Psoriasis

Plaque psoriasis: clinical presentation, and course

The classic and most common presentation of psoriasis is plaque psoriasis, found in approximately 80–90% of patients. The psoriatic plaque is well-demarcated, erythematous, and scaly (Figure 3.1). The scale is dry, silvery, and has been described as micaceous because it is layered and peels in sheets. Centrally, the scale is adherent and when removed, produces pinpoint bleeding due to dilated superficial capillaries, termed the ‘Auspitz sign’. The lesions are often pruritic, but the intensity of the pruritus may vary substantially from patient to patient. Over time, smaller plaques may grow and coalesce into larger lesions. Treatment may cause initial central clearing, resulting in annular plaques. Upon resolution, post-inflammatory hypo- or hyperpigmentation can occur, but scarring is uncommon. Plaque psoriasis is often symmetrical in distribution and favors extensor surfaces, such as the elbows and knees, although it can occur anywhere on the body, including the genitals. The scalp and intergluteal cleft are other common sites of involvement. In addition, the disease may be limited to the palms and soles as in palmoplantar psoriasis.

Plaque psoriasis is typically a chronic disease, and spontaneous remission is rare. The disease may wax and wane, and seasonal variation is
Figure 3.1 Plaque psoriasis. (A) Plaque psoriasis on the lower body. (B) Psoriatic plaques with well-demarcated erythema and adherent silvery scale.