Psoriasis

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Definition

Psoriasis (IDC-10: L 40, possibly F 54) is a common inflammatory dermatosis characterized by an acute exanthematous or chronic course. In most cases, predisposition to juvenile psoriasis is hereditary. Erythrodermic psoriasis (exfoliative psoriasis), pustular psoriasis, and psoriatic arthritis represent very severe forms of psoriasis. Guttate psoriasis is a special form that often occurs after an infection by streptococci and is triggered by bacterial super-antigens.

Dermatological Diagnostics

Anamnesis (including the medical history of the family). It is important to pay attention to former manifestations of psoriatic arthritis (peripheral or axial type) that have enormous somatic (pain, limited mobility) and psychosocial consequences. Dermatological examination and histopathology, if necessary.

Orthopaedic/Rheumatological Additional Diagnostics

Consultant examination by an orthopaedist or rheumatologist (required in any case of arthralgia of unknown genesis).

Psychosomatic Diagnostics

Onset

In some patients psychological factors have only little effect on the clinical course and the symptoms of the disease, in other patients, however, they may well elicit the onset of the disease and affect its clinical course.

Psoriasis is hypothesized to be an autoimmune disease or at least to be mediated by immunological factors. This hypothesis is supported by the principles of psoriasis treatment which are mostly immunosuppressive. Furthermore, activated T lymphocytes have been detected in cellular infiltration plaques of psoriatic skin lesions [Kapp, 1993]. Immunological mechanisms and epidermal proliferation play a pathogenetic role in psoriasis [Lebwohl, 2003]. Frequently, patients with psoriasis describe an aggravation of symptoms by stress, but the psychobiological pathways mediating this effect have not yet been detected in detail. However, psychoendocrinological studies have shown that urinary excretion of adrenalin after stress exposure was more pronounced in patients with psoriasis than in healthy controls [Arnetz et al., 1985]. In addition, stress-induced increases of CD8+/CD11b+ T lymphocytes in the circulation were higher in psoriasis patients than in healthy controls [Schmid-Ott et al., 2001]. These data suggest a heightened vegetative arousal after stress exposure in patients with psoriasis compared to healthy volunteers, indicating that psychological stress may induce immunological changes.

In summary, patients with psoriasis neither have a special disturbance of their psychological profile nor inadequately pronounced aggressive behaviour or a repressed aggression compared to healthy controls [Ginsburg, 1995; Welzel-Ruhrmann, 1995].

Coping

The psychological impact of the disease differs from one patient to another. Concerning stigmatisation and coping with the disease some aspects are of particular interest:

Daily hassles are experienced as more burdening than so-called critical life-events [Gupta and Gupta, 1995]. Particularly, specific everyday events caused by other peoples' reactions to the disfiguring skin lesions have to be considered [Schmid-Ott et al., 1999, 2003; Stangier et al., 1996]. Interventions to

prevent fear of stigmatisation might raise quality of life [Lebwohl and Tan, 1998]. Thus, feelings of stigmatisation seem to play a central role in mediating the impact of disease severity on the quality of life in psoriasis patients [Vardy et al., 2002].

Diagnosics

Required

It is useful to elicit psychosomatic aspects, such as a reactive depressive disorder, a correlation between the exacerbation of the disease and stressful life-events, problems of coping with the disease, a heavy psychosocial burden, and a distinctive stigmatisation experience or social fear. If any of these symptoms is revealed, the following measures should be taken.

Optional

Psychosomatic examination could provide the indication for psychotherapy.

Suitable test procedures are the Dermatology Life Quality Index (DLQI) [Finlay and Khan, 1994; Touw et al., 2001], the Marburg questionnaire for coping with skin diseases (FBH) [Stangier et al., 1996], the Questionnaire on Experience with Skin Complaints (QES) [Schmid-Ott et al., 1999, 2003].

Therapy

Dermatological Therapy

Local therapy contains keratolysis to reduce hyperepidermopoiesis, and agents to inhibit inflammation. Therefore, dithranol, tars, corticosteroids, and vitamin D analogues are administered. Furthermore, UVB phototherapy, particularly in combination with brine or PUVA (oral psoralen followed by irradiation with UVA) are used for treatment. Climatotherapy is often carried out as well. Systemic therapy with corticosteroids is rarely used, and in severe cases acitretin (an oral retinoid), cyclosporin A, and cytostatic drugs (e.g. methotrexate) are administered. New targeted biological treatments promise progress in treating psoriasis [Lebwohl, 2003].

Patients should be informed about the so-called Koebner effect. If necessary, private and job-related activity that contributes to this effect should be avoided.

Antibiotic treatment against streptococci in guttate psoriasis, if necessary.

Orthopaedic/Rheumatological Supplementary Therapy

Early treatment of arthritis with anti-inflammatory drugs; additional physical therapy, if necessary.

Psychosomatic Therapy

Psychosomatic Care

Psychosomatic care, e.g. psychosocial support is indicated in cases of severe fear of stigmatisation or lowered quality of life, or if more detailed information about psychosomatic aspects of the disease help the patient to cope with it.

Indication for Psychotherapy

Clinical experience shows that an indication for psychotherapy should be considered in patients with chronic forms of psoriasis. Only few studies investigated if either psychic or somatic symptoms are influenced by additional psychotherapy. E.g., in hand dermatoses (mixed skin diseases including psoriasis) almost 50% of the patients affected were convinced that 'stress' influenced the course of their disease [Niemeier et al., 2002]. Analysis of variance in this study shows that a high subjective reaction to stress (high-SR) is correlated with higher severity scores, more itching, higher depression scores and more life-events. Patients with high SR are typically younger and onset of their disease is earlier compared to patients with low SR. Serious problems of pain may be an indication for psychotherapeutic support, e.g. special relaxation methods.

Relaxation: During in-patient dermatological rehabilitation, patients with psoriasis found autogenous training helpful [Huckenbeck-Goedecker and Schroepf, 1988]. Clinical experience shows that progressive muscle relaxation by Jacobson might be helpful, too. Stangier [1987] reported that 10 sessions of skin-temperature biofeedback training within 5 weeks did not improve the clinical signs at the end of the sessions but at 6-month follow-up. These findings indicate that continuous skin-temperature biofeedback training could work as a prophylaxis of recurrence. Furthermore, Kabat-Zinn et al. [1998] found that a mindfulness meditation-based stress reduction intervention guided by audiotaped instructions during light treatments significantly improved skin symptoms in patients with moderate to severe psoriasis undergoing phototherapy (UVB) and photochemotherapy (PUVA) compared to the somatic treatment alone.

Psychodynamic or Psychoanalytic Therapy: Only few single-case studies exist [Schur, 1993; Koblenzer, 1995] in which Schur found a stabilisation of the skin status at the time of catamnesis. Thus there is some evidence that additional psychodynamic or psychoanalytic therapy may be useful in psoriasis.

Behaviour Therapy: Zachariae et al. [1996] carried out a controlled randomised study: Individual psychotherapy (7 sessions within 12 weeks; combination of guided imagery, relaxation, and stress management) moderately reduced somatic activity of the disease in psoriasis patients by the end of the therapy.

A 6-week participation in an adjunct cognitive-behavioural Psoriasis Symptom Management Programme (PSMP) resulted in a significantly greater reduction of clinical severity of psoriasis, anxiety and depression (Hospital Anxiety and Depression Scale, HADS), psoriasis-related stress (Psoriasis Life Stress Inventory, PLSI) and disability (Psoriasis Disability Index, PDI) at 6-week and 6-month follow-up than the somatic treatment alone [Fortune et al., 2002].

Training Course: The Arbeitsgemeinschaft Dermatologische Prävention e.V. (ADP) is developing a special training course for patients with psoriasis in Germany [Lemke et al., 2000].

Self-Help: Deutscher Psoriasis Bund e.V. (DPB), Seewartenstr. 10, D-20459 Hamburg, Germany, phone: +49/40/223399, fax +49/40/2270986, www.psoriasisbund.de.

European Federation of Psoriasis Associations (EUOPSO), Fredrikinkatu 27 A 3, FI-00120 Helsinki, phone: +358/9/2511900, fax +358/9/25119088, www.euopso.org. Members (in alphabetical order): Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Italy, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Spain, Slovakia, Sweden, Switzerland, United Kingdom.

International Federation of Psoriasis Associations (IFPA), 6600 S.W. 92nd Av., Suite 300; OR 97223-7195, Portland/USA, phone +1/503/2447404.

Canadian Psoriasis Foundation, 100A-824 Meath St., Ottawa, ON Canada K1Z 6E8.

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