Psoriasis:

Psoriasis is a complex, chronic, multifactorial, inflammatory disease that involves hyperproliferation of the keratinocytes in the epidermis, with an increase in the epidermal cell turnover rate.
Environmental, genetic, and immunologic factors appear to play a role. The disease most commonly manifests on the skin of the elbows, knees, scalp, lumbosacral areas, intergluteal clefts, and glans penis. In up to 30% of patients, the joints are also affected.
Treatment is based on surface areas of involvement, body site(s) affected, the presence or absence of arthritis, and the thickness of the plaques and scale.

Signs and symptoms

Signs and symptoms of psoriasis may include the following:

- Worsening of a long-term erythematous scaly area
- Sudden onset of many small areas of scaly redness
- Recent streptococcal throat infection, viral infection, immunization, use of antimalarial drug, or trauma
- Pain (especially in erythrodermic psoriasis and in some cases of traumatized plaques or in the joints affected by psoriatic arthritis)
- Pruritus (especially in eruptive, guttate psoriasis)
- Afebrile (except in pustular or erythrodermic psoriasis, in which the patient may have high fever)
- Dystrophic nails ,which may resemble onychomycosis
- Long-term, steroid-responsive rash with recent presentation of joint pain
- Joint pain (psoriatic arthritis) without any visible skin findings
- Conjunctivitis or blepharitis

Diagnosis

The diagnosis of psoriasis is clinical, and the type of psoriasis present affects the physical examination findings.

Types of psoriasis

Common types of psoriasis include the following:

- Chronic stationary psoriasis (psoriasis vulgaris): Most common type of psoriasis; involves the scalp, extensor surfaces, genitals, umbilicus, and lumbosacral and retroauricular regions
- Plaque psoriasis: Most commonly affects the extensor surfaces of the knees, elbows, scalp, and trunk
- Guttate psoriasis: Presents predominantly on the trunk; frequently appears suddenly, 2-3 weeks after an upper respiratory tract infection with group A beta-hemolytic streptococci; this variant is more likely to itch, sometimes severely

- Inverse psoriasis: Occurs on the flexural surfaces, armpit, and groin; under the breast; and in the skin folds; this is often misdiagnosed as a fungal infection
- Pustular psoriasis: Presents on the palms and soles or diffusely over the body
- Erythrodermic psoriasis: Typically encompasses nearly the entire body surface area with red skin and a diffuse, fine, peeling scale
- Scalp psoriasis: Affects approximately 50% of patients
- Nail psoriasis: May be indistinguishable from, and more prone to developing, onychomycosis
- Psoriatic arthritis: Affects approximately 10-30% of those with skin symptoms; usually in the hands and feet and, occasionally, the large joints
- Oral psoriasis: May present as severe cheilosis, with extension onto the surrounding skin, crossing the vermillion border
- Eruptive psoriasis: Involves the upper trunk and upper extremities; most often seen in younger patients

Examination in patients with psoriasis includes the following:

- Dermatologic: Most commonly, scaling erythematous macules, papules, and plaques; area of skin involvement varies with the form of psoriasis
- Ocular: Ectropion and trichiasis, conjunctivitis and conjunctival hyperemia, and corneal dryness with punctate keratitis and corneal melt [1]; blepharitis
- Musculoskeletal: Stiffness, pain, throbbing, swelling, or tenderness of the joints; distal joints most often affected (eg, fingers, toes, wrists, knees, ankles); may progress to a severe and mutilating arthritis of the hands, especially if treatment has been suboptimal

Management

Pharmacotherapy

Medications used in the management of psoriasis include the following:

- Topical corticosteroids (eg, triamcinolone acetonide 0.025-0.1% cream, betamethasone 0.025-0.1% cream
- Ophthalmic corticosteroids (eg, prednisolone acetate 1% ophthalmic, dexamethasone ophthalmic)
- Intramuscular corticosteroids (eg, triamcinolone): Requires caution because the patient may have a significant flare as the medication wears off
- Intralesional corticosteroids: May be useful for resistant plaques and for the treatment of psoriatic nails
- Coal tar 0.5-33%
- Keratolytic agents (eg, anthralin, urea): Use of these medications may facilitate more direct steroid contact with the skin
- Vitamin D analogs (eg, calcitriol ointment, calcipotriene, calcipotriene and betamethasone topical ointment)
- Topical retinoids (eg, tazarotene aqueous gel and cream 0.05% and 0.1%)

- Antimetabolites (eg, methotrexate)
- Immunomodulators (eg, tacrolimus topical 0.1%, cyclosporine, alefacept, ustekinumab)
- TNF inhibitors (eg, infliximab, etanercept, adalimumab)
- Phosphodiesterase-4 inhibitors (eg, apremilast)
- Systemic antipsoriatic agent (eg, ustekinumab)
- Artificial tears

The American Academy of Dermatology (AAD) guidelines recommend treatment with methotrexate, cyclosporine, and acitretin, with consideration of contraindications and drug interactions.[2]

A 2013 international consensus report on treatment optimization and transitioning for moderate-to-severe plaque psoriasis include the following recommendations[3]:

- Methotrexate, for as long as it remains effective and well-tolerated
- Cyclosporine, generally used intermittently for inducing a clinical response with one or several courses over a 3 to 6 months
- Transition from conventional systemic therapy to a biologic agent, either directly or with an overlap if transitioning is needed due to lack of efficacy, or with a treatment-free interval if transitioning is needed for safety reasons
- Combination therapy
- Continuous therapy for patients receiving biologic agents
- Switching biologic agents: If due to lack of efficacy, perform without a washout period; if for safety reasons, a treatment-free interval may be required
- Combinations of multiple agents (eg, methotrexate and a biologic) are necessary in some patients but the long-term safety and optimal laboratory monitoring have yet to be defined

Other therapies

Management of psoriasis may also involve the following nondrug therapies:

- Light therapy with solar or ultraviolet radiation
- Stress reduction
- Biofeedback
- Climatotherapy
- Adjuncts, such as sunshine, sea bathing, moisturizers, oatmeal baths
- Punctal occlusion (and ocular lubricants): For keratoconjunctivitis sicca
- Bandage contact lens: To retard corneal melting