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HOMOEOPATHIC MANAGEMENT IN THE TREATMENT OF PSORIASIS – A CASE SERIES

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ABSTRACT

Psoriasis is a chronic inflammatory skin condition characterized by recurrent episodes of erythematous, scaly plaques; it is often associated with physical and psychological stress with impaired quality of life. Homeopathy represents psoriasis as an external expression of internal constitutional and miasmatic disturbance, requiring an individualized therapeutic approach rather than symptomatic suppression. This case series includes three patients clinically diagnosed with psoriasis successfully managed with individualized homeopathic medicines after detailed case taking. The prescribed remedies were Phosphorus, Arsenicum Iodum and Aurum Metallicum. Remedies were prescribed according to the totality of symptoms and administered according to homeopathic principles, follow ups were done over a definite period of time and outcomes were evaluated based on lesion improvement, symptom reduction, relapse frequency and overall sense of wellbeing. All cases showed sustained improvement with notable reduction in lesions, itching and scaling which was calculated using PASI score. No adverse effects or disease suppression was recorded. The findings suggests that individualized homeopathic treatment may be effective in the management of psoriasis. Further controlled and long-term studies are required to substantiate these findings.

INTRODUCTION

Psoriasis is a common, genetically determined, inflammatory skin disorder of unknown cause, which, in its most usual form, is characterized by well demarcated, raised, red scaling patches that preferentially localize to the extensor surfaces. [1]

An estimated 60 million people worldwide suffer from psoriasis.[2] The prevalence of psoriasis in India varies Between 0.44% to 2.8% in 2020. Around 75% of cases develop before the age of 46, with some studies indicating two onset peaks: between ages 16–22 and 57–60. About one-third of patients experience spontaneous remission, which can last up to 50 years, although the disease course remains unpredictable.[3]

Pruritus is a common and often dominant symptom in psoriasis, though typically less severe than in atopic eczema. It affects the majority of patients and contributes to a reduced quality of life, particularly due to disrupted sleep. In more unstable forms of psoriasis, such as erythrodermic or pustular types, patients frequently report sensations of skin tightness and burning. Pain is also common, especially in areas with fissures, such as the palms, soles, or skin folds. The shedding of scales, especially in scalp psoriasis, can be distressing and lead to embarrassment. These symptoms can significantly affect patients' personal relationships, daily activities, and professional lives. The disease course varies widely among individuals, with differing patterns of relapse and remission.[1]

Etiology:[4]

Despite extensive research over the past 30 years, the exact cause of psoriasis remains unknown. Over time, various theories have been proposed

Genetic Factors:

Several chromosomal loci have been associated with psoriasis, including PSORS4 on 1q21, PSORS5 on 3q21, PSORS6 on 19p, PSORS7 on 1p, and PSORS9 on 4q31. Notably, the HLA-Cw*0602 allele located on chromosome 6p is commonly found in individuals with psoriasis, suggesting a strong genetic predisposition.

Epigenetic Factors:

DNA methylation plays a key role in the epigenetic regulation of psoriasis. Increased levels of DNA methyltransferase 1 (DNMT1) have been observed in both skin tissues and peripheral blood mononuclear cells of affected individuals. This heightened DNMT1 activity leads to abnormal DNA methylation within psoriasis-related regions (PSORS), triggering pathogenic mechanisms and producing characteristic histopathological changes in keratinocytes.

Environmental Factors:

Environmental triggers such as UV exposure, diet, certain medications, alcohol consumption, and smoking can influence both genetic and epigenetic mechanisms. These triggers can stimulate the release of inflammatory cytokines, including tumour necrosis factor (TNF) and interleukins, thereby initiating and perpetuating the pathophysiological processes involved in the development of psoriasis.[4]

RISK FACTORS [1]

Infections

- Streptococcal infection (esp. tonsillitis) strongly associated with guttate psoriasis.
- Same T-cell clones found in tonsils, blood, and skin → supports autoimmune trigger.
- Tonsillectomy may improve psoriasis in patients with throat-related flares.
- HIV infection may worsen psoriasis severity.

Alcohol Misuse

- Strongly linked to moderate to severe psoriasis.
- Associated with increased mortality, depression, and cardiovascular risk.

- High prevalence of alcohol misuse (up to 30%) in moderate-severe cases.

Cigarette Smoking

- Increases risk, severity, and psoriatic arthritis.
- Particularly associated with palmoplantar pustulosis.
- Promotes chronic immune activation.

Psychological Stress

- 80% report flares triggered by stress.
- Associated with depression, anxiety, suicidality.
- May reduce treatment response (e.g., PUVA).
- Linked to brain–skin axis dysfunction → neurogenic inflammation (via SUBSTANCE P, CRH, etc.).
- Mindfulness, CBT, and stress reduction may improve PASI and quality of life in some patients.

Sunlight

- Usually beneficial, but 5–20% experience photo-aggravated psoriasis.
- Linked to polymorphic light eruption and Koebner phenomenon.
- PUVA therapy can help photosensitive cases.

Physical Trauma (Koebner Phenomenon)

- Psoriasis may appear at injury or scar sites in ~25% of patients.
- Triggered by wound healing response, innate immune activation, and keratinocyte proliferation.

More common in patients with HLA-C*06:02 allele.

PATHOPHYSIOLOGY [5,6,7]

Psoriasis is a chronic inflammatory skin disease with a strong genetic basis, involving both innate and adaptive immune responses and keratinocyte hyperproliferation. Genetic studies, including family, twin, and population-based analyses, confirm that individuals with affected relatives have a significantly higher risk of developing psoriasis. There are two types: Type I psoriasis, which is early-onset, severe, and strongly associated with HLA-C*06:02, and Type II, which is late-onset and not linked to HLA genes. Twin studies show high heritability (up to 68%), but not complete concordance, indicating an important role of environmental triggers.

At the molecular level, psoriasis is considered polygenic. The most significant susceptibility locus is PSORS1, located in the MHC region on chromosome 6p, especially the HLA-C*06:02 allele. Other loci like PSORS2 (CARD14) and many others have been identified through genome-wide association studies (GWAS), implicating over 40 genes involved in antigen presentation, Th17 differentiation, NF-κB signalling, and skin barrier function. Notably, genes such as IL12B, IL23A, IL23R, TNFAIP3, and TRAF3IP2 are involved in the IL-23/IL-17 axis, which plays a central role in disease pathogenesis.

Environmental factors such as infections, trauma, and stress interact with genetic predisposition to trigger disease onset. The effectiveness of therapies targeting IL-17 and IL-23 confirms the importance of these pathways.

HISTOLOGY [8]

The main changes are the following.

1. Parakeratosis (nuclei retained in the horny layer).

2. Irregular thickening of the epidermis, but thinning over dermal papillae is apparent clinically when bleeding is caused by scratching and the removal of scales (Auspitz's sign).

3.Polymorphonuclear leucocyte microabscesses (described originally by Munro).

4. Dilated and tortuous capillary loops in the dermal papillae.

5.T-lymphocyte infiltrates in upper dermis.

CLINICAL FEATURES [1,8]

Plaque psoriasis is the most common form of psoriasis, accounting for 80–90% of all cases. It presents as well-defined, red, scaly plaques typically distributed symmetrically on the scalp, trunk, and extensor surfaces of the limbs.

- **Lesions**: Red, raised plaques with sharply demarcated edges; often oval or irregular in shape**.**
- **Scaling**: Most plaques have silvery-white scales of varying thickness. In treated or flexural areas, scaling may be minimal or absent.
- **Colour**: The plaques are typically a rich, "salmon pink" hue—diagnostically useful, especially on palms, soles, and scalp. In lighter skin, the colour is magenta-pink; in darker skin tones, the colour intensity may be reduced
- **Koebner Phenomenon**: New plaques may form along sites of skin trauma (e.g., scratches, friction from watches).
- **Halo of Woronoff**: Some plaques are surrounded by a clear peripheral zone.
- **Evolution**: Plaques may coalesce into larger lesions or resolve centrally, forming annular shapes. Post-inflammatory changes (hypo/hyperpigmentation or lentigines) may persist after healing.
- These features can vary between individuals and over time, making diagnosis occasionally challenging. Some researchers propose that plaque psoriasis may encompass distinct subtypes based on its clinical variability.
- **Auspitz Sign**: Scraping off the scales reveals a smooth red surface with pinpoint bleeding.
- **Evolution**: Plaques may coalesce into larger lesions or resolve centrally, forming annular shapes. Post-inflammatory changes (hypo/hyperpigmentation or lentigines) may persist after healing.

- These features can vary between individuals and over time, making diagnosis occasionally challenging. Some researchers propose that plaque psoriasis may encompass distinct subtypes based on its clinical variability.

TYPES[1,8]

1. **Plaque psoriasis**

This is the most common form. The lesions are clearly defined and can vary in size from a few millimetres to several centimetres. They appear pink or red and are covered with thick, dry, silvery-white polygonal scales, resembling candle wax. Commonly affected areas include the elbows, knees, lower back, and scalp.

2. **Guttate pattern**

This condition commonly appears in children and adolescents and may be the initial indication of the disease, frequently following a streptococcal throat infection. Multiple small, round, red spots suddenly emerge on the trunk and soon develop a scaly surface. The rash typically resolves within a few months, though plaque psoriasis may eventually develop.

3. **Scalp psoriasis**

The scalp is frequently affected, with scaly patches interspersed among areas of normal skin. These patches are often more noticeable by touch than by sight due to their uneven texture. Psoriatic lesions commonly extend slightly beyond the hairline, though substantial hair loss is uncommon**.**

4. **Nail psoriasis**

Nail involvement is common and may present as 'thimble pitting', onycholysis (separation of the nail from the nail bed; and occasionally subungual hyperkeratosis.

5. **Flexural psoriasis**

Psoriasis affecting the sub mammary, axillary, and anogenital folds typically lacks the characteristic scaling. However, the condition remains easily identifiable by the presence of smooth, shiny, well-defined red plaques (Fig. 5.9), often accompanied by fissures within the depths of the skin folds. Flexural psoriasis is more frequently seen in women and older adults, and it occurs more commonly in individuals with HIV compared to those without the infection.

6. **Palmo-plantar psoriasis**

Palmar psoriasis can be difficult to identify, as the lesions are often faintly red and lack clear boundaries. Painful cracks may develop on the fingers.

7. **Genital psoriasis**

The glans penis is the most frequently affected area, with scrotal and penile shaft involvement also possible. In circumcised men, lesions on the glans resemble plaques seen elsewhere, while in uncircumcised men, they typically lack scale but maintain a distinct red colour and well-defined borders.

8.Localized pustular psoriasis (Palmo-plantar pustulosis)

This is a stubborn and often painful form of psoriasis, sometimes considered a distinct condition. It primarily affects the palms and soles, where numerous sterile pustules measuring

3–10 mm appear on a red, inflamed base. Over time, these pustules dry up and turn into brown macules or scaly patches.

9. Erythrodermic psoriasis

This rare form of psoriasis can be triggered by irritants such as tar, dithranol, certain drug reactions, or the sudden withdrawal of strong topical or systemic steroids. It presents as widespread, uniform redness of the skin with varying degrees of scaling. Patients often experience malaise, chills, and a sensation of heat and discomfort in the skin.

DIAGNOSIS

Psoriasis: Key Diagnostic Points

- Erythematous scaly plaques
- Well-defined borders
- Scales are dry, loose, and micaceous (shiny/silvery)
- Koebner phenomenon observed
- Auspitz sign positive (pinpoint bleeding upon scale removal)
- Regular, circular pits on the nail plates
- Involvement of distal interphalangeal joints of fingers and toes.
- Histopathology: Presence of spongiform pustules of Kogoj.[9]

PARAMETER USED: Psoriasis area and severity index [PASI]. [3]

Psoriasis Area and Severity Index (PASI) is a commonly used tool for assessing chronic plaque psoriasis, particularly in clinical trials. It measures disease severity, lesions and the area affected into a single score response to treatment, with scores like PASI 50 indicating a 50% improvement from baseline. While effective for tracking progress in chronic plaque psoriasis.

AREA AFFECTED:

The body is divided into four sections (Head (H) 10% of a person skin); Arms(A) 20 %; Trunk (T) 30%; Legs (L) 40%. each of these areas is scored by itself, and then the four scores are combined into the final PASI, for each section, the percent of area of skin involved, is estimated and then transformed into grade from 0 to 6:

0. 0% of involved area.
1. 0 to 10% of involved area.
2. 10 t0 29% of involved area.
3. 30 to 49%of involved area.
4. 50 to 69% of involved area.
5. 70 to 89% of involved area.
6. 90 to 100% of involved area.

Within each area, the severity is estimated by three clinical signs: erythema (Redness), Indurations (thickness), and Scaling of 0 to 4 from none to maximum.

- The sum of all three severity parameters is then calculated for each section of skin, multiplied by the area score for that area and multiplied by weight of respective section (0.1for head ,0.2 for arms ,0.3for body and 0.4 for leg.

PASI=0.1(Rh+Th+Sh)Ah+0.2(Ru+Tu+Su)Au+0.3(Rt+Tt+St)At+0.4(Rl+Tl+Sl) Al

Where A is area (0-6).

R is redness (0-4). T is thickness (0-4). S is scaliness (0-4).

Total score ranges between 0-72

Psoriasis severity at baseline was categorized as severe, moderate and mild.

- PASI SCORE > 12 –severe.
- PASI SCORE; 7 – 12 - moderate
- PASI SCORE; < 7 – mild.

MATERIALS AND METHODS

This case series includes 3 patients diagnosed with Chronic Plaque Psoriasis and who fulfil the inclusion and exclusion criteria were selected from the OPD of Government Homoeopathic Medical College and Hospital, Bangalore. Diagnosis was made clinically based on characteristic skin lesions and supportive history. Patients were enrolled consecutively as they presented during the study period. Each patient underwent a detailed case-taking following Homoeopathic principles, including elicitation of presenting complaints, past history, family history, general symptoms, and constitutional characteristics. Individualized Homoeopathic medicines were prescribed according to the totality of symptoms. No concomitant conventional treatment for psoriasis was used during the observation period. Follow-up was conducted at regular intervals to assess changes in skin lesions, itching, scaling, and associated symptoms. PASI scoring system was used to assess the prognosis and the effectiveness of treatment. Patient-reported outcomes regarding general well-being, sleep, and quality of life were also documented. Photographic records were maintained with consent. Improvement was evaluated qualitatively based on reduction in lesion size, scaling, itching, PASI score and overall patient satisfaction. Safety assessment was carried out by monitoring for any adverse effects throughout the study period.

CASE SERIES

CASE : 1

A 42 year old male, Mr. ABC, resident of Vijayanagar, Bangalore, working as an Electrician visited the OPD of Government Homoeopathic Medical College and Hospital on 21 March 2025, with complaints of itching and scaly eruptions in bilateral lower limbs since 3 years.

History of Presenting Complaint:

The patient presented with multiple scaly eruptions on bilateral lower limbs below the level of knee. Itching is aggravated at night and better by washing with cold water. Scratching of the eruptions leads to bleeding and burning.

K/C/O HTN since 5 years – on Allopathic medication

Past History:

No surgical or allergic history

Family History:

Father- Dead – Old age

Mother – Dead – Old age

Siblings – 1 Elder Brother- Hypothyroidism

Personal History:

Stools – Hard, occasional bleeding

Sleep – Disturbed due to itching

Thermals – Chilly

Life Space Investigation

Born and brought up in Magadi Taluk. Studied until 12th standard. Was good in studies. Had to discontinue due to financial issues and started working as a worker in a factory. Was married at the age of 25 years in an arranged marriage set up and now has 2 children. Patient started having financial issues for 6 years as he had given money on loan to his friends and they never returned the money and patient doesn't want to ask friends for the money as he feels they are already in a bad financial state and he feels sad about it and cannot ask for the money back. Patient is having many discords with his wife regarding the same. He has changed many jobs to support the family but is facing difficulty in making the ends meet and now is worried about his future.

Vitals

BP- 120/90mm Hg

PR – 80 beats/ min

RR-19cpm

Temp – afebrile at the time of examination

General Physical Examination

Patient is conscious and oriented to day, date, time and place

- Built and nourishment - Moderate
- Pallor – absent
- Icterus - absent
- Cyanosis – absent
- Edema – absent
- Clubbing – absent

- Head = Hair –healthy, scalp – healthy
- Eyes – conjunctiva – pink, Sclera – clear
- Ears –no discharge
- Nose – no DNS & Polyp
- Mouth = tongue – clean, teeth – hygienic, gums – pink, buccal mucosa – pink
- Neck – no lymphadenopathy
- Nails = no clubbing

Systemic Examination

Respiratory system = B/L NVBS+

Gastrointestinal system = Soft, non-tender

Cardiovascular system = S1, S2 +, No murmurs

Central nervous system = Conscious & oriented to date, time & place

Local Examination

Site: B/L lower limbs below knee

Shape: Irregular plaques

Itching: Present, worse at night better by washing with cold water

Bleeding and burning on scratching

Induration and scaling on scratching present

PASI score : 6.0

Totality of symptoms

- Anxiety about future
- Sympathetic
- Psoriasis on lower limbs
- Burning after scratching
- Hard stools

Repertorial Totality

- Mind – Anxiety – future, about
- Mind - Sympathetic
- Extremities – Eruptions – Legs – Psoriasis
- Skin – Burning - scratching after
- Stool – Hard

Repertorization proper

Phos – 5/14

Caust – 4/9

Lach – 4/9

Sepia – 4/9

Sulph – 4/9

Prescription

1. Phosphorous 200/ BD/ 3 days
2. Rubrum /BD/ 1 Month

Follow up 1

22/04/2025

Itching – better

Stools – Normal

No bleeding after scratching

Sleep – Refreshing

Eruptions – Present. No new eruptions

PASI – 4.8

Rx - Rubrum /BD/ 1 Month

Follow up 2

20/05/2025

Itching – Better

Eruptions – Decreased . No new eruptions

Generals – Good

PASI – 2.4

Rx - Rubrum /BD/ 1 Month

Follow up 3

30/06/2025

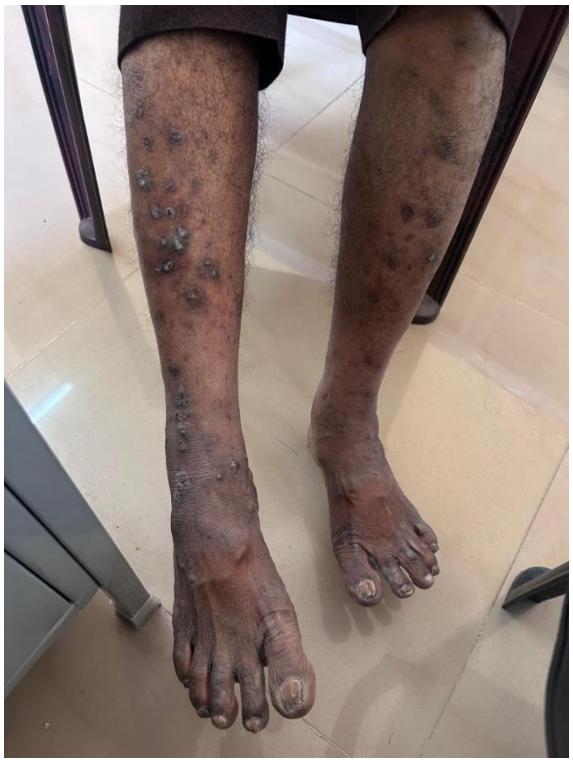
Itching – Nil

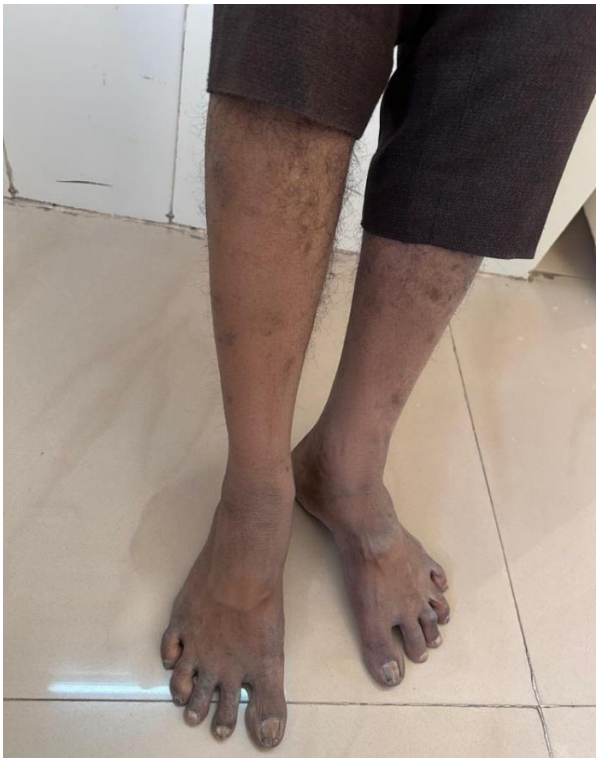
Skin – Clear

Generals – Good

PASI – 0.8

Rx - Rubrum /BD/ 1 Month





Before After

CASE 2:

Patient Mr RS, a 48 years old male from Bangalore, working as a watchman visited OPD of Government Homeopathic Medical College and Hospital on 7th May 2025, with complaints of itching and scaly eruptions on back of neck and scalp since 2 years

History of presenting complaint:

Patient was apparently well before 2 years, patient developed dryness and itching on scalp which he mistaken it as dandruff and did some home remedies but he was not finding any relief for it, after few days the intensity of itching increased along with powdery eruptions and redness, slowly the eruptions started to spread downwards. The skin is dry in nature with itching more at night, on scratching severely bleeding is occasionally noticed. White powdery discharge is noticed more on scratching, thickening of skin is also noticed on scalp. Patient finds mild relief when warm water bath is taken.

Past history:

No history of HTN, no DM

Family history:

Mother and father diet in accident

Has a younger brother apparently healthy

Personal history:

Appetite: Increased

Thirst: Increased

Urine: Normal

Stool: Regular, one time in a day.

Sleep: Disturbed due to itching.

Desire: nothing specific

Aversion: nothing specific

Thermals: Hot

Addiction: NIL

Life space investigation:

Patient is born and brought up in Bangalore, he belongs to a middle-class family, they are two children and he is elder one among all, he lost his parents in his childhood, so he took all the responsibilities of the house and went for work to make his brother study. He is a hardworking man and likes to do some work or the other always. He is an anxious person and worries more about his heath always, he is getting irritated because of his complaints and wants to get rid of it as soon as possible. He has two children and has good relationship with them. He became a contract construction builder after so much of hard work but his work stress is more, he told that he accepted a project few years back that put so much of pressure on him after that only his complaints started appearing, his mind is filled with thoughts about that work sometimes he doesn't get sleep also due to his thoughts, he always expects things to be done perfectly and neatly, he feels that it is because of his perfection that he is in such a big position.

Vital signs:

BP:120/90 mmHg

PR:84 beats/min

RR:17 breaths/min

Temperature: Afebrile at the time of examination.

General physical examination:

Patient is conscious well oriented with time, place and person.

No pallor, no cyanosis, no clubbing, no icterus, no lymphadenopathy

Head to toe examination:

Scalp: scaly eruptions found on scalp with thickening.

Hair: senile greying of hair seen.

Eyes: conjunctiva- pink, sclera- clear

Ears: no discharge, ear wax found.

Nose: no DNS, no polyp, no discharge.

Mouth: buccal mucosa-pink, teeth- hygienic, tongue- pink, gums- pink and healthy.

Neck: no dilated arteries, no lymphadenopathy

Nails: healthy

Systemic examination:

Respiratory system: normal vesicular breath sounds heard, no added sounds.

Cardio vascular system: s1 and s2 sounds heard, no murmurs.

Gastrointestinal system: abdomen scaphoid in shape, umbilicus centrally placed and normal bowel sounds heard.

Locomotor examinations: normal

Local examination:

Skin:

Inspection: scaly patches seen on scalp and back of neck with powdery discharge and red discolouration and thickness.

Palpation: skin appears thick and irregular in nature.

PASI score: 9.2

Totality of symptoms:

Anxiety health about

Workaholic

Perfectionist

Irritable complaints from

Appetite increased

Skin red, scaly eruption with itching

<night, >warm water

Repertorial totality:

Mind – anxiety health about

Mind -fastidious

Mind -industrious

Mind- irritability

Stomach appetite increased

Skin eruptions itching night

Skin eruptions scaly white

Repertorial proper:

Ars- 15/7

Lyc-13/6

Puls-11/6

Thuja-8/6

Prescription:

Arsenicum Iodatum 200 /BD/ 3days

Rubrum /BD /1 Month

Follow up:1

11/06/2025

Itching mildly better, eruptions persist

Sleep improved other generals good

PASI:7.1

Rx: Arsenicum Iodatum 200/BD/3days

Rubrum/BD /1 Month

Follow up:2

15/07/2025

Itching better, eruptions thickness started reducing

Generals good

PASI: 3.8

Rx: Arsenicum Iodatum 200/BD/ 3days

Rubrum/BD /1 Month

Follow up:3

26/08/2025

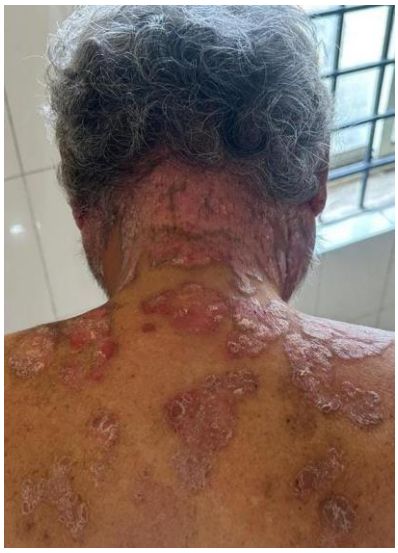
Itching much better, eruptions show no scaling, skin gets clear

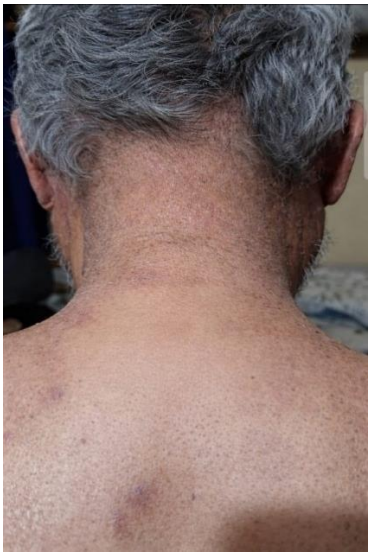
Generals good

PASI: 1.2

Rx: Arsenicum Iodatum 200/BD/3days

Rubrum/BD/1 month





Before After

CASE: 3

A 62-year-old male, Mr. ABC, resident of Hassan, working as a Businessman visited the OPD of Government Homoeopathic Medical College and Hospital on 18 FEB 2025, with complaints of itching and Multiple scaly eruptions over Chest, back of Chest and bilateral lower limbs for 10 years.

History of Presenting Complaint:

The patient presented with multiple scaly eruptions over Chest, back of Chest bilateral lower limbs below the level of knee. Itching is aggravated at Winter season, night. and early morning better by scratching, warm water bath.

K/C/O HTN for 15 years – on Allopathic medication.

DM for 15 years – on Allopathic medication.

CVA 8 years ago.

Past History:

Surgical history: Underwent CABG 8 years ago. now on allopathic medication.

Family History:

Father- Dead – Old age

Mother – Dead – Old age

Siblings – 6.

2 Elder Brothers. Hypertension.

1 younger Brother. Apparently healthy.

2 younger Sisters Apparently healthy.

Personal History:

Diet: mixed.

App: decreased.

Desire: sweets.

Habits: Alcohol consumption over 20 years.

Stools – occasionally constipated.

Sleep – Disturbed due to itching

Thermals – Chilly.

Life Space Investigation

Born and brought up in Hassan. Studied until B.COM. Was good in studies but lazy to continue and was interested in business hence stared business (exporting potatoes). Was married at the age of 30 years in an arranged marriage set up and now has 2 children.

During the COVID-19 pandemic, his business began to collapse, leading to severe financial losses and heavy debt. To repay the liabilities, he sold his property. After clearing the debts, he shut down the business and moved to Bangalore, where he now lives with his son. He regrets about his past things and He remains worried about his situation and wishes to live the rest of his life free from his skin complaints.

Vitals

BP- 110/80mm Hg

PR – 77 beats/ min

RR-18cpm

Temp – afebrile at the time of examination

General Physical Examination

Patient is conscious and oriented today, date, time and place

- Built and nourishment - Moderate
- Pallor – absent
- Icterus - absent
- Cyanosis – absent
- Edema – absent
- Clubbing – absent
- Head = Hair –healthy, scalp – healthy
- Eyes – conjunctiva – pink, Sclera – clear

- Ears –no discharge
- Nose – no DNS & Polyp
- Mouth = tongue – clean, teeth – hygienic, gums – pink, buccal mucosa – pink
- Neck – no lymphadenopathy
- Nails = no clubbing

Systemic Examination

Respiratory system = B/L NVBS+

Gastrointestinal system = Soft, non-tender

Cardiovascular system = S1, S2 +, No murmurs

Central nervous system = Conscious & oriented to date, time & place

Local Examination

Site: over Chest, back of Chest bilateral lower limbs below the level of knee.

No of lesion: multiple.

Shape: Irregular plaques.

Red erythematous, thick scales

Itching: aggravated at Winter season, night. and early morning better by scratching, warm water bath.

PASI SCORE: 38.5

Totality of symptoms

- Regrets past events.
- Anger suppressed.
- Bleeding after itching
- Skin eruptions -psoriasis
- Warm water, scratching amelioration.
- Hard stools

Repertorial Totality

- Mind – Remorse.
- Mind - A/F-anger suppressed.
- Mind- Timidity .
- skin– Eruptions – Psoriasis
- Skin – Eruptions-bleeding - scratching after
- Rectum - constipation .

Repertorization proper

LYC– 6/13

ARS – 5/14

SULPH– 5/14

CALC – 5/12

SEP – 5/10

Prescription

1. LYCOPODIUM 200/ BD/ 3 days
2. Rubrum /BD/ 1 Month

Follow up 1

22/04/2025

Itching – better

Stools – Normal

No bleeding after scratching

Sleep – Refreshing

Eruptions – Present. No new eruptions.

PASI SCORE : 26.5

Rx - Rubrum /BD/ 1 Month

Follow up 2

20/05/2025

Itching – Better

Eruptions – Decreased. No new eruptions

Generals – Good

PASI SCORE: 14

Rx - Rubrum /BD/ 1 Month

Follow up 3

30/06/2025

Itching – Nil

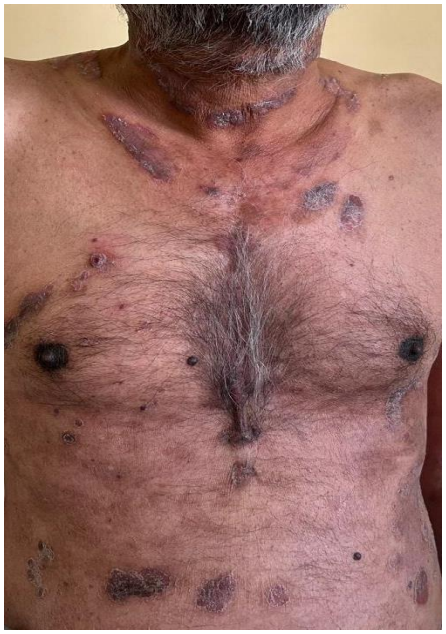
Skin – Clear

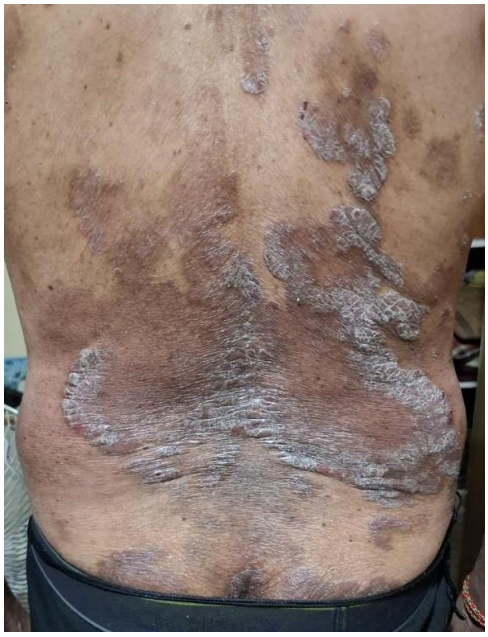
Generals – Good

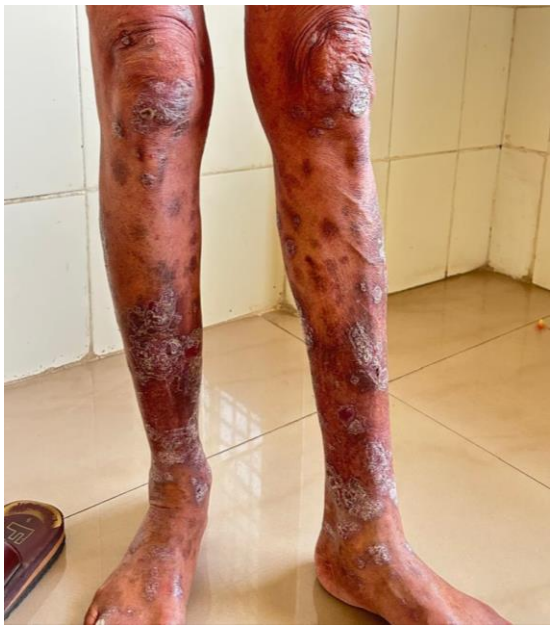
PASI SCORE : 3

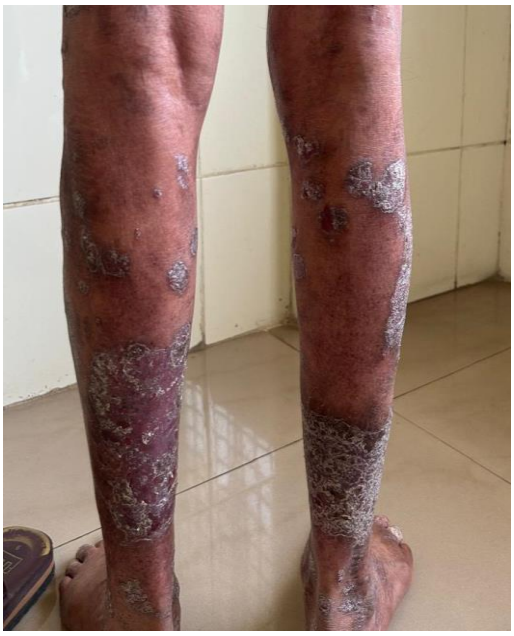
Rx - Rubrum /BD/ 1 Month

Before

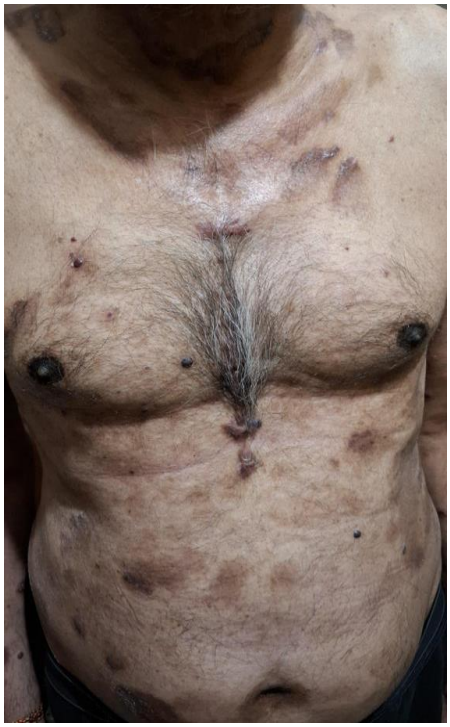


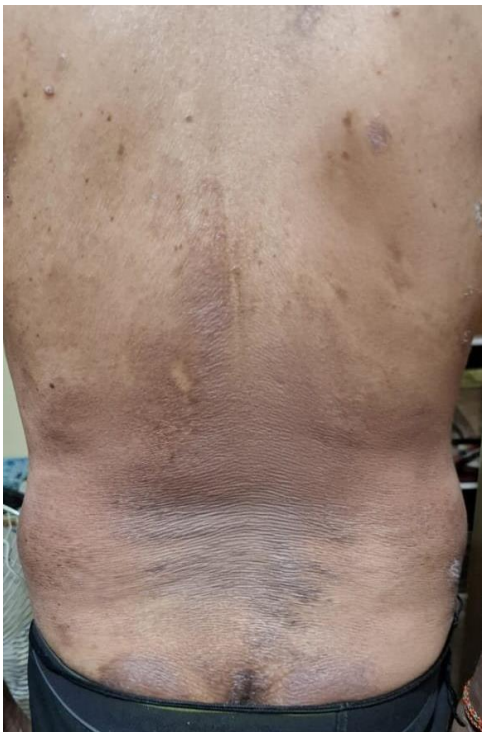


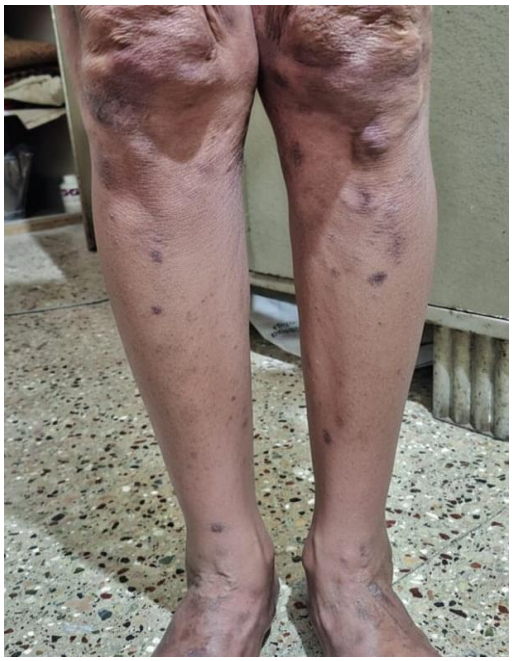


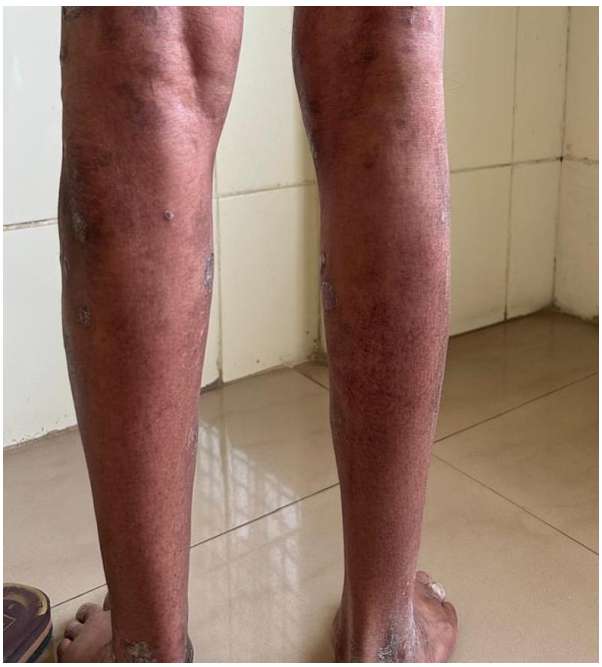


After









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