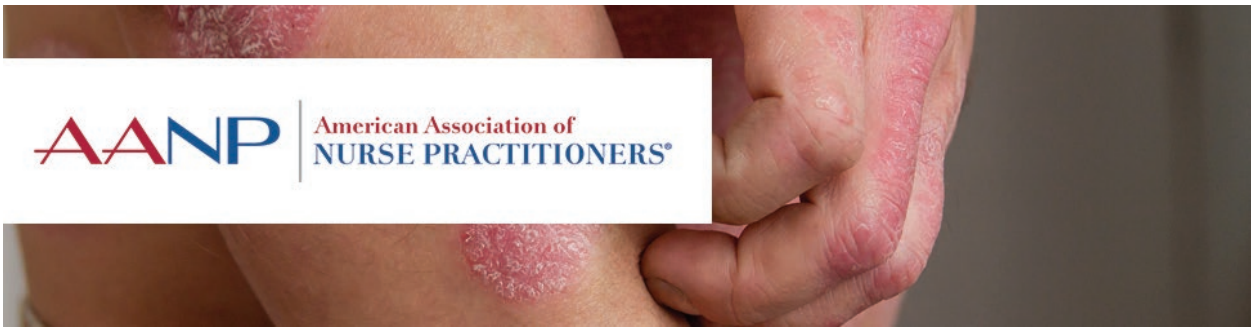

IMPROVING OUTCOMES IN PLAQUE PSORIASIS: THE ROLE OF THE NURSE PRACTITIONER

Ask the Expert

Faculty: Lakshi Aldredge, DCNP, and Peggy Vernon, DCNP

Nurse practitioners (NPs) and other advanced practice providers who completed these two activities on plaque psoriasis within the first several months had the opportunity to pose questions to expert faculty. This document is a summary of your colleagues' questions and faculty answers, along with helpful tips, clinical pearls and resources.

1. What lifestyle factors play a role in psoriatic flares and in treatment and remission?

Stress plays a huge role in psoriasis flares and treatment response. It is well known that emotional and physical stress can contribute to the onset and worsening of psoriasis. Stress can also impact the effect of treatments in that, if patients have increased stress, they may not remember to utilize treatments appropriately or may forget to take them at all. Furthermore, a hectic lifestyle can lead to unhealthy practices, such as eating less healthy foods (fast foods), not getting enough sleep and not exercising. We know that patients with psoriatic disease are a higher risk for developing psoriasis comorbidities, such as hypertension and metabolic disease. Obesity, hyperglycemia and hypertension can all play a part in these conditions, and an unhealthy diet and lifestyle makes patients especially vulnerable.

References:

- Sathyanarayana Rao, T. S., Basavaraj, K. H., & Das, K. (2013). Psychosomatic paradigms in psoriasis: Psoriasis, stress and mental health. *Indian journal of psychiatry*, *55*(4), 313–315. doi:10.4103/0019-5545.120531.
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2. Do you have any dietary recommendations or other natural treatments for plaque psoriasis?

The establishment of a healthy, well-balanced diet is the primary dietary recommendation for patients with psoriasis. There is no single diet that has been proven to be effective for improving psoriasis; specifically, this includes the practice of a gluten-free, lactose-free or low-glycemic diet. There is some

data to support that a low-inflammatory diet, such as the Mediterranean diet, has been helpful, given that psoriasis is an autoimmune, inflammatory disorder.

References:

- Molina-Leyva, A. et al. (2019). Adherence to Mediterranean diet in Spanish patients with psoriasis: Cardiovascular benefits? *Dermatologic Therapy*. 32(2), Retrieved from https://doi.org/10.1111/dth.12810.
- Pona, A. et al. (2019). Diet and psoriasis. *Dermatology Online Journal*. Retrieved from https://europepmc.org/abstract/med/30865402.

3. Can you share more detailed information on how to calculate Body Surface Area (BSA) percentage and use the Psoriasis Area Severity Index (PASI) score?

- The BSA is the most commonly used scoring system for assessing psoriasis severity. Very simply, the surface of one palm equals one BSA. A mild disease has a BSA of 1-3%, 4-9% BSA is moderate and >10% BSA is considered severe.
- The PASI scoring system is much more complicated and is primarily utilized for psoriasis clinical trials. It combines the severity (e.g., erythema, induration and desquamation) and percentage of the affected area (e.g., head, trunk, arms, legs).
- There are several free online calculators that are easy to use:
    - http://pasi.corti.li.
    - PASI calculator.
    - SCORing Atopic Dermatitis (SCORAD) Calculator.

References:

- Aldredge, L.M. (2014). Measuring psoriasis severity: Why does it matter? *Journal of the Dermatology Nurses' Association*, 6(5S). Retrieved from https://journals.lww.com/jdnaonline/fulltext/2014/09001/Measuring_Psoriasis_Severity__Why_Does_it_Matter_.3.aspx.
- Feldman SR, Krueger GG. (2005). Psoriasis assessment tools in clinical trials. *Annals of the Rheumatic Diseases*, 64(ii65-ii68).
- Henseler, T. and Schmitt-Rau, K. (2008). A comparison between BSA, PASI, PLASI and SAPASI as measures of disease severity and improvement by therapy in patients with psoriasis. *International Journal of Dermatology*. Vol. 47 (10) 1019-1023. https://doi.org/10.1111/j.1365-4632.2008.03753.x.

4. Can you share more medication options?

- **Topicals:**
    - Topical glucocorticosteroids, vitamin D analogs, calcineurin inhibitors, keratolytics and moisturizers.
- **Conventional systemics:**
    - Methotrexate, apremilast, acitretin and cyclosporin
- **Phototherapy:**
    - Narrowband UVB, UVA, PUVA and Grenz ray
- **Biologics**:
    - TNF alpha inhibitors (adalimumab, certolizumab, etanercept, infliximab).
    - IL-12/23 inhibitors (ustekinumab).
    - IL-17 inhibitors (brodalumab, ixekizumab, secukinumab).
    - IL-23 inhibitors (guselkumab, risankizumab, tildrakizumab).

References:

- Martin, G., Young, M., & Aldredge, L. (2019). Recommendations for Initiating Systemic Therapy in Patients with Psoriasis. *The Journal of clinical and aesthetic dermatology*, *12*(4), 13–26.

5. Can you further describe punch biopsy techniques?

In order to diagnosis psoriasis, a punch biopsy of the lesion can be helpful. A 4-millimeter (mm) punch biopsy taken directly from a newer, untreated plaque is the most useful. If there is a variety of different presentations of lesions, sample more than one type of plaque.

References:

- Harvey, N.T. et al. (2017) Skin biopsy in the diagnosis of inflammatory skin disease. *Australian Family Physician*, 46(5), 283-288. Retrieved from https://www.racgp.org.au/afp/2017/may/skin-biopsy-in-the-diagnosis-of-inflammatory-skin-disease.

6. Is there any particular treatment for patients that present with psoriasis on the nasal mucosa?

It would be rare for psoriasis to present in the nasal mucosa, although it is possible. Consider taking a small punch biopsy, or swab to rule out bacterial or viral etiology. If it is truly psoriasis, topical corticosteroid, such as triamcinolone, on a cotton swab can be useful.

References:

- https://www.psoriasis.org/about-psoriasis/specific-locations/face

7. I would like more information on common other differential diagnoses, such as psoriasis vs lichen planus. Can you advise?

Psoriasis can look like many other cutaneous disorders:

- Plaque psoriasis: Discoid lupus, squamous cell carcinoma, sarcoidosis, tinea, granuloma annulare, lichen planus.
- Guttate psoriasis: Pityriasis rosacea, pityriasis lichenoides, syphilis, measles.
- Inverse psoriasis: Tinea, candida infections, Paget's disease, Bowen's disease.
- Nail psoriasis: Onychomycosis.
- Scalp/facial psoriasis: Seborrheic dermatitis, tinea.

References:

- Young, M., et al (2017). Psoriasis for the primary care practitioner. *Journal of the American Association of Nurse Practitioners*, 29(3), 157-178. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1002/2327-6924.12443

8. Correction:

Losartan is not dosed in 20 milligrams (mg). This medication is currently available in 25, 50 or 100 mg.

9. Psoriasis: Education Pearls

- Ensure that, at your first visit, you sit down with your patient and hear their story.
    - The establishment of the patient-provider relationship is **essential** for successfully treating psoriasis patients. Patients need to believe that you are listening to them, that you are invested in caring for them through their journey and that there is hope for them to achieve clear or near clear skin.
    - Ask patients about their lifestyle.

        - Are they considering starting a family? This can impact their treatment choices.
        - Are they going to be traveling or going away to school? This would be a factor for treatment options and follow-up/lab monitoring.
        - Are they needle phobic, or do they have a past medical history of intravenous drug use? This could deter them from using biologics.
        - Do they have a safe place to store their medications or a refrigerator? Some patients may be homeless or living in transitional housing.
- Set clear expectations about treatments.
    - Discuss treatment options, including any required lab monitoring, and how often those treatments should occur.
    - Discuss the need for follow-up appointments to assess response and ensure adherence.
    - Discuss the probability or possibility of flares.
    - Ensure that patients have adequate literature or patient education tools to refer to after they leave your office.
    - Consider utilizing biologic "nurse ambassador" programs for additional patient support.
    - Ensure patients have sharps containers and alcohol wipes if they choose biologics.
- Advise patients to call you if they become ill or have a change in their medical status or require surgery.
    - They may need to stop their psoriasis treatment until they return to their normal state of health but reassure patients that you are not abandoning all psoriasis treatments. They need to know that they are still able to get clear skin.
- Advise patients that if their treatment results in clear skin, they need to continue to take their medication as there is no cure for psoriasis. If they stop treatment, they will eventually flare again and may lose response (i.e., develop antibodies) to that treatment. Adherence is important.
- Advise patients to notify you if they change insurance as this may affect their ability to maintain their current therapy.
- Provide patient resources, such as the National Psoriasis Foundation, but caution them about patient blogs and so-called "cures", such as turmeric supplements, purchasing expensive dead sea salts, etc.

References:

- Young, M. et al. (2017). Psoriasis for the primary care practitioner. *Journal of the American Association of Nurse Practitioners*. 29(3),157-178. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1002/2327-6924.12443
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- Bewley, A. and Page, B. (2011). Maximizing patient adherence for optimal outcomes in psoriasis. *Journal of the European Academy of Dermatology and Venereology*, 25(s4), 9-14. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/j.1468-3083.2011.04060.x

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