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In this issue…

Hailey-Hailey disease-chronic but not so benign?

Disease control depends on the quality of the partnership between patient and physician – and that partnership will be strengthened if doctors explore the psychosocial as well as the physical impact of chronic disease (1). Patient and doctor should be realistic about the outcomes of management, but the goals of management should reflect the patient's interests and concerns. How can this be achieved?

Measures of the extent or severity of skin disease can be documented relatively objectively, but a patient-orientated, quality of life measurement that indicates how an individual patient is affected by the skin condition will complement clinical judgements of disease severity. Disease- or dermatology-specific measures of health-related quality of life may be supplemented by general health measures (2, 3).

Drs. Paola Gisondi and colleagues have looked again at the burden that Hailey-Hailey disease places upon patients (p. 132). Hailey-Hailey disease (benign familial chronic pemphigus) is a dominantly-inherited condition that is characterized by erosions predominantly at sites of friction such as the flexures. Twenty of 22 hospitalized patients with Hailey-Hailey disease completed two validated self-administered questionnaires that measured quality of life: the Skindex-29, a skin disease-specific questionnaire that measures symptoms, emotions and social functioning, and a 12-item General Health Questionnaire. This selected group of hospitalized patients suffered considerable physical and psychological distress.

This result may not surprise many dermatologists who care for patients with Hailey-Hailey disease – but should we change our practice? The authors comment that aggressive therapy may be indicated even in patients with limited disease. Doctors who understand what the patient is experiencing and how disease is affecting normal activities are more likely to be able to alleviate their patient's concerns, offer appropriate choices for management, guide the discussion and tailor treatment to the individual (1). Quality of life measures may also be used to assess the outcome of management and even to help us to obtain resources for our patients. Perhaps we should also be using such measures more frequently to audit our own practices – the findings may be revealing.

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Will the atopy patch test become a routine patch test?

In this issue of Acta Dermato-Venereologica Drs. Weissenbacher and colleagues (p. 147) rather convincingly demonstrate that the atopy patch test to house dust mite allergen is highly reproducible similar to other well-known contact allergens in adults without active eczema. This also goes for other environmental allergens although the numbers tested were few. They also confirm that the back is the site for patch testing as for traditional contact allergens. Thus, it seems the house dust mite allergen may be close to routine use in our daily clinics – provided a commercial, stable production can be established. This would then lead to intervention studies, where clearly "extrinsic" atopic eczema patients versus clearly "intrinsic" atopic eczema could be compared in intervention studies – although the observed clinical effects have not been significant (see their refs 21 & 22). Any caveats? The study demonstrates that patients with specific IgE antibodies have positive patch tests to house dust mite, but much less so to other environmental allergens. There seems to be significantly less patch test reactivity to cat dander, pollen etc. Size of the allergen molecules, less irritancy or both? Also, a clinical question: Why is the reproducibility so high on the back, but not on forearms, where the patients are actually more exposed to allergens and where eczema is more common and pronounced than on the back? The atopy patch test has come a along way. But – there are still pieces of its puzzle, which needs to be looked at.

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