ISDInformation

a ray of hope through patient awareness and education

Newsletter of the Inflammatory Skin Disease Institute Volume 3 Number 2

Psoriasis

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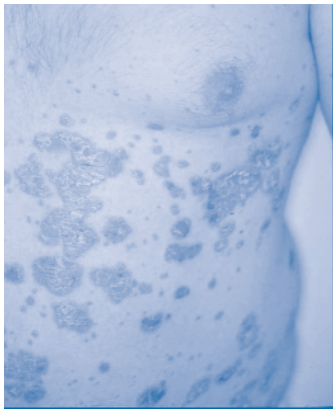

In its typical form, psoriasis appears as sharply margined, pink scaling round patches. Most of the time, it remains localized on the scalp, elbows, knees, or body folds. In other cases it erupts over other areas. In severe cases it can involve the entire skin surface. Although its cause is unknown, dermatologists know a great deal about its biology. For one thing, the tendency to get psoriasis is inherited, even though only one in three patients have a parent or sibling with the disease. Probably because of an abnormal gene function, the epidermis (the outer layer of skin) replaces itself too fast, leading to excessive scale buildup and shedding. The inflammation under the scaling patches can be severe and reminiscent of an immune reaction.

Certain things also cause psoriasis to flare up in certain spots or at certain times. For example, trauma can cause spots to develop after a bruise (Koebner reaction). Drugs including lithium, iodides, antimalaria antibiotics, and the "beta-blocker" type of blood pressure medicines can cause flare-ups. So, too, can infections, especially "strep throats." Stress may exacerbate psoriasis, although its role is often overrated.

In addition to red spots on the skin, the nails can be affected and develop small pits. Or they may thicken and scale may cake under them so that they look fungally infected. Some patients develop thickening and cracking or pus bumps on the palms and soles. Others (fortunately a small minority) also develop an inflammatory arthritis (psoriatic arthritis).

All people with psoriasis hate their skin disease because it's so unsightly. Some patients get depressed or become social hermits. This is unfortunate. Because the molecular cause is unknown, there is no cure. This does not mean there is no hope. The skin between psoriasis spots has the same genes as those in the spots. Drugs can work to "switch off" genes or cause other effects to make psoriasis go away. In other words, there are treatments that work. The decision to use a given form of treatment is usually made jointly by the patient and a dermatologist after an examination and a frank discussion of treatment side effects, costs, and risks to general health. Patients help too by telling their dermatologist how psychologically distressed they are, how much the disease interferes with the quality of their lives, and how much they worry treatments might affect their general health. In all cases, benefits must be weighed against risks and worries.

There are seven major topical ways to treat psoriasis, three forms of ultraviolet radiation therapies, three "pill" therapies, three injection treatments, and a number of other systemic drugs for special circumstances. The topical forms of treatment are discussed below. The next issue of *ISDInformation* will discuss ultraviolet treatments and systemic forms of treatments.

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Note to Our Readers & Dermatologists:

ISDI is still in need of funding for the next year's worth of newsletters. Due to this fact, we will no longer be able to send out multiple copies of the newsletter free of charge. If you are a dermatologist and would like to receive more than one copy of *ISDInformation*, please contact ISDI with your order. The subscription price will be based on the number of copies you request and will entitle you to receive the next four issues of the newsletter. Patients, if you do not want to risk missing an issue, please use the "How Can I Help" form on page 6, a subscription to the newsletter is included with any donation.

Funding is still being sought; contributions of any size will be put to good use and can be mailed to ISDI, P.O. Box 1074, Newport News, VA 23601. If you are in a position to help us fund the next year of the newsletter or have leads as to where we might go for such funding, please contact LaDonna Williams at (757) 223-0795.

Thank you.

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Mission

The goal of the Inflammatory Skin Disease Institute (ISDI) is to promote public awareness and enhanced treatment of inflammatory skin diseases through education, research, and patient advocacy.

Joseph L. Jorizzo, M.D.

Dr. Jorizzo is Professor and Chair of Dermatology at Wake Forest University School of Medicine in Winston-Salem, NC. He currently serves on ISDI's Scientific Advisory Board.

Prior to coming to Wake Forest, Dr. Jorizzo was an Assistant Professor at the University of Texas Medical Branch in Galveston, TX and an Overseas Registrar in Dermatology at St. John's Hospital in London, England. He performed his Internship in Medicine and his Residency in Dermatology at North Carolina Memorial Hospital in Chapel Hill.

Dr. Jorizzo has been honored in *The Best Doctors in America (Dermatologists)* and the *Who's Who in America* for several years. He has authored and co-authored several books in dermatology.

John Koo, M.D.

Dr. Koo is one of the few psycho-dermatologists in the United States. Dr. Koo is a graduate of Harvard Medical School where he graduated as the Harvard National Scholar. He completed his medical internship and psychiatry residency at UCLA, where he was also the Chief Resident in psychiatry. During his psychiatric training, he became interested in the interface between psychiatry and dermatology and, subsequent to the completion of his psychiatry residency; he completed another residency in dermatology at the University of California, San Francisco (UCSF) Medical Center. Dr. Koo joined the faculty of the Department of Dermatology at the UCSF Medical Center when he finished his dermatology residency.

He is currently the Vice Chairman of the Department of Dermatology, as well as the Director of the UCSF Psoriasis Treatment Center, Phototherapy Unit, and Dermatology Drug Research Unit.

Dr. Koo has written many chapters and articles on the topics of psychodermatology, psoriasis treatment, and psychosocial concerns as they pertain to the management of psoriasis patients. As a highly respected member of the dermatological academic community he is on the editorial board of the Journal of the American Academy of Dermatology, on the medical advisory board of the National Psoriasis Foundation, and on the ISDI Scientific Advisory Board.

Smallpox and Eczema Vaccinatum

What is Smallpox?

Smallpox is a serious, highly contagious, and sometimes fatal infectious disease. The symptoms include fever, head and body aches, and a rash of pus bumps and sores that at times develops first on the tongue and in the month then spreads throughout the rest of the body.

What is Eczema Vaccinatum?

Eczema vaccinatum is a risk for people who receive the smallpox vaccine and have atopic dermatitis or have had it in the past. Atopic dermatitis, sometimes called "eczema," is an itchy skin condition, characterized by thickened red and scaly patches. It commonly affects the face in infants, and the inner elbows and knees, neck and eyelids in children and adults. While the precise cause of atopic dermatitis is unknown, the immune system of the skin is altered, and the disease can often be seen in individuals with a personal or family history of asthma or allergic rhinitis ("hay fever"). Eczema vaccinatum in patients with atopic dermatitis but not immune deficiency usually occurs without the internal organ disease seen in immune deficiency patients.