Mortality and Causes of Death among Psoriatics

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Sir,

We studied the entire general population of Gothenburg as of November. 1969, for any death occurring in 1970-1984 among native and immigrant Swedes born in 1940 or earlier; this study population cohort encompassing 125.035 men and 135.725 women at the time of the census. A subpopulation of psoriatics was identified as all those subjects (354 men and 300 women) who had been admitted as inpatients in 1970-1979 to the – at that time – only general hospital of the city.

As compared to the population in general, psoriatic men and, especially, women showed an excessive overall mortality, whatever the cause of death (table 1). Among the deceased psoriatics (162 men, 135 women), we examined the cause-specific mortality according to the death certificate as compared with the population in general. All causes of death having been diagnosed in at least 2 psoriatics were considered. As excessive mortality in psoriatics decreases with age, cause-specific mortality was studied for subjects born in 1901 or later, only. To minimize demographic bias from migration out of the city (with a peak rate in the age group 20-40 years), moreover, subjects born in 1916 or later were excluded from the analyses for cause-specific mortality.

Excessive cause-specific mortality was recorded among female psoriatics only: as expected, we found (1) a 3.4-fold ($p < 0.05$) excessive mortality from lung cancer, and (2) a 1.7-fold ($p < 0.05$) excessive mortality from ischemic heart disease, while – unexpectedly – (3) no excessive mortality from alcohol-related conditions such as liver cirrhosis or violent death was assessed (table 2) [1]. While lung cancer mortality decreases with age in the female population in general, no similar trend was found among psoriatics (table 3).

As reported elsewhere, the life style of cigarette smoking follows that of liberal consumption habits with regard to alcohol among women from Gothenburg; moreover, both habitual cigarette and alcohol consumption vary with marital state, i.e. nonmarried women smoke cigarettes and consume alcohol regularly far more often than married women [2]. Among men as well as women from Gothenburg, furthermore, psoriasis is far more prevalent among nonmarried than among married subjects [3]. Among women, both lung cancer and ischemic heart disease consistently have been associated with a life style pattern which includes habitual smoking of cigarettes [4, 5]. Finally, among skin diseases, palmar keratoses have been associated with both lung cancer and heavy cigarette smoking [6].

The above information, taken together, would suggest that the life style of subjects susceptible to acquire psoriasis may convey factors of etiopathogenetic relevance to the occurrence and course of this disease. Studies into disease association have focused on excessive consumption of

alcohol as such a factor [1. 7]. The data accounted for here, however, would fit in with the hypothesis that heavy cigarette smoking, rather than excessive use of alcohol, is of etiopathogenetic relevance with regard to psoriasis. Explorative studies on cigarette smoking habits among psoriatics, especially among female psoriatics, hence, is warranted.

References

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Letters to the Editor

Table 1. Age- and sex-specific relative mortality among psoriatics from Gothenburg, Sweden

Sex and age (i.e., birth year subcohort)

Population size as of November, 1969; number of psoriatics admitted in 1970-1979

Number of deceased psoriatics and nonpsoriatics in 1970-1984

Excessive mortality of psoriatics: obs/exp ratios (significance by χ^2 test)

psoriatics

others

psoriatics

others

Males

-1895 1896-1900 1901-1910 1911-1940

Females

-1895 1896-1900 1901-1910 1911-1940

40

31

66

217

43 37 69

151

8,972

7,397

22,350

85,962

14,418

9,784

26,524

84,699

38 27 44 53

38 32 32 33

8,059

1.06

p > 0.05

5,474

1.18

p > 0.05

10,587

1.41

p < 0.005

10,326

2.03

p < 0.001

12,138

1.05

p > 0.05

5,541

1.53

p < 0.001

7,667

1.60

p < 0.005

5,569

3.32

p < 0.001

Table 2. Cause-specific mortality in 1970-1984 among psoriatics born in 1901-1915

Males

Main cause of death according to death certificate

Acute myocardial infarction

Ischemic heart disease

Stroke

All cancer

Lung cancer

Violent death

Liver cirrhosis

Females

obs	exp	obs/exp ratio	obs	exp	obs/exp ratio
10	10.3	0.98N.S.	5	6.4	0.78N.S.
14	11.8	1.18N.S.	12	6.9	1.74n <
5	3.9	1.29N.S.	2	4.8	0.42N.S.
9	13.9	0.65N.S.	11	12.9	0.85N.S.
3	3.5	0.87N.S.	4	1.2	3.38n <
1	1.3	0.80N.S.	2	0.9	2.17N.S.
2	0.8	1.21N.S.	0	0.5	0 N.S.

N.S. = p > 0.05.

Table 3. Lung cancer deaths and deaths from whatever cause in 1970-1984 among women from Gothenburg

Birth year
 Psoriatics
 Population in general
 subcohort
 n:N

n:N	
rate per 1,000	
-1895	
1:38	
81:12,176	
6.7	
1896-1900	
0:32	
77: 5,573	
13.8	
1901-1905	
2:20	
85: 4,461	
19.1	
1906-1910	
0:12	
96: 3,238	
29.6	
1911-1915	
2:12	
84: 2,167	
38.8	
Sum total	
15.3	
5:114(43.9/1,000) 423:27,615	
n = Lung cancer deaths; N = deaths from whatever cause.	

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Fixed Drug Eruption Induced by Griseofulvin

Sir.

A male policeman had been treated, in February 1986, for a tinea cruris from which a *Trichophyton rubrum* had been isolated. He received 1 g of griseofulvin daily for a month combined with topical miconazole. He came back 5 months later because the tinea cruris had reappeared. The same treatment was recommended. Forty-five days later he presented with brown pigmented macules of different sizes, round or oval on the left leg, the back and the armpits.

The examination revealed that the lesions represented a typical fixed drug eruption. The patient claimed that 'they reappeared a few hours after intake in the same places as before', i.e. during the first course of griseofulvin. We were not aware of this fact. The evolution toward pigmentation was very quick after the interruption of the treatment.