Treating psoriasis with calcipotriol

Early studies are promising

Psoriasis is a chronic and distressing disease of uncertain aetiology which can be hard to treat. There is no cure. Topical measures such as tars and dithranol are of limited effect and acceptability, and steroids, although addictive to both patients and prescribers, have their well known hazards. Oral agents all have side effects and limitations. An obvious gap therefore exists in the armoury of available treatments.

Sunlight and ultraviolet B radiation work in some cases of psoriasis, and their benefits have been attributed to increased production of cholecalciferol in the skin. Treatment of osteoporosis with 1α-cholecalciferol showed improvement in coincidental psoriasis, and one study found that cholecalciferol helped patients with psoriasis. A larger study could not confirm this, possibly because the dose was too small. The problem is that giving a large enough dose to overcome the resistance to the antiproliferative activity of 1,25-dihydroxycholecalciferol in patients with psoriasis carries the risks of hypercalcaemia and calcinuria: hence the search for analogues of cholecalciferol for topical use.

Calcipotriol is one such drug. Early studies have shown that it is at least as effective as betamethasone, if not more so; and it is superior to short term dithranol. Patients seem to like it, and it can be used for up to a year. Further experience of its use has been encouraging, and official approval has followed. A paper in this week’s journal extends its use to pustular psoriasis, which can be very difficult to manage and has an appreciable mortality (p 868). The benefits of calcipotriol are ease and tolerability of use—the cream is colourless and invisible on the skin and does not stain. The lack of colour and smell appeals to patients, many of whom have had bad experiences with tars and dithranol. It clears chronic plaques, at a varying rate, and the benefits usually appear in two to three weeks. Its use on the face is not recommended as it produces soreness in most patients and perioral dermatitis in about 4%. There is little experience of its use on flexures; some patients may not tolerate it. Many patients experience irritation and soreness in both chronic plaques and the normal skin around them, which increases with time. My own experience suggests that discomfort and poor tolerance of calcipotriol occur mainly in three groups: fair skinned patients who burn easily in the sun; patients who have recently had courses of etretinate, which increases skin sensitivity; and patients who have been treated with strong corticosteroids long term.

Although calcipotriol’s makers recommend its use for only six weeks followed by a gap, there are reports of safe use for a year. The discomfort settles quickly when calcipotriol is withdrawn, and it can usually be reintroduced later without problem. Patients need to be careful about exposure to the sun, but so do many patients with active psoriasis. The maximum recommended amount is 100 g a week to minimise the theoretical risk of hypercalcaemia. Calcipotriol is rapidly inactivated, however, and has a much smaller effect on calcium metabolism than 1,25-dihydroxycholecalciferol. Extensive or unstable disease could alter the absorption of calcipotriol, so it is interesting that up to 300 g has been given in 10 days without problem. These doses were given to sick patients in hospital who were being carefully monitored. The theoretical possibility of resorption of bone has not been confirmed clinically. Long term studies may show problems, but as yet the prospects are optimistic and calcipotriol is already widely accepted.

Calcipotriol’s mode of action is still unclear. Proliferation of epidermal keratinocytes (one of the hallmarks of psoriasis) is reduced and terminal differentiation increased. Inflammation is reduced as is the activity of ornithine decarboxylase. This enzyme suppresses proliferating T lymphocytes, probably by inhibiting the production of interleukin-2. This immunological action suggests that calcipotriol may be useful in other conditions, such as its contact dermatitis, skin cancers, and pityriasis rubra pilaris. Trials are also under way in Darier’s disease and the ichthyoses. We will hear more of calcipotriol.

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Learning from “the South”

Oxfam’s call for global professional solidarity

In 1928, on her first day in an African hospital, Cicely Williams vowed to remove “the families clattering the wards and getting in the way of nurses.” Within a week she recognised the folly of the Western practice of separating mothers from their sick infants; yet, despite her tireless campaigning, it took British paediatric practice much longer to learn the same lesson.

Health professionals in developed countries still have lessons to learn from their colleagues in the developing world, and one of the initiatives marking Oxfam’s fifthtieth anniversary should facilitate this. Although Oxfam is targeting British health professionals to remind them of their responsibilities to support health projects for people worse off than themselves, its appeal goes further: it emphasises the need for solidarity between professionals in the global promotion of good health. For various reasons, health staff in developing countries often know more about our health system than we do about theirs; to pursue solidarity we need to learn from their experiences. But what can we learn, and how do we go about learning it?

One starting point is to compare other practices with our own, thereby challenging some of our guiding beliefs. The predominant British perception is that care in developing countries is compromised by a shortage of doctors and is therefore inadequate. The reality is different: in countries where doctors are scarce, paramedical staff provide most of the health care. Suitably trained cadres with adequate resources and support are able to diagnose and treat meningitis [Papua New Guinea], perform caesarean sections [Zaire], give anaesthetics [Kenya], and set fractures [Tanzania]. Far from being incomplete, care is often rational, accorded with protocols, and is free of unproved and unnecessary medical interventions.

How do these models of health care challenge our guiding beliefs? We might question whether we need so many doctors: could paramedical staff provide more health care, improving its quality and efficiency? Turning to what doctors do, could “clinical freedom” not be an excuse for idiosyncratic practice? Could we standardise more of our medical interventions? We might reconsider hallowed medical interventions that we assume mean better care. For example, few developing countries have ever routinely performed episiotomies, pudendal shaving, and enemas during labour—it took western obstetricians and midwives years to realise that these constituted unnecessary medical interference.

Much may be learnt by comparing different approaches to primary health care. Over the past decade or so developing countries have tried to improve health through community participation. As the British system of health care tries to make itself more democratic and responsive to its public health managers could look overseas for guidance. Some of the messages are already clear: community participation may work on a small scale, but generalising the achievements of special projects to national programmes has often been unsuccessful. The experience of developing countries is relevant—if only to prevent the same mistakes being repeated in Britain.

How can global solidarity between health workers be promoted and experiences exchanged so that practice improves in both worlds? Although the question is not new, the right answer remains elusive. Formalised programmes for exchange could lead to vague statements not addressed to anyone in particular or aimless international conferences and visits. It requires people who are willing to question their own practice, to be good observers and analysts, and to have influence on the delivery of health care. People experienced in primary health care are needed from both worlds, and the framework in which they communicate will need a clear focus or objective. For example, common concerns are how to improve the quality of service and how to tailor services towards the needs of users: this could form a common global objective.

Beyond sharing approaches, health professionals are likely to find many common problems. Front line workers are constantly dealing with sickness caused by socioeconomic deprivation and a poor environment; although they can treat illness, it is not a health service’s responsibility to alleviate the underlying causes. Health workers globally need to advocate better health across continents through national government policies, based on a more equitable distribution of resources, and intersectoral action to improve health. Perhaps Oxfam’s anniversary message will hasten the arrival of a united voice.

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