

PSORIASIS ON SPECIFIC SKIN SITES



NATIONAL
PSORIASIS
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WHAT IS PSORIASIS?

Psoriasis is a noncontagious, lifelong skin disease that has been diagnosed in more than 4.5 million adults in the United States. The most common form, plaque [pronounced plak] psoriasis, appears as raised, red lesions covered with a silvery white buildup of dead skin cells, called scale.

About 10 percent to 30 percent of people with psoriasis also develop psoriatic [sore-ee-AA-tic] arthritis, which causes pain, stiffness and swelling in and around the joints. The hands, feet, wrists, ankles, knees and lower back are most often affected by this type of arthritis.



Three percent to 10 percent of the body affected by psoriasis is considered to be a moderate case. More than 10 percent is considered severe. The palm of the hand equals 1 percent of the skin. However, the severity of psoriasis is also measured by how psoriasis affects a person's quality of life. Psoriasis can have a serious impact even if it involves a small area, such as the palms of the hands or soles of the feet.

To learn more about the types of psoriasis or psoriatic arthritis, contact the National Psoriasis Foundation and request the following booklets:

- *Psoriatic Arthritis*
- *Specific Forms of Psoriasis*

Psoriasis is a lifelong, noncontagious skin disease that can occur on any part of the body. Psoriasis sometimes appears on the eyelids, ears, mouth and lips, as well as on skin folds, the hands and feet, and nails. The type of skin at each of these sites is different and requires different treatments. For example, the skin on the face is very different from the thicker, rougher skin of the elbow. In addition, psoriasis can vary widely among individuals and in its response to treatment. However, effective treatments are available. Because of the increased sensitivity for these areas, it is important to work with your doctor to find an appropriate treatment regimen that works for you.

PSORIASIS ON THE FACE

In diagnosing facial psoriasis, your doctor will examine your lesions and take a personal and family history. Facial psoriasis most often affects the eyebrows, the skin between the nose and upper lip, the upper forehead and the hairline. A biopsy may be needed to distinguish psoriasis from other skin diseases.

Facial psoriasis may respond initially to non-irritating moisturizers and petroleum jelly. Occasional use of mild topical steroids, also called corticosteroids, may be effective. Other treatments include Dovonex (a vitamin D₃ derivative, also known by its generic name calcipotriene), Tazorac (a topical vitamin A derivative, also known by its generic name tazarotene), keratolytic products (scale removers) and ultraviolet light. Dovonex and Tazorac can be irritating, so you should work with your doctor to find a way to address this concern.

In December 2000, the U.S. Food and Drug Administration (FDA) approved a drug called Protopic (also known by its generic name tacrolimus) for eczema. In December 2001, Elidel (also known by its generic name pimecrolimus) was also approved by the FDA for the treatment of eczema. Many dermatologists have also found that both drugs work well for treating psoriasis on the face or other sensitive areas.

Medication used to treat facial psoriasis should be applied carefully and sparingly; creams and ointments can irritate the eyes, and large amounts offer no additional benefits. Because facial skin is delicate, prolonged use of steroids may cause it to become thin, shiny and/or prone to enlarged capillaries (spider veins). Treatment with steroids may be safe if a careful treatment schedule is followed.

PSORIASIS AROUND THE EYES

When psoriasis affects the eyelids, lashes may become covered with scales, and the edges of the eyelids may be red and crusty. If inflamed for long periods, the rims of the lids may turn up or down. If the rim turns down, lashes can rub against the eyeball and cause irritation.

Treating eyelid inflammation may involve washing the edges of the eyelids and eyelashes with a solution of water and baby shampoo. Cotton tip applicators or washcloths are useful for carefully scrubbing the lids. An over-the-counter product, called Ocusoft, can help with removing scales on the lids and eye margins.

After removal of scales, moisturizers without corticosteroids may then be applied. In some cases, a special steroid medication made for use around the eyes may be used to treat scaling. Your doctor must carefully supervise the treatment because eyelid skin can be easily damaged. If topical steroids are overused in and around your eyes, glaucoma and/or cataracts may develop, which is the reason doctors suggest having your intraocular pressure checked regularly by an ophthalmologist (a doctor who specializes in treatment of eye diseases).

Protopic ointment or Elidel cream won't cause glaucoma and is effective on eyelids, but can sting the first few days of use. Using Protopic or Elidel for eyelid psoriasis may help you avoid the potential side effects of topical steroids.

Psoriasis of the eye is extremely rare. When it does occur, however, it can cause inflammation, dryness and discomfort, and may impair vision. Topical antibiotics may be used to treat infection.

PSORIASIS IN THE EARS

Psoriasis in the ears can cause scale buildup that blocks the ear canal. This buildup may lead to temporary hearing loss, and should be removed by a doctor. However, over-the-counter ear-cleaning kits that involve squirting small amounts of fluid into the ear and letting it drain may be used. Plain warm water, followed by a thin layer of mineral oil applied with a cotton swab, is also effective for some people.

Psoriasis generally occurs in the external ear canal, not inside the ear or behind the eardrum.

Prescription steroid solutions can be dripped into the ear canal or applied to the outside portion of the ear canal. Dovonex or Tazorac may cause irritation when used alone and may be best used in combination with a topical steroid. The eardrum is easily damaged. Care should be taken when inserting anything rigid into the ear. Also, impaction of scale already present from psoriasis can occur if medication prescribed for the skin on the ear is not appropriately applied inside the ear canal.

PSORIASIS IN AND AROUND THE MOUTH AND NOSE

For a very small number of people, psoriasis lesions appear on the gums, the tongue, inside the cheek, inside the nose or on the lips. The lesions are usually white or gray. Psoriasis in these areas can be relatively uncomfortable, and can cause difficulty in chewing and swallowing food.

For the most part, psoriasis treatments for the mouth and nose involve the use of topical steroids that have been designed to treat moist areas. Improving hygiene and rinsing frequently with a saline solution can help relieve oral discomfort. Low-potency steroids, such as hydrocortisone 1% ointment, may be useful in treating psoriasis on the lips. Protopic and Elidel may also be effective treatment options for psoriasis in and around the mouth.

PSORIASIS IN SKIN FOLDS

Inverse psoriasis can occur in the armpits, groin, under the breasts and in other skin folds around the genitals and buttocks. This type of psoriasis first shows up as smooth, dry lesions that are very red. Inverse psoriasis is frequently irritated by rubbing and sweating due to its location in skin folds and tender areas.

Steroid creams and ointments are considered very effective in treating inverse psoriasis. Because these areas are prone to yeast or fungal infections, doctors sometimes use diluted topical steroids in combination with other medications, such as 1% to 2% hydrocortisone with anti-yeast or antifungal agents.

Elidel and Protopic are also very effective for treating psoriasis in skin folds. They do not support the growth of yeast or fungus.

For a severe episode of inverse psoriasis, try alternating a moderate-strength steroid, such as betamethasone, for a brief period with an antifungal agent, such as Nizoral, in combination with soothing baths.

Topical steroids should be used with caution because skin folds are more susceptible to thinning of the skin. Skin folds also should not be occluded (covered with an airtight plastic or cloth wrap).

Dovonex and Tazorac may also be used in these areas, but be aware that these medications may cause irritation to sensitive skin folds.

PSORIASIS ON THE HANDS AND FEET

Acute flares of psoriasis on the hands and feet need to be treated promptly and carefully. In some cases, flares are accompanied by cracking, blisters and swelling.

General treatments include the use of moisturizers, mild soaps and soap substitutes. Some patients have helped heal non-bleeding, superficial skin fissures by closing them up with “super glue,” Elmer’s Wonder Bond Glue or Dermaflex, a product by Zila Pharmaceuticals. Use glues sparingly to avoid contact with unaffected skin.

Traditional topical treatment of palm and sole psoriasis includes tar, salicylic acid and steroids. Combinations of these three agents may be superior to each one used individually.

When directed by a doctor, some topical medications may be used with occlusion. This intensifies the effect of the cream or ointment. Cotton or plastic gloves can be worn over creams or moisturizers on the hands. Socks, or special occlusive foot covers, can be used on the feet. An easy way to occlude the feet is by putting each foot in a plastic bag and then putting a sock on over the bag. Try occlusion while you sleep or for an hour or two before going to bed. Soaking the hands or feet in warm water can reduce swelling, and should be followed by an application of medications or moisturizers.

It may be necessary to find additional ways to reduce built-up layers of skin in order for medications and

phototherapy to be effective. You might try soaking in warm water with oilated oatmeal powder or bath oil for 20 to 30 minutes, then gently rub the affected skin with a sponge to remove scales.

Dovonex can also be effective with psoriasis on the hands and feet, however, cotton gloves should be worn to prevent transfer of the medication to sensitive skin sites, such as the face or skin folds. A regimen alternating Dovonex and potent topical steroids may be beneficial.

Occlusion with Tazorac is not usually recommended but could be useful for palm/sole lesions. You may also want to alternate Tazorac with a topical steroid.

If topical medications do not work, your doctor may recommend PUVA, methotrexate, cyclosporine or Soriatane (also known by its generic name acitretin). PUVA involves the use of a light-sensitizing drug called psoralen, which can be taken orally or applied topically, combined with exposure to ultraviolet light A (UVA). Special palm/sole units are available to treat psoriasis on the hands and feet.

Systemic treatments taken by mouth or injection for severe palm and sole psoriasis may be beneficial. In this case, the benefits of treatment may outweigh the risk of side effects. Methotrexate can clear most cases of palm and sole psoriasis within four to six weeks. However, methotrexate has the potential for side effects to the liver, which require regular monitoring by a doctor. Cyclosporine is similarly effective for palm and sole psoriasis but has the potential for kidney side

effects. Biologics may be effective for treating psoriasis on the palms and soles. As a class of drugs, biologics were studied for chronic plaque psoriasis; however, after approval, success in treating all forms of psoriasis has been reported.

For people with scaling plaques of the palms and soles, oral retinoids such as Soriatane will result in thinning of plaques over a period of days or weeks. Thinning the scale buildup on the palms or soles may increase the effectiveness of topical treatments.

Oral retinoids in lower dosages are generally well-tolerated. However, oral retinoids do cause birth defects and should not be taken by women planning a pregnancy within three years.

The risk of side effects from phototherapy are reduced by combining low doses of retinoids with ultraviolet light B (UVB) or PUVA. The combination of retinoids with PUVA is one of the most effective treatments available for palm and sole psoriasis.

PUSTULAR PSORIASIS OF THE PALMS AND SOLES

This form of psoriasis is characterized by white pustules (blisters of noninfectious pus) surrounded by red skin. The pus is not contagious. The lesions are most prominent on the palm toward the base of the thumb, the fleshy part of the palm toward the ring and little finger, and on the soles and sides of the heels. Often, the lesions are painful and disabling. Plaque psoriasis can appear elsewhere on the body at the same time.

Doctors usually prescribe topical treatments such as steroids and coal tar first. However, PUVA, retinoids and methotrexate may have to be used in order to clear this form. Antibiotics are occasionally prescribed with varying results. Oral retinoids, such as Soriatane, can be helpful for pustular psoriasis.

PSORIASIS OF THE NAILS

Nail changes occur in up to 50 percent of people with psoriasis and at least 80 percent of people with psoriatic arthritis.

The nail problems most commonly experienced by psoriasis patients are:

- Pitting—shallow or deep holes in the nail
- Deformation—alterations in the normal shape of the nail
- Thickening of the nail
- Onycholysis—separation of the nail from the nail bed
- Discoloration—unusual nail coloration, such as yellow-brown

Nail treatments

Because psoriasis affects the nail when the nail is being formed, it is difficult to treat. The matrix, where the nail is formed, is difficult to penetrate with topical medications. Injections of steroids into the nail bed or matrix area have been used with varying results. The pain of the injections must be weighed along with the possibility of the relief being only temporary.

The major treatments specifically for nail psoriasis are:

- Topical treatments—Dovonex, Tazorac, corticosteroids, steroid impregnated tape (Cordran), 5-fluorouracil;
- Intralesional—injection of steroids into each affected nail;
- Phototherapy—PUVA (psoralen applied as “paint” or taken by mouth to increase sensitivity to ultraviolet light A);
- Cosmetic repair—nails deformed by psoriasis may be removed surgically or with a strong urea compound. Long, thick nails can be scraped and filed down. Color changes can be covered with nail polish, and pitted nails can be buffed and polished. In some instances, artificial nails may be warranted.

When people have severe, generalized psoriasis, the nail treatment is determined by the treatments they are already receiving for other parts of the body. If a person’s condition requires methotrexate, for example, nails are likely to improve. Similar results may be expected from other systemic psoriasis treatments that are dramatically effective.

Oral retinoids, such as Soriatane, can be beneficial for skin lesions of psoriasis, but usually result in the formation of very thin nails that are not normal in appearance. The nail changes caused by retinoids resolve several months after retinoids are discontinued.

In people whose psoriasis is sufficiently severe that treatment with PUVA is warranted, nails may improve. As with systemic treatments, the nail improvement may lag behind clearance of plaques on the body by several months.

Onychomycosis, a fungal infection that causes thickening of the nails, may be present with nail psoriasis. It can be treated with systemic antifungal agents. About one-third of people who have nail psoriasis also have a fungal infection that could actually be triggering their psoriasis or making the psoriasis worse. It is important to note that treating the fungus may not cause the nail psoriasis to clear.

A double-blind, randomized study of Tazorac gel in the treatment of nail psoriasis found that once-daily applications of the medication can significantly reduce separation of the nail from the nail bed (in occluded and non-occluded nails) and pitting (in occluded nails). In the study, some patients’ nails were wrapped (occluded) with a plastic film after the medication was applied.

Another study published in the July 2003 issue of the *British Journal of Dermatology* found that of 25 patients treated with Tazorac, 19 showed a good clinical response. The study lasted for 12 weeks and people were treated once a day at bedtime.

Nail care

In most cases, the nails should be trimmed back to the point of firm attachment with manicure scissors. Nails should be kept as short as possible. Loose nails continue to be subjected to strain as they rub against surfaces. It is important to protect your nails from damage because trauma will often trigger or worsen

nail psoriasis. One way to do this is to wear gloves while you are working with your hands. Vigorous cleaning and scraping under the nails may break the skin where the nail is attached. Be gentle when using instruments for cleaning under the nails.

Soaking your nails can help. Try three capfuls of tar bath oil in a bowl of warm water. Soak your fingers for 20 minutes and then rub moisturizer into each nail. A variety of tar bath oils and moisturizers are available at local pharmacies.

If your nails are mostly intact, application of a nail hardener or artificial nails can improve their appearance. However, sensitivity reactions to glues and chemicals may be a problem. Rule out any sensitivity reactions before using artificial nails. Be aware that a manicurist may be reluctant to apply the nails to badly eroded fingernails.

Toenails can be improved by soaking the feet for 10 minutes in a tub of warm water, gently filing the thickened part of the toenail with an emery board, and using good clippers to cut off a small piece at a time. The aim is to cut straight across the toenail to help keep it from becoming ingrown. Wearing roomy shoes leaves room for the toes and helps avoid the friction that can cause toenails to thicken.

STAY INFORMED AND INVOLVED. TAKE ACTION.

The National Psoriasis Foundation is committed to improving the lives of people with psoriasis and psoriatic arthritis. Join the Psoriasis Foundation to make a difference in the lives of millions of people with these diseases. Donate today!

Call **800.723.9166**

Visit **www.psoriasis.org**

E-mail **getinfo@psoriasis.org**

The following educational materials are available from the National Psoriasis Foundation:

- Alternative Approaches
- Biologic Medications for Psoriasis & Psoriatic Arthritis
- Conception, Pregnancy & Psoriasis
- Genital Psoriasis
- Phototherapy: Light Treatment for Psoriasis
- Psoriasis: How It Makes You Feel
- Psoriasis Research: Progress & Promise
- Psoriasis on Specific Skin Sites
- Psoriatic Arthritis
- Scalp Psoriasis
- Specific Forms of Psoriasis
- Steroids
- Sun & Water Therapy
- Systemic Medications: Internal Drugs for Moderate to Severe Psoriasis
- Topical Treatments for Psoriasis
- You & Your Doctor: Things to Consider
- Your Diet & Psoriasis

More updated information may be available at

www.psoriasis.org

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MISSION STATEMENT

Our mission is to improve the quality of life of people who have psoriasis and psoriatic arthritis. Through education and advocacy, we promote awareness and understanding, ensure access to treatment, and support research that will lead to effective management and, ultimately, a cure.

The National Psoriasis Foundation, a charitable 501(c)(3) organization, depends on your tax-deductible donations to support more than 5 million people affected by psoriasis and/or psoriatic arthritis. The Psoriasis Foundation is governed by a volunteer Board of Trustees and is advised on medical issues by a volunteer Medical Board. For more information, or to obtain a copy of the Foundation's Annual Report, call 800.723.9166.

National Psoriasis Foundation educational materials are reviewed by members of our Medical Board and are not intended to replace the counsel of a physician. The Psoriasis Foundation does not endorse any medications, products or treatments for psoriasis or psoriatic arthritis and advises you to consult a physician before initiating any treatment.

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