ROLE OF PSYCHIATRIC MORBIDITY AND QUALITY OF LIFE IMPAIRMENT IN PSORIATIC PATIENTS

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INTRODUCTION

Psoriasis (PS) is one of the most common inflammatory dermatitis, which affects approximately 2-3 % of the general population. Dermatologist must consider the role of the environmental and psychological variables. Starting and flares are unpredictable and can generate a great impact at physical, functional and psychological level; interfering seriously in the patients quality of life (QoL).

OBJECTIVE

This study examines whether anxiety and depression are related or not with psoriasis and if an association with demographic variables, clinical severity (Psoriasis Area and Severity Index-PASI; and Body Surface Area-BSA) and QoL domains could be determined.

METHODS

A cross-sectional study of 231 consecutive psoriatic patients was conducted. Each patient was exanimate dermatologically and psychologically in the following visit with different scales: PASI, BSA, Assessment Symptoms of Psiorasis (PSA), Visual Analog Scale for Pain (VAP) and Itching (VAI), the State-Trait Anxiety Inventory (STAI), the Hospital Anxiety and Depression Scale (HADS), Hamilton Rating Scale for Anxiety (HRSA), Montgomery-Asberg Depression Rating Scale (MADRS) and Short-Form 12 (SF-12).

RESULTS

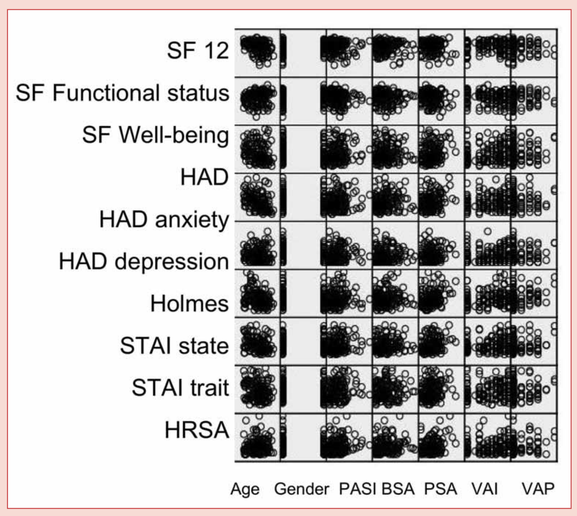
Sociodemographic and clinical:
Mean (SD) age was 50.89 (16.89). 53.5% were women and 46.5% men. Mean PASI score was 10.45 (8.97), BSA mean was 18.71(14.84) and mean follow-up (from onset of disease) 17.23 (15.68) years. 59,7% of patients presented psoriasis flare at consultation and 92.6% of patients suffered at least one flare during last year. 37,2% of the patients had familiar history of PS. 79,6% and 27,8% of patients had active symptomatology of itch and pain respectively (Table 1).

Table 1: Sociodemographic and clinical data

Gender; women n(%)		123 (53,5)
Years; Mean (SD)		50,9 (16,9)
Body Mass Index; Mean (SD)		26,84 (4,85)
Familiar history of PS; n(%)		86 (37,2)
Severity; mean (SD)"		
BSA		18,7 (14,85)
PASI		10,5 (8,98)
Follow-up; mean (SD)		17,23 (15,68)
Active flare n(%)		138 (59,7)
Flare last year n(%)		214 (92,6)
Active itch n(%)		183 (79,6)
Active pain n(%)		64 (27,8)
Gender; n-mean (SD)	Women	Men
HAD Anxiety	122-7,1 (4,08)	107-5 (4,12)
HAD Depression	122-3,9(3,89)	107-2,3(2,5)
STAI	113-18,5(9,5)	99-15,8(8,38)
HRSA	122-6,55(5,51)	106-4,2(4,43)
MADRS	122-7,57(6,3)	107-4,93(4,1)
Holmes	122-22,77(15,27)	107-19,5(11,87)
SF-12	122-39,60(6,27)	107-43,14(4,82)
SF-12/functional status	44,52(9,9)	48,54(6,8)
SF-12/Well-being	35,27(8,56)	37,77(6,52)

Correlations:
The figure 1 presents the correlations between the variables. The results show a relationship between clinical severity of PS (PASI and BSA) and active symptomatology (with VAI rho 0,215; 0,246 p<0,01). The severity of PS also was consisted with PSA (rho 0,317; 0,273 p<0,01). The results show that active itching symptomatology have an impact in patients QoL and psychological distress (p<0,01). The questionnaire SF-12 was correlated with VAI, especially with the social function and corporal pain dimensions (rho -0,188; rho 0,219; p<0,01).
The PS severity (PASI) was correlated with depression (MADRS) and anxiety (HRSA) questionnaires (rho 0,188; rho 0,186; p<0,01). The presence of a flare of PS was associated with impact on QoL (0,133-p<0,01) and with VAI (0,147-p<0,05); but not was correlated with psychological distress.

Figure 1: Stub of dispersed



Stratification gender:
The Table 2 shows the differences of the variables according to the sex. QoL and psychological distress was significantly more impaired in females although the clinical severity was worse in males (PASI 8,8 vs 12,2-BSA 16,3 vs 21,5).

Table 2. Statistics

	U Mann-Whitney	W de Wilcoxon	Z	Sig. (bilateral)	Mean		Percentage of increase
					Women	Men	
PASI	4749	12252	-3,555	0	8,82	12,2	-4,69%
BSA	4972	12475	-3,11	0,002	16,28	21,46	-5,18%
SF12	4157	11660	-4,738	0	39,6	43,14	3,54%
SF functional status	2247,5	6712,5	-2,414	0,016	44,52	48,54	4,02%
SF well-being	2513,5	6978,5	-1,45	0,147	35,27	37,77	2,50%
HAD	4436,5	10214,5	-4,188	0	11,02	7,33	8,79%
HAD anxiety	4430	10208	-4,207	0	7,08	5,03	9,76%
HAD depression	5126,5	10904,5	-2,836	0,005	3,94	2,3	7,81%
HRSA	4510,5	10181,5	-3,87	0	6,55	4,19	4,22%
Montgomery	4871,5	10649,5	-3,323	0,001	7,57	4,93	4,40%
PSA	5929	11600	-0,777	0,437	12,76	10,94	3,78%
STAI state	4591	9541	-2,252	0,024	18,49	15,8	4,52%
STAI trait	3927,5	8877,5	-3,741	0	21,51	16,52	8,32%
Holmes	5833,5	11611,5	-1,386	0,166	22,78	19,5	

CONCLUSIONS

These observations indicate that similar levels of PS clinical severity may be associated with different levels of QoL and psychological distress of patients. Preliminary studies demonstrated that the psychological distress interferes in a negative way with results of treatments in patients with PS. Because of this fact, additional treatment for psychopathological features may be advisable and worth further exploration, especially in those serious patients with active symptomatology.

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