Types of Psoriasis

This resource is intended to give a brief overview of the various types of psoriasis. Further in-depth information on each type of psoriasis, as well as suitable treatments and advice on caring for the skin, is available from the Psoriasis Association.

Plaque psoriasis

This is the most common form of psoriasis- it is estimated that up to 90% of people with psoriasis have this type. It features scaly raised patches, or 'plaques', which vary in size from a few millimetres to many centimetres. These patches appear red or pink on Caucasian skin, or may be a darker colour on other skin tones. The plaques are well demarcated- you can quite easily see and feel where psoriasis ends and normal skin begins. Plaque psoriasis may appear symmetrically and can occur anywhere on the body, although often on 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 areas for plaque psoriasis to affect. There may be thick scale, redness on Caucasian skins or dark patches on other skin tones, and flaking. It can also make the scalp feel itchy and tight. Scalp psoriasis may also be visible around the scalp margins, 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 – but it should grow again once the psoriasis has subsided.

Guttate psoriasis

Guttate psoriasis is also known as 'teardrop' or 'raindrop' psoriasis. It tends to occur in children, adolescents and younger adults, and is a generalised rash of small spots up to one centimetre in diameter. It tends to appear suddenly following a streptococcal infection, often of the throat. It is widespread but does not usually affect the palms and soles, and clears up after several weeks or months depending on how quickly treatment is started. Some of those affected 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.

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Flexural/Inverse psoriasis

This form of psoriasis occurs in skin folds, armpits, under the breasts, in the groin, genitals and between the buttocks. It is described separately to plaque psoriasis because the appearance is very different. It is much less scaly, and is often bright red on Caucasian skin, darker on other skin tones, and shiny. These areas also tend to need treating slightly differently, as warm, covered conditions can absorb topical treatments in a different way to other areas. Because of this, a separate treatment may be needed for psoriasis in these areas, to what is used to treat psoriasis on the rest of the body.

Psoriasis on the face

This is relatively uncommon in adults, but is more common in children, and can be less clearly demarcated than other types of psoriasis, leading to confusion with eczema. Sometimes, scalp psoriasis may form around the hairline or forehead, which may then be considered 'facial' psoriasis rather than 'scalp'. The face is a very sensitive area, and therefore often needs a different treatment to psoriasis on the rest of the body.

Pustular psoriasis

Pustular psoriasis can affect just the hands and feet, with round yellow sterile pustules (similar to blisters containing pus) appearing under the skin surface of the palms or soles, or both. They gradually turn brown as they reach the surface and are shed as scales. Psoriasis on the hands and feet that is not pustular is usually plaque psoriasis. **Generalised Pustular psoriasis** is widespread across the body**,** with sheets of very small sterile pustules on a background of very red, hot skin. This is a medical emergency. A person can become very ill as the skin's ability to regulate temperature is affected, and they may feel feverish, with flu-like symptoms. Generalised pustular psoriasis is sometimes triggered if very large amounts of strong steroid creams have been used to treat widespread plaques or after using certain medications. This sort of psoriasis is quite rare.

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

Erythrodermic psoriasis

This is a rare form of psoriasis, but medical attention is required quickly. Between 90% and 100% of the skin turns red, or dark, and scaling may be fine and silvery. The person may also have flu-like symptoms, a fever, and swelling. Erythrodermic psoriasis is a medical emergency which can lead to loss of fluid and affect the body's ability to regulate temperature, as with generalised pustular psoriasis. There are no pustules but urgent admission to hospital is needed to replace lost fluid and to prevent hypothermia (low body temperature).

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

Psoriasis of the nails

Some people with psoriasis experience changes to the nails. These range from discoloration and pitting of the surface to complete destruction of the nails because the psoriasis can make the nail split away from the nail bed and cause considerable thickening of the skin from under the nail. Nail psoriasis is not just a cosmetic problem, but can be painful and disabling. Nail psoriasis is particularly common in people with psoriatic arthritis.

Psoriatic Arthritis

It is difficult to say how many people with psoriasis develop psoriatic arthritis, but it is estimated as being up to one in five. Psoriatic arthritis can cause inflammation, 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. If psoriatic arthritis is suspected, the person should be referred to a Rheumatologist.

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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This information sheet is currently undergoing a review

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