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Opinion Article

Classifications and Diagnosis of Psoriasis

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DESCRIPTION

Psoriasis is a chronic, multifactorial, complex inflammatory condition that causes the epidermis' keratinocytes to over proliferate and their rate of cell turnover to rise. A role for environmental, genetic, and immunologic factors is suggested. The skin of the elbows, knees, scalp, lumbosacral regions, intergluteal clefts, and glans penis are the areas where the disease most frequently shows up. The joints can be affected in up to 30% of patients.

Treatment is determined by the body site(s) involved, the thickness of the plaques and scale, the presence or absence of arthritis, and the surface areas of involvement.

Classifications

Psoriasis can be categorized in the following ways:

- A long-standing erythematous, scaly area getting worse
- Sudden onset of scaly redness in numerous small areas.
- Viral infection, recent streptococcal throat infection, vaccination, antimalarial drug use, or trauma
- Pain (especially in erythrodermic psoriasis and in some cases of traumatised plaques or in the joints affected by psoriatic arthritis)
- Pruritus (especially in eruptive, guttate psoriasis)
- Afebrile (except in pustular or erythrodermic psoriasis, in which the patient may have high fever)
- Nails that are dystrophic and may resemble onychomycosis
- A long-lasting, steroid-responsive rash that has just started to present with joint pain
- Psoriatic arthritis joint pain without any obvious skin changes
- Conjunctivitis or blepharitis

Diagnosis

Psoriasis is diagnosed clinically, and the physical examination results are influenced by the type of psoriasis that is present.

Psoriasis comes in a variety of common forms, including:

- Chronic stationary psoriasis (psoriasis vulgaris): The scalp, extensor surfaces, genitals, umbilicus, lumbosacral, and retroauricular areas are all affected by the most prevalent type of psoriasis.
- Plaque psoriasis: most frequently impacts the knees, elbows, scalp, and trunk's extensor surfaces.
- Guttate psoriasis: mainly affects the trunk and often develops suddenly, two to three weeks after an upper respiratory tract infection caused by group A beta-hemolytic streptococci. This variant is more likely to itch, sometimes very badly.
- Inverse psoriasis: This condition, which manifests on the skin folds, flexural surfaces, armpit, groyne, under the breast, and in these areas, is frequently misdiagnosed as a fungal infection.
- Pustular psoriasis: presents on the hands and feet or sporadically throughout the body
- Erythrodermic psoriasis: usually covers nearly the entire body's surface area, with red skin and a thin, diffuse scale that is peeling.
- Scalp psoriasis: approximately 50% of patients are affected
- Nail psoriasis: may resemble onychomycosis and be more prone to developing it.
- Psoriatic arthritis: may resemble onychomycosis and be more prone to developing it.
- Oral psoriasis: Serious cheilosis that has spread to the surrounding skin and crossed the vermillion border may manifest.
- Eruptive psoriasis: involves the upper trunk and upper extremities; younger patients are most frequently affected.
- Napkin psoriasis: Psoriasis in the area around a child's diaper
- Linear psoriasis: internal psoriasis that develops in a dermatome
- The following are included in an examination of psoriasis patients:
- Dermatologic: Scaling erythematous papules, plaques, and macules are the most common symptoms; the extent of skin involvement varies depending on the type of psoriasis.
- Ocular: Trichiasis and ectropion, conjunctivitis and conjunctival hyperemia, corneal dryness with punctate keratitis and corneal melt, and blepharitis are all eye conditions.

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- Musculoskeletal: Distal joints are most frequently affected by stiffness, pain, throbbing, swelling, or tenderness; these symptoms can progress to severe and debilitating hand arthritis, especially if treatment has been subpar.

Psoriasis cannot be diagnosed or treated with a blood test. Patients with psoriasis may undergo the following laboratory tests and receive the following results:

- Erythrocyte sedimentation rate: Usually normal, though it may be elevated along with the white blood cell count in cases of pustular and erythrodermic psoriasis.
- Uric acid level: could be increased in psoriasis (especially in pustular psoriasis)
- Examination of fluid from pustules: Culture of sterile bacteria with neutrophil infiltration
- Fungal studies: Especially crucial to determine whether psoriatic nails are also fungus-infected in cases of hand and foot psoriasis that appear to be getting worse with topical steroids.
- Conjunctival impression cytology: increased occurrence of snake-like chromatin, neutrophil clumping, and squamous metaplasia.