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THE NATUROPATH'S GUIDE

PSORIASIS

A focus on the herbal approach for managing psoriasis

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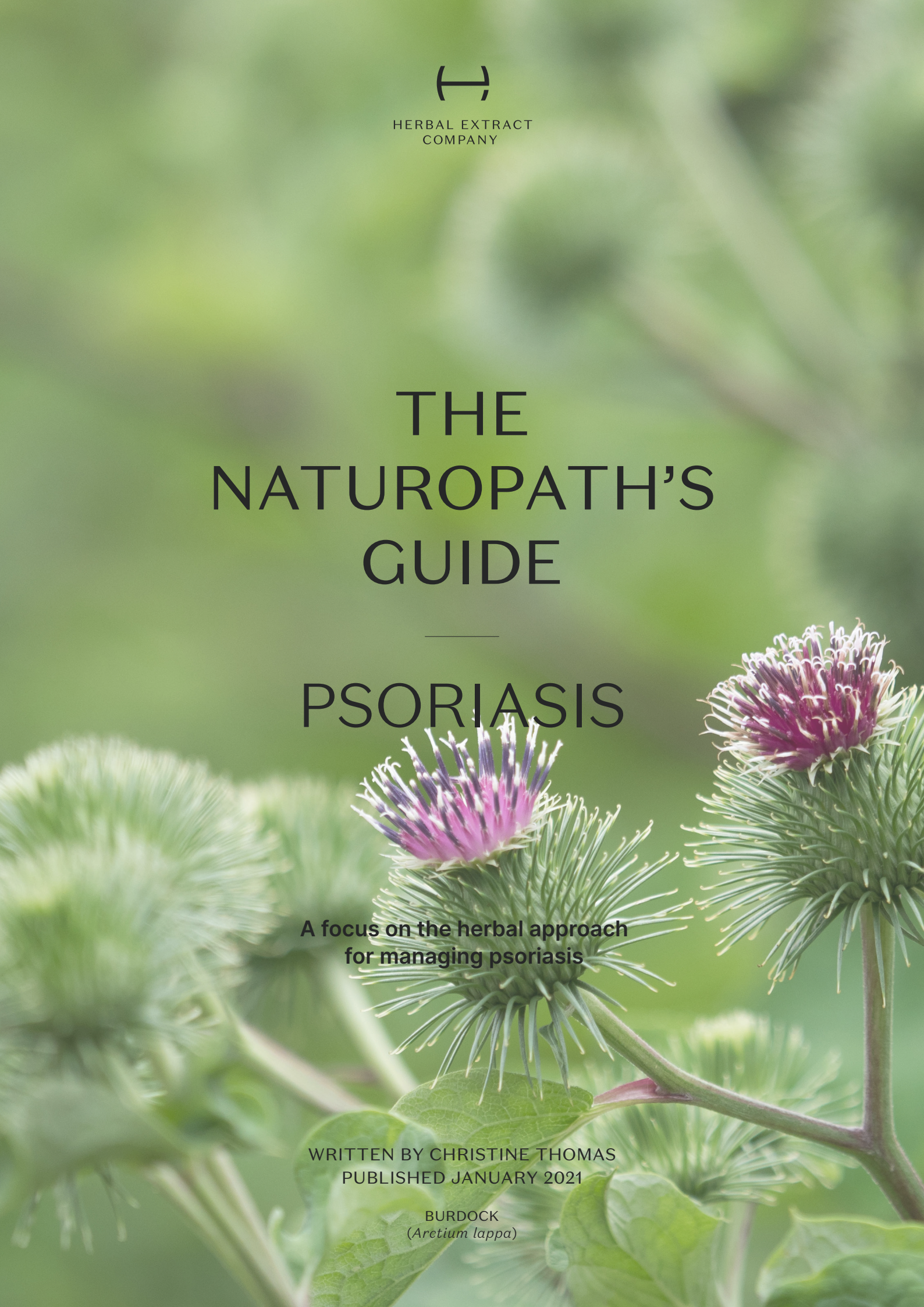

PSORIASIS

Psoriasis is a common, chronic, noncontagious, painful and disfiguring inflammatory skin disease with no clear cause or cure.

While psoriasis causes patches of inflamed, thickened skin lesions it is more than just a skin condition and is systemic, the result of a complex interaction between immunological, environmental and genetic factors.

Condition Overview

Psoriasis can manifest in many different forms however typically it shows up as thickened red patches covered with silvery scales, usually on the scalp, elbows, knees, back and buttocks. It can also affect fingernails and toenails. In addition to the involvement of skin and nails inflammatory arthritis (psoriatic arthritis) may develop. Psoriasis and psoriatic arthritis are both manifestations of psoriatic disease. Psoriasis usually appears on the skin first, sometimes years before the symptoms of psoriatic arthritis begin but, more rarely, psoriatic arthritis can exist on its own or before skin symptoms.

The cause of psoriasis is unknown although it is well accepted that there is an underlying genetic component which, when triggered, causes the immune system to produce an excessive number of skin cells. For this reason it is termed an autoimmune disorder. The keratinocytes of the skin multiply very rapidly and travel from the bottom layer of the epidermis to the surface in approximately four days as opposed to the usual 28 days. The skin cannot shed these cells quickly enough so they build up leading to thick, dry and flaky patches or plaques. It can affect people of all races and ages however most patients are first diagnosed in their early adult years (15 to 20 years) or later in adulthood (55 to 60 years). The patches usually flare up periodically and symmetrically on both sides of the body.

Psoriasis has an unpredictable course of symptoms, a number of external triggers and significant comorbidities including arthritis, cardiovascular diseases, metabolic syndrome, obesity, diabetes, inflammatory bowel disease and depression. Aside from its physical manifestations psoriasis can also result in debilitating psychological effects for those suffering with it. These people may experience significant social stigma which can have an immense negative impact and gravely affect their quality of life. Much of the suffering caused by this complex disease can be avoided by improving access to early diagnosis and appropriate treatment.

There are several types of psoriasis. Each type is unique in its appearance and symptoms and requires a different treatment approach.

Plaque psoriasis is the most common affecting approximately 80 per cent of patients. Plaque psoriasis presents as raised red lesions covered by silvery white dead skin cells. It typically shows up on the scalp, knees, lower back and elbows. It can

often be painful and itchy and has a tendency to crack and bleed.

Guttate psoriasis, which flares up following a viral or bacterial infection and particularly group A streptococcal infections of tonsils, normally affects children and young adults. Guttate psoriasis often starts in childhood, or young adulthood, and presents as multiple small scaly plaques on the torso, arms and legs. About one third of patients with guttate psoriasis will develop plaque psoriasis throughout their adult life.

Flexural psoriasis, sometimes called inverse psoriasis, affects body folds and genitals. It tends not to have silvery scale but has shiny and smooth well defined patches. Complications of flexural psoriasis include secondary fungal infections, particularly Candida albicans.

Pustular psoriasis is mostly found in adults. It appears as white blisters of noninfectious pus surrounded by red skin. Pustular psoriasis can appear on any part of the body but occurs most often on hands and feet.

Scalp psoriasis may occur in isolation or in conjunction with other forms of psoriasis. Scalp psoriasis is characterised by red, thickened plaques with silver white scale, either contained within the hairline, or extending onto the forehead, ears and posterior neck. In many cases scalp psoriasis is associated with intense itching and scale is commonly shed as dandruff.

Nail psoriasis, an extremely common feature of psoriasis is nail involvement. Importantly, 70 to 80 per cent of patients with psoriatic arthritis have nail psoriasis.

Sebopsoriasis is the name for a condition that is an overlap of psoriasis and seborrheic dermatitis in which symptoms of both conditions are exhibited. It is typically found on the scalp, face, ears and chest and appears as red bumps and yellow, slightly greasy scales. In infants the condition is commonly called cradle cap. It is thought to be due to an abnormal immune response to Malassezia yeasts, organisms that reside on the skin, or their irritating metabolites.

Palmoplantar psoriasis is an uncommon chronic pustular condition affecting the palms and soles.

Erythrodermic psoriasis is a rare, severe, acute condition in which over 90 per cent of the total body surface is red and inflamed. It can develop on any kind of psoriasis type, however commonly occurs on people who have unstable plaque psoriasis, and requires emergency treatment. It may result in systemic illness with temperature dysregulation, electrolyte imbalance, pneumonia and cardiac failure.

Common Symptoms

The most frequently reported symptoms connected to psoriasis are:

- Symmetrically distributed red, scaly plaques with well-defined edges on the scalp, elbows and knees, however any part of the skin can be involved.
- Scaling of the skin: typically silvery white except in skin folds where the plaques often appear shiny and they may have a moist peeling surface.
- Painful dry skin cracks or fissures that may bleed.
- Burning or soreness.
- Itching: mostly mild but may be severe in some patients leading to scratching and lichenification (thickened leathery skin with increased skin markings).
- Thickened, pitted or ridged nails.
- Swollen and stiff joints.
- When psoriatic plaques clear up they may leave brown or pale marks that can be expected to fade over several months.

Risk Factors

Several internal and external triggering factors have been identified leading to the first manifestation of psoriasis. Understanding and minimising these triggers can be an important part of managing psoriasis.

Genetics

Psoriasis has a strong genetic predisposition. Evidence shows a concordance rate of 20 to 70 per cent in identical twins and 10 to 20 per cent in fraternal twins. This is among the highest estimated

for autoimmune or chronic inflammatory diseases. Additionally, 23.1 per cent to 31.9 per cent of psoriasis patients have a family history. Scientists are still trying to find which genes are involved however it is known that some people develop psoriasis without having a history of the illness in the family. The individual disease susceptibility can be changed by epigenetic modifications which might be triggered due to diverse environmental exposures. So for psoriasis to appear it seems that a person must inherit a certain combination of genes and must also be exposed to a trigger that starts the development of symptoms. Therefore if a person has psoriasis it does not mean that their children will also have it. Not all psoriasis sufferers will react to triggers so it is important to record consumption of foods, liquids, sleep, stress, exposure to chemicals and other environmental triggers while monitoring symptoms.

Mental Stress

Psychological stress is known to aggravate psoriasis by altering the immune system. Numerous authors have suggested that increases in stress hormone levels, due to activation of the hypothalamus pituitary adrenal axis, may cause psoriasis exacerbation.

Drugs

Several medications have been associated with psoriasis onset as well as exacerbation of the disease. The most commonly reported drugs to trigger psoriasis include antimalarial medications (oxycycline, chloroquine), lithium (depression or psychiatric disorders), angiotensin converting enzyme (ACE) inhibitors (high blood pressure medication), nonsteroidal anti-inflammatory drugs (ibuprofen or indomethacin), beta blockers (taken by patients with heart failure), interferons (used to enhance the immune system for example in cancer), corticosteroids (prescribed for a variety of health conditions), some antibiotics, antifungals and lipid lowering drugs. Sudden discontinuation of relatively high doses can be a trigger e.g. stopping oral steroids.

Vaccination

Vaccination can often trigger and exacerbate psoriasis. Several studies support the association between influenza vaccination and the exacerbation of psoriasis. Influenza vaccination may also trigger the onset of psoriasis. Concerns have emerged regarding the safety of vaccinations in immune mediated inflammatory diseases following recent publications that highlight a stimulating effect of vaccination at the onset of inflammatory disease or during its course. Although a direct and causal relationship between other vaccinations and the flare of the disease has not been detected by any substantial research studies these publications have given rise to a belief among some clinicians that vaccination may have a triggering effect.

Infections

Considerable data suggests that infections are an important trigger for psoriasis, especially among children. Streptococcal throat infection is a significant aggravating or initiating factor. Periodontitis has also been associated with an increased risk for psoriasis. People with weakened immune systems, such as HIV patients, are more susceptible to psoriasis.

Alcohol

A higher than average alcohol consumption is common among individuals with psoriasis. Alcohol may affect psoriasis through several mechanisms such as increased susceptibility to infections, stimulation of lymphocyte and keratinocyte proliferation and production of proinflammatory cytokines. Alcohol consumption has not only been associated with a more severe and a higher incidence of psoriasis but also with a distinctive nature and distribution of the disease. The reason for this is not fully understood but is likely to be multifactorial. Alcohol consumption may be used by patients with psoriasis to cope with their debilitating skin disease.

Smoking

Tobacco smoking is an important risk factor for psoriasis. Smoking is also strongly associated with pustular lesions of psoriasis. Not only has smoking been associated with the onset of psoriasis but it has also been linked with the severity of the disease and response to treatment. Counselling for smoking cessation should be included in caregiving.

Chemical Exposure, Heavy Metals, Oxidative Stress

The increase in air pollution over the years has had major effects on the human skin and various air pollutants such as polycyclic aromatic hydrocarbons, volatile organic compounds, oxides, particulate matter, ozone, heavy metals and ultra violet (UV) radiation damage the skin by inducing oxidative stress. Exposure of the skin to air pollutants has been associated with inflammatory skin conditions such as psoriasis. Cadmium is one of the air pollutants which affect the development of psoriasis. In one investigation in cement factory industrial workers the total concentrations of toxic elements were relatively higher in people with psoriasis than the control people while essential zinc levels were found to be lower, indicating imbalance in the elemental homeostasis.

Hormones

Psoriasis severity has been noted to fluctuate with hormonal changes. Disease incidence peaks at puberty and during menopause. During pregnancy, symptoms are more likely to improve than worsen if any changes occur at all. In contrast, the disease is more likely to flare in the postpartum period again if any changes occur at all. Even though the sex hormones and prolactin are the most implicated in psoriasis development and clinical manifestations there are a lot of other hormonal mechanisms with significant influence on the evolution of psoriasis. These include glucocorticoids, epinephrine, thyroid hormones and insulin. A hormonal assessment should be performed in patients with psoriasis in order to correctly diagnose and treat pathologies that may be related to psoriasis exacerbations.

Diet

A recent observational study found that people with psoriasis who followed a Mediterranean diet, an eating pattern rich in fruits and vegetables, legumes, whole grains, fish, fruit, nuts, and extra-virgin olive oil, experienced fewer severe flare ups. Experts believe the Mediterranean diet contains many foods that have an anti-inflammatory effect in the body and may offer extra protection against psoriasis triggers. Changes to the diet may play a significant role in maintaining the intestinal microbiome and diet induced dysbiosis may induce the cytokine imbalances associated with the development of psoriasis.

Gluten

Epidemiological and clinical studies suggest there is an association between psoriasis, coeliac disease and coeliac disease markers. There is early evidence to suggest that a gluten free diet may benefit some psoriasis patients but further trials in defined populations are needed. Practitioners may want to question their psoriasis patients about symptoms of coeliac disease including diarrhoea, flatulence, fatigue and history of iron deficiency anaemia.

A Microbiota Issue

A disordered micro-ecosystem probably plays a critical role in the development of psoriasis or may be engaged in the disease exacerbation. The intestinal microbiome plays a vital role in maintaining the intestinal mucosal barrier and normal immune function. There is a well known correlation between Crohn's disease and psoriasis. Patients with Crohn's disease have a fivefold higher risk of developing psoriasis than those without Crohn's disease. Emotion induced skin inflammation is related to dysbiosis in the intestinal microbiome.

Skin Injury

Skin lesions can appear at the sight of trauma after various injuries and this is known as the Koebner phenomenon. Radiotherapy, sunburn, nail manicuring, poor fitting shoes, burns, vaccinations, insect bites, shaving, tape stripping, thumb sucking, sunburn and tattoos have been reported to trigger new lesions of psoriasis. It is speculated that increased blood flow to the inner layer of the skin helps bring mediators that play a part in the development of psoriasis.

Sunlight, Weather and Vitamin D

Most patients consider sunlight to be beneficial for their psoriasis. UV radiation from natural sunlight or artificial sources has been used for treating psoriasis in recent decades. Patients report a decrease in illness severity during the summer months or periods of increased sun exposure. However a small

minority of patients find that their symptoms are aggravated by strong sunlight and these individuals actually experience a worsening of their disease in the summer. A severe sunburn can lead to an exacerbation of plaque psoriasis via the Koebner reaction (see above). Some people suspect that their psoriasis flares may link to a drop in humidity and temperature. The incidence of psoriasis may differ among various populations owing to regional differences with distinct UV distribution. More vitamin D can be produced by exposure to UV B. Vitamin D is a hormone which plays a critical role in the treatment of psoriasis. Data shows that the optimal concentration of vitamin D in serum circulating level for maximum effect should be between 30 and 50ng/mL. Therefore if vitamin D is lower than 30ng/mL UV B exposure will benefit patients.

Obesity

Metabolic syndrome is common in patients with psoriasis and obesity is strongly associated with the onset and exacerbation of psoriasis. Patients with psoriasis have a significantly higher prevalence of obesity as well as a higher risk of obesity. Thus weight loss intervention programmes should be part of psoriasis management.

How To Get The Correct Diagnosis

Psoriasis is diagnosed by careful clinical assessment. A formal diagnosis is important because there are other skin conditions that can be mistaken for psoriasis such as eczema.

Doctors will discuss medical history and conduct a physical examination focusing on the skin, nails and scalp, working out how much of the body is covered in the plaques. Based on the type of skin lesions, location, the age of onset and course of disease several clinical classifications of psoriasis are used. In addition categorisation will depend on the clinical severity of the lesions and the patient's quality of life. Psoriasis is considered mild if it affects less than five per cent of the body surface, moderate if it involves five to 30 per cent of the skin and severe if it covers more than 30 per cent. The severity of psoriasis is classified as mild in 60 per cent of patients, moderate in 30 per cent and severe in 10 per cent.

Doctors will also evaluate comorbid factors screening for arthritis, obesity, diabetes and cardiovascular issues such as hypertension. Screening at regular intervals for these associated diseases, and for comedication to prevent drug-drug interactions or drug-triggered psoriasis, as well as recognition of trigger factors and their treatment are an essential part of psoriasis management. If necessary, diagnosis is supported by typical skin biopsy findings. Patients may be referred to a dermatologist or rheumatologist for specialised treatment options and further tests.

Conventional Treatment & Prevention

After decades of studies and research the treatment of psoriasis is still based on controlling the flaring symptoms and inflammation using topical and systemic therapies. The complexity of psoriasis means that prescribing drugs in isolation is insufficient to control the disease and a holistic approach to care is needed. Psoriasis is a chronic relapsing disease which often necessitates long term therapy. It is best to begin managing psoriatic disease early as it can cause permanent problems and disability. The conventional management of psoriasis emphasises avoiding recurrence and improving the prognosis, especially for those who are at high risk with family history. In common with other immune mediated complex diseases there is no definitive cure and available treatment is only to decrease disease activity and improve symptoms. The choice of therapy for psoriasis is determined by disease severity, comorbidities and access to health care. Management starts with education, lifestyle measures and general skin care measures.

Conventional treatments for psoriasis often include topical corticosteroids, coal tar and UV light therapy or, in severe cases, systemic medications such as methotrexate. Systemic corticosteroids are best avoided due to a risk of severe withdrawal flare of psoriasis and adverse effects. Mild psoriasis is generally treated with topical agents alone. Prolonged use of these pharmaceutical drugs, which are basically either immunosuppressant or anti-inflammatory in nature, causes various other

unwarranted complications such as skin irritation, infections, malignancy, atrophy, spider veins, photosensitivity and rebound symptoms.

It is important for patients to keep monitoring their symptoms even after agreeing to a treatment plan with their doctor and they should plan regular check ups to keep on top of any symptom changes. The treatments used for psoriasis can be expensive and lifelong. Self-funding of treatment is often ruinous for the patients and their household budget, particularly as many people suffering from psoriasis cannot undertake professional work for health reasons or because of discrimination. Multiple recurrences, side-effects and cost of treatment can dishearten patients which can lead to poor adherence to therapy and prevent patients from achieving the best possible results from treatment. Low compliance is partly due to insufficient communication regarding instructions on how to use the drug, misperception of possible adverse events and mistaken expectations about the speed and degree of improvement.

"This skin is me, I can't get out."

John Updike

The Journal of a Leper. John Updike (1932 to 2009) was a Pulitzer Prize winning American writer who had psoriasis. His description of his lifelong personal journey with psoriasis is both touching and inspiring for whoever is engaged in psoriasis research.

Clivers
(Gallium aparine)

INTERVENTION	Adaptogens, relaxing nervines, nervine tonics	Alteratives	Anti-inflammatory	Diuretics, hepatic, digestive, antioxidant, immune support	Astringent, emollient, antipruritic, vulnerary
Burdock		✓	✓	✓	
Chamomile	✓		✓	✓	✓
Chickweed					✓
Clivers		✓	✓	✓	✓
Gotu Kola	✓	✓	✓	✓	✓
Lime Flowers	✓			✓	✓
Red Clover		✓	✓	✓	
St John's Wort	✓		✓		✓
St Mary's Thistle			✓	✓	
Sarsaparilla		✓	✓	✓	
Withania	✓		✓	✓	
Yellow Dock		✓	✓		✓

Natural Therapies For Treatment & Prevention

Conventional treatments for psoriasis are not completely effective and unwanted side effects limit their long term use. This, coupled with the fact that psoriasis is a chronic inflammatory disease, means many patients seek alternative therapies and lifestyle modifications to supplement their treatments and help relieve symptoms. Psoriasis is the epitome of a holistic disease and its treatment requires a systemic approach. This is where the tenets of naturopathy seem worthy of mention: First, do no harm, use the healing power of nature and the body's innate healing power, treat the underlying cause of the disease (not just the symptoms), treat the whole person (holistic health), educate the patient about their health and focus on preventing disease. Treating the skin symptoms alone is not sufficient to control this complex disease which has unpredictable and varied manifestations and associated diseases.

So it is important that the management of any underlying systems is undertaken on an individual level. It might be complicated however an individualised treatment plan which considers the person's predisposition, triggers, investigates and identifies predisposing risk factors and underlying systemic factors (e.g. gastrointestinal dysfunction, immune dysregulation) may, once implemented, result in improvement in symptoms fairly quickly (sometimes within days). However, full resolution will often take longer and often relies on the person's ability to avoid exposure to allergens that trigger the symptoms. Treating gastrointestinal function will only benefit the patient if their gastrointestinal system is under functioning. Likewise, removal of common allergens will only reduce the inflammatory response if those allergens are actually relevant to the person. Skin disease is prone to exacerbation during treatment. This can decrease patients' compliance and trust, so small incremental herbal doses are recommended.

While there is no one size fits all approach some basic principles can be applied to the majority of psoriasis patients including:

- Support immunity
- Reduce inflammation
- Improve skin integrity and facilitate wound healing to reduce pain and risk of infection
- Reduce oxidative stress
- Improve digestive function: this involves improving hydrochloric acid secretion, investigating and addressing potential dysbiosis, regulating blood sugar levels, improving fat digestion and absorption, improving stool consistency and frequency. This will help minimise microbial overgrowth, enhance protein digestion and reduce bowel toxaemia.
- Facilitate detoxification and liver function.

Diet

The connection between psoriasis and diet has been recognized for thousands of years in traditional medicine and more recently in modern scientific literature. In 2018 the Medical Board of the National Psoriasis Foundation said select foods, nutrients and dietary patterns may affect psoriasis. They strongly recommended dietary weight reduction with a low calorie diet in overweight and obese patients with psoriasis. They also recommended a gluten free diet only in patients who test positive for serologic markers of gluten sensitivity. For patients with psoriatic arthritis they recommended vitamin D supplementation and dietary weight reduction with a low calorie diet in overweight and obese patients. The omega-3 fatty acids are used as supplements to treat conditions which have an inflammatory or allergic component. Include oily fish such as Atlantic salmon and sardines.

A recent review found that dietary changes alone do not cause a large effect in psoriasis but may become an important adjunct to current first line treatments. A nutrient dense, easy to digest wholefoods diet maximising the intake of anti-inflammatory and antioxidant foods should be consumed to facilitate and support the body's own healing mechanisms. This can be done by increasing consumption of fruits and vegetables, seafood, legumes and low allergenic nuts and seeds.

Adequate Fluid Intake

Three litres of filtered water per day.

Eliminate Aggravating Foods

A customised dietary program is advised to identify and address potential food allergens. Investigate

leaky gut (also known as increased intestinal permeability) and coeliac disease. An elimination diet could be recommended for approximately two months removing gluten, dairy, nuts, eggs and nightshades as appropriate.

Repair The Gut

Incorporate foods that facilitate digestive and liver function. Feed the microbiome with antioxidants and fibres by increasing fruit and vegetable consumption. Include probiotics and prebiotics, bone broth or the weed, feed and seed protocol. Increase the intake of fibre to facilitate bowel motility, elimination and repair.

Things to Limit

Calorie intake (if indicated), alcohol, refined carbohydrates (sugars and processed grains), red and processed meat.

Lifestyle

Topical Treatment

This can provide symptomatic relief. Application of topical treatments can assist in reducing dryness, itching and inflammation. An important factor is the lifting and removal of scales whilst reducing local inflammation. This often means that the form of the application is as important as any remedies it contains. Choice of topical form should be governed to some extent by the personal preference of the patient, often necessitating experimentation. Ointments can be made from comfrey, chickweed or marshmallow. Get exposed to healthy sunshine. A lukewarm bath with Epsom salts or olive oil can soothe the itching and penetrate scales and plaques.

Adequate Rest, Sleep and Stress Reduction

Practice sleep hygiene (sleep before 10pm) and stress reduction techniques such as mindfulness, meditation, yoga, counselling and deep breathing. A recent review found that the complementary and alternative medicine therapies with the most robust evidence of efficacy for treatment of psoriasis included meditation and acupuncture. The patient may have feelings of shame and anger about their condition which can impact on their relationships with others. Referral to a counsellor or psychologist may be of benefit.

Exercise

A women's health study found that women who exercised regularly were less likely to have psoriasis than women who did not like to participate in regular physical activities. Exercise can relieve stress, reduce anxiety and tension, improve emotional wellbeing and help maintain an ideal weight. Moreover outdoor sports encouraging optimal UV radiation exposure is an effective treatment for psoriasis plaque, which can replenish more vitamin D made in the skin regularly.

Potential Treatment Plans

Psoriasis	Burdock	Yellow Dock	Clivers	Chickweed	Gotu Kola	Sarsaparilla
Psoriasis with anxiety	Lime Flowers	Withania	St Mary's Thistle	Red Clover	Gotu Kola	Chamomile
Anti-inflammatory cream to soothe itching and irritation	50g Natural Base Cream		5mL Chamomile		5mL Chickweed	
Cream to reduce redness, scaling and thickness	50g Natural Base Cream		5mL St John's Wort		5mL Gotu Kola	

Desired Herbal Actions and Potential Herbs Include:

Adaptogens, Relaxing Nervines, Nervine Tonics

Address the underlying stress response. These herbs help with the commonly associated problem of anxiety and will ease discomfort in the skin because of the relaxing effect upon the peripheral nerves of the autonomic nervous system. This will reduce itching and even inflammation to some extent. They are particularly useful if there is involvement of high blood pressure or heart signs such as palpitations. Herbs such as bacopa, chamomile, gotu kola, hops, Korean ginseng, lemon balm, lime flowers, mistletoe, motherwort, mugwort, oats, passion flower, reishi, rhodiola, St. John's wort, saffron, schizandra, scullcap, Siberian ginseng, valerian, vervain, withania.

Alteratives (depuratives, blood purifiers)

To herbalists chronic skin problems are associated with an accumulation of toxins due to the inability of the eliminative organs to cope adequately with both exogenous and endogenous toxins. Alteratives enhance and maintain the functions of the organs of elimination (liver, bowel, kidneys, lymphatics) and nudge eliminations into whatever channel is appropriate. Herbs such as black walnut, burdock, blue flag, clivers, dandelion root, gotu kola, golden seal, heartsease, nettle leaf, pau d'arco, poke root, red clover, sarsaparilla, thuja, turmeric, yellow dock.

Anti-inflammatories

These herbs provide relief from painful, inflamed lesions. If applied topically and taken internally they will speed the curative work of the alteratives but not replace them. They are most helpful during periods of flare up and exacerbation. Herbs such as albizia, aloes, andrographis, black walnut, blue flag, burdock, chamomile, clivers, coleus, dandelion root, echinacea, gotu kola, golden seal, liquorice, red clover, sarsaparilla, St John's wort, St Mary's thistle, turmeric, withania, yellow dock.

Diuretics, Hepatic, Digestive, Antioxidant, Immune Support

Improve detoxification of the body by improving digestion and liver/gallbladder function, kidney/bladder function and the immune system plus aid in the elimination of, and reduce, the accumulation of metabolic waste products within the body.

Diuretics: Important in ensuring adequate elimination through the kidneys. Herbs such as blue flag, burdock, clivers, dandelion root, lime flowers, red clover, sarsaparilla.

Hepatic: Hepatics will contribute their special support for liver function and the digestive process. Herbs such as dandelion root, globe artichoke, sarsaparilla, St. Mary's thistle.

Digestive: Improve digestion and help regulate bowel habits therefore assisting in the elimination of toxins. Herbs such as barberry, blue flag, burdock, chamomile, coleus, gentian, ginger, St Mary's thistle, yellow dock.

Antioxidant: Counter the oxidation caused by absorption of free radicals from bowel toxaemia. Herbs such as burdock, chamomile, dandelion root, garlic, gotu kola, maritime pine, St Mary's thistle, pomegranate, saffron.

Immune Support: Modulate the immune response and enhance immunity to assist with wound healing. Herbs such as echinacea, cat's claw, hemidesmus, rehmannia, withania.

Astringent, Emollient, Antipruritic, Vulnerary

Astringents, used topically, may help in reducing redness, heat and itching through a local vasoconstrictive effect. **Emollients** help in the process of scale removal. Antipruritics may help when used topically. **Vulnerary** herbs may support the healing of skin lesions when applied topically. Herbs such as aloes, chamomile, chickweed, clivers, comfrey, gotu kola, golden seal, lime flowers, liquorice, marshmallow, St John's wort, yellow dock.

Herbal Support Could Include:

HERB NAME	DESCRIPTION	ACTIONS
Burdock *(Arctium lappa)* 	Internationally renowned medical herbalist David Hoffman says burdock is the most valuable remedy for the treatment of skin conditions which result in dry, scaly skin. He says it may be most effective for psoriasis if used over a long period of time.	Alterative Diuretic Anti-inflammatory Bitter
Chamomile *(Matricaria chamomila)* 	A 2018 study evaluated the efficacy of a topical herbal formulation containing chamomile and pumpkin seed oil in the treatment of plaque psoriasis. The findings suggest that this combination could be a safe and effective therapeutic option in mild to moderate plaque psoriasis. This therapeutic response could be related to the anti-inflammatory and antioxidant properties.	Anti-inflammatory Antioxidant Bitter Tonic (digestive) Relaxing Nervine Vulnerary
Chickweed *(Stellaria media)* 	Chickweed is associated with accelerating the wound healing process in psoriasis and its emollient properties soothe the itching and irritation.	Vulnerary Emollient Antipruritic Demulcent
Clivers *(Gallium aparine)* 	Clivers can be used both internally and externally for the skin. Its cooling and moving properties make it a good match for moist skin conditions that weep especially with signs of heat.	Alterative Diuretic Anti-inflammatory Vulnerary

Herbal Support Could Include: (Cont.)

HERB NAME	DESCRIPTION	ACTIONS
Gotu Kola *(Centella asiatica)* 	Traditionally used for wound healing and in the treatment of psoriasis, gotu kola has been shown to inhibit keratinocyte proliferation in vitro warranting further research.	Anxiolytic Nervine Tonic Antioxidant Anti-inflammatory Alterative Diuretic Skin Protective
Lime Flowers *(Tilia cordata)* 	A well known remedy for relaxing nervous tension lime flowers are particularly indicated if there are any heart signs such as hypertension.	Nervine Diuretic Mild Astringent
Red Clover *(Trifolium pratense)* 	Red clover is commonly used as an alterative herb to support skin health, both through internal and external use, and is also considered a mild lymphatic. Herbalists use it for a variety of skin ailments including psoriasis. It is commonly combined in formulas with other alterative herbs such as dandelion root, burdock, chickweed and nettle leaf.	Alterative Anti-inflammatory Diuretic
St John's Wort *(Hypericum perforatum)* 	A 2017 double blind, placebo controlled, pilot study showed that St. John's wort ointment could decrease redness, scaling and thickness in patients with mild to moderate plaque psoriasis. The researchers said St. John's wort's efficacy is probably related to its effect on lowering cytokines including tumour necrosis factor-alpha (TNFα). TNFα is known to directly contribute to the characteristic plaque covered in silvery scales through induction of keratinocyte proliferation.	Anti-inflammatory Nervine Tonic Antidepressant Astringent Vulnerary Antiproliferative

Herbal Support Could Include: (Cont.)

HERB NAME	DESCRIPTION	ACTIONS
St Mary's Thistle *(Silybum marianum)* 	Traditionally St. Mary's thistle seeds have been used for psoriasis. It is commonly used for treating digestive disorders and any indication whereby improved liver function or liver protection may be a benefit.	Hepatoprotective Anti-inflammatory Antioxidant Antiobesity Digestive Tonic
Sarsaparilla *(Smilax* spp.*)* 	Sarsaparilla's most enduring recommendations have been for rheumatism and psoriasis. It is particularly useful when there is a lot of irritation. Sarsaparilla was extensively studied as a treatment for psoriasis in the early 20th century prior to the development of many of the steroidal type drugs in common use today. The studies were not nearly as rigorously constructed as modern trials but they show some compelling evidence nevertheless. This is especially persuasive given how difficult it is to successfully treat psoriasis. Two to three months of treatment were commonly required but over 50 per cent of the people suffering from psoriasis improved when given large daily doses of sarsaparilla extracts. The patients who received the most benefit had chronic plaque psoriasis. One more recent preclinical study found that sarsaparilla dramatically improved skin lesions.	Alterative Anti-inflammatory Diuretic Hepatoprotective
Withania *(Withania somnifera)* 	As well as enhancing resistance to various stresses and immunity, withania has traditionally been administered for the management of psoriasis.	Adaptogen Anti-inflammatory Immune Modulating

Herbal Support Could Include: (Cont.)

HERB NAME	DESCRIPTION	ACTIONS
Yellow Dock *(Rumex crispus)* 	Yellow dock root is specifically indicated in the British Herbal Pharmacopoeia 1983 for skin disease, especially psoriasis with constipation.	Alterative Anti-inflammatory Astringent

Conclusion

Psoriasis is by nature a chronic, incurable disease with an unpredictable course of symptoms and triggers. The consequence is often lifelong treatment, therefore, all treatments must meet high quality criteria that are not only efficacious but also safe over long periods. By selecting appropriate interventions that target both the cause of psoriasis and future exacerbations practitioners should be able to reduce the immediate and long term suffering of patients and therefore improve their wellbeing and quality of life.

Resources

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