The "Heart" Break of Psoriasis

By Gregory Cohn, MD.

Psoriasis is one of the most common skin diseases in the world, affecting approximately 125 million people, including about 7.5 million in the United States. While the disease may begin at any age, there are two peak periods of onset: between 15–25 and between 50–60 years of age. The characteristic flaky-appearing psoriatic plaques tend to be symmetrical and typically occur on the elbows, knees, scalp, lower back, and umbilical areas. Clinical manifestations of this disease can range from mild, limited skin involvement to very severe, with a majority of the body surface being involved. Arthritis associated with psoriasis can occur in around 25% of patients, and can actually precede the development of skin lesions in a minority of cases. Regardless of the disease severity, the vast majority of patients with psoriasis report that the disease has an adverse effect on their quality of life, whether it is from physical symptoms, embarrassment at their physical appearance, or other reasons. There are 3 main types of treatment for psoriasis: topical agents, phototherapy, and systemic drugs.

Psoriasis is known to be associated with other disorders, including Crohn's disease, diabetes, and certain types of cancer. However, patients with psoriasis and the medical community at large are mostly unaware of an increased risk for coronary artery disease (CAD) associated with this disease. This fact recently prompted several experts to release a consensus statement about this association in a major medical journal. While they frankly admit that there are large gaps in the available database, and that most of the information does not come from randomized, blinded trials, the existing evidence does point to a link between psoriasis and CAD, especially those with moderate-severe disease. Current thinking holds that the link between these 2 diseases partially stems from the *increased prevalence of common CAD risk factors in patients with psoriasis*. These include obesity, cigarette smoking, elevated levels of LDL and lower levels of HDL-cholesterol, hypertension, and diabetes/Metabolic Syndrome. Depression is also seen with increased frequency in patients with psoriasis, and may be a powerful predictor of cardiovascular risk. It is also felt that *inflammation* provides another critical link in this connection. Inflammation is known to play a significant role in the development of psoriasis, and many patients with psoriasis have elevated levels of hs-CRP, a very sensitive marker of the presence of inflammation. The best available treatments for psoriasis are in fact anti-inflammatory, and the newest class of biologically engineered compounds (Enbrel, Remicade, and Humira) used to treat this disease specifically inhibit an inflammatory pathway closely related to the CRP marker. I have discussed in previous articles the cardiovascular benefits that may ensue from lowering levels of inflammation (most recently seen in the JUPITER study).

Psoriasis can be an extremely challenging disease to treat. Precisely because it may require rapt attention to manage the many physical and emotional aspects of this disease,

risk factors for coronary artery disease, if present, may not be diagnosed or treated as aggressively as is warranted. The take home message here is that if you have psoriasis, particularly if it is moderate or severe, you may have an increased risk for coronary artery disease, and should have an appropriate evaluation by a medical professional. Preventing a heart attack is always better medicine than trying to pick up the pieces after one has already occurred!

Gregory Cohn, M.D. has a concierge Internal Medicine practice in Boca Raton specializing in Cardiovascular Disease prevention and Hypertension. Dr. Cohn is a board-certified internist and clinical lipidologist and has been practicing medicine in Florida since 1991. Dr. Cohn can be reached at (561)367-7447 or www.gregcohnmd.com.