



The Deadly Scales

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Abstract

Here we present a case of 50 year old male suffering from psoriasis vulgaris, presented with central chest pain radiating to left arm. On evaluation the patient's ECG showed ST elevation in anterior leads – hence diagnosed as Anterior Wall MI.

In this case report, we review the evidence regarding association between psoriasis and cardiovascular disorders.

Introduction

Psoriasis is a chronic inflammatory disease, traditionally, regarded as a disease affecting only the skin and joints. In recent years, studies from different countries have shown that psoriasis is a systemic inflammatory disease, which is often associated with various comorbidities.

In particular, there is a greater risk of developing severe vascular events such as cardiovascular and cerebrovascular diseases. In addition, the prevalence rates of cardiovascular risk factors are increased in psoriasis patients, including hypertension, diabetes, obesity, dyslipidemia, subclinical atherosclerosis. It has been proposed that systemic inflammation may provide a link between psoriasis and cardiometabolic disorders. Therefore physicians and dermatologists should be aware of the risk and hence administer

appropriate evaluation and treatment to prevent future development of vascular events.

Case Report

50 year old male patient, non smoker / non alcoholic, on treatment for psoriasis vulgaris for past 17 years, without any family history of any cardiac illness presented with central chest pain with radiation to left upper limb to the medicine casualty. No history suggestive of any autonomic disturbances or hemodynamic instability.

On Examination

Patient conscious, oriented.

Moderately built and nourished.

No pallor, icterus, cyanosis clubbing, lymphadenopathy or edema

No cutaneous markers of atherosclerosis.

Extensive skin lesions were present involving the bilateral limbs, scalp, trunk and gluteal region. The lesions are erythematous, varying in size from pin point to large plaques, with white silvery micaceous scales.



Nails: showed pitting, ridges, lifting of nails away from nail bed



CVS Examination

S1, S2 normal with no murmur or cardiomegaly. No S3 or S4. No pericardial rub.
Other Systems: Within normal limits

Diagnosis

Clinically suspected possibility of a myocardial infarction.

Emergency ECG taken: suggestive of AWTMI

Investigation

Blood Routine Examination

CBC With ESR

- Hb -12.3
- TC - 7400
- DC - N 77 L 22
- PLT - 1.9L
- MCV- 89
- MCH -31
- MCHC-29
- ESR - 54
- Sodium- 132
- Potassium- 4.3
- ALP- 77
- SGOT-43
- SGPT-45
- TP/Alb- 7.5/4
- S.Bilirubin-0.3
- S.Creatinine-0.8
- Blood Urea-39
- FBS/PPBS- 102/170

•LIPID PROFILE –

T.Cholestrol- 187

LDL- 66

HDL-55

TG-100

Lip A – normal

•CPK MB – Positive

•TROPONIN I– Positive (1.2)

•Viral markers, ANA, ANCA -Negative

• Serum electrophoresis -Negative

• ANA profile -Negative

• Anti ds DNA –Negative

• VDRL, APLA, RF, anti-CCP – Negative

• S. Homocysteine – Normal

So patient was treated with thrombolytic therapy, and was put on anti-platelets, statins, other supportive measures.

•ECHO: LV dysfunction with EF : 44%

•CAG: s/o Double vessel disease.

Discussion

Psoriasis is a multisystem disease with following extra dermatological manifestations- 1)Arthritis, 2)Ophthalmic – acute iritis , conjunctivitis, 3)Oral ulcers, 4)GIT :Non specific colitis, polyposis, 5) Metabolic syndrome 6)Premature atherosclerosis Recent studies have shown that psoriasis is associated with atherosclerosis. This association applies to coronary artery, cerebrovascular, and peripheral vascular diseases and hence results in increased mortality.

The presence of psoriasis is an independent risk factor for subclinical atherosclerosis. Psoriasis patients had impaired endothelial function and thicker intima-media thickness (IMT) of the common carotid artery, when compared with the healthy control subjects.

A spiral computer tomography study demonstrated a significantly higher prevalence and severity of coronary artery calcification in patients with psoriasis compared to control

subjects without psoriasis, supporting the fact that psoriasis is an independent risk factor for cardiovascular diseases. Interestingly, the excessive relative risk of MI seems to persist even after adjustment for the major risk factors for cardiovascular diseases, suggesting that psoriasis might be considered as an independent risk factor for MI.

Conclusion

Given the increased prevalence of comorbidities in patients, dermatologists and physicians who treat psoriasis especially more severely affected patients need to approach the disease as a potentially multisystem disorder and must alert these patients to the potentially negative effects of their disease and subject them for routine evaluation for cardiovascular diseases.