INTRODUCTION
Psoriasis is chronic inflammatory skin disease of multifactorial inheritance which is characterized by excessive cell proliferation and incomplete differentiation in lesional epidermis.

Friedman (1955) recounts William Allen Pusey's speculation that prehistoric man cognizant of skin disease and developed way of obliterating sand fleas, parasites, sores, scrabs and other cutaneous affictions.

It is possible that the scribes of the Third Book of the old Testament were referring to psoriasis when they related the words of the Lord to Moses in teaching the people of Israel in diagnosing leprosy and adhering to the laws of cleanliness.

"When a man shall have in skin of his body a swelling or an eruption or a spot and it twins into a leprous disease on the skin of his body, then he shall be brought to Aaron the priest or to one of his sons the priests"

(Leviticus 13.2)

Van Scott and Ekel (1963) said skin mirrors not only the often unkind effect of the environment but internal, physical and emotional conditions as well. Disease of skin accounts for a great deal of misery, suffering incapacity and economic loss.
Psoriasis is a common recurrent disease of skin. It is characterized by rounded circumscribed erythematous dry scaling patches of silver white imbricated and abundant scales. The lesions have predilection for the scalp.

Figure 1: different location of psoriasis
nails, extensor surfaces of limbs, elbows, the knees and the sacral regions. The eruption usually develops slowly but may be exanthematous with sudden onset of numerous guttate lesions or may consist of few patches. Subjective symptoms such as itching is some time present and cause extreme discomfort.

The early lesions are guttate erythematous macules which from the beginning are covered with dry silvery white scales. By peripheral extension and by coalescence the patches increases in size and through accumulation of scales, become thicker. Nummular (coin-shaped) lesions are common. In this variety certain distinctive features may be easily demonstrated. The scales are micaceous. They are loose at periphery adherent at its centre. When patch reaches a diameter of about 5 cm they cease spreading and tend to undergo involution in the centre so that annular lobulated and gyrate figure are produced.

Old patches may be thickened, tough and covered with lamellae of scales so that they resemble the outside of an oyster shell (Psoriasis ostraeca). Various other descriptive terms are applied to the diverse appearance of lesions: psoriasis guttate, in which the lesions are the size of drops" psoriasis follicularis in which tiny scaly lesions are located at the orifices of the pilosebaceous follicles; psoriasis figurate, psoriasis annulatta and psoriasis
Figure 2: different location of psoriasis.
gyrate, in which curved linear patterns are produced by central involution; psoriasis discoidea in which central involution does not occur and solid patch persist; psoriasis rupiodes, in which crustaceous lesions occur resembling syhilitica rupia. Bullous psoriasis has been rarely observed (Eugen M. Farber 1991).

Andra Peserico et al. (1998) said a number of studies has reported an increased prevalence of Hypertension, Dislipoproteinameia, Diabetes mellitus and Hyper uricaemia in psoriasis.

O. Simonett et al. (1992) said changes in plasma lipid and lipoprotein composition in psoriatic patients suggest that psoriasis may be linked to the disorder of lipid metabolism. The modification of plasma lipoprotein composition, more pronounced in patients with severe form of the disease may be related to increased risk of artheosclerosis observed in adult psoriatic patients.

Many epidemiological studies have clearly demonstrated that the risk for coronary heart disease is positively correlated with low density lipoprotein and total cholesterol levels and negatively correlated with HDL levels [JAMA, 1985]. Several studies have also suggested that quantification of apolipoprotein moieties of plasma lipoprotein can provide additional information in this respect (Noma. A. et al., 1983).

A number of studies have demonstrated an increased prevalence of hypertension, hyperlipoproteinamia and diabetes mellitus in psoriasis (Lindegard, 1986). Particular interest has been focused on
hyperlipoproteinaemia because it leads to an increased incidence of coronary heart disease or thromboembolic disorders (Piskin S. et al. 2003, ReynosoVan Dratelnc et al. 2003). Apolipoproteins are constituents of lipoproteins, and they play an important role in the metabolism of lipoproteins in serum. Although there are several studies relating to apolipoproteins in psoriasis but their results are conflicting (Peserico, 1988, Uyanik BsS et al. 2002).

This discrepancy may be explained by differences in the severity of disease in the patients studied and possibly also inclusion of psoriatic patients.

In order to further investigate the abnormalities of plasma lipoprotein, apolipoprotein and total proteins this study has been planned. The aims and objectives of this work are-

1. To find out the significance of Lipid profile, apolipoprotein, total protein and antioxidant enzyme (SOD, GSH-PX and catalase)
2. To find out whether a correlation exist between the severity of disease with lipid profile, apolipoprotein, Total Protein and antioxidant enzymes.