Use of topical treatments in psoriasis management

Tonia Goman

This is the third article in a seven-part series looking at the identification and treatment of psoriasis, explores the active ingredients and action of the main topical treatments for psoriasis. Community nurses are perfectly placed to help patients take control of their skin condition, particularly in advising them on the benefits of topical treatments, which, as they can be applied directly to the skin, allow the area to be targeted, lowering the level of absorption into the bloodstream and reducing side-effects (Psoriasis and Psoriatic Arthritis Alliance [PAPAA], 2017a).

KEYWORDS:
Dermatology ■ Psoriasis ■ Treatment ■ Emollients

This is the third article in a series examining the assessment, diagnosis and management of psoriasis. Previous articles have discussed the different types of psoriasis and the initial treatment strategies as recommended by the National Institute for Health and Care Excellence (NICE) psoriasis treatment pathway (NICE, 2016; Figure 1).

Topical therapies are psoriatic medications that are applied to the skin, but can also be absorbed through the skin, which means they need to be used carefully. Some topical treatments can be obtained over the counter, although most are prescription-only. Clinical guidelines provided by the National Institute for Health and Care Excellence [NICE] (2012) advised that patient preference, the practicalities of application and the product’s cosmetic acceptability should be considered before any topical therapy is prescribed.

In the author’s clinical experience, patients are often confused about the use of active topical treatments. They may use them regularly but be unaware of their purpose or the ingredients they contain. Patients may also be anxious about the use of corticosteroid treatments, for example, because of the reported side-effects. It is also easy to confuse topical treatments, which often have similar names or packaging. Also, when patients have used a range of topical treatments over a long period, they may not always remember which products they have tried, or which were effective.

Figure 1. The psoriasis treatment pathway (adapted from NICE [2016]).

THE SCIENCE — WHAT IS PSORIASIS?

Approximately 2–3% of the UK population is affected by the chronic inflammatory skin condition, psoriasis (Dubois Declercq and Fouliot, 2013). There are various forms of psoriasis, but it generally presents as red plaques that can become thick and scaled. It may start as small red lesions that eventually increase and coalesce (join together). Often starting at the knees and elbows, for many it can be limited only to these areas, whereas for others it can affect other parts of the body such as the scalp. Men and women are equally affected, as are children (Van Onselen, 2011).
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As with emollients, topical treatments may be used in conjunction with other therapies, such as phototherapy, systemic and biologic treatments, to reduce the effects of a psoriasis ‘flare’, for example, or while other treatments begin to take effect. Patients often confuse emollients with topical treatments. Thus, when a topical treatment has been prescribed, the nurse should discuss the product with the patient, highlighting its appearance, mode of action, and side-effects, and provide a written plan to guide the patient in using the product correctly. An audit by Peters et al (2008) highlighted the benefits of involving patients in any discussions about their care and providing comprehensive education around any treatments prescribed, enabling the patient to participate fully in their treatment. Figure 2 highlights some of the basic guidelines that community nurses should follow when caring for a patient who has been prescribed a course of topical treatment.

This article provides a brief outline of a range of topical treatments, which will enable community nurses to better guide patients through the complexities of the different products available.

**TYPES OF TOPICAL TREATMENT**

**Vitamin D analogues**

Vitamin D analogues such as calcipotriol (Dovonex®; LEO Laboratories), tacalcitol (Curatoderm®; Almirall) and calcitriol (Siliks®; Galderma) can be a very effective form of treatment for psoriasis. They are produced in a variety of formats, including creams, ointments and scalp applications, and are not steroid-based. For this reason, vitamin D analogues have the advantage of being a safer option for long-term regular use. They also do not stain and thus can be more cosmetically acceptable to patients. Vitamin D analogues work by slowing cell turnover in the skin, normalising keratinocyte hyperproliferation and inhibiting the production of specific cells responsible for the development of psoriasis, (interleukin-2 [IL-2] and IL-6) (Kim, 2010; Stein Gold, 2016), as well as having an anti-inflammatory effect by reducing the production of psoriatic cells (Kim, 2010; Stein Gold, 2016). It can take up to four to six weeks before any improvement in the patient’s psoriasis symptoms is noted, although it can be cleared within three months (van Onselen, 2011; Psoriasis Association, 2014a).

‘Patients often confuse emollients with topical treatments. Thus, when a topical treatment has been prescribed, the nurse should discuss the product with the patient, highlighting its appearance, mode of action, and side-effects.’

**Side-effects**

Hypercalcaemia (raised calcium levels) can be a side-effect of vitamin D analogues and this treatment should be avoided if the patient has a history of calcium metabolism disorders. It is also advised to use vitamin D analogues with caution in patients with generalised pustular or erythrodermic exfoliative psoriasis (British Medical Association [BMA], 2017a).

The most common side-effect reported by patients using vitamin D analogues is skin irritation, including a burning or stinging sensation. Lesser reported side-effects include skin peeling, rash or worsening psoriasis. Not all vitamin D analogues are suitable for the skin on the face and flexures and the manufacturer’s instructions should be consulted, for example, Dovonex should not be used on the face but Curatoderm or Siliks can be used on the face and other sensitive areas.

**Vitamin A derivatives and topical retinoids**

Topical retinoids such as tazarotene (Zorac®; Allergan) are available as a gel and aim to reduce skin cell reproduction and the inflammatory process (McClelland, 1997). Although not fully understood, it is believed they normalise cell differentiation, suppress the growth of skin cells and restrain inflammatory responses by the body (Saurat, 1993). Originally developed in 1957 for mild-to-moderate psoriasis, topical retinoids are manufactured in two strengths, 0.05% and 0.1%, and are available as prescription only (Psoriasis Association, 2014b). Patients should be advised to begin with the lower strength and only apply a thin layer. Topical retinoids are designed as a once-daily treatment, for up to 12 weeks, before any improvements may be seen.

The main advantage of topical retinoids is that they are non-staining and odourless. They can only be used on the body (as they are too strong to be applied to the face), providing the psoriasis is stable and covers less than 10% of the body’s surface area. If the skin is particularly dry, emollients should be applied before using topical retinoids.

**Side-effects**

Topical retinoids are not regularly used due to the side-effects, which include skin irritation, pruritis (itching) and a burning sensation; initially, they can also cause psoriasis to become redder in colour. However, persistently applying topical retinoids will enable the skin to build up a tolerance to any sensitivity (PubMed Health, 2017). Community nurses should advise the patient to apply a thin layer of gel to the centre of the psoriasis plaque, using a gentle circular motion and working outwards avoiding non-affected skin. If the initial irritation persists, the nurse should advise the patient to reduce the amount applied until the reaction settles (Psoriasis and Psoriatic Arthritis Alliance [PAPAA], 2017a).
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Contra-indications, warnings, side effects etc: Do not use if sensitive to any of the ingredients. Keep away from the eyes, inside the nostrils and mouth. Temporary tingling, itching or stinging may occur with emollients when applied to damaged skin. Such symptoms usually subside after a few days of treatment, however, if they are troublesome or persist, stop using and seek medical advice. Rarely skin irritation (mild rashes) or allergic skin reactions can occur on extremely sensitive skin, these tend to occur during or soon after the first few uses and if this occurs stop treatment. As safety trials have not been conducted during pregnancy and breast-feeding, seek medical advice before using this product.

Care should be taken as emollients which soak into clothing, pyjamas, bedding etc. can increase the flammability of these items. Patients should avoid these materials coming into contact with naked flames or lit cigarettes etc. As a precaution, dressings and clothing, etc., should be changed frequently and laundered thoroughly.

Ingredients: Carbomer, glycerol, isopropyl myristate, liquid paraffin, nicotinamide, phenoxyethanol, sorbitan laurate, trolamine, purified water.

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Further information is available from the manufacturer: Dermal Laboratories, Telmore Place, Gosmore, Hitchin, Herts, SG4 7QR, UK. Date of preparation: August 2017. ‘Adex’ is a trademark.

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Topical retinoids are contraindicated during pregnancy and while breastfeeding. Contraception is also recommended while using this topical therapy, as absorption can harm a foetus. The ‘mini pill’ is not advised, due to it not being the most reliable contraceptive method (Allen, 2015). If pregnancy is reported, the treatment should be immediately discontinued. Patients should also be advised that vitamin A and herbal products should be treated with caution while undergoing treatment with topical retinoids such as benzoyl peroxide, as should antibiotics, diuretics, phenothiazine drugs (antipsychotic medications), sulphonamides (antibacterial medications). Natural sunshine, sunbeds and cold weather should be avoided due to the photosensitive nature of topical retinoids and patients should be advised to apply sun factor 30 or above each day when undergoing treatment. Nurses should also advise patients that topical retinoids must not be used on inflamed, pustular, flexural or facial psoriasis (van Onselen, 2011; Psoriasis Association, 2014b; PubMed Health, 2017).

Coal tar
Coal tar is a renowned topical treatment used for medical purposes since the 1800s, although originally discovered as far back as 1665. It comes in a variety of formats, including creams, ointments, gels and shampoos. It is mainly found as a coal tar solution for products available over the counter. It is cost-effective and safe to use in the treatment of psoriasis.

Various formulations of coal tar include crude coal tar (manufactured by the distillation of bituminous coal at high temperatures), medicated shampoos such as Polytar® (GlaxoSmithKline), and a variety of scalp treatments including Cocos® (Focus Pharmaceuticals), Exorex® (Forest Laboratories) and Psoriderm® (Dermal Laboratories). Coal tar possesses anti-inflammatory properties and works as a keratolytic to reduce the proliferation of skin cells that produce the thick scaling associated with psoriasis. Coal tar is effective against thick-scaled psoriatic plaques, in turn relieving the associated pruritus (Ngan, 2005).

Crude coal tar is effective and can clear psoriasis within a 3–6-week period (Griffiths et al, 2004). Crude coal tar can be produced in a concentration of 1–20% in a soft paraffin base (PAPAA, 2017c). In a controlled trial back in 1997, it was found that 6% crude coal tar was more effective than salicylic acid and petroleum (both overnight, under occlusion) (Kumar et al, 1997). One significant advantage of coal tar is that it is non-steroidal, which means that it does not have the side-effect profile that many patients are wary of (DermNet, 2005).

For decades coal tar was regarded as an effective, daily treatment for patients with severe psoriasis admitted to hospital. Outpatient departments took this on where the patient attended the department daily (Mondays to Fridays) and no longer required the use of a hospital admission. The combination of artificial ultraviolet B (UVB) spectrum phototherapy and coal tar, known as the Goeckerman regimen, was introduced in 1925 and some hospitals are still using this system (van Onselen, 2011). However, availability of coal tar is limited in many departments, as well as practical considerations, such as finding the staff available to apply the coal tar and hospital departments equipped with the shower facilities required to remove it, have often limited the use of the Goeckerman regimen.

There are cleaner forms of coal tar available that can also be applied to the body, such as Exorex and Psoriderm and many of the coal tar products now available come in shampoo format (scalp psoriasis will

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**Retinoids**

Retinoids are potent treatments, which should not be applied to non-affected skin. They are far too strong to be applied to flexures (where skin-on-skin areas double the potency) and facial psoriasis. They will aggravate eczema or open wounds (Psoriasis Association, 2014a). They should be used under caution for patients with a history of skin cancer (including lentigo maligna), as they may make this condition worse (PubMed Health, 2017).

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Figure 2.
General advice for patients undergoing topical treatment.
Dithranol, available as Dithrocream® (Dermal Laboratories) and Psorin® (LPC Pharmaceuticals), suppresses the cell production. It can irritate skin that has not been affected by psoriasis, therefore community nurses should ensure that it is only applied within the border of the psoriasis plaques themselves. Often called a ‘short contact therapy’, dithranol should only be applied to the skin for a limited period of time (20–30 minutes) on a daily basis (Stein Gold, 2016). Dithranol is available in a range of strengths, starting with the lowest dose (0.1%) and graduating to the more potent doses (up to 2%) as the skin becomes more tolerant. Test doses are recommended at the beginning of treatment and as the doses increase.

While some dermatology outpatient departments offer a dithranol service, as with coal tar treatments, resources are limited and the treatment is not widely available (Pugsley, 2009). Prescribed treatment courses, such as Dithrocream, that can be applied at home, are available in varying strengths. Community nurses should advise patients to apply these creams thinly and within the plaque border. When applying the cream, patients should be told to leave it in place for the correct length of time, to carefully avoid normal skin and to wash the cream off after treatment using lukewarm water. Patients should also be advised to immediately wash away any cream that comes into contact with skin unaffected by psoriasis. This regimen will need to be continued over several weeks. If irritation does occur, a lower strength cream can be used; the cream can be applied less frequently; or the length of time the cream is left on can be reduced (MayoClinic, 2017).

As dithranol contains yellow soft paraffin, which is highly inflammable, it should not be used near any heat sources such as electric heaters or lit cigarettes. It should also not be applied to children, postural psoriasis, on flexures, the face or genitals, or to inflamed, broken, ‘weepy’ or blistered skin (National Patient Safety Agency, 2007).

**Topical calcineurin inhibitors**

These topical therapies, which include tacrolimus (Protopic® 0.03% and Protopic® 0.1%; Leo Laboratories) and pimecrolimus (Elidel®, Meda Pharmaceuticals), are classed as immunomodulating agents and act on the immune system by weakening the skin’s defence and reducing inflammation to the skin. They are available as ointments (tacrolimus) and creams (pimecrolimus), and work by blocking a chemical called calcineurin, which is responsible for activating symptoms of inflammation, redness and itching (British Association of Dermatologists [BAD], 2016). At the time of writing, topical calcineurin inhibitors were not licensed for the treatment of psoriasis. However, they are regularly used off-license for psoriasis. They are effectively used and licensed for eczema, with studies showing the efficacy resulting from tacrolimus. Further studies continue with the hope that this will transfer to the treatment of psoriasis also (Malecic and Young, 2016).

Tacrolimus is available in two strengths: the weaker strength, 0.03%, is licensed for use in children aged 2–16 years. The weaker preparation is also suitable for application to the face (DermNet NZ, 2017). Tacrolimus is not a steroid treatment, but is often prescribed to be used ideally in the evening or before bedtime. Often, protopic treatment is used on the face and other active areas to the body may be treated with a corticosteroid or other treatments (Furue et al, 2004). Primarily used for eczema flares, tacrolimus is also prescribed for use on psoriasis. One study concluded that as it does not cause skin atrophy (thinning of the skin), the most appropriate sites to apply tacrolimus are on the face, flexures and genitalia (Wang and Lin, 2014).

Studies have also proven that pimecrolimus has its benefits, mainly reduced side-effects, although it is considered far less effective than tacrolimus (Wang and Lin, 2014).
Side-effects
The main side-effect of topical calcineurin inhibitors is localised skin irritation, often described as an intense tingling, burning or itching sensation. Patients will often experience this within the first week of treatment, but should be advised to persevere as this side-effect is usually temporary (BAD, 2016).

Manufacturers for these topical calcineurin inhibitors (National Eczema Society, 2016) and the British Association of Dermatologists (BAD, 2016) advise that topical treatments should not be used within two hours of application of tacrolimus. One study showed that the use of an emollient on the skin before the protopic was applied resulted in a reduced inflammatory response. Topical calcineurin inhibitors also act as photosensitisers and precautions against exposure to natural ultraviolet light should be taken, i.e. avoiding natural sunshine between the hours of 10.00am-4.00pm, or using a broad spectrum sunscreen that covers UVA /UVB with a minimum SPF of 30 (Skin Cancer Foundation, 2017).

Keratolytics
Keratolytic agents such as Diprosalic® (Merck Sharp & Dohme) come in ointment form and are effective at removing the scale associated with psoriasis, creating a more receptive base for the application of other topical treatments. The main ingredient to keratolytic treatments is salicylic acid. Diprosalic also contains betamethasone, a steroid that helps to reduce the symptoms of psoriasis. In adults, keratolytics can be applied once-to-twice daily over a two-week period, although children should be limited to a single five-day course. The maximum dose per week is no more than 60g (British National Formulary [BNF], 2017).

Side-effects
Continual use of keratolytics can result in striae (stretchmarks), superficial dilation (blood vessels or capillaries noticeable on the skin), or localised skin atrophy (PAPPA, 2017b). Keratolytics should not be applied to more than 20% of the body’s surface as this could induce salicylism, a toxic effect that results in tinnitus, nausea and vomiting (Federman et al, 1999; Menter et al, 2009).

Topical corticosteroids
Topical corticosteroids are effective against psoriasis where their primary action is to suppress the inflammatory reaction in the skin (BAD, 2015). They are easy to apply, provide fast relief and, when used correctly, present a minimal risk of side-effects.

### Table 1: Potency profile of topical corticosteroids (adapted from Oakley, 2009; National Psoriasis Foundation, 2017)

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Potent</th>
<th>Very potent</th>
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<tbody>
<tr>
<td>Hydrocortisone 0.5%</td>
<td>Eumovate® (GliaSmithKline) Clobetasone butyrate</td>
<td>Betnovate® (GliaSmithKline) Betamethasone valerate</td>
<td>Dermovate® (GliaSmithKline) Clobetasol propionate</td>
</tr>
<tr>
<td>Hydrocortisone 1%</td>
<td>Betnovate RD® (GliaSmithKline) Betamethasone valerate</td>
<td>Dovobet® (Leo Laboratories) Calcipotriol + betamethasone as dipropionate</td>
<td>Neritone Forte® (Meadow) Diflucortolone valerate</td>
</tr>
<tr>
<td>Haelan fluocinolone 0.0125%</td>
<td>Synalar 1:4 dilution Fluocinolone acetonide</td>
<td>Diprosone® (Merck Sharp &amp; Dohme) Betamethasone as dipropionate</td>
<td>Elocon® Mometasone furoate (Merck Sharp &amp; Dohme)</td>
</tr>
</tbody>
</table>

**With antimicrobial agents**

Daktacort® (Janssen Cilag) Hydrocortisone Miconazole nitrate | Triomethadone® (GliaSmithKline) Clobetasone butyrate Oxytetracycline, nystatin | Betnovate-N® (GliaSmithKline) Betamethasone as valerate 0.1%, Neomycin sulphate |

Fusidin HP (Leo Laboratories) Hydrocortisone acetate Fusidic acid | Betnovate-C® (GliaSmithKline) Betamethasone, as valerate, 0.1%, Clioquinol | |

Synalar C Fluocinolone acetonide 0.025%, Clioquinol 3% | Synalar N Fluocinolone acetonide 0.025%, Neomycin sulphate 0.5% | | With salicylic acid Dirosal® (Merck Sharp & Dohme) Betamethasone, as Dipropionate, salicylic acid |
from mild, moderate, potent to very potent (Table 1).

As topical corticosteroids are absorbed at different rates depending on the thickness of the skin, the following applications are recommended (Sharma et al, 2017):

- Mild topical corticosteroids such as hydrocortisone or eumovate can be applied to the face
- Moderate-strength topical corticosteroids, alongside antifungals, can be used to treat flexural psoriasis
- Potent and/or very potent topical steroid treatments can be used on the palms of the hands and soles of the feet, as these areas have additional layers of skin.

Oclusion with clingfilm or hydrocolloid dressings can increase the effectiveness of topical steroids, but can also intensify the side-effects (National Psoriasis Foundation, 2016).

**Side-effects**

When a patient is prescribed topical corticosteroid treatment, the potency as well as specific instructions for use should be explained. Side-effects from these treatments can result in (Condoo et al, 2014):

- Irreversible skin atrophy and striae, which can cause the skin to be more prone to psoriasis flaring
- Bruising
- Enlarged blood vessels (telangiectasia)
- Loss of skin pigment
- Folliculitis (infection of the hair follicles)
- Loss of hair growth at the treatment site.

There is evidence that systemic side-effects can develop when topical corticosteroids are applied to extensive psoriasis (over 10% of the body). Patients can also experience an exacerbation of their psoriasis when topical corticosteroid treatments are stopped suddenly; similarly, the withdrawal of very potent corticosteroids can precipitate the development of severe pustular psoriasis (NICE, 2015; BMA, 2017b). Ideally, the patient should be advised to gradually reduce the potency of topical corticosteroid treatment, which can be achieved either by reducing the frequency of application or moving to a weaker strength preparation.

NICE (2012) advised that very potent corticosteroids should not be used continuously at any site for longer than four weeks at a time, and that the potency and formulation should be appropriate to the current status of the patient’s psoriasis. When using potent or very potent topical corticosteroids, a four-week break should be considered with the topical corticosteroid being replaced with vitamin D analogues or coal tar for the duration. NICE (2012) also suggested that a potent topical steroid can be applied once a day in conjunction with a vitamin D analogue at the other end of the day.

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**Table 1.**

<table>
<thead>
<tr>
<th>Child’s age</th>
<th>Number of FTUs needed</th>
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<tbody>
<tr>
<td>3–6 months</td>
<td>1 1/2 1 1/2 1 1/2 1 1/2</td>
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<tr>
<td>1–2 years</td>
<td>2 2 2 3 3</td>
</tr>
<tr>
<td>3–5 years</td>
<td>3 3 3 4 4</td>
</tr>
<tr>
<td>6–10 years</td>
<td>4 4 4 5 5</td>
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**Figure 3.** Measuring fingertip units (FTUs).

**Figure 4.** One fingertip unit.
FINGERTIP UNIT

Due to the varying rates of absorption into the skin, it is important that community nurses assist patients in understanding the correct amount of topical therapy to be applied. For this reason, doses are often referred to as fingertip units (FTU). One adult fingertip unit is the amount of cream or ointment taken from an average 5mm diameter nozzle, applied from fingertip to first crease of the index finger (Figures 3 and 4).

Dose of cream in a fingertip unit varies with age:
- Adult male: one fingertip unit provides 0.5g
- Adult female: one fingertip unit provides 0.4g
- Children of four years — approximately 1/3 of adult amount
- Infants six months to one year — approximately 1/4 of adult amount.

CONCLUSION

As these treatments enable patients to manage their condition at home, community nurses will regularly be asked questions about their implications and use during routine visits for other complaints.

Community nurses are ideally placed to manage patients coping with the symptoms of psoriasis, but it is crucial that they have a comprehensive understanding of the treatments available so that they can provide up-to-date management and advice. Many topical therapies are provided at the beginning of treatment for psoriasis, when patients are still coming to terms with their ‘unsightly’ and uncomfortable skin condition. While GPs commonly prescribe topical therapies, limitations on their time mean that patients are not always provided with enough information about these medications.

While patients may be referred to dermatology specialty nurses, who are well-placed to evaluate them in detail, including discussing the practicalities of topical therapies such as application quantities and how various preparations may affect patients’ daily lives, unfortunately the numbers of dermatology nurses across the UK is limited. This is precisely why it is crucial that community nurses have an understanding of psoriasis and its treatments, which will allow them to provide best practice themselves or refer on to specialist services if necessary.

REFERENCES


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*JCN survey April 2016. n=983, answers in more than one category allowed