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Homoeopathy and Immunology in the Management of Psoriasis

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INTRODUCTION:

The skin is the largest and most prominent organ of the body. In the true sense of the word, if we observe our skin, it is a mirror of our state of health.

Psoriasis is a common disease in society for which the patient uses alternative therapies. Psoriasis is a relapsing disease characterized by the development of erythematous, well-defined, dry, scaly papules and plaques ranging from pinhead to palm size or larger. According to studies conducted in India on patients attending clinics and hospitals, the prevalence is 0.8 to 5.6% and 8.5% of patients have childhood onset.

In my undergraduate studies, when I was studying with a dermatologist, I came across several cases of psoriasis. I went through various books to better understand this chronic disease. And the question occurred to me: How does miasma affect the development of psoriasis? Can we perceive the individuality of disease based on a different miasma? Can we predict the nature of the disease process? How do the underlying and dominant miasmas help to understand psoriasis for homeopathic treatment? Does a lack of understanding of the miasma account for the difficulty in finding a cure and also explain relapse?

In my postgraduate course, I have observed patients who come for their suffering because they have a social stigma and are visible on the external and internal parts of the body and there are certain misconceptions in the society and they are also treated as social outcasts. I have also observed cases of psoriasis that come to SKIN OPD for chronic treatment, these patients treated with their constitutional medicine despite choosing a similar medicine, we have seen a pattern, because the effect of the medicine is exhausted, the dose is repeated or the reaction stops. It is therefore necessary to study the reasons for this with reference to the instructions given by Dr. Hahnemann, the basic miasmatic influences taken into account from them, so I felt the need to adopt a holistic approach to "Homoeopathy and Immunology in the Treatment of Psoriasis".

REVIEW OF LITERATURE:

Definition:

It is a chronic, non-infectious, inflammatory, papulosquamous skin disease where the predominant morphology of the lesion is sharply demarcated, erythematous papules or plaques covered with large, adherent, silvery scales.

Occurrence:

Between one and three percent of most of the population suffers from psoriasis. It can start at any age, but is rare under the age of ten and often occurs between the ages of fifteen and forty. The course of the disease is unpredictable, but is usually chronic with exacerbations and remissions. It is not infectious, and the tendency to it seems to be hereditary in about thirty percent of cases. The sexes are affected equally.

Etiology:

The underlying defect remains unknown, but the following factors have been implicated.

1. Predisposing factors

a) Genetic

There is often a genetic predisposition. A child with one affected parent has a 15% chance of developing the disease, and this rises to 50% if both parents are affected. If non-psoriatic parents have a child with psoriasis, the risk for other children is about 10%. Psoriasis is a genetically complex disease.

There is wide clinical and genetic heterogeneity. Linkages have been demonstrated to various loci, including chromosomes 6p, 17q, 4q, and 2q.

(b) Biochemical

It is not known whether the biochemical abnormalities are the cause or the result of increased epidermal proliferation. In the epidermis there are increased levels of prostaglandins, leukotrienes and HETE acids.

These can cause both the increased cell proliferation seen in psoriasis and inflammatory changes. Increased phospholipase A2 activity appears to be primarily responsible for these changes. Decreased cAMP and increased cGMP are found in the lesions.

(c) Immunopathological

The inflammatory reaction may be part of an immunological response to hitherto unknown antigens. Immune complexes with epidermal antigens have been detected in damaged skin and can activate complement, thereby attracting neutrophils to the area.

Certain interleukins are elevated and adhesion molecules are expressed or upregulated in psoriasis lesions. The mononuclear infiltrate is predominantly of helper T lymphocytes in the dermis and of the cytotoxic type in the epidermis.

2. Precipitating factors:

a) Trauma

When the condition flares up, lesions appear in areas of skin damage, such as scratches or surgical wounds (Koebner's phenomenon)

(b) Infection

Tenfold β-hemolytic streptococcal infections of the neck precede guttate psoriasis. Streptococcal superantigens from the throat appear to be responsible for T-cell activation in guttal psoriasis.

(c) Sunlight

Rarely, ultraviolet radiation can make psoriasis worse.

(d) Drugs

Antimalarials, β-adrenoceptor antagonists, and lithium may worsen psoriasis, and the rash may “recover” after discontinuation of systemic corticosteroids or potent topical corticosteroids. β-adrenoceptor antagonists may worsen psoriasis by inhibiting cAMP formation.

(e) Emotions: Anxiety causes some exacerbations.

Emotional stress can precipitate attacks.

Pathogenesis:

A psoriatic lesion consists of two apparently distinct morphological changes.

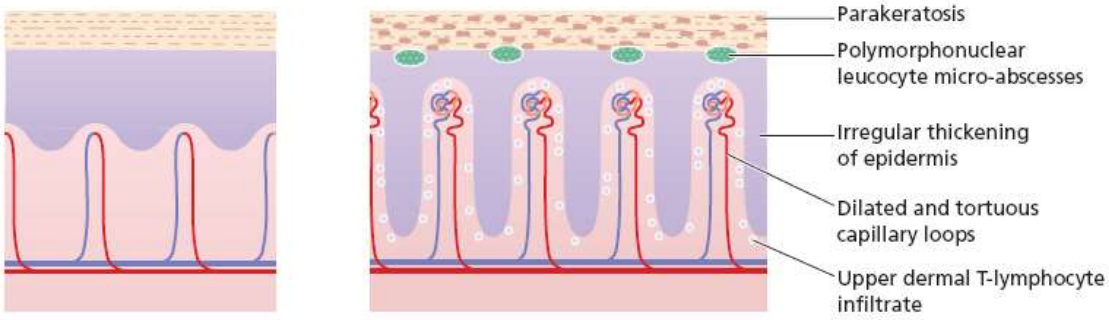
The first of them refers to the dermal capillaries, which are significantly elongated, congested and coiled, with irregular spindle dilation of their walls. It is this vascular change that leads to erythema.

The second aspect of the psoriatic lesion concerns the epidermis. Accelerated epidermal proliferation occurs due to excessive cell division in the basal layers.

The passage time of the keratinocytes of the epidermis is shortened and the epidermal turnover, which normally takes 28 days, i.e. from a basal cell to a fully keratinized horn cell, takes 5 to 6 days in psoriasis, and as a result, the stratum corneum is immature and parakeratotic, i.e. with insufficient maturation of keratinocytes.

It is this parakeratosis that is responsible for the silvery scales that are so characteristic of psoriatic lesions. A small collection of neutrophils (Munro microabscesses) may be present in the stratum corneum. This dense neutrophilic infiltrate leads to a sterile non-infectious lesion5.

Histology of psoriasis (right) compared with normal skin (left).



Clinical signs:

The initial lesion of psoriasis is a barely raised, erythematous papule topped by a whitish scale. Sometimes the scales may not be visible unless the surface is stroked or scratched.

Papules may enlarge or coalesce to form plaques. Thus, fully developed psoriasis consists of well-defined rounded erythematous plaques covered with thick silvery scales. When the scales are removed, spot bleeding is visible on the affected skin (Auspitz's sign it occurs due to severe thinning of the epidermis at the tips of the dermal papillae). When psoriasis is unstable, lesions may be induced by mechanical or other types of trauma (Koebner's phenomenon).

Variation in morphology and distribution of clinical features of psoriasis:

Stable plaque psoriasis or nummular psoriasis:

This is the most common type of presentation in which round or oval shaped lesions are found. The individual lesions are well defined and their diameter ranges from a few millimeters to a few centimeters. The lesions are red with dry, silvery-white scales that may not be visible until the surface is scraped. Predilection sites are elbows, knees, lower back, scalp, nails, palms and soles, submammary and axillary folds5.

Below are some examples with a picture of the lesion:

Elbow:

This site is often affected, probably as a result of repeated local trauma.

Scalp:

The scalp is often affected, probably due to repeated trauma from brushing and combing. Areas of severe scaling are interspersed with normal skin, forming lumps that are easier to feel than to see. Significant hair loss occurs only in the case of severe damage.

Nails

Nails are affected secondary to involvement of the nail matrix or nail bed. The most common manifestations of nail psoriasis are numerous pits in the nail plate, such as those on the thimble (dimples on the thimble) and subungual hyperkeratosis (a build-up of soft keratin under the nail plate).

Other signs of nail psoriasis include separation of the nail plate from the nail bed (onycholysis), oil spots and a nail plate that becomes thick, yellow-brown and brittle.

Guttal psoriasis

This variant is common in children and young adults and has the best prognosis. Gut-like (drop-shaped) papules ending in white scales less than 1 cm in diameter appear all over the body, especially on the trunk.

Such attacks often follow 2-3 weeks after acute tonsillitis.

Pustular psoriasis

The generalized form of pustular psoriasis is life-threatening. The onset is sudden, with myriads of small sterile pustules on an erythematous background.

The patient is ill with fluctuating pyrexia that coincides with the appearance of new pustules and requires hospitalization.

The localized form of pustular psoriasis is more common.

The palms and soles are most often affected.

The eruption consists of numerous small sterile pustules on an erythematous background, leaving behind brown macules or scales.

Some consider it a separate disease entity5.

Complication:

1. Psoriatic arthritis

It is a seronegative inflammatory arthritis that occurs in patients with psoriasis, a past or family history of psoriasis, or characteristic nail changes.

Inflammatory arthritis involving the distal interphalangeal joints, which are not typically involved in rheumatoid arthritis, is the most characteristic form of psoriatic arthropathy and is almost always associated with nail changes that include pitting, onycholysis, subungual hyperkeratosis, and horizontal striations.

There is asymmetric, terminal interphalangeal joint involvement, and relatively little periarticular osteoporosis is observed.

2. Erythroderma (exfoliative dermatitis)

Psoriasis can lead to erythroderma in about 40% of cases. Clinically diffuse and generalized erythema, edema and scaling are observed. Erythroderma can be fatal, especially in the elderly, if not treated promptly and appropriately. This is due to numerous health complications resulting from severe compromise of skin function, increased peripheral blood flow and loss of proteins and essential elements from the skin5.

Investigation:

Few are listed. A biopsy is rarely necessary because the clinical picture is usually characteristic. Throat swabs for β-hemolytic streptococci should be performed in intestinal psoriasis, and an ASO or DNAase B titer may be helpful.

Skin scrapings and nail clippings may need to be examined to rule out tinea.

Radiology and rheumatoid factor tests are important in the evaluation of arthritis5.

TREATMENT: According to modern medicine.

Treatment of psoriasis depends on the type, location and extent of the disease.

All patients should be instructed to avoid excessive drying or irritation of the skin and to maintain adequate skin hydration. Most patients with localized plaque psoriasis can be managed with moderate-potency topical glucocorticoids, although their long-term use is often accompanied by loss of efficacy (tachyphylaxis) and skin atrophy.

A topical vitamin D analog (calcipotriene) and a retinoid (tazarotene) are also effective in the treatment of psoriasis and have largely replaced other topical agents such as coal tar, salicylic acid, and anthralin. Ultraviolet light, natural or artificial, is an effective therapy for patients with widespread psoriasis.

Ultraviolet B (UV-B) light is effective alone or can be combined with coal tar or anthralin. Combining the ultraviolet A (UV-A) spectrum with oral or topical psoralens (PUVA) is also extremely effective for treating psoriasis, but long-term use may be associated with an increased incidence of squamous cell carcinoma and melanoma of the skin. Various other preparations can be used for severe, widespread psoriatic disease. Oral glucocorticoids should not be used to treat psoriasis because of the possibility of developing life-threatening pustular psoriasis when treatment is discontinued.

Methotrexate is an effective agent, especially in patients with psoriatic arthritis; however, liver toxicity and bone marrow suppression limit its use.

The synthetic retinoid, acitretin, is effective in some patients with severe psoriasis. It is a potent teratogen and should not be used in women of childbearing potential.

Evidence implicating psoriasis as a T cell-mediated disorder has directed therapeutic efforts toward immunoregulation. Cyclosporine is highly effective in selected patients with severe disease, but nephrotoxicity and hypertension complicate its use. Much attention is currently focused on the development of biologics with more selective immunosuppressive properties and better safety profiles. Etanercept, a tumor necrosis factor (TNF-) inhibitor, is now approved for the treatment of psoriatic arthritis and is in clinical trials for the treatment of psoriasis.

Other agents in clinical trials target TNF- and other pro-inflammatory cytokines,

Activation of T cells and transport of lymphocytes in an effort to suppress the inflammation characteristic of psoriasis5.

Differential diagnosis of eruptive scaly rashes:

DIFFERENT PLAN

Lichen planus (LP) is a papulosquamous disease in which the primary lesions are pruritic, polygonal, purple flat-topped papules. Close examination of the surface of these papules often reveals a network of gray lines (Wickham's striae). Skin lesions can occur anywhere, but are most common on the wrists, shins, lower back, and genitalia. Affecting the scalp can lead to hair loss. It usually affects the mucous membranes, especially the buccal mucosa, where it can appear as a white, net-like eruption. Its etiology is unknown, but clinically similar skin eruptions have been observed after administration of many drugs, including thiazide diuretics, gold, antimalarials, penicillamine, and phenothiazines, and in patients with skin lesions of chronic graft-versus-host disease. In addition, it may be associated with hepatitis C infection.

Its course is variable, but most patients have a spontaneous remission 6 months to 2 years after the onset of the disease.

Topical glucocorticoids are the basis of therapy5.

PITYRIASIS ROSEA

Pityriasis rosea (PR) is a papulosquamous eruption of unknown etiology that occurs more frequently in spring and fall. Its first manifestation is the formation of a 2- to 6-centimeter annular lesion (herald patch). After several days to weeks, many smaller annular or papular lesions appear, with a predilection for occurrence on the trunk. The lesions are generally oval and their long axis is parallel to the lash lines. Individual lesions can vary in color from red to brown and have a trailing scale.

Pityriasis rosea shares many clinical features with the eruption of secondary syphilis, but lesions on the palms and soles are extremely rare in PR and common in secondary syphilis. The rash is usually moderately itchy and lasts 3 to 8 weeks. Treatment is generally aimed at alleviating pruritus and consists of oral antihistamines, moderately potent topical glucocorticoids and, in some cases, the use of UV-B phototherapy5.

TINEA VERSICOLOR

Tinea versicolor is caused by the non-dermatophytic, dimorphic fungus Malassezia furfur, a normal inhabitant of the skin. As a yeast form, it generally does not cause disease (with the exception of folliculitis in some individuals). However, in some individuals it passes into hyphal form and causes characteristic lesions. Typical lesions consist of oval, scaly macules, papules, and macules concentrated on the chest, shoulders, and back, but rarely on the face or distal extremities. They often appear as hypopigmented areas on dark skin, while they are slightly erythematous or hyperpigmented on light skin.

In some darkly pigmented individuals, they may appear only as scales.

A KOH preparation from scaly lesions will demonstrate the confluence of short hyphae and round spores (so-called spaghetti and meatballs). Solutions containing sulfur, salicylic acid, or selenium sulfide will clear the infection if used daily for a week and then intermittently.

Treatment with a single 400 mg oral dose of ketoconazole is also effective5.

THE FACTS NEED TO BE UNDERLINED:

Psoriasis is not a contagious disease. Psoriasis is not contracted by touching, hugging, kissing, massaging, sharing toilet sheets, drinking or eating from utensils used by a psoriasis patient, or any other casual contact.

Working, socializing and living with people with psoriasis does not cause the disease.

A small collection of neutrophils (Munro microabscesses) may be present in the stratum corneum. This dense neutrophilic infiltrate results in a sterile non-infectious lesion.

A physical relationship with a person suffering from psoriasis does not pose a risk of contracting the disease.

People with psoriasis can donate their blood without hesitation.

Mosquitoes are unable to transmit psoriasis. So a mosquito bite won't give you psoriasis.

If a pregnant woman becomes ill with psoriasis, there is no risk of transmission to the fetus.

Itching is not the primary manifestation of psoriasis, it can be present as an inflammatory disease5.

HOMOEOPATHIC THERAPEUTICS

The following drugs show psoriasis-like lesions

Clarke J.H. explains the indications for the following corrective measures

Phosphorus

Desquamation of the skin. Burning in the skin. Excoriated spots on the skin with cracks and shots. Dry furry tetter. Large ulcers surrounded by small ones.

Ulcers bleed when menstruation occurs. Tingling in the skin. Nettle rash. Lips dry and parched. Cracked in the middle of the lower lips. Ulceration of the corners of the mouth.

Kali bromine.

Moist eczema of the feet with pityriasis of the scalp. Urticaria. Itching at night in bed and at high temperature; appear in winter. Eruption of small ulcers in subsequent crops, mostly on face and trunk.

Vinca minor

Great sensitivity of the skin with redness or pain at the slightest irritation. Corrosive itching, itching. Moist spots on top of right ankle20.

FARRINGTON E.A. provides the following resources:

Sepia

Herpetic eruption, tawny spots, itching, redness, blisters, moist rawness, scaly pustules aggravated by warmth of bed. Psoriasis.

Sarsaparilla

There is a sycotic eruption consisting of small dots barely raised above the skin, they often peel a little, itch unbearably, more in the spring. Moist eruption on the scalp pus from the eruption causing inflammation wherever it touches.

Mezerium

Head covered with a thick, leathery crust under which pus collects and dulls the hair. Eczema, intolerably itchy, with profuse serous exudation, covering the whole leg with raised white scabs, and roughness and scaling here and there, on the back, chest, thighs, and scalp21.

BOERICKE W. shares his views on remedies:

Album Arsenic

Bad consequences of care, sadness, fear; wound dissection.

Skin dry, rough, scaly, dirty, shriveled; worse scratching. 3+

Worse from cold and touch, better from heat and lying with head up. 3+

The skin looks scorched. 3+ Skin like parchment.

Itching, burning, swelling, edema, eruption, papular, dry, rough, scaly:

Urticaria with burning and restlessness. Ice cold body. Burning

relieved by the heat. The smell of the discharge is putrid. Complaints that come back every year.

Thickened skin with itching, burning and swelling. 2+ Free Desquamation.

Skin symptoms alternate with internal affections.

Scalp itches unbearably; circular spots on bald spots; rough, dirty, sensitive and covered with dry scales; night burning and itching.

Related complaints:

Unrest. 3+ Agonizing fear of death. Great exhaustion after the slightest exertion. Burning pains; affected part burns like fire, relieved by heat.

Intense, unquenchable, burning thirst; drinks little and often; he craves ice water, which upsets his stomach and is immediately vomited. 3+

Psorinum

Dry, dirty appearance. Unbearable itching. Sebaceous glands secrete excessively; Oily skin. A crusty eruption all over the body.

Natrum Mur

Dry, dirty appearance. Unbearable itching. Sebaceous glands secrete excessively; oily skin. A crusty eruption all over the body.

Potassium bromate

Psoriasis, pustules, itching; worse on chest, shoulder and face. Anesthesia of the skin 22.

Lycopodium:

Bad effects of fear, horror, sadness, anger, anxiety.

Psoriasis with disorders of the urinary, stomach or liver system. 2+

Skin dry, rawness in folds. The skin becomes thick and firm.

Skin dry, shriveled, especially palms. Dry, scaly eruptions.

Lesions around and behind the ears.

Related complaints:

Symptoms usually affect the right side of the body.

Most complaints are worse between 4-8pm.

Red sand in urine, worse before urination. He craves everything warm.

Kali Arsenicum:

One of the coldest patients to develop psoriasis

Skin dry, scaly, shriveled. 2+ Psoriasis better in monsoon and worse in winter.

Burning sensation with intolerable itching, worse heat, walking, undressing.

Cracks in the bends of the arms and knees. Numerous small nodules under the skin.

Worse touch, noise, night, 1-3 am; better rainy days.

Extreme anxiety about illness.

Related complaints:

A sudden noise or touch sends the whole body into a tremor.

Cool and sensitive to cold, it cannot get too hot even in summer.

Restless, nervous, anemic.

Phosphorus

Ailments from strong emotions, damp weather, loss of vital fluids

Burning sensations 3+, scaling 3+, bleeding- bright red 3+.

Skin extremely sensitive to touch, but better by rubbing.

Psoriasis with great itching. Eruptions are dry and scaly.

The lesions bleed profusely and even when they heal, they reopen.

Psoriasis of knees, elbows, feet and eyebrows.

There are several other drugs with characteristic indications

Arsenic iodate:

Psoriasis worse in dry cold weather and better in fresh air.

Significant exfoliation of the skin in large scales leaving an exudative surface underneath.

Chrysarobinum

Lesions associated with foul-smelling discharge and crusting tend

they merge to create the appearance of a single crust covering the entire area. 3+

Potassium bromate

Psoriasis with nervous symptoms. 2+

Manganum Aceticum

Chronic, inveterate psoriasis with amenorrhoea, worse during menses or at

menopause

Thyroidinum

Psoriasis with adiposity (not in the development phase). 2+

Slow cases and may be associated with hypothyroidism

Dry, depleted skin with cold hands and feet. 2+

Symmetrical, serpentine eruptions.

Psoriatic patches all over the body, as if a design had been made.

Corallium rubrum

Psoriasis of the hands and feet

Patches are absolutely smooth, shiny red, later changing to a copper color.

Hydrocotyle

Gyrate psoriasis on trunk, limbs, palms and soles

Great thickening of the epidermoid layer of the skin and exfoliation of scales.

Absolutely dry skin22.

Lilianthel Samuel explained some of the remedies for psoriasis.

They are as follows -

Mezerium

Intense itching especially after wrapping or heating. Crusts and itching are features. There are small vesicles with terrible itching, the big characteristic is that the secretion dries up quickly and scabs form underneath, which are stinging.

Mercury

Itching, burning, offensive eruption behind ears, ending in scabs, discharge of pus, < by scratching; pustules form and ooze profusely; skin dry, face pale and muscles relaxed.

Alumina

Damp scale, bleeding when scratched, nails brittle, dry skin even in hot weather; The skin appears as if the albumen has dried on its surface.

Potassium sulph

Copious desquamation of the epithelium, leaving the base moist and sticky; discharge often yellow, slimy, sometimes sticky or watery; burning, itching, papular eruption, discharge of pus as moisture23.

Kent J.T. explained some of the indicated psoriasis medications

Phosphorus

There are many types of eruptions. Eruptions are dry and scaly. Dry hairy haze. Psoriasis of knees, feet, elbows and eyebrows, phlegmonous inflammation. The eruptions are dry and scaly; dry furfuraceous herpes; blood blisters; purple spots; yellow spots on chest and abdomen; tingling and itching in paralyzed parts; skin numbness; irregular brown spots on the body; psoriasis of the knees, feet, elbows and eyebrows; urticaria and blood ulcers; phlegmonous inflammation.

Mercury

Offensive forms of eczema.; scaly eruptions, vesicular eruptions, eruptions discharging pus. Vesicles burning and smarting, with irritating discharges, especially on head. Violent itching of the skin, violent, in all parts of the body, as from fleas. Most eruptions are wet with profuse oozing

Graphites

Psoriasis of the hand and fingers; raw moist places between toes; fingernails are thick and brittle; nails turn black and fall off.

Aurum Arsenicum

Eruptions: blisters; cooks; burning eczema; herpes; painful pimples; psoriasis; Red; crusting; scaly; bran-like; cleverness; syphilitic; hives; vesicular; erysipelas.

Arsenicum sulphuretum flavum

Eruptions; blisters; bloody after scratching; cooks; burning; carbuncles desquamating: dry; ECZEMA; smelly; herpes; itch; moist with acrid yellow discharge; painful petechiae; painful pimples; psoriasis; PUSTLES; rash; SCABBY after scratching; brain-like scales; pinching; festering vascular worse after scratching with yellow fluid.

Arsenicum iodatum

Many eruptions on the skin; boils pustules rash and scales; moist eruptions eczema itching eruptions; herpes; psoriasis.

Alumina

Dry weather and dry, cold weather increase aluminum oxide complaints, and this wet weather sometimes improves. A remarkable feature of the drug is chronic dryness of the skin. Pot is rare and rare. Pile up blankets to sweat if you want, but it just gets hot and itchy and doesn't sweat.

Faint sweat. Complete inability to sweat24.

CONCLUSION:

Psoriasis is a common chronic disease (incurable according to the modern school).

medicine) which we encounter in daily practice especially in tropical countries like ours.

From a homeopathic point of view, they are reflectors of internal tension, internal dynamis exhibiting great perversion in the organism. 30 patients with psoriasis were accepted for study. The results of the various observations are discussed below under different headings.

• In this study, most of the cases were between 30 and 50 years of age. The the maximum incidence, i.e. 36.66% is observed in adults aged 41 to 50 years years with 11 cases. The next age group is between 31-40 with incidence 33.33% with 10 cases. The age group of 51 and over has an incidence of 23.33% with 7 cases. The minimum incidence is the age group between 21 and 30 years with incidence 6.67% with 2 cases. All patients were between 29 and 60 years of age. In this study the youngest patient was 29 years old and the oldest 60 years old. That proves it statement of Dr. Dermis Joseph D. that the incidence of psoriasis is between the ages of 31 and 60.

• With regard to the occurrence of gender In this study, men made up 53.37% and women were 46.66% each. The study showed an almost equal male relation to women.

• In this study, some contributing predisposing factors such as cold, emotional And psychological stress was found. Another was a positive family history at 11 cases, which confirms that the genetic link is indisputable. Winter like most an important definitive exogenous predisposing factor was found in 80% of cases.

Rationale for occurrence in European and tropical countries during winter.

Most patients had a history of onset and exacerbation during the winter season.

Similar findings of exacerbation and onset have been reported by many experts. This correlates with the findings of Dr. Dearborn M. Fredrick.

• Common comorbidities in this study were acid peptic disease observed in 30% of patients, followed by recurrent colds and coryza in 20% of patients.

Joint pain with an incidence of 16.67% with 5 cases. Diabetes mellitus a Hypertension had an incidence of 13.33% with 4 cases each. Chronic headache and Back pain had an incidence of 10% each with 3 cases. Recurrent cough, Asthma, hypothyroidism, kidney stones and menorrhagia had an incidence of 3.33% each with 1 case.

• Most patients with psoriasis had scales and plaques as the most common morphology of lesions with the maximum incidence, i.e. 66.67% in 20 cases.

Scaly presenting with fissured lesions had an incidence of 40% covering 12 cases and papular presentation of the lesions had an incidence of 20% covering 6 cases.

• Among the common variants of psoriasis, the maximum incidence is 53.33% is observed Psoriasis vulgaris, i.e. variant of plaque psoriasis as the most common manifestation in 16 cases followed by psoriasis Palmoplantaris 40% incidence in 12 patients and Guttate psoriasis covered 6.67% with 2 cases of the 30

• With respect to the miasmatic diagnosis In this study prevalent miasma was the sycosis. This was followed by a 60.00% incidence observed in 18 cases by 26.66% of cases which showed Syco-Syphilitc miasma and 13.37% of cases showed syphilitics as the predominant miasma in 4 patients. This is confirmed by observing great devotees like Dr. Henry Allen and Dr. Phyllis Speight, who found a sycotic element prevalent in psoriasis.

• According to Garth Boericke: “All treatment of difficult cases is constitutional and a certain class of means has been found to be best for this purpose. Such drugs profoundly affect metabolism and physiological processes contrary to more superficial means whose sphere is functional change when there is action relatively short. Constitutional treatment is never used at the bedside, but afterwards the most exhaustive examination which makes it a physical history examination and laboratory findings."

Constitutional remedies were selected based on a summary of symptoms which was formed by Kent's approach, where more emphasis was placed on patients mental symptoms and PQRS symptoms on Physical General and Physical especially with regard to the miasms and constitution of patients and cases repertorized using the complete repertory from CARA homeopathic software.

• The mentioned constitutional remedies were prescribed strictly individually constitution, the following drugs have been found to be frequently indicated in current study.

Natrum Mur [3], Lycopodium [3], Sulfur [2], Pulsatilla [2], Nux Vomica [2],

Calcarea Carb [2], Lachesis [2], Calc sulph[1], Causticum[1], Ignatia [1],

Arsenic alb [1], Kali carb [1], Merc sol [1], Sepia [1], Veratrum alb [1],

Natrum carb [1], Carcinosin [1], Graphites [1], China off[1], Phosphorus [1].

• In this study, the use and necessity of acute means to manage the acute clinical condition was verified. And also the importance of intercurrent means to treat a chronic disease such as psoriasis is strengthened. At the well event the indicated constitutional remedy is blocked and the patient does not respond to it other medications, obstacles to healing are sought.

In this study, acute treatment was administered to 4 patients, i.e. 13.37%, inter- current treatment was given to 10 cases i.e. 33.33% of all patients except a constitutional remedy for all.

The following emergency resources were provided:

Arsenicum Alb [2], Pulsatilla [1], Bryonia [1] .

Below are the intercurrent corrective actions:

Tuberculinum [5], Psorinum [3], Thuja [1] & Medorrhinum [1].

• As mentioned in the material and methods section, 3 parameters were used assess the results. 1) Restored 2) Improved 3) Unimproved.

It was observed that out of 30 cases of psoriasis, 2 cases i.e. 6.67% recovered. There was a remarkable improvement in mental, physical and symptomatic plane. 19 cases i.e. 63.33% improved. There was a lot of it improvement of symptomatology. In 5 cases, i.e. 16.66%, there was none improvement. Failure to follow the doctor's recommendations during the period treatment was often encountered in these patients 4 cases dropped out.

In this study, most of the patients were treated with allopathic and Ayurvedic treatment of this disease for different periods of time, but it did not help them recover.

As Hahnemann states, “allopathic methods of treatment made use of many things against diseases, but usually unsuitable ones'. There it acts as a suppressive method treatment and not curative

Homeopathy uses a harmonious way of treating diseases. This therapeutic the method is based on natural principles and is therefore non-suppressive in nature.

Constitutional homeopathic treatment is both curative and preventive for psoriasis

Through homeopathic remedies, the miasmata are kept in a quiescent state and thereby diseases are completely extinguished.

In the end, it can be said that real healing takes place only according to homeopathic method of treatment. Hahnemann expresses a similar view in § 7-25

"Homoeopathy is undoubtedly the correct method, which is the fastest and the surest and most permanent cures are obtained, for this healing art rests on the eternal, infallible law of nature. Pure homeopathic healing art is the only correct method, the only one possible to human art, the most direct method of healing, as certain as there is but one straight line between two given points'.

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