



Psoriasis: An Integrative Review of Contemporary Pathogenesis and Homoeopathic Interpretation: A Narrative Review

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ABSTRACT

Psoriasis is a chronic immune-mediated inflammatory disorder increasingly recognised as a systemic disease rather than a condition confined to the skin. The homoeopathic perspective has historically viewed cutaneous manifestations as expressions of an underlying constitutional and miasmatic disturbance. This review aims to examine psoriasis through a homoeopathic lens in the context of contemporary biomedical understanding, with particular emphasis on the relationship between the visible manifestation and the underlying susceptibility of the individual. The aim is to understand psoriasis beyond its cutaneous presentation and to highlight there levanceo fan in dividualised, holistic approach to its management.

KEYWORDS : Psoriasis; Psora; Miasm; Homeopathy; Individualisation; Constitutional Prescribing, Susceptibility.

1. INTRODUCTION

Psoriasis is a chronic, immune-mediated, inflammatory and proliferative skin disease. It presents as well-demarcated, raised, erythematous plaques with overlying silvery-white scale. The underlying defect is abnormal keratinocyte proliferation together with abnormal differentiation. The course is relapsing, with flares often linked to stress, throat infection or change of season. Dermatology no longer regards it as skin-deep: patients are routinely screened for joint disease, metabolic syndrome and mood disorder. This shift towards a constitutional view matches the ground homeopathy has held since Hahnemann's writings on chronic disease, namely that the eruption is the visible part of a disturbance that begins in the susceptible individual, and that the trigger only brings it out.

2. Epidemiology

Global prevalence is about 2–3% (60–125 million people); Indian figures are lower, at 0.4–2.8%. The disease can occur at any age. Two epidemiological patterns are described: type I (onset before 40 years, strong genetic pre disposition) and type II (onset after 40 years, weaker genetic pre disposition); this is an epidemiological grouping only, not a difference in the disease itself. Men are affected about twice as often as women, with onset typically in the third or fourth decade. Up to 30% of patients develop psoriatic arthritis, and the disease is associated with cardiometabolic illness, fatty liver, depression and anxiety.

3. Etiopathogenesis

Psoriasis is multifactorial. It results from inherited susceptibility (family history, HLA-C association), an over-reactive immune system (dysregulation of the IL-23/Th17 axis) and environmental triggers (trauma, infection, stress, smoking and others).

3.1 Genetic Predisposition

The PSORS1 locus (chromosome 6p21, linked to HLA-Cw6, an HLA-C allele) is the strongest known association. A positive family history is common, and first-degree relatives carry a higher lifetime risk. Genetic susceptibility alone is generally not enough; a trigger is usually needed for the disease to appear.

3.2 Immunological Mechanism

In a genetically susceptible host, an environmental trigger activates the immune system. Activated dendritic cells release inflammatory cytokines (IL-12 and IL-23), leading to hyper-

activity of T cells; Th17 cells infiltrate the epidermis and release TNF- α , IFN- γ and IL-17. IL-17 acting together with TNF- α stimulates keratinocytes to produce chemokines, cytokines and antimicrobial peptides, which activate further keratinocytes and set up a self-sustaining inflammatory feedback loop. The activated keratinocytes show increased proliferation (epidermal hyperplasia, acanthosis, thickened plaque) and abnormal differentiation (parakeratosis, scale formation, silvery scale), shortening epidermal turnover from about 28 days to 3–5 days. Inflammation dilates the superficial blood vessels, producing erythema, so that the lesion is a red, thick, scaly plaque. In short, psoriasis develops in a susceptible host through increased proliferation and impaired desquamation.

3.3 Triggers and Aggravating Factors

Triggers are very important: when a trigger is present, a genetically susceptible individual generally develops the disease.

- Skin trauma (Koebner phenomenon: lesions develop at the site of trauma)
- Infections, bacterial and viral; streptococcal throat infection especially precedes guttate psoriasis
- Psychological stress: an aggravating or precipitating factor.
- Drugs: beta-blockers, NSAIDs, lithium, interferons, anti-malarials, abrupt steroid withdrawal
- Smoking and alcohol: aggravate the disease and worsen the prognosis
- Obesity: indirectly related, through a chronic inflammatory state that raises the risk of disease

4. Clinical Features and Classification

1. Plaque psoriasis: Commonest form, presenting with symmetrical, well-demarcated erythematous plaques with silvery scales, mainly on extensor surfaces, scalp and trunk; candle-grease, Auspitz and Koebner signs may be present.
2. Guttate: Small, drop-like scalp papules, often following streptococcal infection.
3. Inverse: Affects flexural folds with moist, minimally scaly lesions.
4. Pustular: Localised or generalised pustules, sometimes with systemic illness.
5. Erythrodermic: Extensive erythema and inflammation with systemic complications; requires urgent care.
6. Nail psoriasis: Pitting, onycholysis, subungual hyperkeratosis and other nail changes.
7. Psoriatic arthropathy: May cause peripheral/axial arthritis, dactylitis and enthesitis.

5. The Homeopathic Understanding of Psoriasis

5.1 Philosophical Basis

Hahnemann placed most non-venereal skin disease under the miasm Psora, a disturbance of the vital force rather than a local fault. The eruption is regarded as the body's way of holding the internal disturbance at the periphery; suppressive local treatment is thought to drive it inward, later appearing as joint, respiratory or other internal disease.

This reading fits the aetiological picture of psoriasis described above. Genetic susceptibility (family history, HLA-C association) is the ground, and trauma, infection, stress, drugs, smoking and alcohol are the triggers. Homeopathy draws the same line between susceptibility, the hereditary and miasmatic background of the patient, and the exciting cause that brings the eruption to the surface. Stress, for example, does not cause psoriasis but can precipitate or aggravate it in a predisposed person, and the Koebner response, streptococcal sore throat and drug reactions are exciting causes in the same sense. Treatment is therefore directed at the susceptible individual and not at the trigger alone. In the same way, the self-sustaining inflammatory feedback loop of immune dysregulation is read as the peripheral expression of an internal disturbance rather than a purely local fault, which is why local suppression alone so often gives only temporary relief.

5.2 Miasmatic Perspective

1.1 Psoriasis is a particularly aclassical disease for understanding miasm. It is chronic, relapsing and genetically predisposed, which is the very nature of disease that Hahnemann's miasmatic theory was built to explain. It also shows the progression of disease from outside to within: simple dry scaling (Psora) gives way to thickened plaques (Sycosis), and finally to nail and joint involvement (Syphilis). Psoriatic arthritis marks the passage from the surface, less vital part to a deeper, more vital one.

Feature	Psoric layer	Sycotic layer	Syphilitic layer
Nature of pathology	Functional change only: irritation, itching, redness	Overgrowth, thickening, proliferation	Ulceration, destruction, deformity, degeneration of bone and tissue
Psoriatic picture	Dry, rough, scaly patches with fine silvery scaling; skin unhealthy but not grossly thickened	Thick, indurated plaques with heavy scaling that regenerates quickly; folds (behind ears, elbow and knee flexures, groins, scalp margin); sticky, glue-like discharge under	Long-standing, disfiguring, erythrodermic or pustular disease; deep, bleeding fissures on palms, soles and joints; nail pitting and thickening; multicoloured,
		scale; proliferative psoriatic arthritis	dark or bluish lesions; arthritis with erosion, deformity or rapid destructive course
History	"Never well since" history	Personal or family history of warts, cysts, gonorrhoea or genito-urinary complaints; suppressed discharge; vaccination	Personal or family history of syphilis, suppressed venereal sore, TB or unexplained chronic skin and joint

	reaction	disease
Mental state	Anxious, insecure, fearful, restless	Suspicious, guarded, fixed ideas, secretiveness, shame or guilt tied to something hidden
		Despairing, self-destructive, hopeless; feels things are beyond repair

5.3 Case-Taking and Individualisation

A comprehensive case history should include the chief complaint and its onset, site, characteristics and triggers; physical and mental generals; detailed lesion examination; modalities; past and family history; previous suppressive treatment; and exciting factors with the chronology of remissions and relapses.

The totality is then analysed and evaluated, PQRS symptoms are prioritised, repertorisation is applied, and the miasmatic assessment is made. The remedy is selected as the similimum, individualised to the totality and correlated with the miasm. Two patients with the same diagnosis may need different remedies, because the totality of symptoms, not the label, is treated.

5.4 Potency and Repetition

Potency is guided by susceptibility and the nature of the disease. Acute, highly reactive and sensitive cases suit higher potencies (200C and above). Chronic, structurally advanced disease, where the vital force is less reactive and a high potency may give a strong aggravation, is started in lower-medium potency and raised gradually. Prominent mental symptoms favour higher potencies; dominant physical symptoms favour lower-medium potencies. An anti-miasmatic nosode may be used intercurrently when a well-chosen remedy stops acting, reflecting the classical idea of a miasmatic obstacle to cure.

Repetition follows the Organon. While improvement continues, the dose is not repeated (§245), since repetition can cause relapse or aggravation or interrupt curative action. In slow-moving chronic cases, repetition is more frequent with each dose slightly altered in potency (§246–248). For a chronic, relapsing disease such as psoriasis, two approaches can be employed: (1) infrequent, well-spaced doses of a single remedy in centesimal potency, escalating only when the same symptom picture relapses; or (2) LM potencies, given in solution with succussion before each dose, as a gentle and frequent stimulation of the vital force without strong aggravation, since repeated centesimal dosing may aggravate long-standing or sensitive cases. Single, well-spaced centesimal doses remain appropriate where the symptom picture is clearer and more reactive. Traditional teaching cautions against local topical remedies because of the risk of suppression, although some case reports use skin-specific remedies pragmatically alongside constitutional treatment during acute flares.

5.5 Susceptibility and Assessment of Cure

Susceptibility is the organism's inherent capacity to be affected by external and internal stimuli. Disease occurs because of susceptibility, and so does cure: only a susceptible person allows the action of the remedy. Higher susceptibility generally calls for a higher potency. Progress under treatment is assessed by Hering's law of cure. In a genuinely improving case, internal and systemic symptoms (joint pain, fatigue) improve before the skin fully clears, and old, previously suppressed skin symptoms may briefly reappear during treatment.

This is the reverse of the outward-to-inward progression of the untreated disease

6. CONCLUSION

Psoriasis is increasingly recognised as a systemic immune-mediated disorder extending beyond its visible cutaneous manifestations. While contemporary medicine elucidates its immunological and multisystem dimensions, homoeopathy has historically approached chronic skin disease as an expression of deeper constitutional disturbance. The concepts of Psora, miasmatic susceptibility and constitutional totality offer a distinctive framework for understanding the individual patient beyond the local lesion. Viewing psoriasis through both perspectives may therefore provide a broader understanding of its complex nature, while encouraging further systematic clinical research into individualised homoeopathic management.

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