PSORIASIS

- Psoriasis always involves an excess of leukotrienes and other pro-inflammatory prostaglandins.

- Psoriasis is an autoimmune condition associated in particular with excess lymphocytic Th1 inflammatory cytokines (particularly Tumor Necrosis Factor-alpha).

- There is often a Dysaerobic Imbalance, and always catabolic oxidative damage.

- There is often a tissue Alkalosis (as in a Dysaerobic Imbalance), but also often a systemic Alkalosis.

- There are frequently allergic triggers that exacerbate symptoms.

We have always found psoriasis to be a fascinating condition. We have seen NUTRI-SPEC work absolute miracles, and yet we have also had many patients for whom we have been able to offer no help whatsoever.

What we have found most clinically fascinating about psoriasis is that psoriasis patients almost always have an elevated saliva pH. The patients who have responded well are those in whom we can get the saliva pH down to normal; and the ones that have been resistant to therapeutic intervention are those whose saliva pH remains stubbornly high.

From a NUTRI-SPEC standpoint, more than half these patients test as Dysaerobic, and the remainder test systemically Alkaline. That Alkaline Imbalance may show upon testing as either a Metabolic Alkalosis, a Respiratory Alkalosis, a Ketogenic Imbalance, or occasionally a Parasympathetic Imbalance.

Those who are Dysaerobic actually fall into the category of what Revici termed "dyschlorobiotic." In other words, their Dysaerobic Imbalance involves a pathological shift of chloride out of the interstitium, and these patients respond beautifully to Proton Plus along with Oxy D, Oxy D+, and Oxy Power.

Those who do not test Dysaerobic but test Ketogenic respond well to Proton Plus and sometimes magnesium chloride, along with their Oxy K.

Those who test Parasympathetic need Complex P plus magnesium chloride plus Phos Drops.

Those who test Alkaline, but not Parasympathetic or Ketogenic, generally benefit from some combination of Proton Plus and Phos Drops, along with Oxy Power.

Do psoriasis patients sometimes test Anaerobic? Yes, absolutely. These are the patients who are not only Anaerobic, but also have a Prostaglandin (leukotrienes) Imbalance plus estrogen stress. Excess estrogen causes an increase in Th1 inflammatory cytokines, and thus is both one of the fundamental causes of the psoriasis, and, one cause of the Anaerobic test pattern these patients show.

Psoriasis is an autoimmune disease associated with excess Th1 inflammatory cytokines. Thus, the use of the drugs Remicade and Enbrel to suppress Tumor Necrosis Factor-alpha, along with methotrexate as a broad-spectrum immunosuppressant. Some doctors still prescribe prednisone, but doing so is often a disaster. Psoriasis patients experience a rebound effect from prednisone such that every time they reduce the dose there is a major flare-up of symptoms. Avoidance of the rebound skin lesions leaves the patient suffering not only from psoriasis but also from the long-term damage from the steroid drug.

All psoriasis patients must strictly avoid HOHUM PUFAs. In other words, they must follow the Prostaglandin dietary recommendations without fail. HOHUM means heated, oxidized, hydrogenated, unmetabolizable polyunsaturated fatty acids. These nasty vegetable oils exacerbate a Dysaerobic Metabolic Imbalance, and, increase the production of leukotrienes and other inflammatory prostaglandins.

In addition to the supplements listed above for each Fundamental Metabolic Imbalance that may underlie psoriasis, all your psoriasis patients will benefit from supplementing with Immuno-Synbiotic. Recall that 75% of the immune system (including the potential to release inflammatory cytokines) resides in the intestinal mucosa. The immune-regulating effects of your Immuno-Synbiotic are a critical component of a psoriasis supplement regimen.

Almost all psoriasis patients benefit from additional vitamin D as an adjunct to NUTRI-SPEC. Vitamin D is immunosuppressive, and particularly suppresses excessive production of T1 inflammatory cytokines as well as leukotrienes. It is often beneficial to recommend 4-5,000 IUs daily of vitamin D for 2 months, and 2,000 IUs thereafter, in addition to what the patient gets from your NUTRI-SPEC regimen. --- However --- vitamin D can exacerbate a Dysaerobic Imbalance. So, in psoriasis patients who do not test Dysaerobic feel free to use the extra vitamin D supplementation. In those who do test Dysaerobic, we recommend holding off on the vitamin D until the Dysaerobic Imbalance is well-controlled with Oxy D, Oxy D+, Oxy Power, and Proton Plus. It generally takes between 3 and 10 weeks to break the pattern of a Dysaerobic Imbalance, at which time you can add the vitamin D.

Does your patient truly have psoriasis?

Physicians are notorious for misdiagnosing skin conditions. We can certainly understand their difficulty, since so many skin lesions look similar even though having entirely different causes. For example, we have an employee who was recently put on antibiotics and broke out in a terrible rash. She was told she had an allergy to the antibiotic, when it was quite obvious that it was a yeast rash in response to the antibiotic. We had a patient not long ago who had what was obviously extensive ringworm, yet it was diagnosed as psoriasis. We had another patient who had scabies that was initially diagnosed as psoriasis. There are many yeast/fungal rashes that (particularly in people with dry skin) will become flaky and resemble psoriasis. In particular, malassezia (also known as pityriasis, also known as tinea versicolor) can cause widespread redness and flakiness.

If your patients' skin lesions are predominantly on extensor surfaces such as the back of the elbows and the front of the knees, then it is probably safe to assume that it is indeed psoriasis. If the lesions are predominantly on flexor surfaces such as the creases of the elbows and the knees, then it is almost certainly not psoriasis. If the lesions include both flexor and extensor surfaces, or are not located primarily on either flexor or extensor surfaces, then you really cannot be certain whether this is psoriasis or some other skin condition.

The nice thing about yeast/fungal type skin lesions is that they can either be ruled in or ruled out by nothing more extensive or expensive than having the patient use a topical antifungal cream twice a day for 10 days on a particular area. If the area being tested clears up significantly, then you know it is a yeast/fungal lesion. If it does not, then you have effectively ruled out yeast/fungal/mold-related causes.

Many skin conditions are associated with immune reactivity triggered in the gut. Particularly in those who test Anaerobic, Alkaline or Parasympathetic, the skin reactions tend to be associated with elevated mast cell and/or eosinophil activity. In most of these patients, you will get a wide, red dermographics test.

Many are also associated with leaky gut syndrome, which leads to multiple food reactivities --- either IgE, or IgG, or IgA-mediated.

Many of these "psoriasis-like" skin conditions respond well to sulfur. It is usually beneficial to use Head and Shoulders shampoo (or some other medicated shampoo) as not only a shampoo but as a body wash.

Sunlight is critical for many reasons.