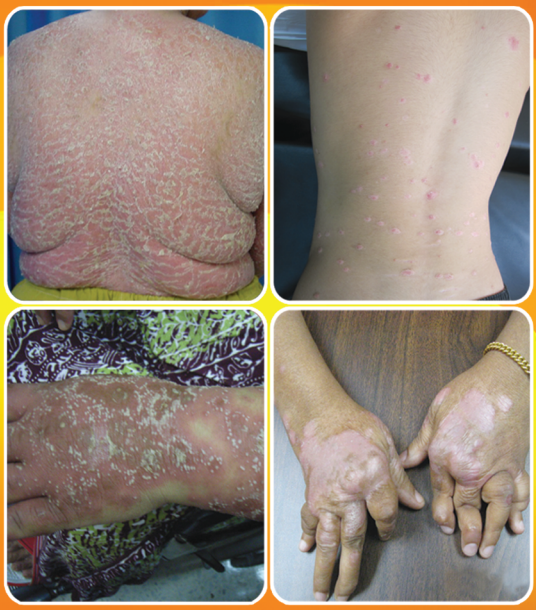
QUICK REFERENCE FOR HEALTHCARE PROVIDERS

MANAGEMENT OF PSORIASIS VULGARIS



Ministry of Health Malaysia

Dermatological Society of Malaysia

Academy of Medicine Malaysia

KEY MESSAGES

- Psoriasis is a genetically determined, systemic immune-mediated chronic inflammatory disease that affects primarily the skin and joints.
- Psoriasis Vulgaris is characterised by well-demarcated erythematous plaques with silvery scales on elbows, knees, lumbosacral region, and scalp, and nail changes.
- Erythrodermic psoriasis affects more than 80% body surface area.
- Generalised pustular psoriasis is widespread erythema studded with superficial pustules which may coalesce to form lakes of pus.
- Psoriasis can be as mentally and physically disabling as cancer, heart disease, diabetes, hypertension, arthritis and depression.
- Psoriatic arthritis affects about 16% of Malaysians with psoriasis. Early recognition and treatment prevent deformities. Assessment should be performed at least annually by looking for relevant signs and symptoms:-
  a. Joint swelling
  b. Dactylitis
  c. Significant early morning stiffness >1/2 hour
- Psoriasis patients are more prone to cardiovascular diseases, stroke, lymphoma and non-melanoma skin cancers, and increased mortality.
- Psoriasis patients should be screened for metabolic syndrome and risk factors of atherosclerosis-related diseases.
- Assess physical severity of psoriasis with Psoriasis Area and Severity Index (PASI) or Body Surface Area (BSA). Assess the impact of psoriasis on the quality of life (QoL) of patients with Dermatology Life Quality Index (DLQI)
- Choice of treatment for pregnant and lactating women should benefit the mother and pose minimal risk to the foetus/baby.

This Quick Reference provides key messages and a summary of the main recommendations in the Clinical Practice Guidelines (CPG) Management of Psoriasis Vulgaris.

Details of the evidence supporting these recommendations can be found in the above CPG, available on the following websites:

Ministry of Health Malaysia	:	www.moh.gov.my
Academy of Medicine Malaysia	:	www.acadmed.org.my
Malaysian Dermatology Society	:	www.dermatology.org.my

PRINCIPLES OF TREATMENT

- Management should start with patient education.
- Treatment of psoriasis should be a combined decision between patients & their healthcare providers.
- Treatment goal and minimal target set should be based on disease severity and patient's preferences.
- Treatment goal achieved should be monitored regularly to detect loss of response which may necessitate modification of therapy.

ASSESSMENT OF SEVERITY
Grading of Psoriasis Severity

Grade of severity	Measurement tools	Interpretation
Mild	• BSA ≤10% • PGA mild • PASI ≤10 • DLQI ≤10	Disease with a minimal impact on the patient's QoL and patient can achieve acceptable symptom control by standard topical therapy
Moderate	• BSA >10% to 30% • PGA moderate • PASI >10 to 20 • DLQI >10 to 20	Disease that cannot be, or would not be expected to be controlled to an acceptable degree by standard topical therapy, and/or disease that moderately affects the patient's QoL
Severe	• BSA >30% • PGA severe or very severe • PASI >20 • DLQI >20	Disease that cannot be, or would not be expected to be controlled by topical therapy and that adversely affect patient's QoL (this include erythrodermic psoriasis, pustular psoriasis and psoriatic arthritis)

TREATMENT GOALS OF VARIOUS MODALITIES

TREATMENT	MINIMAL TARGETS	TIME FOR EVALUATION (WEEKS)	SUBSEQUENT EVALUATION (MONTHS)
Topical therapy	↓ BSA ≥50 or PASI ≥50 or DLQI ≤5	6	6 – 12
Phototherapy Methotrexate Cyclosporine Acitretin	↓ BSA ≥75 or PASI ≥75 or DLQI ≤5	6 16 16 12	6
Infliximab Adalimumab Ustekinumab Etanercept	PASI ≥75 OR PASI 50 to <75 plus DLQI ≤5	10 16 16 24	6

TREATMENT MODALITIES

- Patients with mild or moderate psoriasis with minimal impairment in QoL (DLQI ≤5) should be treated with topical agents.
- Emollient should be used regularly.
- Tar-based preparations may be used as a first-line topical therapy.
- Short-term use of potent and very potent topical corticosteroid may be used to clear limited plaques.
- Mild potency corticosteroid may be used for face, genitalia and body folds.
- Fixed dose combination of vitamin D analogue and corticosteroid may be used for short-term treatment.
- Topical vitamin D analogue may be used but dose should not exceed 100g / week.
- Phototherapy should be offered to patients who have failed topical therapy before starting them on systemic agents.
- Life time exposure to psoralen plus ultraviolet A (PUVA) and ultraviolet B (UVB) should not exceed 200 and 350 sessions respectively.
- Systemic / biologic therapy for moderate to severe psoriasis should be initiated by a dermatologist.
- Pre-treatment assessment and regular monitoring for toxicity should be done during systemic / biologic therapy.
- Methotrexate or acitretin should be used as first-line systemic therapy.
- Cyclosporine may be used as second-line systemic therapy .
- Cyclosporine should **NOT** be used for more than 2 years and avoided in patients with previous PUVA exposure.
- Biologics should be offered to patients who fail, have intolerance or contraindication to conventional systemic treatment and phototherapy.

CRITERIA OF REFERRAL

1. Dermatology Referral

Indications for referral

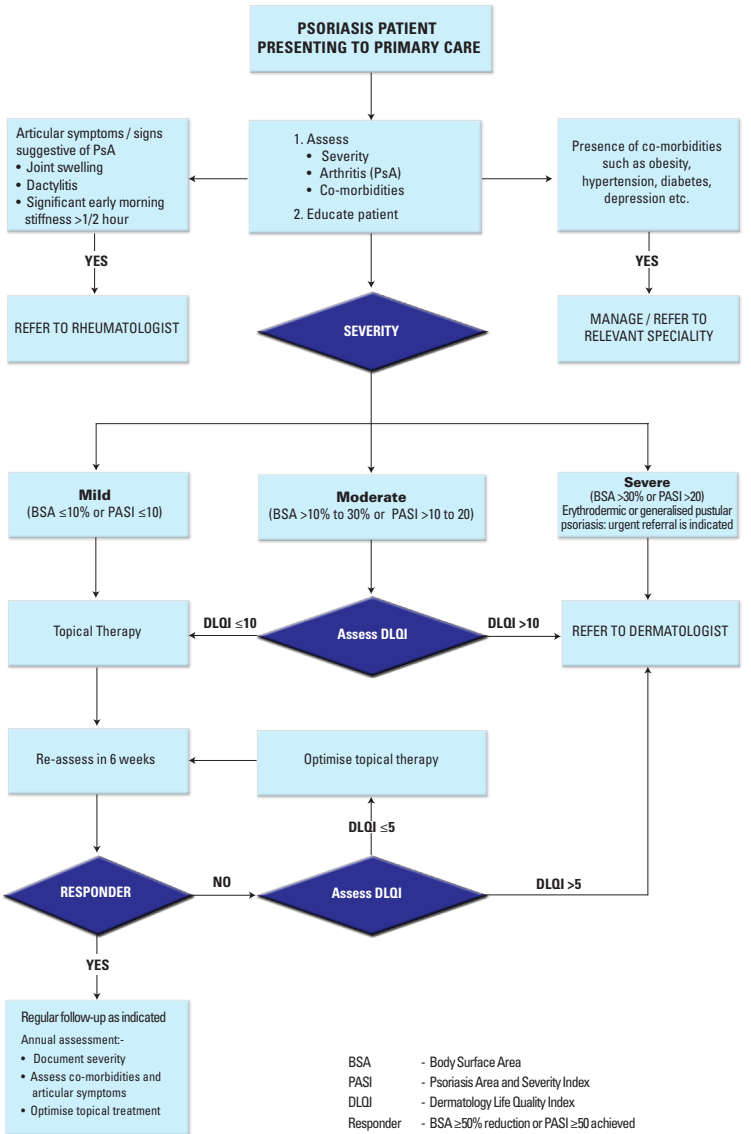
- Diagnostic uncertainty
- Erythrodermic or pustular psoriasis should be referred urgently for specialist assessment and treatment
- Patients who have failed adequate trial of topical therapy for 6 - 12 weeks
- Severe psoriasis that requires phototherapy or systemic therapy

2. Rheumatology Referral

Indications for referral

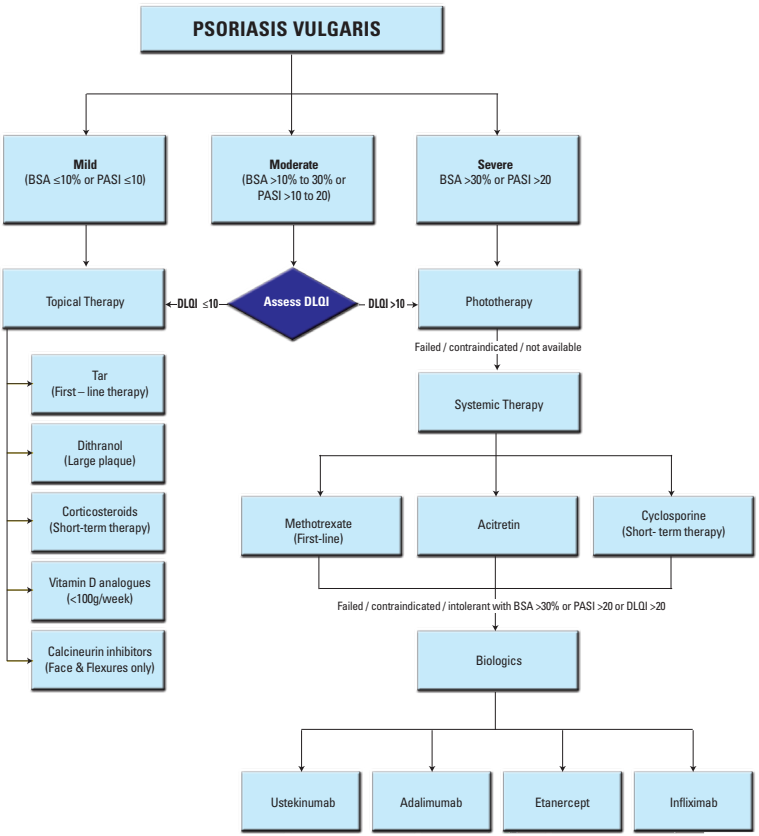
- Diagnostic evaluation of patients with suspected Psoriatic Arthritis (PsA)
- Formulate management plan for PsA

ALGORITHM 1: MANAGEMENT OF PSORIASIS VULGARIS IN PRIMARY CARE



BSA - Body Surface Area
PASI - Psoriasis Area and Severity Index
DLQI - Dermatology Life Quality Index
Responder - BSA ≥50% reduction or PASI ≥50 achieved

ALGORITHM 2: TREATMENT OF PSORIASIS VULGARIS



Recommended Medication Dosing, Side Effects and Contraindications

DRUG	RECOMMENDED DOSAGE	SIDE EFFECTS	CONTRAINDICATIONS	SPECIAL PRECAUTION	DRUG INTERACTION	PREGNANCY CATEGORY
TOPICAL COSTICOSTEROIDS						
Mild Hydrocortisone 1% Cream / Ointment	1- 2 times daily	Worsening of untreated infection, contact dermatitis, perioral dermatitis, acne, depigmentation, dryness, hypertrichosis, secondary infection, skin atrophy, pruritus, tingling/stinging, rosacea, folliculitis, photosensitivity	Untreated bacterial, fungal, or viral skin lesions, in rosacea, and in perioral dermatitis	Avoid prolonged use on the face		C
Moderate Betamethasone 17-Valerate 0.025% Cream / Ointment						
Clobetasone Butyrate 0.05% Cream / Ointment Ointment						
Potent Betamethasone 17- Valerate 0.1% Cream / Ointment				Avoid use on face and body folds Limit continuous use to <4 weeks Limit to 60g/week		
Mometasone Furoate 0.1% Cream / Ointment	Once daily			Avoid prolonged use on face		C
Very Potent Clobetasol Propionate 0.05% Cream / Ointment	1-2 times daily			Avoid use on face and body folds Limit continuous use to <2weeks Limit to 30g/week		C
TAR-BASED PREPARATION	1-2 times daily	Dermatitis, folliculitis, irritation, photo-sensitivity	Avoid in acutely inflammed lesions, and pustular psoriasis	Avoid contact with eyes, genital / rectal areas Avoid use in 1st trimester of pregnancy		C
TOPICAL VITAMIN D ANALOGUE						
Calcipotriol 50 mcg/g Cream / Ointment Calcipotriol 50 mcg/ml Scalp Solution	Twice daily	Itching, erythema, burning, paraesthesia, dermatitis, photosensitivity	Hypercalcemia or evidence of vitamin D toxicity	Avoid use on face Avoid excessive exposure to sunlight and sunlamps Pregnancy Breast feeding		C
Calcipotriol Hydrate 50 mcg/g & Betamethasone Dipropionate 0.5 mg/g Ointment / Gel	Once daily	Worsening of untreated infection, contact dermatitis, perioral dermatitis, acne, depigmentation, dryness, hypertrichosis, secondary infection, skin atrophy, pruritus, tingling/stinging, rosacea, folliculitis, photosensitivity				
DITHRANOL PREPARATIONS	0.1-0.5% suitable for overnight treatment for skin 1-2% short contact therapy 30 mins -1 hour	Local burning sensation and irritation, stains skin, hair and fabrics	Acutely inflammed and pustular psoriasis	Avoid use near eyes and sensitive areas of skin		C
SALICYLIC ACID 2-10% CREAM / OINTMENT	Twice daily	Sensitivity, excessive drying, irritation, salicylism with excessive use		Avoid broken or inflamed skin		C

DRUG	RECOMMENDED DOSAGE	SIDE EFFECTS	CONTRAINDICATIONS	SPECIAL PRECAUTION	DRUG INTERACTION	PREGNANCY CATEGORY
SYSTEMIC AGENTS						
Acitretin	0.5 to 1 mg/kg body wt/day Max: 75 mg/day	Cheilitis, xerosis, alopecia, skin peeling, stickiness, paronychia, periungual pyogenic granuloma, pruritus, hyperlipidemia, transaminitis, hyperaesthesia	Pregnancy or intention to become pregnant, breast feeding, hypersensitivity, severe hepatic or renal dysfunction, concomitant use with methotrexate or tetracyclines	Avoid pregnancy for at least 1 month before, during, and for at least 3 years after treatment	Alcohol, methotrexate, tetracyclines, tigecycline, vitamin A, contraceptives	X
Cyclosporine	2.5 mg-5 mg/kg body wt/day divided twice daily	Hypertension, hyperuricaemia, hyperkalaemia, hypomagnesaemia, hyperlipidaemia, oedema, headache, hypertrichosis, nausea, diarrhoea, tremor, renal dysfunction, infections	Hypersensitivity, abnormal renal function, uncontrolled hypertension, malignancies, concomitant treatment with PUVA or UVB therapy, methotrexate, other immunosuppressive agents, or radiation therapy	Limit use to 2 years, monitor renal function closely, liver function, blood pressure, hyperuricaemia, serum magnesium, pregnancy and breast feeding, acute porphyria, avoid excessive exposure to UV light including sunlight	ACE inhibitors, aliskiren, allopurinol, BCG, bosentan, calcium channel blockers, ivabradine, statins, methotrexate, mifepristone, phenytoin, potassium-sparing diuretics, live vaccines, vincristine	C
Methotrexate	Oral, IM or SC: 10-20 mg/dose once weekly	Nausea & vomiting, malaise, headache, hepatotoxicity, mucositis, myelosuppression, lung fibrosis, immunosuppression	Hypersensitivity, pregnancy, pre-existing liver disease or blood dyscrasias	Chronic alcoholism, obesity, diabetes, Hep B & C, renal insufficiency	Acitretin, BCG, clozapine, cyclosporine, loop diuretics, NSAIDs sulfonamides, trimethoprim	X
BIOLOGICS						
Adalimumab	Loading dose: 80 mg Maintenance dose: 40 mg every other week beginning 1 week after initial dose	Opportunistic infections, reactivation of tuberculosis, malignancy, congestive heart failure, demyelinating disease, injection/infusion reactions, haematological disturbances, hepatotoxicity, development of auto antibodies, and lupus like reaction	**Absolute** Active infection including tuberculosis, malignancy, congestive cardiac failure class 3 or 4, demyelinating diseases **Relative** History of tuberculosis/ malignancy, HIV infection, Hepatitis B/C infection, congestive cardiac failure class 1 or 2, pregnancy or breast feeding, prior PUVA (>200 sessions) and UVB (>350 sessions) exposure	Biologics should be discontinued: • in pregnancy • prior to major surgery (6 weeks for infliximab; 4 weeks entanercept; 10 weeks adalimumab and 12 weeks ustekinumab) Patient should not receive live or live-attenuated vaccine <2 weeks before, during and 6 months after biologics discontinuation	Abatacept, anakinra, BCG, leflunomide, live vaccines	B
Etanercept	25-50 mg twice weekly					
Infliximab	5 mg/kg at 0, 2 and 6 weeks followed by 5 mg/kg every 8 weeks thereafter					
Ustekinumab	45 mg for patients weighing ≤100 kg and 90 mg for patients weighing >100 kg given at weeks 0 and 4 then every 12 weeks					

CLINICAL PRACTICE GUIDELINES SECRETARIAT
Health Technology Assessment Section, Medical Development Division
Ministry of Health Malaysia, 4th Floor, Block E1, Parcel E, 62590 Putrajaya
Tel: 603 8883 1246, e-mail: htamalaysia@moh.gov.my