IRISH SKIN FOUNDATION

What you **need to know** about PSORIASIS

Ps
Psoriasis

The Irish Skin Foundation is a national charity with a mission to improve quality of life for people with skin disorders, promote skin health and the prevention of skin disease through support, advocacy and by raising awareness.

We hope you find this booklet about psoriasis helpful and informative. If you would like more information, visit our website www.irishskin.ie or call our free Helpline on (01) 486-6280.

Welcome to your guide to living with psoriasis

What you need to know about:

PSORIASIS

IRISH SKIN FOUNDATION

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What is psoriasis?

Psoriasis is a common, non-contagious, immune-mediated inflammatory disease in which there is an increase in the rate at which skin cells are produced and shed from the skin. Psoriasis can be a long-term disorder.

Psoriasis is described as an 'immune-mediated inflammatory disease'. This means the inflammation that contributes to the development of psoriasis is brought on by irregularities in the body's own immune system.

Skin cells normally reproduce and mature as they move from the deeper layers of the epidermis (the outermost layer of the skin) to the surface.

In psoriasis, this process is accelerated; the new skin cells reproduce too quickly and move toward the skin surface in an immature form, causing a buildup of white/silvery scale. There is also an increased blood flow to the skin and a thickening of the epidermis, leading to the development of red, raised plaques (a plaque is a raised, red patch covered with a silvery white buildup of dead skin cells or scale).

Diagram A clear skin

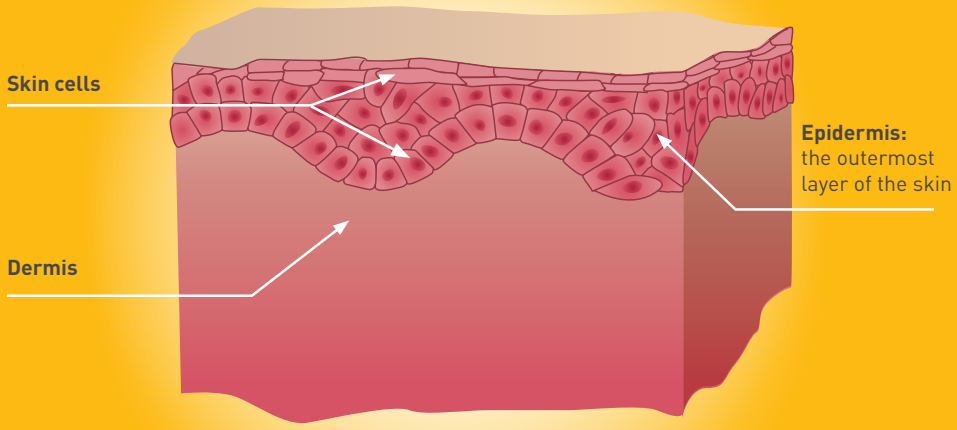

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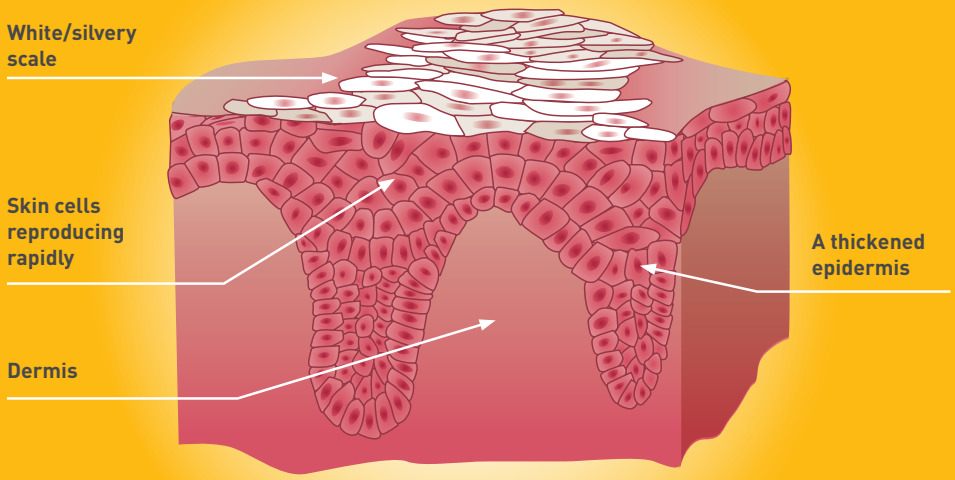
Diagram B skin affected by psoriasis



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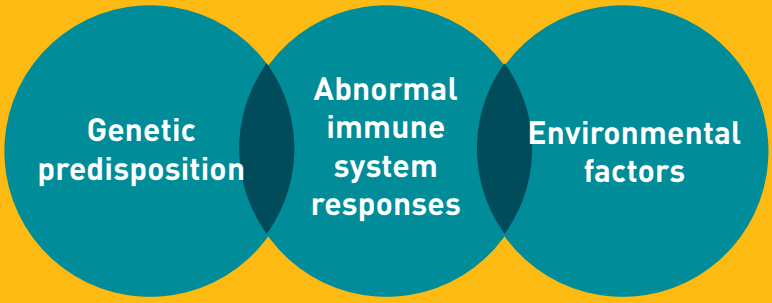
What causes psoriasis?



The exact cause of psoriasis is still not completely understood. It is a condition that tends to run in families. Several different genes have been identified but the exact way in which the disorder moves from generation to generation has not yet been established. What is known is that both the **immune system** and **genetics** are important in its development.

Environmental factors can also play a role in those who are susceptible. In some cases, emotional **stress**, **infection** (such as a streptococcal throat infection), **injury to the skin** (referred to as the Koebner phenomenon) or **certain medications** (e.g. lithium, beta-blockers, antimalarials) can trigger the first episode of psoriasis or exacerbate it, while certain lifestyle factors (such as **drinking too much alcohol** and **smoking**) may worsen it.

POSSIBLE ENVIRONMENTAL FACTORS

Stress

Infection

Injury to the skin

Certain medications

Heavy drinking

Smoking

Psoriasis is not contagious, infectious or the result of poor hygiene.

Psoriasis can start at any time of life, but most commonly occurs between the ages of 18 and 35 years, with a second peak in incidence occurring at around age 50-55 years. It affects males and females equally.

How common is psoriasis?

Psoriasis affects at least 100 million people worldwide, including up to **100,000** people in Ireland, suggesting a prevalence of close to 2-3% of the Irish population.

What's that???

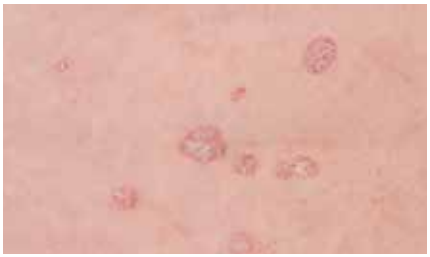
The Koebner phenomenon describes psoriasis appearing at the site of an injury or trauma to the skin, e.g. a scratch, an insect bite, a surgical scar or sunburn. It occurs in approximately one-third of people who have psoriasis. The Koebner phenomenon was named after the physician who first noted it in 1872.

Psoriasis symptoms

Psoriasis mainly involves the skin and nails. There are different types but the most common form is plaque psoriasis, which affects approximately 90% of people with psoriasis and is the main focus of this booklet.

A plaque is a red, raised disc-shaped patch with well-defined edges, often covered with white scales, and can vary in size from around 2cm to several centimetres in diameter.

Some examples of types of psoriasis

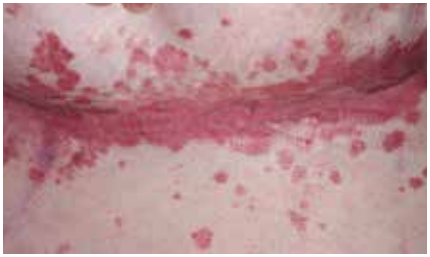


Plaque

Guttate

Scalp

Nail



Flexural

Erythrodermic

Generalised (anywhere on the body)

- **Plaque psoriasis** - this is characterised by red, raised scaly patches (known as plaques) with well-defined edges. The plaques can vary in number and size and affect any part of the skin surface, from one or two small plaques to complete body coverage, but most often occurs in a symmetrical pattern on both elbows, both knees and the scalp.
- **Guttate psoriasis** - this is the second most common form of psoriasis. The word 'guttate' comes from the Latin for 'drop' (gutta). This type of psoriasis occurs more commonly in adolescents or young adults. It usually has a sudden onset, with the widespread appearance of small red 'drop-like' patches, usually on the trunk and limbs. The onset is often preceded by a streptococcal throat infection.

Localised (confined to particular places)

- **Scalp psoriasis** - the scalp is one of the most common sites to be affected by psoriasis, and sometimes is the only area of involvement. Scalp psoriasis may appear as red, raised, scaly plaques which can extend to, or just beyond the hairline and commonly occurs behind the ears.
- **Nails psoriasis** - can affect the nails of both the hands and feet. Changes may include: thickening, loosening, changes in colour and the appearance of pits (small dents/ice pick like depressions on the surface of the nails). Nail changes are often associated with psoriatic arthritis.
- **Flexural psoriasis** - can occur in skin folds (flexures), such as under the breasts, in the armpits or the groin. The plaques are usually red, smooth and shiny. There is very little or no scale, due to the presence of sweat, which moistens the keratin (dead skin cells) and prevents scaling. Painful superficial skin cracks or tears (fissures) sometimes occur in skin creases.
- **Genital psoriasis** - can be difficult and frustrating to treat. However, it generally responds well to treatment. Due to the sensitivity of genital skin, treatment requires special consideration, therefore follow your recommended treatment regimen as prescribed by your doctor.

- **Palmo-plantar pustulosis** – this is a form of psoriasis that is confined to the palms of the hands and/or the soles of the feet. The palms and soles become red and scaly, with white/yellow sterile pustules (blisters of non-infectious pus). It is not an infection and is not contagious. Reddish-brown patches are present as the pustules resolve. Psoriasis affecting the palms and soles can severely limit everyday activities, for example, walking can become difficult. This can be a very painful and debilitating form of psoriasis.
- **Acrodermatitis Continua of Hallopeau** – this is a rare form of pustular psoriasis that can affect the fingers, toes and nails. This can also be a very painful and debilitating form of psoriasis.

Emergency Situations

Though uncommon, certain forms of psoriasis require urgent medical attention.

- **Generalized pustular psoriasis** – this is a rare but serious form of psoriasis, characterised by the development of white/yellow sterile pustules, on a background of red skin. It is not an infection and is not contagious. It tends to be preceded by other forms of psoriasis and is often triggered by an infection, or the withdrawal of certain medications.
- **Erythrodermic psoriasis** – this describes instances where almost the entire body surface is involved, and is characterised by red skin with a diffuse, fine, peeling scale. It is quite rare, generally occurring in those who have unstable plaque psoriasis.

Diagnosis

It is important to visit your GP to establish a diagnosis and receive appropriate treatment. Your doctor will ask you about your medical history and perform a physical examination, focusing on your skin, nails and scalp. Your doctor may also ask you about your joints.

How is psoriasis evaluated?

Your GP is likely to classify your skin/psoriasis using one of the following terms: clear, nearly clear, mild, moderate, severe or very severe,

Following assessment, your GP may refer you to a consultant dermatologist (skin specialist) if:

- your psoriasis is severe or extensive, for example more than **10% of the body surface area** is affected
- any type of psoriasis cannot be **controlled with topical therapy**
- you have acute guttate psoriasis which **requires phototherapy** (depending on availability in your area)
- you have nail psoriasis which has a **major functional impact**
- any type of psoriasis is having a **major impact on a person's physical, psychological or social wellbeing**
- there is **uncertainty** as to whether or not you have psoriasis (i,.e. there is diagnostic uncertainty)

Your GP should make reference to the severity of your psoriasis in their referral letter.

Consultant dermatologists may use a special measurement tool called the **'Psoriasis Area and Severity Index'** (PASI) to make a visual estimate of the severity of your condition based on how much of your body is covered with psoriasis and the levels of redness, thickness, and scaling present in the areas involved.

Measuring the impact of your condition

Psoriasis affects people in different ways. Living with psoriasis can affect you emotionally and socially, as well as physically. Psoriasis can vary in severity in the same person at different times. The unpredictable nature and the visibility of psoriasis can negatively impact on a person's quality of life and personal relationships.

If you are feeling anxious or down, it is important to share your feelings with your doctor.

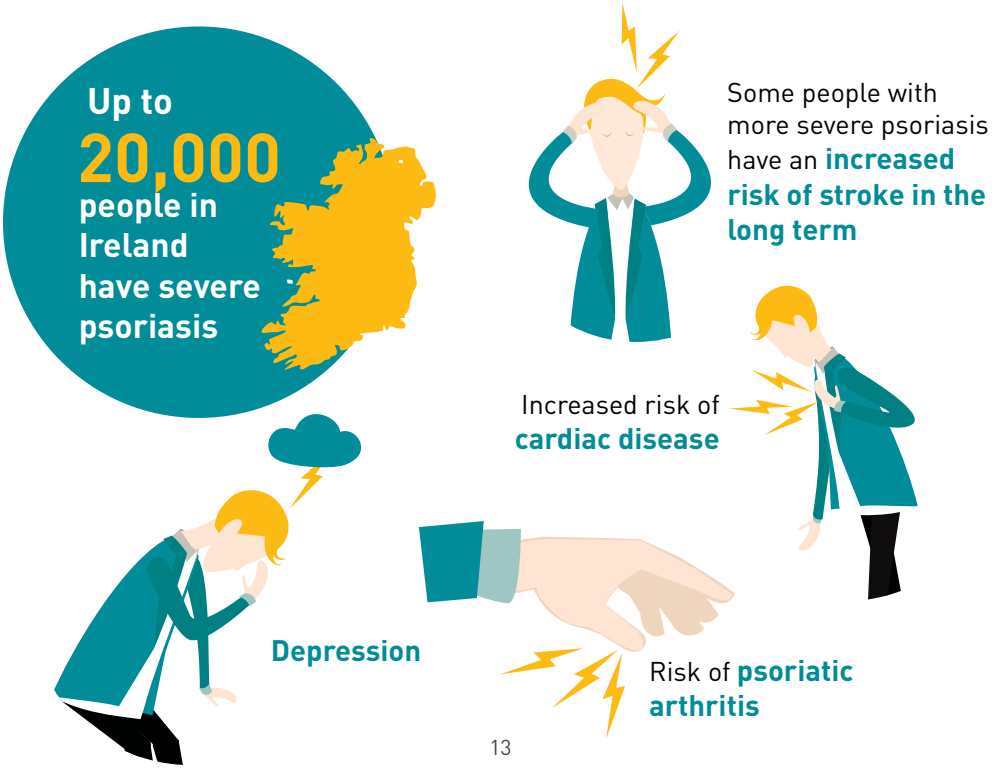
The **'Dermatology Life Quality Index' (DLQI)** is a questionnaire that your doctor may ask you to fill out. It helps the doctor to assess the impact psoriasis is having on a person's life, physically, emotionally, socially and sexually. It also assists the doctor to measure how well treatment is working.

You should try to be as honest as you can when answering the questions.

Associated conditions (co-morbidities)

There are a number of other conditions that have been associated with psoriasis including **cardiovascular disease** and **psoriatic arthritis**. Ask your doctor about your risk for heart disease, type 2 diabetes, high cholesterol and high blood pressure. Your GP is an expert in screening and treating these conditions. If you have symptoms of arthritis, ask for a referral to a rheumatologist (a specialist consultant doctor who can diagnose and treat forms of arthritis and other diseases of the joints, muscles and bones).

People with more extensive or severe psoriasis are more likely to have co-morbidities. It is estimated that at least 20,000 people in Ireland have severe psoriasis.



How do doctors treat psoriasis?

Although there is no cure yet, there are a range of effective treatment options available. Treating psoriasis is important for good disease management, as well as for general health.

Talk with your doctor to find a treatment that is suitable for you. Treatment of psoriasis depends on its severity and location. Try not to become disillusioned if one treatment does not work; psoriasis can sometimes be a challenging condition to treat as no single medication is effective for everyone affected. Your doctor may prescribe a number of different treatments before finding one that works for you. This is usually done in a step-by-step process.

Be sure to talk to your doctor about your symptoms and progress, and if necessary alternative treatment options or onward referral to a consultant dermatologist.

Options include:

- Topical treatments
- Phototherapy
- Systemic treatments
- Biologic treatments

Daily Care and Treatments for Psoriasis

Treatments can be divided into four main categories:

1

TOPICAL TREATMENTS

come in the form of creams, ointments, lotions, gels, foam or mousse which are applied directly to the skin.

2

PHOTOTHERAPY

is a form of artificial ultraviolet light, delivered in hospital dermatology departments.

3

SYSTEMIC TREATMENTS

are drugs that work throughout the body. They may come in the form of a liquid, tablet or injection.

4

BIOLOGIC TREATMENTS

are targeted medicines used to inhibit part of the immune system that drive inflammation. These are mainly injections but some are now being developed in tablet form.

Emollient therapy:
an important part of daily skin care

Emollients are moisturisers which are used in two ways - applied directly to the skin as a leave-on moisturiser, and as a soap substitute instead of soap and shower gel.

Emollients play an important, but often undervalued role in management. Used every day, emollients help to soothe dry itchy skin, soften the scale, and increase the effectiveness of prescribed treatments.

Emollients come as lotions, creams, and ointments. However, ointments work best when the skin is very dry. Sometimes, you may need to use more than one product. You may choose to use an ointment at night and cream or lotion during the day.

Emollients should be applied in a smooth, downward motion, in the direction of hair growth, ideally morning and evening.

PSORIASIS TREATMENTS

TOPICAL TREATMENTS

Option 1 in psoriasis treatment

Topical treatments are typically used when psoriasis is mild to moderate. They work by slowing down the accelerated rate at which skin cells are produced, and/or by reducing the inflammation associated with psoriasis.

If your psoriasis is mild, your care may be managed by your GP (primary care). The topical preparations mentioned below may also be used if your psoriasis is being managed by a hospital team (secondary care). They may be prescribed to be used alongside other therapies.

Topical corticosteroids

A class of drugs, also known as topical steroids, available in varying strengths - mildly potent, moderately potent, potent, very potent. These can be effective, but strong steroid creams can have significant side effects including thinning of the skin and rebound flaring of psoriasis. They are most effective when used alongside other topical treatments. It is important to use as directed by your doctor i.e. the **correct strength**, to the **correct body area**, for the **correct length of time**. Wash hands before and after use. Topical steroids are not recommended for long term use.

Topical non-steroid

Calcipotriol - Dovonex® is a topical form of synthetic vitamin D with efficacy similar to that of moderate strength corticosteroids, but with fewer of their potential side effects e.g. thinning of the skin. Dovonex helps to normalize some of the irregular cell changes in psoriasis. It has no smell and is easy to use. It can be irritating at certain sites, is not recommended on the face, and the maximum dose must not be exceeded.

Tar - tar products may be prescribed as various types of creams, ointments and lotions. It is thought they work by decreasing the accelerated rate at which skin cells are produced in psoriasis. It has a strong smell and some types may stain clothing.

Dithranol - dithranol has been used for many years to treat plaque psoriasis. It is effective in suppressing the over production of skin cells and has few side effects, but can burn the skin if too concentrated. It is typically prescribed as a 'short-contact' treatment under hospital supervision as it stains everything it comes into contact with, including skin, clothes and bathroom fittings. It is applied to your skin and left on for a specified number of minutes before being washed off. It is not suitable for the face or flexural areas. Dithranol is also available as lower strength preparations for use at home.

Calcineurin inhibitors – Protopic® (0.03% and 0.1%) contains the active ingredient tacrolimus, which is a type of medicine known as a topical immunomodulator, and works by decreasing skin inflammation. It is used for the face and flexural areas of the skin as an alternative to topical steroids. It may be prescribed for use once or twice daily.

If protopic is prescribed for your face, minimise exposure of your skin to sunlight, and other forms of ultraviolet light treatment or sunbeds, must be avoided.

Stinging on application is the most common side-effect, but this usually settles within a few days. Protopic should not be applied to infected skin.

TOPICAL COMBINATIONS

Different types of topical treatments may be prescribed to be used in sequence e.g. topical corticosteroids may be used in addition to tar preparations or vitamin D analogues, with one applied in the morning and one in the evening. Products containing two topicals combined are also available: e.g. corticosteroid/tar mixtures, or the combination product betamethasone / calcipotriol (e.g. Dovobet® or Enstilar®) which contains both a potent (strong) corticosteroid and Vitamin D analogue, and which has the advantage of once daily application.

All compounds containing potent corticosteroid preparations carry significant risks. For this reason, there are limits to the amount that can be used on the skin, and to the length of time that they can be used for. These compounds should not be used for certain types of psoriasis (guttate, flexural, erythrodermic, pustular) or at certain body sites (face, body folds). Their use should be closely supervised by a doctor experienced in their use in psoriasis.

TREATMENTS FOR SCALP PSORIASIS

Scalp Psoriasis

Psoriasis affecting the scalp is very common, almost 80% of people with psoriasis will have scalp involvement at some point in their lives.

Some people suffer with mild psoriasis of the scalp whilst others can experience severe scalp psoriasis which causes intense itching.

Symptoms of scalp psoriasis include:

- Dry scalp
- Flaking of the scalp
- Red scaly patches
- Persistent itch which can lead to bleeding, if scratched
- A burning sensation or soreness
- Temporary hair loss

For treatment to be effective it should relieve the symptoms. It is important to remove the scale before you apply any prescribed treatment, because if the scale is thick the treatment will not penetrate to treat the psoriasis.

STEP 1 SOFTEN THE SCALE

Soften the scale to gently remove it. This can be done with coconut oil, olive oil, or almond oil. You may like to warm it slightly and then apply to scalp, wrap your hair in a towel or shower cap. For best results leave oil on the scalp overnight.

Alternatively, your doctor or nurse may recommend a medicated ointment, such as a topical tar preparation.

Topical tar preparation such as Cocois can be effective at softening and removing scale, and is available from your pharmacist without prescription.

Initially the tar may be left on for 1 or 2 hours and then washed out with normal shampoo. If tolerated, it can be left in overnight for subsequent treatments. Follow the instruction of your healthcare provider. Tar can stain clothes and bedclothes so when leaving on overnight, consider using old pillowcases. Alternatively, a shower

cap can be used to protect the bedclothes from staining and it also helps the treatment to penetrate the scale. Cocois should be used daily initially and then according to need.

STEP 2 GENTLY REMOVE SCALE

Gently remove scale. If you have someone to help to remove scale it would be helpful, if not, try and feel with the tips of your fingers where the scale is.

Separate the hair and place a plastic, fine-toothed comb, flat against the scalp and slowly move the comb in an upward motion so that the teeth of the comb gently loosen the scale. Take care not to remove scales too forcefully as this can damage the skin and flare your psoriasis.

STEP 3 WASH HAIR

To remove the coconut/olive/almond oil, apply shampoo before wetting your hair and massage in. Then use warm water to wash your hair and get rid of any loose scale.

Tar based shampoos are useful for treating the scale that is present in scalp psoriasis. To be effective, the lather should be left on the scalp for approximately 5-7 minutes to allow the active ingredients to work, and then rinsed off. Your doctor, nurse or pharmacist can recommend a suitable shampoo.

STEP 4 APPLY PRESCRIBED TREATMENT

Topical steroids are often prescribed to settle a psoriasis flare. They have anti-inflammatory properties. They come in lotions, mousse and gel for the scalp. Apply as directed by your doctor or nurse.

When applying scalp treatments, it is useful if someone can help you so that the treatment is applied to the scalp and not the hair. If your whole scalp is affected, divide the scalp into sections. Part the hair and gently massage the treatment into the affected areas of the scalp.

If applying a lotion be careful not to let the steroid run onto the neck and forehead. The steroid is absorbed better, and is more effective when the thick scale has been removed. Wash hands after application.

Unfortunately, treatment will not cure your scalp psoriasis however the combination of tar preparation, prescribed topical steroid and medicated shampoo may help relieve the itch and calm a flare up when used as directed.

In order to maintain improvement, ongoing maintenance treatment is necessary intermittently.

PSORIASIS TREATMENT OPTIONS 2,3 & 4

If your psoriasis is moderate or severe, you will be referred to a consultant dermatologist and your care may be managed by a hospital team (secondary care).

Consultant dermatologists typically prescribe the following treatments, as patients require on-going monitoring during treatment.

PHOTOTHERAPY

Option 2 in psoriasis treatment

If your psoriasis has not responded to topical therapy, your dermatologist may recommend phototherapy. Phototherapy is a form of artificial ultraviolet light treatment, comprised of either ultraviolet A (UVA) or ultraviolet B (UVB) wavelengths of light, delivered in hospital dermatology day care centres. Phototherapy has been specially designed to treat certain skin conditions, and may help to regulate the accelerated rate at which skin cells turnover in psoriasis.

Narrowband UVB is the most common type of phototherapy used to treat psoriasis. It is usually given 3 times a week.

Another form called **PUVA** may also be prescribed. Ultraviolet light A (UVA) must be combined with a light sensitising medication such as psoralen to be effective. This is commonly known as PUVA (**PUVA** = **P**soralen + **UVA**) and is usually given twice a week.

Exposure time depends on the patient's skin type, as well as UVA or UVB strength. Your doctor will discuss the frequency and the estimated number of treatment sessions with you. Protective eye shields must be worn during treatment. Patients having PUVA treatment must wear protective sunglasses in accordance with the advice of their healthcare professional. Although phototherapy can help to improve symptoms, it may cause side effects, the most common of which is a sunburn-type reaction. Talk to your doctor about the benefits and risks of treatment.

UV 7001

SYSTEMIC TREATMENT

Option 3 in psoriasis treatment

Systemic medication may be prescribed in circumstances where topical treatments and phototherapy have not worked, or are not recommended. Topical treatments and phototherapy only affect the skin, whereas systemic treatments affect the underlying cause of psoriasis - an abnormal immune system response that causes inflammation and an increased rate of skin cell production. Systemic medications work throughout the body to control the psoriasis. They may come in the form of a liquid, a tablet or an injection.

Methotrexate - a drug that reduces immune cell activity in the skin and inhibits the rapid development of skin cells. It is also effective for psoriatic arthritis.

Ciclosporin - a drug that supresses T-cells in the immune system and is only used for short periods for severe flares of psoriasis.

Acitretin - a synthetic compound with biologic activity similar to that of vitamin A. It helps normalise the abnormal, accelerated development of skin cells in psoriasis. It is not usually prescribed for women of child bearing age.

Fumaric Acid Esters (Fumaderm®) - a drug that acts on cells in the immune system called T-cells. Fumaric acid esters are now licensed, throughout Europe, for treating psoriasis. Patients receiving this medication require close monitoring with frequent blood tests.

Apremilast (Otezla®) - this drug belongs to a group of medicines called phosphodiesterase 4 inhibitors, which help to reduce inflammation.

Systemic medications can cause side effects, some of which may be serious. However, patients are reviewed regularly to monitor for, and avoid potential side effects. Some medications affect the body's ability to fight certain types of infections. Talk to your doctor about the benefits and risks of any medication that is prescribed.

Please see the British Association of Dermatologists' Immunisation recommendations for children and adult patients treated with immune-suppressing medicines:

http://www.bad.org.uk/for-the-public/patient-information-leaflets

BIOLOGIC TREATMENTS

Option 4 in psoriasis treatment

A consultant dermatologist may prescribe a biologic when other treatments are not suitable, have not provided symptom relief, or if the patient is experiencing side effects. Unlike systemic agents that act broadly on the immune system, biologic treatments target and inhibit specific parts of the immune system that are responsible for causing inflammation, thereby improving psoriasis symptoms.

The drugs mentioned below are given by injection under the skin or by intravenous infusion i.e. 'drip' (Infliximab). The treatment schedule varies from drug to drug.

The following medications block the action of a protein called tumour necrosis factor alpha (TNF-alpha or TNF α) which is involved in the abnormal immune responses in psoriasis. You may also see these medications referred to as TNF-α Inhibitors or anti-TNF-α agents.

- **Adalimumab** (Humira®)- an anti-TNF monoclonal antibody
- **Etanercept** (Enbrel®)– a TNF-alpha receptor blocker
- **Infliximab** (Remicade®, Inflextra®, Remsima®) – an anti-TNF monoclonal antibody given by intravenous infusion ('drip').

The following medications block the action of proteins called interleukins (IL) that are involved in the abnormal immune responses in psoriasis.

- **Brodalumab** (Kyntheum®) is a monoclonal antibody that targets the activity of IL-17
- **Ixekizumab** (Taltz®) - a monoclonal antibody that targets IL-17A
- **Secukinumab** (Cosentyx®) - a monoclonal antibody that targets IL-17A
- **Ustekinumab** (Stelara®) - a monoclonal antibody that targets IL 12/23

With research on-going, there are a number of new drugs in development.

Biologics can cause side effects, some of which may be serious. However, patients are reviewed regularly to monitor for and reduce the risk of potential side effects. Some medications affect the body's ability to fight certain types of infections. Talk to your doctor about the benefits and risks of any medication that is prescribed.

Please see the British Association of Dermatologists' Immunisation recommendations for children and adult patients treated with immune-suppressing medicines: http://www.bad.org.uk/for-the-public/patient-information-leaflets

THE SCIENCE BIT

Research has shown that psoriasis is an immune-mediated inflammatory disorder, which means the condition is brought on by irregularities in the body's own immune system.

This information has allowed scientists to develop targeted medications (biologics) that block the action of specific types of proteins called cytokines (e.g. tumour necrosis factors and interleukins) and other cells, that stimulate the abnormal immune responses and inflammation that contribute to the development of psoriasis.

In simpler terms, each biologic medicine targets different proteins or cells involved in causing psoriasis, using different approaches to interrupt the activity that causes the skin to flare up.

What are monoclonal antibodies?

An antibody is a protein (a type of molecule) used by the immune system to act against certain cells or other proteins. Monoclonal antibodies (meaning many copies of just one type of antibody) are molecules produced in a laboratory. They are designed to work in different ways depending on the type of protein they are targeting, to block the abnormal immune responses in psoriasis.

Self-care tips: The following general measures may also be very helpful in the management of psoriasis

Stop smoking

Research indicates that smoking worsens psoriasis, and stopping smoking may improve symptoms.
The HSE provides tailored quit plans to help people quit smoking, see: www.quit.ie or Freephone 1800 201 203

Maintain a healthy weight

The World Health Organisation (WHO) defines overweight and obesity 'as abnormal or excessive fat accumulation that may impair health'. Obesity is identified as a risk factor in the development of psoriasis and for the severity of symptoms. It can also reduce the effectiveness of systemic and biologic treatments for psoriasis.

Body mass index (BMI) is a simple measure of body fat based on your weight in relation to your height, and is commonly used to classify overweight and obesity in adults.

For adults, the WHO defines:

- **overweight** is a BMI greater than or equal to 25; and
- **obesity** is a BMI greater than or equal to 30.

The health risks associated with obesity vary depending on the pattern of fat distribution in the body. Abdominal obesity (visceral fat) as measured by waist circumference, is linked to a worsening of psoriasis as well as an increased risk of cardiovascular disease.

Regardless of height, recommended waist measurements are less than 32 inches (80cm) for women and less than 37 inches (94cm) for men.

You may wish to visit: http://www.safefood.eu/Healthy-Eating/Weight-Loss/Stop-The-Spread.aspx to see how you measure up.

Eat a healthy diet

There is no clear link between diet and the severity of psoriasis symptoms, but what is known is that a nutritious balanced diet is very important for health and well-being.

There is a lot of misinformation about excluding certain food groups or types as a treatment for psoriasis. There is no scientific evidence to support this approach.

However, research suggests that excessive alcohol consumption may be a risk factor in the development of psoriasis and severity of symptoms.

Talk to your doctor if you have any concerns about your diet or level of alcohol consumption.

Have your 'risk factors' checked

Your GP is an expert in screening and treating conditions that may be associated with psoriasis such as heart disease, increased blood pressure, raised cholesterol, type 2 diabetes and psoriatic arthritis. It is important to discuss with your GP the risk factors and attend for regular check-ups and monitoring

Exercise

Regular exercise is important for your general health, helping you to maintain a healthy weight and reduce your risk of heart disease and type 2 diabetes. Talk to your doctor before starting any new exercise regime.

Maintaining a healthy weight is important, for example, please see body mass index online calculator: www.bmicalculator.ie

Psoriasis, Social Situations and Relationships

People with psoriasis have two issues to deal with, the skin condition itself, and all too often, other peoples' attitudes to psoriasis.

Feeling self-conscious or embarrassed about visible psoriasis can undermine self-confidence; especially in social situations, meeting new people or with a romantic partner.

Often this is because of anxiety about what others might think. Having psoriasis can be embarrassing and it can cause people to look or stare; but it doesn't mean you have to hide yourself away.

When worried, here are some things to keep in mind:

- Communicate your feelings and anxieties about psoriasis. Be open and truthful. If the other person is not familiar with psoriasis, explain a few basic facts, or offer an information leaflet or link to www.irishskin.ie
- If worries about intimacy seem impossible to overcome, consider consulting a relationship therapist. Everyone has the power to change his or her perspectives, assumptions and attitudes.
- Erectile dysfunction (difficulty maintaining an erection sufficient for sex) may occur in men who have psoriasis. Sometimes this may be related to the worry about psoriasis itself. If this is a problem for you, it is important to discuss it with your GP as it may also be an early warning sign of heart disease.

  Your GP will be able to help you manage this common problem and perhaps screen you for other risks, such as heart disease. Sometimes medication for high blood pressure and depression can also cause erectile dysfunction. Do not be embarrassed to ask to your doctor for more information.

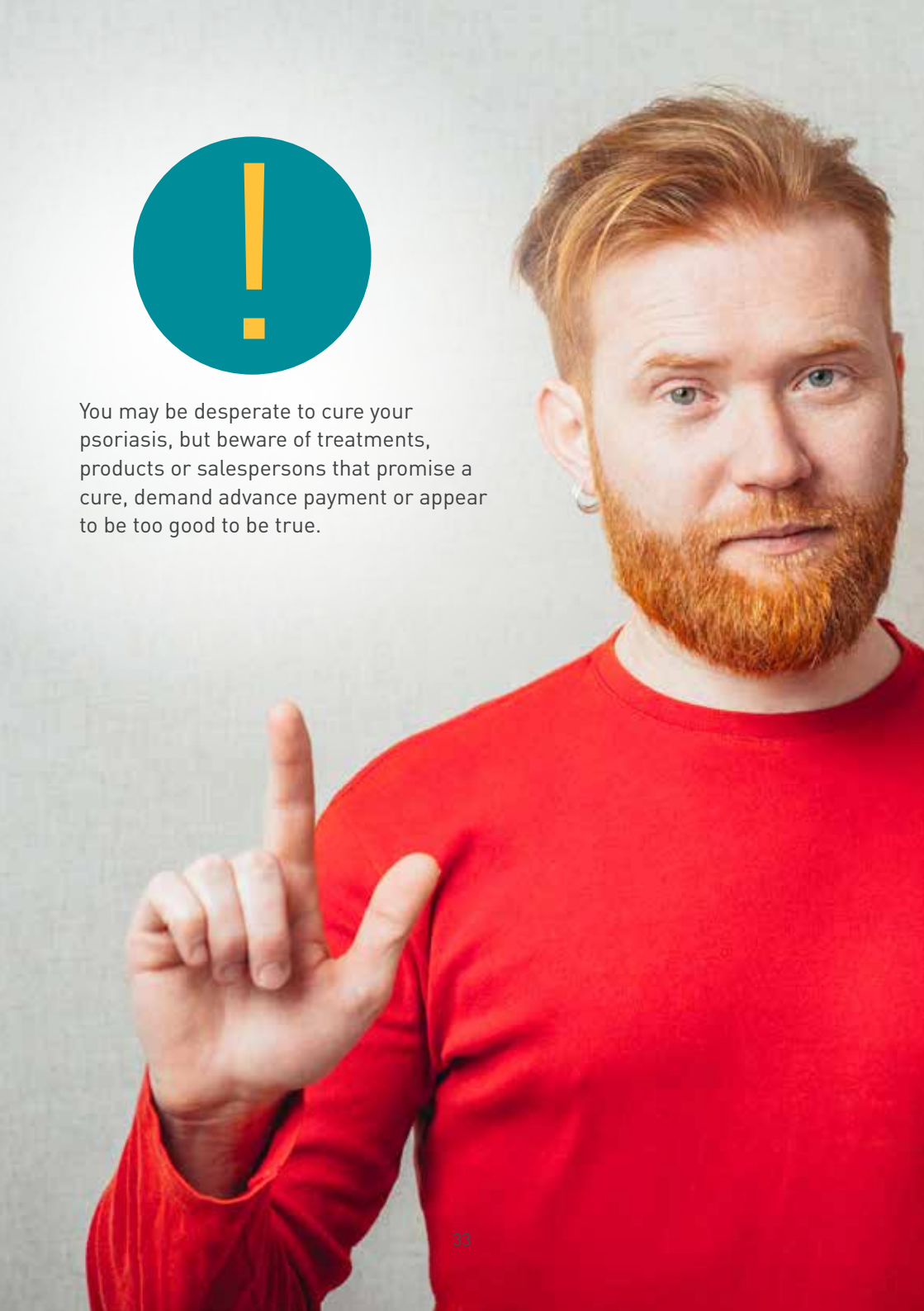
Complementary and alternative treatments for psoriasis

Although you may hear the phrases **complementary therapy** and **alternative therapy** used interchangeably, there are important differences between the two.

- A **complementary therapy** is one that is used **along with** or **alongside** conventional (normal or standard) medical treatment for psoriasis (e.g. emollients, prescribed topical treatments, phototherapy, systemics and biologics). Examples of complementary therapies could include such things as aromatherapy, acupuncture, salt baths or yoga and you may choose to talk to your healthcare professional about the pros and cons of these options. Though sometimes expensive, complementary therapies are generally harmless.
- An **alternative therapy** is one that is used **instead of** conventional medical treatment. Examples could include such things as homeopathy or herbalism, amongst others.

In accordance with Irish and European law, all conventional medical treatments prescribed by your doctor have to go through careful and thorough scientific testing to prove that they are both safe and effective, but alternative therapies are not held to the same standard.

Also, some treatments may interact so it is very important to talk to your doctor before considering using any non-conventional therapies.



You may be desperate to cure your psoriasis, but beware of treatments, products or salespersons that promise a cure, demand advance payment or appear to be too good to be true.

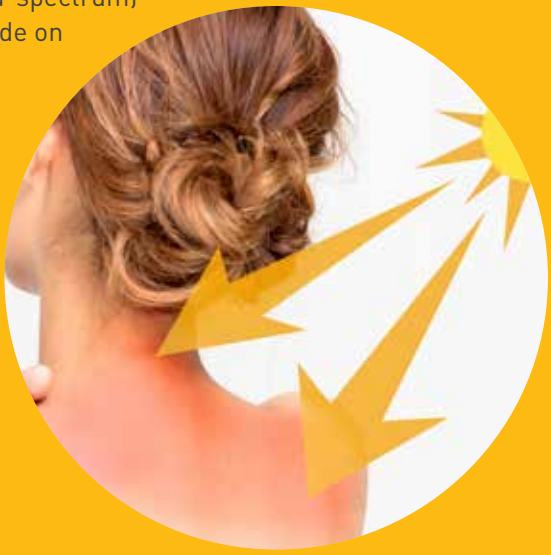
Will the sun help my psoriasis?

Many people who have psoriasis find that sunlight can help their skin to clear. However, being sensible in the sun is important and sunburn must be avoided at all times. While sunburn is a risk for skin cancer, it can also bring about the Koebner phenomenon - this is where psoriasis can develop at the site of an injury, such as a sunburn.

Sun protection is important for everyone, with or without psoriasis. In Ireland, protect yourself from March – September in particular, when the intensity of sunburn producing UV radiation is greatest. Avoid sun exposure between the hours of 11am and 3pm when the sun is at its strongest.

Apply a broad spectrum factor 30+ sunscreen, which offers protection against both UVA and UVB, in addition to protective clothing and shade. Sunscreen should be applied liberally and evenly 15-30 minutes before sun exposure to allow it time to dry, and again shortly after going outdoors to ensure that all areas are covered. Reapply frequently, at least every two hours and after perspiring, sport, swimming, or friction (such as towel drying).

No sunscreen can provide 100% sun protection. Remember the five 'Ss' of sun safety – Slip on a t-shirt, Slop on (broad-spectrum) sunscreen factor 30+, Slap on a hat, Slide on sunglasses, Seek shade.



We want everyone in Ireland to learn to Protect & Inspect their skin!

Download our short guide to checking your skin, written with dermatologists, at www.irishskin.ie/protect-and-inspect/

Suggestions for talking with your doctor

- Be sure to talk with your doctor about your symptoms and progress, and if necessary, other treatment options or onward referral to a consultant dermatologist.
- Do not be embarrassed about asking your doctor questions. Often, the time you spend with your doctor is limited, so it can be useful to make a list of questions beforehand so you don't forget, and take them with you to your appointment.
- Acknowledge your feelings and emotions about your condition. If you are feeling anxious or down, it's important to share your feelings with your doctor.
- Make sure you understand the information your doctor is giving you. It is acceptable to say 'I don't understand'.
- Learn more about psoriasis. This will make it easier to have a conversation with your doctor about treatment options and your progress.
- Keep a diary of your symptoms and how you feel, and note any times that you forgot to take your medication.

Psoriatic arthritis

What is psoriatic arthritis?

Arthritis means inflammation of one or more joints.

Psoriatic arthritis (PsA) is a chronic, inflammatory form of arthritis associated with psoriasis, that can cause pain, swelling and damage to joints, but can be treated.

PsA is less common than other forms of arthritis such as osteoarthritis or rheumatoid arthritis.

What causes PsA?

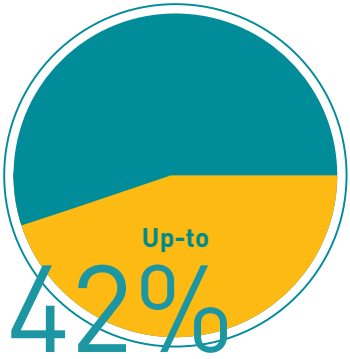
PsA is an autoimmune disease, occuring when the immune system attacks the joints and also tendons.

While the exact cause is not known, research points to the involvement of several different genes. Progression of disease may be genetically determined but environmental factors may also play an important part in triggering PsA.

How common is PsA?

The prevalence of PsA is estimated to be between 0.3 – 1% of the general population. However, amongst patients with psoriasis, studies have indicated prevalence rates ranging between 6% and 42%.

The incidence of PsA is slightly higher in women, with peak onset occurring between 35-45 years of age. Onset may be gradual with mild symptoms developing slowly over a period of years, or progress more rapidly to become severe and destructive.



of psoriasis patients can have accompanying PsA

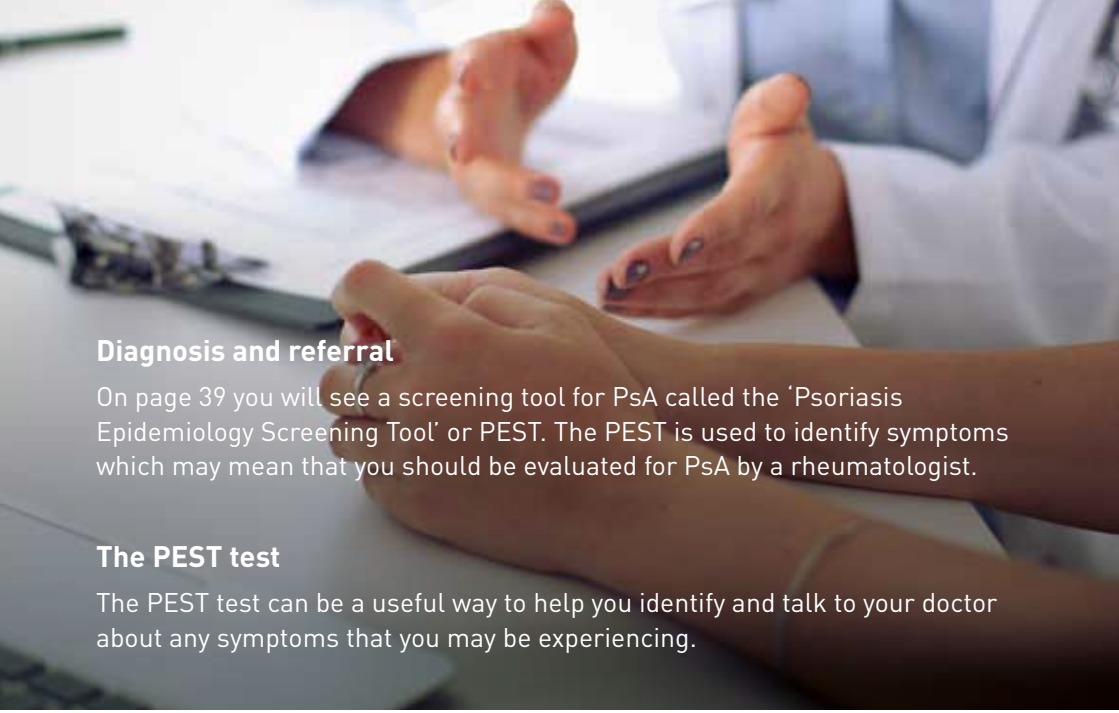
Appearance of symptoms

For the majority of patients, psoriasis develops first, commonly around 10 years before PsA. Joint problems start before psoriasis in approximately 16% of patients, while 15% develop skin and joint problems simultaneously (at the same time). Severe skin disease or psoriasis affecting the nails may indicate a risk for developing PsA.

Some symptoms associated with PsA

Symptoms can vary greatly from patient to patient. Let your doctor know if you have the following symptoms which may indicate psoriatic arthritis:

- **Joint pain** - especially with redness, swelling and tenderness.
- **Inflammation of an entire digit** - known as dactylitis, where either a finger or toe swells up to a sausage shape and can be painful.
- **Nail changes** - loosened, thickened or pitted nails (pits are small dents/ ice pick like depressions on the surface of the nails).
  It has been suggested that the presence of 20 nail pits distinguishes patients with PsA from those with rheumatoid arthritis and psoriasis.
- **Morning stiffness/pain** in the back that improves with movement.
- **Pain in your heel(s) or tennis elbow.**



Diagnosis and referral

On page 39 you will see a screening tool for PsA called the 'Psoriasis Epidemiology Screening Tool' or PEST. The PEST is used to identify symptoms which may mean that you should be evaluated for PsA by a rheumatologist.

The PEST test

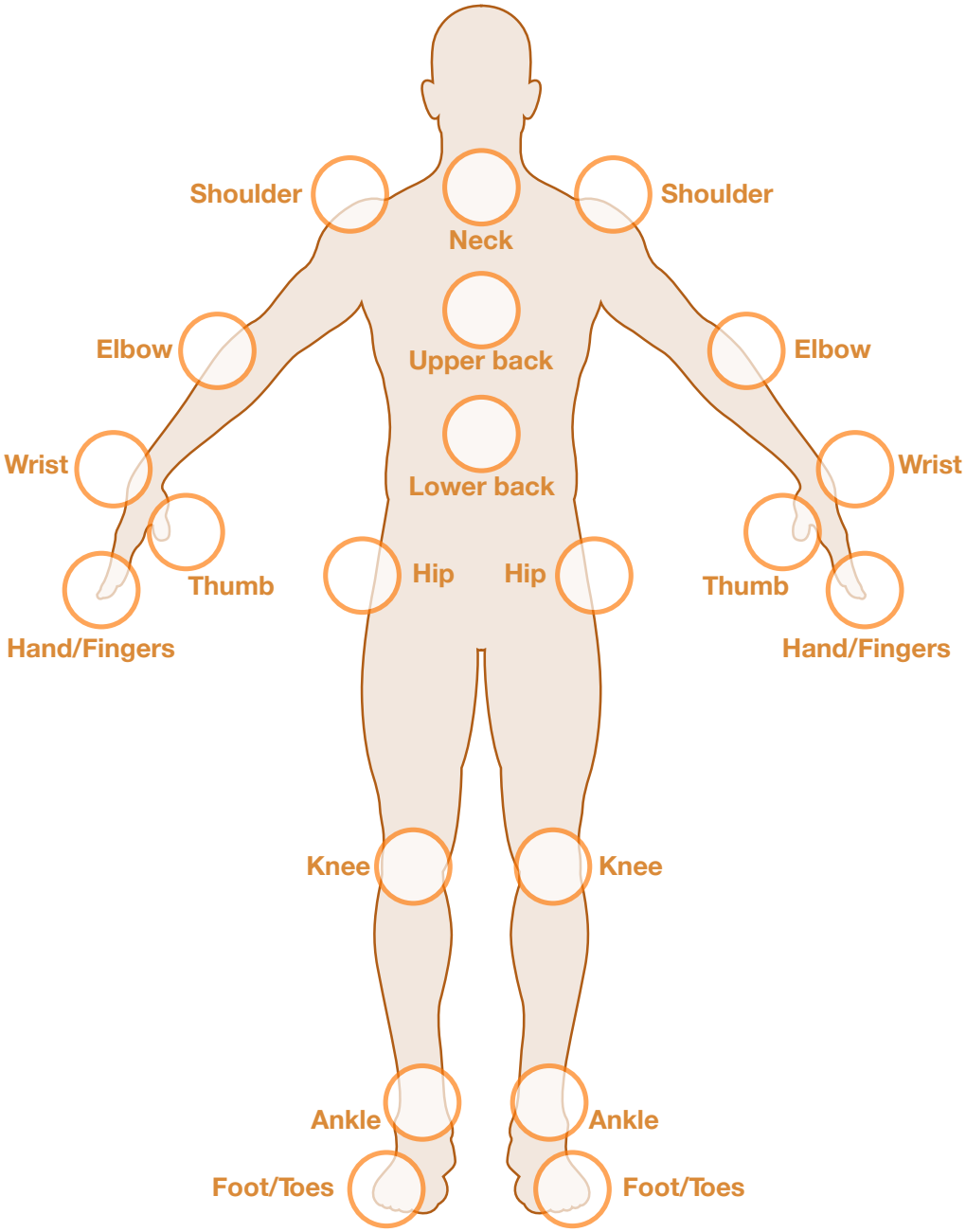
The PEST test can be a useful way to help you identify and talk to your doctor about any symptoms that you may be experiencing.

People with psoriasis who have not been diagnosed with PsA should answer a PEST questionnaire annually. A score of 3 or more indicates that a referral to a rheumatologist should be considered.

Q1.	**Have you ever had a swollen joint (or joints)?**	**Y:** ☐	**N:** ☐
Q2.	**Has a doctor ever told you that you have arthritis?**	**Y:** ☐	**N:** ☐
Q3.	**Do your finger nails or toenails have holes or pits?**	**Y:** ☐	**N:** ☐
Q4.	**Have you had pain in your heel?**	**Y:** ☐	**N:** ☐
Q5.	**Have you had a finger or toe that was completely swollen and painful for no apparent reason?**	**Y:** ☐	**N:** ☐

In the diagram on page 39, please tick the joints that have caused you discomfort (i.e. stiff, swollen or painful joints).

Psoriasis Epidemiology Screening Tool



Reproduced with kind permission of Professor Philip Helliwell (University of Leeds).

Treatment

If a diagnosis of PsA is confirmed by your doctor, treatment is aimed at reducing pain, inflammation, and preventing longer term damage to joints. As the inflammatory process is similar in the skin and joints, treatment targeting one aspect of the condition may benefit the other as well.

Medication

Treatment recommendations may include:

- **Non-steroidal anti-inflammatory drugs (NSAIDs)**
  This class of medication helps to reduce inflammation, joint pain and stiffness. However, they do not improve the long term outcome of the disease.
- **Steroid injections**
  Steroid injections into the joint may be recommended where joints are particularly painful and inflamed.
- **Disease modifying anti-rheumatic drugs (DMARDs)**
  This class of medication differs from the others mentioned above because they can help stop the progression of joint damage, and are often prescribed in combination with NSAIDs and/or steroid injections. One example of a DMARD is methotrexate, which is a drug that affects the immune system. It is used to treat moderate-to-severe psoriasis and PsA. Regular blood tests are taken to monitor for side-effects.
- **Biologic agents (injectable medication)**
  If you are taking a DMARD and not getting symptom relief, or if you are experiencing side effects, your doctor may prescribe a biologic agent. Biologic agents (medicines based on compounds made by living cells) offer another option for the treatment of psoriasis and PsA. These drugs target specific parts of the immune system that are responsible for causing inflammation in psoriasis and PsA. These drugs help restore balance to the immune system.
  Biologics are given by injection under the skin or intravenously (IV), to target and effectively improve psoriasis and PsA symptoms. The treatment schedule varies from drug to drug.

There is always some risk associated with taking any medication.

Talk to your doctor about the risks and benefits of any medication you take.

Non-medication therapies can also be very helpful in the treatment of PsA.

For example:

- Physiotherapy – to help maintain muscle strength, range of movement, and function of affected joints.
- Occupational therapy – advice on ways to reduce strain and prevent further damage to affected joints when going about everyday activities, both at home or at work (including equipment and adaptations).
- Podiatry – for assessment of foot care needs, provides advice on footwear and can fit moulded insoles to help keep the foot in the best alignment (position).
- Dietician – advises on healthy diet and can help with food choices when weight loss is important. Being overweight puts extra strain on joints, especially those of the back and legs.

A number of healthcare professionals may therefore be involved in your care. It is likely though that your dermatologist and rheumatologist will continue to jointly manage your care along with the rest of your team.

Additional support form 'Arthritis Ireland' www.arthritisireland.ie

You can learn more of the skills that will help you deal with PsA on one of Arthritis Ireland's self-management programmes.

For example. 'Living Well with Arthritis' is a course that focuses on what you can do for yourself, how to get the most from your health professionals, handling pain, fatigue and depression, relaxing and keeping active. It is an opportunity to meet and share tips with other people who understand what you are going through.

Where can I get more information, or support for psoriasis?

Reliable sources for patient information are available, including those listed here:

Irish Skin Foundation: www.irishskin.ie
British Association of Dermatologists:
http://www.bad.org.uk/for-the-public/patient-information-leaflets

Some things to remember

1. Know that you are not alone – psoriasis is more common than you might think! Psoriasis affects at least 100 million people worldwide, including more than 100,000 people in Ireland.
2. It is not contagious – you cannot spread it to other people and it cannot be transferred from one part of the body to another.
3. Psoriasis can be controlled - there are many different treatments available. Your doctor may prescribe a number of different treatments before finding one that works for you.
4. Using an emollient to moisturise the skin at least twice a day can help alleviate dryness, scaling, soreness and itch. An emollient bath prepares the skin before the application of prescribed topical treatments.
5. Do not stick your fingers into a tub of emollient! Always use a clean spoon or spatula to prevent contamination. Emollients should be applied in a smooth, downward motion, in the direction of hair growth, after a bath/shower and before going to bed.
6. If you would like more information or support please contact us:

Irish Skin Foundation
Helpline: (01) 486-6280
Email: info@irishskin.ie
www.irishskin.ie

What you **need to know** about
PSORIASIS

This booklet has been prepared by the Irish Skin Foundation in consultation with people with psoriasis, dermatology nurses and consultant dermatologists.

Brought to you by the

Irish Skin Foundation

Supporting people with skin conditions in Ireland

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