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## Consensus Document

# Management of the Impact of Psoriasis on Sexuality: Consensus Recommendations From the Psoriasis Working Group of the Spanish Academy of Dermatology and Venereology



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## ABSTRACT

Sexuality is a key component of quality of life; therefore, sexual dysfunction can affect both physical and emotional well-being. However, despite its high prevalence, the impact of psoriasis on patients' sexual health is often overlooked in clinical practice.

This Delphi study aimed to provide consensus recommendations among dermatologists on the comprehensive management of the impact of psoriasis on sexuality and to identify the barriers they face when addressing this issue.

Consensus was reached on 23 recommendations (88.5%) addressing the impact of psoriasis on sexuality, early detection, management, referral strategies, and sexual dysfunction. Topics considered beyond the scope of dermatologists did not reach consensus.

The main barriers identified were lack of time (20%), patients' reluctance or discomfort (16.1%), lack of awareness of validated questionnaires (14.3%), and insufficient specific training (13.9%).

Overall, these recommendations aim to guide the appropriate management of the impact of psoriasis on sexuality and to promote greater recognition of its relevance in clinical practice.

## Introduction

Sexuality is an essential component of quality of life, with implications for physical health, emotional well-being, and interpersonal relationships.<sup>1-4</sup> Sexual dysfunction has a multifactorial etiology that includes organic, psychological, and social causes.<sup>5-8</sup> It may result from physical conditions such as psoriasis,<sup>5-7</sup> in which the prevalence of sexual dysfunction can reach up to 55%.<sup>9-13</sup> However, sexual health

is often overlooked in clinical practice because of limited professional training and the discomfort associated with addressing the topic.<sup>9</sup>

This study aimed to reach a consensus among dermatologists on recommendations for improving the management of the impact of psoriasis on sexuality and to identify the main barriers to addressing this issue effectively.

## Materials and methods

The Delphi method<sup>14</sup> was used to reach consensus on recommendations concerning the management of the impact of psoriasis on sexuality. After reviewing and discussing the available evidence, the scientific committee, composed of 7 experts from the Psoriasis Group (GPs) of Aca-

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<sup>1</sup> Members of the "Consensus on the Management of the Impact of Psoriasis on Sexuality Study Group" are listed in Appendix A.

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**Table 1**  
Sociodemographic and professional characteristics of the participants.

Variable	Total (N = 56)
<i>Sex, % (n)</i>	
Women	50.0 (28)
Men	50.0 (28)
<i>Years practicing dermatology, mean (SD)</i>	20.0 (11.6)
<i>Autonomous community of practice, % (n)</i>	
Andalusia	10.7 (6)
Aragón	7.1 (4)
Principality of Asturias	1.8 (1)
Balearic Islands	1.8 (1)
Canary Islands	1.8 (1)
Cantabria	3.6 (2)
Castile-La Mancha	1.8 (1)
Castile and León	1.8 (1)
Catalonia	19.6 (11)
Community of Valencia	14.3 (8)
Extremadura	0.0 (0)
Galicia	5.4 (3)
La Rioja	0.0 (0)
Madrid	23.2 (13)
Navarre	1.8 (1)
Basque Country	1.8 (1)
Region of Murcia	3.6 (2)

SD, standard deviation.

*demia Española de Dermatología y Venereología* (AEDV) and 1 specialized advisor, developed a 26-item questionnaire.

All members of the GPs were invited to participate in the Delphi consensus as the expert panel and were given access to the questionnaire online. Each item was rated using a 9-point Likert scale, and participants were able to provide comments.

Consensus was defined as  $\geq 66.6\%$  of participants scoring within the 3-point range containing the median. Dermatologists were also asked about the limitations they encountered when addressing sexuality during clinical consultations.

After the first round, items that did not reach consensus were revised by the scientific committee and returned to the experts for a second round.

## Results

The Delphi questionnaire was sent to all members of the GPs ( $n = 203$ ). A total of 56 and 51 dermatologists responded during the first and second rounds, respectively (participation rates, 27.6% and 91.1%). The sociodemographic characteristics of the participants are presented in Table 1.

After 2 rounds, consensus was reached on 23 of the 26 items (88.5%) (Table 2).

The main barriers reported by dermatologists included lack of time (20%), patient reluctance or discomfort (16.1%), lack of awareness of validated questionnaires (14.3%), and insufficient specific training (13.9%). Less frequently reported obstacles included concerns about invading the patient's privacy (12.6%) and difficulty using appropriate language (4.8%) (Fig. 1).

## Discussion

### *Impact of psoriasis on sexuality*

#### *Item 1. Psoriasis can negatively affect the sexual health of any patient*

The presence of lesions, whether genital or located in visible areas, can lead to embarrassment, low self-esteem, and fear of rejection. In

addition, discomfort and pain may impair the patient's ability to fully enjoy intimate relationships. Some patients also fear that psoriasis may be mistaken for a contagious disease.

The main difficulties reported include reduced sexual activity, changes in usual sexual practices, and, in some cases, complete absence of sexual activity.<sup>9–12</sup>

#### *Item 2. Sexual dysfunction in patients with psoriasis does not always correlate directly with disease severity or lesion location*

Although lesions in the genital area, visible regions such as the face or hands, or severe psoriasis may have a greater impact on sexual function, psychological factors play a critical role. A negative self-image during psoriasis flares contributes to reduced sexual desire and avoidance of intimacy,<sup>15–18</sup> even when lesions are minimal.

#### *Item 3. Sexual health impairment is influenced by comorbid anxiety and depression associated with psoriasis*

Comorbid anxiety and depression significantly affect the sexual health of patients with psoriasis. These conditions can decrease libido, promote insecurity, and intensify fear of rejection, all of which negatively affect sexual relationships.<sup>10,19–22</sup> They may also impair treatment response and worsen self-perception, further exacerbating the impact of psoriasis on sexual health.

#### *Item 4. The impact of psoriasis on quality of life and sexual relationships is underdiagnosed*

Underdiagnosis is often due to factors such as limited consultation time, the taboo surrounding sexuality, insufficient examination or inquiry about the genital area, lack of direct discussion during clinical encounters, and limited awareness of tools such as validated questionnaires that can help identify sexual health problems.

#### *Item 5. Cultural factors such as background, beliefs, and religion should be considered when evaluating the impact of psoriasis on a patient's sexual health*

Cultural factors, including religion, beliefs, and educational level, play an important role in how patients perceive psoriasis, its impact on sexuality, and their willingness to address sexual health concerns during consultations. Additionally, social and relational factors, such as poor communication, relationship conflict, and cultural beliefs, may influence how dermatologic conditions affect sexual well-being.<sup>5,6,23</sup>

#### *Item 6. There is a need to increase awareness among dermatologists regarding sexual health impairment in women with psoriasis, as it is often overlooked*

Sexual health problems in women with psoriasis, reported in up to 79% of cases, are often associated with a higher prevalence of psychological comorbidities and reduced quality of life.<sup>10,19,24–27</sup> In women of reproductive age, the impact may also include issues related to contraception and pregnancy.<sup>28,29</sup> Although sexual health impairment may occur regardless of sex or age,<sup>25,29</sup> these issues frequently go unnoticed, particularly in older women.

#### *Item 7. The impact of psoriasis on sexual health should always be assessed, regardless of the patient's age*

Sexual impairment can occur at any age and should not be underestimated (prevalence of 58.6% among individuals aged 18–69 years).<sup>25,29</sup> It should not be assumed that patients, particularly older adults, lack concerns related to sexuality. This topic should be addressed respectfully with patients of all ages using a proactive approach that does not presume the absence of sexual health concerns.

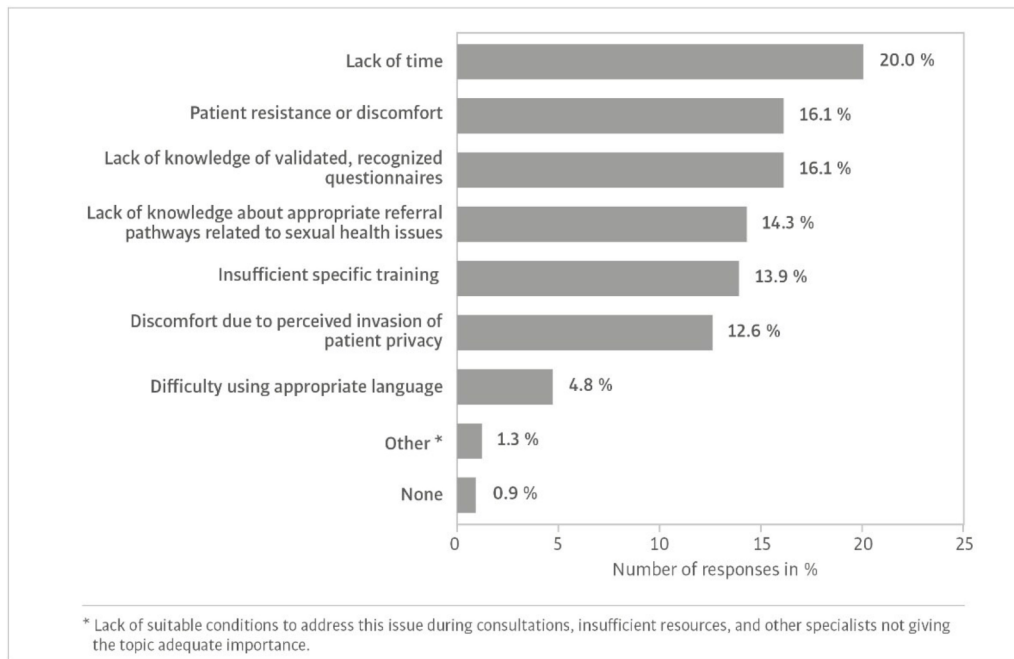
**Table 2**  
Results of the Delphi consensus.

Item	N	Median	Disagreement, n (%)	Uncertainty, n (%)	Agreement, n (%)
<b>Impact of psoriasis on sexuality</b>					
1. Psoriasis can negatively affect the sexual health of any patient.	56	9	0 (0.0)	2 (3.6)	54 (96.5) <sup>a</sup>
2. Sexual dysfunction in patients with psoriasis does not always correlate directly with disease severity or lesion location.	56	9	3 (5.4)	1 (1.8)	52 (92.9) <sup>a</sup>
3. Sexual health impairment is influenced by comorbid anxiety and depression associated with psoriasis.	56	9	0 (0.0)	3 (5.4)	53 (94.6) <sup>a</sup>
4. The impact of psoriasis on quality of life and sexual relationships is underdiagnosed.	56	8.5	1 (1.8)	4 (7.2)	51 (91.1) <sup>a</sup>
5. Cultural factors such as background, beliefs, and religion should be considered when evaluating the impact of psoriasis on a patient's sexual health.	56	9	6 (10.8)	2 (3.6)	48 (85.7) <sup>a</sup>
6. There is a need to raise awareness among dermatologists regarding sexual health impairment in women with psoriasis, as it is often overlooked.	51	8	2 (4.0)	3 (5.9)	46 (90.2)
7. The impact of psoriasis on sexual health should always be assessed, regardless of the patient's age.	51	8	4 (7.9)	3 (5.9)	44 (86.3)
<b>Importance of early detection</b>					
8. Assessment of sexual function should be included in the routine medical history of patients with psoriasis.	56	8	3 (5.4)	7 (12.5)	46 (82.1) <sup>a</sup>
9. The use of validated questionnaires is recommended to evaluate sexual quality of life in patients with psoriasis (e.g., ASEX, DLQI, MGH-SFQ).	56	8	7 (12.5)	11 (19.6)	38 (67.9) <sup>a</sup>
10. Specific and proactive evaluation of genital involvement should be integrated into the medical history and physical examination of patients with psoriasis.	56	9	0 (0.0)	2 (3.6)	54 (96.4) <sup>a</sup>
<b>Strategies for managing individuals with psoriasis</b>					
11. The positive impact of psoriasis treatment on sexual life supports the recommendation for early initiation of therapy.	56	8	0 (0.0)	3 (5.4)	53 (94.6) <sup>a</sup>
12. The treatment approach should consider both the presence and progression of genital lesions.	56	9	0 (0.0)	1 (1.8)	55 (98.2) <sup>a</sup>
13. If sexual dysfunction persists despite improvement in cutaneous lesions, referral to the appropriate specialist is recommended.	56	8	1 (1.8)	5 (9.0)	50 (89.2) <sup>a</sup>
<b>Referral of individuals with psoriasis</b>					
14. When issues related to self-esteem or body image affecting sexual life are identified, referral to the appropriate specialist should be made based on institutional resources.	56	8	3 (5.4)	8 (14.3)	45 (80.4) <sup>a</sup>
15. When genital psoriasis severely interferes with sexual function, individualized referral to appropriate services (sexology, urology, gynecology) is recommended.	51	8	5 (9.8)	6 (11.8)	40 (78.4)
16. If the patient has a partner, the impact of the disease on the relationship should be assessed.	51	6	14 (27.5)	16 (31.4)	21 (41.2)
17. If psoriasis negatively affects the couple's relationship, referral to couples therapy should be considered whenever possible.	51	5	17 (33.3)	17 (33.3)	17 (33.3)
18. A system for periodic follow-up and reassessment of sexual function should be implemented when sexual health issues are identified.	56	8	5 (9.0)	8 (14.3)	43 (76.8) <sup>a</sup>
<b>Special considerations in sexual dysfunction</b>					
19. The impact of psoriasis on sexual function should be evaluated comprehensively, considering physical, psychological, and social factors.	56	9	1 (1.8)	1 (1.8)	54 (96.4) <sup>a</sup>
20. Dermatologists should be aware of the potential organic basis of female sexual dysfunction.	51	8	9 (17.6)	4 (7.9)	38 (74.5)
21. Erectile dysfunction in men and arousal/orgasmic dysfunction in women should be assessed regardless of psoriasis severity.	51	6	11 (21.5)	18 (35.3)	22 (43.1)
<b>Special considerations in psoriasis</b>					
<i>Genital psoriasis</i>					
22. Genital symptoms should be actively assessed in patients with psoriasis.	56	9	1 (1.8)	6 (10.7)	49 (87.5) <sup>a</sup>
23. Psychological morbidity should be carefully assessed in patients with genital psoriasis.	56	8	1 (1.8)	4 (7.2)	51 (91.1) <sup>a</sup>
24. Validated questionnaires should be used to assess the impact of genital psoriasis on sexual health.	56	8	2 (3.6)	8 (14.3)	46 (82.2) <sup>a</sup>
<i>Psoriatic arthritis</i>					
25. Dermatologists should be aware of the impact of psoriatic arthritis on sexual health regardless of disease severity.	56	7	4 (7.2)	14 (25.0)	38 (67.8) <sup>a</sup>
26. Validated questionnaires should be used to assess the impact of psoriatic arthritis on sexual health.	56	7	7 (12.5)	10 (17.8)	39 (69.7) <sup>a</sup>

N, number of responses; Median, median score.

Scoring interpretation: Disagreement (scores 1–3), uncertainty (scores 4–6), agreement (scores 7–9).

Consensus definition: Text in bold indicates consensus ( $\geq 66.6\%$  of participants in agreement or disagreement).<sup>a</sup> Agreement reached in the first round of the Delphi process.



**Fig. 1.** Limitations reported by dermatologists when addressing sexual health during medical consultations.

#### Importance of early detection

**Item 8.** The assessment of sexual function should be included in the routine medical history of patients with psoriasis

Early detection can help prevent the worsening of sexual health problems caused by the physical and psychological impact of psoriasis.<sup>30,31</sup> It is important to ask direct questions about sexual health because many patients do not spontaneously report problems in this area. This approach is essential for providing comprehensive care and identifying issues that might otherwise remain undiagnosed.

**Item 9.** The use of validated questionnaires is recommended to evaluate sexual quality of life in patients with psoriasis, both at the initial consultation and during follow-up (e.g., Arizona Sexual Experience Scale [ASEX], Dermatology Life Quality Index [DLQI], Massachusetts General Hospital-Sexual Functioning Questionnaire [MGH-SFQ])

Validated questionnaires allow an objective assessment of the impact of psoriasis on sexual life and facilitate structured follow-up. However, their use should take into consideration the clinical context, available consultation time, and the patient's willingness to complete them. For example, they may be reserved for cases in which a significant impact on sexual life is evident or when systemic treatment is being considered.

Appendices B and C summarize the main validated questionnaires identified for evaluating sexual health and psychological impact in patients with psoriasis.

**Item 10.** Specific and proactive evaluation of genital involvement should be integrated into the past medical history and physical examination of patients with psoriasis

A specific assessment of genital involvement is essential for appropriate management of psoriasis, as many patients (up to 45.8%) do not spontaneously report symptoms in this area.<sup>32,33</sup> A proactive and sensitive approach should therefore be adopted to facilitate detection of genital involvement, improve quality of life, and guide more precise treatment while minimizing patient discomfort.

#### Strategies for managing individuals with psoriasis

**Item 11.** The positive impact of psoriasis treatment on sexual life supports the recommendation for early initiation of therapy

Effective and early treatment improves cutaneous symptoms of psoriasis<sup>21,24,34–41</sup> and provides psychological and emotional benefits that directly influence sexual health by enhancing self-esteem, reducing anxiety, and decreasing stigma related to visible lesions.<sup>42</sup>

Early treatment does not necessarily imply the use of systemic therapies. It is also important to consider the potential adverse effects of certain dermatologic treatments on sexual function, as they may contribute to the onset or worsening of sexual dysfunction, including erectile dysfunction.<sup>16,17,43–46</sup>

**Item 12.** The treatment approach should consider both the presence and progression of genital lesions

Management of genital lesions requires a sensitive approach due to the delicate nature of the area and the significant impact such lesions may have on the patient's quality of life, including self-perception and intimate relationships. Periodic genital examination should be performed to ensure appropriate disease control and to guide the selection and adjustment of the most suitable therapeutic options.

**Item 13.** If sexual dysfunction persists despite improvement in cutaneous lesions, referral to the appropriate specialist is recommended

A multidisciplinary approach is essential when sexual dysfunction persists after improvement or resolution of skin lesions, or when no dermatologic cause is identified. In such cases, referral to the appropriate specialist—such as a sexologist, psychologist, urologist, or gynecologist—should be considered depending on the clinical scenario and the resources available at the healthcare facility.

#### Referral of individuals with psoriasis

**Item 14.** When issues related to self-esteem or body image affecting the sexual life of patients with psoriasis are identified, referral to the appropriate specialist should be made based on institutional resources (e.g., psychology or sexology services)

Dermatologists may identify these issues but are generally not trained to address them comprehensively. Therefore, referral to a psy-

chologist or sexologist is recommended to prevent the development of conditions such as anxiety and depression,<sup>47</sup> particularly when dermatologic treatment alone does not resolve the identified concerns.

*Item 15. When genital psoriasis severely interferes with sexual function, individualized evaluation for referral to appropriate services (medical sexology, urology, or gynecology) is recommended, depending on availability and institutional protocols*

Dermatologists are the appropriate specialists to manage psoriasis, and treatment of genital lesions often resolves many related problems. However, complex cases may require referral to medical sexology, urology, or gynecology, particularly when the physical consequences of the disease are significant. An individualized approach should be adopted, considering both the severity of symptoms and the availability of relevant specialists within the healthcare center.

*Item 16. If the patient has a partner, it is recommended to assess the impact of the disease on the relationship*

Up to 41.1% of partners of individuals with psoriasis report experiencing some form of sexual dysfunction.<sup>10</sup> Therefore, this potential impact should be considered. However, the dermatologist's role is not to directly assess the partner but rather to focus on managing the patient's condition.

*Item 17. If psoriasis is found to negatively affect the couple's relationship, referral to couples therapy should be considered whenever possible*

Referrals should be evaluated on a case-by-case basis when the impact of psoriasis on the partner or the relationship is evident. This should not be a general recommendation, as the dermatologist's primary role is to treat psoriasis and avoid intervening in areas that exceed their professional scope.

*Item 18. It is recommended to implement a system for periodic follow-up and reassessment of sexual function in patients with psoriasis when issues in this domain are identified*

Follow-up should be incorporated into routine clinical visits to ensure that treatments are effective across all aspects of the patient's well-being, including sexual function. Tools such as the DLQI<sup>48</sup> and ASEX<sup>49</sup> may assist in the periodic evaluation of sexual function. In addition, coordinated care with sexual health professionals or primary care providers, once the primary psoriasis-related concerns have been addressed, may support long-term follow-up.

#### *Special considerations in sexual dysfunction*

*Item 19. The impact of psoriasis on sexual function should be evaluated comprehensively, taking into account physical symptoms, psychological factors, and social determinants*

The impact of psoriasis on sexual function is multidimensional and should be assessed holistically, considering all aspects of the disease that may influence this domain. A multidisciplinary approach is recommended, involving collaboration with other healthcare professionals to effectively address the different dimensions of sexual health impairment.<sup>12,18,22</sup>

*Item 20. Dermatologists should be aware of the potential organic basis of female sexual dysfunction*

The organic basis of female sexual dysfunction remains understudied. However, its high prevalence—reaching up to 79% of affected patients—highlights the importance of increasing dermatologists' awareness of its possible etiologic factors.<sup>19,25,26</sup>

Although dermatologists are not expected to directly manage these dysfunctions, they should be able to recognize potential organic causes and refer patients to appropriate specialists when necessary.

*Item 21. It is advisable to identify erectile dysfunction in men with psoriasis and to assess arousal and orgasmic function in women, regardless of disease severity*

Identification of sexual dysfunction in patients with psoriasis should form part of a comprehensive clinical assessment. Management of these conditions typically falls outside the scope of dermatology and should be undertaken by specialists such as urologists, gynecologists, or sexologists. These dysfunctions may arise from factors beyond psoriasis severity, including chronic inflammation, psychological factors, and cardiovascular comorbidities commonly associated with the disease.<sup>16–18,50</sup>

#### *Special considerations in psoriasis*

*Item 22. It is recommended to actively inquire about and assess genital symptoms in patients with psoriasis*

Genital psoriasis is associated with a significant deterioration in sexual health and emotional well-being.<sup>32,34,51–57</sup> Although examination of the genital area may cause discomfort for some patients, it remains essential for a comprehensive evaluation of the disease and its impact on sexual health.

*Item 23. Special attention should be given to psychological morbidity in patients with genital psoriasis*

The psychological burden of genital involvement is considerable because of its impact on sexual life, body image, and self-esteem. Over time, this may lead to symptoms of anxiety, depression, or body image disturbance.<sup>32,54,55</sup> However, psychological morbidity should be broadly assessed in all patients with psoriasis, regardless of lesion location, to ensure comprehensive care.

*Item 24. The use of validated questionnaires is recommended to support the assessment of the impact of genital psoriasis on the patient's sexual health*

These tools enable an objective and quantifiable assessment of the problem, facilitate monitoring of changes over time, and support individualized management. They may also provide a more discreet and reliable way for patients to express concerns about sexuality and genital involvement, thereby improving communication between physicians and patients.<sup>32,33,56</sup>

*Item 25. Dermatologists should be aware of the impact of psoriatic arthritis on sexual health, regardless of disease severity*

Beyond skin symptoms, joint pain, fatigue, and physical limitations related to psoriatic arthritis negatively affect sexual quality of life.<sup>58–60</sup> Coordination with other specialists, particularly rheumatologists, is essential, as they manage functional impairments caused by pain and joint stiffness that may interfere with sexual activity.

*Item 26. The use of validated questionnaires is recommended to support the assessment of the impact of psoriatic arthritis on the patient's sexual health*

Instruments such as the DLQI<sup>48</sup> and the Psoriatic Arthritis Impact of Disease (PsAID)<sup>61</sup> questionnaire can help quantify disease burden, tailor treatments, and guide structured follow-up. Their use may be particularly beneficial during joint consultations with rheumatologists, who have a more targeted approach to evaluating arthritis-related effects.

The final recommendations agreed upon by the expert panel are presented in [Table 3](#).

Limitations reported by dermatologists indicate that time constraints, insufficient training in specific topics, and structural barriers within the healthcare system hinder the appropriate assessment of sexual health in patients with psoriasis. This highlights the need to enhance professional education, increase available resources, and promote a more individualized approach to achieve comprehensive patient care.

**Table 3**  
Consensus recommendations on the management of the impact of psoriasis on sexuality.

No.	Recommendation
1	The impact of psoriasis on sexual health should be assessed in all patients, regardless of age.
2	Assessment of sexual function should be included in the routine medical history of patients with psoriasis.
3	Dermatologists should actively inquire about and assess genital symptoms in patients with psoriasis.
4	Specific and proactive evaluation of genital involvement should be integrated into the medical history and physical examination of patients with psoriasis.
5	The impact of psoriasis on sexual function should be evaluated comprehensively, considering physical symptoms, psychological factors, and social determinants.
6	Special attention should be given to psychological morbidity in patients with genital psoriasis.
7	Cultural factors such as background, beliefs, and religion should be considered when evaluating the impact of psoriasis on a patient's sexual health.
8	Validated questionnaires are recommended to evaluate sexual quality of life in patients with psoriasis at the initial consultation and during follow-up (e.g., Arizona Sexual Experience Scale [ASEX], Dermatology Life Quality Index [DLQI], Massachusetts General Hospital–Sexual Functioning Questionnaire [MGH-SFQ]).
9	Validated questionnaires are recommended to assess the impact of genital psoriasis on the patient's sexual health.
10	Validated questionnaires are recommended to assess the impact of psoriatic arthritis on the patient's sexual health.
11	Early initiation of appropriate psoriasis treatment is recommended because of its positive impact on sexual health.
12	Treatment strategies should consider the presence and progression of genital lesions when present.
13	When issues related to self-esteem or body image affecting sexual life are identified, referral to an appropriate specialist (e.g., psychology or sexology) should be considered based on institutional resources.
14	When genital psoriasis severely interferes with sexual function, individualized referral to appropriate services (e.g., medical sexology, urology, or gynecology) is recommended according to availability and institutional protocols.
15	If sexual dysfunction persists despite improvement in cutaneous lesions, referral to the appropriate specialist is recommended.
16	Periodic follow-up and reassessment of sexual function are recommended when problems in this domain are identified.
17	Dermatologists should be aware of the frequently overlooked deterioration of sexual health in women with psoriasis.
18	Dermatologists should be aware of the potential organic basis of female sexual dysfunction.
19	Dermatologists should be aware of the impact of psoriatic arthritis on sexual health, regardless of disease severity.

Statements corresponding to items 1–4 of the Delphi questionnaire are not included because they represent statements of agreement rather than specific recommendations.

## Conclusions

The results of this study underscore the importance dermatologists attribute to addressing sexual health in patients with skin diseases that have a significant physical and psychological impact, such as psoriasis. The consensus recommendations presented herein aim to guide appropriate management of the impact of psoriasis on sexuality and to raise awareness of its clinical relevance.

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## Conflicts of interest

J.-M.C. has participated as principal investigator/subinvestigator, guest speaker, and/or advisor for AbbVie, Almirall, Lilly, Janssen, LEO Pharma, Novartis, UCB, Bristol Myers Squibb, and Boehringer Ingelheim.

R.F. has participated as an advisor, speaker, and/or in training courses sponsored by AbbVie, Almirall, Amgen, Bristol, Celgene, LEO Pharma, Sandoz, Lilly, Novartis, Sanofi, and UCB. She has also participated in clinical trials and market studies sponsored by AbbVie, Almirall, Amgen, Bristol, Galderma, Regeneron, Johnson & Johnson, Lilly, Novartis, Pfizer, Rho, Takeda, Incyte, Sanofi, UCB, and LEO Pharma.

A.L.-F. has received honoraria as an advisor and/or speaker from AbbVie, Almirall, Amgen, Boehringer Ingelheim, Bristol Myers Squibb, Johnson & Johnson Innovative Medicine, LEO Pharma, Lilly, Novartis, and UCB. She has also received research grants or participated in clinical trials sponsored by AbbVie, Almirall, Amgen, Boehringer Ingelheim,

Johnson & Johnson Innovative Medicine, LEO Pharma, Lilly, Novartis, Takeda, and UCB.

P.C. has received honoraria as an advisor, investigator, and/or speaker from AbbVie, Almirall, Amgen, Astellas, Beiersdorf, Biogen, Bristol Myers Squibb, Boehringer Ingelheim, Celgene, Gebro, Johnson & Johnson, LEO Pharma, Lilly, MSD, Novartis, Pfizer, Roche, Sandoz, Sanofi, SVR, Takeda, and UCB.

A.A.-S. has received honoraria as an advisor, investigator, and/or speaker from AbbVie, Almirall, Lilly, Janssen, LEO Pharma, Novartis, UCB, Bristol Myers Squibb, and Boehringer Ingelheim.

R.T., S.A., and B.P.-S. declared no conflicts of interest whatsoever.

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## Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at [doi:10.1016/j.ad.2026.104633](https://doi.org/10.1016/j.ad.2026.104633).

ReferenciasReferences

## References

- Luis Arrondo J. La sexualidad supone disfrutar, comunicarse, sentirse mejor y estar más sano. *Rev Int Androl*. 2008;6:260–264.
- Flynn KE, Lin L, Bruner DW, et al. Sexual satisfaction and the importance of sexual health to quality of life throughout the life course of U.S. adults. *J Sex Med*. 2016;13:1642–1650.
- Cybulski M, Cybulski L, Krajewska-Kulak E, et al. Sexual quality of life, sexual knowledge, and attitudes of older adults on the example of inhabitants over 60s of Białystok, Poland. *Front Psychol*. 2018;9:483.

4. Boyacıoğlu NE, Oflaz F, Karaahmet AY, et al. Sexuality, quality of life and psychological well-being in older adults: a correlational study. *Eur J Obstet Gynecol Reprod Biol X*. 2023;17:100177.
5. Brotto L, Atallah S, Johnson-Agbakwu C, et al. Psychological and interpersonal dimensions of sexual function and dysfunction. *J Sex Med*. 2016;13:538–571.
6. Halvorsen JG, Metz ME. Sexual dysfunction. Part I: Classification, etiology, and pathogenesis. *J Am Board Fam Pract*. 1992;5:51–61.
7. Sexual Dysfunction: Symptoms, Causes, and Treatment. <https://www.medicalnews-today.com/articles/sexual-dysfunction> Accessed 18.10.24.
8. Female Sexual Dysfunction – Symptoms and Causes. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/female-sexual-dysfunction/symptoms-causes/syc-20372549> Accessed 18.10.24.
9. Clayton A, Ramamurthy S. The impact of physical illness on sexual dysfunction. *Adv Psychosom Med*. 2008;29:70–88.
10. Salle R, Halioua B, Le Fur G, et al. Psoriasis and sexuality: patients express their feelings. *Skin Health Dis*. 2023;3:e199.
11. Iocca F, Burlando M, Angelo NL, et al. Sexual functioning in patients with psoriasis: the role of body dissatisfaction and cognitive biases toward sexuality. *J Sex Marital Ther*. 2024;50:439–455.
12. Adil A, Najib R, Bouhamidi A, et al. Sexual disorders in psoriatic patients. *Int J Adv Res*. 2023;11:985–991.
13. Molina-Leyva A, Salvador-Rodriguez L, Martinez-Lopez A, et al. Association between psoriasis and sexual and erectile dysfunction in epidemiologic studies: a systematic review. *JAMA Dermatol*. 2019;155:98–106.
14. Diamond IR, Grant RC, Feldman BM, et al. Defining consensus: a systematic review recommends methodologic criteria for reporting of Delphi studies. *J Clin Epidemiol*. 2014;67:401–409.
15. Kędra K, Janeczko K, Michalik I, et al. Sexual dysfunction in women and men with psoriasis: a cross-sectional questionnaire-based study. *Med Kaunas Lith*. 2022;58:1443.
16. Saygin H, Tosun M, Öztürk A, et al. *Effects of Psoriasis and Metabolic Syndrome on Male Sexual Functions*; 2021, <http://dx.doi.org/10.31083/jomh.2021.038>. Epub ahead of print July 8.
17. Aslam AB, Khan RM, Abdullah MS, et al. Assessment of quality of sexual life in male patients with psoriasis. *J Bangladesh Coll Physicians Surg*. 2022;40:223–228.
18. Wojciechowska-Zdrojoway M, Reid A, Szepietowski JC, et al. Analysis of sexual problems in men with psoriasis. *J Sex Marital Ther*. 2018;44:737–745.
19. Nguyen HT, Ngo VTN, Pham NN, et al. Sexual dysfunction and associated factors in women with psoriasis. *Indian J Dermatol*. 2023;68:121.
20. Bardazzi F, Odorici G, Ferrara P, et al. Sex and the PASI: patients affected by a mild form of psoriasis are more predisposed to have a more severe form of erectile dysfunction. *J Eur Acad Dermatol Venereol*. 2016;30:1342–1348.
21. Duarte GV, Calmon H, Radel G, et al. Psoriasis and sexual dysfunction: links, risks, and management challenges. *Psoriasis Auckl NZ*. 2018;8:93–99.
22. Sampogna F, Abeni D, Gieler U, et al. Impairment of sexual life in 3485 dermatological outpatients from a multicentre study in 13 European countries. *Acta Derm Venereol*. 2017;97:478–482.
23. Palominos PE, Gossec L, Kreis S, et al. The effects of cultural background on patient-perceived impact of psoriatic arthritis – a qualitative study conducted in Brazil and France. *Adv Rheumatol Lond Engl*. 2018;58:33.
24. Feldman SR, Malakouti M, Koo JY. Social impact of the burden of psoriasis: effects on patients and practice. *Dermatol Online J*. 2014;20, 13030/qt48r4w8h2.
25. Kurizky PS, Martins GA, Carneiro JN, et al. Evaluation of the occurrence of sexual dysfunction and general quality of life in female patients with psoriasis. *An Bras Dermatol*. 2018;93:801–806.
26. Elsaie ML, Hanafy NS, Hussein SM, et al. Prevalence of female sexual dysfunction among psoriatic females: a cross sectional case controlled study. *Dermatol Pract Concept*. 2023;13:e2023209.
27. Sommer R, Augustin M, Hilbring C, et al. Significance of chronic pruritus for intrapersonal burden and interpersonal experiences of stigmatization and sexuality in patients with psoriasis. *J Eur Acad Dermatol Venereol*. 2021;35:1553–1561.
28. Maccari F, Fougereuse AC, Reguiat Z, et al. Contraception sexuality and pregnancy in women with psoriasis: real-life experience of 235 women. *Clin Cosmet Invest Dermatol*. 2020;13:817–823.
29. da Silva Burger N, Augustin M, Westphal L, et al. Patient needs in women of child-bearing age with psoriasis: retrospective analysis from the German Psobest registry. *Int J Womens Dermatol*. 2024;10:e176.
30. Kouris A, Platsidaki E, Kouskoukis C, et al. Psychological parameters of psoriasis. *Psychiatr Psychiatr*. 2017;28:54–59.
31. Kolli SS, Amin SD, Pona A, et al. Psychosocial impact of psoriasis: a review for dermatology residents. *Cutis*. 2018;102:21–25.
32. Larsabal M, Ly S, Sbidan E, et al. GENIPSO: a French prospective study assessing instantaneous prevalence, clinical features and impact on quality of life of genital psoriasis among patients consulting for psoriasis. *Br J Dermatol*. 2019;180:647–656.
33. Meeuwis KaP, van de Kerkhof PCM, Massuger LFAG, et al. Patients' experience of psoriasis in the genital area. *Dermatol Basel Switz*. 2012;224:271–276.
34. AlMutairi N, Eassa BI. A randomized controlled ixekizumab vs secukinumab trial to study the impact on sexual activity in adult patients with genital psoriasis. *Expert Opin Biol Ther*. 2021;21:297–298.
35. Blauvelt A, Reich K, Mehli S, et al. Secukinumab demonstrates greater sustained improvements in daily activities and personal relationships than ustekinumab in patients with moderate-to-severe plaque psoriasis: 52-week results from the CLEAR study. *J Eur Acad Dermatol Venereol*. 2017;31:1693–1699.
36. Guenther L, Warren RB, Cather JC, et al. Impact of ixekizumab treatment on skin-related personal relationship difficulties in moderate-to-severe psoriasis patients: 12-week results from two Phase 3 trials. *J Eur Acad Dermatol Venereol*. 2017;31:1867–1875.
37. Korman NJ, Sofen H, Fretzin S, et al. Secukinumab provides better relief from the impact of psoriasis on daily activities and personal relationships than etanercept: results of two phase 3 placebo-controlled randomized clinical trials in moderate-to-severe psoriasis. *J Dermatol Treat*. 2017;28:384–389.
38. Yosipovitch G, Foley P, Ryan C, et al. Ixekizumab improved patient-reported genital psoriasis symptoms and impact of symptoms on sexual activity vs placebo in a randomized, double-blind study. *J Sex Med*. 2018;15:1645–1652.
39. Guenther L, Potts Bleakman A, Weisman J, et al. Ixekizumab results in persistent clinical improvement in moderate-to-severe genital psoriasis during a 52 week, randomized, placebo-controlled phase 3 clinical trial. *Acta Derm Venereol*. 2020;100:adv60000.
40. Ryan C, Guenther L, Foley P, et al. Ixekizumab provides persistent improvements in health-related quality of life and the sexual impact associated with moderate-to-severe genital psoriasis in adult patients during a 52-week, randomised, placebo-controlled, phase 3 clinical trial. *J Eur Acad Dermatol Venereol*. 2022;36:e277–e279.
41. Merola JF, Ghislain P-D, Dauendorffer JN, et al. Ixekizumab improves secondary lesional signs, pain and sexual health in patients with moderate-to-severe genital psoriasis. *J Eur Acad Dermatol Venereol*. 2020;34:1257–1262.
42. Gerdes S, Ostendorf R, Süß A, et al. Effectiveness, safety and impact of guselkumab on sexuality and perceived stigmatization in patients with psoriasis in routine clinical practice: Week 28 results from the prospective German multicentre G-EPOSS study. *J Eur Acad Dermatol Venereol*. 2024, <http://dx.doi.org/10.1111/jdv.71992>. Epub ahead of print April 11.
43. Hernández-Fernández CP, Carretero G, Rivera R, et al. Effect of sex in systemic psoriasis therapy: differences in prescription effectiveness and safety in the BIOBA-DADERM prospective cohort. *Acta Derm Venereol*. 2021;101:adv00354.
44. Natalucci F, Bisseron S, Sokolova T, et al. Sexual dysfunction in male patients treated with methotrexate for arthritis: analysis of the IIEF5 questionnaire and hormonal status. *Joint Bone Spine*. 2024;91:105716.
45. Atas H, Yülsek T, Karakoyunlu AN, et al. The impact of low-dose methotrexate on erectile dysfunction, sex hormone profile and spermogram in male patients with psoriasis: a prospective study. *Cutan Ocul Toxicol*. 2024;43:161–166.
46. Female sexual function, distress before, after treatment of moderate, severe psoriasis. *Egypt J Hosp Med*. 2023;92:6075–6081.
47. Lupa PC, Chu C-Y, Fatani M, et al. Psychosocial burden of psoriasis: a systematic literature review of depression among patients with psoriasis. *Dermatol Ther*. 2023;13:3043–3055.
48. Finlay AY, Khan GK. Dermatology life quality index (DLQI) – a simple practical measure for routine clinical use. *Clin Exp Dermatol*. 1994;19:210–216.
49. McGahuey CA, Gelenberg AJ, Laukes CA, et al. The Arizona Sexual Experience Scale (ASEX): reliability and validity. *J Sex Marital Ther*. 2000;26:25–40.
50. Dauendorffer J-N, Ly S, Beylot-Barry M. Psoriasis and male sexuality. *Ann Dermatol Venereol*. 2019;146:273–278.
51. Yang EJ, Beck KM, Sanchez IM, et al. The impact of genital psoriasis on quality of life: a systematic review. *Psoriasis Auckl NZ*. 2018;8:41–47.
52. Kelly A, Ryan C. Genital psoriasis: impact on quality of life and treatment options. *Am J Clin Dermatol*. 2019;20:639–646.
53. Elsadek HM, Ali MS, Elaidy AM. Impact of genital and non-genital psoriasis on genital self-image quality of life, and sexual dysfunction in female patients. *Dermatol Pract Concept*. 2024;14:e2024159.
54. Yi OS, Huan KY, Har LC, et al. Genital psoriasis: a prospective, observational, single-centre study on prevalence, clinical features risk factors, and its impact on quality of life and sexual health. *Indian J Dermatol*. 2022;67:205.
55. da Silva N, Augustin M, Hilbring C, et al. Psychological (co)morbidity in patients with psoriasis: the impact of pruritus and anogenital involvement on symptoms of depression and anxiety and on body dysmorphic concerns – a cross-sectional study. *BMJ Open*. 2022;12:e055477.
56. da Silva N, Augustin M, Langenbruch A, et al. Sex-related impairment and patient needs/benefits in anogenital psoriasis: difficult-to-communicate topics and their impact on patient-centred care. *PLOS ONE*. 2020;15:e0235091.
57. Cather JC, Ryan C, Meeuwis K, et al. Patients' perspectives on the impact of genital psoriasis: a qualitative study. *Dermatol Ther*. 2017;7:447–461.
58. Lobo JN, Ramos LMA, Mont'Alverne AR, de S, et al. Sexuality and sexual dysfunction in patients with psoriatic arthritis: a cross-sectional study. *North Clin Istanbul*. 2024;11:191–200.
59. Boone D, Ronson A, Karsh J. Comparison of Female Sexual Function Index in patients with psoriatic and rheumatoid arthritis and healthy controls. *Musculoskelet Care*. 2019;17:226–230.
60. Haugeberg G, Michelsen B, Østensen M, et al. Perceived influence of health status on sexual activity in patients with psoriatic arthritis. *Scand J Rheumatol*. 2020;49:468–475.
61. Gossec L, de Wit M, Kiltz U, et al. A patient-derived and patient-reported outcome measure for assessing psoriatic arthritis: elaboration and preliminary validation of the Psoriatic Arthritis Impact of Disease (PsAID) questionnaire, a 13-country EULAR initiative. *Ann Rheum Dis*. 2014;73:1012–1019.