Psoriasis

Khakima Khusnitdinova Student, Faculty of Beauty Aesthetics, Yeoju Technical Institute in Tashkent, Uzbekistan, Tashkent

Dilshod Khakimov Health of the Republic of Uzbekistan The Ministry of Health specializes in the Republic dermatolovenerology and cosmetology Scientific-Practical Medical Center, scientific advisor, candidate of sciences medical, Uzbekistan, Tashkent

Bekzoda Askarova Head of the direction "Beauty Aesthetics", Yeoju Technical Institute in Tashkent, Uzbekistan, Tashkent

ABSTRACT

The purpose of the article is to review the most common disease- psoriasis.

Keywords: Psoriasis; psoriasis classification; PUVA therapy; dermatology; cosmetology.

Psoriasis is a widespread, papulo-squamous, chronic, relapsing, multifactorial disease of the skin that occurs in different regions of the world, in people of different ages and sexes.[1]

Neurogenic, endocrine, immune processes, metabolic disorders, hereditary, viral, infectious-allergic factors, and microcirculation disorders are the main factors in the pathogenesis of the disease. More than 50% of cases of the disease occur in children under 10 years of age. Girls are more affected by the disease. In 24.3% to 89% cases of psoriasis, a hereditary predisposition to the disease is noted.[2]

If one of the parents is diagnosed with psoriasis in families, then 8%, if both parents are diagnosed with the disease, then the incidence of psoriasis among children in the family is up to 41%. It should be emphasized that the influence of environmental factors plays an important role in the realization of the state of genetic predisposition to the disease. Such factors include food products, adverse effects of obligate allergens, foci of bacterial disease in the ENT organs, BTsJ revaccination cases, Mantoux tests, mental traumas and colds. [2]

According to the infectious-allergic theory, psoriasis is caused by pneumonia, tonsillitis, influenza or other chronic infectious diseases. The presence of antistreptolysin O and antistreptokinases, strepto- and staphyloallergens in high titers in patients with psoriasis (mainly infants and adolescents) and the improvement of the patient's condition

when sensitization of such patients with streptoantigen and staphyloanatoxin is the cause of strepto-in the pathogenesis of this dermatosis. and shows that staphylococci are of great importance. Supporters of the infectious-allergic theory believe that psoriasis is the result of allergic reactions to viruses, microbes and products formed during their life activity. Chronic infectious diseases weaken the resistance of the body and create conditions for the psoriatic virus to enter the body, and as a result, first hypersensitivity to this virus, and then autosensitization occurs. Such autoimmune reactions are controlled by the body's genes.[3]

According to many scientists, psoriasis is caused by a violation of the trophic (nutritional) properties of the central nervous system. In his experience, the dermatologist often observes that psoriasis occurs as a result of various stress, tension of the nervous system and various emotional excitements. In most patients with psoriasis, various changes in the central and autonomic nervous systems (neurosis, diencephalitis, vegetodystonia, etc.) can be observed. An increase in the amount of physiologically active substances in the body proves that the nervous system is important in the origin of psoriasis. For example, the amount of histamine, serotonin, catecholamine, acetylcholine and other substances in the body and skin of a patient with psoriasis is high. However, the neurogenic theory cannot prove the cause of psoriasis in all cases. For example, in young children (after birth or during infancy), neurosis or emotional disturbances are not observed before the appearance of psoriasis. [3]

Due to the disturbance of metabolism (mainly carbohydrate, protein, fat), functional changes occur in the formation process of the epidermoid layer and epidermopoiesis in normal rhythm. Patients with psoriasis have high levels of prostaglandins and polyamines, and low levels of vitamin D3. Theory of endocrine changes. Psoriasis has been known for many years to be caused by changes in the activity of the endocrine glands, an example of which is the clinical course of psoriasis in pregnant women. In arthropathic or erythrodermic types of psoriasis, the amount of glucocorticoid hormones produced by the cortex of the adrenal gland decreases. [3]

Clinical appearance. Psoriasis skin is characterized by monomorphic, epidermodermal nodules with stone work. Rashes are mainly located on the hairy part of the head, arms and legs and in the writing areas of the body. Nodules have clear borders, dense-elastic consistency, flat, pink-red color, and their surfaces are covered with silvery-flowing scales. Dandruff appears in the middle of the knot, and becomes larger and easier to move. The size of the nodules is different - the size of a point, the size of a mash, the size of a pea. In the clinical course of psoriasis, three stages are distinguished - progressive, stationary and regressive stages. The following clinical features are characteristic of the stage of progressive or initial exacerbation: the formation of new, small dark red nodules, growth around existing nodules, dandruff is observed only in the central parts, a "growth ring" around the nodules. A more dark red border and the triad of psoriasis sign: stearin stain, terminal veil and blood dew phenomena are easily evoked, Kebner's phenomenon, that is, the appearance of new rashes in response to external influences.[1]

In addition, some patients experience itching at this stage. During this period, due to the effects of various stresses, microtraumas, and irrational treatment, the process may escalate, rashes may cover the entire skin surface, and psoriatic erythroderma may occur.

In the stationary stage of psoriasis, new nodules do not appear, the nodules are large, there is no growth ring around them, they are pale pink in color, abundant dandruff is observed on the entire surface of the nodules. The nodules are flattened, an anemic ring is visible around them.

Psoriasis triad is a complete challenge, that is, the phenomenon of blood dew is difficult to observe. Kebner's phenomenon is observed in some cases and not noticed in some cases. Itching is less bothersome.[1]

In the regressive stage of the disease, dandruff on the surface of the nodule is small, almost absent, and the nodules are absorbed

from the center and become ring-shaped (psoriasis annularis) or disappear from the periphery and a depigmented ring appears in its place. Kebner's and psoriasis triad phenomena are negative. Hyper or depigmented surfaces are formed in areas where nodules have been absorbed (leucoderma psoriaticum).

The appearance or exacerbation of the disease is observed more often in spring-summer, and in some cases, in autumn-winter, and accordingly, it is considered a mixed type of psoriasis if summer and winter types of the disease and winter-summer flare-ups occur. In some cases, exudative psoriasis (psoriasis exudativum) is observed.

In this type, bright red scaly nodules are formed, and on their surface there is a strong yellow or brown-brown scale, if the scales are moved, a weak spot of moisture is visible. A rare form of the disease is pustular psoriasis (psoriasis pustulosa). This type of psoriasis is found on the body, hands and feet, and on the skin of the palms and soles. Along with psoriatic rashes, pustulosis is accompanied by a rash of elements, erythroderma, increased temperature, fever, weakness, leukocytosis. Psoriatic erythroderma (erythrodermia psoriatica) is considered one of the severe complications of psoriasis and is often observed after irrational local treatment. In this case, the psoriatic process takes over all parts of the skin, the disease is severe, the patient loses a large amount of fluid, the temperature rises, itches and severe skin itching bothers. Such patients have a high risk of developing heart and kidney failure.[1]

10% of patients with psoriasis develop psoriatic arthropathy (arthrop athiapsoriatica). Mainly, intermediate joints of limbs, spine joints are injured. The first symptoms of the disease: pain in the joints without clinical changes. Later, as the disease progresses, the joints swell, the skin on the surface becomes red, movement is limited, and it becomes painful. Joints gradually lose their movement, and patients become disabled.

Changes in the nails are common in psoriasis (onychia psoriatica): dot-dotted depressions (angishvona symptom), thickening of nails and their breakage are observed.[1]

Diagnosis:

1. Nodules and characteristic clinical appearance.

2. Psoriatic triad symptom (Appendix VI).

3. Histological examinations.

Differential diagnosis:

- Lichen ruber planus;
- Seborrheic dermatitis;
- Rhythriasis rubra pilaris;
- Lichen rosea Gibert;
- Morbus Reiter;
- fungal skin diseases;
- erythroderma;
- Neurodermatitis;
- Syphilis secundaria.[1]

The cure. Treatment of children with psoriasis should be carried out individually based on the general condition of the child's organism, taking into account the stages of the disease, prevalence and the presence of concomitant diseases. In the course of such treatment, sedative, antihistamine, desensitizing, hepatotropic, vitamin, immunomodulatory, hormonal drugs and local ointments are used in the composition of medicinal products. Treatment of the disease consists of two types - basic and symptomatic treatment. In addition, local treatment is also very important. Treatment of children with psoriasis is prescribed by recommending a hypoallergenic, elimination diet, and limiting foods rich in fat and carbohydrates. Phytoncides (garlic, garlic, onion), red products (tomatoes, ketchup, red fruits), eggs, honey, chocolate, butt oil, processed meats, citrus fruits, bitter, pickled products are prohibited to be given to sick children. Meals given to sick children should consist of simple, vitamin-rich, low-fat foods made from rabbit and turkey meat. [2]

Due to the important role of the turban of the allergic condition on the basis of psoriasis disease, patients are often prescribed calcium drugs (calcium chloride, calcium gluconate, calcium lactate), detoxifying and diuretic properties in order to have a hyposensitizing effect. , tin, magnesium drugs (sodium thiosulfate, potassium chloride, potassium and

magnesium asparaginate), adrenal gland stimulating and neutralizing drugs, anti-inflammatory drugs are used. Antihistamine drugs (fecarol, peritol, suprastin, diazolin, dimedrol, diprazine, ketotifen, cimetidine) are used in the course of the disease with acute itching. [2]

Due to the importance of metabolic changes in the course of psoriasis in children, they are recommended to take enzymes (pancreatin, festal, mezim forte) and vitamins (A, C, B1, B6, B12, PP, folic acid) at the same time. [2]

General treatment of psoriasis is necessarily carried out together with local treatment measures. It is advisable to prescribe indifferent creams and ointments (Unna's cream, children's cream, borate ointment) that have a weak effect on the skin during the period of the disease. Sulfur, salicylic acid ointments, naphthalene, ointments are recommended in order to speed up the process of absorption of rashes in cases of reduced or stationary stages of psoriasis.

PUVA therapy is an important tool in the treatment of psoriasis, and it is mainly used in diffuse psoriasis. The use of retinoids in combination with PUVA therapy increases the effectiveness of the treatment.

List of references:

1. Adham Vaisov, "Skin and venereal diseases". "Generation of the new century", 2009. 91-95.
2. Children's skin and genital diseases: Textbook/ Mannanov A.M., Khaitov Q.N.; Ministry of Higher and Secondary Special Education of the Republic of Uzbekistan. Tashkent Pediatric Medical Institute; T.: "Economy-Finance", 2016. 137-147.
3. S.S. Arifov, E.U. Eshboyev. Skin and genital diseases //. "National Encyclopedia of Uzbekistan" State Scientific Publishing House, Tashkent - 1997. 78-85p.