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## PUVA treatment of psoriasis in Italy

SIR, We read with great interest the recent paper by Farr and Diffey,[1] concerning the location and type of PUVA units, and their operation in the treatment of psoriasis in the U.K. They reported data obtained from 132 (78%) of 170 dermatology departments which were sent a questionnaire in 1989. We also mailed a similar questionnaire to all 135 Italian dermatology departments in 1989 and received 98 (72·5%) replies. A preliminary report of our findings was published in a national Italian dermatological journal.[2] We report herein the full results of our investigation and compare them with the U.K. experience.

In Italy, whole-body UVA devices were not available in 28 (29%) of 98 departments; 14 because of insufficient funding or staff, and four because of doubts expressed about the effectiveness and safety of PUVA; reasons were not provided in 10 replies. These 28 departments were mainly located in southern Italy, and this could be related to the greater potential for sun exposure in the south, which may render PUVA therapy less necessary than in the northern part of the country. The other 70 (71%) centres were equipped with a total of 90 units: 70% of centres used one unit, 24% two and 6% three or more. These data virtually parallel those reported by Farr and Diffey:[1] 134 PUVA units were located in 96 (72%) of 132 dermatology centres in the U.K.; 67% of centres had one UVA device, 28% two, and 5% three. There were 72 conventional UVA fluorescent sources in Italy and 129 in the U.K. However, filtered metal halide lamps were more numerous in Italy (18) than in the U.K. (5). Data about the type of UVA sources are relevant, as their biases of wavelengths within the UVA spectrum may influence therapy.[3] The location of the units was also different. In Italy all but one of the PUVA units were located within dermatology departments, whereas in the U.K. 30% of PUVA treatments were carried out in physiotherapy departments.

In the U.K. there was great variation in the methodology of PUVA treatment for psoriasis. Treatments were given twice-weekly in 24 centres, three times in 67, and four times in 5. The minimal phototoxic dose (MPD) was determined in only five centres, whereas in the other 91 the range of the starting doses for each skin type was surprisingly wide. A great inter-departmental variation was also shown in Italy, but with different ratios to the U.K.; PUVA was given four times/week in 48 centres and three times/week in 16. Both schedules were used in five centres, and PUVA was never used as a twice-weekly regimen. Bath-PUVA was used in one centre. However, the MPDs were always determined in only 23 centres, including three centres in which patients were treated three times/week. Hence, only 20 centres strictly followed the directions of the European Cooperative Clinical Trial.[4] In the other centres, the starting doses were based upon the skin type but, as in the U.K., were not always the same. Additionally, our questionnaire revealed great differences in two other disputed areas of treatment: (i) the maximal UVA single exposure ranged between 7 and 15 J/cm$^2$; (ii) maintenance therapy was not performed in 22 centres, and always or often in the others.

In summary, the present study, and that of Diffey and Farr, have found a similar ratio of hospitals where photochemotherapy is available, and a similar mean number of UVA sources. However, differences in the type and location of the UVA sources have been shown. In both countries, there is great variability in the methodology of PUVA therapy in different centres, and even greater variability was revealed when the data obtained in the two investigations were compared. These differences make the interpretation of the results and side-effects in studies of PUVA therapy difficult.

Similar studies in other European countries could contribute towards a goal of establishing uniform, optimum PUVA therapy regimes for the management of psoriasis.

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