بست

علمي او څېړنيزه مجله

ټوک : څلورم

گڼه: لومړی

کال: ۱۴۰۴

بسم الله الرحمن الرحيم

بُست علمي او څېړنيزه مجله

بُست پوهنتون

څلورم ټوک – لومړی ګڼه

کال – ۱۴۰۴

بُست علمی او څېړنیزه مجله

بُست پوهنتون

د امتیاز خاوند: بُست پوهنتون

مسئول مدیر: ډاکټر ذبیح الله انوري

سردبیران: پوهندوی دوکتور علي احمد احمدي او خان محمد وفا

ډیزاین: د بُست پوهنتون د خپرنیزو او فرهنګي چارو مدیریت

د خپرولو کال: ۱۴۰۴

درک: بُست پوهنتون، لښکرګاه، هلمند، افغانستان

د بُست پوهنتون د رئیس پیغام

په ننې ژوند کې د یوې علمي مؤسسې یو له مسؤلیتونو څخه دا دی ، چې نه یوائې خپل محصلان د پوهې په ګانه سمبال کړي، بلکې د پوهنتون د لوړو زده کړو لرونکو پوهانو او استادانو د علمي زیرمتون څخه داسي څه وخت په وخت راوباسي، چې د ټولنې د ژوند د اړتیاوو د پوره کولو لپاره او یا لږ تر لږه د ټولنې د لوستې قشر د خبرولو او که وکولای شي له هغوی څخه د عمل په ډګر کې د ګټې اخیستنې په موخه ، په کار واچول شي.

و دې موخې ته د رسیدلو لپاره پوهنتون باید یو داسې علمي خپرندویه ارګان ولري، چې په هغه کې د پوهنتون ټول با صلاحیته منسوبین که هغه استاد وي، که کارکوونکی او که زده کړه یال ، خپلې علمي او څېړنیزې مقالې او لیکنې د کاغذ پر مخ باندې کښیښودلای شي.

زما په شخصي آند پدې مجله کې لکه له نوم څخه چې یې ښکاري، باید داسي مسائل را برسیره شي، چې نه یوائې په پوهنتون پورې راګیر پاتې شي، بلکې په عام ډول سره د افغانې ټولنې او په ځانګړي ډول سره د هلمند ولایت د اوسیدونکو و ننې او سبا ژوند ته په کتلو سره، بریالیتونونه، ستونزې ، وړاندیزونه او د حل لارې-چارې ، وړاندې کړل شي.هغه وخت به د بُست پوهنتون علمي مجله یوائې د بست پوهنتون نه، بلکې د ټول هلمند ولایت ، آن د سیمې او ټول افغانستان په کچه د پوهې او څېړنې په برخه کې د وخت د غوښتنو سره سم ، د پاملرنې وړ او و ځوان نسل ته د یوې سمې لارې د ښودلو په موخه ، یوه محبوبه او پر زیاتو خلکو باندې ګرانه مجله وي او په ټول هیواد کې به خپل مینه وال ولري.

دا مجله به د بُست پوهنتون د مشرتابه، استادانو ، محصلانو ، فارغانو او ټولو مینه د علمي او څېړنیزو مقالو د خپرولو لپاره که هغوی د پوهې په هر ډګر کې چې وي، یو خپرنیز ارګان وي،چې و خپریدلو ته به یې ټول مینه وال په تمه ناست وي.ځومره به پرځای او ښه خبر وي، چې د ټولنې لوستی قشر په تیره بیا د بست پوهنتون محترم استادان ، فارغ شوي او بر حاله محصلان د علمي او څېړنیزو مقالو و لیکلو ته و هڅول شي.

زه د بُست پوهنتون د ټولو منسوبینو په استازیتوب ویاړ لرم ، چې د بُست پوهنتون د علمې مجلې د خپریدلو له امله د محترم مؤسس، محترم علمي مرستیال او د څېړنې له محترم آمر او همدا رنګه د مجلې له ټولو کارکوونکو او پرسونل څخه د زیار او زحمت په ګاللو سره چې مجله یې و خپریدلو ته چمتو کړې ده ، مننه او قدرداني وکړم، ټولو ته د زړه له کومې مبارکي وایم او هیله لرم چې د بُست پوهنتون د علمي مجلې کارکوونکي به خپل رسالت د پوهنتون او ټول هلمندې ولس او په اخری تحلیل کې د ټول افغان ملت پر وړاندې په پوره او ټینګ عزم سره سرته ورسوي.

په درنښت

ډیپلوم انجنیر محمود سنګین

د بُست پوهنتون رئیس

سریزه

بُست پوهنتون ویاړ لري چې د خپل علمي پرمختګ په لاره کې يې يو بل ډير مهم او اړين ګام پورته کړ او هغه د بُست د علمي او څېړنيزي مجلې د څلورم ټوک، لومړی ګڼې خپرېدل دي . تر هر څه دمخه د پوهنتون ټولو استادانو، محصلانو او د علم او پوهې د لوی کور مينه والو ته د بُست د علمي او څېړنيزي مجلې د خپرېدلو مبارکي وړاندې کوم او ددې سره جوخت د ټولو ملګرو څخه چې ددې مجلې د جواز په تر لاسه کولو، ترتيبولو او خپرولو کې يې نه ستړې کېدونکې ونډه اخيستې ده د زړه له کومې مننه کوم.

د علمي کور کهول او اړوند کسانو ته ښکاره ده او پوره باور لري چې د ننني نړۍ هر اړخيزه پر مختګ د پوهانو د علمي څېړنو د زيار له برکته ممکن سوی او د لوړو زده کړو مؤسسې، اکادميک انستيتوتونه او څېړنيز علمي مرکزونه پکښې مرکزي او پريکنده رول لوبولی دی.

همدې اصل او ارزښت ته په کتو سره بُست پوهنتون غواړي د پرمختللو اکاډميکو نورمونو په رعايت د تدريس، علميڅېړنو او نوښتونو له لارې مسلکي کادرونه وروزي او د معياري تحصيلي اسانتياوو او زمينو په برابرولو سره د ټولنې ځوانانو ته معياري او د لوړ کيفيت لوړې زده کړې وړاندی او د علميڅېړنو پر بنسټ د کره پوهنيزو اثارو د توليد زمينه برابره کړي ، ترڅو د لوړو زده کړو او مسلکي پوهې په ډګر کې د ګټوړو مهارتونو په تر لاسه کولو او د خپلو رښتينو اهدافو په لاسته راوړلو سره د ټولنې او هيواد په پرمختګ او رغونه کې رغنده ونډه واخلي او د رښتيني خدمت جوګه شي.

ژمن يو چې د هلمند ولايت، ګاونډيو ولايتونو او په ټول هيواد کې ځوان نسل ته د اسلامي ، ملي او کلتوري ارزښتونو په رڼا کې معياري د علمي او مسلکي لوړو زده کړو او پراخو علمي څېړونو زمينه برابره او ټولنې او هيواد ته ژمن او روزل سوي کادرونه وړاندې کړو.

د اوس لپاره د بُست علمي او څېړنيزه مجله يوازې د **سائينسي علومو** په برخه کې علمي او څېړنيزې مقالې او ليکنې د چاپ او نشر د تګلارې سره سم مني او خپروي او هيله مند يو چې په راتلونکې کې به نورې برخې هم ور زياتې کړل سي.

ډاډ لرم چې د بُست پوهنتون استادان، محصلان او علمي کارمندان به انشاألله، نن، سبا او په راتلونکې کې د خپلې علمي څېړنيزې مجلې د خپرولو له لارې خپل دغه دروند خو ويارلی دين (پور) ادأ کړي. همدا ډول ټولو د علم او پوهې څښتنانو او مينه والو ته په مينه سره بلنه ورکوو چې ددی علمي او څېړنيزې مجلې او د بُست پوهنتون د پرمختګ په لاره کې خپلې علمي او څېړنيزې ليکنې، آندونه، وړاندیزونه او رغنده نيوکې او مرستې د تل په شان راولورو. او د علم ددې ستر کور په ودانولو کې د خپلې دينې، او ملي برخې د ادايې ويار راوبښې.

مور هوډ کړيدي او هيله مند يو چې انشآ الله د وخت په تيريدو سره به د خپل هيواد و بچيانو او ځوان نسل ته د تدريس ، ښه روزنې او څېړنيز هاند لپاره اړيني او د پام وړاسانتياوې برابرې کړو تر څو په لومړي پړاو کښې خپلو هلمندوالو بيا د سهيل لويديځې حوزې او په پای کښې و ټولو هيوادوالو ته د يو داسې چوپړ مصدر وګرځي چې زمور د ځوريدلي اولس او ويجاړشوي هيواد اقتصادي، فرهنګي، سياسي او ټولنيزې ستونزې حل او افغانستان د نړۍ د پرمختللوهيوادونو په ليکه کې ودريږي.

لړليک

Psoriasis: A Comprehensive Overview of Its Etiology, Clinical Features, and Preventive Strategies

Dr. Zabihullah Anwary[1] and Dr. Ali Ahmad[2*]

[1]Dean of Medical Faculty, Curative Medical Department, Medical Faculty, Bost University

[2]Associate Professor, Curative Medical Department, Medical Faculty, Bost University

Corresponding Author Email: aada.aliahmad@gmail.com

Abstract

The review article titled "Psoriasis: A Comprehensive Overview of Its Etiology, Clinical Features, and Preventive Strategies," conducted in 2025, aims to introduce psoriasis while covering its epidemiology, pathophysiology, symptoms, clinical manifestations, types, and treatment options. Psoriasis is a prevalent, chronic inflammatory skin condition marked by distinct, red, scaly patches that usually appear on extensor surfaces such as the elbows and knees. Various clinical variants of psoriasis have been recognized, including palmoplantar, pustular, erythrodermic, and guttate psoriasis. While the diagnosis is mainly based on clinical evaluation, histological analysis may reveal hyperkeratosis, parakeratosis, epidermal acanthosis, dilated blood vessels, and lymphocytic infiltration. Psoriasis is regarded as an immune-mediated condition, and though its exact cause remains unclear, it is thought to emerge from a mix of genetic and environmental influences. Notably, psoriasis is linked to multiple systemic complications and comorbid conditions, which can considerably impact the quality of life for those affected by the disorder.

Keywords: Psoriasis, Diagnosis, Pathophysiology, Symptoms, Clinical Features, Types, and Treatment

Introduction

Psoriasis is a long-lasting, inflammatory skin disorder marked by red patches covered with silvery scales, especially on the extensor surfaces, scalp, and lumbosacral area. This activity examines the underlying mechanisms, manifestations, and diagnosis of psoriasis, emphasizing the importance of a collaborative approach in its treatment (Nair & Badri, 2023).

According to the Mayo Clinic (2022), psoriasis is a dermatological condition that results in itchy, scaly rashes, predominantly found on the knees, elbows, trunk, and scalp. It is a frequent, chronic condition without a known cure. Psoriasis can be painful, disrupt sleep, and hinder concentration. The disease often goes through cycles, flaring for several weeks or months before easing off temporarily. Common triggers in individuals genetically predisposed to psoriasis include infections, cuts or burns, and specific medications.

Psoriasis is a widespread, chronic inflammatory skin disorder characterized by the development of sharply defined, scaly, red patches. It is a common condition in the United States and worldwide. According to the extensive population-based Multinational Assessment of Psoriasis and Psoriatic Arthritis (MAPP) survey, the prevalence of psoriasis ranges from 1.4% in Spain to 3.3% in Canada, with an overall prevalence of 1.9%. The prevalence in the United States is slightly above the average at 2.2%. Globally, prevalence can vary geographically and among different ethnicities within the same area, with higher rates generally reported in locations farther from the equator (Kimmel & Lebwohl, 2018).

Psoriasis can manifest at any age. However, the onset of the disease shows a bimodal distribution, peaking around ages 20–30 and again at 50–60 years old [Henseler & Christophers, 1985]. A family history of psoriasis is common. About 30% of individuals with the condition have a first-degree relative who also has psoriasis, and the likelihood of developing psoriasis increases with the number of affected family members. Some research suggests that this bimodal distribution indicates two distinct types of psoriasis; patients presenting with psoriasis earlier in life are significantly more likely to have a genetic marker associated with the condition and to have a parent affected by it. Early-onset psoriasis is also correlated with more severe manifestations. Typically, the disease fluctuates over a patient's lifetime, and spontaneous remission without intervention is rare (Menter et al., 2008).

The plaques associated with psoriasis can be disfiguring, extremely itchy, and/or painful. Itching is frequently the most distressing symptom of the condition (Lebwohl et al., 2014). The quality of life can be significantly impacted, and many individuals with psoriasis report significant social and emotional distress along with adverse effects on their physical well-being (Krueger et al., 1998; Pariser et al., 2016). The functional impairment caused by psoriasis is comparable to or even exceeds that seen in other severe illnesses, such as cancer, depression, and heart disease (Rapp et al., 1999).

While most psoriasis patients have lighter skin, the condition can occur across all ethnicities. Research findings suggest psoriasis may be more prevalent in individuals with darker skin than previously recognized. In one study conducted in the U.S., researchers discovered that 3.6% of Caucasians, nearly 2% of African Americans, and 1.6% of Hispanics were affected by psoriasis (Psoriasis: Causes, 2014; Gottlieb & Korman, 2008).

Epidemiology:

Psoriasis is estimated to affect around 2–3% of the global population (Pariser et al., 2007). While the disease is more prevalent in polar regions, it is significant in tropical and subtropical countries like India. In this diverse nation, the prevalence of psoriasis can differ across regions due to various environmental and genetic influences. Only six studies conducted in North India, primarily in

hospital settings, have assessed the prevalence among adult dermatology patients (Okhandiar & Banerjee, 1963; Bedi, 1977; Dogra & Mahajan, 2016). The disease appears more common in males, with peak onset typically occurring in the third and fourth decades of life. A notable study in Northern India found the point prevalence of pediatric psoriasis to be 0.0002% (Dogra S, Kumar, 2003). Among boys, the highest incidence of onset is between ages 6 and 10, whereas for girls, it is between ages 11 and 15. A positive family history of psoriasis is noted in 9.8% to 28% of pediatric cases. Psoriatic arthritis typically develops between the ages of 35 and 50, with no gender bias. Approximately 70% of individuals develop psoriasis before experiencing joint issues; in 15% of cases, arthritis occurs before psoriasis by more than a year, and in the remaining 15%, both conditions manifest within 12 months of each other. The annual incidence and prevalence of psoriatic arthritis are estimated to be 3.0–23.1 cases per 100,000 people and 1–420 cases per 100,000 people, respectively (Prey et al., 2010), with comparable figures in Western countries and China. A systematic review indicated that psoriatic arthritis may impact up to 24% of individuals with psoriasis, although similar data for Indian patients is limited. In children, arthritis can precede the appearance of psoriasis in 50% of cases, with an average onset age of 9–10 years and a higher prevalence in females (Stoll et al., 2008).

Pathophysiology of psoriasis:

The pathophysiology of psoriasis is complex and involves multiple factors, including rapid epidermal growth, abnormal differentiation of epidermal keratinocytes, and inflammation linked to immune changes in the skin. The hyperproliferation is marked by increased DNA synthesis and a significantly reduced turnover rate for the epidermis. Abnormal differentiation of keratinocytes is characterized by elevated levels of certain keratins (6 and 16) and a delay in the expression of other keratins (1 and 10), which are typically found in skin that is differentiating normally. Inflammation arises due to an influx of neutrophils within the epidermis and superficial dermis, along with an accumulation of T lymphocytes in the dermis, notably with a predominance of CD8+ cells (Price & Jackson, 2007).

Causes of psoriasis:

Psoriasis arises when skin cells are replaced at a rate faster than usual. The exact cause of this phenomenon remains unclear, but studies indicate it may be linked to an issue with the immune system. New skin cells are produced in the innermost layer of the skin, gradually moving up through the various layers until they reach the outermost surface, where they die and flake off. This entire process typically takes about 3 to 4 weeks. However, in individuals with psoriasis, this process occurs in just 3 to 7 days. Consequently, immature cells accumulate quickly on the skin's surface, resulting in flaky, crusty patches covered in scales (NHS, 2018).

As noted by the National Psoriasis Foundation (2021), the exact cause of psoriasis remains unclear. It is thought to be influenced by genetics, the immune system, and environmental factors. The plaques associated with psoriasis occur because an overactive immune system accelerates skin cell production. In healthy skin, cells grow and shed (fall off) over a month. In contrast, this cycle happens in three or four days with psoriasis. Instead of being shed, skin cells build up on the skin's surface. Psoriasis-related inflammation can affect other organs and tissues in the body, and those with psoriasis may experience additional health issues. Approximately one in three individuals with psoriasis may develop psoriatic arthritis. While the precise causes of psoriasis remain elusive, we understand that genetics and the immune system are key factors in its onset. One established thing is that psoriasis is not contagious, and you cannot transmit it from one person to another. Generally, specific triggers provoke psoriasis, leading to the onset or aggravation of symptoms. These triggers can differ among individuals.

Symptoms of psoriasis:

Dry, elevated patches on the skin are the most typical indication of psoriasis. These patches frequently have a silvery-white layer known as scales and are often itchy (American Academy of Dermatology Association, 2008). According to the National Institute of Arthritis and Musculoskeletal and Skin Diseases (2023), the symptoms of psoriasis differ among individuals. However, some common signs include thick, red skin patches with silvery-white scales that may itch or burn, typically found on the elbows, knees, scalp, trunk, palms, and soles of the feet. Additionally, there may be dry, cracked skin that itches or bleeds, along with thick, ridged, or pitted nails. Sleep quality can also be poor. Some individuals may experience a related condition called psoriatic arthritis, which is marked by joint stiffness, swelling, or pain; neck or back discomfort; or pain in the Achilles tendon. If you experience symptoms of psoriatic arthritis, it is essential to consult your doctor promptly, as untreated psoriatic arthritis can result in permanent damage. The symptoms of psoriasis may fluctuate over time, and you might notice periods when your symptoms worsen, referred to as flares, followed by intervals of improvement.

Clinical features of psoriasis:

Psoriasis presents as symmetrical, red, and scaly plaques with clearly defined borders. The scales are usually silvery-white, although the plaques often appear shiny in skin folds and have a moist, peeling surface. The most frequently affected areas include the scalp, elbows, and knees, although any part of the skin can be involved. Without treatment, these plaques tend to be quite persistent. While itching is generally mild, it can be severe for some individuals, resulting in scratching and lichenification, which is characterized by thickened, leathery skin and pronounced skin markings. Painful cracks or fissures may develop, especially on the palms and soles. Psoriasis can exhibit the Koebner phenomenon, where new skin lesions arise in areas that have been traumatized or irritated, such as by injuries or burns. When psoriatic plaques resolve, they may leave behind brown or pale marks (postinflammatory hypo- or hyperpigmentation) that typically fade over several months. The Auspitz sign refers to pinpoint bleeding that occurs when the scaly layer is removed in plaque psoriasis, which is connected to the dilated dermal capillaries involved in the histological mechanisms of chronic psoriasis (Oakley, 2023).

Types of psoriasis:

According to the Cleveland Clinic (2022), there are several types of psoriasis, and they include:

1. Plaque psoriasis: Plaque psoriasis is the most prevalent form of the condition. Approximately 80% to 90% of individuals diagnosed with psoriasis experience plaque psoriasis (Figure 1). Psoriasis is a widespread, non-contagious skin disorder that can manifest in various forms. The variations of this condition include plaque, inverse (or skin fold), guttate, erythrodermic, and pustular psoriasis. Plaque psoriasis is a chronic skin disorder that affects around 2% to 3% of the global population. Lesions associated with plaque psoriasis are generally red and elevated, often featuring a scale layer. These may present as papules (small, elevated bumps), plaques (larger raised skin areas, bigger than a thumbnail), or a combination of both. Individuals with plaque psoriasis commonly have thick, white, scaly patches on their skin.

(A) (B)

Figure 1. Plaque psoriasis (Source: Plaque Psoriasis Condition, Treatments and Pictures for Adults, 2022)

2. Inverse psoriasis: This type manifests in skin folds and forms thin plaques that lack scales. Inverse psoriasis, also called hidden psoriasis or intertriginous psoriasis, impacts areas of the skin that fold. These regions are where skin comes in contact with skin. Inverse psoriasis can develop in any area with creases, including the neck, buttocks, under the arms, beneath the breasts, or in the groin and inner thigh regions. Individuals with inverse psoriasis often experience another form, such as plaque psoriasis, on different body parts. While raised patches of dry, scaly skin – a hallmark of plaque psoriasis – usually cover extensive areas, inverse psoriasis is more likely to appear in smaller spots. (Figure 2).

(A) (B) (C)

Figure 2. Inverse psoriasis (Source: Shutterstock, 2024)

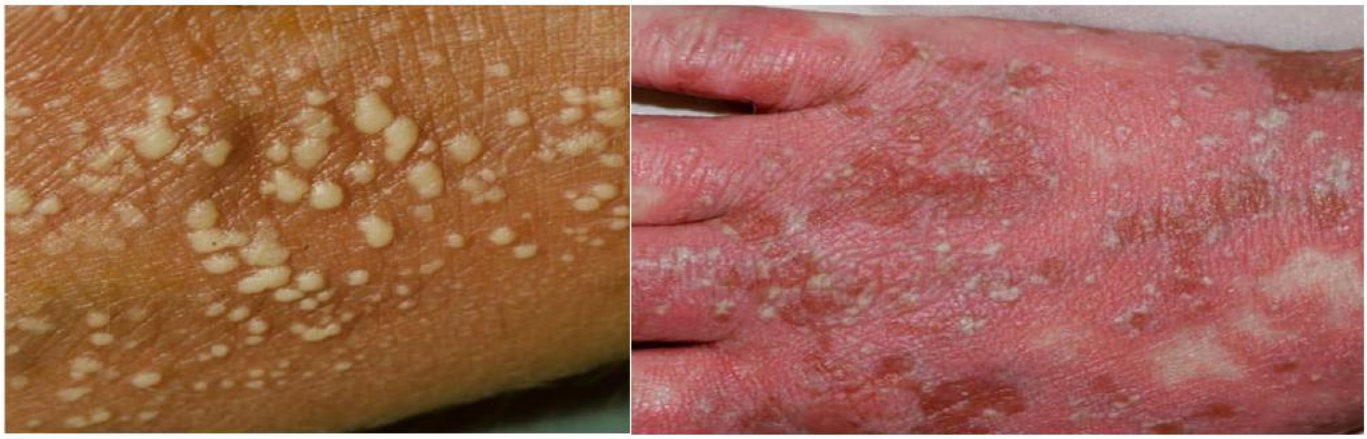
3. Guttate psoriasis: Guttate psoriasis can develop following a sore throat due to a streptococcal infection. It appears as small, red, drop-shaped scaly lesions and frequently affects children and young adults. The primary indicators of guttate psoriasis are tiny drop-shaped, scaly marks that emerge two to three weeks after a strep infection, typically linked to the throat or tonsils. In individuals with lighter skin, the lesions are usually pink or red, while in those with darker skin tones,

the redness may be less visible or manifest as purple, grayish, or dark brown. The affected areas might be topped with thin, white, flaky skin. This rash typically begins on the torso, arms, and legs but can spread to larger regions, including the face, neck, and scalp. Itching is a common symptom linked to guttate psoriasis (Figure 3).

(A) (B)

Figure 3. Guttate psoriasis (Source: Guttate Psoriasis in Adults: Causes, Symptoms, and Treatment, 2023)

4. Pustular psoriasis: Pustular psoriasis is characterized by small, pus-filled lesions on top of plaques. This uncommon and severe form can lead to numerous pustules (pus-filled bumps) on red, inflamed skin. People with pustular psoriasis frequently experience additional symptoms related to their skin condition, including a general feeling of discomfort, fever, itching, or pain in the skin. Pustular psoriasis can manifest as a one-time episode or a chronic condition persisting for many years. Although the precise cause of pustular psoriasis is poorly understood, it seems to stem from an overactive immune response targeting the skin. This variant of psoriasis may develop in those who have experienced plaque psoriasis or those without any prior history. It can also be familial, as several genetic factors associated with pustular psoriasis have been identified. Flares of pustular psoriasis can be triggered by infections, discontinuing topical steroids or other treatments, pregnancy, low calcium levels, certain medications, and various skin irritants like sunburns (Figure 4).



(A) (B)

Figure 4. Pustular psoriasis (Source: DermNet, 2023)

5. Erythrodermic psoriasis: Erythrodermic psoriasis is a severe form of the condition that impacts a significant portion (over 90%) of the skin. It leads to widespread discoloration and shedding of the skin. This is a rare variant of psoriasis, affecting just over 2% of individuals. Plaque psoriasis is typically considered a reliable reference point for those with the condition. It disrupts the skin's ability to regulate temperature and provide protection against infections. If the body struggles to maintain warmth, there is a risk of hypothermia. The primary symptom of erythrodermic psoriasis is a large rash that envelops the entire body. On lighter skin tones, the rash reveals a red appearance; on darker skin, it may appear purple or gray (Figure 5).

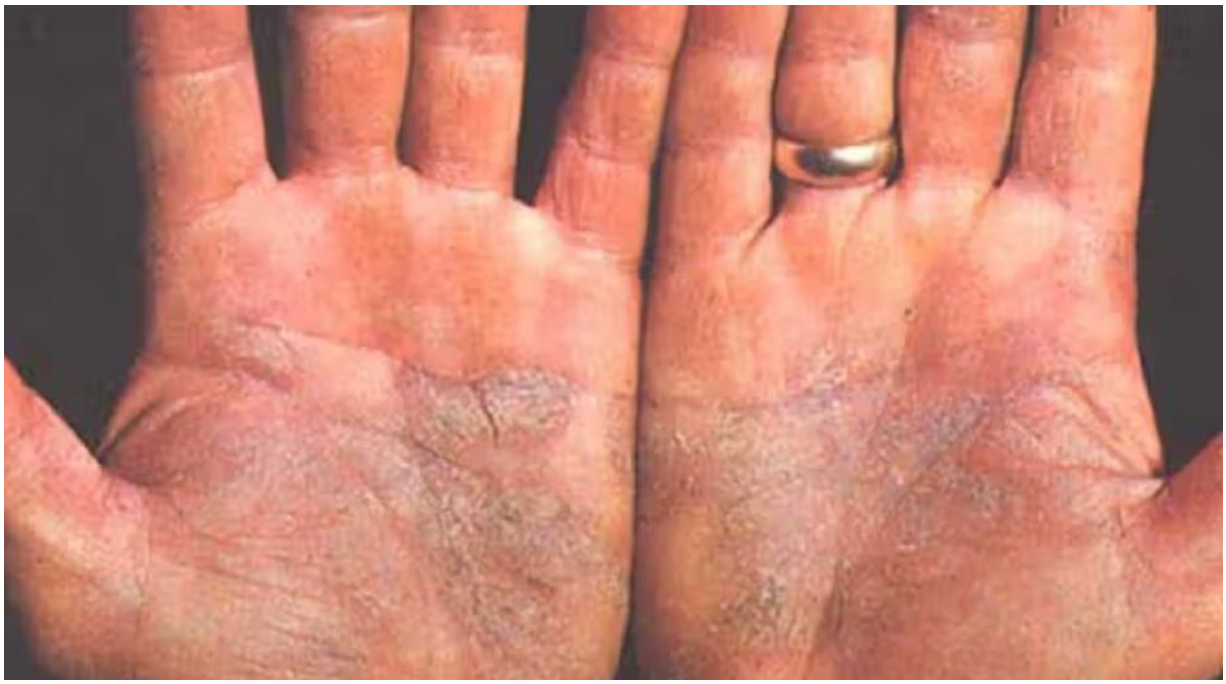


Figure 5. Erythrodermic psoriasis (Source: Watson, 2018)

6. Sebopsoriasis: This condition often manifests on the face and scalp as raised bumps and plaques accompanied by a greasy, yellow scale. Sebopsoriasis represents an overlap of two disorders: seborrheic dermatitis and psoriasis, where characteristics of both ailments are present simultaneously. One can view seborrheic dermatitis as a transitional state between seborrheic dermatitis and psoriasis, exhibiting traits from each condition. The term frequently refers to a psoriasiform rash in a seborrheic pattern when the clinical signs do not permit a definitive diagnosis. Typically, it becomes more evident over time and with the patient's response to treatment, which condition they truly have (Figure 6).

(A) **(B)** **(C)**

Figure 6. Sebopsoriasis (Source: *Sebopsoriasis | DermNet*, 2017)

7. Nail psoriasis: Nail psoriasis leads to changes in color, pitting, and alterations in both fingernails and toenails. Many individuals with psoriasis experience irregularities in their nails. Psoriatic nails frequently exhibit a horizontal white or yellow border at the nail's tip, known as distal onycholysis, which occurs when the nail separates from the surrounding skin. Small indentations can often be found on the nail surface, and the nails are commonly yellow and brittle. Treatments for skin psoriasis can also be effective for nail psoriasis. However, due to the slow growth of nails, it may take some time to notice any improvements. Nail psoriasis can be addressed through phototherapy, systemic treatments (medications that affect the entire body), and topical or injected steroids. If these treatments do not lead to better nail condition, a doctor might surgically remove the nail. Besides peeling, the weakening of the supportive structures of the nails can lead to crumbling. Fungal infections, such as onychomycosis, prevalent among individuals with psoriasis, can also cause nails to thicken. Furthermore, a chalky substance can accumulate beneath the nail, resulting in a condition known as subungual hyperkeratosis, which may cause pain or discomfort (Figure 7).

(A) (B) (C)

Figure 7. Nail psoriasis (Source: Robinson, 2024)

Treatment of Psoriasis:

Although there is no definitive cure for psoriasis at this time, various treatments are available to help control symptoms, enabling you to return to your daily activities and enjoy better sleep. There are several treatment options, and your physician will collaborate with you to determine the most suitable one based on the type of psoriasis, its severity, its location on your body, and the potential side effects associated with the medications. Your treatment plan may encompass the following (Garrick, 2017).

Medications:

Topical therapies: Creams, lotions, ointments, foams, or solutions, particularly those that include corticosteroids, are frequently utilized for the treatment of individuals with mild to moderate conditions. Additional topical treatments consist of vitamin D-based therapies, retinoids (which are related to vitamin A), coal tar, anthralin (a different tar product), phosphodiesterase 4 (PDE4) inhibitors, and medications that activate the aryl hydrocarbon receptor (AhR).

Methotrexate: This medicine is an antimetabolite and can be taken orally or injected. It suppresses the immune system and slows down cell growth and division.

Oral retinoids: These compounds related to vitamin A may help some people with moderate to severe psoriasis. They can be used in combination with phototherapy.

Biologic response modifiers: These medications are injected and block specific immune molecules, helping to decrease or stop inflammation.

Immunosuppressants: These medicines are generally used for severe cases, and they work by suppressing the immune system.

Oral phosphodiesterase 4 (PDE4) inhibitors: These target enzymes inside immune cells and suppress the rapid turnover of skin cells and inflammation.

Oral tyrosine kinase 2 (TYK2) inhibitors: These medications block the activation of certain immune cells.

According to NHS Choices (2022). Treatments fall into 3 categories that are detailed as follows:

1. Topical Treatment: Topical therapies are generally the initial treatments recommended for mild to moderate psoriasis. These consist of creams and ointments that you apply to the areas affected. Emollients are moisturizing products used directly on the skin to minimize water loss and create a protective barrier. If your psoriasis is mild, an emollient is likely the first option your doctor will recommend. The primary advantage of emollients is to hydrate the skin and alleviate itching and scaling. Some other topical treatments are believed to be more effective on skin that is moisturized. It's advisable to wait at least 30 minutes after applying an emollient before using any other topical treatment. Emollients come in a diverse range of products and can be acquired over the counter at a pharmacy or prescribed by your doctor, nurse, or health visitor. Some individuals discover that topical treatments alone are sufficient to manage their condition, although it may take up to six weeks to see a significant effect.

2. Phototherapy: Phototherapy utilizes both natural and artificial light to manage psoriasis. Typically administered in hospitals and specialized centers, artificial light therapy is provided under the supervision of a dermatologist. It's important to note that these treatments differ from using a sunbed.

3. Systemic treatments: If your psoriasis is severe or if other treatments have been ineffective, a specialist might recommend systemic therapies. These treatments operate throughout the whole body. These medications can successfully manage psoriasis, but they all come with the possibility of serious side effects. Every systemic treatment for psoriasis carries its own advantages and risks. Prior to beginning treatment, discuss your options and any associated risks with your doctor. If you are planning to conceive, are pregnant, or considering breastfeeding, you should also consult your doctor before starting any new medication to ensure it is safe for use during pregnancy or while breastfeeding. There are two primary categories of systemic treatments: non-biological (generally administered as tablets or capsules) and biological (typically given via injections).

A. Non-biological medications

Methotrexate

Methotrexate can aid in managing psoriasis by decreasing the production of skin cells and reducing inflammation. It is generally taken once a week. Methotrexate may lead to nausea and can impact blood cell production. Prolonged use may result in liver damage. Individuals with liver disease should avoid taking methotrexate, and it's advisable not to consume alcohol while on this medication. Methotrexate can be extremely dangerous for a developing fetus, making it crucial for women to use contraception and avoid pregnancy during treatment and for at least six months after discontinuation. Men are recommended to wait at least six months after their last methotrexate dose before attempting to conceive.

Ciclosporin

Ciclosporin is a medication that dampens the immune system (immunosuppressant). Initially, it was utilized to prevent the rejection of transplants, but it has also shown effectiveness in managing various forms of psoriasis. It is typically taken on a daily basis. Ciclosporin raises the risk of kidney disease and hypertension, which will require monitoring.

Acitretin

Acitretin is an oral retinoid that decreases the production of skin cells. It is utilized to treat severe psoriasis that has not improved with other non-biological systemic therapies. Typically, it is taken

once daily. Acitretin has a broad spectrum of side effects, which can include dryness and cracking of the lips, dryness in the nasal passages, and, in rare instances, hepatitis. This medication can be extremely dangerous to a developing fetus, so it is crucial for women to utilize contraception and avoid pregnancy while on this medication, as well as for at least three years following cessation. However, it is safe for a man who is on acitretin to conceive a child.

Other drugs

Apremilast and dimethyl fumarate are medications that help decrease inflammation. They are administered as daily tablets. These treatments are advised solely for individuals with severe psoriasis that hasn't improved with other non-biological therapies.

B. Biological treatments:

Biological therapies alleviate inflammation by focusing on hyperactive cells within the immune system. They are typically recommended for individuals with severe psoriasis that has not improved with alternative treatments or when other treatments are not suitable.

Etanercept

Etanercept is administered twice a week, and you'll receive instructions on how to do it. If you do not see any improvement in your psoriasis after 12 weeks, the treatment will be discontinued. The primary side effect of etanercept is a localized rash at the injection site. However, since etanercept impacts the entire immune system, there is a possibility of serious side effects, including severe infections. If you have a history of tuberculosis, there is a chance it may reactivate. You will be monitored for side effects throughout your treatment.

Adalimumab

Adalimumab is administered through an injection every two weeks, and you will receive guidance on how to do this. If you do not see any improvement in your psoriasis after a period of 16 weeks, the treatment will be discontinued. The primary side effects associated with adalimumab consist of headaches, a rash at the site of injection, and feelings of nausea. Nevertheless, since adalimumab impacts the entire immune system, there is a potential risk of serious side effects, such as severe infections. You will be observed for any adverse effects throughout your treatment.

Infliximab

Infliximab is administered via an intravenous drip at the hospital. You will receive three infusions within the first six weeks, followed by one infusion every eight weeks thereafter. If there is no noticeable improvement in your psoriasis after ten weeks, the treatment will be discontinued. The most common side effect of infliximab is a headache. However, because infliximab impacts the entire immune system, there is a potential risk for serious side effects, such as severe infections. You will be closely monitored for side effects throughout your treatment.

Ustekinumab

Ustekinumab is administered at the start of treatment, followed by another dose four weeks later. After that, injections are scheduled every 12 weeks. If there is no noticeable improvement in your psoriasis after 16 weeks, the treatment will be discontinued. The primary side effects associated with ustekinumab include throat infections and a rash at the injection site. However, since ustekinumab impacts the entire immune system, there is a possibility of serious side effects, including severe infections. You will be monitored for side effects throughout your treatment.

Other biological treatments

A growing variety of biological therapies are administered via injections. Among these are guselkumab, brodalumab, secukinumab, ixekizumab, bimekizumab, and isankizumab. These are suggested for individuals with severe psoriasis who have not responded to other therapies or when alternative treatments are inappropriate.

References

49 Inverse Psoriasis Royalty-Free Images, Stock Photos & Pictures | Shutterstock. (2024). Shutterstock. https://www.shutterstock.com/search/inverse-psoriasis.

American Academy of Dermatology Association. (2008). *Psoriasis: Signs and symptoms*. Www.aad.org. https://www.aad.org/public/diseases/psoriasis/what/symptoms.

Bedi TR. (1977). Psoriasis in north India. Geographical variations. Dermatologica, 155:310–4. doi: 10.1159/000250983.

Cleveland Clinic. (2022, September 15). *Psoriasis | Cleveland Clinic*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/6866-psoriasis.

Dogra S, Kumar B. (2003). Epidemiology of Skin Diseases in School Children: A Study from Northern India. Paed Dermatol, 20:470–3. doi: 10.1111/j.1525-1470.2003.20602.x.

Dogra, S., & Mahajan, R. (2016). Psoriasis: Epidemiology, clinical features, co-morbidities, and clinical scoring. *Indian Dermatology Online Journal*, *7*(6), 471–480. https://doi.org/10.4103/2229-5178.193906.

Garrick, N. (2017, April 12). *Psoriasis*. National Institute of Arthritis and Musculoskeletal and Skin Diseases. https://www.niams.nih.gov/health-topics/psoriasis/diagnosis-treatment-and-steps-to-take

Generalised Pustular Psoriasis Images — DermNet. (2023, October 26). DermNet®. https://dermnetnz.org/images/generalised-pustular-psoriasis-images.

Gottlieb A., & Korman NJ. (2008). Guidelines of care for the management of psoriasis and psoriatic arthritis Section 2. Psoriatic arthritis: Overview and guidelines of care for treatment with an emphasis on the biologics." *J Am Acad Dermatol*, *58*(5):851-64.

Guttate Psoriasis in Adults: Causes, Symptoms, and Treatment. (2023, May 3). Skinsight. https://skinsight.com/skin-conditions/guttate-psoriasis-adult/.

Henseler, T. & Christophers, E. (1985). Psoriasis of early and late onset: characterization of two types of psoriasis vulgaris. *J Am Acad Dermatol, 13*(3), 450–456. doi: 10.1016/S0190-9622(85)70188-0.

Kimmel, G. W., & Lebwohl, M. (2018). Psoriasis: Overview and Diagnosis. *Updates in Clinical Dermatology*, 1–16. https://doi.org/10.1007/978-3-319-90107-7_1.

Krueger G, Koo J, Lebwohl M, Menter A, Stern RS, Rolstad, T. (1998). The impact of psoriasis on quality of life: results of a 1998 National Psoriasis Foundation patient-membership survey. Arch Dermatol, 137(3):280–284.

Lebwohl, MG., Bachelez, H., Barker, J., Girolomoni G., Kavanaugh, A., Langley, RG., Paul, CF., Puig, L., Reich, K. & van de Kerkhof, PC. (2014). Patient perspectives in the management of psoriasis: results from the population-based Multinational Assessment of Psoriasis and Psoriatic Arthritis Survey. J Am Acad Dermatol, 70(5), 871–881.e871–830. doi: 10.1016/j.jaad.2013.12.018.

Mayo Clinic. (2022, October 8). *Psoriasis - Symptoms and Causes*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/psoriasis/symptoms-causes/syc-20355840. 16. Menter A, Gottlieb A, Feldman SR, van Voorhees AS, Leonardi CL, Gordon KB, Lebwohl M, Koo JYM, Elmets CA, Korman NJ. (2008). Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol, 58*(5):826–850. doi: 10.1016/j.jaad.2008.02.039.

Nair, P. A., & Badri, T. (2023). *Psoriasis*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK448194/.

National Institute of Arthritis and Musculoskeletal and Skin Diseases. (2023, October). *Psoriasis*. National Institute of Arthritis and Musculoskeletal and Skin Diseases. https://www.niams.nih.gov/health-topics/psoriasis.

National Psoriasis Foundation. (2021). *About Psoriasis*. Www.psoriasis.org. https://www.psoriasis.org/about-psoriasis/.

NHS Choices. (2022, April). *Treatment - Psoriasis*. NHS. https://www.nhs.uk/conditions/psoriasis/treatment/.

NHS. (2018, May 11). *Psoriasis - Causes*. Nhs.uk. https://www.nhs.uk/conditions/psoriasis/causes/.

Oakley, A. (2023). *Psoriasis | DermNet NZ*. Dermnetnz.org. https://dermnetnz.org/topics/psoriasis.

Okhandiar RP, Banerjee BN. (1963). Psoriasis in the tropics: An epidemiological survey. *J Indian Med Assoc, 41*, 550–6.

Pariser D, Schenkel B, Carter C, Farahi K, Brown TM, Ellis CN. (2016). A multicenter, non-interventional study to evaluate patient-reported experiences of living with psoriasis, *J Dermatolog Treat, 27*(1):19–26. doi: 10.3109/09546634.2015.1044492.

Pariser DM, Bagel J, Gelfand JM, Korman NJ, Ritchlin CT, Strober BE. (2007). National Psoriasis Foundation Clinical Consensus on Disease Severity. *Arch Dermatol, 143*, 239–24. doi: 10.1001/archderm.143.2.239.

Parisi, R., Symmons, DP., Griffiths, CE. & Ashcroft, DM. (2013). Global epidemiology of psoriasis: a systematic review of incidence and prevalence. *J Invest Dermatol, 133*(2), 377–385. doi: 10.1038/jid.2012.339.

Plaque Psoriasis Condition, Treatments and Pictures for Adults. (2022, August 16). Skinsight. https://skinsight.com/skin-conditions/plaque-psoriasis/.

Prey S, Paul C, Bronsard V, Puzenat E, Gourraud PA, Aractingi S. (2010). Assessment of risk of psoriatic arthritis in patients with plaque psoriasis: A systematic review of the literature. *J Eur Aacd Dermatol Venereol, 24*, 31–5. doi: 10.1111/j.1468-3083.2009.03565.x.

Price, B. A., & Jackson, J. B. (2007). Psoriasis. *XPharm: The Comprehensive Pharmacology Reference*, 1–6. https://doi.org/10.1016/b978-008055232-3.60794-9.

Psoriasis: Causes. (2014). Www.aad.org. https://www.aad.org/public/diseases/psoriasis/what/causes.

Rachakonda, TD., Schupp, CW. & Armstrong, AW. (2014). Psoriasis prevalence among adults in the United States. *J Am Acad Dermatol, 70*(3), 512–516. doi: 10.1016/j.jaad.2013.11.013.

Rapp SR, Feldman SR, Exum ML, Fleischer AB, Jr, Reboussin DM. (1999). Psoriasis causes as much disability as other major medical diseases. *J Am Acad Dermatol. 41*(3 Pt 1):401–407. doi: 10.1016/S0190-9622(99)70112-X.

Robinson, M. (2024, February 22). *Psoriasis Nails vs. Fungus: Pictures and Differences to Look For*. GoodRx. https://www.goodrx.com/conditions/psoriasis/what-psoriasis-nails-vs-fungus-look-like.

Sebopsoriasis | DermNet. (2017). Dermnetnz.org. https://dermnetnz.org/topics/sebopsoriasis.

Stoll ML, Lio P, Sundel RP, Nigrovic PA. (2008). Comparison of Vancouver and International League of Associations for Rheumatology classification criteria for juvenile psoriatic arthritis. Arthritis Rheum, 59, 51–8. doi: 10.1002/art.23240.

Watson, S. (2018, March 26). *Pictures of Erythrodermic Psoriasis and How to Treat It*. Healthline; Healthline Media. https://www.healthline.com/health/erythrodermic-psoriasis#symptoms#.

سورايسس: د هغې د علت، کلينيکي ځانګړنو او وقايوي ستراتيژيو ته کتنه

پوهنيار ډاکټر ذبيح الله انوري[۱]، پوهندوی ډاکټر علي احمد[۲*]
[۱،۲]معالجوی څانګه، طب پوهنځی، بُست پوهنتون
د مسؤل يميل ادرس: aada.aliahmad@gmail.com

Abstract

دا کتابتوني څېړنه د سورايسس، د هغې د علت، کلينيکي ځانګړنو او وقايوي ستراتيژيو هر اړخيزه کتنې تر عنوان لاندې په ۲۰۲۵ م کال کې ترسره سوې ده. ددې څېړنې عمده موخې د سورايسس جلدي ناروغۍ د پېژندنې ترڅنګ د دې ناروغۍ د خپرېدو، فزيولوژيکي لاملونو، علايمو، کلينيکي نښو، ډولونو او درملنې اړخونه تر پوښتنې لاندې نيسي. سورايسس يوه ډېره عامه، مزمنه او التهابي پوټکي ناروغي ده، چې د پوستکي د روښانه، سور او پر پوټکي ولاړو پوړيو (سکيلونو) په شکل ځرګندېږي او دا اکثره د بدن پر هغو برخو ښکاره کېږي، لکه څنګل او زنګونونه. د سورايسس ببلابېل کلينيکي ډولونه پېژندل سوي دي، چې پالموپلنټار، پوستولر، اريترودرميک او ګټېټ سورايسس شامل دي. که څه هم ډېرې وخت تشخيص د کلينيکي معاينې له لارې ترسره کېږي، خو د پوستکي د نسجونو له تجزيې څخه ښايي ځانګړي نښې وموندل سي، لکه هايپرکراتوسس، پاراکيراتوسس، ايپيډرمال اکانتوسس، ويني رګونه او ليمفوسايتي ننوتنه. سورايسس يوه د معافيت د سيستم له خوا رامنځته کېدونکې ناروغي ګڼل کېږي او که څه هم د دې کره علت لا هم روښانه نه دی، خو داسي باور دی، چې دا ناروغي د جنيټيکي او محيطي فکتورونو د ګډ تاثير له امله منځته راځي. د يادونې وړ ده چې سورايسس له ګڼو سيستېميکي عوارضو او هم مهاله (comorbid) ناروغيو سره تړاو لري کوم، چې د ناروغانو د ژوندانه پر کيفيت باندې ژور اغېز کوي.

کليدي کلېمې: سورايسس، تشخيص، فزيولوژي، علايم، کلينيکي ځانګړتياوي، ډولونه او درملنه.

BOST

Academic & Research National Journal

Volume: 4 Issue: 1

Year: 2025