(Refer to page 116)

ANSWER: SEVERE GENERALISED ERYTHRODERMIC PSORIASIS WITH JOINT AND CUTICLE INVOLVEMENT .

Erythrodermic psoriasis is a common type of erythroderma but a less common variant in psoriasis, representing less than 1-2.25% of the total cases of psoriasis.[1,2] It usually manifests as an inflammatory form that affects majority of the trunk and limbs with no clear demarcations. It is characterised by wide spread erythema and skin exfoliation that can be accompanied by pruritus and pain with often systemic involvement (dehydration, malaise, fever, and malnutrition). It may arise from any type of psoriasis and occurs in all age groups.[1] Known triggers factors include infections, trauma and drugs, such as lithium, trimethoprim, antimalarials, and sulfamethoxazole, as well as psychological, environmental and metabolic factors.[3]

Nail manifestations includes a spectrum from mild pitting with yellowish discoloration to severe onychodystrophy. These symptoms are more pronounced in the fingernails than in the toenails and is often associated with gross functional impairment.[4] Presence of hand-related problems in patients causes psychological distress such as stigmatization, physical disability and psychological stress, besides having marked difficulty of carrying out basic functions and daily activities at home.

Erythrodermic psoriasis is an dermatological emergency and initial treatment should include correction of any fluid, electrolytes and metabolic disturbances along with maintaining a suitable body temperature and ensuring adequate nutrition intake.[2] Patients with erythrodermic psoriasis are at a high risk of sepsis from secondary skin infections, particularly caused by Staphylococcus aureus and therefore institution of a broad-spectrum antibiotics is often needed at admission. [2] The use of immunosuppressants becomes an essential management strategy for recovery. Cyclosporine or infliximab have been suggested as first-line therapy in emergency cases. In less urgent cases, methotrexate and acitretin are the preferred agents.[2]

Second-line treatment options include etanercept or combination therapy. Topical treatment can also act as an adjunct for full recovery. This includes topical corticosteroid and Vitamin D analogues along with occasional use of phototherapy.[2] Is it also important to address the psychological distress faced by the patients and to advice for adherence to medications and follow-ups.

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