Section: Dermatology

Original Research Article

PREVALENCE AND SPECTRUM OF CUTANEOUS MANIFESTATIONS AMONG THE GERIATRIC POPULATION: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Population ageing is increasing globally and in India, leading to a higher burden of age-related dermatological conditions. Geriatric dermatoses include both physiological skin changes and pathological disorders, which vary across populations and require region-specific evaluation. The objective is to assess the prevalence and pattern of physiological skin changes and dermatological disorders among geriatric patients attending a tertiary care hospital.

Materials and Methods: A hospital-based cross-sectional study was conducted among 500 patients aged ≥60 years attending the dermatology outpatient department over a period of six months. Detailed clinical evaluation was performed, and dermatoses were categorized into physiological changes and pathological conditions. Data were analysed using SPSS software, and categorical variables were expressed as frequencies and percentages.

Results: Among 500 patients, 57.0% were males and 43.0% were females (male-to-female ratio 1.32:1). Wrinkles and canities were universal findings (100%). Cherry angiomas (90%) and idiopathic guttate hypo melanosis (54%) were also common. Xerosis was observed in 38% of patients. Among pathological conditions, pruritus was the most common presenting symptom (55%). Bacterial infections (31%) and dermatophytosis (30%) were the most frequent dermatoses, followed by allergic contact dermatitis (28%). Psoriasis vulgaris (18.4%) was the most common papulosquamous disorder. Malignant conditions were observed in 3% of patients, with squamous cell carcinoma being the most common.

Conclusion: Geriatric dermatoses demonstrate a broad spectrum of physiological and pathological conditions. While ageing-related skin changes are nearly universal, infections and eczematous disorders constitute the major disease burden. Early identification and appropriate management are essential to reduce morbidity and improve quality of life in the elderly population.

Keywords: Geriatrics, Dermatoses, Xerosis, Pruritus, Infections, Dermatitis, Psoriasis, Ageing.

INTRODUCTION

Population ageing has become an important demographic transition worldwide. According to the World Health Organization, the number of people aged 60 years and above is expected to rise from 1 billion in 2020 to 1.4 billion by 2030, and by 2050 this population will reach 2.1 billion. The same report also notes that by 2050, two-thirds of the world's population older than 60 years will be living in low- and middle-income countries. This shift has important implications for health systems because older adults contribute increasingly to the burden of chronic disease and age-related clinical problems.[1]

India is also experiencing a steady rise in its elderly population. The India Ageing Report 2023 states that the share of people aged 60 years and above is projected to increase from 10.5 percent in 2022 to

20.8 percent in 2050. The same report further shows that during 2022 to 2050, while the overall population of India will grow by only 18 percent, the older population will grow by 134 percent. These figures indicate that ageing is no longer a marginal demographic issue in India and that health problems of the elderly deserve greater clinical attention.[2]

Skin is one of the organs in which ageing is most visibly manifested. Skin ageing is broadly understood as the combined effect of intrinsic ageing and extrinsic ageing. In the Indian study by Durai and colleagues, photoaging changes were reported less commonly than chronological ageing changes in individuals with skin type IV. This distinction is important in Indian patients because the visible pattern of ageing skin may differ from that described in lighter skin populations.[3]

Several physiological cutaneous changes become common with advancing age. One significant alteration in older skin is xerosis. Pruritus and xerosis are among the most prevalent dermatological issues among nursing home residents, according to Norman, who defined xerosis as dry skin that is pruritic, dry, cracked, and fissured. Wrinkles and cherry angiomas are among the common physiological findings in elderly patients, according to Indian tertiary care studies. In particular, Agarwal and colleagues found that the most prevalent physiological cutaneous symptoms in their aged study population were wrinkles and cherry angiomas. [4,5]

In addition to physiological ageing, elderly patients also present with a wide range of pathological dermatoses. Indian studies consistently show that infections and eczema-related disorders form an important part of geriatric dermatology. In the Uttarakhand study by Jindal et al., infections, senile pruritus, and eczema-dermatitis were highlighted as the major dermatological disorders in the elderly. Another tertiary care study from Northern India reported infective dermatoses as the most common pathological conditions, followed by allergic contact dermatitis. These findings indicate that geriatric dermatology involves substantial pathological morbidity in addition to physiological ageing changes. [5,6]

Pruritus is one of the most relevant symptoms in elderly patients. It is common, distressing, and often multifactorial. Chung and colleagues described dry ageing skin, or xerosis, as a common cause of itch in elderly patients, and also noted that pruritus is more common in the elderly and that quality of life is reduced. The North Kerala study similarly reported that pruritus was the most common presenting complaint among elderly patients. These findings support the clinical importance of assessing pruritus separately while studying dermatoses in the geriatric age group. [7-9]

Systemic diseases also form an important background in elderly patients with skin disorders. In the North Kerala study, hypertension, hyperlipidaemia, and diabetes mellitus were the common comorbidities. Kumar et al. also reported hypertension as the commonest systemic disease, followed by diabetes mellitus, in their elderly dermatology patients. This overlap between dermatological conditions and systemic illness adds to the complexity of evaluation in older adults. [8,9]

Another important point is that the pattern of geriatric dermatoses is not uniform across regions. Hospital-based Indian studies also show differences in sex distribution. Agarwal et al. reported a male-to-female ratio of 1.4, whereas Jindal et al. reported a ratio of 2:1, and the North Kerala study showed female preponderance. These variations imply that local epidemiological information is still crucial for understanding the true prevalence and distribution of geriatric dermatoses in a given location. [5,6,9]

Thus, it is appropriate to conduct a study on pathological dermatoses and physiological skin changes in senior patients who visit a tertiary care dermatology department. In addition to reporting the frequency and trends of prevalent skin problems in this age group, such a study aids in the analysis of the distribution of these conditions by gender and disease category. This is particularly relevant in India, where the number of elderly people is growing quickly and local clinical data are still required for improved care and planning.[2]

Aim

To study the pattern of physiological skin changes and dermatological disorders among geriatric patients attending the Department of Dermatology at a tertiary care hospital.

Objectives

1. To evaluate the prevalence of physiological skin changes associated with ageing in elderly individuals.
2. To determine the pattern and distribution of dermatological disorders in geriatric patients and their association with gender.

MATERIALS AND METHODS

Study design: A hospital-based cross-sectional study was conducted to evaluate the spectrum of physiological skin changes and dermatoses in the geriatric population.

Study setting: Department of Dermatology, Venereology and Leprology, Balvir Singh Tomar Institute of Medical Science and Research, Jaipur, Rajasthan.

Study period: The study was conducted over a 6 months duration, from March 2025 to August 2025.

Study population: All geriatric patients aged ≥60 years attending the dermatology outpatient department during the study period were included.

Sample size: A total of 500 geriatric patients fulfilling the inclusion criteria were enrolled in the study.

Inclusion criteria

- Patients aged 60 years and above
- Patients willing to participate in the study

- Patients presenting with dermatological complaints or physiological skin changes

Exclusion criteria

- Patients younger than 60 years
- Patients not willing to provide consent

Data collection: Detailed demographic information including age, gender, duration of dermatological condition, and associated systemic illnesses was recorded. A thorough clinical dermatological examination was performed in all patients.

Skin findings were categorized into:

1. Physiological skin changes associated with aging
2. Infective dermatoses
3. Eczematous disorders
4. Papulosquamous disorders
5. Connective tissue disorders
6. Immunobullous diseases
7. Drug-related dermatoses
8. Malignant conditions
9. Miscellaneous dermatological conditions

Relevant investigations such as KOH mount, skin biopsy, haematological investigations, and dermoscopy were performed wherever indicated to confirm the diagnosis.

Statistical analysis: Data were entered into Microsoft Excel and analysed using SPSS software. Distribution of Categorical variables were expressed as frequencies and percentages.

RESULTS

A total of 500 geriatric patients were included. Among them, 215 (43.0%) were females and 285 (57.0%) were males, giving a male to female ratio of 1.32:1.

Table 1: Physiological Skin Changes (N = 500)

Condition	Female n (%)	Male n (%)	Total	% (of 500)	F:M
Canities	215 (43.0)	285 (57.0)	500	100.0	1:1.32
Wrinkles	215 (43.0)	285 (57.0)	500	100.0	1:1.32
Cherry angioma	190 (42.2)	260 (57.8)	450	90.0	1:1.37
IGH	120 (44.4)	150 (55.6)	270	54.0	1:1.25
Seborrheic keratosis	95 (45.2)	115 (54.8)	210	42.0	1:1.21
Xerosis	100 (52.6)	90 (47.4)	190	38.0	1.1:1
Fissured feet	85 (53.1)	75 (46.9)	160	32.0	1.13:1
Acrochordon	60 (50.0)	60 (50.0)	120	24.0	1:1
Senile comedo	40 (43.0)	53 (57.0)	93	18.6	1:1.32
Lentigo	40 (44.4)	50 (55.6)	90	18.0	1:1.25
Callosity	25 (35.7)	45 (64.3)	70	14.0	1:1.8
Senile purpura	10 (50.0)	10 (50.0)	20	4.0	1:1

Wrinkles and canities were present in all 500 patients (100%). Cherry angiomas were seen in 450 patients (90%), with more males (260) than females (190). IGH was present in 270 patients (54%). Xerosis was observed in 190 patients (38%), slightly more in females (100 vs 90). Fissured feet were seen in 160 patients (32%), again slightly more in females. Seborrheic keratosis affected 210 patients (42%). Acrochordons were equal in both sexes (60 each). Callosity was more common in males (45 vs 25). Senile purpura was least common (20 patients, 4%).

Table 2: Pathological Dermatoses (N = 500)

Disorder	Female n (%)	Male n (%)	Total	%	F:M
Viral exanthem	8 (30.8)	18 (69.2)	26	5.2	1:2.25
Herpes zoster	11 (35.5)	20 (64.5)	31	6.2	1:1.8
Bacterial infection	70 (45.2)	85 (54.8)	155	31.0	1:1.2
Dermatophytosis	62 (41.3)	88 (58.7)	150	30.0	1:1.42
Onychomycosis	38 (32.8)	78 (67.2)	116	23.2	1:2.05
Allergic contact dermatitis	78 (55.7)	62 (44.3)	140	28.0	1.25:1
Irritant contact dermatitis	30 (60.0)	20 (40.0)	50	10.0	1.5:1
Asteatotic eczema	28 (51.9)	26 (48.1)	54	10.8	1.07:1
Stasis eczema	4 (28.6)	10 (71.4)	14	2.8	1:2.5
Atopic dermatitis	5 (38.5)	8 (61.5)	13	2.6	1:1.6
Nummular eczema	6 (33.3)	12 (66.7)	18	3.6	1:2
Hyperkeratotic hand eczema	3 (13.0)	20 (87.0)	23	4.6	1:6.6
Bullous pemphigoid	4 (30.8)	9 (69.2)	13	2.6	1:2.25
Pemphigus vulgaris	2 (40.0)	3 (60.0)	5	1.0	1:1.5
Dermatitis herpetiformis	1 (33.3)	2 (66.7)	3	0.6	1:2
DLE	4 (44.4)	5 (55.6)	9	1.8	1:1.25
Systemic sclerosis	2 (28.6)	5 (71.4)	7	1.4	1:2.5
SLE	3 (60.0)	2 (40.0)	5	1.0	1.5:1
Vitiligo	14 (46.7)	16 (53.3)	30	6.0	1:1.14
Drug rash	4 (40.0)	6 (60.0)	10	2.0	1:1.5
Fixed drug eruption	7 (36.8)	12 (63.2)	19	3.8	1:1.7
SJS	1 (33.3)	2 (66.7)	3	0.6	1:2
TEN	0 (0.0)	1 (100.0)	1	0.2	—
Vasculitis	6 (40.0)	9 (60.0)	15	3.0	1:1.5

Keloid	13 (44.8)	16 (55.2)	29	5.8	1:1.23
Pruritus	150 (54.5)	125 (45.5)	275	55.0	1.2:1
Acanthosis nigricans	40 (52.6)	36 (47.4)	76	15.2	1.1:1

Pruritus was the most common complaint, seen in 275 patients (55%). It was slightly more in females (150 vs 125). Bacterial infection (155 patients, 31%) and dermatophytosis (150 patients, 30%) were the most common diseases and were more frequent in males. Onychomycosis also showed clear male predominance (78 males).

Allergic contact dermatitis affected 140 patients (28%) and was more in females (78 vs 62). Irritant dermatitis also showed female predominance. Hyperkeratotic eczema showed strong male predominance (20 males vs 3 females). Other conditions like vitiligo, keloid, and acanthosis showed near equal distribution.

Table 3: Connective Tissue Disorders (N = 500)

Disorder	Female n (%)	Male n (%)	Total	% (of 500)	F:M
Discoid lupus erythematosus	4 (44.4)	5 (55.6)	9	1.8	1:1.25
Systemic sclerosis	2 (28.6)	5 (71.4)	7	1.4	1:2.5
Systemic lupus erythematosus	3 (60.0)	2 (40.0)	5	1.0	1.5:1
Dermatomyositis	1 (50.0)	1 (50.0)	2	0.4	1:1

Twenty-three individuals (4.6%) had connective tissue diseases. With nine patients (1.8%) and nearly equal distribution, DLE was the most prevalent. Seven patients (1.4%) had systemic sclerosis, which was more prevalent in men (two females and five males). Five individuals (1.0%) had SLE, with a small gender predominance (three females and two males). Only two patients had dermatomyositis, which was equally distributed.

Table 4: Papulosquamous Disorders (N = 500)

Disorder	Female n (%)	Male n (%)	Total	% (of 500)	F:M
Psoriasis vulgaris	32 (34.8)	60 (65.2)	92	18.4	1:1.87
Genital lichen sclerosus	22 (100.0)	0 (0.0)	22	4.4	Female only
Cutaneous lichen sclerosus	2 (16.7)	10 (83.3)	12	2.4	1:5
Lichen simplex chronicus	20 (100.0)	0 (0.0)	20	4.0	Female only
Cutaneous lichen planus	14 (100.0)	0 (0.0)	14	2.8	Female only
Oral lichen planus	11 (100.0)	0 (0.0)	11	2.2	Female only

171 individuals (34.2%) had papulosquamous diseases. The most prevalent condition was psoriasis, which affected 92 patients (18.4%) and was more common in men (60 vs. 32). There were two types of lichen sclerosus: cutaneous type was more common in males (10 vs. 2), whereas genital type was exclusively found in females (22 instances). In this study, lichen simplex chronicus and lichen planus were exclusively observed in females. This demonstrates how various situations within this group exhibit distinct gender behaviours.

Table 5: Erythroderma and Underlying Causes (N = 12)

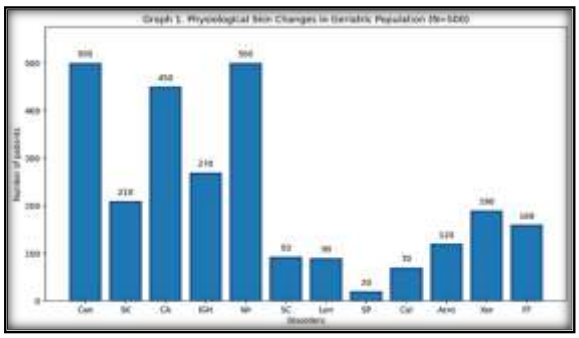
Cause	Female n (%)	Male n (%)	Total	% (of 12)	F:M
Psoriasis vulgaris	2 (22.2)	7 (77.8)	9	75.0	1:3.5
Drug reaction	2 (100.0)	0 (0.0)	2	16.7	Female only
Eczema	1 (100.0)	0 (0.0)	1	8.3	Female only

Twelve patients in all had erythroderma. Nine patients (75%) had psoriasis, which was more common in men (7 males, 2 females). Only females experienced drug reactions (16.7%) and eczema (8.3%). Psoriasis vulgaris was the most common underlying cause of erythroderma in the present study, accounting for 75% of cases. However, the number of erythroderma cases was small.

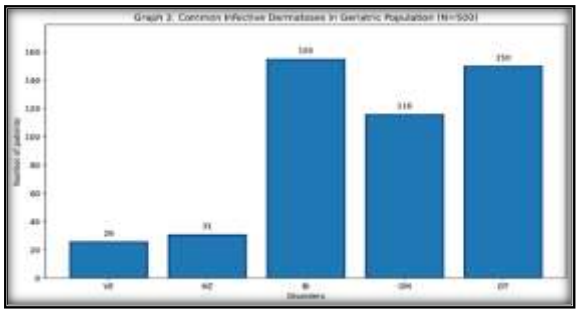
Table 6: Malignant Skin Disorders (N = 500)

Malignancy	Female n (%)	Male n (%)	Total	% (of 500)	F:M
Squamous cell carcinoma	2 (40.0)	3 (60.0)	5	1.0	1:1.5
Basal cell carcinoma	2 (50.0)	2 (50.0)	4	0.8	1:1
Mycosis fungoides	1 (100.0)	0 (0.0)	1	0.2	Female only
Leukaemia cutis	1 (100.0)	0 (0.0)	1	0.2	Female only

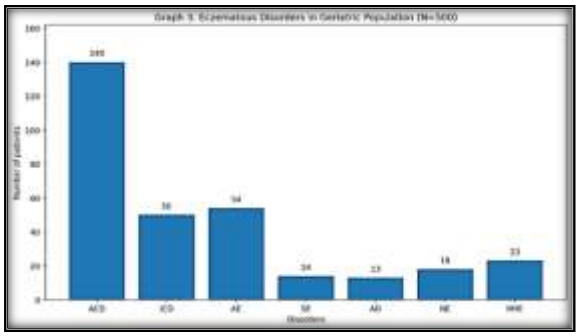
Eleven individuals (3.0%) had malignant conditions. The most common type, squamous cell carcinoma, was observed in 5 cases (1.0%), with slightly higher rates in males (3 vs. 2). Four patients (0.8%) had basal cell carcinoma, which was equivalent for both sexes. Only females had been affected by rare conditions such as leukaemia cutis and mycosis fungoides.



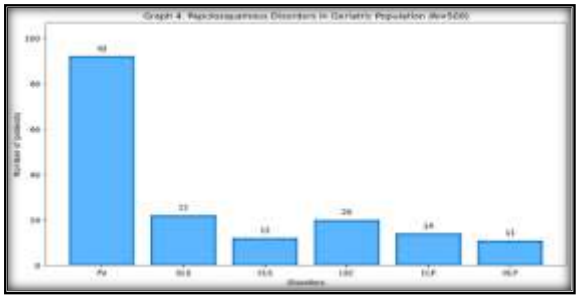
Abbreviations: Can = Canities, SK = Seborrheic keratosis, CA = Cherry angioma, IGH = Idiopathic guttate hypomelanosis, Wr = Wrinkles, SC = Senile comedo, Len = Lentigo, SP = Senile purpura, Cal = Callosity, Acro = Acrochordon, Xer = Xerosis, FF = Fissured feet.



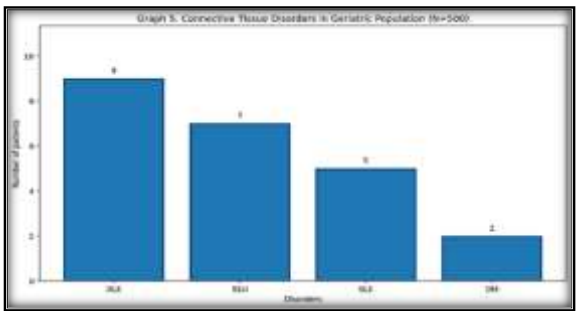
Abbreviations: VE = Viral exanthem, HZ = Herpes zoster, BI = Bacterial infection, OM = Onychomycosis, DT = Dermatophytosis.



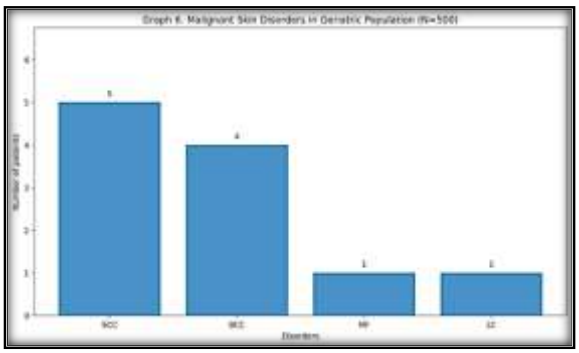
Abbreviations: ACD = Allergic contact dermatitis, ICD = Irritant contact dermatitis, AE = Asteatotic eczema, SE = Stasis eczema, AD = Atopic dermatitis, NE = Nummular eczema, HHE = Hyperkeratotic hand eczema.



Abbreviations: PV = Psoriasis vulgaris, GLS = Genital lichen sclerosus, CLS = Cutaneous lichen sclerosus, LSC = Lichen simplex chronicus, CLP = Cutaneous lichen planus, OLP = Oral lichen planus.



Abbreviations: DLE = Discoid lupus erythematosus, SScl = Systemic sclerosis, SLE = Systemic lupus erythematosus, DM = Dermatomyositis.



Abbreviations: SCC = Squamous cell carcinoma, BCC = Basal cell carcinoma, MF = Mycosis fungoides, LC = Leukemia cutis.

Figure 7: Herpes Zoster Infection

Figure 8: Keloid

Figure 9: Allergic Contact Dermatitis

Figure 111: Wrinkling (physiological dermatoses)

Figure 10: Genital Lichen Sclerosis

Figure 12: Squamous Cell Carcinoma

Figure 13: Canities

Figure 14: Senile Comedones

Figure 15: Onychomysosis

DISCUSSION

Demographic profile: The current study comprised 500 elderly patients, with a male-to-female ratio of 1.32:1, of which 57.0% were men and 43.0% were women. Numerous studies conducted in India have revealed a similar male predominance. A greater percentage of male patients was also noted by Talukdar et al. (2016), Sheethal et al. (2015), and Raveendra (2014). Males made up 66.7% of the population, according to Jindal et al. (2016) and 70.67% according to Kumar et al. (2021). [6,8,12,13,17]
However, this pattern has not been uniform across all studies. A population with a female-to-male ratio of 1.4:1 was reported by Simin et al. in 2021, and a larger percentage of females (57.4%) was collected by Durai et al. in 2012. These variations imply that the distribution of gender in elderly dermatoses may differ based on geography, healthcare accessibility, and health-seeking habits. Male predominance in many hospital-based Indian studies may reflect differences in health-seeking behaviour and access to care. [3.9]
Dermatological issues can coexist with systemic illnesses, which are frequently linked to aging. In contrast to Kumar et al. (2021), who displayed a lower frequency of 25%, Syed et al. (2017) reported systemic illness in 66.5% of patients. Differences in the study population and referral patterns could be the cause of this variation. Comorbidities can affect the incidence and severity of skin diseases in older people. [8,18]
Physiological skin changes: In the present study, wrinkling and canities were observed in all patients (100%). These results are in line with other research that demonstrates these are almost universal alterations in older people. According to Grover et al. (2009), 95.5% of patients had wrinkles, and 98% had greying hair. While Kumar et al. (2021) observed wrinkles in 87.33% and greying of hair in 88%, Raveendra (2014) reported wrinkles in 88% and canities in 90%. Nearly all patients had wrinkles, according to Durai et al. (2012). These findings support the notion that these are fundamental physiological changes associated with aging. [3,8,11,12]
Ninety percent of the participants in this study had cherry angiomas. Agarwal et al. (2019) observed a comparable high prevalence of 91.8%. However, Kumar et al., 2021 (29.33%) and Raveendra (2014) (37%) observed lower numbers. This variation may be related to differences in study population characteristics. [5,8,12]
In the current study, 54% of patients had idiopathic guttate hypomelanosis. Kumar et al., 2021 (49%) and Sheethal et al., 2015 (45.3%) reported similar values. This implies that IGH is frequently detected in older people. [8,17]
42% of patients had seborrheic keratosis. Talukdar et al. (2016) found a lower prevalence (23.3%), while Kumar et al. (2021) and Raveendra (2014) reported higher rates (about 56%). [8,12,13]
In the current study, 38% of patients had xerosis. This is less than that of Raveendra (2014) (93%) and Kumar et al., 2021 (74.33%). Beauregard and Gilchrest (1987) reported 85%, but Paliwal et al. (2019) reported 55.9%. The current study's decreased frequency could be caused by variations in skin care habits, hydration levels, or environmental conditions. [8,12,14,19]
Similar to Kumar et al., 2021 (22.67%), Raveendra (2014) (19.5%), and Talukdar et al., 2016 (20.6%), acrochordons were seen in 24% of individuals. [8,12,13]
The current study's senile comedones (18.6%) and lentigines (18%) are within the broad range documented in previous investigations. Skin type and cumulative sun exposure probably have an impact on these differences.
Overall, physiological changes in elderly individuals are common, but their frequency varies between studies due to environmental and population differences.
Pruritus: In the current study, pruritus was the most prevalent symptom, affecting 55% of patients. Although the frequency varies greatly, similar results have been observed in other research. According to Simin et al. (2021), 68% of patients had pruritus, although Kumar et al. (2021) found a higher prevalence of 88.33%. [8,9]
Grover et al., 2009 (18.5%), Jindal et al., 2016 (9%), and Raveendra (2014) (44%) have all reported lower frequencies. Patange and Fernandez (1995) reported 78.5%, Dhumale et al. (2016) reported 20.5%, and Paliwal et al. (2019) reported 90.6%. Other studies have also demonstrated considerable variation. [6,12-16]
This broad spectrum suggests that while pruritus is a frequent symptom in older people, its incidence varies depending on a number of factors. Pruritus in this age group may be caused by xerosis, systemic illnesses, drug use, and environmental factors.
The majority of these results are in line with research conducted in Indian hospitals, where pruritus is one of the most common complaints among senior citizens.

Infections: A major component of the illness spectrum in the current research included infections in addition to physiological alterations and pruritus. Thirty percent of patients had dermatophytosis, and thirty-one percent had bacterial infections. This suggests that infectious dermatoses play a major role in older people's morbidity.

The most frequent illnesses among elderly people have consistently been found to be fungal infections. According to Patange and Fernandez (1995), 17.5% of patients had fungal infections. Durai et al. (2012) reported a higher value of 34%, while Paliwal et al. (2019) found 21%. Additionally, 27.33% of cases had fungal infections, according to Kumar et al., 2021. These results are consistent with the current study's significant dermatophytosis prevalence. [3,8,14,16]

On the contrary, reports of bacterial illnesses are typically less frequent. 8.5% was recorded by Patange and Fernandez (1995), 8.9% by Talukdar et al. (2016), and just 2.7% by Jindal et al. (2016). A relatively low prevalence of 0.8% was found by Durai et al. (2012). The current study, in contrast, revealed a greater percentage of bacterial infections. Poor cleanliness, linked systemic disorders, or delayed presentation to medical facilities could all be contributing contributors to this discrepancy. [3,6,13,16]

Elderly people were also found to have viral infections. 7.6% of patients had viral infections, according to Jindal et al. (2016), while 9.2% had herpes zoster, according to Goyal et al. (2017). With herpes zoster being one of the prevalent viral illnesses, the current study revealed a similar tendency. [6,10]

When considered together, infections continue to play a significant role in geriatric dermatoses. The frequency of bacterial infections seems to vary amongst populations, whereas fungal infections are consistently widespread across research.

Eczematous disorders: Following infections, eczematous disorders formed another major group in the present study. Conditions such as allergic contact dermatitis, irritant contact dermatitis, and asteatosis eczema were commonly observed.

Eczema has been reported as one of the most frequent dermatological conditions in elderly patients. Talukdar et al., 2016 reported eczema in 34% of patients. Jiamton et al., 2017 reported 31.2%, and Raveendra (2014) also reported 31%. Durai et al., 2012 observed eczema in 24.2%, and Verbov reported 24.7%. Kumar et al., 2021 reported eczema in 28% of patients, with allergic contact dermatitis being a common type. Goyal et al., 2017 reported dermatitis in 10.1% of patients, with atopic dermatitis being the most frequent subtype. [3,8-15]

The findings of the present study are in agreement with these observations, showing that eczema forms a substantial proportion of dermatoses in elderly individuals. Dry skin, repeated exposure to irritants, and compromised skin barrier function may contribute to the development of eczema in this age group.

Papulosquamous disorders: Papulosquamous disorders were also commonly observed in the present study, with psoriasis being the most frequent condition, accounting for 18.4% of patients.

Psoriasis has been reported with varying prevalence in different studies. Patange and Fernandez (1995) reported 10.5%, Raveendra (2014) reported 7%, Jiamton et al., 2017 reported 8.3%, and Paliwal et al., 2019 reported 8.9%. Kumar et al., 2021 reported psoriasis in 7.33%, while Agarwal et al., 2019 reported values closer to 20%. The higher prevalence observed in the present study is therefore within the upper range reported in Indian studies. [5,8,12-16]

Lichen planus has been reported in smaller proportions. Jindal et al., 2016 reported 3.3%, Talukdar et al., 2016 reported 3.6%, Raveendra (2014) reported 5%, and Paliwal et al., 2019 reported 2.6%. The findings in the present study fall within this range. [6,12-14]

These observations indicate that papulosquamous disorders are moderately common in elderly patients, with psoriasis being the dominant condition. The chronic nature of these diseases may explain their persistence into older age. [20,21]

While eczema and infections make up the majority of pathological dermatoses, physiological alterations are nearly universal. Pruritus is still a prevalent problem, frequently linked to xerosis and other underlying diseases.

While there are differences in frequency between studies, the majority of these results are similar to those from hospital-based research in India.

CONCLUSION

The present study shows that geriatric dermatoses comprise both physiological ageing-related skin changes and a broad range of pathological disorders. Wrinkling and canities were universal findings, while xerosis, cherry angiomas, and idiopathic guttate hypo melanosis were also common. Among pathological conditions, infections and eczematous disorders were prominent, with dermatophytosis and bacterial infections being frequent, and psoriasis being the leading papulosquamous disorder. Pruritus was the most common presenting symptom. These findings highlight the need for early recognition and appropriate management of skin disorders in the elderly to reduce morbidity and improve quality of life.

Limitations

- The study was hospital-based and may not reflect the true prevalence in the community.
- Patients attending a tertiary care centre may have more severe or chronic conditions.
- Seasonal variation and environmental factors were not assessed separately.
- Detailed evaluation of systemic diseases and drug history was limited.

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