

Commentary on an exploratory study to investigate health seeking behaviour in patients with psoriasis using framework analysis

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Psoriasis can have a significant detrimental effect on physical and mental health and wellbeing. It is a multi-system disorder which can have serious consequences if left untreated¹. In this issue of the *British Journal of Dermatology* Simpson and colleagues² conducted an exploratory study to investigate health-seeking behaviours in patients with psoriasis with a focus on people who were newly referred to secondary care. Delay in health seeking behaviour has been extensively investigated in some areas, for example, cancer and heart disease³, but less so dermatology. Previous studies in dermatology allude to the perceived pointlessness of seeking medical help for a disease which is sometimes viewed by General Practitioners (GPs) as trivial. Patients may reject help on the grounds that there is no cure for psoriasis, treatment may be unacceptable, have high self-management demand and are often slow to be effective^{4,5}.

Qualitative research is increasingly recognised as being important in understanding the complexities of supporting patients with long-term skin conditions as effectively as possible. Simpson and colleagues² used a rigorous qualitative approach to better understand patient experiences of psoriasis care. Reasons for delay in seeking medical help included: familial experience of psoriasis; lack of follow-up in primary care and beliefs that psoriasis is incurable and not worthy of treatment. Triggers for referral to secondary care included: rapid deterioration; development of co-morbidities; knowledge of other treatment options and influence from family or friends. Median time from diagnosis to secondary care referral was 15 years.

The experiences recounted by patients in this study demonstrate the divergence between existing evidence based guidelines and realities of clinical practice; the evidence to practice gap⁶. The strength of this study is in bringing to the fore the patient experience, however there is also a need to understand the perspectives of GPs. There may be many barriers to providing evidence-based primary care for psoriasis. Two that are worthy of consideration are access to information and incentives. It is easy to suggest that existing guidance should be followed. However when one stops to consider this the magnitude of keeping up to date with the plethora of evidence this becomes more problematic. Even a decade ago it was estimated that to keep abreast with the latest research by reading published literature it would require the average physician to read 19 articles per day 365 days a year. The time reported as being available for such activity is around one hour per week⁷ and

the volume of evidence has undoubtedly increased over time. Much evidence is now synthesised into guidelines, for example those produced by the National Institute for Health and Care Excellence (NICE). However there are in excess of 250 NICE guidelines many of which are relevant in primary care so this still presents a challenge in everyday practice. There is a need to find new methods of moving knowledge and evidence to where it is most useful; arguably to both patients and primary care practitioners. Equally there needs to be more recognition of the impact that skin disease can have, and the importance of working with patients to get treatment right. At present there is limited incentive for this in primary care with the notable absence of most dermatological conditions in the NICE Quality and Outcomes Framework indicators⁸.

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orcid.org/0000-0002-9355-8059