PSORIASIS. Una enfermedad sistémica

MAS PROFUNDA QUE LA PIEL

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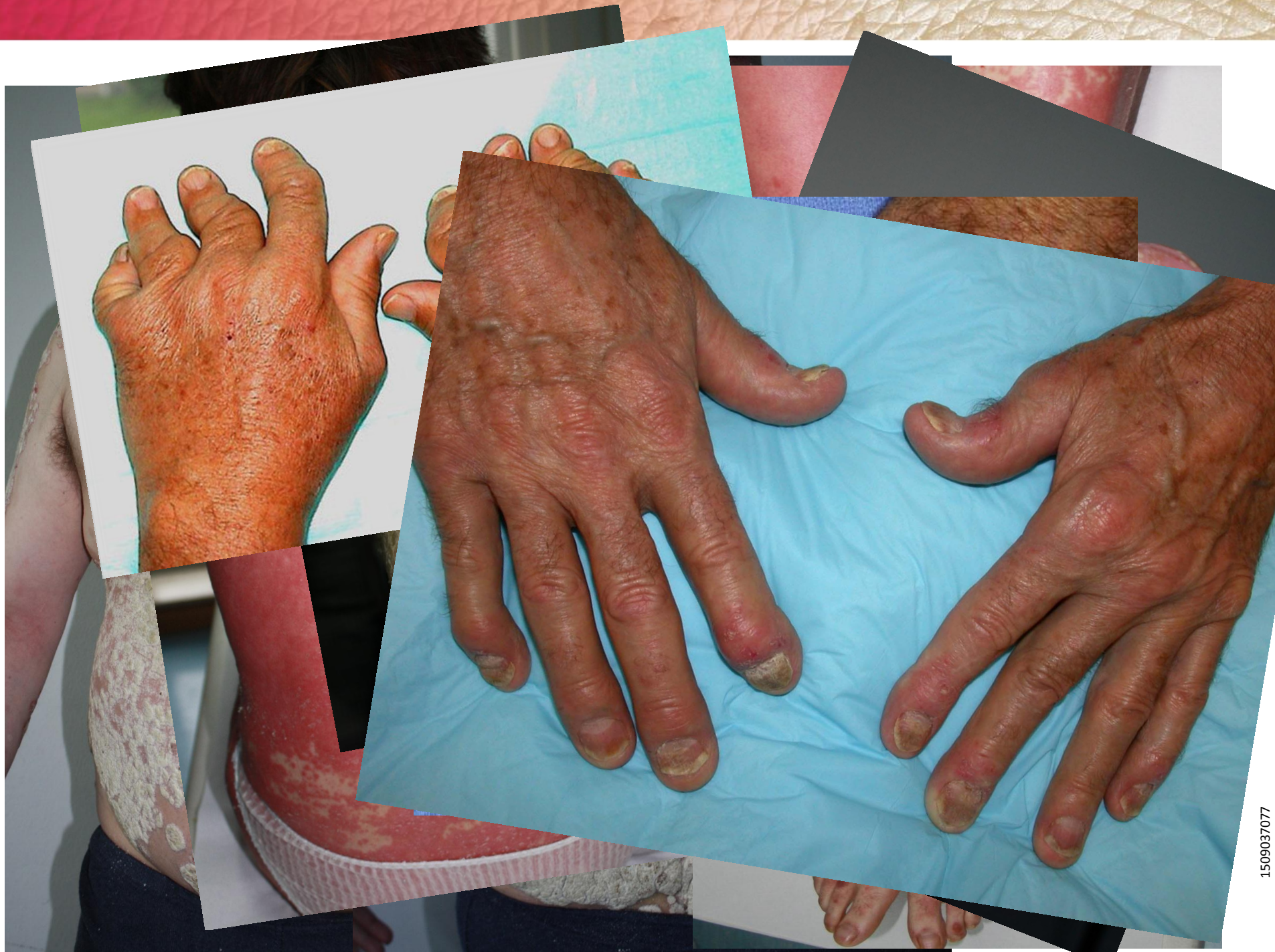
CONFLICT OF INTEREST

- Dr. Pablo Coto-Segura is a consultant and/or speaker, has received speaking fees and/or unrestricted research and/or educational grants and/or conducted clinical trials of Abbvie (former Abbot laboratories), Celgene, Gebro, Lilly, MSD, Novartis, Pfizer, Janssen-Cilag Pharmaceuticals and UCB pharma.



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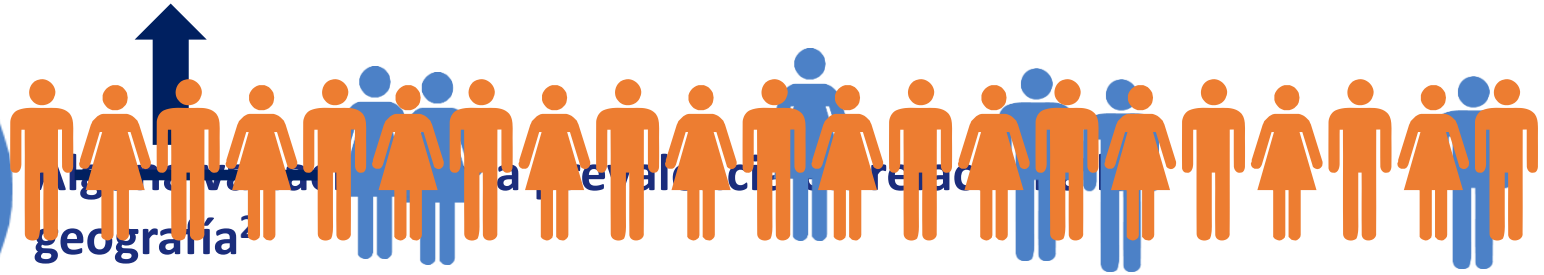
Psoriasis Prevalencia mundial **2%**

Tasas más altas notificadas en las latitudes del norte[3]



Alta variación en la prevalencia relacionada con la geografía[3]

A menudo aparece en la franja de edad de 16-25

... pero se puede desarrollar a cualquier edad[4]

Las tasas son más altas entre las personas de raza blanca que las de otras etnias[3]

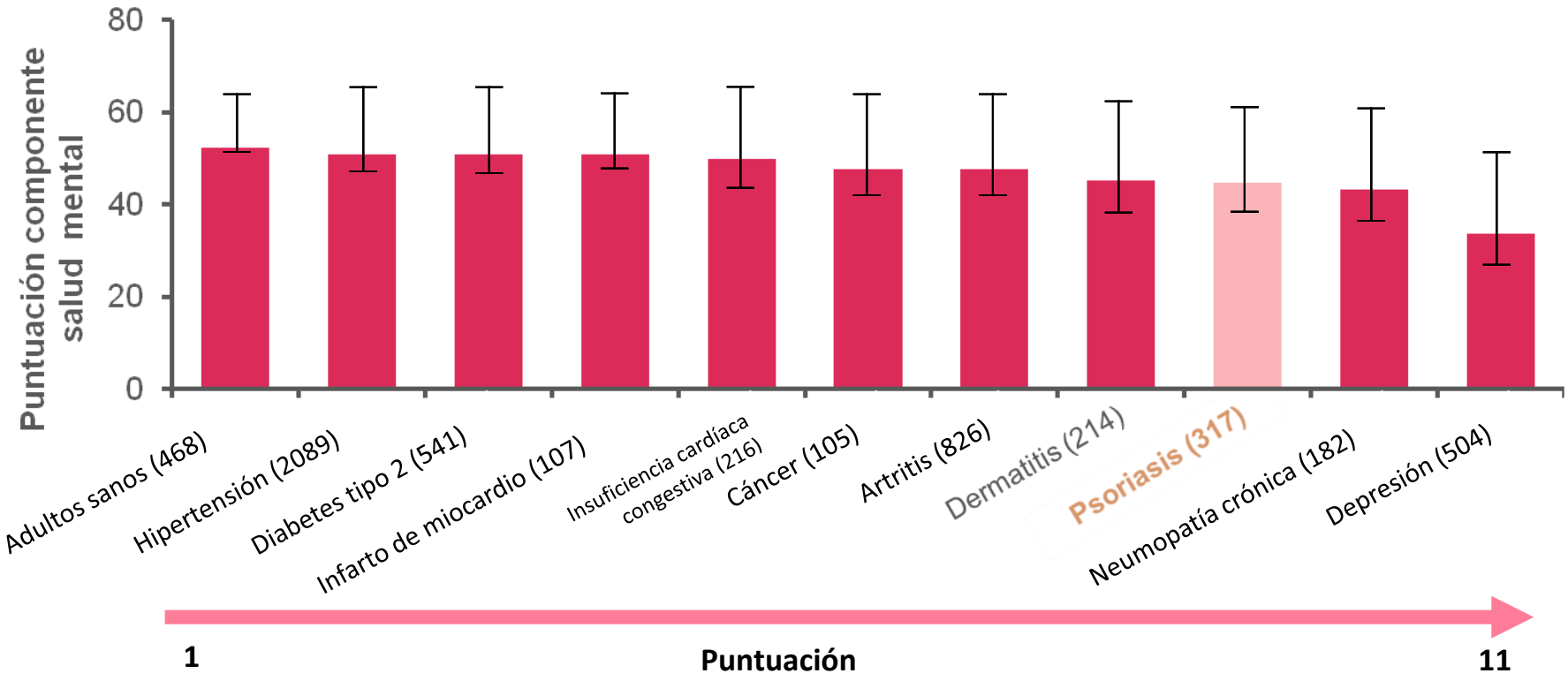
No hay diferencia de género por lo que respecta a la prevalencia[3]

- 1. Christophers E. *Clin Experiment Dermatol* 2001;26:314–20. 2. Parisi R et al. *J Invest Dermatol* 2013;133,377–85. 3. Raychoudhuri SP and Farber EM. *JEADV* 2001;15:16–17. 4. Henseler T and Christophers E. *J Am Acad Dermatol* 1985;13:450–6.

El impacto psicológico de la psoriasis es similar al de otras enfermedades crónicas

Enfermedades evaluadas con el **componente de salud mental del cuestionario SF-36.**

- Una puntuación cercana a **1 indica un mejor funcionamiento.**



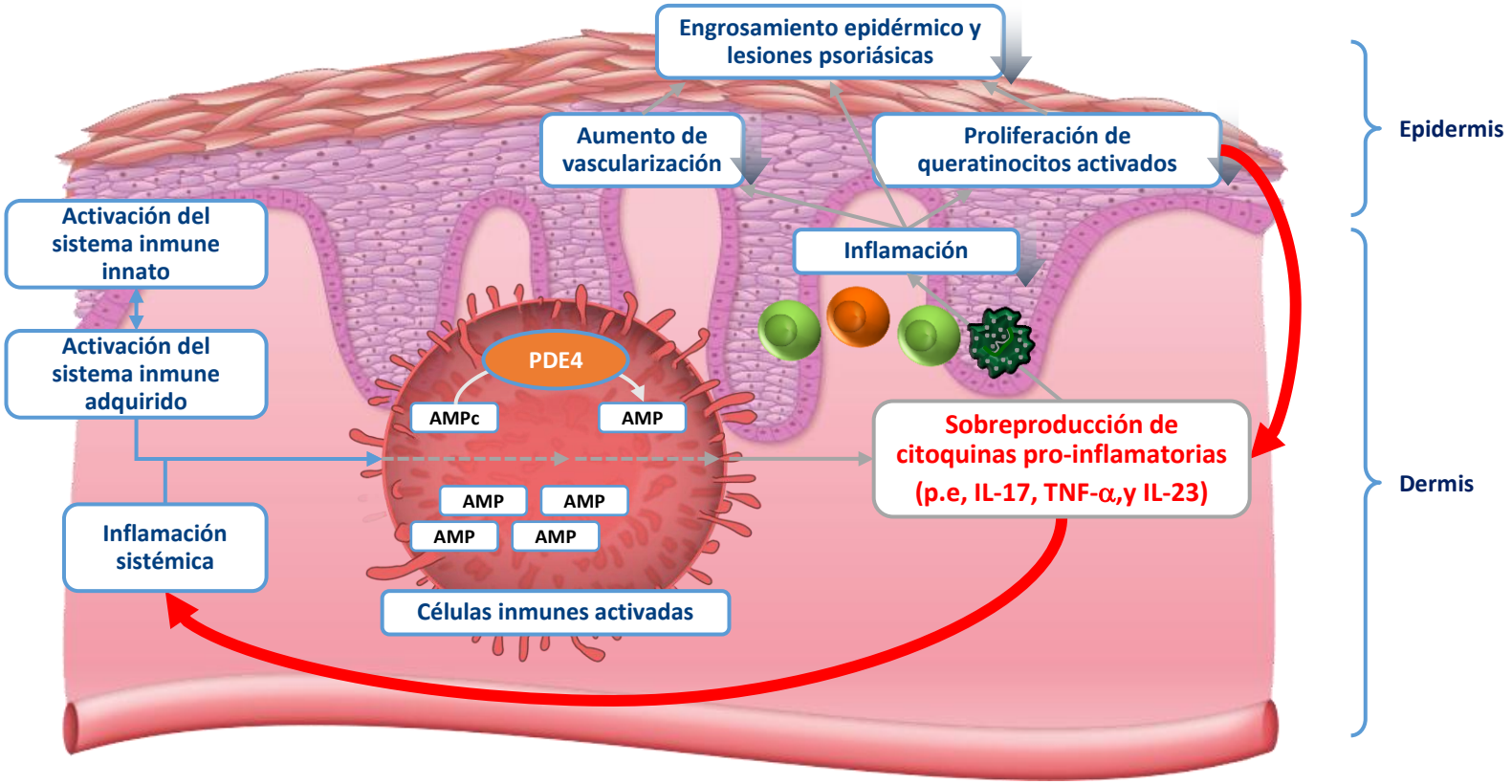
Adaptado de Rapp S, *et al*. *JAAD* 1999;41;401

Psoriasis: Efectos en la calidad de vida

Los **efectos de la psoriasis en la calidad de vida de los pacientes es similar a la de enfermedades como el cáncer**, ataques al corazón, artritis, diabetes tipo 2 y depresión.

Análisis del impacto físico, emocional y social de la psoriasis. Encuesta Accion Psoriasis 2014.

La sobreproducción de mediadores pro-inflamatorios explica muchos signos y síntomas de la psoriasis



PSO=psoriasis; PDE4=fosfodiesterasa 4; AMPc= adenosina monofosfato cíclico; AMP=adenosina monofosfato

1. Pietrzak AT et al. *Clin Chim Acta* 2008;394:7−21. 2. Coimbra S et al. *Int J Dermatol* 2012;51:389−95. 3. Boniface K et al. *J Immunol* 2005;174:3695−702; 4. Detmar M et al. *J Exp Med* 1994;180:1141−6. 5. Nakamura M et al. *Br J Dermatol* 2003;149:718−30. 6. Ash ZR et al. *Ann Rheum Dis* 2012;71:553−6; 8. Nestle FO et al. *N Engl J Med* 2009;361:496−509.

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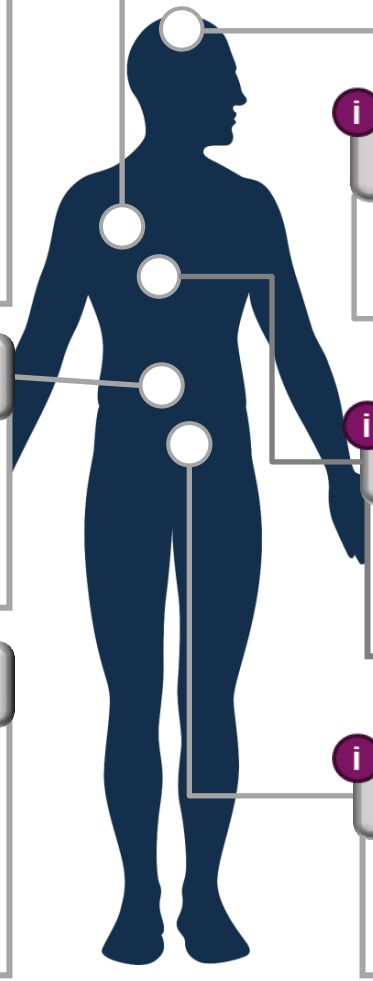
La psoriasis está asociada a muchas comorbilidades



Estilo de vida

- Enfermedad cardiovascular[1,2]
- Diabetes tipo II[2]
- Hipertensión[2]
- Obesidad[1]
- Hiperlipidemia[2]

Autoinmunes[1]

- Enfermedad reumatológica
- Diabetes tipo I

Otras

- Osteoporosis[5]
- Enfermedad hepática[1]
- Cancer[5]
- Infección[5]

Psiquiátrica[3]

- Depresión
- Ansiedad

Trastornos neurológicos[4]

- Esclerosis múltiple

Respiratorias[1]

- Asma
- Enfermedad pulmonar obstructiva crónica

Gastrointestinales

- Úlcera[1]
- Síndrome del intestino irritable[5]

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1. Yeung H et al. *JAMA Dermatol* 2013;149:1173–1179; 2. Kimball AB et al. *J Am Acad Dermatol* 2012;67:76–85; 3. Schmitt JM et al. *Dermatol* 2007;215:17–27. 4. Dobson R et al. *J Neurol* 2013;260:1272–85; 5. Husted JA et al. *Arthritis Care Res (Hoboken)* 2011;63:1729.

DOI: 10.1111/j.1468-3083.2011.04108.x JEADV

SHORT REPORT

Psoriasis and hypertension: a case-control study

S. Armesto,[†] P. Coto-Segura,[‡] C.G. Osuna,[‡] P.M. Camblor,[§] J. Santos-Juanes[‡,¶,*]

Abstract

Background Several studies stated that patient with psoriasis carried an increased risk of psoriasis but some studies did not demonstrate this association.

Objectives The aim of this study was to evaluate the prevalence of hypertension in psoriasis based on a sample of Spanish population.

Methods This was a hospital-based case-control study involving 661 psoriatic patients (cases) and 661 control matched by gender and age. Meta-analysis of the previous studies was made.

Results The prevalence of hypertension was significantly higher in psoriasis patients than controls (30.3%, 21.3%, respectively, $P < 0.001$). In a multivariate analysis, hypertension was associated with psoriasis after controlling for age, gender, diabetes, obesity and smoking (OR = 1.44, 95% confidence interval: 1.07–1.94).

Conclusion The results of this study support the association between psoriasis and hypertension.

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DOI: 10.1111/j.1468-3083.2011.04108.x JEADV

SHORT REPORT

Psoriasis and hypertension: a case-control study

S. Armesto,[†] P. Coto-Segura,[‡] C.G. Osuna,[‡] P.M. Camblor,[§] J. Santos-Juanes[‡,¶,*]

Psoriasis Vulgaris with or without Arthritis and Independent of Disease Severity or Duration Is a Risk Factor for Hypercholesterolemia

Jorge Santos-Juanes[a] Pablo Coto-Segura[b] Ivan Fernández-Vega[a]
Susana Armesto[d] Pablo Martínez-Camblor[c, e]

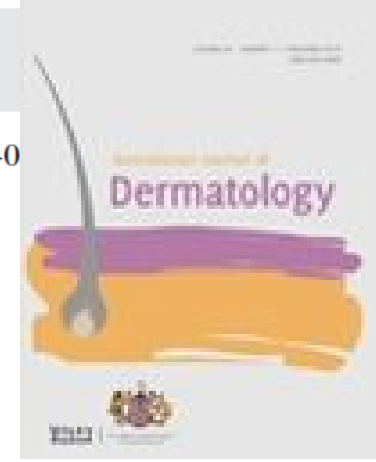
tion. ***Methods:*** A prospective hospital-based study was conducted. A total of 661 Caucasian patients with chronic plaque Ps and 661 sex- and age-matched controls were enrolled.

Table 2. Univariate and multivariate analysis for abnormal lipid levels (logistic regression models) controlled for gender, age, BMI, alcohol consumption, current smoking, HT and DM

Lipid level	Controls, n (%)	Ps, n (%)	Univariate analysis		Multivariate analysis	
			OR (95% CI)	p value	OR (95% CI)	p value
TCh >200 mg/dl	293 (44.3)	352 (53.3)	1.429 (1.150–1.777)	0.001	1.406 (1.115–1.773)	0.004
TGs >150 mg/dl	142 (21.5)	168 (25.4)	1.245 (0.964–1.067)	0.105	1.041 (0.783–1.385)	0.780
LDL >130 mg/dl	253 (38.3)	310 (46.9)	1.424 (1.144–1.773)	0.002	1.375 (1.088–1.738)	0.003
HDL <40 mg/dl	55 (8.3)	84 (12.7)	0.620 (0.433–0.888)	0.009	0.881 (0.599–1.297)	0.522

Australasian Journal of Dermatology

Australasian Journal of Dermatology (2012) 53, 128–130 doi: 10.1111/j.1440-0



Psoriasis and type 2 diabetes risk among psoriatic patients in a Spanish population

Susana Armesto,[1] Jorge Santos-Juanes,[2] Cristina Galache-Osuna,[2] Pablo Martinez-Camblor[3] Eliecer Coto[4] and Pablo Coto-Segura[2]

Table 2. Psoriatic patients also suffered more from DM2 than non-psoriatic patients (12% vs. 6.1%, $P < 0.001$, OR: 2.11 (1.39–3.20)). After adjustment for age, sex, BMI, HT, DL, smoking and alcohol consumption this difference remained significant ($P = 0.001$, OR = 2.138 (1.377–3.330)).

Alcohol consumption	232 (35.1)	223 (33.7)	0.60;1.06 (0.84–1.34)
BMI >30	182 (27.5)	91 (13.8)	<0.001; 2.38 (1.78–3.18)
DL	256 (38.7)	287 (43.4)	0.08;0.83 (0.66–1.03)
HT	200 (30.3)	141 (21.3)	<0.001; 1.60 (1.24–2.07)
DM2	79 (12)	40 (6.1)	<0.001; 2.11 (1.39–3.20)
IC	43 (6.5)	33 (5)	0.23; 1.32 (0.81–2.17)

SYSTEMATIC REVIEW

BJD
British Journal of Dermatology

Psoriasis, psoriatic arthritis and type 2 diabetes mellitus: a systematic review and meta-analysis

P. Coto-Segura,[1,2] N. Eiris-Salvado,[1,2] L. González-Lara,[1] R. Queiro-Silva,[2,3] P. Martinez-Camblor,[4] C. Maldonado-Seral,[1] B. García-García,[1] L. Palacios-García,[1] S. Gomez-Bernal,[1] J. Santos-Juanes[1] and E. Coto[2,5]

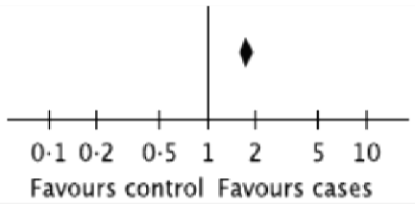
calculated. Forty-four observational studies (in 37 articles) were identified for the final analysis. The pooled OR from random-effects analysis was determined to be 1·76 (95% CI 1·59–1·96). The highest risk was for patients suffering from PsA (OR 2·18, 95% CI 1·36–3·50). We also observed a dose effect in the risk of suffering from type 2 diabetes mellitus, as patients considered as having severe psoriasis had higher risk (OR 2·10, 95% CI 1·73–2·55) than the pooled OR. We

Study or Subgroup	Case Events	Case Total	Control Events	Control Total	Weight	Odds Ratio M-H, Random, 95% CI
Tam 2008	19	102	2	82	0·4%	9·16 [2·07, 40·59]
Alexander 2001	8	69	3	64	0·5%	2·67 [0·68, 10·53]
Warnecke 2011	10	62	6	124	0·7%	3·78 [1·31, 10·95]
Nisa and Qazi 2010	27	150	8	150	1·0%	3·90 [1·71, 8·89]
Warnecke 2011	21	100	10	100	1·1%	2·39 [1·06, 5·39]
Brownstein 1966	18	94	19	94	1·2%	0·93 [0·46, 1·92]
Takahashi 2010	28	151	14	154	1·3%	2·28 [1·15, 4·52]
Driessen 2009	14	107	35	396	1·4%	1·55 [0·80, 3·01]
Naldi 2008	21	560	22	690	1·5%	1·18 [0·64, 2·17]
Tseng 2013	62	371	25	370	1·8%	2·77 [1·70, 4·52]
Armesto 2012	79	661	40	661	2·0%	2·11 [1·42, 3·13]
Gisondi 2007	65	338	70	334	2·1%	0·90 [0·62, 1·31]
Al-Mutairi 2010	54	129	294	1835	2·1%	3·77 [2·60, 5·47]
Sommer 2006	68	581	61	1044	2·2%	2·14 [1·49, 3·07]
Xu 2012	72	400	86	1000	2·2%	2·33 [1·66, 3·27]
Li 2012	52	543	1638	24146	2·4%	1·46 [1·09, 1·95]
Qureshi 2009	60	1813	1500	76248	2·4%	1·71 [1·31, 2·22]
Xiao 2009	162	1619	107	1521	2·5%	1·47 [1·14, 1·90]
Cohen 2007	95	340	1298	6643	2·5%	1·60 [1·25, 2·04]
Neimann 2006	272	3854	457	14065	2·7%	2·26 [1·94, 2·64]
Schmitt 2010	421	3147	357	3147	2·7%	1·21 [1·04, 1·40]
Mehta 2011	270	3603	737	14330	2·7%	1·49 [1·29, 1·73]
Vena 2010	299	3516	1257	17580	2·8%	1·21 [1·06, 1·38]
Han 2006	346	3066	895	12264	2·8%	1·62 [1·42, 1·84]
Brauchli 2008	626	32856	435	32856	2·8%	1·45 [1·28, 1·64]
Langan 2012	454	4065	3445	40650	2·8%	1·36 [1·22, 1·51]
Kaye 2008	1198	44164	4482	219784	2·8%	1·34 [1·26, 1·43]
Cohen* 2008	2324	16850	3556	48677	2·9%	2·03 [1·92, 2·15]
Cohen 2008	2326	16851	4013	74987	2·9%	2·83 [2·68, 2·99]
Solomon 2010	1564	40346	10732	442033	2·9%	1·62 [1·54, 1·71]
Kimball 2008	2605	25556	8336	101507	2·9%	1·27 [1·21, 1·33]
Shapiro 2007	1959	46095	58285	1579037	2·9%	1·16 [1·11, 1·21]
Kimball 2008	2750	20614	9398	82456	2·9%	1·20 [1·14, 1·25]
Azfar 2012	3992	108132	14537	430716	2·9%	1·10 [1·06, 1·14]
Augustin 2010	4118	33981	78738	1310090	2·9%	2·16 [2·09, 2·23]
Neimann 2006	5564	127706	15161	465252	2·9%	1·35 [1·31, 1·40]
Total (95% CI)		**557697**		**5186485**	**100·0%**	**1·76 [1·59, 1·96]**
Total events	34547		229379			

Heterogeneity: $Tau^2 = 0·10$; $Chi^2 = 2174·24$, df = 43 ($P < 0·00001$); $I^2 = 98\%$

Test for overall effect: $Z = 10·56$ ($P < 0·00001$)

Total (95% CI) 557697 5186485 100·0% 1·76 [1·59, 1·96]
Total events 34547 229379
Heterogeneity: $Tau^2 = 0·10$; $Chi^2 = 2174·24$, df = 43 ($P < 0·00001$); $I^2 = 98\%$
Test for overall effect: $Z = 10·56$ ($P < 0·00001$)



0·1 0·2 0·5 1 2 5 10
Favours control Favours cases

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Meta-analysis of psoriasis, cardiovascular disease, and associated risk factors

Cardiovascular disease

Subgroup analysis

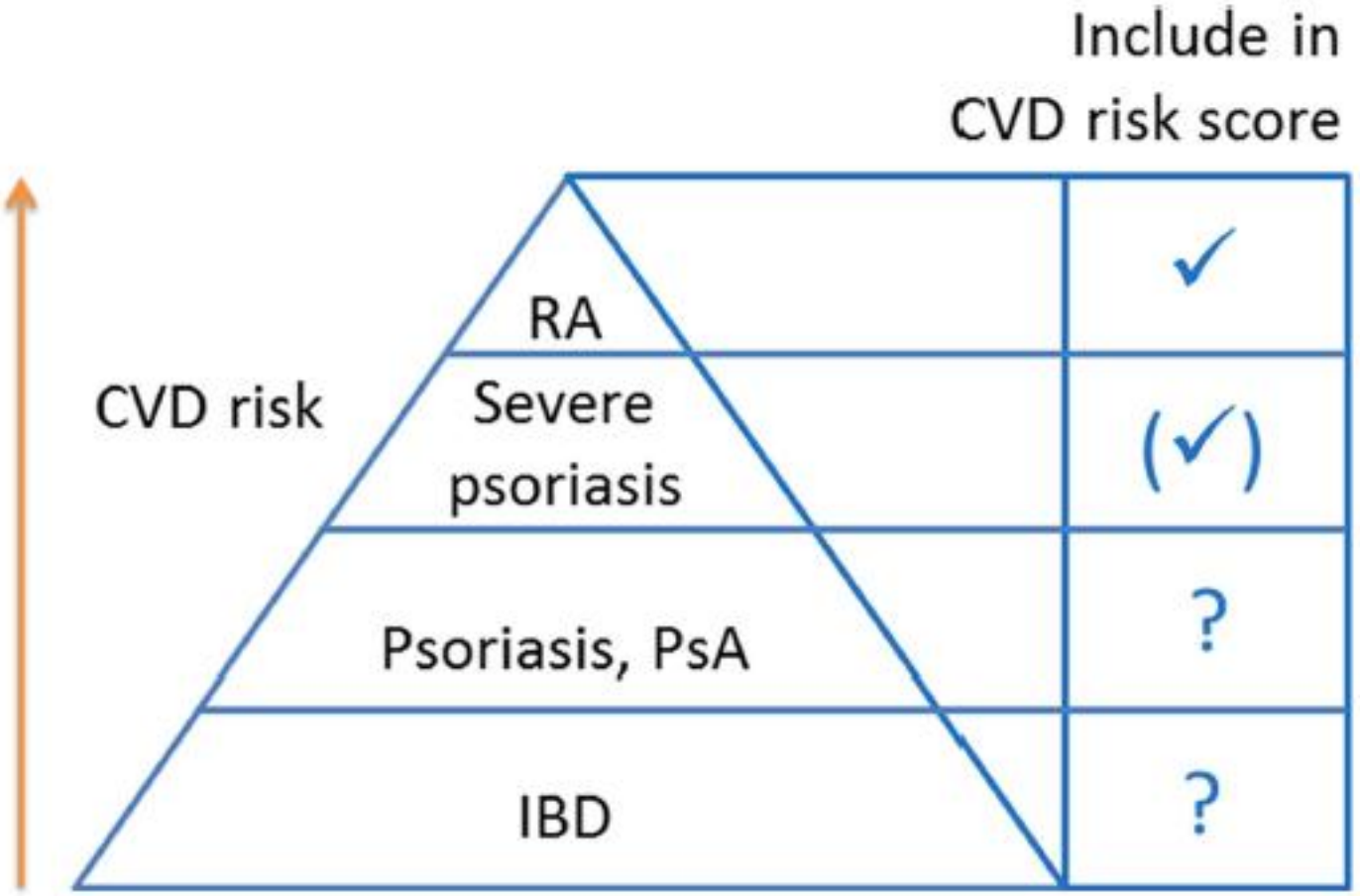
	Odds ratio	I^2 %	Studies	Cases Exposed/Total	Controls Exposed/Total
Cardiovascular disease					
Overall	1.4(1.2-1.7; p<0.001)	98	27	17,260/503,686	805,836/29,686,694
Hospital-based	1.8(1.4-2.4; p<0.001)	74	22	719/11,843	521,149/19,777,018
Population-based (Overall)	1.2(1.0-1.5; p=0.1)	99	15	16,541/491,843	248,034/9,183,728
Population-based (EI)	1.1(0.8-1.7; p=0.5)	100	7	9,664/370,717	248,316/9,195,992
Population-based (Insurance database)	1.2(1.2-1.3; p<0.001)	60	8	6,877/121,126	36,653/725,948
Psoriasis arthritis	1.8(1.2-2.8; p=0.007)	92	5	625/10,520	521,217/19,780,633
Skin psoriasis	1.3(1.1-1.6; p=0.001)	98	31	16,635/493,166	284,619/9,906,061
Ischemic heart disease					
Overall	1.5(1.2-1.9; p<0.001)	98	22	10,459/270,310	/531,425/14,916,935
Hospital-based	1.7(1.2-2.5; p=0.002)	81	14	614/9,108	410,059/9,891,137
Population-based (Overall)	1.3(1.0-1.8; p=0.08)	99	8	9,845/261,202	121,366/5,025,798
Population-based (EI)	1.4(0.8-2.4; p=0.3)	100	4	5,922/200,639	100,226/4,662,824
Population-based (Insurance database)	1.3(1.2-1.4; p<0.001)	70	4	3,923/60,563	21,140/362,974
Psoriasis arthritis	2.2(1.2-4.2; p=0.01)	96	3	522/6,806	410,058/9,891,077
Skin psoriasis	1.4(1.1-1.8; p=0.007)	98	18	9,937/263,504	121,367/5,025,858
Cerebrovascular disease					
Overall	1.1(0.9-1.3; p=0.27)	93	13	6,766/232,856	274,395/14,769,033
Hospital-based	1.5(1.1-2.1; p=0.008)	4	6	70/2,215	111,074/9,885,155
Population-based (Overall)	1.0(0.9-1.2; p=0.8)	96	7	6,696/230,641	163,321/4,883,878
Population-based (EI)	0.8(0.7-1.0; p<0.01)	89	3	3,742/170,078	147,808/4,520,904
Population-based (Insurance database)	1.2(1.1-1.2; p<0.001)	0	4	2,954/60,563	15,513/362,974
Psoriasis arthritis	1.3(1.1-1.7; p=0.01)	0	2	103/3,714	111,159/9,889,556
Skin psoriasis	1.1(0.9-1.; p=0.5)	94	11	6,663/229,142	163,236/4,879,477

.5 1 2345

Odds ratio (95% CI)

Miller et al

J Am Acad Dermatol
December 2013



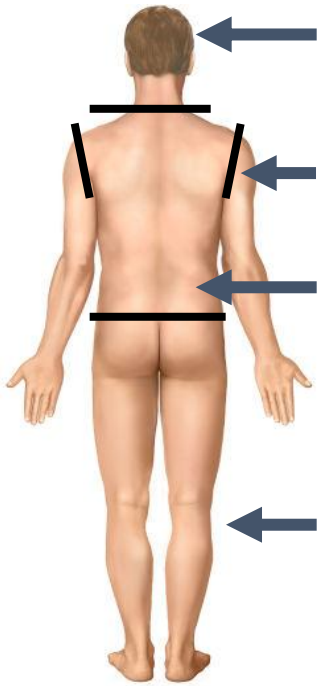
conditions are associated with CVD. From available evidence, it is clear that rheumatoid arthritis (RA) presents an independent risk factor for CVD and requires a risk multiplier as introduced in the JBS3 guidelines. The present study suggests relative risk levels may be similarly elevated in patients with psoriasis receiving disease-modifying antirheumatic drugs, which makes a case to risk-score patients with severe psoriasis in a similar way to those with RA. Future guidelines will look at this. It is also clear that more evidence is needed for patients with psoriatic arthritis (PsA).

¿cuál debe ser nuestro objetivo?

Índice de intensidad y extensión de la psoriasis (PASI)

El índice PASI aúna la evaluación de la intensidad de las lesiones y el área afectada en una única puntuación.

4 zonas corporales



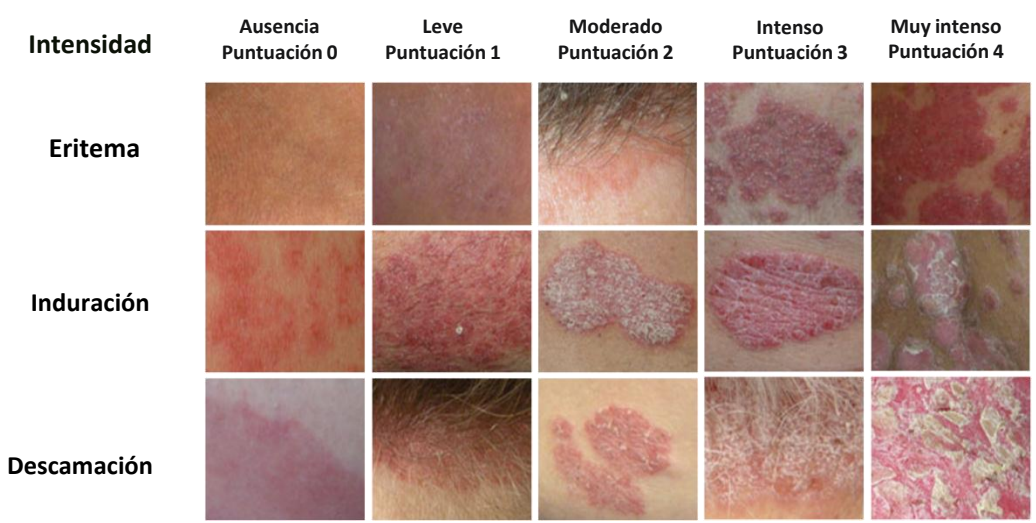
Cabeza
(incluye el cuello)

Extremidades superiores
(incluye las manos)

Tronco
(incluye las axilas y la ingle)

Extremidades inferiores
(incluye las nalgas)

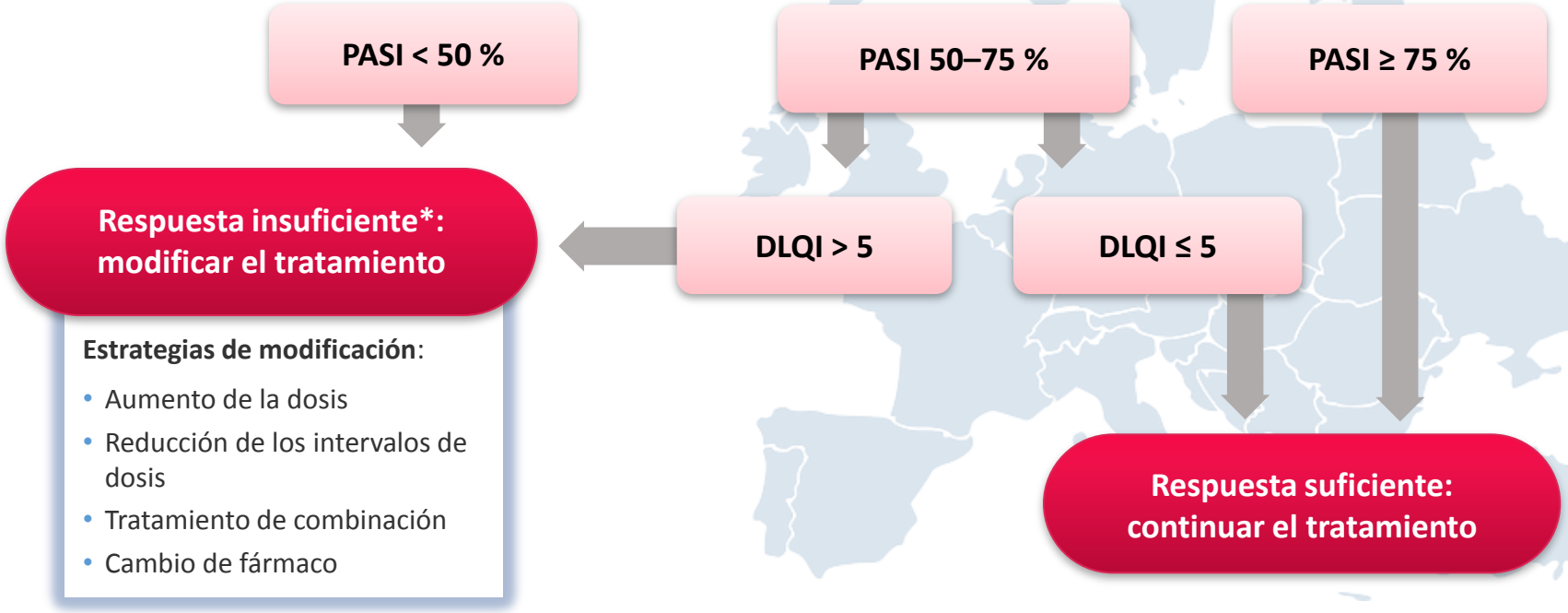
Clasificación de las placas psoriásicas



La imagen de las zonas corporales se ha modificado de la base de datos Smart Image Clasificación de las placas psoriásicas de la escala PASI. Imagen de: Puntuación PASI. http://www.dermnetnz.org/scaly/pasi.html. Adaptado de Fredriksson T, *et al Dermatologica* 1978;157:238; Langley RG, *et al*. *JAAD* 2004;51:563.

Objetivos del tratamiento propuestos para la psoriasis de conformidad con las Directrices Europeas

Para los pacientes **es importante presentar una piel sin placas y una mejora de la calidad de vida** y ambas ideas **se reflejan en los objetivos de tratamiento actuales:**



ΔPASI, mejora desde el periodo inicial. *No hay una definición establecida de respuesta insuficiente. En ensayos clínicos publicados con anti-TNF, la *ausencia* de respuesta primaria se define como no alcanzar PASI 50. Adaptado de Mrowietz U, *et al*. *Arch Dermatol Res* 2011;303:1.

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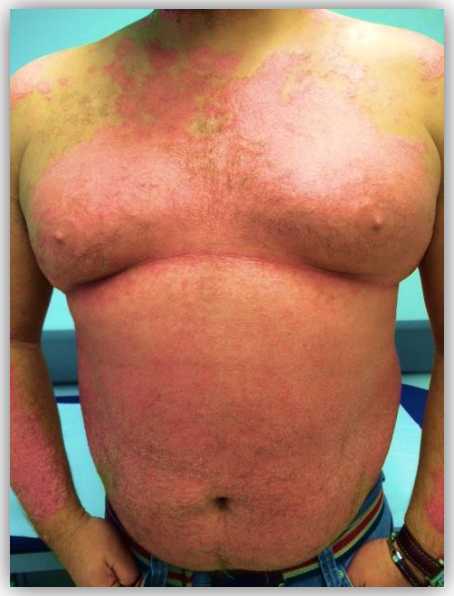
En un paciente con Psoriasis grave (PASI >20). PASI=40

¿Es PASI75 un buen desenlace?



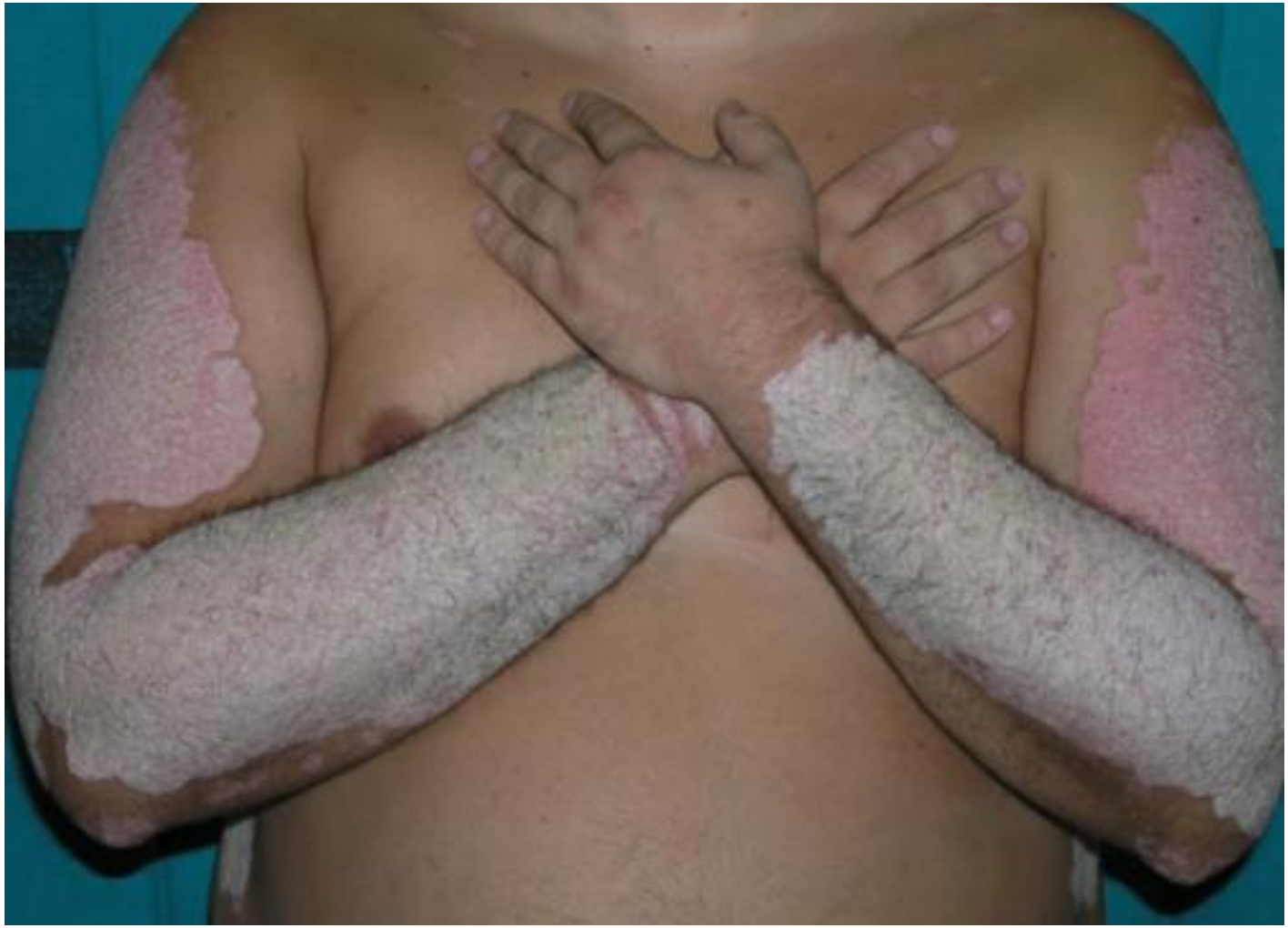
PASI 75

- PASI 10
- PGA 3-4
- Moderate
- No controlable con tópicos
- ¿DLQI?

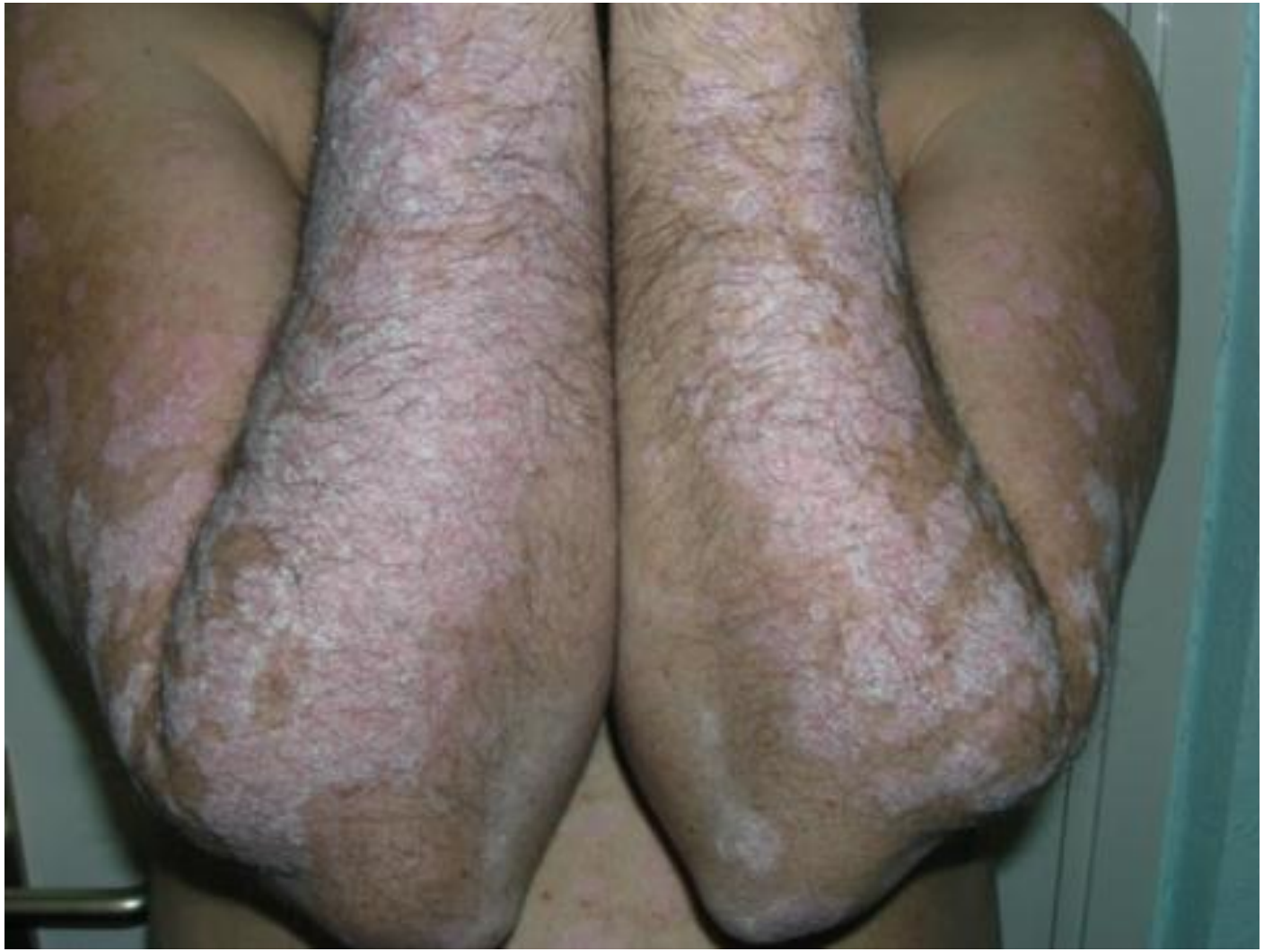
PASI 90

- PASI 4
- PGA 0-1
- Clear/Almost clear
- Controlable con tópicos
- ¿DLQI?

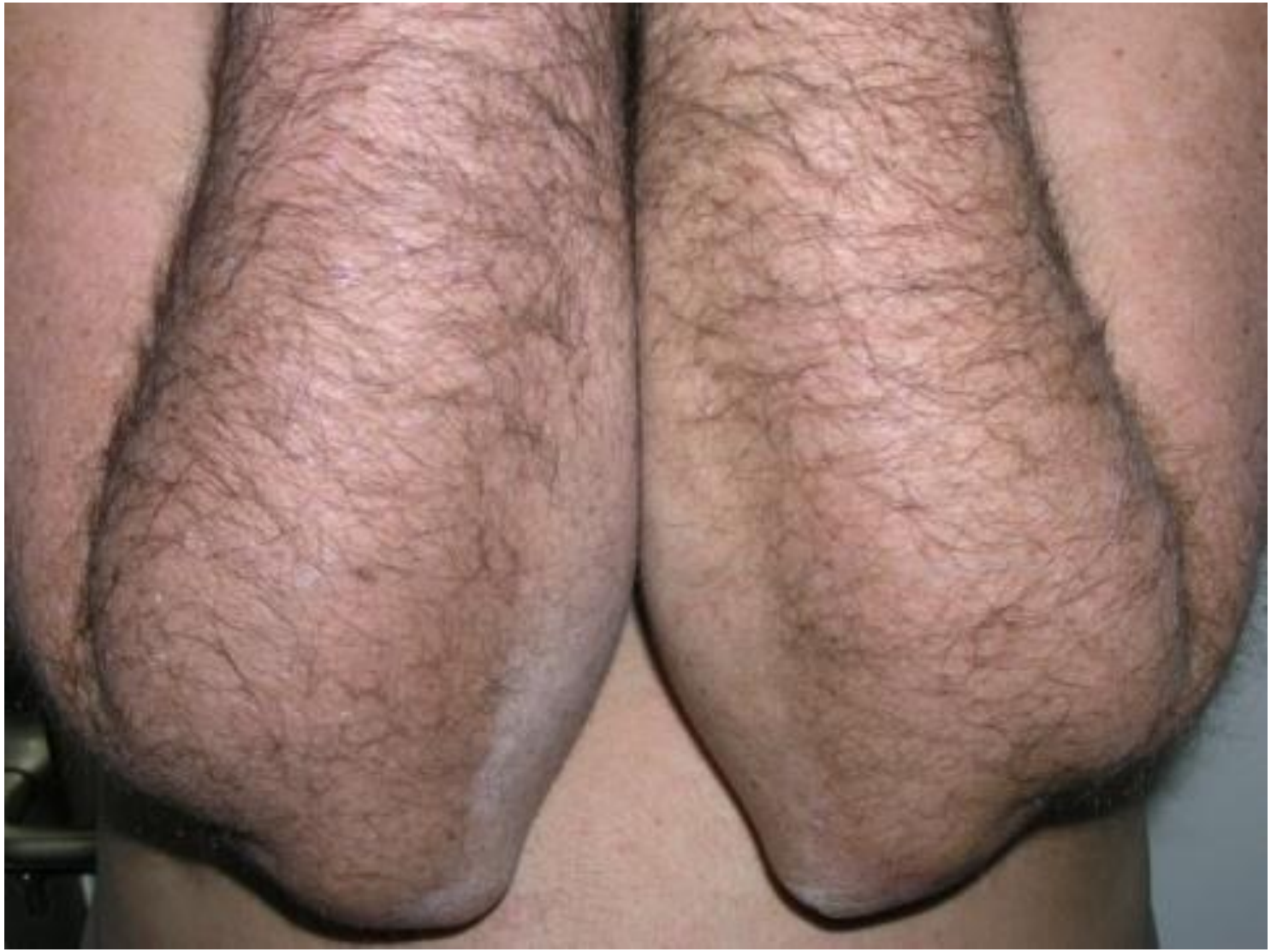
PASI BASAL= 23



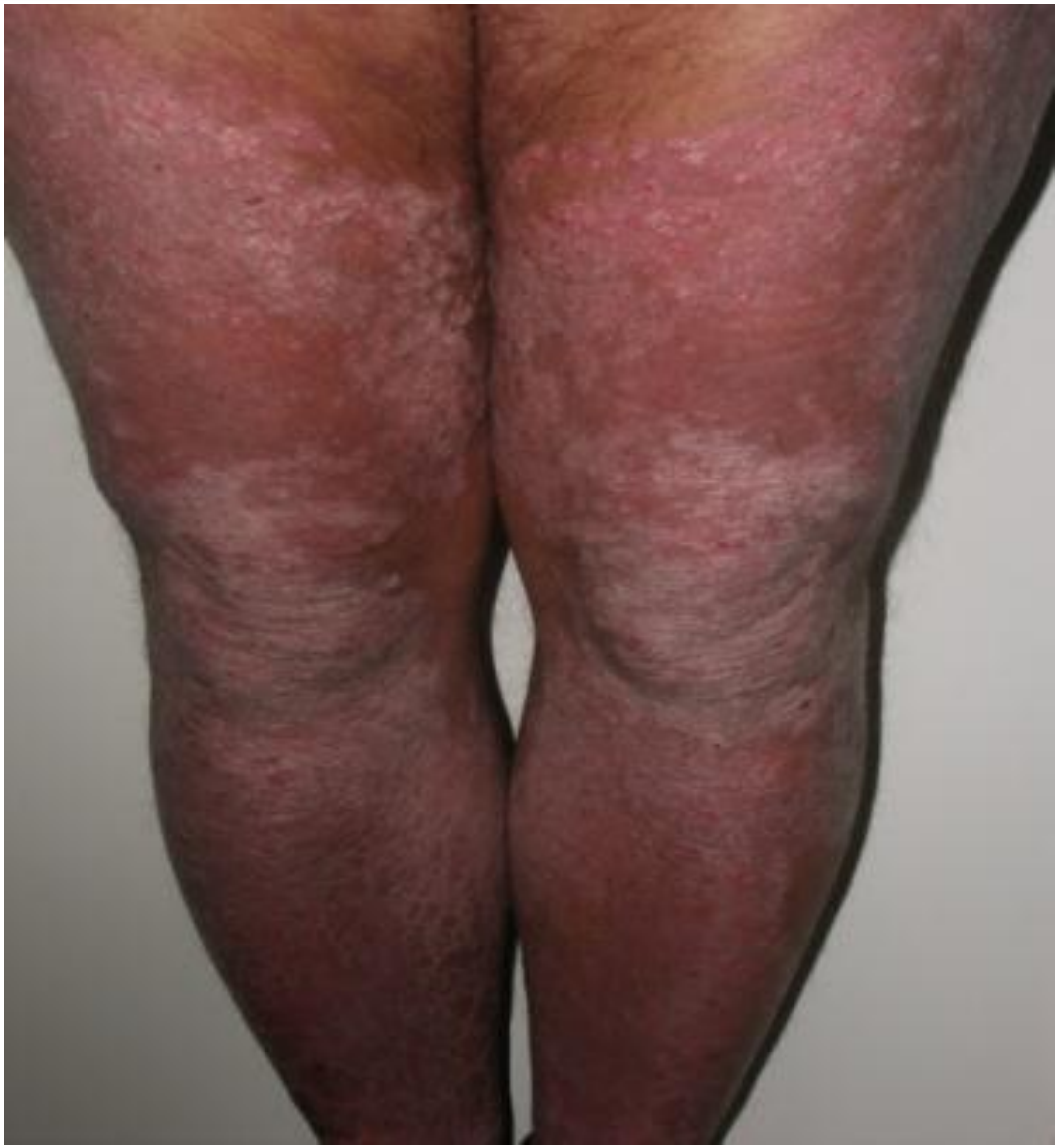
PASI 75 (PASI= 5)



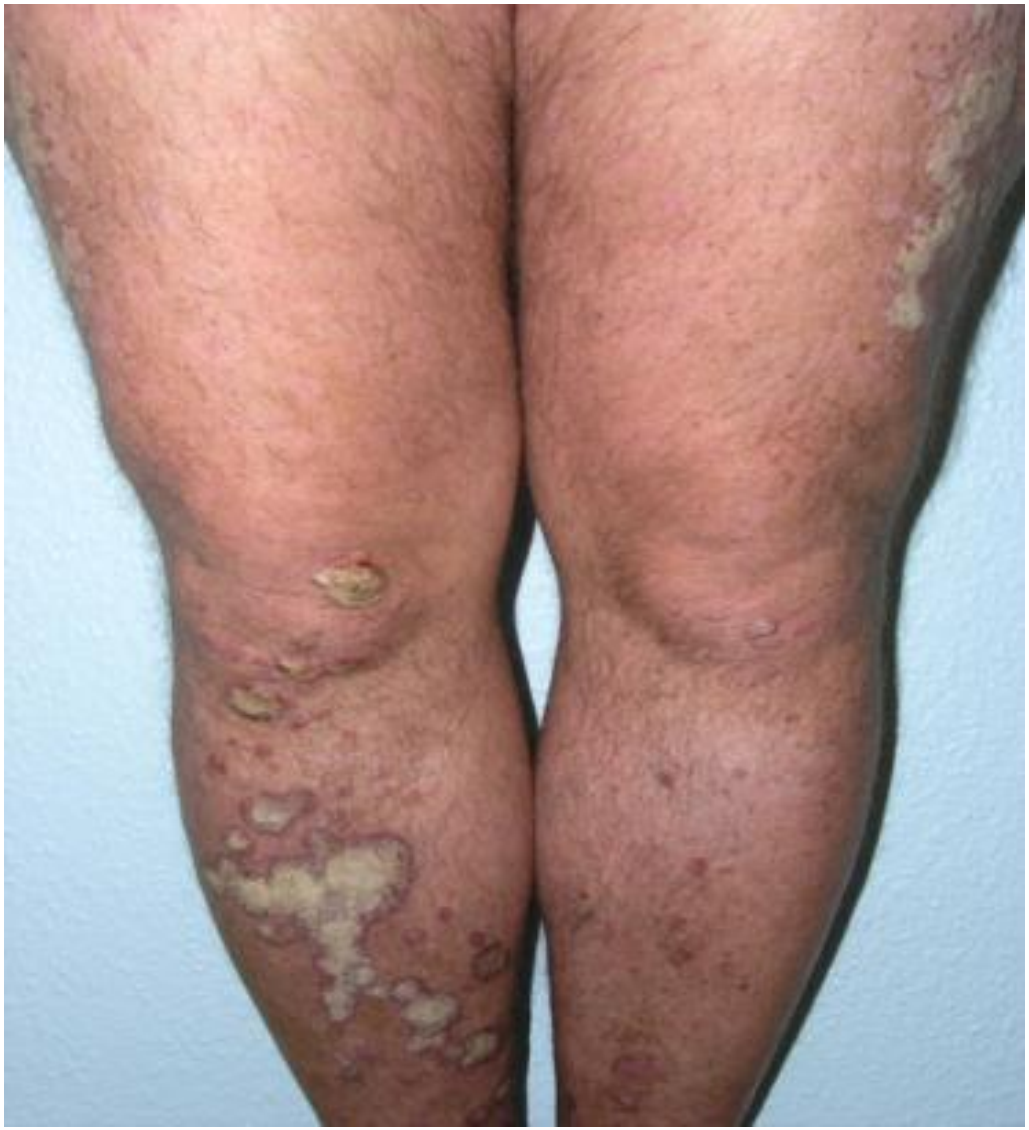
PASI 90 (PASI = 1.8)



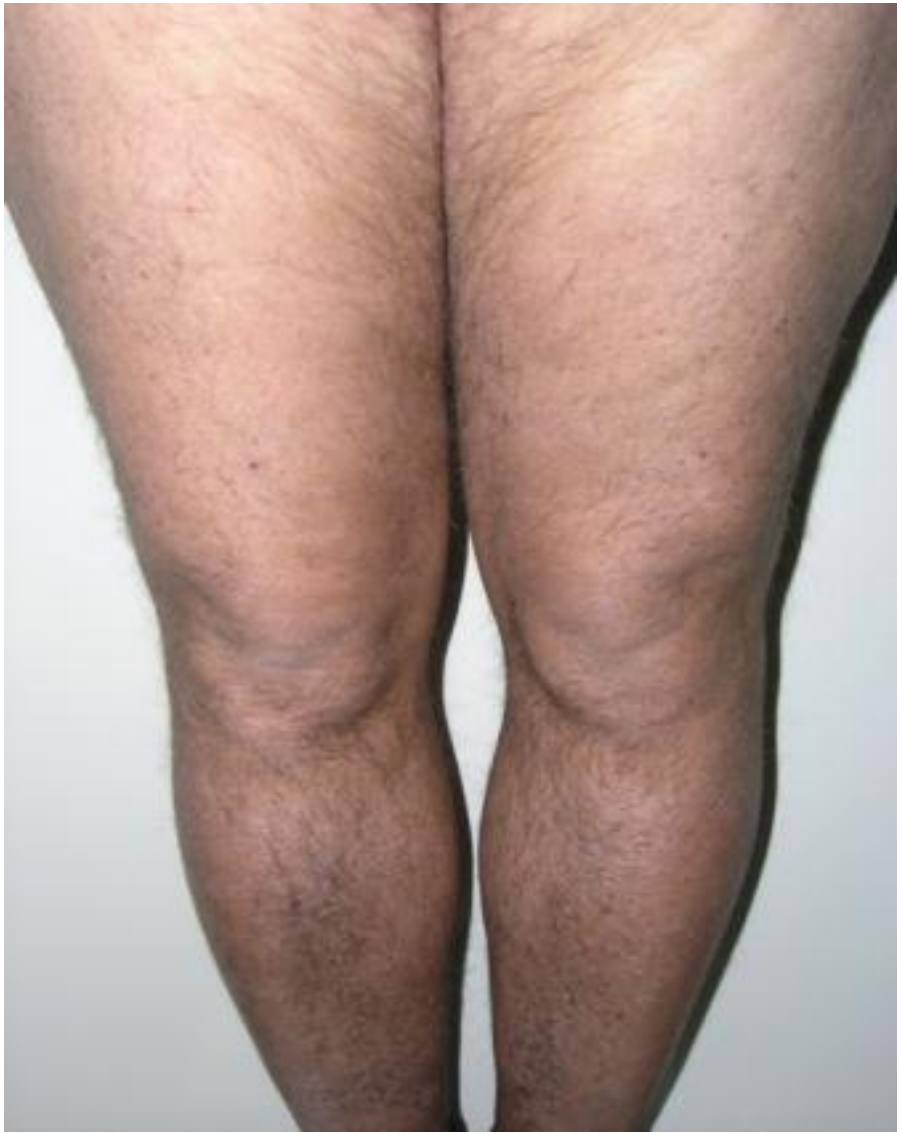
PASI BASAL = 26



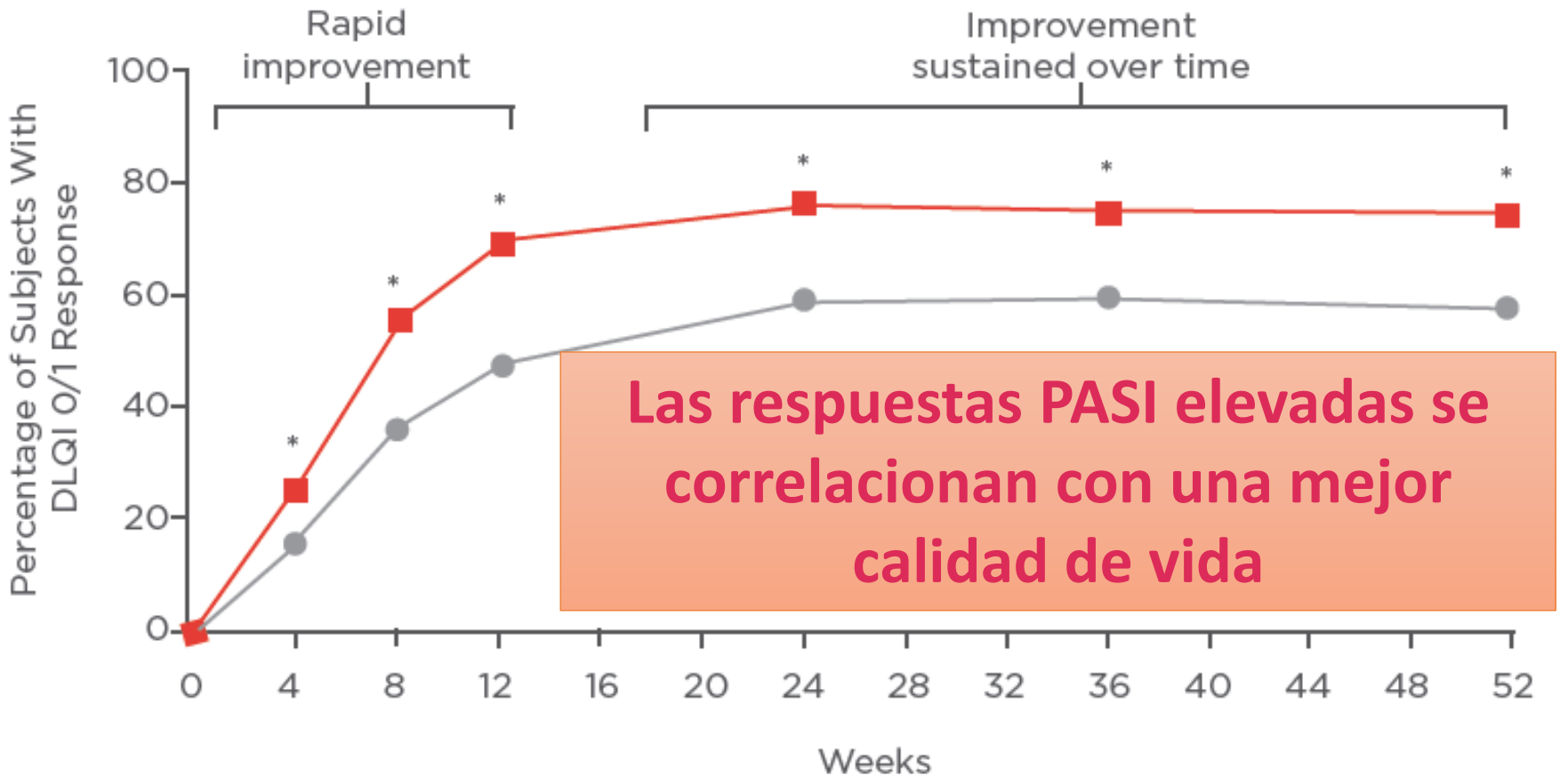
PASI 75 (PASI=4)



PASI 90 (PASI = 1.2)



Achieving almost clear skin (PASI 90) correlates with a better QoL* outcome than PASI 75



Las respuestas PASI elevadas se correlacionan con una mejor calidad de vida

*p<0.001

PASI 90 were estimated to have a 50% higher likelihood of achieving a DLQI 0/1 response than those who achieved PASI 75-89.

CONSENSUS DOCUMENT

Spanish Evidence-Based Guidelines on the Treatment of Psoriasis With Biologic Agents, 2013. Part 1: On Efficacy and Choice of Treatment☆

The ideal outcome for psoriasis treatment is to achieve and maintain in the long term complete or almost complete clearing (PGA ≤ 1, with minimum BSA involvement) or, failing that, a minimal and localized affected area that can be controlled with topical therapy (PGA ≤ 2, PASI < 5).[10]

The therapeutic goal during the induction phase is to achieve at least a PASI 75 response and an optimal response

Meta-analyses of efficacy parameters based on patient evaluation (patient-reported outcomes) and non-PASI outcomes do not adequately differentiate between the biologic agents currently available for the treatment of psoriasis.[58] If the achievement of a DLQI score of 0 or 1 is used as a therapeutic goal, a PASI 90 response or better correlates much more closely with this objective than a PASI 75 response,[59] and the improvement in DLQI compared to baseline is also higher in patients with an optimal response.[60]

CONCLUSIONES

- La Psoriasis es una enfermedad que afecta **todas las esferas de la vida**
- Se asocia a un riesgo aumentado de **comorbilidades**
  - ✓Enfermedad Psoriásica
- Nuevos tratamientos permiten redefinir los **objetivos terapéuticos:**
  - PASI 90
  - PASI ABSOLUTO (<3)
  - DLQI 0/1
  - REDUCCIÓN PICOR