

A cross-sectional study of the clinical patterns and etiological spectrum of non-venereal genital dermatoses in adult males.

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Abstract

Background

Non-venereal genital dermatoses (NVGDs) can mimic sexually transmitted infections and cause diagnostic and psychosocial concerns. This study described the clinical and etiological spectrum of NVGDs among adult males.

Methods

A hospital-based cross-sectional descriptive study was conducted from June 2022 to August 2023 among adult males attending the dermatology outpatient department with non-venereal genital lesions. Clinical examination and relevant laboratory investigations were used for diagnosis.

Results

Among 382 men presenting with genital lesions, 166 had venereal disorders and were excluded; 216 patients with NVGDs were included. Mean age was 36.9 ± 13.9 years, and the 26–35-year group accounted for 27.8% of cases. Scabies was the most frequent dermatosis (56, 26%), followed by vitiligo (37, 17.2%) and candidal balanoposthitis (24, 11.2%). Students constituted 31% of patients. A single genital site was involved in 68%, with the scrotum being the most frequently involved site (120 patients). Genital involvement alone occurred in 53%, while 47% had associated extragenital lesions. Infections and infestations formed the largest etiological category (90, 41%). One case each of erythroplasia of Queyrat and penile squamous cell carcinoma was identified.

Conclusion

Non-venereal genital dermatoses showed a broad clinical and etiological spectrum, with scabies being the most frequent diagnosis and infections and infestations representing the largest etiological group. Careful genital and extragenital examination, targeted investigations when indicated, and appropriate counselling are important for accurate diagnosis and differentiation from sexually transmitted disease.

Keywords: Non-Venereal Genital Dermatoses; male genitalia; scabies; vitiligo; genital dermatology; cross-sectional study
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Introduction

Genital dermatoses may be classified broadly as venereal and non-venereal disorders. Non-venereal genital dermatoses are conditions affecting the genitalia that are not sexually transmitted and may occur as isolated genital disease or as part of a wider cutaneous or mucosal disorder. The clinical spectrum includes infections and infestations, benign and normal variants, inflammatory disorders, pigmentary conditions, and premalignant or malignant lesions.[1–3]

Because genital lesions may be mistaken for sexually transmitted infections, affected patients may experience anxiety, embarrassment, stigma, or delay in seeking medical care. Previous hospital-based studies have demonstrated

substantial variation in the relative frequency of individual non-venereal genital dermatoses according to study setting, population characteristics, and referral patterns.[1–9] Accurate clinical recognition, appropriate laboratory investigation when indicated, and examination of extragenital sites are therefore important in establishing the diagnosis.

Understanding the local clinical and etiological spectrum can assist clinicians in distinguishing non-venereal conditions from sexually transmitted disease and in providing appropriate treatment and counselling. The present study aimed to describe the clinical patterns and etiological spectrum of non-venereal genital dermatoses among adult males attending a tertiary-care dermatology outpatient department.

Methodology

Categorical variables were summarized as frequencies and percentages. Age was summarized using mean, standard deviation, and range. Findings were presented in tables and clinical photographs. No inferential statistical testing was reported in the submitted manuscript.

Statistical analysis

The study was approved by the Institutional Human Ethical Committee of PSP Medical College Hospital and Research Institute, and written informed consent was obtained from all participants. Participant confidentiality was maintained throughout the study. The ethics approval date and approval/IRB number were not provided in the submitted manuscript and should be inserted from the institutional record before submission.

Ethical considerations

Potential selection bias was recognized because this was a single-center, hospital-based study and the case spectrum may have been influenced by referral and healthcare-seeking patterns. Diagnostic misclassification was reduced by performing complete dermatological examination and relevant laboratory or histopathological investigations when indicated. The study was descriptive and did not include a comparison group.

Bias

A structured proforma was used to record demographic, clinical, examination, investigation, and diagnostic information. The collected data were tabulated and analyzed.

Data collection

Diagnosed conditions were classified into five etiological groups: normal and benign lesions; infections and infestations; inflammatory lesions; premalignant and malignant lesions; and miscellaneous conditions. Genital involvement was categorized as single-site or multiple-site involvement. The genital sites assessed were the glans, prepuce, scrotum, and penile shaft. Patients were also classified as having genital involvement alone or genital involvement with lesions at other sites. Circumcision status was recorded.

Classification of lesions

After written consent, a structured history was obtained, including age, occupation, duration of disease, site of involvement, drug intake or topical application, previous similar episodes, marital status, and relevant sexual exposure history. A complete general and dermatological examination was performed. Rapid plasma reagin testing for

syphilis and enzyme-linked immunosorbent assay for HIV were performed to exclude sexually transmitted disease. Gram staining, potassium hydroxide mount, mite scraping, and histopathological examination were performed when clinically indicated. Diagnoses were established from the clinical findings and relevant investigations.

Clinical assessment and investigations

Inclusion criteria were adult males with non-venereal genital lesions, with or without associated skin or mucosal lesions, who provided written informed consent. Patients with venereal disease and those younger than 18 years were excluded.

Eligibility criteria

A total of 216 eligible patients were included in the study. The submitted manuscript did not document the sampling technique or an a priori sample-size formula/calculation. These details should be confirmed from the original study records before final submission; they have not been inferred or added without source documentation.

Sampling and sample size

Adult male patients aged 18 years or older who attended the dermatology outpatient department with genital lesions of non-venereal origin were eligible. Patients with clinically established venereal disease were excluded.

Study population and participants

This was a hospital-based cross-sectional descriptive study conducted over 15 months, from June 2022 to August 2023.

Study design and period

The study was conducted in the Department of Dermatology and STD at PSP Medical College Hospital and Research Institute, Panruti, Kanchipuram District, Tamil Nadu, India.

Study setting

Results

A total of 382 adult male patients presenting with genital lesions attended the dermatology outpatient department during the study period. Of these, 166 patients had venereal disorders and were excluded. The remaining 216 patients with non-venereal genital dermatoses constituted the study population. Thus, 382 patients were assessed, 166 were excluded because of venereal disease, and 216 were included in the analysis. No additional non-participation was documented in the submitted study records.

The patients were aged 18–76 years, with a mean age of 36.9 ± 13.9 years. The 26–35-year age group was the largest, comprising 60 patients (27.8%).

Table 1: Age distribution

Age	Number of patients	Percent
18 -25	51	23.6%
26 – 35	60	27.8%
36 – 45	55	25.5%
46 – 55	28	13.%
56- 65	13	6%
>66	9	4.1%
Total	216	100%

Table 1 shows that the largest age group was 26–35 years (27.8%), while the mean age was 36.9 years.

Distribution of individual dermatoses

Twenty-six different non-venereal genital dermatoses were identified. Scabies was the most

frequent diagnosis (56 patients, 26%), followed by vitiligo (37, 17.2%) and candidal balanoposthitis (24, 11.2%). The complete distribution by etiological category is presented in Table 10.

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Erythroplasia of Queyrat
Lichen Planus Squamous cell carcinoma
Pediculosis pubis Contact Dermatitis
Tinea cruris Lichen Sclerosus Psoriasis Vulgaris
FDE
Scrotal Steatocystoma
Fordyce Spots
0

2 4 6 8 10

Classification by occupation

Students constituted the largest occupational group (67 patients, 31%), followed by IT employees (22, 10.2%), drivers (17, 7.9%), businessmen (14, 6.5%), farmers (12, 5.6%), labourers (8, 3.7%), retired officers (8, 3.7%),

teachers (7, 3.2%), and security personnel (7, 3.2%). Other occupations accounted for the remaining participants. (5.6%), 8 (3.7%), 8 (3.7%), 7 (3.2%) and 7 (3.2%) patients respectively. Men from various other occupations were also involved.

Table 2: Occupational profile of the study population

Sl. No	Occupation	Number of patients	Percentage
1	Students	67	31 %
2	IT employee	22	10.2 %
3	Driver	17	7.9 %
4	Businessmen	14	6.5 %
5	Farmers	12	5.6 %
6	Labourers	8	3.7 %
7	Retired officers	8	3.7%
8	Teacher	7	3.2 %
9	Security	7	3.2 %
10	Electrician, Engineer, Manager, Mechanic, Supervisor	20 (4 patients in each)	9.5 %
11	Construction, Cook, Marketing, Technician, Tailor	15 (3 Patients in each)	7 %
12	Carpenter, Clerk, Conductor, Painter, Police, Administrator	12 (2 Patients in each)	5.4 %
13	Bank officer, Coach, Fisherman, Lawyer, Plumber, Military, Warden	7 (1 Patient in each)	3.5 %
Total		216	100 %

Table 2 shows that students formed the largest occupational group, accounting for 31% of the study population.

Commonly observed dermatoses

Scabies: It was the most frequent dermatosis, occurring in 56 patients (26%). The 26–35-year age group was the most

commonly affected (18 patients), and students constituted the largest occupational group (20 patients). Tables 3a and 3b summarize the age and occupational distribution.

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Table 3a: Age distribution among patients with scabies

Age group	Number of patients
18–25	12
26–35	18
36–45	13
46–55	6
56–65	6
>66	1
Total	56

Table 3a shows that scabies was most frequent in the 26–35-year age group.

Table 3b: Occupational profile of patients with scabies

Occupation	Number of patients
Students	20
Drivers	6
Businessmen	5
IT employees	3
Teachers	3
Others	19
Total	56

Table 3b shows that students constituted the largest occupational group among patients with scabies.

Vitiligo: It was the second most common dermatosis, occurring in 37 patients (17.2%). The 26–35-year age group was most frequently affected (14 patients). Skin

involvement was present in 27 of the 37 patients (72.9%). The age distribution is shown in Table 4.

Table 4: Age distribution among patients with vitiligo

Age	Number of patients
18–25	7
26–35	14
36–45	9
46–55	3
56–65	1
>66	3
Total	37

Table 4 shows that vitiligo was most frequent in the 26–35-year age group.

Single-site involvement was defined as involvement of one of the glans, scrotum, prepuce, or penile shaft, whereas multiple-site involvement referred to more than one of these sites. Single-site involvement was present in 146 patients (68%), while 70 patients (32%) had multiple-site

involvement.

Single site was involved in majority of the patients, seen in 146 patients accounting for 68 % of patients.

Table 5: Number of genital sites involved

Site involved	Frequency	Percent
Single site	146	68 %
Multiple site	70	32%
Total	216	100%

Table 5 demonstrates that single-site genital involvement was more common than multiple-site involvement.

Classification by site involved in genitalia

and prepuce (40).

The scrotum was the most frequently involved genital site (120 patients), followed by the penile shaft (76), glans (60),

Table 6: Distribution of genital sites involved

Site of Involvement	Frequency
Glans	60
Prepuce	40
Scrotum	120
Shaft	76

Table 6 shows that the scrotum was the most frequently involved genital site.

Classification by extra genital site involvement

genitalia. Genital involvement alone was observed in 114 patients (53%), while 102 patients (47%) had associated lesions at other sites.

Non-venereal dermatoses may involve sites beyond the

Table 7: Genital involvement with or without extragenital lesions

Site involved	Frequency	Percentage
Genitalia alone	114	53%
Genitalia with other sites	102	47%
Total	216	100%

Table 7 shows that 53% of patients had genital involvement alone and 47% had associated extragenital lesions.

Among patients with extragenital involvement, skin was the most frequently affected site (99 patients),

followed by oral mucosa (13), scalp (6), and nails (5).

Table 8: Distribution of extragenital sites involved

Other site involvement	Frequency
Skin	99
Mucosa	13
Nail	5
Scalp	6

Table 8 shows that skin was the most frequently involved extragenital site.

Classification by circumcisional Status

Nineteen patients (9%) were circumcised and 197 (91%) were uncircumcised. Preputial involvement was recorded

in 40 patients. These descriptive findings do not establish a causal or preventive relationship between circumcision and non-venereal genital dermatoses.

Table 9: Circumcision status

Circumcision Status	Frequency	Percent
Circumcised	19	9%
Uncircumcised	197	91%
Total	216	100%

Table 9 shows that 91% of the study population was uncircumcised.

Etiological Classification

It was classified the non-venereal genital lesions into 5 major categories, which includes

- (i) Normal and benign lesions
- (ii) Infection and infestation
- (iii) Inflammatory lesions
- (iv) Premalignant and malignant lesions
- (v) Miscellaneous

Infections and infestations formed the largest etiological category, accounting for 90 patients (41%), followed by miscellaneous disorders (45, 21%), inflammatory lesions (40, 19%), normal and benign lesions (39, 18%), and premalignant or malignant lesions (2, 1%).

Table 10: Etiological classification of non-venereal genital dermatoses

Diagnosis	No. of patients	Percentage of total
Normal and benign lesions	39	18%
Angiokeratoma of Fordyce	12	5.60%
Fordyce spots	9	4.20%
Frenular tear	1	0.50%
Mucoid cyst	1	0.50%
Pearly penile papules	15	7.00%
Paraphimosis	1	0.50%
Infection and infestation	90	41%
Candidal balanoposthitis	24	11.20%
Herpes zoster	1	0.50%
Lepromatous leprosy	1	0.50%
Pediculosis pubis	2	0.90%
Scabies	56	26.00%
Scrotal elephantiasis	1	0.50%
Tinea cruris	5	2.30%
Inflammatory lesions	40	19%
Circinate balanitis	1	0.50%
Contact dermatitis	4	1.90%
Fixed drug eruption	7	3.30%
Lichen nitidus	1	0.50%
Lichen planus	2	0.90%
Lichen sclerosus	5	2.30%
Psoriasis vulgaris	6	2.80%
Scrotal eczema	13	6.00%
Zoon's balanitis	1	0.50%
Premalignant and malignant tumors	2	1%
Erythroplasia of Queyrat	1	0.50%
Squamous cell carcinoma	1	0.50%
Miscellaneous	45	21%
Scrotal steatocystoma	8	3.70%
Vitiligo	37	17.20%
Total	216	100%

Table 10 shows the distribution of the 26 diagnosed conditions across the five etiological categories.

FIGURES

CLINICAL PHOTOGRAPHS

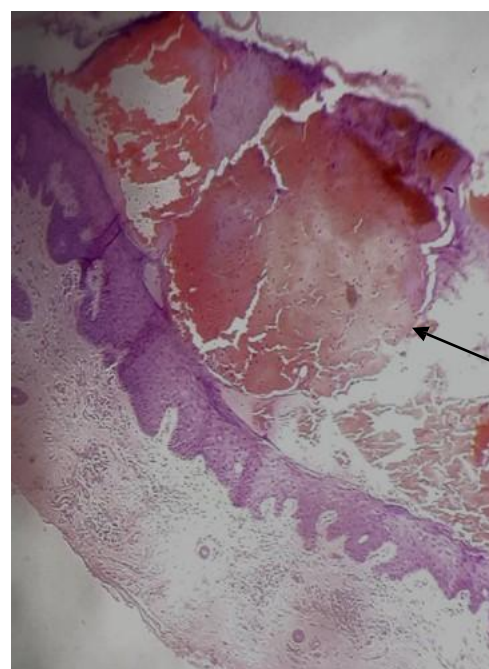




Figure 1: Angiokeratoma
Angiokeratoma (vascular cistern)

Figure 2: HPE of



Figure 3: Candidal Balanoposthitis
(Showing hyaline septate hyphae)

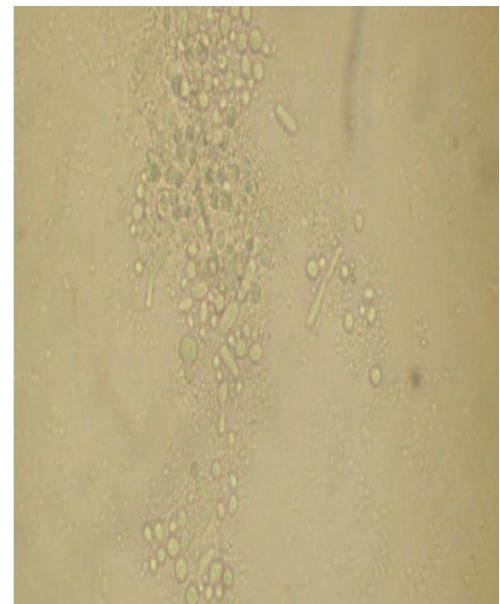


Figure 4: KOH mount



Figure 5: Circinate Balanitis

Figure 6: Contact Dermatitis (to Dithranol)





Figure 7: Erythroplasia of Queyrat



Figure 8: FDE



Figure 9: Fordyce Spots

Figure 10: Frenular Tear



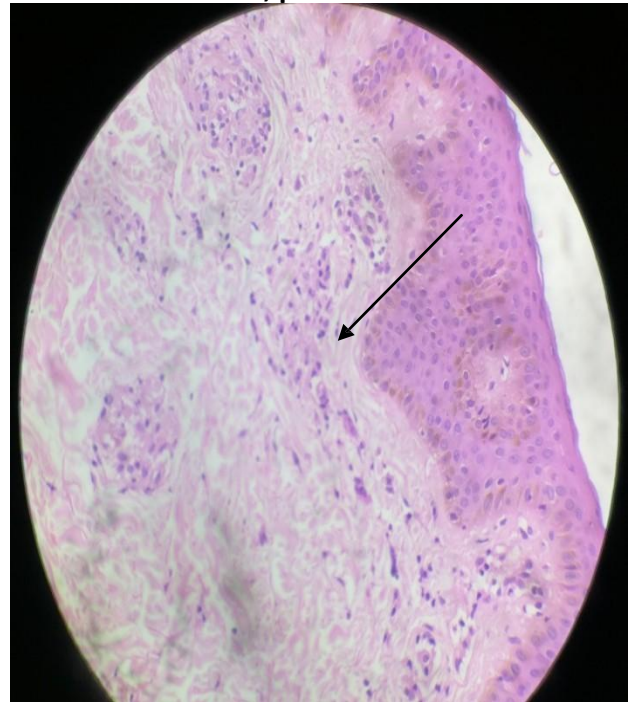


Figure 11a: Lepromatous leprosy Figure 11b: HPE of leprosy nodule (showing granulomas)

Figure 12: Lichen Niditus





Figure 13: Lichen Planus

Figure 14: Lichen Sclerosus



(Balanitis xerotica obliterans)



Figure 15: Muroid Cyst

Figure 16: Pearly Penile Papules





Figure 17: Pediculosis pubis



Figure 18: Crab louse



Figure 19: Paraphimosis



Figure 20: Psoriasis Vulgaris
(Parakeratosis, Elongated rete ridges)



Figure 21: HPE of Psoriasis



Figure 22: Scabies



Figure 23: Scabies Mite



Figure 24: Scrotal Eczema



Figure 25: Scrotal Elephantiasis



Figure 26: Scrotal Steatocystoma
Steatocystoma



Figure 27: HPE of

Figure 28: Tinea cruris (penile shaft)



Figure 29: Scraping showing



Hyphae in KOH mount

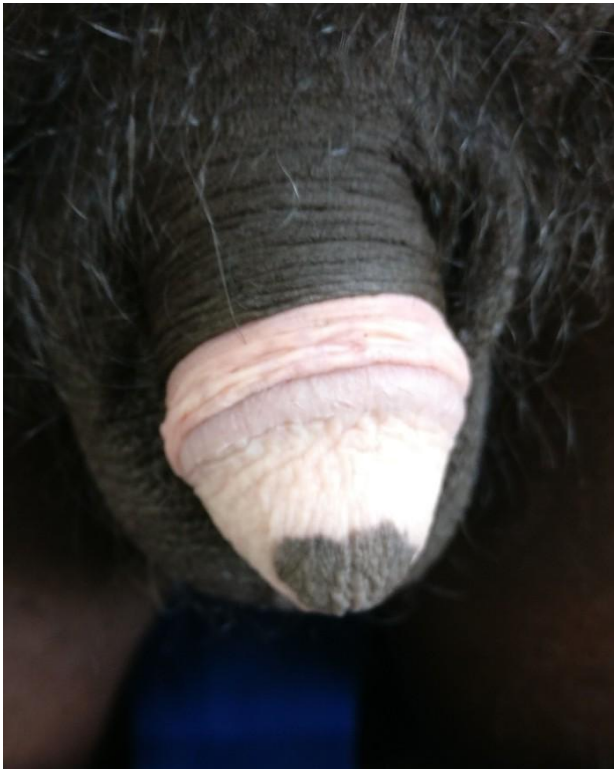


Figure 30: Vitiligo



Figure 31: SCC of Penis
(Elongated rete ridges with atypical cells)

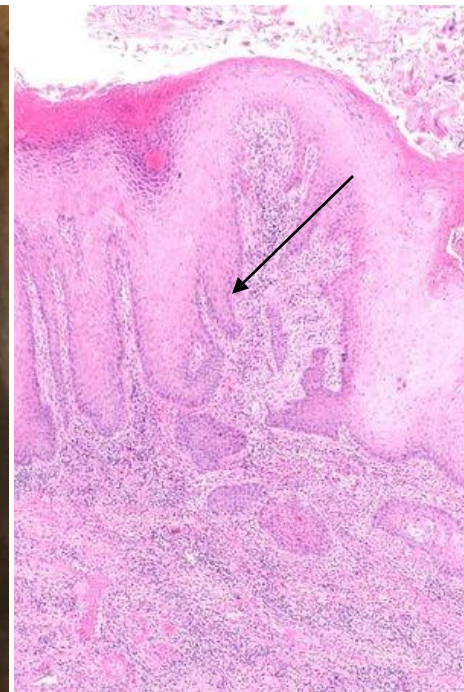


Figure 32: HPE – SCC of Penis

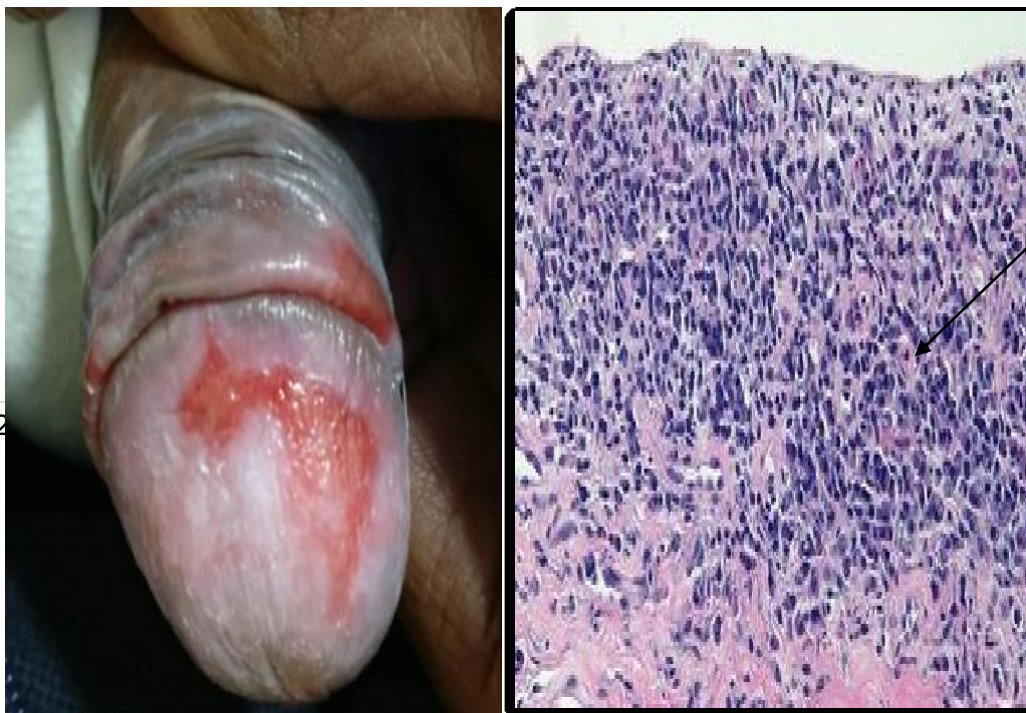


Figure 33: Zoon's Balanitis
Balanitis (plasma cell infiltrates)

Figure 34: HPE of Zoon's

Discussion

Key results

The study objective was to describe the clinical patterns and etiological spectrum of non-venereal genital dermatoses in adult males. Among 382 men presenting with genital lesions, 216 had non-venereal dermatoses after exclusion of 166 venereal cases. The mean age was 36.9 years, with the 26–35-year group predominating. Scabies was the most frequent diagnosis, followed by vitiligo and candidal balanoposthitis. Infections and infestations constituted the largest etiological category. Single-site genital involvement was more common than multiple-site involvement, and the scrotum was the most frequently involved genital site (Tables 1, 5, 6, and 10).

Age and occupational profile

The age distribution was concentrated in younger and middle-aged adults, with 27.8% of patients aged 26–35 years. Saraswat et al. reported that 40% of their patients were aged 21–30 years, while Karthikeyan et al. described greater frequency among patients aged 21–40 years.[1,2] Shinde et al. reported that 79% of patients were aged 21–50 years.[3] Priya et al. also reported a predominance in

the 30–40-year age group.[7] The predominance of younger and middle-aged adults in these hospital-based series may reflect healthcare-seeking patterns and concern about genital lesions rather than a specific age-related susceptibility. Students were the largest occupational group in the present study (Table 2).

Pattern of individual dermatoses

Scabies was the most frequent condition in the present study, accounting for 26% of cases. This differed from the findings of Shinde et al., in which psoriasis was the most common dermatosis, and from Hogade and Mishra, who reported vitiligo as the leading condition.[3,4] Saraswat et al. also reported vitiligo as the commonest condition, followed by pearly penile papules.[1] Rajakumari et al. reported candidal balanoposthitis in 41.6% of patients, whereas the present study found candidal balanoposthitis in 11.2%.[5] Puri and Puri reported scrotal dermatitis as the most common male genital dermatosis (16.6%), followed by vitiligo (14.3%), with fixed drug eruption, scabies, and pearly penile papules each occurring in 10%.[9] The differences between studies may reflect variations in setting, referral patterns, inclusion criteria, geographic distribution, and the relative proportions of specific patient groups.

Benign variants and anatomical distribution

Pearly penile papules were the most frequent benign or normal variant in the present study, accounting for 7% of patients. Khoo and Cheong reported pearly penile papules in 14.3% of male patients attending a public sexually transmitted disease clinic.[6] Direct comparison is limited by differences in study population and clinical setting. Genital involvement alone occurred in 53% of patients, while 47% had associated extragenital lesions. Single-site involvement occurred in 68%, and the scrotum was the most frequently involved site (Tables 5–8).

Circumcision

Nineteen patients (9%) were circumcised and 197 (91%) were uncircumcised. Although preputial involvement was documented in 40 patients, the study was not designed to evaluate circumcision as a risk or protective factor. The observed circumcision distribution therefore cannot establish causality or a preventive effect.

Etiological spectrum and clinically important lesions

Infections and infestations constituted the largest etiological category (41%), followed by miscellaneous disorders (21%), inflammatory lesions (19%), benign or normal variants (18%), and premalignant or malignant lesions (1%) (Table 10). This pattern differs from the 58% predominance of inflammatory disorders reported by Shinde et al. and is closer to studies in which infections and infestations formed a substantial proportion of cases.[3,7] Himaja et al. reported infective dermatoses in 62% of adult males with genital dermatoses, although their study included both venereal and non-venereal conditions.[8] One case each of erythroplasia of Queyrat and penile squamous cell carcinoma was identified. Although uncommon, these diagnoses demonstrate the need for careful assessment of persistent, atypical, ulcerated, indurated, or otherwise suspicious genital lesions and histopathological examination when clinically indicated.

Generalizability

The findings are most applicable to adult men presenting to the dermatology outpatient service of a tertiary-care hospital in Kanchipuram District and should not be interpreted as population prevalence estimates. The spectrum of disease may differ in primary-care settings, community populations, other geographic regions, and services with different referral patterns. The single-center design and the absence of a comparison population limit external validity.

Limitations

The study was conducted at a single tertiary-care center and may therefore be affected by referral and selection bias. The sample represented patients who sought care and may not reflect the community prevalence of individual dermatoses. Rare conditions were represented by very small numbers, resulting in imprecision in their observed frequencies. The study was descriptive and cross-sectional, so causal associations, including any relationship between circumcision and genital dermatoses, cannot be established. Investigations were performed when clinically indicated rather than uniformly for every participant, which may have introduced diagnostic heterogeneity. The submitted study record did not document the sampling technique or an a priori sample-size calculation; these methodological details require confirmation from the investigators. Occupation-specific associations cannot be inferred because the occupational distribution may reflect the hospital catchment population.

Recommendations

Clinicians should avoid assuming that every genital lesion is sexually transmitted. A careful history, complete genital examination, examination of other skin and mucosal sites, and targeted laboratory or histopathological investigation should be undertaken when indicated. Patients should receive clear counselling and reassurance to reduce unnecessary anxiety, stigma, and inappropriate self-medication. Future multicentre prospective studies with standardized diagnostic criteria, predefined sampling and sample-size methods, and assessment of relevant epidemiological and clinical risk factors would improve the generalizability of the findings.

Conclusion

Among 216 adult males with non-venereal genital dermatoses, scabies was the most frequent diagnosis and infections and infestations constituted the largest etiological category. The findings reinforce the need for systematic genital and extragenital examination, appropriate investigation of atypical lesions, and patient counselling to distinguish non-venereal dermatoses from sexually transmitted disease.

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List of abbreviations

NVGD, non-venereal genital dermatoses; OPD, outpatient department; STD, sexually transmitted disease; HIV, human immunodeficiency virus; RPR, rapid plasma reagin; ELISA, enzyme-linked immunosorbent assay; KOH, potassium hydroxide; FDE, fixed drug eruption; SCC, squamous cell carcinoma; HPE, histopathological examination; PSP, PSP Medical College Hospital and Research Institute.

Author contributions

Dr Devanand N: Conceptualization, Methodology, Investigation, Data curation, Writing – original draft. Dr Sasi S: Investigation, Data curation, Formal analysis, Writing – original draft and review. Dr Ashwak Ahmed N: Methodology, Supervision, Writing – review and editing. All authors reviewed and approved the final manuscript.

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Source of funding

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Conflict of interest

The authors declare no conflict of interest.

Data availability

The anonymized study data are available from the corresponding author on reasonable request, subject to institutional and ethical restrictions.

References

1. Puri N, Puri A. A study on non-venereal genital dermatoses in North India. *Our Dermatol Online*. 2013;4(1):304–307. doi:10.7241/ourd.20124.66.
2. Himaja N, Bharathi G, Usha G. A clinical study on patterns of genital dermatoses in adult males in a tertiary care hospital in South India. *IOSR J Dent Med Sci*. 2018;17(1):11–13. doi:10.9790/0853-1701131113.
3. Priya BT, Muthupandian V, Alagar K, Kannan R. A retrospective study on the incidence of non-venereal genital dermatoses in patients attending STI clinic at a tertiary care centre. *Int J Res Dermatol*. 2017;3(2):254–260. doi:10.18203/issn.2455-4529.IntJResDermatol20172207.
4. Khoo LS, Cheong WK. Common genital dermatoses in male patients attending a public sexually transmitted disease clinic in Singapore. *Ann Acad Med Singapore*. 1995;24(4):505–509.
5. Rajakumari DRS, Sudha DR. A descriptive study on non-venereal dermatoses of male genitalia. *Glob J Res Anal*. 2018;7(4):64–66.
6. Hogade AS, Mishra S. A study of pattern of nonvenereal genital dermatoses of male attending skin OPD of tertiary centre in Kalaburagi. *Int J Res Dermatol*. 2017;3(3):407–410. doi:10.18203/issn.2455-4529.IntJResDermatol20173922.
7. Shinde G, Popere S. A clinical study of non-venereal genital dermatoses of adult in a tertiary care center. *Int J Biomed Adv Res*. 2017;8(4):168–173. doi:10.7439/ijbar.v8i4.4111.
8. Karthikeyan KE, Jaisankar TJ, Thappa DM. Non-venereal dermatoses of male genital region-prevalence and pattern in a referral centre in South India. *Indian J Dermatol*. 2001;46(1):18–22.
9. Saraswat PK, Garg A, Mishra D, Garg S. A study of pattern of nonvenereal genital dermatoses of male attending skin OPD at a tertiary care center. *Indian J Sex Transm Dis AIDS*. 2014;35(2):129–134. doi:10.4103/0253-7184.142408.



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