**Who gets psoriasis?**
Psoriasis occurs in both children and adults and may appear at any age, although it is most commonly diagnosed between the ages of 15 and 35. Both men and women of any race may be affected.

**How common is psoriasis?**
About 7.5 million Americans have psoriasis, and more than 150,000 new cases are reported each year.

**What causes psoriasis?**
The exact cause of psoriasis is unknown; however, researchers suspect that whether a person develops psoriasis or not may depend on a "trigger." Possible psoriasis triggers include emotional stress, skin injury, [systemic](http://www.skincarephysicians.com/psoriasisnet/glossary.html#Systemic) infections, and certain medications. Studies have also indicated that a person is born genetically [predisposed](http://www.skincarephysicians.com/psoriasisnet/glossary.html#Predisposed) to psoriasis, and multiple genes have been discovered over the past 5 years confirming this fact. Even so, not everyone with psoriasis will have a family history of the disease.

**Is it possible to have psoriasis and eczema at the same time?**
The biology of skin limits the number of ways in which it can manifest a disease process—by redness, flaking, swelling, etc. Thus, many skin conditions can superficially resemble one another and a dermatologic examination is necessary to establish a diagnosis. Self-diagnosis of a troublesome skin condition can delay proper treatment.

Psoriasis and eczema are two skin problems that seem to be mutually exclusive to a degree, although this is not a hard and fast rule. In persons with psoriasis the incidence of allergic contact dermatitis and atopic dermatitis—two major forms of eczema—appears to be substantially lower than in the general population. A suggested reason is that the immune system dysregulation believed to be a factor in psoriasis is not the same as dysregulation of immune pathways in these forms of eczema.

Other skin diseases that superficially resemble psoriasis can coexist with psoriasis. These include fungal and yeast infections, scabies, cutaneous (skin) lymphoma, and cutaneous manifestations of syphilis. Many skin lesions that superficially resemble psoriasis lack the unique appearance of psoriasis:

* Psoriatic lesions have well-defined borders.
* The surface of a psoriatic lesion has silvery scales that easily flake off.
* The skin under the scales has a shiny red appearance.

**Can psoriasis be cured?**
No. The tendency to develop psoriasis is inherited through a person’s genes. We hope to be able to safely modify these genes in the future, but the technology is not yet developed. We do foresee a time, when we will have more specific and more effective therapies for the various forms of psoriasis. Also, while psoriasis cannot be cured, it can often be completely cleared for periods of months or even years. Occasionally, it never returns at all. In most patients, however, it is a chronic, life-long condition with alternating periods of flaring and clearing.

**Is risk for skin infections higher in people with psoriasis than in people with normal skin?**Studies have shown that psoriatic plaques and adjacent normal skin usually have the same type of bacteria, but the number of bacteria per square millimeter is higher in the psoriatic plaques. This, in itself, is usually not an increased risk for secondary infections.

Risk for secondary infections may increase with hard scratching as this abrades the skin and opens it to bacterial invasion. Hard scratching should be avoided for this reason, and because abrasion of the skin can [trigger](http://www.skincarephysicians.com/psoriasisnet/glossary.html#Trigger) formation of new psoriatic lesions.

A skin hygiene program recommended by a dermatologist is usually adequate to keep bacterial populations in check. Specific anti-bacterial measures may be prescribed by a dermatologist when such measures are warranted.

Symptoms of secondary infection are redness of skin around a psoriatic lesion or increased redness of the lesion, increased warmth in the skin and/or pus in the skin in the area of a lesion. Fever, malaise, and light-headedness can be symptoms of a serious systemic infection.

**Will psoriasis shorten my life?**
Psoriasis itself does not appear to shorten a person’s life. Patients with psoriasis should be able to live full lives into their senior years.

**Will psoriasis cause my hair to fall out?**
Psoriasis itself will not cause the hair to fall out. However, very thick scales in the scalp can entrap hair and as you attempt to remove the scales, you can loose hair in the process. In addition, some medications such as salicylic acid can temporarily damage the hair.

**Should I change my psoriasis skin care regimen during the winter?**
It’s important to increase your use of moisturizing creams and ointments during the winter, applying heavy layers, especially over the skin affected by psoriasis. It is helpful to apply the moisturizing cream while your skin is damp. Also, be sure to pat yourself dry after bathing—don’t rub yourself with the towel.

During the winter months, the humidity is generally lower, especially in homes with forced air heating. This tends to cause dry, itchy skin. Scratching affected skin will worsen your psoriasis and can even cause new lesions to form. Thus, it is important not to scratch, pick, or scrub psoriasis lesions.

**Is it true that getting a skin scrape can lead to a psoriatic lesion?**
Yes. Psoriasis patients can develop lesions at the site of significant skin trauma, especially during a period of active disease. Psoriasis worsens in areas of skin scrapes, scratches, and cuts (such as surgical wounds). That’s why it is so important not to pick, scratch, or scrub the lesions and scales. The development of a psoriatic lesion at the site of skin trauma is called Koebner’s phenomenon.

**Can you control psoriasis with diet?**
Unfortunately no. However, the healthier the diet the better. Especially a diet that includes regular exercise. For more information about exercise and psoriasis, visit the web site of the [National Psoriasis Foundation](http://www.psoriasis.org/).

**For African-Americans and other darker-skinned people, is the treatment for psoriasis different than for people with light-colored skin?**
The immunologic dysfunctions that are a major predisposing factor in psoriasis are believed to be the same in all persons regardless of skin color. The patterns of genetic inheritability for the predisposing factors may vary in different groups.

The pigmentation of skin is controlled by hormonal processes that are unrelated to the immune and inflammatory processes that underlie psoriasis. It is interesting to note that all humans, regardless of skin color, have about the same number of melanocytes (pigment-containing cells) at any given site on the skin. Variations in skin color are due to differences in hormonal regulation of pigment formation within the melanocytes, and transfer of the pigment from melanocytes to keratinocytes (the cells that make up the majority of the outer layer of skin). A principal hormone in the regulation of human skin color is melanocyte-stimulating hormone (MSH).

The incidence of psoriasis is much lower in dark-skinned West Africans and African-Americans than in light-skinned people of European ancestry. Incidence is also low in Japanese and Eskimos, and is extremely low to non-existent in Native Americans in both North and South America. The reasons for this epidemiologic disparity are not known, but are believed to involve genetic, geographic and environmental factors.

The treatment of psoriasis in African-Americans is largely the same as treatment in light-skinned patients. An adjustment is therapy is made in the use of [photochemotherapy (PUVA)](http://www.skincarephysicians.com/psoriasisnet/glossary.html#PUVA) and [phototherapy](http://www.skincarephysicians.com/psoriasisnet/glossary.html#Phototherapy). In PUVA, both the chemical photosensitizer and the ultraviolet dose are adjusted for skin type and pigmentation.

**Are homeopathic treatments effective for psoriasis?**
There is no scientific evidence that homeopathic treatments are effective for treating psoriasis. However, it’s not impossible that some of these treatments might be helpful. Scientific studies need to be done in order to resolve this issue.

**Is there a way to curb scratching? I have had psoriasis for 20 years and my husband has been very supportive, but recently he has started to complain about my constant scratching. He knows I need to scratch to relieve itching, but it seems to bother him more now. I’m afraid we’re heading for marital problems unless I can stop scratching or he can stop letting it bother him. Any suggestions?**
Psoriasis in a spouse can be difficult for both marriage partners. The spouse with psoriasis not only suffers from the disease and perhaps from problems with self-image, but also may be acutely aware of the partner’s struggles to be supportive. Over time, it is the ”little things” that can come between partners—for example, flaked-off skin that must be shaken from bed sheets every morning, or in this case the spouse’s constant scratching that becomes a “last straw” for an otherwise supportive husband.

The husband’s growing irritation may actually be a message worth heeding, however. While scratching is effective in temporarily relieving pruritus, hard scratching can also be a trigger for formation of new psoriatic lesions or worsening of existing lesions. Especially during active phases of psoriasis, abrasion of the skin is one of the causes of Koebner’s phenomenon—the induction of psoriatic lesions by injury to the skin. Hard, constant scratching can cause the type of skin injury that leads to development of Koebner’s phenomenon.

Since pruritus has become a major issue for both husband and wife, the issue should be discussed with the patient’s dermatologist. Pruritus control should perhaps be made a focus of psoriasis treatment, along with educational counseling of both marriage partners. As discussed in May’s Update, general measures for control of pruritus include keeping the skin cool and moisturized and avoiding irritating fabrics. Ice packs may help stop the itching. A heavy moisturizing cream applied twice daily will help control scaling and pruritus. Specific pharmacologic measures should be prescribed by the dermatologist on the basis of the patient’s history of psoriasis and overall medical condition.

**What should I look for in an OTC psoriasis shampoo?**
There are numerous shampoos available at most drug stores. Look for a shampoo that contains tar or salicylic acid. Be sure to treat your scalp gently, as harsh shampoos, scalp massages or scratching can aggravate psoriasis.

**What effect does the sun have on psoriasis?**
Natural sunlight can have a positive effect on psoriasis. The long-known benefits of sunlight provided the basis for the development of ultraviolet light therapy for treating psoriasis and other skin diseases. However, you should never get enough sun exposure to turn your skin red or cause a sunburn, which can actually cause psoriasis to flare and worsen.