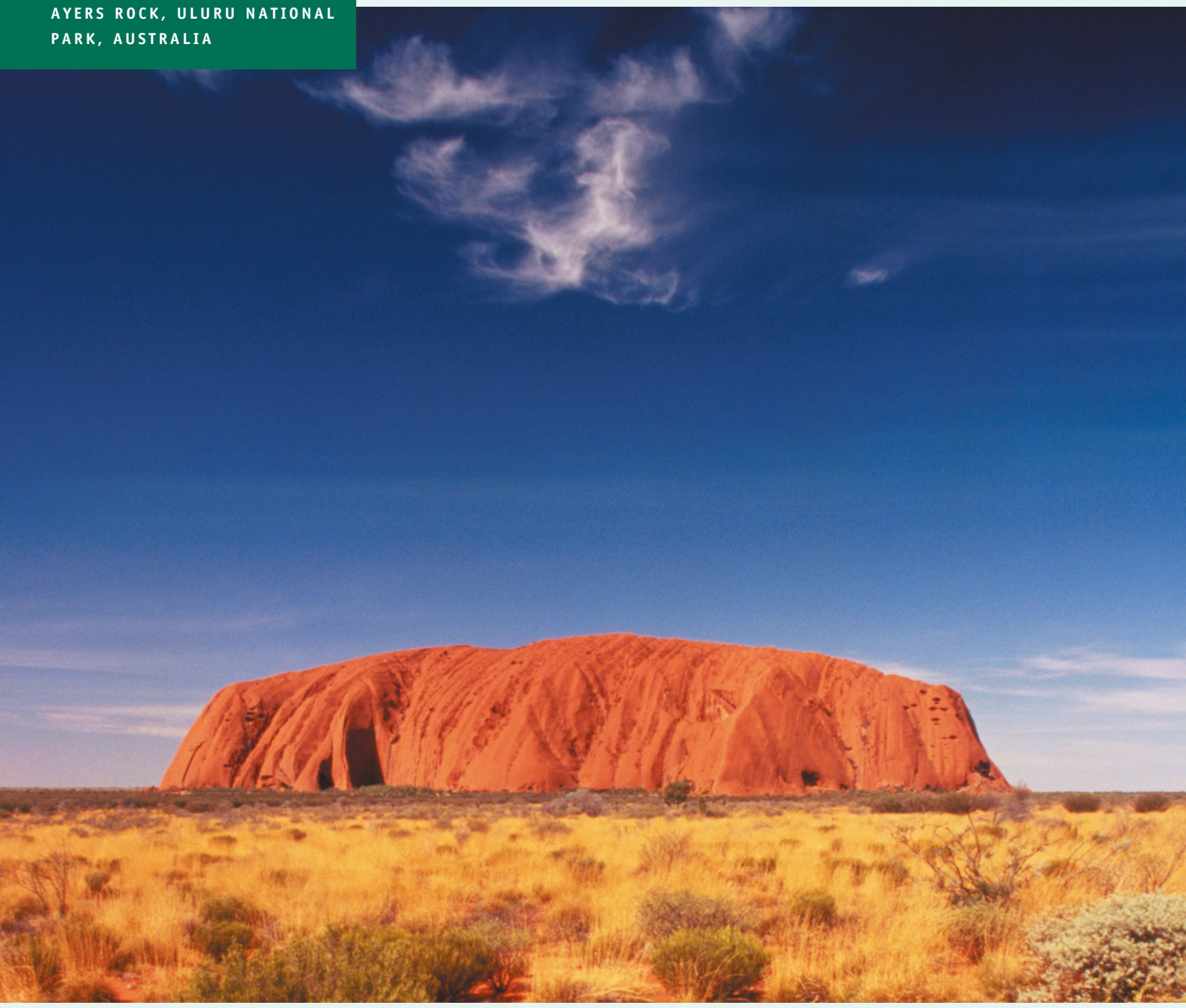
Number **2**

CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

PDP SELF-TEST QUESTIONNAIRE

PSORIASIS



AYERS ROCK, ULURU NATIONAL PARK, AUSTRALIA

UPDATED PDP SELF-TEST QUESTIONNAIRE
2025

‘Plaque’ **a raised lesion where the diameter is greater than the thickness**

CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

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PDP SELF-TEST QUESTIONNAIRE

INTRODUCTION

This 'self-test questionnaire' has been written by Dr Brian Malcolm, based on the updated (2025) Chapter 2 "Psoriasis" of the Core Tutorials in Dermatology for Primary Care. This revised Chapter can be ordered from Dermal at the address below. Alternatively, the Chapter is available to download from the Dermal website www.dermal.co.uk within the Healthcare Professionals Core Tutorials in Dermatology section.

RESOURCES FOR MANAGING PSORIASIS AVAILABLE FROM DERMAL

TRIAL PACKS – Topical treatments are literally worn on the skin of the patient. What feels good for one patient may not be acceptable to another, especially when it comes to emollients, which are used for long periods and often involve large areas. To assist with patient compliance, trial size packs are available on request to healthcare professionals.

PATIENT EDUCATION – To encourage better understanding of the importance of emollients, such as Doublebase for dry skin disorders and Adex Gel when the skin is dry and inflamed, in conditions such as psoriasis, pads of patient information leaflets are available. "You and Your Scalp" booklets are also available to explain about scaly scalp conditions and how to use Capasal Therapeutic Shampoo.

Doublebase.com **AdexGel.com** **www.dermal.co.uk**

To request a supply of any of the above items, contact Dermal at the address below. The patient information leaflets are available to download from the Healthcare Professional Dermatology Resources section of the Dermal website www.dermal.co.uk.

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TEL: (01462) 458866.

QUESTIONS

1. If a parent has psoriasis what is the risk of a child developing the same problem?

2. How commonly do nail changes coexist with skin involvement of psoriasis?

3. What is the 'Koebner' phenomenon?

4. Name 3 distinct patterns of psoriatic arthropathy.

5. Name four different drugs used systemically for more difficult psoriasis.

QUESTIONS

6. What is the mode of inheritance of psoriasis?

7. What three nail changes are characteristic of psoriasis?

8. What percentage of patients develop co-existent arthropathy?

9. What is a DLQI?

10. What is strongly associated with the development of palmoplantar pustular psoriasis?

11. What did I find useful about the learning module on 'Psoriasis'?

12. Having reflected on this module, how might my practice change in managing psoriasis?

QUESTION 1. Answer: 10 – 25% risk.
Ref page 1 "There is a positive family history in one third of sufferers. This is less likely in late onset psoriasis. If one parent is affected there is a 10 – 25% risk to the child, and if both parents are affected the risk increases to 50 – 60%."

QUESTION 2. Answer: Up to 50% of patients.
Ref page 3 "Nail changes are also common, occurring in up to 50% of patients, with a characteristic triad of pitting, subungual keratosis and onycholysis often in a symmetrical distribution. When nail involvement is the sole presentation, the presence of pitting is enormously useful to help distinguish psoriasis from fungal nail dystrophy although the two often co-exist as fungal infection has a predilection for damaged nails."

QUESTION 3. Answer: 'Koebner' phenomenon – follows lines of trauma such as surgical scars or scratch marks.
Ref page 4 "Psoriasis also illustrates the 'Koebner' phenomenon following lines of trauma such as surgical scars or scratch marks. This phenomenon is shared by one or two other common dermatoses, most notably lichen planus and viral warts."

QUESTION 4. Answer: Symmetrical polyarthropathy, oligoarthropathy, sacroileitis or mutilans.
Ref page 5 "There are some very distinct patterns of joint involvement:"

- symmetrical polyarthropathy similar to rheumatoid arthritis;
- oligoarthropathy with one or more large joints involved;
- sacroileitis;
- mutilans – as the name suggests a very severe and destructive form of arthritis."

QUESTION 5. Answer: DMARDs (Disease modifying anti-rheumatoid drugs) methotrexate, ciclosporin, hydroxyurea, acitretin and most recently the biologic drugs.
Ref page 6 "Consultant dermatologists vary tremendously in their enthusiasm for second line treatments, both with phototherapy and, more particularly, with DMARDs (Disease modifying anti-rheumatoid drugs) methotrexate, ciclosporin, hydroxyurea, acitretin and most recently the biologic drugs. Side effects can be hazardous. Often monitoring can be done in an exemplary fashion and still significant morbidity arise… the GP should have a working knowledge of these drugs and their common side effects and interactions. In many parts of the country, the GPs are closely involved in monitoring DMARDs with interval blood tests through locally agreed "shared care" protocols; in others this is seen as exclusively a specialist responsibility."

QUESTION 6. Answer: Polygenic.
Ref page 1 "There is a large subpopulation of genetically predisposed individuals whose psoriasis is triggered by factors both known and unknown. Inheritance is polygenic but one possible likely pattern is autosomal dominance with incomplete penetrance. There are a number of HLA associations. There is a positive family history in one third of sufferers. This is less likely in late onset psoriasis."

ANSWERS (PLEASE TURN UPSIDE DOWN)

ANSWERS

QUESTION 7. Answer: Pitting, subungual keratosis and onycholysis. Discolouration may also be present.
Ref page 3 "Nail changes are also common, occurring in up to 50% of patients, with a characteristic triad of pitting, subungual keratosis and onycholysis often in a symmetrical distribution. When nail involvement is the sole presentation, the presence of pitting is enormously useful to help distinguish psoriasis from fungal nail dystrophy although the two often co-exist as fungal infection has a predilection for damaged nails."

Ref page 9 "NAIL PSORIASIS – This is essentially untreatable with topical preparations although can show some useful response to systemic agents. Be aware that fungal infection is usually a secondary phenomenon superimposed on a damaged and dystrophic nail and will often be recurrent."

Ref page 10 "There is no simple effective topical treatment for nail psoriasis. The presence of pitting helps differentiate between fungal and psoriatic nail dystrophy, although these of course can coexist!"

QUESTION 8. Answer: 7 – 10%.
Ref page 5 "There is an associated seronegative arthritis in 7 – 10% of patients. This is closely associated with HLA B27 tissue typing. There are some very distinct patterns of joint involvement."

Ref page 10 "Severe arthropathy – combined rheumatology/dermatology clinics are sometimes available. Methotrexate can be a particularly 'elegant' way of combining treatment for both skin and a joint involvement."

QUESTION 9. Answer: Stands for Dermatology Life Quality Index; a tool to assess the psychological impact of any skin disease on an individual and a requisite part of the NICE guidelines work up to assess eligibility for biologic drugs in the treatment of psoriasis.
Ref page 5 "There are a number of well established tools quantifying the psychological impact of skin disease on an individual patient including disease specific indices, such as the Psoriasis Disability Index (PDI),[3] and speciality specific indices such as the Dermatology Life Quality Index (DLQI).[4] Indeed, such indexes indicate that patients suffering significant psoriasis perceive themselves more "disabled" than if they had severe ischaemic heart disease! Such scoring systems are also an integral part of the assessment process required to obtain access to newer potent biological treatments."

QUESTION 10. Answer: Cigarette smoking.
Ref page 3 "Palmoplantar pustulosis – This is a rarer presentation of localised pustulation involving the thickened epidermis of the palms of the hands and soles of the feet which can be very disabling due to painful fissuring. It can be differentiated from pompholyx eczema by the dominance of pustulation rather than 'sago grain' vesiculation. It is a notoriously stubborn condition to treat, more commonly occurring in females and has a strong association with cigarette smoking. An associated extreme form of destructive nail and terminal phalangeal involvement called 'acropustulosis' can be enormously disabling."

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