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Unidimensionality of the DLQI – Confirmed at Last

The Dermatology Life Quality Index (DLQI) has been very widely used over the last ten years to measure the impact of skin disease on patients' lives, Mazzotti *et al.* (p. 409) in this issue kindly state that the DLQI is 'easy to complete and score', and 'might be extremely useful even in a busy clinical practice'. This was indeed our original intention when we designed this measure. Although we originally presented in 1994 some initial validation data much more detailed validation has come later and it is only now after a decade that this crucial aspect of unidimensionality validation has been confirmed, at least in psoriasis. It is a considerable relief, as all the use of the DLQI scores had depended on the assumption that it was appropriate to simply sum the scores of the ten answers to give a single overall score: we finally have evidence that this has indeed been valid.

This conclusion is particularly timely as we are now able to interpret DLQI scores in a simple meaningful way using validated descriptive bandings of the overall score. For example scores of 11–20 mean that there has been a very large affect on the patient's life (1).

The new validation by Mazzotti *et al.* and the new score banding bring nearer the time when quality of life measures may be of practical use in informing clinicians in their busy daily practice.

REFERENCE

1. Hongbo Y, Thomas CL, Harrison MA, Salek MS, Finlay AY. Translating the science of quality of life into practice: What do dermatology life quality index scores mean? J Invest Dermatol 2005 (in press).

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[1]Professor A Y Finlay is joint copyright owner of the DLQI.

What Can Be New in Hand Eczema?

If there is one area of the world, where hand eczema has been intensively studied, it is Scandinavia, both regarding epidemiology, clinical symptoms, patch testing in relation to hand eczema, atopic dermatitis and hand eczema, skin physiology and treatment of hand eczema. Many studies have been published in *Acta Dermato-Venereologica*. So, what can possibly be new in the study of Montnémery et al. in this issue (p. 433)? It confirms previous large scale epidemiological studies, including the seminative study of Gun Agrup (see ref. 3 of that paper) which was so convincing because she included clinical examinations. One positive observation is that the incidence of hand eczema in Scandinavia is falling. I agree with the authors that there is much more focus on skin health care among "healthy persons" especially in occupational settings and this is a benefit for all. Two other observations are interesting: In women there is a significant association to smoking, something which has also been observed among nickel-sensitive patients (who are mostly women, see ref. 21 of their paper). This makes me think of an interesting observation done by Dr. Hagforsen et al. (1) on expression of nicotinic receptors in the palmar skin of patients with pustulosis palmoplantaris, related to the increased frequency of this disease among smokers. A second observation is that the prevalence of hand eczema is related to age. Elderly women only have 1.9% 1-year prevalence in sharp contrast to 10% among 20 to 39 years old. How come hand eczema is an early life event, when the tear and wear on the hands is more or less the same during life although maybe not among elderly persons? Is "hand eczema" just "hand eczema"? I am convinced "no". Future epidemiological studies must include clinical examination – and classification – as there is so much difference between the common contact dermatitis of hands, pompholyx and keratotic eczema.

REFERENCE

1. Hagforsen E, Awder M, Lefvert AK, Nordlind K, Michaelsson G. Palmoplantar pustulosis: an autoimmune disease precipitated by smoking. Acta Derm Venereol 2002; 82: 341–346.

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