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PSYCHOSOCIAL BURDEN AND LIFE QUALITY IN VENEREAL VS. NON-VENEREAL GENITAL DERMATOSES

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Abstract:

Background: Any kind of vaginal dermatosis, whether it's a venereal or non-venereal kind, may have a major influence on a person's quality of life in terms of their physical comfort, mental health, and relationships with others. Many patients suffer from increased psychological discomfort and stigma as a result of these illnesses' sensitive nature and location, which may have a negative impact on their quality of life (QoL).

The purpose of this research is to use standardised instruments to evaluate the psychological and social impact of genital dermatoses, both venereal and non-venereal, and to draw comparisons between the two groups.

The participants in this cross-sectional observational research were patients of a tertiary care hospital's dermatology and venereology outpatient clinics. In this study, participants were divided into two groups based on whether they had venereal genital dermatoses (such as herpes genitalis or condyloma acuminata) or non-venereal illnesses (such as psoriasis or lichen sclerosus). A standardised psychological impact questionnaire and the Dermatology Life Quality Index (DLQI) were used to measure levels of emotional discomfort and life quality.

Findings: Patients with venereal dermatoses had higher DLQI ratings, but quality of life was significantly worse in both groups. Due to the stigma and fear of transmission, these people exhibited heightened levels of anxiety, humiliation, and social disengagement. In instances involving chronicity or obvious symptoms, however, individuals with non-venereal diseases also encountered significant psychological repercussions.

In conclusion, genital dermatoses place a heavy psychological and social strain on those who experience them. Social stigma and personal shame, however, make venereal diseases more likely to cause mental suffering. In addition to medical therapy, these results highlight the significance of psychological counselling and stigma reduction as part of comprehensive patient care.

I. INTRODUCTION

Many different types of skin problems may manifest on the outside of the genitalia, collectively known as genital dermatoses. It is possible to classify these diseases as either venereal (transmitted via the genitourinary system) or non-venereal. Both groups have different causes and symptoms, yet they often lead to the same mental and social problems. Affected people have substantial psychological and social concerns due to the delicate anatomical placement, societal stigmatisation of genital symptoms, and consequences for sexual health.

Because they are transmitted sexually, venereal genital dermatoses including syphilis, genital warts, and herpes genitalis are socially stigmatised. Feelings of worthlessness, marital problems, emotional isolation, and dread of revelation may result from this stigma. In contrast, psoriasis, lichen sclerosus, and

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contact dermatitis are not contagious but may nevertheless have a negative impact on a person's quality of life (QoL) due to their persistent pain, visible lesions, and recurring symptoms.

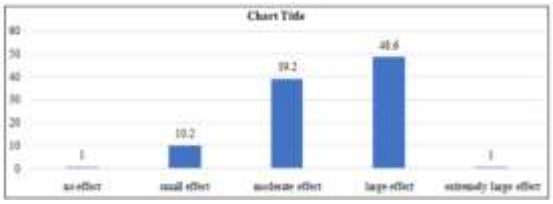
A number of studies have shown that skin illnesses, especially those affecting the face or private parts of the body, are linked to increased rates of anxiety, sadness, and low self-esteem. Nevertheless, there is a lack of comparison research that assesses the distinct effects of venereal genital dermatoses on psychological well-being and quality of life.

To fill this knowledge vacuum, this research will evaluate the impact of venereal and non-venereal genital dermatoses on patients' psychological well-being and quality of life. Researchers want to learn more about the mental, emotional, and social effects of these diseases by administering standardised instruments such the Dermatology Life Quality Index (DLQI) and psychological evaluation scales to patients.

II. MATERIAL AND METHOD

For this research, we enlisted the help of 120 patients (86 men and 34 females) who were at least 18 years old and saw our dermatology outpatient clinic for genital symptoms or genital dermatosis. The patient's medical history and the time of illness start and development were meticulously documented. We did not include patients who had a history of sexual activity. Everywhere it was necessary, relevant tests were conducted, including Gramme stain, KOH, VDRL, and HIV.

Figure 1 shows that all patients had their dermatological life quality index evaluated using the Finlay dermatology life quality index questionnaire.



Statistics

Our statistical analysis was conducted using SPSS version 22. A statistically significant result was defined as $P < 0.05$.

III. RESULTS

Within our study's 120 patients, 86 (71.7%) were found to be male, while 34 (28.3%) were female. The age group of 25–45 accounted for 33.3% of the patients, followed by 45–65 at 30%. Only 27 people, or 22.5%, were single. Of those 93, 77.5% were married. Worker (32.5% of total) was the most common occupation among the participants in the research. In 47 cases (39.1%), the history of several partners was good. Fifty-five patients, or 45.8%, had a history of sexual activity outside of marriage. Out of 120 patients, 101 (or 84.2%) had a sexual history with a known partner, whereas 19 (15.8%) had a CSW. Surprisingly, 56% of men had involvement in the scrotum, 44% in the penis, and 20% in both areas. It was typical for ladies to engage in libido. Genital pruritus(22), LSc(21), and scrotal dermatitis(14) were the most frequent non-venereal dermatoses in our sample. Patients who filled out Finlay's Questionnaire had the highest mean DLQI score (10).

Table 1: Patient Demographics

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Gender	Parameters
Male	86 (71.7%)
Female	34 (28.3%)
Age (years)	
18-25	25(20.8%)
25-45	40 (33.3%)
45-65	36(30%)
>65	19(15.8%)
Marital status	
Married	93 (77.5%)
Unmarried	27(22.5%)
Occupation	
Shopkeeper	28(23.3%)
Labourer	39(32.5%)
Student	14(11.7%)
Housewife	22(18.3%)
Others	17(14.2%)
Multiple partners	
Yes	47(39.1%)
No	73(60.8%)
Pre/extramarital sexual contact history	
Yes	55(45.8%)
No	65(54.2%)
Person known/CSW	
Known	101(84.2%)
CSW	19(15.8%)

Table 2: Non-venereal genital dermatoses and their dermatology life quality index scores.

Diagnosis	Cases (Men)	Cases (Women)	Total Cases	Mean DLQI
Scrotal Dermatitis	14	0	14	14.9
Irritant contact dermatitis	6	4	10	5.2
LSEA	3	2	5	2.0
LSC	11	10	21	7.8
`	4	0	4	1.3
Pemphigus	1	0	1	1.1
Psoriasis	1	0	1	.8
Lichen planus	5	1	6	2.0
Steatocystoma Multiplex	7	0	7	2.5
Vitiligo	1	5	6	3.9
Angiokeratoma of Fordyce	4	0	4	3.8
FDE	4	0	4	1.0
Paraphimosis	1	0	1	5.5
Genital Pruritus	10	12	22	9.8
Scabies	9	0	9	10.8
Pearly Penile Papule	3	0	3	.3
SCC	1	0	1	.5
Lymphangiectasia	1	0	1	.5

METHODOLOGY

Research Methods and Environment

A tertiary care teaching hospital's dermatology and venereology outpatient departments served as the sites of this six-month cross-sectional observational research. All subjects gave their informed permission once the study received ethical clearance from the Institutional Review Board.

Research Participants

There were two groups of 120 adult patients with genital dermatoses (defined as those 18 and up):

Patients with genital warts, herpes genitalis, syphilis, or any other venereal genital dermatosis are classified as Group A.

Group B: Individuals suffering from genital dermatoses other than venereal ones (such as psoriasis, contact dermatitis, or lichen sclerosus)

Criteria for Inclusion:

- Individuals whose genital dermatoses have been diagnosed clinically
- Participation and informed consent are prerequisites.

Things Not Included:

- Individuals who have a history of mental illness or cognitive disabilities
- People whose genital health issues include both venereal and non-venereal components

Tools for Collecting Data

Medical record reviews and structured in-person interviews were the methods used to gather data. A variety of tools were utilised:

There is a validated questionnaire called the Dermatology Life Quality Index (DLQI) that measures how skin disease affects quality of life in many areas, including symptoms, daily activities, job, and relationships.

Anxiety and depression levels may be measured with the use of the Hospital Anxiety and Depression Scale (HADS).

Form for Clinical and Sociodemographic Data: This includes information such as

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gender, age, marital status, length of illness, and diagnosis.

Method

Every single subject went through:

Thorough medical evaluation to establish a diagnosis.

Taking the DLQI and HADS exams, with the help of an assessed interviewer if necessary.

Entering data and making it anonymous so that patient information remains private.

Analysing Statistics

Using SPSS software, the collected data were analysed. Demographic data was analysed using descriptive statistics. The two groups were compared using the Independent Samples t-test or the Mann-Whitney U test, based on the data distribution, for mean DLQI and HADS scores. Statistical significance was determined by a p-value less than 0.05.

IV. DISCUSSION

Since venereal dermatoses inflict so much pain for patients, they are of the highest significance. The dermatological issues that these patients often seek treatment for are often not adequately addressed by urologists or general practitioners. In a study of fifty patients, Neeraj Puri et al. found that among men, the most prevalent non-venereal dermatoses were scrotal dermatitis (16.6%), vitiligo (14.3%), pearly penile papules (fixed drug eruption) (10%), and scabies (10%). Common symptoms were white spots, oedema, soreness, mass, dyspareunia, redness, skin peeling, burning feeling, itchy genitalia, skin lesions that were elevated, bleeding, constipation, ulceration, erosion, and thickening of the skin. The labia majora was involved in 87% of female cases, the labia minora in 48%, and the mons pubis in 10%. The most prevalent location of involvement in males was the penis (52%), followed by the prepuce (32%), and the scrotum (20%).

PK is A research conducted by Saraswat et al. on 100 male patients with non-venereal dermatosis revealed that vitiligo afflicted 18% of the patients, pearly penile papule 16%, fixed drug eruptions 12%, scabies 10%, scrotal dermatitis 9%, and lichen planus 9%. There was a wide age range, from 18 to 65, with 40% of the participants falling between the ages of 21 and 30. [6]

In a study of 293 individuals, N. Vinay et al. identified 25 distinct genital dermatoses. Out of all the patients, 46 (15.7%) had scrotal dermatitis, 37 (12.6%) had lichen simplex chronicus, and 31 (10.6%) had vitiligo. A total of 133 people (45.4% of the total) reported a very big impact of DLQI on their quality of life, whereas 111 people (37-9%) had a moderate effect. 144 people, or 50% of the total, were in the 31-50 age bracket. [7]

One respected and dermatology-specific quality-of-life indicator is the Dermatology Life Quality Index (DLQI). It is well-known that many skin illnesses significantly lower patients' quality of life. Multiple studies have shown that even localised or asymptomatic lesions may have a significant psychological effect and negatively influence the quality of life for both the patient and their loved ones. [9] Patients with genital issues often have a phobia of sexual encounters or the idea that their condition could transfer to their partners. The impact of non-venereal dermatosis on the quality of life of those afflicted has been the subject of little research. [10] The majority of patients with genital pruritus (9.8), scabies (14.9), scrotal dermatitis (14.9), and lichen

simplex of the scrotum (7.8) had DLQI scores of 10. Although it was not clinically significant, patients with a history of CSW and several sexual partners had a higher mean DLQI. One of the reasons that reduced the quality of life was the difficulty in treating chronic dermatosis and the possibility of recurrence, such as lichen simplex of the scrotum.

V. CONCLUSION

The psychological toll and diminished quality of life that individuals with venereal and non-venereal genital dermatoses endure are brought to light in this research. People with venereal diseases, like herpes genitalis or genital warts, had a significantly higher psychosocial burden than the rest of the participants. This is probably because of the shame, fear of transmission, and social isolation that are associated with STDs.

Patients with non-venereal genital dermatoses, on the other hand, suffer from diminished self-esteem and impaired everyday functioning, especially in instances where symptoms persist or deformity is obvious, even if they do not encounter the same degree of social stigma.

The results highlight the need of providing dermatological care that is both comprehensive and patient-centered, including not just physical therapy but also psychological counselling, education, and support. Treatment adherence, quality of life, and mental health may all be improved by attending to these social and emotional aspects.

It is highly advised that dermatological practices include routine mental health screenings, particularly for patients with genital dermatoses, to guarantee the early detection and treatment of psychological disorders.

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