Approaches to Difficult-to-Treat Psoriasis in Specialized Areas

A specialist shares insights on treating psoriasis in specialized areas, such as hands, feet, face, and groin.

By Jerry Bagel, MD

Depending on many confounding factors, psoriasis responds differently to individual treatments from patient to patient. One such factor that impacts a physician’s approach to treatment is location of psoriasis on the body. Just as location can affect a person’s quality of life, it can also determine how psoriasis responds to different forms of treatments. Particular inflamed areas such as the face, groin, hands, and feet require a different approach to treatment. Here are some tips concerning treatment of psoriasis in these areas that have helped many of my patients achieve clearance.

**Hands and Feet**

With psoriasis of the hands and feet, the first thing that physicians must observe is that the skin in these areas is much thicker than other parts of the body. This allows physicians to be more aggressive in treating these particular lesions. I have found that strong topical steroids are effective for psoriasis of the hands or the feet and may be used longer than on other parts of the body. Salicylic acid is also efficacious, especially when compounded with topical steroids. I have also observed that Dovonex in conjunction with steroids or Taclonex sometimes yield better results than steroids alone.

If considering phototherapy, PUVA may be a more appropriate treatment as opposed to systemic therapy. With topical PUVA therapy, the patient would soak the lesions in 1250ml water diluted with 0.3ml of oxsoralen for 20 minutes to better sensitize the skin before light therapy. Systemic PUVA would be more appropriate for patients with psoriasis in more areas than just the hands and/or feet. However, it requires that the patient take oxsoralen in pill-form 75 minutes prior to treatment, during which time they must wear eye protection and keep their skin protected from all light.

Importantly, narrow-band UVB is not as effective on psoriasis of the hands and feet since it doesn’t penetrate the skin as strongly as UVA, particularly UVA in combination with psoralen. For scaly lesions on the hands and feet, I recommend treating the lesion/s with soriatane, Taclonex, or salicylic acid for two weeks before and during PUVA treatment to clear some of the scaliness.

I have used biologic agents to varying degrees of success on these lesions as well. Specifically, Raptiva (efalizumab, Genentech) is highly effective in psoriasis of the hands and feet, perhaps even more so than the other biologic treatments. Over the last several years, Raptiva has developed a niche for treating psoriasis on the hands and feet. The reasons for its effectiveness in treating these areas is still being studied, nevertheless, it is a strong alternative of patients with psoriasis of the hands and feet aren’t responding to other forms of treatment.

**Scalp Psoriasis**

Scalp psoriasis has unfortunately become difficult to treat not due to a lack of treatment options but because reimbursements rates for the available modalities have recently dwindled and are practically non-existent. These include applying a combination of tar solution and 6% salicylic acid under occlusion to the scalp (note that the patient should be wearing a shower cap during this time). After soaking the scalp for a half hour, we would
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place the scalp under oscillating jets of water squirting shampoo. This process helps to rid the scalp of scales before the patient uses any kind of steroids.

Also effective is Short-Contact Anthralin Therapy (SCAT), in which one would apply anthralin to the scalp and leave it on the skin for about 20 minutes. Daily applications of anthralin can clear scalp psoriasis in several weeks. Using Dermasmooth under occlusion every night for two weeks is also very effective. As the psoriasis begins clearing, recommend that the patient begin decreasing the frequency of use. Applying Clobex at night and washing it the next morning, is also effective at clearing scalp psoriasis. I have also used biologic therapies such as Amevive (alefacept, Biogen), Enbrel (etanercept, Amgen), and Raptiva with good success in treating severe scalp psoriasis, especially if the above therapies haven’t yielded positive results.

**Face and Groin**
Because the skin in the face and groin areas is much more sensitive, it is important that physicians take a more cautious approach to treating lesions in these areas. For example, when using steroids, note that it is best to use less potent steroids since the more potent steroids may cause skin on the face or groin to become atrophic. I recommend using a mild steroid for short periods of time.

Other than mild steroids, other topical treatments that are typically effective at reducing irritation and controlling inflammation include Protopic (tacrolimus) ointment and Elidel (pimecrolimus) cream, both of which excel at relieving psoriasis in the face and groin areas.

For patients with psoriasis of the face and/or groin areas, I recommend cleansing these areas with Polytar soap (Stiefel), a highly efficacious cleanser that helps to relieve itching, irritation, and scaling.