Term	Topic content
Psoriasis *(psoriasis vulgaris)*	is a genetically determined chronic autoimmune polysystemic disease of multifactor nature, characterized by the benign epidermal hyperproliferation, papulosquamous eruptions, staging, often severe clinical course and involvement of musculoskeletal system and internal organs in pathological process with corresponding morphological and functional changes.
Epidemiology	Around 2-3% of the world population suffers from psoriasis. The disease is spread across all geographical latitudes among people of different nationalities and races. Although it often appears between the ages of 10 and 25 years, there are the cases of psoriasis occurrence both at the age of 4 to 7 months and at the age of 80 years. Psoriasis affects both sexes equally, but among children it occurs more frequently in girls, and among adults - in men. Disease is less common among Eskimos, Japanese, Africans, and South American Indians. In the general structure of the skin pathology psoriasis specific gravity achieves 8 to 15%, i.e. nowadays it remains an urgent problem of dermatology and common disease of population.
Etiopathogenesis	For 200-year study history of psoriasis the aspects of pathogenesis (from the dermatosis with violation of keratinocytes proliferation to T-cell autoimmune disease), clinic (from skin disease to polysystemic disease) and treatment (from ectylotics to highly selective drugs) have been repeatedly revised. A psoriatic disease as autoimmune genetically determined disease has been thoroughly investigated only during the last decades. Hereditary conception of psoriasis pathogenesis, based on the registration of disease cases among the members of the same family, is generally accepted. According to the different data, familial psoriasis occurs in 5-40% of cases and more. Close relatives of the probands on the father's side suffers more frequently than the ones on the mother's side. The literature describes the cases of psoriasis in twins, with that, the highest concordance is observed among monozygotic individuals. The recent researches established the multifactorial character of inheritance of psoriasis, at which the high risk of disease is observed in the carriers of histocompatibility antigens HLA Al, A9, All, A28; HLA B13, B 17, B27, B38, B39; HLA CW2, CW3, CW4, CW6. Due to the fact, that the hereditary transmission of psoriasis of the majority of psoriasis patients cannot be established, there exists the suggestion, that the disease is not inherited but disposition to it, which in a number

	of cases is realized as a result of complex interaction of genetic factors and adverse environmental effects. However, although a family history is common, there is often no clear-cut inheritance pattern. What does seem clear is that the cascade of changes probably result from an interaction between T-cells and keratinocites, with the involvement of various cytokines and chemoattractants - notably interleukins 1 and 8, tumor necrosis factor-alpha. E selectin and intercellular adhesion molecule-1 It is now considered to be due to T-lymphocytes mediated disease of abnormal keratinocyte proliferation in genetic predisposed subject. According to the modern ideas, immune system disorder and the development of weak immune response of the psoriasis patients is caused by the antigenic mimicry, genetic factors controlling the process of normal differentiation of immunocompetent cells, or disorder of neurohumoral mechanisms. The characteristic feature of immunogram of these patients is the reduction of T-lymphocytes, change of T-helpers to T-suppressors ratio due to significant increase of T-suppressors, the increased level of immunoglobulin IgG, IgA, components of complement C3, C4 that indicates the activation of the autoantibody formation processes, circulating immune complexes and, accordingly, the suppression of defense mechanisms. On this basis, it was concluded, that the pathogenesis of psoriasis is largely autoimmune. The leading pathogenetic link of immune disorders in case of psoriasis is deviation of cytokine profile by Th 1 -type with increased level of interleukins (IL-8) and tumor necrosis factor as the key mechanism of disease development.
Clinical picture and course	Psoriasis vulgaris is characterized by monomorphic eruption, based in most cases symmetrically on the extensor surfaces of the extremities and the hairy part of the head. The nails and musculoskeletal system is often affected. Psoriasis can be accompanied by itching of different intensity (usually in progress stage). The primary element of rash is epidermic-dermic inflammatory papule. Psoriatic papule is round with distinct boundaries, of pink-red colour of different intensity: the recent elements are bright red and the existing longer ones are more faded. The surface of rash elements is covered with silvery white (silver color is connected with the presence of air bubbles) furfuraceous and fine scales, which are easily removed during scraping. On the recent papules the scales are located in the center, and narrow bright circle remains on their periphery. Subsequently, the scaling increases, covering the entire surface of rash element. At the beginning the papules have correct rounded shapes and

	diameter of 1-2 mm. With the progression they are enlarged, form plaques, often achieving significant size and acquiring all possible shapes. Therefore, depending on the sizes of rash elements, the following clinical forms of psoriasis are distinguished: □ Punctate psoriasis (papules ranging in size from millet grain to match head); □ Guttatepsoriasis (elements ranging in size from 3-4 mm to 7-10 mm); □ Psoriasis nummularis (papules from 10 mm to 30 mm); □ Plaque psoriasis (papules in size up to 6-7 cm); □ Large-plaque psoriasis (isolated plaques with size up to 15 cm and more); □ Diffuse-plaque psoriasis (dense confluent lesions, covering separate areas of body, such as back or abdomen, extremities); □ Erythrodermic psoriasis ox psoriatic erythroderma (the patient's skin is the entire affected surface). According to the infiltration rate of the plaques there are moderate, marked and severe (with presence of fissures) pathological skin process. Depending on the extension of this process there can be localized, when the isolated plaques can be visualized on the skin of scalp or extensor surfaces of elbows, knees and other body parts, and disseminated or extensive psoriasis with numerous elements in different parts of the body. Psoriatic erythroderma {erythrodermia psoriatica, seu psoriasis universalis) develops in the result of the effects of adverse exogenous factors, including stress situations and irritating treatment. Psoriatic erythroderma affects 1,5-3% of people with psoriasis, these people are often noted with reduction of immunological indices and high allergic reactivity. And often, the cause of erythroderma cannot be determined. The entire skin surface acquires bright red color with brown shadow. Edema and infiltration are not equally expressed on different parts. There is sharp skin flaking (furfiiraceous desquamation in the hairy part of the head, and lamellate one in other parts), increasing of lymph nodes, possible temperature rise, nails destruction, occurrence of purulent paronychia. Such process without advance psoriatic anamnesis can be difficult to differentiate from other primary and secondary erythroderma. For the diagnostics of psoriasis a range of symptoms, which include psoriatic triad and isomorphic reaction (Koebner s phenomenon), is significant. A psoriatic triad includes three consecutive phenomena, in case of scraping of psoriatic papule,

	these are phenomenon of stearic spot, characterized by intense desquamation, when with light scraping in the result of dyshesion of keratinized plates, the affected skin area looks like porphyrized stearic drop; phenomenon of terminal film appears in the result of the further scraping of papule surface and squamosa erosion, when the wet surface of the spinous layer of epidermis is exposed; phenomenon of pinpoint bleeding (Auspitz' phenomenon), determined by the traumatization of capillary vessels of alpine papillae after light scraping of terminal film. Isomorphic reaction (Koebner s phenomenon or psoriasis traumatica) involves appearing of psoriatic rash in the areas of physical or chemical lesions of skin cover. It takes on the average 7-9 days after skin injury to the isomorphic reaction development. There are three stages in the course of dermatosis, these are progressive, stationary and regressive ones. The progressive stage is characterized by the appearance of new papules, peripheral enlargement of old elements, the presence of inflammatory peripheral rim of papules increase, psoriatic triad, Koebner's phenomenon, the formation of new plaques due to fusion of papules or enlargement of old elements, sometimes accompanying by itching. For the stationary stage the itching is uncharacteristic or weekly expressed, the new elements do not appear, peripheral rim of growth is absent, the surface of papules is entirely covered with silvery white scales, which are easily peeled, Koebner's phenomenon does not occur, pseudo atrophy Voronov's rim appears around the papules (slightly wrinkled white shiny ring up to 5 mm). In the regressing stage the elements of psoriasis are resolving and fading, the desquamation reduces and stops. Whitening of rash elements in the central part gradually leads to the appearance of the secondary eruption rests of various configurations in the form of hypo-, more rarely hyper pigment spots. With the disappearance of psoriatic eruptions, the remission is defined. The spontaneous remissions are marked approximately in 20% of cases, usually in the worm season. Psoriasis is characterized by the process recurrence, appearing under the influence of various factors (climate, neuropsychic traumas, endocrine disorders, exacerbation of chronic infection). On grounds of climate and meteorological factors the winter (exacerbation in cold season), summer and off-season, or mixed, types of dermatosis are distinguished. The winter type of psoriasis occurs much more often than the other types. The nature of popular elements determines typical course of psoriatic process on the skin. Accordingly, they distinguish

	between psoriasis vulgaris (common) and atypical psoriasis. Psoriasis vulgaris is characterized by typical popular rash, on the grounds of location they distinguish between linear psoriasis (psoriasis linearis), gyrate psoriasis (psoriasis gyrata), figured or geographical psoriasis (psoriasis geografica seufigurata), and annular psoriasis (psoriasis annularis). With atypical course of skin pathological process, the signs of other skin diseases are defined in the setting of characteristic clinical picture of psoriasis. Of atypical clinical forms of psoriasis, the most frequent axe follicular, verrucous (papillomatous), ostraceous (rupioides), intertriginous, exudative, eczematous, pustular, plaque, seborrheic, reverse, irritating etc. With follicular psoriasis (psoriasis follicularis) the presence of small conical papules, located in the sebaceous follicular areas, is noted. Papillomatous, or verrucous, psoriasis (psoriasis papillomatosa seu verrucosa) is characterized by significant infiltration and verrucous enlargement of rash elements. Rupioides psoriasis (psoriasis rupioides), in its turn, is presented by lamellate crusty scales on the eruption surface, giving them a conical shape, "snail shell" like. Rupioides and verrucous psoriasis are very often caused by the neglected pathological process (psoriasis inveterata), in which in the basis of pathological foci, there is significant infiltrate with massive scales, which are difficult to remove, and, as a rule, not fully. Asbestoslike psoriasis is a kind of neglected psoriasis. Intertriginous psoriasis (psoriasis inversa, plicarum) develops in nursing infants, suffering from severe diabetes, rheumatism, and in people, suffering from obesity, in advanced age and with high sensibilization. It is characterized by atypical localization on the flexor surfaces of the extremities, joints, on the skin of inguinofemoral and other folds, axillary hollows, on the palms and plantae. Its manifestations usually are nummular exudative plaques of purple red colour with sharp boundaries, insignificant desquamation, wet and macerated surface. It is often accompanied by itching and burning sensation. It is possible, that the given form is, in fact, exudative psoriasis, the clinical picture of which has changed somehow due to localization of the process in the skin folds. With exudative, or wet, psoriasis (psoriasis exudativa seu humida) the elements of rash are impregnated with exudate with the subsequent formation of yellowish-grey loose scaly crusts. With eczematous psoriasis (psoriasis eczematoides) the phenomena of exudation, crust, scratches layer and the pathological process looks like the eczematous one. Two types of pustular psoriasis {psoriasis pustulosa, seu

	suppurativa) are distinguished; these are Cymbush type and Baber s type. The first type can appear primarily without typical picture of dermatosis and develops more frequently secondarily in the result of transformation of vulgar or intertriginous psoriasis. It is severe general illness, accompanied by temperature rise, general ailment, leukocytosis. First, there appear numerous disseminated erythematous and erythematous-edematous foci, which spreading over the entire skin cover, form various figures and diffuse bright red lesions. In this setting there are disseminated pustular elements, which shrivel into yellowish-brown crusts and crusty scales. Dermatosis can have malignant course with lethal outcome. With second type of periarticular injury (enthesitis, tendovaginitis) to arthritis with frank osteoarticular changes, that is citified radiologically. Most of patients have got the joints lesion occurring in three- five years and more after the first psoriatic eruption. Symmetric multiple lesions of small peripheral joints and bones (osteoporosis, mainly in pineal glands, and the joint space narrowing) with the gradual involvement in the process of large joints, sometimes spine is characteristic. With the severe forms there occurs dispersion of end phalanges of hands and feet, and appearing of exostoses (osteophytes). The development of pathological process during psoriasis can occur according to two types. The first type supposes the early manifestation of the disease (with peak at the age of 16-20). It is characterized by the large area of lesion, torpid course and frequent relapses. The second type has got later signs (peak at the age of 40-50). With the first type, the hereditary link is evident (in 44% of cases), whereas in the second type this connection is set only in 1 % of cases.
Differential diagnostics	The skin manifestations of psoriasis should be differentiated primarily from the diseases, for which the characteristic rash element is a papule, covered with scales, namely, lichen planus, parapsoriasis, pink Gibert's lichen, atopic dermatitis, secondary syphilis. In contrast to psoriasis, in case of lichen planus, the papules are polygonal squamous; desquamation on the surface of the rash elements is weakly pronounced; the color of efflorescence is purplish-red on the skin and pearl on the oral mucosa; waxy shine of eruption surface and the presence of umbilication in the center of papule is characteristic; texiform pattern on the surface of papule (Wickham's striae) is localized most frequently on the oral mucosa and on the skin of the flexor surfaces of forearms and lower legs; there is pronounced itch in the rash areas and negative psoriatic triad.

	In case of parapsoriasis, the presence of characteristic phenomena is typical, such as wafer (a round scale is removed from the surface of the papule), occult desquamation (it is evident during scraping of surface of papule), collarette (the central site of papule is covered by greyish-brown scales, which are flaked off peripherally), purpura symptom (it is caused due to intense scraping of rash elements). Pink Gibert's lichen is characterized by the presence of herald patch on the trunk, distribution of the daughter, mainly spotted, rash along the cleavage lines, symptom of "crumpled tissue paper". Atopic dermatitis differentiates by the presence of erythema of dull color, pronounced lichenification, excoriations, localizations of eruptions on the skin of face, neck, upper chest, flexor surface of knee and elbow joints, allergological anamnesis. Psoriasiform syphilides are characterized by pale red with copper color of rash elements, the absence of peripheral growth, the presence of Biett's collarette around papules, the absence of psoriatic triad, detection of pale treponema in the rash elements, positive serological reactions. The differential diagnostics of atypical clinical forms of psoriasis should be carried out as well. Besides, nail psoriasis is often differentiated from onychomycosis on the basis of detection analysis for pathological fungi in the material studied; psoriatic erythoderma from toxicodermas, skin lymphomas and arthropathic psoriasis from the range of chronic arthritis. Arthropathic psoriasis is more frequently differentiated from rheumatoid arthritis.
Treatment	Pathogenetic treatments of psoriasis include systemic and topical treatment, skin care and additional methods of therapy, such as physiotherapy, balneotherapy, climate, psychological, herbal therapy etc. Systemic treatment. The volume of therapeutic interventions with psoriasis is determined by the main parameters of skin (stage, type, duration, course, etc.) and articular (lesions amount and symmetry, clinical anatomic and clinicoroentgenological variants of course etc.) pathologic processes and the degree of systemic manifestations. Systemic treatment is aimed at the elimination of dominating manifestations of associated lesions, reduction of systemic symptoms of psoriasis and the use of preventive and curative interventions in order to improve functional state of skin and articular apparatus in psoriatic processes. Systemic treatment is aimed at the reduction of psoriatic process activity by slowing of cutaneous syndrome progression and

	destruction of bone structure of articular apparatus. Systemic suppressive therapy of psoriasis is recommended with moderate and severe degree of cutaneous and articular sickness syndrome and includes the use of: □ glucocorticosteroids; ■ disease modifying drugs (DMD) - cytostatic immunosuppressants (methotrexate, cyclosporine), sulfasalazine, gold preparations, leflunomide, aromatic retinoid; ■ preparations of biological effects - monoclonal antibodies to tumor necrosis actor and its soluble receptor (infliximab, adalimumab, etanercept); ■ other biological agents (anakinra, alefatsepta, efalizumab, abatacept). Prescription of systemic corticosteroid hormones in the therapy of psoriasis requires comprehensive study. It should be kept in mind that systemic therapy with use of glucocorticosteroids frequently results in destabilization of psoriasis with formation of torpid, severe and atypical forms of dermatosis. Accordingly, the indications for use of such therapy in psoriasis are only generalized arthritis with pronounced exudative components, malignant form of arthropathic psoriasis, sharply pronounced organ manifestations, the combination of articular syndrome and atypical or extensive cutaneous psoriatic process (pustular psoriasis, psoriatic erythroderma and extensive exudative psoriasis), intolerance to disease modifying drugs. Disease modifying drugs (DMD) are the preparations of pathogenic effect with immunosuppressive property and capable of inducing remission of psoriasis or reducing the rate of development of articular destruction and cutaneous pathologic process. Curative effect of DMD appears in one to two months and more after the start of treatment, what is connected with the necessity of their accumulation in organism. In psoriasis those DMD are used, as a rule, which are widely used in rheumatology. Not only methotrexate, cyclosporine, sulfasalazine, leflunomide and the preparations of biological effects are dominating among them, but also colchicine, derivatives of fumaric acid, mycophenolate mofetil, somatostatin, aromatic retinoids. Retinoids, which are already used about 30 years in dermatological practice, are characterized by high efficiency in moderate and severe course of psoriatic disease, psoriasis of hairy part of the head, arthropathic psoriasis and with psoriatic lesion of nail plates. The developments of the recent years have led to the appearance of new aromatic synthetic analogue of retinoid acid - acitretin, mechanism of action of which lies in inhibiting the proliferation of epithelial cells, normalization of

	keratinization processes and stabilization of membrane structures of cells, including liposomes. Prolonged use of SMD and DMD gives the possibility to control the activity of psoriasis and its main syndromes, slow down the rate of disease progression, contribute to preservation of working capacity of patients and improve their quality of life. The use of DMD in therapy has a positive effect on the course not only of the pathological articular process, but cutaneous syndrome, as well, that provides for reduction of use of external therapy. Topical therapy. Among many methods of psoriasis treatment, the preparations of external therapy and skin care products are essential. Rationally found external therapy for psoriasis is of great and often key importance. For the majority of patients with limited plaque form of psoriasis, this choice of therapy under condition of elimination of main initiating agents becomes the only. With other, more severe clinical forms and extensive pathological process, the external therapy is rather ponderable addition to the systemic one. External treatment is carried out first of all considering the process staging. Local therapy is also divided into non-suppressive and suppressive. Non-suppressive treatment of psoriasis provides for use of skin care means (local means with softening and/or moisturizing effect, which do not contain the active substances - emollients), and means, which include salicylic acid (2% in progressive stage, 4% - in stationary stage and 10% - in regressive stage) or urea (2-10%), tar preparations, as well. The use of urea and salicylic acid is connected with their cheratolic, antimicrobial and keratoplastic properties. The best studied pharmacological agents of psoriatic suppressive treatment are topical glucocorticosteroids (TGCS), analogues of vitamin D3, topical retinoids (TP), hydroxiantrons. Topical glucocorticosteroids are important means of external therapy of psoriasis due to their rapid anti-inflammatory effect and pronounced wide range of actions. The strongest TGCS of the IV class of activity such as clobetasol propionate in the form of ointment and cream can be used in the severe recurrent course of psoriasis during short course (one to two weeks), after that it is advisable to prescribe the other, less strong TGCS, in particular, of the III or the II class (Locoid, Eloson, Momederm, Moleskin, CelestodermV, Cutivate, Laticort, Flucinar etc). However, prolonged use and application of corticosteroids on the large surface, inhibition of the function of adrenal cortex and the development of undesirable side effects are possible. For

	such a reason, thorough selection of TGCS is essential, with optimal efficiency and low possibility of occurrence of local and systemic side effects. It especially concerns the prescription of TGCS for children with psoriasis. In this aspect such TGCS as fluticasone propionate (Cutivate), hydrocortisone butyrate (Locoid), methylprednisolone aceponate (Advantan) have the advantage. Combined therapy of TGCS combined with salicylic acid (LorindenA) or urea (Betasalic) is appointed with the pronounced skin flaking. Emollients are the key skin care products for the patients, suffering from psoriasis, providing restoration and protection of the horny layer of epidermis, maintaining hydro lipid balance and preventing transepidermal water loss. By origin the emollients can be hydrophilic, lipophilic and combined (amphophilic). These means can contain various compounds of mineral and organic origin, these are the higher fatty acids, triglycerides, ceramides, phospholipids, squalene, cholesterol, liquid paraffin, white petrolatum, urea, glycerol, etc. Depending on production technology emollients can be presented by simple emulsion in the form of «water in oil» or «oil in waten", laminar emulsions, liposomes/microspheres, nanoparticles and other forms. For the local therapy of moderate and moderately severe psoriasis synthetic retinoids (Tazarotene) and analogues of vitamin D3(Calcipotriol, Tocalcitol) in the form of ointment, cream, gel are used. Phototherapy is one of the effective treatments of psoriasis. The following forms of light therapy are recommended: - Natural insolation (heliotherapy); - Ultraviolet irradiation - selective phototherapy (wave length of 280-320 nm, dose of 0,05-0,1 J/cm2 in a day, during the period up to two months); - PUVA-therapy (systemic and local); - Re-PUVA-therapy (retinoids + PUVA). Photochemotherapy is used in case of moderately severe and severe forms of psoriasis. However, it must be taken into account the possibility of side effects development (itching, erythema, blisters, stimulating of malignant course of neoplasms) and the risk of skin cancer. At the Department of Dermatology and Venereology of Bogomolets National Medical University, zonal UV-irradiation by means of quartz lamps according to the schedule, developed by Professor I.I. Pototsky, is widely used, ensuring the achieving of significant clinical effect in the treatment of different forms of psoriasis. Additional methods of treatment of psoriasis involve

	physiotherapy, balneal and climate treatment, phytotherapy, psychosocial therapy, surgical treatment and others.
Lichen planus	is a peculiar reaction of organism of undetectable etiology, which is manifested as monomorphic papular rash on the skin and mucous membranes. This skin disease is usually regarded as multifactorial. Endogenous and exogenous factors along with genetic anomalies can be essential in the formation and character of the course of pathological process with lichen planus.
Etiology	lichen planus cannot be regarded as finally established. In the development of dermatosis a significant part is assigned to infectious factors (viruses), toxic-allergic effects, as well as neurological and immune disorders. The researchers, who speak in favour of infectious nature of dermatosis, make reference to the good results of treatment with use of antibiotics, cases of familial disease, as well as identification of intracellular viral inclusions in these patients. The theory of neurogenic genesis of the disease is confirmed by frequent cases of lichen planus appearance after stressful situation, effectiveness of hypnosis or reflex-segmental therapy in some patients, and the location of rash sometimes along the nerves. Endocrinal theory of disease appearance is based on the hormonal and metabolic disorders in organism. A genetic predisposition to such pathology, transmitted in an autosomal-dominant pattern of inheritance is established.
Pathogenesis	lichen planus has got a lot of links, the interaction of which is diverse and not completely studied. According to the current judgment, the main organ, where there appears a pathological picture, is a skin, as it is the place, where the pronounced dystrophic and inflammatory reactions occur. The reasons and mechanisms of pathological skin changes in lichen planus are studied insufficiently. Currently, changes in an immune system, including those of autoimmune processes, are proved to be significant in the development of lichen planus.
Epidemiology	Lichen ruber planus (LRP) occurs quite often. According to the data of most researchers, the people at the age of 30 to 60 years prevail among the patients with lichen planus. Lichen planus in children is rare. In general structure of dermatological morbidity, lichen planus constitutes from 1 to 1.5%, it makes from 11 to 30-35% among the disease of oral mucosa. Lichen planus occurs in all countries and in different climatic geographical areas, the incidence of disease varies over a wide range.

Classification	Lichen planus of skin and mucous membranes is characterized by a great variety of atypical forms that significantly complicates diagnostics. Clinical forms of lichen planus: - typical (classical or usual) form; - atypical form;. - linear lichen planus (lichen ruber linearis seu lichen ruber striatus); - annular lichen planus (lichen ruber anularis); - lichen rubber monoloformis (Wise-Reindisease, Kaposi's disease) (lichen ruber planus monitiformis Kaposi); - lichen planus of the scalp (lichen ruber planus capillitii); - lichen planus of the palms and soles (lichen ruber planus palmarum et plantarum); - erythematous form (lichen ruber erythematosus Kaposi); - hypertrophic (verrucous) form (lichen ruber hypertrophicus seu verrucosus); - follicular form (lichen ruber follicularis seu spinulosus); - lichen planus obtusus (Unna) (lichen ruber obtusus Unna), - atrophic form (lichen ruber planus atrophicus); - bullous or pemphigoid form (lichen ruber bullosus seu pemphigoides); - pigmentary form (lichen ruberpigmentosus); - apsoriasiform lichen planus (lichen ruber planus psoriasiformis Broca); - tropical lichen planus (lichenplanus tropicalis). It is accepted to distinguish between six forms of lichen planus on the mucous membrane of the mouth and vermillion border: - typical; - exudative-hyperemic; - erosive-ulcerative; - bullous; - hyperkeratotic; - atrophic.
Clinical picture	Typical form of lichen planus is characterized by monomorphic rash, formed by lenticular inflammatory shiny polygonal papules, on the surface of which there can be observed pathognomonic for the disease Wickham's striae opal-like white and grayish dots and stripes. Striae becomes more visible, if the surface of papules is moisten with water, plant or vaseline oil. Its formation can be explained by uneven granulosis. There is umbilication in the center of some papules. Merging with each other, small papules can form plaques with distinct boundaries

	of bluish discoloration, covered with fine plaques. In advanced stage of disease the positive Koebner's phenomenon (the appearance of rash in the sites of even insignificant skin traumatization) is observed, as well as itching. The rash is localized predominantly on the skin of inner forearms, wrist and ankle joints, sacrum and externalia area. The rash can spread throughout the entire skin cover (except face). With the regression of the process the secondary pigmentation remains on the sites of the papules. Sometimes there occurs cicatrical alopecia on the hairy part of the head. In 25-70% cases of lichen planus, together with skin lesion there occur lesions of oral mucosae (cheeks, tongue, gingivae, palate) and externalia, which can be isolated or combined with skin lesion. Firstly, there appear small papules of greyish-white color, sharply defined on a pink background of mucosa, then the plagues form. The papules on the mucosae do not have typical shine, the infiltrate can be moderately expressed, and the elements hardly rise above the mucosal surface. They are mainly localized on the internal surface of cheeks on the line of the contact of teeth (molars), where they form whitish figure, similar to frond. Change of nail plates in lichen planus is characterized by the formation of sulci, grooves, sites of opacification; the nails can become thinner, or they can be even destroyed in part or in whole, in this connection there are two the most common types of nail changes in this dermatosis, these are onychorrhexis and onycholysis. Thus, the main clinical morphological primary element of rash in lichen planus is lenticular dermo-epidermal inflammatory papule, with the following characteristics for this dermatosis: ■ polygonal outsides; ■ umbilication in the center; ■ absence of tendency to peripheral enlargement; ■ presence of so-called Wickham's striae, which becomes visible in the deep of papules after their surface are moisten with water or oil; ■ bluish-red (or lilac) pearly papules and polished shine of their surface with side lightning.
Diagnostics	Diagnostics is based on the clinical and histological data.
Differential diagnostics	Differential diagnostics is carried out with psoriasis, toxic-derma, neurodermatitis, verrucas plantar, papular syphilides. For clarification of diagnosis a skin biopsy is usually made.

Treatment	Currently, due to absence of a common conception of etiology and pathogenesis of lichen planus there are numerous methods of treatment of this disease. Taking into account the complexity of pathogenesis of lichen planus, success is possible only in the complex pathogenetic individualized therapy with use of modern methods. Thus, it is important to take into account the conditions, enabling disease appearance, risk factors, accompanying pathology, the presence of foci of focal infection, previous treatment. Traditional treatment involves antibiotic therapy, sedatives and antihistamines, topic corticosteroids, vitamins (A, D, E), retinoids (vitamin A derivatives), with use of exogenous interferon and interferonogenes, phonophoresis with sedative and anti-inflammatory drugs, cryomassage and cryodestruction (especially with verrucous form). Retinoids (tigason, neotigason, etretinete) reduce the intensity of inflammatory reaction, influence the state of cell membranes and normalize the processes of proliferation. Retinoids are more effective in lesion of oral mucosa and vermillion zone. In the therapy of lichen planus the analogues of vitamin A carotenoids are used as well, especially in atypical forms, including erosive ulcerous, and in lesions of oral mucosa and genitalia as well. Of topical corticosteroids the preparations of strong and very strong action are used in complex therapy of lichen planus. In case of severe lesion the appropriate therapy should be started according to the principle of "powerful start", using the drugs of the IV power category of action with short courses of administration (one-two weeks) with the following transition to the TGCS of the III or II classes.
Prognoses	lichen planus is favorable. However, the malignant transformation of papules is described in lichen planus. Its erosive ulcerous form on the oral and lips mucosa is considered to be precancerous condition. In this relation, the methods of treatment connected with irritation and cauterization should be avoided. In the long course of erosive ulcerous forms of lichen planus, hardly answering the treatment, it is necessary to carry out a histological study in order to detect malignification.