key points

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There is no standard definition regarding the severity of psoriasis, and a number of factors should be considered, including the extent and stability of skin disease, involvement of joints, response to treatment, and impact on quality of life. Erythrodermic psoriasis and pustular psoriasis are severe conditions and the patient may be systemically unwell and febrile.

NICE recommends that four key areas should be evaluated and recorded when assessing patients: severity, using the static Physician's Global Assessment (sPGA); disease impact on physical, psychological and social wellbeing using the Dermatology Life Quality Index (DLQI); the presence of psoriatic arthritis; and comorbidities. Ideally, patients should be assessed annually for psoriatic arthritis: the Psoriasis Epidemiology Screening Tool (PEST) is a validated tool to screen for psoriatic arthritis in both primary and secondary care. Patients with severe psoriasis should undergo cardiovascular risk assessment at presentation and every five years, or more frequently if indicated.

Referral to secondary care should be made for patients with any type of psoriasis with poor response to topical therapy (after two or three months according to SIGN) and for extensive psoriasis. Cases where the psoriasis is having a significant physical or psychological impact on an individual's quality of life warrant early referral, as do those where the diagnosis is uncertain. Patients with generalised pustular psoriasis or erythroderma should be referred urgently for same-day specialist input. Patients with acute guttate psoriasis who may require phototherapy should also be referred. Children and adolescents with any type of psoriasis should be referred to a specialist at initial presentation.

The range of therapeutic options available can be grouped into three broad categories: phototherapy; systemic non-biological therapy; and biological therapy. Two forms of phototherapy are routinely used to treat psoriasis: narrow-band UVB; and the more potent PUVA (psoralen + UVA). Methotrexate is generally considered as the first-line choice for patients who fulfil the requirement for systemic non-biological therapy, and is effective for both cutaneous and articular psoriasis. Etanercept, adalimumab, and infliximab are TNF-alpha blocking agents, ustekinumab targets the cytokines interleukin-12 and interleukin-23, and secukinumab, one of the newest biologics, targets interleukin-17A.

GPs have an important role, in collaboration with dermatologists and rheumatologists, in the close monitoring of the immunosuppressive agents used to treat psoriasis, with the emphasis on haematological effects, infection, cutaneous and systemic malignancy (especially lymphoproliferative), and conception-related issues.