The Medical Journal of Australia • MJA
MEDIA RELEASE

PSORIASIS: COMORBIDITIES MAKE IT MORE THAN A SKIN DISEASE

EMBARGOED UNTIL 12:01am Monday 11 May 2020

PSORIASIS should no longer be treated purely as a skin disease, but rather as a complex multisystem disorder of a chronic inflammatory nature, according to the authors of a narrative review published online today by the *Medical Journal of Australia*.

Between 2.3% and 6.6% of the Australian population have psoriasis, and while the skin is the most visibly affected organ, there is increasing evidence to support the recognition of many associated disorders, including psoriatic arthritis, cardiovascular disease, obesity, insulin resistance, mental health disorders, certain types of malignancy, inflammatory bowel disease and other immune-related disorders, and hepatic and renal disease.

“Enhanced recognition of these comorbidities may lead to earlier diagnosis and potentially better overall health outcomes,” wrote the authors, led by Dr Tom Kovitwanichkanont, from the Skin Health Institute.

“Acknowledgement and understanding of the relationship between psoriasis and other diseases is important for optimal patient care,” they wrote.

“Primary care providers and general physicians are well placed to identify and manage these comorbid diseases. Although most patients with psoriasis are managed in primary care, the management of extracutaneous manifestations of psoriasis has yet to be fully explored in this context.”

The narrative review details the following areas:

Psoriatic arthritis: a form of inflammatory arthritis, with a prevalence between 6% and 41% in people with psoriasis; early treatment of psoriatic arthritis can significantly improve joint and quality of life outcomes and prevent permanent joint damage.

Cardiovascular disease: psoriasis is an independent risk factor for myocardial infarction, stroke and peripheral vascular disease; cardiovascular disease is one of the leading causes of excess death in patients with severe, but not mild, psoriasis; it is likely related to the inflammatory mediators that are important in the pathogenesis of both psoriasis and atherosclerotic diseases.

Obesity and insulin resistance: psoriasis is associated with several metabolic risk factors, including obesity, type 2 diabetes mellitus, hypertension and dyslipidaemia; weight loss interventions through low-energy diet (800–1000 kcal/day) and gastric bypass were shown to improve psoriasis outcomes; it is estimated that for every 10% increase in body surface area affected by psoriasis, there is a 20% additional increase in risk of diabetes development.

Excessive alcohol and tobacco consumption: cigarette smoking was found to increase the risk of psoriasis development and the severity of psoriasis; excess alcohol consumption has been linked with development of psoriasis, more severe skin disease and less favourable response to psoriasis treatment.

Psychosocial impact and effect on quality of life: individuals with psoriasis have been found to have a significantly increased risk of depression and anxiety compared with non-affected individuals; psoriasis affects several factors that contribute to worsened quality of life, including fear of stigmatisation, impaired social life, higher rates of unemployment, and sexual dysfunction.

Malignancy: people with psoriasis have been found to have a higher incidence of certain malignancies relative to age-matched controls without psoriasis, including lymphoproliferative disorder (strongest association occurring with cutaneous T-cell lymphoma and Hodgkin lymphoma), non-melanoma skin cancer and malignancies of the gastrointestinal tract, bladder, lung and head and neck.

Inflammatory bowel disease and other immune-mediated diseases: psoriasis and psoriatic arthritis have been associated with inflammatory bowel disease and several other immune-mediated conditions, including coeliac disease, alopecia areata, vitiligo, rheumatoid arthritis, autoimmune thyroid disease, and systemic sclerosis.

Hepatic disease: there appears to be an association between psoriasis and non-alcoholic fatty liver disease.

Renal impairment: moderate to severe psoriasis was found to be an independent risk factor for chronic kidney disease; possible explanations include accelerated atherosclerotic injury to the kidneys from chronic inflammation in psoriasis and the greater incidence of glomerulonephritis in patients with psoriasis.

“Given our improved understanding of psoriasis, we should no longer treat psoriasis purely as a skin disease. The chronic inflammatory nature of psoriasis likely contributes to the comorbidities of this complex multisystem disorder,” Kovitwanichkanont and colleagues concluded.

“Given the interdependent relationship between the various comorbidities and psoriasis, effective management of moderate to severe psoriasis is likely to have benefit on comorbidities and overall patient outcome. Primary care providers and general physicians play a crucial role in recognising and managing these comorbid conditions.”

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