8. PSORIASIS IN NORWEGIAN TWINS

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Objectives: To describe the occurrence and risk of psoriasis in Norwegian twins and to explore age and sex specific characteristics of the disease.

Methods: In 1998 the National Institute of Public Health in Oslo conducted a population-based study on 16,000 twin births born between 1967 and 1979. This historical cohort consists of more than 12,000 twins identified through the national Medical Birth Registry. We have analyzed the self-reported history of psoriasis among the 8,045 questionnaires that have been returned.

Results: Altogether, 334 (4.2%) individuals reported a positive history of psoriasis. The overall prevalence in females was 4.7% and in males 3.8%. The prevalence in the teenage four-year intervals were significantly higher in females. A near linear increase in incidence rates was observed for both females and males but peaked at different ages. Sex differences emerged in the absolute risks of developing psoriasis across the whole age distribution, but by the age of 31 the cumulative incidence was similar in both sexes. Mean age at onset of the disease was significantly lower in females than in males (14.8 years and 17.3 years, respectively).

Conclusions: We have found a high prevalence of psoriasis in this historical cohort of twins aged 19–31 years. The observed sex disparity in the natural history of psoriasis will be elucidated. Methodological considerations will be discussed.

9. DEVELOPMENT OF THE GERMAN EVIDENCE BASED GUIDELINE ON THE TREATMENT OF PLAQUE PSORIASIS

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Objectives: To develop an accepted evidence-based guideline for the treatment of plaque psoriasis in Germany.

Methods: In a first step systematic search for existing evidence based clinical guidelines for plaque psoriasis was undertaken. The G.I.N. (German information network in the field of dermatology) and other sources were based. On these results the guideline protocol was developed. The base of the guideline project will be an extensive systematic search of the databases MedLine, Embase and the Cochrane library. The literature will be critically appraised by a group of 10 (5 + 5 group) dermatologists (5 from university hospitals and 5 from private practices). The 5 + 5 group will formulate a first version of the guidelines, which will be discussed in the extended guideline groups that will include other specialists as well as patients. The project will be supported by the Deutsche Dermatologische Gesellschaft (DDG) as well as the Berufsverband Deutscher Dermatologen (BVD), the German organisations for dermatologists in hospitals and private practices.

Results: The G.I.N. database research revealed several guidelines. Among those the Dutch guideline “Photochemotherapy and systemic therapy for severe chronically plaque type psoriasis” was found to serve as a good base for the German guideline. The methodology of the Dutch guidelines will be adapted. The German guideline project started in the beginning of 2004. The first 5 + 5 meeting will take place at the end of June 2004. The aim of this meeting will be critical appraise the Dutch guidelines and familiarize the 5 + 5 group with the critical appraisal of the literature and the verbalisation of the guideline.

Conclusions: There is a strong need for developing broadly accepted evidence based guideline for common diseases like plaque psoriasis. So far the development of guidelines is mostly limited to specific countries. Although in Europe national differences in patient care as well as in therapy preferences may give an opportunity to study the risk factors that are associated with the anticipated rise in prevalence.

10. SELF-REPORTED ITCH AND MENTAL HEALTH. A NORWEGIAN SURVEY AMONG ADULTS

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Background: Itch is a symptom common to several chronic skin diseases and frequently encountered in the dermatological practice. Unlike other dermatological symptoms itch is subjective and often challenging for clinicians.

Objective: The aim of this study was to describe the prevalence of self-reported itch and to analyse the associations of itch with psycho-social factors in the general population.

Materials and Methods: The method was used a questionnaire on self-reported skin complaints, it was previously developed and validated. The design of the study was cross sectional. 40 888 in the city of Oslo, in age groups 30, 40, 50, 60 and 75 received a postal questionnaire. It included questions on self-reported health, and psycho-social factors as well as on itch.

Results: In total, 3708 returned questionnaires were included. The overall response rate was almost 83%. The crude prevalence of itch in 1–6 yrs olds was 2.3%. Age specific prevalences ranged between 1.7 and 4.8%. Prevalence in the city was 2.4%, while the rural prevalence was 3.5%. Prevalence was not associated with immunizations, family size or family income, while a history of childhood diseases appeared to be a contributing factor.

Conclusions: Prevalence in the region is relatively low, without differences between city and rural area. Apparently, the anticipated transition to higher prevalence has not yet occurred. This gives an opportunity to study the risk factors that are associated with the anticipated rise in prevalence.

11. THE MEANING OF SKIN DISEASE: THE IMPORTANCE OF QUALITATIVE RESEARCH

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Skin disease has meanings, which derive from social & cultural understandings, which are of course informed in the contemporary world by scientific & professional research & knowledge. But the latter do not by any means wholly determine popular beliefs and perceptions at all levels of the general public, nor at the level of the individual who has such disease. These meanings are not uncommonly undermining them. Treatment itself is a challenge to understanding, with “meanings” to be determined & unravelled by the patient & the wider community. Nor should it be thought that medical & related concepts, knowledge & practice are insulated from wider cultural conceptions. The EDEN Network findings & others provide ample evidence of this. Life style, clinical decisions & self-care activities are influenced not only by the professional who has been consulted, but by the everyday world of the individual with skin disease is seen & understood in a broader context. It is easy to make the mistake of ignoring such realities, failing to take lay, “folk” or “vernacular” understandings, concerns & behavioural practices seriously, & to dismiss them as simply irrelevant, or falsely founded & problematic, requiring no more than “correction”. Recent enthusiasm for cognitive & behavioural intervention as a component of treatment reflects in some measure a drive to secure patient “pacification”, & behavioural compliance with the specific needs of a therapeutic regime, without any serious attempt to understand the complexity of the social “world” within which the patient operates & the justifiable broader goals & constraints which influence, even direct, him/her. “Chronicity” is a central feature of this experience & the enduring everyday reality which has to be addressed by the patient, his supporters, & those with whom he has wider social encounters. It should not be ignored by the professional who has been consulted.

The meaning of skin disease as a genuine community concern is unlikely to be revealed by means of investigative instruments designed for, & more suited to, quantitative research. An approach akin to the natural observational, ethnographic, interpretive field research traditions of social anthropology and qualitative sociology is more likely to bring useful knowledge & understanding. We know, a give explicit recognition to, all too little of what people actually “do” & “don’t do” & their rationale for this behaviour. Life style influences the life course on a basis, in descriptive fact, nor much by way of a framework for understanding & interpretation of dermatological illness behaviour. Thus far the approach of Dermatologists to “disability”, & their understanding of it, has lagged behind that of colleagues in other specialties. This has made their well-motivated efforts to deal with it individually & collectively less effective than they should & could have been.

In this instance “data” or “evidence” designed to explore this all will be “soft” rather than “hard”, but deserve to be taken seriously nonetheless. Such a concern for uncovering meanings embedded in culture & social organisations, & thus informing professional therapeutic decisions for example, not uncommonly undermining them. Treatment itself is a challenge to understanding, with “meanings” to be determined & unravelled by the patient & the wider community. Nor should it be thought that medical & related concepts, knowledge & practice are insulated from wider cultural conceptions. The EDEN Network findings & others provide ample evidence of this. Life style, clinical decisions & self-care activities are influenced not only by the professional who has been consulted, but by the everyday world of the individual with skin disease is seen & understood in a broader context. It is easy to make the mistake of ignoring such realities, failing to take lay, “folk” or “vernacular” understandings, concerns & behavioural practices seriously, & to dismiss them as simply irrelevant, or falsely founded & problematic, requiring no more than “correction”. Recent enthusiasm for cognitive & behavioural intervention as a component of treatment reflects in some measure a drive to secure patient “pacification”, & behavioural compliance with the specific needs of a therapeutic regime, without any serious attempt to understand the complexity of the social “world” within which the patient operates & the justifiable broader goals & constraints which influence, even direct, him/her. “Chronicity” is a central feature of this experience & the enduring everyday reality which has to be addressed by the patient, his supporters, & those with whom he has wider social encounters. It should not be ignored by the professional who has been consulted.

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