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Review Article

Homoeopathic Pills in the Management of Psoriasis Vulgaris

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ABSTRACT
Psoriasis vulgaris is a chronic, immune-mediated skin disorder characterised by erythematous, scaly plaques with itching and induration. It has a relapsing course and a significant psychosocial burden. Conventional therapies such as corticosteroids and immunosuppressants provide temporary relief but are limited by side effects and relapse on withdrawal. Homoeopathy, with its individualised approach, offers a holistic alternative, though scientific documentation remains limited.
Keywords: Psoriasis vulgaris, PASI, Homoeopathy, Constitutional remedies.

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INTRODUCTION

Psoriasis is a chronic, immune-mediated, inflammatory skin disorder characterised by well-defined erythematous plaques with silvery-white scaling. Among its various forms, psoriasis vulgaris is the most prevalent, accounting for nearly 80-90% of cases worldwide. It follows a relapsing-remitting course and significantly impacts physical, psychological, and social well-being.

In India, the prevalence is estimated between 0.44% and 2.8%, with a slightly higher male predominance and peak incidence between the third and fifth decades. The disease not only causes visible disfigurement but also imposes a heavy psychosocial burden, often leading to depression, social withdrawal, and reduced quality of life.

1. ETIOLOGY AND RISK FACTORS:

i. Genetic and Epigenetic Factors:

Psoriasis exhibits strong familial clustering, with high concordance in first-degree relatives. Specific genetic variants, particularly HLA-Cw6 and genes involved in the IL-23/IL-17 axis, increase susceptibility. Epigenetic modifications such as DNA methylation and microRNA activity influence how genes are expressed, which can vary seasonally and affect disease flares and remission.

ii. Hormonal and Endocrine Factors:

Thyroid disorders, including hypothyroidism and Graves' disease, are associated with an increased risk of psoriasis through shared inflammatory pathways. Psoriasis itself may influence thyroid autoimmunity, suggesting a bidirectional relationship.

Women with polycystic ovary syndrome (PCOS) show a higher incidence of psoriasis, likely linked to insulin resistance, hyperandrogenism, and metabolic disturbances.

iii. Metabolic and Lifestyle Factors:

Metabolic syndrome components, including obesity, diabetes, hyperlipidaemia, and hypertension, are linked to a higher incidence and severity of psoriasis. Lifestyle factors such as smoking and alcohol use exacerbate the disease, particularly in early-onset psoriasis.

iv. Environmental Triggers and Vaccination:
Environmental triggers, including infections, trauma, and pollution, can precipitate flares. Vaccinations, especially COVID-19 vaccines, are generally safe in psoriasis patients; mild, transient flares may occur, but no significant worsening of the disease has been observed.
v. Psychological and Emotional Factors: Chronic stress, anxiety, and depression influence psoriasis via neuro- immuno-endocrine pathways, activating the hypothalamic-pituitary- adrenal axis and increasing pro-inflammatory cytokines, thereby worsening skin lesions. Effective stress management is important for controlling disease activity.

PATHOGENESIS:

Psoriasis is a chronic, immune-mediated Papulosquamous disorder characterised by abnormal keratinocyte proliferation, altered differentiation, angiogenesis, and persistent immune activation. Both innate and adaptive immune responses are involved, leading to the development of erythematous, scaly plaques.

2. CLINICAL FEATURES:

1. Skin Lesions and Distribution

• Psoriasis vulgaris commonly presents as well-demarcated erythematous plaques covered with silvery-white micaceous scales, which represent the hallmark of the disease. (1,2)
• Plaques are raised and palpable due to epidermal hyperplasia and dermal inflammation; thickness is relatively stable in an individual but varies between patients. (1)
• Lesions are typically symmetrical, affecting the scalp, elbows, knees, lumbosacral area, and genital skin. Extensor surfaces are more involved, while flexural areas show thinner plaques due to maceration. (5)
• Morphology varies from small papules to large confluent plaques; annular, arcuate, or polycyclic patterns may form due to centrifugal spread or partial resolution. (1,2)
• Healing plaques often exhibit a hypopigmented macular rim (Woronoff ring), linked to reduced prostaglandin levels. (13)
• Post-inflammatory hypo- or hyperpigmentation is more pronounced in darker skin types. (1)
• Scaling is abundant on classic plaques and minimal in flexural/facial areas. (1,5)
• Diagnostic features include candle-grease sign, last membrane phenomenon, and Auspitz sign. (1,5)
• Koebner phenomenon, where lesions develop at sites of trauma, is frequently observed in active or unstable disease (5)

2. Symptoms

• Psoriasis may be asymptomatic or associated with pruritus, pain, or burning sensations. Pruritus affects up to 80% of patients, especially in flexural, facial, or erythrodermic involvement. (1,5)
• Fissuring of plaques on palms and soles may cause functional limitations. Pustular and erythrodermic forms often present with severe pain and systemic discomfort. (1)

3. Nail Involvement: Nail changes are present in 25–50% of psoriatic patients, increasing to 80% in those with psoriatic arthritis. (1,2,5) Nail matrix disease manifests as pitting, ridging, or trachyonychia; nail bed disease presents as the “oil-drop” sign, subungual hyperkeratosis, onycholysis, and splinter haemorrhages. Severe involvement may lead to complete dystrophy, may mimic or coexist with onychomycosis. (1)
4. Mucosal Involvement: True mucosal psoriasis is rare. Geographic tongue and fissured tongue are more prevalent in psoriatic patients, with a possible genetic association (HLA-C*06:02). (1,2)
5. Ocular Involvement: Ocular changes may occur due to immune-mediated processes or direct involvement. Blepharitis and eyelid margin disease are the most common. Chronic conjunctivitis, xerosis, keratitis, and uveitis (particularly in psoriatic arthritis) may also occur. (1,2)
6. Systemic Associations: Psoriasis is linked to systemic inflammatory and autoimmune manifestations. Patients may experience fatigue, arthralgia, or metabolic comorbidities, particularly with psoriatic

arthritis and metabolic syndrome. (2,5) Erythrodermic psoriasis can cause hypothermia, fluid/protein loss, and secondary infections, while generalised pustular psoriasis may lead to fever, malaise, leukocytosis, and electrolyte imbalance. (1,2)

7. Hallmark Clinical Signs

- Candle-grease sign (lamellar desquamation resembling wax)
- Last membrane phenomenon (glistening layer exposure)
- Auspitz sign (pinpoint bleeding)
- Koebner phenomenon (lesions at trauma sites)
- Woronoff ring (pale rim around healing plaques)
- CLASSIFICATION:

Psoriasis can be classified using several complementary approaches- morphology, extent of involvement, clinical course, age of onset, and severity. These classifications help clinicians in diagnosis, prognosis, and treatment planning.

BASED ON MORPHOLOGY: Morphology remains the cornerstone of clinical classification, reflecting both the clinical presentation and prognosis of the disease.

a. Psoriasis vulgaris (chronic plaque psoriasis)

- The most common subtype, accounting for ~90% of cases.
- Presents as well-demarcated, erythematous plaques covered with silvery-white scales.
- Symmetric distribution, often affecting extensor surfaces (elbows, knees), scalp, sacral region, and lumbosacral area.
- Diagnostic signs: “candle-grease” sign, “last membrane” sign, and Auspitz sign (pinpoint bleeding on scale removal).
- Chronic plaques may persist for months or years, with periods of remission. Woronoff rings (hypopigmented halos) may appear during healing.

b. Guttate psoriasis

- Often seen in children and young adults, frequently triggered by streptococcal infection.
- Abrupt eruption of small, drop-like erythematous papules, mainly on trunk and proximal limbs.
- Most resolve spontaneously within 3–4 months, but can evolve into chronic plaque psoriasis.
- Strong genetic association with HLA-Cw6.

c. Erythrodermic psoriasis

- Severe, unstable form involving >80–90% BSA.
- Diffuse redness and scaling can obscure classic plaques; systemic complications may include hypothermia, fluid loss, and organ dysfunction.
- Often precipitated by flare of plaque psoriasis or abrupt corticosteroid withdrawal. It is a dermatological emergency.

d. Pustular psoriasis

- Generalised (von Zumbusch type): Widespread sterile pustules, systemic toxicity (fever, malaise), recurrent waves of eruption.
- Localised variants:

i. Palmoplantar pustulosis (Barber’s type): Sterile pustules on palms/soles, linked to smoking/contact sensitisation

ii. Acrodermatitis continua of Hallopeau: Chronic pustules on digits with nail dystrophy, possible osteolysis.

iii. Impetigo herpetiformis: Rare pregnancy-related pustular eruption.

e. Inverse psoriasis

- Affects intertriginous areas (axillae, groin, inframammary folds, genitalia).
- Bright red, shiny plaques with minimal scaling due to friction and moisture.
- Often seen in obese individuals; may mimic candidiasis or seborrheic dermatitis.

f. Special variants

- Sebopsoriasis: Overlap with seborrhoeic dermatitis, greasy yellowish scales on scalp and nasolabial folds.
- Napkin psoriasis: Infantile diaper area, may resolve spontaneously, but sometimes precedes chronic plaque psoriasis.

Hyperkeratotic forms: Ostraceous, rupioid, elephantine, and linear psoriasis along Blaschko’s lines.

- COURSE, PROGNOSIS, AND COMPLICATIONS:

COURSE

i. Psoriasis is a chronic, relapsing, and remitting inflammatory disease that follows an unpredictable course. Periods of exacerbation are often triggered by stress,

infection, trauma, or seasonal changes, followed by partial or complete remission.

ii. The disease may remain mild and localised in some patients, whereas in others, it gradually progresses to involve extensive areas of the body with severe systemic associations.

iii. Childhood-onset psoriasis is frequently associated with a more severe and prolonged course compared to adult-onset forms.

iv. Certain types, like pustular and erythrodermic psoriasis, tend to have a more aggressive and unstable course, sometimes requiring hospitalisation.

PROGNOSIS

i. Psoriasis is a lifelong illness marked by relapses and remissions, significantly affecting the quality of life of patients as well as their families.

ii. Remissions may occur in 10–60% of patients, though permanent remission is uncommon

iii. About 10% of patients develop severe deforming arthritis, leading to progressive disability and functional impairment.

iv. Prognosis is poorer in patients with pustular, erythrodermic psoriasis, or psoriatic arthritis, where systemic involvement often complicates disease management.

v. Several studies have established links between psoriasis and depression, suicide, substance abuse, metabolic syndrome, kidney disease, heart disease, and adverse cardiac events, further worsening the prognosis.

COMPLICATIONS

i. Psoriatic Arthritis: Affects nearly 20–30% of patients, leading to chronic joint pain, stiffness, deformities, and progressive disability if untreated.

ii. Metabolic and Cardiovascular Comorbidities: Increased risk of metabolic syndrome, obesity, type 2 diabetes, hypertension, dyslipidaemia, atherosclerosis, and myocardial infarction has been consistently documented.

• Graphites: For thick, leathery, oozing patches with intense itching.

• Arsenicum album: Associated with dry, flaky patches, burning sensations, and symptoms that worsen at night or from cold.

• Sulphur: Used for persistent itching and scaling, especially in warm conditions, and may be indicated for cases with severe powdery scaling.

• Petroleum: May help with cracked skin and general dryness by sealing in moisture.

• Mahonia aquifolium (Oregon Grape): A cream containing a 10% concentration of this herb has some evidence supporting its use for mild to moderate psoriasis.

• Natrum muriaticum: Prescribed for flakiness, particularly if related to stress, and a history of suppressed skin conditions.

• Mezereum: Beneficial for conditions involving crusting, scabbing, and significant scalp irritation.

CASE 1:

PRELIMINARY DATA:

Name: Mr DBP	Education: 10th std	Occupation: Retired stone mill supervisor
Age/sex: 62yrs/ male	Marital status: married for 36 yrs	Date of case taking:14/01/2025
Religion/Caste: Hindu-kshatriya	Address: B	OPD number: 160156/5073

CHIEF COMPLAINTS:

LOCATION	SENSATION	MODALITY	CONCOMITANT
Integumentary system- Skin (since 30 yrs) Scalp (whole head)→ Trunk → B/L legs & hands O- Gradual D- all day (on-off) P- Slow I-Mild Frequency of acute exacerbation- twice every year for 2-3 months	Hard, thickened+3, hyperpigmented disc-shaped patches initially ↓ Itching+3 Scaling+3 Dryness+3 Bleeding+2 after scratching Took Allopathic treatment (not much relief), including creams, soap & shampoo on & off for 10 years for 20 years, and Ayurvedic treatment (gave >85%) in between (left 2 years before starting homoeopathy) Remission- 2 months (with or without allopathic treatment) and 1 year (with ayurvedic treatment)	<monsoon+3 <summers+1 >winters+2 >scratching+2 >applying Vaseline+1	-

DIAGNOSIS: Psoriasis Vulgaris

ASSOCIATED COMPLAINTS:

LOCATION	SENSATION	MODALITY	CONCOMITANT
Respiratory system →Nose O- gradual D-since 40 yrs P- non progressive	Sneezing+3 Feverish feeling+2 Watery, white coryza+3 No cough/ congestion	< dust+3 < strong odour+3 < cold air+2 >eating spicy+3 > covering+2	
F- 1-2 times/ year Eyes Head Throat	Redness+2 (no lachrymation) Heaviness+1 Soreness+1 (no pain)		

DIAGNOSIS: Seasonal allergic Rhinitis
FAMILY HISTORY: Br- HTN, DM; Sis- HTN; Mo- CVA
PHYSICAL GENERALS:

Appetite- normal, Hunger- tolerable Thirst: 3lit/day	Thermal State: ambithermal(C2H2)
Cravings: dairy products+3, pungent+2, sweets+3	Stool: satisfactory, semi-solid, 2-3 times/day Urine: 6-8 times /day
Perspiration: profuse+1, whole body	Sleep: deep, 6 hours/day, sometimes disturbed due to thoughts
Sexual Function: normal, 1-2 times/ month	Dreams: he has done something wrong and the police will catch him+1, travelling+2

LIFE-SPACE:

The patient was born in a poor family. His father worked as a Gram Panchayat Sewak but was suspended twice for not maintaining records properly. As a result, from the age of 10, the patient was required to take responsibility for his own education and contribute to family expenses. He worked on the farm and did a small business of pulses. He had good relations with his parents and siblings and was considered the favourite child as he did not cause trouble. He also helped financially in his sister's marriage. He studied up to the 10th standard, walking 7 km daily to school. He was good at his studies and wanted to pursue further education, but financial problems prevented him from doing so. However, he feels no regrets as he fulfilled his responsibilities and is satisfied with that. He had good relations with friends and teachers and mixed easily with everyone. After SSC, he worked in a stone mill as a supervisor, earning Rs. 5/day for 2 years, then Rs. 6.5/day for 15 years, and after becoming permanent, Rs. 600/month. Later, in 2004, he started working as a labour contractor and then as a land contractor. Sometimes arguments occurred, but he always resolved them without spoiling relationships. Now he is financially stable. He avoids black money, though in the past he had engaged in it to earn more, but later apologised to God.

As a person, he has been religious since childhood, irritable but short-tempered, image- and health-conscious, respectful, and maintains good relationships with everyone to avoid hurt or illness. During case-taking, he spoke respectfully and presented himself in a way that showed he wanted to maintain a good image.

GENERAL EXAMINATION:

Temp: Afebrile	P: 78/minute	RR: 18/minute	BP: 120/80mmHg
Pallor/Lymphadenopathy/Cyanosis/Oedema/Icterus/Eruptions: NAD			

LOCAL EXAMINATION:

Scalp (bilaterally behind ear, frontal to parietal &occipital region): lichenified+3, irregular shaped patches with scaling+3 dryness+3, erythema+3 with black discoloration

Abdomen (Lateral aspects): dry, thickened+1, 3-4 patches of 1-2cm with mild erythema+1 and black discolouration

Back (lumbar area): approximately 16cm in length and 10cm in breadth, irregular patch with dryness+1, lichenification+1, mild erythema+1, and black discolouration

Right leg (surrounding lateral malleolus): 3-4 cm small, dry, thickened, irregularly shaped single patch with dryness+1, lichenification+1, mild erythema+1, and black discolouration

Left leg (lower lateral end of tibia): 2 small lesions of 0.5cm in diameter with mild scaling+1 and lichenification+1

Left leg(below lateral malleolus): 1 patch measuring around 1cm in length and 3 cm breadth with black discolouration and mild thickness+1

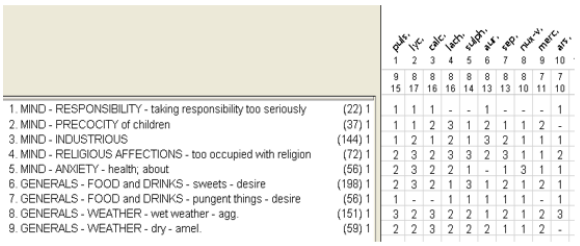
Hands (dorsal aspect): small patches of 1-2cm with dryness+1, lichenification+1, mild erythema+1, and black discolouration

FINAL DIAGNOSIS: Psoriasis vulgaris with Seasonal Allergic rhinitis

TOTALITY OF SYMPTOMS

1) Precocious +3	2) Image conscious+3	3) Anticipatory anxiety+3
4) Hardworking+3	5) Anger suppressed+3	6) Religious+3
7) Anxiety of health+3	8) Responsible+3	9) Conscientious+2
10) Irritable +2	11) Manipulative+2	12) Egoistic+1
13) Fear of disease+2	14) Fear of disease+2	15) Craving- dairy products+3
16) Craving-sweets+3	17) Craving- pungent food+2	18) Dreams- travelling+2
19) Dream- done something wrong, police will catch him+1	20) Perspiration-Profuse+1	21) Skin itching < monsoon+3
22) Sneezing < dust+3	23) Sneezing < strong odour+3	24) Sneezing >eating spicy+3
25) Skin itching > winters+2	26) Sneezing < cold air+2	27) Sneezing > covering+2

REPERTORIAL TOTALITY: (Kent's approach)



		puls.	lyc.	calc.	lach.	sulph.	aur.	rep.	nux-v.	merc.	ars.
		1	2	3	4	5	6	7	8	9	10
		9	8	8	8	8	8	8	8	7	7
		15	17	16	16	14	13	13	10	11	10
1. MIND - RESPONSIBILITY - taking responsibility too seriously	(22) 1	1	1	1	-	-	1	-	-	-	1
2. MIND - PRECOCITY of children	(37) 1	1	1	2	3	1	2	1	1	2	-
3. MIND - INDUSTRIOUS	(144) 1	1	2	1	2	1	3	2	1	1	1
4. MIND - RELIGIOUS AFFECTIONS - too occupied with religion	(72) 1	2	3	2	3	3	2	3	1	1	2
5. MIND - ANXIETY - health; about	(56) 1	2	3	2	2	1	-	1	3	1	1
6. GENERALS - FOOD and DRINKS - sweets - desire	(198) 1	2	3	2	1	3	1	2	1	2	1
7. GENERALS - FOOD and DRINKS - pungent things - desire	(56) 1	1	-	-	1	1	1	1	1	-	1
8. GENERALS - WEATHER - wet weather - agg.	(151) 1	3	2	3	2	2	1	2	1	2	3
9. GENERALS - WEATHER - dry - amel.	(59) 1	2	2	3	2	2	2	1	1	2	-

DIFFERENTIAL REMEDY:

The close coming remedies are lycopodium and arsenic album. The final selection of Lycopodium was made based on his intellectual sharpness, precocity, manipulativeness, ability to maintain all the relationships securely in his life by being emotionally detached, and the use of sarcasm and passive aggression (mature defences) to control his anger. He shows a strong sense of responsibility with underlying insecurities regarding health and maintaining a social image. Physically, he is ambithermal, with strong cravings for sweets, dairy, and spicy foods, unlike arsenic, which is chilly with more marked irritability and poor in maintaining relationships.

SUSCEPTIBILITY & POSOLOGY

STATE	POTENCY CHOICE	REPETITION
Susceptibility at the tissue level: moderate- hyperkeratosis, hypersensitivity, pace- gradual, characteristics ++	200	Frequent
Sensitivity at Mind & Nerve level: moderate- nerves +1, mind+1	200	Infrequent
Reactivity- moderate	200	Infrequent
Suppression: use of corticosteroids (systemic and topical)→ altered susceptibility	200	Frequent
Functional Changes: none	-	
Structural Changes: reversible (Autoimmune, Hypersensitivity)	200	Infrequent
General Vitality: Good	200	Infrequent
Fundamental Miasm: Sycosis Dominant Miasm: Sycosis	200	Frequent

FINAL INDICATED REMEDY: Lycopodium 200

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