Reading Part A Text

Corticosteroids: Texts

Text A

Corticosteroids are usually used topically but may be injected into small or recalcitrant lesions. (CAUTION: *Systemic corticosteroids may precipitate exacerbations or development of pustular psoriasis and should not be used to treat psoriasis.*)

UV light therapy is typically used in patients with extensive psoriasis. The mechanism of action is unknown, although UVB light reduces DNA synthesis and can induce mild systemic immunosuppression.

Methotrexate taken orally is an effective treatment for severe disabling psoriasis, especially severe psoriatic arthritis or widespread erythrodermic or pustular psoriasis unresponsive to topical agents or UV light therapy (narrowband UVB) or PUVA.

Text B

* Be aware that continuous use of potent or very potent corticosteroids may cause:
a) irreversible skin atrophy and striae
b) psoriasis to become unstable
c) systemic side effects when applied continuously to extensive psoriasis (for example, more than 10% of body surface area affected).

* 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 (such as vitamin D or vitamin D analogues or coal tar) as needed to maintain psoriasis disease control during this period.

* When offering a corticosteroid for topical treatment, select the potency and formulation based on the person's need.

* Do not use very potent corticosteroids continuously at any site for longer than 4 weeks.

Text C

* Offer a potent corticosteroid applied once daily for up to 4 weeks as initial treatment for people with scalp psoriasis.

* Show people with scalp psoriasis (and their families or carers where appropriate) how to safely apply corticosteroid topical treatment.

* If treatment with a potent corticosteroid does not result in clearance, near clearance or satisfactory control of scalp psoriasis after 4 weeks consider:
- a different formulation of the potent corticosteroid (for example, a shampoo or mousse) and/or
- topical agents to remove adherent scale (for example, agents containing salicylic acid, emollients and oils) before application of the potent corticosteroid.

If the response to treatment with a potent corticosteroid for scalp psoriasis 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).

Text D

Psoriasis vulgaris (plaque psoriasis)	The most common type of psoriasis. * Inflammatory red, sharply demarcated, raised, dry, differently-sized plaques, usually covered by silvery or white scales. * Involves the scalp and the area behind the ears, the extensor surfaces of the forearms and shins (especially elbows and knees), trunk, face, palms, soles and nails.
Intertriginous psoriasis (psoriasis in folds and genital areas)	* Deep-red or white, flat, sharply demarcated, wet patches or plaques, scales are usually absent. * Affects almost exclusively flexural body sites.
Guttate psoriasis (droplet psoriasis)	* Reddish, drop-like papules and plaques, mainly involving the trunk, arms and legs. * Onset is associated with streptococcal infection of the upper respiratory tract.
Pustular psoriasis	* Coalescing pustules, filled with non-infectious pus. * Involves either small areas such as palms of the hands, fingertips, nails and soles of the feet, or the entire body surface can occur as a single episode after a trigger.
Erythrodermic psoriasis	* Fiery redness and exfoliation of most of the body surface. * The most serious type of psoriasis, potentially life-threatening, because it can lead to hypothermia, hypoalbuminemia and high output cardiac failure.