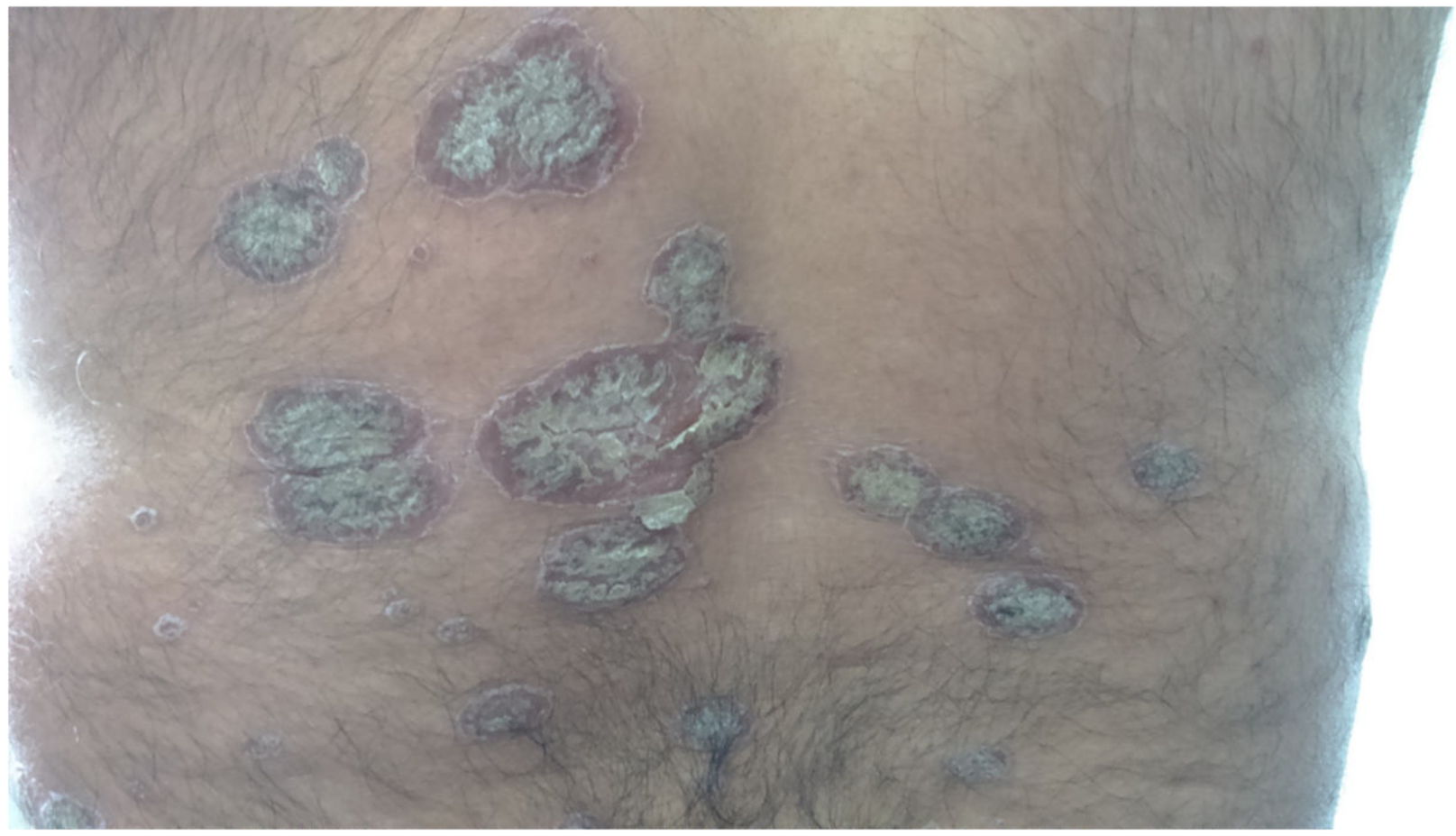
PBL – Papulosquamous Diseases

The Problem

- A 50-year-old male patient
- Presents with a history of skin lesions x 34 years
- Red, itchy, scaly, lesions present all over the body & head
- Lesions increase in summer but improve in winter
- No joint pains
- On clinical examination: BSA: 15% apprx.; Erythematous, scaly, sharply demarcated, plaques, present particularly over the extensor surfaces & scalp
- Palms & soles: largely spared



D/D & D

- Type 1 - hereditary, strongly HLA associated (particularly HLA-Cw6), early onset & more likely to be severe

- Type 2 - sporadic, HLA unrelated, of late onset & often mild

How to Quantify involvement

PASI

Table 35.3 Erythema, scaling and induration are graded in each region and a combined score ranging from 0 to 72 calculated as Psoriasis Area Severity Index (PASI).

	Thickness 0–4	Scaling 0–4	Erythema 0–4	× Area 0–6		Total
Head	a	b	c	d (a + b + c)	× 0.1	= A
Upper limbs	e	f	g	h (e + f + g)	× 0.2	= B
Trunk	i	j	k	l (i + j + k)	× 0.3	= C
Lower limbs	m	n	o	p (m + n + o)	× 0.4	= D
					PASI	= A + B + C + D

Severity	0 = none	Area	0 = no involvement	Axillae = upper limb
	1 = mild		1 = 0 <10%	Neck/buttocks = trunk
	2 = moderate		2 = 10 <30%	Genito-femoral = lower limb
	3 = severe		3 = 30 <50%	
	4 = very severe		4 = 50 <70%	
			5 = 70 <90%	
			6 = 90 <100%	

- PASI – 10
- Moderate

Tests / Sign

- Grattage test - Scales in a psoriatic plaque can be accentuated by grating with a glass slide
- Auspitz sign- 3 steps
- Step A: Gently scrape lesion with a glass slide - This accentuates the silvery scales (Grattage test positive). Scrape off all the scales
- Step B: Continue to scrape the lesion – A glistening white adherent membrane (Burkley's membrane) appears
- Step C: On removing the membrane, punctate bleeding points become visible - positive Auspitz sign

How to treat this patient

- Systemic antibiotics in psoriasis

- Anti-*Streptococcus* medications – may clear guttate attacks

- Diet in Psoriasis

- No clear evidence for / against oral zinc, fish oils, omega-3 fatty acids, turkey meat or diets low in tryptophan, protein or calories

- Some studies demonstrate celiac diseases associated-antibodies – elimination of wheat from diet may bring long-term remissions

- Treatment options

Treatment ladder

Mild plaque psoriasis without psoriatic arthritis[a]

First line

- Coal tar
- Dithranol
- Potent topical corticosteroid
- Vitamin D analogue

Second line

- Local NB-UVB or PUVA
- Excimer laser

[a]In alphabetical order.

Moderate to severe plaque psoriasis without psoriatic arthritis[a]

First line

- NB-UVB or PUVA

Second line

- Acitretin
- Apremilast
- Ciclosporin
- Fumaric acid esters (where available)
- Methotrexate

Third line

- Adalimumab
- Etanercept
- Infliximab
- Secukinumab
- Ustekinumab

Topical therapy

- Emollients - prevent & treat xerosis, decrease scaling
- Moisturizing agents - cream bases, coconut / olive oil, white soft paraffin & liquid paraffin mixtures etc.

Investigations

- Systemic therapy

- Why

- Initiation of systemic therapy - a shared decision between the patient & the clinician
- Careful consideration of risk–benefit profiles of available treatments
- In general, systemic treatment indicated for - extensive disease not responsive to topical therapy or phototherapy; erythroderma; pustular psoriasis; psoriatic arthritis
- Impact of disease – patient may opt for earlier systemic treatment
- Logistics - e.g., inability to attend for regular phototherapy

- Investigations:
- CBCs with ESR & PBF
- LFTs, RFTs, FBS/RBS, HBA1c, Urine R/E, M/E
- HBsAg, HCV, HIV-1 & 2
- CXR-PA
- Other investigations

Systemic Steroids

- When systemic steroid is given for 1st time, clearance of psoriasis is rapid but the disease eventually ‘breaks through’, necessitating progressive increases in dosage, with incidence of side effects

- If withdrawal is attempted, psoriasis tends to relapse promptly & may ‘rebound’

- ‘Rebound’ may take the form of widespread, eruptive psoriasis, erythrodermic psoriasis or generalized pustular psoriasis

- Systemic steroids should NEVER be used in the routine care of psoriasis

- Psoriasis may remain labile & treatment resistant for many months after the withdrawal

- Oral or parenteral corticosteroids should generally be avoided
- Used only when urgent control of complications is needed (e.g., acute respiratory distress syndrome)
- Or when other drugs are contraindicated for instance in pregnancy
- Short-term effects of prednisolone (30–40 mg/day) may be good but serious relapses are liable to occur as the dosage is reduced unless another form of therapy (e.g., acitretin, TNFi) is given simultaneously

Counselling

- Psoriasis – a treatable but *incurable* disease
- 'Psoriasis is at all times and under all forms a very troublesome and, often, an intractable disease, but it is rarely dangerous to life'– **Wilson, 1842**
- 'It is impossible to say, in any particular case, how long the disease will last, whether a relapse will occur, or for what period of time the patient will remain free from psoriasis'– **Hebra, 1868**
- Patients' counseling – paramount

Papulosquamous Diseases

- Psoriasis
- Pityriasis rosea
- Lichen planus
- Erythroderma
- Pityriasis lichenoides
- Pityriasis rubra pilaris
- Parapsoriasis

Erythroderma

- Erythroderma is a morphological diagnosis characterized by generalized erythema and scaling

- Diffuse erythema and scaling of the skin involving more than 90% of the total body skin surface area

- Erythroderma is the term applied to any inflammatory skin disease that affects more than 90% of the body surface

Thank You