Psoriasis Scotland Arthritis Link Volunteers

Patient Factsheet - Scalp Psoriasis

Psoriasis in its classical form usually forms thick dry and scaly plaques on “extensor” surfaces such as elbows and knees. It can be more widespread, occasionally affecting the whole body including the scalp and nails. Sometimes people may have psoriasis affecting just their scalp, which may have been labelled as simple dandruff. Often when making a diagnosis of psoriasis, doctors will specifically ask about associated problems including itchy scalp, dry or flaky ears or redness and scaling along the hair line.

As problems in the scalp are often very visible and noticeable and usually give uncomfortable symptoms such as severe itching, psoriasis here can be disproportionately troublesome. Often sufferers will have lots of white scale on their shoulders and back, particularly noticeable with dark clothing. Occasionally this can spread to affect the forehead, eyebrows, and around the nose. This is often called sebopsorasis, as it’s involving the more oily sebaceous glands of the face. The scalp is a relatively small skin surface area, and therefore the more powerful treatments available for psoriasis are not immediately used. There are challenges when using topical applications depending on the volume and thickness of hair.

Active topical treatments such as vitamin-D analogues, or potent topical steroids are only effective once the scalp has been "descaled". They will not work if there is a thick cap of dried dead skin cells or thick plaques. Therefore, it is very important to descale the scalp and remove all this material so that active agents can penetrate where it is required. As with many psoriasis treatments, this is hard work and often messy, particularly with long hair. Often this works best when applied by another person or a dermatology nurse. Treatment options range from simple olive oil to medicated ointments and salicylic acid. Olive oil is massaged into the scalp and left on overnight with a shower cap and then brushed and washed out with a shampoo such as Ceanel(c). Cocois(c) or Sebco(c) contain coconut oils, tars and salicylic acid which, although they come as ointments, can be used in a similar way. Pure salicylic acid in an aqueous cream could also be used, and comes in various strengths.

Once descaled, potent topical steroids in gels, foams, and lotions can be used along with vitamin-D analogues, dithranols (Micanol(c)) and coal tar preparations (ie Psoriderm(c)). Scalp skin tends to be thicker, and so there is less concern about the steroid skin thinning side effects here. Cade oil is a tree bark extract with a very potent burned smell; it works very well in chronic resistant scalp psoriasis. It normally needs to be applied by specialist dermatology nurses 2 -3 times per week.

Ultraviolet UVB phototherapy light treatment might be limited by hair volume, but very short hair or balder scalps may benefit from its use.

When all the topical agents have been exhausted or if scalp involvement is associated with widespread moderate to severe psoriasis at other body sites, systemic oral or injectable treatments may be considered. Acitretin is less beneficial in scalp psoriasis and can be associated with hair loss. It is not an immune suppressing drug so has fewer side effects and is theoretically safer. Immune modifying tablet treatment such as methotrexate and ciclosporin have been useful in scalp involvement. Given their immune mechanisms and side effects it is often a risk benefit discussion as to whether these are appropriate, particularly for localised

scalp psoriasis. The same would apply when choosing and considering new generation biologic injection treatments.

Hopefully as psoriasis generally becomes better understood, and the focus of more research, the development of exciting new treatments will also benefit those with scalp psoriasis.

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July 2014