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Primary Care's Skin in the Game: Psoriasis Identification, Treatment, & Referral Decisions

Announcer:

This is CME on ReachMD! This activity, titled **Primary Care's Skin in the Game: Psoriasis Identification, Treatment and Referral Decisions**, is brought to you by The France Foundation and supported by an educational grant from Novartis.

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Here's your host, Dr. Shira Johnson.

Dr. Shira Johnson:

When it comes to mild-to-moderate psoriasis, the role of primary care clinicians is continuously expanding. In fact, one-quarter of patients seek psoriasis care from primary care physicians, and while it's not uncommon for PCPs to evaluate and manage a variety of dermatologic issues, knowledge gaps unfortunately still remain. So how can we better address these gaps to optimize patient care?

Welcome to CME on ReachMD. I'm Dr. Shira Johnson, and joining me are Dr. Paul Doghramji, family physician and member of the American Academy of Family Physicians, and Dr. Abby Van Voorhees, chair of dermatology at the Eastern Virginia Medical School in Norfolk, Virginia. Today, we'll be discussing the role of the family physician in the diagnosis and management of psoriasis.

Dr. Doghramji, Dr. Van Voorhees, welcome to the program.

Dr. Van Voorhees:

Thank you.

Dr. Doghramji:

Thank you for having us.

Dr. Johnson:

So, to start us off, Paul, can you tell us what psoriasis looks like and where it is typically located?

Dr. Doghramji:

So psoriasis is an immune-mediated disease of genetic predisposition. No distinct immunogen has been identified, so it really has to do with looking at the skin. There really are five forms of them, all showing three things; erythema or redness, itchiness, and scaliness. Now the most common is plaque psoriasis, and we primary care doctors have seen this. About 90% of the affected patients with psoriasis have plaque psoriasis characterized by well-defined round or oval plaques that differ in size, and often they coalesce. They occur typically on the extensor surfaces; the arms and legs like the elbows and knees, but they can also occur on the scalp, buttock, and trunk. There is another one called inverse psoriasis, which is less scaly than plaque form, and occurs in the skin folds, so it can be a bit confusing. So the flexor surfaces and perineal area, inframammary area, axillary area, inguinal areas, intergluteal areas. Some heat, trauma, and infection may contribute to their development or coming out. The third form is called erythrodermic psoriasis, which is characterized by widespread generalized redness or erythema, and is also associated with systemic symptoms. It may develop slowly from longstanding psoriasis, or it can appear just abruptly by itself as an initial case with psoriasis. A fourth form is called pustular psoriasis, and this can sometimes be confusing, as well. It consists of pustules on the palms and at the soles that have nice, distinct borders at times, and there is no plaque psoriasis associated. It can be confusing. The final one is guttate psoriasis, and it is more

common in patients that are younger than 30 years of age, and these lesions are usually located on the trunk, accounting for a very small percentage, approximately 2% of psoriatic cases. The classical findings are 1-mm to 10-mm pink papules with fine scaling. And interestingly, a lot of times this can come out after a bout of group A Strep infection in the young adult. So those are the five main forms. Again, the most common being plaque psoriasis.

Dr. Johnson:

Dr. Van Voorhees, would you like to comment on psoriatic arthritis?

Dr. Van Voorhees:

Sure. Well, psoriatic arthritis occurs pretty commonly in those with psoriasis. About 30% we estimate of patients who develop skin disease, psoriasis, will ultimately go on to have psoriatic arthritis. In fact, it is the most common concurrent illness that occurs in those with psoriasis. Usually, the psoriasis develops first, so people present with their skin disease and they will often have it on average 10-15 years before they develop the joint disease. That is not always the case. About 10% of patients can develop both the skin disease and the joint disease at the same time. And then rarely, about 5% of patients, will develop the joint disease first before they develop the skin disease. This last form where the joint disease occurs first is the trickiest form, because many of the criteria we use, called the CASPAR criteria, to diagnose psoriatic arthritis are based on the presence of skin disease or a family history of that skin disease. So you can see where it makes it much more challenging to get that diagnosis of psoriatic arthritis if the skin disease is not present or at least a patient has a history of having had it previously. But it is quite a common concurrent illness with psoriasis. Psoriatic arthritis itself can be a little tricky to diagnose. It can occur – usually it occurs where just one single joint will get swollen or inflamed, but it can look a lot like rheumatoid arthritis, so you can have bilateral symmetric joint involvement, as well. So it can be a tricky diagnosis to come forward with, even for people who are experts in the field.

Dr. Johnson:

Now as I understand it, Paul, you actually have a patient case to share with us. What can you tell us about this patient?

Dr. Doghramji:

Here is a 32-year-old gentleman who comes to see me. He presents with these things on his elbows, on his scalp, and I'm going to call them plaques because that is what they look like when he presents with. Again, they are on the elbows and on the scalp. The lesions have persisted for approximately six months or so. They are itchy, scaly, red, bothersome to him, and he thinks they could be psoriasis because his father also had the same thing, and he comes in saying, "What do I have? And what do I want to do about it?" This is a case that none of us should miss.

Dr. Johnson:

Thanks for sharing that with us. What are some clues though that would lead you to suspect this diagnosis? And I know it can be confused with many other differentials.

Dr. Van Voorhees:

Well, I think the key feature is the pattern of involvement. So, as you heard, this patient has involvement of his elbows and his scalp, and those are two of the most common locations for psoriasis to occur. And they've been persistent for a long period of time; in this case, six months. So that also is quite characteristic of psoriasis. And the fact that they are uncomfortable. Generally patients with psoriasis talk about their lesion could be either itchy or painful and tender. This patient reports all of those things. You know, things that you would have to think about – I mean, it's not the only diagnosis it could be. Occasionally, even on the elbows, patients with eczema can present that way. Often physicians are tricked by that, thinking everything on the elbow has to be psoriasis, but in fact, eczema can sometimes occur there, as well. That's probably the thing that is most commonly confused.

Dr. Johnson:

So Paul, now that this patient has been diagnosed, what is the recommended treatment approach? And how do you decide what to start with?

Dr. Doghramji:

Well, this is a mild case of psoriasis and it is affecting less than 5% of the total body, so the current recommendation would be to use topicals. But really it is going to be a topical corticosteroid. I would use super potent one like a Class 1 topical steroid for the elbows and maybe even for the scalp, and if he had it anywhere else like the face and some of the body folds, I might use a low potency or Class 6 or 7 one. Now, regarding the vehicles, this gets a little bit individualized in a sense where I would ask the patient what he would like or prefer. But generally for the scalp, they're going to do well with a gel or a foam because it goes in and it is not messy and kind of disappears pretty nicely. When it comes to young adults like this, they don't really like oily ointments and things, so creams might be a good idea to use. So, generally, again a topical steroid that is a pretty potent one for the areas involved, and probably using a gel for the

scalp and maybe a cream for the elbows.

Dr. Johnson:

So, would you like to comment a little more, Abby, about the Psoriasis Foundation and their Treat-to-Target goals?

Dr. Van Voorhees:

Yes, I think in the last decade or so as treatments have improved, our ability to bring it in to the suffering of patients with psoriasis has also commensurately improved. What the goals say are that patients should get to the point of being clear or almost clear after three, or certainly after six months of a given treatment. So, you know, as Paul was just saying, in that patient where you're using a very strong topical steroid on their elbows and in their scalp, you know, we would expect those areas really would go to the point where the lesions resolved, and the patient would be able to change the administration of those Class 1 steroids to maybe on an as-needed basis or at least not using it twice daily every day. So the goal is to get patients really to the point where they're clear or almost clear.

Dr. Johnson:

You know, Abby, you mentioned earlier that psoriasis can be confused with other conditions. Could you describe a patient case that illustrates this point that may be a little more complicated than the scales on the elbows?

Dr. Van Voorhees:

Yes, so I think this is really a common point of confusion. Imagine a patient who is 50 years old, 20 pounds overweight, so a little heavy, and she complains of a persistent rash under her breasts or in the abdominal folds. And I think very commonly these patients are told that they have intertrigo and are often treated with Nystatin or another anti-yeast agent. And, in fact, this very much can be the presentation, like Paul was mentioning earlier, of intertriginous psoriasis. And one way that's really very helpful to tell these two apart is that candida should have satellite lesion, so you should see little pinpoint red papules at the periphery of the patch of yeast. In contrast, psoriasis doesn't; you really see much more of a sharp margination. So I think that's a good clue. My other favorite clue is to look under the patient's underwear in between their buttock cheeks because this is a very common location for intertriginous psoriasis to develop a plaque. And we call that the supragluteal cleft. So above the rectum, sort of aiming toward the back. If there is involvement there, that's another indication that it may be this type of intertriginous psoriasis. So those two things are really very commonly confused. People often will also confuse it with tinea infection, tinea cruris can certainly occur, especially in the groin and the inguinal fold. There, you usually see a scaly border; we don't tend to see that with intertriginous psoriasis. So that might be a way to distinguish those. Then certainly if there is the appropriate history, you might have to worry about a contact dermatitis. Let's say, a patient was applying a topical medication that they were allergic to the vehicle, for example, you could imagine they could develop a contact dermatitis in those locations, as well. But I think probably the most common thing that is confusing is that is this intertrigo or is it psoriasis.

Dr. Johnson:

So, Abby, we see that this is a little more complicated patient and a little bit more of a differential. To follow up on that, how would you manage this patient?

Dr. Van Voorhees:

Well, I would probably do a couple of things. First of all, I think this is somebody that I would use a low-potency topical steroid on. Remember that when skin touches skin, the absorption of those topical steroids very much is increased. So you don't want to be using your Class 1 steroid in those more private areas like under the breasts, in the belly fold, in the inguinal fold, between the buttock cheeks. So a low-potency topical steroid is often very helpful. I will tell you, as a result of the fact that often that skin gets kind of damp and sometimes can be even more confusing because sometimes secondarily they will develop – that kind of patient will develop a yeast infection in addition. So sometimes I will throw in a little anti-yeast agent too just to kind of get rid of that background possibility. And then the third thing I like to do is use barrier cream. I think from a skin cell point of view, those kind of areas around the groin, around the rectum – you know, stool is very acidic and so is urine, so from a skin cell's point of view, that's a pretty harsh world for those cells to be living in, so I think sometimes these patients have so much trouble because they do what we call Koebnerization, which means that the skin – anywhere the skin is irritated, it develops more psoriasis. And those barrier creams can be hugely helpful at just protecting that skin, so therefore they don't tend to break out as often. And, you know, honestly it's nothing more fancy than the same kind of thing you would recommend to a new mom who just had a baby. So, often I'll tell people to go get whatever your favorite zinc oxide is. I'll have them use that. When that fails, and once in awhile it does, sometimes I'll use the excimer laser to treat just that localized area under those – maybe in the supragluteal cleft or maybe under the breast, and that can be very, very helpful. And when those things don't work, and occasionally they don't, then sometimes it really warrants systemic therapy. You know, I've had patients in my office telling me how they can't sit, they can barely use the bathroom, and certainly can't have sexual relations with their partners. So I think in those most severe examples, systemic therapy sometimes becomes very appropriate.

Dr. Johnson:

So we're mentioning now systemic agents, and I would like to get into that topic a little further. Paul, can you tell us how these agents can be used for treating psoriasis from the viewpoint of the primary care provider, which a lot of our listeners are?

Dr. Doghramji:

Yeah, sure. So with a patient with that extensive of skin disease and have more than 5% of their body involved and topicals are certainly not the right thing and we certainly are not going to use oral steroids, you want to use something systemic. And I think a primary care provider should feel relatively comfortable at least with methotrexate. It's been around for like 60 years or so, and is pretty effective. A couple of other medications like cyclosporine but it's something we can consider using systemically for extensive cases. It is also not approved in children. I've seen it used primarily to suppress a crisis like as a bridge therapy. If I ever have a patient with it and a dermatologist has been involved, acitretin is an oral retinoid as well, and usually combined with phototherapy from what I've seen. The one other medication, apremilast, I do think is pretty good idea for primary care providers to know how to use. But anything after that, I think I'm going to have to defer to somebody like Abby. In fact, when it does come to systemic problems, or more specifically when the psoriasis is more extensive and there is joint involvement, I think it is really important for a family doctor or primary care provider to get a dermatologist involved.

Dr. Johnson:

So, Abby, would you like to take us a little further into the role of biologic and systemic agents in treating psoriasis?

Dr. Van Voorhees:

Sure. Let me start by saying I use all of the agents that Paul has used, as well, because they all have their place in the psoriasis toolkit as how I can think of it. But the last 10-15 years have been nothing short of miraculous in the development in new agents in the field of psoriasis. We started with the TNF inhibitors, then subsequently IL-12/23 agents were developed, then in the last little while we have had the development of the IL-17 inhibitors, and IL-23 inhibitors. It's been one of these wonderful moments in medicine and science where, with each new drug, we came to understand more and more about the immune system and how it really was functioning in our disease. So, you know, it wasn't so long ago that we used to think that psoriasis was a Th1-mediated disease, but now we understand that it is actually most dominantly a Th17-mediated disease. So I think – and we see that bearing out in some of these drugs. So the TNF inhibitors can be hugely helpful for patients and they have that wonderful advantage that they can be effective in both skin and joint disease. So for the patient that has both psoriasis and psoriatic arthritis, that can really be a good thing to take one medicine and have it work for both conditions. The IL-17 inhibitors, they too kind of work in both conditions. And many people have thought they really are even more precise in terms of what they're targeting. In keeping with that, we've seen success rates in getting people clear with the IL-17 agents that really are nothing short of miraculous. So we've taken TNF inhibitors really were our great beginning, then the IL-17 agents take it one step further. The IL-12/23 inhibitor is a medication that probably is working primarily through the IL-23 inhibition, because IL-23 interacts with IL-17. So basically, and the same is true for the IL-23 inhibitors alone. And we see really excellent response here of the skin. The joints respond, but not quite as well as they do with the TNF inhibitors. But what's really great about these drugs is that they can be administered much more intermittently. So, for example, with the IL-12/23 inhibitors, they're given every 12 weeks. So many patients are taking a shot once a quarter. Patients have said to me that 'actually for the first time I could forget I have psoriasis.' So I think the TNF inhibitors definitely have a role, and they especially have a role when joints are involved. But you can see where we have gotten evermore surgical in our strike, if you will, against what we believe the driver of psoriasis over the last 5-10 years, so it's really nothing short of revolutionary. So I think, you know, if you ask me how do I choose, because you know we have now many agents and various different mechanisms of action. Very commonly, it depends on what the patient's other comorbidities are. For example, as I was saying earlier, if a patient has joint disease, then I might go with my TNF inhibitor or my IL-17 agent. If they have just a little bit where I don't need the same amount of power, the IL-12/23 probably will be adequate. On the other hand, if I have somebody who is needle-phobic or somebody who is away at college or those kinds of things, for being able to administer something once a quarter is pretty sweet. So, very commonly, it's what is the rest of the component and that patient's concerns that drives what decision we make.

Dr. Johnson:

So, Paul, going back to the primary care office, how do you delineate limited or extensive psoriasis?

Dr. Doghramji:

I think that one of the best ways is that about mild psoriasis, moderate psoriasis, and severe, with mild psoriasis being less than 3% of body surface, maybe something like just the knees involved or something like just the elbows. Moderate psoriasis being with a larger scale, maybe on both knees and elbows. And then severe psoriasis is anything more than that. So moderate being 3-10% and severe being more than 10%.

Dr. Johnson:

For those just tuning in, this is CME on ReachMD. I'm Dr. Shira Johnson, and I have the pleasure of speaking with Dr. Paul Doghramji and Dr. Abby Van Voorhees about diagnosing and managing psoriasis in the primary care office for the dermatologist or the primary

care physician. So now that we have this information on the treatment of psoriasis, let's turn to our next patient case. Paul, can you give us this patient's background?

Dr. Doghramji:

Alright, let's go to a little bit more difficult case. I'm going to present to you a 58-year-old woman who comes to my practice. She has had psoriasis for approximately 20 years or so. It has been of moderate degree, and she has not been in my practice that long, but she comes in saying she has been treated with topical steroids only. She covers up a large portion of her body just so that people don't see it. She kind of lives with it and figures that is the only thing that anybody can do. She has some comorbidities. She has COPD from smoking. She has hypertension, hyperlipidemia and is on oral medications for those two conditions of pravastatin and lisinopril. So she is coming in for worsening joint pains that have been going on for about a year or so. And she says that her joints in her fingers, especially on the right hand, the DIPs and primarily the DIPs, but some PIPs are affected in some of the fingers, but now also both of her knees. She is really stiff when she gets up in the morning in those joints, taking half an hour or hour or so until some of the stiffness lets up. So, she has been recommended by maybe some friends and maybe even other doctors that use systemic treatments for psoriasis, as well as maybe development of arthritis, but she has not been really accepting, and now she is coming in saying 'maybe I should consider it.' So this is my case.

Dr. Johnson:

So from your point of view, with this patient with extensive disease, Paul, how would you begin to treat this patient?

Dr. Doghramji:

Well, you know, one of the things that Abby mentioned earlier, and I love this idea, about the Treat-to-Target. And what is our goal in this patient? I think she said earlier that it is just to make the skin free and clear. And let's say less than 1% of her skin is involved. I think it's a pretty darn good goal. So if the acceptable response has not been met, nothing is really getting, then the patient may not want to go with that treatment, but maybe another treatment, as well. And there are some others that we mentioned. And again, I think the critical thing here is that this patient is considering systemic treatment. If you already talked about that, then I think I would have no problem putting this patient on methotrexate, but Abby said earlier that it may be good for the skin, but it may not necessarily be good for the joints. So let me turn it to you, Abby. What would you do with a patient like this from the start?

Dr. Van Voorhees:

So, you know, what's interesting about methotrexate is that it makes the joints feel better, so patients are less symptomatic. But, to date, it does not seem like it reverses the bone degeneration that could occur in psoriatic arthritis. So for that reason, if I really thought the patient had true psoriatic arthritis, then this would be somebody I might push to put on one of the biologic agents first. And here, you know, I might be looking at one of the drugs where I really think I have some power in the psoriatic arthritis area, so I might be thinking about one of the TNF inhibitors or one of the IL-17 agents. So, I think that's probably – you never can say for sure because sometimes patients respond to one drug more than another and you could think about apremilast for a patient like this and certainly our IL-12/23, can work quite effectively. But I think if you wanted to go with the highest yield, probably the TNF inhibitors or the IL-17 inhibitors would be the way to go.

Dr. Doghramji:

Abby, could I ask you a question? You said about – interestingly, you said, "If I thought this patient had psoriatic arthritis, there's a psoriasis epidemiology screening tool," is that a good thing for us to use?

Dr. Van Voorhees:

Yes. You know, we're really working on it. Yes, there are screening tools, and there are several of them, and they really do seem to aide clinicians in trying to determine whether the patient truly has psoriatic arthritis, or whether they may just have more garden variety osteoarthritis or sometimes patient's come in and they have fibromyalgia, and everything sort of aches a little bit. So distinguishing that from the patient who truly has psoriatic arthritis, that can be hugely helpful. One of the things which this patient had, which I find is a helpful clue is that their joint pain lasted a long time. So it's very characteristic about psoriatic arthritis is that the pain occurs at rest, so patients will describe that first thing in the morning that they cannot move, they can't get out of bed. And they also say it can last about an hour. So patients who have pain at the point of rest that lasts for a period of 30-60 minutes, you better have your antenna up that this is somebody who should be evaluated. I think if sometimes are just answering the questions, thinking I know what I want to hear, I ask them what happens if they go for a long car drive. How does it feel to get out of the car at that rest stop. And patients with true psoriatic arthritis will tell you that it's near impossible, they can't walk. So it's that very classic pain after rest that is very typical of psoriatic arthritis.

Dr. Doghramji:

And if I'm concerned about psoriatic arthritis, Abby, I'm really concerned about permanent joint dysfunction because once that happens, you can't go back on it.

Dr. Van Voorhees:

That's exactly right. And you know, with some of these biologic agents, that destruction appears to be preventive. So that's huge, because obviously in the old days, patients had crippling arthritis and now we shouldn't be seeing that any longer.

Dr. Johnson:

Abby, can you say a few words to us about – if you're using a biologic agent, about the timeframe for response and also the safety?

Dr. Van Voorhees:

Sure. So, generally when I start a biologic agent, as Paul was saying, usually patients get a nice response usually after about 12 weeks. So usually after about three months, but if it is not completely to my satisfaction, you know, or maybe they've had a partial response but it's not as good as we would like to see, people can continue to improve up to approximately six months. But at that six-month point, if they're still not achieving the target, that clear or almost clear that we are striving for, then it's time to revisit the equation. And it might be simple enough like adding a topical steroid to the mix just to try to push a stubborn plaque along. Or it might be on the other extreme, and might be changing biologic drugs. So it really varies depending on the unique situation of that patient. I think, you know, with all these biologic drugs, the safety profiles look more similar than they look different. The main risk is the risk of infection, and that is clear. Most of the time, those infections are minor, like colds and that sort of thing, but occasionally those infections can be serious and even have been life-threatening. So that certainly is the risk of these biologics across the board. The TNF inhibitors have a little stronger risk than the others of TB reactivation that has to do with TNF and what TNF does in the lungs for tuberculosis. But I think – in general, it is recommended that all patients on all of these biologic agents be screened for tuberculosis. The IL-17 agents we know can increase people's risk of candida infections, so that's unique to that class of drugs. Those infections though are generally minor enough that we can continue treatment and just use a topical anti-yeast agent and achieve – you know, bring that back under control. So those are the main safety risks, so infections are the thing that I spend most of my time talking to patients about.

Dr. Johnson:

So, Paul, can you say a few words on when you would refer to dermatology? And then can each of you address any suggestions you have for optimizing the shared management of patients with psoriasis between primary care and dermatology, especially the complicated patients?

Dr. Doghramji:

Sure. This patient has extensive disease, longstanding disease, and has really been upset by the condition of her skin, and has almost even had sort of a dejected attitude towards it, but now there is also joint disease going on, probably psoriatic arthritis. I am worried about joint destruction. So I think it is important for me to co-manage this case with a dermatologist. I probably would call my dermatologist consult and I would discuss the case with him or her. But in doing so and in thinking ahead that maybe a systemic medication is going to be used, I'm obviously going to look for infection and infection prevention like vaccinations, also doing some blood tests, background blood tests in preparation for the patient to be on a systemic medication. I would also talk to the patient at this point about comorbidities and, as we discussed earlier, this is a systemic problem so I want to make sure that the patient and I and the dermatologist are all aware that we're a team effort here to look for these comorbid conditions, either screen for them, identify them, manage them, and mitigate their issues. But yeah, this patient is likely going to be seen by dermatology and co-managed with me.

Dr. Johnson:

Abby, would you like to add to that?

Dr. Van Voorhees:

Yeah, I couldn't agree more. What I want to stress is the fact that we used to think of psoriasis as just a – and we used to say 'just a skin disease,' but now we know it is associated with systemic inflammation. Patients with psoriasis have a much higher frequency of developing metabolic syndrome, and they have an increased risk of cardiovascular disease in addition to also having increased risk for psoriatic arthritis. So, for all of my patients with psoriasis, I need desperate help from the patient's primary doctors to work with me to try to get these patients to lose weight. They are very commonly overweight. And we know that overweight state increases the severity of their disease. So if they could somehow lose that weight, it makes them more responsive. Even if they need medications, they respond better to them. But they have all the component parts of the metabolic syndrome; they have hypertension, elevated lipids, as well as that increased weight, so all of those things need to be addressed and worked on and prevented if they haven't developed it yet or modified and worked on if they have developed it. In fact, I like sending – even my patients who just have psoriasis alone and they don't have any sign of this, I like sending to the primary care doctor. And the way I look at it is psoriasis is the disease of the young and starts most often when people are in their late teens/early 20s. So if we know that these people are at increased risk for developing metabolic syndrome and increased risk of cardiovascular disease, we have a whole lifetime in these individuals to try to work and mitigate some of those risks. So I really think it's very critical. And often they'll seek out a dermatologist's care because they see the skin. But I find very

commonly they don't have a primary doctor, so I'm often the one saying, 'No, no, no, you've got to plug in.' And so that's – I think that's hugely important we work together on these patients. The other thing is that these patients have a much higher frequency of smoking, and that also correlates with their disease becoming more severe. So again, strategies to work on these kind of better health habits are really so critical for these patients. Hopefully as we mitigate some of these risks, if we can catch them early and mitigate them, hopefully we won't find that psoriasis patients have a five-year shorter life expectancy than patients who don't have psoriasis. But I think that we have a lot of work that we can do to make a difference.

Dr. Johnson:

Well we've certainly covered a lot in this discussion, but just to wrap everything up, what are the key points that you want our audience to remember about the diagnosis and management of psoriasis? Abby, let's start with you.

DR. VAN VOORHEES:

Sure. I think it is to make sure to treat the skin adequately. We want to look for milder forms, look in areas like intertriginous areas to see if it's there. Patients are often shy about bringing it up, but it certainly is very troubling to them there. When – and think about using systemic agents when it is more extensive, or more persnickety. I think know how to use the biologic agents. And monitor those patients for signs of infection. I think if you don't feel comfortable using systemic agents, send them to somebody who does, because both in terms of impacting these patients' mental health, as well as their joint health, as well as their cardiovascular health, we can really make a very significant difference. So I think treating these patients adequately is really very, very important.

Dr. Johnson:

So what about you, Paul? What are the key take-aways that you would like to share with primary care providers?

Dr. Doghramji:

In primary care, the most important thing is knowing. You have got to know this disease, you've got to know this condition. Know what psoriasis looks like. And know that plaque psoriasis isn't the only way, and there are several other forms. Know your dermatologist in the area, consult with them and discuss it. Also know that, again as Abby said and I said earlier, this is a systemic problem; it's an inflammatory systemic problem. As such, number one, you are going to have to be involved in the management of the disorder. If it's just milder form, they need to know what medications to use, whether it's the steroids or non-steroids in the topical form. In the more extensive types, you need to know some of the systemic medications and you need to get comfortable using some of the systemic ones. But again, consult with a dermatologist, and co-manage. There are two other things that primary care providers also need to know when psoriasis is involved and that is early detection and prevention. Early detection means that there are so many comorbidities associated with this and, as Abby said earlier, obesity, metabolic syndrome, cardiovascular disease, and even depression, by the way, goes on with these patients – 60% of patients with psoriasis also have depression. It's important to follow these patients. All my psoriasis patients come in once a year for an annual checkup for me to see how they're doing in general and also to look at their psoriatic condition and how it is being managed. Emphasize the proper treatment there. So, early detection and, as far as prevention goes, vaccination; that's a very important point. In fact, before I send a patient to the dermatologist, I might find myself making sure their vaccines are all up to date and ensuring and encouraging that to happen. These are all very important things for a primary care provider to know; that they need to co-manage the condition, inform your dermatologist what you're doing. One other thing, by the way, is infection. I tell all my patients with psoriasis that because of their immunologic problems that are involved here, if you get any infection or any symptom of an infection, call me earlier than later; don't let this go because it can run away with itself much quicker. Let me really be involved in your care earlier when it comes to infection. These are important points for our primary care audience to know.

Dr. Johnson:

Those are all great points to take with us moving forward. And with that, I'd like to thank my guests, Dr. Paul Doghramji and Dr. Abby Van Voorhees for joining me to discuss the diagnosis and management of psoriasis in the primary care setting. It was really great having you both on the show.

Dr. Doghramji:

It was great to be here.

Dr. Van Voorhees:

Thank you.

Announcer:

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