

Mortality Risk 50% Higher With Severe Psoriasis

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LOS ANGELES — Two studies on psoriasis presented at the annual meeting of the Society for Investigative Dermatology show an association between the disease and increased mortality, and an increased risk for hypertension, heart disease, and diabetes.

In the first study, severe psoriasis was an independent predictor of death and increased patients' mortality risk by 50%,

compared with normal control patients' risk, in a cohort study of more than 713,000 patients. No increased risk for death was seen in patients with mild psoriasis, however, compared with controls, Shanu Kohli Kurd said at the meeting. Ms. Kurd and her associates derived the 50% greater mortality risk for severe psoriasis after adjusting for the effects of age and gender.

Patients with severe psoriasis should receive comprehensive health assessments to try to reduce their risk of death, suggest-

ed Ms. Kurd, a clinical research fellow in dermatology at the University of Pennsylvania, Philadelphia, and her associates. Multiple comorbidities that have been associated with psoriasis may increase mortality, but even after adjusting for the effects of major comorbidities, the risk of death was 40% higher in patients with severe psoriasis, compared with controls.

Severe psoriasis was defined as disease requiring systemic therapy; mild psoriasis did not require such therapy. Data drawn from

the General Practice Research Database, compiled in the United Kingdom from 1987 to 2002, accounted for 3,951 patients with severe psoriasis, 133,568 patients with mild psoriasis, and up to 5 control patients for each psoriasis patient, seen in the same practices in the same time periods.

The overall incidence of death was 12 patients per 1,000 patient-years in each of three other groups: the mild psoriasis group, the 560,358 controls for the mild psoriasis group, and the 15,075 controls for the severe psoriasis group. In patients with severe psoriasis, however, overall incidence of death was 21 patients per 1,000 patient-years, Ms. Kurd reported.

The relative risk of death was greatest for younger patients with severe psoriasis, and was not affected by gender. At age 35 years, patients with severe psoriasis were 2.5 times more likely to die, compared with control patients. By age 95 years, severe psoriasis incurred only a 10% increased relative risk of death. The increased relative risk of death persisted in analyses that excluded patients with concomitant psoriatic arthritis or rheumatologic disease.

The median age of death for patients with severe psoriasis was 74 years in males and 75 years in females, compared with 77 years in males and 81 years in females in the control group.

The study was funded in part by Centocor Inc., which markets infliximab.

The second study found increased rates of hypertension, heart disease, and diabetes in patients with psoriasis, compared with the general population, said Dr. Wayne P. Gulliver. He and his associate at a medical research organization in St. John's, Nfld., analyzed data from the province of Newfoundland and Labrador, where the population has a high prevalence of psoriasis linked to two genetic markers for psoriasis (HLA-Cw6 and tumor necrosis factor- α 238).

Surveys of 100 patients with mild to moderate psoriasis and 100 patients with severe psoriasis—all older than age 50 years—found hypertension in 25% of the mild to moderate group and 21% of the severe psoriasis group, compared with 14% of the general population aged 30-64 years.

Heart disease had been diagnosed in 14% of the mild to moderate group, 10% of the severe psoriasis group, and 4% of the general population. Diabetes was present in 10% of the mild to moderate group, 12% of the severe psoriasis group, and 4% of the general population.

Records on 169 separate patients with psoriasis who had died showed that they lived 10 years fewer, on average, compared with the average life span in Canada. Cardiovascular or genitourinary disease was more likely to be the immediate cause of death in the psoriasis group, compared with death statistics in Newfoundland and Labrador.

In the psoriasis deaths, 44% were caused by cardiovascular disease, compared with 36% in the general population. Genitourinary disease was the cause of 3% of deaths in the psoriasis group and none in the general population. The study was funded in part by Merck Serono S.A., which markets efalizumab in Europe. ■

AzaSITE™

(azithromycin ophthalmic solution) 1%

Sterile topical ophthalmic drops

BRIEF SUMMARY

Before prescribing, please consult the full prescribing information.

INDICATIONS AND USAGE

AzaSite is indicated for the treatment of bacterial conjunctivitis caused by susceptible isolates of the following microorganisms:

CDC coryneform group G*
Haemophilus influenzae
Staphylococcus aureus
Streptococcus mitis group
Streptococcus pneumoniae

*Efficacy for this organism was studied in fewer than 10 infections.

DOSAGE AND ADMINISTRATION

The recommended dosage regimen for the treatment of bacterial conjunctivitis is:
Instill 1 drop in the affected eye(s) twice daily, eight to twelve hours apart for the first two days, and then instill 1 drop in the affected eye(s) once daily for the next five days.

CONTRAINDICATIONS

None

WARNINGS AND PRECAUTIONS

Topical Ophthalmic Use Only

NOT FOR INJECTION. AzaSite is indicated for topical ophthalmic use only and should not be administered systemically, injected subconjunctivally, or introduced directly into the anterior chamber of the eye.

Anaphylaxis and Hypersensitivity With Systemic Use of Azithromycin

In patients receiving systemically administered azithromycin, serious allergic reactions, including angioedema, anaphylaxis, and dermatologic reactions including Stevens Johnson Syndrome and toxic epidermal necrolysis have been reported rarely in patients on azithromycin therapy. Although rare, fatalities have been reported. While these reactions have not been observed with topical ophthalmic use of AzaSite, the potential for anaphylaxis or other hypersensitivity reactions should be considered, since patients with a known hypersensitivity to azithromycin or erythromycin were excluded from study.

Growth of Resistant Organisms With Prolonged Use

As with other anti-infectives, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. If superinfection occurs, discontinue use and institute alternative therapy. Whenever clinical judgment dictates, the patient should be examined with the aid of magnification, such as slit-lamp biomicroscopy, and where appropriate, fluorescein staining.

Avoidance of Contact Lenses

Patients should be advised not to wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

ADVERSE REACTIONS

The most frequently reported ocular adverse reaction in patients receiving AzaSite was eye irritation. This reaction occurred in approximately 1% to 2% of patients. Other adverse reactions associated with the use of AzaSite were reported in

less than 1% of patients and included burning, stinging and irritation upon instillation, contact dermatitis, corneal erosion, dry eye, dysgeusia, nasal congestion, ocular discharge, punctate keratitis, and sinusitis.

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category B. Reproduction studies have been performed in rats and mice at doses up to 200 mg/kg/d. The highest dose was associated with moderate maternal toxicity. These doses are estimated to be approximately 5000 times the maximum human ocular daily dose of 2 mg. In the animal studies, no evidence of harm to the fetus due to azithromycin was found. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, azithromycin should be used during pregnancy only if clearly needed.

Nursing Mothers

It is not known whether azithromycin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when azithromycin is administered to a nursing woman.

Pediatric Use

The safety and effectiveness of AzaSite solution in pediatric patients below 1 year of age have not been established. The efficacy of AzaSite in treating bacterial conjunctivitis in pediatric patients one year or older has been demonstrated in controlled clinical trials.

Geriatric Use

No overall differences in safety or effectiveness have been observed between elderly and younger patients.

STORAGE AND HANDLING

Store unopened bottle under refrigeration at 2°C to 8°C (36°F to 46°F). Once the bottle is opened, store at 2°C to 25°C (36°F to 77°F) for up to 14 days. Discard after the 14 days.

PATIENT COUNSELING INFORMATION

Patients should be advised to avoid contaminating the applicator tip by allowing it to touch the eye, fingers, or other sources. Patients should be directed to discontinue use and contact a physician if any signs of an allergic reaction occur.

Patients should be told that although it is common to feel better early in the course of the therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by AzaSite or other antibacterial drugs in the future.

Patients should be advised not to wear contact lenses if they have signs or symptoms of bacterial conjunctivitis. Patients are advised to thoroughly wash hands before using AzaSite.

Rx only

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U.S. PAT NO. 5,225,196; 5,192,535; 6,239,113; 6,569,443;
6,861,411; 7,056,893; and Patents Pending
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