

The use of complementary medicine by patients referred to a contact dermatitis clinic

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Our aim was to quantify and qualify the use of complementary medicine (CM) by patients referred to our contact dermatitis clinic in Leicester, UK. A face-to-face structured questionnaire study was made of 109 consecutive patients referred to the contact dermatitis clinic. 109 such questionnaires were completed. 21/109 (20%) of patients were Indo-Asian and 86/109 (79%) white Caucasian. 33/109 (30%) had tried some form of CM to treat their skin condition. This use was higher in the Indo-Asian group, where 13/21 (62%) had tried some form of CM. 21/33 (63%) who had used CM were happy to recommend it to other patients with skin disease, even though only 10/33 (30%) of these reported an improvement in their skin condition while using CM. The most frequently used CM treatments were herbal medicine [17/33 (51%)], Chinese herbal medicine [6/33 (18%)], traditional Indian medicine [4/33 (12%)] and aromatherapy [6/33 (18%)]. These proportions were similar in all ethnic groups. In a population of adults referred to a contact dermatitis clinic in a city-centre teaching-hospital dermatology department in Leicester, UK, 30% use, or intend to use, CM and this use is associated with ethnicity.

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We have previously shown that, in a population of children with atopic dermatitis (AD) attending a hospital-based paediatric dermatology clinic in Leicester, UK, 63% use, or intend to use, complementary medicine (CM). In addition, we have shown that this use is associated with ethnicity (1). Patients with skin disease and, more specifically, parents of children with AD increasingly appear to be turning to CM to manage their child's skin (2). Complementary medicine is also frequently used by adults with both psoriasis (3) and AD (3, 4).

There are no studies of the use of CM in adults with contact dermatitis in the English medical literature. Many adults with allergic or irritant contact dermatitis have disease that can be severe and unremitting, both features associated with the use of CM in adults (3, 4). A number of complementary therapies arise from cultures not indigenous to the UK, such as Chinese herbal medicine and ayurvedic medicine. No data exists on whether communities with a high proportion of patients from ethnic minorities are any different from the indigenous population in their use of CM in the management of contact dermatitis. We

devised a questionnaire to qualify and quantify the use of CM and to look for any differences in the patterns of use of CM specifically in adults being investigated for contact dermatitis.

Patients and Methods

Adult patients over the age of 16 years attending the contact dermatitis clinic at Leicester Royal Infirmary, Leicester, UK, were invited to answer a questionnaire. This clinic is the only contact dermatitis unit serving a population of 900 000 based in a city with a high proportion of patients from ethnic minority backgrounds. The majority of patients from an ethnic minority in Leicester come originally from the Indian subcontinent.

109 adults over 16 years of age referred to the clinic for the investigation of contact dermatitis were interviewed over a 3-month period. Informed verbal consent was obtained and the authors interviewed the patients during out-patient consultation. No one approached refused to participate in the study. The questionnaire was performed by a face-to-face structured interview with the patient. As in all our clinics, translators

were available, if needed, for patients whose first language was not English, though no one questioned for this study required this facility.

The questionnaire was piloted on 20 patients, and no changes were deemed necessary at this stage.

The questionnaire was a modified version of that used in our previous study (1) and was additionally validated by the use of a dummy question, the answer to which could be verified by the authors from the medical case notes.

Results were expressed as simple percentages plus a qualitative description of comments where appropriate. The results were analysed by SPSS v9.0 (Statistical Package for the Social Sciences; SPSS Inc., Chicago, IL, USA) with simple χ^2 2×2 contingency tables for potential associations.

Results

Demographics

Response rate to the questionnaire was 100%, with 109 patients interviewed. The average age of the patients was 45 years (range 17–90 years), and there was a female to male ratio of 3:2. The proportions of different ethnic origin were 79% white, 20% Indian and 1% Afro-Caribbean or mixed race, reflecting the high ethnicity in Leicester. The mean duration of skin disease was 70 months (range 3–600 months). 51/109 (47%) of patients had a medical history of atopic disease and 27/109 (24%) had a personal history of AD.

105/109 (96%) of our cohort had used conventional medical therapy, including emollients and topical corticosteroids, but 21/105 (20%) reported that they had found these unhelpful.

Complementary therapy

11/109 (10%) interviewed were currently using CM while under our care. A further 22/109 (20%) had previously used some form of CM. Of the 76 patients who had not used CM for their skin disease, 5/76 (7%) said that they intended to try this in the future. The proportion of all CM use that was accounted for by patients from ethnic minorities was 13/24 (54%). In the Indo-Asian group 13/22 (59%) patients had used CM, compared with no patients in the Afro-Caribbean group.

The breakdown of the different types of CM used and their perceived effect on patients' skin disease is shown in Table 1.

The most commonly used CM in our Leicester population was herbal medicine, used by 17/33 (51%) patients who had used CM, followed by

Chinese herbal medicine used by 6/33 (18%) and aromatherapy used by 6/33 (18%). These proportions were similar in all ethnic groups. In 10/33 (30%) of these episode patients using CM felt that their skin had improved, while 10/33 (30%) reported that it had remained unchanged and 13/33 (40%) reported that their skin disease had deteriorated. 3/33 (9%) had used multiple different therapies, totalling 11 episodes of treatment with CM between these 3 patients.

9/33 (27%) patients had used CM on the recommendation of family or friends with skin disease, and 7/33 (24%) had been advised by family or friends without skin disease. 5/33 (15%) of patients claimed to have had CM recommended by an orthodox healthcare worker (their general practitioner or nurse or pharmacist). A further 7/33 (24%) had used CM on the basis of information from media such as a newspaper or magazine article or the internet.

The majority [34/46 (74%)] of CM treatments were obtained from complementary practitioners, 6/46 (13%) from a pharmacy and 5/46 (11%) from friends or family.

Of patients who had used CM for their skin disease, 21/33 (63%) were happy to recommend the treatment to other patients with the same skin disease even though only 30% reported an improvement in their skin condition when using CM.

In answer to a direct question, nearly all patients [31/33 (93%)] were happy to inform the consulting doctor of their use of CM, and the majority [27/33 (83%)] believed that CM should be available from the UK National Health Service.

The use of CM in this Leicester cohort was strongly associated with ethnicity ($\chi^2=8.23$, $P=0.0163$, two-tailed hypothesis).

Discussion

This survey has been conducted to quantify and qualify the use of CM and provides figures previously unavailable for the frequency of use of CM by patients who had been referred for the investigation of contact dermatitis.

It is known that adults with skin disease commonly use CM. In a population of American students with psoriasis 51% had used some form of CM (3). Norwegian studies have reported that 51% of patients with AD and 43% of patients with psoriasis had used CM (4, 5). Use in these studies was highest in those with the greatest skin involvement, but did not correlate with those patients who required the most intensive conventional therapy (3, 4). These associations did not reach significance in our study. The majority of

Table 1. Complementary therapies used in our population and patients' reported response (some patients used multiple therapies)

Therapy	Number of patients	Response to therapy				
		Much better	Better	No change	Worse	Much worse
Herbal therapy	17	0	4	4	1	8
Chinese herbal medicine	6	0	0	1	1	4
Indian medicine	4	1	1	2	0	0
Homeopathy	3	0	2	0	0	1
Dietary manipulation	4	1	1	0	0	2
Acupuncture	2	0	0	0	1	1
Psychotherapeutic measures	2	0	0	0	2	0
Aromatherapy	6	0	1	2	1	2
Other	2	—	—	2	—	—

patients in the literature did not report improvement in their skin disease while using CM (4, 5), and our study supports this. One of the main sources of information about CM in previous studies was the media (4, 5), which was again confirmed in our study where 24% of our patients obtained their information about CM from newspapers, magazine articles and the internet. However, 27% of patients obtained information from friends and family who themselves had skin disease. This might be explained by the high proportion of patients from ethnic minorities with traditionally close-knit families in our population, compared with the young adult and student populations surveyed in previous studies.

A potential confounding factor in this study is the difference between patients who choose to use CM and those who use orthodox medicine, which may lead to selection bias when comparing the 2 groups (6, 7).

With respect to the type of CM chosen by our population, herbal medicine was chosen most often, followed by Chinese herbal medicine and aromatherapy.

Some interesting differences arose between the population in this study and that of children with AD in our previous study. A lower proportion of patients from ethnic minorities attended the contact dermatitis clinic (20%) compared with the paediatric dermatology clinic (41%), and those attending the contact dermatitis clinic reported a lower failure rate with conventional therapy (20%) than those with AD (44%). There was also a lower overall figure for CM use (30% of the patients who had used CM plus 5% who intended to do so in our current study, compared with 46% of the patients who had used CM plus 17% who intended to do so in our previous study), although the use of CM in those from ethnic minorities was very similar in both groups (60% versus 54%).

The source of recommendation of CM was also different in the 2 groups, with a recommendation

from friends or family with skin disease occurring in only 27% of our current cohort, but recommendation from a media source in 24%, possibly reflecting the older mean age of patients in this study.

Potential sources of bias in this study include: a selection bias due to the population sampling of consecutive patients rather than randomized patients; the fact that the study took place in a secondary care setting; that there was a high proportion of patients from ethnic minorities; and that there are differences between users of CM and orthodox therapy as discussed above. However, selection bias may have been reduced in this study as all patients approached agreed to participate, and any recall bias on the part of patients remembering their previous use of CM would be expected to lower the reported incidence of CM use. The design of the study whereby an orthodox medical practitioner asked a patient about CM use might also decrease the reported incidence of CM use. The true figure for CM use in this population may therefore be even higher than that reported.

The validity of this study may be limited by the ability to generalize from this one outpatients department in a teaching hospital, in a part of UK where there is a high non-white population, compared to other populations. Factors that would increase the validity of this study are that the demographic data and information about the patients' conventional treatment was validated against the hospital notes and concurrence was deemed to be high. In addition, the use of a dummy question, which 96% of patients answered correctly, suggests that the answers given were representative.

Conclusion

In our population of adults referred to a contact dermatitis clinic in Leicester, we have confirmed the findings of other studies that a high proportion

of patients with dermatitis use, or intend to use, CM. The most commonly used CM in our population was herbal medicine. Many patients used CM on the recommendation of family and friends. A significant minority reported benefits from CM and would recommend it to others. The use of CM was associated with ethnicity in the population studied. We recommend that the use of CM is routinely inquired about when interviewing patients in a contact dermatitis clinic.

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