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Original Article

Quality of Life Assessment in Patients Suffering from Psoriasis

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ABSTRACT

Background/Aim: Psoriasis is a chronic disorder marked by thick, silvery-white plaques on the skin. It has a significant impact on the quality of life (QoL) due to its physical manifestations and the potential for severe psychological repercussions, including depression and suicidal thoughts. Despite the clinical diagnosis relying on the presence of erythematous and scaly plaques, the burden of disease is not solely determined by its clinical severity. Quality of life considerations often require a more nuanced understanding beyond the physical symptoms.
Methods: The present prospective observational study was conducted at a tertiary care hospital for 8 months among 150 patients who visited Dermatology Department with complaints of erythema, scaly plaques, and itching and were diagnosed with psoriasis. PASI (psoriasis area and severity index) and DLQI (Dermatology Life Quality Index) were used as parameters to assess the quality of life among patients. Results were analyzed using SPSS version 25.0 keeping level of significance at $p<0.05$.
Results: Maximum subjects were in the age group of 41 to 60 years (47%) and male (62%) were higher in number as compared to females. The mean PASI score of patients was 9.1 ± 3.2 and mean DLQI score of patients was 13.5 ± 4.3. There was significant relationship present between sex and place of residence with DLQI.
Conclusion: This study contributes valuable insights into the multifaceted nature of psoriasis and underscores the importance of addressing both the physical and psychosocial aspects of the disease in clinical practice. The findings reveal a statistically significant association between the Dermatology Life Quality Index (DLQI) scores, which measure the impact of the disease on patients' lives, and the Psoriasis Area Severity Index (PASI) scores, which gauge the clinical severity of the condition.

Keywords*:* DLQI, PASI, Psoriasis, Quality of life.

INTRODUCTION

Psoriasis is a chronic skin disorder that affects 1-2% people. It is characterized by thick, silvery-white plaques that can occur anywhere on the body and associated with hyperproliferation of the epidermis.[1,2] It is a diverse and intricate skin disorder that can profoundly impact the daily lives of those affected.[3] Psoriasis has a significant negative effect on people and can lead to significant morbidity.[4,5]

The cosmetic disfigurement associated with psoriasis may in turn impact the social and psychological health of the affected individuals. The evolving nature of mental health, transitioning from depression to extreme states that can provoke suicidal thoughts, indicates that the psychological aspects of this condition exist on a continuum.[6] Therefore, assessing the extent of psoriasis based on the clinical severity may not be sufficient, and a more comprehensive approach to quality of life is required.[7]

The diagnosis is mainly clinical, characterized primarily by distinct erythematous and scaly plaques with varying severity: mild, moderate, and severe. The severity may be assessed based on the appearance of lesions and the extent of body area affected; however, it's important to note that there isn't a direct correlation between the clinical presentation and the patient's perceived level of physical discomfort.[8]

The burden of disease is not solely determined by the severity of the disease, as determined by tools like the Psoriasis Area and Severity Index (PASI), because even mild psoriasis on visible body areas can negatively impact quality of life.[9] For many years, the helplessness and frustration that psoriasis patients exhibit have been well recorded in western literature. Surprisingly, not many Indian research have looked into the ways that psoriasis sufferers' looks and mental health are damaged by the condition. Hence the present study was conducted to assess the quality of life among patients of psoriasis.

MATERIAL AND METHODS

The present prospective observational study was conducted among patients who visited Dermatology department at a tertiary healthcare center in India for a duration of 6 months with complaints of erythema, scaly plaques, and itching and were diagnosed with psoriasis. The patients were asked to sign an informed consent form after explaining them the complete procedure of research.

Through consecutive sampling total 150 patients of psoriasis who fulfilled the selection criteria were selected for the study. Inclusion criteria were patients with 18 years of age or older, diagnosed with psoriasis at least 3 months ago and had no significant medical condition except psoriasis. Exclusion criteria were patients having psoriatic arthropathy, pustular psoriasis, and psoriatic erythroderma and those who failed to give informed consent.

In accordance with a prestructured proforma, a comprehensive general, physical, local, and systemic examination was conducted after a thorough history was obtained. The Dermatology Life Quality Index (DLQI) and the Psoriasis Area Severity Index (PASI) were used to determine the degree of clinical severity of the condition.

PASI took account of the area and the clinical severity (erythema, scaling, and infiltration) of the skin affected by psoriasis.[10] The scores were calculated by simple addition based on the extent of the symptoms. A single score between 0 = no psoriasis and 72 = very severe psoriasis was obtained, with PASI being interpreted as >12 = severe, 7 − 12 = moderate, and <7= mild.

The patients were asked to answer the questions listed in the “Dermatology life quality index (DLQI)”. The DLQI, which is a dermatology-specific tool to measure health-related quality of life, consists of ten item including 6 dimensions (symptoms and feelings, daily activities, leisure, work and school, personal relationships, and treatment), with four possible responses to each item: 0 (not at all), 1 (a little), 2 (a lot), and 3 (very much). Responses were calculated for the total DLQI score, which is 0-30. The higher the score, the lower the quality of life. DLQI scores from 0-1 meant no effect of the disease on the patient’s quality of life, scores of 2-5 indicated a small effect, scores of 6-10 indicated a moderate effect, scores of 11-20 corresponded to a great effect, and scores of 21-30 indicated a very important effect of disease on the patient’s quality of life.[11]

The statistical analysis was carried out with SPSS version 25.0. For the quantitative and qualitative variables, the Student's test, chi-square, and Fisher's exact test were utilized, respectively. They were deemed statistically significant when $p \leq 0.05$.

RESULTS

In the present study the maximum subjects were in the age group of 41 to 60 years (47%) and least were from 18 to 40 years of age group. Male (62%) were higher in number as compared to females. The subjects suffering from psoriasis were from different professions some were from labor or employed class, housewife etc. Out of all the subjects 45% were having disease from 3 to 6 months, 30% had history of 7 months to 1 years and 25% had from more than one year. In 55% of subjects disease was progressive and in 45% it was non progressive. 70% of subjects were from rural area and the rest belonged to urban area as shown in table 1.

The mean PASI score of patients was 9.1 ± 3.2. Out of all the patients 45% were suffering from mild psoriasis, 53% were having moderate psoriasis, and 2% were having severe psoriasis as shown in table 2.

The mean DLQI score of patients was 13.5 ± 4.3. The mean score of symptoms and feelings, daily activities, leisure work, work and school, personal relationship, and treatment is shown in table 3.

DLQI showed statistically significant association with sex (0.001) and area of residence (0.001) while age, progression of disease, occupation and duration of disease had no effect on quality of life as shown in table 4.

Table 1 Clinico-epidemiological details of the patients enrolled in the study

Variable		Frequency (%)
Age (in years)	18-40	23 (15)
	41-60	72 (48)
	>60	55 (37)
Sex	Male	93 (62)
	Female	57 (38)
Occupation	Labourer	23 (15)
	Housewife	30 (20)
	Student	24 (16)
	Retired professional	23 (15)
	Business	15 (10)
	Other	36 (24)
Duration of disease	3 to 6 months	68 (45)
	7 months to 1 year	45 (30)
	>1 year	37 (25)
Progression of disease	Progressive	82 (55)
	Non progressive	68 (45)
Place	Urban	45 (30)
	Rural	105 (70)

Table 2 Psoriasis area and severity index score according to varying degree of psoriasis severity

PASI score	Frequency / Mean ± SD
Mild psoriasis (<7)	68 (45)
Moderate psoriasis (7-12)	79 (53)
Severe psoriasis (>12)	3 (2)
Mean Score	9.1 ± 3.2

Table 3 Total score of Dermatology Life Quality Index (DLQI) questionnaire

DLQI score	Mean ± SD
Symptoms and feelings	2.96 ± 2.13
Daily activities	2.94 ± 1.80
Leisure work	2.73 ± 1.80
Work and school	1.65 ± 1.00
Personal relationships	2.85 ± 1.91
Treatment	1.32 ± 1.15
Mean Score	13.5 ± 4.3

Table 4 Association of demographic parameters with Dermatology Life Quality Index (DLQI)

Demographic parameters	DLQI (p value)
Age	0.72

Sex	0.001
Occupation	0.72
Duration	0.43
Progress	0.26
Place	0.001

DISCUSSION

Given the widespread occurrence of psoriasis and its chronic nature, it is imperative to assess the alterations in patients' quality of life and compare the outcomes with those of healthy individuals. It is crucial to understand that psoriasis patients may be under profound stress as a result of the effects of the disease on their quality of life.

The maximum patients in our study were from 41 to 60 years which was similar to reported by Vettuparambil et al.[12] and Manjula et al.[13] while Rakhesh et al.[14] and Aghaei et al.[3] reported maximum patients in their 30s. In our study, males outnumbered females. In more recent research, it was discovered that both men and women were equally affected by the impact of psoriasis on appearance and socialisation, but there was a significant difference in the sexual function between them. This is important to note because earlier studies claimed that women were more affected by the cosmetic disfigurement caused by psoriasis.[15]

The majority of quality of life scales have been validated in correlation with disease severity, meaning that the patient's and doctor's perspectives are aligned. Nevertheless, a number of prior data points to inconsistent outcomes. In our study, high PASI was linked to poor QoL, which is consistent with findings from multiple authors.[16–18]

A multicenter, prospective study carried out in Spain found that psoriasis severity was the primary factor affecting QoL, using PASI for the multivariate modelling.[19] On the other hand, other results reported by Benchikhi H, Yang HJ, and Amy De la Breteuque et al. showed a negative relation between PASI and QoL.[17,20,21]

Like our study, study conducted by Vettuparambil et al.[12] included questions about the symptoms and emotions that were most frequently impacted in DLQI, with job, school, and everyday activities. Our research revealed a statistically significant correlation between DLQI and sex as well as location of residence, whereas Manjula et al.[13] study found no relationship between quality of life and age, disease progression, occupation, or length of illness. Although there was no correlation with age or gender, there was a correlation with duration (P = 0.02).
Since our study was conducted in a hospital setting, the conclusions may not be generalized to all psoriatic patients in the general public.

CONCLUSION

Gender and place of residence were the determinant factors of QoL in patients with psoriasis. While DLQI is useful tool for assessing the quality of life in psoriatic patients, PASI is a dependable indicator of the severity of the condition. This study demonstrated a statistically significant link between the quality of life indicators DLQI, and the disease severity indicator, PASI. Improved comprehension and communication between psoriasis patients and their doctors may contribute to better QoL for the patients as well as better clinical outcomes in psoriaris.

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Conflict of Interest
None

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