Location Matters: The Outsize Quality of Life Burden of Psoriasis in High-Impact Areas



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Interview Summary

When patients are living with psoriasis in high-impact body areas, defining disease severity by objective measures of body surface extent affected does not provide the full picture. Scalp, palmo-plantar, nail, genital, and flexural involvement can all place a significant burden on quality of life (QoL) in people with psoriasis. In recognition of this, current consensus guidance recommends moving beyond a purely severity-based classification to a more holistic, patient-centred approach that incorporates disease location, symptom burden, and treatment response. The International Psoriasis Council (IPC) consensus recommends classifying patients as candidates for topical or systemic therapy, with systemic therapy candidacy informed by body surface area (BSA) >10%, involvement of special areas, or failure of topical therapy.

Here, Maria Politou, senior attending dermatologist/venereologist and medical researcher at the Andreas Syggros Hospital in Athens, Greece, and board member of the Hellenic Dermatological and Venereological Society (EDAE), discusses the outsize QoL impact of psoriasis in high-impact areas, explains why location matters just as much as extent, and shares her own approach to holistic assessment and management of psoriasis, including comorbidity and treatment safety considerations.

INTRODUCTION

Psoriasis, a chronic, immune-mediated inflammatory skin disease, affects around 60 million people worldwide.[1] The various psoriasis subtypes include plaque (which accounts for up to 90% of cases), flexural, guttate, pustular, or erythrodermic.[1,2] Psoriasis severity is often classified and tracked using objective methods such as BSA, or the percentage of a patient's skin affected, with moderate-to-severe disease often defined as ≥10% BSA.[2,3]

Politou described psoriasis in high-impact areas as the involvement of anatomical sites where the disease has a disproportionately large burden on the person's QoL, regardless of BSA.[1,4] "This is because the locations are visible, function critical, and particularly sensitive," Politou explained. "We are talking about the scalp, the palms and soles (palmo-plantar), the nails, the genitals, and the flexural areas."[1,4] High-impact area involvement is common in psoriasis.[5,6] A Danish cross-sectional study of more than 4,000 adults with plaque psoriasis found that around 65% had involvement in at least one high-impact area, 42% had involvement of more than two, and 22% more than three.[5] Similarly, a Chinese nationwide population-based study of more than 7,000 patients found that 71%, 37%, and 16% had involvement of ≥1, ≥2, or ≥3 hard-to-treat areas, respectively.[6] Among those with mild-to-moderate disease, defined as <10% BSA, 65% experienced psoriasis in at least one high-impact area, with a significant impact on QoL.[6] Both studies found the most commonly affected sites to be the scalp, the face, and the nails.[5,6]

QUALITY OF LIFE IMPACT OF PSORIASIS IN HIGH-IMPACT AREAS

Psoriasis in high-impact areas can have an "enormous, profound, and often devastating impact" on QoL, said Politou, explaining that it is visible, can impede function, and often carries stigma. The impact is

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wide ranging, with patients frequently reporting embarrassment, shame, low self-esteem, and depression.[7,8] Visible areas of psoriasis, such as on the face and scalp, can increase feelings of social stigma and self-consciousness.[7] Psoriasis on the hands, scalp, or face may interfere with work, social interactions, and daily activities, with patients potentially avoiding public settings or certain clothing and hairstyles, for example.[4,8] Genital psoriasis has been linked with impaired sexual function, intimacy avoidance, pain during intercourse, and a loss of libido, and many patients report significant emotional distress and reduced confidence.[7,9] Hand and/or feet involvement can cause pain, cracking, and sensitivity that may impair walking, standing, manual tasks, and exercise, while nail involvement can affect dexterity and fine motor activities.[10,11] In addition, the pain, irritation, and itch of psoriasis can disturb sleep, potentially reducing overall wellbeing.[12] "It affects people psychologically, with high rates of depression, social isolation, and stigma," said Politou. "It affects them physically, with itching, pain, burning, and restricted mobility. It affects their sexual life, it affects their work life, their social life, and their sleep."[7-12] All of this contributes to poor QoL, and Dermatology Life Quality Index (DLQI) scores in patients living with psoriasis in high-impact areas tend to be high. The UPLIFT survey was a large population and web-based survey conducted in North America, Europe, and Japan between March–June 2020, including 3,806 adults with self-reported HCP-diagnosed psoriasis and/or psoriatic arthritis (PsA), alongside 473 dermatologists.[13] Among patients with psoriasis, limited skin involvement (BSA ≤3%), and the involvement of at least one special area, the mean DLQI score was 9.4, and 56.4% had a DLQI score >5.[13] Such data highlight, Politou explained, that "location matters as much as extent."

ASSESSMENT OF PSORIASIS IN HIGH-IMPACT AREAS

Traditionally, psoriasis severity, a leading consideration in eligibility for systemic therapies, has been classified as mild, moderate, or severe, as guided by objective measurements such as BSA, Physician's Global Assessment (PGA), and the Psoriasis Area and Severity Index (PASI).[3] However, this approach may underestimate severity where high impact areas are involved, and, therefore, exclude patients from systemic therapy access.[3,8] As such, the IPC recommends moving away from the traditional "mild," "moderate," and "severe" classification of psoriasis.[3] In a 2020 international Delphi consensus statement, the IPC proposed classifying patients as either candidates for topical therapy or candidates for systemic therapy, with systemic therapy candidacy defined by at least one of the following criteria: BSA >10%, disease involving special areas, or failure of topical therapy.[3]

"Assessment should be comprehensive and patient centred," Politou said, before going on to describe her own approach. It starts with clinical examination to evaluate extent, morphology, induration, and erythema, as well as PASI and BSA.[3,8,14] "This measurement is crucial, but it is not sufficient alone," Politou added. The next stage is documenting specific site involvement and using patient-reported outcome measures (PROM) to understand the impact of the condition on the individual patients.[8,14] "PROMs are very important," Politou said. "I note the subjective burden of the condition on the patient, not just what I can see." Politou's PROM recommendations include Numerical Rating Scales (NRS) for itch, ease of use, touch avoidance, and sleep disturbance, and the DLQI. In cases of genital involvement, Politou also utilises the Genital Psoriasis Sexual Impact Scale (GPSIS). Factors such as frequency of flares, previous treatment response, and the person's known comorbidities are documented, and Politou also screens for unknown comorbidities that are common in psoriasis. These include metabolic syndrome, PsA, cardiovascular risk, depression, and inflammatory bowel disease (IBD).[8,15,16]

Comorbidity information is critical to guiding patient-centred management decisions, Politou explained.[1] Psoriasis in high-impact areas, particularly the nails, is associated with a higher likelihood of PsA, meaning

they may require additional monitoring.[1,17] Obesity is associated with reduced efficacy of psoriasis therapies, particularly biologics, and may decrease efficacy or potentiate side effects of conventional oral systemic therapies.[18] Psoriasis is also associated with systemic inflammation and comorbidities including depression, cardiovascular disease, non-alcoholic fatty liver disease, and IBD.[16,18,19] In addition, high DLQI scores, which are typical in patients living with psoriasis in high-impact areas, are linked to depression, Politou added.[20]

MANAGEMENT OF PSORIASIS IN HIGH-IMPACT AREAS

The goal of psoriasis treatment should be clear or almost clear skin "with minimal symptom burden and maximum QoL," Politou believes.[14] Politou described her approach to the management as "individualised, step wise, and patient centred." First-line treatment, she went on, would be an appropriate topical therapy, and phototherapy is considered where appropriate and practical for the patient. "High-impact disease often requires more aggressive therapy earlier, because of its outsize impact on QoL," Politou noted.[3,7] "Most importantly, management of psoriasis must be a shared decision-making process. We, the dermatologists, must keep in mind that this is our patients' treatment plan, so their priorities and concerns must guide our choices."

Asked about safety considerations when selecting and recommending therapy, Politou said there were several. Politou reiterated the importance of screening for comorbidities that may impact choice and response to treatment, such as obesity, PsA, IBD, and skin atrophy, and highlighted the increased infection risk among patients using immunosuppressive systemic therapies.[1,14,18] "Screening for latent tuberculosis and hepatitis is essential," Politou said. "We also need to assess malignancy risk, cardiovascular safety, mental health impact, organ-specific toxicity, and pregnancy and fertility."[14]

The overall principle, Politou went on, should be risk stratification at baseline and choosing the most appropriate therapy "for each patient you have in front of you."

Regular monitoring is important, both in terms of evaluating response to treatment and identifying and addressing any emerging comorbidities.[1,14] "Our approach should be patient-centred and holistic," said Politou. "We must remember that, as dermatologists, we are not only here to treat the skin, we are here to treat the patient." At each 3- to 6-monthly visit, Politou monitors treatment response and disease activity, with clinical examination and PASI and BSA assessment, as well as impact, using DLQI and PROMs. It is worth noting that a five-point reduction in DLQI has been shown to correlate with the minimum clinically meaningful change in health-related QoL.[14] In addition, Politou screens for PsA and treatment tolerability, as well as, importantly, lifestyle. "This is something we should be aware of, and we should do at each visit," Politou said, adding that weight reduction may help reduce psoriasis severity and improve quality of life, and may also support treatment response when used alongside psoriasis therapy.[21,22] Every 6–12 months, depending on patient-specific risk factors, Politou screens for metabolic comorbidities, cardiovascular risk, and mental health. "We should always offer psychological support when the DLQI is high," Politou emphasised.

CONCLUSION

Summing up, Politou had three main messages for fellow dermatologists. "First of all, extent matters, but high-impact areas matter as well," Politou said, reiterating the disproportionately high effect this form of the disease can have on QoL.[3-10] "In these patients, we should consider early systemic treatment, and never forget to approach the patient holistically."[1,11,13] The goal is not to prescribe the medicine; it is to treat the person living with psoriasis in high-impact areas, Politou concluded.

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