CHAPTER 40

PSORIASIS VULGARIS (L40.0)

Ayşe Nilhan ATSÜ[1]

REMEMBER

- Psoriasis includes a large group of diseases (guttate psoriasis vs. generalized pustular psoriasis). In this section, the most common form, chronic plaque psoriasis vulgaris, will be discussed.
- Skin lesions vary according to clinical variants. Sharply demarcated erythematous scaly inflammatory plaques in chronic plaque type (most common) psoriasis (=psoriasis vulgaris), multiple small erythematous scaly inflammatory papules and plaques in guttate psoriasis are observed. Sterile pustules in generalized or palmoplantar pustular psoriasis, generalized erythema and scaling (>90%) in erythrodermic psoriasis, and viable erythematous, less scaly plaques in intertriginous areas in inverse psoriasis are the typical presentations. In this section, chronic plaque type psoriasis vulgaris will be discussed.
- Psoriasis vulgaris (PV), is an erythematous-scaly chronic inflammatory skin disease.
- The erythema of psoriasis is sharp and has a red flesh color. There are silvery scales covering the erythema. in color.
- PV affects both genders equally.
- PV can also be observed in the pediatric age group.
- The global general prevalence of the disease is approximately 2%.

[1] MD., Istanbul Kent University, Faculty of Health Sciences, nilhan.atsu@kent.edu.tr

tients with positive tuberculin PPD and/or QuantiFERON test should be consulted with a pulmonologist.

- It should not be forgotten that methotrexate, which is one of the treatment options, can cause pulmonary fibrosis.

Nephrology

- Patients with psoriasis may have an increased risk for chronic kidney disease (CKD).
- A cohort study comparing the risk of moderate to severe chronic kidney disease in adults with, and without psoriasis found an increased risk for chronic kidney disease in patients with severe psoriasis. Therefore, patients should be followed up for CKD.
- In addition, renal functions should be closely monitored in patients given cyclosporine during treatment, and nephrological evaluation should be performed in terms of nephrotoxicity in case of developing high creatinine. The duration cyclosporine use should not exceed two years.

Infectious Diseases

- Infections in psoriasis (especially streptococcal upper respiratory tract infection and HIV infection) may cause the onset or aggravation of lesions.
- In the presence of a triggering infection, treatment of the infection may be beneficial in the regression of the lesions.
- In addition, the risk of serious infection was found to be significantly higher in patients with psoriasis compared to the normal population.
- It should also be kept in mind that there is a tendency to opportunistic infections due to DMARDs and/or biological agents used in the treatment of psoriasis. Patients should be evaluated by an infectious diseases specialist.

Ophthalmology

- Eye diseases such as blepharitis, conjunctivitis, xerosis, corneal lesions and uveitis may occur with increasing frequency in patients with psoriasis.
- Patients may experience flaking or crusting of the eyelashes, swelling of the eyelids, redness of the eyes and/or visual impairment. Symptomatic patients should be assessed by an ophthalmologist.

Medical Oncology

- Numerous studies have shown an increased risk of malignancy in patients with psoriasis such as non-Hodgkin lymphomas, Hodgkin's disease, squamous cell carcinoma (SCC), hepatocellular carcinoma (HCC), esophageal carcinoma, larynx cancer, renal cancer, pancreatic cancer, and colorectal cancer.
- At the slightest symptom, sign or suspicion, malignancy should be kept in mind, and age, and gender appropriate screening should be performed. Therefore, the opinion of the oncologist is important.

Clinical Pharmacology

- If the patient's lesions are thought to be triggered by drugs (e.g., lithium, interferon, β-blockers, or antimalarial drugs), a clinical pharmacologist's opinion can be obtained.

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BÖLÜM 40

PSÖRİAZİS VULGARİS (L40.0)

Ayşe Nilhan ATSÜ[1]

HATIRLA

- Psöriazis, geniş bir hastalık (guttat psöriazis vs. jeneralize püstüler psöriazis) kümesini içermektedir. Bu bölümde en sık görülen form olan kronik plak tipi psöriazis vulgaris tartışılacaktır.
- Klinik varyantlara göre deri lezyonları değişmektedir. Kronik plak tip (en sık görülen tip) psöriazisde (=psöriazis vulgaris) keskin sınırlı eritemli skuamlı inflamatuar plaklar, guttat psöriazisde çok sayıda küçük eritemli skuamlı inflamatuar papül ve plaklar, jeneralize veya palmoplantar püstüler psöriazisde steril püstüller, eritrodermik psöriazisde generalize eritem ve skuam (>%90), invers psöriazisde intertrijinöz alanlarda canlı eritemli, skuamı az plaklar görülür. Bu bölümde en sık görülen form olan kronik plak tipi psöriazis vulgaris tartışılacaktır.
- Psöriazis vulgaris (PV), eritemli-skuamlı plaklar ile karakterize olan, kronik inflamatuvar bir hastalıktır.
- Psöriazisin eritemi keskindir ve canlı et rengindedir, skuamları ise gümüşi renktedir.
- PV, kadın ve erkek cinsiyette eşit sıklıkta görülür.
- Pediyatrik yaş grubunda da izlenebilir.
- Hastalığın dünyada genel prevelansı %2'dir.
- Etiyoloji: Genetik (HLA-Cw6 (3), HLAB17, IL23A geni ile ilişki bildirilmiştir), enfeksiyon (özellikle streptokokal farenjit, HIV (insan immün yetmezlik virüsü) enfeksiyonu), ilaçlar (ör: lityum,

[1] Dr., İstanbul Kent Üniversitesi, Sağlık Bilimleri Fakültesi, nilhan.atsu@kent.edu.tr

- Psöriazisi olan ve olmayan erişkinlerde orta ila ileri düzeyde kronik böbrek hastalığı riskini karşılaştıran bir kohort çalışmasında, şiddetli psöriazisi olan hastalarda kronik böbrek hastalığı için yüksek bir risk bulunmuştur. Hastalar bu nedenle KBH açısından takipte olmalıdır.
- Ayrıca tedavide siklosporin verilen hastalarda renal fonksiyonlar yakından takip edilmeli, gelişen kreatinin yüksekliği durumunda nefrotoksisite açısından nefrolojik değerlendirme yapılmalıdır. Siklosporin kullanım süresi iki yılı aşmamalıdır.

Enfeksiyon Hastalıkları

- Psöriaziste enfeksiyonlar (özellikle streptokokal boğaz enfeksiyonu ve HIV enfeksiyonu) lezyonların başlamasına veya şiddetlenmesine neden olabilir.
- Böyle bir durum varlığında enfeksiyonun tedavi edilmesi lezyonların gerilemesinde fayda sağlayabilir.
- Ayrıca psöriazisli hastalarda normal popülasyona oranla ciddi enfeksiyon riski anlamlı olarak daha yüksek olarak saptanmıştır.
- Tedavide kullanılan DMARD ve/veya biyolojik ajanlara bağlı olarak da oportünisttik enfeksiyonlara yatkınlık oluştuğu da unutulmamalıdır. Hastalar bu sayılan nedenlerden dolayı enfeksiyon hastalıkları uzmanı tarafından değerlendirilmelidir.

Göz Hastalıkları

- Psöriazisli hastalarda blefarit, konjonktivit, kseroz, kornea lezyonları ve üveit gibi göz hastalıkları artan sıklıkta ortaya çıkabilir.
- Hastalarda kirpiklerde pullanma veya kabuklanma, göz kapaklarında şişlik, gözlerde kızarıklık ve/veya görme bozukluğu olabilir. Semptomatik hastalar göz hastalıkları uzmanı tarafından değerlendirilmelidir.

Medikal Onkoloji

- Çok sayıda çalışmada psoriazisli hastalarda malignite riskinin arttığını bulunmuştur. Hodgkin olmayan lenfomalar, Hodgkin hastalığı, skuamöz hücreli karsinom (SCC), hepatoselüler karsinom (HCC), özofagus kanseri, larinks kanseri, renal kanser, pankreas kanseri ve kolorektal kanser gibi.
- En küçük bir semptom, bulgu veya şüphede malignite aklın bir köşesinde bulunmalıdır ve yaş ile cinsiyete uygun taramalar yapılmalıdır. Bu nedenle onkoloji uzmanın görüşü önemlidir.

Klinik Farmakoloji

- Hastanın lezyonlarının ilaçlarla tetiklendiği düşünülüyorsa (ör: lityum, interferon, beta-blokerler, veya antimalaryal ilaçlar) bu ilaçların değişimi yönünden klinik farmakoloji görüşü alınabilir.

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