and advice contact:

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