

# Chapter-2 (i)

## Dermatology

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### Dermatology

- Psoriasis
- Scabies
- Eczema

### Dermatology

**Dermatology** is the branch of medical science in which we study about the skin abnormality appears due to any infections or allergic conditions. In skin disease we discuss many conditions like-

- Melanocyte nevus (pigmented nevus).
- Actinic keratosis.
- Ichthyosis.
- Urticaria.
- Acute eczematous dermatitis.
- Psoriasis.
- Scabies.
- Verrucae (warts).

### Psoriasis.

#### Introduction.

**Psoriasis** is a common chronic inflammatory dermatosis, persistent or relapsing, scaling skin condition. Individual lesions are distinctive in their classic form sharply margined and erythematous and surmounted by silvery scales. Most patients with psoriasis have a limited number of fixed plaques, but there is great variation in clinical presentation. Persons of all ages may develop the disease.

Several lines of evidence have established that genetic factors contribute to the development of psoriasis. Approximately 15% of the patients with psoriasis have associated arthritis. It can affect any joint in the body and may be

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symmetrical or affect one side only. In addition, psoriasis may also be associated with myopathy, enteropathy, and AIDS.

## **Etiopathogenesis.**

- Psoriasis results from interactions of genetic and environmental factors. As in the case of many autoimmune diseases it is linked to genes within the HLA locus. There is a strong association with HLA-C.
- Lymphocytes also produce growth factors for keratinocytes/epidermopoiesis (epidermal proliferation) that may contribute to epidermal thickening.
- In other predisposed individuals, a number of environmental factors, including infection, physical injury, stress, and drugs, can serve as triggers for the development of psoriasis.

## **Clinical manifestations.**

- Psoriatic arthritis.
- Patches covered with silver white flakes.
- Raised and thick skin.
- Dry, swollen and inflamed patches.
- Pain, itching, and burning sensation.
- Red spots on the body.

## **Pharmacological managements.**

- **Anti-allergic drugs**— Ex- Cetirizine, levocetirizine, fexofenadine, diphenhydramine, chlorphenamine, pheniramine.
- **Antifungal agents**— Terbinafine, flucytosine, ketoconazole, miconazole, luliconazole, clotrimazole, salicylic acid, tolnaftate, fluconazole.
- **Antibiotics**— ofloxacin, moxifloxacin, clarithromycin.
- **NSAIDs**— Ex- Naproxen, ibuprofen, piroxicam, diclofenac.
- **Immunosuppressants**— Ex- betamethasone, dexamethasone, deflazacort, cortisone, prednisolone.

## **Non-pharmacological managements.**

- Diet is an important factor in the skin disorder because some food causes the skin allergy and leads to severe conditions.
- Self-awareness is very important because we need to know which substance cause allergy (allergens like dust, smoke, pollen, food etc).

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- Regular hygienic activity is very important factors to overcome the skin disorder conditions. (Like regular bathing, wearing dry and clean clothes etc).
- Regular yoga and physical activity also overcome the disease by maintain the immune system in proper condition.

## Scabies

### **Introduction.**

**Scabies** is an infectious disease of the skin by the human itch mite. The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs. The most common symptoms of scabies are intense itching and a pimple-like skin rash. The scabies mite usually is spread by direct, prolonged, skin-to-skin contact with a person who has scabies.

Scabies is one of the commonest dermatological conditions, accounting for a substantial proportion of skin disease in developing countries. Globally, it is estimated to affect more than 200 million people at any time, although further efforts are needed to assess this burden.

### **Etiopathogenesis.**

Human scabies is a parasitic infestation caused by *Sarcoptes scabiei var hominis*. The microscopic mite burrows into the skin and lays eggs, eventually triggering a host immune response that leads to intense itching and rash. Scabies infestation may be complicated by bacterial infection, leading to the development of skin sores that, in turn, may lead to the development of more serious consequences such as septicaemia, heart disease and chronic kidney disease.

### **Clinical manifestations.**

- Formation of plaques.
- Thickening of skin.
- Puffy and red eye lids.
- Hyperpigmentation of skin.
- Oozing of lesions.
- Formations of cracks.
- Itching, and burning sensation.

### **Pharmacological managements.**

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## **Eczema**

### **Introduction.**

The Greek word eczema, meaning “to boil over,” vividly describes the appearance of acute eczematous dermatitis one of the most common skin disorders. Based on initiating factors, eczematous dermatitis can be subdivided into the following categories.

- Allergic contact dermatitis.
- Atopic dermatitis.
- Drug-related eczematous dermatitis.
- Photoeczematous dermatitis.
- Primary irritant dermatitis.

All types of eczematous dermatitis are characterized by red, papulovesicular, oozing, and crusted lesions that, if persistent, develop reactive acanthosis and hyperkeratosis that produce raised scaling plaques.

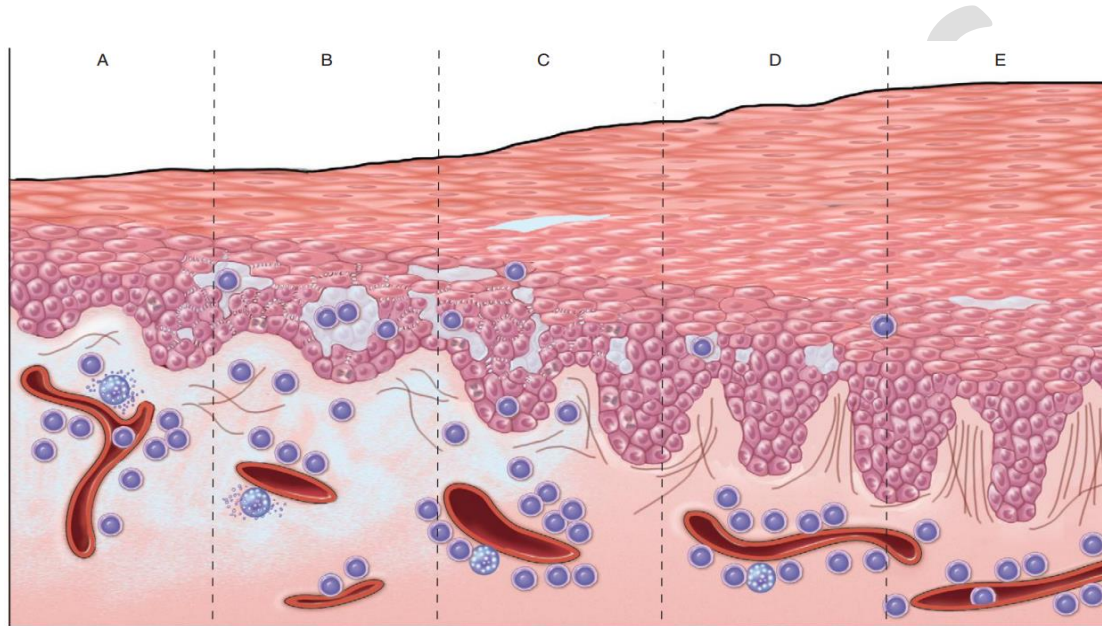
### **Etiopathogenesis.**

Eczematous dermatitis typically results from T cell-mediated inflammatory reactions (type IV hypersensitivity). It is developed in 5 stages.

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- A. Initial dermal oedema and perivascular infiltration by inflammatory cells is followed within 24 to 48 hours.
- B. Epidermal spongiosis and micro vesicle formation.
- C. Abnormal scale, including parakeratosis, along with progressive acanthosis.
- D. Hyperkeratosis.
- E. Appear as the lesion becomes chronic.



## Clinical manifestations.

- Itching, and burning sensation.
- Dryness of skin.
- Cutaneous reactivity.
- Chances of secondary or internal tissue infections.
- Eczematous areas with crusting.
- Macular erythema, papules.
- Lichenification and excoriation.

## Pharmacological managements.

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