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Original article

Assessment of the Dermatology Life Quality Index and Its Association with Medication Adherence among Patients with Chronic Skin Conditions: A Cross-Sectional Study

Rima Elmzughi*, Nouralhuda Alasmer, Sonia Daw

Department of Pharmaceutics, Faculty of Pharmacy, University of Tripoli, Tripoli, Libya
Corresponding Email. r.elmzughi@uot.edu.ly

Abstract
Chronic inflammatory skin diseases significantly impair health-related quality of life (HRQoL), yet data on this impact and its relationship with medication adherence in Libya are scarce. To assess the QoL among Libyan patients with various dermatological conditions using the Dermatology Life Quality Index (DLQI) and to investigate the correlation between QoL and medication adherence. A cross-sectional study was conducted from July to September 2025 at Bir Usta Milad dermatology hospital. A total of 315 adult patients with chronic skin conditions were enrolled via convenience sampling. Data were collected using the DLQI questionnaire, with additional information on demographics, clinical characteristics, and medication adherence. Data analysis was performed using SPSS. The mean overall DLQI score was 5.17 ± 4.107, indicating a "small to moderate" effect on QoL. However, the impact varied significantly by diagnosis. Atopic dermatitis demonstrated the most profound impact on quality of life, with a mean DLQI of 13.33 ± 8.505 ($p < 0.001$), indicating a 'very large effect,' followed by eczema (mean DLQI: 6.67 ±3.915; $p < 0.005$). The most affected life domains were "symptoms and feelings" (itchiness/pain) and "embarrassment", with women reporting significantly greater embarrassment than men ($p=0.021$). A significant negative correlation was found between DLQI scores and medication adherence (Pearson's $r = -0.201$, $p < 0.001$), indicating that worse QoL was associated with a tendency towards reduced adherence. While 76.2% of patients reported no influence of QoL on adherence, 23.8% reported an effect, nearly evenly split between those who intensified (11.4%) and those who reduced (12.4%) their regimen. Dermatological conditions substantially impair HRQoL in the Libyan population, with the burden being diagnosis-specific. The significant correlation between poorer QoL and reduced medication adherence underscores the need for routine QoL assessment in clinical practice. Integrating the DLQI can help identify at-risk patients, enabling targeted interventions to improve both psychological well-being and treatment adherence for holistic patient care.

Keywords. Quality of Life, DLQI, Medication Adherence, Chronic Skin Diseases, Libya.

Introduction

Chronic inflammatory skin diseases significantly impair health-related quality of life (HRQoL) by disrupting emotional well-being, daily functioning, and social relationships [1]. The extent of this impact is influenced by factors such as disease activity, affected body surface area, lesion location, and the presence of symptoms like pruritus and pain. For instance, the intensity of conditions like atopic eczema has been shown to correlate directly with poorer QoL outcomes in both adult and pediatric patients [2]. The visibility of skin lesions often exacerbates this burden, frequently triggering negative emotions, stigmatization, and a negative body image, which significantly impair an individual's mental well-being [3]. This psychological distress, compounded by widespread public misconceptions about dermatological conditions, can lead to social withdrawal, loneliness, and a loss of self-confidence [4]. The consequences extend beyond psychosocial health to include substantial medical costs and lost work productivity [4]. The World Health Organization defines quality of life as an individual's perception of their life position within their cultural context and value systems, relative to their personal goals and concerns [5]. Consequently, assessing HRQoL using tools like the Dermatology Life Quality Index (DLQI) has become a critical component of managing chronic conditions such as psoriasis and atopic dermatitis [6].

The global burden of skin diseases is substantial, with estimates suggesting they affect between 21% and 87% of the worldwide population [7,8]. Despite high prevalence and significant psychosocial impact, with about 24% of patients seeking care for self-image or disfigurement concerns, the importance of dermatological health is often underestimated due to the chronic nature and low mortality of most skin conditions [7]. This burden is particularly acute in developing countries, where access to specialist care is limited. Patients in these regions may spend a disproportionate amount of their income on often ineffective treatments, highlighting a significant economic challenge [7]. Common dermatological disorders include scabies, dermatitis, urticaria, acne, and alopecia areata, while conditions like psoriasis and skin cancer are less prevalent but carry a substantial QoL burden [9]. These conditions are characterized by their chronicity and symptoms; scabies is a contagious infestation causing intense itching [10]; atopic dermatitis presents with pruritic, eczematous lesions [11]; chronic urticaria involves wheals and angioedema persisting beyond six weeks [12]; acne vulgaris is an inflammatory disease of the pilosebaceous unit [13]; alopecia areata causes non-scarring hair loss with significant psychosocial effects [14]; and psoriasis is a chronic immune-mediated inflammatory disease [15]. The high prevalence and profound impact of these conditions underscore the necessity of comprehensive patient care that includes QoL assessment.

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While medication adherence is a key transitional outcome, HRQOL is the ultimate measure of a disease management plan's effectiveness [16], especially for dermatology patients. Generally, improvements in medication adherence precede and contribute to gains in HRQOL. However, this relationship is complex and influenced by other factors. Studies consistently show that chronically ill patients with poor medication adherence also tend to experience a lower QoL [16,17]. Existing research on the QoL of dermatology patients is primarily from developed countries and often focuses on specific diseases. While a study from Libya has assessed the impact of only atopic dermatitis on QoL, there remains a notable scarcity of research in the country that investigates the QoL impact across a wide variety of dermatological conditions [18], and more importantly, how this impairment subsequently influences medication adherence. Therefore, the current study was designed to fill this gap by providing, to our knowledge, the first assessment of QoL among patients with diverse chronic dermatological conditions using the DLQI in Libya. Furthermore, the study investigates the correlation between QoL and medication adherence, a relationship not previously explored in this context.

Methods

Study design and Setting

This cross-sectional study was conducted between July and September 2025 at Bir Usta Milad Dermatology Hospital in Tripoli, a major public referral center for dermatology in northwestern Libya.

Study population and sampling strategy

The single population proportion formula, $ni = (Z\alpha/2)^2 \times p\ (1-p)\ /\ d^2$, was used [19]. With a 95% confidence level ($Z\ \alpha/2 = 1.96$), a margin of error (d) of 5% (0.05), and an assumed prevalence (p) of 50% (0.5) to account for maximum variability, the initial sample size (ni) was calculated as 385. Since the total population of eligible adult patients with chronic skin disease (N=1,640) was finite and less than 10,000, a finite population correction was applied using the formula $nf = (ni \times N)\ /\ (ni + N)$. This adjustment yielded a final required sample size (nf) of 312.

A convenience sampling method was employed. The study population comprised patients attending the dermatology clinic who met the study criteria. Inclusion required participants to be aged 18 years or above, to have been diagnosed with a chronic dermatological condition (duration >6 months), and willing to participate and provide informed consent. Exclusion criteria included an inability to provide informed consent and any history of psychiatric illness or current psychiatric medication. This exclusion was implemented to safeguard data quality by ensuring all participants had the cognitive capacity to comprehend and respond thoughtfully to the study questionnaire.

Data collection

Eligible participants were identified based on the inclusion and exclusion criteria. Data were collected using the Arabic version of the Dermatology Life Quality Index (DLQI), a validated instrument and the first questionnaire specifically designed to measure health-related quality of life in dermatology. The DLQI consists of 10 questions across six domains: symptoms and feelings (items 1-2), daily activities (items 3-4), leisure (items 5-6), work/school (item 7), personal relationships (items 8-9), and treatment (item 10). Participants rate their experiences over the previous week, yielding a total score ranging from 0 to 30. Higher scores indicate a greater impairment of QOL, with established interpretive bands: 0-1 (no effect), 2-5 (small effect), 6-10 (moderate effect), 11-20 (very large effect), and 21-30 (extremely large effect). The DLQI was the first instrument developed [20]. Additional data gathered included demographic variables, clinical information, and medication adherence. The latter was assessed by a single, direct question: Does your skin condition affect your adherence to your medication? Participants who answered ‘yes’ were then asked to specify whether this effect led them to intensify or reduce their medication regimen.

Data analysis

Data analysis was performed using SPSS Statistics, Version 26 (IBM Corp., Chicago, IL, USA). Descriptive statistics were calculated for all variables, including the prevalence of dermatological diagnoses. Continuous data are presented as mean and standard deviation. The Kolmogorov–Smirnov test was performed to see if the data were normally distributed. Non-parametric tests were used for group comparisons. The Kruskal-Wallis test assessed differences in DLQI scores across diagnostic categories, while the Mann-Whitney U test evaluated gender-based differences in individual DLQI domains. The relationship between DLQI scores and medication adherence was assessed using Pearson’s correlation. A p-value of less than 0.05 was considered statistically significant.

Ethical considerations

Ethical approval to conduct this study was obtained from the Biotechnology Research Center (referenced as NBC:001. H. 25. 45). Prior to participation, verbal consent was obtained from all patients. The study adhered to strict confidentiality standards, and no identifiable patient information was collected or utilized.

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Results

Socio-demographic characteristics of the study participants are shown in (Table 1). A total of 315 patients participated in this study. The study population was predominantly female (76.5%) and relatively young, with the largest age group being 18-20 years old (28.9%). Education levels varied, with the majority having completed secondary school (32.4%), a diploma (24.1%), or a university education (28.9%).

Table 1. Socio-demographic characteristics and lifestyle characteristics of the study participants

Variable	**Category**	**Total (n=315)**	
		Frequency	**Percentage**
Gender	Male	74	23.5
	Female	241	76.5
Age (years)	18-20	91	28.9
	21-30	65	20.6
	31-40	36	11.4
	41-50	53	16.8
	51-60	45	14.3
	≥ 61	25	7.9
Education qualification	Illiterate	14	4.4
	Primary school	9	2.9
	Secondary school	102	32.4
	Diploma	76	24.1
	University	91	28.9
	Higher education	23	7.3
Marital status	Married	148	47.0
	Not married	152	48.3
	Divorce	8	2.5
	Widow	6	1.9
Employment	Employed	132	41.9
	Not employed	168	53.3
	Retired	15	4.8
Lifestyle	Smoking	26	8.3
	Coffee drinker	188	59.9
	Healthy diet	118	37.5
	Regular exercise	102	32.4

Participants were nearly equally divided in terms of marital status, with 47.0% married and 48.3% unmarried. Slightly more than half of the participants were not employed (53.3%), while 41.9% were employed. Regarding lifestyle characteristics, the vast majority of patients were non-smokers (91.7%). However, a majority reported being coffee drinkers (59.9%, n=188). While (62.5%) reported adhering to a healthy diet, only (32.4%) engaged in regular exercise. Psoriasis was the most common dermatological condition (33.0%), followed by eczema (19.4%) and acne (18.7%). The duration of having these conditions varied significantly, with 36.5% of patients having been affected for 1-5 years, while a significant proportion (26.3%) had lived with their condition for over a decade. A family history of dermatological disease was reported by 24.8% of participants, with similar rates among parents (12.1%) and siblings (12.7%). The general health status of the participants was notably negative, with 64.8% of patients describing their general status as "unsatisfied and stressed." Concurrent chronic diseases were present in (27.3%) of participants, with diabetes mellitus (10.8%) and hypertension (7.6%) being the most prevalent. See (Table 2).

Table 2. Clinical characteristics and health status of the study participants

Variable	**Category**		**Total (n=315)**	
			Frequency	**Percentage**
Duration of condition (years)	< 1		68	21.6
	1- 5		115	36.5
	5 -10		49	15.6
	> 10		83	26.3
Family history	No		237	75.2
	Yes	Parents	38	12.1

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		Sibling	40	12.7
General status	Satisfied		111	35.2
	Unsatisfied and stressed		204	64.8
Associated chronic disease	Absent		229	72.7
	Present	Hypertension	24	7.6
		Diabetes mellitus	34	10.8
		Asthma	22	7.0
		Thyroid problem	7	2.2
		Dyslipidemia	6	1.9
		Rheumatoid	4	1.3
		Others	15	4.8

The analysis of Dermatology Life Quality Index (DLQI) scores across 315 patients with various dermatologic conditions revealed a significant overall impairment in health-related quality of life, with a mean DLQI score of (5.17 ±4.107), indicating a "small to moderate" effect on patients' lives. The burden of disease, however, varied considerably and significantly between conditions. Atopic dermatitis demonstrated the most severe impact with a mean DLQI of (13.33 ±8.505), classified as a "very large effect," which was statistically significant (p <0.001). Eczema (6.67 ±3.915, p =0.005), urticaria (6.56 ±4.427), and pemphigus (6.42 ±4.295) also showed a "moderate to very large" effect on QoL, with eczema reaching statistical significance. In contrast, conditions such as acne (3.54 ±3.303, p =0.014), hair disorders (2.92 ±2.430), and vitiligo (3.50 ±2.811) were associated with a "small" mean effect, though the impact of acne and melasma (4.12 ±5.23, p=0.016) was still statistically significant relative to the baseline. The distribution of effect severity categories further elucidates these differences; for instance, while the majority of patients with psoriasis, the most prevalent condition (33.0%), fell into the "small" or "moderate" effect categories, a notable proportion (14.3%) experienced a "very large" or "extremely large" effect. These findings underscore that the subjective burden of skin disease is not solely determined by clinical severity but varies profoundly by diagnosis, with inflammatory and pruritic conditions like atopic dermatitis and eczema conferring the greatest detriment to quality of life. The impact on quality of life, as measured by DLQI, is detailed in (Table 3).

Table 3. Dermatology Life Quality Index (DLQI) scores by dermatological condition

Dermatologic condition	**N (%)**						**Mean ± Std. Deviation**	**p-value**
	Total	**No effect**	**Small effect**	**Moderate effect**	**Very large effect**	**Extremely large effect**		
Psoriasis	104 (33.0)	13 (12.5)	46 (44.2)	36 (34.6)	9 (8.7)	--	5.58 ±4.028	0.217
Eczema	61 (19.4)	4 (6.6)	23 (37.7)	27 (44.3)	6 (9.8)	1 (1.6)	6.67 ±3.915	0.005*
Acne	59 (18.7)	18 (30.5)	28 (47.5)	9 (15.3)	4 (6.8)	--	3.54 ±3.303	0.014*
Hair disorder	24 (7.6)	8 (33.3)	12 (50)	4 (16.6)	--	--	2.92 ±2.430	0.101
Melasma	17 (5.4)	8 (47.1)	4 (23.5)	3 (17.6)	2 (11.8)	--	4.12 ±5.23	0.016*
Urticaria	16 (5.1)	1 (6.3)	8 (50)	3 (18.8)	4 (25)	--	6.56 ±4.427	0.173
Pemphigus	12 (3.8)	--	8 (66.7)	1 (8.3)	3 (25)	--	6.42 ±4.295	0.075
Alopecia	8 (2.5)	--	7 (87.5)	1 (12.5)	--	--	3.75 ±2.053	0.193
Vitiligo	6 (1.9)	1 (16.7)	3 (50)	2 (33.3)	--	--	3.50 ±2.811	0.951
Rosacea	5 (1.6)	1 (20)	3 (60)	1 (20)	--	--	4.20 ±3.493	0.929
Atopic dermatitis	3 (1.0)	--	1 (33.3)	--	1 (33.3)	1 (33.3)	13.33 ±8.505	0.000*
Total	315 (100)	54(17.1)	143(45.4)	87 (27.6)	29(9.2)	2 (0.6)	5.17 ± 4.107	0.000*

** Statistically significant*

The analysis of the individual elements of the DLQI delineates a clear hierarchy of impairment, primarily driven by core symptomatic and practical burdens. The most severely affected domains were "Itchiness/pain" (Mean: 1.48 ± 1.176; Median: 2) and "Embarrassment" (Mean: 0.94 ± 1.000; Median: 1), underscoring the profound impact of physical discomfort and associated psychological distress. A significant gender difference was observed for "Embarrassment" (p=0.021), with women reporting a higher median score (2) compared to men (1), suggesting a greater emotional burden in female patients. Secondary yet considerable impacts were noted in daily living activities, including interference with "shopping/home duties" (Mean: 0.58 ± 0.819) and clothing choices (Mean: 0.57 ± 0.792). The burden of "Treatment" itself was also notable (Mean: 0.56 ± 0.739), comparable to the interference with daily duties. In stark contrast, impacts on specific social, interpersonal, and occupational domains were markedly lower. The elements "Sexual difficulties" (Mean: 0.02 ± 0.125) and "Problem with partner/relatives/friends" (Mean: 0.18 ± 0.555) were the least affected. Notably, "Sport difficulties" demonstrated a significant gender disparity (p=0.000), though the overall median score was zero for both groups. No other significant gender differences were detected across the remaining domains (p>0.05). This pattern indicates that the quality of life impairment

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is predominantly confined to direct symptoms and daily management, with relative preservation of core social relationships and intimate life. See (Table 4).

Table 4. Mean of the dermatology life quality index elements in the study participants

Elements of DLQI	**Mean ± Std. Deviation**	**Median (P25;P75)**	**Men Median (P25;P75)**	**Women Median (P25;P75)**	**p- value**
Itchiness/pain	1.48±1.176	2 (0;3)	1 (0;2)	2 (0;3)	0.099
Embarrassment	0.94±1.000	1(0;2)	1 (0;1)	1 (0;2)	0.021*
Interfered with shopping/home duties	0.58±0.819	0 (0;1)	0 (0;1)	0 (0;1)	0.354
Influenced the clothes you wear	0.57±0.792	0 (0;1)	0 (0;1)	0(0;1)	0.453
Affected social/leisure activities	0.38±0.736	0 (0;1)	0 (0;0.25)	0 (0;1)	0.884
Sport difficulties	0.13±0.455	0 (0;0)	0 (0;0)	0 (0;0)	0.000*
Problem at work/studying	0.19±0.733	0 (0;0)	0(0;0)	0 (0;0)	0.479
Problem with partner/relatives/friends	0.18±0.555	0 (0;0)	0 (0;0)	0(0;0)	0.909
Sexual difficulties	0.02±0.125	0 (0;0)	0 (0;0)	0 (0;0)	0.381
Problem with treatment	0.56±0.739	0 (0;1)	0 (0;1)	0 (0;1)	0.413

** Statistically significant*

The relationship between DQOL and medication adherence was evaluated. As shown in (Table 5), the majority of participants (76.2%) reported that their dermatology-related quality of life did not affect their adherence behavior. However, a clinically relevant minority (23.8%) reported that QOL did influence their adherence. This group was nearly evenly split between those who reported an increase (11.4%) in adherence and those who reported a decrease (12.4%). To quantify this relationship, a correlation analysis was performed (Table 5). A statistically significant, weak negative correlation was found between the DLQI score and adherence influence (Pearson's r = -0.201, p < 0.001). This result indicates that as the negative impact on quality of life increases (reflected by a higher DLQI score), there is a slight but significant tendency for patients to be more likely to report a decrease in adherence.

Table 5. Descriptive statistics and correlation between DQOL and medication adherence influence

Influence on Medication Adherence	**Total (n=315)**		**Correlation with DLQI**	
	Frequency	**Percentage**	**Pearson Correlation**	**p-value**
Regimen Intensification	36	11.4	-0.201	0.000*
Regimen Reduction	39	12.4		
Adherence Unchanged	240	76.2		

** Statistically significant*

Discussion

Various instruments have been validated to assess QoL in dermatology. Our findings confirm that the DLQI is a comprehensible and user-friendly tool for patients. Furthermore, we corroborate previous conclusions that scoring the DLQI is both efficient and straightforward [21]. The questionnaire's application is not confined to specialist care; it is also widely employed in primary care settings, demonstrating its broad clinical utility [22]. Utilizing this instrument, this study provides, to our knowledge, the first assessment of the impact of viral dermatological conditions on QoL and its relationship with medication adherence in our specific regional cohort of 315 patients. The resulting findings align with and expand upon the existing global literature, reinforcing the concept that skin diseases impose a significant, yet highly variable, burden on patients' lives [21,22].

The overall mean DLQI score of (5.17 ±4.107) in our cohort indicates a "small to moderate" effect on QoL. This is somewhat lower than the means reported in studies from Brazil (7.7 ± 5.0), Pakistan (10.01 ±3.08), Egypt (10.42 ±3.65), and Turkey (13.25 ± 8.75) [20, 23-25]. This variation is likely attributable to differences in the case mix of dermatological conditions. Our sample had a high prevalence of psoriasis (33.0%), Eczema (19.4%), and acne (18.7%), conditions which in our study demonstrated a "small to moderate" effect. This finding contrasts with the Saudi Arabian study, which also reported a majority of patients experiencing a small effect, but identified urticaria, eczema, and psoriasis as the conditions with the largest percentage of patients reporting a severe impact [26]. This discrepancy highlights that the perceived burden of a condition can be influenced by cultural, social, and healthcare context factors.

The most critical finding of our analysis is the profound diagnosis-specific variation in QoL impairment, a universal theme across various studies [20, 23-26]. Atopic dermatitis emerged as the most debilitating condition in our cohort, with a mean DLQI of 13.33, signifying a "very large effect." This is consistent with previous studies, which also identified atopic dermatitis as a high-impact condition [18, 20]. Similarly, eczema and urticaria in our study showed a "moderate" effect, corroborating their status as consistently

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high-burden diseases in other countries [23,25-27]. The extreme impact of inflammatory and pruritic conditions underscores that symptoms, rather than purely cosmetic concerns, are a primary driver of QoL reduction. Conversely, acne, vitiligo, and hair disorders in our population were associated with a "small" effect. This suggests that the psychosocial burden of cosmetically sensitive conditions is not absolute but is mediated by factors such as patient demographics (our cohort was predominantly young and female) and cultural beauty standards. The analysis of DLQI domains offers granular insight into the nature of this burden. The most severely affected elements were "Itchiness/pain" and "Embarrassment," a finding that resonates perfectly with the conclusions of Tejada et al. [20]. This dual burden of physical discomfort and psychological distress is a hallmark of dermatological disease [20]. The subsequent impact on instrumental daily activities ("shopping/home duties") and practical life choices ("clothing") further demonstrates how skin disease permeates fundamental aspects of daily living [28]. In contrast, the minimal impact reported on sexual difficulties and problems with partners aligns with findings from other studies in conservative social contexts and may reflect a cultural reluctance to disclose issues in these sensitive domains [28].

A novel and significant contribution of our study is the exploration of the relationship between QoL and medication adherence. We found a statistically significant, negative correlation ($r = -0.201$, $p < 0.001$) between DLQI scores and adherence. This indicates that as disease-related QoL impairment worsens, patients are slightly more likely to report a decrease in their medication adherence. This result finds both contrast and consonance when compared to the study by Politiek et al. on vesicular hand eczema [29].

While the majority of our patients (76.2%) reported no influence of QoL on adherence, a clinically critical minority of 23.8% acknowledged that their QoL did affect their behavior. This group was nearly evenly split; 11.4% intensified their regimen, while 12.4% reduced it. The behavior of the former subgroup—where worsening QoL motivates increased engagement—aligns with the patterns observed by Politiek et al. (2020). In their study, patients on systemic therapy, who reported higher treatment satisfaction and lower QoL impairment, demonstrated significantly higher medication adherence (48.2%) compared to those using only topical treatments (27.7%). This suggests that for some patients, the significant burden of disease can catalyze a proactive effort to regain control, a phenomenon likely enabled by a perception of treatment efficacy. Conversely, the patients in our cohort who reduced their adherence in response to poor QoL may represent a state of therapeutic nihilism or frustration. This aligns with the call by Duran & Yürekli for management strategies that extend beyond symptom control to address psychosocial risk factors [25]. It is plausible that the depression, hopelessness, or frustration associated with a high disease burden, as seen in our cohort, where 64.8% described their general status as "unsatisfied and stressed," undermines the motivation to adhere to treatment, particularly if the therapy is perceived as ineffective. This dynamic underscores that the patient's perception of treatment value is the critical moderating factor between QoL and adherence. This principle is reinforced by studies across diverse chronic conditions within the Libyan population [30,31]. Therefore, effective long-term management necessitates routinely assessing and addressing the patient-perceived burden of illness, a primary driver of medication adherence.

The interpretations of this study should be considered in light of its limitations. The single-center design and convenience sampling method may limit the generalizability of the findings and introduce selection bias. Furthermore, the statistical power for analyzing condition-specific burden was limited for less prevalent diagnoses due to the uneven distribution of participants across diagnostic categories. Finally, a significant methodological limitation concerns the measurement of medication adherence, which was assessed via a single, non-validated question rather than a standardized scale. Although this approach captured the patient's perceived influence of their condition on adherence, it is vulnerable to recall and social desirability bias and lacks the depth of a multi-dimensional instrument. Future multi-center studies with larger, balanced cohorts are needed to validate these findings. The use of validated adherence scales in such research is essential to more accurately quantify this relationship.

Conclusion

In conclusion, our findings strongly reinforce the global consensus that dermatological conditions significantly impair QoL, with a burden that is heavily diagnosis-specific and driven by symptoms and embarrassment. The novel link between poorer QoL and a tendency towards reduced medication adherence provides a compelling argument for the routine use of the DLQI in clinical practice. Integrating QoL assessment is not merely an adjunct but a cornerstone of patient-centered care. Identifying patients with high DLQI scores allows clinicians to not only address the physical symptoms but also to proactively engage in conversations about psychological well-being and the potential barriers to treatment adherence, thereby improving holistic patient outcomes.

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Conflicts of Interest. The authors declare no conflicts of interest.

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