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GENITAL PSORIASIS AND PATIENT-REPORTED BURDEN: SEXUAL FUNCTION, GENITAL SELF-IMAGE, AND QUALITY OF LIFE

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ABSTRACT

Genital psoriasis is a common but frequently underrecognized manifestation of psoriatic disease whose burden is poorly represented by conventional measures based on body surface area or overall plaque severity. Local symptoms, including pruritus, burning, pain, fissuring, and postcoital exacerbation, may impair physical comfort, sexual activity, intimate relationships, genital self-image, and psychological well-being. Patients commonly report embarrassment, fear of rejection, avoidance of sexual contact, reduced sexual desire, and concern that genital lesions may be mistaken for a sexually transmitted infection. However, the relationship between genital psoriasis and physiological sexual dysfunction is complex and influenced by age, cardiovascular risk, depression, anxiety, psoriatic arthritis, relationship factors, and psoriasis affecting other sexually sensitive body regions. Generic instruments such as the Dermatology Life Quality Index, Female Sexual Function Index, and International Index of Erectile Function provide useful information but incompletely capture genital-specific symptoms and avoidance behaviors. Genital-specific measures, including the Genital Psoriasis Symptoms Scale and Genital Psoriasis Sexual Frequency Questionnaire, offer greater content validity but require broader independent evaluation. Clinical trials and real-world studies indicate that effective topical, oral, and biologic therapy may improve genital symptoms, quality of life, and sexual activity. Nevertheless, sexual and relationship-related impairment may persist despite cutaneous improvement. This review synthesizes current evidence on the patient-reported burden of genital psoriasis, identifies limitations of available outcome measures, and proposes a patient-centered framework for clinical assessment and therapeutic decision-making.

KEYWORDS

Genital Psoriasis; Vulval Psoriasis; Sexual Function; Sexual Dysfunction; Quality of Life; GPSS; GenPs-SFQ

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1. Introduction

Psoriasis is a chronic immune-mediated inflammatory disease that may involve any cutaneous region. Genital involvement is particularly important because lesions affecting a small surface area can cause a disproportionate physical, sexual, and psychosocial burden. Depending on study design and the distinction between current and lifetime involvement, genital psoriasis has been reported in 7-43% of evaluated patients at a specific time point and in up to approximately 63% during the disease course. Psoriasis may also remain confined to the genital region in a minority of patients. Despite this frequency, genital involvement is often neither volunteered by patients nor actively assessed by clinicians. (Meeuwis et al., 2018) (Wu & Fischer, 2024) (Kelly & Ryan, 2019).

The clinical appearance of genital psoriasis may differ from classic plaque psoriasis. Moisture, friction, and maceration often reduce visible scaling, resulting in smooth, sharply demarcated erythematous patches or thin plaques. Vulval disease commonly affects the labia majora, interlabial sulci, labia minora, perineum, and perianal region, whereas male genital disease frequently involves the glans, prepuce, penile shaft, scrotum, and perineum. The atypical appearance and sensitive location may result in confusion with candidiasis, irritant or allergic dermatitis, tinea, lichen planus, balanitis, premalignant disease, or sexually transmitted infection. (Wu & Fischer, 2024)(Wu & Fischer, 2025).

Conventional psoriasis severity measures may underestimate this phenotype. Psoriasis Area and Severity Index and body surface area assessments are dominated by disease extent and provide limited information about local symptoms, genital self-image, sexual avoidance, or relationship impairment. A patient with limited genital involvement may therefore have a low PASI or BSA but severe disease from a patient-centered perspective. This discrepancy has contributed to under-recognition, undertreatment, and inappropriate restriction of systemic therapy in some healthcare systems. (Wu & Fischer, 2024) (Wu & Fischer, 2025).

The objective of this review is to synthesize evidence on the patient-reported burden of genital psoriasis, focusing on symptoms, quality of life, sexual function, genital self-image, stigma, intimate relationships, communication barriers, and the effects of treatment. Particular attention is given to the distinction between physiological sexual dysfunction and broader psychosexual burden, as well as to the limitations of commonly used outcome measures.

2. Methods

This article is a targeted narrative review based on a predefined corpus of publications identified through PubMed searches concerning genital psoriasis, quality of life, sexual health, sexual dysfunction, genital self-image, stigma, intimacy, pruritus, pain, patient-reported outcomes, and therapeutic response. The initial search results were deduplicated, and clinically relevant reviews, qualitative studies, observational studies, randomized trials, and real-world cohorts were prioritized.

Studies were included when they addressed current or previous genital involvement in psoriasis and reported at least one clinically relevant outcome concerning symptoms, quality of life, sexual activity, sexual function, sexual distress, genital self-image, intimate relationships, avoidance, communication, or treatment response. Studies of general psoriasis-associated sexual dysfunction were used when they helped distinguish the effect of genital lesions from systemic, psychological, cardiovascular, or treatment-related factors. Because the included studies were heterogeneous in design, population, terminology, instruments, disease severity, and treatment exposure, no quantitative synthesis was undertaken.

3. Terminology and Conceptual Scope

The terminology used in the literature is inconsistent. Genital psoriasis usually refers to involvement of the vulva, penis, scrotum, or perineum. Anogenital psoriasis additionally encompasses anal and perianal involvement. More recent research has introduced the broader category of areas of sexual interest, including the genital and anal areas, groin, buttocks, lower back, and chest or breasts. This broader concept is relevant because psoriasis affecting erogenous or visually salient areas outside the genital region may also disrupt sexual function and intimacy. (Molina-Leyva et al., 2014)(Janke et al., 2026)

For the purposes of this review, genital psoriasis is treated as a high-impact anatomical phenotype rather than as a separate biological subtype. Its burden arises from the interaction of four domains:

1. local symptoms and mechanical irritation;
2. genital self-image, stigma, and emotional distress;
3. sexual activity, intimate relationships, and fear of rejection;

4. healthcare barriers, including diagnostic delay, inadequate examination, and insufficiently sensitive outcome measures.

These domains overlap but are not interchangeable. A patient may have severe sexual distress without measurable erectile or orgasmic dysfunction, while another may have physiological sexual dysfunction driven primarily by cardiovascular disease, depression, medication, or psoriatic arthritis rather than by genital plaques themselves.

4. Epidemiology and Under-recognition

Prevalence estimates vary according to whether genital involvement is self-reported, identified by physical examination, or measured as a current, recent, or lifetime manifestation. In the prospective multicenter GENIPSO study, 335 of 776 patients consulting for extragenital psoriasis had genital involvement on examination, corresponding to an instantaneous prevalence of 43.2%. Genital lesions were associated with male sex, greater psoriasis severity, onset after 20 years of age, inverse psoriasis, and involvement of the scalp, nails, and external auditory canal. (Larsabal et al., 2019)

Under-recognition was substantial. All GENIPSO participants with genital disease were aware of their lesions, but only 40% reported having undergone a previous genital examination by a dermatologist. Because patients were enrolled while consulting for extragenital psoriasis, the findings demonstrate that clinically relevant genital involvement may remain undetected even among patients already receiving dermatological care. (Larsabal et al., 2019)

A large German registry-based survey published in 2026 found a 24-month period prevalence of 21.6% and point prevalence of 10.8% for genital psoriasis. Almost 85% of patients with current genital disease were receiving systemic treatment, yet many continued to report active genital symptoms and impaired sexual well-being. The difference between point and period prevalence illustrates the relapsing nature of genital involvement and the limitations of a single clinical examination. (Janke et al., 2026)

Women may experience particularly prolonged diagnostic pathways. In a retrospective cohort of 350 women with vulval psoriasis, the mean age at disease onset was approximately 40 years and the mean age at presentation approximately 50 years, indicating an average diagnostic delay of around 11 years. Only a minority of women with evidence of extragenital psoriasis had previously received a psoriasis diagnosis. (Wu & Fischer, 2025)

These findings support routine but consent-based inquiry regarding genital symptoms and involvement. Examination should not depend solely on spontaneous disclosure, because embarrassment, uncertainty, normalization of chronic symptoms, or concern about judgment may prevent patients from raising the issue.

5. Local Symptom Burden

5.1. Pruritus, burning, and discomfort

Pruritus is consistently reported as the most common and often the most burdensome symptom of genital psoriasis. In a qualitative study of 20 adults with moderate-to-severe genital psoriasis, all participants reported itch and discomfort, 95% reported redness and stinging or burning, 85% reported pain, and 75% reported scaling. Itching and stinging or burning were each identified as the most bothersome symptom by 40% of participants. (Cather et al., 2017)

Patients frequently distinguished genital symptoms from psoriasis elsewhere. Genital itch was described as more persistent, difficult to relieve, and more likely to cause bleeding after scratching. Pain, burning, moisture, and constant awareness of the affected area interfered with walking, sitting, exercise, sleep, work, and urination. Friction, sweat, tight clothing, prolonged activity, and sexual contact commonly aggravated symptoms. (Cather et al., 2017)

In the multicenter study by Ryan et al., 87% of patients with genital involvement reported itch, 39% pain, 42% dyspareunia, 32% worsening after intercourse, and 43% reduced frequency of intercourse. These findings indicate that symptom burden extends beyond visible erythema and should be assessed directly rather than inferred from physician-rated lesion severity. (Ryan et al., 2015).

In the large vulval psoriasis cohort, pruritus was reported by 89.1% of women, pain or fissuring by 36.6%, and dyspareunia by 29.7%. Erythema was nearly universal, whereas scaling was substantially less frequent, emphasizing why symptom questioning is critical when classic plaque morphology is absent. (Wu & Fischer, 2025).

5.2. Erosions, fissures, and mechanical trauma

Erosions, fissures, and ulcer-like changes may intensify pain and restrict sexual activity. In a post hoc analysis of IXORA-Q, 38% of participants had genital erosions, fissures, or ulcers at baseline. These findings were associated with greater genital severity and pain but not necessarily with greater baseline sexual limitation, demonstrating that visible tissue damage and sexual burden are related but not fully concordant domains. (Merola et al., 2020)

Mechanical friction during sexual activity may exacerbate erythema, burning, cracking, or pain, creating a cycle of anticipatory anxiety and avoidance. Genital psoriasis may therefore impair sexual activity through both immediate nociceptive effects and learned fear of postcoital symptom aggravation. (Cather et al., 2017) (Ryan et al., 2015).

6. Quality of Life Beyond PASI and Body Surface Area

Genital psoriasis illustrates a fundamental limitation of extent-based psoriasis assessment. Even when total BSA is low, symptoms in a sensitive anatomical region can produce marked disability. In GENIPSO, patients with genital involvement had a median DLQI of 7 compared with 3 among patients without genital disease. This difference was more pronounced than differences detected by several general sexual-function instruments. (Larsabal et al., 2019)

In a German nationwide cohort of 2,009 patients, the 622 participants with anogenital psoriasis had higher mean PASI and greater DLQI impairment than those without anogenital involvement. After adjustment for age, disease duration, PASI, BSA, and treatment type, anogenital involvement remained associated with worse dermatology-specific quality of life. Patients with anogenital disease also reported a greater need to restore a normal sexual life. (da Silva et al., 2020)

The 2025 Asian observational study reported a mean DLQI of 9.8, indicating moderate quality-of-life impairment despite a mean PASI of 7.0. Higher PASI was associated with worse DLQI, but the investigators emphasized that genital location itself likely contributed substantially to the observed burden. Younger participants also had less favorable depression scores. (Ong et al., 2025)

The vulval psoriasis cohort provides longitudinal evidence that treatment can improve quality of life. VQLI scores decreased from 18.0 at baseline to approximately 9 at follow-up. The greatest improvements occurred in future health concerns, emotions, symptoms, and activities of daily living. Sexual-function and relationship domains improved less consistently than physical and emotional domains, suggesting that psychosexual recovery may lag behind cutaneous response. (Wu & Fischer, 2025)

Quality-of-life impairment should therefore be viewed as a primary manifestation of genital disease rather than a secondary consequence of extensive psoriasis. A treatment decision based exclusively on PASI or BSA may fail to identify patients with substantial genital symptoms, sexual avoidance, or psychological distress.

7. Sexual Function, Sexual Distress, and Sexual Activity

7.1. Distinguishing sexual dysfunction from sexual burden

The term sexual dysfunction includes physiological or psychophysiological impairment of desire, arousal, erection, lubrication, orgasm, ejaculation, satisfaction, or pain. By contrast, sexual burden is broader and includes avoidance, reduced frequency, embarrassment, fear of rejection, altered genital self-image, relationship tension, and symptom exacerbation during or after sexual contact.

This distinction is essential in genital psoriasis. Generic sexual-function questionnaires may show limited differences even when patients report considerable sexual avoidance or distress. Conversely, abnormal FSFI or IIEF scores may be influenced by age, depression, cardiovascular disease, obesity, medication, relationship context, or psoriatic arthritis.

7.2. Sexual frequency and avoidance

In the qualitative study by Cather et al., 90% of participants reported at least one negative sexual consequence. Impaired sexual experience, postsexual worsening, and reduced frequency were each reported by 80%; 75% reported avoidance of sexual relationships, and 55% reported reduced sexual desire. The effects resulted from both physical factors, such as friction, cracking, and pain, and psychosocial factors, such as embarrassment, stigma, and fear of disclosure. (Cather et al., 2017)

A German population-centered survey of 344 individuals found genital psoriasis in 198 participants. Longer disease duration, greater subjective severity, and pain during sex were associated with avoidance of

sexual activity. Shame, pain, and fear of rejection were the most frequently reported reasons for avoidance. (Schielein et al., 2020)

The 2026 PsoBest survey similarly demonstrated persistent sexual burden in routine care. Among patients with current genital psoriasis, 60.5% reported impairment of sexual life during the preceding 30 days. Approximately 13% reported always avoiding sexual activity specifically because of genital psoriasis, while a further 20.9% reported sometimes or often avoiding it for this reason. Pain during sexual stimulation, painful or restricted movement, loss of libido, low self-confidence, and relationship conflict were prominent contributing factors. (Janke et al., 2026)

7.3. Female sexual function

In a cross-sectional study of 52 sexually active women with psoriasis and 30 controls, psoriasis severity correlated negatively with overall sexual satisfaction. Women with genital involvement had greater impairment of sexual function than women without genital lesions or with psoriasis affecting other regions. (Abul Maaty et al., 2013)

A more recent study compared 25 women with genital psoriasis, 25 with non-genital psoriasis, and 25 healthy controls. Sexual dysfunction was identified in 24 women with genital psoriasis, 19 with non-genital psoriasis, and 9 controls. Women with psoriasis also had poorer genital self-image than controls, with significantly more negative Female Genital Self-Image Scale scores among women with genital involvement than among those with non-genital psoriasis. (Elsadek et al., 2024)

In the Asian cohort, the small female subgroup had a mean FSFI score of 13.0, below the threshold for clinically relevant sexual dysfunction, and a mean Female Sexual Distress Scale score of 15.4. Embarrassment was the most frequently reported form of distress, followed by worry and inferiority. All women reported reduced desire, and dysfunction of arousal, lubrication, orgasm, or satisfaction was common. Women also reported greater symptom severity and embarrassment than men but were less likely to be receiving treatment. These results should be interpreted cautiously because women represented fewer than one fifth of the cohort. (Ong et al., 2025)

7.4. Male sexual function and erectile dysfunction

The association between psoriasis, genital involvement, and erectile dysfunction is less straightforward. Psoriasis severity, genital or buttock involvement, psoriatic arthritis, smoking, anxiety, depression, cardiovascular comorbidity, and treatment effects have all been proposed as contributors to male sexual dysfunction. However, studies using different instruments have produced inconsistent results. Genital psoriasis is more consistently associated with global sexual difficulty and reduced satisfaction than with a specific reduction in erectile function measured by IIEF. (Dauendorffer et al., 2019)

In a study of 487 patients summarized in the male-sexuality review, genital involvement was associated with worse DLQI and greater impairment on the sexual item of DLQI, but not with worse erectile function measured by IIEF-5 or global sexual quality measured by a male-specific questionnaire. GENIPSO similarly demonstrated worse DLQI and a modestly lower FSFI in women with genital involvement but no significant reduction in IIEF among men. (Dauendorffer et al., 2019) (Larsabal et al., 2019)

A prospective dermatology-outpatient study found IIEF-5-defined erectile dysfunction in 58% of men with psoriasis and 49% of dermatological controls. Although the age-adjusted association was significant, multivariable analysis identified age and hypertension - not psoriasis diagnosis itself - as independent predictors. The study supports sexual-health screening in psoriasis but cautions against assuming that erectile dysfunction is directly caused by genital plaques. It also highlights erectile dysfunction as a potential marker of cardiovascular risk. (Goulding et al., 2011)

Sexual distress, reduced libido, avoidance, and dissatisfaction should therefore be assessed separately from erectile physiology. An apparently normal IIEF score does not exclude meaningful psychosexual burden, just as erectile dysfunction in a patient with psoriasis does not establish genital inflammation as its primary cause.

7.5. Other sexually sensitive locations

The influence of psoriasis on sexuality is not confined to genital skin. In a prospective case series, lesions affecting the abdomen, genitals, lumbar region, and buttocks in women, and the chest, genitals, and buttocks in men, were associated with increased sexual dysfunction. Multivariable analysis suggested that involvement of these regions may independently contribute to sexual impairment. (Molina-Leyva et al., 2014)

This finding supports assessment of broader areas of sexual interest. Buttock, breast, chest, lower abdominal, or lower-back lesions may impair body confidence, create friction, or remain visible during intimacy. Restricting the definition of sexual burden to genital plaques may therefore underestimate the relevant anatomical phenotype.

8. Genital Self-Image, Stigma, and Intimate Relationships

Genital self-image describes an individual's perceptions, emotions, and satisfaction concerning the appearance and function of the genital region. It is related to but distinct from general body image. Genital plaques, erythema, scale, fissuring, or discoloration may produce shame, self-consciousness, reduced perceived attractiveness, and fear that a partner will misinterpret lesions as infectious or sexually transmitted.

Qualitative interviews demonstrate that patients may become guarded about nudity, changing clothes, showering around others, dating, or initiating new relationships. Some patients fear that potential partners will reject them or assume infidelity or infection. Others avoid sexual contact because disclosure itself is emotionally difficult. (Cather et al., 2017)

In women, genital involvement has been associated with significantly poorer genital self-image than both non-genital psoriasis and healthy status. The relationship between self-image and sexual function is likely bidirectional: visible disease may reduce confidence and desire, while repeated painful or unsuccessful sexual experiences may further worsen genital self-perception. (Elsadek et al., 2024)

Stigma may be externally anticipated rather than directly experienced. Fear of rejection can drive avoidance even in patients whose partners have not expressed negative attitudes. This distinction is clinically relevant because lesion clearance alone may not immediately reverse internalized shame, relationship anxiety, or altered sexual scripts. Psychosexual burden may therefore persist after physical improvement and may require direct communication, reassurance, counseling, or partner-inclusive support.

9. Sex- and Gender-Related Differences

Sex-related differences in genital psoriasis burden are not consistent across studies, partly because different instruments capture different constructs. Women may report greater overall quality-of-life impairment, symptom burden, embarrassment, genital self-image disturbance, and sexual distress. Men may report greater impact on sexual frequency or sex-related treatment needs in some cohorts. These differences should not be interpreted as a universal hierarchy of burden.

In GENIPSO, women were more symptomatic than men and had worse FSFI scores with genital involvement, whereas IIEF did not differ significantly in men. In the Asian cohort, women reported greater symptom and embarrassment burden but were less often treated. By contrast, the large German anogenital cohort found greater sex-related DLQI impairment and treatment need among men, although women had worse overall health and dermatology-specific quality of life. (Larsabal et al., 2019) (Ong et al., 2025) (da Silva et al., 2020)

Differences may reflect cultural norms, relationship status, willingness to disclose, instrument design, sexual activity status, treatment access, and the underrepresentation of women in many genital psoriasis studies. Most research has also used binary sex categories and predominantly heterosexual intercourse-oriented measures, leaving the experiences of sexual and gender minorities insufficiently characterized.

10. Patient-Clinician Communication and Diagnostic Gaps

Communication barriers are among the most modifiable contributors to untreated disease. Patients may not know that genital symptoms are related to psoriasis, may normalize chronic irritation, or may avoid disclosure because of embarrassment. Clinicians may focus on visible extragenital plaques, assume that patients will volunteer genital concerns, or feel uncertain about appropriate terminology and examination.

In a qualitative interview study of 28 patients, 75% reported that their dermatologist had not asked about genital involvement. Eleven participants had experienced genital psoriasis, and two reported diagnostic delays exceeding two years because they were embarrassed to seek help. Terminology preferences varied: half preferred general terms such as "genitals" or "down there," whereas a smaller group preferred specific anatomical terminology. Most participants did not strongly prefer a clinician of the same age or sex. The findings favor an individualized, neutral, and non-assumptive communication style. (Moumen et al., 2023)

Questionnaires may facilitate discussion by allowing patients to disclose symptoms or sexual impact privately. However, in the German anogenital cohort, 23-42% of sex-related questionnaire responses were missing or marked as not relevant. This may reflect true non-applicability, sexual inactivity, discomfort, or limitations of generic item wording. Questionnaires should therefore initiate rather than replace a sensitive clinical conversation. (da Silva et al., 2020)

A practical opening question may be: "Psoriasis can sometimes affect the genital or perianal area. Have you noticed itching, redness, discomfort, or psoriasis in this region?" A second question may address burden: "Has it affected comfort, sexual activity, confidence, or relationships?" Examination should be offered with explicit consent, appropriate privacy, and a chaperone according to local standards.

11. Patient-Reported Outcome Measures

11.1. Generic dermatology and sexual-function instruments

The DLQI is widely used but contains only one question concerning sexual difficulties. It does not distinguish pain, avoidance, reduced desire, erectile function, genital self-image, or postsexual exacerbation. Scoring "not relevant" as zero may underestimate burden in patients who are sexually inactive because of disease.

The FSFI evaluates desire, arousal, lubrication, orgasm, satisfaction, and pain in women, while the IIEF evaluates erectile function, orgasm, desire, intercourse satisfaction, and overall satisfaction in men. These instruments are valuable for physiological and psychosexual function but were not designed for genital psoriasis. They may not capture reduced sexual frequency caused by fear, embarrassment, or postcoital worsening.

The FSDS measures sexual distress rather than physiological function. Discordance between FSDS and FSFI or between male sexual-quality-of-life measures and IIEF has been documented, reinforcing that sexual distress and physiological dysfunction represent separate constructs. (Ong et al., 2025)

The Female Genital Self-Image Scale captures a domain not measured by PASI, DLQI, or FSFI. Its inclusion may help distinguish negative genital self-perception from pain or physiological dysfunction. The VQLI, although not psoriasis-specific, evaluates symptoms, emotions, activities of daily living, relationships, sexual function, future health concerns, and treatment burden in women with vulval disease. (Elsadek et al., 2024) (Wu & Fischer, 2025)

11.2. Genital Psoriasis Symptoms Scale

The GPSS was developed specifically for genital psoriasis through literature review, clinician input, qualitative interviews, and cognitive debriefing. It assesses eight symptoms - itching, pain, discomfort, stinging, burning, redness, scaling, and cracking - using 0-10 numerical rating scales. Symptoms are rated according to their worst severity during the preceding 24 hours. (Gottlieb, Kirby, Ryan, Naegeli, Burge, Potts Bleakman, Anatchkova, & Yosipovitch, 2018)

The instrument provides greater symptom resolution than PASI or sPGA-G and is suitable for monitoring changes over short intervals. Its limitations include overlap between related sensations and limited assessment of psychosocial or relationship consequences.

11.3. Genital Psoriasis Sexual Frequency Questionnaire

The GenPs-SFQ consists of two items assessing the number of sexual activities during the preceding week and how often genital psoriasis limited that frequency. Sexual activity is not restricted to intercourse and includes masturbation. The instrument was developed after 80% of interviewed patients reported an effect of genital psoriasis on sexual frequency, and cognitive debriefing in an additional 50 patients supported its comprehensibility. (Gottlieb, Kirby, Ryan, Naegeli, Burge, Potts Bleakman, Anatchkova, & Cather, 2018)

The GenPs-SFQ distinguishes sexual inactivity caused by genital psoriasis from inactivity for other reasons. However, two items cannot fully capture desire, pain, pleasure, relationship context, genital self-image, or sexual distress.

11.4. Physician-rated genital severity

The sPGA-G is a six-point physician-rated scale from clear to very severe. It is useful in trials and has acceptable inter-rater reliability, but it does not explicitly account for erosions, fissures, secondary infection, adjacent perianal or thigh disease, or patient-reported symptoms. Physician-rated severity and patient-reported burden should therefore be used together. (Kelly & Ryan, 2019).

12. Treatment and Patient-Reported Outcomes

12.1. General principles

Topical corticosteroids, vitamin D analogues, and topical calcineurin inhibitors are commonly used for localized genital psoriasis. The thin, occluded, and sensitive genital skin requires careful selection of potency and duration. However, treatment should not remain exclusively topical when symptoms, sexual burden, or quality-of-life impairment remain substantial.

The large vulval psoriasis cohort found that 13.1% of patients required systemic treatment specifically because of vulval disease. Treatment substantially improved symptoms, emotions, daily activities, and future health concerns, but sexual and relationship-related burden was comparatively persistent. (Wu & Fischer, 2025)

12.2. Ixekizumab

IXORA-Q was the first large randomized, double-blind, placebo-controlled trial designed specifically for moderate-to-severe genital psoriasis. At week 12, clear or almost clear genital skin was achieved by 73% of patients receiving ixekizumab compared with 8% receiving placebo. An absent or minimal limitation of sexual frequency was reported by 78% versus 21%, respectively, and clinically relevant improvement in genital itch by 60% versus 8%. These responses occurred despite inclusion of patients with relatively limited total BSA. (Ryan et al., 2018)

Ixekizumab also rapidly improved erosions, fissures, and ulcers, pain, itch, and sexual health. Resolution of these secondary lesional signs occurred in 62% of treated patients by week 1 and 83% by week 12, compared with 25% and 21% receiving placebo. (Merola et al., 2020)

Long-term IXORA-Q follow-up demonstrated maintenance of clear or almost clear genital skin in approximately three quarters of initially treated patients at week 52, with sustained improvement in genital itch and the impact on sexual frequency. (Guenther et al., 2020)

A small randomized comparison of ixekizumab and secukinumab found that both IL-17 inhibitors improved GPSS symptoms beginning at week 2 and sexual activity from week 4. The small sample and limited follow-up prevent reliable comparative ranking. (AlMutairi & Eassa, 2021)

12.3. Apremilast

DISCREET was the first phase 3 randomized trial designed and powered to evaluate an oral systemic agent using genital-specific outcomes. At week 16, modified genital PGA response was achieved by 39.6% of patients receiving apremilast and 19.5% receiving placebo. Improvements were also observed in genital itch, GPSS, overall psoriasis, and quality of life. (Merola et al., 2024)

During the 32-week extension, clinical and patient-reported improvements were maintained in patients continuing apremilast and emerged after placebo-treated patients switched to active therapy. At week 32, modified genital PGA response was present in 40.3% of continuous-treatment patients and 51.8% of switch patients. Diarrhea, nausea, and headache were the most common adverse events. (Merola et al., 2026)

12.4. IL-23 inhibitors and emerging evidence

A phase 4 randomized trial found that risankizumab produced clear or almost clear genital skin at week 16 in 69.1% of patients compared with 13.0% receiving placebo. The trial included patients with low as well as higher total BSA and reported improvement in symptoms and quality-of-life endpoints. (Song et al., 2026)

Real-world risankizumab data provide direct evidence of psychosexual benefit. In a 52-patient interim analysis, median GPSS decreased from 42 at baseline to 3 at week 16. The proportion reporting that they never avoided sexual activity increased from 10.5% to 46.8%, while 78.9% reported no or very low sexual impact compared with 18.5% at baseline. (Ben-Anaya et al., 2025)

In the prospective GULLIVER study, the genital sPGA target was achieved by 76.5% of patients at week 12 and 97.9% at week 52. Mean DLQI in the genital subgroup decreased from 12.0 to 1.6. Although these findings demonstrate substantial quality-of-life improvement, genital-specific sexual outcomes were less extensively reported than in IXORA-Q or GPS-Best. (Bonifati et al., 2026)

Real-world studies also support rapid genital clearance with bimekizumab, but available reports have emphasized physician-rated clearance more than sexual function, genital self-image, or relationship outcomes. These data therefore establish clinical efficacy more clearly than patient-centered psychosexual benefit. (Orsini et al., 2024) (Bianco et al., 2025)

12.5. Interpreting treatment-related improvement

Improvement in genital lesions often reduces itch, pain, fissuring, and sexual limitation. Nevertheless, sexual function and relationships may recover more slowly than visible skin. Established avoidance behavior, negative genital self-image, fear of recurrence, partner concerns, and psychological comorbidity may persist after clearance.

Treatment studies should therefore assess not only sPGA-G or GPSS but also sexual frequency, avoidance, satisfaction, distress, genital self-image, and relationship outcomes. Dermatological clearance should be regarded as necessary but not invariably sufficient for psychosexual recovery.

13. Limitations of Current Evidence

The literature has several methodological limitations. Most burden studies are cross-sectional and cannot determine whether genital psoriasis directly causes sexual dysfunction or whether associations are mediated by depression, cardiovascular disease, relationship factors, psoriasis severity, or treatment. Tertiary-center cohorts may overrepresent severe or treatment-resistant disease, whereas online surveys may preferentially attract highly affected or highly engaged participants.

Definitions of genital involvement vary, and studies inconsistently separate genital, perianal, inguinal, gluteal, or broader sexually sensitive areas. Some rely on self-report without examination, whereas others assess only current lesions and may miss relapsing disease.

Outcome heterogeneity is substantial. Generic quality-of-life tools, genital-specific symptom measures, physiological sexual-function instruments, and qualitative reports assess different constructs. Discordant findings do not necessarily represent contradictory evidence; they may reflect genuine differences between sexual function, sexual distress, avoidance, and relationship burden.

Women remain underrepresented in several clinical trials, while data on sexual and gender minorities are scarce. Cultural norms and willingness to disclose also limit generalizability. Finally, several genital-specific outcome tools and pivotal trials were developed or funded by pharmaceutical sponsors. This does not negate their validity but supports the need for independent replication and comparative research.

14. Conclusions

Genital psoriasis is a common, high-impact manifestation of psoriatic disease whose burden extends far beyond the limited surface area involved. Pruritus, burning, pain, fissuring, and postcoital exacerbation interact with genital self-image, stigma, fear of rejection, and relationship concerns to impair sexual activity and quality of life.

The relationship between genital psoriasis and sexual dysfunction is multidimensional. Genital involvement is consistently associated with sexual distress, reduced frequency, avoidance, and worse quality of life, but its association with physiological dysfunction such as erectile impairment is less consistent and is strongly influenced by age, cardiovascular risk, mood, medication, and systemic disease.

Generic psoriasis measures cannot adequately represent this burden. Clinical assessment should combine consent-based examination with genital-specific symptom evaluation and sensitive inquiry regarding sexual and relational effects. Effective treatment can improve local symptoms, sexual activity, and quality of life, but psychological and relationship-related recovery may lag behind cutaneous clearance.

Genital involvement should therefore be recognized as a severity-upgrading feature that may justify advanced therapy despite low overall BSA. A patient-centered approach requires clinicians not only to identify and clear genital lesions, but also to address the symptoms, emotions, self-image, and intimate consequences that determine the patient’s lived experience.

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