Psoriasis, psoriatic arthritis and cardiovascular risk: are we closer to a clinical recommendation?

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The issue of vascular risk in chronic arthropathies and especially the magnitude of such risk and its clinical implications in daily practice are of considerable current importance. Similarly, the relative risk across distinct arthropathies and other chronic inflammatory conditions is debated. Ogdie et al1 report associations between psoriasis, psoriatic arthritis (PsA), rheumatoid arthritis (RA) and an increased risk of major adverse cardiovascular events (MACE—myocardial infarction, stroke and cardiovascular death) in data derived from the UK primary care registry. Results are stratified by use of disease-modifying antirheumatic drugs (DMARDs). The risk for MACE appeared overall highest among patients with RA, and higher for DMARD users than non-users in RA and psoriasis. By contrast, combined risk of all outcomes was increased less in patients with PsA, and here, DMARD users had lower risks than non-DMARD users.

The statistical and epidemiological methods applied here are apparently sound, and important new information on increased cardiovascular risk in PsA, together with reaffirmation of earlier findings in psoriasis and RA, is presented. Limitations include their categorical adjustments for lipids and hypertension rather than adjustment for continuously measured risk factors. In addition, their somewhat arbitrary use of treatment (DMARDs). The risk for MACE appeared overall highest among patients with RA, and higher for DMARD users than non-users in RA and psoriasis. By contrast, combined risk of all outcomes was increased less in patients with PsA, and here, DMARD users had lower risks than non-DMARD users.

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Finally, in each of these conditions, we lack clinical trials to show that modulation of inflammation lessens cardiovascular risk, although current observational data with their inherent limitations point in this direction. It is hard to design appropriate cardiovascular disease end-point trials to test the inflammation–cardiovascular disease hypothesis in autoimmune conditions. Healthcare professionals will nevertheless continue to target such disease activity as best they can in line with current guidelines, not least because optimising articular and cutaneous well-being is a priori a critical aim of treatment paradigms. What is now clearly also needed is education programmes for rheumatologists and dermatologists to help them better manage cardiovascular and metabolic risks in their patients. Such education, which does not need to be onerous, will help lessen cardiovascular risks further in their patients.

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