What is Psoriasis?

This information is produced by the Psoriasis and Psoriatic Arthritis Alliance

www.papaa.org

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What are the aims of this leaflet?

This leaflet has been written to help you understand what happens in psoriasis, who it affects, what the different types of psoriasis are, what you can do to control it, treatments, and where you can find more information.

What is psoriasis?

Psoriasis (sor-i'ah-sis) is a long-term (chronic) usually scaling disease of the skin, which affects around 1 in 50 people, which is about 1.3 million, or around 2% of the UK population**. IT IS NOT CONTAGIOUS** and you cannot catch psoriasis from someone else. It usually appears as red, raised, scaly patches known as plaques. In people with skin of colour, the redness is less pronounced, and psoriasis may appear as purple or darkened areas of skin with grey scales. Any part of the skin surface may be involved but the plaques most commonly appear on the elbows, knees and scalp. It can be itchy and, in some instances can cause pain in the affected area. Nearly half of those with psoriasis may be affected by nail changes which includes pitting and ridging. One in 4 of those with psoriasis, about 325,000 people, around 0.5% of the UK population will develop psoriatic arthritis (particularly those with moderate to severe psoriasis). This can cause swelling, stiffness and pain in the joints or stiffness in the lower back.

Although the commonest form features red, raised, scaly plaques, there are a number of types of psoriasis. These look different and may require specific treatment. Remember, although psoriasis is a chronic condition, it can be controlled and go into remission (go away, often temporarily and sometimes permanently). Not all people will be affected in the same way and doctors will class the condition as mild, moderate or severe, although the impact on mental health and the psychological burden can be large irrespective of severity. See our ***Psychological aspects of psoriasis*** leaflet.

Psoriasis presents as mild, moderate or severe. Most cases are classed as mild involving a few patches, which may need treatment but, are not likely to cause problems and can be easily controlled. Although, the impact of small amounts of psoriasis dependant on which part of the body it appears, can cause embarrassment and distress.

With moderate psoriasis more of the skin is affected and it is widespread. It can usually be controlled with self-management under the supervision of a

GP, nurse or equivalent healthcare practitioner, but again can affect people significantly.

For a smaller number of people with psoriasis (around 1 out of 20, or 5%), they will have a severer form, which results in large areas being covered. The condition becomes difficult to self-manage or no longer responds to treatment. At this stage, referral to secondary care at a local hospital outpatient department should take place. It is rare for people to be admitted to hospital, if affected by plaque psoriasis, but in certain circumstances it may be felt necessary, where more advanced therapies may be considered.

What happens in the skin?

Normally a skin cell matures in 21 to 28 days. During this time, it travels to the surface of the skin, where it is lost in a constant, invisible shedding of dead cells. In patches of psoriasis the turnover of skin cells is much faster, around four to seven days, and this means that even live cells can reach the surface and accumulate with dead cells. It is thought that cells in the immune system (T cells) become overactive, leading to rapid growth of skin cells and the formation of psoriatic plaques.

The extent of psoriasis and how it affects an individual varies from person to person. Some may only be mildly affected with a tiny patch hidden away which does not bother them, while others may have large, visible areas of skin involved that significantly affect daily life and relationships. The process is the same wherever it occurs on the body. There are some factors that trigger flares of psoriasis including infection, stress, alcohol and smoking. Obesity is also linked to psoriasis and maintaining a healthy weight can reduce the severity of the disease.

Who does it affect?

It affects men, women and children alike. It can appear at any age in varying degrees but peak incidence is usually between the ages of 10 and 30 or later in life around 60 years of age. The severity of the disease varies enormously, from a minute patch to large patches covering most body areas. Psoriasis can also run in families and it is known that the disease is multi-genetic (a condition where several genes may each have different roles, contributing to specific characteristics of disease) and therefore children may not necessarily inherit psoriasis. It is estimated that if one parent has psoriasis then there is a 3 out of 20 (15%) chance that a child will develop the condition. If both parents have psoriasis this increases to about 15 out of 20 (75%). Interestingly, if a child develops psoriasis and neither parent is affected there is a 1 out of 5 (20%) chance that a brother or sister will also get psoriasis.

Is there a cure for psoriasis?

There is no cure at the moment. However, as a consequence of current research, our understanding about what happens in psoriasis is growing and new drugs are being developed. In the meantime, there are a number of treatments that are effective in keeping psoriasis under control.

The art of treating psoriasis is finding the best form of treatment for each individual. There is no single solution that is right for everyone.

Does this mean I will have psoriasis for life?

In the absence of a cure you will always have psoriasis, but this does not mean that the signs will always be visible. Normally, the condition tends to wax and wane (increase and decrease). There will be periods when your skin is good, with little or no sign of psoriasis. Equally, there will be times when it flares up. The length of time between clear skin and flare-ups differs for each individual and is unpredictable. It may be weeks, months or even years.

What are the types of psoriasis?

- **Chronic plaque psoriasis**: Raised, red, scaly patches mainly occurring on the limbs and the trunk, especially on the elbows, knees, hands, around the navel, over the lower back (sacrum) and on the scalp. The nails may be affected so that they become thickened and raised from their nail beds, and the surface of the nail may be marked with small indentations (pits). This is the most common type of psoriasis, affecting around 9 out of 10 people with psoriasis.
- **Guttate psoriasis (raindrop psoriasis):** Named because it manifests itself over the body in the form of scaly, droplet like patches. Numerous small, red, scaly patches quickly develop over a wide area of skin, although the palms and the soles are usually not affected. It occurs most frequently in children and teenagers, often after a throat infection due to streptococcal bacteria. Some people who have had guttate psoriasis will go on in later life to develop chronic plaque psoriasis.
- **Scalp psoriasis**: Raised, red, thick, scaly plaques on the scalp and around the hairline. It is common and approximately 1 out of 2 (50%) of all people with psoriasis have it on their scalp. The reason it deserves special mention is that it can be particularly difficult to treat and usually requires specifically formulated medicines. It is awkward to treat with creams and ointments because the hair gets in the way. See our ***Scalp Psoriasis*** leaflet.
- **Flexural psoriasis**: Produces red, well defined areas in skin folds (flexures) such as the armpits, between the buttocks, groin and under the breasts. Scaling is minimal or absent. This type of psoriasis is often irritated by rubbing and sweating due to its location in the skin folds

and other tender areas. Such areas can also be prone to yeast or fungal infections, which might cause confusion in diagnosis.

- **Napkin psoriasis:** Develops in the nappy area of an infant to cause a bright red, weeping rash or more typical psoriasis plaques. A child who has napkin psoriasis as a baby does not seem to have a higher risk of developing other forms of psoriasis in later life.
- **Pustular psoriasis:** Looks different to plaque psoriasis in the form of pus spots, although plaque and pustular psoriasis can coexist or one may follow the other. See our ***Pustular Psoriasis*** leaflet.
- **Generalised pustular psoriasis (GPP):** In rarer cases, the pustules are more widespread and accompanied by a fever. The development of generalised pustular psoriasis requires urgent hospital treatment. See our ***Pustular Psoriasis*** leaflet.
- **Palmar-plantar pustulosis (PPP)**: Small, deep seated pustules form that usually only affect the palms and soles. Pustules are caused by the accumulation of white blood cells and are not infected. See our ***Pustular Psoriasis*** leaflet.
- **Acrodermatitis continua of Hallopeau (ACH):** is another rare form of palmar-plantar pustulosis. See our ***Pustular Psoriasis*** leaflet.
- **Erythrodermic psoriasis**: A rare, serious condition where skin redness (erythema) can affect more than 90% of the body surface. Dilated blood vessels in the skin affect blood circulation to other parts of the body, with problems of fluid balance and rapid heat loss. In severe cases, this may be life threatening. Erythrodermic psoriasis is very rare, with approximately 200 to 300 new cases in the UK each year. Those affected need very intensive specialist care in hospital.
- **Nail psoriasis:** In nearly half (40% to 50%) of people with psoriasis there is also major involvement of the nails, with minor involvement seen in some individuals. The fingernails and toenails are affected equally. This may just be one nail, or all of them. Discolouration, pitting and separation from the nail bed (onycholysis) are the most common characteristics of activity. Nails can be a good indicator that psoriasis is present and can help the doctor to diagnose if an associated form of arthritis is present. See our ***Nail Psoriasis*** leaflet.
- **Psoriatic arthritis (psoriatic arthropathy):** About 1 in 4 (25%), which is 0.5% of the UK population or 325,000 people with psoriasis, may develop an associated arthritis called psoriatic arthritis, which causes pain and swelling in the joints and connective tissue, accompanied by stiffness particularly in the mornings and when rising from a seat. Most commonly affected sites are the hands, feet, lower back, neck and knees, with movement in these areas becoming severely limited. Chronic fatigue is a common complaint linked with this condition. If you are experiencing mild aches and pains and have psoriasis, even very mildly, consult your dermatologist, GP or other healthcare professional for further advice and if necessary a referral to a rheumatologist for

further assessments. For more detailed information on psoriatic arthritis see our ***Psoriatic Fatigue*** and ***What is Psoriatic Arthritis?*** leaflets.

If you think or suspect you have any of the conditions or symptoms described above, contact your GP or dermatologist who will be best placed to offer advice and to recommend the best treatment programme for you personally.

What can I do to help my psoriasis?

There may not be a cure yet but there is much you can do to help maintain and control your psoriasis. Psoriasis, regardless of location or type, is often irritated by contact, particularly tight clothing such as elasticated waistbands, socks, tights, and underwear. It may be useful to wear looser clothing where psoriasis is likely to be irritated either when flaring or during periods of treatment. Identifying factors that may cause your psoriasis to flare, using a diary, can be helpful. It is recognised that managing stress, reduction in weight (if overweight), stopping smoking and reducing alcohol intake can improve psoriasis.

Can psoriasis be treated?

Yes, there are many forms of treatment for psoriasis, which range from those you apply to the skin (topical) to tablets, or injectable therapies. See our ***Treatments for Psoriasis: An overview*** leaflet.

Many people who have psoriasis find that the sun and artificial ultraviolet light (UV) helps to improve their skin's appearance although you should not use commercial sunbeds. For some the change is dramatic. Be aware that exposure to the sun and artificial UV therapy can cause damage to the skin, which in turn increases the risk of skin cancer. For further information see our ***Psoriasis and the Sun*** and ***Psoriasis and Phototherapy*** leaflets.

For some people, talking therapies such as cognitive behaviour therapy (CBT) can also help them understand the psychological impact of psoriasis and provide a safe therapy which may help them cope with psoriasis. See our free online CBT programme at **www.papaa.org/cbt**

Your treatment can only be as good as you allow it to be; that means if the treatment takes six weeks, you have to follow it as instructed for six weeks and no ducking out! Adherence to treatment instructions is an essential part of managing your psoriasis.

All treatments may have unwanted side effects or require special precautions (for example, during pregnancy where some treatments are explicitly not to be used or require special precautions). Always make sure you have all the relevant information available before embarking on any course of therapy.

This includes reading the patient information leaflets (PIL) provided with your medicines.

Can diet affect my psoriasis?

A healthy diet is important for wellbeing and can reduce your risk of many long-term illnesses. Moderate to severe psoriasis is known to increase the risk of heart disease and stroke and therefore a healthy diet can reduce this risk. Psoriasis can also be associated with diabetes and obesity, so having a balanced diet alongside regular exercise is key to remaining healthy.

However, there is no clear link between what you eat and the severity of psoriasis symptoms.

- The British Nutrition Foundation suggests eating at least 5 portions of fruit and vegetables a day with 2 portions of oily fish a week for general health (for example, mackerel, herring, salmon, trout, sardines and pilchards).
- Aim to eat more green leafy vegetables, nuts, seeds and wholegrain cereals, which also contain important essential fatty acids.
- Cut back on saturated fats and vegetable oils and use more olive oil and rapeseed oil products.
- Eat fresh, homemade foods rather than pre-packaged convenience food.
- Excessive amounts of alcohol can make psoriasis worse and can also interfere with certain treatments, for example methotrexate.
- A useful source of information can be found on the NHS Live Well website.

See our ***Psoriatic lifestyle and nutrition*** leaflet.

I may have psoriasis – what do I do now?

If you think you have psoriasis, go and see your GP. The GP may start treatment themselves or refer you to a dermatologist for advice.

Don't forget, if you are also experiencing aches and pains in any of your joints, have any other symptoms or if you have a family history of psoriasis, inform the doctor. This will assist with diagnosis and treatment.

Long term outcome

Ongoing research and development are providing a clearer understanding of the causes of psoriatic disease. For those diagnosed and living with psoriasis today, with good therapy and management, it can be controlled and allow for a full and active life.

Summary

- It is very common affecting around 1 in 50 people in the UK.
- Can appear at any time from infancy to old age.
- Regardless of severity it can cause psychological distress.
- It can appear as mild, moderate or severe.
- Erythrodermic psoriasis is very rare, and needs immediate hospital care.
- Scalp psoriasis affects half of those with psoriasis.
- Approximately 1 in 2 people will have some involvement of the nails.
- Around 325,000 of people with psoriasis may go on to develop some form of psoriatic arthritis (inflamed joints).

Useful contacts

For information about health matters in general and how to access services in the UK, including access to financial support and other benefits, the following websites provide national and local information.

- NHS UK: www.nhs.uk
- NHS England: www.england.nhs.uk/
- NHS Scotland: www.scot.nhs.uk/
- Health in Wales: www.wales.nhs.uk
- HSCNI Services (Northern Ireland): http://online.hscni.net

These sites are the official sites for the National Health Service and provide links and signposting services to recognised organisations and charities.

About this information

This material was produced by PAPAA. Please be aware that research and development of treatments is ongoing. For the latest information or any amendments to this material, visit our website: www. papaa.org the site contains information on treatments and includes patient experiences and case histories. Original text written by David Chandler and Julie Chandler with assistance from medical and lay reviewers, August 1997.

Dr Jennifer Crawley, clinical fellow in medical dermatology, St John's Institute of Dermatology, London, fully reviewed and revised this leaflet in 2011.

A peer review has been carried out by Dr Ruth Lamb, consultant dermatologist and Dr Sara Sherif, registrar, in December 2013, March 2016 and March 2018.

A further peer review has been carried out by Dr Amr Salam, consultant dermatologist and Lucy Moorhead, nurse consultant, both from the St John's Institute of Dermatology, at Guy's and St Thomas' NHS Foundation Trust, London in November 2020. A further review took place by the PAPAA editorial team June 2024.

A lay and peer review panel has provided key feedback on this leaflet. The panel includes people with or affected by psoriasis and/or psoriatic arthritis.

Quality and accuracy

To learn more about how this material was developed and produced and the criteria we use to deliver quality support and information, go to our website and read the PAPAA Pledge: www.papaa.org/pledge

If you have any views or comments about this information or any of the material PAPAA produces you can contact us via the details on the back page or online at www.papaa.org/user-feedback

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