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Patient survey reports association between compression stocking use adherence and stasis dermatitis flare frequency

To the Editor: Compression stocking use for stasis dermatitis is an effective treatment to control symptoms, especially during acute flares.[1] The annual health care cost of stasis dermatitis is $195 to $515 million, including unnecessary hospitalizations.[2] High rates of noncompliance (60%-70%) with compression stocking use have been documented, but underlying factors are not well understood.[1] We sought to characterize the patient-reported concerns that influence adherence to prescribed use of compression stockings.

A cross-sectional survey was conducted at Saint Louis University with Institutional Review Board approval. An electronic medical record search identified patients who were seen in the outpatient dermatology clinic between February 1, 2017, and May 1, 2018, and were coded with *International Classification of Diseases, 10th Revision* I87.2 for stasis dermatitis. We reviewed patient records to confirm a board-certified dermatologist had diagnosed stasis dermatitis and recommended compression stocking use at the most recent office visit. We contacted 111 eligible patients, and 100

Table I. Patient demographics and interview responses

Variable	Result* (N = 100)
Demographics and medical history	
Female	54 (54)
Age, y	68.8 ± 12.0
Use of topical steroids	61 (61)
History of hospitalization for cellulitis	22 (22)
Interview responses	
Knowledge of physician recommended stocking use	91 (91)
General understanding of how stockings work	74 (74)
Knowledge of hours recommended by the physician	
<8 h/d	2 (2)
8-12 h/d	9 (10)
12-16 h/d	15 (16)
>16 h/d	7 (8)
Unknown	58 (64)
Knowledge of compression strength	36 (39)
Patient use of compression stockings	
Almost daily	26 (26)
2-3 times/wk	11 (11)
3-5 times/wk	21 (21)
Not at all	42 (42)
Hours compression stockings worn when used	(n = 58)
<8 h/d	11 (19)
8-12 h/d	22 (38)
12-16 h/d	17 (29)
>16 h/d	8 (14)
Number of times reason cited for noncompliance with recommended treatment	
Inability to put on the compression stockings	31
Discomfort (too tight)	25
Unclear how the treatment will help	13
Cost	12
Other (too hot, appearance, other medical conditions, physician's lack of emphasis)	11
Patient-reported interventions to increase compliance	
Education regarding tips for putting on the stockings	30
Prescription for a slightly lower strength of compression	26
Financial assistance	14
Additional education from the physician regarding the utility of compression stockings	12

*Data are presented as number (%), as mean ± SD, or as indicated.

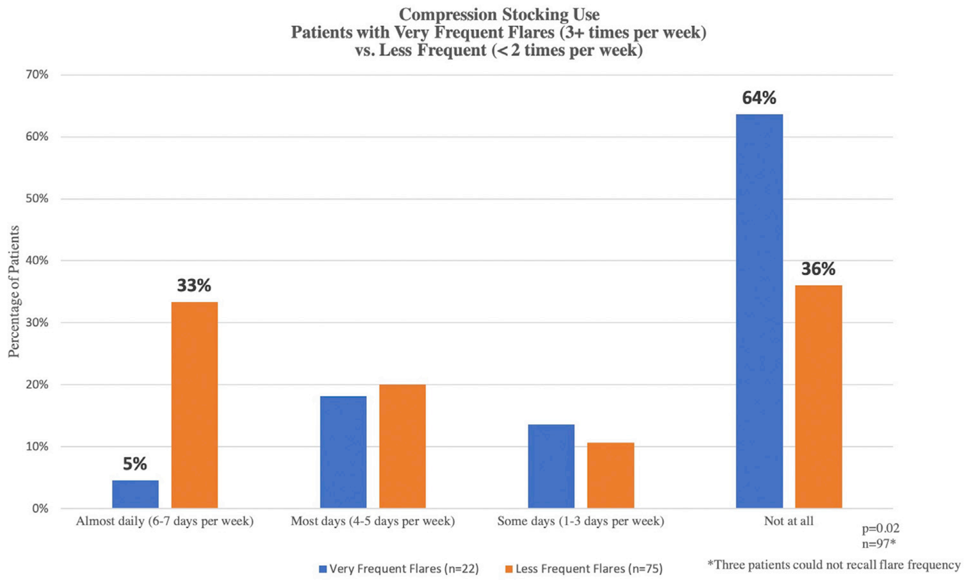

Fig 1. Compression stocking use in patients with very frequent flares (≥3 times per week) vs less frequent (≤2 times per week). Among those who did not wear compression stockings, the percentage of patients with very frequent flares (≥3 times per week) was about double that of patients with less frequent flares, 64% vs 36%. By contrast, only 5% of patients who reported wearing compression stockings daily also had very frequent flares. A statistically significant association ($P = .02$) between flare frequency and compression stocking use was observed.

consented to participate. After obtaining verbal consent by phone, a physician administered an 11-item questionnaire (available online as Supplemental Material via Mendeley at https://doi.org/10.17632/gcfvmthr24.1). A flare was defined as an uncomfortable increase in symptoms, such as edema, erythema, pruritus, or weeping.

Baseline characteristics of the sample ($n = 100$) and responses are described in Table I. Only 26% of patients reported wearing stockings daily as recommended (ie, ≥12 hours daily). A statistically significant association ($P = .02$) between flare frequency and compression stocking use was observed (Fig 1). Approximately 5% of patients with daily stocking use reported very frequent flares (≥3 times weekly), whereas 64% who reported no stocking use had very frequent flares. The most common reasons cited by patients for non-compliance with the physician recommendation, listed in order of frequency, were inability to put on the stockings, discomfort, unclear how the treatment will help, and cost.

The cross-sectional design does not permit drawing conclusions about the temporal relationship between compression stocking use and flare prevention. Sampling from a single, Midwestern academic institution limits the generalizability, and all telephone survey research is subject to recall bias. The sample size limited our ability to conduct stratified analysis.

Patients expressed frustration with the inability to apply compression stockings because of tightness, poor fit, texture, or warmth. Although not as common, some patients reported out-of-pocket cost as a barrier. Furthermore, patients reported wanting physicians to provide more education about compression stocking application and ways of relieving discomfort. Physicians can provide such education during office visits. Early morning application, professionally fitted stockings, and donning-doffing devices can be promoted. If patients cite discomfort, physicians could prescribe a lower strength or recommend an alternate material.

Local medical supply companies can help reduce out-of-pocket costs and offer patient assistance in selecting optimal fit, fabric, color, and length. At the initial encounter, we recommend referral to a local medical company that can assist in optimal stocking design and coordinate insurance benefits whenever possible. At subsequent visits, we recommend physicians regularly address barriers to compression stocking use. These simple interventions can contribute to improved patient compliance with compression stocking use and reduced flare frequency.

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Integrating colocated behavioral health care into a dermatology clinic: A prospective randomized controlled treatment pilot study in patients with alopecia areata

To the Editor: Alopecia areata (AA) is a medical disease with substantial psychosocial burden.[1] Because of a recognized absence in care addressing such burdens, researchers, dermatologists, and patients are calling for increased clinical attentiveness to this issue.[2,3] This call has generally been unanswered, and little research addressing and treating AA psychosocial disease burden exists.

To address this, we developed an AA-specific colocated behavioral health (CLBH) treatment protocol. CLBH involves brief mental health treatment integrated into a medical clinic. It focuses on a patient's condition-related psychosocial factors, with the goal of enhanced patient functioning. Established in primary care, CLBH has resulted in improved physical and psychosocial outcomes.[4,5]

An institutional review board–approved, randomized, controlled pilot study investigated the feasibility of integrating the CLBH protocol into busy hair disease dermatology clinics, patients' perspectives on CLBH provision, immediate perceived benefits of CLBH, and impact on psychosocial functioning 1 month later. Adult patients with AA participated. Twenty patients received up to 2, 30-minute sessions of the AA-specific protocol, providing emotional social support and identifying plans for living better with AA. The first session was held immediately after their dermatology appointment in an adjacent conference room. Control individuals (n = 10) received no behavioral health care.

Participants completed psychosocial outcome measures at study enrollment and 1 month later. Standardized measures were available for depression, demoralization, and appearance shame. For AA-specific emotional social support, coping, negative emotions, and social avoidance, unstandardized measures were developed and pilot tested with patients with AA. After each session, treatment participants answered questions on the perceived

Table I. Treatment participants' (N = 20) level of agreement with statements of perceived benefit immediately after CLBH session 1*

Item: Today's behavioral health appointment …	Mean	SD
Provided me emotional support.	4.75	0.55
Helped me feel less alone.	4.35	0.98
Increased my understanding of AA impacts.	4.4	0.68
Helped me feel normal in how I am responding to my AA.	4.65	0.59
Resulted in me feeling understood.	4.7	0.47
Helped me feel accepted.	4.3	1.17
Helped me feel less trapped.	4.0	1.2
Increased my self-confidence for helping myself live better with AA.	3.9	1.2
Increased my ability to cope with my AA.	3.75	1.12
Overall left me satisfied.	4.6	0.5
Overall helped me.	4.35	0.67
Overall increased my satisfaction with the care I received from the dermatology clinic.	4.75	0.44

AA, Alopecia areata; *CLBH*, colocated behavioral health; *SD*, standard deviation.

*1: strongly disagree; 2: disagree; 3: neither agree nor disagree; 4: agree; 5: strongly agree.