

## Beyond skin:

the need for a new approach to the management of psoriasis in primary care

Psoriasis is a complex, long-term, inflammatory disease associated with significant physical, psychological, and social sequelae.<sup>1,2</sup> It is currently incurable, with the majority of patients being diagnosed before the age of 30 years. This means that for most of their adulthood, people with psoriasis live with a chronic, disabling, and potentially stigmatising condition. The majority of patients are managed in primary care in the UK. Later this year, the National Institute for Health and Clinical Excellence (NICE) will publish guidelines for the management of psoriasis in the NHS in England, Wales, and Northern Ireland. The development of these guidelines closely follows publication of those for Scotland.<sup>3</sup>

The publication of these guidelines is timely given that, in recent years, there has been a paradigm shift in the way that psoriasis is perceived by dermatologists and by the wider scientific community. It is now accepted that psoriasis is an immune-mediated inflammatory disease — in the same class as inflammatory bowel disease and rheumatoid arthritis<sup>4</sup> — and is a product of complex gene-environment interactions that are likely to represent an interplay between an abnormal skin barrier and the innate and adaptive immune systems. There is strong evidence for psoriasis being a prototypic Th17 disease with prominence of interleukins 17 and 22.<sup>5</sup> In addition, rates of occurrence of psoriasis with other conditions, including cardiovascular disease,<sup>6</sup> metabolic syndrome,<sup>7</sup> stroke, and depression, are higher than would be expected by chance; what is still unclear, however, is whether psoriasis can be designated as an independent risk factor for these comorbidities. Research into direct pathophysiological processes underpinning the development of psoriasis, as well as indirect behavioural routes, is currently ongoing in a number of centres in the UK.<sup>8</sup>

### HOW PSORIASIS CAN AFFECT PATIENTS

The significant psychological and social consequences of psoriasis have been documented for over 20 years. Very high levels of distress are reflected in the numbers of deaths by suicide associated with psoriasis<sup>9</sup> but, neither the development of integrated psycho-dermatology services, nor corresponding changes in professional training, have followed. Few specialist

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psychological services for patients with dermatological conditions are available in the UK and opportunities for referral to specialist centres are limited by low levels of recognition of patient need. The clinical (physical) severity of psoriasis does not correspond with patient experiences of distress and impairment of quality of life.<sup>10</sup>

Participants with psoriasis in our recent in-depth study<sup>11</sup> of a diverse community-based sample echoed frustrations reported in large patient surveys. They perceived medical practitioners as lacking expertise in managing patients with psoriasis and as failing to refer appropriately to specialist care, despite the fact that referral guidelines have been shown to be effective for this group.<sup>12</sup> There is evidence of significant dissatisfaction with, and patient disengagement from, NHS services. One implication is that many patients may not be benefiting from major advances in the management of severe psoriasis such as NICE-approved, targeted biologic therapies.

### CHANGING CARE

The last 10 years have seen major changes in the management of long-term conditions such as diabetes. There is an emphasis on regular review and monitoring, case-finding for depression, support and advice about healthy lifestyles, and putting systems in place to address secondary prevention. This is recognised in the *Quality and Outcomes Framework*, which rewards activities carried out in primary care.<sup>13</sup> Systems of

financial incentivisation applied to other conditions may be one way to ensure this gap begins to be narrowed.

A failure to recognise psoriasis as a long-term condition means that there is a misalignment between current understanding about psoriasis and the capacity of current UK health services to respond to the needs of patients with the condition. Primary care practitioners need to be sufficiently skilled to support the psychological and self-care demands associated with psoriasis; there is a need to not only recognise mood disorders associated with the condition, but also to offer regular monitoring, particularly with respect to cardiovascular risk. A move to recognising the link between psoriasis and psychological distress has been made by a joint initiative between the Psoriasis Association and the Mental Health Foundation, ‘See Psoriasis: Look Deeper’.

Adopting a new paradigm for the management of psoriasis has clear implications for decision making among newly formed clinical commissioning groups. Recognition of psoriasis as a complex long-term condition demands appropriately resourced responses. We anticipate that publication of guidance from NICE regarding the management of psoriasis will provide clinicians with an opportunity to consider ways of providing evidence-based practice. However, there is concern that the continued downward pressure on referrals to specialist services

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may mean that access to best treatments will be limited for patients whose health needs are as significant and complex as those of patients with diabetes.

Psoriasis is a complex, lifelong, and potentially life-ruining condition, with significant physical, psychological, and social impacts.<sup>1-2</sup> Viewing it as a simple skin condition is not helpful for patients or for those whom they consult.

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