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ORIGINAL ARTICLE

Do Dermatologic Diagnosis Change in Hot vs Cold Periods of The Year? A Sub-Analysis of the DIADERM National Sample (Spain 2016)[☆]



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Abstract

Background: Knowledge of seasonal variation of cutaneous disorder may be useful for health planning and disease management. To date, however, descriptions of seasonality including all diagnoses in a representative country sample are very scarce.

Objectives: To evaluate if clinical dermatologic diagnosis in Spain change in the hot vs cold periods.

Materials and methods: Survey based on a random sample of dermatologists in Spain, stratified by area. Each participant collected data during 6 days of clinical activity in 2016 (3 in the cold period of the year, 3 in the hot period). Clinical diagnoses were coded using ICD-10.

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Results: With a 62% response proportion, we got data on 10999 clinical diagnoses. ICD-10 diagnostic groups that showed changes were: other benign neoplasms of skin (D23), rosacea (L71) and other follicular disorders (L73), which were more common in the hot period and acne (L70) which was more frequent in the cold period. We describe differences in the paediatric population and in private vs public practice. Some of these differences might be associated to differences in the population demanding consultations in different periods.

Conclusions: The frequency of most clinical diagnosis made by dermatologists does not change over the year. Just a few of the clinical diagnoses made by dermatologists show a variation in hot vs cold periods. These variations could be due to the diseases themselves or to seasonal changes in the demand for consultation.

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PALABRAS CLAVE

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¿Existe variación en los diagnósticos dermatológicos entre la temporada de frío vs calor? Un subanálisis del estudio DIADERM (España 2016)

Resumen

Antecedentes: El conocimiento de las variaciones de las enfermedades dermatológicas a lo largo del año podría ser útil para la planificación en salud y el manejo de las enfermedades. Sin embargo, existe escasa información acerca de la variación de los diagnósticos dermatológicos en diferentes épocas del año en una muestra nacional representativa.

Objetivos: Evaluar si existe variación en los diagnósticos clínicos dermatológicos entre la temporada de frío y calor en España.

Material y métodos: Los datos se han obtenido mediante una encuesta anónima realizada a una muestra aleatoria y representativa de dermatólogos españoles estratificados por área. Cada uno de los participantes recogió todos los diagnósticos clínicos durante 6 días de consulta en 2016 (3 en la temporada de frío y 3 en la temporada de calor). Los diagnósticos se codificaron según la CIE-10.

Resultados: Con una proporción de respuesta de 62%, se recolectaron 11.223 diagnósticos clínicos. Los grupos diagnóstico CIE-10 que mostraron variaciones entre temporadas fueron: otras neoplasias benignas de la piel (D23), rosácea (L71) y otros trastornos foliculares (L73), los cuales fueron más frecuentes en la temporada de calor, y acné (L70) el cual fue más frecuente en la temporada de frío. Además, describimos las diferencias en la población pediátrica y según el tipo de asistencia pública frente a privada. Algunas de estas diferencias podrían estar relacionadas con diferencias en la población que consulta en las distintas temporadas.

Conclusiones: La frecuencia de la mayoría de los diagnósticos clínicos realizados por dermatólogos no sufre variaciones a lo largo del año. Solo algunos de los diagnósticos clínicos muestran variaciones entre la temporada de frío frente a calor. Estas variaciones observadas pueden estar en relación con las propias enfermedades o pueden ser debidas a cambios estacionales en la demanda de consultas dermatológicas.

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Introduction

Seasonal variation in several dermatologic diseases has been previously described. This variation has been mostly attributed to environmental factors and its impact on skin disorders.^{1,2} Examples of this phenomenon are perniosis (chilblains), which is more common in winter and spring^{2,3}; hand, foot, and mouth disease, more common in summer and autumn² and Grover's disease which is more common in winter.⁴ Observations on the seasonality of skin disorders have been reported in isolated diseases, and using data from dermatopathology archives and non-representative small surveys.^{2,4-8} The only description of the seasonality in a representative country sample was done in the USA, using data from the *National Ambulatory Medical Care Survey* 1990-1998.¹

Knowledge of seasonal variation of cutaneous disorder may be useful for health planning and disease management. To date, however, descriptions of seasonality including all clinical diagnoses in a representative country sample are very scarce.

The objective of the present study was to evaluate whether seasonal variation in dermatologic diagnosis in Spain exists and factors associated with seasonality. The study data were derived from the DIADERM national sample⁹

Materials and methods

Data for this study were compiled from an anonymous national randomized survey among a representative sample of Spanish dermatologist belonging to the Spanish Academy of Dermatology and Venereology⁹ (AEDV). The study was

coordinated by the Spanish Group of Epidemiology and Health Promotion from the AEDV in collaboration with the Research Unit of the AEDV.

Sample selection: The sample of dermatologists was obtained from the AEDV Dermatologists membership list, which were selected using randomized sampling, stratified for the different geographical sections of the AEDV. More than 98% of the Spanish dermatologists belong to the AEDV.

Each participant collected data during 6 days of clinical activity in 2016 (January 19, 20 and 21 and May 18, 19 and 20).

The sample size was calculated to get a $\pm 2/1000$ precision for diagnosis in 5/1000 proportions. After assuming a design effect of 2, the number of dermatologist needed for the study were 70. Assuming a response rate of 60% and after adjustment for geographical sections, the number of Dermatologist asked for participation were 124.

Data included in the survey were: clinical dermatologic diagnosis, whether the patient was under age 18 or not, whether it was a presential or a teledermatology consultation, reason for consultation and secondary diagnosis. Other variables were: public or private institution, the origin of the patient (direct access, primary care physician, other specialist or revision) and his destination (discharge, follow-up with the dermatologist or follow-up with another specialist). Personal data and information about therapy were not recorded.

The coding of the different clinical diagnosis was carried out by an expert dermatologist using the 10th version of the International Classification of Diseases (ICD-10). When coding was doubtful a revision was carried out by three Dermatologists with special interest in diagnosis coding from de E-Dermatology and Image group of the AEDV. A quality control of the coding included a review of a random sample of the data and showed 0.16% of errors.

We had data from January (winter) and May (late spring).² The weather conditions during the period of the study were as follows: In January 2016 the average daytime temperature was 9.5°C and the average monthly precipitation was 90 mm; in May 2016 the average daytime temperature was 16.4°C and the average monthly precipitation was 78 mm (data collected from the Spanish Agency of Meteorology (AEMET)).

Statistical analysis: a descriptive analysis was performed considering the sampling method. Continuous variables were expressed as means with standard deviations in symmetric distributions. Categorical variables were expressed as total numbers with percentages. Characteristics in both seasons were compared using either chi-square test or Student's t-test. In addition, crude and adjusted Odds Ratios (OR) with 95% Confidence Intervals (95%CI) were obtained by means of a multilevel model nested in geographical areas, to check if seasonal differences are related to the different demographic characteristics of the sample in each season.

Multivariate models were obtained by means of a backward selection strategy and likelihood ratio test comparisons. Factors used were the variables included in the survey.

The statistical analysis was performed with Stata (version 14.1 Statacorp, Texas, USA). The study protocol was approved by the ethical committee of Granada.

Results

Among the dermatologists selected, 65% (80/124) sent their results in the cold period of the survey and 59% (73/124) in the hot period. A total of 10.999 clinical diagnoses were made in 8953 patients. [Table 1](#) describes the characteristics of the consultations included in each study period. Due to the large numbers, many of the differences are statistically significant, but they are small.

Frequency of dermatologic diagnosis in the different periods: As shown in [Table 2](#) the three most frequent dermatologic clinical diagnosis were the same in both periods; actinic keratosis (L57), other malignant neoplasms of skin (basal cell carcinoma) (C44) and melanocytic naevi (D22). According to crude OR, the only diagnostic groups that showed seasonal changes were: other benign neoplasms of skin (D23), rosacea (L71) and other follicular disorders (L73), more common in the hot season and acne (L70) which was more common in the cold season.

[Table 3](#) compares the frequency of clinical diagnosis in each season, after excluding the effect of differences in sample characteristics (type of consultation, type of diagnosis, patient age group, teledermatology, revision or new consultation, etc.) as potential confounding factors. [Table 3](#) shows a statistically significant seasonal association for other benign neoplasms of skin (D23), being more prevalent in the hot season of the study. On the contrary, acne(L70) seems more prevalent in the cold season of the study.

Age-group subanalysis: For patients aged under 18 we found statistically significant seasonal association for hemangioma and lymphangioma, any site(D18), more prevalent in the hot season of the study. Among those over 18 we found a statistically significant seasonal association for other benign neoplasms of skin (D23) more prevalent in May and acne (L70) more prevalent in January ([Table 4](#)).

Public or private practice subanalysis: In the public practice we found statistically significant seasonal association for acne (L70) and other malignant neoplasms of skin (basal cell carcinoma) (C44) more prevalent in January. In private practice we found a statistically significant seasonal association for other benign neoplasms of skin (D23) more prevalent in May and acne (L70) more prevalent in January ([Table 5](#)).

Discussion

Our study has the advantage of evaluating changes in the frequency of clinical diagnoses in a representative sample of all Spanish consultations. We observed significant variation in acne (L70), which was more common in the cold period, while other benign neoplasms of skin (D23), rosacea (L71) and other follicular disorders (L73), were more common in the hot period. Our results were similar to those of Hancox et al,¹ that only described the 15 most common diagnosis and also found seasonal differences in the frequency of actinic keratosis, dyschromia, psoriasis and seborrheic dermatitis. Another study, including only pathology results, found significant changes over the year in different diseases such as perniosis (chilblains) (more common in winter and spring), hand, foot, and mouth disease (more prevalent in summer

Table 1 Overall description of activity in each period.

	January(N=6113)	May(N=4886)	Total(N=10999)	p-value
<i>Type of consultation</i>				0,0000
General	5433 (89)	4159 (85)	9592	
Monographic	680 (11)	727 (15)	1407	
<i>Type of diagnosis</i>				0,0054
Probable	763 (13)	702 (15)	1465	
Final	5231 (87)	4115 (85)	9346	
<i>Teledermatology</i>				0,0000
No	6024 (99)	4863 (100)	10887	
Yes	89 (1)	23 (0)	112	
<i>Revision or new consultation</i>				0,0023
Revision	3171 (52)	2677 (55)	5848	
New	2942 (48)	2209 (45)	5151	
<i>The diagnosis was the reason for consultation</i>				0,0230
No (secondary)	988 (16)	847 (18)	1835	
Yes (Primary)	5003 (84)	3815 (82)	8818	
<i>Patient under age 18</i>				0,0125
No	5357 (88)	4357 (89)	9714	
Yes	756 (12)	529 (11)	1285	
<i>Public or private practice</i>				0,5809
Private	1871 (31)	1508 (32)	3379	
Public	4086 (69)	3218 (68)	7304	
<i>Origin of the patient</i>				0,0000
Direct access	1742 (29)	1540 (33)	3282	
Primary care physician	1946 (32)	1402 (30)	3348	
Other specialist	251 (4)	242 (5)	493	
Dermatologist	2075 (35)	1544 (33)	3619	
<i>Destination of the patient</i>				0,0003
Discharge	1703 (28)	1267 (27)	2970	
Primary care physician	271 (5)	229 (5)	500	
Specialist	90 (1)	123 (3)	213	
Dermatologist	3938 (66)	3100 (66)	7038	

Data use diagnoses as the unit of analysis and are expressed as absolute number and percentages (%).

and autumn) and erythema multiforme (more common in spring and summer).² Some of the differences in our study disappeared after adjustment, meaning that the variables adjusted for could explain part of the differences in the frequency of rosacea and other follicular disorders.

The observation that acne was significantly more prevalent in January compared to May is in accordance with previous studies which suggests that acne worsens in the winter.^{1,7} Decreased inflammation from ultraviolet light-induce immune suppression has been proposed as a key factor in this phenomenon. Furthermore there is some evidence that sun and phototherapy decrease the reactivity of epidermal Langerhans cells,¹⁰ which could be involved in acne inflammation at some level.¹¹ A recent study which evaluate the seasonal variation of acne supports our results showing that acne worsen in the winter.⁸ We also hypothesize that general practitioners could be more prone to refer the patients to the dermatologist in the cold period for the treatment of acne with oral retinoids.

Our data shows that the clinical diagnosis of other benign neoplasms of skin(D23), was more prevalent in the hot period. A possible explanation for this phenomenon is that in this period of the year people and doctors are more aware of these lesions because of the public awareness campaign

on sun protection and early detection of skin cancer. It has also been proposed that in this season the climate becomes warm enough to encourage lighter clothes that expose more skin area so people are aware of their lesions and seek consultation.¹²

Our data for patients under 18 showed that haemangioma and lymphangioma(D18) were more prevalent in the hot period. We have no explanation for this phenomenon that could result from chance.

Some of the differences that we found between private and public consultations are probably due to differences in the overall clinical diagnoses, as asymptomatic benign lesions and aesthetic complaints are not treated in the public health system.

Possible limitations of the present study include the reduction of dermatologists who participate in the second period of the study, although the percentages of participation were quite adequate for this type of surveys (over 60%). In addition, our results only have relevance for comparisons with data from regions with similar temperate climates. Due to feasibility reasons, we chose the cold period in the coldest part of the year, but the hot period was before the start of summer, as a survey during a holiday period would be more likely to have a low response rate.

Table 2 Most frequent dermatologic diagnosis in the study in each period.

Diagnosis.	January (N=6113)	May (N=4886)	Total (N=10999)	OR for hot season (CI 95%)	p-value
(L57) Actinic keratosis	518 (8.47)	379 (7.76)	897 (8.16)	0.89 (0.77-1.02)	0.0877
(C44) Other malignant neoplasms of skin (basal cell carcinoma)	514 (8.41)	369 (7.55)	883 (8.03)	0.89 (0.78- 1.03)	0.1160
(D22) Melanocytic naevi	470 (7.69)	356 (7.29)	826 (7.51)	0.92 (0.8-1.07)	0.2756
(L82) Seborrheic keratosis	462 (7.56)	345 (7.06)	807 (7.34)	0.93 (0.8-1.07)	0.3001
(D23) Other benign neoplasms of skin	334 (5.46)	353 (7.22)	687 (6.25)	1.35 (1.15-1.57)	0.0002
(L40) Psoriasis	294 (4.81)	253 (5.18)	547 (4.97)	1.07 (0.9-1.27)	0.4420
(L70) Acne	335 (5.48)	204 (4.18)	539 (4.9)	0.75 (0.63-0.9)	0.0018
(B07) Viral warts	266 (4.35)	208 (4.26)	474 (4.31)	0.98 (0.81-1.18)	0.8117
(L81) Other disorders of pigmentation	254 (4.16)	181 (3.7)	435 (3.95)	0.86 (0.71-1.05)	0.1424
(L30) Other and unspecified dermatitis	210 (3.44)	170 (3.48)	380 (3.45)	0.99 (0.81-1.22)	0.9334
(L20) Atopic dermatitis	146 (2.39)	127 (2.6)	273 (2.48)	1.1 (0.86-1.4)	0.4417
(L21) Seborrheic dermatitis	157 (2.57)	114 (2.33)	271 (2.46)	0.91 (0.71-1.17)	0.4632
(L71) Rosacea	105 (1.72)	117 (2.39)	222 (2.02)	1.41 (1.08-1.84)	0.0117
(L72) Follicular cysts of skin and subcutaneous tissue	125 (2.04)	90 (1.84)	215 (1.95)	0.97 (0.73- 1.28)	0.8202
(B35) Dermatophytosis	127 (2.08)	85 (1.74)	212 (1.93)	0.86 (0.65-1.14)	0.3073
(L64) Androgenic alopecia	111 (1.82)	68 (1.39)	179 (1.63)	0.76 (0.56-1.03)	0.0816
(C43) Malignant melanoma of skin	89 (1.46)	60 (1.23)	149 (1.35)	0.84 (0.6-1.17)	0.3026
L60) Nail disorders	62 (1.01)	58 (1.19)	120 (1.09)	1.18 (0.82- 1.7)	0.3661
(L73) Other follicular disorders	52 (0.85)	66 (1.35)	118 (1.07)	1.6 (1.11-2.31)	0.0120
(A63) Other predominantly sexually transmitted diseases, not elsewhere classified	53 (0.87)	55 (1.13)	108 (0.98)	1.37 (0.94-2.01)	0.1025
Other diagnoses	1429 (23.38)	1228 (25.13)	2657 (24.16)	1.11 (1.02-1.21)	0.0189

Data are expressed as absolute number and percentages (%). OR: Odds Ratio; CI: 95% Confidence Interval. Statistically significant differences marked in bold.

Table 3 Adjusted model for seasonal variation.

Most prevalent diagnosis (May vs January)	OR adjusted for higher frequency in hot season (CI 95%)	P value
(L57) Actinic keratosis	0.88 (0.76- 1.02)	0.0847
(C44) Other malignant neoplasms of skin (basal cell carcinoma)	0.86 (0.74-1)	0.0519
(D22) Melanocytic naevi.	0.98 (0.85-1.14)	0.8022
(L82) Seborrheic keratosis	0.9 (0.76-1.06)	0.1957
(D23) Other benign neoplasms of skin	1.34 (1.13- 1.58)	0.0007
(L40) Psoriasis	1.03 (0.86-1.24)	0.7309
(L70) Acne	0.79 (0.65-0.96)	0.0183
(B07) Viral warts	1.03 (0.84-1.25)	0.7879
(L81) Other disorders of pigmentation	0.83 (0.67-1.02)	0.0720
(L30) Other and unspecified dermatitis	0.95 (0.77-1.18)	0.6455

a Odds Ratios adjusted for data included in the survey. Statistically significant differences marked in bold.

This might decrease the differences between the compared periods. Another limitation is that access to private care is usually direct, with short waiting lists, while in private public practice waiting lists are frequently long, and this might decrease the differences between periods in public practice. Lastly, we did not have data to describe full changes over

the whole year, but only a sample of two different periods, limiting the ability to fully describe seasonality.

In conclusion, most clinical diagnoses did not show variation in both periods, but a few showed seasonal changes: acne, benign neoplasms of the skin, rosacea, and other follicular disorders (likely folliculitis). These changes could be

Table 4 Most frequent dermatologic diagnosis in the study by age-group and time of the year.

Patients under 18						Patients over 18							
January			May			p-value	January			May			p-value
Position	Diagnosis	N=756	Position	Diagnosis	N=529		Position	Diagnosis	N=5357	Position	Diagnosis	N=4357	
1	(L70) Acne	121 (16.01)	1	(L70) Acne	74 (13.99)	0.3206	1	(L57) Actinic keratosis	511 (9.54)	1	(L57) Actinic keratosis	374 (8.58)	0.102
2	(L20) Atopic dermatitis	78 (10.32)	2	(L20) Atopic dermatitis	71 (13.42)	0.0876	2	(C44) Other malignant neoplasms of skin (basal cell carcinoma)	509 (9.5)	2	(C44) Other malignant neoplasms of skin (basal cell carcinoma)	364 (8.35)	0.0487
3	(D22) Melanocytic naevi.	75 (9.92)	4	(D22) Melanocytic naevi.	58 (10.96)	0.5469	3	(L82) Seborrheic keratosis	446 (8.33)	3	(L82) Seborrheic keratosis	343 (7.87)	0.4092
4	(B07) Viral warts	74 (9.79)	3	(B07) Viral warts	59 (11.15)	0.4309	4	(D22) Melanocytic naevi.	395 (7.37)	5	(D22) Melanocytic naevi.	298 (6.84)	0.3128
5	(B08) Other viral infections characterized by skin and mucous membrane lesions, not elsewhere classified	43 (5.69)	6	(B08) Other viral infections characterized by skin and mucous membrane lesions, not elsewhere classified	26 (4.91)	0.5415	5	(D23) Other benign neoplasms of skin	301 (5.62)	4	(D23) Other benign neoplasms of skin	324 (7.44)	0.0003
6	(D23) Other benign neoplasms of skin	33 (4.37)	5	(D23) Other benign neoplasms of skin	29 (5.48)	0.3609	6	(L40) Psoriasis	275 (5.13)	6	(L40) Psoriasis	246 (5.65)	0.2579
7	(L30) Other and unspecified dermatitis	25 (3.31)	8	(L30) Other and unspecified dermatitis	18 (3.4)	0.9297	7	(L81) Other disorders of pigmentation	234 (4.37)	7	(L81) Other disorders of pigmentation	173 (3.97)	0.3278
8	(L21) Seborrheic dermatitis	24 (3.17)	10	(L21) Seborrheic dermatitis	9 (1.7)	0.1009	8	(L70) Acne	214 (3.99)	10	(L70) Acne	130 (2.98)	0.0074

Table 4 (Continued)

Patients under 18							Patients over 18						
January			May			p-value	January			May			p-value
Position	Diagnosis	N=756	Position	Diagnosis	N=529		Position	Diagnosis	N=5357	Position	Diagnosis	N=4357	
9	(L81) Other disorders of pigmentation	20 (2.65)	14	(L81) Other disorders of pigmentation	8 (1.51)	0.1685	9	(B07) Viral warts	192 (3.58)	9	(B07) Viral warts	149 (3.42)	0.6699
10	(L40) Psoriasis	19 (2.51)	15	(L40) Psoriasis	7 (1.32)	0.1356	10	(L30) Other and unspecified dermatitis	185 (3.45)	8	(L30) Other and unspecified dermatitis	152 (3.49)	0.9147
14	(Q82) Other congenital malformations of skin	11 (1.46)	9	(Q82) Other congenital malformations of skin	11 (2.08)	0.3996							
16	(D18) Hemangioma and lymphangioma, any site	9 (1.19)	7	(D18) Hemangioma and lymphangioma, any site	21 (3.97)	0.0012							

Data are expressed as absolute number and percentages (%).

Table 5 Prevalence of dermatologic diagnosis in the private practice in the different periods of the study.

Public Practice						Private Practice							
January			May			p-value	January			May			p-value
Position	Diagnosis	N=4086	Position	Diagnosis	N=3218		Position	Diagnosis	N=1871	Position	Diagnosis	N=1508	
1	C44) Other malignant neoplasms of skin (basal cell carcinoma)	426 (10.43)	1	(C44) Other malignant neoplasms of skin (basal cell carcinoma)	295 (9.17)	0.0000	1	(L82) Seborrheic keratosis	185 (9.89)	2	(L82) Seborrheic keratosis	132 (8.75)	0.2586
2	(L57) Actinic keratosis	397 (9.72)	2	(L57) Actinic keratosis	284 (8.83)	0.1941	2	(D22) Melanocytic naevi.	146 (7.8)	3	(D22) Melanocytic naevi.	118 (7.82)	0.9828
3	D22) Melanocytic naevi.	312 (7.64)	3	D22) Melanocytic naevi.	230 (7.15)	0.4278	3	(L81) Other disorders of pigmentation	141 (7.54)	4	(L81) Other disorders of pigmentation	96 (6.37)	0.1857
4	(L82) Seborrheic keratosis	267 (6.53)	5	(L82) Seborrheic keratosis	192 (5.97)	0.3275	4	(D23) Other benign neoplasms of skin	126 (6.73)	1	(D23) Other benign neoplasms of skin	151 (10.01)	0.0005
5	(L40) Psoriasis	239 (5.85)	4	(L40) Psoriasis	211 (6.56)	0.2103	5	(L70) Acne	119 (6.36)	7	(L70) Acne	73 (4.84)	0.0578
6	(L70) Acne	207 (5.07)	7	(L70) Acne	123 (3.82)	0.0107	6	(L57) Actinic keratosis	112 (5.99)	5	(L57) Actinic keratosis	85 (5.64)	0.6661
7	(D23) Other benign neoplasms of skin	186 (4.55)	6	(D23) Other benign neoplasms of skin	176 (5.47)	0.0721	7	(B07) Viral warts	96 (5.13)	6	(B07) Viral warts	81 (5.37)	0.7556
8	(B07) Viral warts	166 (4.06)	8	(B07) Viral warts	121 (3.76)	0.5123	8	(C44) Other malignant neoplasms of skin (basal cell carcinoma)	66 (3.53)	8	(C44) Other malignant neoplasms of skin (basal cell carcinoma)	61 (4.05)	0.4297
9	(L30) Other and unspecified dermatitis	140 (3.43)	9	(L30) Other and unspecified dermatitis	112 (3.48)	0.9075	9	(L30) Other and unspecified dermatitis	65 (3.47)	9	(L30) Other and unspecified dermatitis	52 (3.45)	0.9748

Table 5 (Continued)

Position	Public Practice				Private Practice				p-value	
	January		May		January		May			
	Diagnosis	N=4086 (2.72)	Diagnosis	N=3218 (2.33)	Diagnosis	N=1871 (3.47)	Diagnosis	N=1508 (1.99)		
10	(L81) Other disorders of pigmentation (L20) Atopic dermatitis	111	(L81) Other disorders of pigmentation (L20) Atopic dermatitis	75	(L64) Androgenic alopecia (L20) Atopic dermatitis	10	(L64) Androgenic alopecia (L20) Atopic dermatitis	15	30	0.0097
11	(L20) Atopic dermatitis	96	(L20) Atopic dermatitis	76	(L20) Atopic dermatitis	15	(L20) Atopic dermatitis	10	49	0.1980

Data are expressed as absolute number and percentages (%).

due to the diseases themselves or to changes in the demand for consultation.

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