Queensland Health

Queensland Community Pharmacy Scope of Practice Pilot

Acute Exacerbations of Mild Plaque Psoriasis - Clinical Practice Guideline

Guideline Overview

Pilot and professional obligations

- Initial patient eligibility and suitability for management within the scope of the pilot
- Patient informed consent
  - Pilot participation
  - Financial
  - Pharmacist communication with other health practitioners
- Professional standards
- Privacy
- Documentation and record keeping
- Interprofessional communication

Refer when

Refer to a medical practitioner if:

- The patient has 'red flag' warning signs
- The diagnosis is unclear
- The patient is aged under 18 years
- The patient is planning a pregnancy or pregnant
- The patient presents with a type of psoriasis other than mild plaque psoriasis
- The face, scalp, genitals, palms and/or soles are affected
- The patient is taking a medicine that can exacerbate psoriasis
- There is no response to optimal topical treatment (within 3 to 6 months), or the condition worsens or reoccurs.

Gather information and assess patient's needs

- Patient history
  - Aggravating factors
- Examination
  - Assessment of severity (PASI & DLQI)

Management and treatment plan

- General measures
  - Lifestyle modification
  - Adjunctive agents
- Pharmacotherapy
  - Topical treatments

Treat (if clinically appropriate) and concurrently refer

- The patient has psoriatic comorbidities or risk factors that require management e.g., Arthritis, risk of venous thromboembolism, depression, increased alcohol consumption, signs of lymphoma, skin cancers and solid tumours
- The patient has not seen a medical practitioner for review of their condition in the previous 12 months

Confirm management is appropriate

- Contraindications and precautions
- Drug interactions
- Pregnancy and lactation

Communicate agreed treatment plan

- How to use
- Patient resources/ information
- Adverse effects
- General advice
- Communication with other health practitioners

Clinical review

- Response to treatment
- Adverse effects
- Continue, modify or stop treatment
- Communication with other health practitioners

‘Red flag’ warning signs at patient presentation that necessitate referral to a medical practitioner:

- Psoriatic lesions are infected
- The psoriasis is severe e.g., it is having a marked negative emotional and social impact and/or extensively affecting highly visible areas including the face and scalp, genitals, palms, flexures soles and nails
- The patient is immunocompromised.

Key points

- People presenting with an acute exacerbation of mild plaque psoriasis (psoriasis vulgaris) may receive treatment within the Pilot; all other presentations necessitate a referral to a medical practitioner.
- There is no cure for psoriasis; treatment aims to clear lesions and manage symptoms [1]. Most cases of mild plaque psoriasis can be treated with topical therapies [2].
- As a systemic autoimmune disease, psoriasis is associated with an increased risk of hypertension, obesity, elevated lipid levels, heart disease, diabetes, inflammatory bowel disease, lymphoma and depression [3]. Where appropriate, consider screening for cardiovascular risk and possible eligibility for the Cardiovascular Disease Risk Reduction Program.
- Psoriasis can have marked functional, psychological and social impacts, and this does not always correlate with severity [1, 4]. Psoriasis is difficult to treat, associated with poor cosmetic outcomes and considered severe when it occurs on the face, nails, scalp, genitals, flexure and soles [5].

When applying the information contained within this clinical practice guideline, pharmacists are advised to exercise professional discretion and judgement. The clinical practice guideline does not override the responsibility of the pharmacist to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their carer.

Refer when

- The patient has 'red flag' warning signs
- The diagnosis is unclear
- The patient is aged under 18 years
- The patient is planning a pregnancy or pregnant
- The patient presents with a type of psoriasis other than mild plaque psoriasis
- The face, scalp, genitals, palms and/or soles are affected
- The patient is taking a medicine that can exacerbate psoriasis
- There is no response to optimal topical treatment (within 3 to 6 months), or the condition worsens or reoccurs.

Treat (if clinically appropriate) and concurrently refer:

- The patient has psoriatic comorbidities or risk factors that require management e.g., arthritis, risk of venous thromboembolism, depression, increased alcohol consumption, signs of lymphoma, skin cancers and solid tumours
- The patient has not seen a medical practitioner for review of their condition in the previous 12 months.

Gather information and assess patient's needs

Patient history

Sufficient information should be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- onset, duration, nature, location, severity and extent of the rash and other symptoms
- previous diagnosis of plaque psoriasis and any current or past management plan, including for underlying and associated medical conditions
- underlying and associated medical conditions, including psoriatic comorbidities such as arthritis and common comorbidities such as hypertension, hyperlipidaemia, obesity, type 2 diabetes and depression
- response to any previous treatments
- impacts on quality of life and psychosocial wellbeing
- exposure to factors that can aggravate psoriasis (see Table 1)
- current, recently commenced or recently ceased medicines (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- family history of psoriasis
- allergies/adverse drug effects.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies and current medical conditions.

Table 1. Factors that can aggravate psoriasis (3,6,7)

Table 1. Factors that can aggravate psoriasis [3, 6, 7]	
• streptococcal tonsillitis (strep throat) and other infections e.g., viral • skin trauma and injuries such as cuts, abrasions, sunburn • sun exposure (although gentle exposure is often beneficial) • dry skin • obesity • metabolic factors (calcium deficiency) • smoking • sleep deprivation and emotional stress	• excessive alcohol consumption • hormonal factors (pregnancy or postpartum) • medicines such as lithium, beta-blockers, antimalarials, nonsteroidal anti-inflammatories, antibiotics, ace inhibitors and TNF-α inhibitors • stopping oral steroids or potent topical corticosteroids (TCS) • other environmental factors such as a stressful event.

Examination

- Physical examination of the patient's skin is required to identify, assess and classify the severity of an acute exacerbation of mild plaque psoriasis.
- In darker skin tones, plaques are generally darker or violet in colour, thicker, and with more obvious scale and itch [4].
    - Psoriasis Area and Severity Index (PASI) scores may be underestimated in people with darker skin tones [8].
- Nail changes, include pitting, lifting of the nail (onycholysis) and subungual hyperkeratosis may also be observed, although it may be difficult to distinguish nail changes due to psoriasis from fungal nail infections [1, 4].

Assessment of severity

A Psoriasis Area and Severity Index (PASI) score and Dermatology Life Quality Index (DLQI) score may be used to assess severity and responses to treatment [3, 9]:

- mild to moderate plaque psoriasis = a PASI ≤10 and DLQI ≤10 [9]
- severe plaque psoriasis = PASI >10 and/or DLQI >10 [9]
    - The psoriasis is always considered severe when the DLQI score is > 10, regardless of the PASI score [9].
    - It may also be considered severe if it has significant impacts on the patient's quality of life, due to involvement of visible areas, major parts of the scalp, genitals, palms and/or soles, onycholysis of at least 2 fingernails or pruritus leading to excoriation [9, 10].

Management and treatment plan

Pharmacist management of acute exacerbations of mild plaque psoriasis involves:

- **general measures:**
    - Education and advice regarding lifestyle modification, use of adjunctive agents including emollients/moisturisers, and other measures as per the Therapeutic Guidelines: Psoriasis and the Australian Medicines Handbook: Psoriasis [11, 12].
- **pharmacotherapy:**
    - Topical treatments according to Therapeutic Guidelines: Psoriasis [11].

Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook and other appropriate therapeutic resources to confirm the treatment recommendation is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Pharmacists should confirm the patient has an appropriate management plan for any underlying and associated medical conditions.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) as per the Australian Medicines Handbook and other relevant references should be provided to the patient regarding:

- the typical cycle of psoriasis and the expectations of treatment
- product and medication use:
    - dosing and application instructions for TCS, moisturisers, emollients and other topical products
- how to manage adverse effects
- when to seek further care/and or treatment, including recognising infection
- when to return to the pharmacist for clinical review.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and parents/caregivers if applicable) and compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

Patient resources

- NPS MedicineWise factsheets:
  - Topical treatments for your plaque psoriasis
  - Plaque psoriasis: my options when topical treatments aren't enough
- Skin Health Institute - Patient information sheet

General advice

Patients should be advised that each new treatment may take time to work and should be trialled for 2 to 4 weeks. However, adequate response to optimal topical treatment may take up to 3 to 6 months to be achieved.

The patient should be advised to immediately see their usual medical practitioner if symptoms worsen after commencing treatment.

Common adverse effects of TCS, such as transient burning, stinging or pain on application, can generally be reversed by stopping the medicine. Referral to a medical practitioner is required when adverse effects cannot be managed in the pharmacy setting.

Clinical Review

Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines and other relevant guidelines. Clinical review is recommended **2-4 weeks** after initiation of treatment for an acute exacerbation to assess:

- response to treatment (and compliance)
- if changes are required to the treatment plan
- adverse effects.

If a good response has been achieved, the medication can be reduced or stopped, and the patient can continue using regular moisturiser only. If there has been an inadequate response, the pharmacist should check the patient's compliance with the medication and skin care measures, ensuring enough medication is applied [11].

Pharmacists should generally only prescribe a sufficient quantity of medicine (including repeats) for the period until the patient's review.

Pharmacotherapy for the management of psoriasis may be required longer-term; pharmacists should refer the patient to a medical practitioner for review and ongoing management after the acute flare has been managed. An annual review by a medical practitioner is recommended to assess for adverse effects from TCS therapy [3, 6].

Pharmacist resources

- Therapeutic Guidelines: Dermatology
  - Psoriasis
  - Application and quantity of topical steroids
- Australian Medicines Handbook:
  - Drugs for psoriasis
  - General principles: topical treatment of skin conditions
  - Corticosteroids
  - Topical steroids – how much do I use?
- Pharmaceutical Society of Australia - Fingertip Guide
- DermNet NZ:
  - PASI
  - Psoriasis
- MSD Manual (Professional version) - Psoriasis
- Journal of Clinical Medicine - Topographic Differential Diagnosis of Chronic Plaque Psoriasis: Challenges and Tricks
- Cardiff University - Dermatology Life Quality Index
- Skin Deep - An open-access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public.
- Types of psoriasis (psoriasis pictures) – Mayo Clinic
- NPS MedicineWise - Plaque psoriasis
- The Australasian College of Dermatologists:
  - Consensus statement: Treatment goals for psoriasis
  - A-Z of skin - Psoriasis
  - Taking care of skin: How to recognise and respond to health issues in Aboriginal and Torres Strait Islander Health Peoples (an online course/ teaching resource for Aboriginal Health Workers)

Document version number	Date	Comments
Version 1.0	01.02.2024	

References

1. Brown P. Psoriasis. 2021. In: The A-Z of Skin [Internet]. Melbourne: The Australasian College of Dermatologists. Available from: https://www.dermcoll.edu.au/atoz/psoriasis/.
2. NPS MedicineWise. Plaque psoriasis Surry Hills: NPS MedicineWise; 2022 [cited 2022 June 20]. Available from: https://www.nps.org.au/bdmards/dermatology#hp.
3. Clarke P. Psoriasis. Australian Family Physician. 2012;40:468-73.
4. Oakley AJ, C. Gupta, M.,. Psoriasis: DermNet New Zealand Trust; 2020 [cited 2022 March 8]. Available from: https://dermnetnz.org/topics/psoriasis.
5. Nair PA, Badri T. Stat Pearls: Psoriasis. Treasure Island, Florida: StatPearls Publishing; 2022 [cited 2022 July 7]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448194/.
6. Ngan V, Vather D, Oakley A. Guidelines for the managment of psoriasis: DermNet New Zealand Trust; 2020 [Available from: https://dermnetnz.org/topics/guidelines-for-the-treatment-of-psoriasis.
7. Chiricozzi A. BMJ Best Practice: Psoriasis: BMJ Publishing Group; 2022 [cited 2023 August 18]. Available from: https://bestpractice.bmj.com/topics/en-gb/74.
8. Oakley A. PASI score: DermNet New Zealand Trust; 2009 [cited 2022 March 8]. Available from: https://dermnetnz.org/topics/pasi-score.
9. Baker C, Mack A, Cooper A, Fischer G, Shumack S, Sidhu S, et al. Treatment goals for moderate to severe psoriasis: an Australian consensus. Australasian Journal of Dermatology. 2013;54(2):148-54.
10. The Australasian College of Dermatologists. Consensus Statement: Treatment goals for psoriasis, the Australian Psoriasis Treatment Goals Project. Rhodes, NSW: The Australasian College of Dermatologists; 2017 [cited 2022 June 17]. Available from: https://atep.edu.au/wp-content/uploads/2022/07/ACD-Consensus-Statement-Treatment-goals-for-psoriasis-March-2017.pdf.
11. Therapeutic Guidelines: Dermatology (Psoriasis). Melbourne: Therapeutic Guidelines Limited; 2021 [cited 2022 September 23]. Available from: https://tgldcdp.tg.org.au/viewTopic?topicfile=psoriasis.
12. Autralian Medicines Handbook: Drugs for psoriasis. Adelaide: Australian Medicines Handbook Pty Ltd; 2022 [cited 2022 September 1]. Available from: https://amhonline.amh.net.au/chapters/dermatological-drugs/drugs-psoriasis?menu=vertical.