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Original Research Article

Risk Factors, Clinical Presentation, and Management Patterns of Psoriasis among Patients at a Tertiary Care Centre: A Retrospective Study

Aswini Kumar Das

Associate Professor, Department of Skin and VD, Himalaya Medical College and Hospital, Paliganj, Patna, Bihar, India

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Corresponding Author: Dr. Aswini Kumar Das
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Abstract:

Background: Psoriasis is a chronic immune-mediated inflammatory skin disorder with substantial clinical and psychosocial burden. Its presentation and management are influenced by demographic characteristics, environmental triggers, disease extent, and associated comorbidities. Local data on psoriasis patterns from tertiary-care centres in Bihar remain limited.

Aim: To assess the risk factors, clinical presentation, and management patterns of psoriasis among patients attending a tertiary care centre in Bihar, India.

Methodology: A retrospective observational study was conducted among 78 patients diagnosed with psoriasis who attended the Department of Skin and VD, Himalaya Medical College and Hospital, Paliganj, Patna, Bihar, during a one-year period. Demographic characteristics, risk factors, clinical features, disease characteristics, and treatment modalities were extracted from medical records and analyzed using descriptive statistics.

Result: Psoriasis was predominantly observed among middle-aged males. Stress was the most frequently documented aggravating factor, while smoking and alcohol use were reported in a proportion of patients. Chronic plaque psoriasis was the predominant clinical type, with scaling, plaques, pruritus, erythema, and scalp involvement being common manifestations. Most patients had limited body surface area involvement, while nail involvement and psoriatic arthritis were less frequent. Management was mainly based on topical corticosteroids and emollients, with methotrexate being the most frequently used systemic therapy and narrowband UVB the principal phototherapy modality.

Conclusion: Psoriasis demonstrated diverse risk factors and clinical manifestations, with predominantly limited disease and a treatment pattern favoring topical therapy. Individualized, severity-based management and recognition of modifiable aggravating factors are important for effective long-term disease control.

Keywords: Psoriasis; Risk Factors; Clinical Presentation; Chronic Plaque Psoriasis; Management Patterns; Methotrexate; Phototherapy; Tertiary Care Centre.

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Introduction

Psoriasis is a chronic, immune mediated, inflammatory skin disease with frequent flare-ups of erythematous, well-demarcated plaques, and often evolving scales, which is now known to be a systemic inflammatory disorder and not just a skin disease. Psoriasis has a worldwide prevalence of around 2–3%, but its prevalence is different in various geographical regions, ethnic groups and environment [1]. Although there are a lot of variations in the published epidemiological data, the published studies available in India have reported the adult prevalence ranging from about 0.44% to 2.8%, suggesting a high burden of the disease in the country. Although psoriasis can develop at any age, most patients develop the condition in the third or fourth decade of life and Indian studies have shown a male preponderance.

There is significant variability in the age of onset, distribution, severity, frequency of exacerbations, and duration of the disease [2]. Guttate, inverse, erythema and pustular type may be seen, but the most common clinical type is chronic plaque psoriasis. Lesions can involve scalp, trunk, limbs, palms, soles, nails and genitalia; the extent of the lesions and the anatomical location play a significant part in functional and psychosocial impairment. Involvement of nails and/or palms and soles, face or genitalia can result in disproportionate disability despite small body surface area involved. The recurrent exacerbations and remissions, coupled with the chronic nature of the disease, often necessitate long-term follow-up with changes of treatment based on the severity of the disease and the patient's response.

The effects of psoriasis go far beyond the skin. The impact on quality of life (QoL) experienced by people with psoriasis can be similar to that seen in other major chronic illnesses like diabetes mellitus, ischaemic heart disease and cancer [3]. Physical, psychological, and social well-being can be negatively affected by itching, pain, scaling, disruption of sleep, and restriction of work and social activities and embarrassment of visible lesions. The burden of disease may be compounded by depression, anxiety and social isolation, as well as decreased work productivity. Thus, when assessing psoriasis, one should also take into account disease burden as reported by patients, psychological impact, anatomical sites affected, and severity of symptoms.

Psoriasis is also linked to a plethora of systemic comorbidities and hence can be described as a multisystem inflammatory disease [4]. There is a risk of having psoriatic arthritis, obesity, hypertension, diabetes mellitus, dyslipidemia, metabolic syndrome, cardiovascular diseases, non-alcoholic fatty liver disease, inflammatory bowel disease and psychological disorders. These co-morbid conditions can cause morbidity and mortality on their own and can impact the choice and safety of antipsoriatic treatment. Thus, the recognition of related risk factors and comorbidities plays a crucial role in the overall care of patients with psoriasis. It is currently recommended that in the routine assessment of psoriasis, cardiovascular and metabolic risk factors, mental health disorders, psoriatic arthritis, and other relevant systemic diseases should be evaluated.

Psoriasis develops and is exacerbated by a combination of genetic susceptibility, immune dysfunction and environmental or lifestyle factors. Psychological stress, infections, trauma or Koebner phenomenon, smoking, alcohol intake, obesity and some medications are commonly reported precipitating or aggravating factors. These factors are especially relevant to everyday clinical practice as this could minimise exacerbations if they are modified in conjunction with pharmacological therapy, as these risk factors could be avoidable. The treatment-seeking behavior and therapeutic decisions in the Indian context may also be influenced by socioeconomic factors, the cost of treatment, access to dermatological care, patient preferences, and concerns about side effects.

The treatment of psoriasis is based mainly on the severity of the disease, its clinical phenotype, its anatomic distribution, co-morbidities, prior responses to therapy, and patient preference. Topical treatments, phototherapy, traditional systemic treatments (methotrexate, cyclosporine and acitretin), targeted oral treatments, and biologic agents are all options. But in India, treatment patterns could vary from high-income countries due to various reasons, such as access, affordability, availability of biologics, long-term monitoring needs, and patient acceptance. Methotrexate, cyclosporine, acitretin and apremilast are commonly used systemic agents identified in the Indian expert consensus recommendations and biologic agents are increasingly used in the care of moderate to severe disease.

Although psoriasis is very much a clinical and psychosocial disorder, there is sparse information on its clinic-epidemiological manifestations in various regions of Asia, including India [5]. Specifically, data on risk factors, clinical patterns, associated comorbidities, and real-world treatment practices, in the context of patients attending tertiary-care hospitals in Bihar, is particularly valuable. Bihar is a vast and heterogeneous population and tertiary-care centres are often provided with patients suffering from chronic, severe, recurrent or treatment-resistant dermatological diseases. It is therefore important to be familiar with the characteristics of the psoriasis patients who attend such centres; in order to be aware of the common risk factors, common disease patterns, the prevalence of other comorbidities and the current management patterns.

Therefore, the present retrospective study was conducted to ascertain the risk factors, clinical profile and management pattern of psoriasis in patients of a tertiary care centre of Bihar, India. The study also seeks to create a local clinical-epidemiological picture that could help the clinician in early diagnosis, complete evaluation, and individualized treatment plans for patients with psoriasis with the aim of better long-term management of the patients.

Materials and methods

Study Design: A retrospective observational study was conducted to assess the risk factors, clinical presentation, and management patterns of psoriasis among patients attending the Department of Skin and VD, Himalaya Medical College and Hospital, Paliganj, Patna, Bihar, India. The study involved a review of previously recorded medical records of patients diagnosed with psoriasis during the specified study period. Relevant demographic, clinical, risk-factor, and treatment-related information was extracted from the available patient records using a predesigned and semi-structured data collection form.

Study Area: The study was conducted in the Department of Skin and VD, Himalaya Medical College and Hospital, Paliganj, Patna, Bihar, India.

Study Duration: The study was conducted over a period of one year.

Sample Size: The total sample size of the study was 78 patients (N = 78). All available medical records that fulfilled the predefined eligibility criteria during the study period were considered for inclusion in the study.

Sample Population: The study population consisted of patients with a confirmed diagnosis of psoriasis who attended the Department of Skin and VD during the study period. Patients of either sex and different age groups were included. Information regarding demographic characteristics, age at onset, duration of disease, family history, possible precipitating or aggravating factors, lifestyle-related factors where documented, associated comorbidities, clinical type of psoriasis, anatomical sites involved, body surface area involvement, nail and joint involvement, seasonal variation, and treatment received was collected from the medical records. Early-onset psoriasis was defined as psoriasis diagnosed before the age of 30 years. Disease duration was considered as the period between the documented onset or diagnosis of psoriasis and the patient's assessment recorded in the medical record.

Data Collection: Data were collected retrospectively from the medical records maintained in the Department of Skin and VD. A predesigned and semi-structured data collection form was used to systematically record the required information. The form included details regarding demographic characteristics, potential risk factors, clinical presentation, disease severity or extent, associated clinical findings, and treatment or management patterns. Content validation of the data collection form was performed by subject experts before its use. Information related to family history, smoking, alcohol use, comorbidities, seasonal variation, disease duration, and other relevant risk factors was recorded whenever documented in the medical records. Missing or unavailable information was not inferred and was recorded as unavailable.

Inclusion Criteria: Patients were included in the study if they fulfilled the following criteria:

- Patients with a confirmed clinical diagnosis of psoriasis documented in the medical records.
- Patients who attended the Department of Skin and VD, Himalaya Medical College and Hospital, during the specified one-year study period.
- Patients of either sex.
- Patients for whom adequate medical-record information was available regarding clinical presentation and/or disease characteristics.
- Patients whose records contained sufficient information to assess relevant risk factors and management patterns, wherever applicable.

Exclusion Criteria

The following records were excluded from the study:

- Patients without a confirmed diagnosis of psoriasis.
- Records in which the diagnosis of psoriasis was uncertain or subsequently revised to another dermatological condition.
- Duplicate patient records.
- Records with substantial missing information that prevented assessment of the primary study variables.
- Patients whose records did not belong to the specified study period.
- Records of patients who were referred elsewhere without adequate clinical or treatment information for analysis.

Procedure: The medical records of patients diagnosed with psoriasis during the one-year study period were identified and screened. The records were assessed according to the predefined inclusion and exclusion criteria, and eligible records were selected for the study. Relevant demographic, risk-factor, clinical, and treatment-related information was extracted using the semi-structured data collection form. Clinical characteristics such as type and distribution of psoriasis, sites of involvement, nail and joint involvement, and associated clinical findings were recorded. The extent of psoriasis was assessed according to documented body surface area (BSA) involvement. Patients with BSA involvement ≤10% were classified as having limited psoriasis, whereas those with BSA involvement >10% were classified as having extensive psoriasis. The documented treatment modalities were also reviewed to determine the management patterns followed in the study population. The completed data collection forms were checked for completeness and consistency before being entered for statistical analysis.

Statistical Analysis: The collected data were coded, entered, and analyzed using Statistical Package for the Social Sciences (SPSS), version 25.0 (SPSS Inc., Chicago, Illinois, USA). Descriptive statistics were used to summarize the demographic and clinical characteristics of the study population. Categorical variables were presented as frequencies and percentages, while continuous variables were summarized using appropriate measures of central tendency and dispersion. Associations between categorical variables were assessed using the Chi-square test, while Fisher's exact test was used when expected cell frequencies were small. The unpaired Student's t-test was used to compare normally distributed continuous variables between two independent groups, whereas the Mann–Whitney U test was used for non-normally distributed continuous or ordinal variables. Associations between potential risk factors, demographic characteristics, clinical presentation, disease extent, and management patterns were evaluated using appropriate statistical tests. A P-value <0.05 was considered statistically significant."

Result

Table 1 shows that among the 78 psoriasis patients, the highest proportion belonged to the 41–50 years age group (18, 23.1%), followed by 31–40 years (16, 20.5%) and 51–60 years (13, 16.7%), while 12

(15.4%) patients were aged 21–30 years, 9 (11.5%) were 61–70 years, 6 (7.7%) were ≤20 years, and 4 (5.1%) were >70 years. A marked male predominance was observed, with 61 (78.2%) patients being male compared with 17 (21.8%) females. Regarding marital status, 57 (73.1%) patients were married, whereas 21 (26.9%) were unmarried. In terms of occupation, unskilled workers constituted the largest group (28, 35.9%), followed by skilled workers (18, 23.1%), homemakers (14, 17.9%), business/self-employed individuals (12, 15.4%), and students (6, 7.7%). With respect to residence, 43 (55.1%) patients were from urban areas, while 35 (44.9%) were from rural areas. Overall, the findings indicate that psoriasis in this study was more commonly observed among middle-aged individuals, males, married persons, unskilled workers, and urban residents.

Table 1: Socio-demographic distribution of psoriasis patients (n = 78)

Characteristic	Number	Percentage
Age (years)		
≤20	6	7.7
21–30	12	15.4
31–40	16	20.5
41–50	18	23.1
51–60	13	16.7
61–70	9	11.5
>70	4	5.1
Gender		
Male	61	78.2
Female	17	21.8
Marital status		
Married	57	73.1
Unmarried	21	26.9
Occupation		
Unskilled	28	35.9
Skilled	18	23.1
Business/Self-employed	12	15.4
Homemaker	14	17.9
Student	6	7.7
Place of residence		
Urban	43	55.1
Rural	35	44.9
Total	**78**	**100**

Table 2 presents the distribution of risk factors among the 78 psoriasis patients. A family history of psoriasis was reported in 9 (11.5%) patients, whereas 69 (88.5%) had no family history. Regarding personal habits, 17 (21.8%) patients were smokers, 15 (19.2%) reported alcohol use, 8 (10.3%) reported both smoking and alcohol use, while 38 (48.7%) had neither habit. Among possible aggravating factors, stress was the most frequently documented factor in 21 (26.9%) patients, followed by trauma in 8 (10.3%), infection in 6 (7.7%), and medication-related factors in 4 (5.1%); no specific aggravating factor was documented in 39 (50.0%) patients. Seasonal exacerbation was reported most commonly during winter in 22 (28.2%) patients, followed by summer in 7 (9.0%) and the rainy season in 6 (7.7%), while 43 (55.1%) patients reported no seasonal variation. Overall, the findings indicate that most patients had no documented family history, nearly half had no reported smoking or alcohol habit, stress was the most common identifiable aggravating factor, and more than half reported no seasonal variation in psoriasis symptoms.

Table 2: Distribution of risk factors of psoriasis among the patients (n = 78)		
Risk factor	**Number**	**Percentage**
Family history of psoriasis		
Present	9	11.5
Absent	69	88.5
Personal habits		
Smoking	17	21.8
Alcohol use	15	19.2
Smoking and alcohol use	8	10.3
Neither	38	48.7
Possible aggravating factors		
Stress	21	26.9
Trauma	8	10.3
Infection	6	7.7
Medication-related	4	5.1
No specific factor documented	39	50
Seasonal exacerbations		
Winter	22	28.2
Summer	7	9
Rainy season	6	7.7
No seasonal variation	43	55.1

Table 3 shows the clinical profile of the 78 psoriasis patients. Chronic plaque psoriasis was the most common type, accounting for 58 (74.4%) patients, followed by palmoplantar psoriasis in 7 (9.0%), guttate psoriasis in 5 (6.4%), erythrodermic psoriasis in 3 (3.8%), generalized pustular psoriasis in 2 (2.6%), flexural psoriasis in 2 (2.6%), and other types in 1 (1.3%) patient. Among the clinical features, scales were the most frequently observed finding, present in 69 (88.5%) patients, followed by plaques in 61 (78.2%), pruritus in 57 (73.1%), erythema in 54 (69.2%), and scalp involvement in 43 (55.1%). Auspitz sign was observed in 9 (11.5%) patients, Koebner phenomenon in 7 (9.0%), hyperkeratosis in 6 (7.7%), and pustules in 3 (3.8%). Disease relapse was documented in 19 (24.4%) patients, whereas 59 (75.6%) had no documented relapse. Overall, the clinical profile was predominantly characterized by chronic plaque psoriasis with scales, plaques, pruritus, erythema, and scalp involvement, while less common clinical variants and signs were observed in a smaller proportion of patients.

Table 3: Clinical profile of psoriasis patients (n = 78)		
Characteristic	**Number**	**Percentage**
Type of psoriasis		
Chronic plaque psoriasis	58	74.4
Palmoplantar psoriasis	7	9
Guttate psoriasis	5	6.4
Erythrodermic psoriasis	3	3.8
Generalized pustular psoriasis	2	2.6
Flexural psoriasis	2	2.6
Other types	1	1.3
Clinical features		
Scales	69	88.5
Plaques	61	78.2
Erythema	54	69.2
Pruritus	57	73.1
Scalp involvement	43	55.1
Auspitz sign	9	11.5
Koebner phenomenon	7	9
Hyperkeratosis	6	7.7
Pustules	3	3.8
Disease relapse		
Present	19	24.4
Absent	59	75.6

Table 4 presents the distribution of risk factors and disease characteristics among the 78 psoriasis patients. Regarding age at onset, 20 (25.6%) patients had early-onset psoriasis before 30 years of age, while 58 (74.4%) developed the disease at 30 years or later. A family history of psoriasis was present in 9 (11.5%) patients and absent in 69 (88.5%). Seasonal exacerbation was reported most commonly during winter in 22 (28.2%) patients, followed by summer in 7 (9.0%) and the rainy season in 6 (7.7%), whereas 43 (55.1%) patients reported no seasonal exacerbation. In terms of disease duration, 38 (48.7%) patients had psoriasis for 1–5 years, followed by 18 (23.1%) with a duration of less than 1 year, 13 (16.7%) with 6–10 years, and 9 (11.5%) with more than 10 years of disease. BSA involvement was limited to ≤10% in 51 (65.4%) patients, while 27 (34.6%) had extensive involvement of >10%. Nail involvement was present in 24 (30.8%) patients and absent in 54 (69.2%). Psoriatic arthritis was documented in 8 (10.3%) patients, whereas 70 (89.7%) had no evidence of psoriatic arthritis. Overall, most patients had an onset at ≥30 years, disease duration of 1–5 years, limited BSA involvement, and no family history, nail involvement, or psoriatic arthritis.

Table 4: Distribution of risk factors and disease characteristics according to the study population (n = 78)

Characteristic	Number	Percentage
Age at onset		
<30 years (early onset)	20	25.6
≥30 years	58	74.4
Family history		
Present	9	11.5
Absent	69	88.5
Seasonal exacerbation		
Winter	22	28.2
Summer	7	9
Rainy season	6	7.7
None	43	55.1
Disease duration		
<1 year	18	23.1
1–5 years	38	48.7
6–10 years	13	16.7
>10 years	9	11.5
BSA involvement		
Limited (≤10%)	51	65.4
Extensive (>10%)	27	34.6
Nail involvement		
Present	24	30.8
Absent	54	69.2
Psoriatic arthritis		
Present	8	10.3
Absent	70	89.7

Table 5 presents the management patterns among the 78 psoriasis patients. Topical corticosteroids were the most commonly used topical therapy, administered to 39 (50.0%) patients, followed by moisturizers/emollients in 31 (39.7%) and salicylic acid preparations in 18 (23.1%). Coal tar preparations were used by 7 (9.0%) patients, while topical vitamin D analogues were used by 6 (7.7%). Among systemic therapies, methotrexate was the most frequently prescribed, used in 19 (24.4%) patients, followed by apremilast in 5 (6.4%), cyclosporine in 4 (5.1%), and oral corticosteroids in 4 (5.1%). Antihistamines were prescribed to 29 (37.2%) patients. Narrowband UVB phototherapy was utilized in 13 (16.7%) patients. Alternative management included Ayurvedic treatment in 8 (10.3%) patients and homeopathic treatment in 3 (3.8%). Overall, the management pattern was predominantly based on topical therapy, particularly corticosteroids and moisturizers, while methotrexate represented the most frequently used systemic treatment and narrowband UVB was the principal phototherapy modality.

Table 5: Management patterns among psoriasis patients (n = 78)		
Management modality	**Number**	**Percentage**
Topical therapy		
Topical corticosteroids	39	50
Moisturizers/emollients	31	39.7
Salicylic acid preparations	18	23.1
Coal tar preparations	7	9
Topical vitamin D analogues	6	7.7
Systemic therapy		
Methotrexate	19	24.4
Cyclosporine	4	5.1
Apremilast	5	6.4
Oral corticosteroids	4	5.1
Antihistamines	29	37.2
Phototherapy		
Narrowband UVB	13	16.7
Alternative management		
Ayurvedic treatment	8	10.3
Homeopathic treatment	3	3.8

Discussion

The current retrospective study of 78 patients gives the readers an insight into the demographic data, possible risk factors, clinical spectrum, disease features, and treatment strategies for psoriasis in a tertiary-care hospital. Psoriasis was found to be more common in middle aged adults with the age group 41-50 years having the highest proportion (23.1%) followed by the age group 31-40 years (20.5%) and 51-60 years (16.7%). The age distribution was similar to those seen in earlier Indian and Asian studies with majority of the patients being middle aged. In eastern Uttar Pradesh, Singh and Gupta (2015) [6] reported a predominant adult age group and in a Malaysian registry-based study, Mohd Affandi et al. (2018) [7] reported a wide age distribution of adults. The present findings also revealed that there was a male predominance (78.2%) which is similar to the several Indian studies where male predominance was reported. The occupational profile is different from the one in which farmers or housewives or household workers formed the majority of the patients as unskilled workers were 35.9%. Abdu et al. (2017) [8] and Raghuveer et al. (2015) [9] also showed a significant representation of occupationally exposed population which showed that socioeconomic and occupation factors can affect the profile of patients seeking skin services."

11.5 percent of the present patients had a positive family history. This relatively low percentage suggests that in this population psoriasis was mostly sporadic, meaning it did not run in the family. However, genetic risk factors are known to play a role in psoriasis and discrepancies in family history may be due to differences in study populations and family history documentation. Additional lifestyle factors were also significant with smoking noted in 21.8% of patients and alcohol use in 19.2% and smoking + alcohol use in 10.3%. These findings help to support the relevance of lifestyle factors in psoriasis, however without the control group to form causality. Smoking, alcohol consumption and environmental exposure have also been reported as possibly important in the pathogenesis of psoriasis in previous studies. In the current study, the most commonly reported aggravating factor was stress (26.9%) followed by trauma (10.3%), infection (7.7%) and medication-related factors (5.1%). In previous studies, stress was reported to be an aggravating factor in about 8-48.3% of patients and trauma in 27.2% and seasonal variation in 50-72% of patients [10,11]. The finding in the present study that was related to stress was in the range already reported, while that of trauma and seasonal exacerbation was less described in the literature. Winter exacerbation was seen in 28.2% of the present patients as compared to approximately 55.3% as reported by Singh and Gupta (2015) [6] and Agrawal et al. (2003) [10] respectively. This distinction could be due to climatic, geographic, behavioural or documentation differences.

In the present study, clinically psoriasis was overwhelmingly present as chronic plaque psoriasis with 74.4% cases. This is similar to what is known in clinical practice – chronic plaque psoriasis is the predominant form – and previous studies have reported plaque psoriasis as the predominant phenotype. The major clinical features were scaling (88.5%), plaques (78.2%), pruritus (73.1%), and erythema (69.2%) with typical characteristics of psoriasis, inflammatory and hyperproliferative. 55.1 percent of patients had scalp involvement. This is similar to the previous reports which varied from 28% to 79.8% scalp involvement; Vijayan et al. (2010) [12] reported scalp involvement as an important clinical feature and Singh and Gupta (2015) [6] reported 79.8% scalp involvement. The lower value in the

present study might be due to a difference in examination, severity of illness, and patient characteristics. Thirty-eight percent (30.8%) had nail involvement, which is in the spectrum of previous studies of 1.9-75% [7,9]. Psoriatic arthritis was found in 10.3% of patients, which is similar to the 9.3% reported elsewhere and within a range of 0.6-31% reported in other studies [13,14] . This discovery confirms the need for screening of musculoskeletal symptoms in psoriasis patients.

The present study revealed that early onset of psoriasis occurred in 25.6% and late onset in 74.4% of patients. Forty percent of patients (48.7%) had a disease duration of 1–5 years, meaning that a large proportion of them had psoriasis for years before or at the time of presentation. Limited disease (≤10% BSA) was seen in 65.4% while >10% BSA was seen in 34.6%. This distribution is in contrast with other published studies which have reported extensive psoriasis in 16.3–45.9% of patients, with the current population having a relatively lower proportion of extensive psoriasis than some of the tertiary-care populations. It may also be that the majority of the BSA are not involved to the same degree as this may account for the treatment pattern observed.

Topical therapy was the dominant treatment of management (50% topical corticosteroid preparations, 39.7% moisturizers/emollients and 23.1% salicylic acid preparations). This is a clinically appropriate pattern for a cohort with almost two-thirds with limited BSA involvement. The most common systemic agents documented were methotrexate (24.4%), apremilast (6.4%) and cyclosporine and oral corticosteroids (5.1% each). 16.7% received narrowband UVB phototherapy and 37.2% received anti-allergic drugs, reflecting the high incidence of pruritus. The use of topical corticosteroids and systemic agents is generally similar to the treatment frequencies reported in tertiary-care psoriasis studies, with the frequency of use dependent on the severity of the disease and the standard of practice in individual institutions [7,12]. Co-occurrence of alternative treatment practice in this population was also documented including ayurvedic treatment (10.3%) and homeopathic treatment (3.8%).

In summary, the results show that psoriasis in this tertiary-care population most commonly occurred in middle-aged males, was linked to stress and lifestyle factors, was mainly chronic plaque psoriasis with typical scaling and pruritus, and was treated mostly topically, and less often with systemic therapy or phototherapy.

Conclusion

This retrospective study highlights that psoriasis is a chronic and heterogeneous dermatological disorder with diverse demographic, risk-factor, clinical, and management patterns among patients attending a tertiary care centre. Our results showed that psoriasis predominantly occurred among adult males and that chronic plaque psoriasis was the most common clinical form, scales, plaques, erythema and pruritus were the most common clinical manifestations. Family history was recorded in a minority of patients, but modifiable factors (smoking, alcohol intake, and possible precipitants such as psychological stress, trauma, infection, and medications) were found in some patients and there was a seasonal variation in some patients. The majority of patients presented with limited body surface area involvement while nail involvement and psoriatic arthritis were only present in a smaller proportion of patients. The primary management principles were to use topical therapy, primarily corticosteroids and emollients, with systemic therapy used in severe disease, depending on the clinical needs, such as methotrexate and phototherapy. The overall message of the study is that understanding individual risk factors and clinical features, targeting modifiable aggravating factors and adopting a severity-based treatment strategy is crucial for better long-term control of the disease and fewer relapses and complications.

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