



## Complete Summary

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### GUIDELINE TITLE

Psoriasis.

### BIBLIOGRAPHIC SOURCE(S)

Finnish Medical Society Duodecim. Psoriasis. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2007 Dec 26 [Various]. [23 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Finnish Medical Society Duodecim. Psoriasis. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2005 May 25 [Various].

### \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse:** This guideline references drug(s) for which important revised regulatory and/or warning information has been released.

- [May 1, 2008, Enbrel \(etanercept\)](#): Amgen and Wyeth Pharmaceuticals informed healthcare professionals of changes to the BOXED WARNING section of the prescribing information for Enbrel regarding the risk of serious infections, including bacterial sepsis and tuberculosis, leading to hospitalization or death. The ADVERSE REACTIONS section of the label was updated to include information regarding global clinical studies and the rate of occurrence of tuberculosis in patients treated with Enbrel.
- [October 20, 2008, Raptiva \(efalizumab\)](#): The U.S. Food and Drug Administration (FDA) notified healthcare professionals of extensive labeling changes, including a Boxed Warning, to highlight the risks of life-threatening infections, including bacterial sepsis, viral meningitis, invasive fungal disease, progressive multifocal leukoencephalopathy and other opportunistic infections with the use of Raptiva. In addition, the prescribing information will be updated to describe a potential risk for the permanent suppression of the immune system with repeat administration of Raptiva in children. Raptiva is not approved for children under 18 years of age.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### **DISEASE/CONDITION(S)**

Psoriasis

### **GUIDELINE CATEGORY**

Diagnosis

Treatment

### **CLINICAL SPECIALTY**

Dermatology

Family Practice

Internal Medicine

### **INTENDED USERS**

Health Care Providers

Physicians

### **GUIDELINE OBJECTIVE(S)**

Evidence-Based Medicine Guidelines collect, summarize, and update the core clinical knowledge essential in general practice. The guidelines also describe the scientific evidence underlying the given recommendations.

### **TARGET POPULATION**

Patients who have psoriasis or cutaneous lesions suspicious of psoriasis

### **INTERVENTIONS AND PRACTICES CONSIDERED**

**Diagnosis**

1. Assessment of clinical features and patterns of cutaneous lesions
2. Assessment for family history of psoriasis
3. Biopsy of lesion
4. Differential diagnosis

## **Treatment**

1. Topical treatment
  - Salicylic acid preparations
  - Emollients
  - Vitamin D and analogues: calcitriol, calcipotriol
  - Corticosteroids
  - Combination ointment (calcipotriol and betamethasone dipropionate)
  - Tars and dithranol
  - Retinoid analogue: tazarotene
  - Occlusive dressings
  - Pimecrolimus and tacrolimus
2. Phototherapy
  - Natural sunlight
  - Climatotherapy (heliotherapy)
  - Ultraviolet B (UVB) radiation treatment
  - Combination psoralen/ultraviolet A radiation therapy (PUVA)
  - Selective UV phototherapy (SUP)
3. Systemic drug therapy
  - Acitretin
  - Methotrexate
  - Ciclosporin
  - Biological agents: efalizumab, etanercept, infliximab
4. Referral to dermatologist

**Note:** Antistreptococcal therapy is considered but not recommended.

## **MAJOR OUTCOMES CONSIDERED**

- Psoriasis clearance rate
- Remission rate
- Adverse effects of (tolerance to) treatment

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The evidence reviewed was collected from the Cochrane database of systematic reviews and the Database of Abstracts of Reviews of Effectiveness (DARE). In

addition, the Cochrane Library and medical journals were searched specifically for original publications.

## NUMBER OF SOURCE DOCUMENTS

Not stated

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

### Classification of the Quality of Evidence

Code	Quality of Evidence	Definition
<b>A</b>	<b>High</b>	Further research is very unlikely to change our confidence in the estimate of effect. <ul style="list-style-type: none"><li>• Several high-quality studies with consistent results</li><li>• In special cases: one large, high-quality multi-centre trial</li></ul>
<b>B</b>	<b>Moderate</b>	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate. <ul style="list-style-type: none"><li>• One high-quality study</li><li>• Several studies with some limitations</li></ul>
<b>C</b>	<b>Low</b>	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate. <ul style="list-style-type: none"><li>• One or more studies with severe limitations</li></ul>
<b>D</b>	<b>Very Low</b>	Any estimate of effect is very uncertain. <ul style="list-style-type: none"><li>• Expert opinion</li><li>• No direct research evidence</li><li>• One or more studies with very severe limitations</li></ul>

GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group 2007 (modified by the EBM Guidelines Editorial Team)

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Not stated

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

The levels of evidence [A-D] supporting the recommendations are defined at the end of the "Major Recommendations" field.

### **In General**

- The prevalence of psoriasis in the adult population in Scandinavia and Western Europe is approximately 2% (Smith & Barker, 2006). It is rare in young children (see picture 1\* in the original guideline document).
  - There are two peaks of onset, and both have a different genetic background.
    - Early onset psoriasis develops before the age of 40 years, is familial and, on average, more severe than the late onset type (Henseler & Christophers, 1985).
  - The triggering factor in early onset psoriasis, particularly in guttate psoriasis, is often a streptococcal infection, whereas late onset psoriasis is highly associated with preceding stressful life events (Mallbris et al., 2005).

- Excessive alcohol consumption, smoking and certain drugs are other known risk factors.
- Psoriasis is a chronic, disfiguring and stigmatising disease which may adversely affect the patient's self image and quality of life (Rapp, Feldman, & Exum, 1999). It may be associated with significant anxiety and depression (Fortune, Richards, Griffiths, 2005).
- Psoriasis is associated with an increased risk of diabetes, obesity, dyslipidaemia and cardiovascular illnesses (Henseler & Christophers, 1995; Gelfand et al., 2006).

## **Clinical Features**

- The diagnosis of psoriasis is based on the clinical picture.
  - In special cases, a biopsy specimen (see the Finnish Medical Society Duodecim guideline "Indications for and Techniques of Skin Biopsy") may be beneficial. The specimen should be taken from the middle of an untreated plaque using a 4 to 6 mm biopsy punch.
- Plaque psoriasis (nummular psoriasis, psoriasis vulgaris; see picture 2\*) is the most common type (about 90% of all cases). The characteristic plaques are symptomatic and symmetrically distributed on the elbows (see pictures 3 and 4\*), knees (see picture 5\*), legs, lower back (see picture 6\*) and scalp (see pictures 7, 8 and 9\*).
  - The plaques are sharply demarcated, red and thickened patches with a diameter of no less than 0.5 cm (see picture 10\*). The plaques are covered with a layer of silvery scales, the thickness of which is patient specific and varies according to treatment (Griffiths et al., 2007).
    - Gentle scraping of the scales reveals minute capillary bleeding points (Auspitz sign; see picture 11\*).
    - Plaque psoriasis is further divided into large plaque psoriasis (plaques over 3 cm, see picture 2\*) and small plaque psoriasis (plaques less than 3 cm, see picture 12\*).
  - When the plaques are localised within apposed skin surfaces – submammary region, navel (see picture 13\*), groin (see pictures 14 and 15\*), gluteal cleft (see picture 16\*), axillae – scaling is uncommon (flexural psoriasis, psoriasis inversa).
- Guttate psoriasis is a widely distributed skin eruption (see picture 17\*); typically in a young person after streptococcal tonsillitis. The condition usually resolves itself, but it may flare up later with small individual spots or it may develop into plaque psoriasis.
- Pustular forms of psoriasis are rare. These include acral psoriasis (see pictures 18 and 19\*), palmoplantar and generalised psoriasis, and erythrodermic psoriasis, which involves the entire skin (see pictures 20 and 21\*).
- The fingernail changes, including pitting, oily macules (see pictures 22 and 23\*), distal onycholysis (see picture 24\*), subungual hyperkeratosis (see picture 25\*) and crumbling of the nail plate, are often useful in differential diagnosis. They are commonly seen in psoriatic arthritis (see the Finnish Medical Society Duodecim guideline "Psoriatic Arthropathy").

## **Differential Diagnosis**

### **Scalp**

- In seborrhoeic dermatitis (see the Finnish Medical Society Duodecim guideline "Seborrhoeic Dermatitis") (see picture 26\*) the flakes are thinner, "greasier" and the condition responds better to treatment. It is often difficult to differentiate seborrhoeic dermatitis from psoriasis unless other skin areas offer additional information.
- Fungal infection of the scalp (see the Finnish Medical Society Duodecim guideline "Dermatomycoses") is uncommon in Western populations. It mostly affects children. This diagnosis can be excluded by a negative fungal culture.
- Neurodermatitis of the neck (lichen simplex nuchae) is characterised by an isolated, itchy plaque covered with thin scales.

### **Flexures with Apposed Skin Surfaces**

- Seborrhoeic dermatitis (see the Finnish Medical Society Duodecim guideline "Seborrhoeic Dermatitis") (see picture 27\*) may resemble flexural psoriasis. Examine other skin areas. It is not always necessary to differentiate between these two conditions, as the treatment is the same.
- Fungal infection (tinea, see the Finnish Medical Society Duodecim guideline "Dermatomycoses") may resemble psoriasis; however, it usually heals in the centre and expands peripherally. Positive fungal culture is diagnostic.
- Candidiasis in the flexural areas is not often seen in the age groups affected by psoriasis (i.e., the young or middle-aged patients). It presents as a moist area of erythema and maceration with outlying "satellite eruptions". Candidiasis diagnosis may be confirmed with a culture.
- Erythrasma is a macular brown area with few symptoms, most often found in the armpit or groin. It is caused by an overgrowth of diphtheroids in the normal skin flora. These areas fluoresce coral pink under long-wave ultraviolet radiation (Wood's light).

### **Palms, Soles of Feet**

- Pictures 28 and 29\*
- It may be difficult to differentiate hyperkeratotic eczema of the palms and palmoplantar pustulosis (see pictures 30 and 31\*) from psoriasis. Examine the entire skin.
- Fungal infection (see the Finnish Medical Society Duodecim guideline "Dermatomycoses") is usually unilateral and is easily diagnosed by direct microscopy from a good quality specimen.

### **Treatment**

- Treatment should aim to improve any illness-induced impairment of the patient's quality of life.
  - It is not necessary to treat psoriasis that has no adverse effect on the patient.
  - A totally asymptomatic state is rarely achievable with current treatment modalities.
  - Psoriasis may be associated with anxiety or depression that requires further management.
- Current treatment practices are listed in table 1 in the original guideline document. The treatments are divided into topical treatment, phototherapy

and systemic treatment, and they are provided for the different levels of health care.

- The choice of treatment (see picture 32\*) depends on
  - The psoriasis subtype and the effect it has on the patient's life
  - The extent, severity and location of the lesions
  - The availability, feasibility and cost of treatment modalities
  - The patient's age and life situation as well as response to earlier treatment and the possible presence of comorbidities.
- Psoriasis is a chronic condition and, in addition to the acute phase treatment, a long-term treatment plan must be considered.
- Consideration should also be given to diseases and risks associated with psoriasis (e.g., metabolic syndrome and associated disorders) as well as to lifestyles with a detrimental effect on psoriasis (alcohol consumption, smoking).

### **Topical Treatment**

- Topical treatment is the main form of treatment available for a general practitioner, and in most cases it is all that is needed for psoriasis management (Mason, Mason & Cork, 2002).
- Ointments and creams may also enhance the effect of other treatment regimes (Ashcroft et al., "Combination regimens," 2000).

### **Plaque Psoriasis**

- If the lesions are covered by a thick layer of scales it may be appropriate to start the treatment with scale removal. Salicylic acid preparations (5%) are available over the counter, and should be applied for a couple of days. Scales must not be removed by scratching or rubbing.
- Emollients may be used either simultaneously with other treatments or as follow-up treatment. In very mild cases they may suffice as the sole treatment form.
- Topical preparations of vitamin D and its derivatives (calcitriol and calcipotriol) are efficient and safe in long-term management of plaque psoriasis (Ashcroft et al., "Systematic review," 2000) [**A**]. Local skin reactions may occur. The use of topical vitamin D may be hampered by the need to apply the preparation regularly twice daily in order to achieve full efficacy and, moreover, treatment response will not be evident until after 4 to 6 weeks. This is the safest and most recommended treatment form, but only a few patients are able to continue long-term with the regular applications.
- Topical corticosteroids (potent to very potent, i.e. group III to IV) have a rapid onset of action and will also alleviate itchiness, which is present in about 70% of patients (Mason, Mason, & Cork, 2002). They should initially be used continuously for 2 to 4 weeks followed by gradual dose reduction and cessation. Abrupt cessation should be avoided as it will lead to early recurrence. An attempt must be made to avoid the emergence of known adverse effects of long-term use and the patient must be appropriately monitored.
- The combination ointment of calcipotriol and betamethasone dipropionate is the fastest and most effective topical treatment for plaque psoriasis (Mason, Mason & Cork, 2002) [**A**]. Once daily application is sufficient. The initial

treatment period lasts for 4 weeks and should be followed by one of the following studied maintenance regimes:

- Calcipotriol once or twice daily long-term
- Calcipotriol on weekdays and the combination ointment on weekends or
- The combination ointment when required.
  - In a 52-week study, 4.8% of users developed corticosteroid-induced adverse effects.
- Tars and dithranol (Naldi & Rzany, 2005) [**A**] are old and effective treatment forms but due to the smell and mess are not well tolerated and, therefore, they are no longer used in some countries.
- Tazarotene (Weinstein et al., 1997) [**B**] is a retinoid analogue; it is not available in all countries as a registered medicinal product.
- Occlusive dressings used alone with no added medication have been reported to be effective in localised plaque psoriasis. They may enhance the efficacy of corticosteroid and calcipotriol preparations, particularly when treating isolated persistent plaques.

### **Plaque Psoriasis in Specific Areas**

- Scalp psoriasis (see pictures 33 and 34\*) is treated with frequent shampooing. If necessary, salicylic acid exfoliation may be used initially followed by a corticosteroid solution.
  - A layer of scales will prevent the penetration of medicated preparations.
  - Salicylic acid is often used as a 5% to 10% mixture (prepared in the pharmacy) in a cream, castor oil or macrogol ointment base.
- Psoriasis on the face may be treated by
  - Moderately potent corticosteroid preparations
  - Pimecrolimus and tacrolimus (check reimbursement status)
- Flexural psoriasis may be managed with the same preparations as those used on the face. Some patients may also tolerate vitamin D preparations in flexural areas.
- The treatment of psoriasis on the palms and the soles of the feet (see pictures 35, 29, and 36\*) consists of the above mentioned medicines used in plaque psoriasis. To treat hyperkeratosis, salicylic acid may be mixed up to 20% potency. In more severe cases, systemic acitretin may be prescribed.

### **Guttate Psoriasis**

- If guttate psoriasis is not very extensive, the topical treatment forms described for plaque psoriasis may be used, particularly topical corticosteroids.
  - Ultraviolet B (UVB) phototherapy is the treatment of choice for extensive guttate psoriasis.

### **Pustular Psoriasis and Erythrodermic Psoriasis**

- The principal treatment regime consists of systemic drugs, which may be supplemented with emollients and topical corticosteroids.

### **Phototherapy**

- Phototherapy may be used in extensive guttate and plaque psoriasis in persons whose skin tolerates exposure to the sun and tans easily.
- Certain photosensitising medications may be a contraindication for phototherapy.
- Spending time in natural sunlight will alleviate psoriasis.
  - To achieve a good treatment response, the daily exposure to sunlight must continue for 3 weeks.
- Organised heliotherapy (climatotherapy) is an effective but relatively expensive treatment modality due to lost working days (Snellman et al., 1998).
  - Heliotherapy may be covered by national health insurance schemes. The insurance cover varies from country to country. Lost earnings may also be reimbursable.
- Ultraviolet B radiation (UVB treatment). The prescribing physician must be familiar with the patient's particular skin type as well as the radiation spectrum and dose rate emitted by the phototherapy equipment. Moreover, the amount of radiation exposure and the cumulative dose must be recorded. If the treatment has benefited the patient, a general practitioner may prescribe repeat sessions.
  - The conventional broadband UVB therapy is effective in guttate psoriasis and in mild plaque psoriasis (Griffiths et al., 2000). The therapy is not associated with an increased cancer risk (Lee, Koo, & Berger, 2005).
    - It may be possible to install a phototherapy unit at the patient's home. Home UVB phototherapy is a very cost-effective treatment modality (Lee, Koo, & Berger, 2005).
  - Narrowband UVB therapy (311–313 nm) is more effective than broadband therapy and is the phototherapy of choice in psoriasis (Ibbotson et al., 2004). Many hospitals have changed their old broadband units to new narrowband units.
    - The treatment efficacy is as good as, or better than, that achieved with bath-combination psoralen/ultraviolet A radiation (PUVA) (using topical psoralens) (Snellman et al., 2004).
    - So far there is inadequate data as regards the risks of long-term use.
- In PUVA therapy (combining a psoralen and ultraviolet A) (Griffiths et al., 2000; Spuls et al., 1997) [**A**], the patient's skin is sensitised to light with a psoralen, which is administered either topically (bath-PUVA or cream-PUVA) or by mouth (oral-PUVA). Only a specialist physician may prescribe PUVA therapy.
  - PUVA therapies have been replaced in many countries by the more cost-effective narrowband UVB therapy.
  - Oral-PUVA is actually a form of systemic treatment. The popularity of its use has declined after reports of associated risk of cutaneous cancer (Stern et al., 1979).
- SUP therapy (selective UV phototherapy) may slightly alleviate thin plaque psoriasis with little scaling, but scientific evidence on its effect in the treatment of psoriasis is lacking (Paul et al., 1983).

## **Systemic Drug Therapy**

- Acitretin (Griffiths et al., 2000) [**C**], methotrexate (Griffiths et al., 2000) [**C**] and ciclosporin (Griffiths et al., 2000) [**A**] may be prescribed by a dermatologist to patients with severe psoriasis. Their use requires specialist experience and careful follow-up. Methotrexate and ciclosporin are almost equally effective in moderate to severe plaque type psoriasis (Heydendael et al., 2003).
- Biologicals may be considered for the treatment of moderate to severe psoriasis refractory to other treatments or when other treatments are contraindicated or not tolerated.
  - Efalizumab, etanercept and infliximab are licensed for the treatment of psoriasis and adalimumab for psoriatic arthritis (the licensed indications may vary from country to country).
  - The use of biologicals is associated with several risks, which all treating physicians should bear in mind, in particular
    - Rapid progress, severity and atypical presentation of ordinary bacterial infections
    - Activation of latent tuberculosis, often as miliary tuberculosis or with atypical presentation
    - Opportunistic infections

### Referral to Specialist

- Children affected by psoriasis (pictures 10 and 1\*) and patients with psoriasis not responding to usual treatment modalities should be referred to a dermatologist.
- An experienced dermatologist can be more helpful in the diagnosis of problematic psoriasis than sending off a skin biopsy.
- If excessive corticosteroid use is suspected (see pictures 37 and 38\*) the patient should be referred to a dermatologist.

### Related Resources

Refer to the original guideline document for related evidence, including Cochrane reviews and other evidence summaries.

\***Note:** All pictures identified in this summary can be found in the original guideline document.

### Definitions:

### Classification of the Quality of Evidence

Code	Quality of Evidence	Definition
<b>A</b>	<b>High</b>	<p>Further research is very unlikely to change our confidence in the estimate of effect.</p> <ul style="list-style-type: none"> <li>• Several high-quality studies with consistent results</li> <li>• In special cases: one large, high-quality multi-centre trial</li> </ul>

<b>Code</b>	<b>Quality of Evidence</b>	<b>Definition</b>
<b>B</b>	<b>Moderate</b>	<p>Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.</p> <ul style="list-style-type: none"> <li>• One high-quality study</li> <li>• Several studies with some limitations</li> </ul>
<b>C</b>	<b>Low</b>	<p>Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.</p> <ul style="list-style-type: none"> <li>• One or more studies with severe limitations</li> </ul>
<b>D</b>	<b>Very Low</b>	<p>Any estimate of effect is very uncertain.</p> <ul style="list-style-type: none"> <li>• Expert opinion</li> <li>• No direct research evidence</li> <li>• One or more studies with very severe limitations</li> </ul>

GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group 2007 (modified by the EBM Guidelines Editorial Team)

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **REFERENCES SUPPORTING THE RECOMMENDATIONS**

[References open in a new window](#)

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

Concise summaries of scientific evidence attached to the individual guidelines are the unique feature of the Evidence-Based Medicine Guidelines. The evidence summaries allow the clinician to judge how well-founded the treatment recommendations are. The type of supporting evidence is identified and graded for select recommendations (see the "Major Recommendations" field).

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Accurate diagnosis and effective treatment of psoriasis

### **POTENTIAL HARMS**

- An attempt must be made to avoid the emergence of known adverse effects of long-term use of topical corticosteroids and the patient must be appropriately monitored.
- Tars and dithranol are old and effective treatment forms but due to the smell and mess are not well tolerated and, therefore, they are no longer used in some countries.
- Oral-combination psoralen/UVB therapy is actually a form of systemic treatment. The popularity of its use has declined after reports of associated risk of cutaneous cancer

## **CONTRAINDICATIONS**

### **CONTRAINDICATIONS**

Certain photosensitising medications may be a contraindication for phototherapy.

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

An implementation strategy was not provided.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Living with Illness

### **IOM DOMAIN**

Effectiveness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Finnish Medical Society Duodecim. Psoriasis. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2007 Dec 26 [Various]. [23 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

2002 May 7 (revised 2007 Dec 26)

**GUIDELINE DEVELOPER(S)**

Finnish Medical Society Duodecim - Professional Association

**SOURCE(S) OF FUNDING**

Finnish Medical Society Duodecim

**GUIDELINE COMMITTEE**

Editorial Team of EBM Guidelines

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Primary Author:* Tapio Rantanen

**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

**GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Finnish Medical Society Duodecim. Psoriasis. In: EBM Guidelines. Evidence-Based Medicine [Internet]. Helsinki, Finland: Wiley Interscience. John Wiley & Sons; 2005 May 25 [Various].

**GUIDELINE AVAILABILITY**

This guideline is included in "EBM Guidelines. Evidence-Based Medicine" available from Duodecim Medical Publications, Ltd, PO Box 713, 00101 Helsinki, Finland; e-mail: [info@ebm-guidelines.com](mailto:info@ebm-guidelines.com); Web site: [www.ebm-guidelines.com](http://www.ebm-guidelines.com).

**AVAILABILITY OF COMPANION DOCUMENTS**

None available

**PATIENT RESOURCES**

None available

**NGC STATUS**

This summary was completed by ECRI on December 17, 2002. The information was verified by the guideline developer as of February 7, 2003. This NGC guideline was updated by ECRI on October 4, 2004. This summary was updated by ECRI on July 21, 2005 following the Food and Drug Administration (FDA) advisory on Raptiva (efalizumab). This summary was most recently updated on November 14, 2005. This summary was updated by ECRI on February 7, 2006 following the Food and Drug Administration (FDA) advisory on Hydrea and Droxia (hydroxyurea capsules). This summary was updated by ECRI Institute on May 15, 2008 following the U.S. Food and Drug Administration advisory on Enbrel (etanercept). This NGC summary was updated by ECRI Institute on December 3, 2008.

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