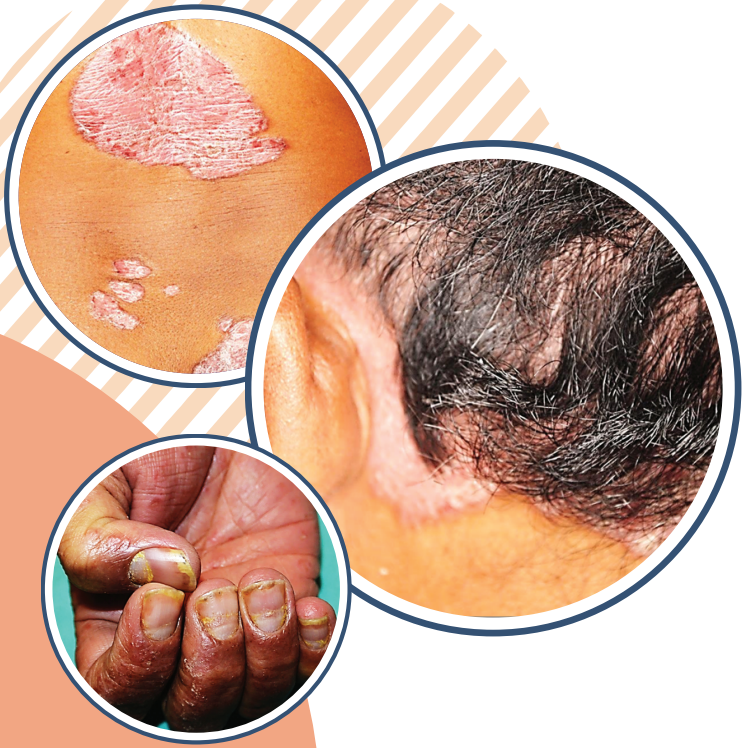
QUICK REFERENCE FOR HEALTHCARE PROVIDERS

MANAGEMENT OF PSORIASIS

SECOND EDITION 2024



Ministry of Health Malaysia
Dermatological Society of Malaysia
Academy of Medicine Malaysia

KEY MESSAGES

1. Psoriasis is a chronic inflammatory disease that primarily affects the skin & joints with a prevalence in Malaysia estimated to be at 0.34% & an incidence of 34.2/100,000 person-year.
2. Genetic susceptibility, streptococcal infection, stress, smoking, obesity & alcohol consumption are established risk factors for psoriasis.
3. All patients with psoriasis should be screened for cardio-metabolic disorders, psychiatric disorders & other associated co-morbidities.
4. All psoriasis patients should be assessed for disease severity & quality of life (QoL) using Body Surface Area (BSA), Psoriasis Area and Severity Index (PASI) & Dermatology Life Quality Index (DLQI).
5. Topical corticosteroids is used as the first-line topical treatment either as monotherapy or in combination with other treatment options.
6. Narrowband ultraviolet B given 2 - 3 times/week should be considered as the first line phototherapy in moderate to severe psoriasis.
7. Methotrexate (MTX) should be used as the first-line conventional systemic therapy for moderate to severe psoriasis. Ciclosporin & acitretin are other alternatives.
8. Biological therapy should be offered to patients with moderate to severe psoriasis who have intolerance/contraindication or failed phototherapy & conventional systemic therapy. It may be considered as a first-line treatment in severe disease based on clinical judgement where sufficient treatment success cannot be expected with a conventional therapy.
9. Screening for early detection of psoriatic arthritis (PsA) should be performed at least annually.
10. Psoriasis clinical features, diagnosis, disease severity assessment & treatment in paediatrics are similar to the adults.

This Quick Reference provides key messages & a summary of the main recommendations in the Clinical Practice Guidelines (CPG) Management of Psoriasis (Second Edition).

Details of the evidence supporting these recommendations can be found in the above CPG, available on the following websites:

Ministry of Health Malaysia: www.moh.gov.my
Academy of Medicine Malaysia: www.acadmed.org.my
Dermatological Society of Malaysia: https://www.dermatology.org.my

CLINICAL PRACTICE GUIDELINES SECRETARIAT
Malaysian Health Technology Assessment Section (MaHTAS)
Medical Development Division, Ministry of Health Malaysia
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ASSESSMENT TOOLS FOR MEASURING PSORIASIS SEVERITY & QOL

Tools	Description
BSA	• Measures percentage of body surface area affected by psoriasis based on "rule of 9" or taking patient's one palm-size (flat hand with thumb & fingers) as 1%
PASI	• The best validated tool with good internal consistency, good intraobserver variation and acceptable interobserver variation • Measures severity (erythema, scaling & induration) & extent of involvement based on four regions (head & neck, upper limbs, trunk & lower limbs) with score ranging from 0 - 72
PGA (Physician's Global Assessment)	• Validated tool to assess physical severity with good intraobserver & acceptable interobserver variation • Measures severity based on induration, erythema & scaling
DLQI/CDLQI (Children Dermatology Life Quality Index)	• Questionnaire to assess impact of psoriasis on QoL • It consists of ten questions related to symptoms, mental health, impact on daily life, leisure, work & school, personal relationships & burden of psoriasis treatment. • Score ranges from 0 to 30

DEFINITION OF PSORIASIS SEVERITY

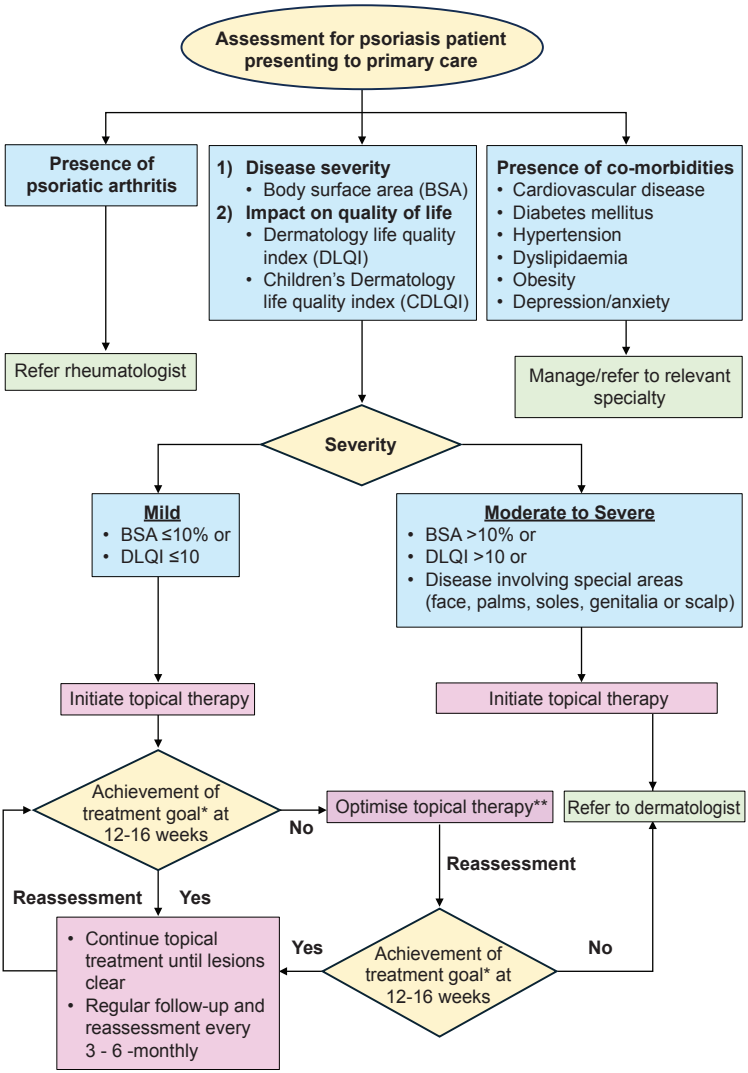
Grade of Severity	Definition
Mild	Candidate for topical therapy: • BSA ≤10% or • PASI ≤10 or • DLQI ≤10
Moderate to Severe	Candidate for phototherapy or systemic therapy (non-biologics and biologics): • BSA >10% or • PASI >10 or • DLQI >10 or • disease involving special areas (face, palms, soles, genitalia or scalp) or • failure of topical therapy

TREATMENT GOALS FOR PSORIASIS

Treatment	Treatment Goal*		Time for assessment
	Disease severity	Quality of life	
• Topical	BSA ≤3%	DLQI ≤5	Induction Phase 12 - 16 weeks after initiation Maintenance Phase 3 - 6-monthly
• Phototherapy • Systemic therapy • Biologics • Oral small molecules	BSA ≤3% or PASI ≤5 or PASI75** response	DLQI ≤5	

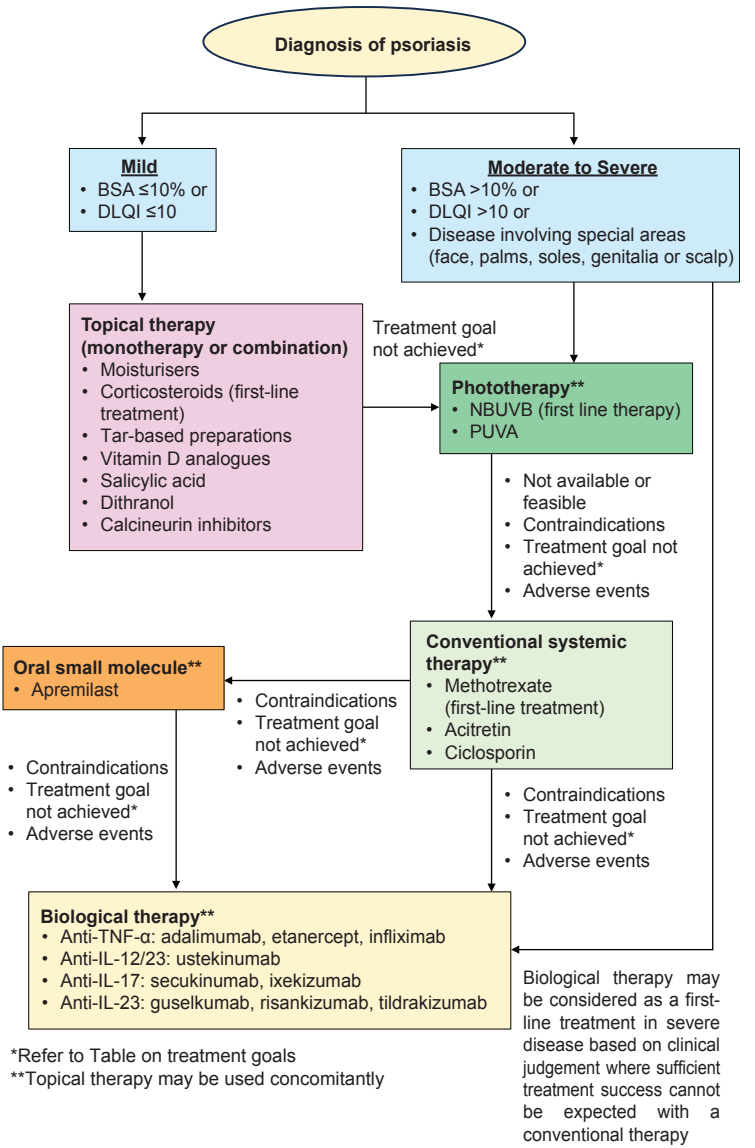
*Treatment goal must include both disease severity and quality of life
**PASI 75 = 75% reduction in PASI score after treatment

ALGORITHM ON MANAGEMENT OF PSORIASIS IN PRIMARY CARE



*Treatment goal: BSA ≤3% AND DLQI ≤5
** This may be optimised by increasing the potency of the topical steroid or in combination with another topical agent

ALGORITHM ON TREATMENT MODALITIES IN PSORIASIS



*Refer to Table on treatment goals
**Topical therapy may be used concomitantly

CONVENTIONAL SYSTEMIC TREATMENT

Contraindications & Precautions	Methotrexate	Ciclosporin	Acitretin
Absolute contraindications	• Severe hepatic disease • Severe infection • Renal failure • Pregnancy/breastfeeding • Alcohol abuse • Bone marrow dysfunction • Immunodeficiency • Acute peptic ulcer • Reduced lung function	• Impaired renal function • Uncontrolled hypertension • Severe infection • Current or history of malignancy • Simultaneous or previous phototherapy • High risk of cutaneous malignancy • Severe hepatic disease • Breastfeeding	• Severe renal/hepatic dysfunction • Severe hypertriglyceridaemia • Pregnancy (teratogenic) • Breastfeeding • Blood donation • History of pancreatitis
Relative contraindications	• Renal or hepatic diseases • Old age • Ulcerative colitis • History of hepatitis • Lack of compliance • Actively trying to become pregnant • Gastritis • Obesity • Diabetes mellitus (DM) • Previous malignancy	• None	• Women of child-bearing age
Recommended monitoring	• Monitor full blood count (FBC), liver function test (LFT), renal profile (RP) ○ Two weeks after initiation ○ Subsequently monthly for two months & 3-monthly thereafter • Perform blood test 5 - 7 days after last ingested dose of MTX • Procollagen III aminopeptide (PIIINP), if available, to be performed every 3 - 6 monthly to monitor for liver fibrosis • Vibration controlled transient elastography, magnetic resonance elastography or liver biopsy if MTX-induced hepatotoxicity or cirrhosis are suspected	• Monitor FBC, RP, LFT and fasting lipid profile (FLP) ○ Monthly for four months ○ Subsequently 2-monthly • Urinalysis at four weeks, then every 4 - 8 weeks	• Monitor FBC, LFT and FLP ○ Monthly for two months ○ Subsequently 3-monthly • Pregnancy test should be performed periodically during treatment and up to three years after discontinuation

DOSING & ADVERSE EFFECTS FOR COMMONLY USED MEDICATIONS IN PSORIASIS

DRUG	DOSING (ADULT)	DOSING (PAEDIATRIC)	ADVERSE EFFECTS
Topical Corticosteroids	1 - 2 times daily		• Acne/folliculitis • Depigmentation • Hypertrichosis • Secondary infection • Skin atrophy
CONVENTIONAL SYSTEMIC AGENTS			
Acitretin	0.5 - 1 mg/kg/day (Max: 75 mg/day)	0.1 - 1 mg/kg body weight/day (Max: 35 mg/day)	• Cheilitis • Xerosis • Alopecia • Paronychia • Hyperlipidaemia • Transaminitis
Ciclosporin	2.5 - 5 mg/kg/day in two divided doses	2 - 5 mg/kg/day in two divided doses	• Hypertension • Hyperuricaemia • Hyperkalaemia • Hypomagnesaemia • Hyperlipidaemia • Hypertrichosis • Gum hypertrophy • Renal dysfunction • Immunosuppression
Methotrexate	Oral, IM or SC: 5 - 25 mg/dose once weekly	0.2 - 0.7 mg/kg Dose once weekly	• Nausea/vomiting • Hepatotoxicity • Mucositis • Myelosuppression • Lung fibrosis • Immunosuppression
ORAL SMALL MOLECULES			
Phosphodiesterase-4 (PDE-4) Apremilast	Day 1: 10 mg OM Day 2: 10 mg BD Day 3: 10 mg AM, 20 mg PM Day 4: 20 mg BD Day 5: 20 mg AM, 30 mg PM Day 6 onwards: 30 mg BD	-	• Diarrhoea • Nausea • Weight loss • Risk of infection • Depression & suicidal behaviour
BIOLOGICAL AGENTS			
Anti-TNF-α			
Etanercept	SC: 50 mg twice per week for 12 weeks then 50 mg per week (50 mg twice per week may be required in some patients)	Age; ≥6 years • 0.8 mg/kg once weekly for up to 24 weeks • Maximum dose: 50 mg weekly	• Infections • Injection site reactions • Infusion reactions • Hepatotoxicity, (infliximab) • CHF • Drug-induced SLE • Cytopaenia • MS
Adalimumab	SC: 80 mg at week 0, then 40 mg 1 week later then 40 mg every 2 weekly	Age: ≥ 4 years • 0.8 mg/kg at weeks 0 and 1 and then every 2 weekly • Maximum dose : 40 mg every 2 weekly	
Infliximab	Intravenously at a 5 mg/kg at weeks 0, 2 and 6 then 5 mg/kg every 8 weekly	-	
Anti-IL12/IL23			
Ustekinumab	• Weight ≤100 kg, SC 45 mg at week 0, 4 then 12 weekly • Weight >100 kg, SC 90 mg at week 0, 4 then 12 weekly	Age: ≥ 6 years • ≤60 kg: 0.75 mg/kg • >60 kg to ≤100 kg: 45 mg • >100 kg: 90 mg SC at week 0 , 4 then 12 weekly	• Hypersensitivity reactions • Infections

Anti-IL-17			
Ixekizumab	SC: 160 mg at week 0 followed by 80 mg on weeks 2, 4, 6, 8, 10,12 then 80 mg 4-weekly	Age: ≥ 6 years • <25 kg: 40 mg at week 0 then 20 mg 4-weekly • 25 - 50 kg: 80 mg at week 0 then 40 mg 4-weekly • >50 kg: 160 mg at week 0 then 80 mg 4-weekly	• Hepatotoxicity • Worsening of inflammatory bowel diseases • Neutropaenia • Infections • Injection site reaction
Secukinumab	SC: 300 mg at weeks 0, 1, 2, 3, 4 then 300 mg 4-weekly	Age: ≥ 6 years • <50 kg: 75 mg • ≥50 kg: 150 mg SC at week 0,1,2,3 then 4-weekly	
Anti-IL-23			
Guselkumab	SC: 100 mg at week 0, 4 then 100 mg 8-weekly	-	• Infection
Risankizumab	SC: 150 mg at week 0, 4 then 150 mg 12-weekly	-	
Tidrakizumab	SC: 100 mg at week 0, 4 then 100 mg 12-weekly	-	

SELECTION OF BIOLOGICAL AGENT IN PATIENTS WITH CO-MORBIDITIES

Co-morbidity	Anti-TNF				Anti-IL-12/23	Anti-IL-17			Anti-IL-23		
	Etanercept	Infliximab	Adalimumab	Certolizumab	Ustekinumab	Secukinumab	Ixekizumab	Brodalumab	Guselkumab	Risankizumab	Tildrakizumab
PsA	✔✔	✔✔	✔✔	✔✔	✔✔	✔✔	✔✔	✔	✔✔	✔	✔
Crohn's disease	✔	✔✔	✔✔	✔✔	✔✔	×	×	×	✔	✔	✔
Ulcerative Colitis	✔	✔✔	✔✔	✔	✔✔	×	×	×	✔	✔	✔
DM/Metabolic Syndrome/ Dyslipidaemia	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Chronic kidney disease	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Chronic liver disease	✔	✔	✔	✔	✔✔	✔✔	✔✔	✔✔	✔	✔	✔
Advanced heart failure	×	×	×	×	✔	✔	✔	✔	✔	✔	✔
Ischemic heart disease	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
History of malignancy	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Latent/treated TB	×	×	×	×	✔	✔	✔	✔	✔	✔	✔
Hepatitis B#	-	-	-	-	-	-	-	-	✔	✔	✔
Hepatitis C#	-	-	-	-	-	-	-	-	✔	✔	✔
HIV*	✔	✔	✔	-	✔	✔	✔	-	-	✔	-

✔✔	Preferred option
✔	Alternative option
×	Avoid
-	Insufficient or no evidence

#Patients must be co-managed with hepatologist;
*PLHIV with undetectable viral load