Transcript Details
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Practical Dermatology Roundtable: Generalized Pustular Psoriasis, Ch. 1

Dr. Neal Bhatia:
Hi, I am Dr. Neal Bhatia. I'm chief medical editor of Practical Dermatology, and I'm with two of my best friends in dermatology, Dr. Laura Ferris and Dr. Jason Hawkes.

Hi, Laura.

Dr. Laura Ferris:
Hi. Nice to be here.

Dr. Neal Bhatia:
How are you doing, Jason?

Dr. Jason Hawkes:
Good. Thanks for having me today.

Dr. Neal Bhatia:
Jason, I'll give you the first crack at telling us, what do you know about generalized pustular psoriasis and not only the challenges that we pose with it in terms of diagnosis, but some of the triggers behind it?

Dr. Jason Hawkes:
Yeah, when we talk about psoriasis, we're always talking about a bucket. It's like everything's just psoriasis. But we know from managing these patients that there's a number of subtypes and variants. So we've obviously got inverse disease and guttate disease, palmar plantar involvement, localized versus generalized disease. And then of course we have the two variants where sort of our flags go up, the more emergent urgent variants. So we're talking about erythrodermic psoriasis and generalized pustular psoriasis. And interestingly, those two can be quite difficult to tease out, and they often have features of each other.

So these patients with generalized pustular psoriasis, they can't be categorized in the same bucket as our plaque psoriasis patients because they often have much more widespread involvement, most of these patients have 75, 80, 90% of involvement, and quite different from plaque psoriasis and presenting primarily with the monomorphic pustules, that desquamation, the widespread erythema that we see. You may have some plaques, but it's not going to be that predominant feature. And I think what makes this variant also a little more difficult and quite distinct from plaque psoriasis, just the things that trigger it. We see these patients who, new onset of medication or abrupt discontinuation, we see oral steroids, especially as we start to taper off, we see pregnancy, there's been some descriptions of electrolyte changes, primarily changes in calcium that we can kind of see some of these triggers, infections.

So these patients have a different course as opposed to this more gradual chronic course. We see these abrupt changes, this triggering of this very high level of systemic inflammation that these patients often end up in emergency rooms, urgent care. So these aren't our typical outpatient psoriasis patients that come in.

Dr. Neal Bhatia:
And Laura, to Jason's point, I mean, you see some of these patients not only just looking very toxic and their presentations are not typical psoriasis, but how do we get this cycle to not continue? I mean, do we give these patients a bracelet or a copy of their path report? I mean, what's the best strategy once not only the tissue diagnosis is made, but the clinical diagnosis is made? Where do we go from there?

Dr. Laura Ferris:
Yeah, that's a great question. I think education is so important. So education of the patient to give them the name of their disease so that they know what it is. Give them some basic education on what is a good treatment for a flare, what is not a good treatment, and who do you call when you have a flare. So I think education of our patients. And then education of our colleagues, particularly outside of dermatology. So in internal medicine and primary care and in the emergency room.

Dr. Neal Bhatia:
Yeah, actually you're in a unique scenario. So in an institution where you could actually go down to the emergency room and give them a little picture and say, "If you see this, this is not folliculitis. Don't give these people steroids and antibiotics over and over again." But that's a little tougher for those out in the community. I mean, what kind of strategies do we have in dermatology to make awareness, not just for our own colleagues, but for, say, the urgent care in the ER? I don't know if there really is any.

Dr. Laura Ferris:
I think a lot of us get asked to do little talks like dermatology for the internist or dermatology for the primary care physicians. And I think this is actually an important topic to put in there, a couple slides just to say, be aware of what this disease is. It's not the same as plaque type psoriasis. It's not infectious. I think outreach to our colleagues. Even if I walked into the emergency department at UNC, they're so backed up with a million other problems. I don't think it'll hit home. I think really doing it sort of in the educational setting is important.