Fire, skin, and fat: Inflammation, psoriasis, and cardiovascular disease

Perhaps 3% of the population has psoriasis. Thus, it is impossible to practice any aspect of internal medicine without encountering patients with this disease.

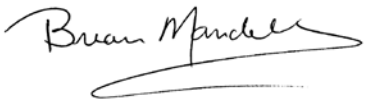
In this issue of the *Journal* (page 413), Dr. Jennifer Villaseñor-Park and her colleagues discuss the clinical patterns and management of psoriasis and the links between psoriasis and cardiovascular disease—links that should bind the internist and dermatologist in a shared mission of comanagement.

The connection between inflammation and atherosclerosis is now well known. Many of the same cellular and biochemical players have active roles in the inflammation of rheumatoid arthritis, systemic lupus erythematosus, psoriasis, and atherosclerosis. The observation that patients with inflammatory diseases have a higher prevalence of cardiovascular disease seems to strengthen this apparent link and supports the concept that drugs used to treat inflammation in the joints and skin might also reduce the burden of cardiovascular disease.

But addressing this risk is not so straightforward. Since the increased cardiovascular risk in rheumatoid arthritis and systemic lupus erythematosus is not completely explained by traditional risk factors, research is ongoing to identify the potential mechanisms of this risk, such as high-density lipoprotein particles modified by inflammation and high circulating levels of interferon, both of which may be atherogenic. It remains to be seen whether these and other potential nonclassic mediators of atherosclerosis can be targeted and cardiovascular events reduced.

But psoriasis is a little different. Compared with patients with rheumatoid arthritis and lupus (if they have not been affected by corticosteroid treatment), patients with psoriasis tend to be heavier and to have a higher prevalence of fatty liver disease and the metabolic syndrome. A debate continues as to whether psoriasis per se is a unique risk factor for cardiovascular disease or whether in fact these comorbidities constitute the major risk for cardiovascular events in patients with psoriasis.

The epidemiologists can continue to crunch the data in attempts to attribute the relative risks of poor outcome. But in the office, we should be vigilant and, in patients with psoriasis, should not ignore the traditional cardiovascular risk factors included in the metabolic syndrome, which is more prevalent in these patients.



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