© July 2024| IJIRT | Volume 11 Issue 2 | ISSN: 2349-6002

A Case of Psoriasis and Its Homoeopathic Treatment

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Psoriasis is a non-infectious, chronic inflammatory disease of the skin, characterised by well-defined erythematous plaques with silvery scale, with a predilection for the extensor surfaces and scalp, and a chronic fluctuating course.

There appear to be two epidemiological patterns or types of psoriasis:

- 1st shows the onset in the teenage and early adult year. Such individuals frequently have a family history of psoriasis and there is an increased prevalence of HLA Cw6.
- In 2nd pattern disease onset is in the fifties or sixties, a family history is less common and the HLA Cw6 is not so prominent.

HISTORY OF PSORIASIS

As with other medical conditions, the understanding of psoriasis has changed over time. Psoriasis likely affected the earliest humans, but it was not until the 1800s that doctors recognized it as its own condition.

In Ancient Greece, Hippocrates (460–377 B.C.E.) described inflammatory skin conditions, including psoriasis, using two words: "psora," meaning itch, and "lopoi," describing dry, scaly skin.

Centuries later, in the Roman Empire, a nobleman named Cornelius Celsus (25 B.C.E.–50 C.E.) described a skin condition affecting the skin and nails. The grouping of skin conditions did not end for several centuries. During the Middle Ages, people with psoriasis shared the same treatment- essentially being cast out from society, as people living with leprosy.

During the Renaissance, an Italian named G. Mercuriale (1530–1606) wrote a book on skin diseases and described psoriasis as a skin condition called "lepra grecorum."

In 1809, an English doctor named Robert Willan (1757–1812) produced a simple diagnostic description of several skin conditions, including psoriasis. He also defined some psoriasis types, including guttate, scalp, and palmar psoriasis. However, in his description, he used the term lepra vulgaris.

Throughout the rest of the 1800s into the 1900s, doctors continued to describe and refine what they knew about psoriasis.

Researchers today understand that psoriasis is more than just a skin disease. It is a chronic autoimmune disorder that causes systemic inflammation. This newer understanding has helped shape modern medical treatments, including the use of biologics.

PSORIASIS, MODERN VIEW

AETIOLOGY

Basic defect

There are two key pathophysiological aspects to the abnormalities in psoriatic plaques:

1. Keratinocytes hyperproliferate with a grossly increased mitotic index and an abnormal pattern of differentiation involving the retention of nuclei in the stratum corneum.
2. There is large inflammatory cell infiltrate comprising polymorphs, T cells and other inflammatory cells.

Precipitating factors

- Trauma:

When the condition is erupting, lesions appear in areas of skin damage such as scratches or surgical wounds (koebner phenomenon)

- Infection:

Beta hemolytic streptococcal throat infections precede guttate psoriasis.

- Sunlight:

Rarely, UV rays worsen psoriasis

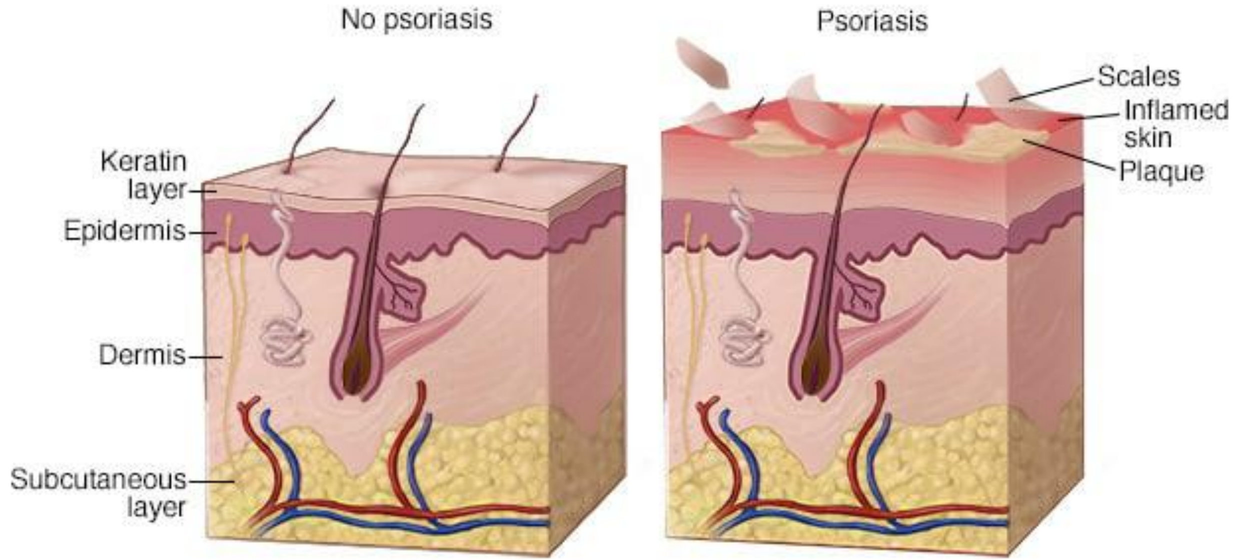
- Drugs:

Antimalarials, beta blockers and lithium may worsen psoriasis and the rash may 'rebound' after systemic corticosteroids or potent local corticosteroids are stopped.

- Emotion:

Anxiety precipitates some exacerbations.

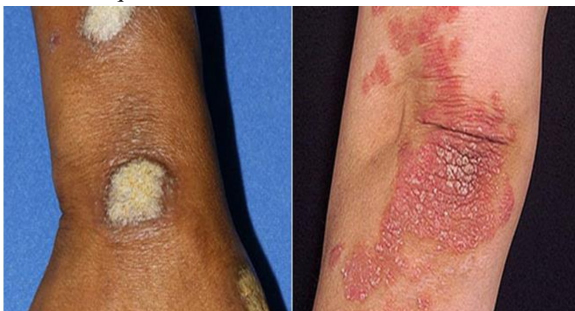
PATHOPHYSIOLOGY



The pathophysiology of psoriasis is multifactorial and involves epidermal hyperproliferation, abnormal differentiation of epidermal keratinocytes, and inflammation with immunologic alterations in the skin. The hyperproliferation is characterized by increased DNA synthesis and a markedly decreased turnover rate for the epidermis. Abnormal keratinocyte differentiation involves increased expression of certain keratins (6 and 16) and a delay in expression of other keratins (1 and 10) that are expressed in normally differentiating skin. Inflammation results from an infiltrate of neutrophils in the epidermis and superficial dermis and an infiltrate of T lymphocytes in the dermis with a predominance of CD8+ cells.

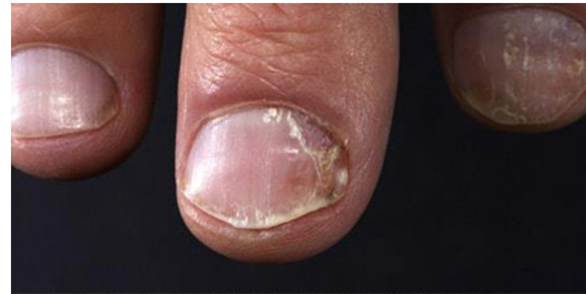
CLINICAL FEATURES

Stable Plaque Psoriasis:



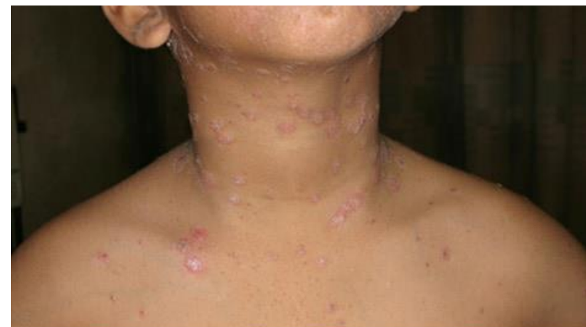
Plaque psoriasis

This is the most common type. Individual lesions are well demarcated and range from a few millimeters to several centimeters in diameter.the lesions are red with dry silvery white scale, which may be obvious after scraping the surface. The elbow, knees,and lower back are commonly involved, also occur on scalp, nails, flexures and palms etc.



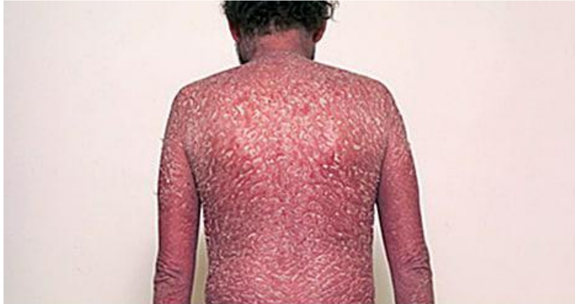
Nail psoriasis

Guttate Psoriasis:



This is most commonly seen in children and adolescents and may follow a streptococcal sore throat. The rash often appears rapidly. Individual are droplet-shaped, small(seldom greater than 1 cm in diameter) and scalybouts of guttate psoriasis may clear in few months but respond well to early treatment with phototherapy. The majority of these patients will develop plaque psoriasis later in life.

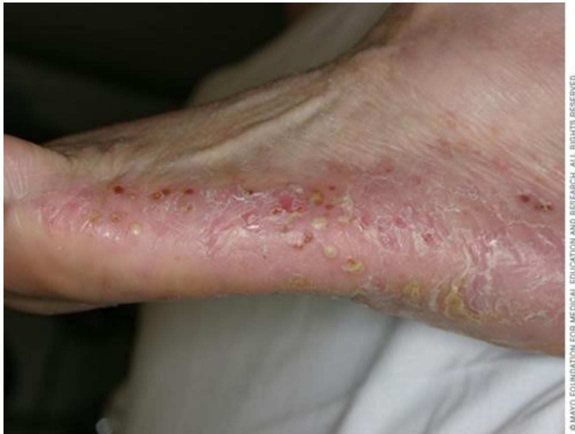
Erythrodermic Psoriasis:



Erytrodermic psoriasis

The skin becomes universally red or scaly, or more rarely just red with very little scale present. As in other forms of erythroderma temperature regulation becomes problematic with a danger of either hypothermia or hyperthermia developing.

Pustular Psoriasis:



There are two varieties of pustular psoriasis:-

The generalized form is rare but serious. The onset is usually sudden with large numbers of small sterile pustules erupting on a red base. The patient may rapidly become ill with swinging pyrexia coinciding with the appearance of new pustules.

The localized form is more common which primarily affects the palms and soles. This eruption is chronic and comprises small sterile pustules which lie on a red base, and resolve to leave brown macules or scaling on their wake.

INVESTIGATION

- Biopsy seldom necessary when there is genuine doubt in d/d psoriasis and eczema of the palms and soles.
- Throat swab for streptococcal infection
- Rheumatological investigations for joint symptoms.

GENERAL MANAGEMENT OF PSORIASIS

Explanation, reassurance and instruction are vital but neglected; they must be based on insight into the patient’s state of mind. No two patients, even with identical pattern of psoriasis, have the same experience of disease. Certain factors viz. alcohol, stress etc having little evidence to support the association with the disease, should be cared for. What is clear is that doctors need an awareness of the impact that this disease can have on many individuals.

TREATMENT

Treatment can be classified in four broad categories:

- Easily applied topical agents such as emollients, corticosteroids, vitamin D agonists, or weak tar or dithranol preparations.
- Ultraviolet therapies such as Psoralans Ultraviolet A(PUVA) and Ultraviolet B (UVB)
- Systemic agents such as retinoids or immunosuppresssives such as cyclosporine, or one of a range of new biological therapies (TNF-alpha and receptors involves in T cell trafficking etc but very expensive).
- Intensive inpatient or day- patient care with topical agents and under UVR under medical supervision.

HOMOEOPATHIC VIEW

In homoeopathy psoriasis is classified as natural miasmatic chronic disease with miasmatic status as

Psora ++

Sycosis +++

Syphilis +

The relapsing nature of the disease shows the involvement of tubercular miasm also.

Thus for the best results the selection of the remedy should be done on the basis of symptom similarity as well as the dominant miasm in the case.

CASE OF PSORIASIS

A male patient Mo. ABC aged 46years,lean thin emaciated, presented in the OPD with complaint of dryness of skin with desquamation in irregular spots on the extremities, trunk, back and scalp with severe itching that was aggravated at night preventing sleep and change of weather and winters since 20 years.
Personal, past and family history was insignificant. He was a vendor. His skin condition hampered his business as the skin looks bad. The itching got worse on exposure to heat and from sweat. He got relief from open air.
CVS, RESPIRATORY SYSTEM, GIT, URINARY and other systems- NAD

On the basis of symptoms and presentation of complaints patient was diagnosed as suffering from Guttate Psoriasis tending to be Stable Plaque Psoriasis.

Classification of Symptoms:
Desquamation of skin (Pathological general)
Eruptions with itching (Pathological general)
Aggravation, night(General modality)
Aggravation, winter (common disease symptom)
Aggravation, heat (General modality)

Totality of Symptoms:
Desquamation of skin
Eruptions with itching
Aggravation, night
Aggravation, heat
Aggravation, winter
Selection of Repertory: As the case presented with pathological generals and modalities, the case was repertorized with BBCR.

Repertorial totality:

S.N.	Symptoms	Reason	Rubric	Pg no.
	Desquamation of skin	Pathological general	SKIN AND EXTERIOR BODY- Desquamation	949/L
	Eruptions with itching	Pathological general	SKIN AND EXTERIOR BODY-Itching, eruption	959/L
	Aggravation, night	General modality	CONDITIONS IN GENERAL, TIME- Night	1104/L
	Aggravation, heat	General modality	AGGRVATION AND AMELIORATION IN GENERAL- Sun (heat of) in the agg	1144/R

Repertorial Result: Puls 11/4; Sulph 11/4; Acon. 10/4; Bell 10/4; Graph 9/4; Ant. Crud 9/4; Calc. 8/4; Ars. 7/3; Iod. 7/3

Miasmatic consideration: syco-psoric miasm with tubercular background.

PDF: after consulting the material medica Ars. iod. is selected for the case.

Selection of remedy and doses: as disease is chronic and patient is tubercular constitution. Ars iod 30 minimum dose selected.

Prescription and Follow Up:
Rx
Ars. iod 30 was given to the patient in minimum doses. He showed improvement. In the follow up signs of improvement continued with the same remedy. Intercurrent Tuberculinum 1M was administered.

REMARKS

As the remedy covered the symptoms as well as the miasm, it just suited to the constitution with the minimum doses therefore minutest homoeopathic aggravation reported with improvement in the follow up. The eruptions in the lower extremities were the first to disappear and that on the scalp were the last.
He though suffers minor appearance of eruptions here or there in change of weather that disappear within 2-5 days with SL or the indicated remedy. Patient is considered as cured.