
Three weeks in the sun

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New and effective drugs to treat psoriasis have changed the preconditions for sending patients to undergo climate therapy on Gran Canaria.



Photo: Einar Nilsen

Psoriasis is a chronic, fluctuating skin disease characterised by red, thickened and scaly patches on various parts of the body. Many patients with psoriasis have a reduced quality of life (1). Until the turn of the millennium, patients with extensive psoriasis tended to be hospitalised for three to four weeks for topical treatment with dithranol, coal tar or other sticky emollients. Climate therapy under the auspices of the public health services, at first in Yugoslavia, later in Lanzarote and Gran Canaria, began in the 1970s as an alternative to hospitalisation. Clinical experience and some evidence indicated that three weeks of daily, controlled sun exposure and bathing in seawater was just as suitable and effective as hospitalisation. The Norwegian Association of Psoriasis and Eczema Patients lobbied for these trips, which received – and still receive – political support and a separate item in the Norwegian state budget. The scheme is based on a separate set of regulations (2).

Comprehensive immunological and clinical research over the last 10–15 years has provided new and far better treatment options to patients suffering from extensive psoriasis. Biological drugs that specifically target certain cytokines and other key points in the inflammatory process, have revolutionised the treatment. Most patients with extensive psoriasis can now be treated with regular injections or intravenous infusion in outpatient clinics. New biological drugs that have other action points, better effect and few adverse effects, and that are able to eradicate virtually all psoriasis patches in a large proportion of the patients, will be soon be available. These drugs are very costly, but the tendering procedure used by the regional health authorities in Norway has caused the prices to drop significantly, especially since the advent of bioequivalent drugs (3).

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Today, nearly all patients with moderate to extensive psoriasis are treated as outpatients, with biological drugs, light therapy (i.e. UVB radiation) or peroral drugs, most often methotrexate. Topical ointments is used less extensively and the application requires less effort. The Department of Dermatology at Oslo University Hospital, which is the only dermatological department in the South-Eastern Health Region, no longer has 50–60 beds, as it did in the 1980s; the number of beds has been reduced to 14. Similar reductions in inpatient capacity has taken place at the departments of dermatology in Bergen, Trondheim and Tromsø. Hardly any psoriasis patients are now hospitalised.

Climate therapy on Gran Canaria under the auspices of the public health services has become an option for a dwindling number of patients with psoriasis. The number of applications has declined, and a majority of those who travel have minor or moderate rash upon arrival (unpublished data). The stay is increasingly characterised by patient education, talking therapy and help in coping with the disease. Combined with the sunbathing, this has a positive effect on the disease activity, insight into the disease, and quality of life, at least in the short term (4). Such effects should not be underestimated (5). However, it should be considered whether the benefits are sufficient to warrant a continuation of the scheme.

In 2004, the authors of an evaluation report asked whether climate therapy is a welfare scheme or a treatment measure, and called for better patient selection, cost-benefit analyses and a reassessment of the scheme (6, 7). The proposal met with resistance from patients (8) and came to nothing. In the following years, the development of biological drugs has gathered momentum, further weakening the reasons for sending psoriasis patients to Gran Canaria at cost to the public purse. The preconditions for the scheme have changed. What consequences should this entail?

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