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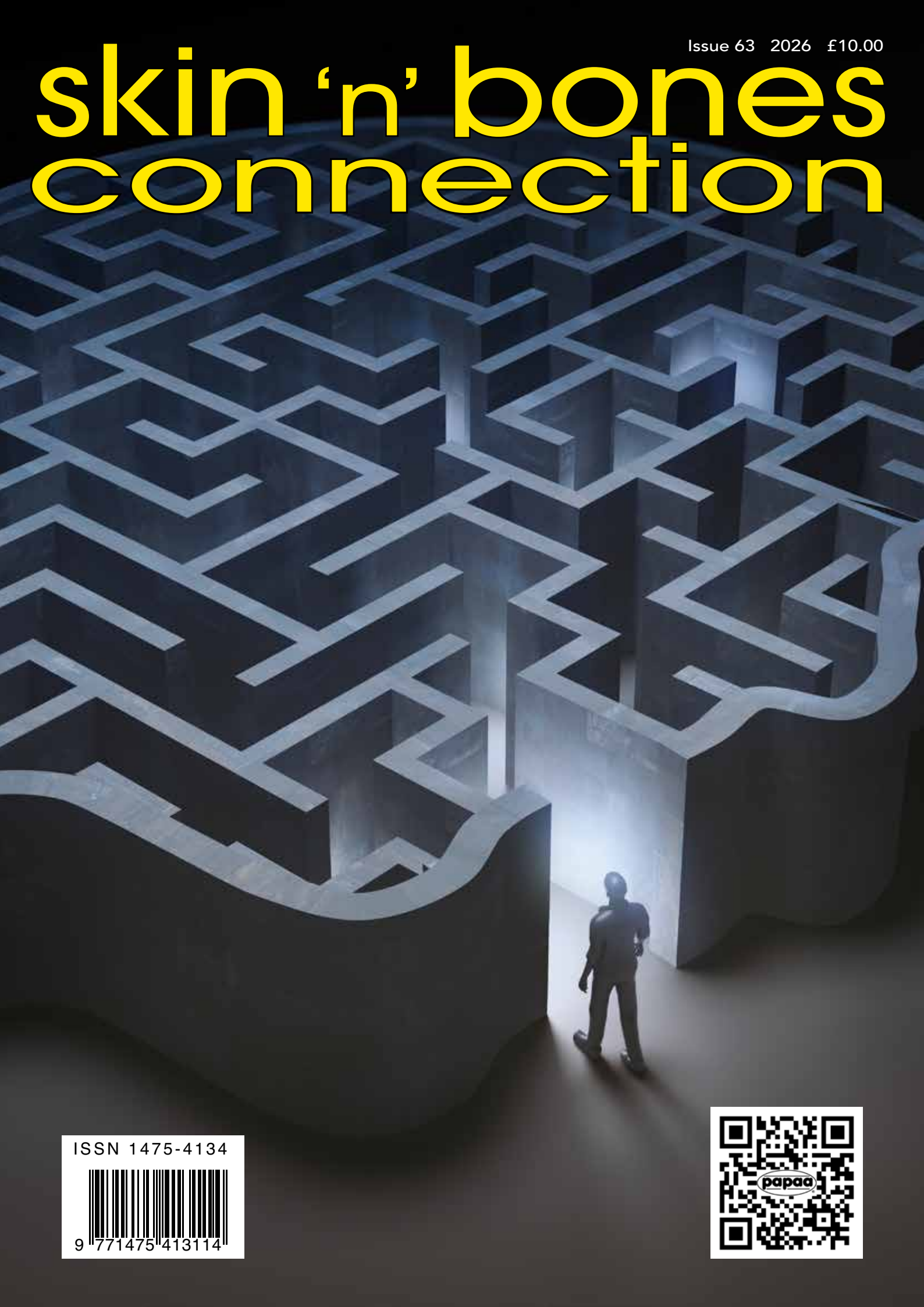

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Dear Reader

In this edition we have focused on change and innovation in care for people living with psoriatic disease. You'll see on page 3 how national NHS plans and neighbourhood health frameworks are reshaping where and how care is delivered, with more support intended closer to home.

On pages 4-5 you'll also find clear guidance that challenges harmful myths about sunbeds, explains the difference between medical phototherapy and commercial tanning, and highlights the importance of early melanoma detection.

We explore on pages 6-7 advances in treatment for psoriatic arthritis and the growing move towards more personalised, evidence-based care.

Throughout this issue, particularly on pages 14-15, we show why having patient organisations in the room – alongside clinicians and policymakers – is essential if lived experience is to influence how healthcare is planned, delivered and improved.

Managing editor

Transparency:

To uphold our independence and provide unbiased support and information, we primarily rely on donations, grants, and other sources of not-for-profit income. When we collaborate with for-profit organisations, we follow strict guidelines to protect our integrity. If the organisation is a pharmaceutical company, we also comply with ABPI standards. All partnerships are evaluated transparently to ensure they align with our mission and benefit our constituents.

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COVER PHOTO:

The maze of the mind and thoughts.

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For years, many people have thought of the NHS mainly in terms of hospitals and GP surgeries. But now in 2026, the direction of travel is becoming much clearer: more care is expected to happen in communities, on local high streets and in people's homes, rather than always through hospital outpatient departments.

This change sits at the heart of the NHS 10 Year Health Plan, published in 2025, which set out three major shifts for the NHS: from hospital to community, from analogue to digital, and from sickness to prevention. A year on, that first shift is no longer just a policy idea. In March 2026, the Department of Health and Social Care and NHS England published a Neighbourhood Health Framework, describing how services are meant to be organised more locally and confirming that implementation begins in 2026/27.

For patients, this does not mean hospitals are disappearing. It means that more of the care people use regularly, especially support for long-term conditions, prevention, monitoring and some urgent treatment, is intended to be available closer to where they live. That includes community clinics, neighbourhood health centres, home-based services, virtual wards and, importantly, high-street pharmacies.

High-street pharmacies are one of the clearest examples of this shift already happening in everyday life. Community pharmacy has long dispensed prescriptions and offered advice, but its role is widening further as the NHS tries to make care easier to reach without always relying on a GP or hospital visit. In recent years, pharmacies have expanded their role in treating common conditions, checking blood pressure, supporting new medicines use and helping with prevention and self-care.

That role is still evolving in 2026. Negotiations on the 2026/27 Community Pharmacy Contractual Framework have been underway, and updated settlement information was published in June 2026. At the same time, legislative changes that came into force in January 2026 allow pharmacists to authorise pharmacy teams to hand out checked and bagged prescriptions, a practical change intended to free pharmacists for more clinical work. Together, these developments show how pharmacy is being positioned not just as a dispensing point, but as a more active part of neighbourhood care.

For people living with long-term conditions such as psoriasis or psoriatic arthritis, this shift could matter in several ways. A local pharmacy may increasingly be the place where blood pressure is checked, medicines are reviewed, side effects are discussed, or minor infections are treated more quickly. Alongside this, some treatments may continue to move into the home through clinical homecare, while follow-up support and monitoring may be provided through more local teams rather than always through hospital clinics.

The neighbourhood model also matters because it aims to join up services better. The 2026 framework describes local systems in which NHS organisations, councils and community partners work together around local populations, rather than expecting patients to navigate lots of separate silos. Over time, this is meant to lead to fuller neighbourhood health plans and the building or upgrading of 250 Neighbourhood Health Centres across England.

There are clear opportunities here. Care closer to home can mean less travel, less disruption to work or family life, and faster access to help for common or ongoing problems. But there are also understandable concerns. Community services, general practice and pharmacy are already under pressure, and any move away from hospital-based care will only succeed if these local services are properly staffed, funded coordinated, and expanded.

So, where are we in 2026? Not at the end of the journey, but beyond the stage of broad promises. The national direction has been set, the neighbourhood framework is in place, and early implementation is underway. For patients, that means the familiar parts of the NHS already on the doorstep, especially high-street pharmacy, are likely to become even more important in the years ahead, as more care is designed to happen closer to home.

If you would like to read the full national plan behind these changes, the government's ***"Fit for the Future: 10 Year Health Plan for England"*** is available on GOV.UK:

www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Tanning myth exposed

More than 200 cases of children illegally using sunbeds have been recorded across England, including one child aged just 10, raising fresh concerns about misleading claims that sunbeds can benefit skin conditions such as psoriasis.

The figures, uncovered through a Freedom of Information request, come as the Advertising Standards Authority (ASA) banned adverts from five sunbed-related companies for suggesting their services were safe or could help treat medical conditions including psoriasis and eczema.

For people with psoriasis, this ruling is particularly important. While controlled ultraviolet (UV) light can be used as a medical treatment, known as phototherapy, under specialist supervision, commercial sunbeds are not a safe or effective substitute. The ASA found that claims promoting sunbeds as a health or treatment option were misleading and irresponsible.

Dr Conal Perrett, Consultant Dermatologist at The Devonshire Clinic, said the ruling was an important but overdue step in protecting the public from harmful misinformation: *"There is no such thing as safe tanning using UV radiation, and the science on this has been clear for decades,"* Dr Perrett said.

"When adverts suggest sunbeds are safe or imply health benefits, they fundamentally mislead people about the risks they are taking with their skin and their long-term health."

Health experts are clear that UV radiation is the main cause of skin cancer in the UK. Sunbeds deliver intense, uncontrolled doses that damage skin cell DNA and significantly increase the risk of melanoma, the most serious form of skin cancer.

For people with psoriasis, the distinction between medical phototherapy and sunbed use is critical:

- Phototherapy is carefully prescribed, with controlled doses and clinical monitoring.
- Sunbeds deliver inconsistent, often stronger UV exposure without medical oversight.
- Sunbeds do not target psoriasis safely and can worsen skin damage over time.

Dr Perrett warned that portraying sunbed use as a wellness or medical solution was particularly concerning: *"Claims that sunbeds can improve mood, or help manage medical conditions are inaccurate and risk discouraging people from seeking proper medical advice and evidence-based treatment,"* he added. *"That is why the ruling matters, it draws a clear line between health information and commercial promotion."*

The findings also highlight ongoing failures to enforce laws banning sunbed use by under-18s. Despite regulations, more than 200 incidents were recorded over 15 years, with limited penalties issued.

Beyond cancer risk, sunbed use can lead to severe burns, premature ageing, and long-term skin damage. These effects can complicate the management of psoriasis and overall skin health.

For those living with psoriasis and considering UV-based treatments, the safest approach is to:

Avoid commercial sunbeds entirely.

- Use approved treatments tailored to your condition.
- Speak to a GP or dermatologist about clinically supervised phototherapy.
- Consider safer cosmetic alternatives such as self-tanning products if appearance is a concern.

Finally, regular skin checks remain essential. People with psoriasis should not assume all skin changes are related to their condition. Watch for warning signs such as changes in moles, unusual new marks, or lesions that behave differently from your usual plaques.

Spotting melanoma early can save lives, so knowing what to look for is key. Here are five mole changes to watch out for:

1. **Uneven shape or border** – Moles that are asymmetrical or have blurred, jagged edges may need a closer look.
2. **Colour changes** – Be alert to moles with multiple shades of brown, black, red, or blue.
3. **Growth or evolution** – Any mole that's getting larger, changing shape, or starting to itch, bleed, or crust over should be assessed.
4. **The "odd one out"** – A mole that looks different from your others, the 'ugly duckling', could signal something new.
5. **New or unusual marks** – On darker skin, melanoma may appear on the palms, soles, or under nails. Any new dark patch in these areas deserves attention.

"If something looks or feels different, don't ignore it," says Dr Perrett. "Most skin changes are harmless, but when caught early, melanoma is highly treatable, so trust your instincts and get it checked."

Source:

Adapted from reporting in
The Independent, 28 January 2026.

Read our information on
Psoriasis and Phototherapy and
Psoriasis and the sun.

A changing picture

There are times in healthcare when change feels slow and frustrating, and there are times when the picture begins to shift more noticeably. For people living with psoriatic arthritis, 2026 feels like one of those moments. Research is moving forward, treatment options are widening, and understanding of the condition is becoming more detailed and more personal.

That does not mean the challenges have disappeared. Many people still face delays in diagnosis, uncertainty about which treatment is right for them, and the day-to-day impact of pain, stiffness, fatigue and reduced confidence. But what does seem to be changing is the sense that psoriatic arthritis can no longer be seen as a condition with only a small number of standard answers. Increasingly, it is being understood as a complex disease that needs a more tailored response.

More treatment choice

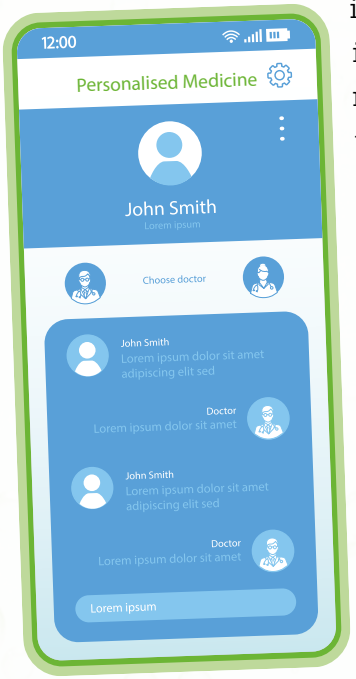
One of the clearest developments in recent years has been the growth in treatment options. Alongside older medicines and TNF inhibitors, clinicians now have access to newer biologic and targeted therapies that act on different parts of the immune system, including interleukin-17 and interleukin-23 pathways.

Reviews of the latest evidence suggest that these advances are improving the chances of finding treatments that work well for both joints and skin, especially for people whose disease has not responded well to earlier options.

This matters because psoriatic arthritis is not the same in every person. For some, joint pain and swelling are the biggest problem. For others, skin psoriasis, nail disease, tendon pain, spinal symptoms or overwhelming fatigue may dominate. Newer treatments are helping to move care away from a one-size-fits-all model and towards something more individual, where the pattern of disease and the person's wider health can play a bigger role in treatment decisions.

Personal approach

The phrase "personalised medicine" is often used in medical research, but in psoriatic arthritis it is becoming more meaningful. Researchers are increasingly interested in why some people respond very well to one treatment while others do not, and whether blood tests, imaging or other markers might one day help predict that response. The hope is that treatment could become more precise, reducing the long periods of trial and error that many patients know all too well.



At the same time, a truly personal approach means more than biology. It also means recognising the practical realities of living with a long-term condition. A treatment may look good on paper, but it also has to fit around work, family life, hospital visits, side effects and a person's own preferences. That broader understanding of personalised care is just as important as the scientific advances now being discussed.

Wider work

Much of the current research is focused not just on developing new drugs, but on understanding the condition more deeply. Recent reviews point to growing interest in the mechanisms that drive psoriatic arthritis, the links between inflammation and metabolic health, and the

reasons some people progress from psoriasis to joint disease while others do not. There is also increasing attention on the idea of treating earlier and more effectively, before irreversible joint damage has time to develop.

The treatment pipeline also remains active. Reports published so far this year suggest that several drugs and new approaches are continuing through clinical trials, while major rheumatology meetings are highlighting the importance of therapy sequencing, disease domains and long-term treatment targets. In other words, the question is no longer simply whether there are treatments available, but how best to use them, in what order, and for whom.

Looking ahead

For those supporting people with psoriatic arthritis, this changing landscape brings both opportunity and responsibility. There is genuine reason for hope in the progress being made, particularly for people who have struggled to find an effective treatment or who have felt that their condition was poorly understood. At the same time, it is important to stay realistic. Not every new treatment will suit every person, and not every research finding will lead quickly to changes in everyday NHS care.

Even so, the overall direction is encouraging. The field is moving towards more choice, more precision and a clearer sense that psoriatic arthritis should be actively managed, with meaningful goals and regular review. For people living with the condition, that matters. It means that the future of care may be not just about controlling symptoms, but about creating a better quality of life and a stronger sense of what is possible.

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When you live with a long-term condition, hospital appointments can start to dictate the rhythm of your life. Work meetings are planned around clinic days, family events are shifted for infusions, and there is always the background worry about transport, parking or what happens if a flare coincides with a "must-attend" visit. Clinical homecare is one way the health system is trying to give some of that time and control back.

Clinical homecare means that some treatments normally organised through hospitals can be delivered and supported in your own home instead. This might involve medicines being shipped directly to your door, a nurse visiting to give an infusion or injection, or you being trained and supported to manage injections yourself with a clear safety net in place. Your hospital team still leads your care, but the setting moves from a ward or day unit to your living room, kitchen or bedroom.

For many people with psoriasis or psoriatic arthritis, that shift can be transformative. It may mean fewer long journeys when joints are painful or fatigue is overwhelming. It may reduce the childcare and travel juggling that so often sits behind a "simple" outpatient visit. It can also help protect your working life, as you are no longer losing half a day or more each time you need treatment. Instead of organising everything around hospital timetables, treatment can start to fit more around you.

Of course, bringing treatment home is not just about convenience. It also has to feel safe, reliable and well organised. Clinical homecare services are expected to meet clear standards and to work closely with NHS teams so that medicines, monitoring and follow-up fit into your overall treatment plan. That should include straightforward information about who is involved, how they are regulated, and what to do if something does not go to plan.

In practice, a typical clinical homecare pathway might look like this. Your hospital specialist decides that a particular medicine is right for you and discusses the benefits and risks. If that medicine is routinely delivered through a homecare company, the team will ask for your permission to share your details and make a referral. The homecare provider then contacts you directly to arrange your first delivery or visit, explain how the service works, and check anything important about your home environment. After that, they become one of the faces of your care: the person on the phone when a box goes missing, the nurse at your door with a sharps bin, the text reminding you that your next delivery is due.

Because homecare sits at this junction between hospital, pharmacy, courier and front door, there are several layers of oversight. Nationally, the National Clinical Homecare Association (NCHA) brings together many of the organisations that provide these services. It works with the NHS and other partners on shared expectations for quality, safety and governance, and on practical issues such as complaints handling and incident reporting. At the same time, regulators such as the Care Quality Commission and professional bodies set standards for aspects of nursing, pharmacy and medicines handling.

Patients and charities are part of this picture too. As a national psoriasis and psoriatic arthritis charity, PAPAA regularly hears from people who receive treatments through clinical homecare. Some describe brilliant, flexible nurses and the relief of not having to travel for every dose. Others share stories of missed deliveries, confusion over who to contact, or anxiety when boxes of medicine arrive with little explanation. By listening to these experiences, PAPAA can highlight what is working, what is fragile, and what needs to change to keep patients safe and supported.

That lived experience matters because homecare is not simply a logistics service. It is part of the emotional and practical reality of living with a long-term condition. A delayed delivery is not just an inconvenience; it can mean days of extra pain or the fear that a carefully won period of control might slip away. A kind, unhurried nurse visit is not just a tick on a pathway; it can be the moment you feel able to ask a question you were too embarrassed to raise in a rushed clinic.

If you are offered clinical homecare, it is reasonable to take a little time to understand how it will work for you. Some questions you might want to ask include:

- Who is responsible for my care day to day – the hospital team, the homecare provider, or both?
- How will deliveries or nurse visits be arranged, and how much notice will I get?
- What happens if I am away, something changes at home, or I need to pause or switch treatment?
- Who do I contact if there is a problem with my medicine, delivery or equipment?
- How will my hospital team stay updated on what is happening at home?

Having clear answers can make treatment at home feel less like something being done "to" you and more like a partnership you are part of. It can also give you confidence to speak up if something does not feel right.

Clinical homecare will not be the right option for everyone or for every medicine. Some treatments are still safest in hospital, and some people simply prefer the reassurance of being on a ward. But when it works well, bringing care closer to home can free up hospital capacity, protect your time and energy, and give you more space to live the life you want beyond appointments.

PAPAA will continue to listen to your experiences of clinical homecare – good and bad – and to feed those insights into national discussions. As these services grow, the goal is not just more care at home, but better care at home: joined-up, safe, and shaped by the people who rely on it every day.

You can always let us know about your experiences, both good or bad, and we'll feed those into the discussions we have within the role we have with the NCHA.

For more information visit:
https://www.clinicalhomecare.org/

AI in healthcare

Artificial intelligence (AI) is being talked about (and already in use) as a way to speed up diagnoses, free up staff time and personalise care. You may also hear worries about safety, mistakes and jobs. It is understandable to feel unsure about what all this means for you as a patient.

The following explains, in everyday language, what AI and large language models are, how they are starting to be used in health, what the NHS and public bodies are doing, and how to think about these tools alongside your usual care.

What is AI in health?

Artificial intelligence, or AI, is a broad term for computer systems that can do tasks that normally need human intelligence, such as recognising patterns, learning from data or working with language.

In healthcare, AI is already used in a number of areas. Examples include tools that help radiologists read X-rays and CT scans, systems that help triage patients or flag those at higher risk, and software that helps staff spot trends in large pools of patient data. In many cases these systems work behind the scenes, so you may benefit from them without realising it.

NHS England's own guidance emphasises that AI should support, not replace, clinicians and that patient benefit, safety and fairness must be central whenever new technology is introduced.

Machine learning

Most of the AI you hear about in health is based on machine learning. Instead of being given fixed rules, a machine-learning system "learns" from examples. For instance, a model can be trained on thousands of anonymised records to help predict which patients are most likely to need unplanned care, so that teams can offer support earlier.

Neural networks are a common type of machine-learning model, loosely inspired by how brain cells connect. Deep neural networks can find complex patterns in scans, pathology slides or electronic records and are used in areas such as radiology, dermatology and cardiology.

Large language models (LLMs) are a particular kind of AI that work with text. They are trained on very large amounts of written material so they become good at predicting the next word in a sentence. Because of this, they can answer questions in a chat-style conversation, summarise long documents, and help draft letters or patient information in everyday language.

In health, LLMs are being explored for tasks such as drafting clinic letters that clinicians then check and edit, turning spoken consultations into written notes, supporting staff to look up guideline snippets and helping patients understand their conditions.

How this can help patients

Used carefully, AI and LLM-based tools can make some parts of healthcare feel more manageable They can make information less overwhelming. For example, a patient-facing tool could help explain parts of a clinic letter or test report in simpler language, while leaving decisions to your clinical team. LLMs have also been tested for generating patient information leaflets on health conditions, with mixed but improving results.

They are available at any time of day, so you can explore questions outside clinic hours. They can help you prepare for appointments by turning your thoughts into a short list of questions or concerns you want to raise. They can help you keep track of what was agreed, by turning rough notes into a clear action plan.

Behind the scenes, AI is also helping researchers and clinicians spot patterns across large groups of patients. In psoriatic disease, for example, recent reviews describe AI being used to analyse skin photographs, estimate severity scores and identify new clusters of patients in registries, with the aim of supporting earlier diagnosis and more tailored treatment decisions.

Real risks and limits

Despite the promise, there are important limits you should know about. LLMs can "hallucinate": they sometimes give confident-sounding answers that are wrong or made up. A recent user study found that people who used chatbots to make decisions about medical scenarios did not make better choices than those who relied on traditional methods, and sometimes struggled to separate good and bad advice in the same answer. Separate work on patient leaflets has shown that LLMs may miss key points on psychosocial impact and shared decision-making, even when their language is clear.

AI systems also inherit biases from their training data. If some groups are under-represented, the model may work less well for them, which can worsen existing inequalities. In dermatology, reviews have raised concerns about under-representation of darker skin tones in image datasets and limited validation in diverse populations.

Crucially, AI does not know you as a person. It cannot examine you, sense when something feels "not right" in the way an experienced clinician can, or weigh up family, work and personal values. Because of this, experts and regulators stress that AI should not be used alone for diagnosis, deciding treatment or dealing with urgent symptoms.

Who is doing what with AI in the NHS?

Several parts of the NHS and government are involved in deciding how AI is used. NHS England sets strategy and guidance. Its AI and machine-learning overview explains how these tools should be deployed safely, and its NHS AI Lab and Artificial Intelligence in Health and Care Award support and evaluate new AI technologies in real services. A growing number of case studies describe AI helping with imaging, risk prediction and workflow improvements.

The Department of Health and Social Care and central government provide policy and funding. They have announced large-scale AI trials in screening programmes and backed a major pilot of Microsoft 365 Copilot across 90 NHS organisations, reporting potential savings of hundreds of thousands of staff hours per month on administrative tasks. Government has also set out plans for an AI-enabled system to scan NHS data for early signs of patient-safety concerns.

Local NHS organisations, such as hospital trusts and integrated care systems, decide how to use AI in their own services. Examples include tools that help

predict which patients are at higher risk of repeated A&E attendance, AI to support radiology reporting, and systems to reduce missed appointments. These sit within wider digital-health programmes aimed at improving access and efficiency.

Skills and regulation are being addressed too. Programmes like the NHS Digital Academy help clinicians and managers build the skills needed to lead digital and AI projects safely. The AI and Digital Regulations Service and related guidance help organisations understand what evidence, regulatory approvals and information-governance safeguards are needed before new AI technologies are used in care.

Using AI tools safely alongside your care

If you choose to use AI-based tools yourself, a few ground rules can help keep you safe:

Use tools offered or endorsed by trusted organisations, such as national health services, hospitals, universities or long-established charities, rather than random apps or websites. Use them to understand and organise information, and to prepare for appointments, not to make major decisions alone. Be cautious about what personal details you share, especially in general consumer apps whose privacy and data-sharing policies you do not fully know.

Above all, treat AI output as a starting point, not the final word. If something an AI tool tells you about your health feels surprising, worrying or too good to be true, bring it to your clinician and ask what they think. The safest way to think about AI is as an extra pair of hands: helpful for reading, writing and pattern-spotting, but most useful when its results are brought back into real conversations with the people who know you and are responsible for your care.

Fear and the future

Living with psoriasis or psoriatic arthritis is not just a matter of creams, tablets and clinic visits. It gets into the small corners of everyday life. It can affect what you wear, where you sit on a bus, whether you hug someone, and how you feel about your own body when you look in the mirror.

Many people describe a constant background layer of worry. Sometimes it is a quiet fear that a good spell will not last. Sometimes it is a loud fear that a flare will arrive just before a holiday, a work event or a family celebration. On top of this, there is the awareness that other people can see your skin, or that they might notice your nails or your stiffness when you move. All of this takes energy, even on days when nothing "dramatic" is happening.

Over time, these feelings can shape how you live. You might develop habits that once felt like sensible self-protection and now feel more like a cage. Many people with psoriatic disease recognise some version of this.

How worry and fear show up

Fear does not always arrive as a full-blown 'panic attack'. Often it creeps into ordinary situations. You may notice that you never go swimming anymore. You might realise that you always choose long sleeves, even in a heatwave, or that you automatically say no to invitations that involve changing rooms, overnight stays or physical closeness.

For some, work becomes a major source of dread. There is the worry that colleagues will see plaques, or that pain and fatigue will be misunderstood as laziness or lack of commitment. You might sit in meetings thinking more about whether someone is looking at your skin than about what is being discussed. Constantly watching yourself and other people's reactions is exhausting.

Clinical settings can bring their own fears. Some people feel sick at the thought of blood tests or injections. Others dread the moment a doctor looks up from the screen and says something has changed. It can be very tempting to put off appointments, leave letters unopened or skim results and then immediately search online for the worst possibilities.

These reactions are understandable. Research shows that people with psoriasis are more likely than the general population to experience anxiety and depression, and that visible lesions and involvement of intimate areas are linked to higher distress. When fear starts to dictate your choices and shrink your world, clinicians might talk about "phobic" patterns. In everyday terms, it just feels like life getting smaller.

Stigma, misunderstanding and the extra weight they add. One of the hardest parts for many people is the sense of being seen as "different". You may have had strangers move away, stare, make comments or ask if your skin is contagious, even though psoriasis is not. You may have had health professionals focus only on the visible plaques and not ask how you are coping emotionally.

Studies on stigma in psoriasis describe people feeling ashamed of their appearance, judged by others and misunderstood even by close friends or partners. This can lead to keeping the condition secret, hiding skin at all costs or avoiding intimacy. Over time, secrecy becomes another burden. It is hard to ask for help with feelings you have never felt safe to share.

Pain and itch add a further layer. Chronic itch and cutaneous pain disturb sleep, worsen mood and make it harder to concentrate, which in turn feeds frustration and hopelessness. The result for many people is a mix of fear, sadness, anger and shame that can feel very lonely, particularly if those around you see "just a skin problem".

What can actually be done?

There is no single fix, but several approaches have been shown to help. Clinicians increasingly recommend that psoriasis care includes regular checks for anxiety, low mood and suicidal thoughts, and that dermatology and mental-health teams work together where possible. Psychological therapies such as cognitive behavioural therapy (CBT), stress-management training and relaxation techniques can improve coping and may even help disease control for some people.

Practical steps might include:

- Talking honestly about worry and low mood with your dermatologist, rheumatologist or GP.
- Asking about access to talking therapies, including programmes designed for people with long-term conditions.
- Connecting with patient organisations or peer support, so you can hear from others who "get it".

Further resources

You may find it helpful to read more about the psychological aspects of psoriasis, including stress, anxiety and low mood, in PAPAA's information materials and booklets. If you are interested in self-help tools based on CBT principles, you might also want to look at PAPAA's electronic Targeted Intervention for Psoriasis (eTIPs). Details on how to access these resources can be found on the PAPAA website.

Patients in the room

This summer saw the 106th Annual Meeting of the British Association of Dermatologists (BAD). The BAD is the professional body for hospital dermatologists and the wider community of skin specialists, including many of the clinicians who readers will meet in outpatient clinics. The purpose of these meetings is to educate and update healthcare professionals, supporting their development and, more importantly, helping them deliver best-practice care based on emerging research and the latest medical advances.

As a charity working in this area, or Patient Advocacy Support Group (PASG), as BAD describes us we are offered a free exhibition space to promote our work. "Free" does not mean cost-free: this year's meeting was in Manchester, so travel and overnight accommodation had to be weighed carefully, and we chose to attend for a single day to keep costs down. That decision is typical of patient organisations: every event is a balance between the value of being there and the reality of limited resources.

Other exhibitors include commercial companies who provide the medicines and services that support clinicians to deliver care. There are also clear constraints on what exhibitors can do, particularly pharmaceutical companies. They are bound by UK law on the promotion of prescription medicines and by their own industry body code of practice, which is produced by the Association of the British Pharmaceutical Industry (ABPI). The code includes specific requirements for how they work with clinicians, the public and of course patient organisations. In simple terms, companies can support patient groups through grants, sponsorship or contracted services, but they must not use that support to drive the group's agenda or turn patient-facing information into branded advertising. For PAPAA, that means any support we receive must be transparent, documented and independent of the content we produce.

For patient organisations, that creates a distinctive role at meetings like BAD. We are there partly to provide balanced information on treatment options – including biologics, oral therapies and other approaches – but also to represent what living with psoriatic disease actually feels like. That combination of evidence and lived experience is what makes our presence useful.

Attending the BAD AGM gives us several things in return. We see first-hand how clinical practice is evolving, hear directly about new research and therapies, and understand what dermatologists are most concerned about in their day-to-day work. We also have informal conversations at our stand that reveal where patients feel well supported – and where the system still falls short. All of this feeds back into our educational materials, our advocacy priorities and the way we support people who contact PAPAA. It helps ensure that the information you read in this journal and on our website is grounded both in current evidence and in real-world experience.

Patient organisations exist because lived experience matters. The deeper question is why that still needs to be said. If healthcare were consistently joined-up, respectful and genuinely responsive, patient-led organisations would have far less reason to exist. Their presence is not a weakness in the system; it is evidence of the distance still to travel.

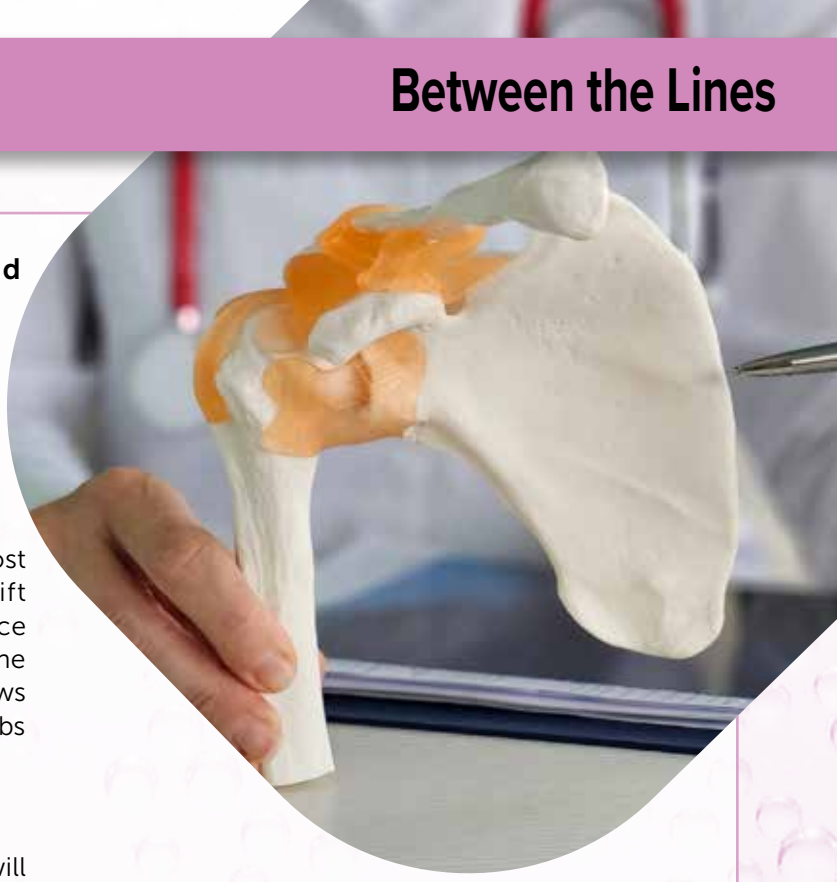
Over many years in patient advocacy, we have learned that progress is rarely blocked by a lack of goodwill. More often, it is slowed by habits: hierarchy, assumptions and the tendency to speak about patients rather than with them. Events like the BAD's are valuable precisely because they give us a chance to challenge those habits in constructive ways – by being in the room, asking questions, and offering a patient-centred lens on the same evidence clinicians are discussing.

It is also worth remembering that people are "patients" only for a short time during an appointment; the rest of the time they are simply people with lives to live. The most meaningful work happens when they are treated not as an add-on, but as a source of insight, challenge and partnership. The key question is not whether patient voice is valuable; it is whether we are willing to let it change how healthcare thinks, behaves and improves. We should not just ask patients to share their story. We should ask what the system – including those of us who attend meetings like BAD's – are prepared to do differently because of it.

To learn more visit:

BAD: www.bad.org.uk

ABPI: www.abpi.org.uk



Over the past year, specialists from around the world continue to meet to share new research on psoriasis and psoriatic arthritis, these conferences are mainly aimed at doctors and researchers, but much of what is discussed has real-life implications for people living with these conditions.

Behind the scenes, large professional bodies host these meetings and education groups then sift through hundreds of talks. The European Alliance of Associations for Rheumatology (EULAR) runs the major European rheumatology congress, while news services such as RheumNow and online psoriatic hubs highlight what is most useful for everyday care.

Skin to joints

One major theme has been who with psoriasis will go on to develop psoriatic arthritis, and when that happens. At meetings such as the EULAR congress in London, researchers have shown scan images and, in some studies, tiny samples from the lining of joints that suggest inflammation can be present before joints look obviously swollen or damaged.

In everyday terms, this supports what many patients have been saying for years: there is often a "grey zone" where the skin is flaring and the joints are starting to complain, but the diagnosis is not yet clear. The message for anyone with psoriasis is to take ongoing stiffness, puffy fingers or toes, heel pain or a sore back seriously and to mention these early to a GP or dermatologist. The aim of the research in the background is to give doctors better tools to spot psoriatic arthritis before permanent damage is done.

Rethinking treatment

Another important discussion has been around when to move on from first-line drugs. For many years the usual pattern has been to start with painkillers and simple anti-inflammatory tablets, then try older disease-modifying drugs such as methotrexate, and only later consider biologics or newer targeted tablets. Recent trial results shared at international rheumatology meetings are prompting doctors to ask whether this "slow and steady" approach is always right, especially in more active disease.

Some studies suggest that, for certain people, bringing in stronger medicines earlier can reduce inflammation more effectively and protect joints in the long term. In very difficult, long-standing cases, researchers are even looking at carefully combining advanced treatments in clinical trials. This work is still being weighed up by expert groups and is not a blanket recommendation, but it is shaping the conversations that happen in clinic. For patients, it means that if symptoms remain active despite treatment, it is reasonable to ask whether there are other options and what the realistic goals of treatment should be.

Why weight?

Lifestyle topics can sound like the dull part of a medical conference, but they are getting more attention. Analyses presented at EULAR and reported through rheumatology news channels suggest that body weight can have a big effect on how well treatments work, and in some situations may influence outcomes as much as the choice of biologic.

This does not mean that weight is the cause of psoriatic disease, or that people should be blamed for their condition. Instead, it is leading clinics to build more support for weight management, physical activity and stopping smoking into routine care, rather than treating these as optional extras. Research is also looking closely at heart and circulation problems, because we now know that psoriasis and psoriatic arthritis are linked with higher risks of heart disease, stroke and, in some studies, abnormal heart rhythms. Behind the scenes, this is encouraging closer teamwork between rheumatologists, dermatologists, cardiologists and GPs.

Safety

Another area where background work really matters is vaccination. Since the COVID-19 pandemic, professional societies such as EULAR have been reviewing the evidence and updating advice on vaccines for people on immune-modifying treatments. Recent sessions have discussed newer shingles vaccines, pneumonia vaccines and how best to time doses around biologics and targeted tablets.

Occupational therapy

Psoriatic arthritis often affects the hands, feet, wrists, ankles, lower back, and neck, and for some people it can interfere with work, sleep, hobbies, and everyday tasks. Occupational therapy is designed to help people continue doing the things they need and want to do, even when symptoms make those activities harder.

An occupational therapist looks at how PsA affects daily life in practical terms. That might mean asking how you dress, cook, clean, drive, work, or manage your energy through the day. The aim is not simply to reduce discomfort, but to find better ways of doing tasks so that joints are protected and symptoms are less likely to worsen.

A key part of occupational therapy is learning joint protection techniques. These are simple changes that reduce stress on painful or vulnerable joints. For example, it helps to avoid staying in one position too long, especially during activities such as reading, sewing, driving, or sitting at a computer. Regular breaks, small changes in position, and pacing activities can prevent stiffness from building up.

People with PsA are also encouraged to avoid tight gripping and pinching. This is especially important when using tools, writing, opening packages, or handling cutlery. Thicker-handled pens, utensils, and toothbrushes can make these tasks easier, while foam grips and adapted equipment can reduce the effort needed from small hand joints. Using the strongest and largest joints available is another useful principle. Pushing a door with the shoulder or hip, carrying objects close to the body, and using two hands instead of one can all reduce strain.

Occupational therapists may also recommend changes to the home or workplace. Helpful equipment can include lever taps, wheeled trolleys, kettle tippers, adapted cutlery, long-handled tools, non-slip mats, and bath or toilet aids. In more complex cases, a therapist may advise on larger adaptations such as grab rails, a raised toilet seat, a stair lift, or a wet room. Small environmental changes can make a major difference to confidence and independence.

Fatigue management is another important part of support. PsA can drain energy, and people often push too hard on good days and then struggle afterwards. Occupational therapists can help with planning routines, balancing rest and activity, and improving sleep and relaxation habits. They may also suggest ways to reduce fatigue at work, such as reminder software for breaks and ergonomic changes to desk setups.

Splints can be useful for some people, especially when hand or wrist pain affects activities or sleep. These are usually used for specific tasks or overnight, rather than all the time, and should be combined with exercise rather than replacing it. Exercise remains important because too little movement can lead to stiffness and weakness. Gentle, tailored exercises help maintain range of motion, muscle strength, and overall function.

Work is another area where occupational therapy can help. Under the Equality Act 2010, some people with long-term conditions may be entitled to reasonable adjustments. An occupational therapist can advise on these adjustments and help people talk to employers with more confidence. They can also support study, retraining, or return-to-work planning if needed.

In short, occupational therapy is about finding practical ways to live well with PsA. It helps people protect their joints, conserve energy, manage pain, and stay involved in everyday life with as much independence as possible.

Accessing occupational therapy:

Ask your GP or rheumatology team for an occupational therapy referral, or contact your local council's adult social care team via GOV.UK for a home assessment. You can also self-fund, but make sure any therapist is HCPC-registered.

https://www.hcpc-uk.org/check-the-register/

Can atopic eczema and psoriasis coexist?

Eczema is significantly more common than psoriasis, affecting up to 10–20% of the population, particularly children. Psoriasis affects approximately 2–3% of the global population. While eczema (specifically atopic dermatitis) is more common, both conditions are chronic, immune-mediated inflammatory skin diseases whose symptoms – rashes and itching – overlap. Eczema however does tend to be much itchier than psoriasis and the skin lesions more superficial, whilst psoriasis is characterised by thick, scaly plaques. But can these two conditions co-exist?

Previous studies have reported that they are actually mutually exclusive, whilst others have shown that they can co-exist. However, no systematic appraisal of the relationship has been carried out, until now.

In this study, Ovid MEDLINE and Ovid Embase were searched around the key terms 'atopic eczema' (AE), 'psoriasis' and 'co-existence'. In all, researchers identified 31 studies and 20,523 individuals with psoriasis and 1,405,911 with AE. Eight studies reported the prevalence of AE in those with psoriasis and values ranged from 0.17% to 20%: the overall prevalence was 2%. Seven studies reported the prevalence of psoriasis in those with AE and values ranged from 0.3% to 12.6%; the overall prevalence was 2%.

Comment:

This study provides evidence that, whilst unusual, psoriasis and eczema can indeed co-exist in the same individual. Clinicians need to be aware of this possibility, especially since the two conditions are often confused and their treatments are different.

Reference:

Cunliffe A, Gran S, Ali U, et al. Can atopic eczema and psoriasis coexist? A systematic review and meta-analysis. Skin Health Dis. 2021;1(2):e29.

New research on diet and psoriasis

With the bewildering number of new drugs now available for the treatment of psoriasis, it becomes all-too-easy to forget the simpler lifestyle adjustments that can make a real difference. This study from King's College, London is not only a timely reminder of how important dietary factors are in the management of psoriasis, but offers new insights into how dietary patterns may be related to psoriasis severity in non-Mediterranean populations.

The research analysed survey data from 257 adults with psoriasis who had completed an online questionnaire. Several specific food frequency questionnaires were used, each of which evaluated adherence to different components of the diet, including the Mediterranean Diet Score, the Dietary Approaches to Stop Hypertension (DASH) score, and the Healthy Plant-based Diet Index. In essence, the DASH diet, the Mediterranean diet and plant-based diets all emphasise whole foods, fruits, vegetables, and lean proteins while minimising processed foods. DASH focuses on low-fat dairy and strict sodium reduction to lower blood pressure, the Mediterranean diet emphasizes healthy fats (e.g. olive oil) for heart health, and plant-based diets prioritize plants while minimising or eliminating meat and other animal products. Psoriasis severity was self-assessed using a validated questionnaire.

Key findings from the study indicate that individuals with very low adherence to the DASH diet index and the Healthy Plant-based Diet Index were significantly more likely to report higher psoriasis severity. Further analysis of the different components of the DASH diet showed that the higher the red and processed meat intake, the more

severe the psoriasis, even when body mass index (BMI) was considered. Fruits, nuts and legume intakes were also associated with less severe psoriasis, but this relationship was not independent of BMI.

Conclusion:

These findings remind us that paying close attention to diet – especially with regard to animal products and over-processed foods containing large amounts of salt, fat and sugar – is an important tool in the management of psoriasis. It can make a significant contribution to reducing disease severity and may allow lower doses of medication to be used, thus reducing the frequency and severity of drug-associated side-effects. Ideally, all patients with psoriasis should have access to a dietician able to give advice regarding the optimal diet.

Reference:

Zanesco S, Maruthappu T, Griffiths C.E.M et al. Associations between diet quality indices and psoriasis severity: results from the Asking People with Psoriasis about Lifestyle and Eating (APPLE) cross-sectional study. British Journal of Nutrition, 2025; 1 DOI: 10.1017/S0007114525000340T

Psoriasis and gender

It is well known that whilst the prevalence of psoriasis is about equal between men and women, men typically experience more severe disease, which may lead to differences in approaches to treatment and clinical outcomes. The aim of this study was to investigate gender differences in treatment patterns among psoriasis patients, with a particular focus on how these differences vary according to the time of onset.

Researchers utilised electronic health records (EHRs) obtained between 1998-2022 from Clalit Health Services (CHS) in Israel. Patients with psoriasis were classified as either early-onset (diagnosed before age 40) or late-onset (diagnosed at age 40 or older). Current medication was recorded for each participant, along with information regarding physical activity patterns, smoking and body mass index (BMI).

A total of 3999 patients met the inclusion criteria, of whom, 2613 (65.3%) were male and 1386 (34.7%) were female, indicating a higher proportion of male patients.

Results showed that women had an earlier onset of disease than did the men (37.2 vs 40.1 years). Moreover, in the early onset group, significantly more men received systemic (17.9% vs 6.5%) and biological therapies (3.8% vs 1.6%) and initiated these treatments earlier. These findings are consistent with earlier studies which showed that men tend to have more extensive and severe manifestations of the disease than women. In contrast, no significant gender-based treatment differences were observed in late-onset cases.

Comment:

The major limitation of this study is that it lacked specific information on disease severity or PASI scores, the current standard for guiding treatment decisions. Thus, the claim that men were treated more aggressively in the early onset group because they had more severe disease, is an inference and no more. Nevertheless, these findings indicate that the timing of disease onset may play a role in treatment decisions, emphasising the importance of a more inclusive approach to psoriasis management that considers both gender and the age of onset.

Reference:

Lax T, Stemmer E, Fallach N, et al. Exploring the Impact of Gender and Age of Onset on Psoriasis Treatment Management. J Clin Med. 2025; 14(12):4090.

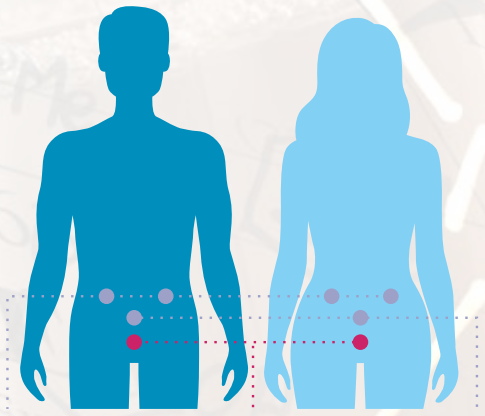
Update on genital psoriasis

Surveys show that up to two-thirds of patients with psoriasis elsewhere, have genital psoriasis. Historically it has tended to be a neglected and under-treated condition, despite the fact that it has a profound negative impact on quality of life, especially sexual function. It is not currently taken into account in any of the standard severity scores (e.g. PASI) used to assess psoriasis.

In this Australian study, researchers carried out a comprehensive review of the scientific literature on genital psoriasis. In all, 632 articles concerning genital psoriasis in adults were found in the period 1946-2022. Of these articles, 25 were original research studies that investigated various treatments for genital psoriasis among 877 patients. A further six studies explored quality of life measures in 2546 patients (61% male).

The key findings from this review are as follows:

- There is wide variation in the reported prevalence of genital psoriasis, ranging from 17% to 64% and it tends to occur 6–10 years after the onset of psoriasis.
- The burden of genital psoriasis on an individual's quality of life is underappreciated and whilst 80% of patients mentioned genital psoriasis to their doctor/dermatologist, these discussions are usually initiated by the patient.



- The impact on sexual activity appears to be more pronounced in women, not primarily due to reduced libido, but rather subjective sexual distress such as feelings of reduced physical attractiveness.
- Given that the peak onset of psoriasis lies between 15 and 30 years of age where individuals are creating and maintaining sexual relationships, it is essential for clinicians to elicit and address sexual concerns.
- Current evidence supports initial treatment with topical steroids, though systemic treatments and biologics (specifically ixekizumab) are effective for more severe disease.

Comment

This review clearly shows that genital psoriasis is seriously underappreciated and under-treated. Given the prevalence of genital psoriasis, clinicians involved in the management of psoriatic patients must themselves initiate discussion about genital involvement, especially in younger patients. Effective treatments are available, though much more research is needed to identify which regimen is the most efficacious. Most importantly, future studies need to take into account the under-representation of females in studies exploring quality of life and treatment options for genital psoriasis especially since women have been shown to experience more sexual dysfunction compared to their male counterparts.

Reference

Wu M, Fischer G. Adult genital psoriasis: An updated review for clinicians. Australas J Dermatol. 2024; 65:e1-e12.

Pso Pscience is written and brought together by PAPAA senior medical advisor Dr David Ashton, MD, PhD.
To read/download all issues, go to:
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Making a difference

At PAPAA, we believe no one should face the challenges of psoriasis and psoriatic arthritis alone. Our mission is to provide everyone affected by these conditions with the best resources, and trusted information, they need to live healthier lives.

How we help

- **Informed choices:** We provide clear, reliable information to help people manage their conditions confidently.
- **Real stories:** People living with psoriatic disease share their experiences to inspire and show that no one is alone.
- **Interactive tools:** From self-help programmes to helpful articles, we aim to give people the tools to take charge of their health.

Creating change

We work to improve lives through education, research, and advocacy. By supporting medical research and training healthcare professionals, we aim to make sure people with psoriatic disease get the care they deserve.

How we are helped

PAPAA depends on supporters to drive its mission.

Here's how you can help:

Fundraise:

Organise events or nominate PAPAA to receive funds.

Keep informed:

Stay updated on research and ways to help.

Spread awareness:

Share materials and raise awareness.

Donate:

Fund vital resources for those living with psoriatic disease.

Give regularly:

Boost impact through regular donations and Gift Aid.

Volunteer:

Support research, review materials, and advocate for the cause.

Supporters: Make PAPAA's work possible and change lives.

Why support matters

Psoriasis and psoriatic arthritis affect millions, but too many still lack the knowledge they need. Help, whether through donations, fundraising, or raising awareness, makes a real difference. Together, we can ensure that no one faces psoriatic disease alone.

PAPAA is funded by donations, and grants, ensuring our work remains independent and focused on the needs of people with psoriatic disease. This means that all support provides an ongoing legacy for today and tomorrow.

Together, we can create change. Visit our website to learn more and get involved: **www.papaa.org/donate**

www.papaa.org