‘You look fine to me’: Conceptualising cardiovascular disease risk with people with psoriasis

A. Chisholm¹, K. Kane¹, P.A. Nelson¹, C.J. Pearce¹, C. Keyworth¹, C.A. Chew-Graham², C.E.M. Griffiths¹,³, L. Cordingley¹,⁴

Affiliations:
¹Manchester Centre for Dermatology Research, Institute of Inflammation and Repair, University of Manchester, ²Research Institute, Primary Care and Health Sciences, Keele University, Keele, UK. ³Salford Royal NHS Foundation Trust, ⁴Manchester Centre for Health Psychology, University of Manchester, Manchester Academic Health Science Centre, Manchester, UK

Presented at the 7th International Congress of Psoriasis: from Gene to Clinic, London, UK, December 2014

BACKGROUND AND AIM: Having psoriasis can be associated with unhealthy behaviours which increase cardiovascular disease (CVD) risk. There is a complex interplay between unhealthy behaviours, mood, capacity for self-management and onset/exacerbation of psoriasis. Health policy directives recommend that practitioners working with people with psoriasis address unhealthy lifestyle issues as part of routine care. However, barriers to addressing lifestyle with patients are common and research suggests opportunities to discuss salient lifestyle issues with people with psoriasis are frequently missed. It is unknown, in the context of psoriasis, how practitioners interpret CVD risk and explain this to patients. We report how healthcare practitioners conceptualise CVD risk in people with psoriasis.

METHODS: People with psoriasis were invited to attend a primary care consultation about CVD risk; 130 consultations were digitally recorded, and 12 of the 13 practitioners who conducted these consultations were subsequently interviewed using tape-stimulated recall. Forty-nine practitioner-patient dyads were selected for analysis. Qualitative analysis employing constant comparison techniques was used to identify patterns in the data indicating different ways in which practitioners conceptualised CVD risk with psoriasis patients. To place each patient case in context, descriptive biomedical data were independently extracted to create objective risk profiles for each patient (e.g. smoking status, body mass index and blood pressure).

RESULTS: Practitioners often minimised risk factors and adopted a reactive approach to consultations; this was demonstrated in various distinct ways. Firstly, practitioners emphasised that risk factors such as blood pressure or weight, were ‘high, but only a bit high’, thus acknowledging identified risk factors whilst downplaying the extent to which they are present in the individual. Second, they attempted to ‘put it into perspective’ by comparing identified risk factors to other less problematic risk factors/contexts. Third, practitioners emphasised that ‘one score is not enough’ (i.e. that individually high risk factor scores do not in themselves indicate the presence of risk, preventive discussions were unwarranted). Fourth, practitioners described lay/personal perceptions and experiences which informed their interpretations of risk including the ‘normalisation of common risk factors’.

CONCLUSION: Cues to initiate discussions about risky lifestyle behaviours arose frequently but practitioners did not interpret risk factors as needing preventive discussions with patients, and instead minimised this risk in consultations. Training is needed to enable practitioners to make the most of these ‘teachable moments’ with people with psoriasis, thereby reducing the likelihood of psoriasis-related co-morbidity.