NHS
Harrogate and Rural District
Clinical Commissioning Group

Clinical Thresholds

Condition or Treatment	Psoriasis
Commissioning Threshold	Most patients with psoriasis can be managed in primary care. NHS Harrogate and Rural District CCG patients should only be referred to a specialist service such as GPwSI in dermatology or to secondary care if they have any of the following: • Generalised pustular or erythrodermic psoriasis • Psoriasis is acutely unstable • Widespread symptomatic guttate psoriasis that would benefit from phototherapy Consider referring to GPwSI / secondary care in any of the following circumstances: • The condition is causing severe social or psychological problems; prompts to referral should include sleeplessness, social exclusion and reduced quality of life or self-esteem • The rash is sufficiently extensive to make self-management impractical • The rash is in a sensitive area (such as face, hands, feet, genitalia) and the symptoms are particularly troublesome • The rash is leading to time off work or school sufficient to interfere with employment or education • They require assessment for the management of associated arthropathy (refer to rheumatology) • the rash fails to respond to management in general practice. Failure is probably best based on the subjective assessment of the patient. Sometimes failure occurs when patients are unable to apply the treatment themselves **Prior to referral** Referrals should only be made if patients have had initial treatment in primary care as follows: • Chronic plaque psoriasis on extensor dry surfaces of trunks and limbs: Vitamin D analogues and/or coal tar and/or dithranol and/or topical steroids if indicated and /or emollients. • Scalp psoriasis: mild scaling: coal tar shampoo. Thin plaques: calcipotriol scalp lotion. Thick plaques: cocois ointment, coal tar pomade or salicylic acid, and steroid lotion or gel (thick plaques). • Guttate psoriasis: topical agents e.g. coal tar or vitamin D

	analogues. • Flexural psoriasis: potent topical steroid cream. • Facial psoriasis: weak or moderately potent topical steroid or weak tar treatments such as Exorex lotion.
Referral Guidance	Referral guidance only.
Effective from	April 2013
Summary of evidence / rationale	Psoriasis affects 1-2% of people in the UK. It is a chronic, relapsing condition which can present at any age. The rash has various distinct patterns. Patients with the most common form (plaque psoriasis) typically have red, scaly plaques, most commonly on the extensor aspects (knees, elbows), over the sacrum or scalp, in the flexures and on the soles and palms. Plaques can become inflamed and / or aggravated (unstable psoriasis) on starting topical treatments, after prolonged use of topical corticosteroids or after suddenly stopping systemic steroids. Very rarely, psoriasis presents as generalised erythema with less scaling (erythrodermic psoriasis) or with numerous pustules (generalised pustular psoriasis). There is also a localised form of pustular psoriasis affecting the palms and soles. In some patients, psoriasis presents as showers of small, scaly, red lesions (guttate psoriasis) following a streptococcal infection. In older people, particularly, the lesions may be eczematous. Psoriasis can cause nail deformity. In some patients it is associated with arthritis. In some patients, symptoms are sufficient to cause disability and can have a major social and psychological impact. With proper management, the outlook for most patients can be greatly improved.
Date	October 2014
Review Date	October 2016
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