Medicine for Managers

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Psoriasis

You may not realise it but skin is amazing. It replaces itself completely every 28 days or so. As many of you will remember from your 'O' level biology, newly formed skin cells develop in the basal germinal layer and gradually become flattened, move to the surface of the skin and die as they do so. They are shed from the surface.

In psoriasis during attacks, the normal process speeds up and skin cells replace themselves too quickly, in about five days resulting, commonly, in thick plaques of chronic psoriasis.

The disorder, which affects about 2% of the population, mostly develops between the ages of 10 and 40. It commonly presents as red, scaly, crusted patches often found overlying the knee cap, on the outer surface of the elbow and in the scalp, though it can appear just about anywhere in the body, except the face, and sometimes finger and toenails and even joints may be involved. It is subject to remissions and exacerbations and sometimes it may clear for prolonged periods.

The Psoriasis Association has an excellent website at www.psoriasis-association.org.uk

Nobody knows what causes psoriasis and therefore it is impossible to prevent. It is not infectious and so cannot be passed from person to person. Genetic factors play a part in about 30% of sufferers. Some suspect that viruses may trigger the onset. Others postulate that the immune system is in some way involved and one type of lymphocyte (white cell) may attack the skin resulting in an immune response involving the formation of new skin. The severity of the condition is very variable. At one extreme, the skin changes may be minor with only a few small patches that pass unnoticed. At the other, there may be many raised, red, scaly patches which may be several inches in diameter and which can look most unsightly.

About eight out of ten people have chronic plaque psoriasis in which these large scaly lesions develop. The plaques are often itchy but the principal problem with them is the appearance. Some people with this form of the disorder may only have it in the scalp where the thick plaques may mat the hair and the scales have the appearance of severe dandruff. It may be localised or widespread and, if severe, may lead to hair loss. In other patients this form of the condition affects the flexures, such as in the groin, axillae, under the breasts and in skinfolds. In this form it is red but does not usually appear scaly.

There are other variants too. In one strange form the skin changes are confined to pustular crops of spots on the palms and soles. Half of all psoriasis sufferers also have nail changes which show multiple pits and the nail becomes loose on the bed. Guttate psoriasis, which often follows a sore throat, is different to other forms. Large numbers of small lesions, less than 1 cm in diameter, cover many areas of the body, may last for up to four months and then disappear never to return.

Patients with psoriasis commonly have flares-up. Many factors have been identified and they include stress, trauma to the skin, concurrent infections, medication (including beta-blockers, anti-inflammatory drugs, ACE inhibitors, some antibiotics and lithium), smoking and, in women, hormonal changes. In some women psoriasis starts and is severe during the years around puberty but may improve during pregnancy, only to recur some months following delivery. Being fat seems to be a risk factor too. Paradoxically some patients find that their psoriasis worsens in the sunlight whilst, for others, it improves during the summer months.

About 10% of patients develop an associated arthritis most commonly affecting the fingers and toes. A smaller number of patients also develop an inflammatory bowel disease called Crohn's disease.

Psoriasis is usually easy to diagnose from the typical appearances. There are a variety of treatments but unfortunately there is no cure for the condition. Many are applied directly to the skin lesions in the form of ointments, creams or lotions for body or scalp. Moisturisers soften the hard plaques and may be all that is required. Coal tar has been used for many years and its mode of action is not fully understood. It does have a strong smell and can be messy. Salicylic acid is an old favourite and works by loosening and lifting the scales of the plaques. Dithranol is also a treatment that has been used for a long time. It is effective at eliminating the plaques but it does irritate healthy skin. Normally a low strength preparation is used initially and higher strengths are employed over time. Vitamin-D preparations, such as calcipotriol, are popular and work by slowing the rate at which skin cells divide. They may be cosmetically more acceptable than other treatments. Steroid creams and ointments are also commonly used and are often effective at treating difficult or resistant areas. Problems with steroids can include a rebound phenomenon when use is stopped, damage to surrounding healthy skin and, when potent forms are used for a long time, suppression of adrenal gland function because of absorption of the drug through the skin. Many of the treatments are used in combination or sequentially. Some patients with severe psoriasis are given intense courses of combination therapy which is applied with dressings.

In hospital dermatological practice patients with severe psoriasis may be treated either with phototherapy (light) using ultraviolet (UVB) light, or with PUVA (psoralen and ultraviolet light A). The psoralen is a taken as a tablets and the patient then undergoes the UVA therapy.

A more modern treatment is to use one of a number of very powerful drugs which can suppress the body's inflammatory response. These drugs are only used under specialist supervision and the most common are methotrexate, ciclosporin and infliximab.

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Prognosis is difficult to predict. Some people have the skin changes in mild form whilst, for others, they are very severe. In about 30% of patients the plaques disappear completely eventually. Some people have remissions which may last months or years and then the condition recurs.