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DERIVING THE RUBRICS CORRELATING MIND AND BODY IN PSORIASIS USING RADAR SOFTWARE

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ABSTRACT:

Psoriasis is a genetically determined disorder of keratinization. Characterized by chronic well-defined silvery scales, erythematous plaques. It mainly affects the extensor aspects of the limbs, trunk and scalp. Nail involvement is often the key to diagnosis.

A retrospective study of 30 cases of psoriasis was performed by simple random sampling. These cases were studied in terms of LSMC (location, sensations, modalities, accompanying phenomena), ODP (onset, duration, course) and physical examination to diagnose different clinical variants of psoriasis.

The Life Space Chart (LST) was used to understand the mind-body relationship to create a cause and effect relationship.

RADAR software, The Repertory was used to create the Repertorial Totality and derive mind-body correlation rubrics. And assess the usefulness of the RADAR software.

KEYWORDS: Psoriasis, Rubric, Mind, Body, RADAR, Constitutional Homoeopathic Medicines, Repertory, Homoeopathy.

INTRODUCTION:

Psoriasis is a non-infectious, chronic inflammatory, genetically determined disease characterized by the formation of well-defined scales, plaques on the extensor parts of the limbs, trunk, back and scalp. Nail involvement is common. Psoriasis can be localized or generalized. A characteristic feature is high variability and unpredictability. Psoriasis is considered an autoimmune disease. Precipitating and aggravating factors such as intercurrent infections, endocrine imbalance, physical trauma, and psychological stress play a role in the course and prognosis of the disease. During my internships at UG, a neighbor approached me for a consultation regarding his son's skin condition. He suffered from palmoplantar psoriasis since he quit his job 8 months ago. After taking over the case, I found out that his boss had insulted him in front of his colleagues, he suffered feelings of shame and anger and decided to quit his job. Within days of his resignation, his palms and soles began peeling and by the end of 4 months it had gotten so bad that he couldn't even move out of the house, he stopped hanging out with his friends. I used the Synthesis repertoire for Repertoring after several remedies failed; I prescribed Staphysagria in LM potency, within 4 months all the skin deposits cleared up. This was the event that encouraged me to pursue the topic of "Mind-Body Correlation in Psoriasis". In the above situation there was a sense of humiliation and insult, embarrassment and repressed anger - with such sensitivity that he left his work - that his skin began to thicken and ooze pus and blood to form a complete picture of palmoplantar psoriasis. This experience motivated me to study psoriasis. In this study, 30 cases of psoriasis are studied. Life Space Table (LST) is used to analyze and evaluate Life Space Investigation. RADAR software is used to repertorize these cases in order to assess its usefulness.

REVIEW OF LITERATURE:

Embryologically, the relationship of the skin to the brain is well known, both originating from the epiblast. In the field of psychosexual development, this skin-mind relationship is also a well-known phenomenon. From birth, constant perceptual stimuli fall on the surface of the body, which help the child to distinguish itself from the material environment and the concept of "Ego" develops. Touch and warmth associated with satisfying his biological activities such as bathing, feeding, urinating, defecating, etc. they help him distinguish between painful and pleasant sensations. Thus, the skin is not only an extension of the primitive central nervous system, but also becomes an essential part of the individual's temperament and personality.
The skin is the canvas on which most of the common emotions like anger, fear, embarrassment etc. are reflected. The state of mind and the state of the skin influence each other, and the individual's reaction is further conditioned by his personality and the social attitude of the community towards skin problems. Scales, crusts and sores usually have an unsightly appearance and cause fear of infection. Many people believe that itching, regardless of the

cause, is caused by impurities. So they stay away from patients with skin diseases. Since childhood, he has been the target of rejection, withdrawal of affection and ridicule. He can't blend in properly with people, he can't participate in groups, sports and recreational activities. In the case of girls, the chance of marriage is adversely affected and the chance of marital discord increases. The social background of patients with diseased skin must be kept in mind by every doctor who attends to them. This immediately alerts us to the fact that skin diseases cannot always be treated as superficial somatic lesions. They are of multifactorial origin and are conditioned by various constitutional and environmental factors.

There are many cases of dermatoses in which causative factors play a more or less significant role. For example: urticaria, psoriasis, atopic dermatitis, nummular eczema, lichen planus, alopecia areata. Emotional instability, stress, tension, anxiety and frustration seem to be the underlying psychological factors in these patients. In these cases, these may be causative factors. Sometimes, of course, it's the other way around. A person who has disfiguring lesions or great irritation is subject to neurotic manifestations secondary to the eruptions.

When dealing with such patients, the physician must ask three sets of questions:

1. What type of person am I dealing with? - Inherited and acquired characteristics, physical and mental constitution.
2. What did he encounter? - Bacteria, allergens, emotionally disturbing experiences, etc.
3. What happened? - Physiological mechanism and psychopathogenesis.

So history and observation of behavior is essential. The doctor must be "inquisitive", attentive to all visible evidence, watch over every statement of the patient. Above all, he must know what to look for.

"The eyes cannot see what the mind does not know."

One such skin condition that carries a social stigma is psoriasis. The history of psoriasis is interesting. Galen was the first to use the term psoriasis. The Roman sage Aurelius Cernelius Celsus is credited with the first clinical description of psoriasis. In 1808, Robert Willian specifically distinguished it and described it as a recognizable entity. In 1841, Hebra definitively differentiated the clinical symptoms of psoriasis from leprosy.

Psoriasis is a genetically determined disorder of keratinization, characterized by the appearance of chronic, well-defined, silvery mica scales, symmetrical, erythematous plaques on the extensor side of the limbs, especially on the elbows, knees, trunk, back and scalp. Nail involvement is very common and often provides the key to diagnosis. Psoriasis can be localized or generalized. A characteristic feature of this chronic disability is high variability and unpredictability. Psoriasis is considered an autoimmune disease and has a strong genetic predisposition in the form of polygenic autosomal dominant inheritance with variable penetrance. Precipitating and aggravating factors such as the physiological changes of puberty and pregnancy, intercurrent infections, endocrine imbalance, physical trauma and psychological stress have a certain role in the cause, course and prognosis of the disease.

The clinical development of psoriasis is largely influenced by genetic and environmental factors. This results in large differences in disease prevalence between different groups and in different parts of the world. Other patients with minimal clinical manifestations often do not seek medical help. Most prevalence studies are based on information from clinical examinations, interviews and census studies. Estimates of the prevalence of psoriasis in different parts of the world range from 0.1% to 3%. The few studies that have been conducted in India to determine the prevalence of psoriasis included patients attending clinics and hospitals, so their findings of 0.8 to 5.6% do not reflect the true prevalence of psoriasis in the general population.

Psoriasis can appear at any age and can appear right after birth or in old age. There is a bimodal age of onset, the first peak at age 15-20 and the second at age 55-60. Other Indian studies report the highest incidence in the second decade or reproductive age group. A North Indian study found that the mean age of onset was higher in men than in women. Possession of certain HLA antigens, particularly HLA-Cw6, is associated with an earlier age of onset and a positive family history.

This has led to the belief that there are two clinical manifestations of psoriasis:

Type I disease: Hereditary form, which accounts for more than 75% of cases - is HLA linked with a positive family history, begins before age 40, and is more severe and relapsing.

Type II disease: Sporadic form, onset later in life and without any family history or HLA-Cw6.

The high familial incidence of psoriasis, ranging from 7% to 36%, suggests that genetic factors play a role in the etiology. If both parents are affected, the prevalence in offspring is 50%. If one parent is affected, the prevalence drops to 16%. And if neither parent is affected, the prevalence is 8%. Psoriasis occurs with equal prevalence in men and women. Psoriasis is more common in relatives of first- and second-degree psoriasis patients than in the general population. It is estimated that 30% of patients with psoriasis vulgaris have an affected first-degree relative. The risk is 2 to 3 times higher in monozygotic twins than in fraternal twins. Patients with psoriasis have an increased frequency of HLA-B13, HLA-B17 and HLA-Bw16. One of the most important susceptibility factors for psoriasis is the presence of HLA-Cw6.

Psoriasis is a lifelong disease that is subject to unpredictable remissions and relapses. It must be distinguished from other disorders of red/scaly epidermis. The pathogenesis of psoriasis is characterized by hyperproliferation and abnormal differentiation of epidermal keratinocytes, lymphocytic infiltration of mainly T lymphocytes, various endothelial vascular changes in the dermis, such as angiogenesis, dilation, and high formation of endothelial venules. Hypotheses about the pathogenesis of psoriasis have changed over the decades, but its etiology is still unknown.

Pathological cooperation between innate and acquired immunity (mediated by T lymphocytes) causes the production of cytokines, chemokines and growth factors that contribute to the inflammatory infiltrate seen in psoriatic plaques.

The increased proliferation of keratinocytes in psoriasis is thought to be due to an increase in the proliferating cell compartment in the basal and suprabasal layers, rather than due to a shortened cell cycle time. In normal skin, the basal keratinocyte cycle is around 10%, while in lesional skin this cycle is accelerated by up to 100%. In normal skin, the transition from basal keratinocytes to desquamated cells takes 4 to 6 weeks. But with psoriasis, it happens within a few days. This accelerated process manifests itself in regenerative aging, which is considered a program triggered when normal skin is injured.

However, keratinocytes in psoriatic plaques express some immune-related molecules that are not normally associated with wound-related regenerative hyperplasia. This accelerates the proliferation of basal keratinocytes and the abnormal differentiation of spiny and granular keratinocytes – leading to incomplete parakeratosis, the stratum corneum barrier is not formed properly in psoriatic plaques, resulting in a defective barrier and flaking of stratum corneum fragments in large sheets of scales and scales. flakes.

Psoriasis can be triggered by a variety of factors, including physical damage to the skin - Koebner's phenomenon, rapid withdrawal of immunosuppressive drugs such as corticosteroids, repeated systemic infections, obesity, seasonal fluctuations, pregnancy, emotional stress, HIV infection, alcohol consumption, tobacco smoking, etc. Psoriatic lesions tend to develop at sites of skin injury. Induction of lesions by skin trauma isomorphic reaction is called the Koebner phenomenon. Lesions will be induced when both the epidermis and the papillary dermis are affected by trauma. It usually occurs within 7 to 14 days, but the interval can be as short as 3 days or 3 weeks. In most patients, skin lesions worsen in winter. High humidity is usually beneficial.

Psoriasis is more "sensitive to stress" than many other skin conditions. Up to 60% of patients describe "stress" as a key exacerbater or trigger of their illness. The disease itself can cause reactive depression in the patient, which can further worsen their psoriasis. There is evidence for the release of sensory neuropeptides from cutaneous sensory nerve endings in psoriasis. Capsaicin, known to deplete neuropeptides from peripheral nerve endings when applied topically, improves psoriasis.

Upper respiratory tract infections and tonsillitis in children, especially if caused by streptococci, can worsen existing psoriasis or precipitate an attack of acute intestinal psoriasis, usually associated with an elevated antistreptolysin "O" titer. HIV infection is associated with exacerbation of psoriasis.

Many medications can precipitate and exacerbate psoriasis, especially beta blockers, ACE inhibitors, antimalarials, chloroquine, tetracycline, lithium-based medications, and interferons. Psoriasiform lesions induced by such drugs are less scaly and less erythematous. These eruptions usually resolve within 2 to 6 weeks after stopping these medications. Certain medications, such as NSAIDs, ibuprofen, salicylates, and indomethacin, have not been reported to accelerate or worsen psoriasis. Severe depression alone can be a cause of psoriasis. When patients with manic-depressive psychosis are treated with lithium-based drugs, patients with stable psoriasis vulgaris may develop generalized pustular psoriasis. Discontinuing corticosteroids or strong tropical corticosteroid ointments too quickly in patients with psoriasis may precipitate generalized pustular psoriasis or may cause erythroderma as a rebound phenomenon.

Sunlight can only make psoriasis worse if you don't suffer from photosensitive psoriasis. Excessive alcohol consumption worsens existing psoriasis. Past or current smoking, more than 20 cigarettes per day, is associated with a twofold increase in the risk of severe psoriasis and may also play a causative role. Psoriasis patients have high rates of excessive alcohol intake and death from alcohol-related diseases. Obese patients are more likely to develop severe forms of psoriasis.

Psoriasis may worsen with progression of immunosuppression due to loss of regulatory T cells and increased CD8T cell activity in patients with HIV infection. In HIV patients, psoriasis may be misdiagnosed as seborrheic dermatitis due to clinical similarities.

Psoriasis can be clinically classified as:

1. Intestinal psoriasis
2. Chronic plaque psoriasis
3. Exfoliative psoriasis
4. Pustular psoriasis
5. Psoriasis unguis
6. Mucosal psoriasis
7. Arthropathic psoriasis
8. Regional variation in psoriasis

A research study by MM Kossakowská, C. Cieścińská, J Jaszewská and WJ Placek on 60 patients with psoriasis found that patients with maladaptive anger control processes tend to suffer from psoriasis and recommended the use of psychological therapies to help patients.

In a study by Ramón Martín-Brufau, Santiago Romero-Brufau, Alejandro Martín-Gorgojo, Carmen Brufau Redondo, Javier Corbalan and Jorge Ulnik on 823 patients with psoriasis, they found positive associations between the extent and severity of skin lesions and negative and submissive emotions, negative correlations with emotions dominance and no association with positive emotions. The study concluded that there is a relationship between emotions and skin lesions. It also makes it possible to distinguish associations between psoriasis lesions and a specific type of emotion.

In a study conducted by Sampogna Francesca; Tabolli Stefano and Abeni Damiano evaluated 936 patients using the emotional and functional scales of the Skindex-29 questionnaire. They found that the most frequently experienced emotions are shame, anger, fear, difficulties in daily activities and social life. The intensity of these emotions was directly correlated with the severity of psoriasis and with depression or anxiety. They found that shame, worry, and annoyance were more common in women than men, and shame and anger were also associated with low levels of education. Work/hobby impairment was significantly higher in patients with palmo-plantar psoriasis and in patients with arthropathic psoriasis.

In a study by Stephen Rapp, Steven R Feldman, M LynExum, Alan B FleischerJr, David M Reboussin of 317 psoriasis patients who were asked to respond to a psoriasis patient quality of life questionnaire, they found that psoriasis reported reduced physical and mental functioning comparable to with reductions seen in cancer, arthritis, hypertension, heart disease, diabetes and depression.

In Gundimeda Ram Mohan's study of 25 patients with psoriasis, it was found that patients felt guilty that they could pass the lesions on to their children and relatives, rejected feelings that caused anger, frustration and depression, difficulty with daily activities, reactive depression in alcoholics - these negative emotions caused by psoriasis.

"Without fire there could be no smoke!"

Without permanent causes there can be no effect, in another sense effects always precede some cause. The relationship between cause and effect is modified and controlled from phenomenon to phenomenon by time, space and momentum. There can be no spontaneous initiation of anything. There must always be a cause of disease. Causative factors are individual patient characteristics and vary from individual to individual.

The disease concept advocated by Dr. Hahnemann's is that disease is a primary disorder of the vital force. When harmonious health is disturbed by any causative disease, this power changes. This disharmony from external or internal stimuli results in disease. External stimuli can be mechanical, such as injury or trauma, or physical, such as living in adverse conditions, or mental, such as prolonged sadness, anxiety, repressed anger, etc. According to Dr. Hahnemann, diseases originate from 3 different causes:

1. Exciting cause
2. Preservation of the cause
3. The root cause

It is clear that Dr. Hahnemann wants to teach that it is the disorder of the inner man, the lack of harmony or lack of balance that gives the signs and symptoms by which we recognize disease. In the course of time we will see that the change in the shape of the cell is primarily the result of the disorder, that the disorder of the immaterial vital principle is the very beginning of the disorder and with it the change of feeling. which one can

1. Basic/ primary/ remote predisposition/ essential/ effective/ essential
2. Secondary/ immediate/ accelerating/ exciting

to recognize this beginning which occurs long before any visible changes occur in the material substance of the body.

The mental image is important to the homeopathic physician because it reveals the inner man. It adds character to the image and thus helps to distinguish it. Dr. Kent emphasizes the mental side of the picture, which the physician should pay special attention to in the development of the case. On the other hand, Dr. Boenninghausen believes that the correct mental image is difficult to create, hence his stance on modalities.

Causality is the action of causal energy, the relationship of cause and effect, and the belief that every event in nature has an unchanging set of antecedents whose occurrence in a specified manner at successive instants of Time would be necessary for that event to occur. The causes are classified as:

-Physical, chemical and biological environment

- Sociocultural economic-political environment

-Psycho-spiritual, philosophical and religious environment

3. Maintenance/Modifications

One of the key questions to ask during questioning and examination is the exciting cause or circumstances leading to the patient's main symptoms or illness. Sometimes "causality" alone leads us to the patient's drug history. Dr Clarke devoted an entire chapter to causation in his clinical repertoire.

The cause and its well-marked causality, especially on the emotional level, can be considered the equivalent of mental symptoms. Causality has a characteristic factor in the patient's history and sometimes outweighs or dominates all other symptoms. Sometimes it can be our only thing that guides us and the medicine that the patient needs at that moment. This is especially true when the patient says that he has never felt well since a certain complaint, such as sadness, fear, trauma or vaccination, etc., especially after emotional trauma, sadness, mental shock, disappointed love, etc. mental and physical symptoms which in themselves give no clue. These secondary symptoms distract us from treatment because the patient only accentuates these symptoms. This is a psychosomatic expression. Asthma attacks from an acute infection with whooping cough or chronic dyspepsia from excessive blood loss a year ago are similarly striking examples. "Causative" symptoms must be key symptoms. Similarly, a history of physical trauma can produce a range of symptoms, and here the "injury" becomes more important than the other symptoms. However, very often we tend to ignore its importance in our news analysis.

All events or circumstances that contribute to the onset of the current medical condition should be recorded. Sometimes the patient forgot or thought it was not important. Boger mentioned that so much depends on knowing the cause of the disease that without it one cannot safely select a homeopathic remedy.

An etiologic factor, gross or subtle, may serve to distinguish one case from another, even when in other respects they appear similar. A patient who develops a stroke after a long period of sleep loss may need a different drug than another with the same condition but a history of suppressed anger. The pathology may be the same, the diagnosis or nosological label may be the same, but the etiology (cause) may be of fundamental importance to the diagnosis of homeopathic remedies. Fortunately, we have a variety of drugs in our repertoire that cover a wide range of such etiological factors.

Dr. Hahnemann always tried to emphasize the importance of causative factors in the environment - both physical and emotional - that may be responsible for the development of disease. He advises the doctor to first eliminate the cause whenever possible. But at the same time, he warned doctors against the dangers of theorizing and speculating about the ultimate cause or mechanism of disease. He warns the true homeopath to remove all obstacles to cure before administering a similar remedy. The causal factors of the case form the core of the picture of the patient in his illness. Their identification and inclusion in the picture is therefore necessary if the prescription is to prove that they are homeopathic and therefore medicinal.

The homeopathic physician, who is keenly interested in doing the best for his patient under the circumstances, has a very difficult task in selecting remedies. Fortunately, one of the greatest tools at our disposal for navigating the symptom maze of such a large number of remedies in the Materia Medica is the "Homoeopathic Repertoires." study thoroughly before we can use them properly.

The Homeopathic Repertory is an index to the large number of symptoms of the various remedies of the Homeopathic Materia Medica. It adds nothing, changes nothing, but serves only as a guide to the matter we have a separate analysis for classification and easy reference. Using repertoires and studying them frees the mind from the shackles of stuck thoughts of memorized key notes of several important remedies. The repertoire also helps us to be more objective and get rid of prejudices. Those who don't use Repertories tend to develop some favorite drugs, but reportage studies help us shake off those tendencies.

"No one can know everything, and therefore it must be admitted in all honesty that no conscientious homeopathic physician can practice homeopathy in a serious and truly scientific manner without a repertory." – Dr. Pierre Schmidt.

The mind-body rubrics for psoriasis identified from RADAR are as follows:

- MIND - CHEERFUL - itching eruption; although it exists
- MIND - DELUSIONS - crazy - go crazy; one will - itching; with
- MIND - DESPAIR - itchy skin, from
- MIND - IMPATIENCE - itching, from
- MIND - IRRITABILITY - itching, from
- MIND - RESTLESSNESS - itching, after
- MIND - SADNESS - itching, from

- MIND - STARTING - itching and biting, from
- MIND - SUICIDE - itchy skin; from
- MIND - ANGUIS - skin eruption; with
- MIND - ANXIETY - eruption; after suppression
- MIND - DULLNESS - eruption; from suppressed
- MIND - ERUPTIONS; mental symptoms after suppression
- MIND - HYPOCHONDRIASIS - eruption; after suppression
- MIND - MADNESS - eruption; after suppression
- MIND - ANGER - general disgust - eruption; before
- MIND - MANIA - eruption; after suppression
- MIND - OBSTINATE - eruption, during
- MIND - SADNESS - eruptions - suppressed eruptions; with
- MIND - SOMNAMBULISM - eruption; after the old one is gone
- MIND - STUPEFACTION - eruption; from suppressed
- MIND - SUICIDAL disposition - eruption; from
- MIND - UNCONSCIOUSNESS - eruptions - slowly appear; when an eruption occurs
- MIND - UNCONSCIOUSNESS - eruptions - suppression of eruptions; after
- SKIN - ERUPTIONS - psoriasis - sadness or repressed emotions; after
- SKIN - ITCHING - despair from itching

CONCLUSION:

A Retrospective study was done to derive the Rubrics correlating Mind and Body in cases of Psoriasis using Synthesis 9.1 Repertory. From the study of 30 cases following conclusions were derived:

1. The maximum cases are from age group of Third and Fourth decade.
2. Out of 7 various clinical presentations of Psoriasis; Psoriasis Vulgaris is the most Common variant.
3. Predominantly Anger followed by Anxiety and then Grief, are Primary Causative Emotions for development of Psoriasis.
4. In this study, 22 cases have Single Causative factor, while 8 cases have Multiple causative factors. Number of causative factors can vary case to case.
5. All 30 cases have developed Psoriasis after being affected by Morbid Individual experiences with certain varieties of underlying Emotions. It is understood very well through LST.
6. In this study, it is seen that patients with Psoriasis; Negative changes in their Emotions, Thought processes and also in Subconscious mind reflected through Dreams. Most cases have Hopelessness to get cured off Psoriasis. One case also reflected that patient developed Despair for Life due to Psoriasis.
7. Natrum Mur, Silicea and Staphysagria are most prescribed remedies in Psoriasis in this study.
8. Centesimal potency is Two times more used; as compared to 50 Millesimal potency.
9. Synthesis 9.1 Repertory is prominently Useful in treating cases of Psoriasis having Mind and Body correlation.

SUMMARY :

A Retrospective study of 30 cases of Psoriasis was selected by Simple Random method. This was undertaken to understand the Mind and Body Correlation in cases of Psoriasis and assess the Utility of Synthesis 9.1 Repertory.

All the cases are studied in terms of the Clinical presentations through LSMC, ODP and Physical examination, Life events correlation with disease development using Life Space Table (LST) and formulation of the totality with Prime preference to Causative Rubrics. Every case of Psoriasis presents in its own Individualized way.

Based on Causative rubrics, and other indicated rubrics from the case, Repertorisation is done from Synthesis 9.1 Repertory. Based on Repertorial Totality remedy covering Causative Rubrics were prescribed with potency suitable for the case.

Keeping in mind the Accompaniments seen against the chief complaint in LSMC were also considered. As Psoriasis also caused various mental symptoms. The study points at importance of "Ailments from" in arriving at Similimum in Auto Immune disease like Psoriasis.

After studying 30 cases it can be concluded that Synthesis 9.1 Repertory is useful in treating cases of Psoriasis having Mind and Body correlation.

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