ORIGINAL RESEARCH

Evaluation of comparison of management and clinical features of psoriasis

Dr. Ashok Roopchand Wadhwani

Assistant Professor, Department of Dermatology, Venereology & Leprosy, National Institute of Medical Sciences & Research, Jaipur, Rajasthan, India

Corresponding Author
Dr. Ashok Roopchand Wadhwani
Assistant Professor, Department of Dermatology, Venereology & Leprosy, National Institute of Medical Sciences & Research, Jaipur, Rajasthan, India

Received: 09 December, 2016 Accepted: 15 January, 2017

ABSTRACT

Background: A typical skin cell takes a month to fully develop and shed.1 Skin cells in psoriasis only take three to four days to complete this. The skin cell builds up on the skin's surface rather than shedding. Psoriasis plaque is said by some people to itch, burn, and sting, Scales and plaques can develop anywhere on the body. **Materials & Methods:** 90patients of psoriasis of both genders were divided into 2 groups of 40 each.Psoriasis area severity index (PASI) was assessed in both groups. **Results:** Common clinical features were scaling seen in 16 in group I and 14 in group II,red lesion seen 12 in group I and 13 in group II, burning pain seen 8 in group I and 11 in group II, thick lesions seen 9 in group I and 6 in group II, it chin seen in 27 in group I and 24 in group II and joint pain seen in 12 in group I and14 in group II respectively. The difference was non-significant (P>0.05). **Conclusion:** Authors found that Methotrexate found to be superior than clobetasol propionate. Combination therapy is more effective in management of cases of psoriasis.

Keywords: Clobetasol propionate, Psoriasis, PASI

INTRODUCTION

Psoriasis is a common, chronic inflammatory immune-mediated illness that mostly affects the joints and skin. Psoriasis is caused by an overactive immune system that accelerates the development of skin cells. It takes a month for a skin cell to mature fully and shed.1. Psoriasis skin cells can finish this in as little as three to four days. Instead of shedding, the skin cell accumulates on the skin's surface. Some claim that psoriasis plaque stings, burns, and itches. Anywhere on the body might get covered in scales and plaques. Even so, they are often found on the elbows, knees, and scalp. Inflammation brought on by psoriasis can impact different organs and tissues in the body. The disease tend to worsen with time and can be caused by a variety of circumstances. Psoriasis can develop for a variety of reasons.7. Large sections of the knees, elbows, and other skin that are subjected to friction or mild damage are prime candidates for the development of psoriasis.2.

"Individual view of their place in life in relation to their objectives, expectations, standards, and concerns in the context of the culture and value systems in which they live" is how the World Health Organization (WHO) defines quality of life.3. The best conventional treatment for psoriasis depends on the severity and location of the lesions. First-line topical treatments were recommended for mild to severe cases of psoriasis. This group includes 4 corticosteroids, vitamin D3 analogs, and calcipotriol betamethasone dipropionate combo medications. The preferred course of treatment for both scalp and plaque psoriasis is calcipotriol, an analog of vitamin D3.5.The current study aimed to compare the management of psoriasis cases.

MATERIALS&METHODS

The present study comprised of 90 patients of psoriasis of both genders. All enrolled patients gave their consent.

Data such as name, age, gender etc. was recorded. Patients were divided into 2 groups of 40 each. Patients in group received clobetasol propionate (0.05%) + salicylic acid (3%) lotion for scalp application and betamethasone valerate (0.05%) cream for body surface application and patients in group II receivedtablet methotrexate (7.5 mg/week) along with topical treatment; clobetasol propionate (0.05%) + salicylic acid (3%) lotion for scalp application and betamethasone valerate (0.05%) cream for body surface application. In both groups, Psoriasis area severity index (PASI) was assessed. All

the recruited patients were followed up at 1 month and 6 months of treatment. Data thus obtained were subjected to statistical analysis. P value < 0.05 was considered significant.

RESULTS

Table 1 Distribution of patients

Groups	Group I	Group II
Drug	clobetasol propionate (0.06%) + salicylic acid (4%) lotion+ betamethasone valerate (0.05%)	Methotrexate+ clobetasol propionate (0.06%)+ salicylic acid (4%) lotion+ betamethasone valerate (0.06%) cream
M:F	25:25	21:29

Group I consisted of 25 males and 25 females, while group II contained 21 males and 29 females, according to Table 1.

Table 2 Comparison of PASI score

PASI	Group I	Group II	P value
Baseline	14.3	16.6	0.02
1 month	14.0	13.3	0.72
2months	13.1	8.81	0.01

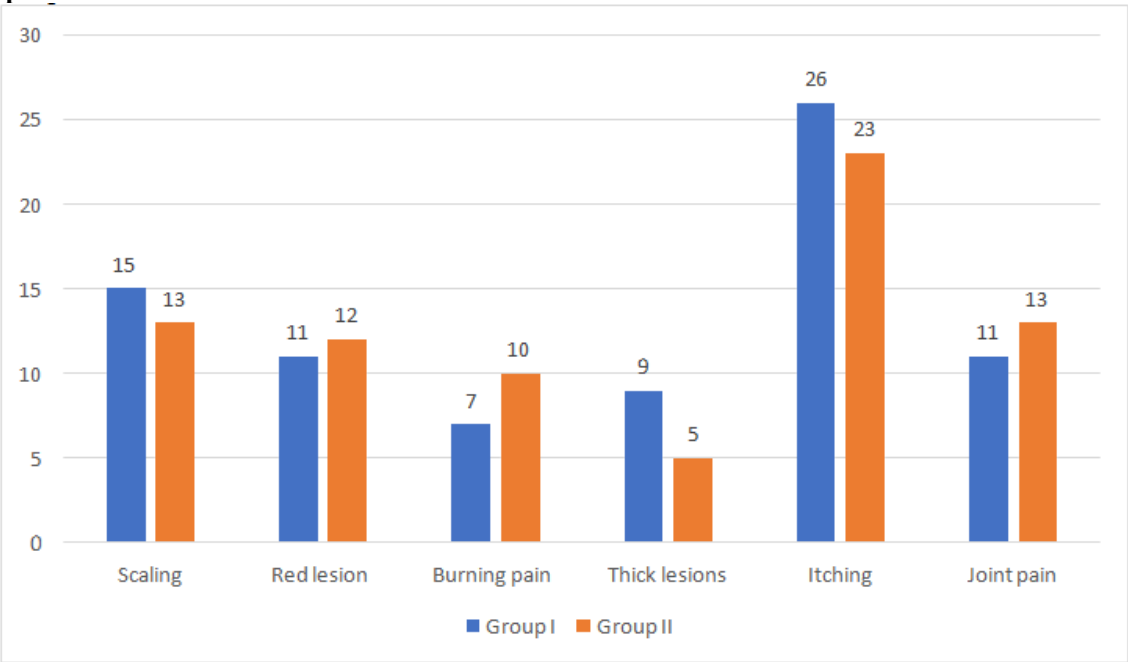
According to Table 2, the mean PASI score for Group I and Group II was 14.3 and 16.6 at baseline, 14.0 and 13.3 at one month, and 13.1 and 8.81 at two months, respectively. There was a substantial difference (P<0.05).

Table 3 Assessment of clinical features

Clinical features	Group I	Group II	P value
Scaling	16	14	0.93
Red lesion	12	13	
Burning pain	8	11	
Thick lesions	9	6	
Itching	27	24	
Joint pain	12	14	

Table 3, Graph I, illustrates the common clinical features exhibited by the following groups: burning pain observed in 8 groups I and 11 groups II; thick lesions observed in 9 groups I and 6 groups II; it chin observed in 27 groups I and 24 groups II; scaling observed in 16 groups I and 14 groups II; red lesion observed in 12 groups I and 13 groups II; and joint pain observed in 12 groups I and 14 groups II, respectively. There was no discernible difference (P>0.05).

Graph I Assessment of clinical features



DISCUSSION

It's a genetically determined dermatological ailment that has a relapsing and remitting course. Although the precise frequency and incidence of psoriasis are

difficult to determine, older persons account for a significant portion of cases.6-7 Given that psoriasis is usually a chronic condition with life expectancies comparable to those of the general population, it is expected that the disorder's prevalence will increase with age. The development and management of psoriasis are also greatly influenced by comorbidities and therapies for other diseases, and it is evident that older individuals are more likely to encounter these problems.8.Psoriasis can be caused by a wide range of inflammatory, chemical, and physical changes to the skin.9, 10 These consist of abrasions, shaving, rubbing, and cutting. Psoriatic lesions can arise from the manifestation of cutaneous lymphocyte antigen, which is brought on by some toxins, such as bacterial toxins that stimulate T cells. Infections were the root cause of between 15 and 76% of illnesses. Studies show a high correlation between psoriasis infections and S. pyro genes. Eleven The current study aimed to compare the management of instances of psoriasis.

We found that although group II had 16 men and 24 women, group I had 20 men and 20 women. After one month, the mean PASI scores in groups I and II were 12.5 and 7.84, respectively, from baseline to one month's end, and 13.8 and 15.5 at that point. 371 individuals (218 males and 153 women) ranging in age from 18 to 85 years, 70 of whom were over 65, were included in a study by Fernandez-Torres et al. (12). Patients over 65 had a statistically significant higher prevalence of diabetes mellitus, hypertension, left ventricular hypertrophy, waist-hip ratio, and raised blood glucose levels. Furthermore, a relationship was observed between the degree of psoriasis, alcohol and tobacco product intake, and overall quality of life. We observed that common clinical features included redness (11 in group I and 12 in group II), burning pain (7 in group I and 23 in group II), thick lesions (5 in group I), scaling (15 in group I and 13 in group II), itching (26 in group I and 23 in group II), and joint pain. A study by Karamata et al. (2013) divided 114 patients into three groups: Group A got topical treatment only, Group B got topical therapy plus methotrexate, and Group C got topical therapy with cyclosporine. The efficacy of the treatment was assessed using the Psoriasis Area Severity Index (PASI). QOL was computed using the Psoriasis Disability Index. Patients were checked on after one and six months of treatment. Of the 126 patients who were enrolled, 114 completed the trial. Each treatment group's PASI score was significantly (P 0.001) lower at the six-month mark, and Group B and C's QOL scores were significantly (P 0.001) lower than baseline. When compared to patients in Group A, patients in Groups B and C had a significant (P 0.001) decline in their QOL and PASI score. There was no appreciable relationship seen in any of the three therapy groups between QOL and efficacy.

CONCLUSION

Authors found that Methotrexate found to be superior than clobetasol propionate. Combination therapy is more effective in management of cases of psoriasis.

REFERENCES

1. Ferrandizc,PujolRM,García-PatosV,BordasX,smandiaJá. Psoriasis of early and late onset: á clinicalandepidemiologicstudyformspain.Jámácadderm atol2002;46:867-73.
2. Ibrahim G, Waxman R, Helliwel Ps. The prevalence ofpsoriasisarthritisinpeoplewithpsoriasis.árthritisRheu m2009;61(10):1373-8.
3. Tey Hl, ee Hl, Tan ás, Theng Ts, Wong sn, Khoo sW.Risk factor associated with having psoriatic arthritis inpatientswithcutaneouspsoriasis.Jdermatol2010;37(5): 426-30.
4. Grossman RM, chevret s, ábi-Rached J, Blanchet F,dubertretl.longtermsafetyofcyclosporineinthetreatme ntofpsoriasis.árchdermatol1996;132:623-9.
5. Liao YH, chen KH, Tseng MP, sun cc. Pattern of skindiseases in a geriatric patient group in Taiwan: a 7-yearsurveyfromtheoutpatientclinicofaUniversityMedica lcentre. dermatology2001;203:308-13.
6. McFaddenn,HandeKo.Asurveyofelderlynewpatientsata dermatologyoutpatientclinic.áctadermVenereol1989;69 :260-2.
7. Kaur I, Handa s, Kumar B. natural history of psoriasis:astudyformIndiansubcontinent.Jdermatol1997 ;24:230-4.
8. Kavli G, FørdeoH, árnesen e, stenvold se. Psoriasis:familial predisposition and environmental factors. BrMedJ(clinResed).1985;291(6501):999-1000.
9. BissonnetteR,HoV,langleyRG.safetyofconventional systemic agents and biologic agents in thetreatmentofpsoriasis.JcutanMedsurg2009;13:s2(67-76).
10. AlsufyaniMá, Golantál, lebwohl M. Psoriasis and themetabolic syndrome. dermatolTher2010;23:137-43. 19.VenaGá,VestitaM,cassanon.Psoriasisandcardiovasc ulardisease.dermatolTher2010;23:144-51.
11. HayesJ,KooJ.Psoriasis:depression,anxiety,smoking, and drinking habits.dermatolTher2010;23:174-80.
12. Fernandez-TorresRM,ParadelaS,FonsecaE.Psoriasis in patients older than 65 years. A comparativestudy with younger adult psoriatic patients. The journalofnutrition,health&aging.2012Jun;16(6):586-91.
13. Karamata VV, Gandhi AM, Patel PP, Sutaria A, DesaiMK. A study of the use of drugs in patients sufferingfrompsoriasisandtheirimpactonqualityoflife.In dianJPharmacol2017;49:84-8.