

# Genital Psoriasis: The Care Gap Between the Legs

Dermatologists need to lead in initiating the exam, obtaining the correct diagnosis, and discussing the impact of genital psoriasis with all psoriasis patients.

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**D**ermatologists have the greatest job in the world. We can save a life by finding a skin cancer and we can forever change a life by treating psoriasis appropriately early in the patient experience. Both are equally important. It will be easier for most dermatologists to cure cancer than treat psoriasis appropriately, but we hope to give you a few pearls to help you navigate this complicated disease.

When it comes to psoriasis, we have come a long way. In the 1980s, psoriatic arthritis was felt to be a benign arthropathy. Yet, today we know it can be as debilitating as rheumatoid arthritis. In 2010, Gelfand rocked the dermatology world by showing that the lives of patients with severe psoriasis are five years shorter, compared to those without the disease. The latest revelation in psoriasis-land: genital psoriasis occurs in one- to two-thirds of patients at some point during the course of their disease.<sup>1,2,3</sup>

When was the last time you wanted someone to look at your genitals? With lights on? With several people in the room? In today's society, exposing genitalia in some ways seems to be acceptable, with "naked" on social media and other slang terms commonly used from early adolescence to geriatrics. Whatever your patients call "down there," and even if you see the modest patient uncomfortable with the subject and genitalia assessment, medical professionals have to be prepared to initiate the conversation. We still have the greatest job in the world, but it just got a little more complicated.

## THE IMPACT OF GENITAL PSORIASIS

Genital psoriasis significantly impacts patients' quality of life and sexual health.<sup>4,5</sup> Pruritus, pain, worsening of disease after sexual interactions, and avoidance of sex are common complaints.<sup>6</sup> Not all of these issues can be addressed during

one office visit; however, the sooner the dialogue begins, the more quickly patients can be appropriately treated. Often in our practice one of our medical assistants initiates the dialog as patients are roomed. Every patient is asked about areas of involvement, presence of joint symptoms, and presence of genital involvement. We still see patients who have no idea their joint pain is related to their psoriasis. Similarly, genital involvement may not be viewed by the patient as related to psoriasis.

It is not surprising that psoriasis patients with genital involvement frequently have been treated for years for yeast, tinea, dermatitis, and sexually transmitted diseases.<sup>2</sup> We are just beginning to realize how many medications patients with genital psoriasis have been needlessly exposed to—antifungals, antibiotics, antiseptic solutions, topical pain medications, and steroids—due to inaccurate diagnosis. Patients have had multiple encounters at acute care clinics, emergency rooms, urology clinics, and gynecology clinics with variable success but rarely control.

The quality of life impact of genital psoriasis is far reaching—work, education, and sexuality may all be negatively affected as well as the quality of life of their coinhabitants.<sup>4,7-9</sup> Although we discuss "private parts," we should acknowledge that one's genitals are rarely just for that individual. Therefore, the impact of genital psoriasis is far reaching. Genital psoriasis can cause sexual distress, which may include worsening of symptoms after intercourse, change in the frequency of sexual function, and even avoidance of sex due to psoriasis.<sup>4,5,8,9,16</sup> Patients will report altering plans or acting on sexual desires because of or to prevent traumatizing the skin, which can also lead to Koebnerization and the perpetual cycle of irritated genitalia and perineum. One third of patients with genital involvement report worsening of symptoms after intercourse.<sup>4</sup>

## KEY CONSIDERATIONS: GENITAL PSORIASIS



- Symptoms include itching, which may be chronic and recurrent, and discomfort. Irritation may be increased after sexual activity.
- Misdiagnosis may include yeast, tinea, dermatitis, and STDs, leading to unnecessary exposure to antifungals, antibiotics, antiseptic solutions, topical pain medications, and steroids.
- Even in patients with diagnosed psoriasis, genital involvement may not be recognized as a manifestation of the disease.
- Genital psoriasis can cause sexual distress, delayed conception, and avoidance of vaginal birth.

Disease affected skin of the genitalia can affect one's ability to attempt conception and alter plans for vaginal delivery. Regardless of overall disease severity, lesions in the genital area are associated with lower self-esteem compared to lesions involving face and hands.<sup>10</sup> Patients complain about chronic intense itching, burning skin, and pain.<sup>4,11-15</sup>

Symptoms of genital psoriasis commonly include itching, which may be chronic and recurrent, and discomfort.<sup>4,11-14</sup> Genital psoriasis is often misdiagnosed as an infectious disease, allergy, or neoplastic. Looking for lesions on scalp, sacrum, elbows, knees, and nails helps with diagnosis. Examining the nooks and crannies including the ears, gluteal cleft, and folds near the pelvic region can also provide clues for psoriatic disease. Past medical history of arthritis and family history of psoriasis or psoriatic arthritis also may aid in the diagnosis.

## TREATMENT CONSIDERATIONS

The American Academy of Dermatology therapeutic guidelines for genital psoriasis includes topical therapies (corticosteroids or diluted calcipotriene) but advises close monitoring for irritation or toxicity, since the skin of the genital region is fragile. If a step-wise approach is taken and the patient does not improve with topicals, systemic agents may be used in patients with genital psoriasis only or genital psoriasis associated with

plaque psoriasis elsewhere, since quality of life is not dictated by extent of involvement but rather on the impact the disease has on an individual's life. Genital skin may account for about one percent BSA, however, the potential effect of genital psoriasis on function and its impact on psycho-social well-being justify treatment with systemic therapies or biologics, potentially even as first-line treatment options in certain cases. Note that patient questioning is beneficial, as many patients have tried and failed topicals before they arrive at the dermatologist, so it may be sufficient for the dermatologist to document this treatment failure and move on to alternative therapies.

Taltz (ixekizumab, Lilly) is the only systemic agent that has been studied in genital psoriasis in a randomized, placebo controlled trial. After the induction dose, at week 2 patients did notice some improvements—pruritus was better as well as redness. At week 12, 73 percent of patients' genitals were clear or almost clear and there was a 63 percent reduction in pruritus. Additionally, patients noted that their disease did not worsen after sex and they were not avoiding sexual activities as much. Ixekizumab is indicated for plaque psoriasis and psoriatic arthritis. It is great to know ixekizumab improves quality of life with regard to sexual activities.

## TAKING THE LEAD

Dermatologists need to lead in initiating the exam, obtaining the correct diagnosis, and discussing the impact of genital psoriasis with all of our psoriasis patients. We have the opportunity to clear what may be the most important one percent of the body. As a specialty, we want to treat the visible and invisible impacts of psoriasis—both are important! ■

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1. Fouéré S, et al. How patients experience psoriasis: results from a European survey. *J Eur Acad Dermatol Venereol.* 2005; 19(Suppl 3):2-6.
2. Meeuwis KA, et al. Genital Psoriasis: A Systematic Literature Review on this Hidden Skin Disease. *Acta Derm Venereol.* 2011; 91:5-11.
3. Meeuwis KA, et al. Genital psoriasis: a questionnaire-based survey on a concealed skin disease in the Netherlands. *J Eur Acad Dermatol Venereol.* 2010; 24:1425-1430.
4. Ryan C, et al. Genital psoriasis is associated with significant impairment in quality of life and sexual functioning. *J Am Acad Dermatol.* 2015; 72:978-983.
5. Meeuwis KA, et al. Genital Psoriasis Awareness Program: Physical and Psychological Care for Patients with Genital Psoriasis. *Acta Derm Venereol.* 2015; 95:211-216.
6. Cather JC. Patients' Perspectives on the Impact of Genital Psoriasis: A Qualitative Study. *Dermatol Ther.* 2017.
7. Sullivan JR, et al. Treatments for severe psoriasis: update. *Australian Prescriber.* 2009; 32:14-18.
8. Meeuwis KA, et al. Quality of life and sexual health in patients with genital psoriasis. *Br J Dermatol.* 2011; 164:1247-1255.
9. Martínez-García E, et al. Quality of life in persons living with psoriasis patients. *J Am Acad Dermatol.* 2014; 71:302-307.
10. Schmid-Ott G, et al. Validity study for the stigmatization experience in atopic dermatitis and psoriatic patients. *Acta Derm Venereol.* 1999; 79:443-447.
11. Lambert J. Pruritus in female patients. *Biomed Res Int.* 2014; 2014:541867.
12. Zamirská A, et al. Vulvar pruritus and burning sensation in women with psoriasis. *Acta Derm Venereol.* 2008; 88:132-135.
13. Weichert GE. An approach to the treatment of anogenital pruritus. *Dermatol Ther.* 2004; 17:129-133.
14. Barchino-Ortiz L, et al. Vulvar inflammatory dermatoses. *Actas Dermosifiliogr.* 2012; 103:260-275.
15. Meeuwis KA, et al. Genital Psoriasis Awareness Program: Physical and Psychological Care for Patients with Genital Psoriasis. *Dermatology.* 2012; 224:271-276.
16. Gupta MA, et al. Psoriasis and sex: a study of moderately to severely affected patients. *Int J Dermatol.* 1997; 36:259-262.