Living with Skin Disease

There has been a stigma attached to diseases of the skin for centuries. Lepers were cast out from society in biblical and medieval times as they were considered ‘unclean’. Some labelled and persecuted as lepers had other diseases such as eczema or psoriasis. The stigmatisation of lepers was not a public health measure to control spread but an expression of fear, ignorance and prejudice.

Skin disease is often obvious and very visible to others. Those who have skin diseases have not only to cope with the effects of their disease but also the reaction of others to their condition. There is stigma attached to a wide range of skin diseases, affecting many millions of people, just as there is for mental illness and sexually-transmitted infections.

The skin diseases are often incurable and treatments aim to reduce symptoms. Common examples include eczema, psoriasis, acne, rosacea and vitiligo. Whether these conditions are common or very rare, the impact on quality of life can be far-reaching and profound even without stigmatisation. Stigmatisation is an expression of prejudice and ignorance which the medical profession has a duty to combat with information and education. This should be extended to those with skin diseases, their families, schools and the wider community.

Epidemiology[1]

- Skin diseases are very common. Indeed it is true to say that everyone will at some time in their life have some form of skin disease.
- In any 12-month period about 24% of the population consult their GP to discuss a skin problem.
- About 14% of consultations with GPs are for skin conditions.

Acne

Acne is a common skin condition which illustrates some of the difficulties of living with skin disease. Many people will be able to relate first-hand to the impact of acne on their lives. Acne occurs at an age when those who have it are undergoing other physical changes which also have major psychological effects. Many papers have looked at the implications of acne for young people. For example:

- A study reported that acne can cause psychological abnormalities including depression, suicidal ideation and anxiety. Psychosomatic symptoms, including pain and discomfort, embarrassment and social inhibition, can also occur.[2] Effective treatment of acne was accompanied by improvement in self-esteem, affect, obsessive compulsiveness, shame, embarrassment, body image, social assertiveness and self-confidence. Acne is associated with a greater psychological burden than a variety of other disparate chronic disorders.
- Acne is a common disorder in adolescents and appears to have a considerable impact on emotional health in this age group. Acne should be treated early to avoid scarring and the psychosocial consequences in adolescence.[3]
- A study looked at patients with chronic acne, severe enough to merit treatment with isotretinoin. They found that treatment with oral isotretinoin alleviated depressive symptoms. Improvements in depression were directly related to acne-related life quality improvements rather than to improvement in acne grade.[4]
- A Korean study found that psychological morbidity was better correlated with perceived degree of acne than objective assessment.[5]

When treating patients with acne:

- It is important not to underestimate the impact of even mild acne on patients’ well-being.
- Use the opportunity to educate and inform. Discuss causes, principles of treatment and popular myths.
- Anger is a common problem and it affects quality of life, emotional stability and satisfaction with treatment.[6]
- It is important to identify those in need of intervention and to start treatment early before both dermatological morbidity and psychological morbidity become established.[7]

Education can be given not only to individuals but also within schools and to the wider community. Campaigns to educate more widely serve to encourage patients to seek help and to raise awareness and greater empathy in the wider community. Such campaigns may or may not succeed but it is interesting to reflect that, if it is difficult in the case of so common a condition, the task with the myriad of other conditions seems daunting indeed.

Wider aspects of skin disease

The psychosocial impact

Skin diseases can be difficult to cope with and have a big psychological impact on patients. Even mild skin diseases can have an adverse effect and disrupt enjoyment of life for those who have the diseases. Such disruption can range from embarrassment and concerns about self-image to low self-esteem and severe depression. For example:
Further reading & references

- Patients with eczema, vitiligo or psoriasis face embarrassment, worry and depression. A survey of patients with psoriasis revealed that many deliberately avoid swimming. In addition, few wear short sleeves, shorts or skirts because they feel that people regard them as 'untouchable' or 'contagious'.
- Playing sport is a problem for psoriasis sufferers. Children with psoriasis are more likely to be bullied.
- Impairment of quality of life (QOL) correlates poorly with severity of disease. A Polish survey found that disease severity was related to impact on employability and family finances.
- The poor correlation of QOL with severity of disease and other demographic variables, such as gender and education, has also been reported.
- Stress, either environmental or psoriasis-induced, has important implications for the management of psoriasis. Depression and even suicide may occur.

The holistic approach to treatment

The treatment of skin disease can be complicated and will often place restrictions on the lives of those who have a skin disease. For example:

- The application of creams or pastes to large areas of the body is time-consuming and can require help from others.
- Remember this when prescribing for someone who lives alone. Medications can be unpleasant to apply. For example, coal tar is smelly (short-contact dithranol is preferable, as it is washed off after a few hours).
- Some preparations have to be left on overnight. Whilst this is preferable to having them on by day, they may stain bedding and nightwear.
- Skin disease may cause pruritus. This is distracting by day and causes insomnia by night. If itching is caused by histamine, as in urticaria, antihistamines may be useful.
- Psoriasis and eczema are common conditions but there are some that are much more severe and fortunately rare, such as epidermolysis bullosa in which the body is covered with painful bullae and every morning starts with changing dressings from painful, oozing lesions. Strong analgesia such as morphine may be required to cover this time.
- For some skin diseases including vitiligo, blemishes or scars, it is possible to use camouflage to cover them.

The impact of the disease

The treatment of skin disease can be complicated and will often place restrictions on the lives of those who have a skin disease. For example:

- The impact of the disease is not necessarily related to objective measurement of severity.
- Consider the impact of the disease on the patient at work, at home, in leisure activities and in all aspects of their relationships with others.
- Consider the practicalities of applying medication and the possible effects.
- Consider the impact of discomfort and itching. Think of a wider list of complications arising from the condition. For example, with eczema think not just of secondary infection but also of the impact on sleep and psychosocial functioning.
- Consider the side-effects of medication.
- Do not underestimate the effects of being visibly different, especially for children. Be aware of bullying in schools and the adverse effects of this on children.
- The impact of the disease is not necessarily related to objective measurement of severity.
- There is much myth and misunderstanding and so education for all is often very important. There are many common myths, and beliefs can be hard to dispel. For example, acne is not caused by poor hygiene and patients with rosacea are not necessarily alcoholic.

Further reading & references

- Primary Care Dermatology Society

1. Care of People with Skin Problems; Royal College of General Practitioners, 2010 (updated 2014).
16. The British Association of Skin Camouflage

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