ARC Journal of Dermatology
Volume 8, Issue 7, 2025, PP 11-20
ISSN No. (Online) 2456-0022
DOI: https://doi.org/10.20431/2456-0022.0807002
www.arcjournals.org

Primary Care Approach to Pediatric Psoriasis: A Review of Evidence-Based Management

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Received: 22 August 2025 Accepted: 04 September 2025 Published: 13 September 2025

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Abstract

Although less prevalent than adult cases, pediatric psoriasis can significantly impact quality of life. Despite its chronic, immune-mediated nature and psychosocial consequences, primary care providers (PCPs) remain underutilized in early diagnosis and management. Current evidence indicates a critical need to empower PCPs with knowledge and tools to initiate treatment and reduce reliance on dermatologic transference. This review critically examines the epidemiology, clinical burden, diagnostic challenges, and management strategies of pediatric psoriasis. It evaluates the role of PCPs in early intervention and ongoing care, highlighting effective primary care practices and evidence-based treatment protocols. A comprehensive literature search was conducted across PubMed, Embase, Cochrane Library, and Scopus for studies between January 2000 and March 2025. Eligible studies include pediatric populations (0-18 years of age) and address diagnostic, therapeutic, or management approaches with documented clinical outcomes. A narrative synthesis was then employed to integrate diverse study designs. Two comparative tables summarize the study characteristics and outcomes. Findings reveal an increased prevalence of pediatric psoriasis with notable psychosocial effects and treatment gaps. Topical therapies, including corticosteroids and vitamin D analogs, remain the cornerstone of initial treatment. PCPs demonstrate the capacity to manage mild to moderate cases effectively, improving access and timeliness to care. However, diagnostic uncertainty and limited knowledge persist, often prompting unnecessary dermatologic referrals. Primary care presents a viable, evidence-supported setting for managing pediatric psoriasis. Strengthening PCP education and integrating clinical guidelines can alleviate care delays, optimize outcomes, and reduce psychological burden. Urgent focus is needed to address educational disparities and foster early, accurate intervention.

Keywords: *Pediatric psoriasis, Primary care, Dermatology*

1. INTRODUCTION

Psoriasis is a chronic inflammatory skin condition that can develop at any age, from childhood to adulthood. Although it is more commonly diagnosed in adults, pediatric psoriasis also represents a significant health burden. Psoriasis is a common chronic autoimmune condition that affects approximately 7.5 million to 8 million people in the United States and 125 million individuals worldwide (Jailman, 2024). In a large-scale, retrospective claims-based study conducted in the United States, data from the Truven Health Analytics Marketscan® Commercial Claims and Encounters database, covering over 4.3 million children under 18, was analyzed to determine the prevalence rate in 2015. The overall prevalence of psoriasis in pediatric individuals was 128 cases per 100,000 (95% Confidence Interval (CI): 124-131), with moderate to severe cases accounting for 16 cases per 100,000 (95% CI:15-17). Prevalence was higher among females than males and increased with age, peaking in adolescents aged 12-17 at 205 cases per 100,000 (Paller et al., 2018). Jaliman (2024) found that it affects both genders equally, but there is a higher prevalence observed in adults than in children. The specific reasons for increased incidence in age groups 20 - 30 and 50 - 60 remain unclear, but contributing

factors include alterations in immune function, skin aging, genetic predisposition, and access to healthcare. Genetically, if one or both parents are affected, with a 10% change for a single affected parent and a 50% change for both parents being affected, psoriasis increased by 1 in 3 people (Jaliman, 2024). A higher determining factor is race and ethnicity, with a greater prevalence found among White Americans. According to a 2021 study, the prevalence of psoriasis among adults (20 and older) was as follows: 3.6% whites, 2.5% Asians, 1.9% Hispanics, and 1.5% African Americans. Additionally, diagnostic errors affecting racial and ethnic groups could result in underreporting of cases due to conditions such as eczema or infections being misidentified as psoriasis (Jaliman, 2024).

Salman et al. (2018) propose that psoriasis considerably affects the psychosocial health of children and adolescents. In mild diseases, psoriasis can cause severe impairment in quality of life (QoL) across different areas, including school, interpersonal relationships, and sleep.

This is especially evident in children between 7-18 years of age, where psychological symptoms of anxiety and depression are common. Another study found that almost 36% of children with psoriasis had a moderate to severe impact on QoL, as quantified by the Children's Dermatology Life Quality Index (CDLQI). Furthermore, the chronicity of the disease, indicated by extensive disease course and observable lesions on the skin, increases the psychological burden. The study indicated a positive association between the history of psoriasis and the growing impairment in QoL, especially in the emotional and social dimensions. Depression and anxiety levels were also reported to be higher with more scores on the Children's Depression Inventory (CDI) and the State-Trait Anxiety Inventory for Children (STAIC), indicating the chronic emotional issues that these patients encounter (Baker et al., 2021).

The restricted coping ability in children, coupled with the chronic clinical course of disease, requires a multidisciplinary approach that involves medical management, psychological guidance, and family counseling. This team-based approach is necessary in decreasing the psychosocial burden on children and adolescents, enhancing the physical quality of life in affected children and their families (Salman et al., 2018).

Because of uncertainty in diagnosis, complexity in treatment, and caregiver preference,with the growing utilization of teledermatology and biologics, pediatric primary care physicians refer cases to dermatologists. Reports suggest underconfidence of PCPs and highlight the advantage of specialists' assessment for proper diagnosis and specialized treatment (Carmona-Rocha et al., 2025; Long and Chandran, 2022; Eichenfield et al., 2018). Research indicates that early intervention through diagnosis and treatment by PCPs can reduce severe conditions, creating healthier outcomes. (Herbert et al., 2023;

Young et al., 2017). PCPs are most likely the initial healthcare professionals to see children with skin diseases and play a key role in early diagnosis (Seyger et al., 2022). In addition, treating psoriasis in primary care is more convenient and decreases the time of care (Crowlet et al., 2021; Kang et al., 2021). There is evidence for PCPs utilizing first-line therapeutic agents like vitamin D analogues and topical corticosteroids successfully, optimizing patient outcomes with or without any urgency of referrals to dermatologists (Kim et al., 2017; Beroukhim et al., 2015; Eichnfiel et al., 2018).

2. METHODS

A systematic literature search was used to find studies that were published on pediatric psoriasis, specifically looking at diagnosis, treatment plans, management strategies, and outcomes of treatment. The strategy involved searching major electronic databases such as PubMed, EMbase, Cochrane Library, and Scopus with a publication period from January 2020 to March 2025.

Keywords and Medical Subject Headings (MeSH) included a combination of terms such as: *"pediatric psoriasis," "childhood psoriasis," "psoriasis treatment," "topical therapy," "systemic therapy," "biologics," "diagnosis," "management," "primary care,"* and *"quality of life."*

Studies were included if they met the following criteria: (1) involved participants aged 0-18 years of age, (2) addresses diagnostic criteria, treatment options or disease management specifically in the pediatric population and (3) presented clinical outcomes such as PASI (Psoriasis Area and Severity Index), CDLQI (Children's Dermatology Life Quality Index) and high-quality narrative or systematic reviews were considered. Studies that involved mixed adult-pediatric populations were included only if pediatric-specific outcomes were clearly delineated.

Exclusion criteria included studies focusing solely on adult populations, animal models, or those not reporting clinical outcomes relevant to psoriasis care. A narrative synthesis approach was employed to summarize findings across heterogeneous study designs. This method allowed for the integration of diverse evidence, ranging from randomized controlled trials to expert consensus guidelines and case series, while contextualizing results in light of methodological strengths and limitations. Common themes emerged in studies, such as diagnostic difficulty in primary care, heterogeneity of treatment access and adherence, the rise of biologics in pediatrics, and the impact of disease clearance on quality of life. The results are presented in two detailed tables: one presenting the study characteristics and methods, and the other presenting the quantitative results, efficacy rates, and major conclusions. This systemic format facilitates a comparative perspective of interventions and outcomes across various settings and groups.

Table 1. *Study Characteristics and Methodology*

Study #	Author(s)	Year	Design	Population	Sample Size	Duration/Follow-up	Intervention	Methodology
1	E. Osmancevic et al.	2024	RCT (double-blind, placebo-controlled)	Adults with psoriasis + low vitamin D	121 (60 Vit D, 61 placebo)	4 months	Oral vitamin D3	Random allocation; PASI, SAPASI, DLQI assessed
2	Finola M. Bruins et al.	2018	Prospective cohort	Children with psoriasis	319 patients, 399 episodes	2008–2018	Topical, systemic, biologics	Observational registry (Child-CAPTURE)
3	Haulrig et al.	2021	Review article	Children/adolescents with psoriasis	50 studies	Varied	Topical, systemic, phototherapy, biologics	PubMed literature review
4	Shah KN et al.	2015	Review article	Pediatric psoriasis patients	Not specified	N/A	Adherence strategies	Literature review on adherence
5	Katakam B. Kumar et al.	2021	Clinical guideline	Indian children with psoriasis	98 articles reviewed	2000–2020	Topicals, biologics, CAM	Systematic review + expert consensus
6	Bronckers et al.	2017	Retrospective cohort	Children with moderate-severe psoriasis	390 (203 girls, 187 boys)	1990–2014	Systemic therapy	Multicenter retrospective review
7	Burden-Teh et al.	2021	Diagnostic accuracy study	Children with psoriasis vs. other rashes	330 (170 cases, 160 controls)	2017–2019	Diagnostic criteria assessment	Blinded clinical criteria assessment
8	Patra et al.	2025	Review	Children with psoriasis + AD	Not specified	N/A	Diagnostic + treatment comparison	Review of immuno-pathways
9	Goenaga-Vázquez et al.	2020	Review	Children <12 years	20,000 annual diagnoses	N/A	Pediatric treatment options	Guidelines, trials, reports analysis
10	Hebert AA et al.	2023	Narrative review	Pediatric psoriasis patients	Not specified	N/A	Diagnostic, treatment, support	Expert commentary and literature
11	Ruggiero et al.	2023	Narrative review	Pediatric psoriasis (mod-severe)	Not specified	N/A	Biologics, small molecules	Literature review of systemic tx
12	Napolitano et al.	2016	Review	Pediatric psoriasis patients	Varied	Not specified	Systemic therapies	Literature review (PubMed etc.)

3. RESULTS

Table 2. *Outcomes, Quantitative Data, Findings, Limitations*

Study #	Primary Outcome(s)	Secondary Outcome(s)	Quantitative Data	Key Findings	Limitations / Biases
1	PASI change (−0.34 vs −0.41; *p*=0.52)	SAPASI (*p*=0.30), DLQI (*p*=0.11), PGA (*p*=0.37)	PASI: −0.34±0.98 (Vit. D), −0.41±0.97 (Placebo); SAPASI: −0.50±2.26 vs +0.25±3.96; DLQI: −0.59±3.54 vs +0.10±3.17; 25(OH)D ↑ from 15.1±3.4 to 29.7±5.2	Vit D increased serum levels but no significant clinical improvement	Small sample; short duration
2	CDLQI by PASI/BSA clearance	CDLQI by treatment type	PASI≥90: CDLQI –6.6; BSA≥90: CDLQI –6.8	Higher clearance → better QOL; systemic > topical	Observational, single-center
3	Off-label treatment efficacy	PASI75, adverse events	MTX: 32–40%; Adalimumab: 43.6–57.9%; CsA: 39.4–77%; NB-UVB: 65–93%	Topical, MTX, biologics effective; no pediatric approval	Heterogeneous, small samples
4	Adherence rates	Barriers: forgetfulness, side effects	MEMS cap: 18%–109%	Simplified regimens improve adherence	No pediatric-specific data
5	Evidence-based recommendations	PASI use, comorbidities	N/A	Developed India-specific pediatric guidance	Consensus, not RCT
6	MTX AEs: 48.1%; Biologics AEs: 38.7%	Serious AEs: 6 cases	Age at dx: 8.4±3.7; BMI: 21.8±5.7; Folic acid ↓ GI AEs (*p*<0.01)	TNFi safer; folic acid protective	No efficacy comparison
7	Sensitivity: 84.6%, Specificity: 65.1%, AUC: 0.75	Best model: Sens 76.8%, Spec 72.7%, AUC 0.84	ORs: 2.17–7.89; *p*<0.001–0.091	Identified best predictive signs	Selection bias; needs validation
8	Th17 vs Th2 in PsO vs AD	Diagnostic overlap, biopsy risks	None	Symptoms overlap; biopsy risky in kids	Review only; no data
9	FDA approvals (only 6)	Off-label variability	Ustekinumab: 77% clearance (12w)	Very limited pediatric treatments	Relies on adult data
10	Early Dx, access to tx	Psychosocial support, misdiagnosis	Avg. PsO cost: $2528/year	Early access improves outcomes	No original data
11	Biologic efficacy (PASI)	CDLQI, PsA	Adalimumab: 80–83%; Secukinumab: 87.5%; Ixekizumab: 90%; PASI100: 55.1%; Ustekinumab: 77%	Biologics highly effective and safe	Limited pediatric trials
12	PASI75, safety	QOL, AEs	MTX: 33.3%; CsA: 77.3%; Etanercept: 57%; Ustekinumab: 78.4–80.6%	Systemics effective in kids	No RCTs; case reports only

The table shown employed a range of study designs, such as randomized controlled trials (RCTs), prospective cohorts, retrospective cohorts, and narrative or systematic reviews. A single study (Osmancevic et al., 2024) was a double-blind, placebo-controlled randomized controlled trial that evaluated adults with psoriasis and low vitamin D status with oral vitamin D3 as an intervention. Outcomes were assessed by the Psoriasis Area and Severity Index

(PASI), the Self-Administered PASI (SAPASI), and the Dermatology Life Quality Index (DLQI). Some of the studies were pediatric in nature, and assessments included the Children's Dermatology Life Quality Index (CDLQI), body surface area (BSA) clearance, and the Physician's Global Assessment (PGA). Shared interventions between studies were topical treatments, systemic treatments like methotrexate (MTX) and cyclosporine A (CsA), phototherapy like narrowband ultraviolet B (NB-UVB), and biologic therapies. Complementary and alternative medicine (CAM) was also taken into consideration in guideline-recommended reviews. Diagnostic tests were tested for precision using sensitivity, specificity, and the area under the curve (AUC). The methodological strategies involved expert consensus, blinded evaluation, and registry data (e.g., Child-CAPTURE). Several reviews discussed the overlap of psoriasis with atopic dermatitis (AD), the risk of biopsies in children, and the scarcity of Food and Drug Administration (FDA) approved treatments for children aged less than 12 years. Psychological issues, quality of life (QOL), adherence to medications with Medication Event Monitoring System (MEMS) caps, and preventative measures such as folic acid to prevent gastrointestinal (GI) adverse events (AEs) were also discussed in studies. Tumor necrosis factor inhibitors (TNFi) were consistently tested for efficacy and safety. Odds ratios (ORs), 25-hydroxyvitamin D [25(OH)D] levels, and diagnosis (dx) of age were documented as well. For the most part, the systemic treatments have encouraging results, but shortcomings include small sample sizes, heterogeneity of the data, and absence of randomized controlled trials in pediatric subjects.

4. Data Interpretation

In the pediatric population, psoriasis affects approximately 0.5-1.2% of children and adolescents (Haulrig et al., 2021). Diagnostic sensitivity for clinical criteria is relatively high at 84.6%, but specificity remains suboptimal at 65.1%, contributing to frequent misdiagnosis, such as eczema, tinea corporis, and atopic dermatitis, due to overlapping clinical features (Burden-Teh et al., 2021; Patra et al., 2015). Systemic therapies such as methotrexate (MTX) yield PASI75 responses in 32-40% of patients but are associated with adverse effects in nearly half of users, including gastrointestinal toxicity (24.8%) and transaminitis (13.3%), although folic acid supplementation significantly reduces these risks (Bronckers et al., 2017; Haulrig et al., 2021)> Biologic agents demonstrate superior efficacy: adalimumab achieves PASI75 in 80% of cases within 16 weeks, secukinumab shows PASI90 rates of 75-80% at one year and ustekinumab produces PSI75 in 77% of patients by week 12 (Ruggiero et al., 2023; Goenaga-Vasquez et al., 2020). NB-UVB phototherapy also shows high efficacy with PASI75 rates ranging from 65-93% (Haulrig et al., 2021). In terms of safety, biologics are associated with fewer adverse events than MTX ($p=0.03$), though mild injection site reactions occur in 18.9% of cases; serious adverse events are rare and primarily linked to MTX (Bronckers et al., 2018). Skin clearance correlates with improved quality of life, with PASI greater than or equal to 90 associated with a 6.6 to 6.8 point reduction in CDLQI scores. Systemic treatments offer greater quality of life benefits than topical therapies, even when controlling for PASI outcomes (Bruins et al., 2018). Despite these advances, management remains constrained by limited FDA-approved therapies for pediatric use; only six agents are approved, and substantial reliance on off-label treatments is supported by over 50 studies (Haulrig et al., 2021; Goenaga-Vasquez et al., 2020). Financial burden is considerable, with average annual out-of-pocket costs reaching $2,528 (Herbert et al., 2023). Current evidence confirms the superior efficacy and safety of TNF inhibitors and IL-17/23 blockers over MTX, yet biologics remain underutilized due to access and cost barriers. Early and accurate diagnosis is essential to prevent treatment delays. Importantly, there are no standardized guidelines for pediatric psoriasis, and care remains inconsistent across providers (Katakam et al., 2021). Prompt referral for systemic therapy in moderate to severe cases should be prioritized (Bruins et al., 2018). Overall, pediatric psoriasis is inadequately diagnosed, consistently mistreated, and poorly studied, indicating an urgent need for targeted clinical frameworks and pediatric-specific research investment.

5. Discussion

Pediatric psoriasis remains a complex and under-addressed condition in primary care, where adult-derived evidence continues to dominate therapeutic strategies due to the paucity of pediatric-specific trials. Diagnostically, primary care physicians encounter substantial barriers. Misidentification is common given overlapping features with other dermatoses like eczema or fungal infections, particularly in early or atypical presentations such as inverse or napkin psoriasis. Although Burden-Teh et al. (2021) have

suggested consensus-based criteria with fair sensitivity and specificity, such tools have not been applied in general primary care because they have not been validated or trained. Tools such as PASI and SAPASI are currently not well known and underutilized, hence, there is a subjective assessment mainly based on visual observation and symptomatic complaint. Underuse of these tools is a lost opportunity for early detection and correct triage.

The lack of dermatologic knowledge in the medical education system contributes to the problem. Shadid et al. (2023) observed that pediatric dermatology accounts for less than 10% of U.S. medical education, leaving clinicians unaware of early guttate lesions or nail dystrophies– fine cues of possible systemic evolution. Dermoscopy, clinically very promising to differentiate psoriasis-specific vascular patterns, is seldom employed in primary care due to time limitations, training deficits, and economic considerations. In addition, pediatric psoriasis also substantially varies in clinical morphology, with reduced scaling and increased intertriginous or facial involvement, adding further misdiagnosis and delays often exceeding 12 months. The delays have psychosocial implications that are particularly destructive during these developmental years.

Despite technological progress, there is a stark lack of use of clinical decision support systems (CDSS) in pediatric dermatology. Kuwaiti et al. (2023) note the promise of AI-based models in electronic health records to facilitate real-time diagnostic thinking. Such systems are theoretical at best or restricted to the tertiary care system, continuing to perpetuate systemic limitations imposed on primary care physicians. The diagnostic deficits are thus multifactorial due to undertraining, poor integration of tools, and lack of pediatric-specific algorithms, and need to be addressed with specific interventions to bridge this knowledge and infrastructure gap.

Treatment strategies in primary care frequently start with topical corticosteroids and vitamin D analogs. Yet, their efficacy, particularly for monotherapy, remains contested. Osmancevic et al. (2024) demonstrated that increased serum 25(OH)D levels did not correlate with improved psoriasis outcomes in adults (OR = 0.66, p = 0.37), casting doubt on the utility of vitamin D monotherapy in children, where data is even more sparse. Similarly, adherence to topical treatments is notoriously poor. Corticosteroid phobia, driven by misinformation, undermines treatment consistency. Shah et al. (2015) reported stark differences between self-reported (50%) and electronically monitored (18–109%) adherence, revealing how miscommunication and insufficient education directly impacted the outcomes. These findings underscore the need for simplified regimens and robust patient education, which are often sidelined in rushed primary care settings.

Systemic and biologic agents have more promise for moderate-to-severe disease but are marred by safety and access concerns. Methotrexate (MTX) and NB-UVB phototherapy are both effective in children, with 32–40% and 65–93% PASI75 responses, respectively (Haulrig et al., 2021). MTX is not without marked toxicity, however, 48.1% of children's side effects were primarily gastrointestinal upset (OR = 11.49, $p < 0.001$), based on Bronckers et al. (2017). Folic acid supplementation offers a statistically significant reduction in toxicity (OR = 0.16–0.21, $p < 0.01$), and thus it is an essential add-on to MTX therapy.

Nevertheless, systemic monitoring is underprioritized in primary care, where low awareness of potential complications like infection risk due to TNF inhibitors exists. Gerriets et al. (2023) reported a 10% infection rate using TNF inhibitors, although their safety profile remains superior to MTX in the majority of cases. Primary care physicians need to be able to manage such risks, using prophylactic measures such as folic acid supplementation and repeated infection screening to maximize long-term results.

Biologic therapies such as adalimumab, ustekinumab, secukinumab, and ixekizumab demonstrate striking efficacy in pediatric populations. Ruggiero et al. (2023) and Napolitano et al. (2016) have reported PASI75 response in greater than 75% of cases with adalimumab and ustekinumab. Secukinumab attained PASI90 in a highest of 80%, and ixekizumab reached complete skin clearing (PASI100) in 55.1% by week 108. Despite these promising findings, widespread use is prevented by a myriad of things: only three biologics are FDA-approved for pediatric use; off-label use persists by necessity rather than preference; and cost is a substantial obstacle. Hebert et al. (2023) noted that mean annual out-of-pocket costs are $2,528—an amount unaffordable for many families.

Furthermore, injection avoidance by children and parents can compromise adherence, even where biologics are clinically appropriate.

Restrictions on access are also enhanced by regulatory loopholes and shortages of country-level treatment guidelines. Regional efforts, such as those of Katakam et al. (2021) in India, are an example of context-relevant guidelines. Their guidelines, established through 98 studies and expert consensus, include topicals, phototherapy, systemic medications, and CAM with emphasis on PASI scoring and comorbidity screening.

Though lacking statistical outcomes, the regional specificity makes them particularly relevant for primary care, where imported guidelines often fall short due to population and resource discrepancies. The absence of such contextualized frameworks in other regions underscores the need for similar efforts globally. Quality of life (QOL) considerations remain underrepresented in pediatric psoriasis care, especially in primary care settings. Bruins et al. (2018) found strong associations between high levels of skin clearance (PASI and BSA >90%) and significant improvements in CDLQI scores (−6.6 to −6.8). Perhaps most important, systemic therapies were associated with favorable QOL outcomes regardless of clearance status. The impact of these effects is often overwhelmed by brief consultations in the clinic setting. Bullying, social withdrawal, and self-esteem issues are rarely addressed, even though they play a significant role in a child's overall health. This failure signals an underlying lack of provider education and a need for psychosocial integration within current management.

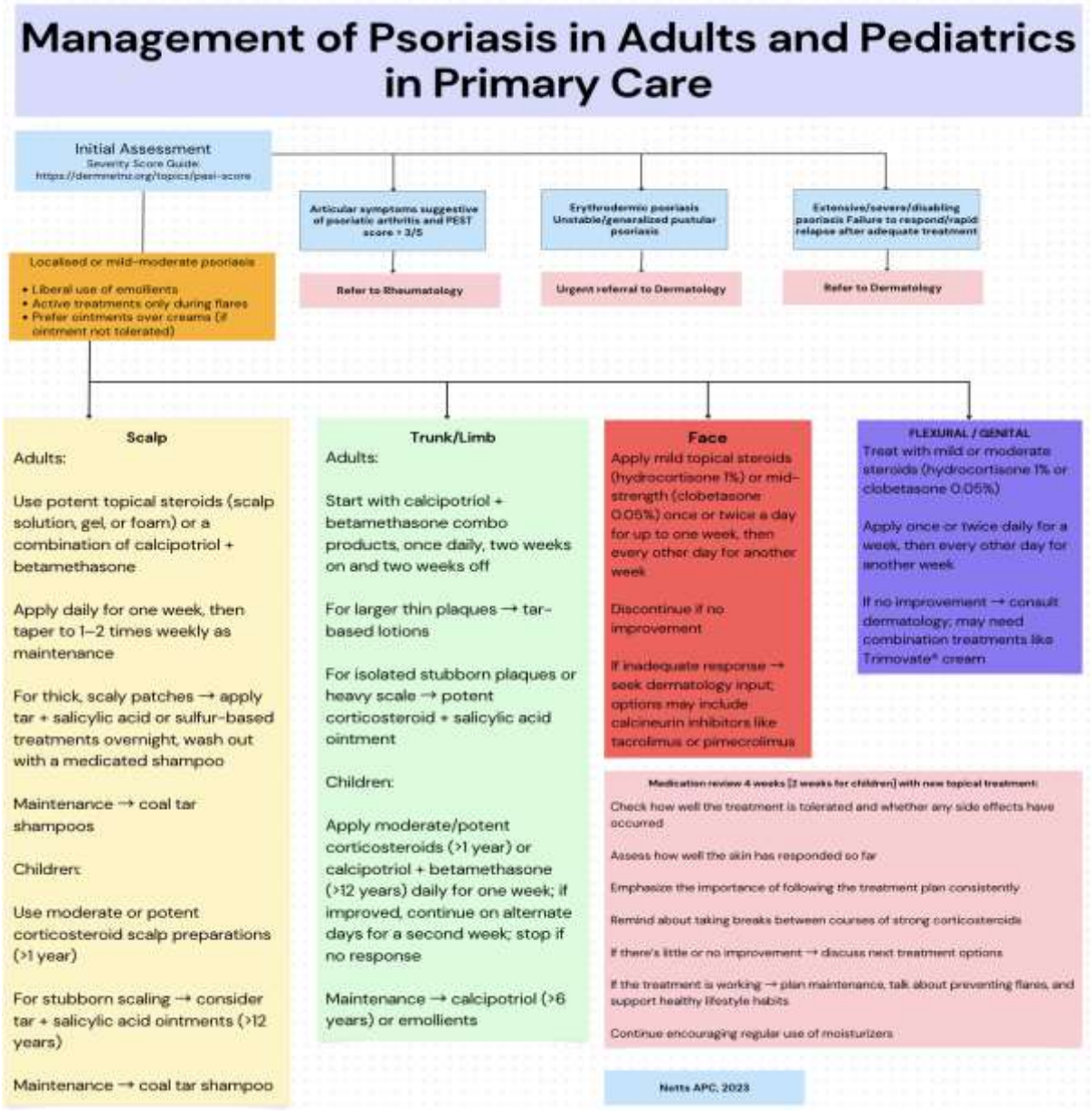

Figure 1. *Management of Psoriasis in Primary Care Flowchart*

Recent work by Patra et al.(2025) shows the importance of the correct differentiation of pediatric psoriasis from mimics like atopic dermatitis, given the similar presentation and divergent immunopathology– Th17/IL-23 in psoriasis versus Th2/IL-4/IL-3 in atopic dermatitis. Their work shows the value of non-invasive testing with the potential for innovation and future guideline optimization. Moreover, diagnostic accuracy will have to be complemented with a holistic approach in psychological, educational, and financial fields to provide fair and effective care. Primary care's role in the management of pediatric psoriasis is crucial but ever facilitated by structural, educational, and systems limitations. The PCP faces a web of challenges at every stage, often with limited resources to guide decision-making.

Increasing precise diagnosis with good, accessible standards and better education, simplifying and demythologizing treatment to improve patient compliance, and encouraging affordable and safe systemic and biologic drugs are changes necessary for healthier outcomes. Addressing the problems associated with the psychosocial burden of the disease and incorporating quality-of-life considerations into standard care programs can aid in treatment regulations. Closing these gaps required interdisciplinary cooperation, technological integration, region-specific policies, and most importantly, the reform of health policy in prioritizing child-specific dermatology care.

6. Conclusions

Primary healthcare professionals play an essential part in the early recognition and management of psoriasis in children. Evidence suggests that empowering PCPs with the most current clinical advice, triage, and necessary tools can create positive outcomes in this population. The use of topical agents in the management of mild to moderate cases treated in primary care, can promote increased access to care, resulting in decreased psychosocial distress. Enhancing PCP training, streamlining referral procedures, and integrating comprehensive care are necessary to counteract diagnosis uncertainty and emotional strain.

A strengthened primary care system ensures equitable, effective, and child-centered psoriasis care, eliminating long-term complications and improving general well-being in the pediatric population.

List of Abbreviations

AD = atopic dermatitis; CAM = complementary and alternative medicine; CI = Confidence Interval; DLQI = Dermatology Life Quality Index; NA = not available; PASI = Psoriasis Area and Severity Index; PCP = Primary Care Provider; RCT = randomized controlled trial; TNF = Tumor Necrosis Factor.

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Citation: *Mustafa I. Ansari, et al. Primary Care Approach to Pediatric Psoriasis: A Review of Evidence-Based Management. ARC Journal of Dermatology. 2025; 8(7):11-20. DOI:https://doi.org/10.20431/2456-0022.0807002*