A new treatment paradigm is emerging for psoriasis—multidisciplinary clinics that care for patients who present with multiple symptoms.

Most of the dozen or so of these clinics now scattered around the country combine dermatology and rheumatology—a logical pairing for a disorder that strikes both systems.

The Rochester Clinic

Just as concerning are misdiagnosed patients who have been prescribed unnecessary biologics, said Dr. Francisco A. Tausk, a professor of dermatology and psychiatry at the University of Rochester, and a staff physician at the university’s psoriasis center. “We have had patients who have been told they have psoriatic arthritis and psoriasis and didn’t have either one,” he said.

“‘It goes both ways.’ Dr. Tausk runs the weekly clinic, which opened last April. Twice a month, he’s joined by rheumatologist Dr. Christopher Ritchlin and psychiatrist Dr. Andrea Sandoz, both of the University of Rochester.

The National Health and Nutrition Examination Survey (NHANES) concluded that 5 million adults in the United States have psoriasis, and that as many as 3.6 million have active but undiagnosed disease. (J. Am. Acad. Dermatol. 2008 [doi:10.1016/j.jaad.2008.09.022]).

“Using eye shields, you could easily treat those,” however, noted Dr. El-Attar, who is a laser and cosmetic skin surgeon in Somerset, N.J.

For purposes of the study, efficacy and patient satisfaction were assessed 4 weeks after each treatment session and again 6 months after the final session.

OF THE LESIONS, 98% CLEARED OR IMPROVED.

A 33-year-old man complained of patchy hair loss that started in his beard and spread to the rest of his body over the past 6 years. He had a history of chronic scaly lesions on his elbows and knees for 12 years. The only normal hair growth left was within scaly red plaques on his forearms and legs.

WHAT’S YOUR Diagnosis?

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Diode Laser from page 1

treatment. Patient evaluations of their outcome ranged from “satisfied” to “very satisfied.”

The 532-nm Diolite™ laser, a diode-pumped, frequency-doubled Nd:YAG laser, is widely used in office-based dermato-

ology for treatment of facial telangiectasia.

The green light wavelength laser is extremely lightweight, affordable, easy to use, and readily moved between treat-

ment rooms. The small spot size and limited depth of penetration permit the op-

erator to avoid laser-induced purpura, Dr. El-Attar explained.

The 532-nm diode laser enables patients being treated for DPN to go back straight to work with no down-
time for recovery. The key to the excellent results, Dr. El-Attar stressed, is to treat cautiously, spreading the work over the three or four sessions separated by

about 4 weeks in patients with numer-

ous lesions.

“The end point of treating these le-

sions is graying of the lesion. You don’t

want to go past this end point. Because

African americans and others with dark-

er skin types are very prone to pigmen-
tary changes, we try to be very conserva-
tive. That’s why we use several sessions.

We never go overboard. We always un-
dertreat,” he said.

Depending upon the size and thick-

ness of a lesion, he uses a repetition rate of

5.7 Hz at 10-16 J/cm² of power. Most lesions are adequately treated in a single session. Particularly large or thick ones may require laser debulking in one session followed by final treatment in the next.

Most patients can tolerate the proce-
dure without a topical anesthetic. When

needed, Dr. El-Attar applies EMLA cream for about 15 minutes prior to treatment.

The treated lesions immediately turn gray and then black and exfoli-

ate over the course of a few days to a week. Because patients occasionally have developed mild itching as a reaction to topical antibiotics, Dr. El-Attar generally

has patients apply Vaseline or another

blending oil-based topical product to treated areas as they heal.

Because ‘African Americans and others with darker skin types are very prone to pigmen-
tary changes, we try to be very conservative. That’s why we use several sessions.’

Therefore there are footprints: changes in coloration where the lesions were.

The tinea versicolor may need to be treated this far in order to clear the lesion, but if the patient is in a rush we can use some medical chemical peeling and that takes care of it 100%, he said in an interview.

Dermaplastosis papillosa nigra is an extremely common benign cutaneous condition in African American and other races and persons who have Fitzpatrick skin types IV-VI. DPN is believed to have a strong genetic component and is analogous to seborrheic keratoses in lighter-skinned patients. The small, hyperpigmented lesions tend to become numerous through adulthood.

Conventional treatments of DPN in-
clude cryotherapy, curettage, excision, and electrodesiccation. All are notoriously associated with increased risks of hyper- and hypopigmentation in darker skin types, said Dr. El-Attar, who had no financial conflicts of interest to disclose in connection with this study.

This patient—like the others in the study—was distressed by her lesions.