DEPARTMENT OF DERMATOVENEREOLOGY

QUALITY OF LIFE AND ITS DETERMINANTS AMONG PSORIASIS PATIENT AT ALERT HOSPITAL, ADDIS ABABA ETHIOPIA

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Quality of life and its Determinants among psoriasis patient at ALERT hospital, Addis Ababa Ethiopia

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Contents

List of acronyms

AAU:	Addis Ababa University
ALERT:	All African Leprosy Rehabilitation Training Center
BSA:	Body Surface Area
DLQI:	Dermatology Life Quality Index
ETB:	Ethiopian Birr
G.C:	Gregorian calendar
HRQL:	Health-related quality of life
IQR:	Inter Quartile Range
IRB:	Institutional Review Board
OPD:	Outpatient department
PI:	Principal Investigator
QoL:	Quality of life
SD:	Standard deviation
SPSS:	Statistical Package for Social Sciences version 27
USA:	United States of America
WHO:	World Health Organization

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Abstract

Background: Psoriasis is a common chronic inflammatory disease characterized by skin inflammation and epidermal hyperplasia. Psoriasis can significantly impact a person's quality of life. Physical discomfort, such as itching, and pain, can interfere with daily activities. The visible nature of the condition can lead to emotional distress, social stigma, and mental health issues like anxiety and depression. People with psoriasis are also at a higher risk for other health conditions, such as psoriatic arthritis, cardiovascular diseases, and mental health issues. Understanding psoriasis and its wide-ranging effects on individuals is essential for providing effective care and improving the lives of those affected by this chronic condition

Objective: This study aimed to Quality of life and its Determinants among psoriasis patient at ALERT hospital, Addis Ababa Ethiopia

Methods: A hospital-based cross-sectional study was conducted at ALERT Comprehensive Specialized Hospital, Addis Ababa, from May to August 2025. A total of 128 patients aged 16 years and above with a confirmed diagnosis of psoriasis and at least six months of follow-up were included using consecutive sampling. Data were collected through face-to-face interviews using a structured questionnaire and the Dermatology Life Quality Index (DLQI). Sociodemographic and clinical data were recorded. Data were entered and analyzed using SPSS version 27. Due to non-normal distribution of DLQI scores, non-parametric tests (Mann–Whitney U, Kruskal–Wallis H, and Spearman correlation) were applied. Statistical significance was set at $p < 0.05$.

Result: The median DLQI score was 13 (IQR: 9–18), indicating a very large impact of psoriasis on quality of life. More than half of the patients experienced very large to extremely large impairment. Poor quality of life was significantly associated with older age, marital status, social drug habits, family history of psoriasis, early age at diagnosis, pustular psoriasis, and involvement of functionally or socially sensitive sites such as extremities, genitals, palms, soles, and nails. Disease duration, sex, educational status, income level, and most comorbidities showed no significant association with quality of life.

Conclusion: Psoriasis has a substantial negative impact on the quality of life of patients attending ALERT Hospital, even among those with mild clinical severity. Quality of life impairment was influenced more by disease characteristics and lesion location than by sociodemographic factors. Routine assessment of quality of life and integrated clinical and psychosocial management approaches are essential to improve patient outcomes.

Key words: Quality of life, Psoriasis, ALERT, Ethiopia

1. Introduction

1.1 Background

Psoriasis is a remitting relapsing chronic immune mediated inflammatory skin disease that is characterized by reddish, scaly spots and plaques on the skin. It has an estimated prevalence of 2-3% in the entire world and has a significant role to play in causing physical discomfort, mental agony and social disability(1). Even though psoriasis is mainly a skin-related condition, it is currently being identified as a systemic disease with many comorbidities, including: psoriatic arthritis, cardiovascular disease, metabolic syndrome, and depression, all of which may further impair the quality of life (QoL) of patients (2, 3).

Psoriasis does not limit its loads only to clinical severity. The presence of symptoms like pruritus, pain, bleeding, as well as scaling, and the presence of lesions typically result in stigma, low self-esteem, anxiety, and withdrawal(4, 5) . Consequently, patients will be subjected to impairments in their daily lives, employment efficiency, social interactions, and sex lives. Evidence from diverse settings shows that the psychosocial impact of psoriasis can be comparable to, or even exceed, that of other chronic non communicable diseases (3, 6) .

Quality of life has therefore emerged as a key outcome measure in the management of psoriasis. Instruments such as the Dermatology Life Quality Index (DLQI) are widely used to capture patients' subjective experiences and to complement clinical severity indices (6, 7) . Several studies have demonstrated that QoL impairment does not always correlate with objective measures of disease extent, as factors such as lesion location, disease chronicity, coping mechanisms, and cultural perceptions play a critical role(7, 8) .

In low- and middle-income countries, including Ethiopia, the impact of psoriasis on quality of life may be further amplified by limited access to specialized dermatologic care, financial constraints, and inadequate psychosocial support systems(8, 9) . Despite this, data on psoriasis-related QoL and its associated factors in Ethiopia remain scarce. Understanding the magnitude of QoL impairment and its determinants is essential for informing patient centered care, guiding clinical decision making, and optimizing comprehensive management strategies for individuals living with psoriasis.

Psoriasis is heterogeneous in affected site and morphology. Based on the affected site it includes scalp psoriasis, sebopsoriasis, inverse psoriasis, genital psoriasis, mucosal psoriasis, palmo plantar psoriasis, follicular psoriasis, nail psoriasis and psoriatic arthritis. And based on morphology it includes plaque psoriasis, guttate psoriasis, pustular psoriasis, Erythrodermic psoriasis and Linear psoriasis. Chronic plaque psoriasis, the most common subtype of psoriasis, is characterized by well-demarcated, erythematous plaques with overlying silvery scale particularly distributed over the extensor area. Other major subtypes of psoriasis include guttate psoriasis, which typically presents as the acute onset of numerous small, inflammatory plaques; pustular psoriasis, and erythrodermic psoriasis, which exhibits cutaneous erythema and scale involving most or all of the body surface area(1).

According to the site of the lesion there are different types of psoriasis. These are scalp psoriasis which is one of the commonest areas and it may involve the whole scalp diffusely or multiple discrete plaques may be seen and it may be associated with hear loss. Others include follicular psoriasis which affects the hair follicles on the trunk and limbs, seborrheic psoriasis which occurs in typical distribution areas of seborrheic dermatitis, flexural psoriasis which usually involves inguinal crease, axilla and sub mammary folds, genital psoriasis which mainly affects the genitalias, nail psoriasis and non-pustular palmoplantar psoriasis.

Psoriasis has also been associated with multiple comorbidities. Psoriatic arthritis is a common comorbidity that should be screened for in all patients. Examples of other comorbidities that are more common in individuals with psoriasis and may warrant intervention include obesity, metabolic syndrome, hypertension, diabetes, and atherosclerotic disease.(1, 10)

Psoriasis is a relatively common disorder that occurs in children and adults worldwide, though the prevalence varies among populations(2). A systematic, worldwide review found the prevalence of psoriasis ranged from 2 to 3 percent in adults. The prevalence of psoriasis tends to increase with increasing distance from the equator.(11)

There are multiple proposed risk factors for psoriasis. Genetic predisposition is considered a key contributor, and environmental and behavioral factors may also play roles (12). In particular, elevated rates of smoking, obesity, and alcohol use are found among individuals with psoriasis (13). Medications and infections have also been identified as potential triggering or exacerbating factors for psoriasis.(11)

The symptoms of psoriasis significantly impair patients’ quality of life by reducing overall well-being and provoking concerns about personal appearance. These concerns often lead to feelings of shame and guilt, low self-esteem, social withdrawal, and difficulties in the workplace. Collectively, these physical and psychosocial challenges contribute to increased levels of anxiety and depression among individuals living with psoriasis (14).

1.2 Statement of the problem

Psoriasis is a serious health issue in the world with millions of people infected. In Ethiopia, psoriasis is also worsened by the lack of health care and social rejection. Nevertheless, even with the progress in medical care, numerous patients still have a significant deterioration in their quality of life (QoL), which why a deeper insight into this problem in the Ethiopian context is needed(15).

Patients in Ethiopia may not obtain sufficient symptom management, which may make their physical and emotional load worse since medical treatments may be insufficient in developed countries(15).

Psoriasis is usually visible and thus, causes a lot of psychological and emotional suffering(16).The appearance of their skin can make patients feel embarrassed, ashamed, and have low self-esteem. This may lead to social isolation because people may stay away in places or even socializing so that they do not face judgment and discrimination(16). Anxiety and depression among other psychological conditions may arise as a result of a society that misunderstands and stigmatizes skin conditions. These challenges are also worsened by the fact that there are no mental health support services in most areas in Ethiopia and the patients are left without the means to deal with such challenges (17).

Psoriasis has social consequences not only to an individual but also to families and communities. Also, the cost is significant in terms of economics. Patients can incur higher medical cost of treatments and medications most of which could not be easily accessible and affordable in Ethiopia. Physical discomfort and psychological distress can also be a hindrance to the work of patients and worsen financial problems(18).

1.3 Significance of the study

Although psoriasis has a very high influence on the quality of life in patients, there is little information on its determinant factors that influence the quality of life in Ethiopia. This knowledge gap prevents the design of specific interventions and policies that can be used to assist patients. It is essential to comprehend the particular problems of patients with psoriasis in Ethiopia to develop the relevant approaches and enhance the results.

The proposed study will address this gap by evaluating the QoL of psoriasis patients in Ethiopia, determining the factors involved, and suggesting ways of improving patient care.

The knowledge of the QoL of psoriasis patients is vital due to a number of reasons. Through QoL, health workers will be in a better position of understanding the physical, emotional, and social issues of patients, which will result in improved and more personalized treatment strategies. The results may be used to inform the policies of the health sector and redistribute the resources so that the patients with psoriasis could be provided with the needed support and interventions. Psoriasis may result in a lot of psychosocial distress such as depression, anxiety, and social stigma. The management of such problems can enhance the overall well-being and decongest the mental health services. Chronic illnesses such as psoriasis usually lead to a higher cost of healthcare and loss of productivity. With enhanced QoL, the healthcare system and economic burden on patients can be cut. The paper adds to the existing literature on psoriasis in the scenario of the low socio-economic status countries and the role the skin issue plays, creating a new level of cooperation and knowledge sharing.

In addition, this research will form a ground-level information of the research which will be conducted in subject matter.

Overall, the study is important because it sheds light on the quality of life of psoriasis patients in Ethiopia and the determinant of it, informing healthcare professionals, policy makers, and researchers to come up with measures of improving patient care and welfare.

2. Literature review

Even though there is a data limitation in low- and middle-income countries. the quality of life of patients with psoriasis has been studied world wide with different study designs(11).

Globally, A set of surveys was conducted in Department of Dermatology and Venereology, Medical University of Bialystok, Poland where 56 patients with psoriasis were hospitalized. Questionnaires used include the Dermatology Life Quality Index, WHO Quality of Life questionnaire, International Questionnaire of Physical Activity, and a self-invented stress survey. Results showed that patients with psoriasis were found to be significantly less satisfied with their health and had lower scores in WHO social, environmental, and psychological domains, comparing to controls. Patients reported higher stress severity and lower satisfaction with sex life and physical appearance than controls. Patients with psoriasis also tended to perform less intensive physical activity than controls.(19)

A growing body of international literature has consistently demonstrated that psoriasis has a substantial negative impact on patients' quality of life, often comparable to that observed in other chronic and debilitating conditions. Studies from Europe, North America, and Asia report that patients with psoriasis experience marked impairment in physical comfort, emotional well-being, social functioning, and occupational performance(6, 8) . Symptoms such as pruritus, pain, and scaling are repeatedly identified as major contributors to daily discomfort and reduced life satisfaction.

In another cross-sectional study done in Phototherapy Clinic of Razi Hospital, Tehran, Iran, conducted from April 2014 to January 2015, One hundred patients with plaque type psoriasis from the Iran were selected and asked to complete questionnaires. The Psoriasis Area Severity Index (PASI) was used to measure the severity of psoriasis, and the Dermatology Life Quality Index (DLQI) was used for the assessment of the quality of life. The result showed that the total DLQI score of the all participants was between 0 and 29 with a mean score of 10.6 ± 6.4. The DLQI scores ranged from "very large" to "extremely large" in 45% of the patients. The mean score was 9.2 ± 6.6 in the male group and 12.1 ± 5.9 in the female group, which showed a statically significant difference (*P*=0.02). Other variables associated with an impaired QoL were age (*P*=0.002) and PASI (*P*=0.01). The impact on QoL was higher in younger patients, and in patients with higher PASI scores (20).

In Ethiopia, a cross-sectional study was conducted in Hiwot Fana Specialized University Hospital located in Harar, eastern Ethiopia. to assess quality of life and identify factors associated with poor quality of life among patients with psoriasis in the region. The study involved 219 patients. The result showed that the proportion of poor quality of life was 54.8%. and factors associated with poor quality of life were those who could not read and write, duration of the disease more than 5 years, new body site affected and affected body surface area (21).

Several investigations have shown that the impact of psoriasis on quality of life is not solely dependent on clinical severity. Research using patient-reported outcome measures, including the Dermatology Life Quality Index (DLQI), indicates that patients with mild disease based on body surface area or Psoriasis Area and Severity Index (PASI) scores may still experience severe quality-of-life impairment (22, 23) . Lesion location, chronicity, coping mechanisms, and individual psychological resilience have been identified as key modifiers of quality of life outcomes. Sociodemographic and clinical factors associated with quality of life in psoriasis have been widely explored. Older age, female sex, longer disease duration, early age at onset, joint involvement, and specific clinical subtypes such as pustular or erythrodermic psoriasis have been associated with poorer quality-of-life scores in various settings, although findings are not always consistent across studies (24, 25).

The poor quality-of-life is also associated with lifestyle practices such as smoking and alcohol consumption, which may happen due to their impact on the severity of disease and mental health (26). Low- and middle-income countries have limited evidence but do indicate that, among patients with psoriasis, a disproportional burden of the quality of life is present. African and other resource stranded studies note that delayed diagnosis, inaccessibility to effective treatment, financial limitations and absence of psychosocial services contributes to the worsening of the disease related distress(27,28). In Ethiopia, there is limited literature on the quality of life and determinants of psoriasis as available literature has concentrated on clinical patterns. This highlights the necessity of more studies to deeply evaluate the quality of life effects of psoriasis so as to guide context specific management approaches that are patient focused.

Another cross-sectional study which has been done in dermatology clinic of ALERT center in Addis Although, there have been preceding researches done to determine the quality of life in the patients of psoriasis, the current study has brought out more updated and extended evidence by laying more focus on the psychosocial impact and other related factors affecting the quality of life. Unlike earlier work, this study explores a broader range of determinants, including lesion location, age at disease onset, social drug habits, family history, and clinical subtype, using patient-reported outcome measures. Furthermore, by reflecting current clinical practices and patient experiences, the findings offer contemporary and context specific insights that are essential for improving patient centered care. Ababa, Ethiopia 207 patients with psoriasis attending the clinic were included. Dermatology Life Quality Index (DLQI) was used to measure patients' QoL. Among 207 study participants, 122 (58.9%) were females. Majority of study participants, 145 (70.0%) had plaque psoriasis followed by sebo psoriasis, 24 (11.6%). The majority of plaque psoriasis (80%) cases were managed by topical corticosteroids with or without salicylic acid or coal tar and only 21 (14.5%) treated by methotrexate alone. The mean DLQI was 6.25 corresponding to a moderate effect. Symptoms and feelings were the most affected domains of QoL. Factors associated with poor QoL were female, low family income and primary education level. Being on systemic therapy was predictor of better QoL. Poor QoL was predominant in females, low income patients, and patients with primary education level (15, 29).

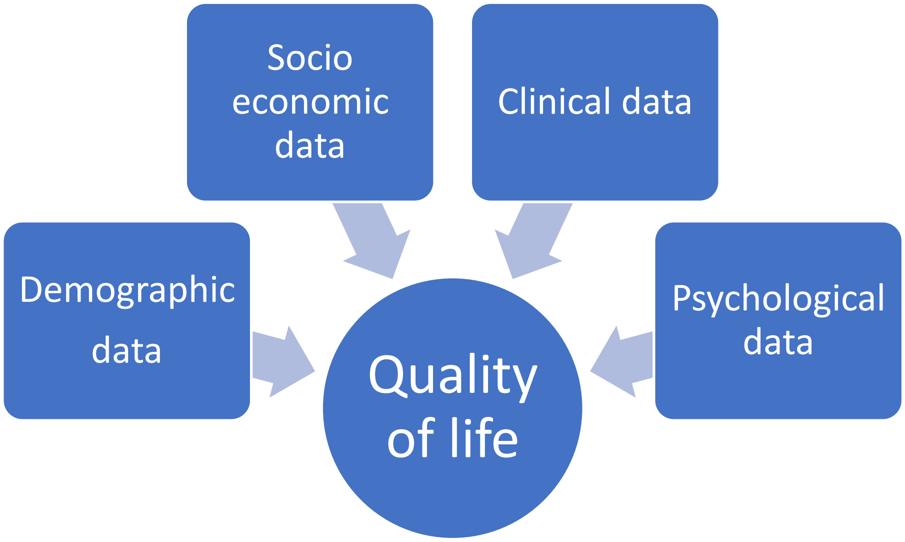

Fig 1 conceptual framework

3. Objective

3.1 General Objective

- To assess quality of life and its determinants among patients with psoriasis at ALERT hospital 2025, Addis Ababa Ethiopia.

3.2 Specific Objective

- To determine quality of life among patients with psoriasis at ALERT hospital 2025, Addis Ababa Ethiopia.

- To identify factors associated with quality of life among patients with psoriasis at ALERT comprehensive hospital 2025, Addis Ababa Ethiopia.

4. Method and Materials

4.1. Study area

The study was conducted in ALERT Hospital, officially known as the All Africa Leprosy, Tuberculosis and Rehabilitation Training Centre, which is located on the edge of Addis Ababa, Ethiopia. It was originally established to focus on Hansen's disease (leprosy), but its scope has since expanded to include comprehensive medical care, including dermatology, ophthalmology, surgery, and orthopedics. It was founded in 1922 by Dr. Thomas Lambie and was initially called the Princess Zenebe Work Hospital.

4.2 Study period

- The study was conducted from May 2025 to August 2025 G.C

4.2. Study design

- Hospital-based cross-sectional study was carried out.

4.3. Population

4.3.1. Source population

- All patients who have been diagnosed with psoriasis at ALERT comprehensive hospital dermatology units.

4.3.2. Study population.

- Patients who have been diagnosed with psoriasis at ALERT comprehensive hospital dermatology unit from May 2025 to Aug 2025 G.C.

4.4. Eligibility

4.4.1 Inclusion

- All patients Clinically diagnosed with psoriasis visiting dermatologic clinic during the study period, and with the age of 16 years and above that were on follow-up for 6 months and above and receiving treatment.

4.4.2 Exclusion criteria

- Patients with mental disorders that could interfere with the assessment of quality of life
- Patients who have other concomitant chronic skin diseases other than psoriasis

4.5. Sample size determination and sampling technique

4.5.1 Sample Size Calculation

The sample size was determined using a single population proportion formula

$$sample\ size(n) = \frac{z^2 \times p(1-p)}{d^2}$$

taking p value of 78.5% is taken from a previous study done at University of Gondar comprehensive specialized hospital to assess the QoL among patients with psoriasis.(20), 95% CI and 5% margin of error.

Where:

n = sample size,

Z = Z value at 95% confidence level (standard 1.96) and

d = tolerance of error 5% or (0.05).

Therefore, based on the formula, n = $(1.96)^2$*0.785*(1-0.785)/ (0.05)2= 259.

A situational analysis conducted at ALERT Hospital indicated that approximately 52 patients with psoriasis are seen per month. Accordingly, the estimated study population over the four-month study period was 209 patients. As this population size is less than 10,000, a finite population correction (reduction) formula was applied as follows:

Nf=n/(1+n/N)

Where.

n=required sample size (259 in this case)

N=the estimated population size (209 in this case)

Nf= the final sample size we used when the study population is less than 10000). So,

Nf=259/(1+259/209)

Nf=115.67

After adding a 10% allowance for non-response, the final calculated sample size was 127.2, which was approximately 128 participants.

4.5.2 Sampling Technique

A convenience, non-probability sampling technique was used to select patients for the assessment of quality of life among individuals diagnosed with psoriasis attending the Dermatology Department of ALERT Comprehensive Specialized Hospital. Data collection commenced on the first day of the study period, and all patients with a confirmed diagnosis of psoriasis who fulfilled the inclusion criteria were consecutively enrolled until the required sample size was achieved. Data were collected using a structured questionnaire.

4.6 Data Collection Tool and Procedures

Data was collected using a structured questionnaire administered through face-to-face interviews with patients diagnosed with Psoriasis. The questionnaire included sections on demographic characteristics such as age, sex, address, occupation, educational level, marital status, and religion. Socioeconomic information, including average monthly income, occupational functioning, leisure activities, and school-related activities, was also collected. Psychological aspects, such as feelings of embarrassment and depression, were assessed in accordance with the Dermatology Life Quality Index (DLQI) tool. In addition, clinical information including severity of symptoms, adherence to treatment, and commitment to follow-up was obtained.

4.7 Data Quality assurance

To ensure data quality, several measures were implemented. Data collectors received training on the data collection procedures and tools prior to the commencement of data collection. The questionnaire was pretested on 5% of the calculated sample size to identify and correct potential problems. Regular supervision and audits of the data collection process were conducted, and immediate feedback was provided to data collectors to ensure consistency and completeness of the data.

4.8. Variables

4.8.1 Dependent

- Quality of life of patients with Psoriasis

4.8.2. Independent

- Socio-demographic variables: Age, Sex, occupation, education, marital status and Monthly income.
- Site of Psoriatic lesions
- Type of therapy
- Modality of treatment
- Duration of the illness

4.10 Operational Definitions

- Psoriasis: is a chronic and recurrent skin eruption diagnosed by a dermatologist/ resident
- Unaffected quality of life: Patients with the dermatology life quality index score of 0-1.
- Mildly affected quality of life: Patients with the dermatology life quality index score of 2-5.
- Moderately affected quality of life: Patients with the dermatology life quality index score of 6-10.
- Severely affected quality of life: Patients with the dermatology life quality index score of 11-20.
- Extremely affected quality of life: Patients with the dermatology life quality index score of 21-30.
- Quality of life (QoL): The individuals' perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. In this study DLQI will be used to measure QoL.

  DLQI: Consists of 10 questions classified to subscales: symptoms and feelings (questions 1 and 2), daily activities (questions 3 and 4), leisure (questions 5 and 6), personal relationships (questions 8 and 9), work and school (question 7), and treatment (question 10). (30)

Each question has four possible responses: not at all,’’ a little,’’ ‘‘a lot,’’ or ‘‘very much,’’ with scores of 0, 1, 2, and 3, respectively. ‘‘Not relevant’ is also scored as 0. The DLQI score is calculated by summing the scores of the 10 questions. The maximum score is 30 and the minimum is 0. The DLQI score are interpreted as follows; DLQI scores of 0-1 mean no effect on the patient’s QOL, DLQI scores of 2–6 mean a small effect on patient’s QOL, DLQI scores 7–12, moderate effect on patient’s QOL; DLQI scores 13–18 very large effect on patient’s QOL; DLQI scores 19-30 extremely large effect on patient’s QOL.(31)

4.12. Data processing and Analysis

After data collection, the questionnaires were checked for completeness, coded, and entered into SPSS version 27 for analysis. Data cleaning was performed to identify and correct inconsistencies, missing values, and entry errors. Potential confounders were controlled through a combination of study design and statistical analysis. Relevant sociodemographic and clinical variables were identified a priori based on the literature and included in the analysis. Following bivariate analysis, variables with statistical and clinical relevance were entered into a multivariable regression model to adjust for confounding effects. This approach allowed identification of independent factors associated with quality of life among patients with psoriasis. Residual confounding due to unmeasured variables cannot be completely excluded.

Descriptive statistics were used to summarize the socio economic status, and psychological details characteristics of the study participants. Frequencies, percentages, means, and standard deviations were calculated as appropriate for categorical and continuous variables.

The Dermatology Life Quality Index (DLQI) scores were computed according to the standard scoring guidelines. DLQI total scores were summarized using means and categorized into severity levels to determine the extent of quality-of-life impairment among patients with Psoriasis.

Since QOL scores violated normality assumptions, non-parametric tests were applied. Mann–Whitney U tests were used for binary variables, Kruskal–Wallis H tests for variables with more than two groups, and Spearman correlations for continuous predictors. Statistical significance was declared at $p < 0.05$.

4.13. Ethical consideration

Ethical approval was obtained from the Addis Ababa University Institutional Review Board (IRB). Written informed consent was obtained from each participant prior to data collection. Participants were provided with adequate information regarding the purpose of the study, study procedures, potential risks and benefits, and their right to withdraw from the study at any time without any consequences. Confidentiality of participant information was strictly maintained throughout the study. All data were anonymized to protect participants' identities, and access to the data was restricted to authorized members of the research team only. All research activities were conducted in accordance with established ethical standards. Patients identified as having poor quality of life were managed according to routine clinical practice. When significant psychosocial distress was identified during interviews or clinical encounters, the information was communicated to the treating dermatologist, and appropriate counseling or referral to mental health services was recommended. The findings highlight the need for routine quality-of-life assessment and integrated psychosocial care in the management of psoriasis.

4.14. Dissemination and utilization of results

The findings of this study will be disseminated through a formal report submitted to Addis Ababa University, School of Medicine and Health Sciences, Department of Dermatology, as well as to ALERT Comprehensive Specialized Hospital. In addition, the results will be presented at national and international scientific conferences and submitted for publication in peer-reviewed medical journals.

5. Result

5.1 Demographic Characteristic of study population

A total of 128 patients were included in the study. Of these, 68 (53.1%) were male and 60 (46.9%) were female. The more than a quarter 37(28%) were in age group 40–49 years, followed by those aged 19–29 years (34, 26.6%). Regarding marital status, more than half 71 (55.5%) were married, 39 (30.5%) were single, 11 (8.6%) were divorced, and 7 (5.5%) were widowed. In terms of educational status, 51 patients (39.8%) had attained higher education (diploma and above), while 41 (32.0%) had completed secondary education. More than one third 46(36.7%) of the patents were Employees. With respect to monthly income, 47 (36.7%) had a monthly income greater than 10,000, whereas 34 (26.6%) reported having no regular income. The details of sociodemographic characteristics of study population is presented in table 1.

Table 1 Demographic characteristics patients attending at the ALERT, Hospital 2025GC

		Frequency	**Percent**
Sex	Male	68	53.1
	Female	60	46.9
	Total	128	100.0
Age	16-18 years	2	1.6
	19–29 years	34	26.6
	30–39 years	22	17.2
	40–49 years	37	28.9
	50–59 years	14	10.9
	≥ 60 years	19	14.8
	Total	128	100.0
Marital status	Single	39	30.5
	Married	71	55.5
	Divorced	11	8.6
	Widowed	7	5.5

	Total	128	100.0
Educational status	Unable to read and write	10	7.8
	Can read and write only	3	2.3
	Primary school (Grade 1–8)	23	18.0
	Secondary school (Grade 9–12)	41	32.0
	Higher education (Diploma and above)	51	39.8
	Total	128	100.0
Occupation of the patient	Farmer	21	16.4
	Merchant/self-employed	16	12.5
	Employee	46	35.9
	Unemployed	6	4.7
	Housewife	15	11.7
	Student	14	10.9
	Daily laborer	5	3.9
	Others	5	3.9
	Total	128	100.0
If Other	Retired	5	100
Monthly income	<1500	4	3.1
	1500–3000	1	0.8
	3001–5000	10	7.8
	5001–10000	32	25.0
	>10000	47	36.7
	None	34	26.6
	Total	128	100.0

5.2 Clinical characteristics

Among 128 patients with psoriasis, Early-onset psoriasis (<40 years) was observed in 85 patients (66.4%), while 43 patients (33.6%) had late-onset diseases. Most patients had a disease duration of less than five years, accounting for 86 (67.2%), whereas 42 (32.8%) had a duration of 5–10 years.

Regarding lifestyle factors, more than third 89 (69.5%) of patients reported no social drug habits. Cigarette smoking was reported by 20 (15.6%), regular alcohol consumption by 11 (8.6%), and other substance use by 8 (6.3%). The family history of psoriasis was uncommon, with 113 patients (88.3%) having no family history and 15 (11.7%) reporting a positive history.

In our finding, psoriasis most frequently affected the extremities, 91 (29.0%), followed by the trunk, 84 (26.8%), and the scalp, 61 (19.4%). Plaque psoriasis was the most prevalent clinical type, observed in 89 cases (44.5%), followed by scalp psoriasis, 63 (31.5%), and palmoplantar psoriasis, 24 (12.0%). Pustular, erythrodermic, and guttate psoriasis were rare.

In terms of disease severity, most patients had mild disease, with 94 (73.4%) having less than 10% body surface area involvement, while 31 (24.2%) had 10–30% involvement and only 3 (2.3%) had involvement greater than 30%.

Regarding treatment, topical therapy was the most used modality, administered to 85 patients (66.4%), whereas 9 (7.0%) received systemic therapy alone and 34 (26.6%) received both topical and systemic treatments.

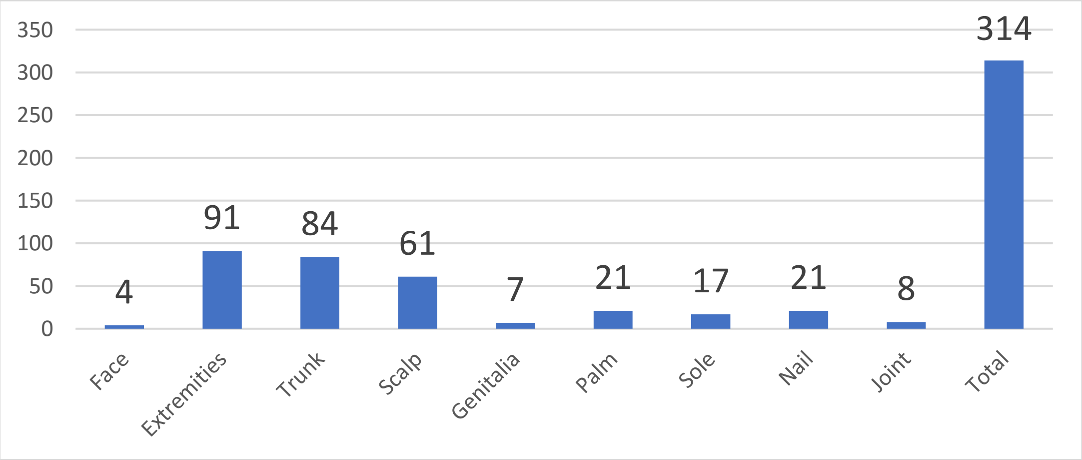

Fig 2 Site affected patients attending at the ALERT, Addis Ababa, Ethiopia, 2025GC

Table 2: Clinical Characteristics of patients with Psoriasis attending at the ALERT Hospital 2025GC

		Frequency	Percent
Age at initial diagnosis (in years)	Early onset (<40)	85	66.4
	Late-onset (>40)	43	33.6
	Total	128	100.0
Duration of the disease (in years)	<5	86	67.2
	5-10	42	32.8
	Total	128	100.0
Social drug habits	Cigarette smoker	20	15.6
	Regular alcohol user	11	8.6
	Other drug abuse	8	6.3
	None	89	69.5
	Total	128	100.0
if Other	None	4	100.0
Family history of psoriasis	No	113	88.3
	Yes	15	11.7
	Total	128	100.0
Site of Psoriasis	Face	4	1.3%
	Extremities	91	29.0%
	Trunk	84	26.8%
	Scalp	61	19.4%
	Genitalia	7	2.2%
	Palm	21	6.7%
	Sole	17	5.4%
	Nail	21	6.7%
	Joint	8	2.5%
	Total	314	100.0%
Type of Psoriasis	Plaque	89	44.5%
	scalp	63	31.5%
	Palmoplantar	24	12.0%
	Pustular	3	1.5%

	Inverse	2	1.0%
	Nail	17	8.5%
	Erythrodermic	1	0.5%
	Guttate	1	0.5%
	Total	200	100.0%
Comorbidity	DM	8	5.8%
	Hypertension	9	6.5%
	HIV AIDS	2	1.4%
	Cardiac diseases	3	2.2%
	None	114	82.6%
	Other	2	1.4%
	Total	138	100.0%
BSA involved	less than 10%	94	73.4
	10% to 30%	31	24.2
	More than 30%	3	2.3
	Total	128	100.0
Type of the treatment	Topical medication	85	66.4
	Systemic medication	9	7.0
	both	34	26.6
	Total	128	100.0

5.3 Quality of life of patients with Psoriasis

Quality of life of patients with Psoriasis was assessed using an 10-item questionnaire with a maximum score of 30 and minimum score 0, and overall Quality of life of patients were categorized The DLQI score are interpreted as follows; DLQI scores of 0-1 mean no effect on the patient’s QOL, DLQI scores of 2–6 mean a small effect on patient’s QOL, DLQI scores 7–12, moderate effect on patient’s QOL; DLQI scores 13–18 very large effect on patient’s QOL; DLQI scores 19-30 extremely large effect on patient’s. In this study, the median Quality of life score was median QoL score of 13 (IQR: 9–18).

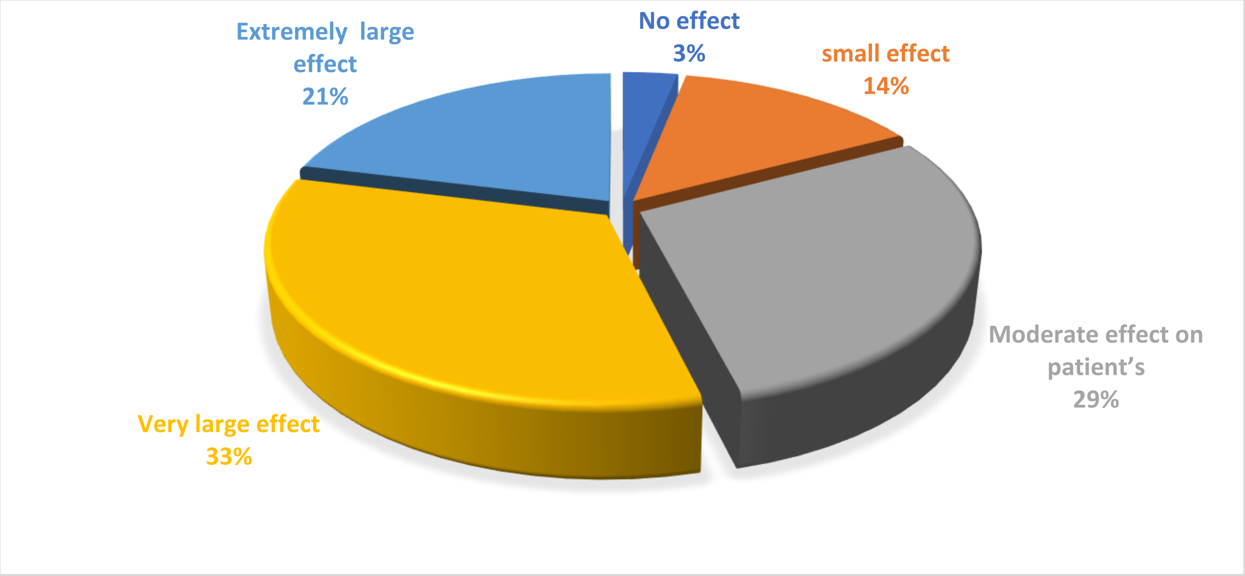

Fig 3 Psoriasis Impact on quality-of-life patients attending at the ALERT, Addis Ababa, Ethiopia, 2025GC

The effect of psoriasis on patients' quality of life varied considerably. A small number of patients, 4 (3.1%), reported no effect, while 18 (14.1%) experienced a small effect. About one-third, 37 (28.9%), reported a moderate effect, and the largest group, 42 (32.8%), had a very large effect. Additionally, 27 (21.1%) of patients experienced an extremely large effect.

Table 3: Quality of Life Impact patients attending at the ALERT, Addis Ababa, Ethiopia, 2025GC

		Not at all %	**A Little %**	**A lot %**	**Very much %**
QOL1	**How much symptoms like itching, pain, or discomfort bother you?**	5.5	33.6	27.3	33.6
QOL2	**How much embarrassed or self conscious have you been because of your skin ?_**	8.6	18.0	38.3	35.2
QOL3	**How much has your skin influenced the cloth you wear?**	18.8	24.2	21.9	35.2

QOL4	**How much has your skin affected any social and leisure activity?**	14.1	31.3	28.1	26.6
QOL5	**How much has your skin made it difficult to do any sport?**	48.4	24.2	11.7	15.6
QOL6	**Has your skin prevented you from working or studying?**	100			
QOL7	**If no , over the last week how much has your skin been a problem at work or studying**	46.1	39.1	14.8	
QOL8	**How much has your skin created problem with your partner or any of your close friends or relatives?**	17.2	35.9	23.4	23.4
QOL9	**How much has your skin caused any sexual difficulties?**	47.7	24.2	14.1	14.1
QOL10	**How much of a problem has the treatment for your skin been, for example by making your home messy or by taking up time?**	11.7	20.3	31.3	36.7

5.4 Factor affecting QOL

The association between sociodemographic and clinical factors and quality of life (QOL) among patients with psoriasis was examined using non-parametric tests due to non-normal distribution of QOL scores.

Quality of life showed a statistically significant negative correlation with age (Spearman's $\rho = -0.263$, $p = 0.003$), indicating poorer QOL among older patients. Significant associations were also observed with marital status ($H = 11.023$, $p = 0.012$), social drug habits ($H = 9.157$, $p = 0.027$), and family history of psoriasis ($U = 580.5$, $p = 0.048$).

Regarding disease-related characteristics, early age at initial diagnosis was significantly associated with lower QOL ($U = 1090.0$, $p < 0.001$). Patients with pustular psoriasis had significantly poorer QOL compared to those with other subtypes (U = 33.5, p = 0.015). Involvement of functionally or visibly important sites including extremities (U = 1291.5, p = 0.039), genitals (U = 177.0, p = 0.010), palms (U = 656.5, p = 0.003), soles (U = 466.0, p = 0.001), and nails (U = 772.5, p = 0.024) was significantly associated with lower QOL. Joint involvement showed a borderline association with QOL (U = 281.5, p = 0.050).

No statistically significant associations were found between QOL and sex, educational status, occupation, monthly income, face, trunk, or scalp involvement, other psoriasis subtypes, disease duration, or comorbidities including diabetes mellitus, hypertension, HIV/AIDS, and cardiac disease (Table 4).

Table 4. Factors associated with Quality of Life (QOL) score among patients (n = 128) attending at the ALERT, Addis Ababa, Ethiopia, 2025GC

Variable	**Statistical test**	**Test statistic**	**p-value**	**Association with QOL**
Age (years)	Spearman	ρ = −0.263	**0.003**	Significant
Sex	Mann–Whitney U	U = 2006.0	0.871	Not significant
Educational status	Kruskal–Wallis	H = 7.138	0.129	Not significant
Marital status	Kruskal–Wallis	H = 11.023	**0.012**	Significant
Occupation	Kruskal–Wallis	—	>0.05	Not significant
Monthly income	Kruskal–Wallis	H = 9.255	0.099	Not significant
Social drug habits	Kruskal–Wallis	H = 9.157	**0.027**	Significant
Family history of psoriasis	Mann–Whitney U	U = 580.5	**0.048**	Significant
Face involvement	Mann–Whitney U	U = 124.0	0.089	Not significant
Extremities involvement	Mann–Whitney U	U = 1291.5	**0.039**	Significant
Trunk involvement	Mann–Whitney U	U = 1464.5	0.054	Not significant
Scalp involvement	Mann–Whitney U	U = 1756.5	0.170	Not significant

Genital involvement	Mann–Whitney U	U = 177.0	**0.010**	Significant
Palm involvement	Mann–Whitney U	U = 656.5	**0.003**	Significant
Sole involvement	Mann–Whitney U	U = 466.0	**0.001**	Significant
Nail involvement	Mann–Whitney U	U = 772.5	**0.024**	Significant
Joint involvement	Mann–Whitney U	U = 281.5	**0.050**	Borderline
Age at initial diagnosis	Mann–Whitney U	U = 1090.0	**<0.001**	Significant
Duration of disease	Mann–Whitney U	U = 1572.5	0.235	Not significant
Pustular psoriasis	Mann–Whitney U	U = 33.5	**0.015**	Significant
Other psoriasis subtypes	Mann–Whitney U	—	>0.05	Not significant
Diabetes mellitus	Mann–Whitney U	U = 473.5	0.949	Not significant
Hypertension	Mann–Whitney U	U = 511.0	0.819	Not significant
HIV/AIDS	Mann–Whitney U	U = 57.0	0.184	Not significant
Cardiac disease	Mann–Whitney U	U = 117.0	0.266	Not significant

Note: Statistical significance set at $p < 0.05$. Non-parametric tests were used due to non-normal distribution of QOL scores

6. Discussion

This study is a hospital based cross sectional prospective study on the quality of life and it's determinants among patients with Psoriasis was conducted at ALERT Hospital, Addis Ababa, Ethiopia. A total of 128 patients were enrolled from May 2025 to August 2025 This hospital-based cross-sectional study assessed the quality of life and its determinants among patients with psoriasis attending ALERT Comprehensive Specialized Hospital, Addis Ababa. The findings revealed that psoriasis exerts a substantial negative impact on patients' quality of life, even among individuals with relatively limited body surface area involvement. The majority of participants experienced moderate to extremely large impairment in quality of life, highlighting the multidimensional burden of the disease. The present study assessed the impact of psoriasis on quality of life (QoL) and identified factors associated with poor QoL among patients attending ALERT Comprehensive Specialized Hospital. The findings demonstrate that psoriasis has a very large negative impact on patients' quality of life, highlighting the substantial psychosocial and functional burden imposed by the disease.

The warring score of 13 in the current study represents a huge impact of psoriasis on the quality of life. This observation can be compared to the findings of the researches that have been done in Iran, India, and other low- and middle-income nations, as median DLQI scores of between 11 and 15 were reported, indicating the high level of QoL impairment of patients with psoriasis. African environments have also shown the same amount of similarities thereby indicating that the cost of psoriasis is always very high in terms of quality of life in different populations. Nevertheless, the observed DLQI score is greater than the one reported in a number of European research where lower median scores have been explained by the previous diagnosis, greater access to advanced treatments and the interconnected psychosocial support services. The increased load witnessed in the present study could thus be attributed to lack of access to special treatment, late presentation and lack of psychosocial needs in the local environment.

Over fifty percent of the respondents in this paper reported very large to extremely large deterioration in quality of life. This percentage is regarded as the same in the studies carried out in Asia and Middle East but higher than the ones reported in certain high-income countries. It can be associated with the difference in terms of the healthcare infrastructure, availability of treatments, and cultural beliefs about skin disease, which can impact the stigma and wealth-handling responses.

Aging was found to be a serious factor that affected the quality of life in the current study. This observation is congruent with the ones in China and Turkey, where the researchers reported more QoL loss in older patients, which might be attributed to the accumulating disease burden, weakening physical resilience, and co-morbid disability. On the contrary, other studies have indicated the impairment of patients in the Western world to be higher in patients who are younger, with this being attributed to increased anxieties surrounding body image, social relations, and job. The difference could be a manifestation of a variability in sociocultural expectations, coping and social role in both the elderly and the young generation.

There was also an association between poor quality of life and early age of onset of disease which was in agreement with other international studies. Psoriasis commencing at an early age puts people at risk of long-term psychosocial stress, stigma, and disease-related restrictions at the most crucial period of their lives in education, career, and socialisation, which may be the reason why there is an overall higher long-term effects on quality of life in this group.

In this study, quality-of-life impairment was strongly dependent on the location of lesions. Participation of functionally and socially sensitive locations such as the extremities, palms, soles, genitals and nails were closely linked with low QoL. This result is in line with several studies, which have also found that lesions to visible or functional regions disproportionately disrupt everyday activities, social interaction, and emotional wellbeing, despite the general severity of the disease being mild.

Pustular psoriasis was also related to considerably worse quality of life when compared to other clinical subtypes. This conforms to past researches that have defined pustular psoriasis as the suffering and serious form of the illness, and involves painful sores, regular flare-ups and high treatment map. The association points out the significance of taking into account clinical subtype in measuring patient-reported outcomes.

Poor quality of life was highly linked to social drug habits. Other researchers have reported similar associations in which substance use was associated with poorer psychological outcomes and low treatment adherence. Substance use can be one of the maladaptive coping strategies to chronic stress and the stigma of living with psoriasis, which again contributes to the deterioration of quality of life.

The present study has identified that poor quality of life is connected with family history of psoriasis. The literature has had inconsistent findings on this. Some of the studies also indicate that an experience of coping with the disease can be facilitated by familiarity, but others, as it is the case in the current study, suggest that the awareness of chronicity of the disease and fear of long term complications can adversely affect the psychological well-being.

There was no notable correlation between the quality of life and sex, education level, income, and period of disease. The same result has been achieved in a number of studies, which may indicate that clinical features and psychosocial variables might have a stronger influence on the quality of life, rather than sociodemographic ones. The differences between studies however point to the effects of the context and cultural factors.

In general, the results of the given research are mostly in line with the current literature but also indicate context-related variations. The identified differences provide further evidence of the significance of localized evidence in order to build patient-centered management plans and clarify the necessity of periodic quality-of-life evaluation and combined psychosocial care during psoriasis treatment.

In the current research, the margin of male dominance was low; males represented 53.1 percent of the respondents. This observation can be compared to the studies previously done at ALERT Hospital as well as other dermatology centers in Ethiopia where there was a little more representation of males. Nevertheless, worldwide studies indicate that there is no significant difference between males and females in psoriasis cases, and the difference could be explained by the disparities in healthcare-seeking behavior and not by the prevalence of the disease.

The average age of the participants was 41.32 +- 14.9 years with the highest percentage of the sample being in the age bracket of 40-49 years. This observation is in line with the psoriasis prevalence observed in Ethiopia, Iran, and other developing nations, where psoriasis is mostly common in people who are in the economically productive age bracket. The implications of this are significant, since quality of life deficits in this stage can have a great impact on productivity, family roles and social roles. Psoriasis was noted to have been present at a very early age of 66.4 percent of the study population, which is consistent with the traditionally proposed to be the bimodal distribution of psoriasis onset that was observed in the literature. The majority of patients had a disease duration of less than five years, implying that they presented to healthcare facilities either relatively late or had more access to dermatologic services at ALERT Hospital.

The most common subtype was the plaque psoriasis, with scapegoat and palmoplantar psoriasis coming next. This trend is in line with the other Ethiopian researches and the world literature.

Most of the patients were mildly diseased depending on the body surface area affected. Nonetheless, a good percentage of them reported that their quality of life was highly impaired, which suggests that the impact of the disease, on its own, is not solely reflected by its severity. The location of lesion, symptoms, and the psychosocial impact are very important in defining the well-being of the patients.

The most prevalent type of treatment modality was topical therapy, which is aligned with the common clinical practice in resource-limited areas, and the prevalence of the mild disease. Nevertheless, the fact that there is a significant quality of life impairment even with treatment highlights the necessity of integrated management solutions.

In this study, the median score of Dermatology Life Quality Index was 13 with the interquartile range of 9-18, which means that the effects of psoriasis on the quality of life of patients is very large. This is a greater finding than Ethiopian and European studies although it is similar to those carried out in Iran and other low- and middle-income nations.

Over 50 percent of the respondents had very large to extremely large quality of life impairment. Itching and pain, embarrassment, limitations in clothing choices, interference with social activities, and burden of treatment were some of the key contributors to low quality of life. These results prove that psoriasis does not influence physical health only, but also emotional, social, and functional spheres.

The high scores of the DLQI could be described by social stigma of visible skin diseases, the lack of access to modern treating methods, the course of the chronic disease, and insufficient psychosocial support services.

Poor quality of life was also significantly related to increasing age, and it could be concluded that the older the patients, the more impaired they were. This could be attributed to the cumulative disease burden, diminished coping abilities as well as co-existence of age related functional impairments.

There was significant correlation between marital status and quality of life. Social support, emotional relationships, and family responsibilities differences could be one of the explanations of why perceived disease burden could be different in various marital groups.

Poor quality of life was also largely linked to social drug habits. Drugs and alcohol use can intensify the severity of the disease, affect adherence to treatment and reflective maladaptive coping mechanisms related to psychological distress related to chronic illness.

Poor quality of life was linked with family history of psoriasis. This could be associated with an increased awareness about the diseases, fear of chronicity or common psychosocial stressors in the affected families.

Engagement of functionally and socially delicate body parts such as the extremity, the genitals, the palm, soles and nails had a strong relation with poor quality of life. Damages to these regions disrupt mobility, manipulations, sexuality, and socialization, which disproportionately impact the everyday functioning and emotional well-being. The results are in agreement with other international researches.

At an early age of diagnosis, there was a significant decrease in the quality of life, which could have been related to the duration of the disease and the accrual of psychosocial effects on education, career growth, and social interactions. Also Pustular psoriasis was also shown to have a very low quality of life and this was related to its acute symptoms and challenging course of the disease. The joint involvement was borderline related, and indicated that there was a supplementary adverse impact on physical functioning.

Sex, education level, income, length of disease, and comorbidities did not significantly relate with it, meaning that psychosocial and clinical aspects might be a more important determinant of quality of life than sociodemographic factors.

7. STRENGTHS AND LIMITATIONS OF THE STUDY

7.1 Strengths of the Study

There are a number of strengths regarding this study. It also deals with a relevant but understudied area of psoriasis management in Ethiopia because it does not only investigate the quality of life of patients but also clinical severity. The reliability and comparability of findings with national and international studies is improved by the application of the validated and the widely accepted instrument, the Dermatology Life Quality Index. Primary data were gathered face-to-face, via interviews with patients, thus the data were minimized and the completeness of responses increased. Also, the analysis of various sociodemographic and clinical factors were measured, which made it possible to evaluate many factors linked with the quality of life in psoriasis patients at a tertiary care facility.

7.2 Limitations of the Study

Although these are the strength of the study, the study has some limitations. The cross-sectional design of the study, which is a hospital based design, restricts the ability to make a causal inference and fails to capture the changes in the quality of life with time or with treatment. The study could have been conducted in one tertiary referral hospital which could restrict the extent to which the results can be applied in other health care systems especially in primary and rural hospitals. Convenience sampling can also have presented selection bias since the patients who attended follow-up in the study period might not be the same with those who did not attend follow-up.

Self-reported instrument was used to measure quality of life and this could be affected by recall and social desirability bias. The evaluation of the severity of disease was also mainly made depending on the involvement of body surface area and the more detailed measures of the severity like the Psoriasis Area and Severity Index were not involved. Moreover, the aspects of depression, anxiety, coping strategies and social support were not assessed through the use of standardized instruments, which could have restricted the psychosocial analysis.

8. Conclusion

Psoriasis significantly affects the quality of lives of the patients who attend ALERT Comprehensive Specialized Hospital negatively. Most of the patients had moderate to very large impairment in quality of life, as well as those with mild clinical severity as indicated by body surveillance area involvement.

The determinants of quality of life were highly linked with age, marital status, social drug use, family history of psoriasis, age of diagnosis, subtype of psoriasis as a functional and social sensitive site. These results prove that psoriasis is a chronic and multidimensional disease, which goes beyond the physical symptoms and has a substantial psychological and social impact on life.

Intensive, patient focused management strategies that encompass clinical and psychosocial issues in psoriasis have to be applied to enhance the quality of life in patients.

9. Recommendations

Based on the findings of this study, the following recommendations are proposed.

9.1 Recommendations to Policymakers

Regular quality of life measurement instruments, including the Dermatology Life Quality Index, should become the part of a regular psoriasis care provided by the Ministry of Health. The national treatment guidelines must focus on holistic treatment of the disease taking both the psychosocial and physical factors in consideration. They should work towards enhancing the accessibility of high treatment options among patients with high quality of life impairment. The campaigns about psoriasis should be enhanced to eliminate the stigma and confusion.

9.2 Recommendations to Health Institutions and Clinicians

Quality of life among patients with psoriasis should be regularly evaluated by healthcare providers and used to make a personalized choice of treatment. Patients with early-onset disease, postural psoriasis and sensitive body sites should be given special attention. Dermatology services should be incorporated with psychological counseling and patient education. There should be multidisciplinary collaboration especially in patients who have joint involvement.

9.3 Recommendations for Future Research

Longitudinal designs should be used in future research to determine how the quality of life varies according to time and treatment. More studies are required to determine the efficacy of psychosocial intervention and integrated care models in enhancing the quality of life in Ethiopian psoriasis patients.

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Annex 1 Questionnaire

Addis Ababa University School of medicine Subject information written consent form

Hi, my name is --------------------------------, I am here on behalf of Dr. Samrawit Admassu., a student in Addis Ababa University School of medicine, department of Dermatology. She is conducting a research thesis on “Assessment of the quality of life among patients with psoriasis at ALERT comprehensive hospital 2025,Addis Ababa Ethiopia”. She has got formal permission from Addis Ababa University School of medicine and ALERT comprehensive hospital officials to conduct the study. You are selected to participate in this study. There will be no direct benefit by participating in this study, but in the future information gathered by this study will helps policy makers, programmers and researchers to give appropriate attention on issues of interest and design specific treatment options.

The information will be kept confidential by using only code numbers and locking the data. Only the members of the study team will have the access to the non-coded data and the data will not be used for purposes other than the study. Your willingness and active participation are very important for the success of this study.

If you need any further information or explanation regarding to the study, you can have this address to contact.

Name: Dr. . Samrawit Admassu Tel- +251-912249021 Email-

Would you be willing to participate.[put “x’’ mark]?

Yes…………………

No………………

MRN ....

Questionnaire

Part 1 Socio-demographic data

1. Sex
    a. Male
    b. Female
2. Age in years …………….

3. Marital status
    a. Single
    b. Married
    c. Divorced
    d. Widowed
4. Occupation of the patient
    a. Farmer
    b. Merchant/self-employed
    c. Employee
    d. Unemployed
    e. Housewife
    f. Student
    g. Daily laborer
    h. Others*
5. Monthly income
    a. <1500
    b. 1500–3000
    c. 3001–5000

    d. 5001–10000
    e. >10000
    f. Non
6. Social drug habits
    a. cigarette smoker
    b. Regular alcohol user
    c. Regular chat chewer
    d. Other drug abuse……………………….
7. Family history of psoriasis
    a. Yes their is family history
    b. No their is not
8. Educational status
    a. Unable to read and write
    b. Can read and write only
    c. Primary school (Grade 1–8)
    d. Secondary school (Grade 9–12)
    e. Higher education (Diploma and above)

Part 2 clinical characteristics of psoriasis

1. Site of psoriasis
    a. Face
    b. Extremities
    c. Trunk

    d. Scalp

    e. Genitalia

   - f. Palm

   - g. Sole

   - h. Nail

   - i. Joint

2. Age at initial diagnosis (in years)-
   - a. Early onset (<40)
   - b. Late-onset (>40)
3. -Duration of the disease (in years)-
   - a. <5
   - b. 5-10
4. Types of psoriasis-
   - a. Plaque psoriasis
   - b. Scalp psoriasis
   - c. Palmoplantar psoriasis
   - d. Pustular psoriasis
   - e. Inverse
   - f. nail psoriasis
   - g. Erythrodermic
   - h. Guttate
5. Comorbid diseases
   - a. DM
   - b. HTN
   - c. HIV/AIDS
   - d. Cardiac diseases

    e. None
    f. Other

6. BSA involved
    a .less than 10%
    b . 10% to 30%
    c. more than 30%
7. Type of the treatment patient is on ………………
    a . topical medication
    b. systemic medication
    c. both

Part 3 Quality of life

All questions are asked about symptoms which occurred over the last week

1. How much symptoms like itching, pain, or discomfort bother you?
    a. Very much
    b. A lot
    c. A Little
    d. Not at all
2. How much embarrassed or self councious have you been because of your skin ?
    a. Very much
    b. A lot
    c. A Little
    d. Not at all
3. How much has your skin interfered with you going shopping or looking after your home or garden?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant

4. How much has your skin influenced the cloth you wear?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
5. How much has your skin affected any social and leisure activity?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
6. How much has your skin made it difficult to do any sport?

    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
7. Has your skin prevented you from working or studying?
    a. Yes
    b. No

If no , over the last week how much has your skin been a problem at work or studing ?

a . A lot

b .A little c .Not at all

8. How much has your skin created problem with your partner or any of your close friends or relatives?
    a. Very much
    b. A lot
    c. A little

d. Not at all
e. Not relevant

9. How much has your skin caused any sexual difficulties?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
10. How much of a problem has the treatment for your skin been , for example by making your home messy or by taking up time ?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant

የመጠይቁ የአማርኛ ቅጅ

በአዲስ አበባ ዩኒቨርሲቲ የሕክምና ትምህርት ቤት የስምምነት ቅጽ

ሰላም ______________እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ የሕክምና ትምህርት ቤት የቆዳ ህክምና ትምህርት ክፍል ተማሪ በሆነችው ዶ/ር ሳምራዊት አድማሱን በመወከል ነው እዚህ ያለሁት። በ2025 በ ALERT ሆስፒታል አዲስ አበባ ኢትዮጵያ የ psoriasis ታማሚዎችን የህይወት ጥራት ግምገማ ላይ ጥናትና ምርምር ትሰራለች። ጥናቱን ለማካሄድ ከአዲስ አበባ ዩኒቨርሲቲ የህክምና ትምህርት ቤት እና ከ ALERT አጠቃላይ ሆስፒታል ኃላፊዎች መደበኛ ፈቃድ አግኝታለች። በዚህ ጥናት ላይ ለመሳተፍ ተመርጠዋል። በዚህ ጥናት ውስጥ በመሳተፍ ምንም አይነት ቀጥተኛ ጥቅም አይኖርም, ነገር ግን ወደፊት በዚህ ጥናት የሚሰበሰቡ መረጃዎች ፖሊሲ አውጪዎች, ፕሮግራመሮች እና ተመራማሪዎች በፍላጎት ጉዳዮች ላይ ተገቢውን ትኩረት እንዲሰጡ እና ልዩ የሕክምና አማራጮችን እንዲነድፉ ይረዳል።

የኮድ ቁጥሮችን ብቻ በመጠቀም እና ውሂቡን በመቆለፍ መረጃው በሚስጥር ይጠበቃል። በኮድ ያልተደገፈ መረጃን ማግኘት የሚችሉት የጥናት ቡድኑ አባላት ብቻ ሲሆኑ ውሂቡ ከጥናቱ ውጪ ለሌላ አገልግሎት አይውልም። ለዚህ ጥናት ስኬት የእርስዎ ፍላጎት እና ንቁ ተሳትፎ በጣም አስፈላጊ ናቸው።

ስለ ጥናቱ ተጨማሪ መረጃ ወይም ማብራሪያ ከፈለጉ፣ በዚህ አድራሻ ማግኘት ይችላሉ።

ስም፡ ዶ/ር ሳምራዊት አድማሱን Tel- +251-912249021 ኢሜል-

ለመሳተፍ ፈቃደኛ ትሆናለህ።["x" ምልክት አድርግ]?

አዎ…………………

አይ………………

ክፍል 1 የማህበራዊ እና ግላዊ መረጃዎች

1. ጾታ
   - I. ውንድ
   - II. ሴት
2. እድሜ በአመት
   - i. 16–35
   - ii. 36–60
   - iii. >60

3 የጋብቻ ሁኔታ

- i. ያላገባ/ች
- ii. ያገባ/ች
- iii. የተፋታ/ች
- iv. የተፋታ/ች

4 የስራ ሁኔታ

- I. ገበሬ
- II. ነጋዴ
- III. ተቀጣሪ
- IV. ስራ የሌለው
- V. የቤት እመቤት
- VI. ተማሪ
- VII. ቀን ሰራተኛ
- VIII. ሌላ

5 ወርሃዊ ገቢ

- i. <1500
- ii. 1500–3000
- iii. 3001–5000

    iv. 5001–10000
    v. >10000

9. የ ሱስ ሁኔታ
    i. ሲጋራ የሚያጨስ
    ii. በአቅራቢያው ሲጋራ የሚያጨስ ሰው ያለው
    iii. ሲጋራ የሚያጨስ የነበረ አሁን ያቆመ
    iv. አልኮል
    v. ጫት
    vi. ሌሎች

10. የትምህርት ሁኔታ
    a. ማንበብ እና መጻፍ የማይችል
    b. ማንበብ እና መጻፍ የሚችል
    c. ከ 1–8 የተማረ
    d. ከ9–12 የተማረ
    e. ኮሌጅ እና ከዚያ በላይ

ክፍል 2 የጤና ሁኔታዎች

8. በ ህመሙ የተጠቃው ክፍል
    a. ፊት
    b. እጅ እና እግር
    c. ወገብ
    d. የመራቢያ አካላት አካባቢ
    e. ጭንቅላት
    f. መገጥጠሚያ
    g. ጥፍር

9. ቢኤማይ (BMI) (Kg/m^2)

    a. 18.5
    b. 18.5–24.9
    c. 25.0–29.9
    d. >30

10. በሽታው ሲታወቅ የታካሚው እድሜ-
    a. <40
    b. >40
11. -ታካሚው ከበሽታው ጋር የቆየባቸቸው አመታት
    a. <5
    b. 5-10
12. የበሽታው አይነት (Types of psoriasis)-
    a. Plaque psoriasis
    b. Scalp psoriasis
    c. Palmoplantar psoriasis
    d. Pustular psoriasis
    e. -Inverse and nail psoriasis
    f. Erythrodermic? Guttate
13. ተጓዳኝ ህመሞች
    a. ስኳር
    b. የደም ግፊት
    c. ኤድስ
    d. የልብ ህመም
    e. ሌሎች
    f. የለም
14. ታካሚው እያገኘ ያለው ህክምና
15. PASI score

ክፍል 3 የህይወት ጥራት

11. ማሳከክ እና ህመሙ ምን ያክል ያስቸግርሃል/ሻል?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
12. በሽታው (psoriasis) ምን ያክል የ እለት እንቅስቃሴህን ይጎዳል?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
13. በሽታው (psoriasis) ምን ያክል የ መዝናኛ እንቅስቃሴህ ላይ ጫና ይፈጥራል?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
14. በሽታው (psoriasis) ምን ያክል ስራህ እና ትምህርትህ ላይ ጫና ይፈጥራል?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
15. በሽታው (psoriasis) ምን ያክል ግላዊ ግንኙነቶችህ ላይ ጫና ይፈጥራል?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
16. ህክምናው ምን ያክል ጫና ፈጥሮብሃል ?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ
    c. በከፍተኛ ሁኔታ
17. በሽታው (psoriasis) ምን ያክል ትሸማቀቃለህ?
    a. በዝቅተኛ ሁኔታ
    b. በመካከለኛ ሁኔታ

c. በከፍተኛ ሁኔታ

18. በሽታው (psoriasis) ምን ያክል የልብስ ምርጫህ ላይ ጫና ይፈጥራል?

a. በዝቅተኛ ሁኔታ

b. በመካከለኛ ሁኔታ

c. በከፍተኛ ሁኔታ

19. በሽታው (psoriasis) ምን ያክል ማህበራዊ እንቅስቃሴህ ላይ ጫና ይፈጥራል?

a. በዝቅተኛ ሁኔታ

b. በመካከለኛ ሁኔታ

c. በከፍተኛ ሁኔታ

20. በበሽታው (psoriasis) ምክንያት ምን ያክል እንቅስቃሴህን ትገድባለህ?

a. በዝቅተኛ ሁኔታ

b. በመካከለኛ ሁኔታ

c. በከፍተኛ ሁኔታ

Annex III: Declaration form

This is to certify that the thesis is prepared by **Dr. Samrawit Admassu, Quality of life and its Determinant among psoriasis patient at ALERT hospital, Addis Ababa Ethiopia**. submitted in partial fulfillment of the requirements of speciality comply with the regulations of the university and meets the accepted standards with respect to originality and quality. This thesis has not been presented for a degree in any other university, and all sources of materials used for the thesis have been duly acknowledged.

ASSURANCE OF PRINCIPAL INVESTIGATORS

I, the undersigned, declare that this postgraduate degree thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used for the thesis have been duly acknowledged.

1.Name of the student: ______________________________Signature_________ Date. _______

APPROVAL OF THE ADVISORS

This thesis has been submitted with my approval as university advisor.

APPROVAL OF ADVISOR

Name of the first advisor: ___________________________Signature _____ Date. ____________

Name of the second advisor: __________________________Signature _____ Date. ____________

APPROVAL OF EXAMINER

Name: ____________________________

Signature __________________ Date. _____________________