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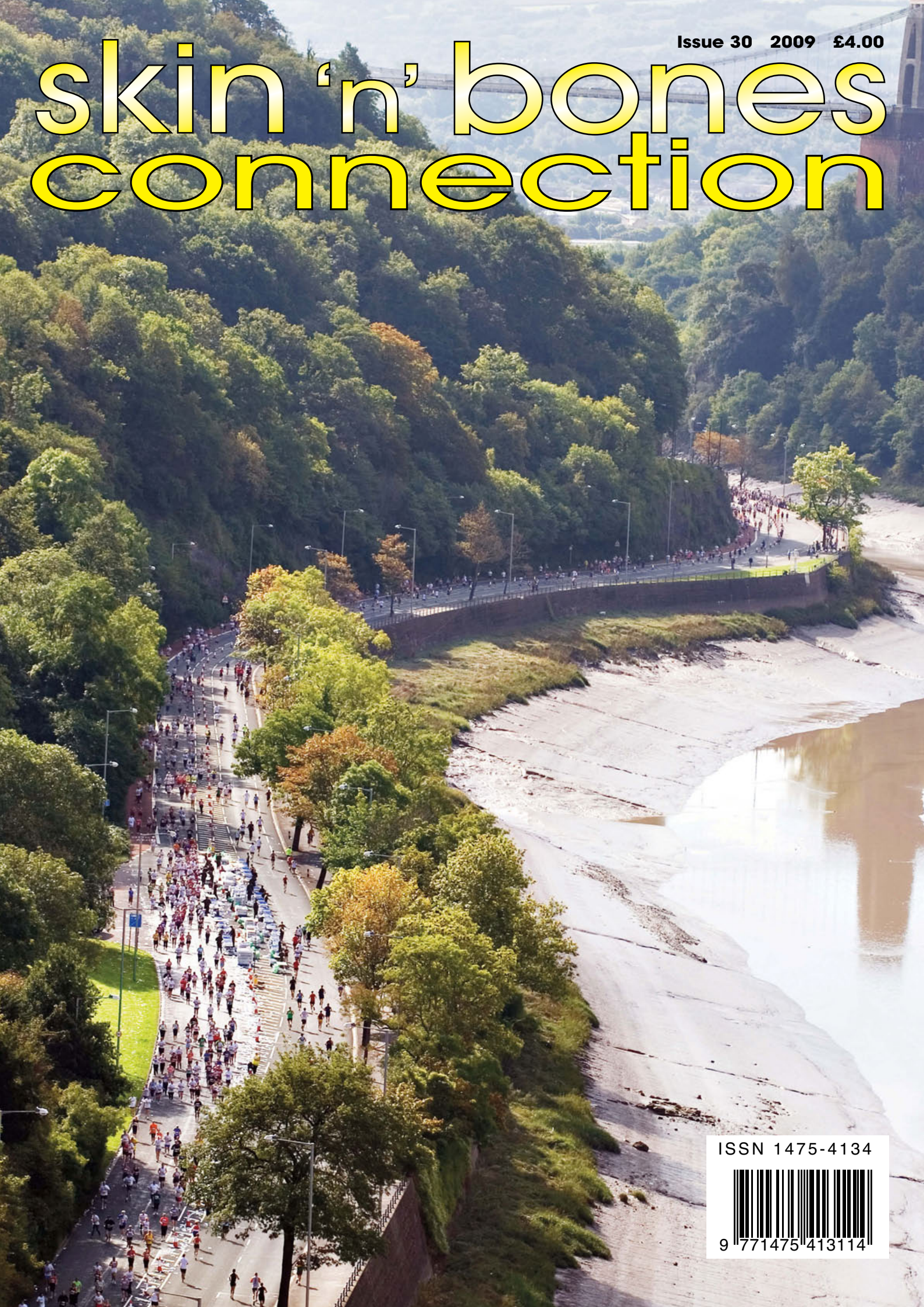
skin 'n' bones connection



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Dear Reader

In this issue we have featured the work we are funding at the University of Manchester. You will find a report on pages 10, 11 and 12. The research is part of our plans to provide positive solutions for people with psoriasis and/or psoriatic arthritis.

The future of disease management does not just lie with the development of research into new drug treatments; there is also a need to understand why some treatments fail and any long-term safety.

On pages 4 and 5 we are looking at the newer biological treatments and the work of the British Association of Dermatologists' patient biological register (BADBIR). This research is vital for patient safety and for future generations who will be able to make informed choices about which treatments have the safest profiles.

We are also looking to expand our own research funding and will take into account the views of people with psoriasis and psoriatic arthritis, by funding projects which will be most beneficial to both the current generation, whilst being mindful of providing a positive legacy for the next.

Managing editor

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Disclaimer

The contents of the journal are aimed at providing information that may be of interest to people with psoriasis and/or psoriatic arthritis or those who have a specialist interest, whether in a personal or professional capacity. Some articles which will be included are of general interest and may or may not relate directly to either psoriasis or psoriatic arthritis. This material may include aspects related to health, services or products that are available.

We believe that at the time of printing all information is correct and cannot be held responsible for any inaccuracies that may occur, nor do we endorse any products that may appear in this journal.
All opinions are of the contributors and not necessarily those of the Psoriasis and Psoriatic Arthritis Alliance.

Always consult your own doctor or medical healthcare provider.

The Psoriasis and Psoriatic Arthritis Alliance (PAPAA) is the new single identity of the Psoriatic Arthropathy Alliance and Psoriasis Support Trust The organisation is independently funded and aims to be a definitive source of information and educational material for people with psoriasis and psoriatic arthritis in the UK. To be a support to both patients and professionals by providing material that can be trusted (evidence based), which has been approved and contains no bias or agendas. We will be looking to provide positive advice that enables people to be involved as they move through their healthcare journey in an informed way, which is appropriate for their needs and any changing circumstances.

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Cover Photo:
Aerial view of the Bristol half marathon tracking through the stunning Avon Gorge, and under Brunel's famous Clifton Suspension Bridge; see page 3 for Barry Cotter's article.

Reebok Bristol Half Marathon 2009 on 6th September

My name is Barry Cotter and I am a 46 year old barrister and part-time judge living in Bristol. My skin psoriasis started in my early teens and has persisted ever since. However the condition was not serious enough to really affect my lifestyle. It seems likely that the trigger for the onset of my arthritis was the breaking of my shoulder in a rugby match. Since then I have suffered with problems with both shoulders, back, knees (leaving one permanently swollen), elbows, hands and ankles. At one stage, I struggled to walk any distance due to the ankle swelling. After courses of physiotherapy, hydrotherapy, 12 cortisone injections (six in the ankles) together with methotrexate and an NSAID (non-steroidal anti-inflammatory drug - rofecoxib), my lifestyle eventually stabilised, but with quite significant restrictions.

I took none or very little exercise for over two years and my weight increased. However, as I had a sedentary job my work was largely unaffected, save for some problems with fatigue. Had I not chosen to stop methotrexate to try for a third child, I do not know what course my overall health would have taken. When off the methotrexate I found that although symptoms grumbled on in various sites I was able to cope pretty much as when on it.

The real breakthrough for me came when I eventually tried a personal trainer (recommended as he had a number of clients with various disabilities). What then happened was a slow, phased increase in fitness and movement. For about six weeks there was no gym equipment used and some of the exercises, I now realise, were pilates based. Then he planned an exercise regime based on increasing fitness and coping with whichever part of the body the arthritis was affecting at any given time. Progress was slow and there were setbacks, but the overall trend was upwards and I was coping with no drugs at all.

September will see both the third anniversary of my first visit to my personal trainer and my first attempt at the Bristol Half Marathon. The training has been difficult and I have to watch my knee very carefully, but I feel the benefits, both mental and physical, of the regime of running. For the race itself you may not be surprised that as someone who could not walk easily not many years ago, I am interested only in finishing rather than achieving any set time.

For a long time I dismissed the idea of going to a gym as impossible given my arthritis and I now regret the wasted time. I lived within what I believed to be my limitations and adjusted my lifestyle accordingly. However the truth was that with structured training I was in fact capable of very much more, despite the fact that the arthritis was still present. However whether it includes running 13 miles remained to be seen!

Well, the big day came and I managed the 13.1 miles in a time of 2 hours 9 minutes. At the end the arthritic knee and toes were painful but it was a great feeling to pass the finishing line. In the end I raised (with gift aid) over £2,000 for PAPAA. A few years back I would never have thought it possible. I really would encourage anybody who can to exercise sensibly (and with advice, such as from a personal trainer) and to the greatest extent that their arthritis will allow. Who knows, you may well surprise yourself. I know I did.

Biologics, safety and you

Are you currently being treated with a biologic agent for your psoriasis? If so, it is likely that you have been prescribed one of the following treatments:

- **adalimumab (Humira®)**
- **etanercept (Enbrel®)**
- **infliximab (Remicade®)**
- **ustekinumab (Stelara®) (most recent addition)**

These biologic treatments are relatively new entrants into the field of psoriasis management and are designed to resemble normal human molecules; hence the term 'biologic'. They are proteins derived from human or animal, rather than artificial chemicals, much in the way that insulin was made from animal sources in the past.

It is thought that overactive cells in the immune system set off a series of events in the body, eventually causing psoriasis to develop on the skin and/or arthritis symptoms to develop in the joints. In psoriasis certain T (thymus) cells are mistakenly activated and they move into the skin. Once in the skin they begin to act as if they are fighting an infection or healing a wound and this results in a rapid growth of skin cells. In psoriasis, skin cells grow much faster than normal and this overproduction causes cells to pile up at the skin's surface.

Some biologics act by preventing the activation and/or migration of T cells, by reducing the number of psoriasis-involved T cells in the body, or both. Others work by blocking the action of chemical messengers released by activated T cells, particularly TNF-alpha (tumour necrosis factor alpha). The messages communicated by TNF-alpha lead to the rapid growth of skin cells found in psoriasis and/or to the joint pain and stiffness associated with psoriatic arthritis.

The biologic medications are very expensive and so they have been the subject of a lot of investigations with doctors being advised when they should be administered. They cost – up to £10,000 per patient per year, only work in a proportion of patients and their long-term safety has not yet been established. As a result they are not considered first-line therapy.

Who gets biological therapy?

Depending on the individual guidance and licence indications, biological therapies are prescribed for moderate to severe psoriasis only if the psoriasis has not responded to standard systemic therapies, including ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet radiation), or the person is intolerant of or has a contraindication to these treatments. The definition of moderate to severe psoriasis is based on both objective measures of psoriasis (ie: a score of 10 or more for the Psoriasis Area and Severity Score (PASI)), and a measure of how the psoriasis is affecting a patient's quality of life (ie: a score of up to 10 on the Dermatology Quality of Life Index (DLQI)).

In a recent costing statement[1] for the use of ustekinumab the National Institute for Health and Clinical Excellence (NICE) estimated the following:

"Using an estimate of 1.63% for the prevalence of psoriasis in the UK[2] and assuming that 1.1% of people with psoriasis are eligible for treatment with a biological therapy,[3] an estimated 7100 people in England would be eligible to receive a biological therapy for their psoriasis.

Clinical opinion suggests that approximately 50%[4] (3550) of these people may actually receive a biological therapy…"

Biologics register

The British Association of Dermatologists (BAD) is the professional organisation for consultant, trainee, staff and associate specialist dermatologists in the UK and Eire.

Established in 1920, it is a registered charity with an incorporated body of trustees, the executive committee, who are all dermatologists elected by the membership. The officers, supported by the professional staff, carry out the day to day business from Willan House, the headquarters building in central London.

The BAD works with many other organisations to achieve its aims of supporting patients and improving standards; these include patient support groups, special interest groups, international dermatology groups and the medical royal colleges.

As part of the process of improving standards and providing education to doctors and patients, the BAD has set up a national register to monitor the use of and collect important data on these biological treatments used to treat psoriasis.

BADBIR

The British Association of Dermatologists' Biologics Register (BADBIR) is a national register of all patients receiving biologic therapy for the treatment of psoriasis in the United Kingdom.

The National Institute for Health and Clinical Excellence (NICE) has recommended that all patients in the UK receiving these new therapies for psoriasis should be registered with BADBIR. The primary aim of the register is to monitor the safety of these drugs.

The purpose of the research study is to assess whether the new biological medications used in the treatment of psoriasis have any side effects (when used long-term in real life) that were not revealed during shorter-term clinical trials. These side effects, if any, will be compared to those seen with established treatments such as ciclosporin, methotrexate and PUVA. The study therefore involves following up patients taking a number of different drugs for psoriasis (and other skin conditions) and assessing the frequency of long-term side effects.

The study design is an epidemiological prospective observational cohort study, comparing patients receiving biologic therapy with those receiving conventional therapy for psoriasis. A similar register, the British Society for Rheumatology Biologics Register (BSRBR), which was set up 5 years ago to investigate use of these biologics in rheumatoid arthritis, has revealed important information on their long-term safety and efficacy for this indication.

Clinical data is being collected using a web-based system. BADBIR are also asking patients to complete short questionnaires by post.

If you are currently receiving a biological agent, ask your dermatologist about the register. The BADBIR website gives more information about the register and the centres around the country which are involved in the research.

For further information:
Web: www.badbir.org
Telephone: 0161 306 1896
Email: badbir@manchester.ac.uk

References:

1. C1. Costing statement: Ustekinumab for the treatment of adults with moderate to severe psoriasis (NICE technology appraisal guidance 180 (TA180)) Available from: www.nice.org.uk/TA180
2. Estimated prevalence of psoriasis obtained from costing template and report: adalimumab for the treatment of adults with psoriasis' (2008). NICE technology appraisal guidance 146 (TA146). Available from: www.nice.org.uk/TA146
3. Estimated proportion of people with severe psoriasis eligible for biological therapy obtained from costing templates and reports for TA103 and TA146. Available from: www.nice.org.uk/TA103 and www.nice.org.uk/TA146
4. Based on clinical expert opinion

Doctors' licence to practice

To practise medicine in the UK, a doctor has to be registered with the General Medical Council (GMC), but from 16 November 2009, all doctors will need a licence in addition to their GMC registration to undertake any form of medical practice in the UK, including, but not limited to, writing prescriptions, holding a post as a doctor in the NHS, and signing death and cremation certificates.

Since 20 April 2009, the GMC has been contacting all doctors on its register to find out whether they wish to take a licence. Some doctors, such as academics or researchers, won't need a licence to practise and are therefore choosing to hold registration without a licence.

GMC chair, Professor Peter Rubin, said:

"We have received a good response to the licensing campaign, having asked 225,000 doctors whether they want a licence to practise. So far, almost 50% of doctors have responded, with the vast majority choosing to take a licence.

"The introduction of the licence is the first step towards a new system called revalidation, the process through which doctors will be asked periodically to demonstrate that they are up to date and fit to practise in the job they do.

"Licensing is a major milestone. The next stage is to implement revalidation. Once we have the results back from the pilots we will be in a position to draw together a more coherent revalidation timetable."

Relicensing

All licensed doctors will need to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC (as described in Good Medical Practice).

For most doctors, they will need to do this every five years. This is the process known as relicensing.

In order to relicence, doctors will need to collect a folder of information about their practice. This will include, for example, information about appraisal, continuing professional development (CPD), audit, and patient and colleague feedback.

Relicensing will have three main elements:

- Participation in an annual appraisal within the workplace (based on the doctor's folder of information)
- Participation in an independent process for obtaining feedback from patients (where applicable) and colleagues
- Secure confirmation from the responsible officer (usually the medical director) in their local healthcare organisation that any concerns about their practice have been resolved.

Most doctors already participate in annual appraisal and obtain feedback from patients and colleagues. Relicensing will build on what they are already doing.

The responsible officer will provide a recommendation to the GMC, on the basis of which the GMC will make a decision whether the doctor's licence should be renewed.

The GMC does not expect to begin relicensing doctors until some time after they have introduced the licence to practise. This is intended to give doctors ample notice before they are required to relicense.

About the GMC:

The GMC registers doctors to practise medicine in the UK; its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Source:
www.gmc-uk.org
Accessed 30 September 2009

Psoriasis and beer drinking

It was reported recently in the journal of the Society for Investigative Dermatology that an analysis of data from the Nurses' Health Study in the USA found that beer drinking was a significant independent predictor for the development of psoriasis.

Dr Patrick Dominguez, of Harvard and Brigham and Women's Hospital in Boston USA, presenting at the Society for Investigative Dermatology meeting said: "These findings have implications for psoriasis prevention and management."

At study entry in 1989, women were asked about their level of alcohol consumption in grammes per week.

Over a 14-year period, biennial questionnaires were used to monitor both the amount and type of alcohol they consumed: beer, light beer, red wine, white wine, or spirits.

In 2005, Dr Dominguez and his colleagues asked participants if they had psoriasis. A total of 2,169 reported a diagnosis of psoriasis, with 1,162 of these being prevalent cases, and the remaining 1,007 being new onset, or incident cases.

After excluding incident cases for which there was incomplete information on alcohol consumption, a total of 955 participants with new onset psoriasis were included for analysis.

Compared with abstainers, women who drank alcohol (defined as consumption of 30 grammes, or roughly two drinks or more per week) had a significantly increased risk of developing psoriasis.

However, when the researchers examined the data by type of alcohol, only consumption of beer with five or more cans a week was a significant independent predictor. For any amount of light beer, wine, or spirits consumed, the relative risks were not significant.

There was no difference in age between abstainers and women who drank alcohol. Abstainers had a slightly higher BMI (Body Mass Index), and drinkers were more physically active, with a higher percentage of drinkers also reporting current or past smoking.

"We also measured dietary folate, which may be a modifier for alcohol's effect in psoriasis, and folate intake was higher in the drinkers, but not significantly so," said Dr Dominguez.

Note:

This study was published as an abstract and presented orally at a conference. These data and conclusions should be considered to be preliminary until published in a peer-reviewed journal.

It is also worth noting that this study was based on analysis of data from an observational study so the findings should be considered hypothesis-generating and not necessarily based on clinical tests and examinations.

If you are concerned about your health and alcohol consumption, contact your doctor or healthcare provider to discuss the options available.

Source reference:
Qureshi AA "Alcohol intake and risk of incident psoriasis in US women: A propective study" SID 2009; Abstract 375.

New arc report

The Arthritis Research Campaign (arc) has just produced a new report that reveals overweight people are 14 times more likely to get osteoarthritis of the knee than those within a healthy weight range.

The report findings included the following:

- More than two out of three knee replacements and one in four hip replacements in middle-aged women in the UK are attributable to obesity
- The body weight of a woman with osteoarthritis is a major factor in whether or not she will require joint replacement surgery. In a British cohort of almost half a million women aged 50 to 69 years, those who were obese were ten times more likely to need knee replacements and two to three times more likely to need hip replacements compared to women with a healthy weight.
- Very obese women are 19 times more likely to need knee replacement surgery and four times more likely to need hip replacement surgery compared to women with a healthy weight.

The full report can be downloaded as PDF by visiting:

http://www.arc.org.uk/pdfs/ARC_report_osteoarthritis_obesity.pdf

PsA risk with obesity

At a recent meeting of the Society for Investigative Dermatology (SID), researchers from Montreal presented a study which shows that patients with psoriasis face a greater risk of developing psoriatic arthritis if they are overweight.

Since 2002, Dr Kristina Duffin and colleagues at the University of Utah recruited more than a thousand psoriasis patients into the Utah Psoriasis Initiative (UPI). They have previously reported a higher prevalence of obesity among subjects with psoriasis compared with the general population. The mean Body Mass Index (BMI kg/m^2) in this population is 29, compared with 26 in the general population, and 34% of study participants have a BMI of 30kg/m^2 or more, compared with 18% in the general population.

At study entry, participants - who are on average 48 years old – were asked to recall the age at which their psoriasis began, together with an estimate of their weight at the age of 18. Analysis of the data shows that at the time of recruitment into the study, patients with psoriatic arthritis were heavier than those with psoriasis only (BMI 30.5 vs 27). Furthermore, BMI at aged 18 predicted the development of arthritis later. Among those with a BMI of less than 25 at 18 years, 26.5% went on to develop psoriatic arthritis; in those with a BMI of 25-30, 35.4% developed arthritis; and in those with a BMI of greater than 40, 40% went on to develop arthritis. In fact a one-unit increase in BMI increases the risk of psoriatic arthritis by 5.4%.

Comment:

There are several points to be aware of in this report. Firstly, the study was published as an abstract and presented orally at a scientific meeting. It has yet to be published in a peer-reviewed scientific journal. This is important, because the results need to be scrutinised very carefully before we finally accept them as part of the established scientific literature. Another important point is to do with study design; participants were asked to recall their weight at aged 18 years. Most of us are rather bad at recalling such information which means that there is a real risk of "recall bias" in these results. Another observation which seems strange is that they report the prevalence of obesity in the general population of 18%, which seems extraordinarily low (most developed countries have obesity prevalence rates of 25-30%).

Overall, however, these findings are potentially important. Not only are patients with psoriasis more likely to have weight problems, the heavier they are, the more likely they are to develop psoriatic arthritis. These data emphasise again the important of maintaining a healthy weight, especially if you have psoriasis. Put another way, if you have psoriasis and you are obese, the odds of avoiding psoriatic arthritis are stacked against you.

Reference:
Duffy KC; Abstract and oral presentation at Society for Investigative Dermatology Meeting (SID), Montreal, Canada 2009

Screening for arthritis in people with psoriasis

A new 5-centre UK study looks at undiagnosed psoriatic arthritis

Dr Philip Helliwell, University of Leeds

Many people with psoriasis have psoriatic arthritis and don't know it.

A recent study[1] found that up about 1 in 6 people have psoriatic arthritis but about a third of these people *don't know that they have it!*

There are 2 possible reasons why there are people with undiagnosed psoriatic arthritis:

1. **Some people never see their doctor to describe unusual symptoms.**
2. **Some doctors may not recognise psoriatic arthritis because it is hard to diagnose without a complete assessment by a specialist.**

People with psoriasis may also have abnormalities in their bones and joints without knowing it. These abnormalities may be the early signs of arthritis. Sometimes the only way to see these abnormalities is with an ultrasound scan. There has been a lot of progress in the treatment of arthritis recently, and the earlier that treatment starts, the more chance it has of being successful in halting the disease.

So, what can be done to improve the diagnosis of psoriatic arthritis?

Education is the most important step to improving the identification of people with psoriatic arthritis. Both doctors and people with psoriasis need to be aware of the symptoms that should alert them to the need for further investigations, and a simple screening questionnaire would be an invaluable tool for doctors who do not specialise in psoriatic arthritis.

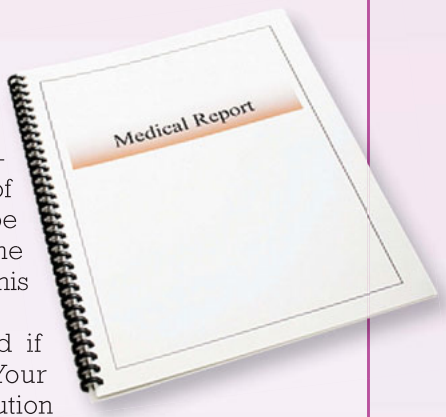
Not all aches and pains will be due to arthritis, but if a simple questionnaire can lead to the early diagnosis of those who have psoriatic arthritis, then early treatment can lead to a significant improvement in their lives.

Over the last two years, three such questionnaires have been developed, two in the United States, and one in the UK, but we don't know which is best.

To answer this question, the University of Leeds is sponsoring a study in 2010 in 5 UK centres;

- **Leeds**
- **Bath**
- **Newcastle**
- **Glasgow**
- **Manchester**

This study will ask people with psoriasis attending dermatology departments to complete three questionnaires and undergo an examination by a bone and joint specialist (a rheumatologist).



If you attend a dermatology department in one of these five centres you may be asked to take home some information to read about this study.

We would be delighted if you decide to take part. Your participation and contribution will help to decide which of the psoriatic arthritis screening questionnaires is the best for people in the UK.

About the author:

Philip Helliwell is currently senior lecturer in Rheumatology at the University of Leeds, in the UK, and honorary consultant rheumatologist for the Bradford Hospitals NHS Trust.

Previous appointments include: member of NHS R&D Research Committee on Physical and Complex Disabilities, member of the executive council, Centre for Biomechanics and Medical Engineering; treasurer and member of executive committee, Society for Back Pain Research; member of Education Committee, Arthritis Research Campaign; and editor for the ARC Patient Information Leaflets and Convener Publications Working Group. His main research interest is in clinical features and classification of psoriatic arthritis. He was a founding member of the GRAPPA group in 2003 and served on the executive committee until 2008. He was the PI of the CASPAR study and is now leading the GRAPPA composite measure exercise in preparation for OMERACT 2010.

Between 1997 and 2000, Dr Helliwell was a member of the Heberden Committee, at the British Society for Rheumatology where he was involved in research, training and educational matters. He was also a member of Council at the British Society for Rheumatology.

Dr Helliwell is also a referee for MRC, EPSRC, ARC and several European and North American Journals.

Note from the editor: **Get involved**

If you are interested in the study and attend one of dermatology centres mentioned above, ask your dermatologist about taking part at your next appointment, or look out for details at the centre.

Reference:

1. Ibrahim G, Waxman R, Helliwell PS. The prevalence of psoriatic arthritis in people with psoriasis. Arthr Care & Res 2009; 61(10):1373-1378.

Psychology, Wellbeing,

We all think we know what psoriasis is but many people consider it only a skin condition. In fact it is a condition that involves the entire immune system, the system that protects us from infections, called the immune system. New research shows strong links between the immune response and psychological distress. Psoriasis can create both physical and psychological distress, and this is now widely accepted by clinicians.

Psychology and Your Skin

When people think about psychology they tend to think of stress. What is stress? The term stress means our assessment of whether we have the inner resources to deal with a challenge. This means it is personal to individuals; one person may see losing their job as stressful while another may see it as an opportunity to work in a different way. With practice we can learn to see the event differently and change our physical and psychological reaction to it.

Stress responses have evolved from the times when we needed to escape from threats to life and the only two options were to stay and fight or run away. The brain releases hormones that prepare our body to step up a gear and blood and energy are diverted to muscles in order to do this. This is useful in the short term but these stress hormones are not cleared from our system for up to 48 hours after the stressful event. If the stress is long-term our body adapts slightly but our ability to effectively manage the stress reduces over time and one thing that is notable is our resistance to infections reduces.

Mind and Body are Linked

How we think, feel and act are all related and whether you think of an event or situation as stressful or not matters because this signals to your body to release different hormones and brain chemicals. This is mostly without us being aware of it but we can learn to tune in to our reactions to stress as a way of understanding this link. There are some things its' helpful to tune into. For example, some people get tension headaches, some get stomach upsets and others get more tired than usual when they are faced with challenges. Knowing how you react to stress is a key part of health and wellbeing as it is the first step to changing it.

Needless to say, good diet and plenty of water is essential to wellbeing and health. However, they tend to be given a lower priority when we are coping with a stressful situation and can wear us down physically. Make sure you get enough sleep when you are stressed as this is one of the early signs things are not good. We find it very hard to focus on solving problems when we are tired. There is also good research evidence that we do a lot of our problem-solving when we are asleep. Sleep is as important for psychological wellbeing as it is for physical health.

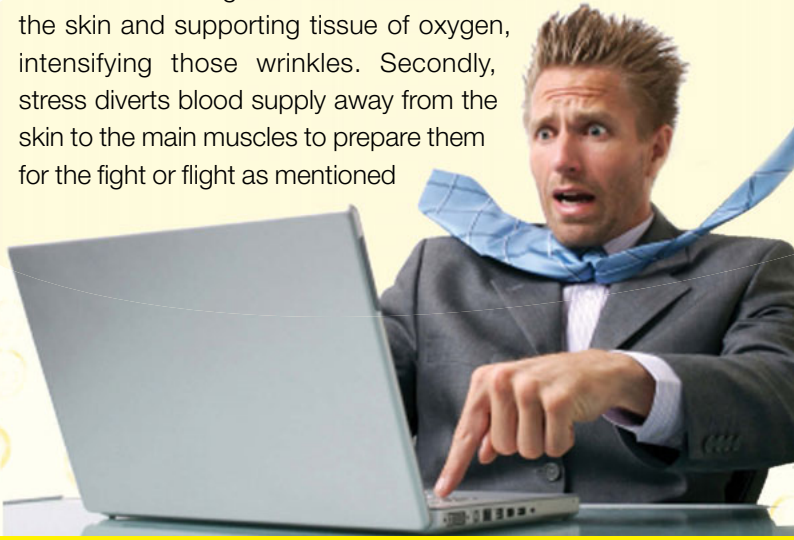
Spotting Behaviour Patterns

Our behavioural reactions (what we actually do) in relation to events differ depending on whether they make us anxious, sad, angry or happy, peaceful or grateful. Some people notice they tend to drink more alcohol if they are feeling stressed or smoke to help manage the unpleasant feeling of stress. Similarly, people say when they are feeling good they can cope much better with demands. There is good research evidence supporting this. You need to know how to spot behaviour patterns before you can learn to change them.

Stress and Skin

We have known for some time that stress can affect skin and people with skin problems such as psoriasis know only too well how stress can trigger it and make a flare-up worse.

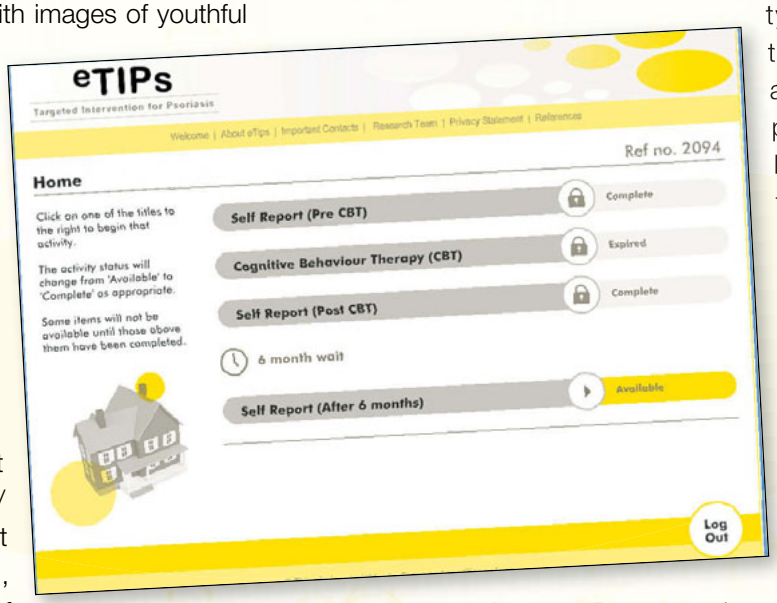
Stress can affect skin and appearance in two ways. Firstly, it increases tension in facial muscles which can contribute to wrinkles developing, which makes us look stressed. This physical tension sets up a feedback loop to the brain and we interpret this sensation of tension as being stressed. If you smoke as well, then you are likely to smoke more when feeling stressed and this starves the skin and supporting tissue of oxygen, intensifying those wrinkles. Secondly, stress diverts blood supply away from the skin to the main muscles to prepare them for the fight or flight as mentioned



Stress and Psoriasis

above. This means there will be less oxygen and fewer nutrients supplied to the skin, resulting in slower cell turnover on the surface, which produces a dull and rather flat complexion. Coupled with the altered immune reaction from chronic stress it is likely that stress affects the way the skin reacts to flare-ups of psoriasis.

We live in a society where images of young, healthy and apparently flawless people are everywhere. Some would argue we are obsessed with images of youthful perfection, even when it does not exist but is created by advertising agencies. Psoriasis, especially, but not only, when visible, can lead people to be reluctant to expose parts of the body affected by it. This causes distress and people report poorer quality of life. Patients say that psychological stress/ distress plays a significant role in the initiation, exacerbation or relapse of psoriasis and our research supports this. We also know stress has a detrimental affect on treatment outcomes (Fortune, and colleagues, 1998, 2003). But psychological symptoms are often not treated as well as the physical symptoms by dermatologists and as a result people feel they don't have the psychological or emotional support they need to help manage psoriasis.



It is important to address these psychological symptoms and so we at the University of Manchester have developed a new psychological programme to add to the excellent medical treatments available for psoriasis patients. This new programme is called eTIPs (electronic Targeted Intervention for Psoriasis) and is funded by PAPAA.

eTIPs

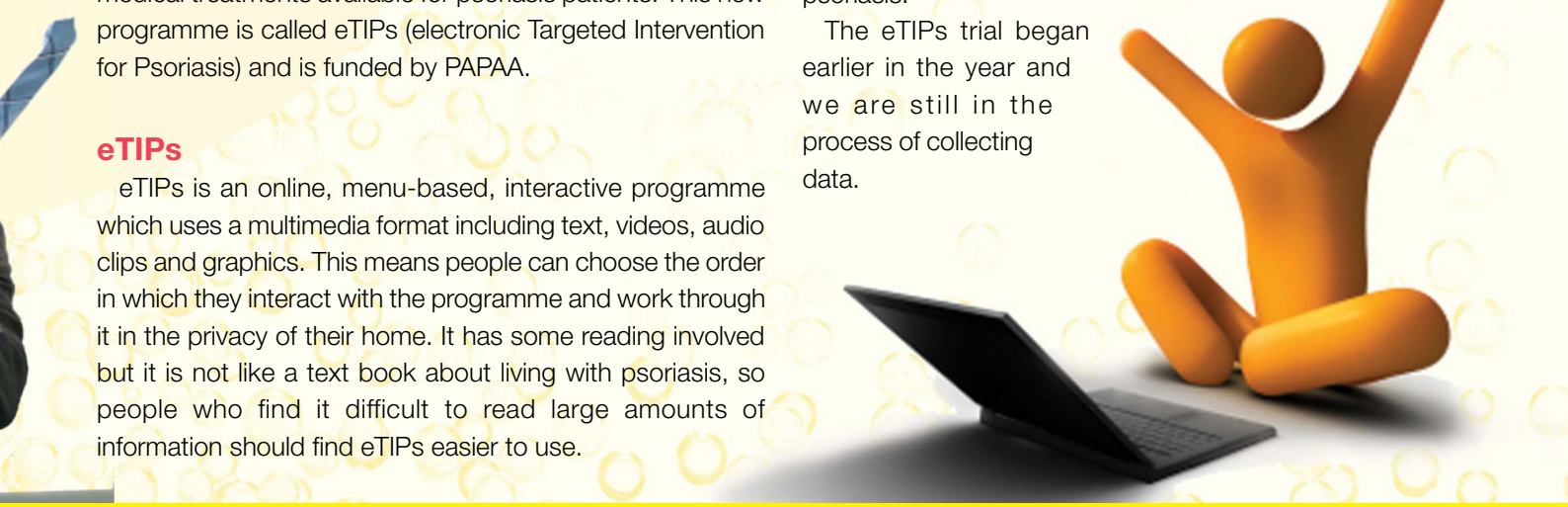
eTIPs is an online, menu-based, interactive programme which uses a multimedia format including text, videos, audio clips and graphics. This means people can choose the order in which they interact with the programme and work through it in the privacy of their home. It has some reading involved but it is not like a text book about living with psoriasis, so people who find it difficult to read large amounts of information should find eTIPs easier to use.

The programme uses the principles of cognitive behaviour therapy (CBT) - a popular form of psychological therapy which focuses on helping individuals to understand that the way they think about a situation can affect the way they feel and act. CBT requires patients to practise thinking-type exercises designed to help them understand their personal patterns in order to improve psychological wellbeing and to give ideas on how to manage their psoriasis better.

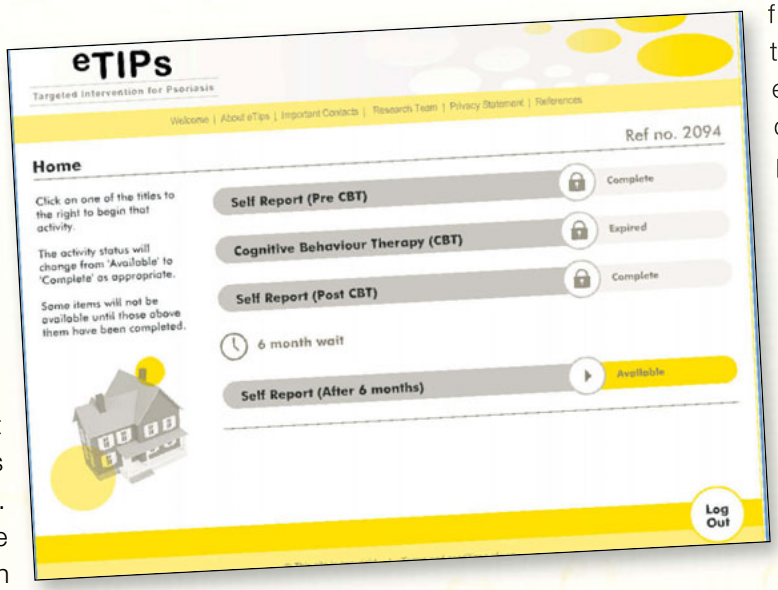
The programme starts with an introduction to the different types of psoriasis and treatments available, CBT and how the eTIPs programme is set out. People then work through a further five sections which target psychological aspects that people have told us are important to living with psoriasis – self-esteem, thinking styles, low mood and depression, stress and tension and coping (Richards, & colleagues, 2001; Fortune, & colleagues, 2000; Jowett & Ryan, 1985).

We have recruited 86 patients out of a target of 150 to date. Selecting people with mild to moderate plaque psoriasis allows us to test if new treatments are effective for the majority of people with the condition. We proceed in small steps with designing any treatments so that we can have confidence they work with the wide range of people with psoriasis not just those with a particular type of problem. If we find it is effective for mild to moderate plaque psoriasis, the next stage will be to test it with other sub-groups of people with psoriasis.

The eTIPs trial began earlier in the year and we are still in the process of collecting data.



Descriptive results collected so far indicate that the majority of patients entered into the trial are married or living with a partner (71%) and there is an equal male/female patient split. Previous research suggests appearance is a problem for people with psoriasis because of this emphasis society places on the appearance of females. There is more pressure on women in our society to look good and the psychological impact on females to remain beautiful and youthful is greater than for men (Roenigk and Roenigk, 1978). Men report greater work-related stress (Gupta & Gupta, 1995). However, this may change with increasing equality in gender roles (eg, equal salaries and opportunities in the work environment, the encouragement of paternity leave, the acceptability of house-husbands, marketing of beauty/lifestyle products and magazines targeting both males and females). In the near future we are likely to see similar levels of psychological impact on male and female psoriasis patients. Once all the complete findings of the trial are analysed, we will be able to investigate this psychological trend.



Many of the participants in the eTIPs trial report anxiety, depression and relatively poor quality of life. Stress was reported as exacerbating psoriasis symptoms, 85% showed moderate to high levels of anxiety, and over half cited less enjoyment than previously experienced and caring less about their appearance. These results echo past findings which suggest approximately 30-40% of psoriasis patients suffer from psychological distress, such as anxiety and depression (Richards & colleagues, 2004; Russo, Ilchef & Russo, 2003; Fried & colleagues, 1995). Psychosocial distress may further impair quality of life (Fortune & colleagues, 1997) which in turn may reduce the effect of treatment (Kabat-Zinn & colleagues, 1998). Certainly in the present trial we can see that 82% of psoriasis patients felt embarrassed or self-conscious due to their skin, and 85% described their skin as itchy, sore, stinging or painful.

The results collected so far indicate many of the eTIPs participants experience psychosocial distress relating to their psoriasis. When all findings are collected and analysed we will be able to examine how effective the eTIPs trial is on reducing these symptoms.

In Conclusion …

Psychological distress and stress have an impact on psoriasis and therefore highlighting the importance of psychological interventions, such as eTIPs, to help reduce the impact and help patients to cope better with their psoriasis. The full extent of the benefit of the eTIPS trial will be reported in Skin 'n Bones once all data are collected and analysed.

Dr Chris Bundy, Ms Binder Kaur for the eTIPs team.

References:

1. Fortune, D.G., Main, C.J., O'Sullivan, T.M. & Griffiths C.E.M. (1997). Quality of life in patients with psoriasis: the contribution of clinical variables and psoriasis-specific stress. British Journal of Dermatology, 137, 755-760.
2. Fortune, D.G., Richards, H.L., Kirby, B., McElhone, K., Markham, T., Rogers, S., Main, C.J. & Griffiths, C.E.M. (2003). Psychological distress impairs clearance of psoriasis in patients treated with photochemotherapy. Archives of Dermatology, 139, 752-756.
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4. Fortune, D.G., Richards, H.L., Main, C.J. & Griffiths, C.E.M. (2000). Pathological worrying, illness perceptions and disease severity in patients with psoriasis. British Journal of Health Psychology, 5, 71-82.

Jowett, S. & Ryan, T. (1985). Dermatology patients and their doctors. Clinical and Experimental Dermatology, 10, 246-254.

Richards, H.L., Fortune, D.G., Griffiths, C.E.M., Main, C.J. (2001). The contribution of perceptions of stigmatisation to disability in patients with psoriasis. Journal of Psychosomatic Research, 50, 11-15.

Online support groups

A study carried out in the USA about the use of online (internet based) communities concluded that people with psoriasis can get valuable educational, psychological and social support.

The study included 260 adults who took part in one of five online support groups. The participants – mostly white, female, college-educated and averaging 40 years old – included 188 (73.7 per cent) with moderate or severe psoriasis and 206 (79.9 per cent) who rated their health as average or better.

The availability of resources was the key factor in their use of an online support group, followed by convenience, access to good advice and lack of embarrassment when dealing with personal issues. In addition, about 75 per cent of the participants said anonymity was an important feature of online support use.

The study found that 49.5 per cent of participants said they believed their quality of life improved, and 41 per cent perceived improvements in psoriasis severity, after they joined an online group.

"Although online psoriasis support groups are still in their nascent stage, they have captured a loyal and growing audience," wrote Shereene Z Idriss and colleagues at the Centre for Connected Health, Massachusetts General Hospital and Harvard Medical School, all in Boston.

"The dermatology community should consider leveraging the infrastructure of online support groups to build on delivering personalised and integrated medical care to individuals affected by psoriasis."

Note from editor:

It is worth considering that this survey only asked people who were already using online support sites, and therefore might be biased towards their usefulness. The group may also not be typical of the psoriasis population in general as psoriasis affects men and woman of all ages and class equally.

Reference:

Benefits of Expanded Social Networks to Patients With Psoriasis

Shereene Z. Idriss, BA; Joseph C. Kvedar, MD; Alice J. Watson, MBChB, MRCP, MPH Arch Dermatol. 2009;145(1):46-51.

Copper bracelets

Copper bracelets and magnetic wrist straps are ineffective in relieving arthritis pain, according to a new study led by a University of York academic.

Researchers conducted the first randomised placebo-controlled trial on the use of both copper bracelets and magnetic wrist straps for pain management in osteoarthritis.

It appears that any perceived benefit obtained from wearing a magnetic or copper bracelet can be attributed to psychological placebo effects.

The devices are used worldwide for helping to manage pain associated with chronic musculoskeletal disorders. The results of this trial conflict with those from previous studies, by showing that both magnetic and copper bracelets were ineffective for managing pain, stiffness and physical function in osteoarthritis. The research is published in the latest issue of the journal Complementary Therapies in Medicine.

The trial was led by Stewart Richmond, a research fellow in the Department of Health Sciences at the University of York, who said: "This is the first randomised controlled trial to indicate that copper bracelets are ineffective for relieving arthritis pain."

"It appears that any perceived benefit obtained from wearing a magnetic or copper bracelet can be attributed to psychological placebo effects. People tend to buy them when they are in a lot of pain, then when the pain eases off over time they attribute this to the device. However, our findings suggest that such devices have no real advantage over placebo wrist straps that are not magnetic and do not contain copper.

"Although their use is generally harmless, people with osteoarthritis should be especially cautious about spending large sums of money on magnet therapy. Magnets removed from disused speakers are much cheaper, but you would first have to believe that they could work."

The trial involved 45 people aged 50 or over, who were all diagnosed as suffering from osteoarthritis. Each participant wore four devices in a random order over a 16-week period – two wrist straps with differing levels of magnetism, a demagnetised wrist strap and a copper bracelet.

The study revealed no meaningful difference between the devices in terms of their effects on pain, stiffness and physical function.

Magnet therapy is a rapidly growing industry, with annual worldwide sales of therapeutic devices incorporating permanent magnets worth up to $4 billion US.

The trial also involved researchers from the universities of Hull, Durham, and the NHS.

Source www.york.ac.uk

Reference:

Therapeutic effects of magnetic and copper bracelets in osteoarthritis: A randomised placebo-controlled crossover trial Publication year: 2009 Stewart J. Richmond, Sally R. Brown, Peter D. Campion, Amanda J.L. Porter, Jennifer A. Klaber Moffett,…

Complementary Therapies in Medicine, In Press, Corrected Proof, Available online 28 August 2009

Home UVB therapy for psoriasis as effective and safe as hospital treatment

For patients with psoriasis, treatment with ultraviolet B (UVB) at home is as effective and as safe as conventional hospital based phototherapy, concludes a study published on bmj.com.

Patients also find home UVB therapy less of a burden and are more satisfied with treatment, the findings show.

UVB treatment is safe and effective, but few patients in the UK ever receive it because of limited availability and time constraints (a course of treatment typically involves attending hospital three times each week for eight to 10 weeks).

Furthermore, most dermatologists believe that home phototherapy is inferior to hospital treatment and that it carries more risks, despite there being no evidence to support this.

So a team of researchers in the Netherlands compared the safety and effectiveness of home phototherapy with standard hospital-based phototherapy. They identified 196 patients with psoriasis from 14 hospital dermatology departments. Patients were randomised to receive either home UVB phototherapy or hospital-based phototherapy.

The home group used a phototherapy unit in their homes, while the hospital group received the treatment at their local hospital. Both treatment at home and at the hospital were applied according to standard routine practice. Disease severity after treatment was measured using recognised scoring scales. Side effects and total cumulative dose of UVB were also recorded.

Both groups completed questionnaires to assess the burden of treatment, quality of life and patient satisfaction for the two treatment settings.

The results show that home phototherapy is equally safe and equally effective as outpatient phototherapy, both clinically and in terms of quality of life. Patients treated at home reported a significantly lower burden of treatment and greater satisfaction with treatment.

And the majority of patients said they would prefer home UVB therapy over hospital-based therapy in the future.

This study clearly shows that home UVB phototherapy is a good alternative that should be considered instead of the standard outpatient UVB phototherapy for patients with psoriasis, say the authors. They suggest that current guidelines should be updated to reflect this.

Writing in an accompanying editorial, Professor Alex Anstey from the Royal Gwent Hospital says: "This study highlights an important gap in the provision of treatment for patients with psoriasis and it is timely to reassess conventional treatments such as UVB. To make home-based phototherapy become a reality, an economic assessment of different UVB service models is needed.

"Meanwhile, healthcare commissioners should work with local dermatologists to improve access to UVB phototherapy services. Experience in Germany, the US, the Netherlands, and Scotland confirms that it would be feasible and practical to implement home-based UVB phototherapy."

Reference:

Home versus outpatient ultraviolet B phototherapy for mild to severe psoriasis: pragmatic multicentre randomised controlled non-inferiority trial (PLUTO study)

http://www.bmj.com/cgi/doi/10.1136/bmj.b1542

New advice on over the counter analgesics containing codeine

The Medicines and Healthcare products Regulatory Agency (MHRA) on 1st September 2009 announced new advice on over-the-counter (OTC) medicines containing codeine and dihydrocodeine (DHC) to minimise the risk of overuse and addiction.

This follows recent advice from the government's scientific advisory body, the Commission on Human Medicines (CHM).

The package of measures includes clear and prominently positioned warnings on the label and patient information leaflet (PIL) about the risk of addiction, and the importance of not taking these medicines for longer than three days.

The revised guidance on the use of these products will focus on treating moderate pain not relieved by simple painkillers such as paracetamol and ibuprofen. There will also be updated controls on advertising to ensure the new warnings are clearly presented.

Large packs of effervescent codeine-containing products will no longer be sold in the pharmacy but will be available on prescription, which further strengthens the voluntary action taken by manufacturers in 2005 on pack size reduction. All packs containing up to 32 tablets remain available for sale through a pharmacy.

MHRA director of vigilance and risk management of medicines, Dr June Raine said: "that taken in the correct manner and for the right purposes, codeine and DHC are very effective and acceptably safe medicines.

"However, these products can be addictive and we are taking action to tackle this risk," she said.

"The MHRA is ensuring that people have clear information on codeine-containing medicines on what they are to be used for and how to minimise the risk of addiction.

"Anyone who has concerns should speak to their pharmacist or a doctor."

The MHRA's action is being taken in parallel with the Department of Health's review of policy on addiction to prescription and OTC medicines.

Source:
MHRA press release. September 2009
http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON057115

Fame and psoriasis

It is an interesting phenomenon that the use of well-known people in the public domain to raise awareness of a condition can give a certain level of credibility to the status of a disease. It becomes better known or at least associated with an individual who is respected or trusted.

Think of a disease and you'll probably also think of a well-known person who either has the condition or is associated with it.

Now think about psoriasis and think of someone associated with the condition in the public eye. You've probably come up with a couple of names. Now consider what you think of that individual and their fame. Does it change your view of the individual? Does it help you to feel better about your psoriasis?

Recently British actress Barbara Windsor said that during a period of ill health *"I was covered in psoriasis, I went deaf, my eyes ran and then the depression set in. I'd pray I wouldn't wake up in the morning. I felt suicidal, hopeless."* So even the most confident of people can find it difficult to cope with what appear to be insurmountable difficulties

The following is a list of people, some better known than others, who have either publicly stated they have psoriasis or it has been reported they have or had psoriasis.

Jason Donovan – Australian actor-singer, born 1968
Ben Elton – English comedian, writer and director, born 1959
Art Garfunkel – American singer-songwriter, actor, born 1941
Robert (the) Bruce – Robert I, King of Scots, (1274-1329)
Tom Waits – American singer-songwriter-composer-actor, born 1949.
Dennis Potter – English dramatist (1935-1994)
Joseph Stalin – General Secretary of the Communist Party of the Soviet Union's Central Committee (1878-1953)
John Updike – American writer (1932-2009)
Jean-Paul Marat – Swiss-born French scientist (1743-1793)
Abimael Guzman – Shining Path leader, born 1934
LeAnn Rimes – American singer, born 1982
John Thomson – British actor, born 1969
Nadia Sawalha – British actress, born 1964
Terry Wogan – Irish broadcaster, television presenter, born 1938
Alan Carr – British comedian, born 1976.

Sources:
www.disabled-world.com, www.psorsite.com
http://answers.google.com

Letters

Dear PAPAA,

I am 26 years old and have suffered from pain and stiffness in my joints since I was around 9 years of age. When I reached the age of 13 I developed psoriasis.

It was not until last year that I was diagnosed as having psoriatic arthritis and began receiving treatment.

I got your address from a woman's magazine which had an article on psoriatic arthritis. I was very pleased to see this article because before I was diagnosed I had never even heard of it and this was the first I ever heard or read of it since being diagnosed.

The article stated that around 40,000 people in Britain suffer from this disorder. Reading this made me feel relieved that I was not alone, that there are other people who have heard of what I have.

MW

Dear PAPAA,

I have psoriasis on the soles of my feet and have been seeing a dermatologist for the past 15 years. My sister and I were the only ones in a large family that have suffered with this but now my niece has psoriasis very bad. What is the likelihood of my children developing psoriasis?

BC

Dear BC,

If one parent has psoriasis a child has a 1 in 4 chance of developing the condition. If both parents have psoriasis the risk rises to a 3 in 5 chance.

PAPAA

Q Dear PAPAA,

I am writing to ask if you could send me some information on this condition.

My mother suffers from both psoriasis and related arthritis. I am now in my early 30s and also have psoriasis, although only mildly, which I have had since about 16 and have for some years had frequent aches and pains in joints.

I am particularly interested to know if there is anything I can do now to prevent the arthritis getting worse and would be very grateful for any information which would be of help.

TS

A Dear TS,

Psoriatic arthritis is a progressive condition, and your rheumatologist should be able to advise you on treatments that can help the symptoms. You may want to think about seeing a rheumatology physiotherapist, who will able to advise you on exercises to help mobility and reduce pain. We produce a booklet called *Physiotherapy & Exercise: Psoriatic Arthritis* ISBN: 978-1-906143-05-3 which is available free or can be downloaded from our website.

PAPAA

Dear PAPAA,

I first had signs of psoriasis in 1986 where it developed to the extent I went into hospital for 8 days, for UVA treatment. My more recent visit for light treatment used UVB over a longer period of time.

Originally it started as one small patch at the back of my head in the hair. But there are times when it covers my face and whole body.

I continually look for new methods of treatment, homeopathy etc but I feel no one really treats the cause, only the symptoms. When you are particularly down, because of how you look to others, your level of motivation and optimism becomes really threatened.

It was nice to discover your website and as they say, knowledge is power.

Thank you for taking the time to read this letter. I know many suffer far more than I do, although I always seem to let the condition control me, rather than the other way around.

PC

Q **Dear PAPAA,**

I hope you can help me. I have a lot of trouble finding the right shampoo for my hair and scalp.

LW

A **Dear LW,**

There are a number of shampoos available for scalp psoriasis; some are only available on prescription from your doctor, whilst others can be purchased from a pharmacy. Speak to your GP or pharmacist about these as they will be able to advise you on what is the most suitable shampoo for your circumstances.

PAPAA

Dear PAPAA,

I have just received your ***Scalp Psoriasis*** leaflet and I'm so surprised to find such an informative leaflet.

It covers every aspect of this annoying and relentless condition and its treatment.

I have had this malady for sixty six years, with ups and downs in severity, but never ever disappearing.

I have read so much about it over the years, but never seen such an excellent covering of all one needs to know.

Wouldn't it be great if the NHS (and private consultants) could issue this leaflet to those afflicted?

In my experience, few GPs know anything much about skin trouble and particularly psoriasis; have they ever wondered how the ointments they prescribe are applied to inaccessible areas by lone elderly sufferers?

Anyway, I just feel I must applaud you.

JW

P.S. Gadgets are OK, if joints are flexible!

Dear JW,

Thank for your kind words, and remarks about gadgets, we'll keep this in mind for the future.

PAPAA

Q **Dear PAPAA,**

Having been a subscriber to PAPAA from the early days, I would like to place on record my thanks to your organisation for all the info received whilst I have been a member.

I have had psoriasis since my early twenties and have now reached the ripe old age of 76. It was not until I started finding out about various treatments that were on prescription did I get a real improvement in my condition, by asking my GP for shampoos and ointments seen in your journals and leaflets.

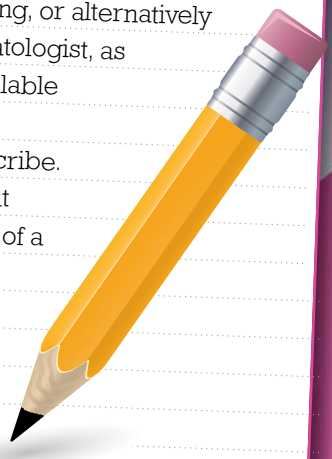
My main concern these days is the psoriasis in my groin and I would like to ask your medical advisors via the Q and As section what they recommend as a cream to treat this area as all ointments or creams state 'not to be used in skin fold areas'. Apart from my groin, I have got my psoriasis under control apart from a few minor areas ie one elbow and a few small spots on my back. If I have had the support of PAPAA in my younger days I would have been able to lead a more 'normal' life in the past and would have been able to go swimming and wear short sleeve shirts. Thanks for all the info received in the past and I look forward to seeing my question in the journal.

PT

A **Dear PT,**

Thank you for your supporting letter. You are correct that treating sensitive areas is difficult and that many treatments are not recommended for use in these places. Talk to your GP about this as he/she maybe able to guide you on which treatments are less irritating, or alternatively seek a referral to a dermatologist, as there may be options available from secondary care that your GP is unable to prescribe. You may like to think about using an emollient as part of a daily routine as these can soothe the skin and make sensitive areas more comfortable.

PAPAA



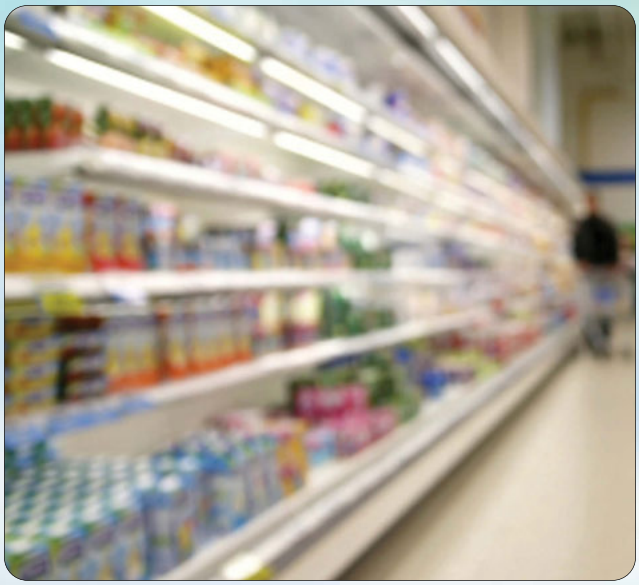
Please note: letters and emails have been edited and names withheld for privacy

European Food Safety Authority (EFSA)

EFSA has published its first series of opinions on the list of 'general function' health claims compiled by Member States and the European Commission. Experts on EFSA's Panel on Dietetic Products, Nutrition and Allergies (NDA) evaluated the scientific evidence for more than 500 claims[1]. The opinions will help inform future decisions of the European Commission and Member States concerning the authorisation of health claims[2].

The opinions provide scientific advice on 523 health claims relating to over 200 foods and food components such as vitamins, minerals, fibre, fats, carbohydrates, probiotic bacteria, and botanical substances. For approximately one third of the claims the outcomes of the evaluations were favourable as there was sufficient scientific evidence to support the claims. These related mainly to functions of vitamins and minerals, and also included dietary fibres, and fatty acids for maintenance of cholesterol levels, and sugar-free chewing gum for maintenance of dental health. Almost half of the evaluations with unfavourable outcomes were owing to a lack of information on the substance on which the claim is based, for example probiotic bacteria and botanical substances. Without clear identification of the substance in question, the panel could not verify that the scientific evidence provided to EFSA related to the same substance for which the health benefits are claimed.

Commenting on these first results, Professor Albert Flynn, chair of EFSA's NDA Panel stated: "EFSA's independent scientific advice will help ensure that the health claims made on foods are accurate and helpful to consumers in making healthy diet choices. The scientific opinions will inform future decisions of the Commission and Member States concerning the authorisation of health claims."



EFSA convened a meeting with experts from Member States and the European Commission on 6 October 2009 in Brussels to discuss the evaluation of the 'general function' claims. A briefing document prepared for discussion at the meeting explains EFSA's approach to the evaluation of these claims.

Between July and December 2008 EFSA received from the European Commission a draft list with 4,185 claims to be evaluated. This list was the result of a consolidation process carried out by the Commission, after examining over 44,000 claims supplied by the Member States. The panel is proceeding with the adoption and publication of scientific opinions on the outstanding claims on the list. EFSA is liaising with the European Commission in order to define a more precise timetable for completion of the work, taking into account possible additional claims to be evaluated.

References:

1. 'General function' claims defined under Article 13.1 of the Regulation 1924/2006 on nutrition and health claims made on food include: The role of a nutrient/substance in growth, development and the functions of the body; psychological and behavioural functions; slimming and weight control or reduction of hunger, increase of satiety or the reduction of available energy from the diet. These claims do not include those related to children's development or health or disease risk reduction.
2. EFSA is responsible for verifying the scientific substantiation of the claims. EFSA's advice is taken into account by the European Commission and Member States in authorising health claims.

About the European Food Safety Authority (EFSA)

The European Food Safety Authority (EFSA) is the keystone of European Union (EU) risk assessment regarding food and feed safety. In close collaboration with national authorities and in open consultation with its stakeholders, EFSA provides independent scientific advice and clear communication on existing and emerging risks.

New legal rights for NHS patients

NHS Constitution: a consultation on new patient rights

NHS patients will have legal rights to maximum waiting times for urgent cancer referrals and elective (non-emergency) procedures, under new proposals. People aged 40 to 74 will also have the right to an NHS health check every five years.

From 1 April 2010 patients will have the legal right to start treatment by a consultant within 18 weeks of being referred by a GP.

Cancer patients will have the legal right to be seen by a cancer specialist within two weeks of being referred by a GP.

If the NHS can't meet this commitment, it will have to take all reasonable steps to find a range of alternative providers that can.

This will allow a patient to get their care more quickly, if this is what they want. The alternatives could include private providers at NHS prices.

Everyone aged 40 to 74 will also have the right to an NHS health check every five years to assess their risk of:

- **heart disease**
- **stroke**
- **diabetes**
- **kidney disease**

Identifying any risk early may help to reduce cases of these diseases and the damage they cause.

Prime Minister Gordon Brown said: "These measures build on the high standards and rightly rising expectations of patient care.

"Every single person who has to go into hospital or go through the difficulty of cancer will have clear rights and real power guaranteeing them quick access to care, or the offer of going private or to another NHS provider if these standards are not met."

Have your say on NHS patient rights

As well as comments on the rights mentioned here, your views are wanted on what other patient rights could be introduced in the future.

These could include the right to:

- die at home
- NHS dentistry
- personal health budgets
- choose a GP practice offering extended access to evening and weekend appointments
- tests for suspected cancer patients within one week of seeing a GP

If you want to comment on the proposals you have until 5th February 2010 to do so.

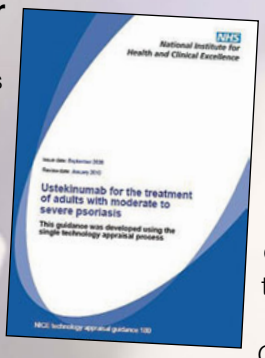
To find out more and to have your say, go to:
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_108012

For further information contact:
NHS Constitution Team
Richmond House, 79 Whitehall, London, SW1A 2NS
Email: NHSConstitution@dh.gsi.gov.uk

NHS National Institute for Health and Clinical Excellence

Ustekinumab guidance

The National Institute for Health and Clinical Excellence (NICE) published in September final guidance recommending the use of ustekinumab as a treatment option for adults with severe plaque psoriasis.



It is recommended if the person is assessed as having severe disease that has not responded to standard systemic therapies including ciclosporin, or for adults who cannot use those therapies. Treatment with ustekinumab should stop if an adequate response has not been achieved by 16 weeks (after the start of treatment) as defined by assessment based on severity of the psoriasis and quality of life.

Dr Carole Longson, director of the Health Technology Evaluation Centre at NICE said: "Plaque psoriasis can have a huge impact on an individual, with the condition causing significant discomfort and in severe cases it can be painful. The characteristic raised red patches of skin covered with silvery scales are commonly seen on elbows, knees or scalp, but in severe cases can cover most of the body. This new guidance recommending ustekinumab will offer hope to adults whose severe plaque psoriasis hasn't been helped by systemic therapies including ciclosporin, methotrexate and psoralen with long-wave ultraviolet radiation."

Ustekinumab is recommended on the basis that the manufacturer provides the higher dose needed for people who weigh more than 100 kg at the same total cost as for the lower dose needed for people weighing 100 kg or less. Healthcare professionals should take into account any physical, sensory or learning disabilities, or other communication difficulties that could affect assessment responses.

Ustekinumab is classed as a biological therapy. Other similar treatments available with NICE guidance include adalimumab, etanercept and infliximab.

Ustekinumab is a prescription-only medicine (POM) and is commercially known as Stelara and marketed in the UK by Jansan Cilag.

The guidance is available at:
http://www.nice.org.uk/TA180

Market Place

Here are a few items that have been brought to our attention by our readers. These are for your interest and in no way are we endorsing or recommending these products.

We've been sent some interesting items for this edition, so thank you if you have provided suggestions.

Are you having trouble finding shoes to fit your feet or are your feet extra wide? Here are some outlets that may have a solution for you.

Cosyfeet is a family-owned company based in Street, Somerset, specialising in extra-roomy footwear, socks and hosiery for men and women.
The range includes solutions for everyone, with shoes that may help anything from aching legs to sore feet.

DUO is also based in Somerset and supplies shoes and boots. The company has tried to dispel the myth of one-size-fits-all footwear and provides a range off bigger calf-width boots up to 50 cm

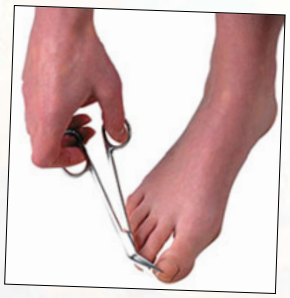
DUO™
style is nothing without fit

Another specialist company is the **Hotter Comfort Concept** shoe factory based in Lancashire. The company makes a range of shoes, boots and other footwear for all styles, tastes and needs, including extra-wide fittings.

Continuing the theme of foot comfort, how about this **Long Reach Foot Care System** available from **Readers Offers** and **Viva Direct**; if you struggle to bend, this kit helps you to clean, buff and polish your toenails. With its 15cm extension arm, this system makes it easy and there's even a built-in light.

Powered by 2 x AA batteries (not supplied) it has eight different heads to clean, shape, polish, buff and even remove calluses. Code: E832 or 145/7747
Prices from £12.95

Also available from **Viva Direct** are these long handled precision-made toenail scissors that will help to keep your nails neatly shaped and healthy – with the added benefit of being particularly easy to use. The extra-long handles provide increased leverage that cuts through tough nails with ease.
Code 138 8912 Price £7.95



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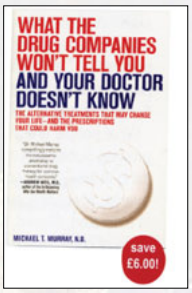

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