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Editorial

Adherence to treatment in patients with psoriasis: a long way to go in Hong Kong

Adherence in health care has been defined as the extent to which a patient's behaviour matches with healthcare advice. In a broader sense, it includes the ability of the patient to attend clinic appointments as scheduled, perform recommended investigations, follow recommended lifestyle changes and take or apply medications as prescribed.[1]

The most accurate and objective measures of medication adherence include determining blood levels of the prescribed drug or measuring urinary excretion of the medication or a metabolic by-product. These objective methods require sophisticated but often impractical procedures. Other measures of medication adherence include pill count and interview methods.

However, for patients suffering from psoriasis or dermatological conditions in general, it is difficult to measure the adherence. The most objective means is by measuring the weight of used topical medications. However, this does not guarantee the accuracy as the patients may just discard the topical medications without really applying them onto their skin.

Apart from the difficulty in measuring the adherence, the interactions between adherence and other individual factors are complicated. These include the severity and location of psoriatic lesions, the patient's personality, age, sex, occupation, and accessibility to the health care system. In patients with psoriasis, the area of skin disease involvement is often not a reliable guide to disability. Rather, psoriasis affects the psychological well-being of patients in different ways according to their social background and circumstances. In this issue, it is good to see that some of our colleagues have tried to raise the awareness of this subject by performing a pilot study in Hong Kong.

Among the various factors that can affect adherence, (which include complexity of regimen, forgetfulness, satisfaction with the treatment, knowledge about the usefulness and side-effects of the medications etc.), it seems that time is a major determining factor not only from the clinicians' perspective but also for the patient. As most of our patients come from the working population, they are very time-conscious. For example, when phototherapy is offered to them, it is commonplace to find that only those who have retired would attend.

Application of topical medications takes a lot of time, especially for those with extensive involvement. Patient education and establishing rapport also take time. The typical consultation time for a doctor in the

public sector for each patient is less than five minutes. This accounts for the poor adherence in many young and knowledgeable patients as they also lack the time and patience to listen to their doctors who try their best to achieve their mission within the time constraints. These patients perceive treatment failure more readily than those who are less knowledgeable. This is a vicious cycle which can never be solved if there are no extra resources. Hopefully, by raising the attention of not only the dermatologists, but also the policy-makers of the public dermatology service, the problems of non-adherence in patients with psoriasis can be tackled in the future.

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Reference

1. Haynes RB. Introduction. In: Haynes RB, Sackett DL, Taylor DW, eds. Compliance in Health Care. Baltimore, Md: Johns Hopkins University Press; 1975:1-6.

Erratum

The publisher would like to draw the reader's attention to an amendment in the following article:
HH Wong, RK Huynh, MPHS Toh, DCW Aw. Quality of life in adults with endogenous eczema in Singapore. Hong Kong J. Dermatol. Venereol. (2016) 24, 5-16.

The qualifications for the two authors should be corrected as below.
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