safe skin practices, including sun avoidance and SSE. Safe skin practices are as important as regular exercise and smoking cessation and should be included in routine health education counseling.

With evidence suggesting the importance of SSE, it is concerning that most of the Hispanic participants did not report performing them. Physicians should educate their patients, demonstrate for them how to perform a proper SSE, explain what to look for, and provide resources with examples. Physicians should also teach their Hispanic patients to pay particular attention to acral areas and extremities because there is a higher incidence of melanoma on those areas in Hispanics.2

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than 1 posttreatment visit, the first posttreatment visit was used. All responders and nonresponders were pooled together, regardless of which systemic therapy was initiated, and Skindex-29 subscale scores were compared between the pretreatment visit and the first posttreatment visit.

Skindex-29 subscale scores were normally distributed, and paired t tests were used. Spearman correlation tests were performed between change in Skindex-29 subscale score and change in CLASI activity score. Stata software, version 11.0 (StataCorp LP) and GraphPad Prism, version 5.0 (GraphPad Software Inc) were used for data analysis.

Results. For 23 responders of 39 patients initiated on an antimalarial or antimetabolite therapy, the mean (95% CI) Emotions score decreased from 53.9 (40.6-67.1) to 38.8 (28.2-49.4) (P = .002); Functioning score decreased from 32.7 (20.5-44.9) to 20.9 (13.1-28.7) (P = .01); and Symptoms score decreased from 47.2 (37.8-56.6) to 33.7 (26.6-40.8) (P < .001) (Figure, A). For the 16 nonresponders, the mean (95% CI) Emotions, Functioning, and Symptoms scores were unchanged: 48.0 (33.3-62.7) to 53.0 (38.3-67.6) (P = .30); 25.1 (13.2-37.1) to 25.1 (13.2-37.1) (P > .99); and 44.2 (32.4-56.0) to 43.0 (28.1-57.8) (P = .81), respectively (Figure, B). Differences in pretreatment CLASI scores, duration between visits, diagnosis (CLE only vs CLE and SLE), age, sex, and smoking status between responders and nonresponders were not statistically significant. Change in CLASI activity score was correlated with change in Skindex-29 subscale scores: Emotions, r = 0.39 (P = .01); Functioning, r = 0.29 (P = .07); and Symptoms, r = 0.33 (P = .04).

Comment. Response in disease activity was accompanied by an improvement in skin-specific quality of life measures. Correlation analysis suggests that disease activity is not the only factor influencing quality of life. The impact of treatment adverse effects on quality of life is unaccounted for in this study because various medications were used. Larger studies of systemic therapies in CLE that focus on quality of life and its contributory factors are needed.

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Mortality of Bullous Pemphigoid in China

Bullous pemphigoid (BP) is the most common acquired autoimmune blistering disorder that occurs mostly in elderly people. The first-year mortality has been reported to range from 6% to 41%. This study determined the 1-, 2-, and 5-year mortality of patients with BP in China and identified risk factors affecting survival. The mortality of patients with BP was compared with age-matched persons in the general population.

Methods. This was a retrospective cohort study. Inclusion criteria were a diagnosis of BP based on clinical characteristics and confirmed by at least a typical histologic pattern and the presence of autoantibodies against the basement membrane zone detected by direct and/or indirect immunofluorescence testing. The treatment for BP was oral corticosteroids with or without adjuvant therapy such as dapsone, cyclophosphamide, and others. Data were obtained of all patients with a discharge diagnosis of BP between January 1991 and 2011. Information on the status of patients who became unavailable for follow-up by the hospital department was obtained by telephone calls.

The mortality at 1, 2, and 5 years after first hospitalization was calculated based on the Kaplan-Meier survival estimate. Cox logistic regression in multivariate analysis was used. For the analysis, if no predefined cutoff points were available, continuous variables were categorized on the basis of the median. The ratio of the observed to expected death rates, or the standardized mortality ratio (SMR), was calculated for age categories. The study was approved by the ethics committee of Peking Union Medical College.

Results. A total of 140 patients with BP and a follow-up time 1 year or longer were included. The median age was 67 years, and the mean (SD) age was 64.3 (13.6) years (age range, 18-93 years). The median time from onset of disease to hospitalization was 2.94 months (range, 7 days to 30 years). The median follow-up time was 3 years. The 1-year mortality was 12.9% (95% CI, 8.3%-19.6%); the 2-year mortality was 20.1% (95% CI, 14.4%-28.0%); and the 5-year mortality was 33.5% (95% CI, 25.6%-43.1%) (Figure).

In the univariate analysis, several variables increased mortality (Table 1). Nonsignificant comparisons included smokers vs never smokers (P = .20), drinkers vs never drinkers (P = .33), urban vs rural population (P = .06), duration of disease longer than 2.94 months vs 2.94 months or shorter (P = .25), and erythrocyte sedimentation rate higher than 23 mm/h vs 23 mm/h or less.

The SMR varied from 3.08 to 6.14 depending on age group (Table 2). Based on these data, we concluded that the mortality of patients in our BP cohort was higher than would be expected in age-matched persons in the general Chinese population.

Comment. In our study, the 1-year mortality was 12.9%, which is similar to rates reported in previously pub-

Figure. Kaplan-Meier curve of overall survival of patients with bullous pemphigoid.