Algorithm 1: How to assess people with psoriasis

Psoriasis

Psoriatic arthritis

All settings

For people with any type of psoriasis assess:

- disease severity
- the impact of disease on physical, psychological and social wellbeing
- whether they have psoriatic arthritis
- the presence of comorbidities.

When assessing the disease severity in any healthcare setting, record:

- the results of a static Physician's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)
- the patient's assessment of current disease severity, for example, using the static Patient's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)
- the body surface area affected
- any involvement of nails, high-impact and difficult-to-treat sites (for example, the face, scalp, palms, soles, flexures and genitals)
- any systemic upset (eg in people with erythroderma or generalised pustular psoriasis).

Assess the impact of any type of psoriasis on physical, psychological and social wellbeing by asking:

- what aspects of their daily living are affected by the person's psoriasis
- how the person is coping with their skin condition and any treatments they are using
- if they need further advice or support
- if their psoriasis has an impact on their mood
- if their psoriasis causes them distress (be aware the patient may have levels of distress and not be clinically depressed)
- if their condition has any impact on their family or carers.

Ask children and young people age-appropriate questions.

Use a validated tool to assess adults for psoriatic arthritis in primary care and specialist settings, for example the Psoriasis Epidemiological Screening Tool (PEST). Be aware that the PEST does not detect axial arthritis or inflammatory back pain.

Specialist settings

In specialist settings, use a validated tool to assess severity of psoriasis, for example the Psoriasis Area and Severity Index (PASI) (in addition to the assessments indicated in recommendation 8).

Be aware that:

- PASI and body surface area are not validated for use in children and young people
- erythema may be underestimated in people with darker skin types, such as skin types V and VI on the Fitzpatrick scale.

Use the Nail Psoriasis Severity Index to assess nail disease in specialist settings:

- if there is a major functional or cosmetic impact **or**
- before and after treatment is initiated specifically for nail disease.

In specialist settings, and if practical in non-specialist settings, use a validated tool to assess the impact of any type of psoriasis on physical, psychological and social wellbeing, for example the:

- Dermatology Life Quality Index (DLQI) for adults **or**
- Children's Dermatology Life Quality Index (CDLQI) for children and young people.

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

Psoriasis

*See Algorithm 1: How to assess people with psoriasis

Assess* the severity and impact of any type of psoriasis:
- at first presentation
- before referral for specialist advice and at each referral point in the treatment pathway
- to evaluate the efficacy of interventions.

Following assessment in a non-specialist setting, refer people for dermatology specialist advice if:
- there is diagnostic uncertainty or
- any type of psoriasis is severe or extensive, eg more than 10% of the body surface area is affected or
- any type of psoriasis cannot be controlled with topical therapy or
- acute guttate psoriasis requires phototherapy or
- nail disease has a major functional or cosmetic impact or
- any type of psoriasis is having a major impact on a person's physical, psychological or social wellbeing.

! People with generalised pustular psoriasis or erythroderma should be referred immediately for same-day specialist assessment and treatment.

Refer children and young people with any type of psoriasis to a specialist at presentation.

Psoriatic arthritis

Offer annual assessment for psoriatic arthritis to people with any type of psoriasis. Assessment is especially important within the first 10 years of onset of psoriasis.

As soon as psoriatic arthritis is suspected, refer the person to a rheumatologist for assessment and advice about planning their care.

Identification of comorbidities

Offer adults with severe psoriasis of any type a cardiovascular risk assessment at presentation using a validated risk estimation tool. Offer further assessment of cardiovascular risk every 5 years, or more frequently if indicated following assessment. For further information see NICE CG67.

Discuss risk factors for cardiovascular comorbidities with people who have any type of psoriasis (and their families or carers). Where appropriate offer preventative advice, healthy lifestyle information and support for behavioural change tailored to meet the needs of the individual in line with the following NICE guidance: CG67; CG43; PH35; PH25; PH24; PH10; PH2; PH13 and PH17.

Be aware that psoriasis of any type, especially if severe, is a risk factor for venous thromboembolism in adults, and:
- explain this risk to adults with any type of psoriasis
- offer advice on how to minimise the risk (for example, during hospital admission, surgery, or periods of immobility)
- manage the risk in line with NICE CG92.

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 NICE CG28.

General points

Patient support and information

Offer people with any type of psoriasis (and their families or carers), support and information tailored to suit their individual needs and circumstances, in a range of different formats so they can confidently understand:
- their diagnosis and treatment options
- relevant lifestyle risk factors
- when and how to treat their condition
- how to use prescribed treatments safely and effectively (eg how to apply topical treatments, how to minimise the risk of side effects through monitoring for safety of medicines)
- when and how to seek further general or specialist review
- strategies to deal with the impact on their physical, psychological and social wellbeing.

For people with multiple comorbidities and/or multimorbidities and any type of psoriasis needing second- or third-line therapy, ensure multidisciplinary working and communication between specialties and, if needed, interdisciplinary team working (eg when both skin and joints are significantly affected).

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.

Algorithm 3: Treatment pathway

First-line

Offer people with psoriasis topical therapy*.

Offer second- or third-line treatment options (phototherapy or systemic therapy) at the same time when topical therapy alone is unlikely to adequately control psoriasis, such as:

- extensive disease (eg more than 10% of body surface area affected) or
- at least 'moderate' on the static Physician's Global Assessment or
- where topical therapy is ineffective, such as nail disease.

*See:

- Algorithm 4: Topical treatment strategies – ADULTS
- Algorithm 5: Topical treatment strategies – CHILDREN AND YOUNG PEOPLE

Second-line (specialist settings)

Offer narrowband ultraviolet B (UVB) phototherapy* to people with plaque or guttate-pattern psoriasis that cannot be controlled with topical treatments alone. Treatment with narrowband UVB phototherapy can be given 3 or 2 times a week depending on patient preference. Tell people receiving narrowband UVB that a response may be achieved more quickly with treatment 3 times a week.

Offer systemic non-biological therapy* 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).

*See Algorithm 6: Phototherapy

*See Algorithm 7: Systemic (non-biological) treatment

Third-line (specialist settings)

Offer biological therapy – see recommendations 99-107 as replicated from the relevant NICE technology appraisals.

[The GDG did not review evidence for any aspect of the use of a first biological agent as guidance on this is already available in the existing NICE technology appraisals 103, 134, 146 and 180.]

Consider changing to an alternative biological drug in adults if:

- the psoriasis does not respond adequately to a first biological drug as defined in NICE technology appraisals (at 10 weeks after starting treatment for infliximab, 12 weeks for etanercept, and 16 weeks for adalimumab and ustekinumab; primary failure) or
- the psoriasis initially responds adequately but subsequently loses this response, (secondary failure) or
- the first biological drug cannot be tolerated or becomes contraindicated.

For adults in whom there is an inadequate response to a second biological drug, seek supra-specialist advice from a clinician with expertise in biological therapy.

If a person has both psoriasis and psoriatic arthritis, take into account both conditions before initiating or making changes to biological therapy and manage their treatment in consultation with a rheumatologist (see also NICE TA199 and NICE TA220).

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.

Site

Trunk and limbs

Offer a potent corticosteroid applied once daily plus vitamin D or a vitamin D analogue applied once daily (applied separately, one in the morning and the other in the evening) for up to 4 weeks as initial treatment. (See also #)
If there is little or no improvement at 4 weeks, discuss the next treatment option with the patient.

If once-daily application of a potent corticosteroid plus once-daily application of vitamin D or a vitamin D analogue does not result in clearance, near clearance or satisfactory control after a maximum of 8 weeks, offer vitamin D or a vitamin D analogue alone applied twice daily.

If twice-daily application of vitamin D or a vitamin D analogue does not result in clearance, near clearance or satisfactory control after 8–12 weeks, offer either:

- a potent corticosteroid applied twice daily for up to 4 weeks (see also #) or
- a coal tar preparation applied once or twice daily.

If a twice-daily potent corticosteroid or coal tar preparation cannot be used or a once-daily preparation would improve adherence offer a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily for up to 4 weeks. (See also #)

Face, flexures and genitals

Offer a short-term mild or moderate potency corticosteroid^ applied once or twice daily (for a maximum of 2 weeks).

^ Please refer to recommendation 55 and the footnote for off-label usage.

If the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is serious risk of local corticosteroid-induced side effects, offer a calcineurin inhibitor^ applied twice daily for up to 4 weeks. Calcineurin inhibitors should be initiated by healthcare professionals with expertise in treating psoriasis.

^ Please refer to recommendation 57 and the footnote for off-label usage.

Scalp

Offer a potent corticosteroid applied once daily for up to 4 weeks as initial treatment. (See also #)

If treatment with a potent corticosteroid does not result in clearance, near clearance or satisfactory control after 4 weeks consider:

- a different formulation of the potent corticosteroid (eg a shampoo or mousse) and/or
- topical agents to remove adherent scale (eg agents containing salicylic acid, emollients and oils) before application of the potent corticosteroid. (See also #)

If the response to treatment with a potent corticosteroid remains unsatisfactory after a further 4 weeks of treatment offer:

- a combined product containing calcipotriol monohydrate and betamethasone dipropionate^ applied once daily for up to 4 weeks or
- vitamin D or a vitamin D analogue applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis).

^ Please refer to recommendation 51 and the footnote for off-label usage.

If continuous treatment with either a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily or vitamin D or a vitamin D analogue applied once daily for up to 8 weeks does not result in clearance, near clearance or satisfactory control offer:

- a very potent corticosteroid applied up to twice daily for 2 weeks (see also #) or
- coal tar applied once or twice daily or
- referral to a specialist for additional support with topical applications and/or advice on other treatment options.

*Adults not controlled with topical therapy, see:

- Algorithm 6: Phototherapy
- Algorithm 7: Systemic (non-biological) treatment

In people whose psoriasis has not responded satisfactorily* to a topical treatment strategy, before changing to an alternative treatment:

- discuss with the person whether they have any difficulties with application, cosmetic acceptability or tolerability and where relevant offer an alternative formulation
- consider other possible reasons for non-adherence in line with NICE CG76.

General points

When offering topical therapy

Offer practical support and advice about the use and application of topical treatments. Advice should be provided by healthcare professionals who are trained and competent in the use of topical therapies.

- take into account patient preference, cosmetic acceptability, practical aspects of application and the site(s) and extent of psoriasis to be treated
- discuss the variety of formulations available and, depending on the patient's preference, use:
  - cream, lotion or gel for widespread psoriasis
  - lotion, solution or gel for the scalp or hair-bearing areas
  - ointment to treat areas with thick adherent scale
- be aware that topical treatment alone may not provide satisfactory disease control, especially in people with psoriasis that is extensive (eg more than 10% of body surface area affected) or at least 'moderate' on the static Physician's Global Assessment.

Maintaining control

Discuss with people whose psoriasis is responding to topical treatment:

- the importance of continuing treatment until a satisfactory outcome is achieved (eg clear or nearly clear) or up to the recommended maximum treatment period for corticosteroids (see section 8)
- that relapse occurs in most people after treatment is stopped
- that after the initial treatment period topical treatments can be used when needed to maintain satisfactory disease control.

Offer a supply of their topical treatment to keep at home for self-management.

Aim for a break of 4 weeks between courses of treatment with potent or very potent corticosteroids.
Consider topical treatments that are not steroid-based (eg vitamin D or vitamin D analogues or coal tar) as needed to maintain psoriasis disease control during this period.

Using corticosteroids safely

Be aware that continuous use of potent or very potent corticosteroids may cause:

- irreversible skin atrophy and striae
- psoriasis to become unstable
- systemic side effects when applied continuously to extensive psoriasis (eg more than 10% of body surface area affected).

Explain the risks of these side effects and discuss how to avoid them.

Do not use potent or very potent corticosteroids on the face, flexures or genitals.
Do not use very potent corticosteroids continuously at any site for longer than 4 weeks.
Do not use potent corticosteroids continuously at any site for longer than 8 weeks.

Offer a review at least annually to those using intermittent or short-term courses of a potent or very potent corticosteroid (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

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.

Site

Trunk and limbs

Consider[1] either:
- calcipotriol applied once daily (only for those over 6 years of age) or
- a potent corticosteroid applied once daily (only for those over 1 year of age).

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.

Face, flexures and genitals

Offer[1] a short-term mild or moderate potency corticosteroid^ applied once or twice daily.

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.
^ Please refer to recommendation 55 and the footnote for off-label usage.

Scalp

Offer[1] a potent corticosteroid applied once daily as initial treatment. (See also #)

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.

If treatment with a potent corticosteroid does not result in clearance, near clearance or satisfactory control, consider[1]:
- a different formulation of the potent corticosteroid (eg a shampoo or mousse) and/or
- topical agents to remove adherent scale (eg agents containing salicylic acid, emollients and oils) before application of the potent corticosteroid. (See also #)

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.

If the response to treatment with a potent corticosteroid remains unsatisfactory, offer[1]:
- a combined product containing calcipotriol monohydrate and betamethasone dipropionate^ applied once daily or
- vitamin D or a vitamin D analogue applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis).

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.
^ Please refer to recommendation 51 and the footnote for off-label usage.

If continuous treatment with either a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily or vitamin D or a vitamin D analogue applied once daily does not result in clearance, near clearance or satisfactory control offer[1]:
- coal tar applied once or twice daily or
- referral to a specialist for additional support with topical applications and/or advice on other treatment options.

[1]Please refer to the BNF for children for information on appropriate dosing and duration of treatment.

*CYP not controlled with topical therapy, see:
- Algorithm 6: Phototherapy
- Algorithm 7: Systemic (non-biological) treatment

In people whose psoriasis has not responded satisfactorily* to a topical treatment strategy, before changing to an alternative treatment:
- discuss with the person whether they have any difficulties with application, cosmetic acceptability or tolerability and where relevant offer an alternative formulation
- consider other possible reasons for non-adherence in line with NICE CG76.

General points

When offering topical therapy

Offer practical support and advice about the use and application of topical treatments. Advice should be provided by healthcare professionals who are trained and competent in the use of topical therapies.

- take into account patient preference, cosmetic acceptability, practical aspects of application and the site(s) and extent of psoriasis to be treated
- discuss the variety of formulations available and, depending on the patient's preference, use:
  - cream, lotion or gel for widespread psoriasis
  - lotion, solution or gel for the scalp or hair-bearing areas
  - ointment to treat areas with thick adherent scale
- be aware that topical treatment alone may not provide satisfactory disease control, especially in people with psoriasis that is extensive (eg more than 10% of body surface area affected) or at least 'moderate' on the static Physician's Global Assessment.

Maintaining control

Discuss with people whose psoriasis is responding to topical treatment:
- the importance of continuing treatment until a satisfactory outcome is achieved (eg clear or nearly clear) or up to the recommended maximum treatment period for corticosteroids (see section 8)
- that relapse occurs in most people after treatment is stopped
- that after the initial treatment period topical treatments can be used when needed to maintain satisfactory disease control.

Offer a supply of their topical treatment to keep at home for self-management.

Aim for a break of 4 weeks between courses of treatment with potent corticosteroids. Consider topical treatments that are not steroid-based (eg vitamin D or vitamin D analogues or coal tar) as needed to maintain psoriasis disease control during this period.

Using corticosteroids safely

Do not use very potent corticosteroids in children and young people.

Offer a review at least annually to those using corticosteroids of any potency (either as monotherapy or in combined preparations) to assess for the presence of steroid atrophy and other adverse effects.

Be aware that continuous use of potent corticosteroids may cause:
- irreversible skin atrophy and striae
- psoriasis to become unstable
- systemic side effects when applied continuously to extensive psoriasis (eg more than 10% of body surface area affected).

Explain the risks of these side effects and discuss how to avoid them.

Algorithm 6: Phototherapy

UVB

Offer narrowband ultraviolet B (UVB) phototherapy to people with plaque or guttate-pattern psoriasis that cannot be controlled with topical treatments alone. Treatment with narrowband UVB phototherapy can be given 3 or 2 times a week depending on patient preference. Tell people receiving narrowband UVB that a response may be achieved more quickly with treatment 3 times a week.

Offer alternative second- or third-line treatment when:

- narrowband UVB phototherapy results in an unsatisfactory response or is poorly tolerated or
- there is a rapid relapse following completion of treatment (rapid relapse is defined as greater than 50% of baseline disease severity within 3 months) or
- accessing treatment is difficult for logistical reasons (for example, travel, distance, time off work or immobility) or
- the person is at especially high risk of skin cancer.

See Algorithm 3: Treatment pathway

See Algorithm 7: Systemic (non-biological) treatment

PUVA

When considering PUVA for psoriasis (plaque type or localised palmoplantar pustulosis) discuss with the person:

- other treatment options
- that any exposure is associated with an increased risk of skin cancer (squamous cell carcinoma)
- that subsequent use of ciclosporin may increase the risk of skin cancer, particularly if they have already received more than 150 PUVA treatments
- that risk of skin cancer is related to the number of PUVA treatments.

Consider psoralen^ (oral or topical) with local ultraviolet A (UVA) irradiation to treat palmoplantar pustulosis.

^ Please refer to recommendation 62 and the footnote for off-label usage.

Do not routinely offer co-therapy with acitretin when administering PUVA.

Managing skin cancer risk

Do not use PUVA in people with psoriasis of any type and a genetic predisposition to skin cancer for example, xeroderma pigmentosum or familial melanoma.

Do not routinely use phototherapy (narrowband UVB, broadband UVB or psoralen plus UVA [PUVA]) as maintenance therapy.

Ensure that a permanent record of the person's cumulative number of UV treatments is kept (eg in a national record).

Do not use PUVA when other appropriate treatments are available in:

- people with a personal history of skin cancer or
- people who have already received 150 PUVA treatments or
- children.

Use PUVA with caution or consider other treatment options in:

- people at risk of skin cancer (melanoma and non-melanoma type) (see 'Improving outcomes for people with skin tumours including melanoma' [NICE cancer service guidance])
- people with lighter skin types, such as skin types I or II on the Fitzpatrick scale
- people who are likely to require ciclosporin or long-term methotrexate
- young people.

Offer lifetime skin cancer surveillance to people treated with PUVA who have:

- had more than 150 PUVA treatments or
- developed skin cancer.

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^ 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.

^ 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^ 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.

^ 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.