



PSORIASIS – AN OVERVIEW

What are the aims of this leaflet?

The British Association of Dermatologists offers three patient information leaflets on psoriasis. This leaflet has been written to provide you with an overview of psoriasis. It tells you what psoriasis is, what causes it, what can be done about it, and where you can find out more about it. The two other leaflets ([Topical treatments for psoriasis](#) and [Treatment of moderate and severe psoriasis](#)) give more details about the different types of treatment.

What is psoriasis?

Psoriasis is a common inflammatory skin disease affecting 2% of the population. It occurs equally in men and women, can appear at any age, and tends to come and go unpredictably. It is not infectious, therefore you cannot catch psoriasis from someone else. It does not scar the skin although sometimes it can cause a temporary increase or reduction in skin pigmentation. Although psoriasis is a long-term condition there are many effective treatments available to keep it under good control.

Psoriasis can affect the nails and the joints as well as the skin. About half of people with psoriasis have psoriasis affecting the nails. For people with moderate to severe psoriasis about one in three will develop psoriatic arthritis at some time. Psoriatic arthritis produces swelling and stiffness in the joints or stiffness in the lower back and should be managed by a rheumatologist who works closely with your dermatologist and/or your GP.

Psoriasis, particularly moderate to severe psoriasis, is associated with an increased risk of anxiety and depression. Moderate to severe psoriasis increases the risk of heart disease and stroke and treatment of psoriasis may reduce this risk. Psoriasis can also be associated with an increased risk of harmful use of alcohol and with diabetes, obesity and venous thromboembolism.

What causes psoriasis?

Both inherited and environmental factors play a role in the development of psoriasis. Some people are more likely to develop psoriasis than others, particularly if someone in their family has psoriasis.

Skin affected by psoriasis is red and scaly. The outer layer of skin (the epidermis) contains skin cells which are continuously being replaced. This process normally takes between three and four weeks. In psoriasis, the rate of turnover is dramatically increased so that cells are formed and shed in as little as three or four days.

For many individuals factors such as infections, stress, alcohol and/or smoking have a role triggering flares of psoriasis. Certain medications such as beta blockers (used to treat high blood pressure and angina), lithium and tablets used to treat malaria, can also cause psoriasis to flare. The relationship between diet and psoriasis has not been fully established, but obesity is associated with psoriasis and exercise and losing weight can be beneficial.

Is psoriasis hereditary?

Yes, but the way it is inherited is complex.

What are the symptoms of psoriasis?

- Psoriasis may not have any associated symptoms but it can be itchy and painful. Certain sites such as the scalp, lower legs and groin can be particularly itchy. If psoriasis affects the hands and feet, painful fissures or cracks can develop and these can affect use of the hands and walking. Severe psoriasis on the body can also develop fissures which are painful and can bleed.
- Psoriasis can affect the nails and lifting of the nail plate from the nail bed can be painful.
- Psoriatic arthritis produces pain, swelling and stiffness in one or more joints, particularly in the morning.

What does psoriasis look like?

The skin changes of psoriasis (often known as *plaques*) are pink or red areas with silvery-white scales. Many people have just a few plaques but some individuals with moderate to severe psoriasis may have several plaques covering large areas of their body.

Four patterns of psoriasis are recognised:

- Chronic plaque psoriasis is the most common type of psoriasis. Plaques of psoriasis are usually present on the knees, elbows, trunk and scalp, although others areas can be involved too.
- Guttate psoriasis consists of small plaques of psoriasis scattered over the trunk and limbs. It can be precipitated by a bacteria called Streptococcus which can cause throat infections.
- Palmoplantar psoriasis is psoriasis affecting the hands and feet. Psoriasis may appear at other sites too.
- Pustular psoriasis is rare type of psoriasis where the plaques on the trunk and limbs are studded with tiny pus spots. It can be localised or generalised and can flare rapidly necessitating hospital admission for treatment.

Nail psoriasis is present in about half of people with psoriasis. The features of nail psoriasis are:

- Pitting (indentations) of the surface of the nail;
- Salmon pink areas of discolouration under the nail;
- Separation of the nail plate from the nail bed; and
- Thickening of the nails.

How will psoriasis be diagnosed?

- Psoriasis is usually diagnosed on the appearance and distribution of the plaques.
- Psoriatic arthritis is usually diagnosed by a rheumatologist but your dermatologist or GP may ask you if you have any joint symptoms or ask you to complete a screening questionnaire.

How is psoriasis assessed?

Psoriasis may be assessed using a variety of tools:

- Physician global assessment (PGA): this ranges from mild to very severe and is a physician's overall impression of the severity of the psoriasis.

- Patient global assessment: this is the same as the physician global assessment but is the overall impression of the severity of psoriasis provided by the person with psoriasis.
- PASI (Psoriasis Area and Severity Index) is calculated by looking at four areas: the head and neck, upper limbs, lower limbs and the trunk. In each of these areas the redness, scaliness, thickness and surface area affected are assessed and used to calculate the PASI score. This score ranges from 0–72 with 0 being no psoriasis and 72 being severe. In practice any score above 10 indicates severe psoriasis.
- DLQI (Dermatology Life Quality Index) is a series of 10 questions which asks how psoriasis has impacted on your life in the past 7 days. The score ranges from 0–30 with 0 indicating no impact and a score above 10 indicating a considerable impact on quality of life. DLQI does not assess distress.
- PEST score (Psoriasis Epidemiology Screening Tool) is used to screen for possible psoriatic arthritis.
- HADS (Hospital Anxiety and Depression Scale) or other scales may be used to screen for depression and/or anxiety.

Blood tests may be recommended by your GP or dermatologist. If you are considering tablet treatment for your psoriasis then blood tests will be needed before and during treatment.

Can psoriasis be cured?

There is no cure for psoriasis but there are several effective treatments available.

How can psoriasis be treated?

Treatment of psoriasis depends upon your individual circumstances. It may be that you find that treatment applied to the surface of the skin (topical treatment) is sufficient to treat your psoriasis. For people with more extensive or difficult to treat psoriasis, light treatment (phototherapy), tablet treatment or injection treatment may be required.

1. Topical treatments:

- These include creams, ointments, gels, pastes and lotions. Topical treatments are dealt with in more detail in another of our leaflets ([Topical treatments for psoriasis](#)).

2. [Phototherapy](#):

- Phototherapy is ultraviolet light delivered in a controlled way to treat psoriasis. A course of treatment usually takes about 8-10 weeks and will require treatment sessions two to three times a week. This usually means attending a dedicated Phototherapy Unit.
- Two types of light are used: narrowband ultraviolet B light (nbUVB/TLO1) and ultraviolet A light (PUVA). The latter requires a sensitiser, known as a psoralen that can be taken as a tablet or added to a bath prior to treatment.
- Phototherapy is used to clear psoriasis and then keep it away for a period after treatment.

Further information on phototherapy is available in the following information leaflets: [Treatments for moderate and severe psoriasis](#) and [Phototherapy](#)).

3. *Internal (systemic) treatments*

- Tablet options include [acitretin](#) (related to vitamin A), [ciclosporin](#) (suppresses the immune system), [methotrexate](#) (slows down the rate at which cells are dividing in psoriasis), and in some centres fumaric acid esters and apremilast.
- Injectable treatments for psoriasis include [etanercept](#), [adalimumab](#), [infliximab](#), ustekinumab, secukinumab and ixekizumab.

Further details of these treatments can be found in the [Treatments for moderate and severe psoriasis](#) and individual drug patient information leaflet.

What can I do to help?

- Discuss your psoriasis and how it affects your life with your GP or dermatologist and identify treatment goals.
- Manage your risk factors for heart disease and stroke with your GP.
- Adopt a healthy lifestyle: eat a balanced diet, try to lose weight if you are overweight and exercise regularly.
- Stop smoking.
- If you drink excessive alcohol, reducing your intake might be helpful.
- Reduce stress, where possible.
- If you have joint symptoms discuss with your GP or dermatologist.

Where can I get more information about psoriasis?

NICE guidance on the assessment and management of psoriasis [CG153]:

<http://www.nice.org.uk/guidance/cg153/informationforpublic>

Links to patient support groups:

The Psoriasis Association

Dick Coles House
2 Queensbridge
Northampton, NN4 7BF
Tel: 0845 676 0076
Web: www.psoriasis-association.org.uk

Psoriasis and Psoriatic Arthritis Alliance (PAPAA)

3 Horseshoe Business Park
Lye Lane
Bricket Wood
St Albans
Hertfordshire
AL2 3TA
Tel: 01923 672837
Web: www.papaa.org

Psoriasis Scotland Arthritis Link Volunteers

54 Bellevue Road
Edinburgh, EH7 4DE
Tel: 0131 556 4117
Web: www.psoriasisScotland.org.uk

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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