OCCUPATIONAL ENGLISH TEST

R000009

READING SUB-TEST – TEXT BOOKLET: PART A

INSTRUCTIONS TO CANDIDATES

You must **NOT** remove OET material from the test room.

Psoriasis: Texts

Text A

Diagnosis of cutaneous psoriasis is usually straightforward based on the clinical appearance. The most frequent presentation is chronic plaque psoriasis (psoriasis vulgaris) and is characterised by well demarcated bright red plaques covered by adherent silvery white scales. These may affect any body site, often symmetrically, especially the scalp and extensor surfaces of limbs. The differential diagnosis includes eczema, tinea, lichen planus and lupus erythematosus. The appearance of the plaques may be modified by emollients and topical treatments, which readily remove the scale. Scaling is reduced at flexural sites, on genital skin and in palmoplantar disease. Guttate psoriasis describes the rapid development of multiple small papules of psoriasis over wide areas of the body. The differential diagnosis includes pityriasis rosea, viral exanthems and drug eruptions. Generalised pustular psoriasis is rare and is characterised by the development of multiple sterile non-follicular pustules within plaques of psoriasis or on red tender skin. This may occur acutely and be associated with fever. The differential diagnosis includes pyogenic infection, vasculitis and drug eruptions.

Text B

Adult Psoriasis Topical Treatment Pathway

Emollients should be applied regularly to reduce fall of scales at all steps in therapy and for all body areas (excluding scalp)

	Trunk and Limbs	Face, Flexures and Genitals
Step 1	ONCE daily potent corticosteroid + ONCE daily vitamin D preparation (betamethasone + calcipotriol) Review at 4 weeks* Discontinue if Ineffective after maximum of 8 weeks treatment	ONCE or TWICE daily mild or moderate corticosteroid (clobetasone or hydrocortisone) applied for maximum of 2 weeks. Discontinue if unsatisfactory response or continuous treatment required to maintain control
Step 2	Vitamin D preparation (calcipotriol or tacalcitol) TWICE daily Discontinue if ineffective after a further 12 weeks treatment	Calcineurin inhibitor TWICE daily (off-label use) for up to 4 weeks To be initiated on the advice of a clinician with expertise in psoriasis e.g. GPwSI Continue to review for improvement as directed
Step 3	Potent corticosteroid (betamethasone or fluocinolone) TWICE daily for 4 weeks * or Coal tar containing preparations ONCE daily for 4 weeks * Discontinue if the patient cannot tolerate or once daily is preferred to improve adherence	
Step 4	Potent corticosteroid + vitamin D combination preparation (betamethasone + calcipotriol) ONCE daily for up to 4 weeks* Discontinue if Ineffective after maximum of 4 weeks treatment	Refer patients whose psoriasis is not controlled to the specialist dermatology service

*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 to maintain psoriasis disease control during this period.

Dithranol could be considered as an alternative to coal tar preparation at this stage in therapy for suitable patient groups.

Text C

Psoriatic arthritis (PsA) is an inflammatory disease associated with psoriasis. It is unclear exactly how many patients with psoriasis will develop PsA, but it could be as high as 42%. PsA may develop at any time, but usually presents between 30-50 years of age. PsA is characterised by pain and stiffness in affected joints. If left untreated, PsA could result in progressive joint damage leading to severe disability. Therefore, early detection and treatment are paramount. On physical examination, affected joints may have asymmetric stress pain, joint-line tenderness, and effusions, with approximately 50% of cases affecting the distal interphalangeal (DIP) joints.

CASPAR (**C**l**AS**sification criteria for **P**soriatic **A**rthritis) Criteria

A patient must have inflammatory articular disease and ≥3 points from the following categories

Category	Description	Points
Current psoriasis or personal or family history of psoriasis	Current psoriasis: skin or plaque disease confirmed by rheumatologist or dermatologist. Personal history: obtained from patient, family physician, dermatologist, rheumatologist or other qualified health care provider. Family history: presence of psoriasis in 1° or 2° relatives as reported by patient.	2 (current) OR 1 (history)
Psoriatic nail dystrophy on current examination	Onycholysis, pitting, hyperkeratosis	1
Negative rheumatoid factor (RF)	Any method except latex, but preferably Enzyme-linked immunosorbent assay (EUSA) or nephelometry, using local laboratory reference range.	1
Dactylitis (current or on history as recorded by rheumatologist)	Swelling of an entire digit	1
Radiographic evidence of juxta-articular new-bone formation	Ill-defined ossification near joint margins but excluding osteophyte formation on plain X-rays of the hand or foot.	1

Text D

Children and Young People – Psoriasis Topical Treatment Pathway

Suitable quantities of preparations to be prescribed for specific areas of the body.

Area of body	Creams and Ointments (Steroid)	Creams and Ointments (Non-Steroid)
Face and neck	15 to 30g	15 to 30g (face only)
Both hands	15 to 30g	25 to 50g
Scalp	15 to 30g	50 to 100g
Both arms	30 to 60g	100 to 200g
Both legs	100g	100 to 200g
Trunk	100g	400g
Groin and genitalia	15 to 30g	15 to 25g

Maximum amounts of Vitamin D analogues to prescribe:

Calcipotriol 6 – 12 years max. 50g weekly; over 12 years max. 75g weekly

Calcitriol – not more than 35% of body surface to be treated daily, max. 30g daily.

Tacalcitol – max. 10g ointment or 10mL lotion daily (max. total tacalcitol 280 micrograms in any one week)

END OF PART A
THIS TEXT BOOKLET WILL BE COLLECTED

Any answers recorded here will not be marked.

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