NSW Government-Sponsored Clinical Trial: Management of Dermatology Conditions by Community Pharmacists

Clinical Practice Guidelines for Herpes Zoster (Shingles); Impetigo (School Sores); Mild to Moderate Atopic Dermatitis and Acute exacerbations of Mild Plaque Psoriasis

Approved 22 November 2024 V3.0

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DERMATOLOGY MANAGEMENT

Herpes Zoster (Shingles)| Clinical practice guideline (1/3)

Treatment Algorithm 1. Arriving at a diagnosis for Herpes Zoster (Shingles)

Age of the patient

Aged 18 years and over

Aged under 18 years of age → Refer GP

Does the patient present with adequate clinical presentations of Herpes Zoster (Shingles)?

1. **Prodromal symptoms:** observed between 48 to 72 hours before the localised, characteristic vesicular rash becomes evident:
   - Localised nerve pain (usually described as stabbing, prickling or burning)
   - Lethargy, fever, headache
   - Abnormal skin sensations such as burning, itching, hyperesthesia and/or paraesthesia
   - Photophobia (approximately 80% of cases).
2. **Rash**:
   - Typically, unilateral with a dermatomal distribution and distinct anterior and posterior midline cut-offs (satellite lesions may also appear)
   - New lesions continue to erupt for 3-5 days following the nerve line, becoming pustular, before scabbing and crusting over between 7-10 days
   - Most affected areas are the chest, neck, forehead (ophthalmic) and lumbar/sacral sensory nerve supply regions
   - When the ocular nerves are affected, the patient will present with a blistering rash around the eye/eyelid with associated pain, swelling and redness. Urgent referral to a medical practitioner is required (more details and referral type will be discussed in sections to follow)
   - If the facial nerve is affected (herpes zoster oticus/Ramsay Hunt Syndrome) symptoms will include earache, blistering in and around the ear canal, with or without external ear and facial paralysis.

No → Refer ED/GP

Referral to ED in settings and situations where GP review is not available within the appropriate timeline. This will be decided by the pharmacist during the consultation based on the assessed patient needs.
Referral is required where patient presents >72-hours from the onset of symptoms as efficacy of antiviral medication is limited.

Yes

Has the patient history and examination of the rash confirmed the appropriateness for provisional diagnosis?

- **Patient history:** Sufficient information should be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines for the patient, including age, pregnancy and lactation status, nature, severity and frequency of symptoms, nature of rash (distribution, appearance, number of lesions), onset and duration of symptoms, precipitating and relieving factors, history of Varicella Zoster Virus (VZV) infection, underlying medical conditions (e.g. renal impairment), current medications, medications and other strategies tried to treat current symptoms, drug allergies/adverse drug effects, immunisation status.
- **Examination:** examination of the rash and documentations of its characteristics and location, as well as signs of complications for diagnosis of HZ and exclusion of differential conditions.
  - Laboratory confirmation is generally not required for typical presentations and uncomplicated cases of HZ.

Yes

Provisional diagnosis for Herpes Zoster (Shingles)

Exclusion from trial- refer to medical care

Immediate ED or GP referral – no treatment

Treat & Referral to GP - conservative treatment as required

Provide conservative treatment

Herpes Zoster (Shingles)| Clinical practice guideline (2/3)

Treatment Algorithm 2. Identifying primers for differential diagnosis and referrals

Provisional diagnosis of Herpes Zoster (Shingles)

- Complications of Herpes Zoster (HZ) have been presented? (13%-26% of patients and most prevalent in older people and those who are immunocompromised):
  - **Postherpetic Neuralgia (PHN):** Neuropathic pain that persists for at least 3 months beyond the duration of the rash or re-occurs; sharp/shooting and intermittent, described as constant burning, often with extreme sensitivity to touch (allodynia).
  - **Herpes Zoster Ophthalmicus:** HZ affecting the ophthalmic branch of the trigeminal nerve with a high incidence of eye complications, occurring in 10-25% of the cases and commonly causes keratitis as well as conjunctivitis, uveitis, retinitis and glaucoma. Vesicles on the nose have been found to be predictive of eye involvement.
  - **Herpes Zoster Oticus (Ramsay Hunt Syndrome):** Affecting the facial nerve resulting in ear pain, taste loss, facial weakness or paralysis, and other neurological symptoms.
  - **Disseminated zoster (Varicella zoster virus – VZV dissemination):** Whilst most individuals have some lesions external to the primary dermatome, disseminated zoster is defined as 20 lesions outside of the dermatome and may be clinically indistinguishable from varicella infection. Viral dissemination to the central nervous system and viscera (lungs, gut, liver and brain) may occur, more frequently in immunocompromised patients, although rare overall.
  - **Other complications:**
    - Neurological complications such as meningoencephalitis and myelitis (particularly in the elderly).
    - Secondary bacterial skin infections (referral to a medical practitioner for swab and culture is required).
    - Scarring.
    - Pneumonia.
    - Patients who are acutely immunocompromised (e.g. patients receiving active chemotherapy). *Noting those who are receiving stable immunosuppressing medications (e.g. methotrexate and prednisolone for Rheumatoid arthritis) can be treated and referred to their GP.*
  - **Pregnancy & Breastfeeding:** Pregnant women who are exposed to VZV (chicken pox or HZ) for the first time (no or uncertain history of previous chicken pox infection) may develop chicken pox which can have serious consequences, including maternal mortality and morbidity, foetal varicella syndrome and the associated abnormalities. Urgent referral to a medical practitioner is required as zoster immunoglobulin (ZIG) should be given to all seronegative women within 96 hours (4 days). Unlike chicken pox, it is thought that HZ contracted during a healthy pregnancy is not associated with intrauterine infection or an increased foetal risk.

Yes → Refer ED/GP

Referral to ED in settings and situations where GP review is not available within the appropriate timeline. This will be decided by the pharmacist during the consultation based on the assessed patient needs.

- Immediate ED referral – no treatment
- Immediate GP referral – no treatment
- Treat & referral to GP – conservative treatment as required

No → Diagnosis is uncertain

- Confirmatory pathology testing (initiated by a medical practitioner) is required for cases where diagnosis is uncertain, or in cases of HZ in people who have been previously vaccinated against HZ.

Proceed to appropriate treatment

Yes → Treat

- Exclusion from trial- refer to medical care
- Immediate ED or GP referral – no treatment
- Treat & Referral to GP - conservative treatment as required
- Provide conservative treatment

Herpes Zoster (Shingles)| Clinical practice guideline (3/3)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Provide **supportive management** with education and advice regarding care for lesions and transmission precautions

- Education and advice regarding care for lesions (use of dressings, cleaning and appropriate clothing).
- Education and advice regarding transmission precautions in accordance with the NSW Health Shingles Fact Sheet.

Provide **pharmacotherapy – antiviral therapy and analgesia** in accordance with the Therapeutic Guidelines if required and appropriate for the patient[1]:
1) Valaciclovir 1g (2x500mg) PO q8h for 7 days
1) Famciclovir 500mg PO q8h for 7 days
2) Aciclovir 800mg PO 5 times daily for 7 days

- **Antiviral treatment** in accordance with Therapeutic Guidelines, to reduce acute pain, duration of the rash, viral shedding and ocular complications, if commenced within 72 hours of the first appearance of the rash. Antiviral therapy is not indicated in all patients – it is indicated for the following groups:
  - Immunocompetent adults who present within 72 hours of the onset of the rash.
  - All immunocompromised patients (including those with a HIV infection) regardless of the time elapsed since rash onset. *Note these patients are referred to their GP in the trial.*
  - Patient with Zoster Ophthalmicus, regardless of the time lapsed from rash onset. *Note these patients are referred to ED in the trial.*
- **Analgesia** for mild nociceptive shingles pain in accordance with the Therapeutic Guidelines (oral paracetamol or nonsteroidal anti-inflammatory drugs – NSAIDs).

Note that patients reporting neuropathic pain or moderate to severe nociceptive pain should be referred to a medical practitioner for review.

Confirm management is appropriate **and state specific public health legislation for disease notifications[2]** is followed, and communicate agreed management plan

- Consult the Therapeutic Guidelines, Australian Medicines Handbook, Australian Immunisation Handbook and other relevant references to confirm the treatment recommendation is appropriate, inc. for contraindications/precautions, drug interactions, pregnancy/lactation.
- Provide advice and counselling to patients on medicine use (e.g. dosing), managing side effects, HZ vaccinations, seeking further care, when to return to the pharmacist for clinical review.

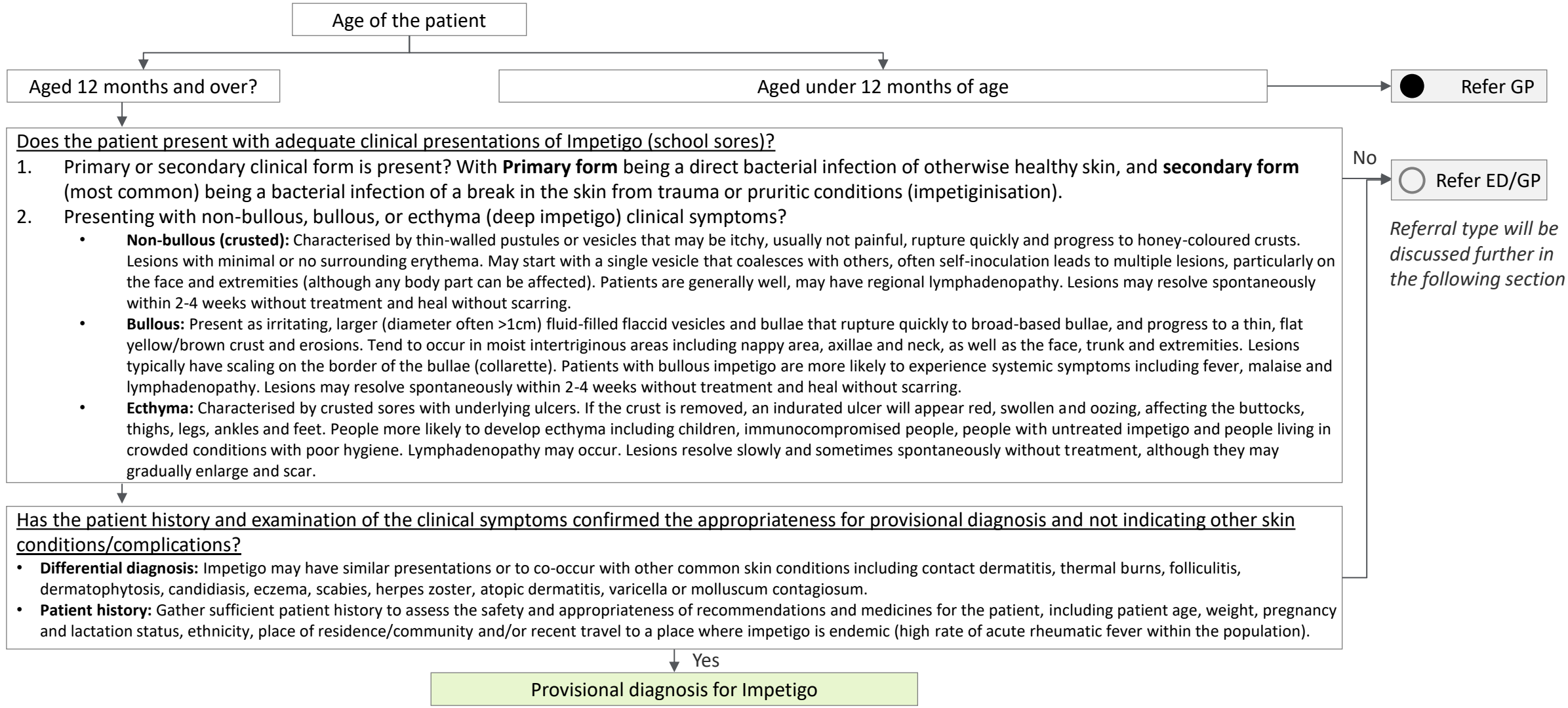
Provide **general advice** around preventing transmission, vaccination and **undertake clinical review**

- **Provide general advice:** Patient should be advised to contact a medical practitioner if not responding to treatment, and/or when their clinical signs and symptoms worsens, and/or when they are experiencing complications.
- **Preventing Transmission:** Infectious from 1-2 days prior to the onset of rash until vesicles have dried and scabbed (usually 5 days after the onset of the rash); high-risk contacts who have had significant contact (i.e. household contacts or where direct face-to-face contact exceeds 5 minutes/being within the same room for >1hr), need to seek medical care as soon possible. Rash should be covered with appropriate dressing till no longer infectious and contact with pregnant women and immunocompromised people must be avoided.
- **Advice on zoster vaccination:** Vaccination is not indicated during an acute HZ episode or to treat PHN. People who have had a previous episode of HZ can be vaccinated against a recurrence, refer to the Australian Immunisation Handbook for HZ vaccination information and recommendations.
- **Undertake clinical reviews:** Clinical review with the pharmacist is recommended 48-72 hours after the initial presentation to assess for progression of the rash, the clinical signs or symptoms of HZ, screening for complications, and adverse effects.

1. Noting that dose adjustment is required for patients with documented severe renal impairment to the following dosing regimens:
   - 1) Valaciclovir: CrCl 15-30mL/minute, 1g twice daily; CrCl<15mL/minute, 1g once daily.
   - 1) Famciclovir: CrCl 30-50mL/minute, 250mg three times daily; CrCl 10-30 mL/minute, 250mg once daily.
   - 2) Aciclovir: CrCl 10-25mL/minute, 800mg q8h; CrCl <10mL/minute, 800mg q12h.
2. Note that shingles is notifiable in ACT

Impetigo| Clinical practice guideline (1/3)

Treatment Algorithm 1. Arriving at a diagnosis for Impetigo



Exclusion from trial- refer to medical care

Immediate ED or GP referral – no treatment

Treat & Referral to GP - conservative treatment as required

Provide conservative treatment

Impetigo| Clinical practice guideline (2/3)

Treatment Algorithm 2. Identifying primers for differential diagnosis and referrals

Provisional diagnosis of Impetigo

1) There are plans for a more detailed trial for patients from endemic areas and those who identify as Aboriginal and Torres Strait Islander to potentially access additional treatment, further details to be confirmed via more detailed stakeholder engagement and input from the NSW Ministry of Health.

- Complications of Impetigo have been presented or clinical presentations that warrants further investigations?
  - **Patient in an endemic community**[1]: Patient who currently is or has recently resided in a community where impetigo is endemic and has additional risk factors for ARF/RHD – see Appendix A of this document.
  - **People at risk of acute rheumatic fever (ARF) and rheumatic heart disease (RHD)**[1]**:** Patients presenting for treatment of impetigo within the clinical trial should be assessed on a case-by-case basis to determine the appropriate treatment pathway, whether a referral to a medical practitioner for intramuscular (IM) benzathine benzylpenicillin is required – see Appendix A of this document.
  - **Complications of Impetigo, particularly bullous and ecthyma:** Lymphangitis, lymphadenitis, widespread infection, cellulitis, gangrene and bacteraemia, permanent scarring.
  - Presence of systemic symptoms (e.g. fever, food/drinking aversion in the child).
  - Vesicles present in more than one location (e.g. Face plus arms) indicating moderate infection. *Noting that multiple vesicles can be present in a single location (e.g. near the mouth).*
  - **Complications arising from Group A Streptococcal skin infections**: more likely within endemic settings including APSGN and chronic kidney disease, ARF, sepsis, osteomyelitis.
    - **APSGN (Acute Poststreptococcal Glomerulonephritis):** immune-mediated sequalae of nephritogenic strains of *S.pyogenes*. May occur within 2-3 weeks after skin or throat infection of Group A streptococcus bacteria, affect children aged between 12 months and 17 years most frequently, with common signs and symptoms including facial and orbital swelling, particularly upon walking, elevated blood pressures, proteinuria and macroscopic haematuria with dark brown urine, and lethargy, weakness and/or anorexia.
    - **ARF (Acute Rheumatic Fever)**: immune-mediated sequalae of *S.pyogenes* involving multiple systems and organs, including the heart, joints and central nervous system. May occur between 1 and 5 weeks post Streptococcal infection, and is common after recurrent Streptococcal infections, particularly pharyngitis and impetigo. May affect children aged 5 and 14 years more frequently, with clinical symptoms of sore and/or swollen joints, fever, increased resting heart rate facial or peripheral oedema, Sydenham chorea. Please see Appendix A of this document for an extract of those individuals at high risk of developing ARF.
  - Symptoms have not resolved after the first course of antibiotic treatment, symptoms significantly or rapidly worsen, or if impetigo infection re-occurs frequently.

Yes → Refer ED/GP

No → Proceed to appropriate treatment

Yes → Treat

- Immediate ED referral – no treatment
- Immediate GP referral – no treatment
- Treat & referral to GP – conservative treatment as required

- Exclusion from trial- refer to medical care
- Immediate ED or GP referral – no treatment
- Treat & Referral to GP - conservative treatment as required
- Provide conservative treatment

Impetigo| Clinical practice guideline (3/3)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Provide **supportive management** with education and advice regarding care for lesions and transmission precautions

- Provide general and preventative measures with advice and education to reduce the spread of impetigo as per the Sydney Children's Hospital Network Impetigo (School Sores) Fact Sheet.
- Provide treatment of co-occurring skin conditions (if required) with standard pharmacist care or referral to a medical practitioner.

Provide **pharmacotherapy** in accordance with the Therapeutic Guidelines if required and appropriate for the patient

- Treatment of impetigo reduces the duration of the illness, the spread of lesions, and decreases the risk of complications.
- **Topical antibiotics (e.g. Mupirocin** applied 3 times daily to the affected areas for 5 days) are considered sufficient treatment for the majority of patients who present with a single location of vesicles. They are however not adequate if the infection is widespread or multiple family/community members are infected, due to the risk of rapid resistance.
- **Oral antibiotics** can be prescribed by the pharmacist as per the Therapeutic Guidelines recommendations for moderate to severe infection (e.g. multiple skin sores in more than one location). Oral antibiotics are usually not required for the management of impetigo.

Confirm management is appropriate **and state specific public health notification legislation** is followed**,** and communicate agreed management plan with the patient

- Consult the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the treatment recommendation is appropriate, inc. for contraindications/precautions, drug interactions, pregnancy/lactation.
- Provide advice and counselling to patient as per the Australian Medicines Handbook on medicine use (e.g. dosing), non-pharmacological, general and preventative measures, managing side effects, seeking further care, when to return to the pharmacist or GP for clinical review.

Provide **general advice** including the adequacy of the use of topical antibiotics.

- Providing general advice on the correct use of antibiotics is essential. Extended or incorrect use may increase the risk of antimicrobial resistance, particularly for topical antibiotics.
    - Discussing the treatment regimen with patients, patient/caregiver reduces the risk that antibiotics will be used incorrectly.
    - Where a carer's ability to administer is in doubt, consider referral to GP for oral antibiotics or IM benzathine benzylpenicillin.
- Clinical review with the pharmacist is generally **not** required, however if the condition does not improve or resolve, the patient should be advised to see a medical practitioner for further investigation.

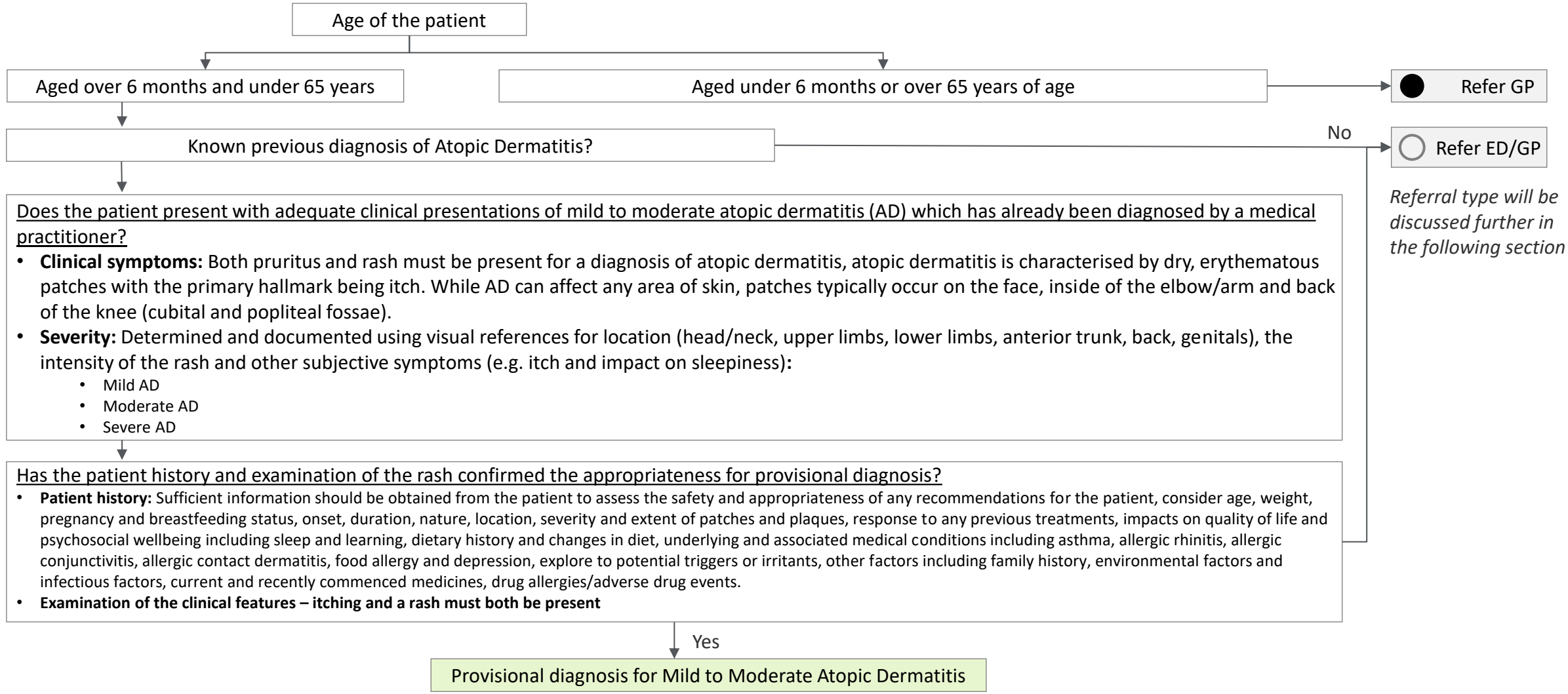
Appendix A

Individuals at high risk of developing Acute Rheumatic Fever (ARF)

Patient Group	Description of individuals
Individuals aged 40 years and under	• Aboriginal and Torres Strait Islander people residing in a rural or remote area, or living in a household affected by household overcrowding (>2 people per bedroom) or of lower socioeconomic status. • Māori and/or Pacific Islander person living in a household affected by overcrowding or socioeconomic disadvantage. • People with a recent personal or family/household history of ARF or rheumatic heart disease (RHD).
Additional risk factors for individuals aged <= 40 years (particularly 5 to 20 years)	• People living in a household affected by household overcrowding (>2 people per bedroom) of lower socioeconomic status. • People with current or recent residence (including frequent or recent travel to) in an area with a high rate of ARF (Australia or internationally) e.g. refugees and migrants from low-middle income countries, rural and remote communities.

Mild to Moderate Atopic Dermatitis| Clinical practice guideline (1/4)

Treatment Algorithm 1. Arriving at a diagnosis for Mild to Moderate Atopic Dermatitis



Exclusion from trial- refer to medical care

Immediate ED or GP referral – no treatment

Treat & Referral to GP - conservative treatment as required

Provide conservative treatment

Mild to Moderate Atopic Dermatitis| Clinical practice guideline (2/4)

Treatment Algorithm 2. Identifying primers for differential diagnosis and referrals

Provisional diagnosis of Mild to Moderate Atopic Dermatitis

- Complications of Atopic Dermatitis have been identified:
  - **Secondary bacterial infections (Impetiginisation)** are the most common application of AD: early treatment of concurrent infection is important, suspected impetigo must be assessed and treated as per the clinical practice guidelines for Impetigo if suited
  - **Eczema Herpeticum** is an infection of the AD with herpes simplex virus, presenting with vesicles in areas of active or recent AD, followed by onset of high fever and adenopathy; painful corneal lesions will develop if the eye is involved and if the HSV infection becomes systemic which may be fatal. Refer to a medical practitioner if eczema herpeticum is suspected.
- **Clinical symptoms** warranting referral
  - Widespread rash with painful skin
  - Raised purple rash that doesn't blanch
  - Generalised erythema that covers 90% or more of the skin
  - Blistering of the skin and mucous members (may include mouth and eyes)
  - Rash with signs of systemic illness including fever, lethargy, nausea and vomiting, headache
  - Chronic sores or ulcers
  - The AD is severe.
- Other medical conditions and medications
  - Patient is pregnant or planning to become pregnant*
  - Patient is immunocompromised due to an underlying medical condition and/or medicines
  - Patient is having a marked negative emotional and social effect
  - A paediatric patient presents with a history of immediate or delayed-type hypersensitivity to food, poor feeding or sleep, concerns about failure to thrive.
- Diagnosis is uncertain.
- The patient requires large quantities of topical products/topical corticosteroids that would generally require authority from the PBS (full body coverage is approximately 20g ointment or 30g cream for an average adult).
- The condition does not respond to optimal treatment, worsens or re-occurs within 2-4 weeks, specifically when there is no improvement within 1-2 weeks, failure to achieve stable long-term disease control, and presence of ongoing impairment (e.g. pruritus, pain, loss of sleep, learning difficulties and poor quality of life while on treatment).

*Note for pregnancy or planning a pregnancy: Use the lowest appropriate potency of topical corticosteroid for the shortest time necessary where moisturisers and other simple measures are inadequate. As safety data are lacking for desonide and mometasone (Australian category B3), use others in preference.

Yes → Refer ED/GP

No → Proceed to appropriate treatment

Yes → Treat

- Immediate ED referral – no treatment
- Immediate GP referral – no treatment
- Treat & referral to GP – conservative treatment as required

- Exclusion from trial- refer to medical care
- Immediate ED or GP referral – no treatment
- Treat & Referral to GP - conservative treatment as required
- Provide conservative treatment

Mild to Moderate Atopic Dermatitis| Clinical practice guideline (3/4)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Provide **supportive management** with education and advice regarding care

- Develop an eczema action plan based on Australasian Society of Clinical Immunology and Allergy Action Plan for Eczema template
- Advice regarding skin care and minimising aggravating factors as per the Therapeutic Guidelines and the Australian Medicines Handbook

Provide **pharmacotherapy – topical corticosteroid (TCS), tar preparations, and emollient** in accordance with the Therapeutic Guidelines and previous treatment regimens if required and appropriate for the patient

- **Topical corticosteroids** as per the Therapeutic Guidelines and in line with the patient's previous treatment. Particularly for short-term supply where the patient is unable to attend their regular medical practitioner; noting that underuse of TCS is a common cause of previous treatment failure. Potent TCS should not be used for children aged 12 months of age or younger:
  - Potent TCS: Class 3 containing betamethasone dipropionate 0.05%, betamethasone valerate 0.1%, methylprednisolone aceponate 0.1% or mometasone furoate 0.1%.
  - Face: Hydrocortisone 1%, applied once daily until skin is clear.
  - Trunk / limbs: Triamcinalone 0.02% ointment applied once daily.
  - Finger and foot: Betamethasone dipropionate 0.05% ointment applied once daily, or betamethasone valerate 0.1% ointment applied once daily, OR mometasone 0.1% ointment applied once daily.
  - Scalp: Betamethasone 0.05% lotion applied once daily, OR methylprednisolone 0.1% lotion applied once daily, OR mometasone 0.1% lotion applied once daily.
  - Axillae and groin: Hydrocortisone 1% ointment applied once daily, OR Desonide 0.05% lotion applied once daily.
- **Pimecrolimus** 1% cream applied once or twice daily.
- **Crisaborole** 2% ointment applied BD for up to 4 weeks.
- **Tar preparations 3-6% LPC + salicylic acid 2-6% in aqueous cream or ointment base, applied once daily at night.**
- Applicable for all treatments, if symptoms have not resolved within 7 days, or become worse, the patient should seek further advice and management from their regular medical practitioner.
- For further information on management options, please refer to the Therapeutic Guidelines.

Continued on next page

Mild to Moderate Atopic Dermatitis| Clinical practice guideline (4/4)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Confirm management is appropriate**,** and communicate agreed management plan

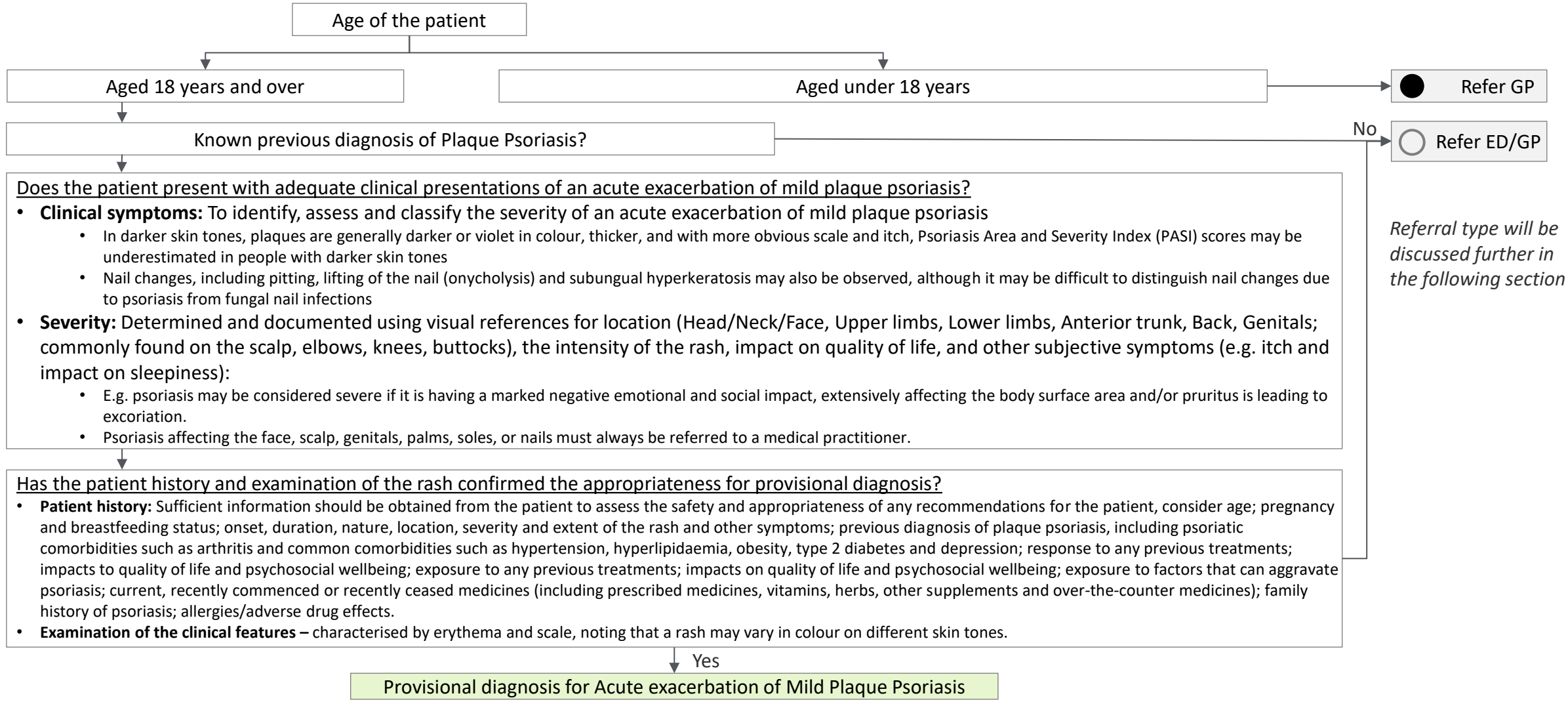
- Consult the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the treatment recommendation is appropriate, including for contraindications/precautions, drug interactions, pregnancy/lactation.
- Provide advice and counselling to patient on medicine use (e.g. dosing), managing side effects, topical corticosteroid, tar preparations and wet dressing use, and emollient, seeking further care, when to return to the pharmacist for clinical review.

Provide **general advice** to prevent flare ups, and **undertake clinical review**

- **Provide general advice:** treatment may be unsuccessful when there is poor adherence with therapy, skin infection, allergy or severe dermatitis, the patient should be advised to immediately see their medical practitioner if the symptoms worsen after commencing treatment. Consideration should be given to whether the patient would be eligible for a PBS authority prescription where larger quantities of cream can be obtained at a more cost-effective price; this is especially the case of concession card holders. If appropriate, consider discussing this with the patient and the need for a follow up appointment with their regular medical practitioner.
- **Advise the common side effects of TCS,** such as transient burning, stringing or pain on applications, which can generally be reversed by stopping the medicine.
- **Undertake clinical reviews:** Clinical review with the pharmacist is recommended 7-14 days after the initial treatment and/or changes to the treatment plan, clinical review should consider response to treatment, adverse effects, and if changes are required to the treatment plan. Decisions to continue, modify or stop treatment should be reflected in the patients Eczema Action Plan.
    - Pharmacists should generally only prescribe a sufficient quantity of medicine for the period until the patient's next review & if longer-term pharmacotherapy is required, patients should be advised to return to their usual medical practitioner if large quantitates of topical treatments are required.

Acute exacerbation of Mild Plaque Psoriasis| Clinical practice guideline (1/4)

Treatment Algorithm 1. Arriving at a diagnosis for exacerbations of mild plaque psoriasis



Referral type will be discussed further in the following section

Exclusion from trial- refer to medical care

Immediate ED or GP referral – no treatment

Treat & Referral to GP - conservative treatment as required

Provide conservative treatment

Acute exacerbation of Mild Plaque Psoriasis| Clinical practice guideline (2/4)

Treatment Algorithm 2. Identifying primers for differential diagnosis and referrals

Provisional diagnosis of exacerbations of mild plaque psoriasis

- Complications of exacerbation of mild plaque psoriasis has been identified:
  - Psoriatic lesions are infected.
- Clinical symptoms warranting referral:
  - The psoriasis affects the face, scalp, genitals, palms, soles, or nails. Pharmacists must not provide treatment and must always refer to a medical practitioner.
  - The patient presents with a type of psoriasis other than mild plaque psoriasis or where there is a new diagnosis (including plaque psoriasis that is moderate or severe).
- Other medical conditions and medications:
  - Patient is immunocompromised due to underlying medical condition(s) and/or medications, including uncontrolled diabetes
  - Patient is pregnant or planning a pregnancy*
  - The patient is taking a medicine that can exacerbate psoriasis.

- Diagnosis is unclear.
- There is no response to optimal topical treatment (within 3 to 6 months), or the condition worsens or reoccurs.
- The patient has psoriatic comorbidities or risk factors that require management (e.g. arthritis).
- The patient has not seen a medical practitioner for review of their condition in the previous 12 months.

*Note for pregnancy or planning a pregnancy: Use the lowest appropriate potency of topical corticosteroid for the shortest time necessary where moisturisers and other simple measures are inadequate. As safety data are lacking for mometasone (Australian category B3), use others in preference.

Yes → Refer ED/GP

No → Proceed to appropriate treatment

Yes → Treat

- Immediate ED referral – no treatment
- Immediate GP referral – no treatment
- Treat & referral to GP – conservative treatment as required

- Exclusion from trial- refer to medical care
- Immediate ED or GP referral – no treatment
- Treat & Referral to GP - conservative treatment as required
- Provide conservative treatment

Acute exacerbation of mild plaque psoriasis| Clinical practice guideline (3/4)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Provide **supportive management** with education and advice regarding care

- Provide education and advice regarding lifestyle modification, use of adjunctive agents including emollients/moisturisers, and other measures as per Therapeutic Guidelines and Australian Medicines Handbook

Provide **pharmacotherapy – topical corticosteroid, calcipotriol and emollient** in accordance with the Therapeutic Guidelines and Australian Medicines Handbook if required and appropriate for the patient

Treat according to anatomical location and in line with the patient's previous treatment, particularly for short-term supply where the patient is unable to attend their regular GP.

Topical corticosteroids (TCS). Reducing/withdrawing the TCS therapy when possible is recommended, especially for more potent TCS, because of the long-term effects. However, underuse of TCS is a common cause of treatment failure. See Therapeutic Guidelines for recommendations.

- **Face, scalp, genitals, palms, soles, or nails: immediately refer to a medical practitioner without providing treatment.**
- **Trunk/limbs:** Methylprednisolone aceponate 0.1% cream/ointment/fatty ointment OR mometasone furoate 0.1% cream/hydrogel/ointment once daily until skin is clear (usually 2 to 6 weeks). If response is inadequate after 3 weeks try betamethasone dipropionate 0.05% cream/ointment once daily until skin is clear (usually 2 to 6 weeks) and refer to a medical practitioner.
- **Flexural (excluding genital):** Methylprednisolone aceponate 0.1% ointment/fatty ointment topically once daily until skin is clear (may take several weeks).

Tars (e.g. LPC) are usually added to therapy when symptoms have been controlled using a TCS. See Therapeutic Guidelines for recommendations.

- **Trunk/limbs:** LPC 4-8% + salicylic acid 3% cream/ointment, twice daily for 1 month.
- **Flexural (excluding genital):** LPC 2% in emulsifying ointment, once daily.

Calcipotriol + betamethasone

- **Trunk/limbs:** calcipotriol + betamethasone dipropionate 50 + 500micrograms/g ointment/foam can be considered for patients with only a few scattered plaques of psoriasis that do not respond to a tar preparation or need longer term control with a topical corticosteroid. See Therapeutic Guidelines.

If no response to therapies after 2-4 weeks, the pharmacist must refer to a medical practitioner.

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Acute exacerbation of mild plaque psoriasis| Clinical practice guideline 4/4)

Treatment Algorithm 3. Provide appropriate treatment, documentations, and follow-ups

Proceed to appropriate management and treatment plan

Confirm management is appropriate**,** and communicate agreed management plan

- Consult the Therapeutic Guidelines, Australian Medicines Handbook, and other relevant references to confirm the treatment recommendation is appropriate, including contraindications/precautions, drug interactions, pregnancy/lactation.
- Provide advice and counselling to the patient on typical cycle of psoriasis and expectations of treatment, product and medication use, (dosing and application instructions for TCS, moisturisers, emollients, and other topical products) managing side effects, when to seek further care, when to return to the pharmacist for clinical review.

Provide **general advice** and **undertake clinical review**

- **Advice on common side effects of TCS treatment,** such as transient burning, stringing or pain on applications, which can generally be reversed by stopping the medicine. Referral to a medical practitioner is required when adverse effects cannot be managed in the pharmacy setting.
- **Undertake clinical reviews:** Clinical review with the pharmacist is recommended 7-14 days after the initial treatment and/or changes to the treatment plan, clinical review should consider response to treatment, adverse effects, and if changes are required to the treatment plan.
    - Pharmacists should generally only prescribe a sufficient quantity of medicine for the period until the patient's next review & if longer-term pharmacotherapy is required, patients should be advised to return to their usual medical practitioner if large quantitates of topical treatments are required.
- Consideration should be given to whether the patient would be eligible for a PBS authority prescription where larger quantities of cream can be obtained at a more cost-effective price; this is especially the case of concession card holders. If appropriate, consider discussing this with the patient and the need for a follow up appointment with their regular medical practitioner.