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A Study to Estimate the Prevalence and Pattern of Non-Venereal Pruritic Inguinal Dermatoses in Pediatric Population

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Abstract

Background: Genital pruritus in children is challenging for a clinician to treat. The moisture, occlusion, and exposure to irritants like urine and feces make them prone to genital pruritus.

Aim: To study the prevalence of non-venereal inguinal pruritic dermatoses and their association with demographic variables in the pediatric population.

Methods: A cross-sectional study was conducted in 384 children from 0 to 12 years, who presented with non-venereal genital dermatoses of either sex. Their age was categorized into three groups: 0-1 year, 1-4 years, and >4 years. Chi-Square test was applied, and statistical analysis was done.

Results: A total of 384 children were included in the study, with 207 males and 177 females (1:17) and a mean age of 66.92±188.43 months. The most common pediatric dermatoses were inflammatory dermatoses observed in 167 (43.5%) children, followed by infection 165 (43%), birthmark 36(9.4%), genetic defects 8(2.1%), burns 6(1.6%), and trauma 2(0.5%). In 0-1-year-old children presented with candida intertrigo and diaper dermatitis, in 1-4-year-old scabies and impetigo and in more than 4-year, scabies and urticaria were common.

Conclusion: Infections are the most common dermatoses observed in our center. Health education about cleanliness and early treatment is required to prevent the spread and suffering of the child.

Keywords: Non-Venereal; Genital; Dermatose; Pediatric

Introduction

The presentation of inguinal dermatoses differs in adults and children. Infants up to 2 years of age are more susceptible to dermatologic diseases than children [1] This is because of the thin stratum corneum, immature corneocytes, an unformed acid mantle of the skin [2]. Impaired skin barrier leading to more water loss [3], and poor immunity. Inguinal dermatoses can be classified into two types based on the mode of transmission: venereal and non-venereal dermatoses. Nonvenereal can be either infective or non-infective.

The prevalence and pattern of disease found in a community depend on factors such as climate, external environment, literacy, dietary habits, socio-economic status, health, and hygiene of an individual [3,4] In India, 47% of skin diseases are due to infections and infestations, and the remaining 27% are due to eczema.5 In a study conducted in Punjab, the prevalence of genital dermatoses was 86% [4,5]. In school-going children, especially in rural communities, communicable diseases like parasitic infestations, bacterial, and fungal infections are more common [6,7]. non-venereal genital dermatoses in children can be of various etiologies. It can be infectious, inflammatory, traumatic, benign, and genetic. This study aims to determine the prevalence of non-venereal genital pruritic dermatoses and their association with demographic variables in the pediatric population.

Materials and Methods

This is a hospital-based cross-sectional study conducted in the Department of Dermatology and Pediatrics from 25th December 2023 to 25th May 2024. The Institutional Ethical Committee approved the study. Informed consent was taken from every parent or guardian before enrollment.

Sample Size: Assuming the prevalence to be 50% as it provides the maximum sample size, at 5% level of significance and 3% absolute error, the sample size calculated was 384 subjects.

Inclusion Criteria: All the children from 0-12 years who presented with skin lesions and whose parents or guardians had consented were included in the study.

Exclusion Criteria: Patients are not willing to participate, and guardians are not willing to allow their children for the study. Infants who manifested only physiological cutaneous changes (neonatal erythema, lanugo, physiological desquamation, genital hyperpigmentation, vernix caseosa, axillary pigmentation, suckling pads, and vaginal bleeding). Cases with h/o sexual contact were excluded, any known c/o HIV, immunocompromised status, any history of topical and systemic treatment taken within a month from the visit in the opd were excluded from the study.

Methodology

The study was conducted in the Department of Dermatology. The children were categorized into three groups based on their age. The age range was classified as 0-1 year, 1-4 years, and >4 years. In a preset study, a detailed history was taken, which included name, age, sex, associated family history, related significant history, history of present complaints, and history of sexual exposure. General and systemic examination, details of vulva and penile cutaneous lesions were noted, and after examination provisional diagnosis of genital dermatoses was made. If required, it was confirmed by relevant bedside laboratory investigations. Microscopic examination of skin scrapings in potassium hydroxide (KOH) solution, Gram stain, pus culture, and sensitivity were performed for children with relevant complaints, and histopathological examination of lesional skin was done wherever required. A diagnosis of candida intertrigo was made when hyphae/pseudo-hyphae were observed in a KOH smear of skin scrapings. When infants presented with intertrigo, and hyphae/pseudo-hyphae were not observed in the KOH smear, the diagnosis was kept as intertrigo.

After clinical examination, a diagnosis was made. The nonvenereal dermatoses were classified into five groups: inflammatory diseases (psoriasis, seborrheic dermatitis, lichen planus, vitiligo, urticaria, lichen sclerosis, lichen nitidus, penile edema, lichen nitidus, diaper dermatitis, popular urticaria/ popular urticaria, atopic dermatitis, chronic bullous disease of childhood, miliaria pustulosa, lip lick cheilitis, cradle cap, pityriasis alba, umbilical granuloma, alopecia areata, keloid), infections like (bacterial: impetigo, furunculosis, folliculitis, vulvovaginitis, fungal: candida intertrigo, tinea, viral: viral: rash, chicken pox, genital wart, molluscum contagiosum, scabies, perianal pruritis, Pediculosis pubis), genetic- tuberous sclerosis, benign abnormalities (hemangioma, nevus lipomatous superficialis, sebaceous cyst, phimosis) and traumatic: burns, scald, circumscional injuries. Genital dermatoses imply that the dermatoses were confined to the inguinal region only. Generalized spread of dermatoses means that the dermatoses were spread to the whole body, including the inguinal region. Localized spread of dermatoses means the lesions are present in other parts of the body except the inguinal area.

Grade of Itch: The pruritus was graded into four grades: grade 4- very severe, grade 3- severe, grade 2- moderate, grade 1- mild, and Grade 0- nil.

Statistical Analysis: Data was entered in the Microsoft Excel software and thereafter analyzed on the ZAMOVI software. The proportion of various dermatoses was reported as percentages. Chi-square test was applied, and the p-value was judged at 5% level of significance.

Results

A total of 384 children were included in the study, with 207 males and 177 females (male-to-female ratio was 1:17) having a mean age of 66.92±188.43 months. The most common pediatric dermatoses were inflammatory dermatoses observed in 167 (43.5%) children, followed by infection 165 (43%), birthmark 36(9.4%), genetic defects 8(2.1%), burns 6(1.6%), and trauma 2(0.5%) as shown in (Figure 1). For age group, 0-1 year inflammatory 32(19.2%) dermatoses were common followed by infection 25(15.2%) followed by birthmark 28(77.8%). In 1-4 year of age group inflammatory dermatoses 51(30.5%) was common followed by infection 38(23%) followed by birthmark 7(19.4%) and Geno dermatoses 2(25%). Amongst age >4 years, infection 102 (61.8%) was common, followed by inflammatory dermatoses 84(50.3%), Geno dermatoses 6(75%), and birthmark 1(2.8%). This difference was statistically significant between the age and diagnosis (p-value <0.05) (Table 1).

Amongst the gender distribution boys presented with inflammatory dermatoses 94(56.3%) followed by infection 84(50.9%) followed by birthmark 22(61.1%), Geno dermatoses 4(50%) and traumatic 2(100%). Girls presented with infections 81(49.1%) as the most common followed by inflammatory dermatoses 73(43.7%) followed by birthmark 14(38.9%), burns 5(83.3%), Geno dermatoses 4(50%) and traumatic 2(100%). This difference was not statistically significant between the genders and diagnoses (p-value>0.05) (Table 1). Of 264, 235 children had pruritus (Grade 1- Grade 4), Grade 4 pruritus was observed in 14 children with infection, 12 with inflammatory dermatoses. Grade 3 pruritus was present in 42 children with inflammatory dermatoses and 32 children with infection. Grade 2 pruritus was present in 53 children with infection, and 39 children with inflammatory dermatoses, and Grade 1 pruritus was present in 52 children with infection and 38 children with inflammatory

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dermatoses 3 children with burns and 2 children with trauma, and 97 children and no pruritus (Figure 2). Amongst the pattern distribution, 122/271 (31.8%) children were affected in the genital area and 149(38.8%) children had dermatoses spread generalized over the body, and 113(29.4%) children presented in the regional area. Generalized spread of inflammatory dermatoses was observed in urticaria 21(95.5%) followed by atopic dermatitis 17(94.4%), and in localized spread diaper dermatitis 13(100%) followed by LSC 5(100%). In the infective dermatoses, the genital area was frequently affected with genital warts in 18(94.7%) and vulvovaginitis in 11(100%), and in the generalized spread scabies 36(92.3%) and impetigo 14(100.0%). The difference between the pattern and diagnosis was found to be statistically significant (p-value <0.05) (Table 2).

Table 1: Association of Age and Gender with the Diagnosis.

Demographic Variables		Infection	Inflammatory Dermatoses	Burns/Scald	Birthmark / Birth Defect	Dermatoses	Traumatic	Chi Square /P Value
Gender	Male	84 (50.9%)	94 (56.3%)	1 (16.7%)	22 (61.1%)	4 (50.0%)	2 (100.0%)	6.84 /0.23
	Female	81 (49.1%)	73 (43.7%)	5 (83.3%)	14 (38.9%)	4 (50.0%)	0 (0.0%)	
Age	0 to 1 Year	25 (15.2%)	32 (19.2%)	0 (0.0%)	28 (77.8%)	0 (0.0%)	1 (50.0%)	83.98 /0.00
	1 Year to 04 Year	38 (23.0%)	51 (30.5%)	1 (16.7%)	7 (19.4%)	2 (25.0%)	1 (50.0%)	
	>4 Year	102 (61.8%)	84 (50.3%)	5 (83.3%)	1 (2.8%)	6 (75.0%)	0 (0.0%)	
	Age (in Months)	65.10±39.53	80.0±281.82	84.00±24.62	14.36±20.29	66.50±30.44	22.00±19.80	F=0.754 P=0.583

Table 2: Association of Clinical Characteristics with Dermatoses.

Characteristics		Infection	Inflammatory Dermatoses	Burns/ Scald	Naevus	Genodermatoses	Traumatic	Chi Square /P Value
Genital Pruritis prevalence	No	22 (13.3%)	58 (34.7%)	6 (100.0%)	23 (63.9%)	4 (50.0%)	0 (0.0%)	60.28 /0.00
	Yes	143 (86.7%)	109 (65.3%)	0 (0.0%)	13 (36.1%)	2 (0.0%)	2 (100.0%)	
Pattern	Localized (genital)	57 (34.5%)	49 (29.3%)	0 (0.0%)	13 (36.1%)	1 (12.5%)	2 (100.0%)	74.21 /0.000
	Regional	22 (13.3%)	58 (34.7%)	6 (100.0%)	23 (63.9%)	4 (50.0%)	0 (0.0%)	
	Generalized (Including Genital)	86 (52.1%)	60 (35.9%)	0 (0.0%)	0 (0.0%)	3 (37.5%)	0 (0.0%)	
Past Family History	Absent	56 (33.9%)	127 (76.0%)	5 (83.3%)	35 (97.2%)	8 (100.0%)	2 (100.0%)	93.89 /0.00
	Present	109 (66.1%)	40 (24.0%)	1 (16.7%)	1 (2.8%)	0 (0.0%)	0 (0.0%)	
H/O Past treatment	Absent	129 (78.2%)	107 (64.1%)	6 (100.0%)	29 (80.6%)	2 (25.0%)	2 (100.0%)	21.31 /0.001
	Present	36 (21.8%)	60 (35.9%)	0 (0.0%)	7 (19.4%)	6 (75.0%)	0 (0.0%)	

Precipitating factors like overcrowding were commonly observed with scabies in 11 children, genital warts in 7 children, molluscum in 1 child, and wearing of diapers or tight undergarments predisposed the children to candida intertrigo in 5 children. Coexisting infection in the family also helped in the spread of diseases like impetigo in 9 children and chicken pox in 9 children. Inflammatory dermatoses like urticaria observed in 9 children also had similar complaints in family members (Table 2). Family history of similar dermatoses was present in 151 of 271 children. Children presented with the family history predominantly in infective dermatoses like scabies 38 children, tinea in 12 children, genital warts in 11 children, molluscum in 10, chicken pox in 10 children, impetigo in 5 and P rosea in 3 and in inflammatory dermatosis- atopic dermatitis in 18 children and vitiligo in 4 children. The difference between the pattern and diagnosis was found to be statistically significant (p-value <0.05).

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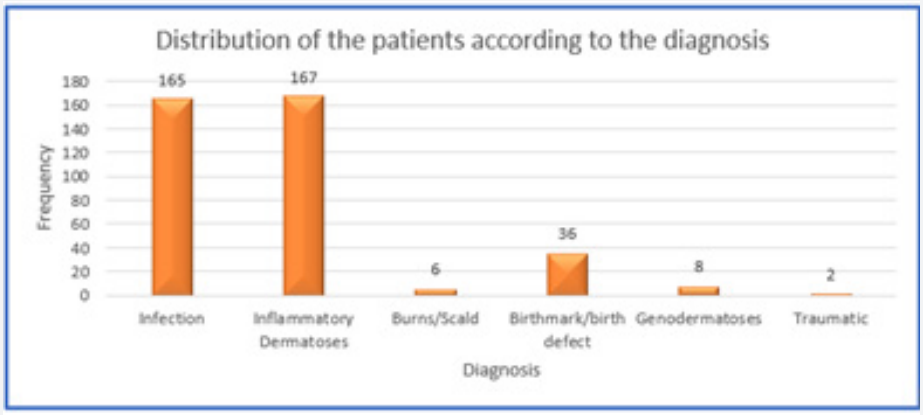

Figure 1: Distribution of the patients according to their diagnosis.

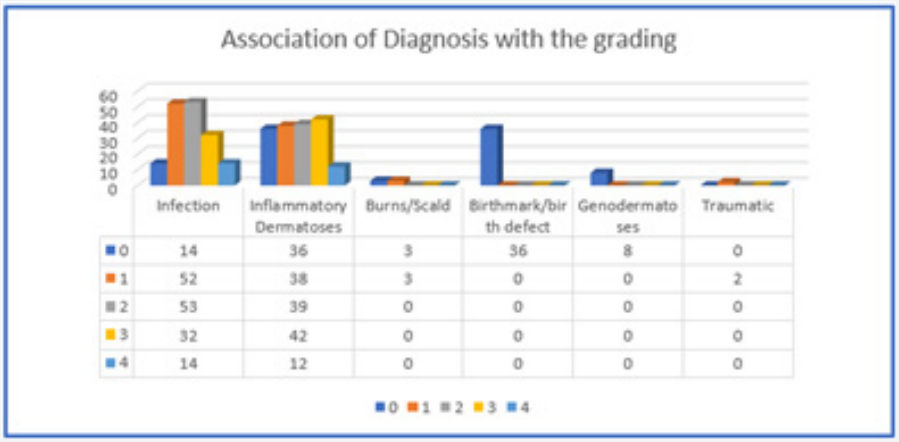

Figure 2: Association of diagnosis with the grading of pruritus.

Figure 3: Genital wart in 4-year-old girl

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Figure 4: Scabies in 5 years old boy

Figure 5: Insect bite hypersensitivity in 3 years old boy

Figure 6: Diaper dermatitis 2-year-old girl

Discussion

In this study, 384 children participated, where boys were 207 and girls were 177, having a mean age of 66.92±188.43 months. The mean duration of the disease on average was 4.92 months. The most common precipitating factors causing these dermatoses were overcrowding, coexisting infections in the family, wearing of diapers or tight clothing, and burns. The majority of patients attending the hospital were of lower socio-economic status. Most of them were unaware of disease severity and its complications. They were illiterate and had poor hygiene. Grover S, et al. [8] Found the prevalence in Allahabad to be 80% and in our study, it was 83% Infections and inflammatory dermatoses were the most common diseases observed in our study. Karthikeyan K, et al. [9] found infective dermatoses to be 54.5% and Negi KS, et al. [10] (50.9%). However, Sreedevi L, et al. [11] and Sailaja, et al. [12]

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in their study found it to be 173(86.5%) and 80% respectively. others like Acharya, et al. [13], Degboe, et al. [14], and Devi, et al. [15] had similar findings.

Parasitic

Sreedevi L, et al. [11] conducted a study in 200 children from 0-18 years, where scabies was the most common infection, 173/200 (83%), and in the adolescent age group, 21.46% were affected. Similar findings were observed by Mistry [16], Gupta, Das where genital scabies was 25.19%. Saraswat PK, et al. [17] found genital scabies to be 11.04% & scabies with secondary infection (10.44%) in the age group of 9-18 years, 4%. Elloudi S, et al. [18] found the prevalence of scabies to be 8%. These results were similar to our study, where the frequency of scabies was 10.2% and was commonly seen in the adolescent age group (61.5%) of 4-12 years than in 1-4 years (23.1%) or 0-1 years (15.4%). Karthikeyan K, et al. [9] found genital scabies (24.86%) and scabies with secondary infection (15.03%), observed in male children (54.5%). The latter is similar to our study as in 22 boys (56.4%) than in girls 17(43.6%).

Bacterial

Sardana K et al21 found a higher frequency of bacterial infections, 27.39% in their study. Karthikeyan K, et al. [9] found the most common bacterial infection to be bullous impetigo (5.20%). Saraswat PK, et al. [17], and Devi, et al. [15] also had similar findings, 8.12% in preschool children. Sreedevi L, et al. [11] found 9.5% in bullous impetigo, followed by folliculitis (3.5%), furunculosis (2%), respectively. Negi KS, et al. [10] found pyoderma in 15.4%. Das18 found that out of 127 children, bacterial infections were 12.59% of which bullous impetigo was 11.02% followed by folliculitis (1.57%), respectively. Similar were our findings where impetigo was 18(4.7%), folliculitis was 3% and furunculosis 5(1.3%). Bacterial infection was the most common infection observed in Singh N, et al. [19] and Pathak, et al. [20] studies, and amongst the bacterial infections, bullous impetigo was the common. Folliculitis was the commonest one reported by Gurumayum, et al. [21].

Fungal

Mistry F, et al. [16], Elloudi S, et al [18], Devi, et al. [15], Sreedevi L [22] and Rajasekhar (7.5%), Sardana K, et al. [23], Jawade, et al. [24] observed that the most common fungal infection was tinea cruris (7.5 -10%). These results were similar to our findings 178(4.4%). However, Sailaja, et al. [12] found a higher incidence of fungal infection, 26.5%. Concerning candida intertrigo, Karthikeyan K, et al. [9], Sailaja [12], and Mistry, et al. [16] found the incidence of intertrigo (5%-7.5%) to be almost similar to our study (8%, 2.1%), predominantly in the 0–1-year age group. Candidiasis was the most common infection observed in Paudel, et al. [25], Joshi, et al [26], Puri, et al. [27], Gurumayum, et al. [21], and Sardana, et al. [23]. Fungal infections were predominantly seen in toddlers, except for tinea cruris, which was more prevalent in the adolescent age group.31 In our study, amongst the genders, 17.4% girls were affected and 9.28% boys were affected.

Viral

Sardana K, et al. [23] found the incidence of viral infections in 3.68% which correlates with our study (3.5%). Our study showed P. rosea was 12(3.1%), chicken pox 12(3.1%), genital wart 21(5.5%), molluscum contagiosum 14(3.6%), which was similar to the findings of Sreedevi L [22], and Gosh, et al. [28]. in contrast, Elloudi S [18] reported HPV infections in 10%. Gosh SK, et al. [28] and or study shows viral infection predominantly affecting boys. Boys >4years were affected with genital warts were 10(55.6%), whereas girls were affected with P. rosea, 4(80%), and chicken pox, 2(100%). Similar to the results of our study: p alba (5%), Fordyce spots (2.5%), Lichen Planus (2.5%), Lichen Striatus (2.5%), Hemangioma (2.5%), Phimosis (2.5%), and Traumatic ulcer (2.5%) respectively.

Non- Infective Dermatoses

Sailaja, et al. [12] found the incidence of non-infective dermatoses was 20% of which eczema was 10%, except the vitiligo vulgaris, which was 7(1.8%) in our study. Sailaja [12] and Sreedevi [22] found 22.5% and 15.8% respectively. Karthikeyan K, et al. [11] found prevalence to be 14.1 per 10000. Out of 25 non-venereal dermatoses, the most common disorder was Genital vitiligo. Mistry18 found 31.6% eczema, which was the most common, followed by genital psoriasis (1.57%), lichen planus (1.57%), lichen sclerosis (0.79%), and nevi (2.37%). In contrast, Negi [10] found the prevalence of non-infective dermatoses to be (25-29.6%) pityriasis alba (10.4%) and eczema (8.1%), which did not align with our research. Fischer & Rogers [29] evaluated 130 girls, where there was a higher prevalence of inflammatory dermatoses as compared to our study. Of these patients, 41 (33%) had irritative dermatitis, 23 (18%) had lichen sclerosis, 21 (17%) had psoriasis, 15 (12%) had benign vulvar tumors, and 13 had streptococcal vulvovaginitis. In our study, male children had a higher prevalence of inflammatory dermatoses (56.56%) compared to female children 43.44%.

In 0-1 year, in the inflammatory conditions like diaper dermatitis 8(61.5%), miliaria 3(60%) was common, followed by infective candidal intertrigo 8 (100%) and scabies 6(15.4%). In 1-4 years, in the inflammatory condition atopic dermatitis 10(55.6%), urticaria 7(31.8%) were common, followed by infection -scabies 9 (23.1%), impetigo 8(57.1%). In >4-year infection - scabies 24(61.5%), vulvovaginitis 11(100%) followed by inflammatory -urticaria 14(63.6%), vulvovaginitis 11(100%) were common. In our study, the most common pruritic genital dermatoses were infective of which scabies was most common, followed by genital warts and tinea, and in inflammatory dermatosis it is diaper

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dermatitis was most common, followed by vulvovaginitis. For age group, the most common pruritic dermatoses in 0-1-year-old children were candida intertrigo and diaper dermatitis, and scabies were common. In 1–4-year, scabies, impetigo, atopic dermatitis, and urticaria were common, and in > 4-year scabies, urticaria vulvovaginitis genital warts were common. The majority of the genital infections were found in male children compared to female children **(Figure 3-6)**.

Conclusion

This concludes that infective genital dermatoses are still very common because of poor hygiene, lack of awareness and insight, and the myth of not using simple soap and water during an infective condition. Since children are embarrassed about reporting their genital dermatoses to parents so by the time they seek medical treatment, the disease becomes florid and spreads to other parts of the body or their siblings. Hence, it's our prime responsibility to organize and promote educational programmed at the primary levels.

Limitations

The study was carried out in the outpatient clinic of the dermatology department of a tertiary referral center, and the cross-sectional design was the major limitation.

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