

tively. Feasibility was tested by computing the number of missing answers; content validity was tested by computing the frequency of questions considered as “not relevant” by the patients; reliability was tested in terms of internal consistency and test-retest reproducibility. **RESULTS:** No missing answers were present in both the first and the second interview. The frequency of “not relevant” questions was 5.4% on first and 7.7% on second interview. The Cronbach’s alpha coefficient for internal consistency was 0.787 on the first and 0.828 on the second interview. Regarding reproducibility, the intraclass correlation coefficients for the total score was 0.983 ($p < 0.0001$), and the method by Bland & Altman excluded the presence of biases for this score. The weighted kappa coefficient of agreement calculated for each question ranged from 0.644 (“social & leisure”) to 0.984 (“sport”). **CONCLUSION:** The Italian version of the DLQI questionnaire is feasible, valid and reliable. This instrument can be used to evaluate Health Related Quality of Life in adult people affected by skin conditions and can be used to assist decisions on treatment and on health care resource allocation.

PSN21

IMPACT OF CORTICOSTEROID-SPARING EFFECT OF AN EMOLLIENT MILK ON FAMILY’S QUALITY OF LIFE OF INFANTS AFFECTED BY ATOPIC DERMATITIS

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OBJECTIVES: The aim of this open label, multicentric study was to evaluate the corticosteroid-sparing effect of an emollient milk containing Oat Rhealba® extracts on quality of life of family in a group of infants aged less than 1-year old with Atopic Dermatitis (AD). **METHODS:** Children with mild to moderate AD (SCORAD index ≥ 20 and ≤ 70) were randomised in two parallel groups: a group with the emollient milk applied twice daily, and a group receiving no emollient. The use of topical corticoids (class II & III non-fluorinated desonide corticoids) was allowed in the event of inflammatory flare-ups in both groups. The primary end point was measurement of the total amount of topical steroids used (grammes) at six weeks. The secondary end points were, clinical rating changes (SCORAD index), and Quality of Life (QoL) using DFI scale. The DFI scale (Dermatitis Family Impact questionnaire) was completed by the parents and aimed at measuring the impact of dermatosis on the quality of life of children affected and their family. **RESULTS:** DFI total score and all its dimensions were comparable upon inclusion between treated and non treated groups (total score: 5.30 (5.23) versus 6.42 (5.32) respectively). Improvement was noted for both groups. A significant improvement was only noted in the treated group for the items about sleep (In the past seven days, has the child’s eczema had any effect on the sleep of other family members?) and about consequences (In the past seven days, has your participation in the child’s treatment had any consequence on your life?). **CONCLUSIONS:** After six weeks of treatment, we noted in the parents of the treated group a significant improvement in sleep due to treatment impact and a reduced treatment impact on daily life.

PSN22

SENSITIVE SKIN: IMPACT ON QUALITY OF LIFE

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OBJECTIVES: To assess among the French adult population, the impact of sensitive skin on quality of life using two validated questionnaires, the SF-12 and HAD-Depression scale.

METHODS: In July 2004 a sample of 1001 individuals selected among a national representative sample of the French adult population were interviewed by phone according to the quota method (gender, age, profession of head of family, town category and region) by ISPOS. Questions on how they perceived their skin sensitivity and possible aggravating factors were asked. Quality of life was then assessed through the SF-12 and the HAD depressive symptomatology scale. **RESULTS:** When asked «Do you have sensitive skin?», 20.7% answered “very sensitive”, 38.2% “sensitive”, 27.5 % “hardly sensitive”, 13.2% “not sensitive” and 0.5% “gave no answer”. Physical and mental quality of life was assessed through the SF-12. Regarding the physical dimension, mean PCS-12 score was 49.2 (SD = 8.6) in the group “very sensitive or sensitive” against 50.6 (SD = 8) in the group “hardly or not sensitive” ($p = 0.0134$). Regarding the mental dimension, mean MCS-12 score was 45.9 (SD = 9.9) in the group “very sensitive or sensitive” against 48.1 (SD = 9.7) in the group “hardly or not sensitive» ($p = 0.0004$). Evaluation of depressive symptomatology using the HAD scale showed that there was no significant link between depressive symptomatology and skin sensitivity: in the group “very sensitive or sensitive”, 4.3% of subjects presented a certain depressive symptomatology against 4.8% in the group “hardly or not sensitive”. **CONCLUSION:** According to the SF-12 scale, the higher the sensitivity, the more affected is quality of life. Nevertheless, the HAD-Depression scale, which measures depressive symptomatology, did not bring to the fore any relation with skin sensitivity.

PSN23

FACTORS INFLUENCING QUALITY OF LIFE IN ATOPIC DERMATITIS

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OBJECTIVES: To identify the most important determinants of quality of life (QoL) for adults with Atopic Dermatitis (AD) and for the parents of children with AD. **METHODS:** The QoLIAD is a 25-item needs-based instrument assessing QoL in adults with AD. The PIQoL-AD is a 28-item instrument assessing the QoL of parents who have children with AD. These questionnaires have a simple “Yes”/“No” response option and scores range from zero to 25/28. Data collected in a six-month, multinational, open-label study were analysed using Stepwise Multiple Regression. Demographic, symptom and disease-related variables were included in the analyses. **RESULTS:** A total of 319 AD patients completed the QoLIAD (mean 37.8 years) and 182 parents of children with AD completed the PIQoL-AD (mean age of child = 7.4). Regression analyses for the QoLIAD identified five variables; how unhappy/depressed flare-ups make them feel, performance at work, number of nights woken during flare-up, percentage of body affected and age. These five variables accounted for 27.2% of the variance in patients’ reported quality of life ($p < 0.0001$). For the PIQoL-AD 32.9% of the variance ($p < 0.0001$) was accounted for by seven variables; number of nights woken during flare-up, number of days child misses school, performance at work, age of child, how unhappy/depressed their child’s flare-ups make them feel, number of flare-ups per year and total time spent with a flare-up each year. Specific symptoms such as swelling, itch and redness did not contribute significantly to either model. **CONCLUSION:** These results reveal that the QoL of adults with AD and the parents of children who have AD are influenced by a number of similar factors. A focus on the symptoms of AD would omit important influences on QoL.