International Journal of Innovative Studies in Medical Sciences (IJISMS)
www.ijisms.com Volume: 1 Issue: 1 | 2017

Features of the Course of Psoriasis during Pregnancy

Bayramova A.N

Obstetrician-gynecologist, Russia

Abstract: *Pregnancy is a special period in the life of every woman that makes her beautiful and happy. The time when a tiny creature grows and develops inside the mother's body, each woman perceives with special trepidation and reverence. A storm of emotions and experiences sweeps from the moment when the fact of pregnancy is confirmed by the doctor and does not let go until the very birth.*

Keywords: *psoriasis, pregnancy.*

1. INTRODUCTION

Naturally, every woman wants this period of life not to be overshadowed, no matter what unpleasant moments. In the process of bearing a child, the organism of the future mother experiences a huge physical and emotional load. Is it worth talking about those experiences that a pregnant woman experiences? However, pregnancy does not always go smoothly and safely. All nine months is not such a small period of time. During this time, the woman will have to register with a gynecologist, undergo a lot of examinations, pass a huge number of tests and visit many doctors. Each action like this is accompanied by excitement: is everything all right, is the baby developing correctly?

One of the diseases that bring a lot of discomfort to a pregnant woman is psoriasis. Probably, it is in connection with this circumstance that many potential moms are wondering: how dangerous is this disease in pregnancy, will it affect the development of the baby?

Therefore today the topic of our conversation will be precisely psoriasis, which is also called the disease of the 21st century.

Psoriasis during pregnancy is not something extraordinary. Quite a lot of women know firsthand what it is. Therefore, answering the question of how dangerous this disease is and whether it is an obstacle for bearing a child, you can reassure future mothers, this disease can not be an obstacle to the bearing of a child and happy motherhood.

Medical research, conducted over a period of dozens of years, suggests that psoriasis does not interfere with the bearing of a child, nor does it interfere with the reproductive function of the female body. It should only be said that the risk of transferring the gene responsible for the development of this disease from mother to child, if it is diagnosed in one of the parents is from 8 to 15%. In the presence of this disease in two parents the chance that the baby will inherit it increases to 60%.

It should be mentioned that in pregnant women psoriasis passes without any obvious features. The course of the disease and its dependence on pregnancy are of an individual nature.

So what is psoriasis?

Psoriasis is a chronic non-infectious disease, a dermatosis that mainly affects the skin. Currently, the autoimmune nature of this disease is assumed. Usually psoriasis is manifested by the formation of red, excessively dry, raised spots above the surface of the skin - the so-called papules that merge with each other, forming plaques. These papules are inherently sites of chronic inflammation and excessive proliferation of lymphocytes, macrophages and keratinocytes of the skin, as well as excessive angiogenesis (the formation of new small capillaries).

Psoriasis is one of the most common skin diseases and occurs in 1-2% of the population of developed countries.

In the development of psoriasis, hereditary predisposition, disturbances in the function of the immune, endocrine, nervous systems, unfavorable effects of environmental factors, etc., are of great importance.

A number of genes (PSORS) are described, the presence of which predisposes to the development of the disease. In particular, in patients with psoriasis, antigens HLACw6 and HLADR7 are more often detected. Among the provoking factors include psychoemotional overstrain, chronic infections (more often streptococcal), alcohol abuse, taking medicines (lithium salts, beta-blockers, chloroquine /

hydroxychloroquine, oral contraceptives, interferon and its inducers, etc.).

Psoriasis is often combined with systemic diseases, including metabolic syndrome, type II diabetes, ischemic heart disease, arterial hypertension, pathology of the hepatobiliary system.

How should you plan pregnancy if you have psoriasis?

It is necessary first of all to wait for the period of remission so that you do not have to go to the hospital and use hormonal ointments or other systemic drugs that negatively affect your unborn child. You can also conduct pre-conception treatment by informing your physician so that he can choose the appropriate treatment. Passing the next course of treatment, ask about the time that must pass before the conception of the child. Patients who take systemic action drugs (neotigazone, methotrexate) should remember and know about the length of time during which they need to be protected. Try not to use hormonal and systemic drugs.

What is the course of psoriasis during pregnancy?

Most women note that during pregnancy the disease proceeds more easily, and after childbirth its course becomes heavier.

In most cases, the bearing of the fetus in women suffering from psoriasis, is the same as in the other pregnant women. Psoriasis itself does not affect the human reproductive system, and although many women report a significant improvement in the course of psoriasis or a reduction in external manifestations of the disease during pregnancy.

The causes of such phenomena are not precisely clarified. It is suggested that improvements are associated with an increase in the level of the hormone progesterone, which extinguishes the excessive immune response that causes symptoms of psoriasis. Some scientists attribute a positive dynamics to an increase in the amount of the hormone cortisone, which has anti-inflammatory properties. Deterioration can be associated with stress and hormonal disorders. In contrast, within three months after delivery, about 30% of women report no change in the dynamics of the disease, 10% feel better, and 60% have worse psoriasis.

The disease does not affect the ability of a woman to become pregnant.

Psoriasis is a systemic autoimmune disease, often accompanied by concomitant health problems. An increased risk of an unfavorable outcome of pregnancy can be associated with them, but psoriasis as such is not associated with birth defects of the fetus or the probability of a miscarriage. In women with severe forms of psoriasis, children are more likely to have low weight at birth, but this pattern does not apply to pregnant women with moderate and mild disease. A special, complex and very rare case is the form of generalized pustular psoriasis is herpetiform impetigo. Such psoriasis occurs during pregnancy due to fluctuations in the hormonal background and metabolism. When this disease occurs, the risk of miscarriage is high.

Treatment of psoriasis in pregnant women is difficult, especially if it has a severe form. During pregnancy, women should stop treatment with most drugs for systemic use, as they can lead to a disruption of the intrauterine development.

The greatest concern in pregnancy is the drugs used to treat psoriasis. Although some drugs are completely safe, others can lead to miscarriage and birth defects.

The safest drugs during the carrying of a child are related to local treatment, especially moisturizing and softening drugs: vaseline, essential and edible oils, herbal remedies. It is necessary to monitor the skin and not to allow dryness. Glucocorticoid-based drugs (hormonal ointments) can be used in small areas of the skin in small amounts and preferably in the second and third trimesters. Mostly, these are ointments from the first category according to the Russian classification (hormonal ointments with a weak effect), which contain hydrocortisone and prednisolone. When breastfeeding it is necessary to avoid applying them to the breast, in extreme cases you need thoroughly rinse before feeding. They can also lead to the appearance of stretch marks.

Salicylic acid may be used in limited quantities to exfoliate small areas of the skin. With moderate, severe forms of psoriasis and lack of effect from the use of local remedies, narrow-band ultraviolet - UVB- and UVA-therapy can help. Preparations based on cyclosporine are permitted in severe cases, when the expected benefit justifies the potential risk to the fetus. Nevertheless, its many side effects have a negative impact on the mother's body and should not be applied unless absolutely necessary.

Stress, violation of diet, fatigue can lead to exacerbation of psoriasis, therefore, due to the limitations of possible treatments, it is especially important to avoid provoking factors.

If psoriasis worsens during pregnancy, the following treatment can not be used: PUVA therapy, since it uses psoralens that suppress the cell division and have a negative effect on the fetus. The derivatives of vitamin A and D: the first has a teratogenic effect, and the second accumulates in the body, causing poisoning. Systemic drugs used to treat psoriasis: "Methotrexate", "Acitretin" (like other retinoids). They cause malformations of the fetus. Scientists warn that the first drug should be abandoned three months before the planning of pregnancy, and this applies to men too, since the drug affects sperm. "Acitretinum" reception stops at least two months before pregnancy.

It is necessary to inform the obstetrician-gynecologist about the presence of psoriasis in a woman, and the dermatologist - about pregnancy. This will allow you to choose the right treatment and respond in time to the development of the symptoms of the disease.

Psoriasis and cesarean section

The presence of psoriasis should not interfere with the time or method of delivery - psoriasis can occur in places where the skin is traumatized (Köbner phenomenon or isomorphic reaction), but this effect has not been reported for the epithelium of internal organs, although theoretically it can occur anywhere in the epidermis. The risk of infection and delayed wound healing after caesarean section is theoretically higher, but no studies have been conducted to assess this risk.

What threatens women with psoriasis after childbirth?

Postpartum period

In the first three months after childbirth, the majority of women suffering from psoriasis have rashes on their skin, including those in areas previously marked with improvement. However, the data of different studies are ambiguous. In addition to hormones, a caring mother is harassed by intense fatigue, uneven and nondescript eating, intermittent sleep - all these are the same provoking factors.

Psoriasis does not affect the possibility of breastfeeding and the quality of milk.

Women suffering from psoriasis, including those who get sick during pregnancy and after childbirth, can breastfeed.

Avoid breastfeeding is only for women who use systemic drugs or local remedies on large areas of the skin, since these drugs can be absorbed into the milk and ingested with it in the child's body

No drug is 100% safe. Factors of potential risk for the child in relation to the factors of severe exacerbation in the mother (the need for symptomatic treatment) should be carefully weighed. Consult your doctor before taking even non-prescription drugs (including Aspirin), herbal teas or supplements.

2. CONCLUSION

Thus, it becomes clear that the presence of psoriasis in a woman planning a pregnancy should not be an obstacle. At the same time, careful monitoring of the symptoms of the disease must be done, as well as the course of pregnancy. This requires a well-coordinated work of a dermatologist and obstetrician-gynecologist.

REFERENCES

[1] Camarasa J.M., Ortonne J.P., Dubertret L. Calcitriol shows greater persistence of treatment effect than betamethasone dipropionate in topical psoriasis therapy. J Dermatolog Treat 2003; 14: 8–13.

[2] Chuang T.Y., Samson C.R. Clinical efficacy and safety of augmented betamethasone dipropionate ointment and diflorasone ointment for psoriasis—a multicentre, randomized, doubleblinded study. J Dermatol Treat 1991; 2 (2): 63–66.

[3] Douglas W.S., Poulin Y., Decroix J. et al. A new calcipotriol/betamethasone formulation with rapid onset of action was superior to monotherapy with betamethasone dipropionate or calcipotriol in psoriasis vulgaris. Acta Derm Venereol 2002; 82: 131–135.

[4] Gottlieb A.B., Ford R.O., Spellman M.C. The efficacy and tolerability of clobetasol propionate foam 0.05% in the treatment of mild to moderate plaque-type psoriasis of nonscalp regions. J Cutan Med Surg 2003; 7(3):185–192.

[5] Katz H.I., Tanner D.J., Cuffie C.A. et al. A comparison of the efficacy and safety of the combination mometasone furoate 0.1%/salicylic acid 5% ointment with each of its components in psoriasis. J Derm Treat 1998; 9: 151–156.

[6] Kaufmann R., Bibby A., Bissonnette R. et al. A new calcipotriol/ betamethasone dipropionate formulation (DaivobetTM) is an effective once-

daily treatment for psoriasis vulgaris. Dermatology 2002; 205: 389–393.

[7] Koo J., Cuffie C.A., Tanner D.J. et al. Mometasone furoate 0.1%-salicylic acid 5% ointment versus mometasone furoate 0.1% ointment in the treatment of moderate-to-severe psoriasis: a multicenter study. Clin Ther 1998; 20 (2): 283–291.

[8] Lowe N., Feldman S.R., Sherer D. et al. Clobetasol propionate lotion, an efficient and safe alternative to clobetasol propionate emollient cream in subjects with moderate to severe plaque-type psoriasis. J Dermatolog Treat 2005; 16: 158–164.

[9] Papp K.A., Guenther L., Boyden B. et al. Early onset of action and efficacy of a combination of calcipotriene and betamethasone dipropionate in the treatment of psoriasis. J Am Acad Dermatol 2003; 48: 48–54.

[10] Jarratt M.T., Clark S.D., Savin R.C. et al. Evaluation of the efficacy and safety of clobetasol propionate spray in the treatment of plaque type psoriasis. Cutis 2006; 78: 348–354.

[11] Douglas W.S., Poulin Y., Decroix J. et al. A new calcipotriol/betamethasone formulation with rapid onset of action was superior to monotherapy with betamethasone dipropionate or calcipotriol in psoriasis vulgaris. Acta Derm Venereol 2002; 82: 131–135.

[12] Guenther L., van de Kerkhof P.C., Snellman E. et al. Efficacy and safety of a new combination of calcipotriol and betamethasone dipropionate (once or twice daily) compared to calcipotriol (twice daily) in the treatment of psoriasis vulgaris: a randomized, double-blind, vehicle-controlled clinical trial. Br J Dermatol 2002; 147:316–323.

[13] Kragballe K., Noerrelund K.L., Lui H. et al. Efficacy of once-daily treatment regimens with calcipotriol/betamethasone dipropionate ointment and calcipotriol ointment in psoriasis vulgaris. Br J Dermatol 2004; 150:1167–1173.

[14] Ortonne P., Kaufmann R., Lecha M., Goodfield M. Efficacy of treatment with calcipotriol/ betamethasone dipropionate followed by calcipotriol alone compared with tacalcitol for the treatment of psoriasis vulgaris: a randomised, double-blind trial. Dermatology 2004; 209:308–313.

[15] Sadeghian G., Ziaei H., Nilforoushzadeh M.A. Treatment of localized psoriasis with a topical formulation of zinc pyrithione. Acta Dermatovenerol Alp Pannonica Adriat 2011; 20 (4): 187–190.

[16] Coven T.R., Burack L.H., Gilleaudeau R. et al. Narrowband UV-B produces superior clinical and histopathological resolution of moderate-to-severe psoriasis in patients compared with broadband UV-B. Arch Dermatol 1997; 133: 1514–1522.

[17] Snellman E., Klimenko T., Rantanen T. Randomized half-side comparison of narrowband UVB and trimethylpsoralen bath plus UVA treatments for psoriasis. Acta Derm Venereol. 2004; 84: 132–137.

[18] Bagel J. LCD plus NB-UVB reduces time to improvement of psoriasis vs NB-UVB alone. J Drugs Dermatol 2009; 8 (4): 351–357.

[19] De Leeuw J., Van Lingen R.G., Both H. et al. A comparative study on the efficacy of treatment with 585 nm pulsed dye laser and ultraviolet BTL01 in plaque type psoriasis. Dermatol Surg 2009; 35: 80–91.

[20] Leenutaphong V., Nimkulrat P., Sudtim S. Comparison of phototherapy two times and four times a week with low doses of narrow-band ultraviolet B in Asian patients with psoriasis. Photodermatol Photoimmunol Photomed 2000; 16 (5): 202–206.

[21] Yones S.S., Palmer R.A., Garibaldinos T.T. et al. Randomized double-blind trial of the treatment of chronic plaque psoriasis: efficacy of psoralen-UV-A therapy vs narrowband UV-B therapy. Arch Dermatol 2006; 142: 836–842.

[22] Goldinger S.M., Dummer R., Schmid P. et al. Excimer laser versus narrow-band UVB (311 nm) in the treatment of psoriasis vulgaris. Dermatology 2006; 213(2):134–139.

[23] Kaur M., Oliver B., Hu J., Feldman S.R. Nonlaser UVB-targeted phototherapy treatment of psoriasis. Cutis 2006; 78: 200–203.

[24] 24. Grundmann-Kollmann M., Ludwig R., Zollner T.M. et al. Narrowband UVB and cream psoralen-UVA combination therapy for plaque-type psoriasis. J Am Acad Dermatol 2004; 50: 734–739.