

COMMENTARY

Too many instruments for measuring Quality of Life in Atopic Dermatitis

Editor

Are Quality-of-Life (QoL) measurements really interesting when you are in private practice? Usually NOT – although as a clinician we know that impairment of QoL might vary considerably and does not always correlated with disease severity. Therefore on an individual base, we have to listen to our patients even if the clinical severity is not really impressive to make sure that we do not miss a deeply unhappy patient. QoL instruments when used at all in clinical practice serve mostly secondary purposes, e.g. supporting reimbursement claims against patient insurances when it comes to expensive treatments.

In clinical trials, however, the role of QoL instruments is quite different. Here, these instruments are complementing the clinical severity measurements. Everything started approximately two decades ago when Finlay and Khan¹ published the Dermatology Life Quality Index (DLQI). Since then the number of QoL instruments has increased considerably. In general as said before, disease-specific severity scores correlate well with the QoL instruments used.² However, *honi soit qui mal y pense*, sometimes one has the impression that for some drugs and/or interventions QoL instruments are often highlighted when during the treatment period the disease-specific severity scores are not really impressively changed in contrast to difference in the QoL measurements.^{3,4}

With the large number of available QoL instruments, it becomes much more difficult to choose the best possible one for, e.g., a specific clinical trial. The paper by⁵ and EADV Task Force Position Paper focuses on health- and family-related QoL instruments in atopic dermatitis (AD). The paper gives an excellent overview on these instruments making it very helpful for

those designing clinical trials for AD. What is missing? I would have liked if the paper would have taken a stronger position on those QoL measurements that can be recommended for a specific clinical trial design. I would have loved the idea of cutting the QoL questionnaires down to a decent number of say five or six!

What else comes in my mind? That if there is any need for further QoL instruments in AD or another disease the need should be clearly defined before starting a new questionnaire. Not every QoL scientist needs his own instrument.

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