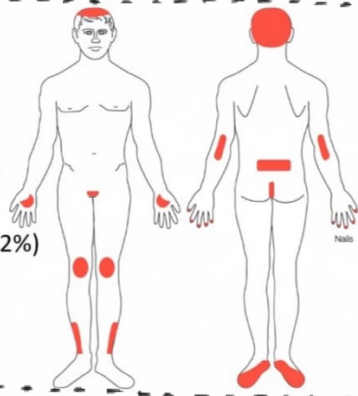


Psoriasis vulgaris

Classic anatomical location for psoriasis

- Scalp (80%)
- Elbows (78%)
- Legs (74%)
- Knees (57%)
- Nails (10-55%)
- Gluteal cleft
- Palms/soles (12%)



Chronic plaque psoriasis well demarcated & irregular in shape.



Palmoplantar psoriasis



Guttate psoriasis



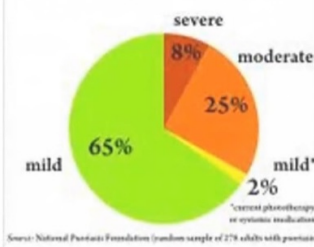
Common skin disorder

- Prevalence variable: ~ 0.3–2.5%¹

- Prevalence equal in males and females

mild اعلى

Distribution of psoriasis severity



Age of onset

- Mean age: ~ 23–37 years¹

2 distinct peaks with possible genetic associations

Early onset (16–22 years)

- More severe and extensive
- More likely to have affected first-degree family member

Late onset (57–60 years)

- Milder form
- Affected first-degree family members nearly absent

Psoriasis is a T-cell mediated, autoimmune disease

Current hypothesis:

- Unknown skin antigens stimulate immune response
 - Antigen-specific memory T-cells are primary mediators
- Leads to impaired differentiation and hyperproliferation of keratinocytes

Clinical variant

- Chronic plaque psoriasis MC.
 - Generalized, palmoplantar, scalp, Nail
- Guttate psoriasis اعطانا صعب
- Erythrodermic psoriasis اخر صعب عذ
- Generalized pustular psoriasis (von Zumbusch)
- Localized pustular psoriasis
 - Palmaris et plantaris
 - Acrodermatitis continua
- Inverse psoriasis

Flexural psoriasis



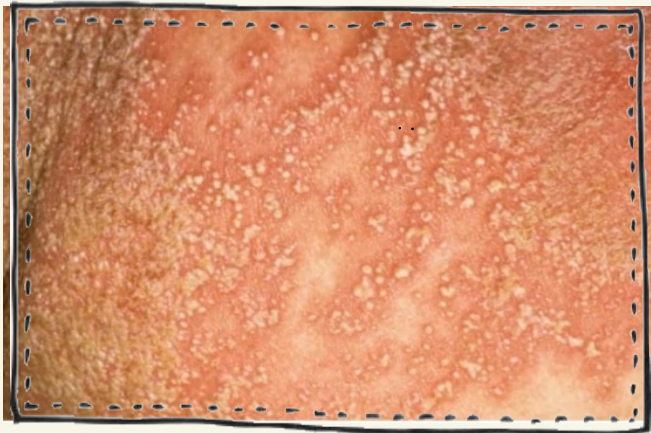
Erythrodermic psoriasis

الاحمر



Pustular psoriasis

sterile



Scalp psoriasis



Nail psoriasis

Pitting nails & oil spots
onycholysis, hyperkeratosis

Psoriatic arthritis

5-20% have associated arthritis



Managing psoriasis

Before starting treatment

- Establish relationship of trust with patient
- Provide patient with information

Considering:

- Disease pattern, severity and extent
- Coexistent medical conditions → *افترى الادوية على*
- Compliance of patient and treatment expense
- Previous treatments for psoriasis

Goals of management

- Improve quality of life
- Achieve long-term remission and disease control
- Minimise drug toxicity
- Evaluate and monitor efficacy and suitability of individual treatments

Treatment options for psoriasis

- Reduction of trigger factors
- topical therapy
- Phototherapy
- Systemic and biological therapies

Trigger factors

- Stress
- Smoking
- Alcohol
- Trauma
- Drugs
- Infections

Drugs exacerbate psoriasis

- Beta blockers
- Lithium
- IFN-alpha
- Antimalarials
- ACE inhibitors
- Rebound with withdraw of cyclosporine & prednisone

Majdy Nair

Topical therapies

- Approximately 70% of patients with mild-to-moderate psoriasis can be managed with topical therapies alone
- Coal tar
- Dithranol
- Corticosteroids
- Calcipotriol (Daivonex®)
- Calcipotriol/betamethasone dipropionate ointment (Daivobet®)

Other therapies

- Phototherapy
- Systemic therapies
- Biological agents

Phototherapy

- Immunomodulatory and anti-inflammatory effects
- Three main types of phototherapy:
 - Broadband UVB
 - Narrowband UVB
 - PUVA (administration of psoralen before UVA exposure)

Methotrexate

- Most commonly used systemic treatment for psoriasis
- Slows epidermal cell proliferation and acts as immunosuppressant
- Closely monitor kidney, liver and bone-marrow function

Cyclosporin

- Immunosuppressive agent
- For patients with severe psoriasis that is refractory to other treatments
- Requires monitoring of blood elements, and renal and liver function

Acitretin

- Oral retinoid
- For treatment of all forms of severe psoriasis
- Once-daily oral therapy
- Teratogenic – pregnancy must be avoided

Biological agent

- Target key parts of immune system that drive psoriasis
- Biological agents include:
 - Tumour necrosis factor-alpha inhibitors
 - Etanercept (Enbrel)
 - Adalimumab (Humira)
 - Infliximab (Remecade)
 - Interleukin (IL-12 and IL-32) inhibitor
 - Ustekinumab (Stelara)



HUDA
AHMED
OTHMAN

IUG