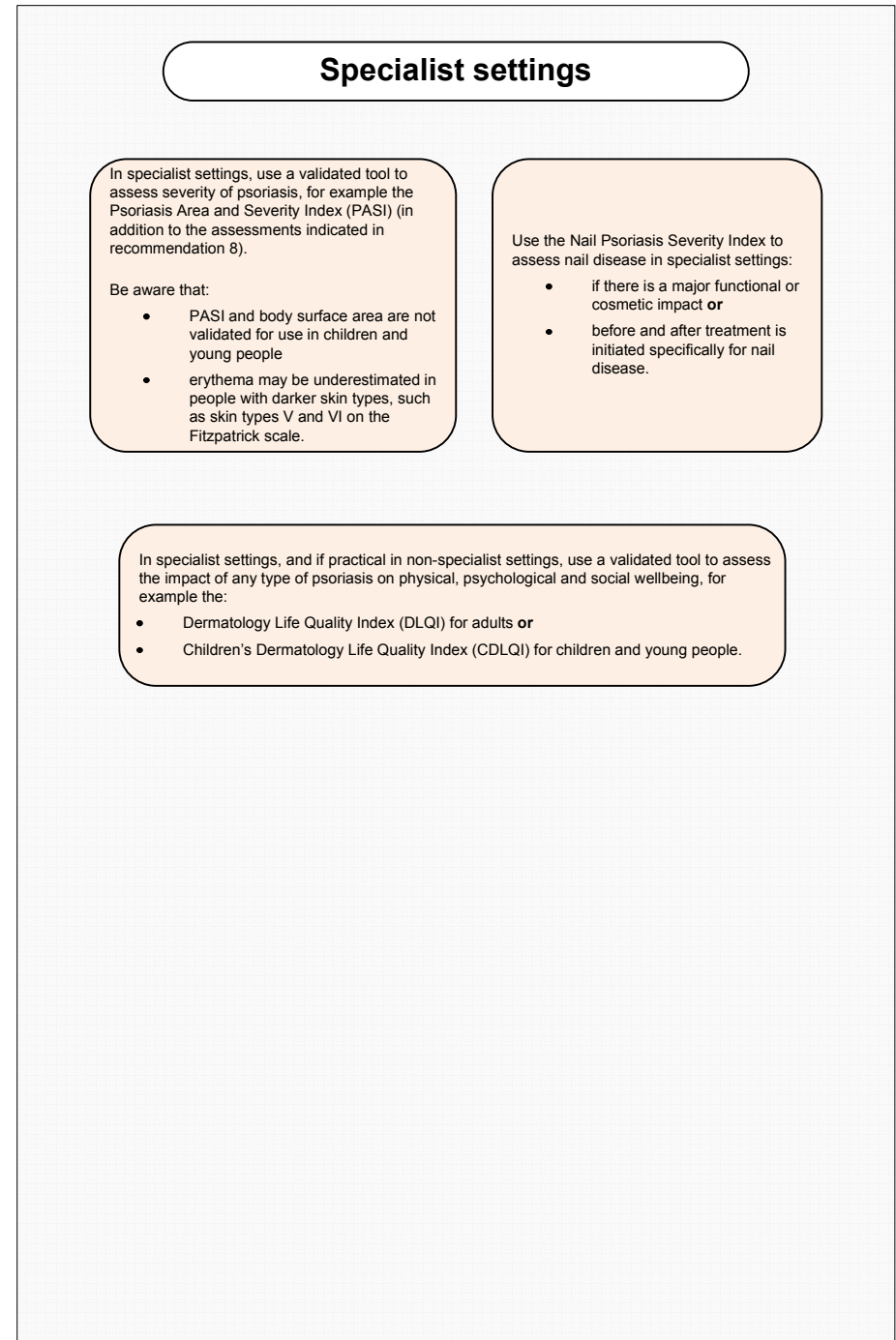
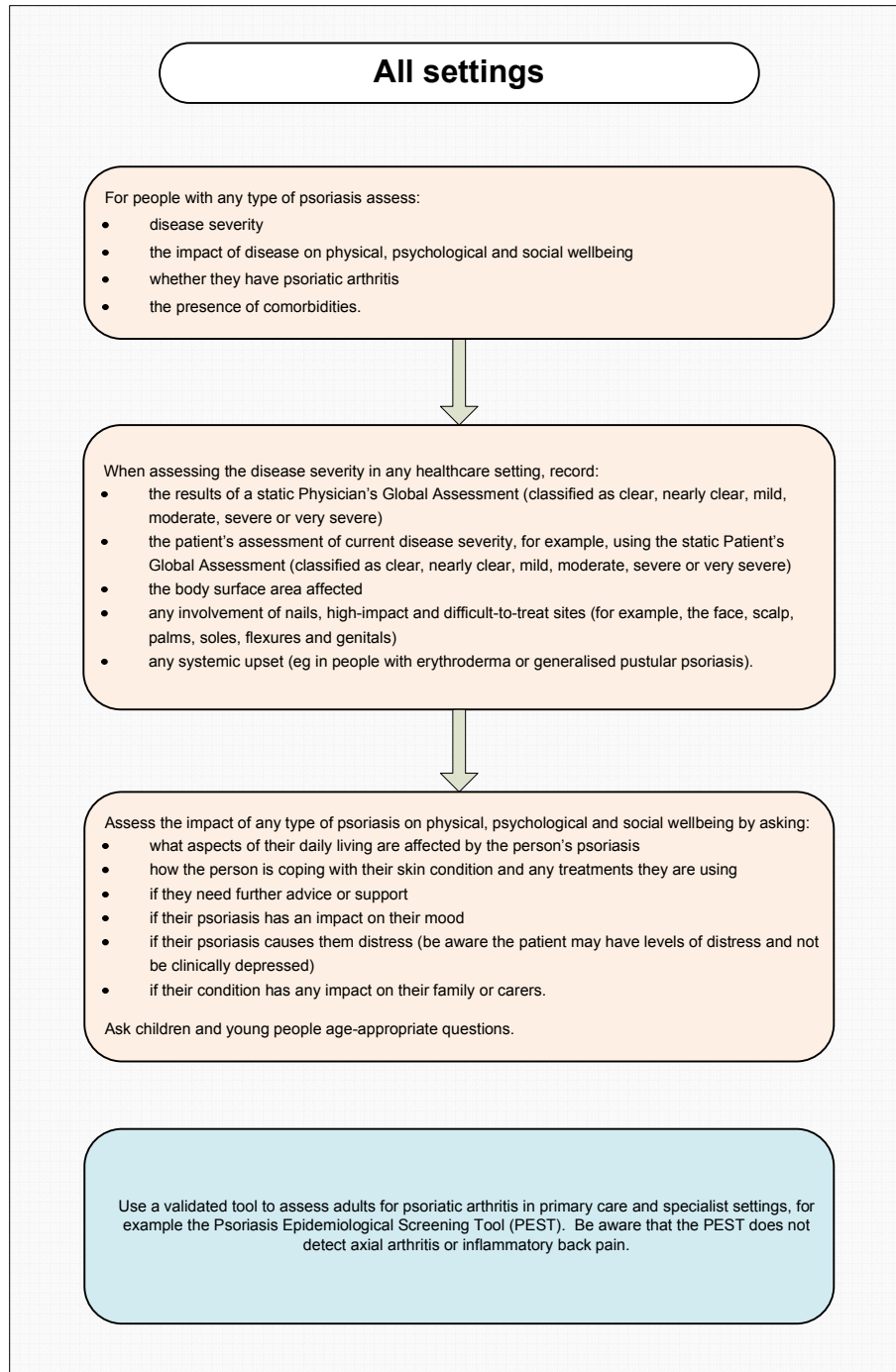


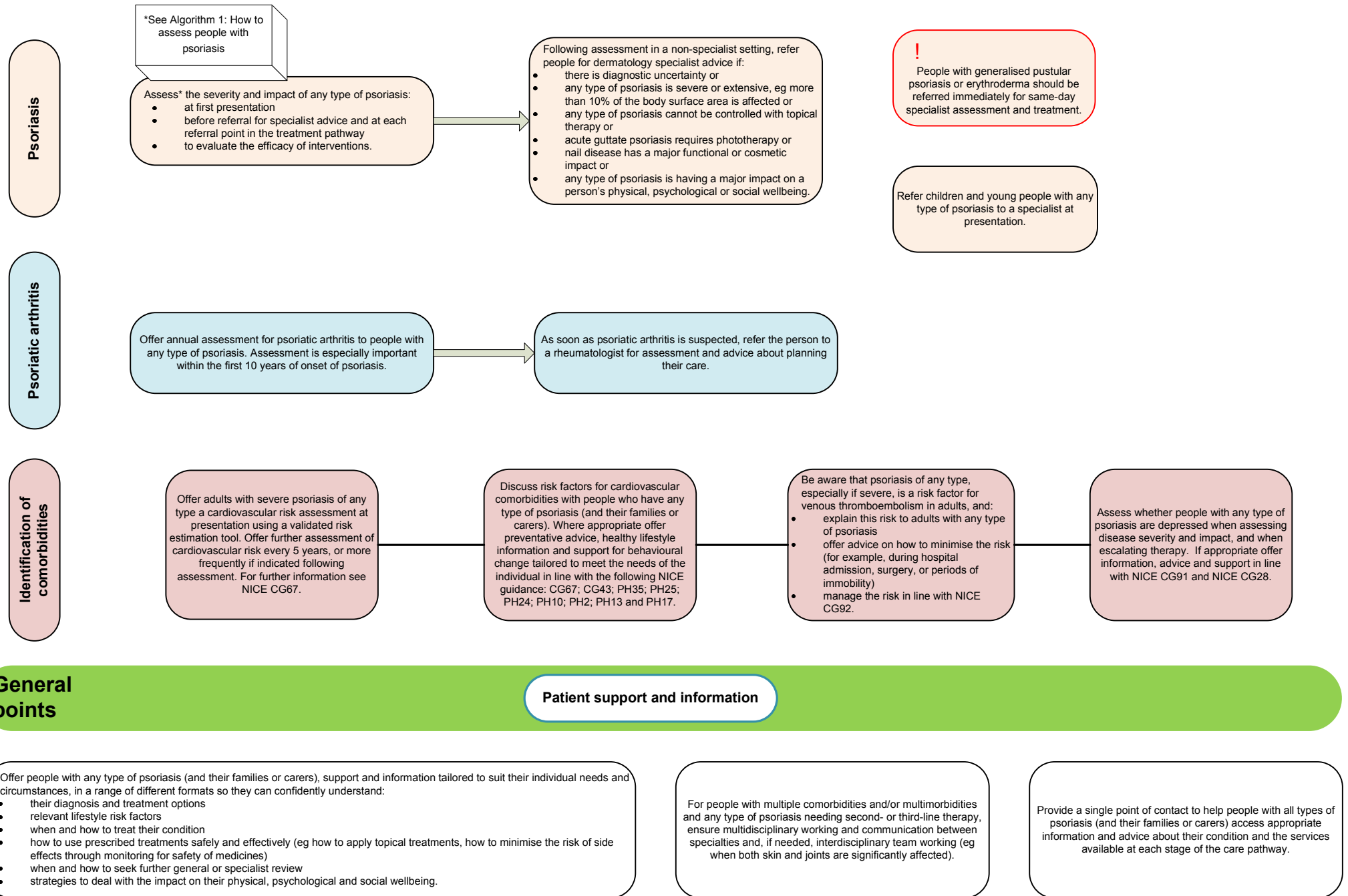
Algorithm 1: How to assess people with psoriasis

Psoriasis

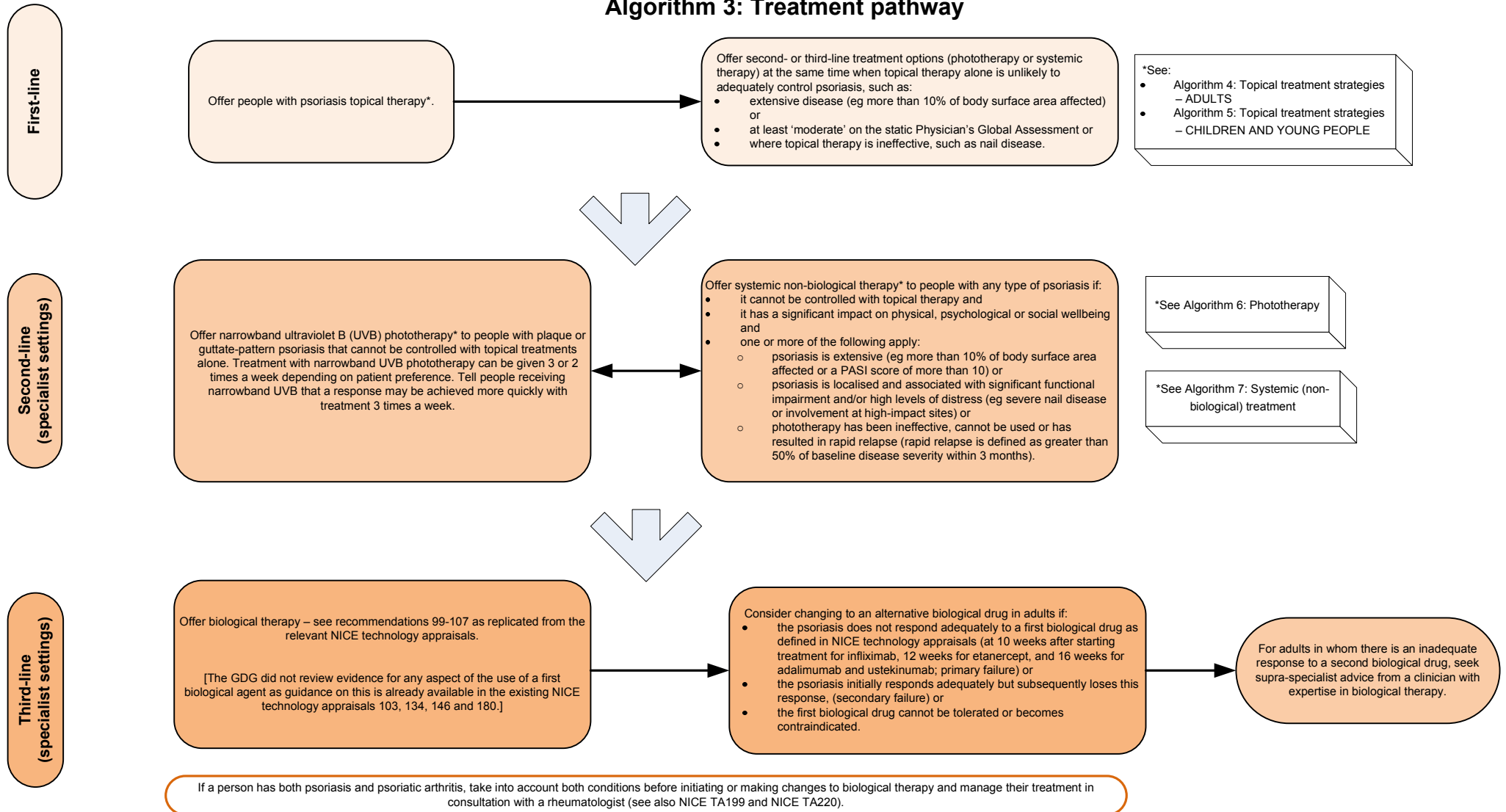
Psoriatic arthritis



Algorithm 2: When to offer assessment and indications for referral for specialist advice



Algorithm 3: Treatment pathway



General points

Patient support and information

- When offering treatments to a person with any type of psoriasis:
- ensure the treatment strategy is developed to meet the person's health goals so that the impact of their condition is minimised and use relevant assessment tools to ensure these goals are met
 - take into account the age and individual circumstances of the person, disease phenotype, severity and impact, co-existing psoriatic arthritis, comorbidities and previous treatment history
 - discuss the risks and benefits of treatment options with the person (and their families or carers). Where possible use absolute risk and natural frequency
 - discuss the importance of adherence to treatment for optimising outcomes.

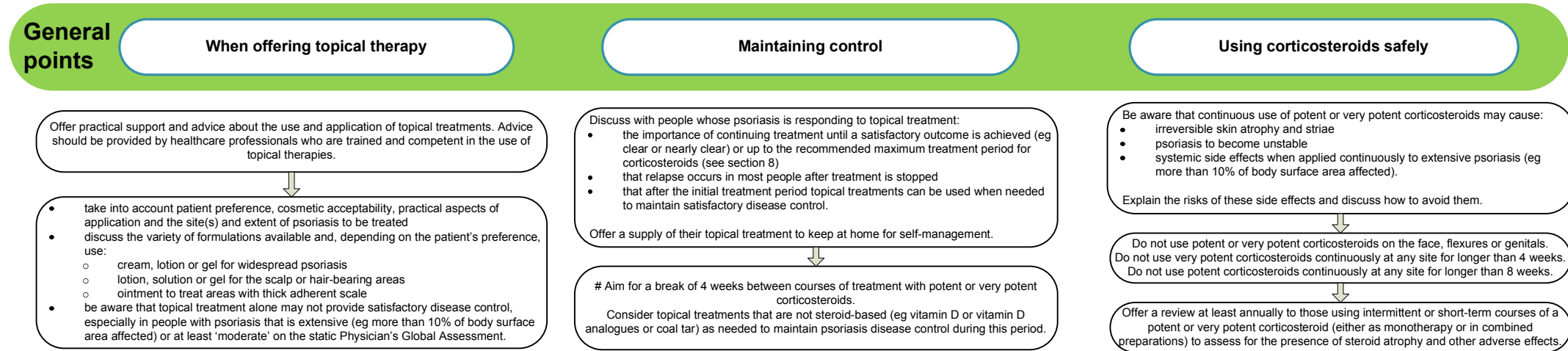
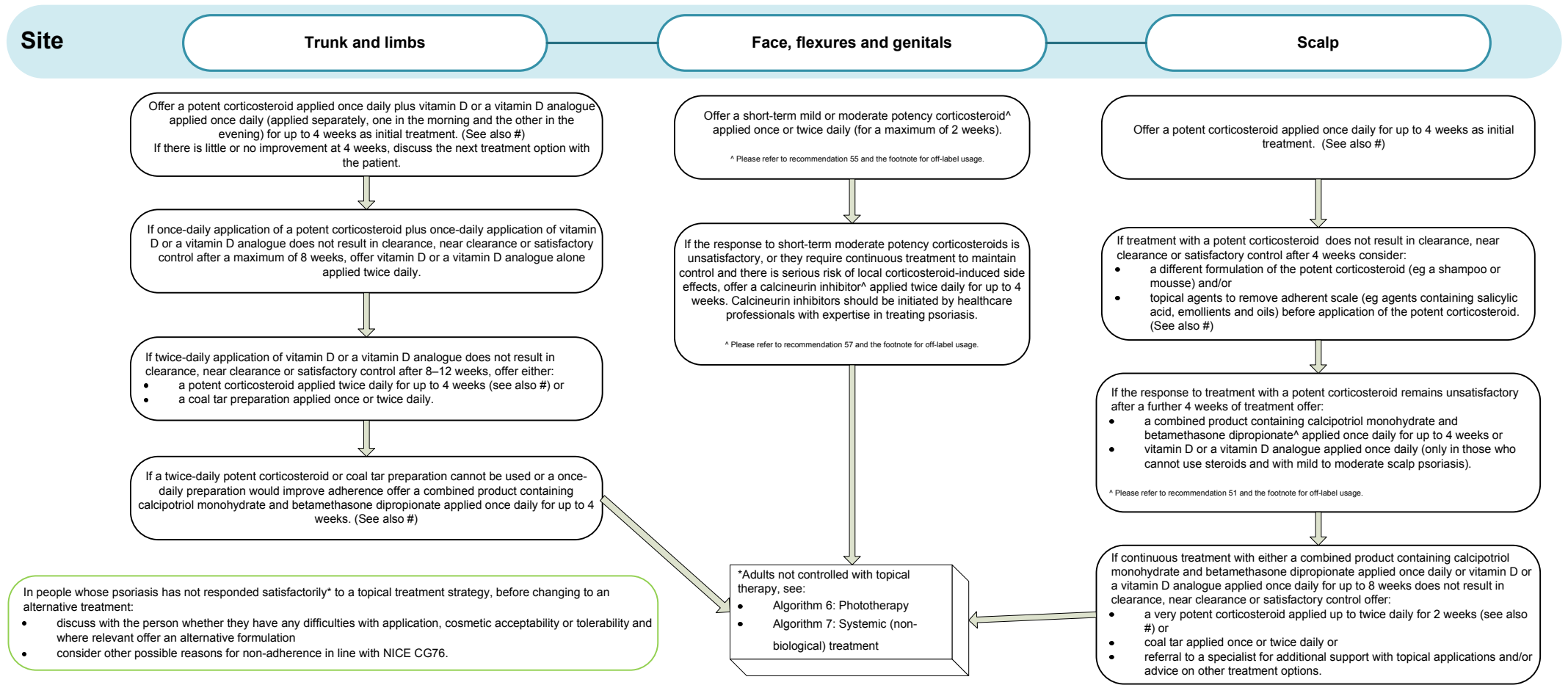
For more information about involving patients in decisions and supporting adherence see NICE CG76.

Provide a single point of contact to help people with all types of psoriasis (and their families or carers) access appropriate information and advice about their condition and the services available at each stage of the care pathway.

Assess whether people with any type of psoriasis are depressed when assessing disease severity and impact, and when escalating therapy. If appropriate offer information, advice and support in line with NICE CG91 and CG28.

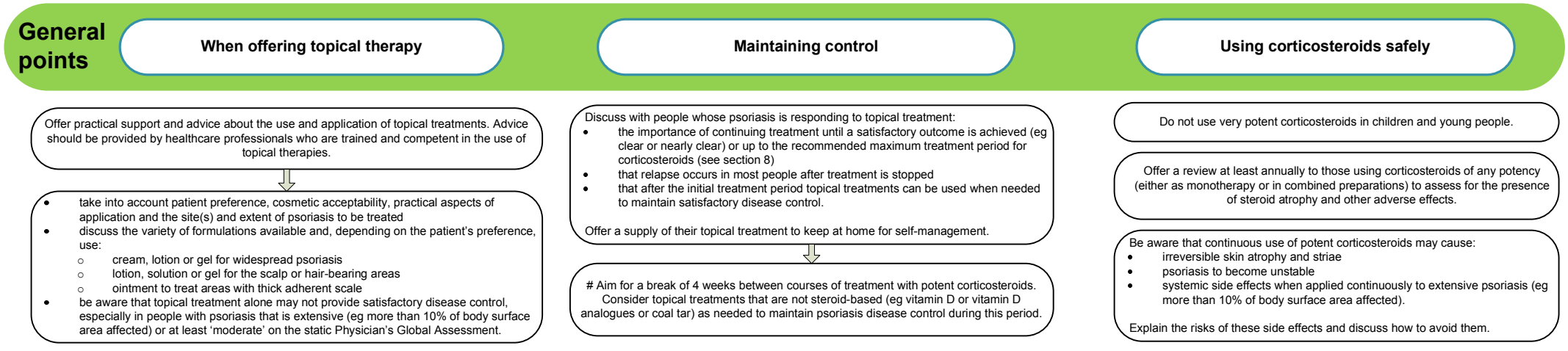
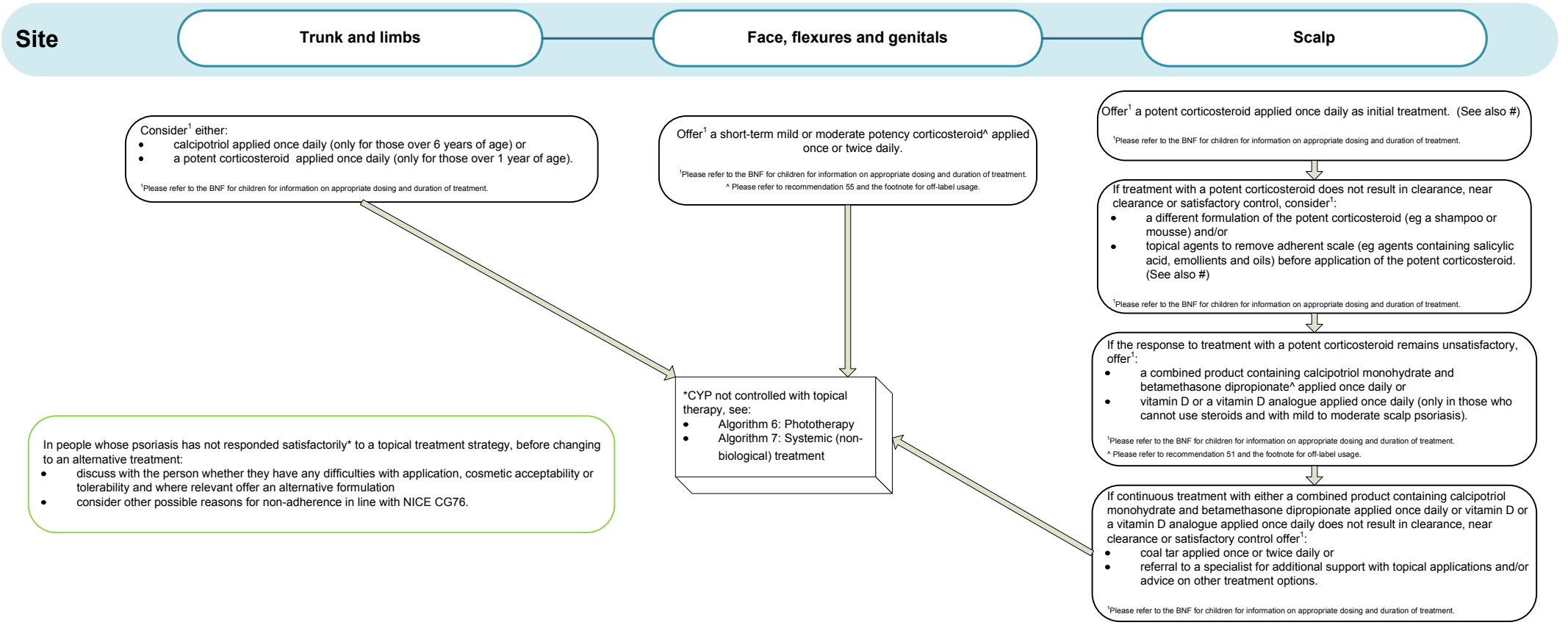
Algorithm 4: Topical treatment strategies – ADULTS

The treatment pathway in this guideline begins with active topical therapies. The GDG acknowledged that the use of emollients in psoriasis was already widespread and hence the evidence review was limited to active topical therapies for psoriasis. Please refer to the BNF for guidance on use of emollients.

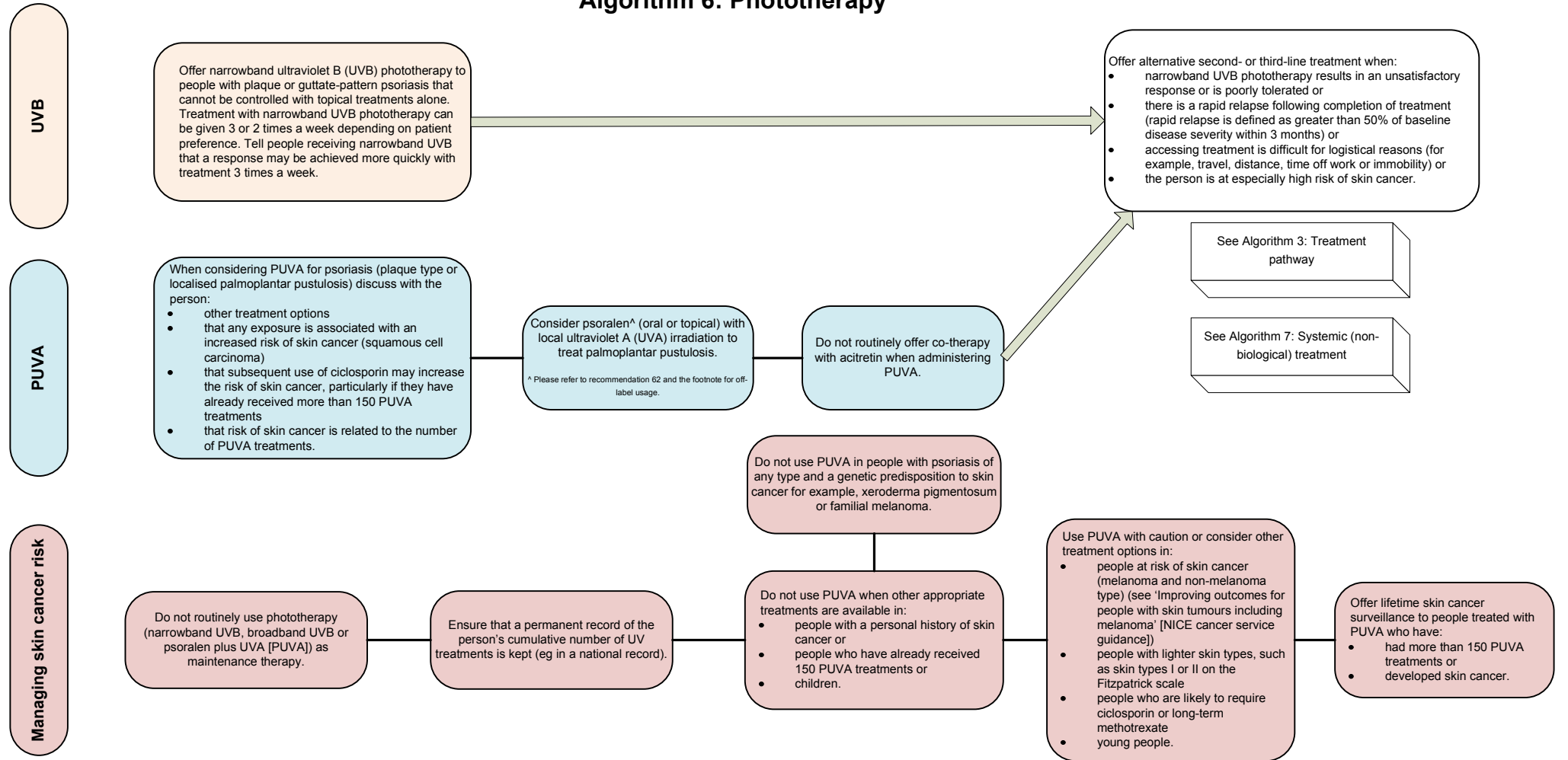


Algorithm 5: Topical treatment strategies – CHILDREN AND YOUNG PEOPLE

The treatment pathway in this guideline begins with active topical therapies. The GDG acknowledged that the use of emollients in psoriasis was already widespread and hence the evidence review was limited to active topical therapies for psoriasis. Please refer to the BNF and cBNF for guidance on use of emollients.



Algorithm 6: Phototherapy



General points

Optimising efficacy

- Consider topical adjunctive therapy in people receiving phototherapy with broadband or narrowband UVB who:
- have plaques at sites that are resistant or show an inadequate response (eg the lower leg) to phototherapy alone, or at difficult-to-treat or high-need, covered sites (eg flexures and the scalp), and/or
 - do not wish to take systemic drugs or in whom systemic drugs are contraindicated.

Optimising safety

Ensure that all phototherapy equipment is safety-checked and maintained in line with local and national policy.

Healthcare professionals who are giving phototherapy should be trained and competent in its use and should ensure an appropriate clinical governance framework is in place to promote adherence to the indications for and contraindications to treatment, dosimetry and national policy on safety standards for phototherapy.

Algorithm 7: Systemic (non-biological) treatment

Responsibility for its use should be in specialist settings only. Certain aspects of supervision and monitoring may be delegated to other healthcare professionals and completed in non-specialist settings, in which case, such arrangements should be formalised.

When offering, tailor the choice of agent and dosing schedule to the needs of the individual and include consideration of:

- the person's age
- disease phenotype, pattern of activity and previous treatment history
- disease severity and impact
- the presence of psoriatic arthritis (in consultation with a rheumatologist)
- conception plans
- comorbidities
- the person's views.

Offer this to people with any type of psoriasis if:

- it cannot be controlled with topical therapy and
- it has a significant impact on physical, psychological or social wellbeing and
- one or more of the following apply:
 - psoriasis is extensive (eg more than 10% of body surface area affected or a PASI score of more than 10) or
 - psoriasis is localised and associated with significant functional impairment and/or high levels of distress (eg severe nail disease or involvement at high-impact sites) or
 - phototherapy has been ineffective, cannot be used or has resulted in rapid relapse (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months).

In people with both active psoriatic arthritis and any type of psoriasis that fulfils the criteria for systemic therapy consider the choice of systemic agent in consultation with a rheumatologist.

Choice of drugs

Offer methotrexate^a as the first choice for people with psoriasis who fulfil the criteria for systemic therapy except in the circumstances described in recommendations 84 and 92.

^a Please refer to recommendation 82 and the footnote for off-label usage.

Consider changing from methotrexate to ciclosporin (or vice-versa) when response to the first-choice systemic treatment is inadequate.

Offer ciclosporin^a as the first choice for people who fulfil the criteria for systemic therapy and who:

- need rapid or short-term disease control (eg a psoriasis flare) or
- have palmoplantar pustulosis or
- are considering conception (both men and women) and systemic therapy cannot be avoided.

^a Please refer to recommendation 84 and the footnote for off-label usage.

Consider acitretin for adults, and in exceptional cases only for children and young people, in the following circumstances:

- if methotrexate and ciclosporin are not appropriate or have failed or
- for people with pustular forms of psoriasis.

In people not responding to, or who cannot use systemic (non-biological) treatment, see Algorithm 3: Treatment pathway, and recommendations 97-109.

Drug regimens

Use incremental dosing of methotrexate (eg starting with an initial dose of 5–10 mg once a week) and gradually increase up to an effective dose and a maximum of 25 mg a week. Assess the treatment response after 3 months at the target dose of methotrexate and stop treatment if the response is inadequate (eg a decrease of less than 75% in PASI score or a decrease of less than 50% in PASI score and 5 points in DLQI score).

Use the lowest possible therapeutic dose of methotrexate to maintain remission.

Use 2.5–3 mg/kg a day of ciclosporin. Escalate to 5 mg/kg a day after 4 weeks only when there is no response to the lower dose or when rapid disease control is necessary (eg in severe unstable disease). Assess the treatment response after 3 months at the optimum dose of ciclosporin and stop treatment if the response is inadequate (eg less than a 75% decrease in PASI score or less than a 50% decrease in PASI score and less than 5 points in DLQI score).

Use the lowest possible therapeutic dose of ciclosporin to maintain remission for up to 1 year. Consider other treatment options when disease relapses rapidly on stopping ciclosporin therapy (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months of stopping treatment). Do not use ciclosporin continuously for more than 1 year unless disease is severe or unstable and other treatment options, including systemic biological therapy, cannot be used.

Use incremental dosing of acitretin to minimise mucocutaneous side effects and achieve a target dose of 25 mg daily in adults. Consider dose escalation to a maximum of 50 mg daily when no other treatment options are available. Assess the treatment response after 4 months at the optimum dose of acitretin and stop treatment if the response is inadequate, eg:

- in plaque-type psoriasis, less than a 75% decrease in PASI score or less than a 50% decrease in PASI score and less than 5 points in DLQI score
- in pustular forms of psoriasis, not achieving clear or nearly clear on the static Physician's Global Assessment.

General points

Optimising efficacy

When reviewing response, take into account:

- disease severity compared with baseline (eg PASI baseline to endpoint score)
- control of psoriatic arthritis disease activity (in consultation with a rheumatologist if necessary)
- the impact of the disease on the person's physical, psychological and social wellbeing
- the benefits versus the risks of continued treatment
- the views of the person and their family or carers.

Offer adjunctive topical therapy to optimise treatment outcomes.

Optimising safety

Monitor people for all types of psoriasis in accordance with national and local drug guidelines and policy. Take appropriate action in the event of laboratory abnormalities or adverse events.

Offer people with psoriasis who are starting treatment the opportunity to participate in long-term safety registries (eg the British Association of Dermatologists Biologic Interventions Register).

See recommendations 93-96 on monitoring methotrexate hepatotoxicity

Patient support and information

Be aware of the benefits of, contraindications to and adverse effects associated with systemic treatments. Explain the risks and benefits using absolute risks and natural frequencies when possible. Support and advice should be provided by healthcare professionals who are trained and competent in the use of systemic therapies.