PROPRANOLOL TX FOR HEMANGIOMAS HAS ITS RISKS, PAGE 26

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COURTESY DR. JAMES M. SPENCER

The Seal of Recognition program reflects the academy's efforts "to do everything possible to reduce the incidence of skin cancer," said Dr. James M. Spencer.

AAD Seal Program Off to a Slow Start

BY DOUG BRUNK

Two years after the American Academy of Dermatology's Seal of Recognition program was launched, six products have been recognized for their sun protection benefits.

In an interview, Dr. James M. Spencer, who oversees the program, said that he expected the list of recognized products "to be somewhat larger" by now. He acknowledged that part of the slow start may stem from controversy the program generated at the AAD's annual meeting in 2008, most notably by the late dermatopathologist A. Bernard Ackerman.

"He did not feel that sunlight causes melanoma," recalled Dr. Spencer, who also chairs the AAD's Melanoma/Skin Cancer Committee. "If you have that position, why would you want to encourage people to wear sun protection products? He also felt that [the Seal of Recognition program] was a conflict of interest financially; that it tainted the AAD. We're all sensitive to that. Potential conflicts of interest come up in practice all the time. Professionalism means putting your duty ahead of your personal benefit."

Dr. Spencer of Mount Sinai School of Medicine, New York, went on to emphasize that while he is sensitive to the arguments against the program, "at the end of the day it's like giving a medication: We weigh the risks versus the benefits. The benefits are, if we can get people to use effective sun protection products more, that's a benefit. The risks are that it may make us appear like we've sold out somehow. We have to weigh those two against each other. To me,

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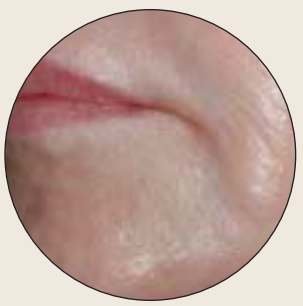
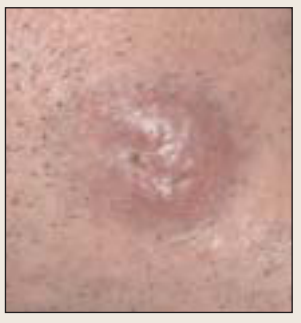
INSIDE





Psoriasis Doesn't Up Hospitalization For Heart Disease

New study contradicts recent findings.

BY BRUCE JANCIN

BUDAPEST — The last word on the relationship between psoriasis and cardiovascular disease may not be in, according to the results of a new study.

Contrary to earlier studies, psoriasis was found to not be an independent risk factor for hospitalization for ischemic heart disease in a large Dutch study, Dr. Marlies Wakkee reported at the annual congress of the European Society for Dermatological Research.

Even after subdividing the 15,820 Dutch psoriasis patients in the study into those who used only topical therapy versus patients with more severe disease—as defined by use of systemic therapies or hospitalization for psoriasis—the more severely affected patients did not have a higher rate of ischemic heart disease (IHD) hospitalization, said Dr. Wakkee of Erasmus University Medical Center, Rotterdam.

The same held true when the analysis was narrowed to hospitalization for acute myocardial infarction (MI). The psoriasis patients, even those with more severe skin disease, did not have a greater rate of MI than controls, she added.

The study relied upon hospi-

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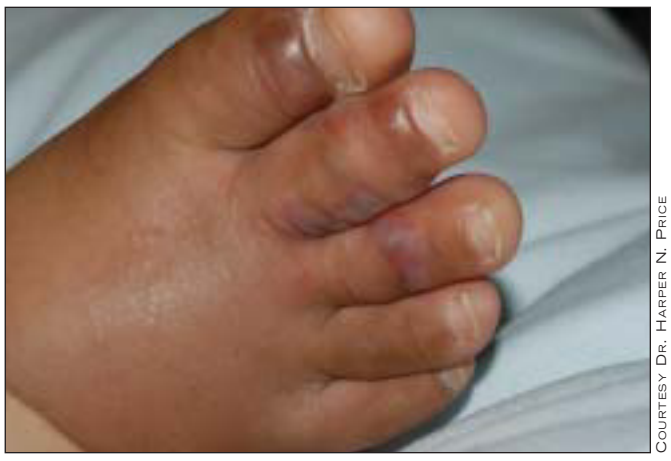
CASE OF THE MONTH



COURTESY DR. HARPER N. PRICE

A 5-year-old African American child presented with a 2-week history of swollen legs, abdominal pain, fever, fatigue, and blisters on her feet and toes. Her spleen was palpable, and she had an elevated white blood count and a low platelet count. What's your diagnosis? *See* **Case of the Month,** *page 47*.

More Research Is Warranted

Psoriasis *from page 1*

tal and pharmacy linked databases covering 2.5 million Dutch patients. The 15,820 psoriasis patients and 27,577 non-psoriatic controls (mean age 48 years) were followed for a mean of 6 years.

The IHD hospitalization rate was 611 cases per 100,000 person-years in psoriasis patients and 599 in controls. MI hospitalization rates were also similar: 234 per 100,000 person-years in psoriasis patients and 235 in controls.

At study entry, the psoriasis patients had slightly, but statistically significantly, higher rates of antihypertensive drug therapy, compared with controls (19.4% vs. 16.4%, respectively), lipid-lowering drugs (7.0% vs. 6.2%, respectively), and antidiabetic medications (4.4% vs. 3.6%, respectively). This wasn't surprising, said Dr. Wakkee, given that prior studies have shown the prevalence of metabolic syndrome to be elevated in psoriasis patients. Psoriasis patients also had more hospitalizations for reasons other than psoriasis in the prior 6 months.

The only way to resolve the controversy is to conduct a large, detailed, long-term prospective study.

DR. WAKKEE

In a multivariate analysis adjusted for age, gender, medications, and hospitalizations in the prior 6 months, the relative risk of IHD hospitalization during 6 years of follow-up was 5% higher in psoriasis patients, and the MI hospitalization risk was 6% lower than in controls. These differences were far from statistical significance, she said.

Dr. Wakkee noted that her study findings are at odds with those of a much-publicized analysis of the U.K. General Practice Research Database (JAMA 2006;296:1735-41), which concluded that psoriasis patients had a small but significantly increased risk of MI.

It is possible, she said, that the earlier finding was due to detection bias. This potential confounder could occur because psoriasis patients have greater consumption of health care.

Further muddying the waters, investigators at the University of Basel in Switzerland recently analyzed the U.K. General Practice Research Database and found no overall increased risk of MI, stroke, or transient ischemic attack (TIA) in patients with recently diagnosed psoriasis, although there was a suggestion of a possible small absolute increase in MI risk in patients younger than age 60 with severe psoriasis (Br. J. Dermatol. 2009;160:1048-56).

So the question remains: Is psoriasis as a systemic inflammatory state an independent risk factor for cardiovascular events, or does the increased risk, if present, result from psoriasis patients' increased prevalence of obesity, smoking, metabolic syndrome, and other cardiovascular risk factors?

Dr. Wakkee said the only way to resolve the controversy is to conduct a large, detailed, long-term prospective study. Whether that is realistic is unclear, she said. In the absence of definitive data, physicians will have to help their psoriasis patients work hard to optimize their cardiovascular risk factor profile. ■

Continued from previous page

cally has a 2- to 3-month delay in action, and it's difficult not to treat patients during this delay. This is why we're using low-dose corticosteroids, especially to treat the pain in our patients with mucosal lesions. A dose of 0.5 mg/kg per day of prednisone is not sufficient to lead to clearance in these patients, but it's a dose that has an anti-inflammatory effect and will decrease their pain," Dr. Joly explained.

In light of the timing of relapses in the original 5-year study, the new trial incorporates maintenance rituximab at 500 mg given at 12 months and again at 18 months in an effort to avoid relapses in the second and third year. The dose and timing of the maintenance therapy were chosen in consultation with rheumatologists, who have the most experience with rituximab. The biologic agent's approved indications are for treatment of rheumatoid arthritis unresponsive to anti–tumor necrosis factor therapy and in B-cell lymphomas.

The study was supported by the French Society of Dermatology and Roche. ■