

Editorial

Clinical severity and life impact of atopic dermatitis

The clinical severity of a patient's disease is a major factor in guiding the choice of therapy. In atopic dermatitis (AD), a number of standardised scoring systems have been developed to grade the severity. These include three-item Severity Score (TIS); Six Area Six sign Atopic Dermatitis (SASSAD) and the more complicated Eczema Area and Severity Index (EASI), to name but a few. These scoring systems have one thing in common – objective measurement of physical signs.

In addition to physical assessment, SCORing Atopic Dermatitis (SCORAD), a scoring system widely used in clinical trials of atopic dermatitis, also takes the symptoms of pruritus and sleep loss into account. These self-reported symptoms account for 20% of the final score in SCORAD.

Undoubtedly, pruritus and sleep loss are major sufferings of people with atopic dermatitis, but their sufferings are not limited to these. The chronic relapsing nature of the disease conceivably has significant negative impact on the quality of life (QOL). As in many other skin diseases, the visibility of skin lesion and the associated disfigurement may lead to feelings of embarrassment, decreased self-confidence, rejection and social withdrawal. It was reported that anxiety, neuroticism, depression and hypochondria tend to be more common among people with atopic dermatitis.¹ Adults with AD were found to have an increased incidence of psychiatric disorders.² Children with AD were more likely to have excess of dependency, fearfulness and behavioral problems.³

Do dermatologists have good insight into the extent of impact that skin disease has on their patients? Hermansen et al showed that the life impact estimated by dermatologists may not be as accurate as they believed,⁴ in part because physician assessment largely relies on clinical signs which provide only a snapshot of the disease activity. Little information is gained on how the patients' quality of life was for the last month or longer period. Clients with different personality trait or social setting may also react differently with the same severity of disease. Therefore, the reliable way to assess the QOL is based on patient's individual perspective and cannot be replaced by physician observation based on physical signs. Considerable insight into the impact of skin disease on patients can be gained by the use of validated QOL instruments.

Similar to physical assessment, validated QOL instruments can be used for clinical purpose in deciding the type of therapy and monitoring the progress of the disease. It is worth remembering that the treatment we prescribe can sometimes add to the burden of disease. Patients may report the messiness of ointment and the trouble of topical application. The financial burden of therapy and loss of working days due to medical follow up may be reflected by QOL instrument but not by the physical assessment. As a result, many clinical trials of skin diseases also include QOL measurements as the clinical end point.

Quality-of-life instrument may be used for financial/ political purpose. Using generic QOL

instrument such as SF-36, the impact of skin diseases can be compared with health related QOL of general population or people with other diseases. Kiebert et al were able to show that adult patients with AD had significantly lower mental health component scores of SF-36 than patients with diabetes and hypertension.⁵ This kind of effort can be used to convince the funding sources that patient with skin diseases and atopic dermatitis alike warrant medical attention. Funding should be prioritised according to their impact on QOL.

In this issue of Hong Kong Journal of Dermatology & Venereology, Lam studied the severity of AD by SCORAD and the life impact by using two validated QOL instruments, SF-36 and DLQI. Lam's article showed that the association between physician-assessment and patient-reported health-related QOL was weak. Although the severity of the two major symptoms is considered, SCORAD is not robust enough to assess health-related QOL of people with AD. Dermatologists should spend more time with their patients to discuss the burden of disease. This can enhance the dermatologists' understanding to what the unmet needs are and open the opportunity for the caring

dermatologists to deal with the issues adequately. In an UK study, David et al reported that little information concerning QOL is elicited during dermatology outpatient consultations.⁶ How well are we doing in the busy clinics of Hong Kong?

References

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