Introduction

Psoriasis is a common chronic immune mediated disease affecting about 3% of general population worldwide (Mandell, 2012). Psoriasis affects both sexes equally, and can occur at any age but the commonest incidence occurs between 15 and 25 years age. Psoriasis is a multi-factorial disease, so its development and or exacerbation appear to involve an interaction between genetic and environmental risk factors such as stress, trauma and infection (Ghazizadeh et al., 2010).

The most common type of psoriasis is the plaque type which characterized clinically by sharp demarcated erythematous plaques covered by silvery scales especially on extensor surfaces of the body (Schon and Boehncke, 2005).

Psoriasis is characterized by epidermal hyperproliferation, abnormal differentiation of epidermal keratinocytes and lymphocyte infiltration consisting mostly of T-helper lymphocyte which release type I cytokine like Interferon gamma (IFN-γ), tumor necrosis factor α (TNF-α) and interleukin (IL) II (Wakkee et al., 2007).

It is widely believed that psoriasis is not just a skin disease but a systemic inflammatory process mirrored by the elevation of inflammatory biomarkers in the patients' blood and this inflammation drives the process of atherosclerosis in psoriasis patients (Boehncke and Boehncke, 2012).

There is a considerable evidence to show that psoriasis patients have a significantly increased risk of cardiovascular disease and cardiovascular risk.
factors such as obesity, diabetes mellitus, hypertension, hyperlipidemia and smoking compared to the general population (Ryan and Menter, 2012). These factors contribute to the formation of atherosclerosis which is the hallmark of cardiovascular disease in which inflammation plays a major role (Hansson, 2005). Hyperhomocystenemia which is considered a risk factor for atherosclerosis and thrombosis has also been reported in psoriatic patients (Kazemi et al., 2006).

Systemic medication used to treat psoriasis such as acitretin and cyclosporine can also increase the risk of cardiovascular diseases through inducing hypertension and hyperlipidemia (Choi et al., 2010).

An increased risk of atherothrombosis has been reported in psoriasis patients (Gisondi and Girolomoni, 2009), but the relationship between inflammatory markers, haemostatic variables and coagulation markers in patients with psoriasis have not been adequately studied (Karabudak et al., 2008).