

# Comprehensive Report on Psoriasis: Cure Status and Treatment Options

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## Executive Summary

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Psoriasis is a chronic autoimmune dermatological disorder characterized by persistent inflammation and hyperproliferation of keratinocytes. No established cure exists, as confirmed by extensive randomized controlled trials (RCTs). Current therapies focus on symptom management, achieving significant reductions in disease severity (e.g., Psoriasis Area and Severity Index [PASI] scores >90% improvement) but with high relapse rates and potential adverse effects. This report synthesizes biological evidence, treatment efficacy, industry influences, and preliminary alternative approaches.

## Pathophysiology and Cure Status

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Psoriasis arises from dysregulated immune responses involving T-helper cells (Th17/Th1 pathways), cytokines (IL-17, IL-23, TNF- $\alpha$ ), and genetic predispositions (e.g., HLA-Cw6 allele). Environmental triggers such as stress, infections, and trauma exacerbate flares. Decades of longitudinal studies and RCTs demonstrate its relapsing-remitting nature, with no interventions inducing permanent remission in the majority of patients. Complete cure remains unachievable due to underlying genetic and immunological persistence.

# Established Treatments

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## Topical Therapies

First-line for mild disease: Corticosteroids (e.g., clobetasol) and vitamin D analogues (e.g., calcipotriene). Combination regimens yield PASI-75 response rates of 50-70% at 8 weeks.

## Phototherapy

Narrowband UVB (NB-UVB) or excimer laser: Effective for moderate disease, with clearance rates of 60-80% after 20-30 sessions. Maintenance dosing required to prevent relapse.

## Systemic Non-Biologic Agents

Methotrexate (7.5-25 mg/week) and cyclosporine (2.5-5 mg/kg/day): PASI-75 rates of 40-60%; limited by hepatotoxicity, nephrotoxicity, and contraindications in comorbidities.

## Biologic Agents

Targeted therapies dominate moderate-to-severe cases:

- IL-17 inhibitors (secukinumab, ixekizumab): PASI-90 rates >70% at 12 weeks.
- IL-23 inhibitors (guselkumab, risankizumab): Sustained PASI-90 >80% at 1 year.
- TNF- $\alpha$  inhibitors (etanercept, adalimumab): PASI-75 rates 50-70%.

These achieve rapid onset but carry risks of immunosuppression, infections, and rebound flares upon discontinuation (relapse in 80-90% within 6 months).

## Efficacy and Limitations

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Meta-analyses of >100 RCTs report mean PASI reductions of 75-95% with biologics versus 40-60% for conventionals. However, long-term data (5+ years) show sustained clearance in <50% of patients, with cumulative side effects (e.g., malignancies, IBD flares). No therapy addresses root causes, prioritizing symptom suppression.

## Industry Influences and Evidence Gaps

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High-quality evidence is predominantly from pharmaceutical-sponsored RCTs (e.g., Novartis for secukinumab, Janssen for guselkumab), comprising >90% of phase III trials. Independent studies on non-patentable interventions (e.g., dietary modifications, probiotics) are limited by small sample sizes, lack of blinding, and poor replication. This skew suggests bias toward recurrent-revenue biologics (annual costs \$20,000-50,000/patient) over preventive or low-cost options.

## Emerging and Grey-Zone Approaches

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Preliminary data from small trials, case series, and anecdotes indicate potential adjunctive roles:

- **Dietary Protocols:** Pagano diet (anti-inflammatory, gluten/dairy-free) or low-FODMAP reported remission in 20-50% of self-selected cohorts; unconfirmed by RCTs.
- **Gut Microbiome Modulation:** Probiotics (e.g., Lactobacillus strains) show PASI reductions in pilot studies (n<100); leaky gut hypothesis links dysbiosis to flares.
- **Herbal Remedies:** Oregon grape (Mahonia aquifolium) topical extract yields 70% improvement in mild cases (small RCTs).
- **Stress Reduction:** Mindfulness-based interventions reduce flares by 30-50% in observational data.

These warrant rigorous, independent RCTs to assess causality (e.g., allergies, toxins as triggers), currently suppressed by dominant narratives favoring pharmacotherapies.

## Recommendations

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Adopt stepwise therapy per guidelines (AAD/National Psoriasis Foundation): Topicals/phototherapy for mild; systemics/biologics for severe. Monitor for comorbidities (psoriatic arthritis, cardiovascular risk). Encourage multidisciplinary care incorporating lifestyle factors pending confirmatory trials.

## Conclusion

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Psoriasis management has advanced markedly, yet absence of a cure underscores need for precision medicine targeting immunogenetics. Balanced research into alternatives is essential to mitigate biases and optimize outcomes.

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## Additional Phase References

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[14] Pagano dietary protocol observational data (Alternative Medicine Review, 2000)

[15] Phase 1 & 2 synthesis summaries

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## **DISCLAIMER:**

This analysis is for research and educational purposes only. It provides critical analysis of medical literature and evidence-based information but does **not** constitute medical advice, diagnosis, or treatment recommendations.

## **Always consult qualified healthcare professionals**

for medical decisions, treatment plans, and health-related questions. The information presented here should not replace professional medical judgment or be used as the sole basis for healthcare choices.

## **Key Limitations:**

- Medical knowledge evolves rapidly; information may become outdated
- Individual health situations vary significantly
- Not all studies are equal in quality or applicability
- Risk-benefit assessments must be personalized
- Drug interactions and contraindications require professional evaluation

This analysis aims to inform and educate, not to direct medical care. When in doubt, seek professional medical guidance.