

# **Psoriasis**

## **Report by the Secretariat**

1. The report aims to provide a basis for discussion of psoriasis, with information on its prevalence, aetiology, natural history, health-related quality of life, diagnosis, management, research needs, and implications for health care services, as well as country-level actions that can strengthen the care of people with psoriasis.

### **Features of psoriasis**

2. Psoriasis is a noncommunicable disease that manifests as a chronic inflammatory skin disease. It is characterized by sharply demarcated, scaly, red, coin-sized skin lesions most often on the elbows, knees, scalp, hands and feet. Symptoms include itching, irritation, stinging and pain. Rarely, the entire skin surface of the body may be involved; this extensive form of psoriasis can be fatal, as the extreme inflammation and peeling of skin can disrupt the body's ability to regulate temperature and damage the skin's barrier functions.

3. About 10% of individuals with psoriasis develop arthritis, which may affect the hands, feet, wrists, ankles, neck and lower back. In some cases joints become deformed, causing significant disability. Fingernails and toenails may be affected by scaling and crust formation and there may be shedding of nail plates, causing disfigurement.

4. The manifestations of psoriasis are not limited to the skin. Comorbidities may complicate moderate to severe psoriasis. In particular, the relative risks of ischaemic heart disease, stroke, hypertension, dyslipidaemia, diabetes and Crohn disease are increased in people with psoriasis. The higher rates of hypertension and diabetes may partly explain the increased risk of heart attacks, stroke, and cardiovascular mortality in people with severe psoriasis, reported in large population-based cohort studies.

5. The impact of psoriasis may change the behaviour of affected individuals, resulting in obesity, increased alcohol consumption and an increased incidence of smoking. Smoking has been suggested to elicit psoriasis, whereas obesity appears to be a result of behavioural change in response to the condition. The reported relationship between alcoholism and psoriasis is possibly due to the psychological impact of psoriasis on affected individuals.

## Prevalence

6. The worldwide prevalence of psoriasis is around 2%, but studies in developed countries have reported higher prevalence rates of on average about 4.6%.<sup>1</sup> Nearly two thirds of people with psoriasis have a mild form of the disease, with less than 3% of the skin surface of the body affected, but others have more extensive involvement of the skin.

## Natural history

7. In about three-quarters of patients, the onset of psoriasis is before the age of 40 years, and in about one-third it appears before the age of 20 years. Psoriasis occurs in 0.70% of children. The natural history of the disease is usually chronic with intermittent remissions and exacerbations. However, periods of complete remission do occur and remissions of five years or more have been reported in a minority of cases.

## Aetiology

8. The cause of psoriasis is not fully understood. Abnormal keratin formation, epidermal proliferation, activation of the immune system and hereditary factors appear to play roles in the pathogenesis of the disease. Psoriasis occurs more frequently in some families. The risk of a child developing psoriasis is 41% if both parents are affected with psoriasis, 14% if one parent is affected and 6% if one sibling is affected.

9. Both external and systemic factors can trigger psoriasis in genetically predisposed individuals. In about a quarter of people with psoriasis, lesions are provoked by injury to the skin. Psoriatic lesions can also be induced by sunburn and skin diseases. Psychogenic stress also can trigger psoriasis with initial presentations of the disease as well as exacerbations being seen a few weeks to months after a stressful event.

10. In up to 45% of cases, bacterial infections may induce or aggravate psoriasis. Pharyngitis is the most common trigger but dental abscesses and skin infections may also be triggers. HIV infection may aggravate psoriasis; in HIV-positive patients psoriasis is more often resistant to treatment and more frequently associated with arthritis.

11. Several medicines are known to induce psoriasis, including lithium salts, interferon,  $\beta$ -blockers and antimalarial agents, and the discontinuation of corticosteroids may have a similar consequence.

## Impact on health-related quality of life

12. Psoriasis affects health-related quality of life to an extent similar to other noncommunicable diseases. Depending on the severity and location of skin lesions, individuals may experience significant physical discomfort and disability. Itching and pain can interfere with basic functions, such as self-care and sleep. Skin lesions in the hands can prevent individuals from working at certain occupations, engaging in sports and caring for family members at home.

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<sup>1</sup> Parisi R, Symmons DPM, Griffiths CEM, Ashcroft DM, the Identification and Management of Psoriasis and Associated Comorbidity project team. Global epidemiology of psoriasis: a systematic review of incidence and prevalence. *Journal of Investigative Dermatology*, 2013, **133**:377–385.

13. Afflicted individuals may feel self-conscious about their appearance and have a poor self-esteem that stems from fear of public rejection and psychosexual concerns. They are known to suffer psychological distress, especially as a result of stigmatization, which can cause discrimination in employment and social isolation. Many studies have documented higher rates of depression and anxiety among people with psoriasis compared to the general population. Epidemiological studies have indicated that children with psoriasis may have a higher risk of developing psychiatric disorders compared to children without psoriasis.

### **Diagnosis and management of psoriasis**

14. The diagnosis of psoriasis is usually based on the presence of typical skin lesions. There are no special blood tests or diagnostic procedures. Rarely, a skin biopsy or scraping may be needed to exclude other disorders and to confirm the diagnosis.

15. Currently there is no cure for psoriasis and treatment is directed at decreasing signs and symptoms and modifying the natural progression of the disease. A repertoire of topical and systemic therapies is available for the treatment of psoriasis, such as vitamin D<sub>3</sub> analogues, corticosteroids, coal tar, dithranol, phototherapy, methotrexate, cyclosporine, systemic retinoids and biologics. Typically, topical agents are used for mild disease, phototherapy for moderate disease and systemic agents for severe disease.

16. The management of psoriasis is not restricted to the treatment of the skin lesions, but also aims to deal with the different comorbidities. Health professionals need to be aware of the likelihood of comorbid conditions in order to ensure their early detection and also to manage psoriasis with consideration of the possible impact on associated comorbidities. Patients with severe psoriasis should be screened for cardiovascular risk factors and receive appropriate counselling and treatment. Ensuring a healthy diet and appropriate levels of physical activity and management of other risk factors including over-weight are important elements of care. Weight reduction may enhance the efficacy of psoriasis treatment, as demonstrated in recent studies.

17. The long-term management of psoriasis requires tailoring therapy to the individual, reconciling the extent of the disease and the patient's perception of the severity of the disease as well as the potential side effects of the specific treatments. It is noteworthy that, in surveys of patients with psoriasis, significant numbers report frustration with the ineffectiveness of their current treatment, and an unmet medical need persists as no long-term solutions are available for most patients.

### **Need for research**

18. Further research is needed into the pathogenesis of psoriasis, novel treatments, and the reasons for comorbidities and their implications on treatment and management of psoriasis.

### **Implications for health care services**

19. Interventions to manage psoriasis should be part of existing health care services in primary care. Services should combine the best possible patient care, encompassing patient education, counselling and the availability of different treatment options. Depending on countries' health care capacities, these services should go beyond primary care to include dermatologists and relevant specialist clinical services in secondary and tertiary health care.

20. Patients with psoriasis, like many patients with other noncommunicable diseases, often have multiple comorbidities and complex needs for health care. It is important to consider where the balance should be struck between care provided by professionals with generalist training, able to tackle a wide range of problems at one consultation, and care provided by a wide range of specialists with cross-referral between themselves.

21. A strong programmatic and multidisciplinary approach to disease management that includes the coordination of care with specialists and other health care professionals, as well as consideration of patients' needs and preferences are central to the management of all noncommunicable diseases including psoriasis. The Secretariat has an important potential role to play in identifying successful approaches for integrating management of psoriasis into existing services for noncommunicable diseases at all levels of care.

### **Potential actions to strengthen services**

22. There are several country-level actions that can support the development and strengthening of services for the care of people with psoriasis. Many of the services and interventions for managing psoriasis are already within the reach of low-income and middle-income countries; others can be added as needs and resources determine.

23. Key actions to improve the care of people with psoriasis include:

- (a) ensuring the commitment of policy-makers and provision of adequate managerial support;
- (b) improving access to services and essential medicines to manage psoriasis;
- (c) education and training for health care providers, particularly in primary care settings;
- (d) creation of a core network of dermatologists and other relevant specialists that can be expanded in response to demand;
- (e) organization of health-education, counselling and self-care programmes for patients with psoriasis;
- (f) establishment of effective mechanisms that foster the development of organizations, providing support for people with psoriasis and their families.

### **ACTION BY THE EXECUTIVE BOARD**

24. The Board is invited to note this report.

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