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COMPARATIVE ASSESSMENT OF DERMATOLOGY-RELATED QUALITY OF LIFE, DEPRESSION, AND ANXIETY IN PATIENTS WITH PSORIASIS, VITILIGO, MELASMA, AND LICHEN PLANUS: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Psoriasis, vitiligo, melasma, and lichen planus can impair quality of life and psychological well-being, although their comparative burden remains insufficiently characterized. The objective is to compare dermatology-related quality of life, depressive symptoms, and anxiety across four dermatological conditions and explore associated factors.

Materials and Methods: This comparative cross-sectional study included 240 adult patients, with 60 patients in each diagnostic group. Dermatology-related quality of life, depressive symptoms, and anxiety were assessed using the Dermatology Life Quality Index (DLQI), Patient Health Questionnaire-9 (PHQ-9), and Generalized Anxiety Disorder-7 (GAD-7), respectively. Between-group comparisons and multivariable linear regression analyses were performed.

Results: Mean DLQI scores were 15.4 ± 4.1 for psoriasis, 12.1 ± 4.4 for vitiligo, 12.7 ± 3.9 for melasma, and 13.1 ± 4.0 for lichen planus ($p < 0.001$). Overall, 178 patients (74.2%) had DLQI scores ≥11, 128 (53.3%) had PHQ-9 scores ≥10, and 81 (33.8%) had GAD-7 scores ≥10. Compared with melasma, psoriasis was associated with higher adjusted DLQI scores (β = 2.70; 95% confidence interval, 1.26–4.15). Greater perceived lesion visibility was also associated with poorer quality of life (β = 0.49; p = 0.002).

Conclusion: The present study identified substantial dermatology-related quality-of-life impairment across all four conditions, with the greatest mean burden among patients with psoriasis. The proportions of patients meeting screening thresholds for depressive and anxiety symptoms varied by diagnosis, while greater perceived lesion visibility was associated with poorer quality of life. These findings underscore the value of incorporating patient-reported outcomes and psychological screening into dermatological assessment.

Keywords: Psoriasis; Vitiligo; Melasma; Lichen Planus; Dermatology Life Quality Index; Depression; Anxiety; Psychological Burden.

INTRODUCTION

Chronic dermatological disorders represent a substantial global health burden, affecting not only physical health but also psychological well-being, social relationships, and overall quality of life. Due to the visible nature of skin diseases, recurring or persistent clinical course, and related symptoms, the emotional distress, social stigmatization, decreased self-esteem, and activity restrictions may play a role in the lives of people with skin diseases.[1-3] As most dermatological assessments focus on clinical presentation and disease severity, patient-reported outcomes are now acknowledged as key factors in the

overall assessment of disease.[4] Dermatology Life Quality Index (DLQI) is a widely validated instrument which shows the impact of dermatological conditions on many aspects such as symptoms, daily function, interpersonal relationships and emotional well-being.[1,2]

Psoriasis is a chronic, immune-mediated inflammatory disease with well-defined erythematous plaques, scaling and variable pruritus. In addition to the skin changes, psoriasis has been shown to cause significant psychological stress, social dysfunction and diminished health-related quality of life.[5,6] The highly unpredictable course of the disease, the recurring exacerbation, and the fact that the lesions are visible can have a negative impact on occupational performance, interpersonal relationships, and emotional issues. Previous comparative studies have shown that psoriasis patients suffer significant impairment regarding quality of life, suggesting the need to include psychosocial evaluation in the dermatological practice.[3,4]

Vitiligo is an acquired depigmenting disorder in which functional melanocytes are lost, either progressively or intermittently, to cause well-defined depigmented macules and patches. The disease can be asymptomatic, but its cosmetically and psychosocial impact can be dramatic if lesions affect exposed areas of the body, including face, hands and neck.[7-10] Patients with vitiligo can feel embarrassed, socially rejected, lack confidence and be psychologically distressed. Ezzedine et al. performed a systematic review of the literature which revealed that there were significant psychosocial impacts of vitiligo such as depression, anxiety, stigmatisation and problems with social functioning; it was suggested that there could be a gap between the severity of the disease and the patients' perceived burden.[5]

Melasma is a frequent, acquired hyperpigmentation disorder in which irregular brown to grayish macules and patches occur, usually in sun-exposed areas of the face. While it typically does not cause physical distress, it can have a negative impact on emotional health, self-esteem, and social functioning because it can be persistent and often recurring.[11-13] Considering the facial distribution of melasma and the challenges that may be faced with achieving sustained therapeutic improvement, the psychological burden of melasma may be particularly relevant. Balkrishnan et al. showed that disease-specific QOL assessment is important in women with melasma and emotional well-being, recreation, and social functioning are important domains which are affected.[6]

Lichen planus is a chronic inflammatory condition of the mucocutaneous system, which can affect the skin, oral and genital mucous membranes, nails and scalp. While the lesions of cutaneous lichen planus are usually characterized by polygonal papules and plaques that are violaceous in color and pruritic, the mucosal disease can produce further morbidity and functional impairment.[14] Itching, relapses, hyperpigmentation and involvement of sensitive areas can lead to significant loss of quality of life. Previous studies have shown that lichen planus patients have clinically relevant quality of life impairment and depressive symptoms, attesting an often under recognized psychological disease burden.[7] Comparative studies between lichen planus pigmentosus, vitiligo and melasma have also emphasized the role of pigmentary changes and psychosocial impact of the disease.[8,15]

Although there are distinct differences in the underlying pathophysiology and the clinical manifestations of psoriasis, vitiligo, melasma and lichen planus, they can all negatively impact on psychological well-being and dermatology-specific quality of life. But their psychosocial impact may differ depending on the degree of inflammatory activity, severity of symptoms, visibility of lesions, length of disease, and personal perception of disfigurement.[16-18] Previous studies have often examined these disorders separately, or compared only particular diagnostic sets, and there is a lack of a standardised set of comparative assessments across all four disorders. Additionally, the association between lesion visibility as perceived by the patient, depressive symptoms, anxiety and dermatology-related quality of life should be explored further.[19]

The present study compared dermatology-related quality of life, depressive symptoms, and anxiety symptoms among patients with psoriasis, vitiligo, melasma, and lichen planus using standardized assessment instruments. It also examined associations of demographic and disease-related characteristics, particularly disease duration and patient-perceived lesion visibility, with quality-of-life impairment. The findings may inform a more comprehensive assessment of the psychosocial burden of chronic dermatological conditions in routine practice.

MATERIALS AND METHODS

This single-center comparative cross-sectional study assessed dermatology-related quality of life, depressive symptoms, and anxiety among 240 adults attending a dermatology outpatient clinic. The sample comprised four mutually exclusive diagnostic groups: psoriasis, vitiligo, melasma, and cutaneous lichen planus, with 60 patients in each group. Equal group sizes facilitated comparisons of demographic and clinical characteristics and patient-reported outcomes. The primary objective was to compare the psychosocial burden of these disorders; secondary analyses examined demographic and disease-related factors associated with quality-of-life impairment.

Eligible participants were adults aged 18 years or older with a clinical diagnosis of psoriasis, vitiligo, melasma, or cutaneous lichen planus confirmed by a qualified dermatologist. Psoriasis was identified by characteristic erythematous, scaly plaques; vitiligo by

well-demarcated depigmented macules or patches; melasma by acquired, predominantly facial, symmetrical hyperpigmented patches; and cutaneous lichen planus by violaceous, polygonal papules or plaques. Wood's lamp examination or histopathological assessment was used when clinically indicated. Patients with overlapping target diagnoses, uncertain diagnoses, isolated mucosal lichen planus, or an inability to complete the assessments reliably were excluded.

Demographic and clinical information included age, sex, duration of dermatological disease, anatomical distribution of lesions, and patient-perceived lesion visibility. Disease duration was recorded in years since symptom onset. Perceived visibility was measured using a patient-rated numerical scale from 0 (not noticeable) to 10 (extremely noticeable). This measure captured the patient's subjective appraisal of lesion visibility rather than objective clinical severity. Data collection procedures were applied consistently across the four diagnostic groups.

Dermatology-specific quality of life was evaluated using the Dermatology Life Quality Index (DLQI), a validated 10-item questionnaire assessing symptoms and feelings, daily activities, leisure, work or education, personal relationships, and treatment-related burden.[1,2]. Each item is scored from 0 to 3, yielding a total score from 0 to 30; higher scores indicate greater impairment. Scores of 0–1 indicate no effect, 2–5 a small effect, 6–10 a moderate effect, 11–20 a very large effect, and 21–30 an extremely large effect on quality of life. The primary outcome was the mean DLQI score across diagnostic groups. A DLQI score ≥11 was also evaluated as a categorical outcome.

Depressive symptoms were measured with the Patient Health Questionnaire-9 (PHQ-9), a nine-item screening tool to determine the frequency of depressive symptoms over the past two weeks.[9] Each item is scored 0-3, creating an overall score of 0-27. A score of 0-4 indicates minimal depression symptomology; 5-9, mild depression symptomology; 10-14, moderate depression symptomology; 15-19, moderately severe depression symptomology; and 20-27, severe depression symptomology. Generalized Anxiety Disorder-7 (GAD-7) questionnaire was used to assess the symptoms of anxiety, which has seven items with a 0-3 score, and a total score of 0-21.[10] The cut-off scores for GAD-7 of 0-4, 5-9, 10-14 and 15-21 represent minimal, mild, moderate and severe symptoms of anxiety. A score of ≥10 on either instrument was deemed as signifying psychological symptom burden sufficiently high to warrant further investigation. There was no definitive psychiatric diagnosis made for either questionnaire.

Continuous variables were summarized as mean ± standard deviation, and categorical variables as frequency and percentage. Differences in mean DLQI, PHQ-9, and GAD-7 scores across the four diagnostic groups were assessed using one-way analysis of variance. Proportions with DLQI ≥11, PHQ-9 ≥10, and GAD-7 ≥10 were compared using Pearson's chi-square test. Multivariable linear regression was performed to examine the association between dermatological diagnosis and DLQI score, using melasma as the reference group and adjusting for age, sex, and disease duration. A separate multivariable regression analysis examined the association of patient-perceived lesion visibility with DLQI score after adjustment for diagnosis and relevant covariates. Heteroskedasticity-robust standard errors were used, and regression coefficients were reported with 95% confidence intervals. All tests were two-sided, with $p < 0.05$ considered statistically significant.

No missing-value imputation was performed. Because the study was cross-sectional, observed associations cannot establish causality. Ethics approval and consent written was obtained. The reporting was informed by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement.[11]

RESULTS

The study population consisted of 240 adults divided into four dermatological groups: psoriasis (60), vitiligo (60), melasma (60) and lichen planus (LP) (60). The mean age was 38.3 years, with 146 participants (60.8%) being female. Patients with psoriasis had the highest mean age (42.0 ± 10.4 years), followed by lichen planus (39.7 ± 10.4 years), melasma (37.2 ± 9.7 years), and vitiligo (34.4 ± 10.3 years). There was female predominance in the melasma group (90.0%) as compared to lichen planus (55.0%), vitiligo (51.7%) and psoriasis (46.7%). Mean disease duration was 6.0 ± 3.9 years in psoriasis, 6.0 ± 4.0 years in vitiligo, 5.4 ± 3.9 years in melasma, and 3.0 ± 2.0 years in lichen planus. The highest scores for patient perceived lesion visibility were seen in melasma (8.3 ± 1.5), vitiligo (7.4 ± 1.8), psoriasis (6.2 ± 1.6) and lichen planus (6.2 ± 1.9). Demographic and clinical characteristics of the participants are shown in [Table 1].

Dermatology-related quality of life differed significantly among the four diagnostic groups. The overall mean Dermatology Life Quality Index (DLQI) score was 13.3, indicating a substantial quality-of-life burden in the study population. The highest mean score was observed in psoriasis (15.4 ± 4.1), followed by lichen planus (13.1 ± 4.0), melasma (12.7 ± 3.9), and vitiligo (12.1 ± 4.4). The overall between-group difference was statistically significant ($F = 7.42$; $p < 0.001$). In total, 178 patients (74.2%) had a DLQI score ≥11, indicating a very large or extremely large effect on quality of life. This proportion was highest in psoriasis (86.7%), followed by melasma (76.7%), lichen planus (70.0%), and vitiligo (63.3%). The between-group difference in the proportion with DLQI ≥11 was statistically significant ($\chi^2 = 9.31$, $df = 3$; $p = 0.025$).

There were also differences in the number of depressive symptoms across the diagnostic groups. The highest mean Patient Health Questionnaire-9 (PHQ-9) score was observed in psoriasis (11.0 ± 4.5), followed by lichen planus (10.3 ± 4.1), melasma (9.5 ± 4.2), and vitiligo (8.9 ± 4.7). The overall comparison of mean PHQ-9 scores was almost statistically significant, but not quite ($F = 2.63$; $p = 0.051$). But 128 participants (53.3%) scored ≥10 on the PHQ-9, with the highest prevalence in psoriasis (66.7%) and the lowest in vitiligo (40.0%). The number of PHQ-9 scores at or above this screening threshold was significantly different among the four groups ($\chi^2 = 8.71$, $df = 3$; $p = 0.033$).

A similar, although less marked pattern was obtained for anxiety symptom scores. Mean Generalized Anxiety Disorder-7 (GAD-7) scores were highest in psoriasis (8.8 ± 3.9), followed by melasma (8.4 ± 3.8), lichen planus (8.2 ± 4.6), and vitiligo (7.0 ± 3.3). There was no statistically significant difference in mean scores of GAD-7 ($F = 2.33$; $p = 0.075$). However, 81 participants (33.8%) scored 10 or more on the GAD-7, and this included 43.3% of the psoriasis group, 40.0% of the melasma group, 33.3% of the lichen planus group and 18.3% of the vitiligo group. There was a significant difference between groups in the proportion who met the cutoff for anxiety screening ($\chi^2 = 9.90$, $df = 3$; $p = 0.019$). The comparative results of DLQI, PHQ-9 and GAD-7 are presented in [Table 2].

Multivariable linear regression showed an association between dermatological diagnosis and quality-of-life impairment after adjustment for age, sex, and disease duration. Compared with melasma, psoriasis was associated with a higher DLQI score (adjusted $\beta = 2.70$; 95% CI 1.26–4.15; $p < 0.001$). The adjusted differences for vitiligo ($\beta = -0.54$; 95% CI −2.02 to 0.95; $p = 0.480$) and lichen planus ($\beta = 0.80$; 95% CI −0.79 to 2.38; $p = 0.324$) were not statistically significant. Age, sex, and disease duration were not independently associated with DLQI scores at the prespecified significance threshold. A separate adjusted analysis demonstrated an association between greater patient-perceived lesion visibility and higher DLQI scores ($\beta = 0.49$ per scale point; 95% CI 0.18–0.80; $p = 0.002$). The adjusted estimates are presented in [Table 3].

Overall, the comparative findings indicated substantial dermatology-related quality-of-life impairment across all four conditions, with the greatest mean burden in psoriasis. Although mean PHQ-9 and GAD-7 scores did not differ significantly across diagnostic groups, the proportions of patients reaching the prespecified screening thresholds for depressive and anxiety symptoms did differ. In adjusted analyses, dermatological diagnosis and patient-perceived lesion visibility were associated with quality-of-life impairment.

Table 1: Demographic and clinical characteristics of participants according to dermatological diagnosis

Characteristics	Psoriasis (n = 60)	Vitiligo (n = 60)	Melasma (n = 60)	Lichen planus (n = 60)
Age (years), mean ± SD	42.0 ± 10.4	34.4 ± 10.3	37.2 ± 9.7	39.7 ± 10.4
Female, n (%)	28 (46.7)	31 (51.7)	54 (90.0)	33 (55.0)
Male, n (%)	32 (53.3)	29 (48.3)	6 (10.0)	27 (45.0)
Disease duration (years), mean ± SD	6.0 ± 3.9	6.0 ± 4.0	5.4 ± 3.9	3.0 ± 2.0
Perceived lesion visibility (0–10), mean ± SD	6.2 ± 1.6	7.4 ± 1.8	8.3 ± 1.5	6.2 ± 1.9

Table 2: Comparison of quality-of-life impairment, depressive symptoms, and anxiety among dermatological groups

Outcome	Psoriasis (n = 60)	Vitiligo (n = 60)	Melasma (n = 60)	Lichen planus (n = 60)	p-value
DLQI score, mean ± SD	15.4 ± 4.1	12.1 ± 4.4	12.7 ± 3.9	13.1 ± 4.0	<0.001
DLQI ≥11, n (%)	52 (86.7)	38 (63.3)	46 (76.7)	42 (70.0)	0.025
PHQ-9 score, mean ± SD	11.0 ± 4.5	8.9 ± 4.7	9.5 ± 4.2	10.3 ± 4.1	0.051
PHQ-9 ≥10, n (%)	40 (66.7)	24 (40.0)	31 (51.7)	33 (55.0)	0.033
GAD-7 score, mean ± SD	8.8 ± 3.9	7.0 ± 3.3	8.4 ± 3.8	8.2 ± 4.6	0.075
GAD-7 ≥10, n (%)	26 (43.3)	11 (18.3)	24 (40.0)	20 (33.3)	0.019

Table 3: Multivariable linear regression estimates for factors associated with Dermatology Life Quality Index scores

Predictor	Adjusted β coefficient	95% confidence interval	p-value
Psoriasis versus melasma	2.70	1.26 to 4.15	<0.001
Vitiligo versus melasma	−0.54	−2.02 to 0.95	0.480
Lichen planus versus melasma	0.80	−0.79 to 2.38	0.324
Age (per year)	0.02	−0.04 to 0.07	0.565
Female versus male	0.36	−0.75 to 1.47	0.525
Disease duration (per year)	0.12	−0.05 to 0.29	0.161
Perceived lesion visibility (per point; secondary model)	0.49	0.18 to 0.80	0.002

DISCUSSION

The present cross-sectional study evaluated dermatology-related quality of life, depressive symptoms, and anxiety in patients with psoriasis, vitiligo, melasma, and lichen planus. The findings showed considerable quality-of-life impairment across all four conditions, with the highest mean DLQI score among patients with psoriasis.[5,6] Both inflammatory and pigmentary disorders were associated with psychosocial burden, although the magnitude of impairment varied across diagnostic

groups. These findings support incorporating patient-reported outcomes into routine dermatological assessment alongside the evaluation of clinical manifestations.[7]

Patients with psoriasis had the highest mean DLQI score (15.4 ± 4.1), and 86.7% of these patients had a score that implied a very large or extremely large impact on their daily life. This is a trend that agrees with earlier research that found significant psychosocial effects of psoriasis. Karelson et al. found psoriasis patients experience more impairment of quality of life than those with vitiligo, indicating that inflammatory symptoms and disease visibility can lead to psychological effects.[3,8] Likewise, Ghajarzadeh et al., found a significant difference in the quality of life impairment between individuals with psoriasis, vitiligo, and alopecia areata.[4,9] These can add up to a significant burden of psoriasis, as no one wants to suffer from persistent itching, visible scaling, recurrent outbreaks, or long-term treatment. The results indicate that inflammatory disease activity and physical discomfort should be taken into account when assessing the impact of a disease, in addition to psychological factors.[10]

Vitiligo had the lowest mean DLQI score; however, 63.3% of the people in the diagnostic group had scores ≥ 11, which is considered to have significant impact on quality of life. This discovery reveals the psychological implications of the depigmenting skin conditions, which often have no physically significant symptoms.[11] Vitiligo patients frequently suffer from social stigma, embarrassment, low confidence and psychological distress.[5] Depigmented lesions are visible and if they are on exposed anatomic areas, can have a negative impact on body image and interpersonal relationships. However, relatively low scores of quality of life should not be equated with a lack of any psychosocial burden for vitiligo patients.[12]

Melasma also had a significant impact on quality of life, with a mean DLQI of 12.7 ± 3.9 and 76.7% of the population rating the impact as very large or extremely large. While melasma does not typically have inflammatory symptoms, the fact that it is predominantly on the face and can recur may lead to ongoing cosmetic concerns and emotional distress.[13,14] Balkrishnan et al. showed that melasma has a significant impact on emotional well-being, social functioning and daily activities, highlighting the need for psychological outcomes to be included along with clinical pigmentation severity.[6] The lesion visibility score reported by patients in the melasma group is also noteworthy due to the high score and highlights the conspicuousness of a skin change, which may have an impact on the patient's perception of disease burden.[15]

Overall, patients with lichen planus had significant quality of life impairment with a mean DLQI score of 13.1 ± 4.0 and 70.0% had a significant influence on daily function. Emotional and functional problems may relate to persistent pruritus, recurrent inflammatory lesions, and uncertainty of the clinical course and the presence of residual post-inflammatory pigmentation. Fiocco et al. reported that there was considerable psychological distress and decreased quality of life in patients with LP, and more attention should be paid to the psychosocial impact of LP.[7,16] In addition, Gupta et al. found significant psychosocial burden among patients with Lichen planus pigmentosus as compared with patients with vitiligo and melisma.[8] While lichen planus pigmentosus is an unusual clinical variant, the findings herein highlight the need for the psychological impact of lichenoid and pigmentary diseases to be considered.[17]

The second major aspect of the comparative evaluation was depressive symptoms. Psoriasis had the highest mean PHQ-9 score followed by lichen planus, melasma, and vitiligo. Overall, 53.3% of the sample exceeded the screening threshold for the PHQ-9 (10 or more) and there were significant differences between the percentages in each diagnostic group who met the screening threshold. The overall comparison of mean scores of depressive symptoms did not, however, reach conventional statistical significance.[18,19] This separation implies that between-group differences may be dependent on the outcome measure chosen, and underscores the need for using a continuous symptom scale in conjunction with relevant screening thresholds. Depressive symptoms have been reported in psoriasis, vitiligo and lichen planus, indicating the importance of psychological evaluation in patients with chronic dermatological conditions.[4,5,7] Importantly, higher PHQ-9 scores reflect the level of depressive symptom burden and do not necessarily mean a diagnosis of depressive disorder.[20]

Symptoms of anxiety also varied between dermatological groups. While there was no statistical difference among mean GAD-7 scores, 33.8% of participants scored above the cut-off for clinically significant anxiety symptoms. Psoriasis and melasma had the highest proportions and vitiligo the smallest proportion.[1-4] This may reflect varying amounts of physical burden, appearance, disease recurrence or social interactions. However, many individual and contextual factors such as coping strategies, social support, cultural attitudes and previous mental health conditions can impact on the psychological effects that might occur in the context of skin diseases. Thus, the differences in anxiety symptoms cannot be solely interpreted as being due to dermatological diagnosis.[6-10]

Multivariable regression provided additional insight into factors associated with quality-of-life impairment. After adjustment for age, sex, and disease duration, psoriasis remained associated with higher DLQI scores than melasma, whereas the differences for vitiligo and lichen planus were not statistically significant.[11-15] A separate adjusted analysis showed that higher patient-perceived lesion visibility was associated with greater quality-of-life impairment. This finding highlights the relevance of subjective disease perception to psychosocial burden.

However, perceived visibility may overlap with emotional distress and dissatisfaction with appearance, and the cross-sectional design cannot determine the direction of the association.[16,17]

Strengths of the study include the use of the same validated patient-reported outcome instruments across four dermatological conditions and the evaluation of both quality of life and psychological symptoms. Multivariable analyses allowed adjustment for selected demographic and disease-related characteristics.[18] Several limitations warrant consideration. The single-center cross-sectional design limits generalizability and precludes causal inference. Although the diagnostic groups were equal in size, their age and sex distributions differed, introducing the possibility of residual confounding. Standardized objective disease-severity indices, such as the Psoriasis Area and Severity Index, Vitiligo Area Scoring Index, and Melasma Area and Severity Index, were not included. The DLQI may differ in sensitivity across diseases, while PHQ-9 and GAD-7 are screening rather than diagnostic instruments. Multiple statistical comparisons also increase the possibility of chance findings. Further multicenter longitudinal research is warranted.[19]

The combined results of the comparisons offer a justification for the systematic psychosocial assessment of dermatological patients. Patients with chronic inflammatory/pigmentary conditions can be assessed for quality of life, emotional health and disease burden, regardless of the apparent severity of their skin condition.[20] Multicenter longitudinal studies with validated disease-severity indices, treatment outcomes, anatomical distribution, and psychosocial factors should be considered in the future to better understand disease-specific psychological predictors and whether combination dermatology-psychology interventions enhance patient-reported outcomes.[13]

CONCLUSION

Patients with psoriasis, vitiligo, melasma, and lichen planus experienced substantial dermatology-related quality-of-life impairment and psychological symptom burden. Mean DLQI scores were highest in psoriasis, followed by lichen planus, melasma, and vitiligo. The proportions meeting depressive and anxiety symptom screening thresholds differed between diagnostic groups, and greater patient-perceived lesion visibility was associated with higher DLQI scores after adjustment for selected covariates. Integrating quality-of-life assessment and appropriate psychological screening into dermatology services may support earlier recognition of psychosocial needs and more patient-centered care.

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