Erythrodermic Psoriasis

Synonyms: psoriatic erythroderma, erythroderma psoriatica

Erythroderma refers to a generalised redness of the skin. It involves all, or nearly all (usually stated as at least 90%), of the skin's surface. Erythroderma may arise as a result of many inflammatory skin conditions such as eczema, drug eruptions and malignancies. Psoriasis is the most common cause of erythroderma in adults.

Erythrodermic psoriasis usually occurs in two contexts:
- In the setting of known, progressively worsening chronic plaque psoriasis.
- It may be precipitated by infection, tar, drugs, or withdrawal of corticosteroids. It is then considered to be part of the spectrum of unstable psoriasis.

Very occasionally, it can be the first presentation of psoriasis.

Erythroderma is a dermatological emergency: the generalised erythema signals skin failure which can be complicated by a number of serious problems (see 'Complications', below). It can be fatal and requires urgent inpatient management.

Presentation
- The whole skin is red and hot with the dermatological characteristics of psoriasis often lost - scale is usually finer and flakier than the classic silvery, coarse scale of psoriasis.
- Pain and itching are usual and may be severe.
- The patient is systemically unwell.

Differential diagnosis
Distinguish from other causes of erythroderma:
- Eczema (contact, atopic, seborrhoeic).
- Lymphoma, particularly Sézary's syndrome.
- Drug eruption - eg, allopurinol, gold, isoniazid, phenytoin, sulfonamides, sulfonyleureas.
- Pityriasis rubra pilaris.
- Ichthyosiform erythroderma.

Investigations
- Diagnosis is clinical, based on the history and presentation.
- Where the cause of the erythroderma is known to be psoriasis, investigations look for the presence of complications and their extent. So, in addition to the baseline observations, blood tests (eg, FBC, U&Es, LFTs, inflammatory markers, blood cultures) are taken to look for acute kidney injury, anaemia, hypoalbuminaemia and infection. Additionally, efforts will be made to identify any triggers.

Associated diseases and precipitants
- Infections.
- Hypocalcaemia.
- Oral (or strong topical) corticosteroid withdrawal.
- Strong coal tar preparations.
- Drug-induced - eg, lithium, antimalarials, interleukin-2.

Management
Following emergency admission, management will require skilled nursing care and include:
- Bed rest in a warm room (30-32°C).
- Emollients and cool, wet dressings.
- Treatment of complications.
- Nutritional support.

There is a dearth of high-quality evidence on which to base treatment decisions:
- Topical tar therapy and phototherapy should be avoided in the early phases of treatment.
Retinoids have also been reported to induce this condition.\textsuperscript{[1,7]}
Corticosteroid treatment is tricky: subsequent withdrawal may worsen the clinical state but, sometimes, this is the only effective treatment for the acute episode.
Ciclosporin and infliximab are the most rapid-acting agents, with acitretin and methotrexate the slower-acting first-line choices.
Combination therapy may be more effective but this remains unproven.
Effective treatment with golimumab, a human monoclonal antibody, has been reported but further research is required.\textsuperscript{[8]}

Complications\textsuperscript{[1,3]}
- Dehydration.
- Impaired thermoregulation and hypothermia.
- Cardiac failure.
- Overwhelming infection.
- Protein loss and oedema.
- Anaemia (loss of iron, vitamin B12 and folate).
- Lymphadenopathy.
- Death.

Prognosis
Prognosis is variable: where there is pre-existing, extensive plaque psoriasis, treatment is usually well-tolerated and the prognosis is good; however, with unstable psoriasis, the course is often prolonged, relapses are frequent and there is an associated mortality.

Prevention
There are no specific preventative measures other than optimising the management of any pre-existing psoriasis and avoiding precipitants identified above.

Further reading & references
- The Psoriasis Association
5. Diagnosis and management of psoriasis and psoriatic arthritis in adults; Scottish Intercollegiate Guidelines Network - SIGN (October 2010)

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