Academy of PHYSICAL MEDICINE

Transcript

54R- Eczema & Psoriasis with Olivia Stevenson

Steven Bruce

because we're manual therapists we're turning once again to Dr. Olivia Stevenson for some talk about dermatitis and all the itchy scratchy problems that we might find under our hands in clinic. Olivia, welcome back. Hello. Is this this number three for you with us on number four. I can't remember. Anything free. Is it right? Well, we didn't get we didn't get further than dermatitis last time, I think you know. So. Today we're going to talk about eczema psoriasis and psoriatic arthritis. I've already had a question about eczema so yummy. Right? Well, as usual, I'm not quite as up to scratch as I should be. So this is mainly psoriasis. Today, we can certainly talk about eczema, but I'm focusing mainly on psoriasis because of the association with psoriatic arthritis and the fact that you're then more likely to be seeing people with joint pains. You might be able to pick up things because of the sort of joint pains that they're experiencing and be alerted to the fact that maybe this isn't just in your remit and need some specialist advice. So let's start with what psoriasis is. So psoriasis is an inflammatory condition of the joints and theses, tendons,

Olivia Stevenson

tendons, sheets and their skeleton that affects patients, usually between the ages of 35 and 45.

And although psoriasis psoriatic arthritis can occur in the absence of psoriasis, most patients do have a history of psoriasis and psoriasis can precede that by 10 to 15 years sometimes. And I think people who are dermatologists especially but you know anyone who's examining a patient wholly is in a unique position to recognise psoriasis and psoriatic arthritis because of that association. So I just thought I'd start with some some pictures of psoriatic arthritis. Psoriasis typically affects the flexors. Psoriasis typically causes very well demarcated patches on the skin. So typically it affects the elbows and knees. And there are some specific sites which tend to be affected. So psoriasis mainly affects several sites and it causes very well demarcated salmon pink patches. Now that's what you read in the textbook salmon pink. But that's actually useful because the colour of the pink of psoriasis really does help us make a diagnosis changing between eczema and lots of other rare conditions. And this salmon pink is a really deep pink that you'll get from the fridge compartment in Sainsbury's. It's that really deep salmon pink, and I'm going to show you a lovely picture of that colour. So we've got very

well demarcated patches. So this is very, very different from eczema. Because the patches have a very good line around them, they don't fade out, and this deep pink colour and the silvery scale so we get a classic silvery scale to make a diagnosis of psoriasis. And there are particular sites now when you get undressed to go to the Osteopath I've been to visit a couple of myself, they tend to get you into very little. So natal cleft involvement can be a real help, because it's so typical, and it happens in virtually nothing except psoriasis at the top of the buttocks, the natal cleft. When you get a rash there, you can very typically see psoriasis. So, in the nasal cleft, you can see psoriasis, right going into the buttocks. Now when psoriasis affects the soft sight, so under the breath, armpits, groynes in the natal cleft, you sometimes lose the scale and it ends up being just read and raw,

Steven Bruce

well demarcated as well, compared to

Olivia Stevenson

how many you could still draw around that edge pretty well. But certainly, you're quite right that when we see psoriasis in the genitals in the groynes, it can be harder to make a diagnosis than it would be if you had the type of typical elbows and knees. But there's a really good reason it's important to make that diagnosis because of the association with psoriatic arthritis. Now, I'm always a bit unsure as to how much you would know about that condition. And I guess that will differ in from different different osteopath, different clinicians, depending on their special interests and how much learning they've done in that area. But in general, what do you learn about those disease processes or when you

Steven Bruce

but it won't do anybody any harm to have you run through it again, for us with your group, much greater expertise than ours?

Olivia Stevenson

And my superzoom skills? Yes. Right. Okay, so So here we are, these are the joints that are commonly affected by psoriatic arthritis. Now it used to be they would classify psoriatic arthritis. There are five types. So there was your, your large joint oligo arthritis, so just a few joints, your spondylitis, dactylitis, arthritis neuter lands and an RA type. And I think they've kind of said, Okay, well, that's not very useful to be fair. And they don't. They don't We don't pigeonhole patients very much like that. And there are newer classifications for psoriatic arthritis. But basically, the important thing is the relationship between the psoriasis and psoriatic arthritis and the things that can help us make that diagnosis. So when we see psoriasis, we know that there is a correlation between the amount of psoriasis and the risk of developing psoriatic arthritis so people with a very extensive severe psoriasis are more likely to develop psoriatic arthritis. They are more likely to develop psoriatic arthritis if they have a positive family history of psoriasis. They are more likely to develop psoriasis if they have scalp, a nail involvement. And those are quite useful things to see. Because obviously, psoriasis is actually hugely common. Three to 4% of population will have psoriasis. And so

not all of those patients will develop psoriatic arthritis. So it's useful to know what puts people at risk.

Steven Bruce

Tell me Olivia, the if someone suffers from psoriasis, are they likely to be aware that they may also get psoriatic arthritis? Or would that come as a surprise to them?

Olivia Stevenson

I think that's half and half. I think most GPS won't have mentioned it to them. And in fact, it's much more than that. I think it's it's actually it's amazing that most people don't know that actually, it's not even just a skin and joint. This is a multi system disease. And we are realising more and more that psoriasis is not just an inflammatory skin and joint disease and it's a widespread systemic, systemic inflammation. And I think that's a really important reason. That's why I kind of decided to focus a bit more on psoriasis because actually, although I, myself had a slightly more interest in eczema because I've suffered X Psoriasis is a is a more important disease. It's associated with mortality as well as morbidity, you know, there is is what we call an independent risk factor for cardiovascular disease. So psoriasis on its own, you can equate when you talk to patients, that the plaques we see on the skin, you can get very similar inflammatory plaques affecting the arteries. And that's why they're at risk of heart disease because they get inflammatory plaques within their arterial system. And

Steven Bruce

you didn't say as well that you're at greater risk of psoriatic arthritis if you've got a family history of psoriasis. Does that mean a family history regardless of whether it's psoriatic arthritis

Olivia Stevenson

know, you've definitely got a greater history greater risk of psoriatic arthritis if you have a family history of psoriatic arthritis, okay, the whether or not you have it with their families of psoriasis is a bit debatable. The studies are sometimes yes, sometimes no. So we haven't been able to be conclusive on that.

Steven Bruce

We've had a couple of questions as well Rebecca was in early with this one and a few others have joined her to ask whether you've got any images of psoriasis on other coloured skin, because presumably it's a bit more difficult to pick up on dark skin on black skin. Okay,

Olivia Stevenson

you know what I do, but not very helpful ones. So it is very difficult. Psoriasis on darker skins can be a challenge because the nature of pink can be very difficult to see this is just a skin type for Asian patients with hyperkeratotic psoriasis. I do find that many of my patients with darker skins do have hyperkeratotic psoriasis and much thicker, scaly plaques than my white patients but Caucasian patients but I'm not entirely sure whether that's not just partly because they don't treat so promptly because it's not visible. Whereas a paler patient would be treating those red patches because they're very unsightly. A dark skinned patient might be ignoring them because they're not particularly visible. So I'm not entirely sure whether they get more thicker disease. They also I mean, as we know, darker skin types, especially black Afro Caribbean patients do tend to have a problem with dry skin anyway. And they do often have a thicker epidermis, so thicker, generally thicker skin, but Google image will do fine. I'm sure we can find some pictures of bugs in psoriasis, but it's actually not as common. It's a much more present lent in Caucasians,

Steven Bruce

Evelyn's asked, she's asked how do we get GPS to take it more seriously, I think you perhaps implied that GPs are not taking it seriously. Yeah,

Olivia Stevenson

I mean, all the evidence at the moment suggests that we are treating patients too slowly, too late. So we know that disease modifying agents are important earlier in the disease. So psoriasis, severe psoriasis has an impact on quality of life equivalent to that, that you'd see with heart disease and heart failure. It's a huge impact on quality of life. And when you join in that arthritis, then obviously, you've got an even bigger impact. But psycho socially, patients find it very, very difficult disease. This one is a picture, which gives you a clue to one of the other issues we have with our patients, say, Psoriasis can affect the males. And I'm going around, and I don't find it very easy with these to kind of talk in the loop I wanted to, but it's fine. We'll get them in the end. So this chap is obviously a smoker, nice yellow nicotine state. So smoking is much more prevalent and arthritis patients as is drinking too much. And of course, both of those adversely affects quality of life and cardiac status.

Steven Bruce

So is there is that an association or is there a causal effect between these? Right, I see, yeah,

Olivia Stevenson

they're unhappy patients, which is, it's a really tricky one. I mean, I enjoy my excellent patients more than my psoriasis patients and paid people will will agree and disagree on this. But psoriasis patients are a morbid lot. They're not very happy. They're an unhappy bunch in general.

Steven Bruce

Or psoriasis.

Olivia Stevenson

You know, have let's have a look through some pictures because I've got them here. And they're nice to look at. And we can talk through some of the things. So I wanted to look at simple plaques.

Steven Bruce

So again, sorry, I guess my my comment there sounded a bit facetious, but it wasn't meant to be it was all the all they worried and depressed a lot because of their psoriasis or did the psoriasis arise because of that stress?

Olivia Stevenson

Okay, but hugely, both hugely, both patients with psoriasis will find when they're stressed, this rice just gets worse. And the rice is makes them quite depressed. It's very, it's very much chicken and egg. A minute, what are we so tell you about GPS taking it seriously, I think it really is important. But I think the point is that a lot of GPS don't realise that actually, this is a multi system disease. We are treating it too late because we can prevent joint damage. And most of the people watching will realise that you know, all these disease modifying agents that we use to treat arthritis, the whole point is that we can prevent joint damage. And if we don't prevent it, you know, you can't go back with that with the joint damage skin, it's a bit different. You know, we're treating symptomatically. And funnily enough, there is no real correlation with the extent and severity of psoriasis at any given time, with the extent and severity of their psoriatic arthritis. So although there is a link between having very severe psoriasis and being more at risk of developing psoriatic arthritis, although there is a link there, that doesn't mean that at the same time, so you can have very severe psoriasis and your joints be perfect, and your joints be awful. And you can have virtually no psoriasis. So you can't use that to correlate

Steven Bruce

the treatment for this, then you've said any of this as a direct link to heart disease, cardiovascular disease, how much is that modified by the interventions that you can make?

Olivia Stevenson

Okay, well, actually, quite a lot of evidence says that we are, especially with the new biologic agents, we are dramatically improving that. So with the old fashioned drugs we didn't and in fact, methotrexate is one of the old drugs that we've been using for years for arthritis and for psoriasis and lots of other conditions. And in fact, unfortunately, neither trek state is an independent risk factor for cardiovascular disease. So although we're does modifying the disease, and improving that, we're giving you another risk factor instead. I think what's quite interesting to look at though, is the sort of psoriasis that might point you to looking for psoriatic arthritis. So if you have a patient who presents with fairly typical silvery pink patches, what particular aspects it might have, it might make you wonder whether their back pain is related to psoriatic arthritis and there are several things

which really are linked and I will pull them up. So firstly here we go, goodness me I'm so so hot on this on time that's disappeared completely. So that didn't come. So firstly, scalp involvement. And my picture of scalp involvement disappear, there it is. So scalp involvement and nail involvement are two of the features which are most closely correlated with scalp and ears. And we can see that well demarcated line of erythema with a very thick silvery scale, very typical effects inside the ear tends to affect the hairline creeping onto the face, this very common silvery scale. And then also, if we are looking at nails, we can see that there are several ways that the Psoriasis can affect the nails. And an oil drop change is very typical. So nail changes are very important in detecting that. In fact, one of the biggest correlations is dactylitis, and inflammation of that very distal nailfold. So if you see patients who have psoriasis, who have very inflamed fingers, that is a very close correlation with psoriasis.

Steven Bruce

Would it be just fingers or would the toes be affected as well? as well? Yeah.

Olivia Stevenson

Yeah, absolutely. So let me just looking at the pictures

Steven Bruce

you've showed me, I'd struggled to differentiate between sort of a fungal infection and psoriasis if that were toes particularly. Yeah, absolutely.

Olivia Stevenson

And that's very useful. So let's have a look at some more nails. So we get pitting. Pitting is these little dents in the nail, and Annika lysis. So the difference between this so Annika licence just means the nail plate is no longer stuck to the nail bed. So you get this area where it's just not stuck down as if you put something under the nail. And you can just see a couple of tiny pits in this nail. And this one has lifted away. And the real reason that's not a fungal infection is with a fungal infection underneath that lifted now you'll get debris. So you'll get mushy, crumbly debris with psoriatic nail changes, although that nail blade can lift up, and there can be something under the nail. It's more nail that's under the nail. So it's thick, hard, you're basically just getting a thickened nail plate rather than something with every but it can be tricky. One of the things is just the pattern, though, you know, if you've got one or two nails, then I suppose infections more likely when you've got very widespread involvement. It's Rice's, but even for us, it can be a challenge sometimes. We've

Steven Bruce

got a number of people ask what the nutritional contribution to psoriasis is, and how much rubbish is there being touted out there on the internet about what spares you from psoriasis or causes it?

Olivia Stevenson

There is nothing that suggests that there's any dietary element to psoriasis of any significance at all.

Steven Bruce

Okay, and robins asked about reports that you hear about symptoms improving with exposure to sun, so presumably vitamin D and a mood link, he says do they respond to taking supplements in winter months? Do the benefits extend to the joints? Or is it just improvement in skin symptoms?

Olivia Stevenson

That's a really interesting question. So, these are the typical involvement sites while we can stare at that while we talked about that, so there is a huge improvement with sunlight and there, there is an odd link with vitamin D. Actually, UV radiation itself is the anti inflammatory that helps psoriasis so it's the anti anti the penetration of UV light through the skin that has an anti inflammatory action, which is the same reason it's also pro cancer. So anti inflammatory, pro cancer. So any, that's why most inflammatory skin diseases, whether it's eczema, psoriasis, acne, they all tend to improve in sunlight. And there is a little bit of that that can be affected on joints, but we don't really fully understand the mechanism of that. We do also know that vitamin D deficiency is associated with psoriasis. So there is a complex link there between vitamin D and sun exposure and psoriasis.

Steven Bruce

Sorry, it's asked what's the fundamental connection between psoriasis and arthritis? Okay, same time.

Speaker 1

They are the same disease. They're the same disease. So it's basically just like someone with asthma getting exercise induced asthma as well as hey, you know, allergy induced asthma is the same disease process affecting different organs. That's why rather than call that rather than saying you've got psoriasis or you've got psoriatic arthritis, this is a multi system disease. If you have one, you have the other waiting to happen. You know, really, it is all part and parcel of the same process.

Steven Bruce

And somebody at Red fin osteopaths has asked whether patients on methotrexate should be having their medicine reviewed if they have psoriasis.

Olivia Stevenson

If psoriasis is if we the tracks that is controlling their skin, then it's their job. Since then, no, it's a great drug, it's relatively safe. It's pennies, you know, for for our for treating, it's a good drug. I mean it if it works, it's a great drug. So you shouldn't stop it people just need to be aware that there is a

there is an independent risk factor and we do what we what we mainly do, putting up something else here. What we mainly do with psoriasis patients is explained to them about this multifactorial disease and ask them about weight loss strategies. Many of our patients are obese, about stopping smoking, about reducing the things that they can to improve their cardiovascular risk factors.

Steven Bruce

So obesity, loss of obesity won't affect the psoriasis. It's just going to affect the cardiovascular risk that they suffer as well. It

Olivia Stevenson

affects everything. Yeah, so right weight loss can improve your psoriasis and your psoriatic arthritis and improve your cardiovascular risk factors. So yeah, there was another link there.

Steven Bruce

What about is there a relationship between psoriasis and inflammatory bowel disease? Eastlands asked that question.

Olivia Stevenson

There is a rare HLA link. So there are there is a genetic increased risk with having both but they are directly associated. Okay.

Steven Bruce

And Gemma says either Neal symptoms uniform across all nails or just one or two or random.

Olivia Stevenson

Okay. The nail changes. Yes, you can have them in one or 20 nails. So, yeah, just about random. So looking at psoriasis, I've looked at some pictures of the typical plaques. I'll show you these plaques, obviously, the fixed scale. So we get this fixed silvery scale. So we've kind of gone around a bit, but the typical site should get make you suspicious, no involvement should make you suspicious. And then moving on to when is it not psoriasis? I thought I'd move to so how you would you differentiate the red pink rash with in someone who happens to have back pain, from psoriasis to something else. So the common things would be eczema. So, Eczema is just about as common as psoriasis. And bizarrely, they rarely so even though both of them affect you know, a huge proportion of population actually very uncommon to happen together. Psoriasis though the X the patches are just paler. So with eczema, we find that the redness is more diffuse, and just a paler colour. So this poor chap here is red and blotchy. So you can see the patches are not so well demarcated. They tend to be a little bit heavier. So you can see around here, he's a bit of dermatitis. So he's not just got the red patches, he's got some some swelling associated with that. And you see that on a skin biopsy, you get a lot of

edoema in the tissue. with eczema, you get tend to get more scratch marks more bleeding on the skin, because in general X was more richer than psoriasis. So you can see on his arms he's covered in in scratch marks. And quite clearly, you can't really draw around the patches so well and there's not so much scale. So Eczema is a horrible disease to have, but there's no association with joint disease. So obviously you don't have to think could this be linked? So that can be quite an important differentiation to make

Steven Bruce

in terms of treating these patients given that you know, a lot of what we asked you as chiropractors and physios do is hands on stuff. Are we likely to aggravate the condition or are we like to spread the condition we'd like to contract psoriasis ourselves from treating Okay, so

Olivia Stevenson

no, no, no, no. So it's not a contagious disease a little my patients will worry that some patients who live with people with eczema for many years develop eczema and I'm sure that's a kind of habitual scratchy thing. But we learned to scratch off off our off our spouse, but there is no direct contagiousness to it. Unless it's overtly infected, in which case they're probably not coming to see you because they're sore and feeling ill themselves that you're not going to spread anything. So obviously if someone had weeping eczema or psoriasis, you probably wouldn't be wanting to rub your hands over their body anyway. In fact, most of the oils if you do some, you know people will do use hot rubs or oils. When doing deep tissue massage. They're helpful. So you'd be slow. You might want to ask your patient if they've got any allergies, but other than that we don't tend to have any issues at all.

Steven Bruce

Okay, Julie's asked if you've been diagnosed but are apparently symptom free aside from slight scalp psoriasis. Should you ask your GP for a drug review? Or could there be hidden damage going on?

Olivia Stevenson

Okay. So if you have have a diagnosis of psoriasis. And you think, Okay, wow, that's some, that's a scary thing that can be an issue. And I have a patient myself who has the very milder psoriasis, but he's really quite obsessive about having a drop down dead of all the comorbidities associated with it, you know, but it's about looking at the whole picture. So if you don't have any other symptoms, there is nothing that you need to do, we're not going to be treating anything, you just need to look at the fact that okay, I now have a disease that is putting me at higher risk of cardiovascular disease. Therefore, I'm going to keep to a low fat diet, I'm going to make sure my cholesterol stays within normal limits, I'm going to make sure my blood pressure stays within normal limits, etc. There's nothing that you would do beyond that, unless you start to develop joint pains.

Steven Bruce

Okay. Jamie's asked about the presentation of low back pain in a psoriasis patient. Is there a pattern to it? Is it morning stiffness? Are there any other clues that might associate the two?

Olivia Stevenson

No. I kind of think that you'd probably be better at diagnosing a spondylitis or arthritis than me, certainly. But yeah, morning stiffness, and low back pain and fatigue. I think one of the things with patients with inflammatory arthritis, they tend to get more of the associated symptoms. So apart from just the local pain, they're more likely to have fatigue with it. And yeah, look, look at the natal cleft, look at the nails. Look at the scalp. If there's any skin disease, then they may well have an inflammatory arthritis. And

Steven Bruce

we've had following on what you're saying about sunlight affecting psoriasis and eczema, we've had a lot of questions about black light and UV light being used as a treatment intervention.

Olivia Stevenson

Yeah, I mean, we use UV light, some patients will buy their own box, which we don't necessarily advocate, because of course, this is under dosed. And we know that too much sun exposure can put your risk of skin cancer, but we use UV light and we use UVB so we use a very narrow wavelength, what we call T L O one, a narrow wavelength of UV B, which gives the best penetration with the fewest side effects regarding ageing, photo damage and carcinogenesis. And if that doesn't work, we also sometimes use poovar, which is a UVA, UVA doesn't get very well absorbed into skin. So we add Saarland which is the P and poovar. We add that either by mouth or painting on the skin to improve the penetration. So both UVA and UVB have a very good anti inflammatory effect. The trouble is it's pretty short lived. So they get better whilst they're having the treatment. And that benefit may last six weeks, sometimes three or four months, but not much longer than that. Probably

Steven Bruce

quite good psycho psychologically for them to get rid of it. Even

Olivia Stevenson

some of our patients do really like their like treatment, they just want to keep having that once a year taught me up, I'll have another treatment. But obviously, eventually we have to say hang on now we're just doing more damage than good.

Steven Bruce

Several people have apparently asked about the success rate for treating psoriasis permanently using conventional treatments. What's the success rate of treating with non conventional methods such as acupuncture and herbal treatments, don't if you know anything about those?

Olivia Stevenson

I guess if they work, they don't come and see me. So I don't know. None of my patients who are clutching at straws have ever ever had any success with those methods? I must say, I'm going to have a lot of patients who have tried everything. To be fair, more of the eczema patients than psoriasis patients tend to resort to acupuncture, Chinese teas, etc. But yeah, I don't tend to get much success at all in the ones that do try but it's not something I have a huge experience of.

Steven Bruce

So Joelle is asked, What do you advise in sort of early stages for self management for psoriasis patients, particularly the mild ones that might not necessarily need to be seen clinically. Okay,

Olivia Stevenson

well, I mean, I guess what we find as dermatologists is there's a huge variety, some people will be totally, their life is ruined by their to elbow patches, and other patients can, you know can really be very badly affected. You know, and, you know, just pull up just for a bit of dramatic effect.

Steven Bruce

suspense is killing us.

Olivia Stevenson

I know. Some people can be read all over and really not that bothered. And it is it's really important to decide from a patient's point of view what it is they want to achieve. So really, there is very little that you can buy over the counter that is likely to improve psoriasis to any significant degree very mild psoriasis. If you moisturise two or three times a day it will not be scaly and that's about it. You know, there isn't anything except steroids and vitamin A analogues. Vitamin D analogues that improve psoriasis. Not all of them are prescribed except you know, you can buy better hydrocortisone over the counter. So in general, if a patient has psoriasis and they don't like it, they should get some cream from the GP. Okay.

Steven Bruce

Robin has asked a really useful question from our perspective as manual therapists, is there always a correlation between the location of psoriasis and the affected joints in arthritis?

Olivia Stevenson

No, except hands. So patients with severe fingertip dermatitis and fingernail involvement are more likely to have severe finger disel pharyngeal involvement. So that would be the only time that you really see that. So you can see. So this patient has a little bit has very bad nail disease, but you can see also he has very significant nail distal involvement here with swelling enthesitis dactylitis here. So significant nail involvement, some skin involvement, but very severe changes to the distal fan joints. That quite nice there. Can we see that? Yeah, yeah. So So yeah, in general, as I said right early on, the extent and severity of the psoriasis doesn't necessarily correlate to the disease, except in very specific situations. Or Joanne has

Steven Bruce

asked if untreated, psoriasis is more likely to result in psoriatic arthritis.

Olivia Stevenson

You Yes. So this is all the cytokines that are released in psoriatic plaques. So the trouble is, these plaques are huge hives, of cytokines and of pro inflammatory chemicals, which induce more inflammation. So the more psoriasis you have on the body, the more likely you are to develop joint psoriasis as well. So it's difficult because there's a whole chicken and egg situation because we know that people with very severe psoriasis are more likely to have psoriatic arthritis. And so trying to separate the two from where would they have had psoriatic arthritis if we'd have treated them earlier is a challenge. But there's certainly a lot of evidence about how these pro inflammatory cytokines exist within plaques. They're within the joints, they're within the arteries. And this is the driver for psoriasis and this is where we're targeting with the newer biologic therapies to really get rid of that, that inflammation.

Steven Bruce

I'm going to ask you one on eczema because as I said, right at the beginning, it came in early and it will be rude of me not to ask the question. But felicities asked about eczema in the under ones and the pathway that seems to exist between non e mediated CMP I, I don't know what that is myself, and eczema. She's observed 80% of baby eczema seems to be reduced with cutting out CMP from mother or baby's diet. But I heard an eczema talk last year by a dermatologist who said eczema wasn't related to allergy. And I'm not sure why there is this discrepancy with my findings in clinic. Perhaps she was only referring to AG mediated reactions.

Olivia Stevenson

Oh, wow. Going into real science. Okay, so

Steven Bruce

your sound surprised that osteopaths and chiropractors might be interested in the real stuff. Just you know,

Olivia Stevenson

just throwing me really just trying to just sort of catch me out. That's what it is. They're

Steven Bruce

all busy on Google trying to find the complicated questions.

Olivia Stevenson

I'll google that now. Okay, so I think one of the big things is there's a real issue. We've had what's called True atopic eczema, so patients with eczema, asthma, hay fever, this is a genetic, you know, risk of developing eczema, asthma and hay fever. And what we have found over the recent years, has been classified with something called the atopic March. Now, in the past, it was felt that diet and allergy that came in as soon as babies were weaned around four to five months, was the trigger for eczema, which then develops on to asthma and hay fever as well. Food allergies were felt to be the initiating thing, which would then trigger the eczema in the last decade, it's actually felt to be the other way around. So it is actually there's more evidence that eczema develops at about four months. And this, unfortunately is the time we wean. And if we don't win till six, seven months, they still develop eczema around four months. So four months is the time when Eczema is most likely to develop in an infant. And so a lot of mothers will assume therefore, that it was because they started weaning they brought in bottle they brought in foods etc. What happens is the broken skin allows chemicals to enter the system, and we end up with what's called the leaky gut syndrome. So we end up with allergens coming in through the skin, which can then trigger the guts to become sensitive to those foods. So there's a very much chicken and Next situation. I don't have a full answer onto whether this is the the true allergy. What does she want cm, GMP, GMP? Yeah. Because and I think the reason that the data isn't there is because we don't study babies under one. And this is the huge the biggest problem we have with all of the food allergy related stuff under one is that babies aren't recruited unless they are awful. And in those really, really bad Xmas, we find that they're allergic to everything. And so trying to nitpick and pick out what is relevant and what is not is a real is a real challenge. And I'm, I will I will back out there because I don't have enough knowledge of the science behind those IGE mediated allergens in infantile eczema, because it is a huge field.

Steven Bruce

Thank you. We've got one of our audience members we're beginning is beginning to make himself very well known, I think, because he calls himself a potato viewer, which doesn't sound much like a hobby to me, but the potato viewer says, Will those skin lesions be more vulnerable vulnerable to things like COVID-19 from surface contact and healthy skin?

Olivia Stevenson

So far? No, there's no evidence that broken skin seems to make them more at risk of COVID.

Steven Bruce

Right. Okay. And Evelyn says how commonly do blood tests show negative in spite of obvious symptoms?

Olivia Stevenson

For psoriatic arthritis,

Steven Bruce

sorry, I'll come back to arthritis. Sorry.

Olivia Stevenson

It's not uncommon for patients to have zero negative psoriatic arthritis. So yes, completely normal Bloods, but still obviously got psoriatic arthritis. And then,

Steven Bruce

is there any evidence of fever in those with lumbar spine? psoriatic arthritis? Yeah,

Olivia Stevenson

some of them the systemic the fatigue, you can also get a pyrexia.

Steven Bruce

Okay. Caroline says this, Carolyn says this class doesn't auto immune disease.

Olivia Stevenson

Psoriasis is an autoimmune disease. And that's a big short answer. But this is a new change, actually. Because you know what, that that the whole classification of autoimmune diseases, you know, people tended to hear of lupus and that was about it. But now we're bringing in so many diseases and so patients, I think find it quite alarming that they've suddenly been told they've got an autoimmune disease.

Steven Bruce

Yeah, it is. And Claire's asked if there are atypical presentations of psoriasis, unlike the pictures you've shown us already.

Olivia Stevenson

Definitely. So there are lots of ways writers can present. Because most patients go through their GP first, we tend to see more typical psoriasis because it's been there a few years. got eight psoriasis is the psoriasis that appears when you have a strep infection. And you get these little raindrops, tiny little paint slats of psoriasis. And they're quite typical. And the big plaques are very typical. But when we see psoriasis that only affects the nails, or psoriasis, that only affects the flexors, it can be quite challenging. Even when we see this rises in the pictures. Let me see if I got anything nice to show you here. Really, really thick plaques, it can be difficult to distinguish that from something called like and plainness is that that I showed you earlier as being read all over. He in fact doesn't have psoriasis. So, but they're a little clues. So he's got little white patches. And this is a rare disease called pitter iasis rubra pilaris, which can mimic psoriasis. So it's not always easy to make that differential diagnosis. You know, but it's those silvery plaques that are typical. This chat and looking at the hands and feet are quite nice as well. So very well demarcated, and silver scale and they often fish on the hands and feet as well. pustules on the fan hands and feet is also another form of psoriasis. So that can be an atypical presentation.

Steven Bruce

But last question for you the age of onset does not have any relationship to the severity.

Olivia Stevenson

Ultimately, so there's two peaks of incidence for psoriasis, the most likely time to develop it or in your teens in your 60s, and therefore more likely to have severe joint disease if you started in your teens.

Steven Bruce

Thank you. That's 45 minutes gone, like a flash as always, Olivia. And we have had so many questions I'm told just like last time, and I'm sorry, I apologise to those people whose questions I couldn't ask. But thanks for giving us your time. Thanks for answering so many of those questions so thoroughly. Were really useful to everybody in clinic and provided you're willing, I have no doubt that people will be very keen to see you on the show again.

Olivia Stevenson

Okay, maybe with slightly smoother zooms. And we'll we'll

Steven Bruce

work on that.

Olivia Stevenson

All right, thanks.