Original Article

DEPRESSION IN COMMON DERMATOLOGICAL PATIENTS ATTENDING OUTPATIENT DEPARTMENT

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Abstract:

Skin is the organ which covers our whole body and its condition directly influences our well being. Its psychological impacts are enormous, as evident by the efforts we put for taking care of our skin condition. The aim of this study was to find the presence of depression among the patients with dermatological disorders. Total 100 dermatological patients were assessed by the Hamilton Depression Rating Scale (HAM-D), 38% of patients had depression. Depression was highest in atopic dermatitis (71.43%), followed by psoriasis (58.82%), acne vulgaris (47.62%) and vitiligo (44.44%). Suicidal ideation was more common patient with atopic dermatitis (28.57%, 2 among 7) followed by psoriasis (23.53%, 4 among 17).

Introduction:

Skin is the largest organ of the body. It not only protects our selves but it also expresses our self. So it is not unusual that skin condition affect our psychological well being and it is also natural to assume that if the skin condition is compromised it will have negative impact on our mental health.

Results from a growing number of investigations suggest that both dermatology outpatients and hospitalized patients have a higher prevalence of psychiatric disorders, especially depression and anxiety, than the general population[1, 2].

Certain diagnoses such as psoriasis, atopic dermatitis, urticaria and generalized pruritus have often been found to be associated with psychological symptoms such as anxiety and depression[3-6].

A study conducted in United State found that occurrence of depression in association with dermatologic disease is common and the depression had varied presentations. Psychiatric disturbance is reported in approximately 30% of dermatology patients[7].

Hughes et al. administered the 30-item General Health Questionnaire (GHQ) (Goldberg, 1972) to 196 consecutive new dermatology out-patients and found thirty per cent of the patients obtained high scores and high GHQ scores were associated with (a) diagnoses of acne, eczema, psoriasis or alopecia; with (b) extensive lesions on exposed parts of the body; and with (c) the use of high potency topical steroid[8].

Gupta & Gupta6 examined and found greater prevalence of depression and suicidal thoughts among patients with severe psoriasis than other patient groups, including patients with acne and atopic dermatitis. The number of psychological symptoms has generally been found to be related to the severity of the disease[9].

What mediates the associations generally found between disease severity and psychological problems is not yet clear. In a study of 3125 dermatology outpatients, health-related quality of life (QoL) was found to be a much stronger predictor of psychiatric morbidity than physician-rated disease severity[10], suggesting that it is not the disease in itself, but its impact on the daily activities and social relations that is associated with psychological problems. Several other

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factors may also mediate the psychosocial impact of dermatological disorders, including the timing of onset, the course of the disease, and the age and sex of the patient[11]. Disease-specific factors, such as the degree of pruritus, have also been suggested to mediate the relationship between skin disease and psychological problems, e.g. depression[12, 13].

Findings from previous studies suggest that dermatological diseases such as psoriasis and atopic dermatitis may be associated with an increased risk of suicide and with greater prevalence of suicidal thoughts[6, 14-16]. This was confirmed by our findings that 21.2% of the psoriasis patients and 18.9% of the atopic dermatitis patients reported that they had thoughts about suicide within the last 2 weeks, while patients with eczema and urticaria did not differ from healthy controls.

A study conducted Sialkot, Pakistan by Bashir et al. found that out of the 114 adult males with dermatological disorders, 39 (34.11%) had depression. The frequency and percentage of depression in dermatological conditions was 6 (100%) in psychocutaneous disorders, 2 (66.6%) in urticaria, 3 (66.6%) in pruritus, 7 (57.5%) in acne vulgaris, 4 (50%) in psoriasis, 4 (44.4%) in vitiligo, 3 (37.5%) in melasma, 1 (33.3%) each in hyperhidrosis and alopecia areata, and 9 (20.4%) in eczema[17].

The aims of this study are to determine the frequency of depression in adult dermatology outpatients in Khwaja Yunus Ali Medical College and Hospital (KYMCH), which is a rural tertiary care hospital in Bangladesh.

Study Place:

The Khwaja Yunus Ali Medical College and Hospital (KYMCH) is located 21 kilometers from the Bangabandhu Setu (Jamuna Bridge) and 28 kilometers from Sirajgonj city. Most of the patients came from the Rajshahi division and south-west region of Bangladesh. Approximately 400 patients come to the hospital daily. Almost all disciplines are available in this hospital. On an average 20 patients attend in the dermatology OPD daily.

Methodology:

Patients were first selected in the dermatology department according to the most frequent diagnosis and duration of their illness. Most frequent diagnosis were seborrheic dermatitis, psoriasis, acne vulgaris, chronic eczema, vitiligo, atopic dermatitis, chronic folliculitis. Those below the age of 18 years and duration of illness below 4 months duration were excluded. Other disorders presented in dermatology OPD, like sexually transmitted disease, allergic problems, urticaria, sexual disorders were also excluded from the psychiatric evaluation.

Total 117 patients were referred from the dermatology department for evaluation of depression to the psychiatric department. Psychiatric evaluation was done by psychiatrist, using the Hamilton Depression Rating Scale (HAM-D) and the scoring was based on the first 17 items. Out of 127 patients 8 patients did not came for psychiatric evaluation and 9 patients were unwilling to participate in psychiatric evaluation. So first 100 patients who came and were willing for psychiatric evaluation were included in the study consecutively. The study started on 15th June, 2011. Depression was assessed on mild, moderate and severe according to the Hamilton Depression Rating Scale (HAM-D) and given below

Sum the scores from the first 17 items.
0-7 = Normal
8-13 = Mild Depression
14-18 = Moderate Depression
19-22 = Severe Depression
??23 = Very Severe Depression

Patients were recorded serially (consecutively) as they were referred and consented. Patient's age, sex, residence, educational status, economical status, dermatological disorder and their durations, psychiatric diagnoses were taken as variables. Data were handled with Statistical Package for Social Science (SPSS) -17.

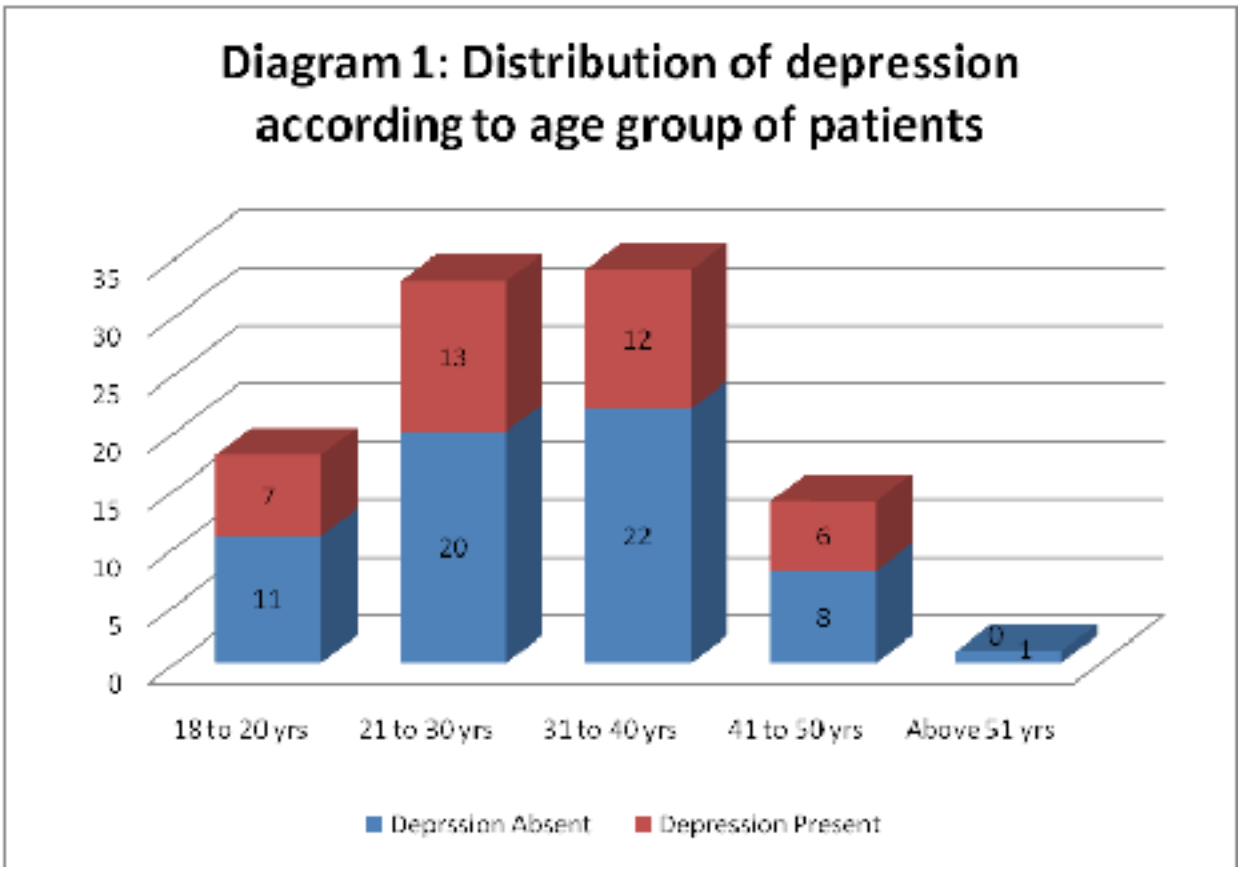
Results and Discussion:

Total 117 patients were referred from the dermatological department within this 1 month period for evaluation of depression. 17 patients were not evaluated as they either did not came to psychiatric OPD or after explanations did not gave consent for psychiatric evaluation. Main reasons for refusing psychiatric evaluation were lack of any benefit and fear of getting any psychiatric label (diagnosis). The presence of depression among the different dermatological conditions is shown in table 1.

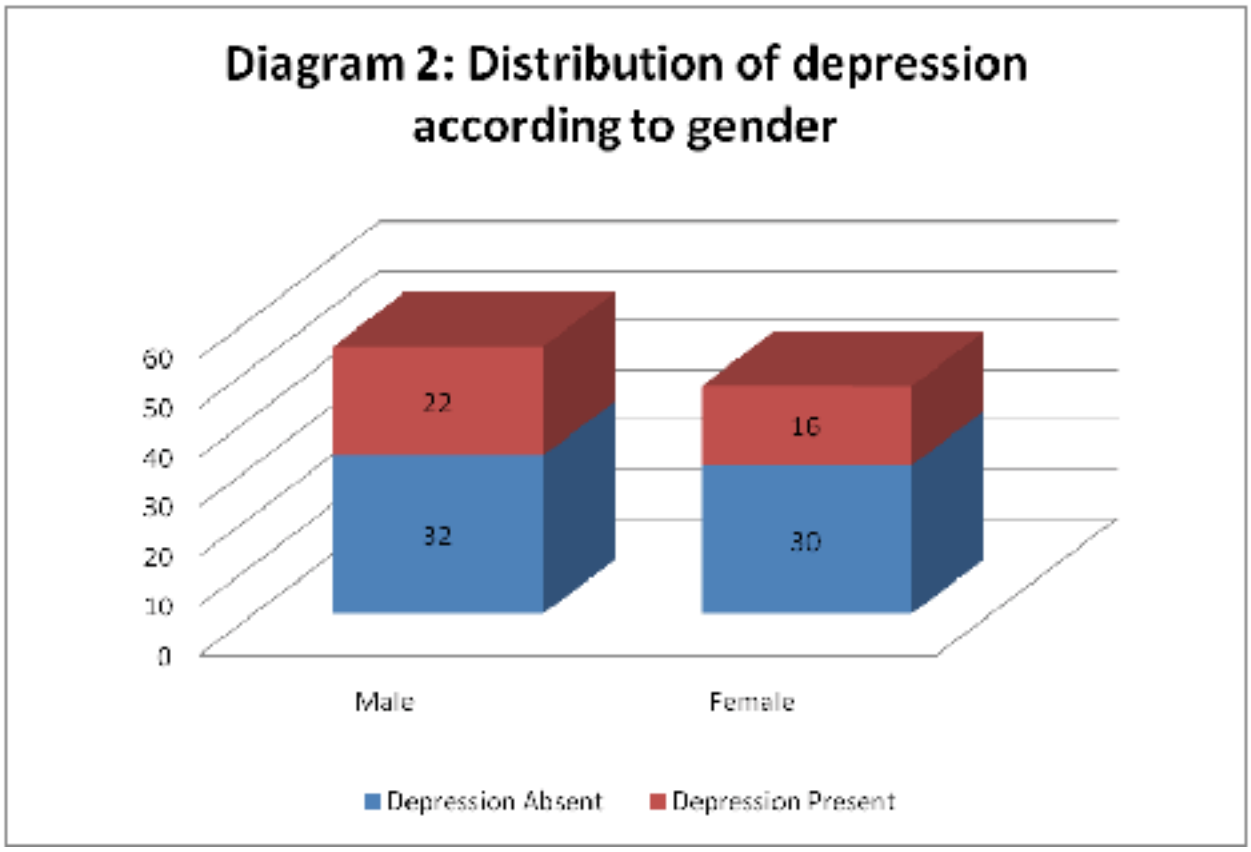
Table 1: Severity of depression among different types of dermatological disorders

Diseases	Severity of depression				Total
	Absent	Mild	Moderate	Severe	
Seborrheic dermatitis	14	2	5	1	22
Psoriasis	7	3	5	2	17
Acne vulgaris	11	5	4	1	21
Chronic eczema	14	0	1	0	15
Vitiligo	5	0	2	2	9
Atopic dermatitis	2	0	4	1	7
Chronic Folliculitis	3	0	0	0	3
Others	6	0	0	0	6
Total	62	10	21	7	100

Distributions of the patients according to their age group are shown in diagram 1. Most of the patients were in the 31 years to 40 years group (34%). Depression was most common among the 41 years to 50 years age group (42.85%). This finding is not consistent with study conducted by Badouxet al5 and Picardi et al[10], where they found depression was less among the elder population.



Distributions of the patients according to their gender are shown in diagram 2. 54% of the patients were male and 46% of the patients were female. Depression among male and female were 40.74% and 53.33% respectively. This result shows that depression is always greater among the females, but as in the general population, where the ratio is male: Female= 1:2. This findings are also consistent with other studies conducted abroad[5,10,18].



Distributions of the patients according to their gender are shown in diagram 3. Most of the patients were from rural background (61%). This may be due the location of the hospital. Depression among them was almost same (rural = 37.70% and urban = 38.46%). This lack of difference in the percentage of depression may explained as the perception or the impact of the skin disease is same between the both populations. Distributions of the patients according to their educational status are shown in diagram 4. Depression was highest among the primary educated group (48.15%), followed higher secondary group (38.89%). This is not is not consistent with the common assumption that the higher the educational level, higher the awareness and concern about beauty, higher will be the depression.

Diagram 3: Distribution of depression according to habitants

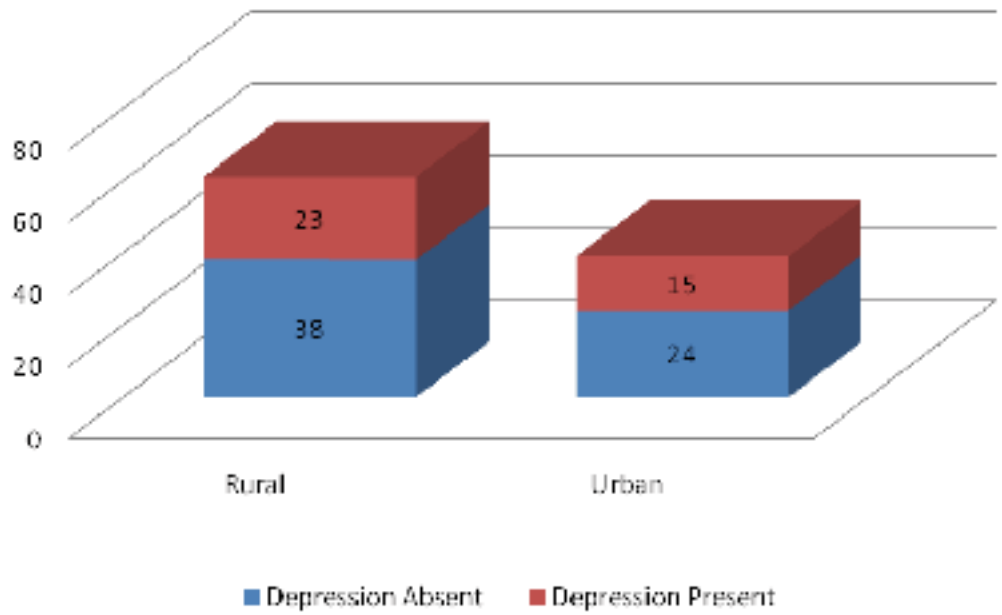
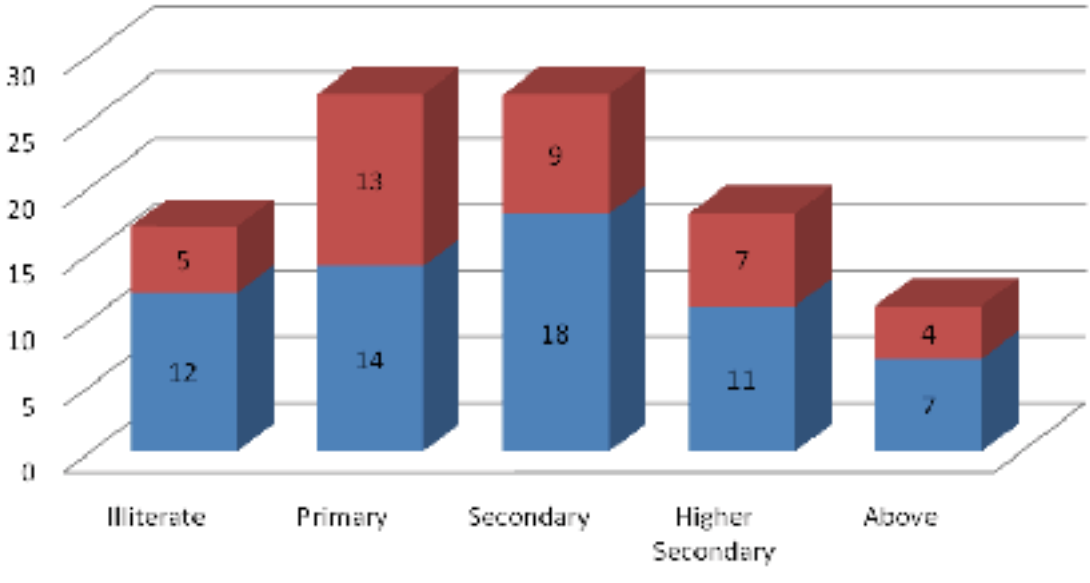
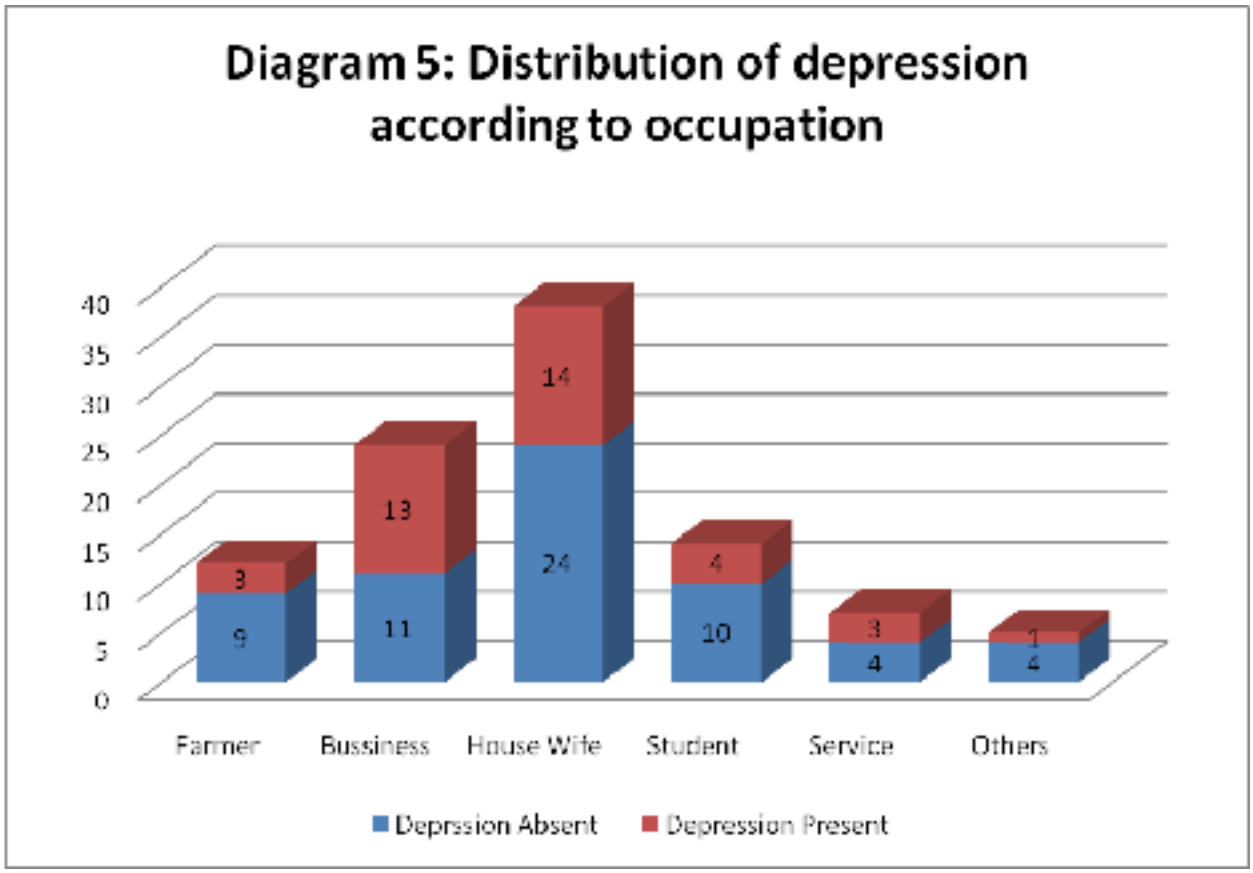


Diagram 4: Distribution of depression according to educational status





Distributions of the patients according to their occupations are shown in diagram 5. Depression were highest among the service holders (42.86%), followed by businessmen (29.55%). This reflects the awareness and impact of the dermatological disorders among these population groups.

Distributions of the patients according to their economical status are shown in diagram 6. Depression was highest among the group of 10000 to 15000 tk per month income (29.55%). This also reflects the awareness and impact of the dermatological disorders among these population groups.

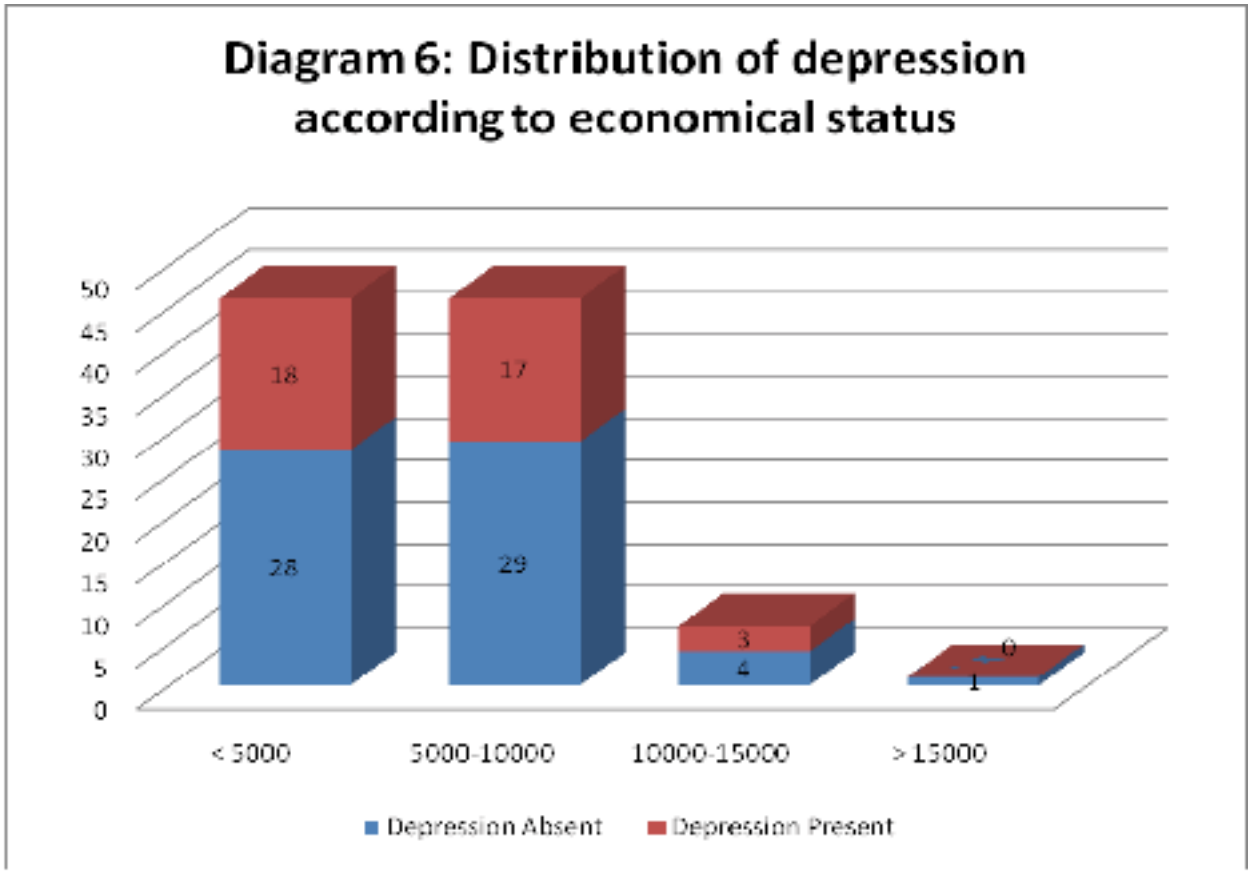


Diagram 6: Distribution of depression according to economical status
50
45
40
35
30
25
20
15
10
5
0
18
28
17
29
3
4
0
1
< 5000
5000-10000
10000-15000
> 15000
Depression Absent
Depression Present

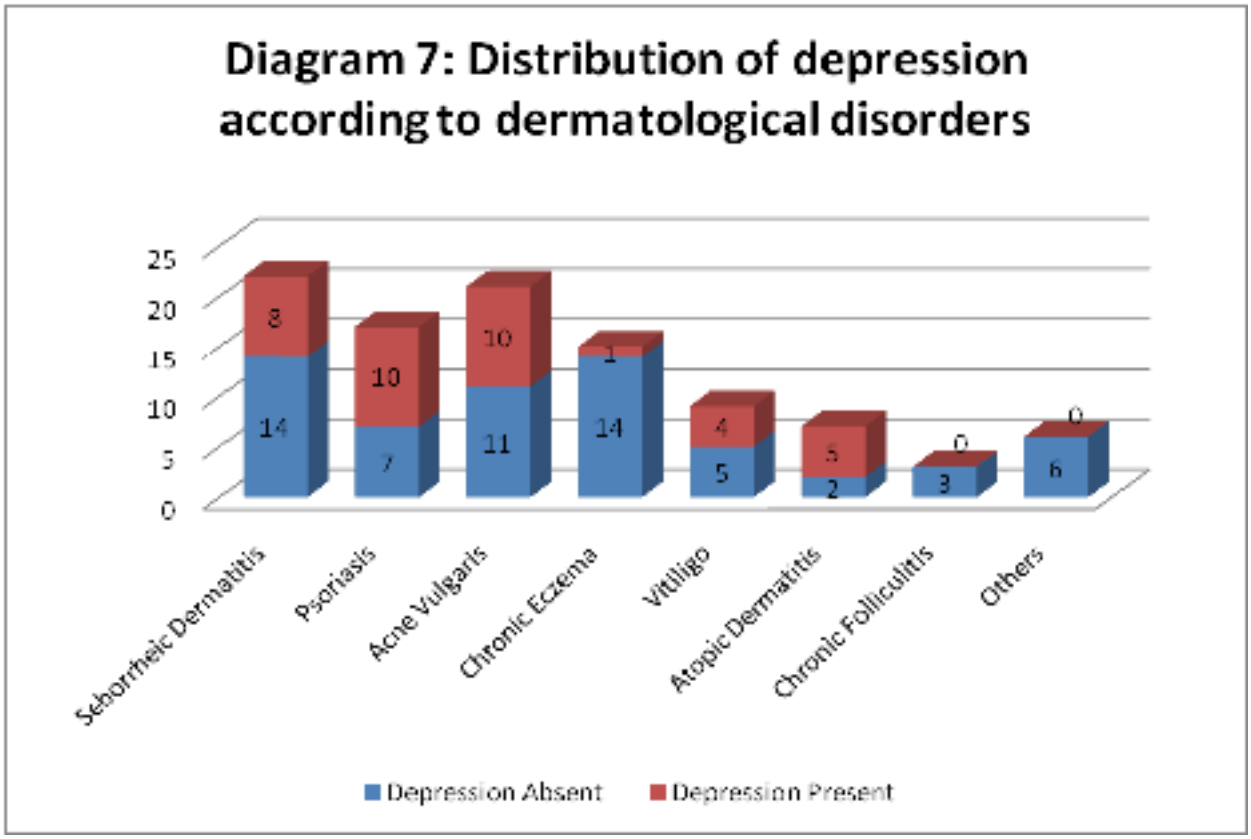


Diagram 7: Distribution of depression according to dermatological disorders
25
20
15
10
5
0
8
14
10
7
10
11
1
14
4
5
5
2
0
3
0
6
Seborrheic Dermatitis
Psoriasis
Acne Vulgaris
Chronic Eczema
Vitiligo
Atopic Dermatitis
Chronic Folliculitis
Others
Depression Absent
Depression Present

Distributions of the patients according to the dermatological conditions are shown in diagram 7. Depression was highest with atopic dermatitis (71.43%), followed by psoriasis (58.82%), acne vulgaris (47.62%) and vitiligo (44.44%). These findings are consistent with other studies. There was significant correlation between the duration of the skin disorders and presence of depression(Pearson Correlation = 0.616, $p<0.01$). Suicidal ideation was more common patient with atopic dermatitis (28.57%, 2 among 7) followed by psoriasis (23.53%, 4 among 17). These finding are similar with the disease patterns but greater in percentages than the study findings of Zachariae R et al[18].

Conclusion:

From the above findings it is evident that the importance of psychiatric assessment, particularly for depression is very crucial to the complete management of the dermatological patients. It is also important, to be alert for any suicidal ideation among these patients.

References:

1. Hughes JE, Barraclough BM, Hamblin LG, White JE. Psychiatric symptoms in dermatology patients. Br J Psychiatry 1983; 143: 51 - 54.

2. Woodruff PWR, Higgins EM, Vivier AD, Wesseley S. Psychiatric illness in patients referred to a dermatopsychiatry clinic. Gen Hosp Psychiatry 1997; 19: 29 - 35.

3. Cotterill JA. Psychophysiological aspects of eczema. Semin Dermatol 1990; 9: 216 - 219.

4. Lyketsos GC, Stratigos J, Tawil G, Psaras M, Lyketsos CG. Hostile personality characteristics, dysthymic states and neurotic symptoms in urticaria, psoriasis and
alopecia. Psychother Psychosom 1985; 44: 122 - 131.

5. Badoux A, Levy DA. Psychologic symptoms in asthma and chronic urticaria. Ann Allergy 1994; 72: 229 - 234.

6. Gupta MA, Gupta AK. Depression and suicidal ideation in dermatology patients with acne, alopecia areata, atopic dermatitis and psoriasis. Br J Dermatol 1998; 139: 846 - 850.

7.Fried RG, Gupta MA, Gupta AK. Depression and skin disease. Dermatol Clin. 2005 Oct;23(4):657-64.

8.Hughes JE, Barraclough BM, Hamblin LG, White JE. Psychiatric symptoms in dermatology patients. Br J Psychiatry. 1983 Jul;143:51-4.

9.Hashiro M, Okumura M. Anxiety, depression and psychosomatic symptoms in patients with atopic dermatitis: comparison with normal controls and among groups of different degrees of severity. J Dermatol Sci 1997; 14: 63 - 67.

10. Picardi A, Abeni D, Melchi CF, Puddu P, Pasquini P. Psychiatric morbidity in dermatological outpatients: an issue to be recognized. Br J Dermatol 2000; 143:
983 - 991.

11. Ginsburg IH. The psychosocial impact of skin disease. Dermatol Clin 1996; 14: 473 - 484.

12. Sheehan-Dare RA, Henderson MJ, Cotterill JA. Anxiety and depression in patients with chronic urticaria and generalized pruritus. Br J Dermatol 1990; 123: 769 - 774.

13. Gupta MA, Gupta AK, Schork NJ, Ellis CN. Depression modulates pruritus perception: a study of pruritus in psoriasis, atopic dermatitis, and chronic idiopathic urticaria. Psychosom Med 1994; 56: 36 - 40.

14. Gupta MA, Gupta AK, Haberman HF. Psoriasis and psychiatry: an update. Gen Hosp Psychiatry 1987; 9:157 - 166.

15. Cotterill JA, Cunliffe WJ. Suicide in dermatological patients. Br J Dermatol 1997; 137: 246 - 250.

16. Humphreys F, Humphreys MS. Psychiatric morbidity and skin disease: what dermatologists think they see. Br J Dermatol 1998; 139: 679 - 681.

17. Bashir K, Dar NR, Rao SU. Depression in adult dermatology outpatients. J Coll Physicians Surg Pak. 2010 Dec;20(12):811-3.

18. Zachariae R, Zachariae C, Ibsen HH, Mortensen JT, Wulf HC. Psychological symptoms and quality of life of dermatology outpatients and hospitalized dermatology patients. Acta Derm Venereol. 2004;84(3):205-12.