ii18 REPORT Psoriasis: epidemiology, clinical features, and quality of life R G B Langley, G G Krueger, C E M Griffiths

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AnnRheumDis2005;64(SupplII):ii18–ii23.doi:10.1136/ard.2004.033217 The molecular genetic basis of psoriasis is complex with Psoriasisisacommonchronic,recurrent,immunemediated evidence that multiple genes are involved.
Seven major disease of the skin and joints.
It can have a significant psoriasis susceptibility loci have been reported.
Many negative impact on the physical, emotional, and, psycho- investigators have established that a major susceptibility social wellbeing of affected patients.
Psoriasis is found locus for psoriasis is at 6p21, referred to as PSORS1 and is worldwide but the prevalence varies among different ethnic overrepresented in all populations tested.10–15 As noted, an groups.Ithasastronggeneticcomponentbutenvironmental association between psoriasis and other loci has also been factors such as infections can play an important role in the reportedonchromosomes1p(PSORS7),141q(PSORS4),163q presentationofdisease.Therearesevera lclinicalcutaneous (PSORS5),17 4q (PSORS3),18 17q (PSORS2),19 and 19p manifestations of psoriasis but most commonly the disease (PSORS6).20Thestrengthofassociationsbetweensuchgenes presents as chronic, symmetrical, erythematous, scaling andsusceptibilitytopsoriasis,apartfromPSORS1,isvariable papules and plaques.
The epidemiology, clinical features, as replication of these findings has been incomplete.
The andimpactonqualityoflifeofpsoriasisarereviewed.
difficulty of confirming psoriasis susceptibility loci may relate,inpart,toheterogeneityamongdifferentpopulations.
Whereastheexistenceofageneticcomponentinpsoriasisis certain,theexactlocationsofthegenesinvolvedremainsto Thispaperreviewstheepidemiologyandclinicalfeatures bedefinitelydetermined.
ofpsoriasisanditsimpactofpatients’qualityoflife.
CLINICAL FEATURES EPIDEMIOLOGY Psoriasis is a papulosquamous disease with variable mor- Although psoriasis occurs worldwide, its prevalence varies phology, distribution, severity, and course.
Papulosquamous considerably.
In the USA, approximately 2% of the popula- diseases are characterised by scaling papules (raised lesions tionisaffected.Highratesofpsoriasishavebeenreportedin ,1cm in diameter) and plaques (raised lesions .1cm in people of the Faroe islands, where one study found 2.8% of diameter).
Other papulosquamous diseases that may be thepopulationtobeaffected.1 Theprevalenceofpsoriasisis considered in the differential diagnosis include tinea infec- lowincertainethnicgroupssuchastheJapanese, andmay tions, pityriasis rosea, and lichen planus.
The lesions of beabsentinaboriginalAustralians2andIndiansfromSouth psoriasis are distinct from these other entities and are America.3 classically very well circumscribed, circular, red papules or Psoriasiscan presentatany ageand hasbeenreported at plaques with a grey or silvery-white, dry scale.
In addition, birth and in older people of advanced age.
Accurate the lesions are typically distributed symmetrically on the determinationoftheageofonsetofpsoriasisisproblematic, scalp,elbows,knees,lumbosacralarea,andinthebodyfolds as studies which do so typically rely on a patient’s recall of (fig 1).
Psoriasis may also develop at the site of trauma or the onset of lesions or determine the onset from the injury, known as Koebner’s phenomenon.
If psoriasis is physician’s diagnosis as recorded on the initial visit.
Data progressive or uncontrolled, it can result in a generalised basedonpatientrecallcanbeinaccurate;determiningonset exfoliative erythroderma.
Nail involvement may be present, based on first visit to a physician could underestimate