

Stress and quality of life in dermatological patients: Are out-patients' needs different?

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Abstract

The debut, progression and maintenance of skin disease are related to stress (acne, alopecia areata, atopic dermatitis, lichen planus, psoriasis, urticaria, vitiligo, herpes, hyperhidrosis, pemphigus, rosacea or seborrheic dermatitis). Environmental, socio-professional, life events are representing external factors. Personality, previous experiences, traits of anxiety are individual

factors influencing the state of stress. Perceived stress could be more harmful especially in "high reactors" to stress. Coping abilities to stress could be increased in social programs. There was a recent interest in measuring the quality of life in the last years. There are dermatology and disease specific questionnaires that could help. Out-patients have less time to wait for very sophisticated procedures. They expect faster results. For simple, acute diseases it is important to have a good communication and good understanding of the instructions to get results as soon as possible. For chronic diseases a strong long-term alliance is needed, so the patients should revisit for his benefit and not for giving up. Small questions regarding potential stressful events, impact on the quality of life, stigmatization, the level of symptoms (pruritus), psychiatric comorbidities (anxiety, depression), short questionnaires for quality of life give us a better picture, personalize the doctor-patient relationship and could influence the choice of treatment. Many skin disorders could be seen from a psychosomatic point of view and the final goal, especially for the chronic diseases, is to improve through our treatments the impact on the quality of patient's life.

Key words: Stress; Perceived stress; Quality of life; Out-patients; Dermatology life quality index; Children dermatology life index

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Core tip: The debut, progression and maintenance of skin disease are related to stress. Besides external factors, individual factors could influence the state of stress. Perceived stress, high reactors to stress, coping abilities, quality of life questionnaires are some directions to discuss. Out-patients have different needs and expectations than in-patients. Good communication, empathy, personalized questions, short questionnaires could make a strong, long-term doctor-patient relationship with better results and satisfaction for both sides.

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The interest for stress involvement in dermatological conditions and also for the impact of cutaneous diseases on the quality of patient's life increased in the last years. I have made an extended review^[1] reporting that stressful events could induce, aggravate or maintain different skin diseases such as: Acne, alopecia areata, atopic dermatitis, lichen planus, psoriasis, urticaria, vitiligo. There were described such connections even with herpes, hyperhidrosis, pemphigus, rosacea or seborrheic dermatitis.

Other aspect is represented by the secondary stress induced by the skin disease itself, influencing the quality of life.

The impact of a stressful situation on patient's life (perceived stress) could induce more harm than the situation itself. There are patients "high reactors" to stress. For them it is a risk of developing psychosomatic diseases after some minor life situations perceived as stressful.

The state of stress could be influenced by external and individual factors. Environmental, socio-professional factors or different life situations are some of external factors. Major life events that appear in the list of Holmes and Rahe provoke important reactions to people. Serious illness of the patient or of beloved ones, death of family members or friends, separations or divorces are expected to induce anxious-depressive states with different psychosomatic appearances. Personal needs or previous experiences, personality and attitude facing different situations, family models represent individual factors that can also change the state of stress. For example reactions to exams, to quarrels, to changes of jobs, environment could be very different from a person to another. The psychological vulnerability of the person (ex high trait of anxiety) could change the appearance, the development and the progress of the psychosomatic disease.

There is a study^[2] on out-patients with dermatoses that describes women having higher perceived stress. The perceived stress was higher in patients with psoriasis and acne than in tumors and was correlated to mental quality of life.

The reaction of the individual is an attempt to restore the balance and depends on the coping abilities. Social programs including stress management and psychological support are important in the achievement of coping abilities^[3].

Persons with high stress resistance are characterized by a control on the events and life situations, acceptance of the responsibility of the facts that are happening. They are involved in everything they are doing and they accept the changes as natural.

More than 3000 of papers are studying the impact of skin diseases on the patient's quality of life and more than half have been published during the last 5 years, showing an increasing interest on this subject. For the measurement^[4] there are generic instruments and also specific instruments (dermatology and disease specific). There are scales for adults, children, teen-agers, families, infants, etc., in the need for more specific data.

After 15 years of working only with out-patients (more than 100000 consultations) in Romania, I think there are different needs for them. I know that there are different aspects regarding cultural habits, but people have general needs of care. I work with National Insurance System and patients have facile access to ambulatory after a reference from the general practitioner. In our country from Eastern Europe, people want and need to talk and to be listened. There is no intrusion in their intimacy if you ask personal aspects or if you try to personalize the doctor-patient relationship. Usually, there is a close relationship, because the patients are coming back for controls or for other acute episodes. Through years, if there is a good and trustful relationship, the doctors get to know the entire family.

Out-patients have less time to wait for results and other expectations than in-patients. Usually, in the ambulatory they are coming for common skin conditions and the alliance is very important. For simple diseases it is important to get results as soon as possible (ex: Impetigo, different kinds of superficial mycoses, contact eczemas, scabies aso), so, good communication and good understanding of the instructions will have the best benefit. They need detailed information and they should ask questions. For chronic diseases such as acne, psoriasis, atopic dermatitis, onychomycosis, chronic urticaria, warts, etc., the alliance will represent the key point for the patient to return and not to give up with the long-term therapy.

In an era of fast movements and expectations, I consider that it will be very helpful for both doctor and patient to keep in mind small questions regarding potential stressful events, impact on the quality of life, stigmatization, the level of symptoms (pruritus), psychiatric comorbidities (anxiety, depression). Even they seem to be time-consuming this kind of questions will increase the trust and the satisfaction of the patient and will give us additional information and a more complete picture that could influence the choice of the treatment. Deeper, personalized questions will show to the patient the care and the empathy. For example, I use dermatology life quality index^[5] and children's dermatology life quality index^[6] for almost every patient with acne. There are 10 questions and it takes a few minutes to be filled in. The results of the questionnaires could give me information about the necessity of more aggressive lines of therapy in case of high impact on the quality of life and complex approach (for example, together with endocrinologist, psychologist or psychiatrist). On the other hand, if the impact on the quality of life is very low, even the lesions are important,

that could be a predictor that the patient is not ready for a long-time commitment in therapy.

Questionnaires are usually used in clinic for different types of studies. They are very complex and it takes a long time to be completed. In hospitals, where there are teams that work together they could be done by residents and there are not time-restricted.

But, a consultation for out-patient is short and short questionnaires are more convenient. They have to be very simple (a few questions), easy to be filled in by patients. Some of actual questionnaires have been already translated and used also for outpatients, but maybe it could be interesting to design some new ones especially for a facile use in ambulatories.

Many skin disorders could be seen from a psychosomatic point of view and the final goal, especially for the chronic diseases, is to improve through our treatments the impact on the quality of patient's life.

Questionnaires are not only for the clinics, doctors in ambulatories should be open to use them in daily practice as good instruments for measuring the severity and impact or the needs of patients. The short questions could point sensitive areas that could need deeper approach. Translations, validations and a wide use of questionnaires could give us new perspectives.

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