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When Psoriasis Isn't Obvious: Clues to Clarify Diagnosis

Announcer:
You're listening to *On the Frontlines of Psoriasis* on ReachMD. And now, here's your host, Dr. Shelina Ramnarine.

Dr. Ramnarine:
Welcome to *On the Frontlines of Psoriasis* on ReachMD. I'm Dr. Shelina Ramnarine, and joining me to discuss how we can better recognize and diagnose psoriasis is Dr. Chris Sayed. He's a Professor in the Department of Dermatology at the University of North Carolina School of Medicine.

Dr. Sayed, thanks for being here today.

Dr. Sayed:
Very happy to be here. Thank you for having me.

Dr. Ramnarine:
So to start us off, Dr. Sayed, what features lead you to suspect that a patient may have psoriasis?

Dr. Sayed:
When patients first come into clinic with a rash, there's a very broad differential, and so there's a lot of different things it could be. But there are definitely some clues to psoriasis in particular. I think one of the most typical things we look for is that it's been chronic; it's been happening over time for them usually. Occasionally, people come in, and it's only been there for a few weeks, and they've just had their first onset. But often they've had rashes on and off over time and weren't quite sure what it was.

There's also typical locations, like on the elbows or the knees or on the scalp. So very often I'm peeking around and looking at those classic psoriasis areas to try to figure out, do they have those typical areas involved? Or is it more like something along the lines of eczema, which has a very different distribution for most patients where it's more diffuse, like on the inside of the elbow as opposed to the outside of the elbow?

There are atypical presentations, so some people get what's called inverse psoriasis, where it's in places like the underarms or the crease of the groin, and they think they maybe just have had yeast infections on the skin or intertrigo. But on closer questioning, they don't respond to typical treatments for those things, and it tends to be very persistent.

Looking for those classic locations is one thing. There's also a connection with psoriatic arthritis, which is where joints can become inflamed along with skin psoriasis. And so when I'm suspecting psoriasis, I always ask about that. Things like, "Is there stiffness in the morning when you wake up that takes more than just five or ten minutes for some of those joints to get going?" "Have you ever had a finger that's just swollen up all by itself or one or two digits that do that?" That's very typical in psoriasis. It doesn't happen super often, but when it happens, it's a very strong sign of psoriatic arthritis. Or things like pain on the back of the heel or the bottom of the foot that might have been mistaken for plantar fasciitis can all be clues that there's psoriasis going on and that's the cause for the rash.

Similarly, nail involvement is very common in psoriasis, where people get small pits or little dark spots on the fingernails. And so if I'm differentiating some of these other common conditions like atopic dermatitis, I might also check their nails very carefully for signs that they have involvement of their nails with psoriasis.

Dr. Ramnarine:
What variations across patients or body sites are especially important for us to recognize?

Dr. Sayed:
Psoriasis can end up looking very different among different patients. One of the most important things probably is that in lighter skin types, we often see things like areas that are pink and red with scales covering them. But in darker skin types, they might look more purplish. And so that's one important thing to recognize; people have trained in programs where they didn't see a lot of variety in skin types and colorations, they may not recognize it quite as easily. It's really important, and we work that into trainings more intentionally in a lot of places now where people don't see as much skin tone variety.

Psoriasis vulgaris is a term you may also hear, and vulgaris just means common. That probably makes up 85 percent of cases of psoriasis, and that's those typical red scaly plaques that we see in all the areas I described previously. I mentioned inverse psoriasis. We call it inverse because as opposed to being on external surfaces of the elbows, it's again more in the skin folds, which is what we don't think about for typical psoriasis, and people can have both of those things. And then there are less common forms of psoriasis, like pustular psoriasis, where people get covered sometimes in little tiny pustules all over the place, and that can be an even bigger burden to deal with and very explosive in onset. Or palmoplantar psoriasis can affect the palms or the soles of the feet, and that can be these very deep pustules that can be very itchy and sometimes kind of tender. That particular type often gets mistaken for other things for a long time. People think they have athlete's foot or even a staph infection because of the pustules, but it doesn't tend to respond to any treatments for those things. So that can often fool people and lead to misdiagnosis and inappropriate treatments for a long time for some patients.

And occasionally, people can just be red from head to toe. We call that erythrodermic psoriasis, where for whatever reason, something explosive happened for their immune system that caused psoriasis to just go all over the place all at one time. And that's one of the trickiest forms because there are several things that can cause an erythrodermic presentation like that, where people are red all over. And until we get a biopsy back, if there's no history of psoriasis, it can be hard to predict that, and can be very tricky to treat as well.

Dr. Ramnarine:
For those just tuning in, you're listening to *On the Frontlines of Psoriasis* on ReachMD. I'm Dr. Shelina Ramnarine, and I'm speaking with Dr. Chris Sayed about best practices in diagnosing psoriasis.

So Dr. Sayed, when is the clinical presentation sufficient to diagnose psoriasis, and when does the workup need to go further?

Dr. Sayed:
It's a great question because the typical way to diagnose psoriasis is to do a small skin biopsy, which is not a huge burden, but it means an injection of numbing medicine, a small piece of skin is taken, it's looked at under the microscope, and there's a small scar left behind afterwards. And it's not infrequent that if we're going to escalate to stronger systemic therapy, some of the newer things that are around, we might want to confirm the diagnosis as much as we can first.

But there are some cases that are very classic, and if it's elbows and knees, scalp, all those classic places with a very typical presentation, it's probably not always necessary to do that step. But there are times when it's not clear-cut. Often, patients have started applying treatments to their skin by the time they get to us, and they can make the presentation a little bit less distinctive. And then you're wondering, "Is this really psoriasis? Is there something else going on?" And before you treat it, you want to make sure you know exactly what you're dealing with. Areas like the palms can also be very tricky. People get things like hand dermatitis that cause itching and scaling, and it can look just like psoriasis on the hand sometimes. So occasionally we'll do biopsies there too to try to distinguish if we should be treating more of an eczema-type presentation or more of a psoriasis-type presentation, because the treatments can be very different between those two things.

And I mentioned things like erythrodermic psoriasis. It is very hard to tell once somebody is red all over exactly what did it. And there are some other dangerous things like drug reactions or types of rare cutaneous lymphomas, these unique cancers that can affect mostly the skin, where people can present and it looks almost identical. So until we have a biopsy and we know what exactly what we're treating in those situations, we can't really tailor our therapies to the individual needs of the patients very well.

Dr. Ramnarine:
And before we close, what are the most important diagnostic habits or clinical pearls you want clinicians to remember when evaluating a patient who may have psoriasis?

Dr. Sayed:
Psoriasis fortunately has come a long way when it comes to treatments. So getting a good diagnosis and thinking through good treatment regimens makes a huge difference for patients. It used to be that 30 years ago, patients ended up hospitalized often with very bad psoriasis all over the place and had these intensive regimens for weeks at a time sometimes. But those days have mostly passed, and so recognizing psoriasis before it gets way out of control and offering treatments is a huge help to them.

Diagnosing psoriasis, again, if you have classic lesions, classic locations, and the typical scaly plaques, often isn't a huge challenge. But when there are questions about it, when it's possible something just isn't quite adding up, or somebody's not responding to typical treatments like they should, it's worth going that extra step and getting that clinical confirmation.

And I think I can't understate the importance of asking about joints. Joint disease in psoriasis is destructive, and it tends to be worse and more common when patients have very extensive psoriasis on their skin. But even with milder psoriasis, it can occur. And if patients are getting, again, swollen joints, atypical sort of morning stiffness, or things like that, like I mentioned earlier, treating them earlier is always better because psoriasis of the joints can destroy those joints over time, and it's hard to get function back once it's lost.

So making sure that's recognized early and treated aggressively with all the good treatments we have now is just as important as being mindful of the skin.

Dr. Ramnarine:
That's a great comment for us to think on as we come to the end of today's program. I want to thank my guest, Dr. Chris Sayed, for joining me to discuss his perspective on the evaluation and diagnosis of psoriasis.

Dr. Sayed, it was great having you on the program.

Dr. Sayed:
It was wonderful to be here. Thank you for having me.

Announcer:
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