Psoriasis is a common inflammatory dermatosis, affecting 2% of the population. Scalp involvement is common. Indeed, scalp involvement may be the only manifestation of the disease.

It may be difficult to distinguish between psoriasis and dandruff or seborrhoeic dermatitis. Psoriasis usually presents with more well-demarcated, erythematous plaques covered with thick, silvery scales. Seborrhoeic dermatitis is less well demarcated and scales are finer and have a more greyish colour. Both conditions can itch.

Scratching a psoriasis plaque lifts the surface scales, making their silvery colour more obvious. Picking off the silvery scales results in bleeding points, a finding known as the Auspitz sign.

Psoriasis is one of those skin conditions that preferentially involves damaged skin, the so-called Koebner phenomenon. Many patients with dandruff/seborrhoeic dermatitis scratch their scalp. In psoriasis patients, the disease may Koebnerise to the scratched scalp. Indeed, many patients present with features of psoriasis and seborrhoeic dermatitis: so-called sebopsoriasis.

Scalp psoriasis significantly impinges on quality of life:
• It is a highly visible disease, especially when it spreads beyond the hair margins
• There are problems with scales falling on clothing
• There may be persistent itch
• It is traditionally difficult and messy to treat.

Treatment has to include a thick coverage of scalp hair. This is difficult to achieve with creams, ointments and especially pomades.

Patient compliance and tolerability can play a crucial role in efficacy. Therefore, when it comes to treatment, choice of vehicle can be as important as the choice of therapy itself.

Topical corticosteroids have been widely used in general practice. Steroids are effective thanks to their anti-inflammatory action. There are two problems with steroid applications when used as sole therapy. Firstly, they are usually only partially effective. Secondly, continued use over a period of time gives less and less of a response, i.e. tachyphylaxis.

Traditional tar and dithranol treatments are just not used in general practice due to their messiness and side-effect profile.

Two approaches have been adopted in an attempt to improve acceptability and effectiveness of topical treatment:

Reduce messiness of treatment

Cocos contains tar and salicylic acid. It has a bit of a smell but is generally well tolerated. It is more effective if left on the scalp for longer than recommended by the manufacturers. It can be applied at night and washed out in the morning. A shower cap helps protect bedding.

Combination treatments
• Combine steroid and salicylic acid (Diprosalic scalp application): The salicylic acid is an excellent keratolytic and helps break down scale
• Combine steroid and tar: Cocos can be applied, as above, at night. A steroid is applied after washing out Cocos in the morning
• Combine steroid and a vitamin D analogue: calcipotriol (Dovonex) applied at night with a steroid in the morning has been used for many years.

Applying even cosmetically acceptable applications to the scalp is difficult. Understandably, regimens needing twice daily treatments have a poor compliance record.

A recent addition to our therapeutic options combines a steroid, betamethasone with a vitamin D analogue, calcipotriol (Xamiol).

Psoriasis of the face and hair margin

The hair margin is an important dividing line between the tougher skin of the scalp and the more delicate skin of the face. This has implications when treating psoriasis that extends beyond the hair margin:

• Potent steroids will cause thinning of facial skin
• Tar and vitamin D analogues may irritate facial skin. Calcitriol (Silkis) is less effective than calcipotriol (Dovonex) but appears less irritant on delicate skin, such as on the face.

We therefore tend to combine a moderate potency steroid, clobetasone ointment (Eumovate), with calcitriol (Silkis). They should be applied at different times of the day.

If this does not give an acceptable result one may try tacrolimus (Protopic). Tacrolimus is generally ineffective on chronic plaque psoriasis. However, on the thinner skin of the face it is effective in up to 90% of patients.