



Allopathic and Homeopathic Treatments in Psoriasis

Arote Sayali K*, Bhangale Charushila J

Pravara Rural Education Society's College of Pharmacy for Women, Chincholi, Nashik, Maharashtra, India.

*Corresponding author's E-mail: sayaliarote98@gmail.com

Received: 06-11-2021; Revised: 17-01-2022; Accepted: 26-01-2022; Published on: 15-02-2022.

ABSTRACT

Psoriasis is a long standing autoimmune disease. Psoriasis is a noncontagious, chronic skin disease that produces plaques of thickened, scaly skin. Psoriasis is a multifactorial disease arises from a complex interaction of genetics, immune system, and environmental aspects. The disease is deeply seated and hence it needs a systematic and well-planned treatment. In allopathic treatments, the doctors mainly focus on the symptoms of the disease and not on the root cause of the disease. Allopathy offers only a partial cure as the drugs are made only to treat the symptoms and not the root cause. Recent therapeutic advances with targeted biological drugs have revolutionized the management of severe psoriasis. Homeopathy relies chiefly on the individual personality traits of the patient to make a diagnosis and treat. Homeopathy has the potential to stimulate the body's natural healing capacity and restore the disturbed immune system. Homeopathy is a medical system that uses highly diluted substances to treat disease with the intention of triggering the body's innate ability to heal. Remedy selection takes into consideration the patient's symptoms, personality traits, physical and psychological states, and life history. Psoriasis treatments aim to stop skin cells from growing so quickly and to remove scales.

Keywords: Psoriasis, Homeopathy, Allopathy, Treatment, Proliferation, Inflammation, Topical Therapy, Lesion.

QUICK RESPONSE CODE →

DOI:

10.47583/ijpsrr.2022.v72i02.021



DOI link: <http://dx.doi.org/10.47583/ijpsrr.2022.v72i02.021>

INTRODUCTION

Psoriasis is a chronic autoimmune inflammatory skin disease. In this disorder, changes occur in the life cycle of skin cells and cells are made 10 times faster than normal. Due to excess accumulation of cells on the surface of the body, this develops scaly and red patches that are rough, itchy and may be painful. The lesion mostly occurs on the elbow, knee, scalp and lower back, but it can appear anywhere on the body.¹ Psoriasis is a disease in which genetic and environmental factors have a significant role. The prevalence varies from 0– 11.8%. In India it is between 0.44- 2.8%. The gender ratio was found to be 2:1 (male: female).² Psoriasis is a non-contagious, dry, inflammatory and ugly skin disorder, which can involve entire system of person.³ Psoriasis can occur at any age, however there is a bimodal peak in incidence in early adulthood (age 18–25) and in later adulthood (age 50– 55).⁴

PATHOPHYSIOLOGY

The disease is defined by a series of linked cellular changes in the skin: hyperplasia of epidermal keratinocytes, vascular hyperplasia and ectasia, and infiltration of T lymphocytes, neutrophils, and other types of leucocyte in affected skin. Psoriasis involves hyperproliferation,

abnormal differentiation of epidermal keratinocytes and inflammation with immunologic alterations in the skin, featured by small and localized lesions that can occur all over the body. Pathophysiology of the disease includes mainly the activation and migration of T cells to the dermis triggering the release of cytokines which lead to the inflammation and the rapid production of skin cells.⁵

TYPES OF PSORIASIS

Flexural Psoriasis - It is also known as intertriginous or inverse psoriasis. It is well circumscribed, minimally scaly, thin plaques localized to the skin folds (under the breast, in the armpits, inflammatory, axillary, groin, genital, natal cleft regions).²

Nail Psoriasis - It produces a variety of changes in the appearance of finger and toe nails. These changes include discolouring under the nail plate, pitting of the nails, lines going across the nails, thickening of the skin under the nails and crumbling under the nails.²

Erythrodermic Psoriasis -It is acute or subacute onset of generalized edema covering 90% or more of the patient's entire body with little scaling. It might be associated with hypothermia, hypoalbuminemia, electrolyte imbalances, and high-output cardiac failure and could be a life-threatening emergency. It is also called as exfoliative psoriasis, is a rare psoriasis that looks like severe burns.²

Pustular Psoriasis - It has sheets of monomorphic pustules on painful, inflamed skin and is most commonly localized to palms and soles. It appears as raised bumps that are filled filled with non infectious pus. The skin under and surrounding pustules is red and tender.²



Scalp Psoriasis – Scalp psoriasis is very common. When psoriasis occurs on scalp, psoriasis often causes silvery-white scale, which may be misdiagnosed as dandruff. Skin cells grow too quickly on the scalp and cause red lesions covered with scale to appear. It is one of the most common sites of psoriasis and is difficult to treat.⁶

Palmoplantar Psoriasis - Palmoplantar psoriasis, psoriasis involvement of the palms and soles, occurs in up to 40% of plaque psoriasis patients and is often associated with pain, functional limitations, a severe impact on patients' quality of life and resistance to treatment.⁶

Guttate Psoriasis - Guttate psoriasis accounts for about 2% of patients with psoriasis, and most commonly develops in children and young adults after a β -hemolytic streptococcal infection. Lesions are the size and shape of water drops, typically 2–5 mm in diameter.⁶

Plaque psoriasis - Plaque psoriasis, or psoriasis vulgaris is the most common form of psoriasis. An estimated 80 to 90 percent of people with psoriasis have plaque psoriasis. It is characterized by thick red patches of skin, often with silver or white scaly layer. It has erythematous plaques with sharp boundaries, localized in knees, elbows, scalp, and sacral region.⁶

TREATMENT OF PSORIASIS

Non-biologic systemic therapies for psoriasis

Cyclosporine

Cyclosporine, which is believed by most dermatologists to be the most effective available oral therapy to treat patients with psoriasis, was originally developed to prevent rejection of organ transplants. Even though cyclosporine is extremely effective in all of the subtypes of psoriasis, including pustular and erythrodermic psoriasis, concern about potential side effects and lack of both training and experience have prevented many dermatologists from utilizing this extremely effective therapy. Cyclosporine is a cyclic peptide of 11 amino acids produced by a fungus, *Tolypocladium inflatum gams*. Cyclosporine shows preferential binding to a group of cytoplasmic proteins called cyclophilins, in particular cyclophilin A. This complex binds and inhibits calcineurin, an enzyme that normally increases the production of numerous cytokines including interleukin-2 (IL-2), tumor necrosis factor alpha (TNF-alpha), IL-3, IL-4, CD40L, granulocyte macrophage colony-stimulating factor, and interferon-gamma.^{4,6}

Acitretin

Acitretin is an oral retinoid that modulates keratinocyte proliferation and differentiation but also inhibits the induction of helper T lymphocytes via suppression of interleukin-6 (IL-6) by modulating gene expression. Acitretin is modestly effective in the treatment of psoriasis and cannot be used in women of childbearing potential due to its teratogenicity. Its use is further limited by side effects with potential health risk, including liver toxicity

and elevation of triglycerides, or that many patients find intolerable, including dry skin and lips and hair loss.⁴

Apremilast

Apremilast is an oral small molecule inhibitor of phosphodiesterase type 4 that reduces production of several cytokines including TNF α , IL-2, IL-12, and IL-23. Apremilast is a small molecule therapy which was licensed in 2014 to treat moderate–severe psoriasis and active psoriatic arthritis. It inhibits phosphodiesterase (PDE) 4 and thus reduces expression of proinflammatory mediators such as TNF- α and IL-23.⁴

Methotrexate

Methotrexate (MTX) is an effective agent in the treatment of psoriasis, including pustular psoriasis, psoriatic erythroderma, psoriatic arthritis and for extensive chronic plaque psoriasis not controlled by conventional therapy. Methotrexate is usually reserved for patients with moderate to severe disease who have at least 5% of their skin covered with psoriasis who are not responsive to, or eligible for, topical or ultraviolet light treatments (including UVB and PUVA). MTX inhibits dihydrofolate reductase (DHFR), which is required to produce tetrahydrofolic acid, the active form of folate in humans. Folate is essential for purine and pyrimidine synthesis and thus for the replication of DNA. Methotrexate acts on this enzyme binding to it some 1'000 times more tightly than folate itself resulting in a substantial negative effect on rapidly dividing cells, including cancer cells. When MTX was incidentally noted to improve psoriatic lesions in the 1960s, it became clear that it possessed anti-inflammatory properties in addition to its antiproliferative effects.^{6,9}

Topical Treatment

For mild to moderate psoriasis topical therapy is first line of treatment.

Salicylic Acid

Salicylic acid is used as a topical keratolytic agent in the treatment of psoriasis. Its mechanism of action is believed to involve the reduction of the binding between keratinocytes; as well as reducing the pH of the stratum corneum, it minimizes scaling and softens psoriatic plaques. Topical salicylic acid use for 8-16 weeks is recommended for the treatment of mild to moderate psoriasis. Salicylic acid is effective for the treatment of psoriasis, alone or combined with other topical therapies, including corticosteroids and topical immunomodulators. Another notable keratolytic treatment option is a dimethicone-based topical solution (Loyon) that removes scaling of the scalp in a physical rather than pharmacological mechanism, as opposed to urea and salicylic acid.^{2,6}

Coal tar

Coal Tar is the dry distillation product of organic matter heated in the absence of oxygen Coal tar, in concentrations 5- 20% can be compounded in creams, ointments,



shampoos and pastes. It is often combined with salicylic acid (2-5%), which by its keratolytic action leads to better absorption of the coal tar. Disadvantages include: allergic reactions, folliculitis, it has an unwelcome smell and appearance and can stain clothing and other items. Coal tar is carcinogenic.³

Corticosteroids

Topical treatments can induce irritation. Improvement is usually achieved within 2 to 4 weeks, then maintenance is achieved by use in the weekends only where other topical treatments can induce irritation. Topical steroids under of recalcitrant psoriasis of the scalp, hands, feet and other areas to avoid systemic effects of glucocorticoid, a maximum of 50 g ointment may be used per week. Most of the preparation use are in ointment, gel, cream, and lotion form.⁶

Topical immunomodulators

Tacrolimus and pimecrolimus are two topical calcium-dependent phosphatase (calcineurin) inhibitors that can downregulate antigen-specific T cell reactivity. They bind to macrophilin-12

(FKBP-12), blocking calcium signal transduction in T lymphocytes by impeding nuclear factor of activated T cells (NF-AT). Topical immunomodulators inhibit transcription of inflammatory cytokines, including interleukin (IL)-2, IL-3, IL-4, IL-5, interferon (IFN)-and tumor necrosis factor (TNF), which normally contribute to psoriatic lesions. Topical immunomodulators can also inhibit mast cell degranulation, preventing the release of histamine, cytokines and other inflammatory factors that contribute to the pathogenesis of psoriasis.⁶

Anthralin

Anthralin, also known as dithranol, is derived from the Arroba tree and has been used for the treatment of psoriasis for many decades. Because of its chemical instability, anthralin must be formulated in a precise and consistent manner. It is available as 0.1% and 1.0% concentrations in lotion, ointment or paste vehicles. Although the exact mechanism of action is unclear, anthralin is able to reduce keratinocyte proliferation, prevent T cell activation and restore cell differentiation, probably through mitochondrial dysfunction. In addition, the therapy forms free radicals, which may also contribute to its effect against psoriasis.⁶

Vitamin D

Potent topical corticosteroids are superior to Calcipotriene. The efficacy of calcipotriene is not reduced with long-term treatment. Calcipotriene is applied twice daily. A systematic review found that combination topicals consisting of corticosteroids and vitamin D analogs were more efficacious than both topical corticosteroid and vitamin D monotherapy alone in the treatment of scalp psoriasis.⁸

Moisturizers

Non-medicated moisturizers are available in several formulations (i.e., creams, ointments, lotions, gels, etc). They can be used as part of a general treatment regimen for psoriatic patients to help reduce itching and desquamation. Emollients, one type of moisturizer, exert their action by retaining moisture in the stratum corneum. An RCT showed the combination of mometasone plus emollient improved the area of palmoplantar skin affected, desquamation, and symptoms compared to mometasone alone after 4 weeks of treatment. Emollients have no known contraindications unless there is hypersensitivity to their ingredients.¹⁰

Traditional systemic therapy: retinoids and others (hydroxyurea, thiopurine antimetabolites, mycophenolic acid, sulfasalazine)

Retinoids

The oral retinoids are vitamin A metabolites that were introduced for clinical use in the 1970s and have since been established as a successful treatment for psoriasis. Initially found to be useful anticancer agents, they were subsequently studied in proliferative disorders because of their effects on proliferation, differentiation and apoptosis.

Hydroxyurea

Its success in the treatment of recalcitrant psoriasis was first reported in 1969; a subsequent double-blind study by Leavell and Yarbrow confirmed hydroxyurea's efficacy. There are several hypotheses regarding hydroxyurea's mechanism of action. Hydroxyurea inhibits ribonucleotide reductase, which catalyzes the conversion of ribonucleotides to deoxyribonucleotides, the rate-limiting step in DNA synthesis. DNA production is impaired at the S-phase of the cell cycle thereby inhibiting DNA replication; cells in the G1/S-phase accumulate and eventually undergo apoptosis. It also affects pyrimidine synthesis and blocks pyrimidine nucleoside incorporation into DNA. In the basal layer of the epidermis, hydroxyurea has been noted to inhibit cell replication. Lastly, hydroxyurea has been noted to normalize the amount of keratin in psoriatic plaques.

Thiopurine antimetabolites

The thiopurine antimetabolites are steroid-sparing immunosuppressants and include azathioprine (AZA), 6-mercaptopurine (6-MP), and 6-thioguanine.

Mycophenolic acid

The immunosuppressant mycophenolic acid (MPA) is a reversible and noncompetitive inhibitor of inosine monophosphate dehydrogenase. It therefore blocks *de novo* purine synthesis and DNA and RNA production, which affects T- and B-lymphocyte proliferation and subsequently antibody production. MPA was first used successfully to treat psoriasis in the 1970s.



Sulfasalazine

The exact mechanism of action of sulfasalazine is not fully understood; however several theories have been investigated. Studies have shown that it may prevent T and B-lymphocyte proliferation by inhibiting DNA synthesis. It may also act as an anti-inflammatory by preventing the production of inflammatory leukotrienes, prostaglandins, and cytokines as well as impeding the function of macrophages and neutrophils (phagocytosis, chemotaxis, and adhesion).⁶

Tazarotene

Tazarotene is a topical retinoid available for the treatment of psoriasis since 1997. It exerts its therapeutic effects by acting on keratinocyte differentiation and proliferation, and by downregulating the expression of pro-inflammatory genes. The use of topical tazarotene for 8-12 weeks is recommended for the treatment of mild to moderate psoriasis with several studies demonstrating its efficacy. It is a third-generation retinoid. It reduces mainly scaling and plaque thickness, with limited effectiveness on erythema. It is available in 0.05 percent and 0.1 % gels, and a cream. When used as a mono therapy, a significant proportion of patients develop local irritation (especially with the 1% formulations).¹⁰

Phototherapy**Ultraviolet B**

The mechanism of action of Ultraviolet B (UVB) treatment is not fully understood. The number of epidermal T lymphocytes and dendritic cells decrease and there is a reduction in keratinocyte proliferation. UVB treatment is a standard treatment for moderate to severe plaque psoriasis and guttate psoriasis. The former use of broad-band UVB (BB-UVB) (290–320 nm) is now often replaced by narrow-band UVB (NB-UVB) (311±2 nm). The most common side effects of UVB therapy are erythema and burning. BB-UVB is not thought to lead to a risk of developing skin cancer, but the risk of NB-UVB is under debate.¹¹

Psoralen + Ultraviolet A

PUVA treatment is psoralen (oral or bath) in combination with Ultraviolet A (320-400 nm). Psoralen is a compound in a family of natural products known as furocoumarins. Psoralen intercalates into the DNA and, on exposure to ultraviolet UVA radiation, form covalent interstrand cross-links with thymine, inducing apoptosis. Exposure to more than 350 oral PUVA treatments greatly increases the risk of developing squamous cell carcinoma (SCC) and PUVA treatment has therefore declined over the past few years. However, no risk of developing skin cancer has been seen with bath-PUVA treatment.¹¹

Biologic therapy for psoriasis

Biological therapies ('biologics') are proteins that target specific cytokines in the psoriasis pathway. The use of biological therapy has revolutionized the management of

severe psoriasis and contributed much to our understanding of the underlying disease pathogenesis. Biological therapy can also be indicated in patients who have difficult localized disease at high-impact sites (face, hands, genital area, nails). Several biological drugs are also licensed for use in psoriatic arthritis.¹²

Adalimumab

Adalimumab is a human IgG1 monoclonal tumor necrosis factor alpha (TNF-) antibody. The binding of adalimumab to TNF-results in its inactivation, thus reducing inflammatory activity. Adalimumab is currently approved for the treatment of psoriatic arthritis, and has completed Phase III clinical trials for its potential use in the treatment of psoriasis. It can be administered like etanercept, via subcutaneous injection.^{12,14}

Infliximab

Infliximab is a chimeric (mouse-human) IgG1 monoclonal antibody that binds to tumor necrosis factor (TNF). It also inhibits production of other proinflammatory cytokines, reducing cell infiltration and eventually keratinocyte proliferation. Infliximab and ustekinumab have the most evidence of efficacy and safety for the treatment of postular psoriasis.¹³

Efalizumab

Efalizumab is a humanized monoclonal antibody against the CD11a molecule. CD11a and CD18 comprise subunits of leukocyte function-associated antigen- 1 (LFA-1), a T cell surface molecule important in T cell activation, T cell migration into skin, and cytotoxic T cell function. Binding of this drug to CD11a on T cells blocks the interaction between LFA-1 and ICAM-1, its partner molecule for adhesion. The blockade is reversible and does not deplete T cells.¹⁴

Alefacept

Psoriatic plaques are characterized by infiltration with CD4+, CD45RO+, CD8+ and CD45RO+ memory-effector T lymphocytes. The recombinant protein alefacept binds to CD2 on memory-effector T lymphocytes, inhibiting their activation and reducing the number of these cells.¹⁴

Tofacitinib

It is a Janus Kinase pathway inhibitor which suppresses IL-15, decrease K16 expression, epidermal thickness, and lymphocytes in plaques of psoriasis. The adverse effects include nasopharyngitis, headache, and upper respiratory infections.¹⁴

Secukinumab, Ixelinumab

The current consensus is that psoriasis is a disease driven by the IL-23/TH17 cell pathway. For this reason, current therapeutic strategies are now focused on the development of novel

agents that disrupt IL-23 or IL-17 cytokine signalling. Three IL-17 pathway antagonists have been approved for the



treatment of psoriasis: secukinumab was the first approved in 2015, and since then ixekizumab and brodalumab have come to market. Ixekizumab and secukinumab target IL-17A, while brodalumab targets the receptor subunit IL-17RA. Both secukinumab and ixekizumab have been approved for psoriatic arthritis. Phase III studies have demonstrated favourable efficacy and safety profiles. The latest biologic group to be licensed for the management of psoriasis are those which specifically target the p19 subunit of IL23. Three drugs have been licensed: guselkumab, rizankizumab and tildrakizumab. The suppression of neuropeptide secretion in the skin by BTX injection might inhibit nerve elongation, the infiltration of immune cells, as well as IL-17 production, resulting in the improvement of psoriasis. Neuropeptide inhibitor could also be applied to the treatment of psoriasis.¹⁴

Taxifolin

It inhibits keratinocyte proliferation and ameliorates imiquimod-induced psoriasis-like mouse model via regulating cytoplasmic phospholipase A2 and PPAR- γ pathway. Psoriasis is a skin disease with autoimmune tendency, and taxifolin is an effective flavonoid with anti-inflammatory activity. It has been reported that taxifolin alleviates psoriatic dermatitis, but the detailed regulatory mechanism of keratinocyte proliferation is unclear. Our results show that taxifolin prevented proliferation cycle of keratinocyte in a concentration-dependent manner. Taxifolin treatment improved erythema and scales of psoriatic lesions in mice, and reduced the proportion of CD3 + cells, especially δ T cells, in lesions and thymus. Therefore, taxifolin decreased the expression level of IL-17A-dominated inflammatory cytokines. Taxifolin significantly reduced p-cPLA2 and increased PPAR- γ protein level in keratinocytes and lesions induced by IL-17 and imiquimod respectively. Meanwhile, phosphorylation of ERK and P-38 were also inhibited.¹⁵

Botulinum toxin

The suppression of neuropeptide secretion in the skin by BTX injection might inhibit nerve elongation, the infiltration of immune cells, as well as IL-17 production, resulting in the improvement of psoriasis. Neuropeptide inhibitor could also be applied to the treatment of psoriasis. Suppression of neuropeptide by botulinum toxin improves imiquimod-induced psoriasis-like dermatitis via the regulation of neuroimmune system.¹⁶

How does homeopathy help in psoriasis treatment?

The standard form of treatment for psoriasis is application of topical ointments and lotions, which primarily contain steroids and retinoids. UV light therapy along with oral medication all work at a superficial level and reduce cell turnover to remove flakes from the skin. In severe cases, steroid injections may be given for psoriatic arthritis. It is important to note that these medications can have side effects if used for long term and can only put psoriasis into a state of remission, but not cure. Homeopathy brings

hope for psoriasis. This alternative form of medication believes in treating the disorder right from the root and is holistic in approach. Since immunity plays a vital role in this condition, homeopathy which can strengthen the defense system helps in not just palliating, but curing psoriasis. Homeopathy consider the whole patient as an individual taking into account their environment, the person's temperament and other symptoms. With minimal and potentized doses of medications, immune system becomes strong enough to identify its own body cells and slowly the autoimmunity settles down.¹⁷

Why homeopathy can offer lasting relief in psoriasis?

Homeopathic remedies work at the nanomolecular level and help the immune system to set the right the misplaced defense attacks. Thus homeopathy does not only have a long lasting effect, but a lasting cure. After thorough consideration of the constitutional makeup of an individual a detailed history taking of the patient's mental as well physical preferences and characteristics, a suitable homeopathic remedy is given. The remedy is different for different patients as no two patients are same even though they are suffering from same medical condition.¹⁷

Homeopathy Treatment for Psoriasis

Research and scientific studies show that homeopathy offers scientific solutions for psoriasis. Many patients who have been suffering from psoriasis with little or no relief from conventional treatment have dramatically improved with these sweet insignificant-looking globules. Apart from this, there has been a considerable improvement in the quality of life of patients with psoriasis treated with homeopathy.¹⁷

Types of homeopathy treatments for psoriasis

There are two types of homeopathy treatment for psoriasis. One form of treatment acts at a superficial level and give temporary relief only. This is called as an acute treatment for sudden exaggeration. The other, preferable mode of treatment, is constitutional treatment. Here the mental and physical characteristic both taken into consideration to give the lasting cure.¹⁷

Homeopathic Medicines for Psoriasis

There are a number of homeopathic remedies, which are excellent for psoriasis based on the patient's individual case. However, below are some of the best known homeopathic remedies for psoriasis, along with patient characteristics in whom they may be effective.

Graphites – This is one of the best known remedies for psoriasis when accompanied with constipation. It is ideal for patients where the skin is rough, dry, hard and joints are usually affected. The psoriasis may be accompanied by eczema. One of the indispensable remedy when it comes to the management of chronic skin diseases. This remedy executes positive influence over the digestive system, female reproductive system, etc. This remedy is suited more to obese individuals who are sensitive to cold. The



menstrual cycle is scanty, short and delayed in women patients.¹⁷

Arsenic Iodatum – This medication is effective when psoriatic patches present with different colors and, when they come out in the form of scales, they present with a raw exuding surface. Severe itching, scaling and dryness are seen. It is useful for individuals with persistently irritating and corrosive discharge from various regions of the body. The discharge causes irritation of the various membranes that come in contact with it.

Sepia – This is a deep acting remedy, especially for women. This is prescribed when the patches and eruptions emit a foul odor.

Sulphur – This medicine is used for severe itching and redness. It is used for patients who are irritable and always messy. Itching is accompanied with severe burning.

Lycopodium – This is also commonly prescribed for mentally active and alert individuals, but with poor muscular power. Skin is dry, rough and usually skin complaints occur with gastric, liver or urinary disorders. Lycopodium Clavatum is best suited for malnourished and weak individuals and individuals with poor digestion. It is useful for individuals with chronic inflammatory condition.

Natrum muraticum – This is good for patients with oily skin. Dry crusty eruptions occur at the corner of the hair, joints and scalp. Psoriasis attacks are triggered after an episode of fright, grief or anger.

Antimonium crudum – This is a good remedy for psoriasis of nails. Nails are outgrown, out of shapes and tend to split. Discolouration of nails is also present.

Calcarea carb – This is an effective type of remedy for scalp psoriasis, where there is profuse sweating as scalp as well as other parts of the body. The psoriasis is aggravated by cold and wet weather.¹⁷

Carcinosin- The unique feature of Psoriasis homeopathy cure is that there are simple yet very effective medicines to counter genetic tendencies that form the basis of diseases like psoriasis. One such deep acting remedy to counter genetic predisposition is Carcinosin. This homeopathy remedy is derived from cancer tissue. It is astonishing to know that the unique mode of drug preparation of homeopathy, 'Potentization' can activate the healing powers from dreaded ailment-cancer. Carcinosin is indicated for a wide range of chronic diseases including psoriasis for patients having a family history of cancer or a similar condition, for patients having skin discoloration in the form of brownish-blackish spots on the body, individuals who are sensitive emotionally.¹⁸

Mezereum – It is one of the frequently prescribed remedies for psoriasis and also for eczema, especially on the scalp. In such cases thick and leathery crusts cover the head and there is pus beneath these crusts. This medication is prepared using the bark of the spurge olive

tree, also known as mezereum. It can treat skin and scalp psoriasis quite effectively.¹⁸

Thyroidism – It is considered as one of the best homeopathic medicines for psoriasis with obesity. In such cases the itching gets worsened at night. It is a remedy for chilly and anaemic patients suffering from dry impoverished skin along with cold hands and feet.

Kali Brom – It is helpful in case of syphilitic psoriasis whose symptoms include skin cold, blue, spotted corrugated, large, indolent, painful pustules.

Radium Brom – Radium Brom is helpful in treating psoriasis of penis, itching eruptions on face oozing and patchy erythema on forehead.¹⁹

Arsenic Album – This is used for patients who are restless, feel very cold and thirsty for small quantities of water.²⁰ This remedy is for psoriatic patients who experience an improvement in their condition under warm conditions and a worsening of the psoriasis in cold and wet conditions.²¹

Kali Arsenicum - This psoriasis homeopathic treatment is prescribed to patients who suffer from severe itching, especially in warm conditions. It also is prescribed to those who have cuts and oozing lesions along the inner side of the elbow and behind the knees. Kali Arsenicum is the homeopathic treatment for people suffering from psoriatic arthritis.²¹

Carbolicum Acidum - This remedy is best suited for individuals with severe pain abscess due to physical exertion, discharge with offensive odour, spasmodic cough or arthritis. It is useful in symptoms such as: Itching vesicles and burning pain, burns that leads to ulceration of the skin.²²

Chrysarobium – It is primarily used in individuals with skin diseases such as psoriasis and ringworm. Other symptoms treated with this remedy are: dry crust on skin with pus underneath, vesicular lesion with foul smelling discharge.²²

CONCLUSION

Psoriasis is a dreadful disease affecting physical, mental and social status of the victims. The treatment of Psoriasis in modern medicine is very limited and provides only short term relief with some side effect. Even though many new allopathic drugs have emerged, the risk of adverse effects and economical constraints limit their use. Homeopathy can be used as effective therapy for the management of chronic psoriasis. The present review suggests that there are different modalities of therapy for psoriasis. Treatment with topical medications is superior to oral therapies. Ultimately, further head-to head research is needed to determine the most effective options when treating psoriasis.



REFERENCES

1. Dr.Bhadoriya Y, Homeopathic Management of Psoriasis- A case study, World Journal of Pharmaceutical and Medical Research, 2020;6(6):250-252.
2. Premkumar B, A review on Allopathic and Herbal Remedies for Psoriasis, International Journal of Frontiers in Science and Technology, 2017;5(4):1-15.
3. Papola V, Kumar A, Sah S, Nautiyal H, Fight Psoriasis Naturally through Ayurveda, Indo American Journal of Pharmaceutical Research, 2016;6(7):6280-6290.
4. Kupetsky EA, Mathers AR, Ferris LK, Anti-cytokine therapy in the treatment of psoriasis, Cytokine, 2013;61(3):704-712, DOI: 10.1016/j.cyto.2012.12.027; PMID: 23410503.
5. Krueger JG, A Bowcock, Psoriasis pathophysiology: current concepts of pathogenesis, Ann Rheum Dis, 2005;64(2):30-36, DOI: 10.1136/ard.2004.031120; PMID: 15708932.
6. Weinberg JM, Parnham MJ, Bruinvels J, Treatment of psoriasis (Milestones in Drug Therapy). Edn 2008th, Birkhauser Verlag AG, New York; 2007. p. 23.
7. Abraham N, Krishnan N, Raj A, Management of psoriasis- Ayurveda and Allopathy-A review, International Journal of Dermatology and Clinical Research, 2019;5(1):18-23, DOI: <https://dxdoi.org/10.17352/2455-8605.000033>.
8. Mosca M, Hong J, Haderl E, Brownstone N, Bhutani T, Liao W, Scalp Psoriasis: A Literature Review of Effective Therapies and Updated Recommendations for Practical Management, Dermatol Ther (Heidelb), 2021;11:769-797, DOI: [10.1007/s13555-021-00521-z](https://doi.org/10.1007/s13555-021-00521-z); PMID: 33893995.
9. Bernardes MT, Agostini BN, Pereira GR, Silva LP, Silva JB, Bruschi ML, Novaes RD, Carvalho FC, Preclinical Study of Methotrexate-based Hydrogels versus Surfactant based Liquid Crystal Systems on Psoriasis Treatment, European Journal of Pharmaceutical Sciences, 2021;165:1-12, DOI: 10.1016/j.ejps.2021.105956; PMID: 34314841.
10. Elmets CA, Korman NJ, Prater EF, Wong EB, Rupani RN, Kivelevitch D, Armstrong AW, Connor C, Cordoro KM, Davis DMR, Elewski BE, Gelfand JM, Gordon KB, Gottlieb AB, Kaplan DH, Kavanaugh A, Kiselica M, Kroshinsky D, Lebwohl M, Leonardi CL, Lichten J, Lim HW, Mehta NN, Paller AS, Parra SL, Pathy AL, Siegel M, Stoff B, Strober B, Wu JJ, Hariharan V, Menter A, Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures, Journal of the American Academy of Dermatology, 2020;80:24-28, DOI: 10.1016/j.jaad.2020.07.087; PMID: 32738429.
11. Hearn RM, Kerr AC, Rahim KF, Ferguson J, Dawe RS, Incidence of Skin Cancers in 3867 patients Treated with Narrow-Band Ultraviolet B phototherapy, Br J Dermatol, 2008;159(4):931-935, DOI: 10.1111/j.1365-2133.2008.08776.x; PMID: 18834483.
12. Yiu ZZ, Exton LS, Lopez ZJ, Mustapa FM, Samaresekera EJ, Burden AD, Murphy R, Owen CM, Parslew R, Venning V, Ashcroft DM, Griffiths CE, Smith CH, Warren RB, Risk of serious infections in patients with psoriasis on biologic therapies: A systematic review and meta-analysis, Journal of Investigative Dermatology, 2016;136(8):1584-1591, DOI: 10.1016/j.jid.2016.03.035; PMID: 27085754.
13. Leyre A, Rafael F, Oswald Y, Oscar w. Biological Therapy for Postular Psoriasis: a systemic review, International Journal of Dermatology, 2019;59(3):284-296, DOI: 10.1111/ijd.14671; PMID: 31612467.
14. Smith CH, Yiu ZZ, Bale T, Burden AD, Coates LC, Edward W, Macmahon E, Mahil SK, Macguire A, Piercy CN, Owen CN, Parslew R, Uthman OA, Woolf RT, Manounah L, Ezezimofor MC, Exton LS, Mustapa MF, British Association of Dermatologists guidelines for biologic therapy for psoriasis- a rapid update, British Journal of Dermatology, 2020;183(4):628-637, DOI: 10.1111/bjd.19039; PMID: 32189327.
15. Tingting D, Zhai C, Zhao J, Wang Y, Chen Z, Li P, Taxifolin Inhibits Keratinocyte Proliferation and Ameliorates Imiquimod-induced Psoriasis-like Mouse Model via Regulating Cytoplasmic Phospholipase A2 and PPAR-γ pathway, International Immunopharmacology, 2021;99(3):1-8, DOI: [10.1016/j.intimp.2021.107900](https://doi.org/10.1016/j.intimp.2021.107900); PMID: 34233233.
16. Amalia SN, Uchiyama A, Baral H, Inoue Y, Yamazaki S, Fujiwara C, Sekiguchi A, Yokoyama Y, Ogino S, Torii R, Hosoi M, Ishikawa O, Motegi S, Suppression of Neuropeptide by Botulinum Toxin improves Imiquimod-induced psoriasis-like Dermatitis via the regulation of Neuroimmune system, Journal of Dermatological Science, 2021;101(1):58-68, DOI: [10.1016/j.jdermsci.2020.11.003](https://doi.org/10.1016/j.jdermsci.2020.11.003); PMID: 33176965.
17. <https://www.medindia.net/patients/patientinfo/psoriasis-cure-with-homeopathy-fact-or-fiction.htm>
18. <https://www.askdrshah.com/app/psoriasis/psoriasis-medicines.aspx>
19. <https://www.lybrate.com/topic/psoriasis-11-homeopathic-remedies-for-it/636fab1b9c44314cea27e194309970ed>
20. Agarwal HH, Jahagirdar VL, Farouqi ZF, Kelkar O, Individualized Homeopathic Treatment: Better Option in Management of Psoriasis, Journal of Drug Delivery and Therapeutics, 2019; 9(5):151-153, DOI: <http://dx.doi.org/10.22270/jddt.v9i5.3539>.
21. <https://www.stylecraze.com/articles/homeopathy-treatments-for-psoriasis/>
22. www.myupchar.com/en/disease/psoriasis/homeopathy

Source of Support: The author(s) received no financial support for the research, authorship, and/or publication of this article.

Conflict of Interest: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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