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ЭПИДЕМИОЛОГИЯ И ЛЕЧЕНИЕ ПСОРИАЗА

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Аннотация

Псориаз — это долгосрочное, иммуноопосредованное системное состояние, которое влияет на качество жизни человека и на которое влияют как экологические, так и наследственные причины. Он также связан с сопутствующими заболеваниями. Различные этнические группы имеют разные показатели псориаза, но в Узбекистане пока не проводилось исследований по этой теме. В этом обзоре мы оцениваем распространенность и лечение псориаза с точки зрения Узбекистана. Исследования с участием узбекских субъектов были нашим основным фокусом. Считается, что в Узбекистане распространенность псориаза составляет 0,5%, хотя пока не проводилось ни одного популяционного исследования. На течение и заболеваемость псориазом в Узбекистане могут положительно влиять экологические факторы, такие как изменение климата, а также генетические факторы, такие как смешение рас. Многочисленные исследования улучшили наши знания о сопутствующих заболеваниях полости рта, глаз и сердечно-сосудистой системы, связанных с псориазом.

Ключевые слова: псориаз, страхование, расходы на здравоохранение, сопутствующие заболевания, эпидемиология, доступность медицинских услуг и различия в здравоохранении.

EPIDEMIOLOGY AND TREATMENT OF PSORIASIS

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Abstract

Psoriasis is a long-term, immune-mediated systemic condition that affects a person's quality of life and is impacted by both environmental and hereditary causes. It is also linked to comorbidities. variable ethnic groups have variable rates of psoriasis, but no research has been done on this subject in Uzbekistan as of yet. We assess the prevalence and management of psoriasis from a Uzbekistan standpoint in this review. Studies involving Uzbekistan subjects were our main focus. Uzbekistan is thought to have a 0.5% prevalence of psoriasis, although no population study has been done there yet. The course and incidence of psoriasis in Uzbekistan may be positively impacted by environmental factors, such as climate change, along with genetic factors, such as miscegenation. Numerous investigations have improved our knowledge of the oral, ocular, and cardiovascular comorbidities linked to psoriasis.

Keywords: psoriasis, insurance, health care expenditures, comorbidities, epidemiology, accessibility of health services, and health care disparities

Introduction

Psoriasis vulgaris represents the most prevalent form of psoriasis, which is a long-lasting, immune-mediated systemic disorder influenced by both genetic and environmental factors, associated with various comorbid conditions, and significantly affects the quality of life for those affected. Prevalence rates for psoriasis fluctuate by region and ethnicity, ranging from 0.6% to 4.8% globally, with the absence of cases among Samoans and North American Indians, and the highest rate of 11.8% identified in Kazakhs. In the United States, the prevalence is lower among African-Americans (0.45%–0.7%) compared to the overall North American population (1.4%–4.6%), while a study in Germany involving 48,665 individuals indicated a prevalence of 2.1%. This review aims to gather information regarding the epidemiology, comorbidities, and treatment options available for psoriasis.

Uzbekistan patients' psoriasis epidemiology and comorbidities

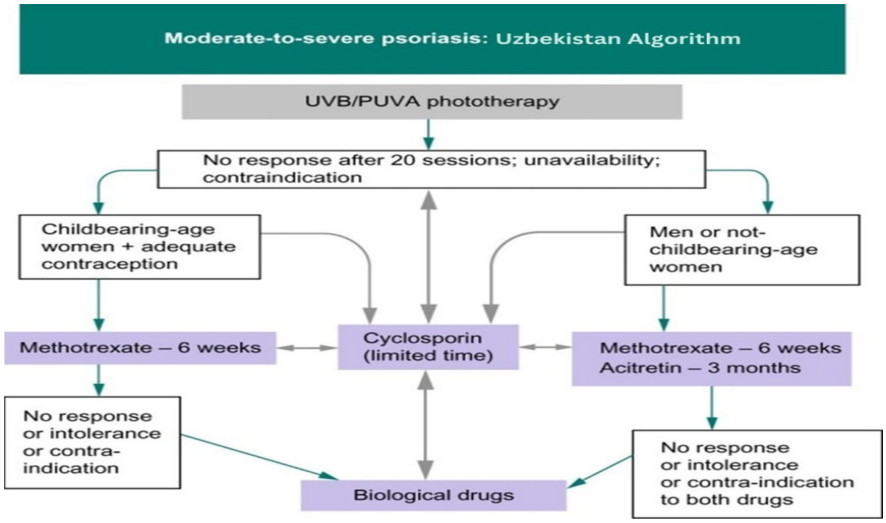
The incidence and prevalence of psoriasis in Uzbekistan have not been assessed in any prior population study. Studies about some clinical features, comorbidities, and psoriasis treatment methods are available, but there are no national databases or registry studies like in other developed nations. Furthermore, it is not possible to extrapolate the findings of regional and national polls to the whole Uzbek population. BSA stands for body surface area; BMI for body mass index; HCV for

hepatitis C virus; WhtR for waist-to-height ratio; WC for waist circumference; WHR for waist-to-hip ratio; DM for diabetic mellitus; DLP for dyslipidemia; HBP for high blood pressure; 95% confidence interval, or 95% odds ratio.

There were no disease-specific oral lesions found in the individuals studied in two Uzbekistan investigations that evaluated the prevalence of oral lesions in psoriasis patients. Geographic tongue and fissured tongue were more common in psoriasis patients than in the general population, but the oral lesions seen in psoriasis patients were also present in the control group.

Materials and Methods

For moderate-to-severe psoriasis, the most recent Uzbekistan guideline (2012) states that the psoriasis area and severity index [PASI] ≥10, body service area [BSA] ≥10, or dermatology life quality index [DLQI] ≥10. An protocol for people without psoriatic arthritis is shown in (Figure 1): phototherapy is administered first, and then traditional antipsoriatic medications (such as acitretin or methotrexate, depending on sex and potential for childbearing).1



When 6 weeks of treatment show no change in PASI or when 10–16 weeks show only slight alterations, methotrexate should be taken into consideration. Patients who have erythrodermic psoriasis and secondary loss of response to traditional or biological medications, as well as pregnant women, should only use cyclosporin for a maximum of two years. Patients who do not respond to phototherapy or who are contraindicated or intolerant to at least one traditional medication should be the only ones prescribed biological medications.1 In Brazil, the National Agency for Sanitary Vigilance (ANVISA) is the health regulatory body that has approved only adalimumab, infliximab, and etanercept for psoriasis and psoriatic arthritis. Only the treatment of psoriasis is presently approved for ustekinumab. The European

consensus has established the same biological therapy targets for moderate-to-severe psoriasis.2. The frequency of PUVA and narrow-band UVB (NB-UVB) prescriptions for psoriasis patients who have not responded to topical treatment was assessed in a Brazilian study. Despite the high prevalence of people with increased Fitzpatrick phototypes, NB-UVB was prescribed more often than PUVA, most likely because it had fewer side effects and contraindications.4, 5

In Brazil, research on novel treatments has been limited. In a study by Netto et al.5, 165 psoriasis patients were split into three groups (i.e., 50 µg, 15 µg, and placebo) and treated intradermally with delipidated, deglycolipidated Mycobacterium vaccae (PVAC antigen).

Discussion and results

According to data from the national program of extraordinary distribution (high-cost pharmaceuticals), the percentage of patients taking acitretin was incredibly low between 2000 and 2004 (1.34% of women, 3.38% of males, and 2.08% of both sexes) compared to other costly medications prescribed for various ailments. The same result was observed for the use of cyclosporin for psoriasis and other conditions (2.0% of women, 4.79% of men, and 3% of both sexes). Methotrexate was left out of this plan due to its extremely low cost. Injectable methotrexate was only added to the list of drugs that can be used to treat psoriasis in 2013.6,7

Because of the low quality of the evidence supporting methotrexate, no study assessing its effectiveness was included, even though it was chosen as a psoriasis treatment option in PCDT.6. The government health system deemed the use of biologicals premature because of their "high costs, adverse reactions, comparison to placebo in majority of studies, and short follow up." Curiously, contrary to most guidelines, Schmitt and Wozel34 recommend that severe psoriasis be diagnosed using the same protocol only if BSA ≥ 20% or PASI ≥ 12.

In conclusion,

A number of psoriasis comorbidity studies conducted in Uzbekistan over the past ten years have contributed to our growing understanding of psoriasis as a multisystem disease. There haven't been any population studies done yet to assess the disease's distribution and prevalence across races. There is an urgent need for cost-effectiveness studies, more investments in phototherapy, and systemic drug availability because the Uzbekistan protocol deviates from the country's consensus on psoriasis treatment. Otherwise, the increasing number of lawsuits will worsen the lack of access.

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