PSORIASIS

-Multi factorial

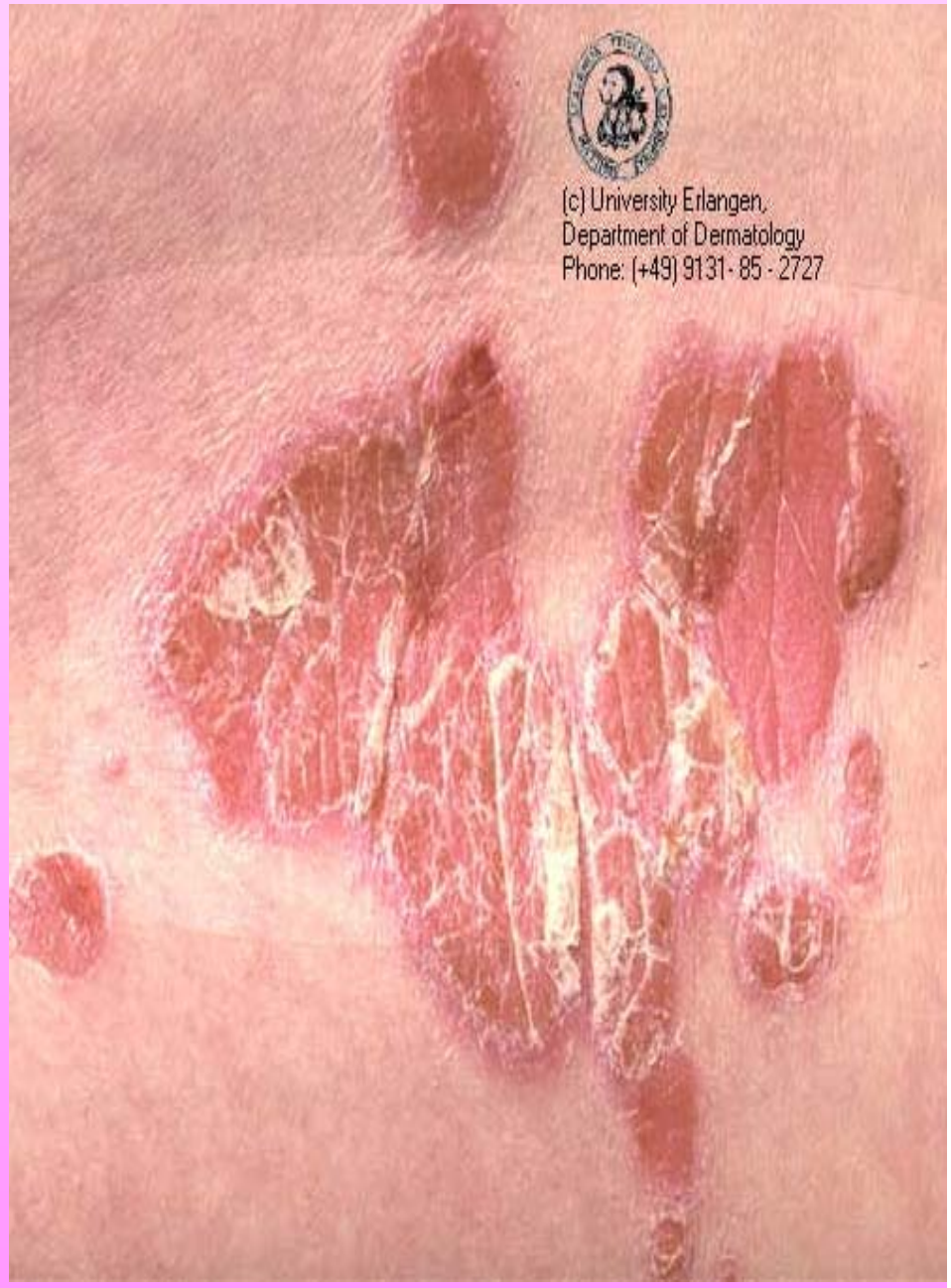
-Papulosquamous disorder

-Genetically determined (few)

-Chronic Scaly lesions

-Seasonal variations

-Recurrences & remissions



Etiology & Pathogenesis

T-cell mediated autoimmune disease

-Early onset – Hereditary
– HLACW6

-Late Onset – Non inheritable

Genetic Predisposition

- Multifactorial
- Familial aggregation
- HLA B13, HLA B17, HLACW6

PREDISPOSITION

-Familial

- Risk 3 times – one parent

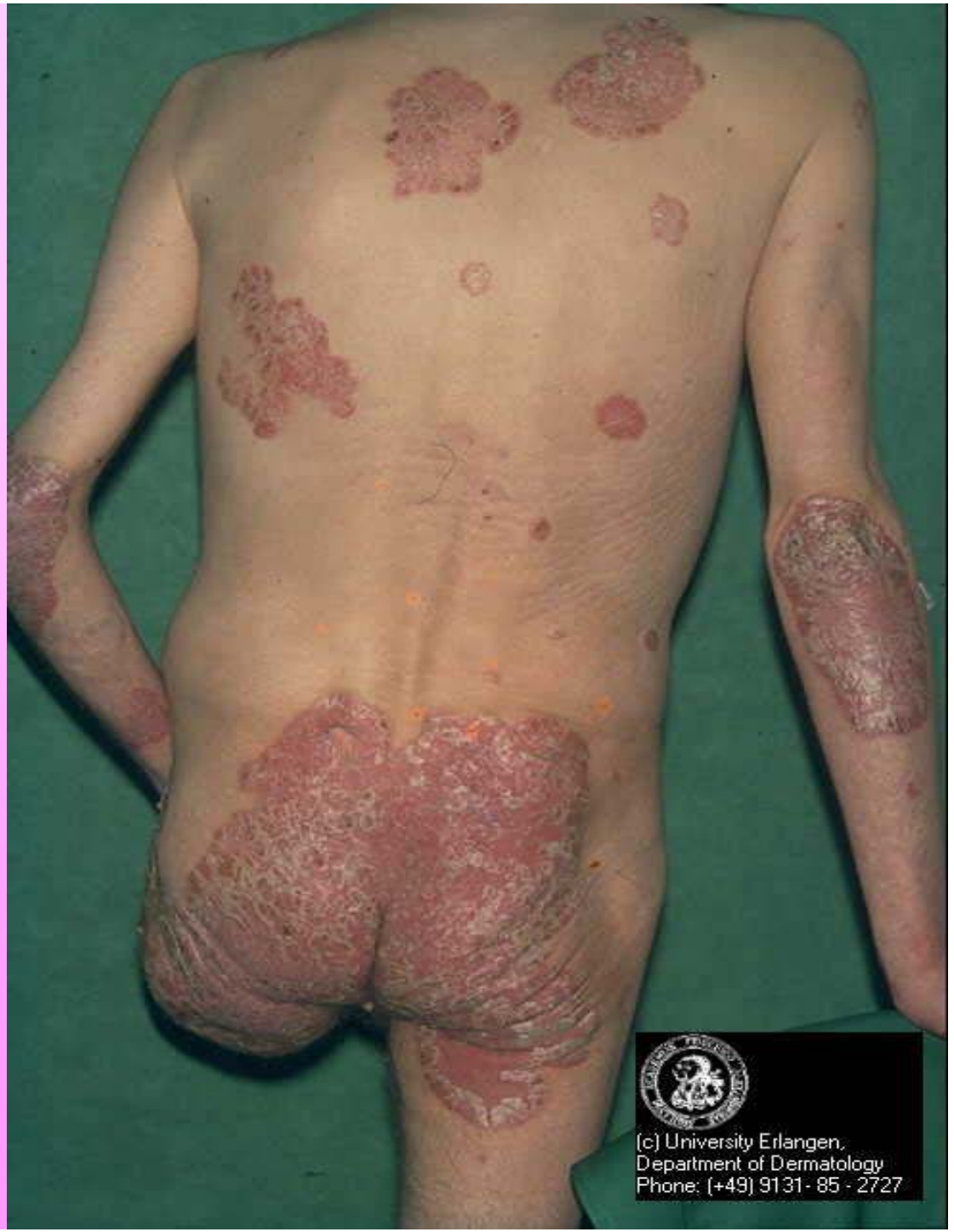
-60% children – both parent

-Genetic

-Autosomal dominant

-Twin heritability - 90%

-HLA B_{13} B_{17} B_{27}



PROVOKING/PRECIPITATING FACTORS

-Predisposed individual

-TRAUMA

(Isomorphic/Koebner's phenomena)

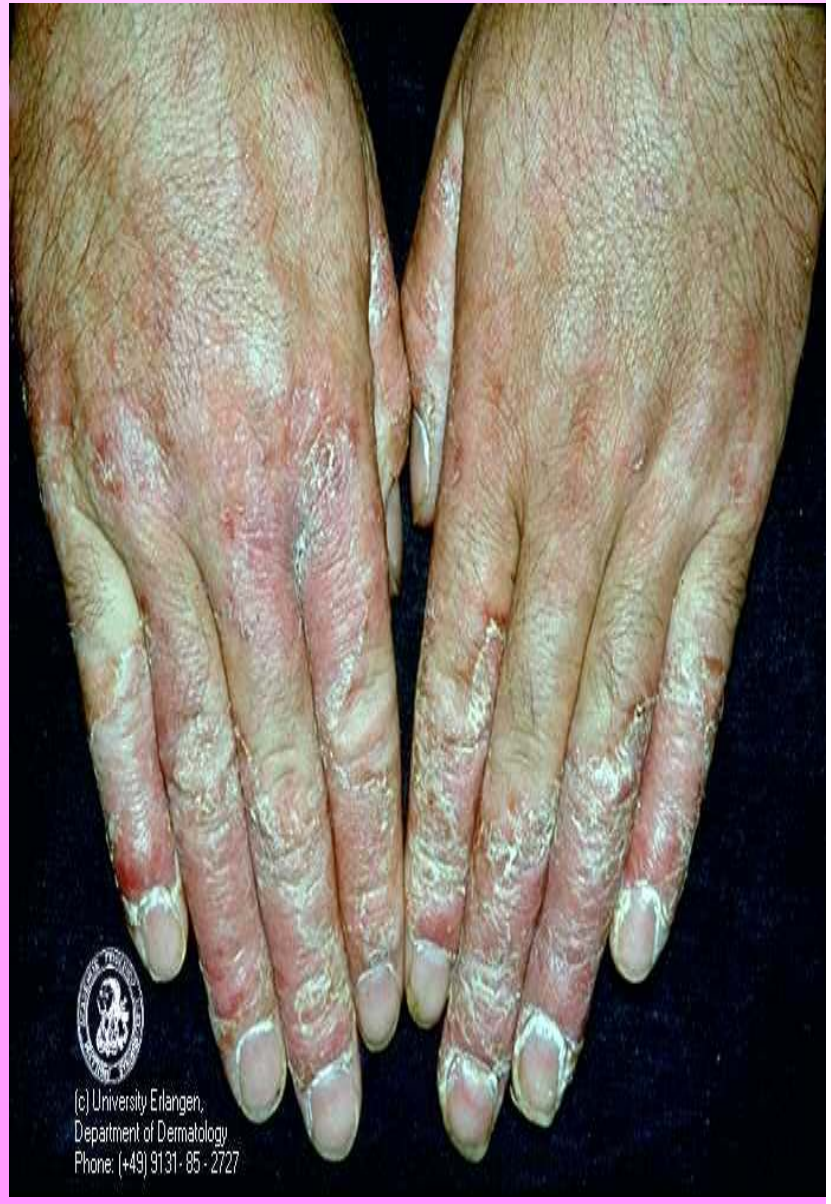
-INFECTION

(Streptococcal – Guttate Psoriasis)

-PREGNANCY(Pustular Psoriasis)

-CLIMATE : Summer ↓ ,Winter ↑

-HYPOCALCEMIA



Drugs

-Anti malarial

-B-Blockers

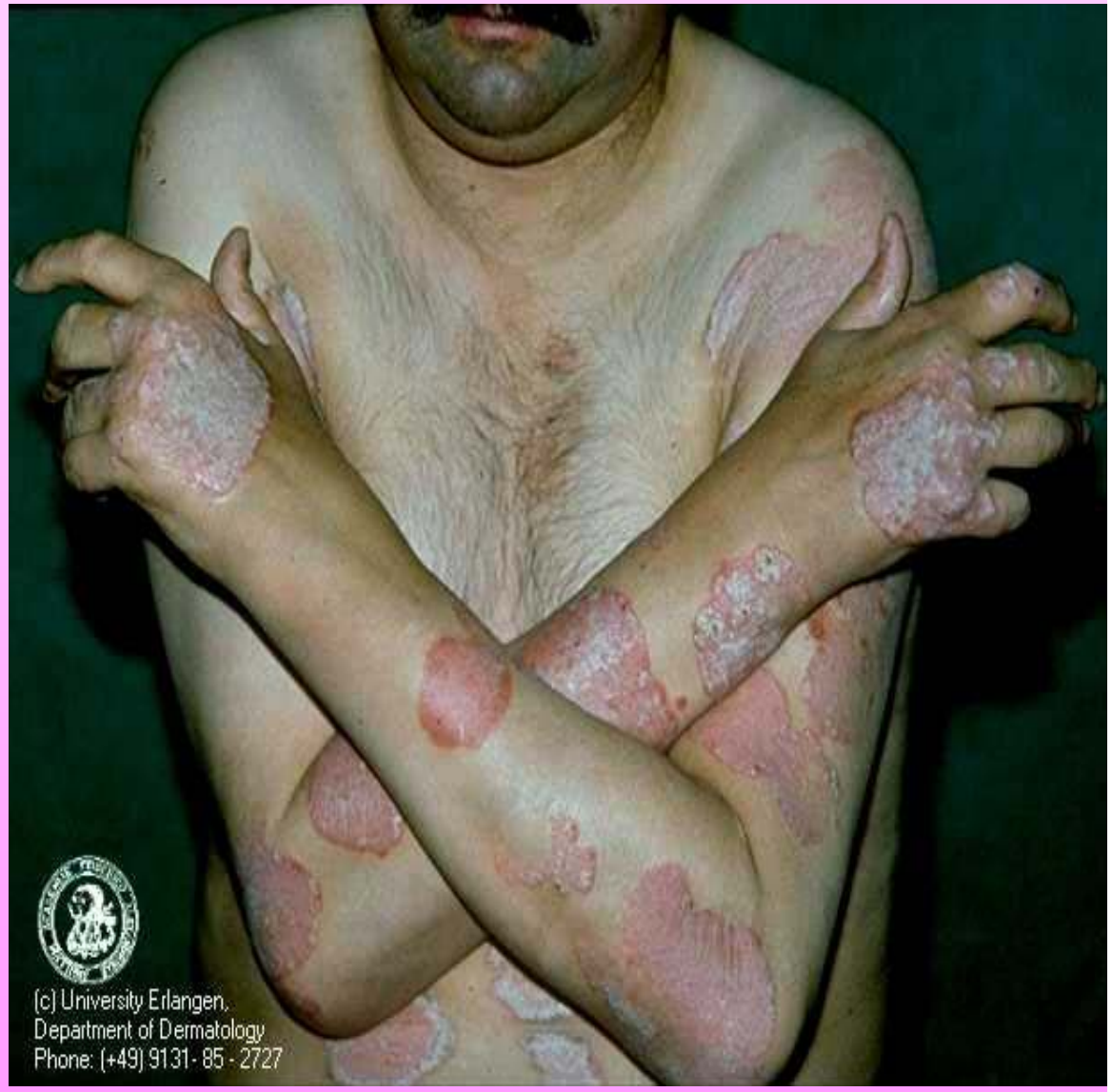
-Lithium

-High dose steroid

(sudden withdrawal)

Psychogenic factors

Dialysis



Mechanism of Proliferation

↓ Cell cycle time

Basal epidermis – cycling & resting cells

↑ Recruitment of cycling cells

↑ Growth fraction

Accelerated epidermopoiesis

HISTOPATHOGENESIS

Accelerated epidermopoiesis- Main feature

Parakeratosis**-** Nucleated cells in s.corneum

Absence of granular layer

Presence of PMNL

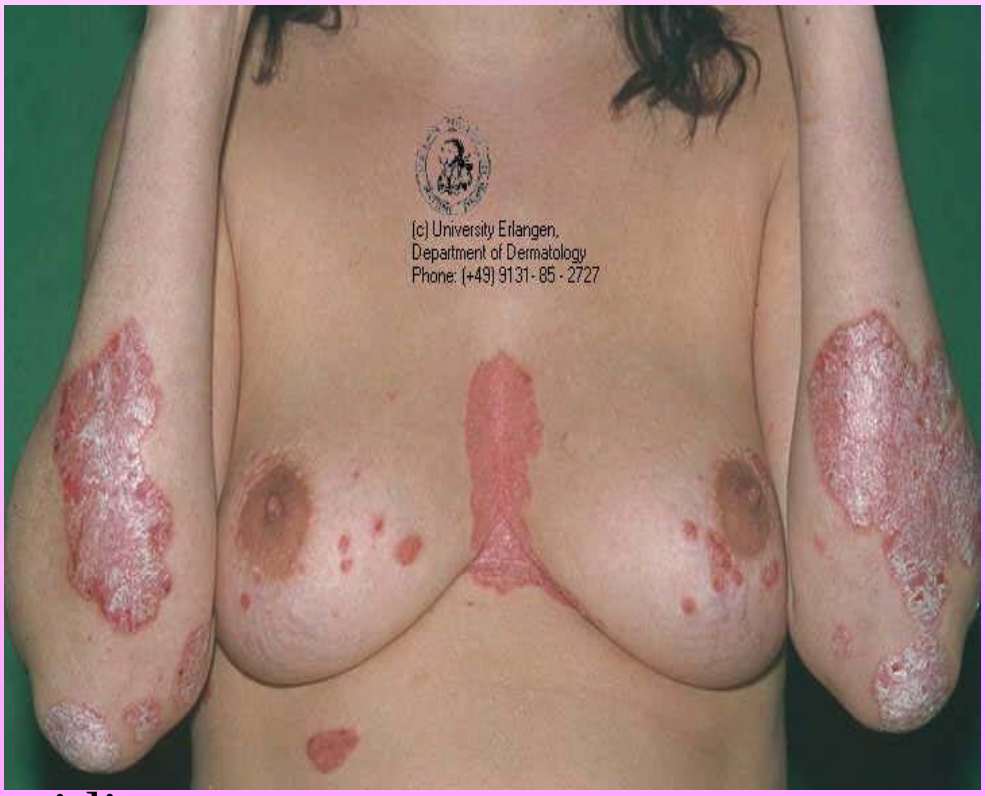
Intradermal abscess of PMNL

- Spongiform pustules of Kogoj

- Munro microabscesses

Mechanism

Immunological disease



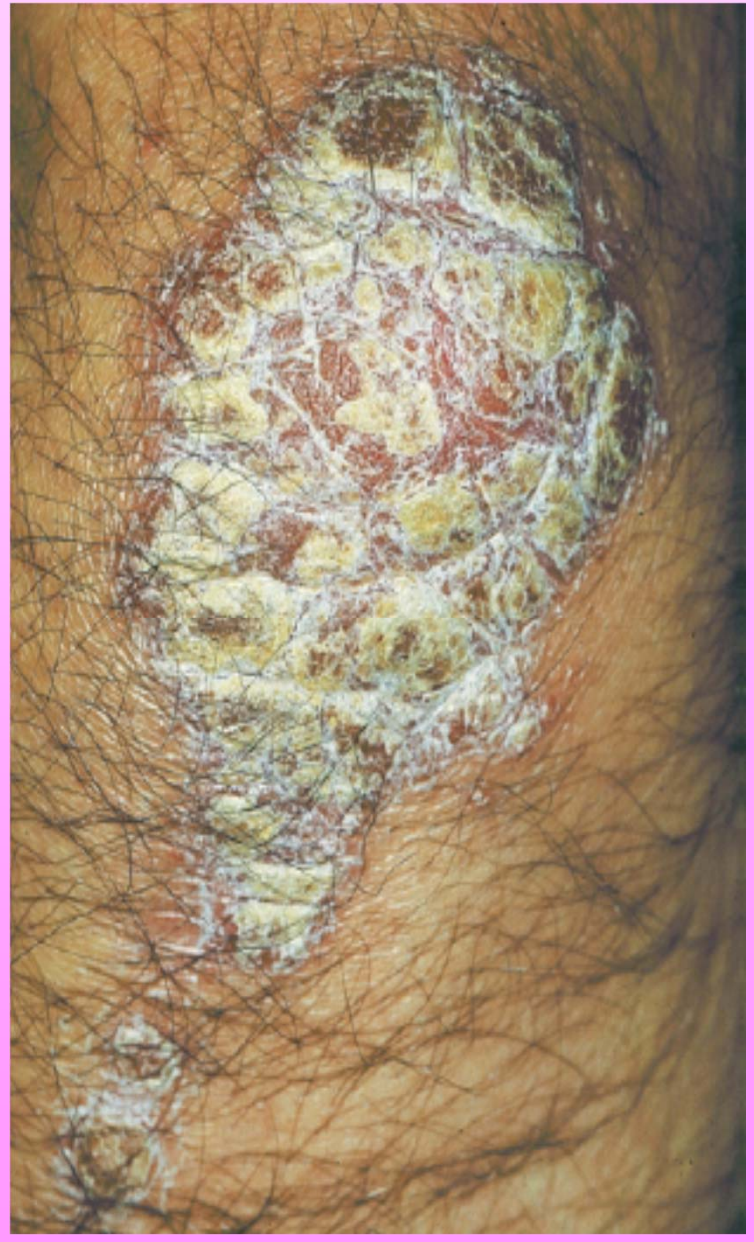
- Cyclic AMP ↓ ,Cyclic GMP ↑
- Arachidonic acid & by products like PG (HETE), Leukotrienes
- Polyamines : Putresine & spermidine
- Proteinase activity ↑
- Interleukins
- Activity of PMNL↑, Langerhans cells, monocytes

- **HPE : Variable**
- Acanthosis
- Parakeratosis, absence of granular layer
- Elongation of rete ridges
- PMNL infiltrate in dermis
- Munro’s micro abscess (epidermis)

Clinical Features

Both sexes equally affected
Females earlier

Age of onset – 16-22 years
– 57-60 years



PSORIASIS VULGARIS

-Both sexes,

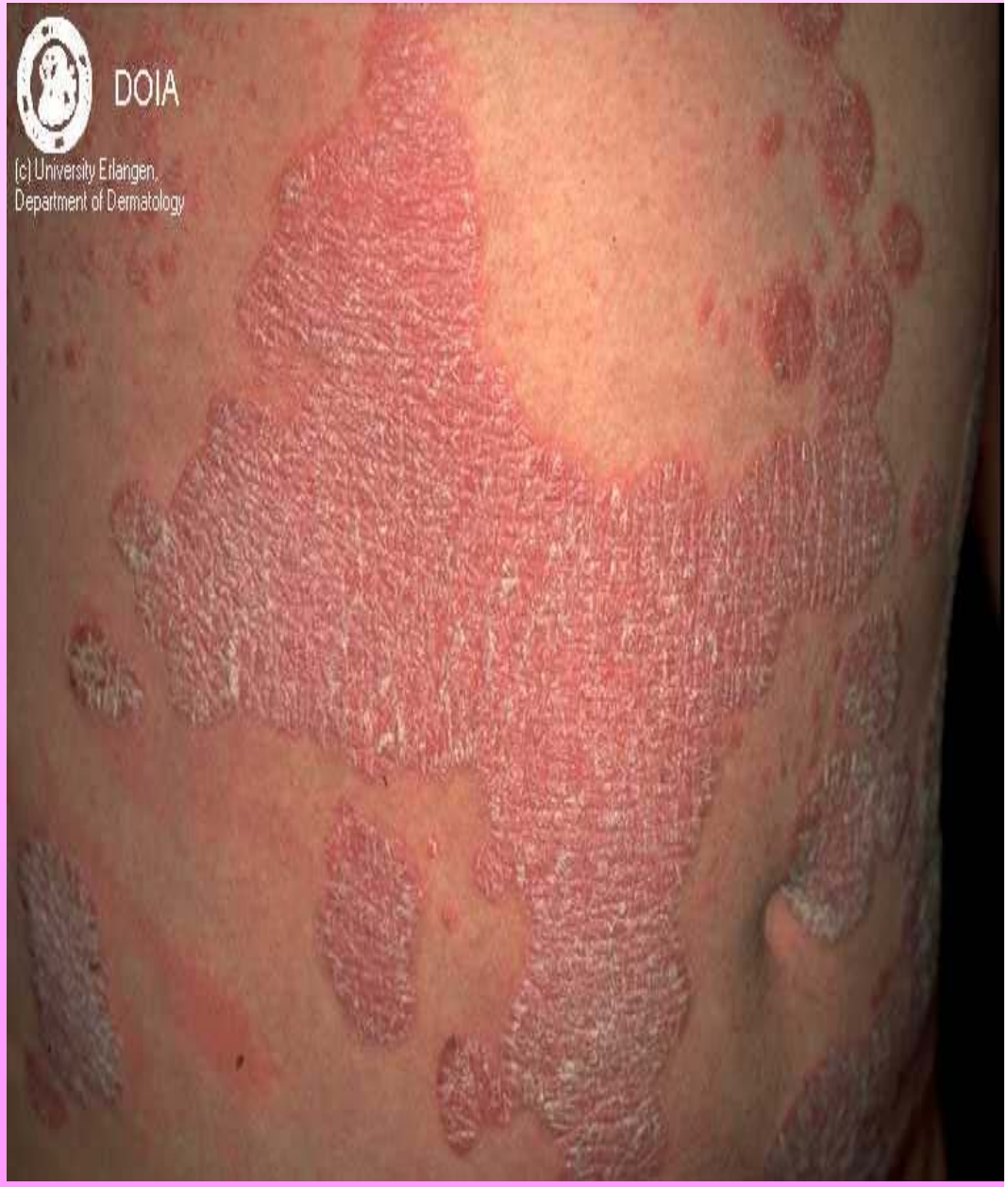
-All ages (20-40 years)

Clinically

–Extensors, palms, soles, scalp

–Well defined lesions

–Scaly plaques , papules



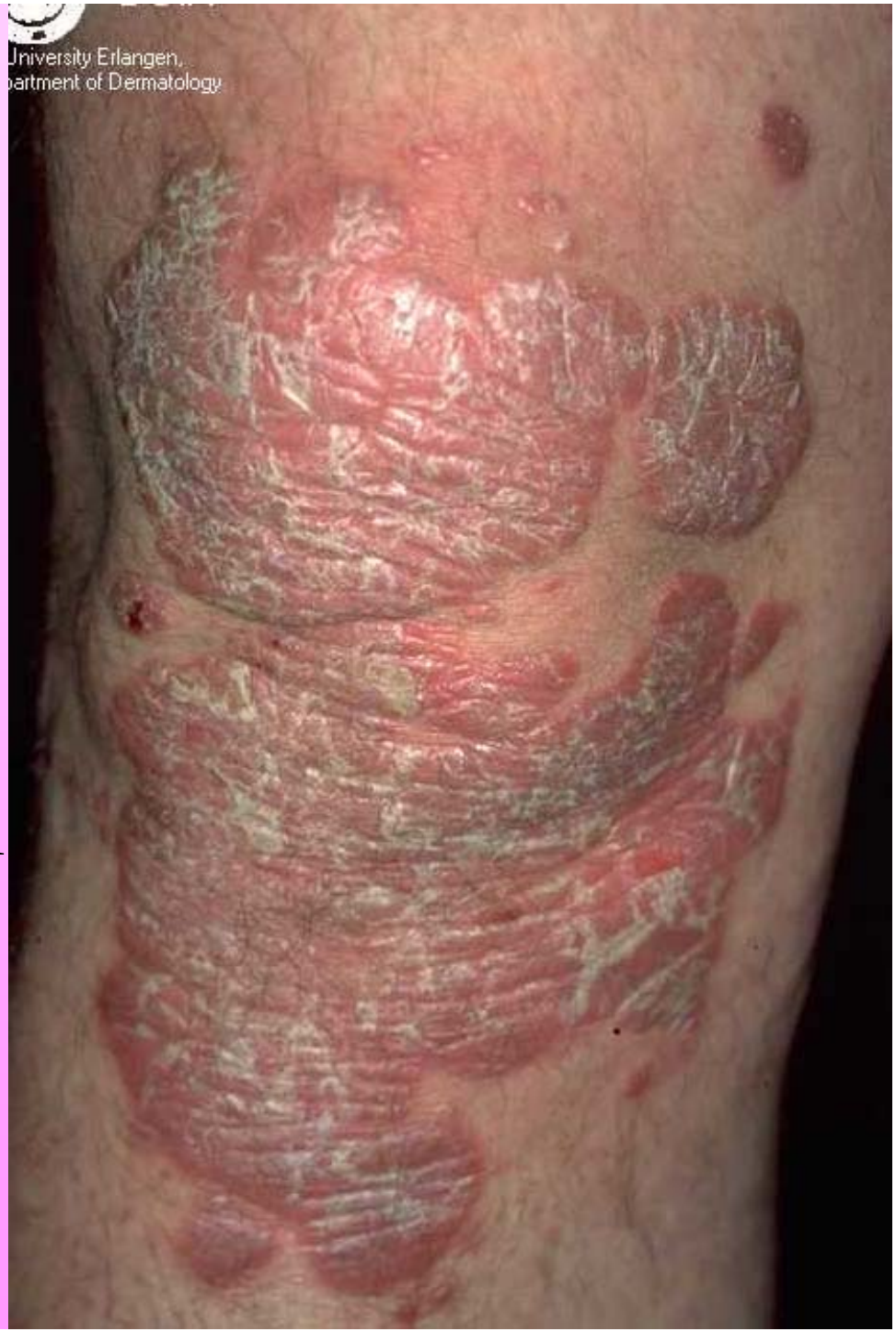
Characteristic sign

- Easily removable silvery scales

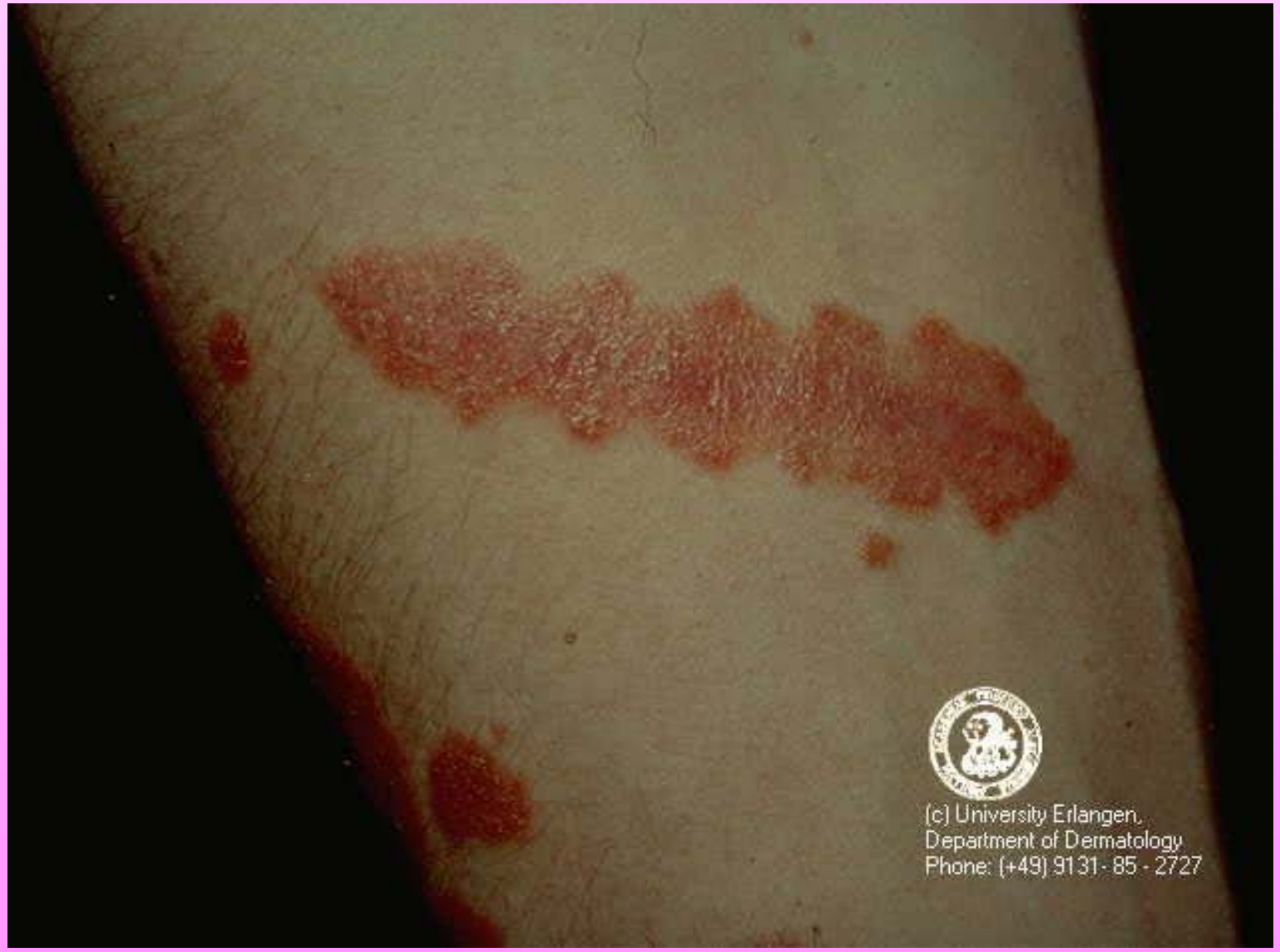
GRATTAGE SIGN

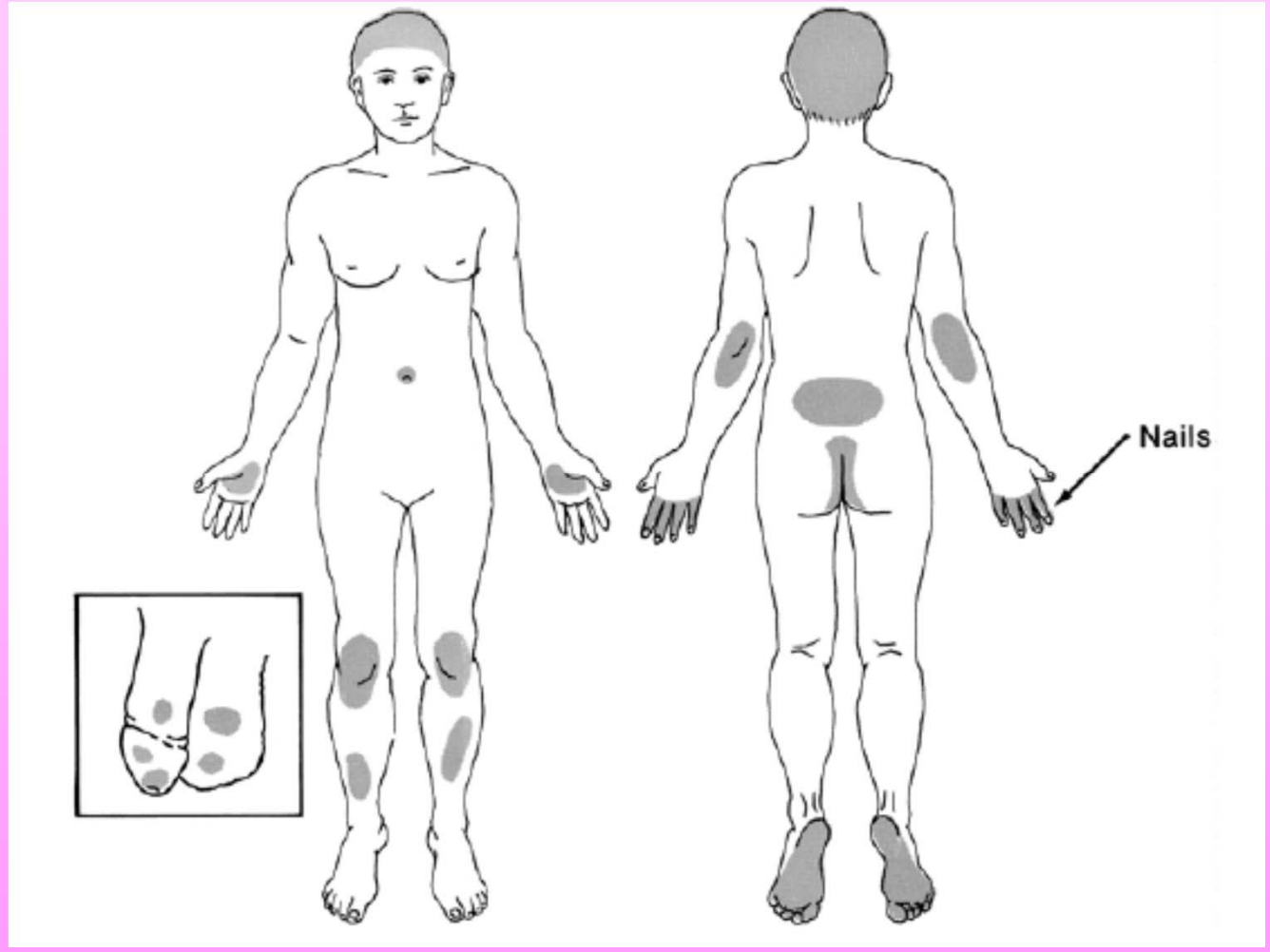
AUSPITZ SIGN

- Halo of Woronoff-clear peripheral zone



- Koebner phenomena present



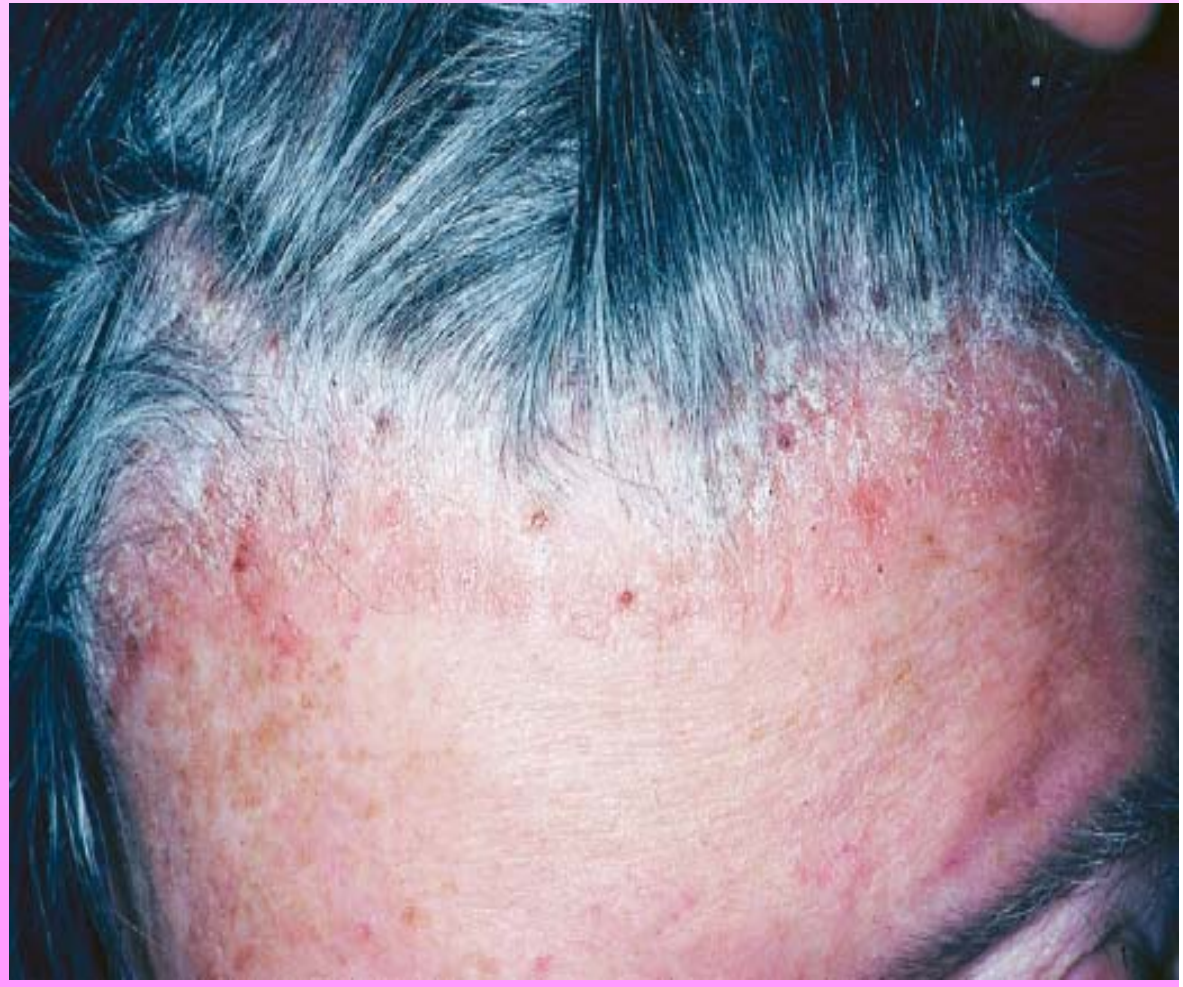

Nails

Modification by site

- **Scalp**

-Asbestos like scaling

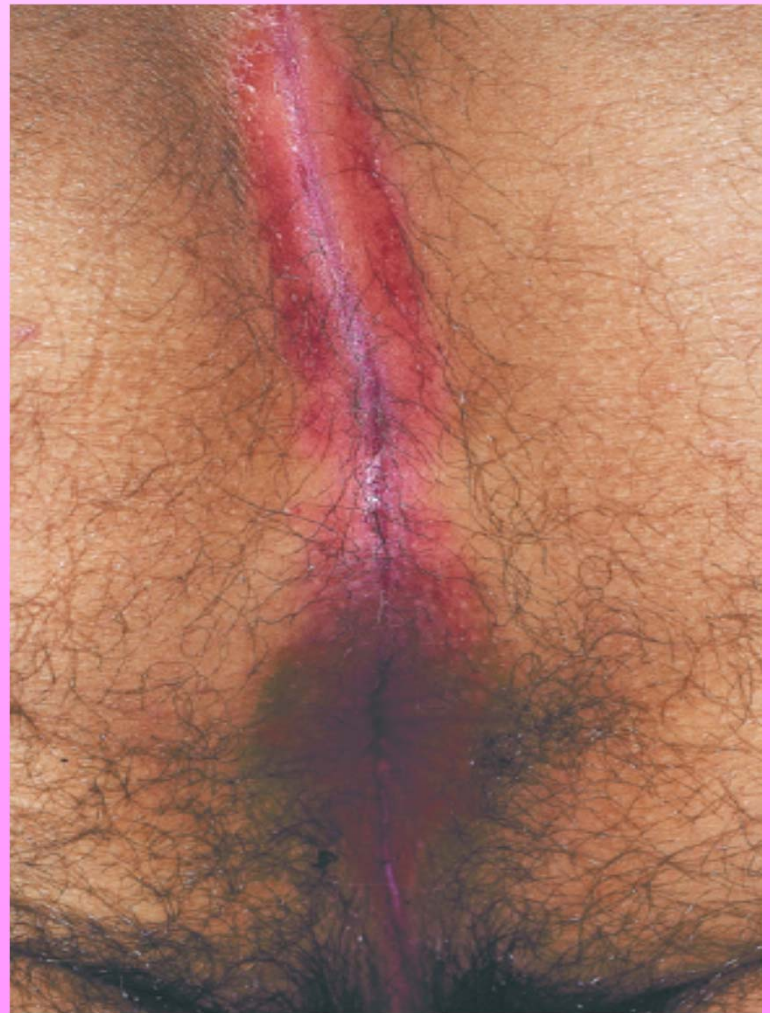
-Pityriasis amiantacea



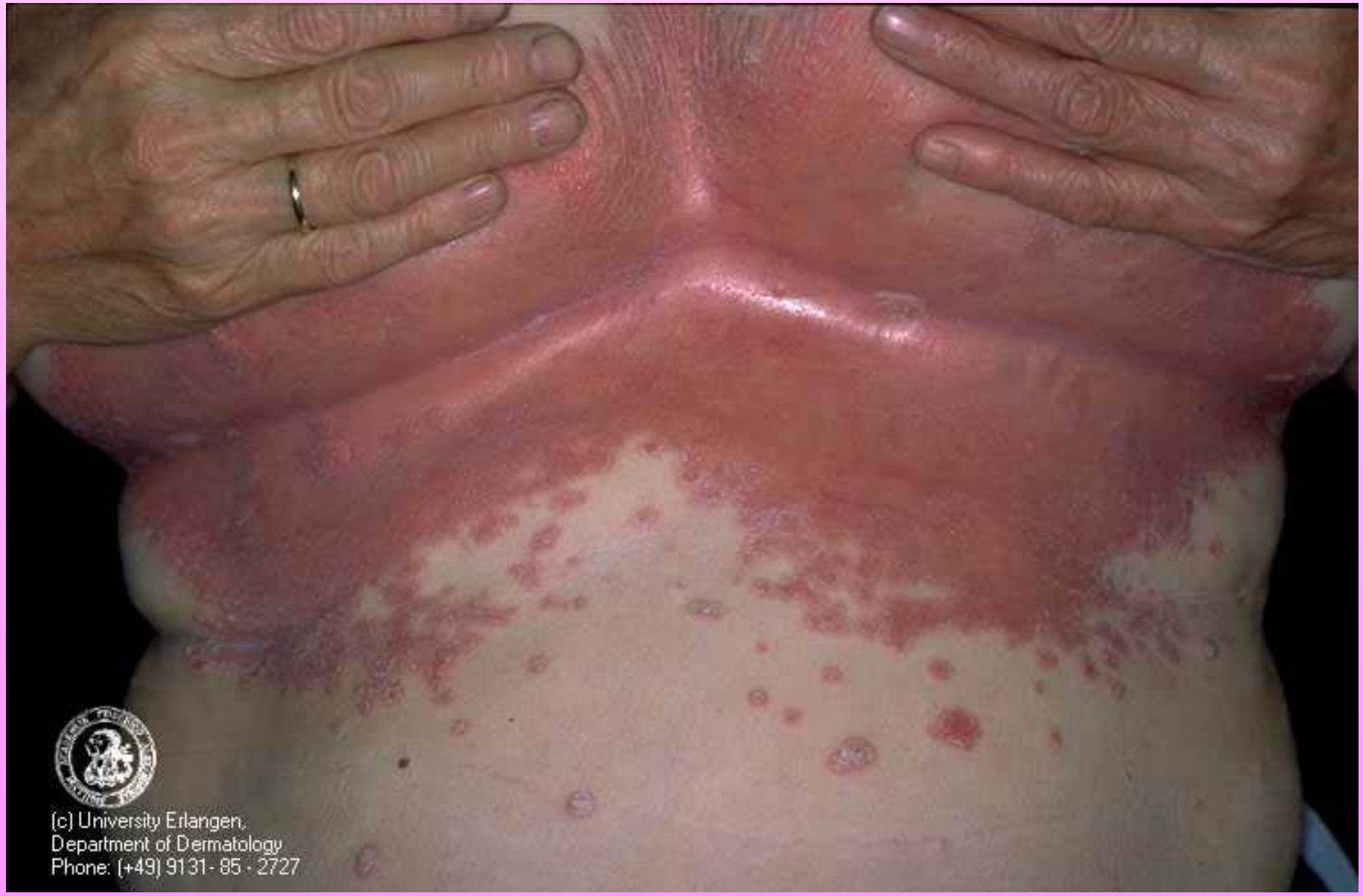
- **Flexural**

  - No scaling,

  - Glazed hue



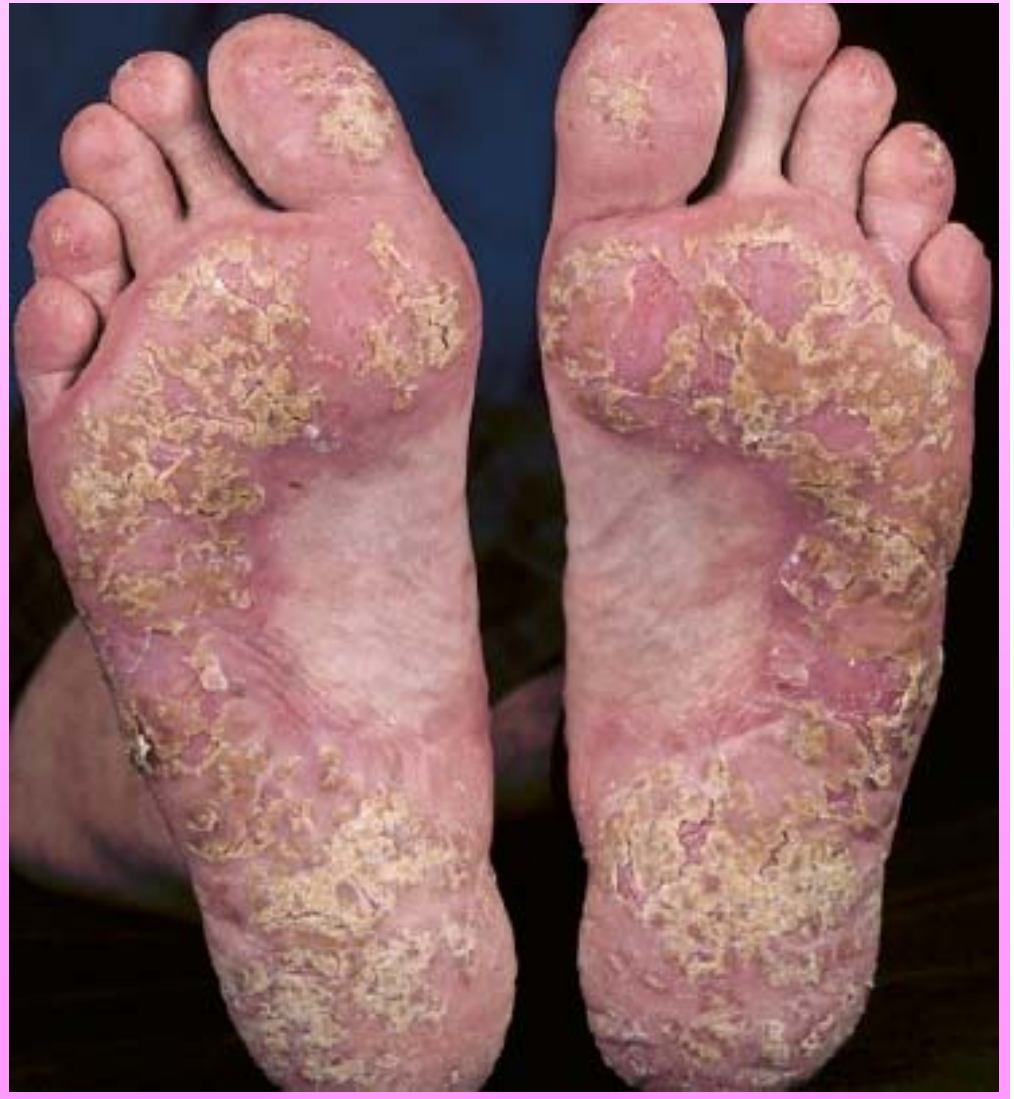
Flexural Psoriasis

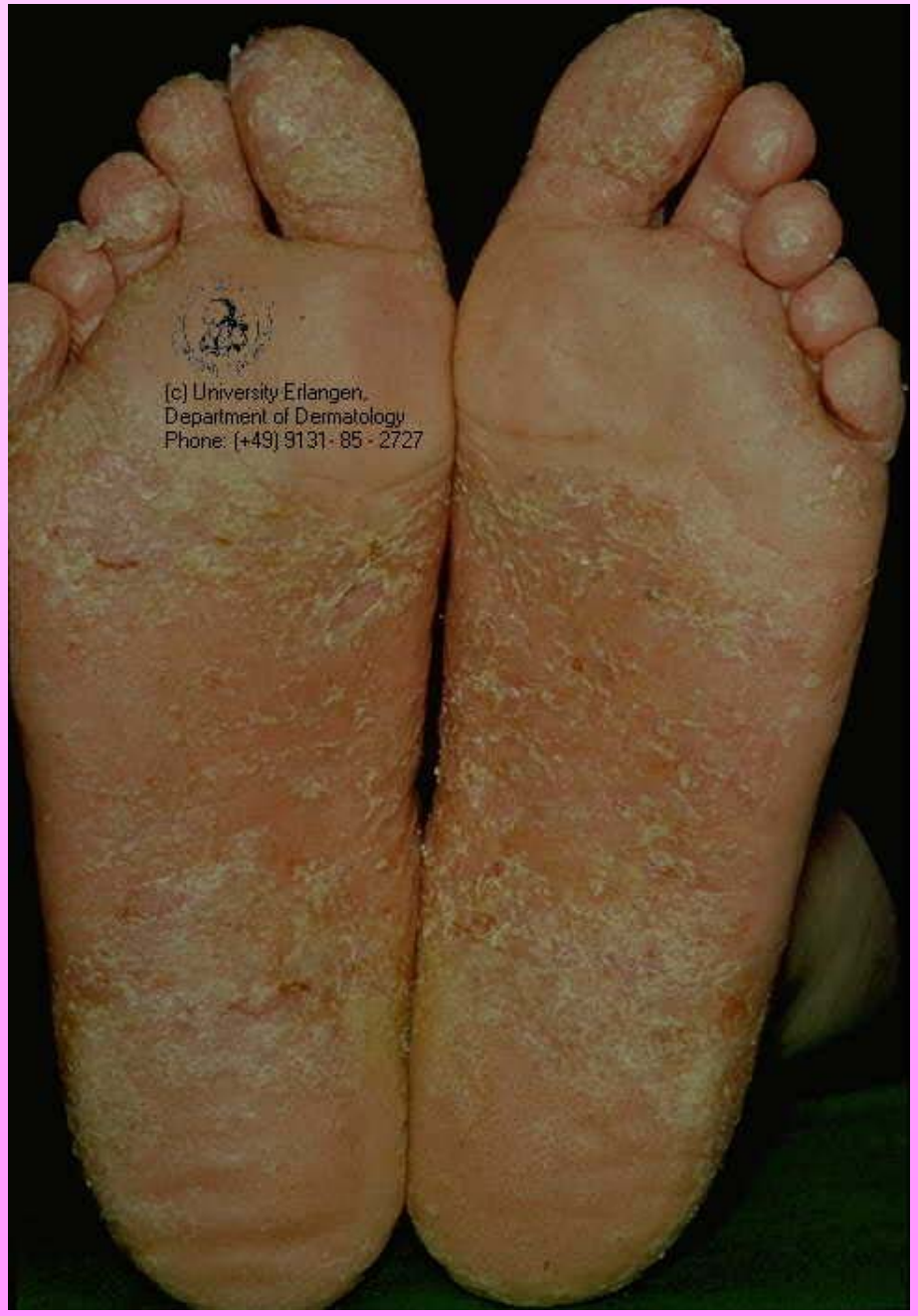


- **Napkin** Psoriasis
- **Penis –** No scaling
- **Linear/Zonal** psoriasis

- **Palmoplantar Psoriasis**

  Palms/ soles

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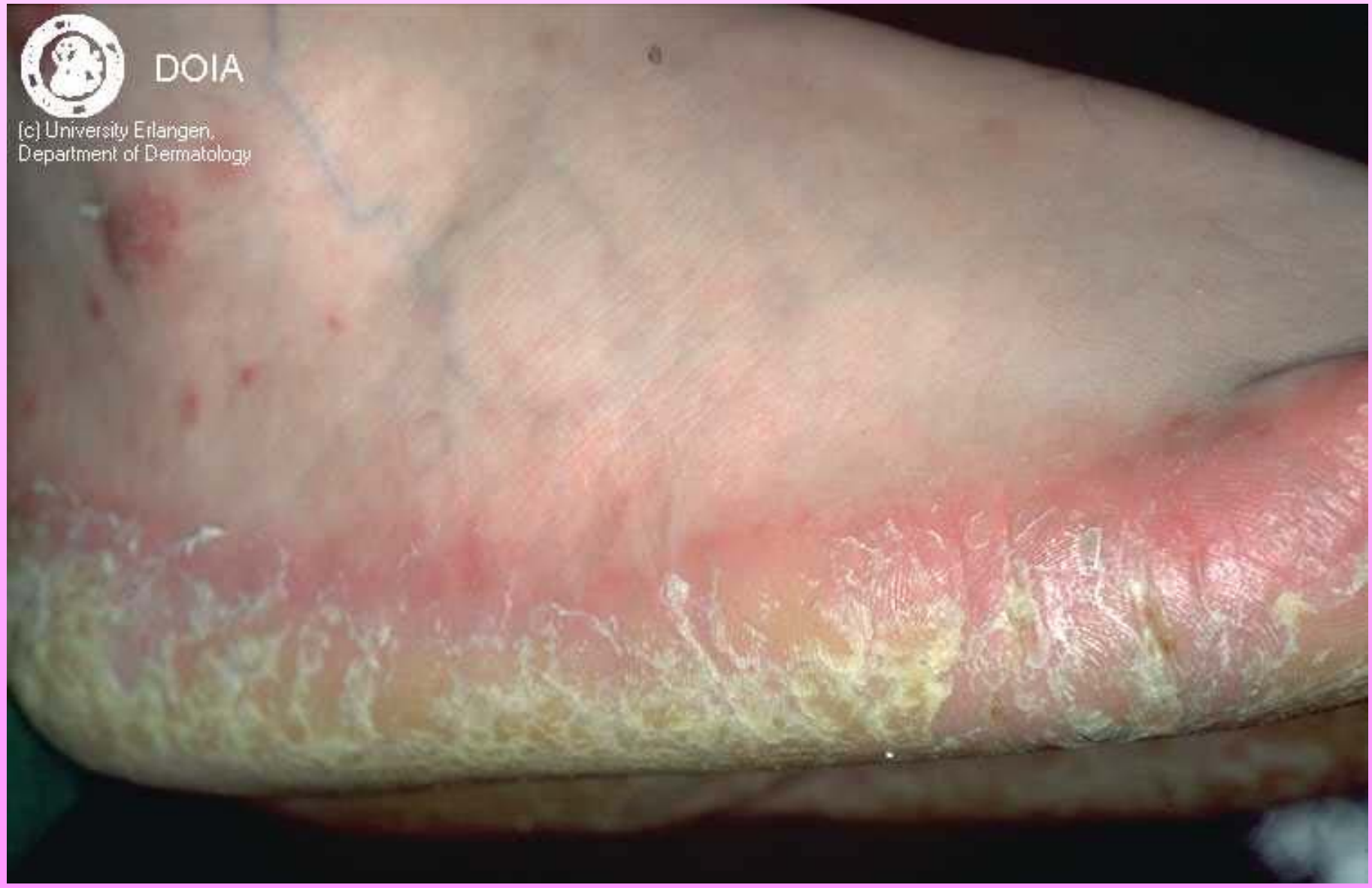
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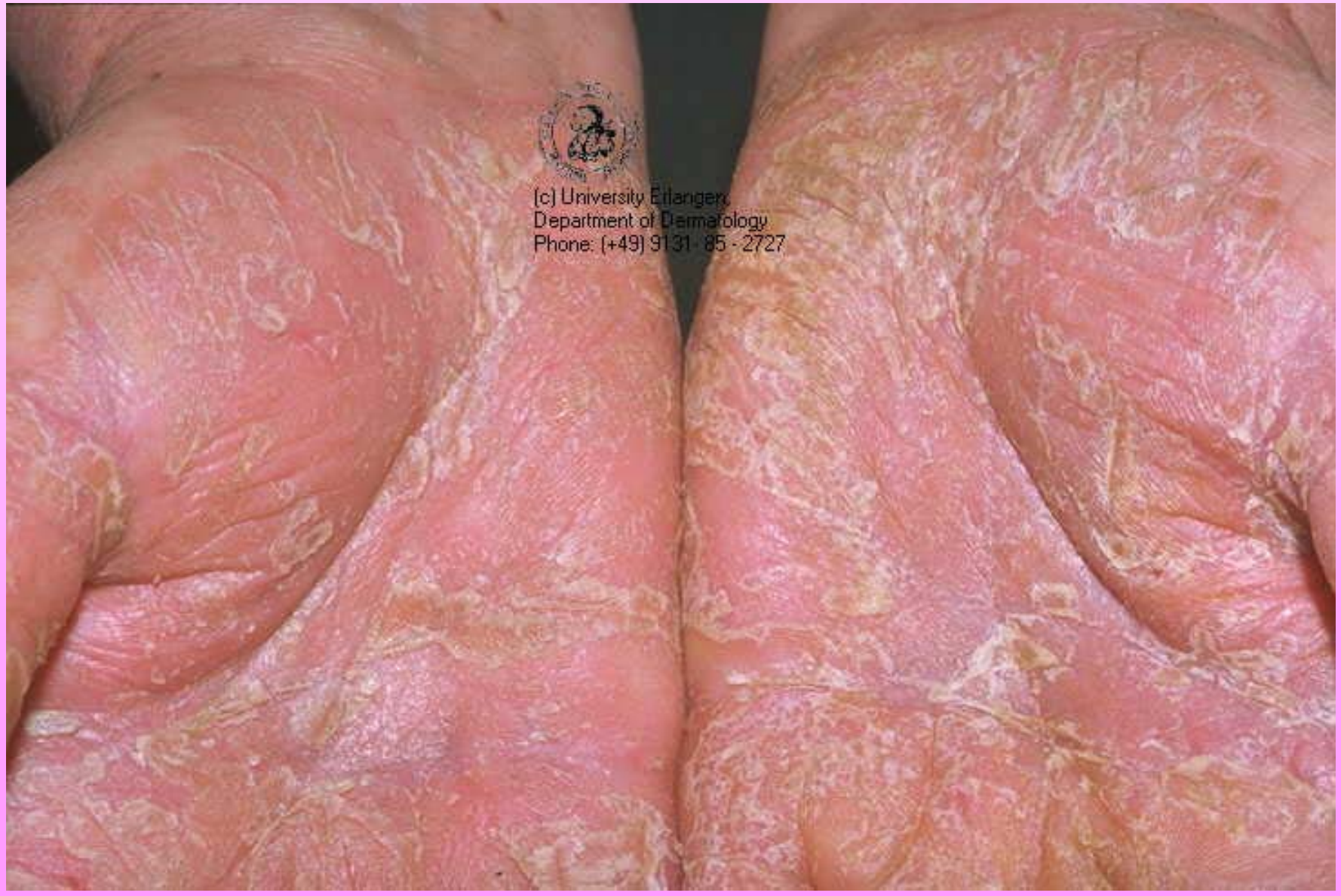

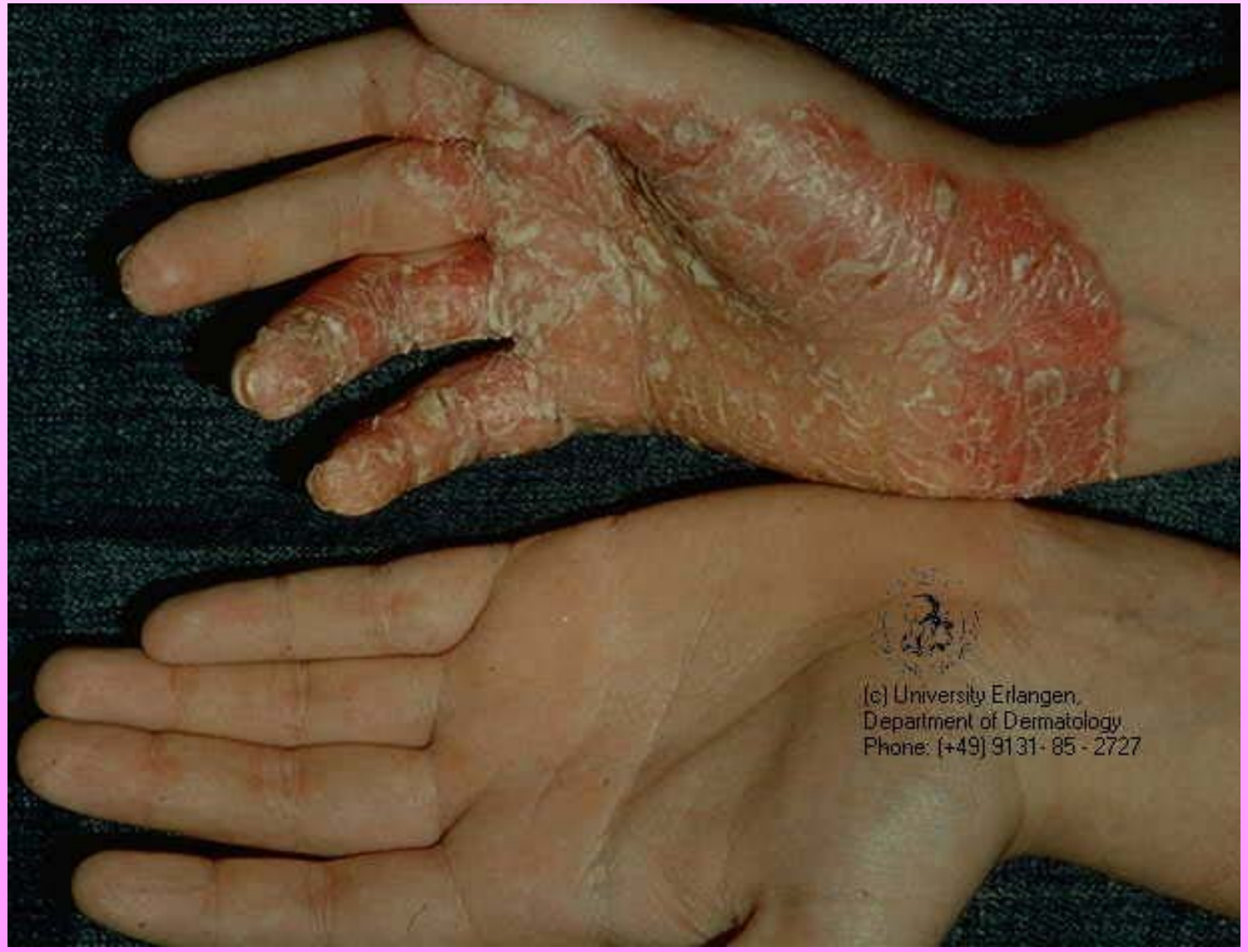
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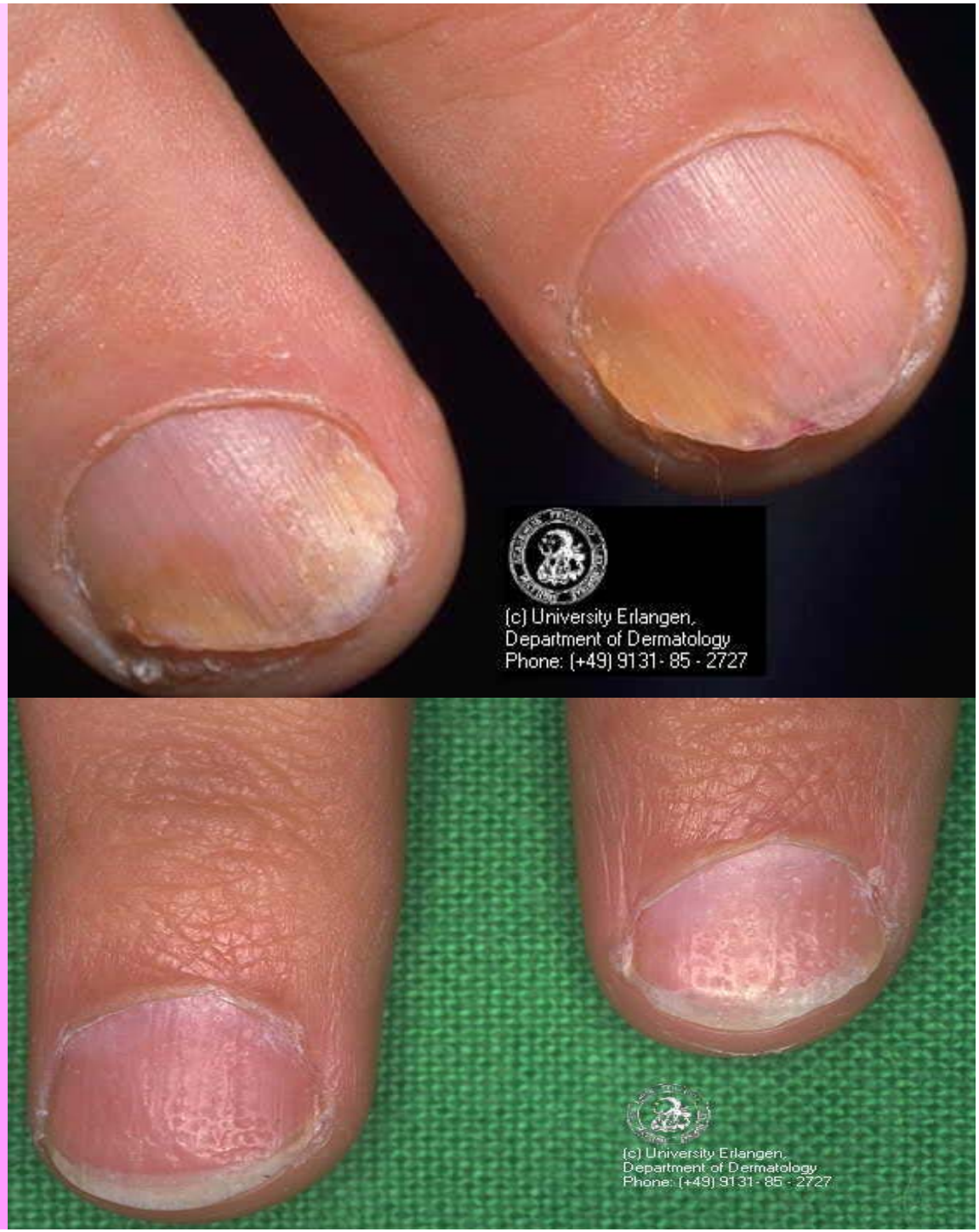
NAIL CHANGES

(25-50%)

- Distal onycholysis
- Subungual hyperkeratosis
- Oil drop sign
- Pitting
- Destruction/Discoloration



NAIL CHANGES

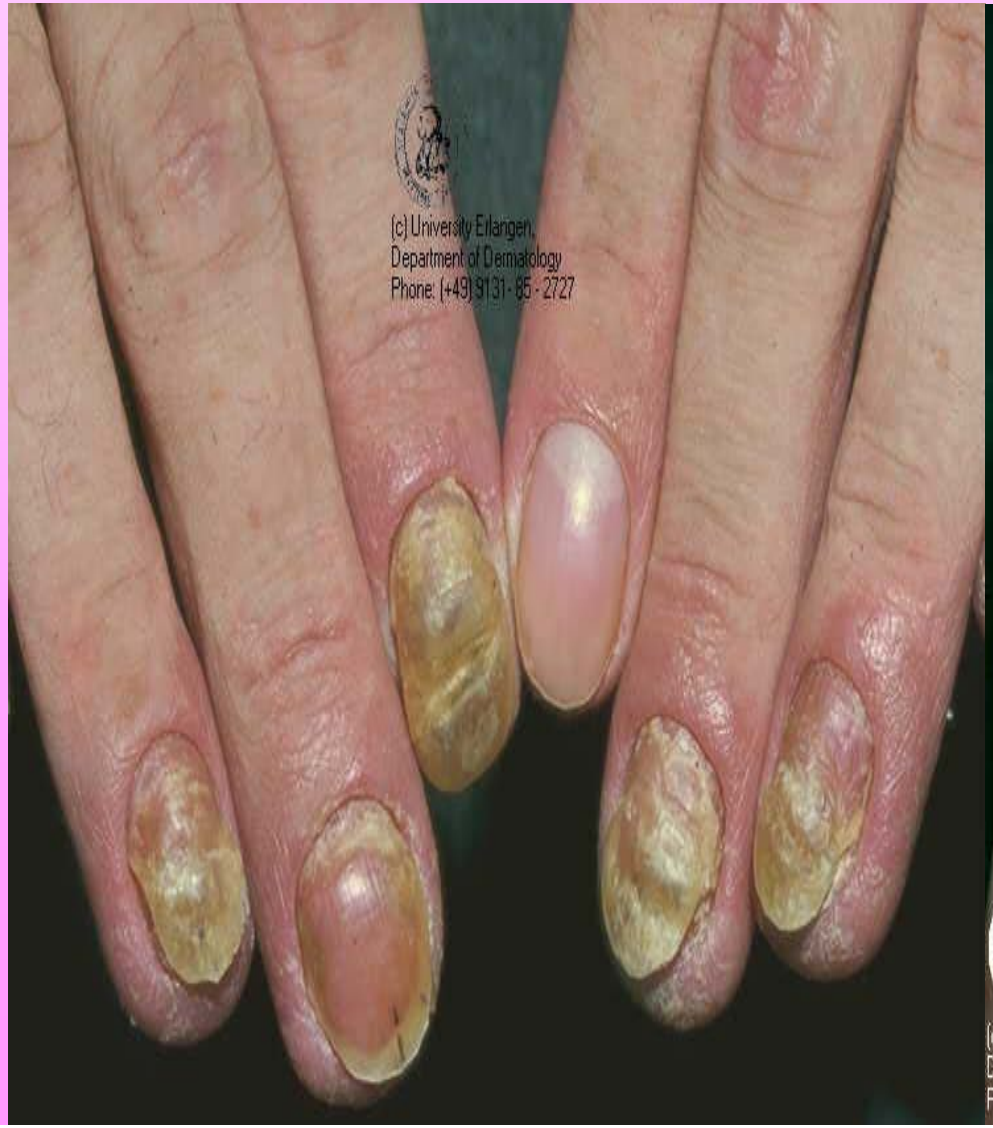
Nail Matrix - Pitting

- Ridges & grooves

Nail Bed - Subungual hyperkeratosis

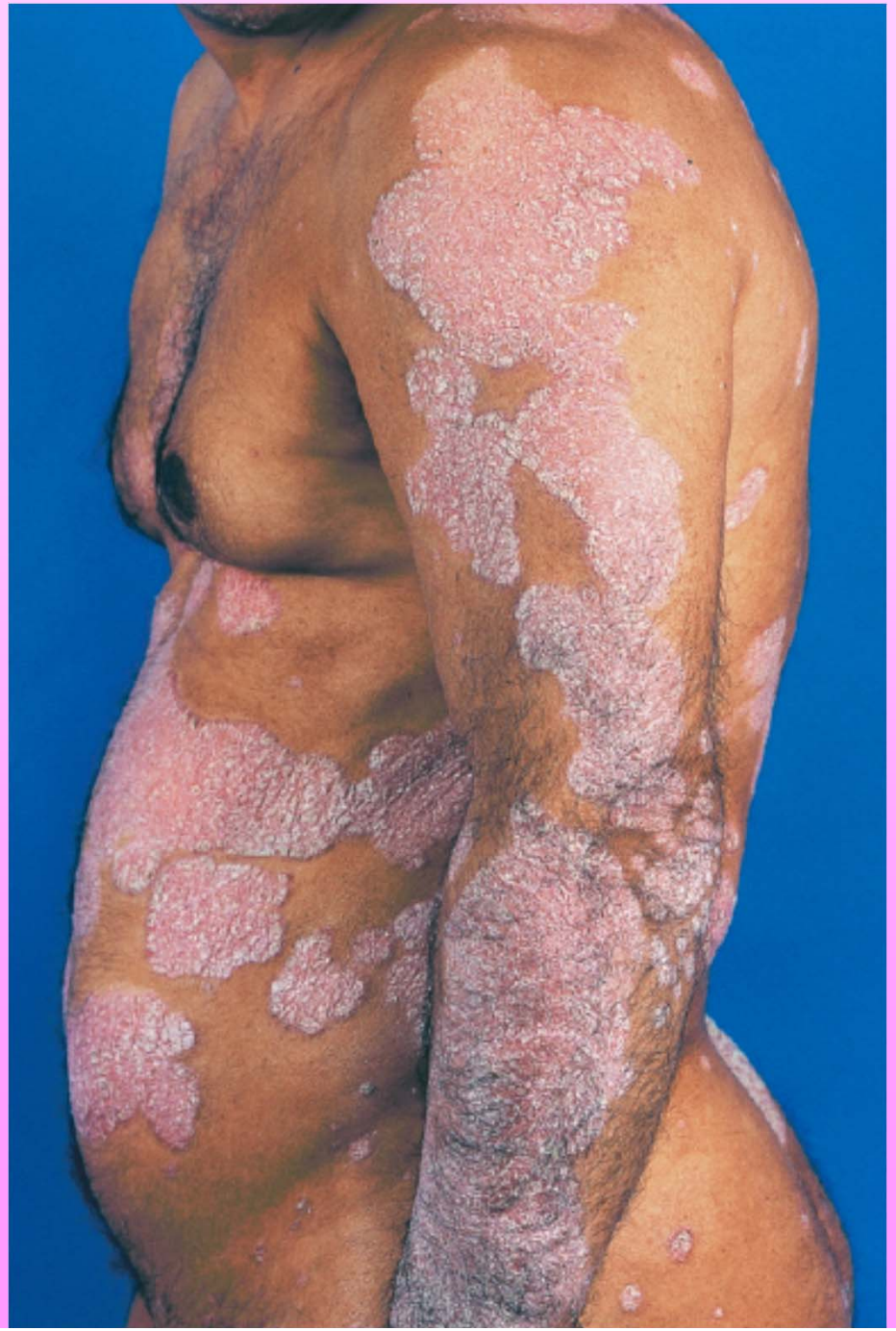
- Onycholysis

Nail Changes

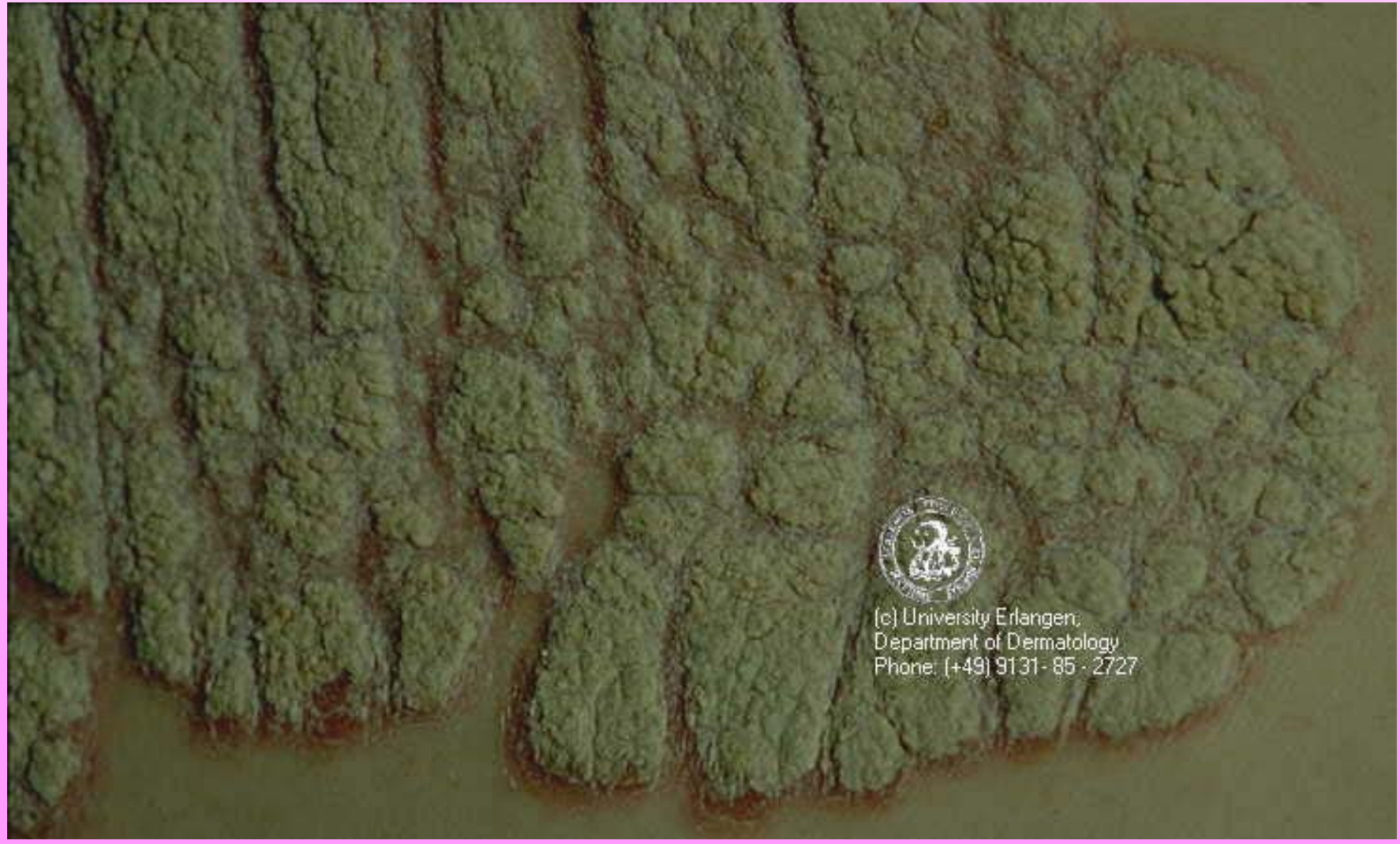


Clinical Variants

- Psoriasis vulgaris



- Elephantine Psoriasis



- Rupioid Psoriasis
- Ostraceous Psoriasis
- Atypical psoriasis
- Guttate Psoriasis

Guttate Psoriasis

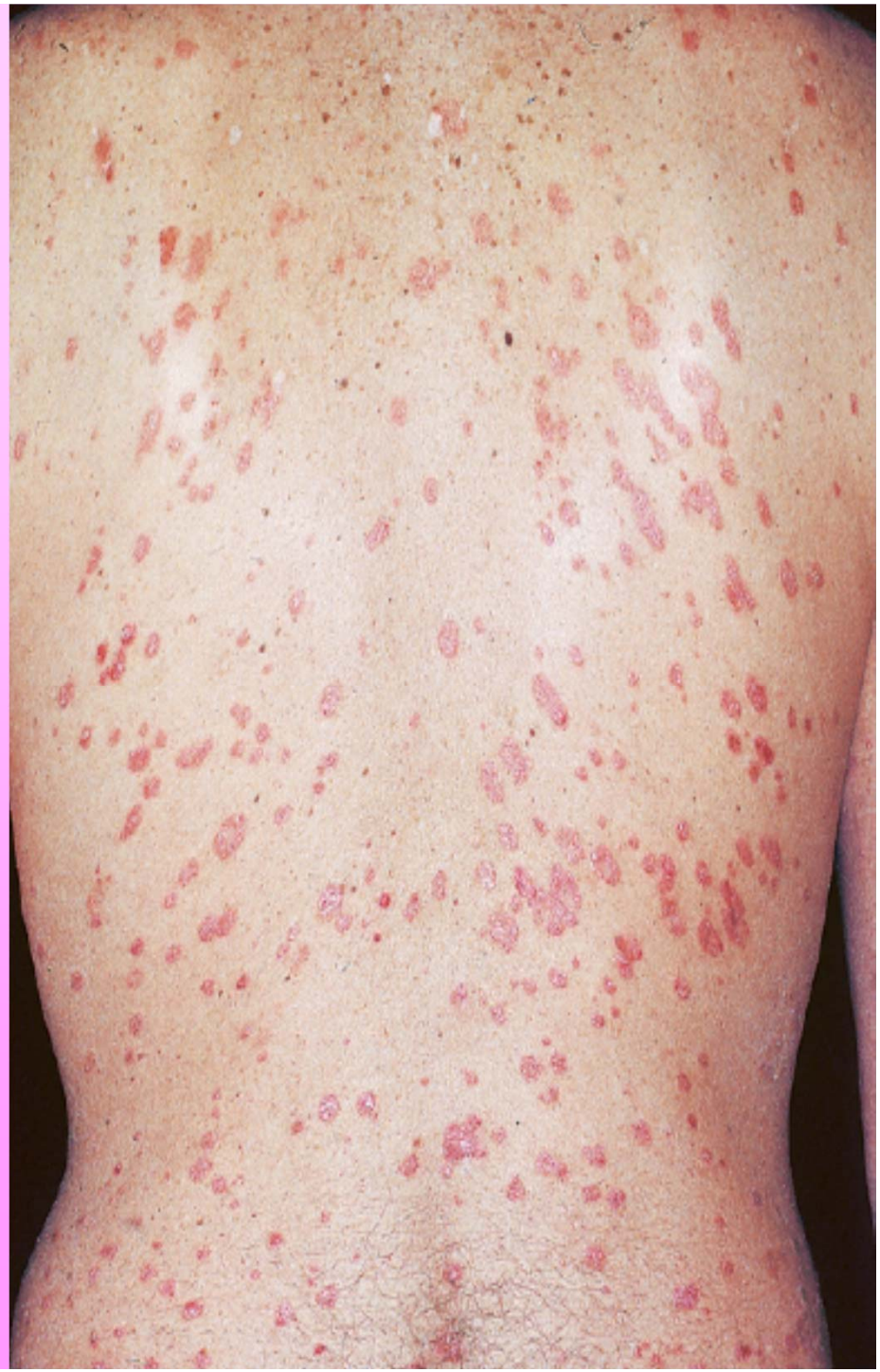
Streptococcal throat infections

Child – Adolescent

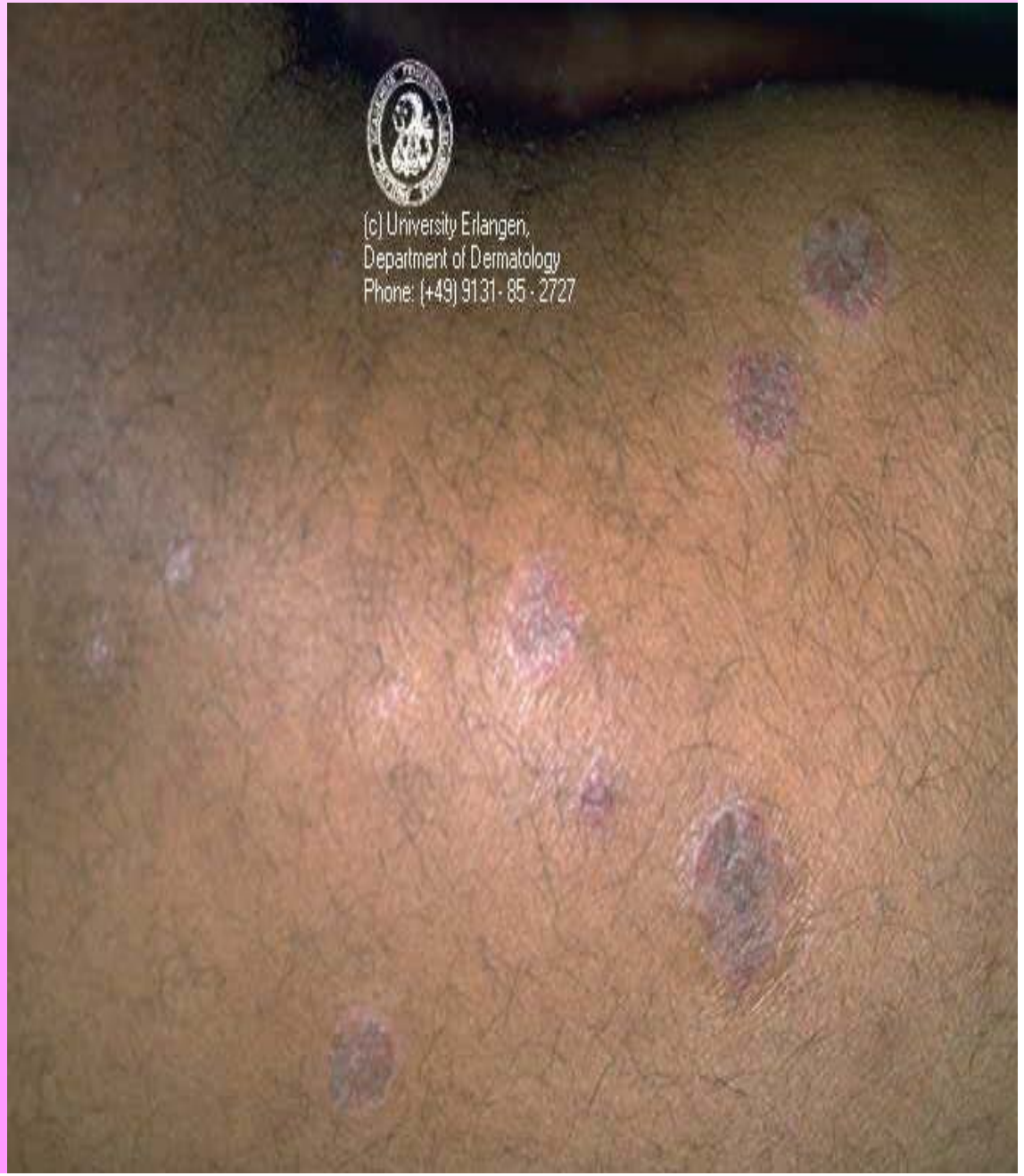
Monomorphic

Respond to antibiotics

May lead to Psoriasis vulgaris in predisposed



Guttate Psoriasis



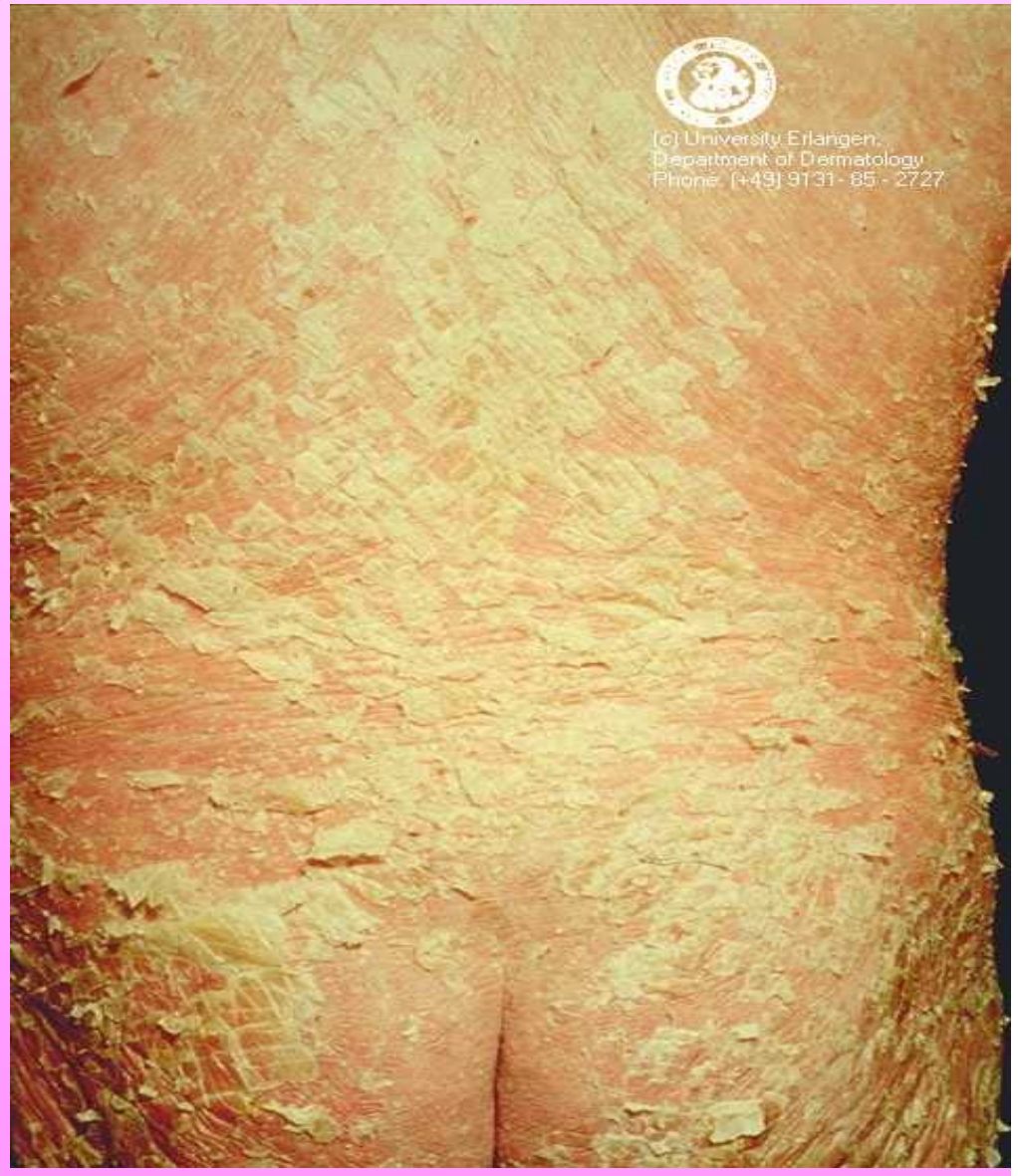
Erythrodermic Psoriasis

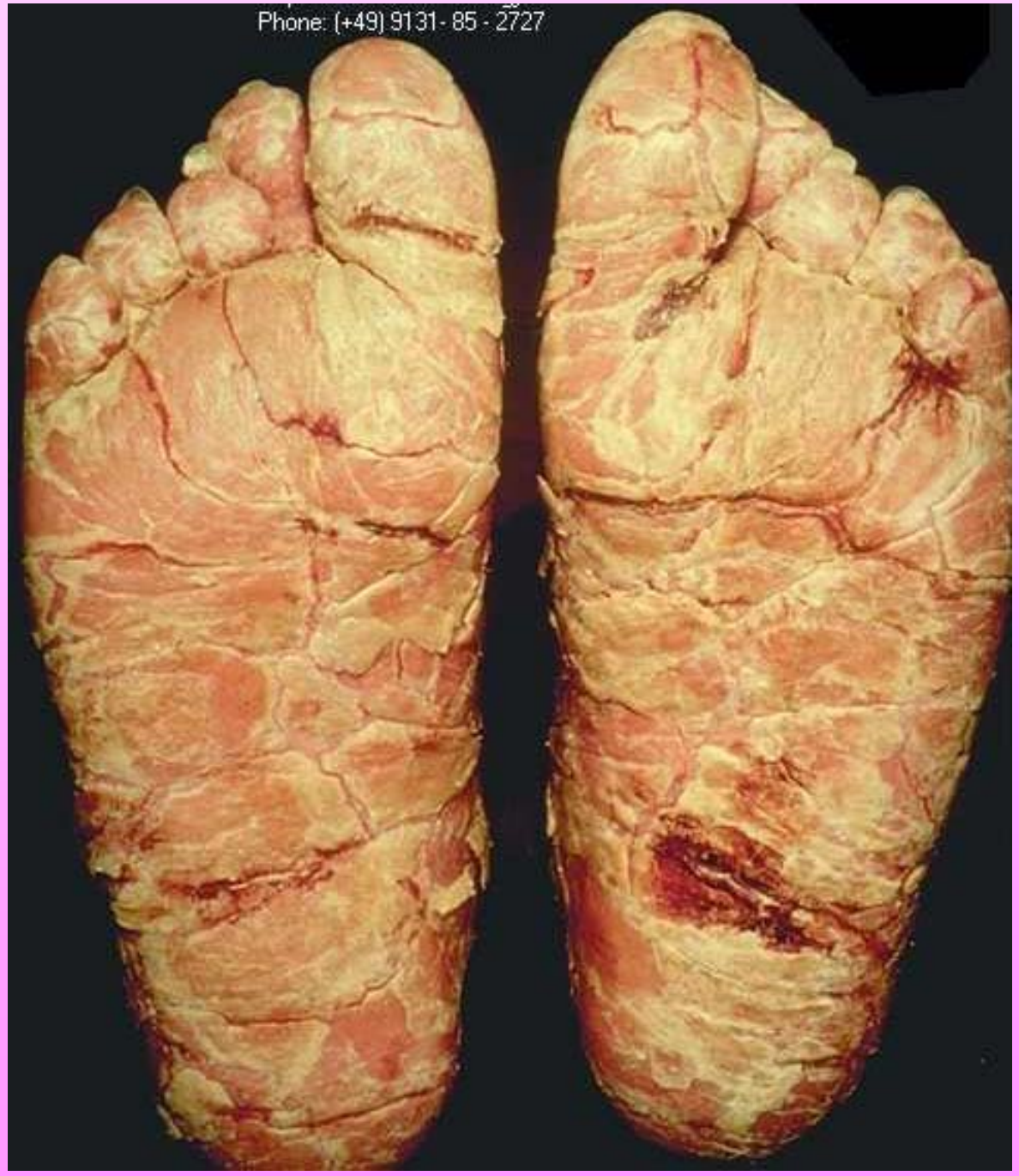
-Some ppt. factor

-Disease characteristics may be lost

-Febrile

-Severe itching

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Metabolic complications

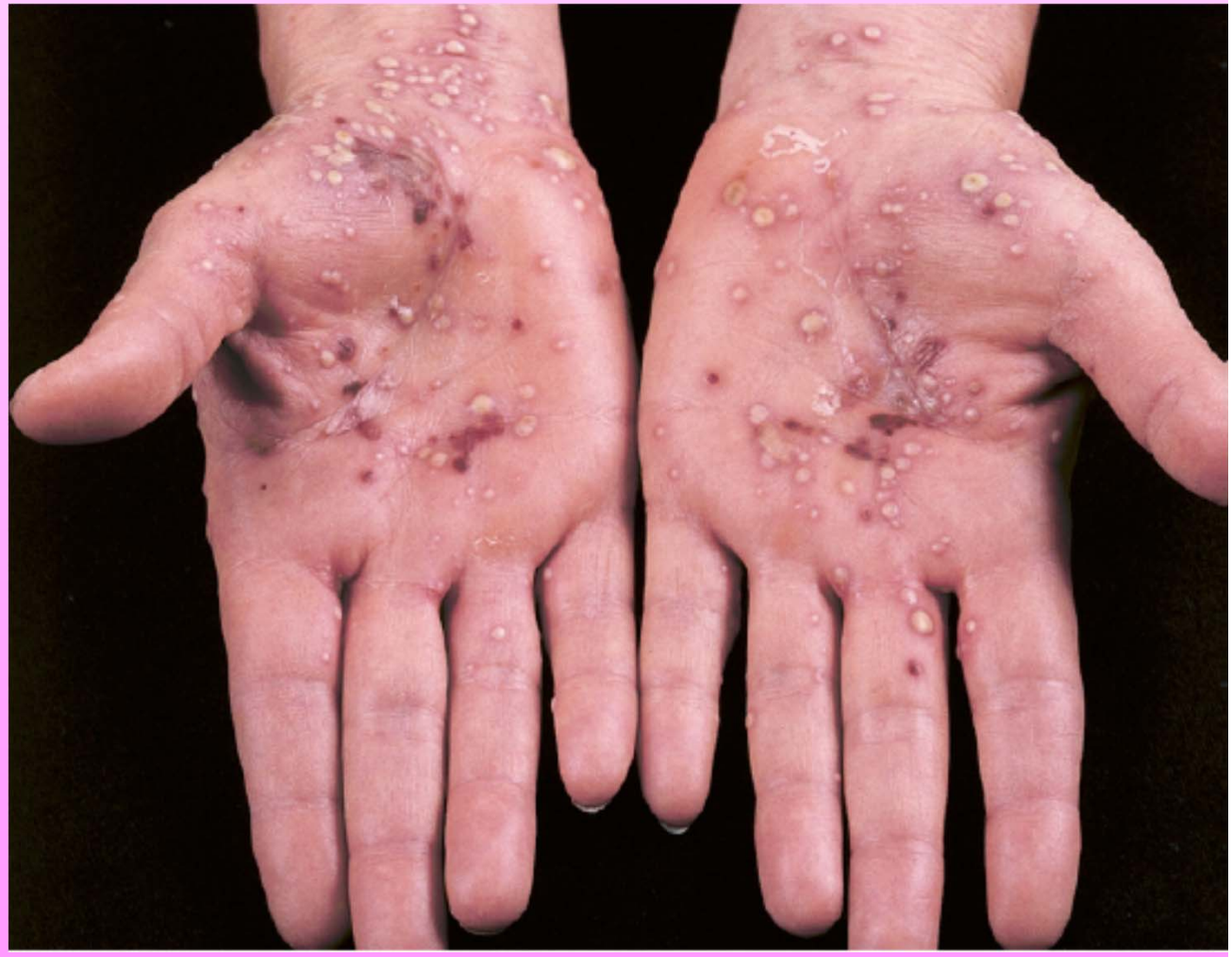
- Hypo/Hyperthermia
- High output cardiac failure
- Hypoalbuminaemia
- Malabsorption

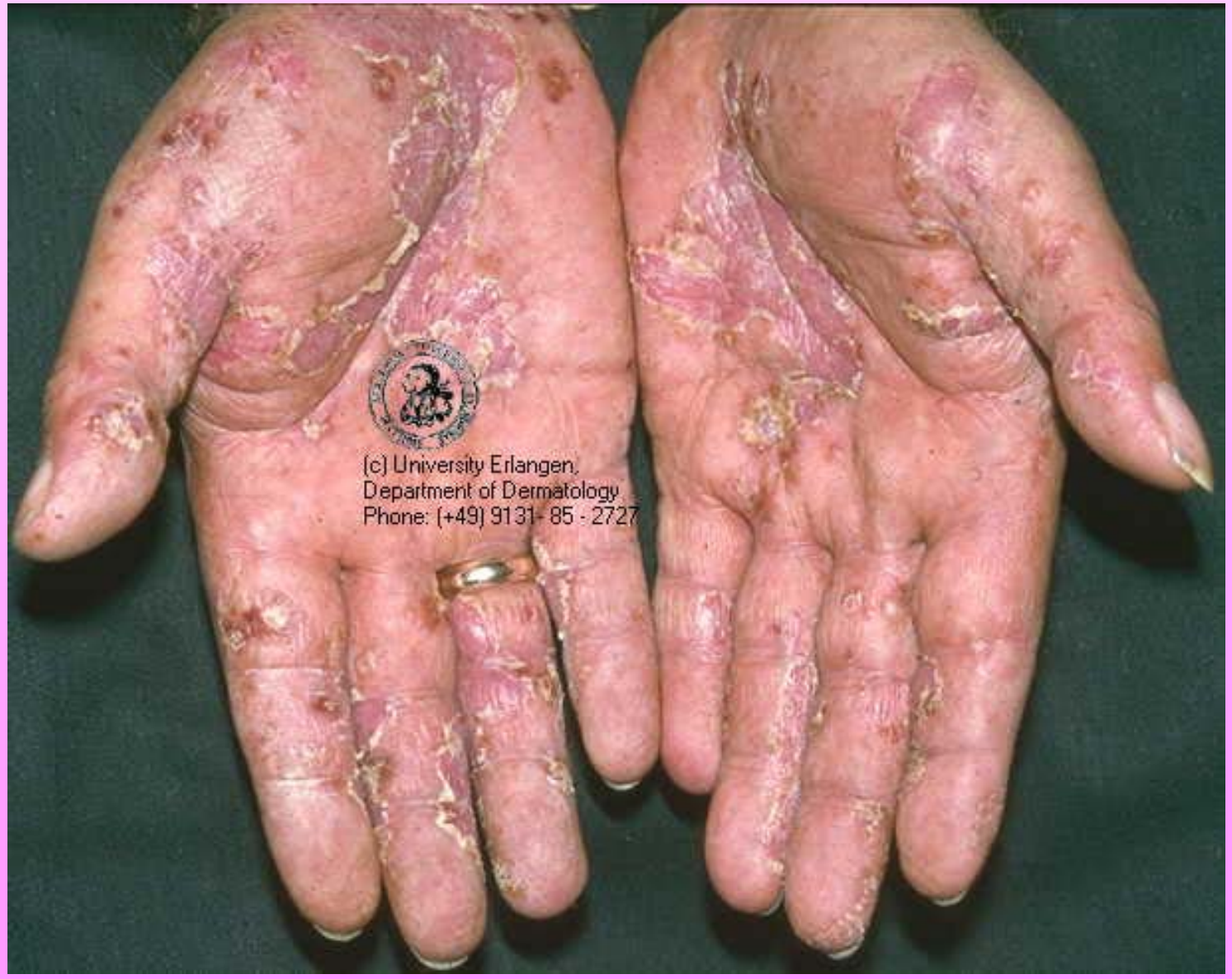
Pustular Psoriasis

- Localized

-Chronic

-Palmoplantar

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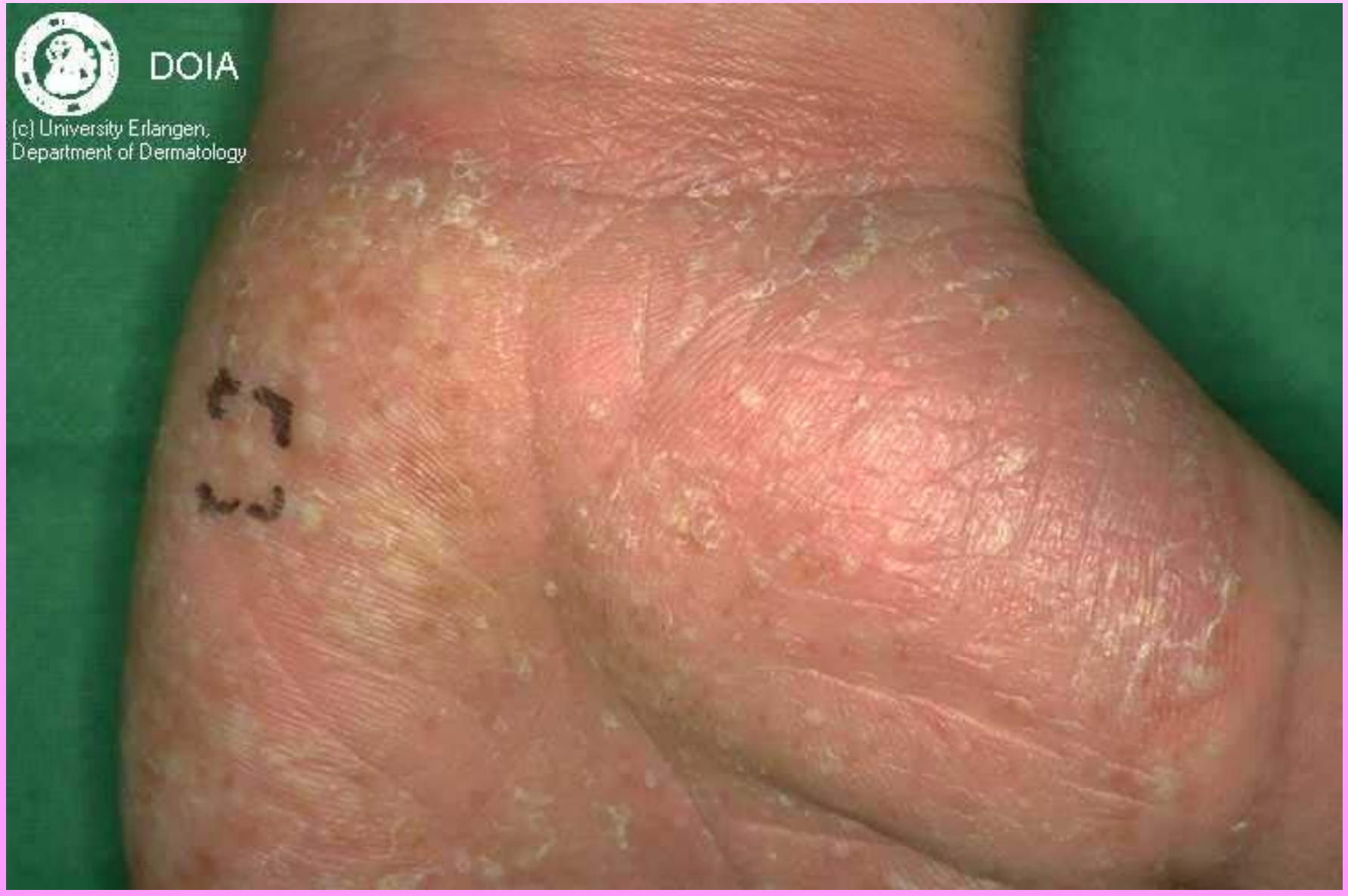
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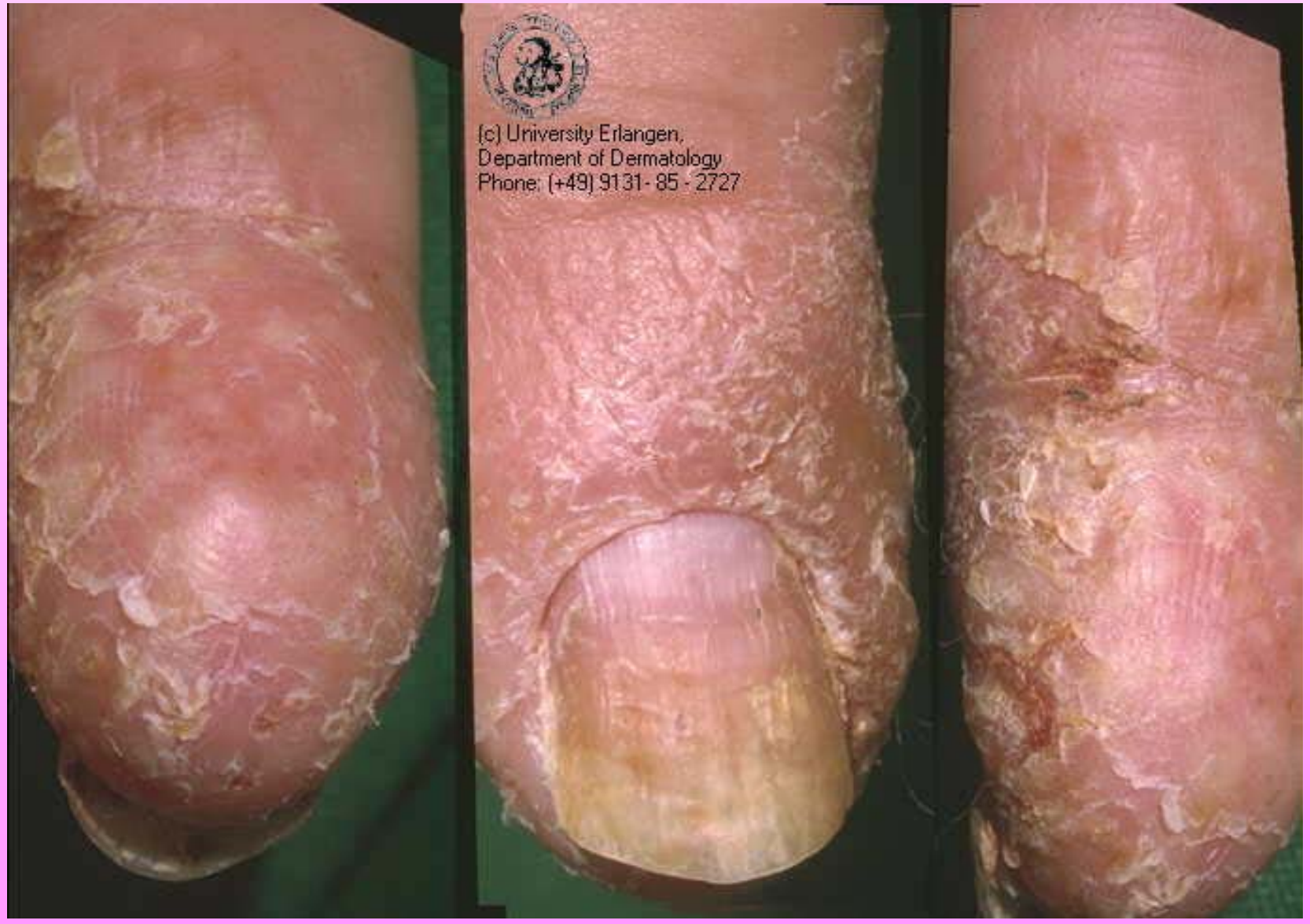
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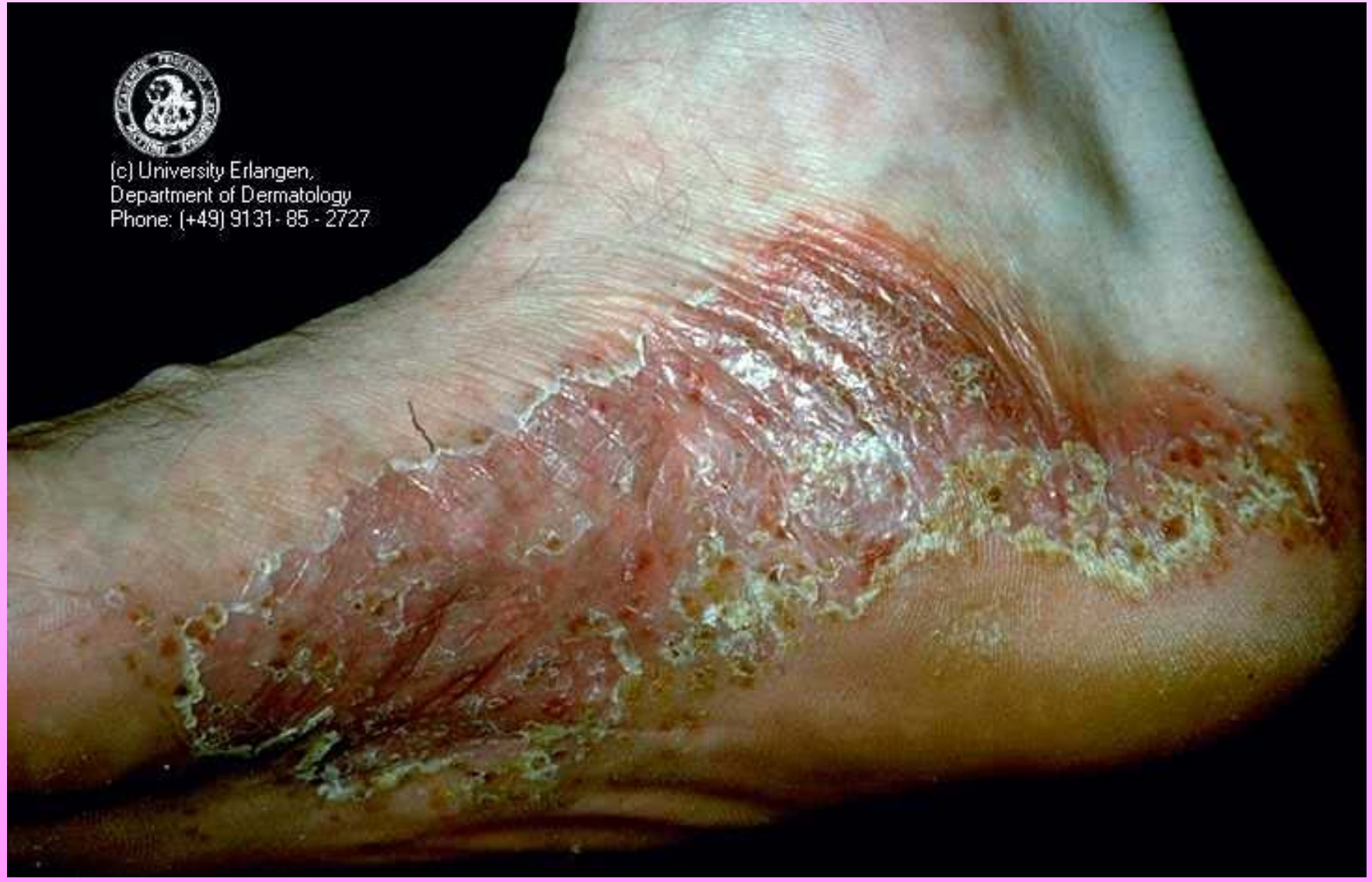
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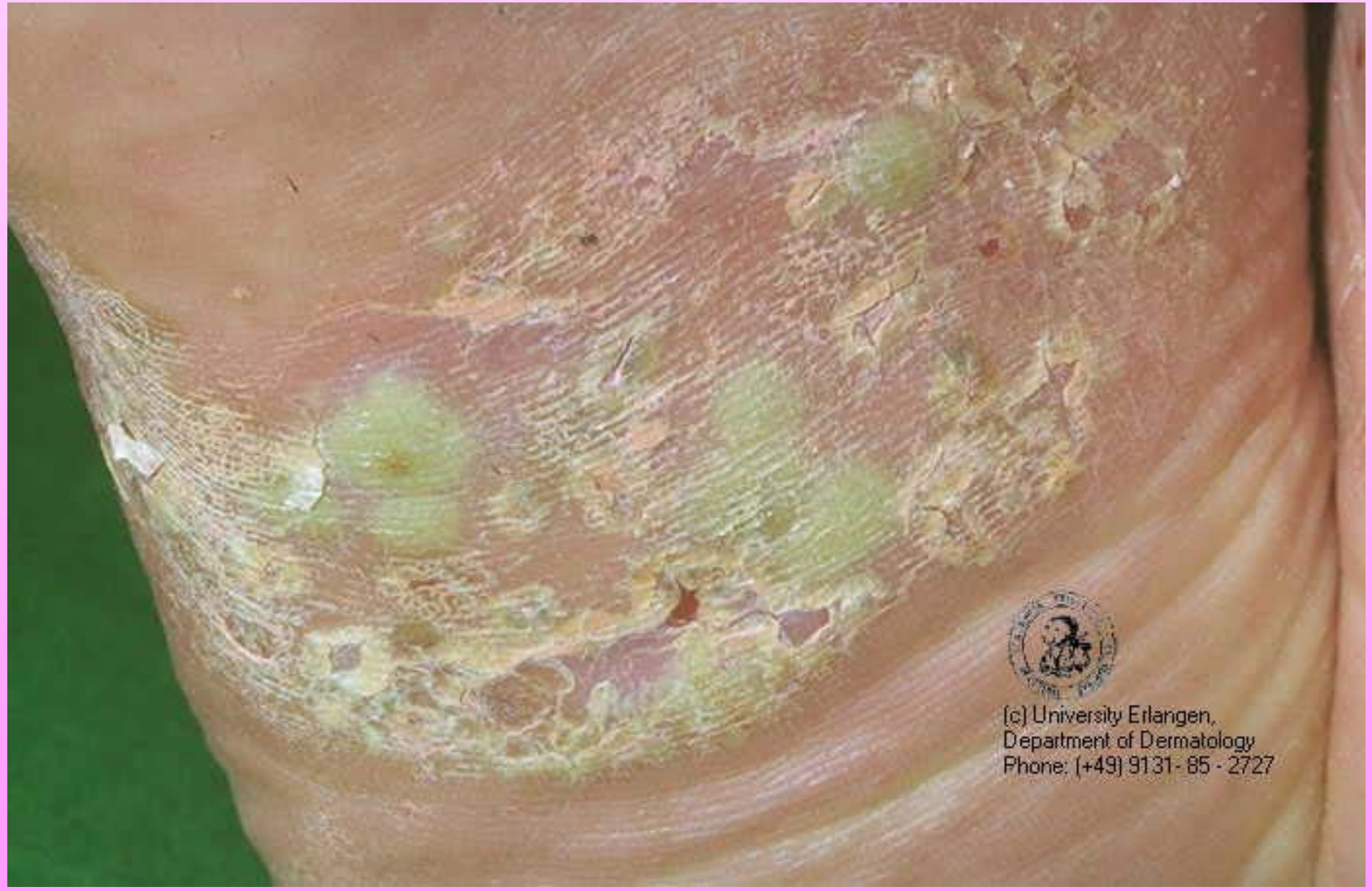
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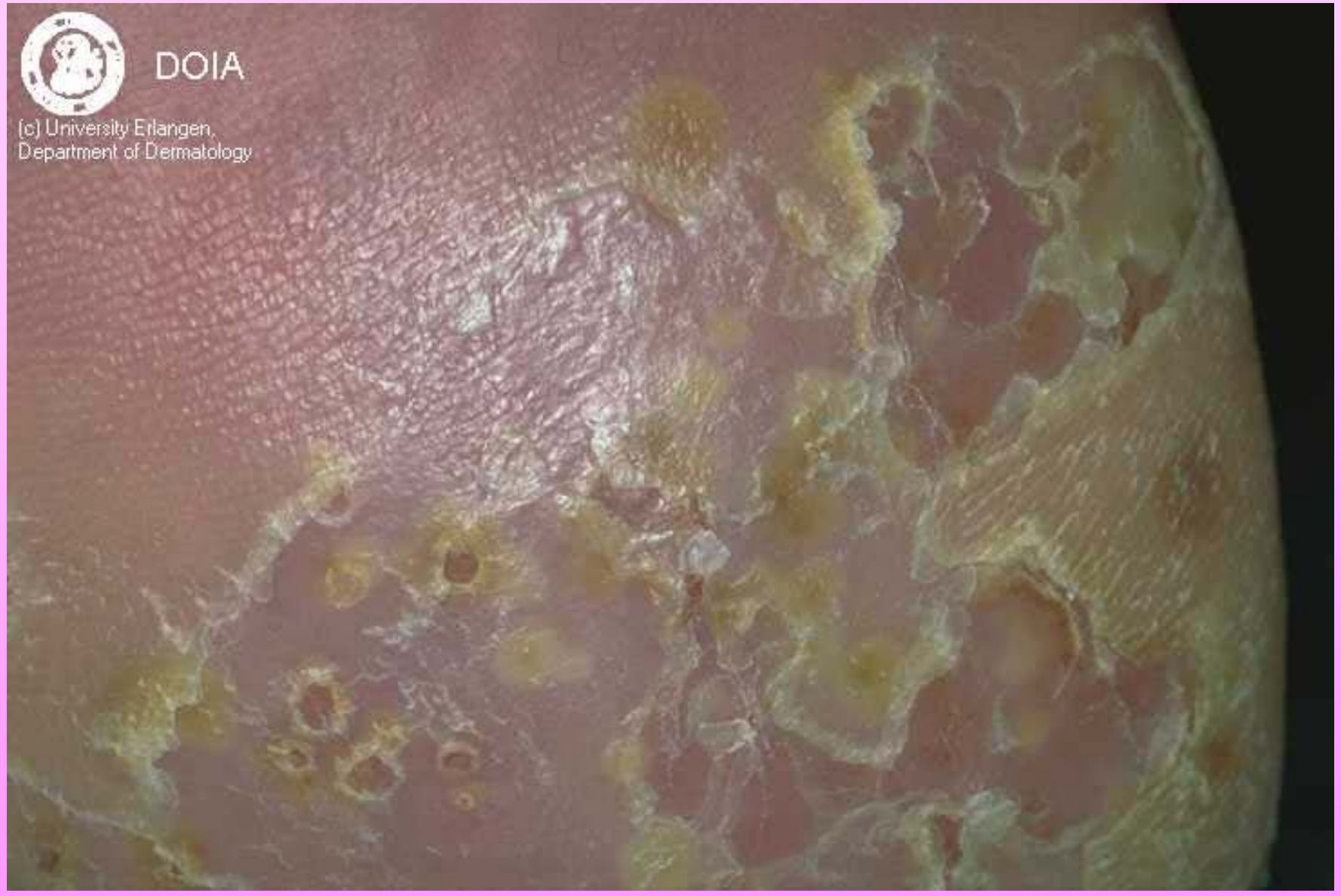
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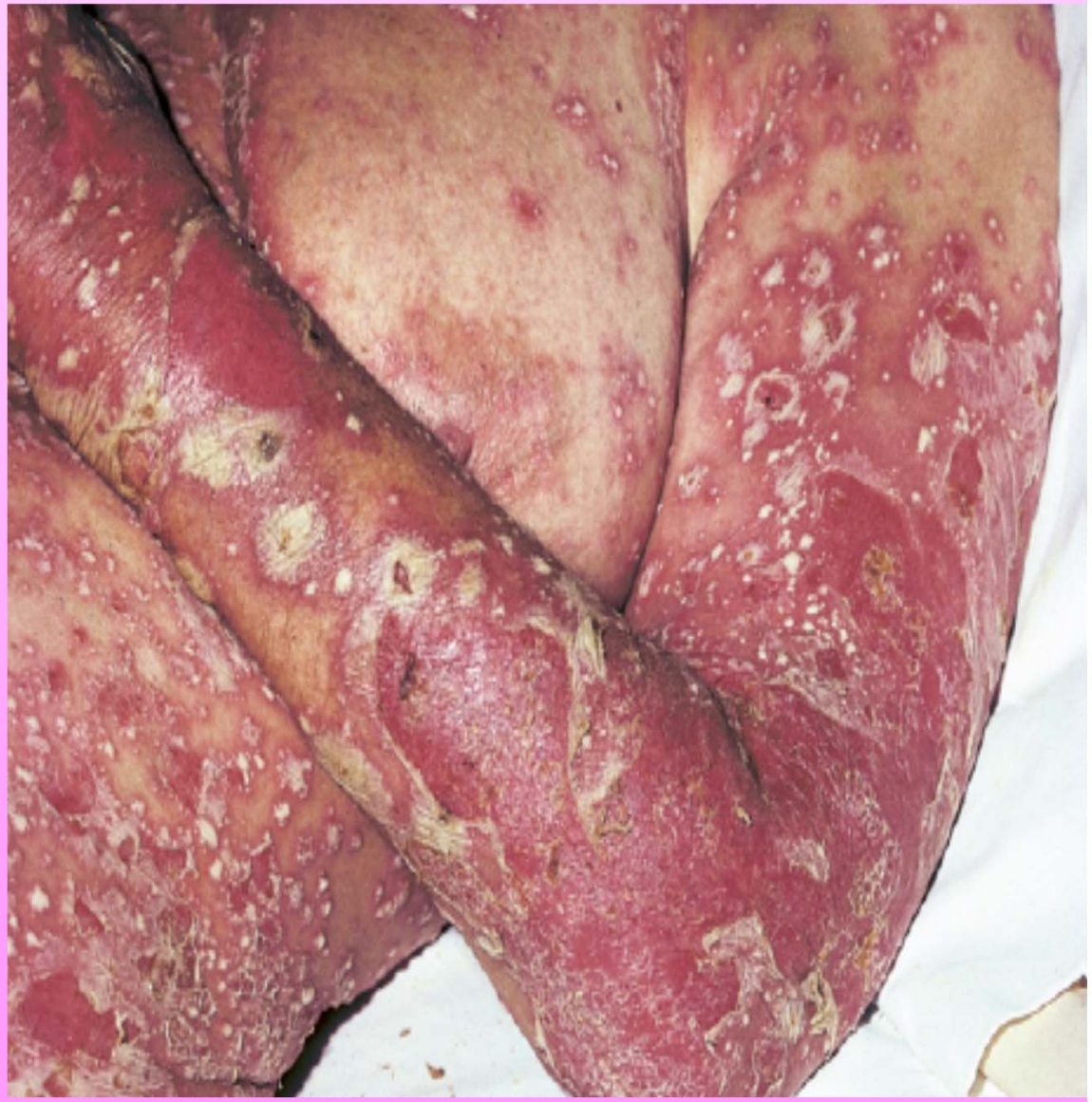
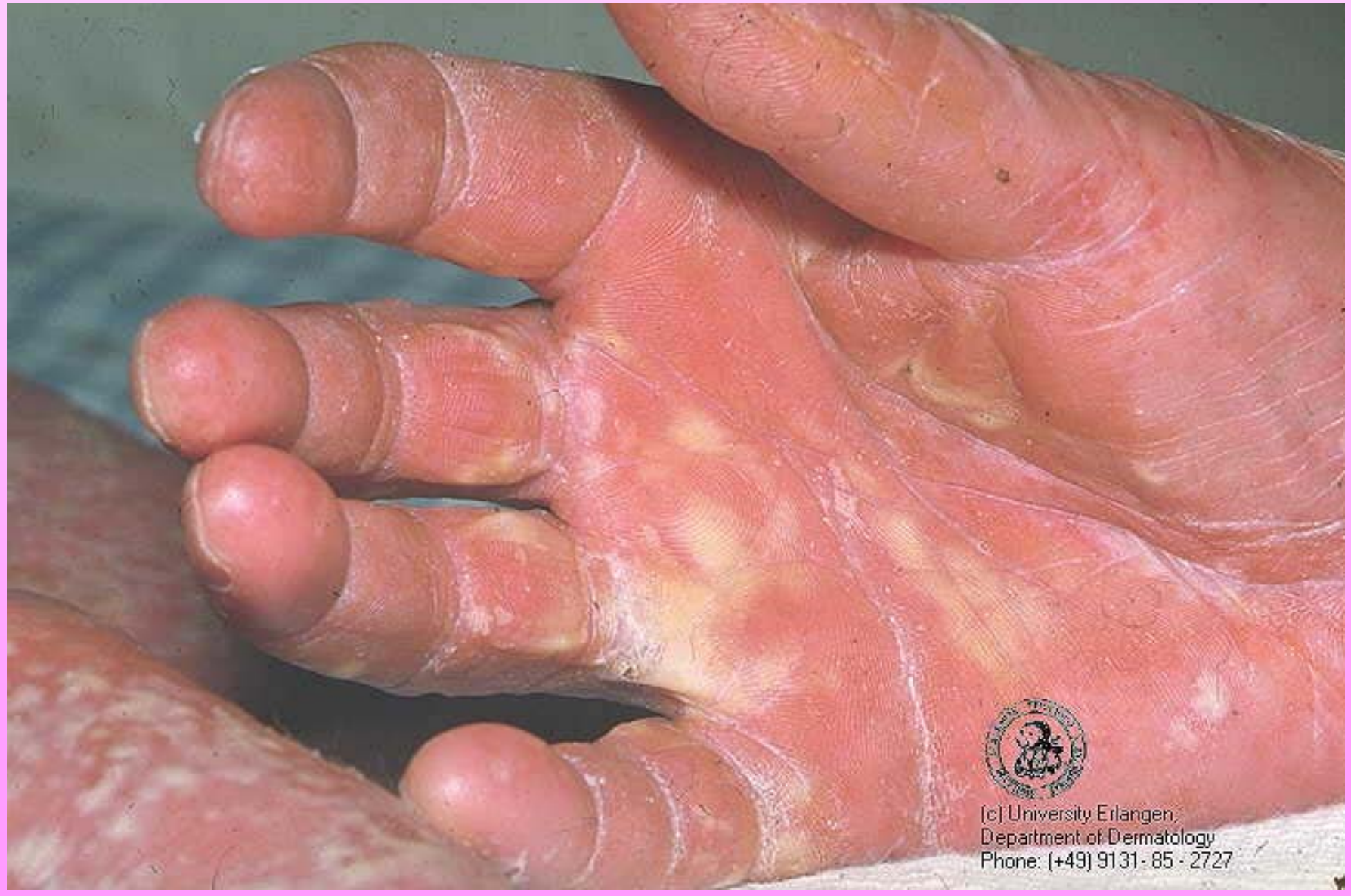
Pustular Psoriasis

- Generalized

-Von Zumbusch

-Acute

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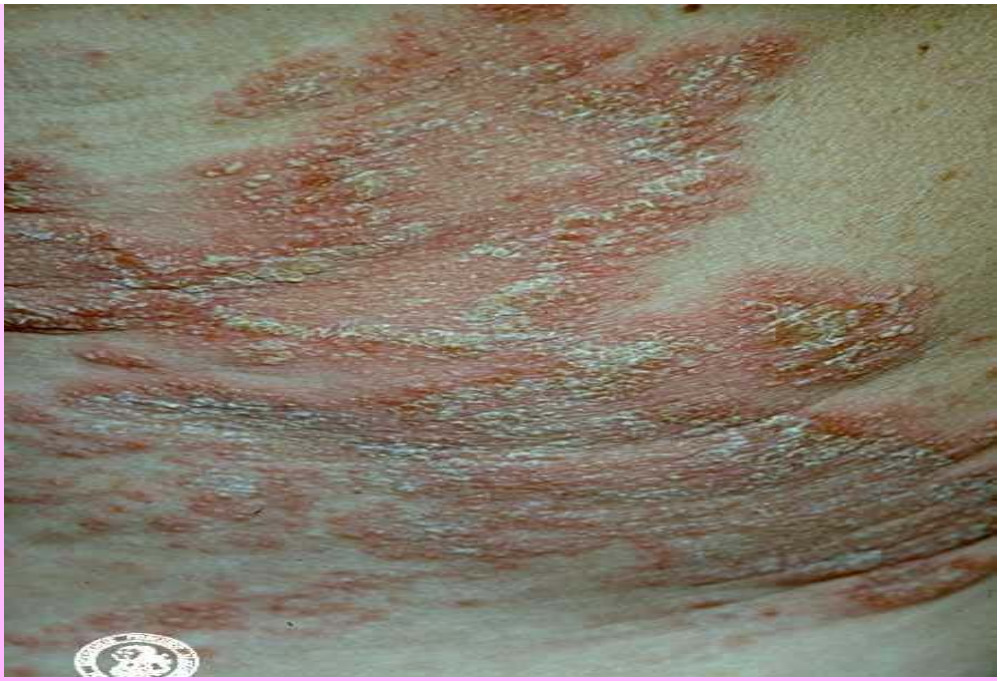
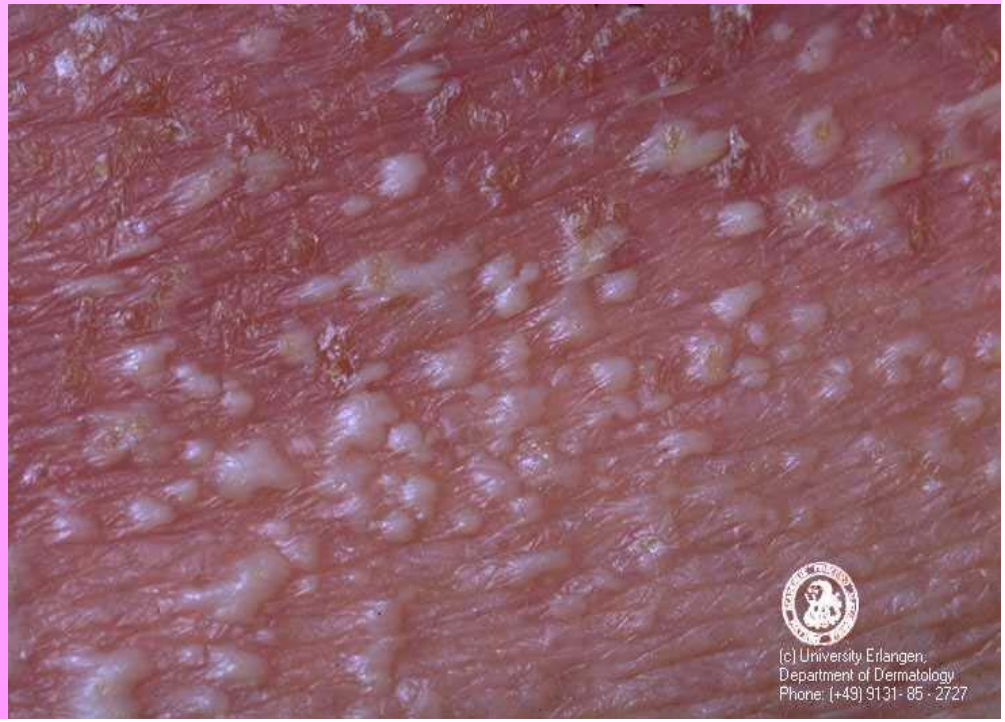
Pustular psoriasis

Withdrawal of steroid

Erythrodermic psoriasis





Impetigo Herpetiformis

-Pregnancy

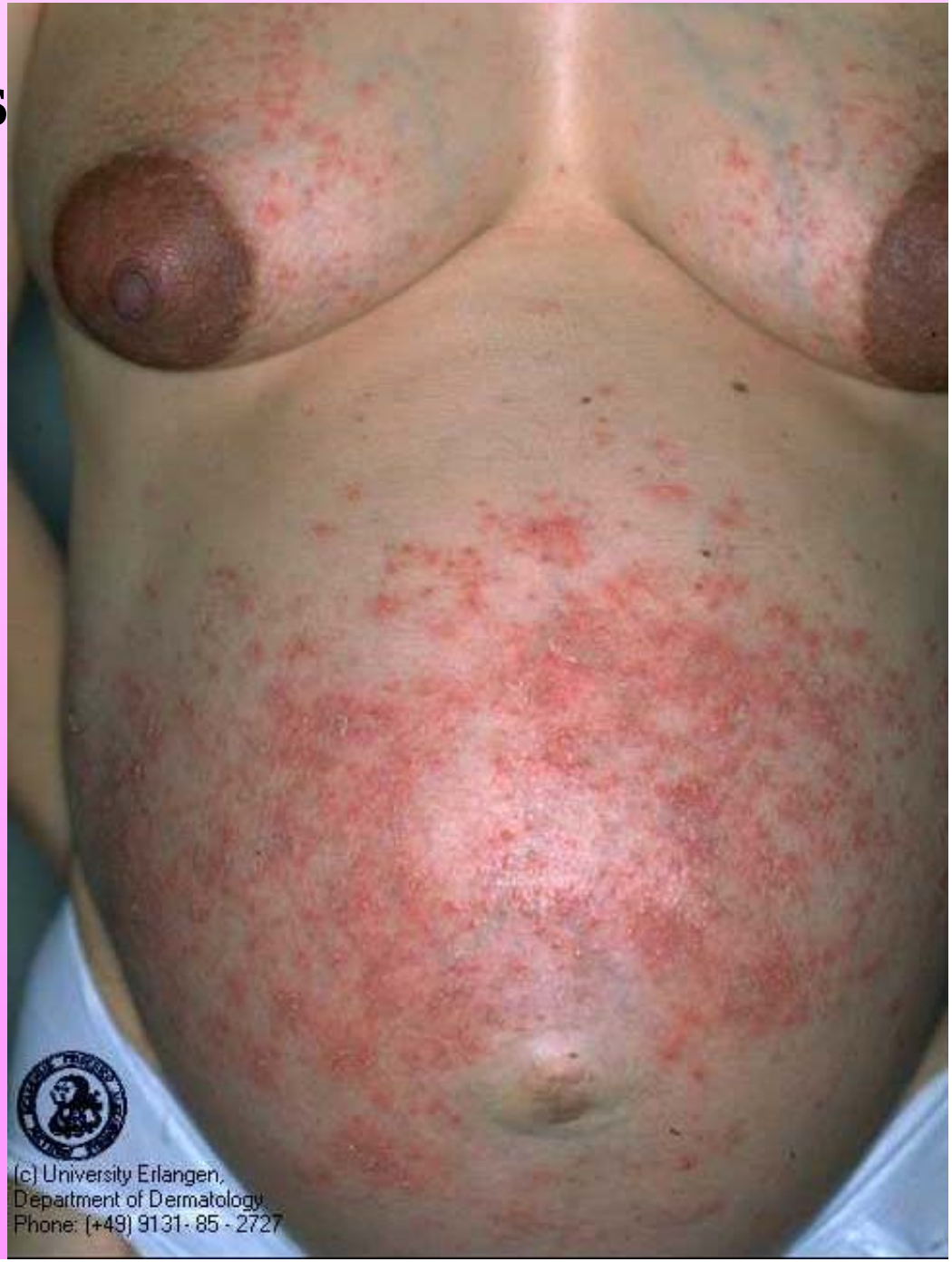
-Onset in last trimester

-Starts in flexures

-Severe constitutional disturbance

-Risk of placental insufficiency

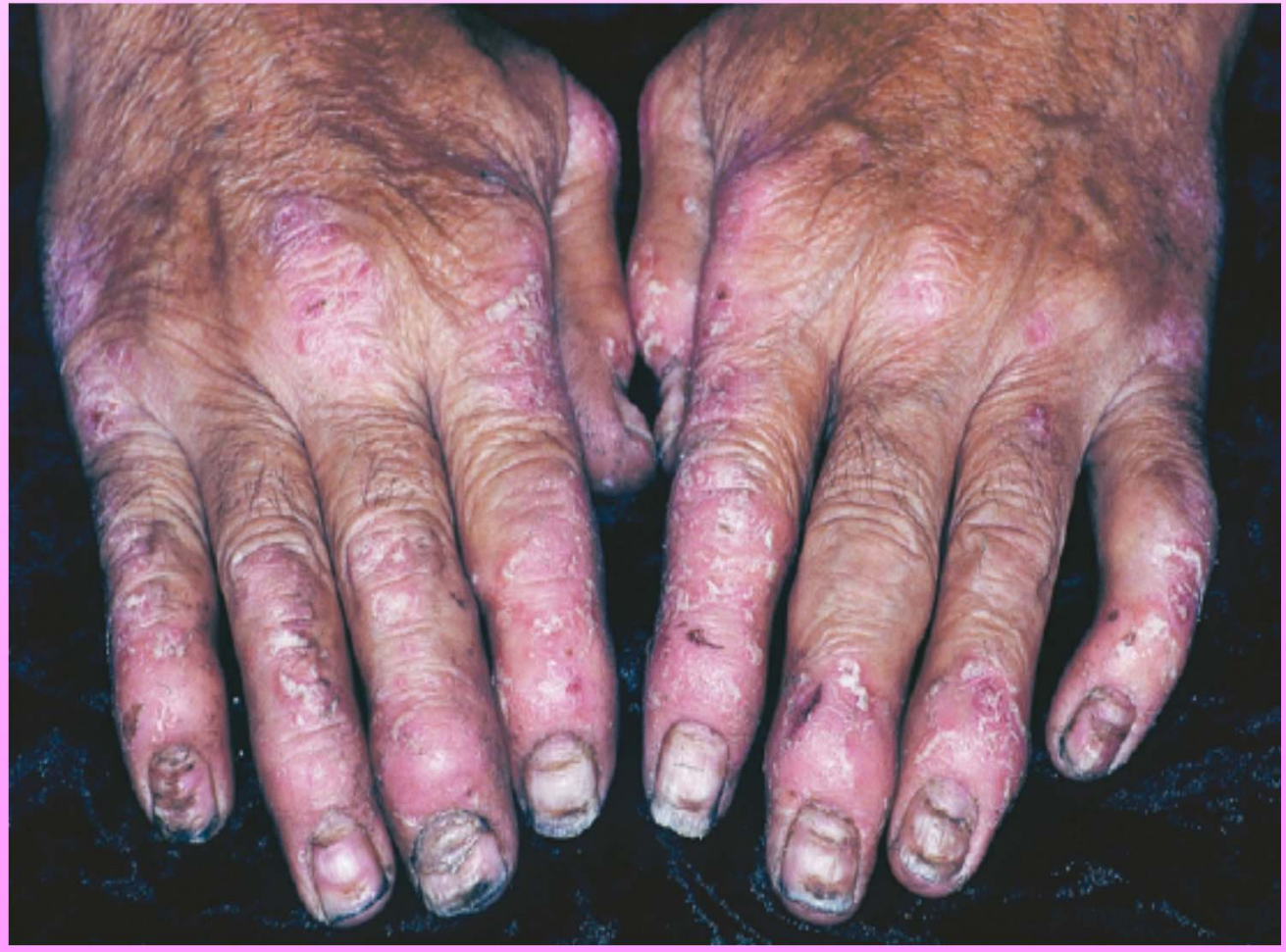
-Recurs



Psoriatic arthritis

-Seronegative

-HLA B27



Psoriatic arthropathy

-Distal symmetrical I.P.

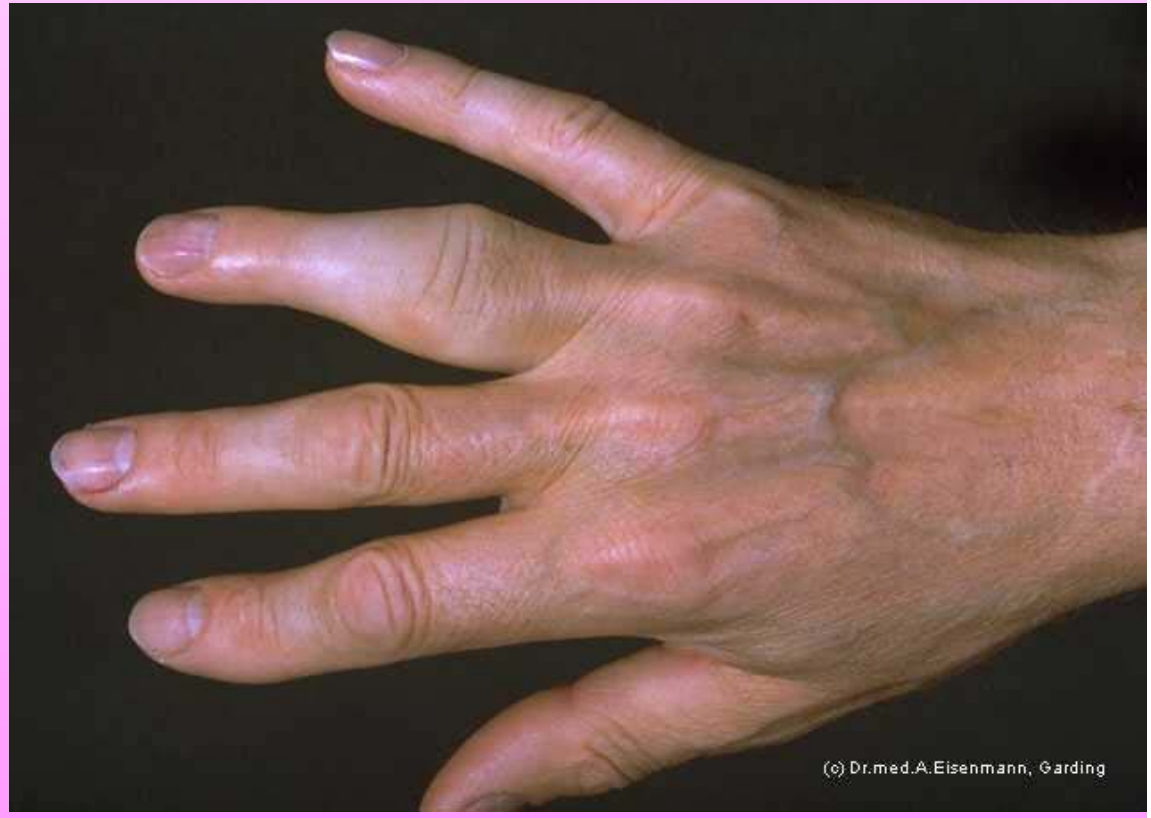
-Oligo- mono arthritis

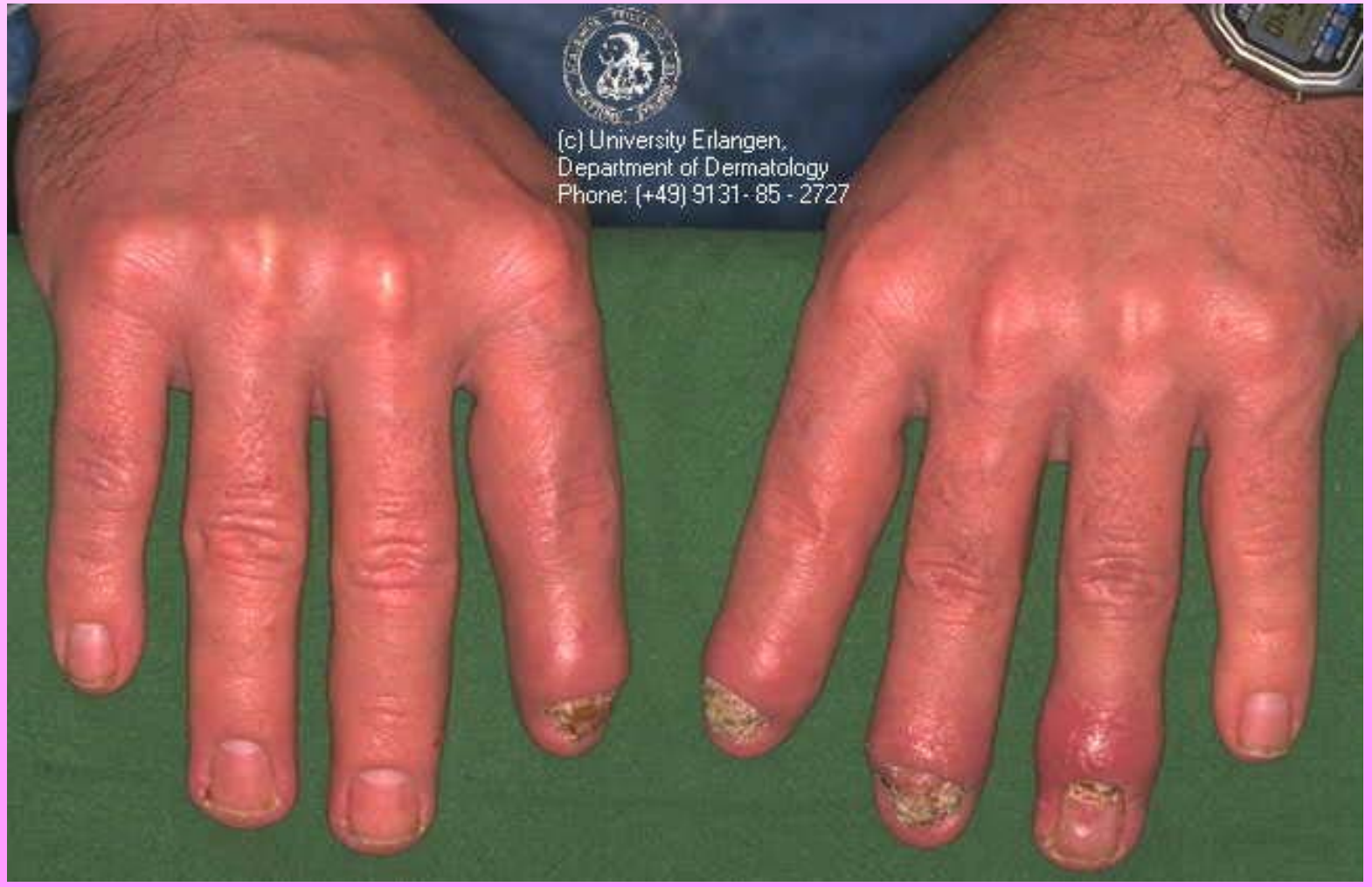
-Seronegative Rh. Arthritis

like arthritis

-Psoriatic arthritis multilans

-Ankylosing spondylitis like

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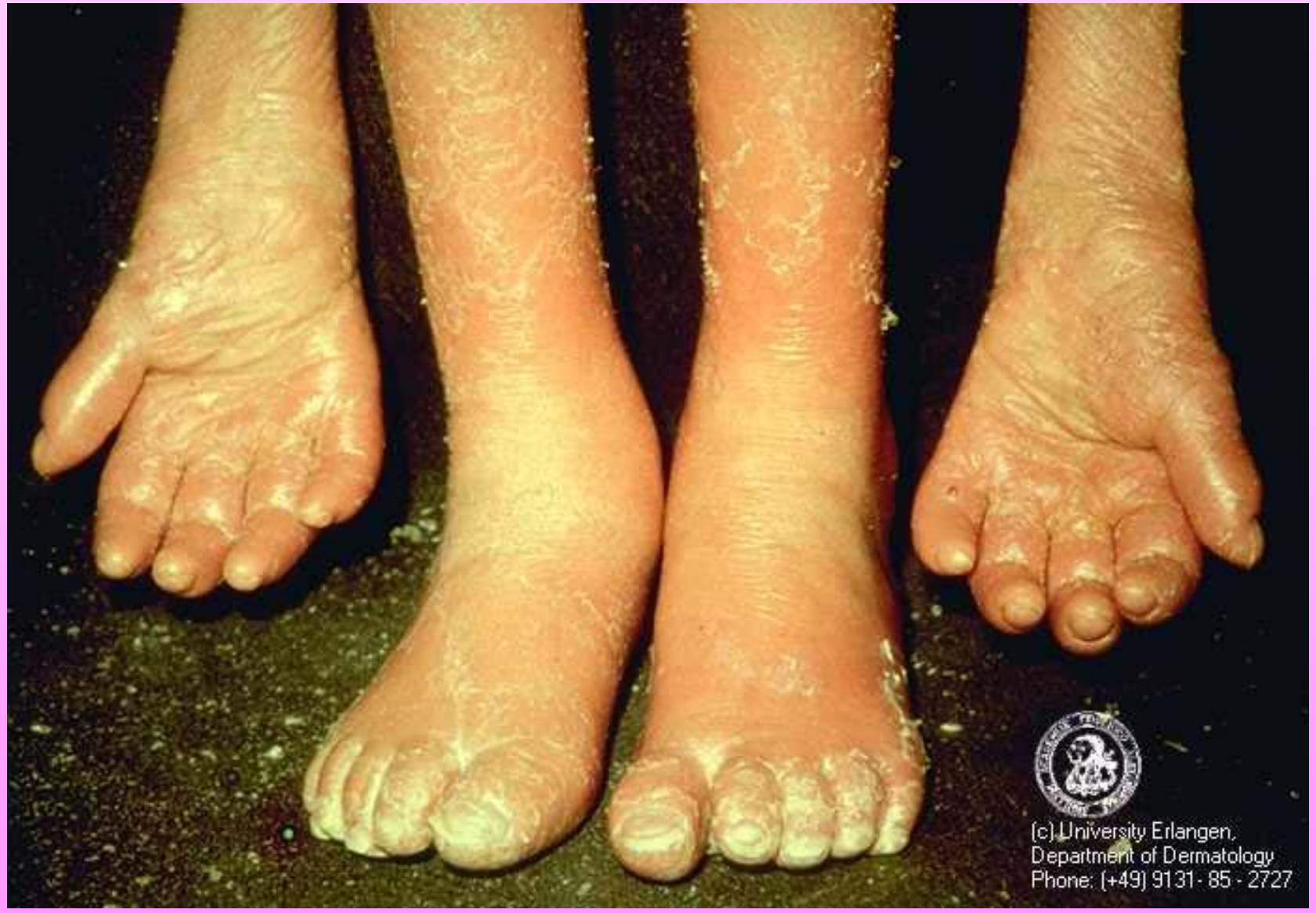
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X-ray Findings

- Local demineralization

- Pencil in cup deformity

Course & Prognosis

- Chronic
- Intractable
- Relapse is the rule

TREATMENT

a)Topical -5% Crude coal tar(Goekerman's regimen)

- Dithranol (anthranilin) 1-2%

  (short contact therapy)

- Combined coal tar + Dithranol (Ingram regimen)
- Topical steroids (mild)
- UV-B Therapy

Topical treatment Contd.

- Liquor Picis carbonis
- Keratolytics

Emollients

- Topical PUVA
- Topical Methotrexate
- Calcipotriol – Vit. D analogue

b) Systemic Therapy

- Methotrexate (0.3-0.5mg/kg/week)
- PUVA – Psoralens + UVA
- Retinoids – etretinate/ acitretin

  0.5mg/kg/day
- Cyclosporine
- Corticosteroids

Thank You