

The authors could also have included apremilast, which, while not a biologic agent, has a similar acquisition cost.

More complex models have been proposed based on periods of 52 weeks⁴ and 2 years.⁵ One difference between those 2 studies is the choice of rescue treatment for patients who experience treatment failure (conventional systemic treatment or phototherapy in the German model⁴). In the study that considers the perspective of the Spanish health system,⁵ with a 2-year time horizon, indirect costs were not taken into account and assumptions were made regarding the rates of treatment intensification and switches to other biologic treatments as well as the cost-effectiveness of these interventions. The order of efficiency reported in that study differs from that reported in the study in this issue.

Despite its limitations, which actually represent possible alternative approaches, the study is interesting and informative. The methodology is correct (there is always room for debate about whether or not the last dose should be included in the calculation of the interval or apportioned) and the inclusion of a sensitivity analysis based on the results corresponding to the endpoint for each drug (ranging from 10 to 16 weeks) is appropriate, with the limitation of between-trial differences in the duration of that period. The usefulness of this article could be greatly enhanced through the inclusion, as an on-line supplement, of an Excel sheet or a link where the reader could access or download a small Java, Android or Apple application, depending on the platform. This application would enable clinicians or pharmacists to calculate the results for the specific situation of each hospital (given the current highly variable and fluid pricing situation) and to incorporate new drugs as they become available, and even modify the NNT data as new meta-analyses are published.

Conflicts of Interest

L. Puig has received fees as a consultant or lecturer and/or has served as a researcher in clinical trials sponsored

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Patient-Reported Outcomes in Psoriasis Validated in Spain: PROs and Cons[☆]



Patient reported outcomes en psoriasis validados en España: PROs y contras

This issue of *Actas Dermo-Sifiliográficas* features a systematic review of studies that have validated or used patient-reported outcome tools in Spanish patients with psoriasis.¹ The review includes 5 tools that have been

validated for use in Spain: 2 skin disease-specific quality of life questionnaires (the Dermatology Life Quality Index [DLQI] and Skindex-29), 2 psoriasis-specific questionnaires (the Psoriasis Disability Index [PDI]) and PSO-LIFE, which was developed in Spain), and a treatment satisfaction questionnaire (CESTEP), also developed for psoriasis patients in Spain. The authors are to be commended for their review of PRO tools that have been culturally adapted for use in Spain and for evaluating their characteristics.

Among the notable findings of the review is the weak to moderate—and variable—correlation observed between health-related quality of life (HRQoL) measures and clinical severity measured by the Psoriasis Area and Severity (PASI) index. The nature of this correlation can be explained by the fact that PASI may not capture the effects of lesions in certain areas of the body (hands, arms, genitals, scalp, and nails)² or those of certain symptoms and lesion visibility.³

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Although DLQI has a higher floor effect than Skindex-29, which is also more responsive to clinical changes,⁴ the introduction of a modified DLQI scoring system that takes into account “not relevant” responses⁵ may help to overcome the notable floor effect of DLQI, which would have particularly important consequences when assessing female, elderly, unemployed, and less well-educated patients.⁶

Other important considerations are the nonlinear relationship between PASI and HRQoL (greater relative impact for lower PASI scores) and the larger impact of improvements in PASI on HRQoL of women.⁷ Female sex, together with PASI, is the strongest determinant of PDI in our setting, and it is well-known that disease of equal severity affects women more than men in terms of its impact on DLQI scores and other HRQoL measures in both psoriasis and other chronic inflammatory diseases.⁸ This greater impact was not determined in this review.

In the discussion section of their article, the authors mention that the three generic HRQoL questionnaires validated for use in Spain—the 36-item Short-Form Health Survey (SF-36), the EuroQol 5D (EQ-5D), and the Nottingham Health Profile (NHP)—have low sensitivity to clinical change. The most useful of these questionnaires is perhaps EQ-5D,⁹ which has different versions that can be used in psoriasis^{10,11} and for which algorithms exist to generate utility scores from DLQI scores in patients with psoriasis.¹² These scores could be used in pharmacoeconomic studies to define quality-adjusted life years gained with certain therapeutic interventions.

A final point worth noting is the good psychometric properties (internal consistency, reliability, and content and structural validity) observed for CESEPT, the Spanish psoriasis satisfaction treatment questionnaire,¹³ compared with other psoriasis-specific, skin-specific, and generic measures.¹⁴

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