

A DESCRIPTIVE STUDY ON CLINICO EPIDEMIOLOGICAL PATTERN OF GENITAL DERMATOSIS IN ADOLESCENTS AT TERTIARY CARE CENTRE

^{*1}Dr. Karthik S, ²Dr. Benita P, ³Dr. Chippi Pradeep, ⁴Dr. Murali Narasimhan, ⁵Dr. Muthu Bharathi

¹Post Graduate, Department of Dermatology, Venereology & Leprosy, SRMCH&RC,

²Post Graduate, Department of Dermatology, Venereology & Leprosy, SRMMCH&RC,

³Post Graduate, Department of Dermatology, Venereology & Leprosy, SRMMCH&RC,

⁴Head of Department, Department of Dermatology, Venereology & Leprosy, SRMMCH&RC

⁵Senior Resident, Department of Dermatology, Venereology & Leprosy, SRMMCH&RC

*Corresponding Author
Dr. Karthik S

Article History

Received: 08.09.2025

Revised: 20.10.2025

Accepted: 05.11.2025

Published: 05.12.2025

Abstract:

Introduction Genital dermatoses denote skin disorders impacting the genitalia and adjacent areas in both sexes. These conditions may be venereal or non-venereal and can manifest at any age. Adolescents (10–19 years) experience substantial physical, cognitive, and emotional growth, rendering them susceptible to genital dermatoses influenced by changing sociocultural factors. **Objectives** The objective of this study is to examine the clinic-epidemiological patterns, prevalence, dermatological manifestations, and the effect on quality of life associated with genital dermatoses in adolescents. **Methodology** A cross-sectional observational study was performed at SRM Medical College Hospital, encompassing 220 adolescents (aged 10–19 years) who presented with genital lesions at the Dermatology outpatient department. Demographic data, clinical characteristics, and quality of life (assessed via DLQI) were analysed via IBM SPSS Version 26.0. **Results** Among the 220 participants, 60.91% were aged 15 to 19 years. Males were more prevalent in both the lowest (21.31%) and highest (10.66%) socioeconomic levels. Itching was the predominant complaint among both sexes (females: 44.9%, males: 42.62%). Psoriasis exhibited the most significant influence on quality of life (mean DLQI: 12.46). Scabies was the most commonly diagnosed condition across all age demographics, particularly among males. **Conclusion** This study highlights a substantial prevalence of both sexually and non-sexually transmitted genital dermatoses in teenagers, significantly impacting quality of life. Timely diagnosis, enhanced healthcare accessibility, and awareness campaigns are essential. The results underscore the necessity for psychological support in management and additional research on long-term outcomes and more extensive population samples.

Keywords: Genital dermatosis, clinico epidemiological pattern, frequency, dermatological pattern, dermatological life quality index.

INTRODUCTION

Genital dermatoses refer to a diverse range of skin disorders that affect the genital region, including male and female genitalia as well as the surrounding areas. These conditions can be broadly categorized into venereal and non-venereal dermatoses. The classification is based on etiology, clinical presentation, inflammatory, infective, traumatic and miscellaneous causes^[1,2]. The World Health Organization (WHO) defines adolescence as the age group of 10 -19 years. Adolescents are particularly vulnerable to conditions due to their transitional physiology and inadequate education about personal hygiene and sexual health^[3,4]. Furthermore, evolving sexual behaviours have heightened the risk of sexually transmitted infections (STIs)^[5, 6]. Non-venereal dermatoses such as lichen planus and contact dermatitis, are commonly reported, while venereal conditions like genital herpes and syphilis are more prevalent in sexually active populations. Infective dermatoses caused by bacterial, fungal, viral, or parasitic agents, also remain prevalent in this age group^[7,8]. Incorporating routine genital examinations into dermatological practice is essential to identify and manage these conditions effectively^[9-11].

MATERIAL AND METHODS

Study Design and Setting

This study was conducted as a descriptive observational study (cross-sectional study) at SRM Medical College Hospital and Research Centre. The study aimed to analyze the prevalence, clinical presentation, and epidemiological patterns of genital dermatoses among adolescents attending the Dermatology, Venereology, and Leprosy outpatient department.

Study Population

The study population comprised adolescents aged 10 - 19 years who presented with genital lesions at the outpatient department.

Sample Size Calculation

Sample size was calculated and determined as 220 participants were included in the study.

Inclusion Criteria

- Adolescents aged 10 - 19 years presenting with genital dermatoses.
- Those who provided informed consent (for minors, parental consent was obtained).

Exclusion Criteria

- Adolescents with pre- existing systemic illnesses that could potentially confound the study findings.
- Participants who refused consent to participate in the study.

Data Collection Procedure

Each participant underwent a systematic clinical assessment as per the study protocol.

1.Consent Process

Informed written consent was obtained from all participants. In the case of minors, parental consent was acquired before enrollment.

2.Clinical History

Patient demographics, including age, gender, socioeconomic status, and lifestyle habits. Chief complaints related to genital dermatoses, including onset, duration, and progression of symptoms. u

- Type of genital lesions (macular, papular, nodular, ulcerative, vesicular, verrucous, etc.).
- Site of involvement (penile shaft, glans penis, vulva, scrotum, perineum, etc.).
- Any associated cutaneous findings (extra- genital skin lesions).

Clinical photographs were taken (with participant consent) to aid in diagnosis and documentation.

4.Investigations

Microbiological Tests

- Gram stain – to identify bacterial infections.
- Potassium Hydroxide (KOH) mount – to detect fungal infections.
- Leishman stain – to assess for parasitic infections.
- Wet mount – for *Trichomonas vaginalis* and *Candida* spp. detection.

Serological Tests

- Venereal Disease Research Laboratory (VDRL) test or Rapid Plasma Reagin (RPR) test – for syphilis screening.
- HIV testing –to assess for underlying immunosuppression.
- Hepatitis B surface antigen (HBsAg) and Anti - HCV – for viral hepatitis screening.

Histopathological Examination

- Biopsy of lesions was performed in suspected cases of lichen sclerosus, lichen planus, malignancies, or chronic non-healing ulcers.

Culture and Sensitivity Tests

- Samples from ulcerative lesions were sent for bacterial and fungal cultures to identify infectious etiologies.

Data Analysis

Data were analyzed based on the site, type, and associated dermatological findings of genital lesions. Results were documented in a structured proforma to maintain consistency and accuracy in data collection. Statistical analysis was performed using SPSS software, with categorical variables expressed as percentages and proportions.

Ethical Considerations

Ethical approval was obtained from the Institutional Ethics Committee (IEC) before commencing the study. All participants were assured of confidentiality, and their participation was voluntary. No physical, psychological, or social risks were identified for participants.

Outcome Measures

1.Prevalence of Genital Dermatoses

The study aimed to establish the epidemiological burden of genital dermatoses in adolescents.

2.Clinical Presentation

Detailed analysis of common dermatological patterns and their distribution across the adolescent population.

3.Impact on Quality of Life

Assessment of the psychosocial effects of genital dermatoses on adolescents, including potential emotional distress and stigma.

RESULTS AND OBSERVATIONS:

DEMOGRAPHIC DISTRIBUTIONS

The gender distribution shows that 55.45% of the patients are male (122 individuals), while 44.55% are female (98 individuals). This indicates a slight predominance of male patients over female patients. The pie chart visually represents this distribution, with the male portion occupying a slightly larger section compared to the female portion. This data may be useful in understanding gender trends related to dermatological conditions in the study population. The gender- wise age group distribution shows that the majority of patients (60. 91 %) belong to the 15 - 19 years age group, while 39.09% fall within the 10 -14 years age group. Among males, 34.09% are in the 15 - 19 years category, and 21. 36% are in the 10 - 14 years category, making up a total of 55.45% of the dataset. Similarly, among females, 26. 82% are in the 15 - 19 years category, and 17.73% are in the 10 -14 years category, accounting for 44. 55% of the total population. The gender- wise economic status distribution reveals distinct patterns across different socioeconomic classes . Males have a higher representation in both the lowest economic class (Lower V: 21.31%) and the highest economic class (Upper I: 10.66%) , indicating a wider spread across economic categories. In contrast, females are more concentrated in the Lower Middle (III) class, making up 38. 78% of the female population , compared to 28.69% of males in this category. The Upper Lower (IV) and Upper Middle (II) classes show a relatively balanced distribution between genders, with both males and females making up nearly equal proportions. This suggests that while economic disparities exist, particularly among males, both genders have comparable representation in the middle -income groups. The distribution of economic status across

genders, for lower (v) class, Female: 14 individuals (14.29%), Male: 26 individuals (21.31%). Males have a higher proportion in the lowest economic category. For lower middle (iii) class, Female: 38 individuals (38.78%), Male: 35 individuals (28.69%). More females belong to this economic category compared to males. For upper (i) class, Female: 5 individuals (5.1%), Male: 13 individuals (10.66%). Males are more represented in the highest economic class. For upper lower (iv) class, Female: 26 individuals (26.53%), Male: 29 individuals (23.77%). Both genders have a similar distribution in this category. For upper middle (ii) class, Female: 15 individuals (15.31%), Male: 19 individuals (15.57%). Both genders are almost equally distributed in this category (Table 1).

GENDER-WISE DISTRIBUTION OF MORPHOLOGY OF LESIONS

The morphology of lesions among male and female patients varies significantly, highlighting different dermatological presentations.

1.MOST COMMON LESIONS IN FEMALES

Depigmented Patches: 15.31% of female cases presented with depigmented patches, a significantly higher proportion than in males (4.1%). Pustule: 15.31% of females had this type of lesion, compared to 9.02% of males. Dome-Shaped Papules: 10.2% of female cases exhibited this morphology, whereas only 3.28% of males had similar lesions. Erythematous Plaques: 11.22% (6.12% + 5.1%) of female cases had erythematous plaques, while 6.56% of males had them. White Discharge: Reported in 6.12% of females, compared to 2.46% of males.

2.MOST COMMON LESIONS IN MALES

Verrucous Papules: 5.74% of males had verrucous papules, compared to 2.04% of females. Vesicles/Pustules: More common in males (1.64%) than females (0%). Ulcers and Nodules: Ulcers and nodules appeared slightly more frequently in males (Ulcers: 3.28%, Nodules: 4.1%) than in females (Ulcers: 1.02%, Nodules: 2.04%). Umblicated Papules: Seen in 3.28% of males and 3.06% of females, showing nearly equal distribution.

DLQI (DERMATOLOGY LIFE QUALITY INDEX) ANALYSIS BASED ON DIAGNOSIS

The Dermatology Life Quality Index (DLQI) analysis reveals that Psoriasis has the highest impact on patients' quality of life, with a mean DLQI of 12.46 and a maximum score of 30, indicating severe impairment in daily activities. Syphilis (mean DLQI: 10.33) and Vulvovaginal Candidiasis (mean DLQI: 9.11) also significantly affect patients, likely due to their chronic nature and social stigma. Furuncle (mean DLQI: 9.57), Sebaceous Cyst (9.75), and Lichen Nitidus (LN) (8.10)

show a moderate to high impact, potentially due to pain, inflammation, or visible lesions. Conditions like Vitiligo (mean DLQI: 7.95) and Lichen Planus (7.13) also have a noticeable effect, likely due to aesthetic concerns. Scabies, which was previously divided into two groups, now has a lower combined mean DLQI of 5.02, indicating a relatively moderate impact on quality of life, despite its widespread prevalence. Dermatophytosis (mean DLQI: 5.71) and Molluscum Contagiosum (8.00) also have a moderate impact. At the lowest end, Herpes Genitalis has the least effect on daily life (mean DLQI: 1.0), likely due to its episodic nature and effective treatment options. Overall, Psoriasis, Syphilis, and Vulvovaginal Candidiasis have the most significant effect on quality of life, while Scabies and Dermatophytosis cause a lesser but notable impact. (Table 2)

ANALYSIS OF DIAGNOSIS DISTRIBUTION BY GENDER AND AGE GROUP

1.COMMON DIAGNOSES ACROSS AGE GROUPS

Scabies is the most frequently diagnosed condition across all age groups, particularly among males aged 10-14 years (15 cases) and 15-19 years (14 cases). Among females, the highest cases are in the 15-19 years group (11 cases). Dermatophytosis (Fungal Infections) is also common, with a higher prevalence in the 15-19 years group for both genders. Lichen Nitidus and Lichen Planus are more commonly seen in the 15-19 years group, with males showing slightly higher cases than females. (Table 3)

2.GENDER DIFFERENCES IN DIAGNOSES

Males have higher cases of Balanoposthitis and Gonorrhea, which are conditions specific to male genital health. Females exclusively have cases of Vulvovaginal Candidiasis, with most cases occurring in the 15-19 years group. Psoriasis and Vitiligo show a relatively even distribution across both genders and age groups. (Table 3)

3.AGE-RELATED TRENDS

Younger patients (10-14 years) show a high frequency of infectious conditions, such as Scabies, Furuncles (Boils), and Dermatophytosis. Older adolescents (15-19 years) show a higher prevalence of chronic conditions like Psoriasis, Lichen Planus, and Molluscum Contagiosum, possibly indicating a shift toward more long-term dermatological issues. (Table 3)

4.RARE CONDITIONS

Syphilis, Herpes Genitalis, and Gonorrhea appear in very few cases, mostly in the 15-19 years age group, suggesting a link with sexual activity initiation. Warts appear only in a single case in the male 15-19 years group. (Table 3)

Table:1 Frequency of gender Distributions :

VARIABLES	COUNT	PERCENTAGE (%)
Gender		
Male	122	55.45
Female	98	44.55
Age		
10 – 14 years	86	39.09
15- 19 years	134	60.91
Socioeconomic status		
Lower middle(III)	73	67.74
Upper Lower(IV)	55	50.3
Lower(V)	40	35.6
Upper middle(II)	34	30.88
Upper(I)	18	15.76

Table 2 : Analysis based on DLQI score :

Diagnosis	Mean DLQI	Min DLQI	Max DLQI
Psoriasis	12.46	2.0	30.0
Syphilis	10.33	5.0	17.0
Sebaceous Cyst	9.75	0.0	23.0
Furuncle	9.57	0.0	26.0
Vulvovaginal Candidiasis	9.11	1.0	27.0
Lichen Nitidus	8.10	1.0	25.0
Molluscum Contagiosum	8.00	0.0	20.0
Vitiligo	7.95	0.0	29.0
Balanoposthitis	7.55	1.0	14.0
Lichen Planus	7.13	0.0	27.0
Dermatophytosis	5.71	0.0	19.0
Scabies	5.02	0.0	23.0
Herpes Genitalis	1.00	1.0	1.0

Table 3a : Analysis Of Diagnosis Distribution by Gender and Age Group :

Diagnosis	Female (10-14 years)	Female (15-19 years)
Furuncle	8	2
scabies	7	11
Vitilgo	6	5
Dermatophytosis	4	13
Lichen Nitidus	4	5
Lichen Planus	4	4
Vulvovaginal Candidiasis	2	7
Psoriasis	2	4
Syphilis	1	1
Sebaceous Cyst	0	1
Herpes Genitalis	0	0
Gonorrhea	0	1
Molluscum Contagiosum	0	1
Wart	0	0

Table 3b : Analysis Of Diagnosis Distribution by Gender and Age Group :

Diagnosis	Male (10-14 Years)	Male (15-19 years)
Scabies	15	14
Dermatophytosis	6	15
Vitiligo	6	5
Lichen Nitidus	5	6
Furuncle	3	8
Lichen Planus	2	6
Psoriasis	2	5
Balanoposthitis	2	8
Sebaceous cyst	1	2
Syphilis	0	1
Herpes Genitalis	0	1
Gonorrhea	0	0
Molluscum Contagiosum	0	2
Wart	0	0

TABLE LEGENDS :

Table:1 : Frequency of gender Distributions

Table 2 : Analysis based on DLQI score

Table 3a : Analysis Of Diagnosis Distribution by Gender and Age Group

Table 3b : Analysis Of Diagnosis Distribution by Gender and Age Group

FIGURE LEGENDS :

1. INFECTIVE DISORDERS :

A. Scabies

B. Tinea corporis

C. Furuncle

2. PAPULOSQUAMOUS DISORDERS:

A. Genital psoriasis

B. Irritant contact dermatitis

3. KERATINIZATION DISORDERS :

A. Genital porokeratosis

4. DRUG REACTIONS :

A.Fixed drug eruption

B.Toxic epidermal necrolysis

5. PIGMENTARY DISORDERS :

A. Genital vitiligo

6. DISORDERS OF SEBACEOUS GLAND :

A . Scrotal sebaceous cyst

7. SEXUALLY TRANSMITTED INFECTIONS :

A. Molluscum contagiosum

B. Genital wart

FIGURES:

1.INFECTIONS :

A.SCABIES :



B. DERMATOPHYTOSIS :



C. FURUNCLE :



2. PAPULOSQUAMOUS DISORDERS :
A. GENITAL PSORIASIS :



B. IRRITANT CONTACT DERMATITIS :



3. DISORDERS OF KERATINIZATION:
A. POROKERATOSIS :



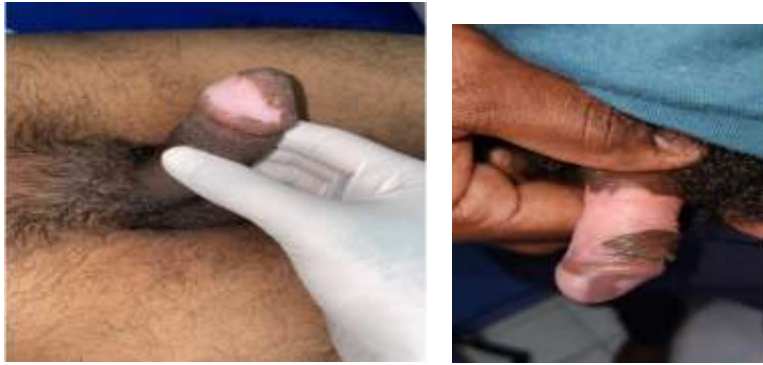
4. DRUG REACTIONS :
A. FIXED DRUG ERUPTION :



B. STEVEN JOHNSON SYNDROME / TOXIC EPIDERMAL NECROLYSIS :



5. PIGMENTARY DISORDERS :
A. GENITAL VITILIGO :



6. DISORDERS OF SEBACEOUS GLAND :

A. SCROTAL SEBACEOUS CYST :

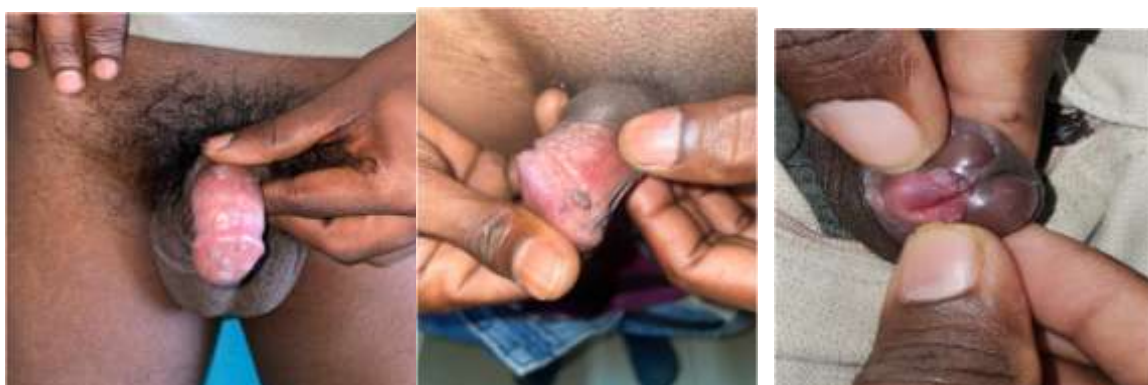


7. SEXUALLY TRANSMITTED INFECTIONS :

A. MOLLUSCUM CONTAGIOSUM :



B. GENITAL WART :



DISCUSSION

The majority of research participants were aged 15–19 years (60.91%), with a little male predominance (55.45% men compared to 44.55% females). This age distribution is crucial, as it signifies the latter phase of adolescence during which physiological transformations, including sexual maturation and enhanced social autonomy, heighten vulnerability to genital dermatoses. Our adolescent-focused study substantially differs from prior research by Nivalika and Prabhu [2024] [12], which revealed a mean age of 37.73 years in their cohorts, highlighting their emphasis on adult populations. This gap highlights that adolescent genital dermatoses may be underdiagnosed or underreported, possibly due to sociocultural taboos, insufficient awareness, or reluctance to seek care. The socioeconomic analysis in our study indicated a broad distribution of male participants across both lower and upper economic levels. Conversely, female participants primarily belonged to the lower middle class. The data indicate that guys, irrespective of socioeconomic class, are more inclined to get dermatological treatment for genital concerns. In contrast, females from both higher and lower socioeconomic backgrounds may have further obstacles, including stigma, parental oversight, or insufficient access to healthcare services. Sivayadevi et al. [13] corroborated our findings, indicating that 72% of their participants were married, implying that marital status, and consequently sexual activity, may affect health-seeking behaviour. This development corresponds with the greater recognition that socioeconomic and marital characteristics are crucial drivers of healthcare access in India. The predominant presenting symptom in our study was pruritus, with 44.9% of female individuals and 42.62% of male participants reporting itching. Discharge and burning sensations were prominent, with discharge occurring more frequently in males (35.25%) and burning sensations more commonly reported in females (28.57%). These results closely resemble those of Gupta et al. [14], who identified genital pruritus as the primary complaint in 70.12% of male patients. Our findings corroborate earlier studies, indicating that pruritus is a primary issue in patients with genital dermatoses, requiring meticulous clinical assessment to

distinguish between venereal and non-venereal aetiologies. The length of time symptoms persist before obtaining medical attention offers essential insights. In our group, 33.67% of females and 34.43% of males reported symptom durations of 1 to 3 months, whereas 16.33% of females and 15.57% of males experienced symptoms for beyond six months. The trend of delayed consultations may be ascribed to shame, insufficient parental support, fear of stigma, or misinterpretation of illness severity. Vinay et al. [15] similarly indicated that extended illness had a moderate effect on the quality of life for 37.9% of patients. Our findings further underscore the imperative for adolescent-friendly services and awareness initiatives to promote prompt medical consultation. Examination of lesion morphology indicated tendencies specific to gender. Females primarily displayed depigmented patches (15.31%) and nodules with pustules (15.31%), whereas males more commonly exhibited verrucous papules (5.74%) and vesicles/pustules (1.64%). These disparities may indicate fundamental etiological variables, including fungal infections, inflammatory diseases, or sexually transmitted infections (STIs), with gender-based susceptibilities potentially shaped by anatomical and hygienic distinctions. The distribution patterns of the sites were also significant. In males, the scrotum (44.26%) and penile shaft (27.87%) were the most impacted regions, whereas in females, the labia majora (67.35%) was the primary site. This corresponds with the findings of Singhal and Nair (2021), who identified scabies (13.5%), dermatophytosis (9.5%), and scrotal dermatitis (8%) as the predominant non-venereal genital diseases in males. This study underscores the necessity of thorough genital inspection, even in the absence of explicit symptoms, particularly in sexually active teens or individuals in high-risk settings such as hostels or slums. The Dermatology Life Quality Index (DLQI) scores indicated the significant psychosocial effects of specific conditions. Psoriasis had the highest mean Dermatology Life Quality Index (DLQI) at 12.46, followed by syphilis at 10.33 and vulvovaginal candidiasis at 9.11. These scores indicate not just physical discomfort but also emotional distress, humiliation, and social alienation frequently encountered by teenagers with visible or stigmatised

genital lesions. In contrast, genital herpes, although a prevalent STI, exhibited a low DLQI score of 1.0, perhaps attributable to its episodic nature and the efficacy of antiviral medications that rapidly mitigate symptoms. Our findings align with those of Sadhukhan et al. [17], who indicated that 76% of their individuals had varying degrees of venereophobia. This psychological disorder, marked by an acute fear of sexually transmitted infections, illustrates the significant emotional distress experienced by teenagers with genital lesions. Incorporating psychological assessment and counselling into dermatology clinics could markedly enhance the overall well-being and treatment compliance of adolescent patients. The illness spectrum identified in our investigation underscores the clinical variability of genital dermatoses in adolescents. Infectious disorders such as scabies and dermatophytosis were the predominant diagnosis among both age groups and genders. Chronic inflammatory disorders, including psoriasis, lichen planus, and lichen nitidus, were more common in the 15–19 age demographic, possibly attributable to the cumulative impact of untreated symptoms or inherent autoimmune susceptibilities. Sexually transmitted infections, including syphilis, genital herpes, and gonorrhoea, were more prevalent among older teenagers, underscoring the necessity for early and thorough sexual education. Our study identified a higher prevalence of balanoposthitis and gonorrhoea in males, but vulvovaginal candidiasis was exclusively observed in females. Nivalika [49], Prabhu [2024], and Gupta (12) similarly showed that vulvovaginal candidiasis accounted for around 38.8% of venereal diseases in women. Sivayadevi et al. (13) additionally observed that STIs were more prevalent among sexually active adolescent females. The relationship among age, sexual activity, and STI prevalence highlights the critical necessity for the establishment of adolescent-targeted STI prevention initiatives and regular screening programs.

CONCLUSION

Our study highlights high STI prevalence and dermatological conditions in adolescents, emphasizing the need for early diagnosis, improved healthcare access, and targeted awareness programs. The significant QoL impact of conditions such as psoriasis, syphilis, and candidiasis underscores the necessity for holistic patient care, including psychological support. Future studies should explore long-term outcomes and broader population samples to refine treatment strategies further.

REFERENCES

1. Devi VN, Balachandrudu DP. Prevalence and patterns of genital dermatoses in children. *Methodology.* 2011 Jul; 2013.
2. World Health Organization. Adolescent health. Geneva: WHO; 2020.

3. Mallikharjuna M, Uday P. Genital lesions in children: A study at tertiary care center. *IOSR J Dent Med Sci.* 2019; 18(3):40 -4.
4. Anitha B, Shivanna R. Genital lesions in a female child: Approach to the diagnosis. *Clin Dermatol Rev.* 2018;2(2):49 - 57.
5. Elloudi S, Lahlou A, Lakjiri S, Baybay H, Gallouj S. Childhood genital dermatosis. *Int J Pediatr Health Care Adv.* 2016; 3(3):21 -3.
6. Shah M, Patel A. Adolescent genital dermatoses: A comprehensive review. *Indian J Dermatol.* 2020;65(4):310 - 8.
7. Devi VN, et al. Non- venereal dermatoses of genital region: An overview. *Int J Dermatol.* 2015; 54(2): e72 -6.
8. Narasimhan M, et al. Patterns of genital dermatoses in Indian adolescents. *Indian J Dermatol Venereol Leprol.* 2018; 84 (3):303 -9.
9. Karthik S, Narasimhan M. Clinicoepidemiological patterns of genital dermatoses in adolescents: A descriptive study. *SRM J Dermatol.* 2025; 12 (1):22 -30.
10. Mekala M, Uday P. Genital lesions in adolescents: An emerging concern. *Pediatr Dermatol.* 2021;38(5):789 -95.
11. Khanna N, et al. Inflammatory dermatoses of the genital region: Clinical perspectives. *J Clin Diagn Res.* 2018; 12 (6): WE01 - 6.
12. Nivalika(49) AS, Prabhu SS. An observational study on female genital dermatoses and the impact of chronic genital dermatoses on quality of life in adult females. *Indian J Dermatol.* 2024;69(5):385 - 90.
13. Sivayadevi (50) P, Anandan H. A study of pattern of non - venereal genital dermatoses in female patients at a tertiary care center. *Int J Res Dermatol.* 2019;5(1):134 -8.
14. Gupta (51) S, Kaur R, Arora R, Sarangal R, Chopra D, Malhan S. Recognizing the patterns of non - venereal genital dermatoses in males of different age groups presenting to a tertiary care center in North India. *J Pak Assoc Dermatol.* 2024; 34(4):929 - 37.
15. Vinay N, Ranugha PSS, Betkerur JB, Shastry V, Ashwini PK. Non-venereal genital dermatoses and their impact on quality of life—A cross-sectional study. *Indian J Dermatol Venereol Leprol.* 2022;88(3): 354 - 9.
16. Singhal RR, Nair PA. A study on clinical patterns of nonvenereal male genital dermatoses at a rural -based tertiary care center. *Clin Dermatol Rev.* 2021;5(1):78 - 84.
17. Sadhukhan S, Bains A, Bhardwaj A, Patra S, Vedant D, Sharma C, et al. Clinical and dermoscopic profile of non -venereal genital dermatoses and its impact on the quality of life: A cross-sectional study of 550 cases. *Indian J Dermatol Venereol Leprol.* 2025;(Epub ahead of print).