Types of Psoriasis

Psoriasis is an immune-mediated inflammatory disease (IMID) which means that the immune system is not functioning correctly. In psoriasis, the immune system is overactive, and this can cause symptoms on the skin and sometimes in the joints.

There are several different types of psoriasis, and they can affect different parts of the body. This resource provides a brief overview of the main types:

- **Plaque psoriasis**
- **Scalp psoriasis**
- **Guttate psoriasis**
- **Flexural / Inverse psoriasis**
- **Psoriasis on the face**
- **Pustular Psoriasis (PPP and GPP)**
- **Erythrodermic psoriasis**
- **Psoriasis of the nails**
- **Psoriatic Arthritis (PsA)**

Although there are several clearly defined types of psoriasis, people with the condition may have an overlap of 2, 3 or 4 of these different types.

Psoriasis on visible or sensitive areas, like the face, scalp, nails, or skin folds is often described as 'high impact', because it can affect daily life more, even when only a small area is involved.

Further in-depth information on each individual type of psoriasis, as well as suitable treatments and advice on caring for the skin, is available from Psoriasis UK.

Plaque psoriasis

Plaque psoriasis is the most common form of psoriasis, and it is estimated that up to 90% of people with psoriasis have this type.

It causes red raised patches of flaky skin covered with silvery scales (known as plaques), that may feel itchy. Plaques can vary in size from a few millimetres to several centimetres. On

lighter skin tones, these plaques usually look red or pink while on more diverse skin tones, they may look purple or dark brown, and the scales can appear grey.

Plaques have clear edges, so you can easily see and feel where the psoriasis stops and normal skin starts. For some people the plaques will be thin whereas for others they are much thicker.

Plaque psoriasis may appear symmetrically and can occur anywhere on the body, although often in areas such as the backs of the elbow and the fronts of the knees. The lower back and top of the buttocks is another common site for large plaques. Some people get plaque psoriasis on the hands and feet, which can make everyday activities difficult as it is easily irritated and prone to cracking.

Scalp psoriasis

The scalp is one of the most common places where plaque psoriasis appears, and it is often the first area to be affected. It can occur on parts of the scalp or across the whole scalp. It appears as raised, red (or dark on darker skin tones) patches of skin covered with silvery, white or yellow scales.

Loose scaly skin can often look similar to dandruff and might be particularly noticeable in the hair or on dark clothing. It can also make the scalp feel itchy and tight.

Scalp psoriasis may be visible around the hairline, on the forehead, neck and behind the ears. Some people with scalp psoriasis that is severe or has very thick scaling may have temporary thinning of the hair, which should grow again once the psoriasis has subsided.

Guttate psoriasis

Guttate psoriasis is a distinctive form of psoriasis which is also known as ‘teardrop’ or ‘raindrop’ psoriasis. It occurs most often in children, adolescents and younger adults, and is characterised by a generalised rash of small spots that is widespread across the body. These spots can be up to one centimetre in diameter.

It can occur in people who have never had psoriasis before, appearing suddenly following a streptococcal infection, usually of the throat or tonsils, or it can develop in someone who

already has long-term plaque psoriasis. It does not often affect the palms and soles and usually clears up after several months depending on how quickly treatment is started.

Some people will not have a further flare, but others may continue to have sporadic flares, or find it evolves into one of the other types of psoriasis.

Flexural/Inverse psoriasis

This form of psoriasis occurs in skin folds, where the skin is thinner, such as the armpits, under the breasts, in the groin, genitals and between the buttocks. It is described separately from plaque psoriasis because the appearance is very different. It is much less scaly and may look bright red on lighter skin tones, or darker in colour on deeper skin tones, often with a smooth and shiny surface.

These areas are often covered by clothing or where skin rubs against skin, which makes them warm and moist. Because of this, treatments applied to these areas can be absorbed more easily than on other parts of the body. As a result, different or milder treatments are sometimes recommended for psoriasis in skin folds compared with those used elsewhere on the body. It can be made worse by friction and sweating so can be particularly uncomfortable in hot weather.

Psoriasis on the face

Psoriasis on the face is less common in adults but can occur more often in children. The patches may be less clearly defined than in other types of psoriasis, which can sometimes make it harder to tell apart from eczema

Sometimes, scalp psoriasis may form around the hairline or forehead, which may then be considered ‘facial’ psoriasis rather than ‘scalp’ psoriasis. The face is a very sensitive area and often needs a different treatment to psoriasis on the rest of the body.

Some people may experience something known as sebo-psoriasis overlap. This means that some people may have a combination of two common skin conditions: seborrheic dermatitis (a type of eczema linked to yeast that normally lives on the skin) and psoriasis.

When someone has features of both conditions at the same time, treatment is usually aimed at managing both, rather than treating just one of them. This helps control the different causes of the skin inflammation and improves symptoms more effectively.

Pustular Psoriasis

When people use the term 'pustular psoriasis', it can refer to two different types of psoriasis, pustular psoriasis of the palms and soles, also referred to as Palmoplantar Pustulosis or PPP and Generalised Pustular Psoriasis (GPP) which refers to pustular psoriasis across the whole body.

Palmoplantar Pustular Psoriasis (PPP)

(*'palmo' meaning palm of the hand and 'plantar' meaning sole of the foot)* is a rare condition which causes pustules filled with fluid on the palms of the hands and the soles of the feet.

The pustules are small, round and yellow and can look similar to blisters containing pus. They appear under the skin surface of the palms or soles and can affect just the hands, just the feet, or both. They can also be very itchy and painful.

They gradually turn brown as they reach the surface and are shed as scales. They are not infected or contagious but are simply a collection of cells. As it can often look very similar to a fungal infection, a doctor may take a skin scrape to check for this or to rule out a bacterial infection. Psoriasis on the hands and feet that is not pustular is usually plaque psoriasis.

There is a strong association between palmoplantar pustulosis and cigarette smoking, which is one of the most common risk factors for developing the condition. Up to 95% of people with Palmoplantar pustulosis either currently smoke or have smoked in the past. Other possible triggers include metal sensitivities (particularly to nickel), infections, trauma, stress, and certain medications.

Anybody can get palmoplantar pustulosis, but it is more common in women than in men. It is rare in children. Those with family members who have palmoplantar pustulosis or psoriasis are more likely to be affected and it is more common in people who have other autoimmune conditions such as arthritis, diabetes, thyroid disorders, or coeliac disease.

Generalised Pustular Psoriasis (GPP)

GPP, which can also be known as von Zumbusch psoriasis, is quite rare, but is a serious, life-threatening condition that requires urgent medical attention. It is widespread across the body**,** with sheets of very small sterile fluid filled pustules on very red, hot and inflamed skin.

It is considered a medical emergency, and a person can become very ill as the skin's ability to regulate temperature is affected. Someone with GPP may feel feverish and have flu-like symptoms. Headaches, nausea, fatigue, shivers and a high temperature can also be experienced. These flares can usually last between 2-5 weeks but can persist up to 3 months. GPP can sometimes develop if very large amounts of strong steroid creams have been used to treat widespread plaques for a long time. It can also be triggered by using certain medications or by pregnancy.

It is more common in females and unlike plaque psoriasis, it is more prevalent in people of Asian ethnicity.

Although it has historically been grouped with plaque psoriasis, GPP is a distinct condition. It involves different processes in the immune system and often requires different treatments.

The pustules that are seen in both types of pustular psoriasis are sterile and are not contagious or infectious.

Erythrodermic psoriasis

Erythrodermic psoriasis is a very rare and severe form of psoriasis that affects 1-2% of those who already have psoriasis. It affects all the skin on the body and can cause intense itching, burning and inflammation. Between 90% and 100% of the skin turns red, or dark, and scaling may be fine and silvery.

Individual plaques of psoriasis cannot be seen because they have merged together. Scaling may be fine and silvery and less noticeable than the scale seen with plaque psoriasis, while the skin may feel warm to touch.

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The person may also have flu-like symptoms, a fever, and swelling, may develop peeling skin that comes off in large sheets or lose fingernails and toenails. In some cases, people may experience hair loss and joint and muscle aches.

It can occur quickly over a few days or weeks or more gradually over several months from pre-existing psoriasis.

Erythrodermic psoriasis can be difficult to manage and affects the body's ability to control temperature. It is a medical emergency and urgent admission to hospital is needed to replace lost fluids and to prevent hypothermia (low body temperature) and dehydration.

It can sometimes be triggered by using certain medications, such as some types of anti-malarials. The underlying psoriasis will also need to be treated once the person has been stabilised.

Psoriasis of the nails

As well as growing more quickly in people with psoriasis, some people can also experience changes to the appearance of their nails. These changes can include discolouration, small dents in the nail surface (called pitting), or more severe damage. In some cases, the nail can lift or separate from the skin underneath (the nail bed) and the skin below the nail may become thickened.

Nail psoriasis is not a cosmetic problem and can be painful and disabling. It is particularly common in people with psoriatic arthritis.

Psoriatic arthritis (PsA)

It is difficult to say how many people with psoriasis develop psoriatic arthritis (PsA), but it is thought that around one quarter of people with psoriasis will go on to develop psoriatic arthritis.

Psoriatic arthritis (PsA) is an inflammatory condition of the joints which can cause pain and swelling in affected joints and areas with tendons and ligaments, which may lead to stiffness and reduced movement.

It most commonly affects the joints in the hands and feet, but can also affect larger joints, including the knees, elbows, hips and the spine. The pain can be quite variable and can ebb and flow in a similar way to skin psoriasis. It is often worse in the morning and after resting. Symptoms can develop slowly, and many people may not realise they are developing PsA.

A large number of people with psoriatic arthritis (estimated as between 50 and 80%) also have nail psoriasis. Nail psoriasis can and does occur in people who do not have psoriatic arthritis, but, because of the large amount of people who have both conditions, it can be an important early indicator of possible psoriatic arthritis.

People with psoriasis affecting the nails, scalp, or palmoplantar psoriasis may have a slightly higher chance of developing psoriatic arthritis, usually a few years after the psoriasis first appears. For this reason, it is important to be aware of any possible new joint symptoms, such as pain, swelling, or stiffness, and to mention these to your healthcare professional if they occur.

If psoriatic arthritis is suspected, you should seek a referral to a Rheumatologist as soon as possible.

For more information, or for a list of resources used in the production of this information sheet, please contact the Psoriasis Association.

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