Tower Bridge Hospital London

Tower Bridge Hospital London
97–99 Whitechapel Road, London E1 1DT
020 7916 0029 · Open 7 days, 9am–7pm
towerbridgehospital.co.uk

PATIENT INFORMATION · DERMATOLOGY

Psoriasis
a whole-body condition that shows on the skin

Psoriasis is an immune-driven condition in which skin cells are produced far faster than they can be shed, forming thickened, scaly plaques. It is not contagious, not caused by poor hygiene, and not simply a cosmetic problem — it is associated with joint disease and with cardiovascular risk.

Seek urgent assessment if you have

- psoriasis covering **most of the body with fever, shivering or feeling unwell**
- **widespread small pustules** on red, tender skin, coming on rapidly
- skin that is **peeling in sheets**, with difficulty controlling your temperature
- **severe joint pain and swelling**, or a whole finger or toe swollen like a sausage
- a **rapid flare after stopping oral steroids**

Erythrodermic and generalised pustular psoriasis are dermatological emergencies affecting fluid balance and temperature regulation. Oral steroids are avoided in psoriasis precisely because stopping them can precipitate these. In an emergency call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

Recognising it

- **Plaque psoriasis** — well-defined raised patches with silvery scale, typically on elbows, knees, lower back and scalp. On darker skin plaques often look violet, grey or dark brown rather than red, and are frequently missed or misdiagnosed.
- **Scalp psoriasis** — thick scale along the hairline, often mistaken for dandruff.
- **Nail changes** — pitting, thickening, or the nail lifting from its bed. Nail involvement is strongly associated with joint disease.
- **Guttate psoriasis** — a shower of small drop-like spots, classically two to three weeks after a streptococcal throat infection, often in teenagers.
- **Flexural psoriasis** — smooth, shiny red areas in skin folds, without scale.

What triggers flares

- streptococcal throat infection, particularly for guttate psoriasis
- stress, and poor sleep
- skin injury — cuts, sunburn, tattoos — where plaques appear in the damaged area
- smoking and alcohol, both of which worsen it and reduce treatment response
- medicines including lithium, beta-blockers, antimalarials, and withdrawal of oral steroids
- cold, dry weather; most people improve in summer

Treatment

- **Emollients**, used generously and consistently, to soften scale and reduce itch. The foundation of everything else.
- **Topical steroid plus vitamin D analogue** — the standard first-line combination, usually applied once daily for up to four to eight weeks, then reviewed.
- **Coal tar and salicylic acid** preparations, particularly useful for the scalp and for thick scale.
- **Phototherapy** — controlled ultraviolet light in a hospital unit — for widespread disease not responding to creams.
- **Oral treatments** such as methotrexate or ciclosporin for moderate to severe disease, with blood monitoring.
- **Biologic injections** for severe psoriasis, which have transformed outcomes for people who previously had none.

Never take oral steroids for psoriasis

Prednisolone clears psoriasis impressively and then, on stopping, frequently causes a severe rebound — sometimes into pustular or erythrodermic psoriasis, which is dangerous. If another clinician offers oral steroids for a skin flare, mention that you have psoriasis. This is a well-recognised trap.

Beyond the skin

Up to a third of people with psoriasis develop psoriatic arthritis, often years after the skin disease. Early treatment prevents permanent joint damage, so tell us about joint pain and stiffness lasting more than 30 minutes in the morning, swollen fingers or toes, or heel and lower back pain — do not wait to be asked.

Psoriasis is also associated with a higher risk of cardiovascular disease, type 2 diabetes, fatty liver and depression. Annual review of blood pressure, cholesterol, glucose and mood is part of proper care, not an add-on.

> **Book an appointment if** your psoriasis is not controlled, is affecting your scalp or nails, is causing distress, or you have joint symptoms. Our dermatology team can review treatment, arrange phototherapy through our CQC-registered partners, or systemic therapy, and screen for the associated conditions.

Where to get help

Tower Bridge Hospital London
97–99 Whitechapel Road, London E1 1DT

020 7916 0029

WhatsApp **07903 284 189**
info@mhwclinic.co.uk
Open 7 days, 9am–7pm

In an emergency
Call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

When we are closed and it is not an emergency
Call NHS 111 or visit 111.nhs.uk.

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Written and reviewed by Dr H Bolat, GP & Clinical Director **Review date: 26 July 2026** **Next review due: July 2028**

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This leaflet is based on current NHS and NICE CG153 guidance on the assessment and management of psoriasis. It is general information and does not replace advice from a clinician who has assessed you. If your symptoms change or you are worried, contact us on 020 7916 0029, call NHS 111, or call 999 in an emergency.