Guttate psoriasis is a distinctive acute skin eruption characterised by small drop-like, salmon-pink papules which usually have a fine scale. This variant primarily occurs on the trunk and the proximal extremities but it may have a more generalised distribution. A history of an upper respiratory infection secondary to group A beta haemolytic streptococci often precedes the eruption by 2-3 weeks. Guttate psoriasis may be chronic and unrelated to streptococcal infection.

Epidemiology

- It is more common in individuals younger than 30 years. [1]
- Genetic predisposition: guttate psoriasis has been linked with HLA-BW17, HLA-B13, HLA-CW6. [2, 3]
- It is most often associated with streptococcal infection - two thirds have evidence of a recent streptococcal throat infection - but may also be associated with stress, trauma (Köbner's phenomenon) or drugs - eg, antimalarials, lithium, non-steroidal anti-inflammatory drugs, beta-blockers. [4]

Presentation

- In most cases there is a history of an antecedent streptococcal infection, usually of the upper respiratory tract, such as pharyngitis or tonsillitis, 2-3 weeks prior to the eruption.
- There may be a positive family history of psoriasis.
- The onset of the skin lesions is often acute, with multiple papules erupting on the trunk and the proximal extremities.
- Lesions may sometimes spread to involve the face, the ears and the scalp.
- The palms and the soles are rarely affected.
- The rash is often associated with mild itching.
- Like other forms of psoriasis, guttate psoriasis tends to improve during the summer and worsen during the winter.
- Examination of the skin reveals characteristic lesions consisting of multiple, discrete drop-like salmon-pink papules. A fine scale may be seen on established lesions.

- Nail changes characteristic of chronic psoriasis (eg, pits, ridges and the oil-drop sign) are usually absent.
Differential diagnosis

- Nummular dermatitis.
- Pityriasis rosea.
- Lichen planus.
- Drug eruption.
- Viral exanthem.
- Syphilis.
- Cutaneous T-cell lymphoma.
- Pityriasis lichenoides.

Investigations

- Diagnosis is clinical and biopsy is usually not required.
- Dermoscopy may be useful in differentiating guttate psoriasis from chronic pityriasis lichenoides.\(^5\)
- Serology: levels of antibodies to streptolysin O (ASO) may be elevated.
- Cultures: bacterial culture of the throat or perianal area.

Management\(^6\)

Treatment of acute guttate psoriasis is not based on trial evidence; rather, it is guided by expert opinion.

- Usually, the rash resolves within a few weeks to months without treatment, so simple reassurance and emollients may therefore be sufficient.
- Clearance of guttate lesions can be accelerated by judicious exposure to sunlight or by a short course of narrow-band ultraviolet B (UVB) phototherapy, so consider early referral in those who do not respond to topical treatment.\(^7\)
- Topical treatment with a vitamin D preparation, topical corticosteroid, or coal tar preparation can be considered but may be difficult due to the extent, size and wide distribution of lesions.
- Antibiotic treatment has often been given because of the association between guttate psoriasis and streptococcal infection but there is no evidence of any definite benefit.\(^8\) Some advocate that potential streptococcal infection in guttate psoriasis should not routinely be investigated or treated, as treatment has not been shown to alter the course of the cutaneous disease nor are there documented risks of post-streptococcal sequelae associated with this condition.\(^9\)
- A prospective study reported that the use of tonsillectomy for patients with chronic guttate psoriasis may be beneficial.\(^10\)
- Targeted therapy may result from research exploiting the role of the cytokine interleukin (IL)-17 in the pathogenesis of guttate and several other forms of psoriasis.\(^11\)

Complications

Complications are largely iatrogenic:

- Steroid-induced cutaneous atrophy, telangiectasia, hypopigmentation.
- PUVA side-effects - eg, nausea and vomiting, photosensitivity.

Prognosis

- Guttate psoriasis often runs a self-limited course over several weeks to a few months with complete remission in about 60%. Other patients go on to develop chronic plaque-type psoriasis. Good prognosis is associated with younger age and high ASO titres, whilst poorer prognosis is associated with a family history of psoriasis.\(^12\)
- Scarring is not a problem.
- Previously affected areas may show post-inflammatory hypopigmentation or hyperpigmentation.
- Recurrent episodes may occur, especially with pharyngeal carriage of streptococci.
Further reading & references

- The Psoriasis Association
- Psoriasis and Psoriatic Arthritis Alliance
- Guttate Psoriasis; DermIS (Dermatology Information System)

6. Cunliffe D; Guttate Psoriasis, Primary Care Dermatology Society
7. Diagnosis and management of psoriasis and psoriatic arthritis in adults; Scottish Intercollegiate Guidelines Network - SIGN (October 2010)

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