PSORIASIS CLINICAL PATHWAY

Adapted from **Rizal Medical Center Psoriasis Clinical Pathway** *(2019)*
Reviewed by **PDS Photodermatology Subspecialty Core Group** *(2021)*

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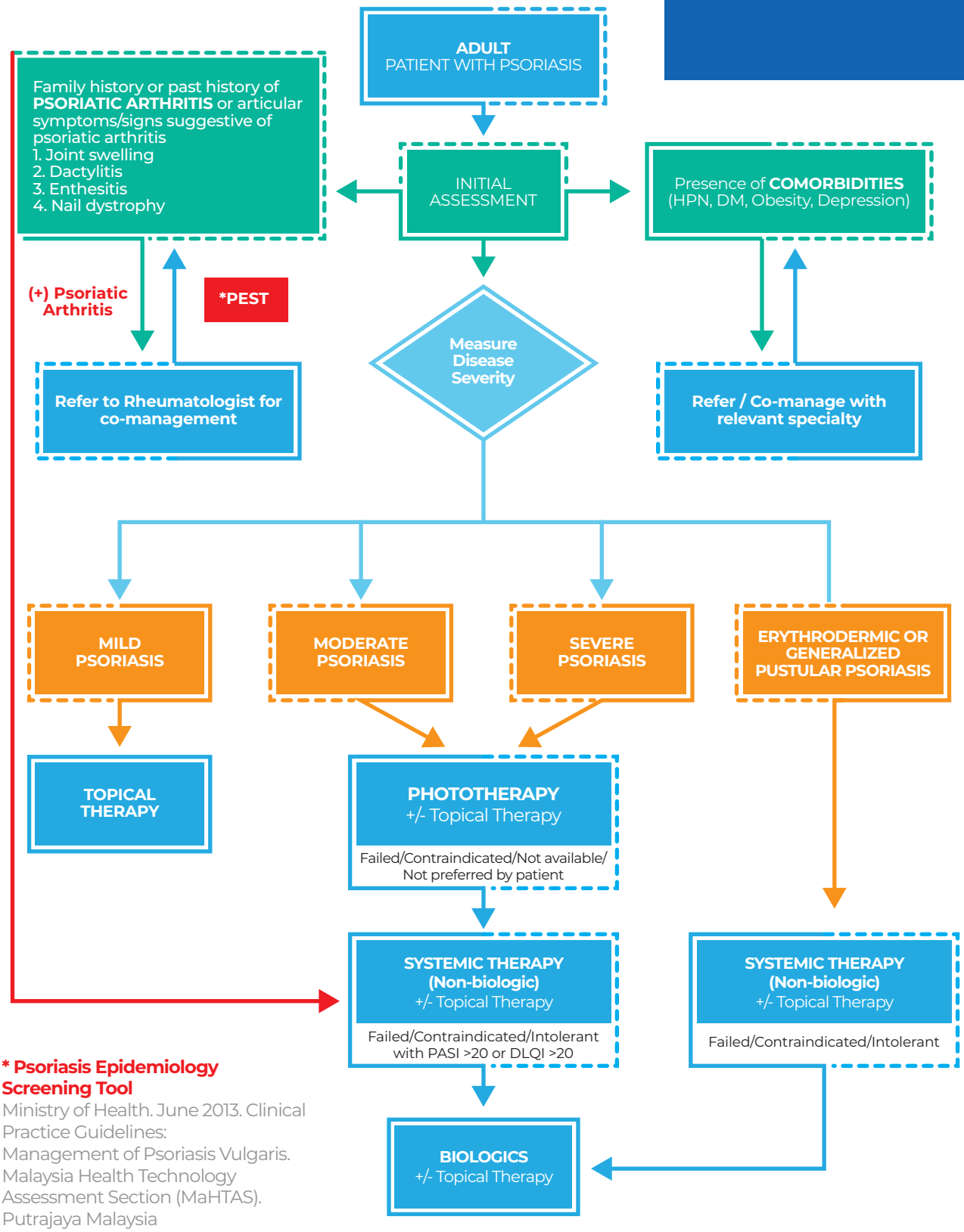

*** Psoriasis Epidemiology Screening Tool**

Ministry of Health. June 2013. Clinical Practice Guidelines: Management of Psoriasis Vulgaris. Malaysia Health Technology Assessment Section (MaHTAS). Putrajaya Malaysia

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CLASSIFICATION	RIZAL MEDICAL CENTER PSORIASIS CLINICAL PATHWAY (2019)			*PDS PHOTODERM SUBSPECIALTY RECOMMENDATIONS (2021)	
	Disease Severity		Treatment	Disease Severity (Consider the highest grading)	Treatment
MILD	MILD	PASI ≤10 DLQI ≤10	*TOPICAL TX*	**BSA < 3%** PASI <5 **DLQI <5**	*TOPICAL TX*
		PASI ≤10 DLQI ≥10	*PHOTOTHERAPY and/or SYSTEMIC TX +/- TOPICAL TX*		
MODERATE	MODERATE TO SEVERE	PASI >10 DLQI ≤10		**BSA 3% - 10%** PASI 5 – 10 **DLQI 5 - 10**	*PHOTOTHERAPY and/or SYSTEMIC TX +/- TOPICAL TX*
SEVERE		PASI >10 DLQI >10		**BSA >10%** PASI >10 **DLQI >10**	
ERYTHRODERMIC OR GPP	**(BSA) (DLQI) +(PRO)** + Patient reported outcomes		*SYSTEMIC TX +/- TOPICAL TX*		*SYSTEMIC TX +/- TOPICAL TX*

*IMAFUKU, S. et.al. **Asian consensus on assessment and management of mild to moderate plaque psoriasis with topical therapy.** Journal of Dermatology 2018 Ministry of Health. June 2013. Clinical Practice Guidelines: Management of Psoriasis Vulgaris. Malaysia Health Technology Assessment Section (MaHTAS). Putrajaya Malaysia

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TOPICAL THERAPY FOR PSORIASIS:

Trunk and Limbs

Initial Treatment:

* **Potent corticosteroid** OD-BID X **4 weeks** OR
* **Very potent corticosteroid** (for rapid response & only for limited plaques) OD- BID X **2 weeks** OR **Potent corticosteroid OD and vitamin D or vitamin D analogue OD** (separately) x **4 weeks.**

* VP or P CS Max. 50 g/week

2-4 weeks

If no clearance, near clearance or satisfactory control, ** **vitamin D or a vitamin D analogue alone BID.**

** Max.100 g/week

8-12 weeks

If no clearance, near, clearance or satisfactory control after 8–12 weeks offer either: • combined product: *** c**alcipotriol monohydrate and betamethasone dipropionate OD x 4 weeks.**

*** Max. 15 g daily or 100 g weekly

Adjunct topicals: Emollients, Tar, Salicylic acid

Scalp

Initial Treatment:

Potent corticosteroid solution OD x **4 weeks OR Very potent** corticosteroid (for rapid response and only for limited plaques) BID x **2 weeks.**

2-4 weeks

If no clearance, near clearance or satisfactory control after **4 weeks** consider:

• a different formulation of the potent corticosteroid (for example, a shampoo) **and/or**

• topical agents to remove adherent scale before application of the potent corticosteroid.

4 weeks

If response remains unsatisfactory after a further **4 weeks** of treatment offer:

• a combined product **containing calcipotriol monohydrate and betamethasone dipropionate OD** for up to **4 weeks.**

4 weeks

If continuous treatment for up to **8 weeks** does not result in clearance, near clearance or satisfactory control offer:

• a **very potent** corticosteroid solution BID x **2 weeks.**

Face, Genitals, Flexures

Initial Treatment:

Mild or moderate potency corticosteroid BID x 2 weeks.

2 weeks

For adults with psoriasis of the **face, flexures or genitals** 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 BID x 4 weeks.**

If treatment is unsatisfactory, please see phototherapy or systemic treatment pathway.

Suggested reassessment : initial review after 4 weeks; treatment unsatisfactory- if no control after 12 weeks

National Institute for Health and Care Excellence (2017) Assessment and Management of Psoriasis (NICE Guideline 153)
Ministry of Health. June 2013. Clinical Practice Guidelines: Management of Psoriasis Vulgaris. Malaysia Health Technology Assessment Section (MaHTAS). Putrajaya Malaysia

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PHOTOTHERAPY:

For patients with moderate or severe psoriasis (including subacute to chronic exfoliative dermatitis) or if topical treatment is unsatisfactory

Persons with **guttate** or **plaque** psoriasis that cannot be controlled with topical treatments alone

Offer **Narrowband UV** phototherapy.
Refer to a phototherapy specialist.

Persons with **palmoplantar pustulosis**

Offer **Psoralen with local UVA** irradiation (PUVA).
Refer to a phototherapy specialist.

Photodermatology Directory (PDS Website)

If treatment is unsatisfactory or poorly tolerated;
there is *rapid relapse following completion of treatment;
accessing treatment is difficult for logistical reasons;
or patient is at high risk of skin cancer,
Please see SYSTEMIC pathway.

Suggested reassessment – after 12 weeks

*Rapid relapse is defined as greater than 50% of baseline disease severity within 3 months.

National Institute for Health and Care Excellence (2017) Assessment and Management of Psoriasis (NICE Guideline 153)

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SYSTEMIC NON-BIOLOGIC THERAPY:

For patients with moderate or severe psoriasis, or if phototherapy +/- topical tx is unsatisfactory. All patients who will undergo systemic treatment should have normal baseline screening.

Methotrexate

- Initial drug of choice

Dosage:
Incremental dosing of methotrexate starting with an initial dose of **5-10 mg once a week** and gradually increase up to an effective dose. Maximum is **25 mg a week.**

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

Supplement with **folic acid** 5 mg once a day (except the day of methotrexate) or 5mg once a week (the day after methotrexate)

Assess tx after 3 months at the target dose

Please see pathway for monitoring AE.

If treatment is inadequate

Cyclosporine

- For short term control (e.g. psoriatic flare, erythrodermic, generalized pustular)
- Palmoplantar pustulosis
- Considering conception (men and women)

Dosage:
Use **2.5-3 mg/kg** a day of cyclosporine. **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.

Use the lowest possible therapeutic dose of cyclosporine to maintain remission for **1 year.**
Consider other treatment options when disease relapses rapidly on stopping cyclosporine therapy*

Do not use cyclosporine continuously for more than 1 year unless disease is severe or unstable and other treatment options, including systemic biological therapy, cannot be used.

Assess tx after 3 months at the target dose

Acitretin

- Pustular psoriasis (1st line)
- If methotrexate and cyclosporine are not appropriate or failed

Dosage
Use incremental dosing of acitretin to minimize mucocutaneous side effects and achieve a target dose of **25 mg** daily in adults. Consider dose escalation to a maximum of **50 mg OD** when no other treatment options are available.

Assess tx after 4 mons at the target dose

If treatment is unsatisfactory or poorly tolerated, please see biologics pathway

Suggested reassessment – after 12 weeks

*Rapid relapse is defined as greater than 50% of baseline disease severity within 3 months.

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National Institute for Health and Care Excellence (2017) Assessment and Management of Psoriasis (NICE Guideline 153)

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MONITORING:

METHOTREXATE:

Repeat **complete blood count, AST & ALT,** and **creatinine** within **2 weeks** of initiation.

Monitor CBC, AST & ALT and creatinine
- o Every **1 to 2 weeks** during dose escalation
- o **Monthly** for the first 3 months
- o Subsequently **every 1 to 3 months**

Do blood tests **5 - 7 days** after last dose of MTX

Consider procollagen III aminopeptide / **fibroscan / fibrotest / liver biopsy:**
without risk factors for hepatotoxicity - cumulative dose of **3.5 to 4.0g**
with risk factors for hepatotoxicity – cumulative dose of **1.0 to 1.5g**

CYCLOSPORINE:

Blood pressure, creatinine, AST & ALT, complete blood count, serum bilirubin (if clinically indicated), and **magnesium** monitored **monthly**

ACITRETIN:

Get baseline **lipid profile** and **AST & ALT** and repeat every **4 - 8 weeks** during dose escalation, then **every 12 weeks**

Thrombocytopenia/ Anemia/ Neutropenia

STOP TREATMENT & GIVE ALTERNATIVE

Raised AST & ALT

Repeat **Hep B / C** screening

positive

Refer to Gastroenterologist/ hepatologist

negative

(+) RISK FACTORS hepatoxicity

NO

YES

Persistent AST & ALT elevation (>2 fold for 2 to 3 months)

>3 fold above normal limits of AST & ALT

2-3 fold above normal limits of AST & ALT

Repeat AST & ALT in **2 to 4 weeks. Decrease dose** as needed.

Persistent elevation in **5 out of 9** AST & ALT in a year

Consider procollagen III, fibroscan©, fibrotest / liver biopsy **Consider other treatment**

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OTHER SYSTEMIC AGENTS FOR PSORIASIS:

NOTE: These medications are NOT FDA-approved for psoriasis.
May have value for psoriasis in certain instances.

Available in the Philippines

- HYDROXYUREA
- MYCOPHENOLATE MOFETIL
- AZATHIOPRINE
- TOFACITINIB
- TACROLIMUS
- +ISOTRETINOIN

Not Available in the Philippines
AS OF 2021

- THIOGUANINE
- LEFLUNOMIDE
- FUMARIC ACID ESTERS

- *Apremilast – FDA approved, not yet available in the Philippines*

Sources:

- Menter A. et.al. Joint American Academy of Dermatology National Psoriasis Foundation Guidelines of care for the management of psoriasis with systemic nonbiologic therapies. JOURNAL OF AMERICAN ACADEMY OF DERMATOLOGY. JUNE 2020, Vol. 82, No.6:1445-86. https://doi.org/10.1016/j.jaad.2020.02.044

+ Chu S. et.al. Oral isotretinoin for the treatment of dermatologic conditions other than acne: a systematic review and discussion of future directions. ARCHIVES OF DERMATOLOGICAL RESEARCH. NOV. 2020. doi: 10.1111/1346-8138.14338

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SYSTEMIC BIOLOGIC TREATMENT:

For patients with moderate or severe psoriasis, or if other treatment modalities are unsatisfactory.
All patients who will undergo systemic treatment should have normal baseline screening.

Child/Young: Moderate to Severe Psoriasis

Adalimumab (≥4 y/o) | **Etanercept** (≥6 y/o)
Ustekinumab (≥12 y/o) | **Secukinumab**+ (≥6 y/o)

Adult with Moderate to Severe Psoriasis PASI >10 and DLQI >10

Adalimumab, *Etanercept, Secukinumab, Ustekinumab, *Infliximab, Guselkumab, Ixekizumab

*with biosimilars

Review Response

Infliximab (10 wks)
Etanercept (12 wks)
Secukinumab (12wks)
Ustekinumab (12 wks)
Adalimumab (16 wks)
Guselkumab (16 wks)

PASI < 50

Stop Biologic Therapy
Consider other biologic

PASI 50 to 74 and DLQI >5 improvement

Escalate dose
Consider combination w/ methotrexate or UVB

PASI 75 OR PASI >50 + DLQI ≤ 5

Continue Biologic Therapy

Review every 24 weeks

+ National Psoriasis Foundation 2021, accessed 22 June 2022, <https://www.psoriasis.org/advance/cosentyx-receives-pediatric-indication/>
Ministry of Health. June 2013. Clinical Practice Guidelines: Management of Psoriasis Vulgaris. Malaysia Health Technology Assessment Section (MaHTAS). Putrajaya Malaysia

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BASELINE SCREENING FOR SYSTEMIC TREATMENT:

HISTORY AND EXAMINATION:

For the following established or suspected conditions, clear with specialist or give alternative treatment:

1) Tuberculosis (TB) (Internal Medicine/ Infectious disease/Pulmonologist)
2) Malignancy
3) Active infection other than TB, HIV-AIDS or viral hepatitis
4) HIV-AIDS (HACT team)
5) Hepatitis B or C
6) Congestive heart failure
7) Demyelinating disease
8) Pregnancy, Desire for pregnancy, or Breast-feeding

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BASELINE SCREENING FOR SYSTEMIC TREATMENT:

REQUIRED INITIAL LABORATORY TESTS:

- CBC
- AST & ALT
- Creatinine

* Chest X-ray
* PPD Test

*Screening for TB: If symptomatic or with hx of PTB or any CXR abnormalities in the past
➔ DO CXR. Otherwise, do PPD Test.

OPTIONAL LABORATORY TESTS, IF CLINICALLY INDICATED:

- ESR/CRP
- Urinalysis
- Lipid profile
- Fasting blood sugar
- Interferon gamma release assay (TB Quantiferon)
- HBsAg – Required prior to biologic use (If positive, refer to Gastoenterologist)
- Hepatitis B core antibody- If positive refer Gastroenterologist
- HCV Ab - If positive refer Gastroenterologist
- ANA – If positive to refer Rheumatologist
- Urine pregnancy test (UPT)
- COVID-19 TEST (as indicated)

PATIENT EDUCATION & COUNSELING

Ministry of Health. June 2013. Clinical Practice Guidelines: Management of Psoriasis Vulgaris. Malaysia Health Technology Assessment Section (MaHTAS). Putrajaya Malaysia

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PSORIASIS CLINIC CHECKLIST (1ST VISIT)

PROCESS	OUTPATIENT PSORIASIS CLINIC	1ST VISIT DATE: MM DD YYYY YES	NO	REMARKS
HISTORY TAKING / CHECK FOR COMORBIDITIES / PSORIATIC ARTHRITIS	Current and previous history of TB infection			
	Current and previous history of malignancy			
	Active infection			
	HIV infection			
	Hepatitis B / Hepatitis C infection			
	Congestive heart failure			
	Demyelinating disease			
	Pregnancy			
	(For women) Intention to get pregnant			
	Currently breastfeeding			
	Check for joint pains			
	Vital signs (BP, PR, RR, Temp)			
PHYSICAL EXAMINATION	Weight / BMI			
	Skin Examination			
	Nail Examination			
	Hair/scalp examination			
	Examination of joints			
	PASI score			
	DLQI score			
DIAGNOSTICS / LABORATORIES / RADIOLOGIC EXAMINATION	Skin biopsy (if indicated)			
	REQUIRED INITIAL ANCILLARIES:			
	CBC			
	AST & ALT			
	Creatinine			
	Chest x-ray			
	OPTIONAL ANCILLARIES:			
	ESR / CRP			
	Urinalysis			
	Lipid profile			
	Fasting blood sugar			
	HBsAg			
	Hepatitis B core Ab			
	HCV Ab			
	ANA			
	PPD Test			
	Interferon gamma release assay			
	Urine Pregnancy Test			
THERAPEUTICS	Topical medications (as indicated)			
	Phototherapy (as indicated)			
	Non-biologic systemic oral/parenteral medication (as indicated)			
	Biologic medication (as indicated)			
PATIENT EDUCATION	Diet / Nutrition			
	Weight reduction (if necessary)			
	Smoking cessation (if necessary)			
	Regular exercise			
REFERRALS (as needed for management of comorbidities/ complications/ need for financial assistance)	Rheumatology (psoriatic arthritis)			
	Endocrinology (diabetes mellitus)			
	Cardiology (hypertension, cardiovascular disease)			
	Gastroenterology (IBD)			
	Pulmonology (pulmonary TB)			
	Pediatrics (pediatric cases)			
	Pediatric rheumatology (pediatric patient with psor arthritis)			
	Ophthalmology (uveitis)			
	Mental health / Psychiatry (depression)			
	Dietician / Nutritionist (overweight/obese)			
	Rehab medicine (complications of psoriatic arthritis)			
	Social service (financial assistance)			
FOLLOW-UP	Appointment schedule			
DISCHARGE	Review the checklist & pathway			

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PSORIASIS CLINIC CHECKLIST (FOLLOW-UP)

PROCESS	OUTPATIENT PSORIASIS CLINIC	VISIT NO. MM DD YYYY YES	VISIT NO. MM DD YYYY NO	REMARKS	VISIT NO. MM DD YYYY YES	VISIT NO. MM DD YYYY NO	REMARKS
HISTORY TAKING	Ask for associated symptoms						
	Review of systems						
	Check for joint pains						
PHYSICAL EXAMINATION	Vital signs (BP, PR, RR, Temp)						
	Weight / BMI						
	Skin Examination						
	Nail Examination						
	Hair/scalp examination						
	Examination of joints						
	PASI score						
	DLQI score						
DIAGNOSTICS / LABORATORIES / RADIOLOGIC EXAMINATION	*On Methotrexate:*						
	CBC						
	AST & ALT						
	Creatinine						
	Fibroscan (if indicated)						
	Liver biopsy (if indicated)						
	On Cyclosporine:						
	CBC						
	AST & ALT						
	Creatinine						
	Serum bilirubin (if indicated)						
	Magnesium (if indicated)						
	On Acitretin:						
	AST & ALT						
	Lipid profile						
THERAPEUTICS	Topical medications (if indicated)						
	Phototherapy (if indicated)						
	Non-biologic systemic						
	oral/parenteral medication (if indicated)						
	Biologic medication (if indicated)						
PATIENT EDUCATION	(as indicated)						
REFERRALS	(as indicated)						
FOLLOW-UP	Appointment schedule						
DISCHARGE	Review the checklist and pathway						

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ACKNOWLEDGMENT

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