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THE ROLE OF HOMOEOPATHY IN PSORIASIS MANAGEMENT: A REVIEW

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ABSTRACT

Background: Psoriasis is an immune-mediated disease clinically characterized by erythematous, sharply demarcated papules and round plaques covered by silvery micaceous scale. It is a long-term inflammatory skin disease. Epidemiological investigations conducted in India have reported a prevalence of psoriasis ranging between 0.44% and 2.8%. The majority of patients present during their third or fourth decade of life, consistent with the peak onset observed in early to middle adulthood. Objective**:** This review synthesizes current knowledge on the epidemiology, immunopathogenesis, clinical variants, and therapeutic strategies for psoriasis, with particular attention to both conventional and homoeopathic management.

Methods: Information was collected from medical studies, clinical reports, and homoeopathic literature to understand both conventional and homoeopathic approaches.

Results: Psoriasis appears in different forms such as plaque, guttate, inverse, pustular, and erythrodermic. Conventional treatment includes creams, light therapy, medicines, and biologic drugs that target the immune system. Homoeopathic remedies like *Arsenicum album, Graphites*, and *Sulphur* are often used based on the patient's overall symptoms. Some reports suggest improvement in skin lesions and quality of life, but more scientific studies are needed.

Conclusion: Psoriasis is a complex disease that affects both skin and general health. Conventional medicine has advanced with biologic drugs, while homoeopathy offers an individualized approach. Combining modern and homoeopathic perspectives may provide better care for patients.
Keywords: *Dermatology, Scaly plaques, Autoimmune, Psoriasis, Homoeopathy, Inflammation.*

1. INTRODUCTION

Psoriasis is a chronic inflammatory disorder mediated by immune-system dysfunction. It is typically characterized with well-defined, reddish papules and plaques, often accompanied by characteristic silvery-white scales. It is a long-term inflammatory skin disease [1]. Epidemiological investigations conducted in India have reported a prevalence of psoriasis ranging between 0.44% and 2.8%. The disease demonstrates a distinct male predominance, with men affected approximately twice as frequently as women. The majority of patients present during their third or fourth decade of life, consistent with the peak onset observed in early to middle adulthood [2]. It can appear in people of any age, sex, or race, but is most common in young adults (16–22 years) and later in life (57–60 years). Around 1–10% of the population may be affected worldwide. Causative factors- Genetic factors (e.g., HLA-CW*0602, IL-23/17 pathway), stress, cold weather, trauma, smoking and beta-blockers. Infections such as streptococcal throat infection can trigger guttate psoriasis, especially in children. Psoriasis can occur in several clinical forms which are: Psoriasis vulgaris (most common, 80–90% of cases), Pustular, Guttate, Inverse, Erythrodermic, and Palmoplantar psoriasis. It can be associated with psoriatic arthritis [3]. Normally, skin cells renew at a steady pace, replacing old cells over time. In psoriasis, this cycle accelerates, leading to thick scales and inflamed, itchy patches. These lesions often appear on the elbows**,** knees**,** scalp**,** and lower back**,** though severe cases may affect larger areas. The disease stems from an abnormal immune response**,** where the body attacks healthy skin cells. Psoriasis is not contagious and affects about 125 million people worldwide, or roughly 2–3% of the population [4,5].

2. METHODOLOGY

This narrative review was prepared using information from standard medical, dermatological, and homoeopathic literature (Google scholar, PubMed)(2018-2026). Relevant sources addressing the epidemiology, classification, aetiology, pathogenesis, clinical features, diagnosis, conventional management, and homoeopathic management of psoriasis were reviewed. Standard textbooks and

homoeopathic references cited in this article were included as the primary sources. The search utilized keyword such as “Psoriasis”, “Pathogenesis”, “Conventional treatment”, “Homoeopathy in dermatology”, and specific remedy names (e.g., “*Arsenicum album”, “Sulphur”, “Graphites”).* Relevant clinical studies and published reports were also considered. Duplicate, irrelevant, and non-scientific sources were excluded.

3. CLASSIFICATION

- **Cutaneous varieties** [1]
  - Plaque-type psoriasis: The most common form characterized by stable, slowly enlarging, symmetric plaques predominantly on the elbows, knees, gluteal cleft, and scalp.
  - Inverse psoriasis: A localized form affecting areas such as axilla, groin, breast, belly button. Lesions are sharply demarcated, moist, and typically lack scale.
  - Guttate psoriasis (Eruptive psoriasis): An acute form presenting as small, erythematous, scaling papules, most common in children and young adults.
  - Pustular psoriasis: Lesions characterized by sterile pustules on intense erythema.
- **Psoriatic arthritis (PsA) subtypes** [1]
  - Symmetric PsA: ~50% of cases; clinically resembles rheumatoid arthritis.
  - Asymmetric PsA: ~35% of cases; can involve any joint and often manifests with “sausage digits”.
  - Distal PsA: ~5% of cases; the classic form primarily affecting distal joints and heavily associated with nail dystrophy.
  - Spondylitis: ~5% of cases; presents as a severe, deforming arthritis primarily affecting small joints of the hands and feet.
  - Arthritis Mutilans: <5% of cases; a severe, destructive form of arthropathy.

Fig.- Type of psoriasis

4. CAUSES

Risk factors for psoriasis include both genetic and environmental triggers.

- **Genetics:** If one parent has psoriasis, a child has about a 15-20% chance of getting it. If both parents have it, that risk jumps to 50% e.g., HLA-CW*06, IL-23/17 pathway. Many of the genes involved are tied to the immune system and skin barrier function.
- **Environmental triggers:** Injuries, infection, smoking, alcohol, certain medications (beta-blockers, lithium, antimalarials, antidepressants). Infections such as streptococcal throat infection can trigger guttate psoriasis, especially in children. Stress can also trigger the condition. [3].

5. PATHOGENESIS

1. Abnormal epidermal proliferation (keratinocyte hyperproliferation) – accelerated cellular changes, rapid shedding, corneal layer hypertrophy
2. Microvascular alterations (vasodilation in dermal capillaries) – neovascularization (angiogenesis), leukocyte extravasation
3. Cascade of inflammatory signalling (proinflammatory mediator release) – upregulated cytokines production, T-lymphocyte stimulation, cascade induction [3]

6. DIFFERENTIAL DIAGNOSIS

- **General/ Plaque forms:** Nummular dermatitis, seborrheic dermatitis, pityriasis rosea, syphilis, atopic dermatitis, mycosis fungoides.
- **Pustular Forms:** Acute generalised exanthematous pustulosis, IgA pemphigus, and pustular drug eruptions.
- **Localized pustular form:** Bacterial paronychia, herpetic whitlow, chronic candidiasis, and acrodermatitis enteropathy [3].

7. PROGNOSIS

The outlook for psoriasis is no longer considered poor. Many patients experience good temporary relief, and there is hope for long-term control or even cure. Starting treatment early, when the disease is mild, improves outcomes. Younger patients, those with less chronic disease, and those with recurrent types generally have a better prognosis [6].

8. INVESTIGATIONS

- **Clinical assessment**: Diagnosis is mainly clinical, based on the appearance and distribution of lesions.
- **Severity scoring**: Tools like PASI (Psoriasis Area and Severity Index) and

DLQI (Dermatology Life Quality Index) are used to measure disease severity and its impact on quality of life.

- **Laboratory tests:** Blood tests may be done to rule out other conditions or monitor treatment effects.
- **Infection screening:** Patients with severe psoriasis may be screened for infections, including HIV, as these can worsen the disease or influence treatment choices.
- **Comorbidity evaluation:** Since psoriasis is linked with metabolic syndrome, cardiovascular disease, and arthritis, doctors often check for these associated conditions [8].

9. MANAGEMENT AND TREATMENT

Treatment selection is highly individualized, depending on the clinical type, severity, extent, duration, how the patient has responded to past treatments, and their psychosocial status.

1. Topical Treatments

Topical therapies are generally the first line of defense and are usually sufficient for mild to moderate cases:

Corticosteroids: Provide anti-inflammatory, antiproliferative, and immunosuppressive actions. High-potency steroids are typically started initially, followed by lower-potency formulations for maintenance. High-potency options should generally not be used for more than a few weeks at a time. Low- to medium-potency steroids are reserved for the face and inverse areas**.**

Keratolytic Agents: Combining thick, scaly plaques with salicylic acid, urea, or a retinoid (e.g., tazarotene) helps increase skin penetration**.**

Vitamin D Analogues (Calcipotriol): Suppresses inflammation and reduces epidermal keratinocyte proliferation. It can be used alone or combined with topical corticosteroids to reduce scale thickness, especially on the scalp.

Calcineurin Inhibitors (Tacrolimus and Pimecrolimus): Particularly effective as maintenance treatment and for use in children.

Anthralin and Coal Tar: Historically used with some benefit, though largely replaced by newer topical steroids and steroid-sparing agents. Anthralin is mostly preferred for plaque psoriasis in short-term contact or combined treatments, while coal tar can effectively reduce scale thickness.

2. Systemic Treatments

Systemic therapies are preferred for moderate to severe cases or for disease that is resistant to topical therapy or phototherapy. Main agents include:

Acitretin: Can be used across all types of psoriasis and is especially helpful in pustular psoriasis. Response is typically observed within 4–6 weeks, with maximal effects seen at 3–4 months. Once stabilized, the dose can be reduced for maintenance [3].

10. HOMOEOPATHIC MANAGEMENT

Homoeopathic remedies are selected based on individual totality of symptoms, constitutional type, and modalities:

Ammonium carbonicum- Ammonium carb. acts on psoriasis eruption white pea-sized spots upon the cheek, which continually exfoliate. Skin very sensitive to cold. Aversion to being washed. Nosebleed when washing the face in the morning. In weak nervous individuals [7,9].

Arsenicum album- It is indicated for psoriasis characterized by dry, rough, scaly, papular eruption accompanied by intense itching and burning; worse cold and scratching. Great restlessness with weakness and prostration [7,9].

Arsenicum iodide- Dry scaly burning itching eruption on various parts. Persistent itching on the back. In obstinate, chronic cases [7,9].

Borax- Itching on back of finger-joints. Unhealthy skin; slight injuries suppurate. Erysipelatous inflammation with swelling and tension. Tardy eruptions on fingers and hands, itching and stinging [7,9].

Calcarea carbonica- Scurfy spots on the leg. Burning and itching. Skin cracks. Profuse sweat from the slightest exertion [7,9].

Fluoric acidum- Roughness on the forehead like a rough line with its convexity upwards. Reddish spots above the eyebrows. Desquamation on the eyebrows. Nails brittle, edges bent in [7,9].

Graphites- Skin eruptions, oozing out a sticky exudation. Rawness in bends of limbs, groins, neck, behind ears. Unhealthy skin; every little injury suppurates. It is also an effective remedy for scalp psoriasis, where painful, itchy, and scaly lesions develop on the head, often accompanied by a burning feeling on the crown. These scalp eruptions frequently extend to the skin behind the ears. Additionally, Graphites helps address nail psoriasis, which is marked by thickened, brittle, and distorted nails. [7,9].

Iris versicolor- Irregular psoriatic patches on the knees and elbows, covered with shining scales. Skin fissured and irritable. Gastric and bilious derangements [7,9].

Kalium arsenicosum- Intolerable itching aggravated when undressing. Dry, scaly,

wilted skin. Restless, nervous and anaemic patient [7,9].

Kali bromatum- Itching; worse on chest, shoulder and face. Psoriasis. Anaesthesia of skin.

Mercurius- Psoriasis of hands. Psoriasis in spots all over the body. Scaling off and exfoliation of the fingernails. The scalp is painful to touch. Easy perspiration without relief [7,9].

Mezereum- Scurf-like scales on the back, chest, scalp and thighs. Roughness and scaling here and there. Pruritus increased by scratching or when undressing [7,9].

Natrum arsenicosum- Thin whitish scales, which when removed leave the skin slightly red [7,9].

Petroleum- Petroleum is well indicated for skin of the hands cracked rough. Unhealthy skin. Aversion to the open air. Extreme sensitiveness to slight touch. Falling off of the hair. Itching worsens at night and sensitive to cold [7,9,10].

Phosphorus- Psoriasis of the arms and on the knees and elbows. Arms and hands become numb. Coldness of the knees at night in bed. Falling out of the hair in large bunches, dandruff-like desquamation with acute inflammation [7,9].

Phytolacca- Surface of the skin shrunken and of a leaden colour. Squamous eruption. Rheumatic pains in the extremities [7,9].

Psorinum- Deep-acting remedy for chronic, stubborn cases with foul-smelling eruptions and extreme itching. Skin eruption blackish, shiny, scaly, coppery [7,9,10].

Selenium- Dry scaly eruption on the palms of the hands, with slight itching [7,9].

Sepia- Psoriasis on the face. Red roughness of the skin. Falling off of the hair. During pregnancy and nursing. Dark complexioned individuals [7,9].

Silicea- Elevated scurfy spots near the coccyx. Small white scales on the face and neck. White spots on the cheeks. Sensation of the numbness in the extremities. Brittleness of the nails. In scrofulous, large-bellied children. Imperfect assimilation [7,9].

Sulphur- Its action is centrifugal from within outward with elective affinity for skin. It produces heat and burning with itching; made worse by heat of bed. Pimple-like eruption, pustules, hang-nails [7,9].

Teucrium- Psoriasis on the index finger of the right hand [7,9].

X-RAY- It is deep-acting medicine, such as imponderabilia (energy) can be indicated. Their drug action is subtle, potent and penetrating, which can go deeper into the

strata of miasm due to their nature of composition. It can be used as an intercurrent remedy.[11]

11. DISCUSSION

Psoriasis is a chronic, immune-mediated inflammatory disease influenced by genetic and environmental factors. Its recurrent nature and associated comorbidities require individualized and long-term management. Conventional treatment is selected according to disease severity and clinical presentation and includes topical, phototherapeutic, systemic, and newer biologic therapies.

Homoeopathic literature describes an individualized approach based on the patient's characteristic symptoms, with remedies such as *Arsenicum album, Graphites, Kali arsenicosum, Sulphur,* and *Sepia* described for different clinical presentations. However, these traditional indications should be distinguished from clinical evidence of efficacy.

The available clinical evidence for homoeopathy in psoriasis remains limited. Therefore, further well-designed clinical studies with standardized outcomes and adequate follow-up are required. Homoeopathy should be considered only as a complementary approach and should not delay established treatment, particularly in severe disease or psoriatic arthritis.

12. CONCLUSION

Psoriasis is a chronic, relapsing inflammatory skin disease with diverse clinical manifestations and important effects on quality of life. Its pathogenesis involves genetic susceptibility, immune dysregulation, inflammatory signalling, and environmental triggers. Diagnosis is primarily clinical, while disease severity and associated comorbidities should be assessed systematically. Conventional treatment includes topical therapy, phototherapy, systemic medicines, and targeted biologic therapies according to disease severity and individual patient factors.

Homoeopathy provides an individualized therapeutic framework described in traditional homoeopathic literature, and a small number of clinical studies have reported potentially beneficial outcome. Nevertheless, the evidence base remains limited by sample size, study design, and the need for independent replication. Further rigorous clinical research is required before definitive conclusions can be drawn regarding its role in psoriasis management.

13. DECLARATIONS

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