On Psoriasis and Associated Diseases

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Sir,

The data of Lindegård [1] concerning diseases associated with psoriasis are of considerable interest. A similar study was carried out at the Institute of Dermatology and Venerology in Sofia for a 5-year period on 10,435 inpatients older than 16 years [2]. A higher incidence of diabetes in psoriasis patients (5.15%) was found both in males (5.42%) and in females (4.8%), as compared with the incidence of diabetes in the total in-patient population of the Institute (4.66%) and with a control group of 8,322 patients, hospitalized in an institute of internal diseases (3.89%).

On the other hand, the incidence of urticaria in psoriasis patients was found to be significantly lower (1.03 %) than the incidence of urticaria in the whole in-patient population of the Institute (8.6%) [2, 3].

22

Letters to the Editor

Our results point to a higher incidence of diabetes not only in females but also in males with psoriasis. They do not agree with the conclusion of Lindegård [1] that urticaria is more frequent in psoriatics.

References

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In Reply

Coexisting Diseases or Disease Association?

Since the days of Hippocrates and up to the immunogenetic era of today, studies into disease association represent a major source of contribution to our scientific understanding of the origin and mechanism of disease. Among the Hippocratic aphorisms, we will find the following statement (Section VI, No. 42): 'In cases of jaundice it is a bad sign when the liver becomes hard' [1]. Modern immunogenetic research has revealed, for example, that the HLA complex of A1, B8, DR3 indicates relationships between diseases such as early-onset diabetes, alcoholic liver

disease, myasthenia gravis or dermatitis herpetiformis not yet explained by laboratory medicine [2]. Community-based studies of a general population for coexistence of two diseases like psoriasis and diabetes mellitus or urticaria are

aimed at the same scientific goal. This is what clinical epidemiology is about.

Any physician, whether he is placed in a hospital ward or in a district practice, will notice the simultaneous occurrence of different diseases in a given patient. Such observations, however, do not permit of general conclusions as to the relationship between the diseases under consideration. Instead, their coexistence may be occasional in a given case or spuriously suggesting a disease association if observed in a sample of patients: it may reflect local principles of patient referral to a particular hospital ward, outpatient clinic, and so forth. For example, in one general hospital cerebrovascular diseases may be taken care of at the department of neurology while in another at the department of internal medicine. Statistics on coexistence between stroke and diabetes will obviously yield different outcome in these two hypothetical hospitals and both will presumably differ from the outcome of studies performed on a general population basis in the research setting of a community-based inquiry [3].

The communication of Dr. Krasteva and associates, I am sorry to say, suffers from these methodological shortcomings and their data accounted for, hence, may reflect local conditions at their hospital ward rather than the relationship in general between psoriasis and diabetes or urticaria. For better or worse, they are not alone in overlooking basic principles of clinical epidemiology; recent contributions in other distinguished medical journals have required similar comments [4, 5].

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