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Published in Acta Dermato Venereologica - August 2017
DOI: 10.2340/00015555-2760

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Determinants of Psychosocial Health in Psoriatic Patients: A Multi-national Study

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There are limited data on the differences in the impact of psoriasis between various countries with respect to quality of life (QoL). The aim of this study was to explore the psychosocial health of patients with psoriasis in different European countries. A total of 682 patients were recruited in 13 European countries. All patients completed a questionnaire regarding sociodemographic information, negative life events, suicidal ideation and satisfaction with their dermatologist. Depression and anxiety were assessed with the Hospital Anxiety and Depression Scale (HADS), and QoL with the Dermatology Life Quality Index (DLQI) and EuroQoL (EQ-5D). The lowest anxiety and depression scoring was noted in patients from Denmark, the lowest level of impairment in QoL in subjects from Spain, and the highest level of impairment in QoL in patients from Italy. The most relevant parameters influencing patients’ well-being were severity of pruritus and satisfaction with their dermatologist. The level of anxiety and depression symptoms correlated significantly with suicidal ideation.

Key words: psoriasis, quality of life, depression, anxiety, self-esteem.

Accepted Aug 9, 2017; Epub ahead of print Aug 10, 2017


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Psoriasis is a common chronic inflammatory skin disorder with a substantial emotional impact on patients. Prevalence studies have shown uniformly high rates of psychopathology among people with psoriasis (1–4). For instance, anxiety symptoms were found much more commonly in patients with psoriasis compared with controls, with an adjusted odds ratio (OR) of 2.91 (95% confidence interval (95% CI) 2.01–4.21) for anxiety disorders in subjects with psoriasis (4). People with psoriasis were also more likely to be clinically depressed (1). Of note, psychological factors, such as stress, anxiety and depressed mood, may influence the course of the disease and, along with the impact of psoriatic symptoms, impair patients’ quality of life (QoL). Importantly, the impact of psoriasis on health-related QoL (HRQoL) seems to be as great as that of other major medical conditions, such as cancer, heart failure, diabetes and depression (3). Moreover, there was a significant association between having psoriasis and having suicidal thoughts: 67.6% of subjects with psoriasis reported suicidal ideation because of their skin problem (4). Depression in psoriasis might also be linked with higher cardiovascular morbidity and mortality, as it may play a role in promoting subclinical atherosclerosis beyond traditional cardiovascular risk factors. It was shown that depression might be associated with increased vascular inflammation and formation of coronary plaques (5, 6). Therefore, it could be recommended that patients with psoriasis should be systematically screened to identify clinically important levels of depression and anxiety that may be missed while assessing HRQoL alone (7).

It is not known whether depression level and other psychopathological symptoms in psoriasis correlate with disease severity, as current data are contradictory. Some authors have suggested that social stigmatization, high stress levels, physical limitations, depression, employment problems and other psychosocial co-morbidities experienced by patients with psoriasis are not always proportional to, or predicted by, other measurements of disease severity, such as body surface area involvement or plaque severity (2). However, other researchers report that the severity of psoriasis has a significant impact on the wellbeing of affected individuals, as the burden of overall medical comorbidities increases with disease severity in the psoriatic population, and severe psoriasis
increases overall mortality, while mild psoriasis does not (8, 9). Therefore, although there may be discordance between severity of skin lesions and distress, severity of psoriasis may have some effect on rates of depression and suicidality (8).

The psychosocial health of psoriatic patients may be influenced not only by the disease itself, but also by other factors, such as patients’ economic status, occupation and family support. Also, wider factors, such as the healthcare system organization, access to different therapeutic options, or even climate may play a role (10, 11). However, despite the psychological aspects of psoriasis having been widely reported, there is little comparative information from different countries (12, 13). It is probable that patients with psoriasis from different regions may perceive their disease differently. In the present study we performed detailed analysis of data to identify differences among psoriatic patients from various countries, especially regarding determinants of psychosocial health deterioration, including HRQoL, anxiety and depression.

MATERIALS AND METHODS

This study focused on the psoriatic patients participating in the project “The psychological burden of skin diseases: a cross-sectional multicenter study among dermatological outpatients in 13 European countries” run by the European Society of Dermatology and Psychiatry (ESDaP). In this observational, cross-sectional multicentre study, patients were recruited from dermatological outpatient clinics in 13 European countries from November 2011 to February 2013. At each study centre consecutive adult outpatients were invited to participate in the study on one or more random days, until 250 participants per centre were reached. The study protocol was approved by the Regional Committee for Medical Research Ethics in Norway (REK 2011/1087). Local ethics approval was also obtained in all participating countries. The study was conducted in accordance with the principles of the Declaration of Helsinki.

All patients participating in the study met the following inclusion criteria: age ≥18 years; able to read and write in the local language; no severe psychosis. Subjects provided signed informed consent and were examined for dermatological and other physical conditions. Further details of the study have been published elsewhere (4). Out of a total of 3,635 dermatological patients recruited, 682 (18.8%) had psoriasis and were included in the current study for analysis of demographic and socio-economic factors. Further details of the study have been published elsewhere (4). Out of a total of 3,635 dermatological patients recruited, 682 (18.8%) had psoriasis and were included in the current study for analysis of demographic and socio-economic factors. Analysis of demographic and socio-economic factors revealed significant correlation between age and general health status assessed with EQ-5D, indicating that higher age was associated with poorer general quality of life.

RESULTS

Differences between psoriatic patients from various European countries

A total of 151 psoriatic patients (22.1%) had HADS-A scoring ≥11 points (indicating clinically relevant anxiety) and 91 patients (13.3%) recorded marked depressive symptoms (≥11 points). Significant differences regarding self-assessed overall health status, HRQoL, anxiety and depression were observed among psoriatic patients from various European countries (Table 1). The lowest anxiety and depression values were scored by patients from Denmark (HADS-anxiety: 5.0 ± 4.4 points, HADS-depression: 3.2 ± 3.2 points); and the best HRQoL was observed in subjects from the Netherlands (overall health status: 77.9 ± 14.4%; DLQI: 6.5 ± 5.2 points) and Spain (overall health status: 74.9 ± 16.8%; DLQI: 3.7 ± 4.9 points), while patients from Italy were the most impaired (HADS-anxiety: 10.6 ± 3.9 points, HADS-depression: 9.6 ± 4.4 points, overall health status: 55.6 ± 22.2%, DLQI: 14.3 ± 6.6) (Fig. 1). Detailed data on anxiety and depression in particular countries are shown in Table S1.

Analysis of psychosocial health status with respect to demographic data and disease severity

Analysis of demographic and socio-economic factors revealed significant correlation between age and general health status assessed with EQ-5D, indicating that higher age was associated with poorer general quality of life.

https://www.medicaljournals.se/acta/content/abstract/10.2340/00015555-2760
Table I. EuroQoL (EQ-SD), Hospital Anxiety and Depression Scale (HADS) and Dermatology Life Quality Index (DLQI) scoring for psoriatic patients from various European countries

<table>
<thead>
<tr>
<th>Country (% of all patients from each country)</th>
<th>General health status – Mean ± SD [95% CI]</th>
<th>Self-rated health status – EQ-SD Mean ± SD [95% CI]</th>
<th>HADS – Anxiety Mean ± SD [95% CI]</th>
<th>HADS – Depression Mean ± SD [95% CI]</th>
<th>DLQI Mean ± SD [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium (n = 43, 17.4%)</td>
<td>6.7 ± 1.4 [6.2–7.1]</td>
<td>70.2 ± 14.8 [65.3–75.0]</td>
<td>9.5 ± 4.7 [7.9–10.9]</td>
<td>5.6 ± 4.1 [4.1–6.8]</td>
<td>5.7 ± 5.0 [4.1–7.3]</td>
</tr>
<tr>
<td>Denmark (n = 46, 16.1%)</td>
<td>6.9 ± 1.6 [6.4–7.4]</td>
<td>70.3 ± 17.6 [64.7–75.8]</td>
<td>5.0 ± 4.4 [3.7–6.4]</td>
<td>3.2 ± 3.2 [2.2–4.2]</td>
<td>5.2 ± 5.8 [3.4–7.1]</td>
</tr>
<tr>
<td>France (n = 17, 13.2%)</td>
<td>6.9 ± 1.3 [6.2–7.6]</td>
<td>69.1 ± 16.5 [60.6–77.6]</td>
<td>7.8 ± 3.2 [6.1–9.4]</td>
<td>5.0 ± 3.3 [3.3–6.7]</td>
<td>5.7 ± 5.7 [2.5–8.8]</td>
</tr>
<tr>
<td>Germany (n = 29, 9.9%)</td>
<td>7.4 ± 1.5 [6.9–8.0]</td>
<td>62.1 ± 22.4 [53.6–70.6]</td>
<td>8.6 ± 5.4 [5.6–9.1]</td>
<td>6.6 ± 5.1 [4.6–8.5]</td>
<td>10.4 ± 8.3 [7.3–13.6]</td>
</tr>
<tr>
<td>Hungary (n = 40, 9.8%)</td>
<td>6.4 ± 1.8 [5.8–7.1]</td>
<td>72.5 ± 18.8 [64.8–80.3]</td>
<td>5.1 ± 4.0 [3.8–6.4]</td>
<td>4.8 ± 4.1 [3.4–6.1]</td>
<td>6.1 ± 7.9 [3.5–8.6]</td>
</tr>
<tr>
<td>Italy (n = 83, 16.4%)</td>
<td>8.0 ± 1.8 [7.6–8.4]</td>
<td>55.6 ± 22.2 [50.8–60.5]</td>
<td>10.6 ± 3.9 [9.7–11.4]</td>
<td>9.6 ± 4.4 [8.7–10.6]</td>
<td>14.3 ± 6.6 [12.8–15.7]</td>
</tr>
<tr>
<td>Netherlands (n = 23, 11.5%)</td>
<td>6.4 ± 1.1 [5.8–7.0]</td>
<td>77.9 ± 14.4 [70.3–85.6]</td>
<td>5.4 ± 4.1 [3.6–7.2]</td>
<td>4.6 ± 3.9 [2.9–6.2]</td>
<td>6.5 ± 5.2 [4.3–8.7]</td>
</tr>
<tr>
<td>Russia (n = 73, 27.2%)</td>
<td>7.2 ± 1.7 [6.8–7.6]</td>
<td>63.9 ± 19.9 [59.2–68.5]</td>
<td>5.8 ± 4.0 [4.9–6.8]</td>
<td>5.2 ± 3.4 [4.4–6.0]</td>
<td>11.3 ± 7.7 [9.5–13.1]</td>
</tr>
<tr>
<td>Spain (n = 52, 20.1%)</td>
<td>6.1 ± 1.4 [5.7–6.5]</td>
<td>74.9 ± 16.8 [70.2–79.6]</td>
<td>6.2 ± 3.9 [5.0–7.2]</td>
<td>3.8 ± 3.2 [2.9–4.7]</td>
<td>3.7 ± 4.9 [2.3–5.1]</td>
</tr>
<tr>
<td>Turkey (n = 27, 10%)</td>
<td>7.4 ± 1.9 [6.6–8.2]</td>
<td>65.2 ± 18.1 [58.0–72.3]</td>
<td>6.4 ± 4.0 [4.8–8.0]</td>
<td>5.7 ± 3.9 [4.2–7.3]</td>
<td>11.1 ± 6.9 [8.4–13.9]</td>
</tr>
<tr>
<td>UK (n = 50, 18.3%)</td>
<td>6.8 ± 2.0 [6.3–7.4]</td>
<td>70.0 ± 17.0 [65.1–74.9]</td>
<td>7.1 ± 4.1 [6.0–8.3]</td>
<td>4.8 ± 4.0 [3.7–5.9]</td>
<td>6.8 ± 7.2 [4.8–8.9]</td>
</tr>
</tbody>
</table>

SD: standard deviation; 95% CI: 95% confidence interval.

of life (EQ-questionnaire r = 0.15, p<0.001 and EQ-VAS r = -0.12, p = 0.002), and between age and HRQoL impairment measured with DLQI (similarly, higher age was linked with more decreased HRQoL, r = -0.11, p = 0.005). Also, there was significant correlation, albeit weak, between patients’ age and satisfaction with their dermatologist, indicating that older people are more satisfied with their treating physicians (r = 0.12, p = 0.003) (Table II).

Statistically significant differences between males and females were demonstrated in all analysed aspects, except satisfaction with their dermatologists. Females presented lower overall health status, more intense anxiety and depression symptoms, greater HRQoL impairment and more intense itch compared with males (Table II).

The degree of satisfaction with a dermatologist was inversely proportional to the level of education. There was a low level of anxiety in patients with lower educational attainment, and a high level of anxiety in those with higher educational attainment (Table II).

There were no statistically significant relationships between level of education and severity of pruri-
Suicidal thoughts in psoriatic population

A total of 115 patients out of 668 (17.2%) reported present or past suicidal ideations; out of these patients, 77 (11.5%) stated such ideas to be related to their psoriasis. These patients were characterized by significantly higher severity of pruritus, lower overall health status, more severe anxiety and depressive symptoms, and lower HRQoL compared with patients without suicidal thoughts (p = 0.23), overall health status (p = 0.19, p = 0.21), severity of depressive symptoms (p = 0.4) and HRQoL (p = 0.12). Marital status was significantly linked with itch intensity, general health status (EQ-5D questionnaire) and severity of anxiety and depressive symptoms. Divorced people reported more intense itch, higher overall health status impairment, higher anxiety level and more severe depressive symptoms. There were no statistically significant differences between marital status regarding satisfaction with a dermatologist (p = 0.13), self-rated health status (EQ-5D VAS) (p = 0.13) and QoL (p = 0.22) (Table II).

Patients with the lowest socioeconomic status (status self-assessed by the respondent as low, middle, or high) demonstrated the highest overall health status impairment, had more severe anxiety and depressive symptoms and the highest HRQoL impairment (Table II).

Disease severity was weakly related to patient’s psychosocial health status, documenting that higher disease severity was linked with poorer well-being. The closest relationship was with DLQI score (r = 0.21, p < 0.001), followed by EQ-5D score (r = 0.18, p < 0.001), EQ-5D VAS (r = −0.17, p < 0.001), depression (r = 0.14, p < 0.001), and anxiety (r = 0.1, p < 0.001). A detailed multiple regression analysis on the studied variables influencing the patient well-being is presented in Table SII1.
### Table III. Relationships between suicidal ideation and psychosocial well-being of psoriatic patients

<table>
<thead>
<tr>
<th>Presence of suicidal ideation</th>
<th>Suicidal ideation related to skin condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 115)</td>
<td></td>
</tr>
<tr>
<td><strong>Itch intensity</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>5.8 ± 3.4 (5.2–6.4)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>Satisfaction with your dermatologist</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>7.0 ± 3.0 (6.4–7.5)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td><strong>General health status: EQ-5D questionnaire</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>8.4 ± 1.8 (8.1–8.7)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>Self-rated health status: EQ-SD (VAS)</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>55.8 ± 21.6 (51.7–59.9)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>Anxiety level: HADS</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>11.2 ± 4.9 [10.2–12.0]</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>Depression level: HADS</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>8.9 ± 4.7 [7.9–9.7]</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td><strong>QoL: DLQI</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
</tr>
<tr>
<td>13.7 ± 8.4 [12.2–15.3]</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

SD: standard deviation; 95% CI: 95% confidence interval; QoL: quality of life; VAS: visual analogue scale; EQ-SD: EuroQoL; HADS: Hospital Anxiety and Depression Scale; DLQI: Dermatology Life Quality Index.

### Table IV. Relationships between itch and psychosocial parameters in psoriatic patients

<table>
<thead>
<tr>
<th>Presence of itch</th>
<th>Chronic itch (&gt;6 weeks)*</th>
<th>Itch intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n = 474)</td>
<td>(n = 313)</td>
<td>(n = 106)</td>
</tr>
<tr>
<td>Yes</td>
<td>Mean ± SD [95% CI]</td>
<td>No</td>
</tr>
<tr>
<td>7.4 ± 2.7 [7.1–7.6]</td>
<td>&lt; 0.001</td>
<td>8.4 ± 2.2 [8.1–8.8]</td>
</tr>
<tr>
<td>7.5 ± 1.8 [7.3–7.6]</td>
<td>&lt; 0.001</td>
<td>6.4 ± 1.5 [6.2–6.7]</td>
</tr>
<tr>
<td>62.9 ± 20.5 [61.0–64.8]</td>
<td>&lt; 0.001</td>
<td>72.4 ± 16.6 [70.0–74.8]</td>
</tr>
<tr>
<td>7.7 ± 4.7 [7.3–8.1]</td>
<td>&lt; 0.001</td>
<td>5.7 ± 3.8 [6.1–6.2]</td>
</tr>
<tr>
<td>6.2 ± 4.5 [5.8–6.6]</td>
<td>&lt; 0.001</td>
<td>3.7 ± 3.0 [3.2–4.1]</td>
</tr>
<tr>
<td>10.9 ± 7.6 [10.2–11.6]</td>
<td>&lt; 0.001</td>
<td>4.9 ± 5.9 [4.1–5.8]</td>
</tr>
</tbody>
</table>

*In 55 patients the duration of itch was not provided.

SD: standard deviation; 95% CI: 95% confidence interval; QoL: quality of life; VAS: visual analogue scale; EQ-SD: EuroQoL; HADS: Hospital Anxiety and Depression Scale; DLQI: Dermatology Life Quality Index.

**disc**

The highest prevalence of suicidal thoughts was found in Turkey (44.4%), the lowest in France (5.9%) and the second lowest in Denmark (9.1%) (p = 0.02).

Multiple regression analysis revealed that the presence of suicidal thoughts was independently related to patients’ age (β = –0.1, p < 0.05), socio-economic level (β = –0.09, p < 0.05), stressful life events during the last 6 months (β = –0.18, p < 0.001), general health status according to EQ-5D questionnaire (β = 0.12, p < 0.04), and anxiety level (β = 0.25, p < 0.001), while suicidal ideation related to skin condition were significantly dependent only on stressful life events during the last 6 months (β = –0.1, p < 0.05), and anxiety level (β = 0.24, p < 0.001).

### Itching in psoriatic patients

A total of 474 psoriatic patients (69.5%) reported itching, of whom 74.7% reported the presence of chronic itch, i.e. lasting longer than 6 weeks. In some countries the prevalence of itch was extremely high (Italy 91.6%, Germany 82.8%, the Netherlands 82.6%) in comparison with some other countries (France 35.3%, UK 52.0%) (p < 0.001). Significant differences were also observed regarding itch intensity, with the highest scores reported among patients from Italy (mean VAS 6.6 ± 1.9 points), UK (mean VAS 5.8 ± 2.3) and Germany (mean VAS 5.7 ± 3.2), and the lowest scores by patients living in Russia (mean VAS 2.5 ± 3.2), Hungary (mean VAS 3.5 ± 3.3) and Spain (mean VAS 3.5 ± 3.3) (p < 0.001). Detailed data on itch severity scoring are demonstrated in Table SIII.

Patients with chronic itch had more severe pruritus than those with acute itch (6.0 ± 2.5 points vs. 5.3 ± 2.4, p < 0.01). They were also more depressed (Table IV). Patients with itch had lower overall health status and HRQoL as well as significantly more severe anxiety and depressive symptoms compared with patients without itch. There was a statistically significant correlation between the severity of itch and satisfaction with dermatologist, overall health status, severity of anxiety and depression symptoms, and HRQoL (Table IV).

### DISCUSSION

Psoriasis is a common chronic skin condition that can markedly impair patients’ HRQoL (19–21). Many people with psoriasis report decreased self-esteem and problems in establishing relationships with other people (22). However, in our current study using a validated set of questionnaires we have demonstrated significant variations among different European countries of psychosocial health status of patients with psoriasis. It is possible that cultural differences, different access to possible treatments, differences in the organization of healthcare systems, and differences in climate may influence the impact of psoriasis on patient’s well-being. Differences regarding well-being do not correlate with latitude,
patients within the larger cohort, leading to differences
in numbers of psoriatic patients recruited from each
centre. Depending on the local system of referral to
the clinic, the clinical severity of the psoriasis patients
may have differed between centres. Some of the differences
in scores between countries may have been caused by
cultural differences in answering the questionnaires.
Although validated translations of the measures were
used in different countries, giving assurance that the
meaning of the questions was as close as possible in the
different languages, it cannot necessarily be assumed that
the scores from the measures can be directly compared
between different countries (28), even though this as-
sumption is made in the interpretation of, for example,
multinational drug trials (29). This is a difficulty across
all patient-reported outcome measurements in medicine
and is not confined to dermatology. Furthermore, disease
severity was assessed using only 3 severity categories
(mild, moderate, severe). The Psoriasis Area and Se-
verity Index (PASI) would probably be more appropriate
as it gives more objective data on psoriasis severity and
extent, thus not using PASI should be considered as a
further limitation. The same refers to measurement of
pruritus intensity, as the VAS is assessing only symptom
severity, but does not take into account, for example,
pruritus extent or number and durations of itch episodes.
Thus, performing only one method of assessment of pru-
ritis severity limits the results for itch. According to the
guidelines published by the International Forum for the
Study of Itch (IFSI) (8) VAS is one of the most widely
used pruritus measures and is recommended for use in all
clinical trials on itch. Of course, this instrument, as any
other, has some limitations, which have been mentioned
in the discussion.

Future studies focusing on the influence of pruritus on
patient well-being should consider other measurement
tools, such as itch questionnaires (30). However, despite
the large number of questionnaires used in our study, in
order to keep the study as feasible as possible we decided
to include only VAS as a measure of pruritus intensity.

In conclusion, significant variations were observed
among different European countries regarding the
psychosocial health status of patients with psoriasis.
Patient selection biases may have partly influenced the
results of the present study, and these findings need to
be confirmed in future studies; however, this study in-
dicates that results from one country should not simply
be transferred to patients living in other countries, as
perception of psoriasis and coping with the disease may
take place in a completely different ways. The study
clearly indicates that psoriasis is significantly linked
with depression, anxiety and impairment of QoL. It is
essential to include measures of psychosocial morbidity
when assessing psoriasis severity and treatment efficacy,
because of the substantial role that psychosocial burden
plays in patient perception of disease severity, QoL and
disease course (2). Such knowledge also requires the prompt implementation of active interventions to detect and treat psychological disturbances early, in order to improve QoL of patients with psoriasis.

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