Research Article: by John Andrews

Psoriasis and Iridology

Psoriasis is a chronic skin disease in which itchy, scaly pink patches form primarily on the elbows, knees and scalp; but can also spread to most other areas of the body. The nails of psoriasis sufferers can display discolouration, pitting, deformity of nail plates and onycholysis. Psoriasis is one of the most prevalent skin conditions in the UK, with approximately 2% pf the adult population being affected. According to current orthodox medical thinking the cause(s) of psoriasis remains unknown. However, the disorder often runs in families, with the commonest time of onset being in adolescence. It sometime occurs in association with arthritis; as is cases of psoriatic arthritis.

Psoriasis can be very severe, affecting most of the skin; which leads to considerable discomfort, debility and distress for the patient. While psychological stress may cause an exacerbation of the psoriasis, the only significant event that precipitates the condition according to medical thought is a preceding streptococcal infection. Drugs such as lithium or beta-blockers may also be occasionally responsible.

Orthodox medical treatment tends to use strong steroid-based medicaments internally and applied externally in attempt to treat the condition. The vitamin D analogue *calcipotriol* is also used as well as retinoid and PUVA. According to the latest medical texts, there is no known cure for psoriasis and current thinking suggests there are possible auto-immune implications – a skin-cell proliferation imbalance. Strong immune suppressants such as cyclosporin and methotrexate are frequently prescribed for severe cases. Certainly in Iridological terms there is a prevalence of iris markings and signs in accordance with auto-immune conditions and general immune dysfunction, such as leaf lacunae positioned on the border of the collarette with a Hypertrophic collarette or IPB structure refer to *Immunology & Iridology* for further elaboration.

In general though, psoriasis as a disease represents a stumbling block for Iridology in regards to the symptomology. According to the research we have conducted, looking at 100 medically diagnosed and confirmed cases of psoriasis – the general symptomology does not marry up with the Iridology theory. We have a great difficulty in identification of consistent Iridological and pupillary markers; even with analysis according to new iridian topography located inside the collarette – the embryological topography. This difficulty has been a shared experience across international borders with Dr Vincenzo Di Spazio, *et al* in Italy summarising the same conclusion, but with research between psoriasis and the Inner Pupillary Border. (Reference: Il Terreno Diatesico in

Iridologia – Torti/Di Spazio, Maria Ricchiuto Editore, 2nd Edition 1992, pp282-285).

Traditional Iridology informs us that a *scurf rim* (acc. Jensen) or skin ring is present in the eyes on the periphery of the iris, with conditions such as psoriasis. Recent research has shown us that a *scurf rim* is rarely present; it is also difficult to pin down any genetic inheritance to either irises. For example, the paternal side or maternal side of the family does not tally with either iris. Pupillary dynamics vary wildly too, also in some cases contraction furrows are present; in some cases not. Psoriasis presents many different morphological IPB manifestations; as Di Spazio *et al* discovered.

The only consistent signs are general hepatic signs, particularly pigment and space risk signs at zone 11/12 on the IPB. (These give an indication of the cause of the problem).

Also in regards to immune/auto immune implications the aforementioned leaf lacuna, hypertrophic collarette (occasionally with zig-zagging) and general discolouration with a greying haze in the intestinal area denoting intestinal dysbiosis tendency are prevalent – the basis for immune dysfunction – and gastro-intestinal disturbances. Both can lead to complex skin problems.

A Stress Axis (main markings in the hypothalamus, pituitary and adrenal gland topographies) illustrates the neuroendocrine reflex and response; and is often present in cases of psoriasis. With the majority of the male patients in the study, psoriasis developed after the loss of their mother or the onset of marital problems.

So you can see that with Iridology things are not always clear cut. We can and do face challenges. This is good! Perhaps in the case of psoriasis and Iridology we are being taught an important lesson. That the disease process may not be the physical symptoms; that there are underlying causes. These underlying causes can be both physical and, moreover, psycho-emotional.

Summary of Iridology Sign in 100 Psoriasis Case Studies

Iridology Sign	% Prevalence in Case Studies
Stress Axis	60%
Leaf Lacuna on External Border of Collarette	40%
Scurf Rim/Skin Ring	32%
Contraction Furrows	50%
Hepatic Pigment (Brown)	62%
Space Risk Zone 11/12 (78.6° to 91° on IPB)	64%
Zig-Zag Structure within the Collarette	53%
Grey Haze Discolouration within Intestinal Zone	59%

Prospective Naturopathic Protocols

- Light Therapy/Heliotherapy
- Nutritional consideration – establish adequate zinc, magnesium, vitamin E, beta carotene, vitamin C, Essential Fatty Acid, selenium and germanium levels.
- Relaxation-related therapies such as Reflexology, Shiatsu and CranioSacral Therapy
- Botanical medicines:
  Externally - Jojoba Oil (*Simmondsia chinensis olea*), *Mahonia aquifolium* cream and coconut butter
  Internally – *Berberis aquifolium/Mahonia aquifolium radix, Thuja occidentalis folia, Urtica dioica herba, Carduus marianus semen, Andrographis, Smilax ornata radix, Rumex crispus radix, Arctium lappa radix* and *Iris versicolor radix* as a liquid extract
  Dosage 5 to 10ml 3 to 4 times daily
- Avoidance of refined flours, sugars and dairy products
- Emotionally address any unresolved issues in regards to feelings of suppressed anger, resentment, grief or financial worries