

Assessment of dermatology life quality index (DLQI) in patients attending skin clinics in Csth

D R D Ratnayake¹, J M S D Ranasinghe¹, C M Undugodage², M C Dedigama³, S D Kamaladasa⁴

Sri Lanka Journal of Dermatology, 2009, 13, 18-19

Introduction

Dermatological diseases can have a significant effect on the quality of life of a patient. This may be due to the symptoms caused by the disease itself such as itching, soreness and pain or due to the psychological impact caused by a breakdown of interpersonal relationships and social isolation. Skin diseases like psoriasis have been proven to be as debilitating as major medical conditions like arthritis and cardiovascular disease¹. The effect of dermatological disease on a patient's quality of life is often overlooked in skin clinics in Sri Lanka. This study was carried out among patients attending the Professorial Unit Skin Clinic and other Skin Clinics at the Colombo South Teaching Hospital.

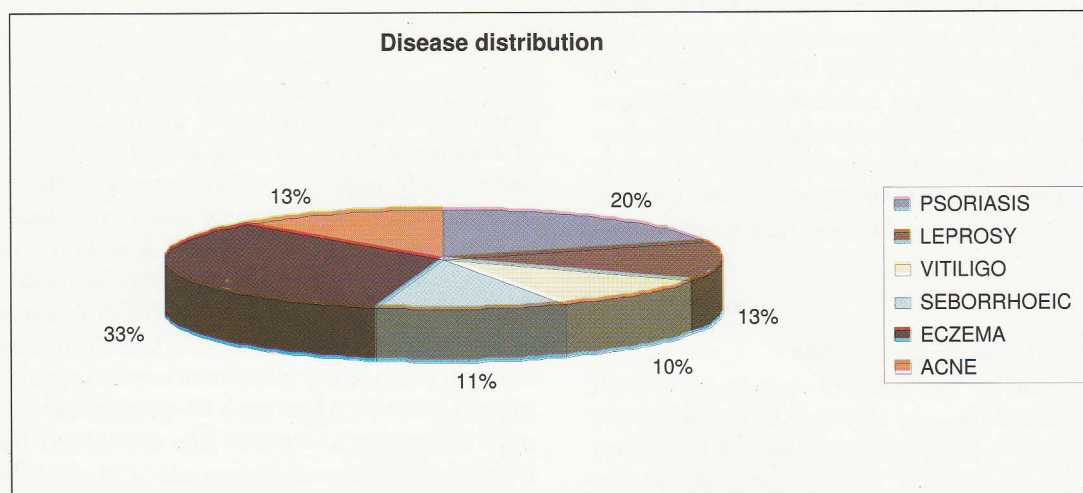
Method

Various tools have been devised to assess the quality of life of patients with dermatological disease^{2,3}. Some are disease specific such as Psoriasis Disability Index (PDI) and the Cardiff Acne Disability Index (CADI).

For the purpose of this study we have used the dermatology life quality index⁴ (DLQI) while not being specific to a particular dermatological condition can be used to assess the effect on the quality of life in patients with dermatological diseases.

The DLQI is calculated using a questionnaire which consists of ten questions. Each question has 4 answers having a value from 0 to 3 points (patients have to be above the age of 16). The maximum score that can be obtained is 30 points and the minimum is 0. A score of between 21 to 30 would mean that there is a severe effect and a score of 1 would mean there was a minimal effect on the patient's life.

In our study we included 215 patients. All were above 16 yrs of age. We limited the study to patients with 6 common skin conditions namely; eczema, vitiligo⁵, leprosy, acne vulgaris⁶ psoriasis^{7,8} and seborrheic dermatitis.



¹Medical Officer, ²Registrar in Medicine, ³Senior House Officer, ⁴Consultant Dermatologist and Senior Lecturer in Medicine, Colombo South Teaching Hospital, Kalubowila.

Results

The highest mean DLQI score was seen in psoriasis, eczema and acne (scores of 8, 7.5 and 6.5 respectively). The DLQI score was the highest for acne in the age group of 15 to 30 while it increased with age in all other skin conditions. The increase with age was statistically significant ($p=0.045$). Males scored higher than females (mean DLQI - male:7.15, female:5.3). There was a significant association between gender and DLQI ($p=0.048$). Married patients had a higher score than unmarried patients (mean DLQI - married:6.9, unmarried:5.3). As expected the mean DLQI increased significantly with the duration of the disease (4.8 when the disease was present for 1 year or less and 7 when present for up to 10 years).

With regard to specific dermatological diseases it was noted that patients with atopic eczema had a higher score than patients with discoid eczema. The same pattern was seen when comparing segmental to diffuse vitiligo as well. Female patients with leprosy had a higher score than males (mean DLQI 2.6 and 2.2 respectively). Acne associated with keloid formation and scarring had higher scores than inflammatory acne alone (mean DLQI 6.2 and 10 respectively).

Conclusion

This study highlights the significant impact of skin diseases on patient's quality of life. The impact is determined by the type of disease as well as its severity, age of the patient and duration of illness. Males seem to be more affected by dermatological diseases as are married people of both sexes.

Clinicians should try to identify patients who fall into the categories above. Early assessment of DLQI will help clinicians identify the patients who need assistance. They should help these patients improve their quality of life while treating the underlying skin disease.

References

1. David SE, Ahamed Z, Salek MS, Finlay AY. Does enough quality of life related discussion occur during dermatology out patient consultation. *Br Journal of Dermatology* 2005; **153**: 997.
2. Finlay AY. Quality of life measurement in dermatology: A practical guide. *Br Journal of Dermatology* 1997; **136**: 305.
3. Andrew Y, Finlay AY. Quality of life assessments in dermatology. *Seminars in Cutaneous Medicine and Surgery* 1998; **17**: 291-6.
4. Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI) – a simple practical measure for routine clinical use. *Clinical and Experimental Dermatology* 2006; **19**: 210.
5. Mazharini N, Andrew. DLQI score in vitiligo: Reliability and validity of the Persian version. *BMC Dermatol* 2004; **4**: 8.
6. Newton M, Stewert Brown K, Finlay R. The quality of life in acne: A comparison with general medical conditions using generic questionnaires. *Br Journal of Dermatology* 1999; **140**: 672.
7. Mazeedi KA, El-ShazlyM, Al-Ajmi HS. Impact of psoriasis on quality of life in Kuwait. *International Journal of Dermatology* 2006; **45**: 418.
8. Richards HL, Fortune DG, Weidmann A, Sweeney SKT, Griffiths CEM. Detection of psychological distress in patients with psoriasis. *British Journal of Dermatology* 2004; **151**: 1227.