Original

Pruritus and its Impacts on Quality of Life of Citizens of Ejigbo Osun State, South West Nigeria: A Cross- Sectional Study

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Abstract

Background: Pruritus is a common yet challenging dermatological symptom that significantly impacts quality of life (QoL). Despite its high prevalence, particularly among the elderly, its true burden remains underexplored in Nigeria. This study investigates the prevalence, etiology, and impact of pruritus on QoL in Ejigbo, Osun State, Nigeria.

Methods: A cross-sectional study was conducted among over 200 adults (≥18 years) in Ejigbo using a semi-structured questionnaire. Participants were recruited through simple random sampling, and clinical assessments, including physical examinations and laboratory tests, were performed. Data were analysed using SPSS 25.

Results: Pruritus was associated with multiple systemic conditions, including iron deficiency anaemia, polycythaemia, chronic kidney disease, diabetes, and complicated hypertension. Individuals with pruritus were more likely to be underweight ($p = 0.003$) and experience breathlessness ($p = 0.001$). Chronic pruritus (>6 weeks) was the most common presentation, primarily affecting the extremities. It was exacerbated by heat and bathing and relieved by antihistamines. Participants with pruritus reported significant disruptions in sleep, leisure activities, and daily tasks. Notably, impaired renal function (elevated creatinine, $p = 0.022$; reduced GFR, $p = 0.046$) was observed in those with pruritus compared to those without.

Conclusion: This study highlights the significant impact of pruritus on QoL and its potential association with systemic diseases. Improved awareness and comprehensive management strategies are necessary to mitigate its burden, particularly among individuals with chronic illnesses.

Keywords: Pruritus, quality of life, chronic itch, systemic diseases, Nigeria, cross-sectional study

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INTRODUCTION

Pruritus is a frequent yet challenging symptom in dermatological practice, particularly among the elderly. While virtually anyone can experience pruritus at any stage of life, older adults are disproportionately affected, with studies reporting that up to two-thirds of the elderly population experience chronic pruritus. The diagnosis is complicated by its multifactorial etiology and the occasional lack of visible skin lesions, which necessitates consideration of a broad differential that includes both dermatologic and systemic causes.

Current clinical definitions describe chronic idiopathic pruritus in persons over 65 years as persistent itching without an obvious dermatological trigger or primary skin lesions, though secondary excoriations are common. The symptom most frequently stems from xerosis or eczema, yet systemic origins such as hepatic, hematologic, infectious, pharmacological, and malignant conditions must also be investigated, given their established association. Chronic itch may seem to be enfeebling as chronic pain.[1-3]

Frequently ignored, pruritus has the potential to severely compromise quality of life. Nocturnal scratching in atopic dermatitis, for example, might considerably impair sleep and cause fatigue and irritability symptom[4]. Pruritus being an undesirable condition that stimulates itching, may affect unfavorably the sleep and the quality of life (QoL). Its actual incidence in the population is not clearly understood but it is thought to involve an imbalance of itch-inducing mediators, including pathways that do not rely on histamine.[5-9]

Individuals with idiopathic pruritus often suffer from ongoing or intermittent itching without primary skin lesions, although they may develop secondary scratches from scratching. The itching can be localized or widespread, with varying intensity throughout the day. Commonly affected regions include the back, arms, and lower legs.[10-11] Pruritus is related with many systemic diseases, psychological problems or use of drugs; if the condition exceeds six weeks it is considered to be chronic pruritus.[6-7]

The problems or diseases associated with skin affect only one organ, but can influence the psychosocial status of the patient, his/her social interactions, his/her daily activities and his/her QoL. Pruritus affects primarily the QoL in pruritic dermatosis. Nonetheless, only a few studies have investigated the impacts of itching on the QoL.[11-17]

Despite this significant morbidity, pruritus remains under-recognized in both clinical and community settings. Previous Nigerian research has largely focused on hospital populations, such as Olumide Yetunde and Oresanya Felix's retrospective study of generalized pruritus presentations, and another survey on chronic kidney disease patients in Ondo. Both highlight the QoL impact but do not provide community-based prevalence data or systematically investigate etiologies.[18-19]

The present study investigated the prevalence, aetiology and impact of pruritus and its intensity on the QoL in patients with chronic pruritus by using a test comprising pruritus-focused questions.

Materials and Methods

Study area: This was a cross-sectional study carried out in Ejigbo, Osun state Nigeria. Ejigbo is a prominent town in Yoruba Land and the headquarters of Ejigbo Local Government Area of Osun State. Ejigbo is strategically placed in the middle of the region, as 35 kilometres north-east of Iwo, 30 km from Ogbomoso in the north and 24 km from Ede in the south-east. It is about 40 km north-west of Osogbo, the capital and about 95 km north-east of Ibadan. It is part of the Ede North/Ede South/Egbedore/Ejigbo Federal Constituency. The population was put at of 132,641 at the 2006 census. Farming is the traditional source of economy in Ejigbo. It is based on production of food crops, such as yam, cassava, cocoyam, potato, maize, guinea corn, cowpea and cash crops like cocoa, palm oil, kola-nut, coconut and varieties of fruits. Trading in textiles and imported goods is also common in the town. Ejigbo is home to College of Agriculture, Osun state University. Ejigbo indigenes reside in Ivory Coast, Togo, Benin Republic and some other Francophone Countries thereby giving them the opportunity to speak French in addition to Yoruba, their mother tongue. They also occupy key positions in some of these countries.

Study Design: This is a cross-sectional study carried out in Ejigbo, Osun state, South west Nigeria. The study involved 246 consented respondents within the study area. The respondents were adults of 18years and above in Ejigbo and its environs.

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A sample size of 246 respondents was taken. Two hundred and forty-six respondents were recruited across the Local government using a simple random sampling technique after obtaining their informed consent. A semi-structure questionnaire was used as the survey instrument. The questionnaires were filled by the principal researcher who is a consultant physician and dermatologist along with 2 research assistants who were resident doctor in internal medicine who had been previously trained on the questionnaire and examination to look out for. The questionnaire was explained in English and the patient local language which is mainly yoruba. General physical and systemic examinations were performed in a secluded environment within the community health centre not far from where the respondents were gathered under a shelter. Simple non-invasive test like urinalysis was performed to rule out chronic metabolic diseases like diabetes and renal diseases. Blood sugar, electrolytes, urea and creatinine were also done to rule out diabetes mellitus and chronic kidney diseases respectively. Data was analysed using SPSS 25.

Inclusion Criteria and Exclusion Criteria:
Respondents were considered eligible if they were 18 years of age or older and provided their informed consent to take part in the research. In contrast, individuals were excluded from the study if they were younger than 18 years, suffered from chronic debilitating diseases deemed too stressful for participation, or declined to give their consent for enrolment.

Sample Size Determination: The minimum sample size for the study was calculated using the formula described by Lwanga and Lemeshow (1991),[20] which is widely recognized for determining sample sizes in health research. Using a qualitative outcome variable, the formula applied was $n=Z\alpha 2pq/d2$, where n represents the minimum sample size, $Z\alpha$ is the standard normal deviate at the 5% significance level (1.96), p is the expected prevalence from prior studies (13.5% based on the Heidelberg Pruritus Prevalence Study)[21], $q=1-p$, and d is the desired precision (5%). Substituting the relevant values produced an initial minimum sample size estimate of 179. Because the estimated target population was below 10,000 people, the sample size was adjusted using the correction formula, $nf=n/[1+(n-1)/N]$, with N=1,000 as obtained from the bricklayer association. This yielded a revised sample size of approximately 152. To account for potential nonresponse, an additional 10% (15.2 participants) was included, increasing the adjusted sample size to roughly 167. For improved representation and practicality, the final sample size was rounded up to 200 participants.

RESULTS

The demographic result of the study as shown in table 1. Two hundred and forty-six subjects participated in the study. About 75% of the participants were female while 25% were male. One hundred and three of the participants gave history of pruritus, about nineteen were indifferent while half of the participants gave no history of pruritus. The prevalence of pruritus in this study is 41.9%.

Table 1: showing the prevalence of pruritus in Ejigbo

Variable		Freq (n)	Percent (%)	Prevalence (%)
Sex	Male	62	25.2	
	Female	184	74.8	
Pruritus	Yes	103	41.9	41.9
	Indifferent	19	7.7	
	No	124	50.4	

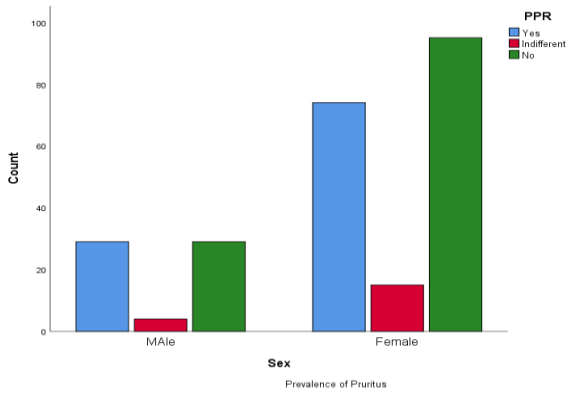

Figure.1: PPR-Prevalence of Pruritus

Table 2 showed demography of pruritus among male and female. Twenty-nine males gave history of pruritus while seventy-four females gave history of pruritus with a significant difference observed between the two sex groups. Regarding New York Heart Association

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(NYHA) class I to IV, depression, chest pain and intermittent claudication, there is no statistical significance, but noteworthy associations were found among them. Individuals with pruritus were significantly more likely to be underweight (p = 0.003) and to experience palpitation and breathlessness (p=0.048) and (p = 0.001) respectively. This suggests potential links between pruritus and these specific clinical manifestations.

Table 2: Demographic and other clinical variables of those with and without pruritus

Variables	With Pruritus	Without Pruritus	*P* value
Sex			
Male	29	51	
Female	74	92	
Underweight			
No	**95**	**140**	**0.017**
Yes	**8**	**3**	
NYHA			
1	87	130	0.399
2	14	11	
3	1	2	
4	1	0	
Depression			
No	73	119	0.265
Yes	30	24	
Chest Pain			
No	69	115	0.068
Yes	34	28	
Palpitations			
No	**57**	**128**	**0.048**
Yes	**46**	**20**	
Breathlessness			
No	**68**	**124**	**0.005**
Yes	**35**	**19**	
Intermittent Claudication			
No	77	111	1.000
Yes	26	32	

Table 3 expresses the characteristics of pruritus in the affected individuals. The majority of patients experienced chronic pruritus. The extremities were the most reported location of pruritus. Furthermore, dry skin was the most frequently associated symptom. These findings are consistent with prior observations of pruritus characteristics in various populations.

Table 3: Characteristics of pruritus in those affected

Variables	Freq
Duration of Pruritus	
Acute (<6 weeks)	42
Chronic (>6 weeks)	61
Associated rash	
No	54
Yes	49
Worse with heat	
No	64
Yes	39
Worse with cold	
No	93
Yes	10
Worse with Bath	
No	75
Yes	28
Worse with sponge use	
No	98
Yes	5
Relieved with avoiding heat	
No	76
Yes	27
Relieved with avoiding cold	
No	97
Yes	6
Relieved with bathing warm water	
No	92
Yes	11
Relieved with avoiding sponge	
No	73
Yes	30
Relieved with antihistamines	
No	58
Yes	45
Number of Chronic Illnesses*	
None	71
1	26
2	6
Pruritus degree	
<6hrs/Day	64
6-12 hrs/day	36
12-18hrs/day	2
All day long	1
Pruritus degree scale	

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Variables	Freq
Not present	4
Mild	76
Moderate	9
Severe	14
Unbearable	0
Pruritus direction	
Completely resolved	11
Much better, but still present	60
Little bit better, but still present	18
Unchanged	9
Getting worse	5
Pruritus sleep	
Never affects sleep	38
Occasionally delays falling asleep	22
Frequently delays falls asleep	6
Delays falling asleep &, occasionally wakes up at night	32
Delays falling asleep & frequently wakes up at night	4
Not available	1
Pruritus leisure scale	
Never affects leisure	18
Rarely affects leisure	24
Occasionally affects leisure	15
Frequently affects leisure	24
Not available	1
Pruritus errand	
Never affects errand and housework	19
Rarely affects errand and housework	24
Occasionally affects errand and housework	10
Frequently affects errand and housework	30
Not available	20
Pruritus work and school scale	
Never affects work or school	18
Rarely affects work or school	15
Occasionally affects work or school	30
Frequently affects work or school	20
Not available	20
Number of body parts	
NA	56
0	0
1	9
2	8
3	4
4	7
5	3
6	3
7	2
8	2
9	1
11	1
13	1
14	2
16	4

*Chronic illness: Diabetes mellitus, Hypertension, CKD, chronic liver disease

Table 4 demonstrates significant differences in renal function between those with and without pruritus. Specifically, patients with pruritus due to non-idiopathic exhibited a significantly higher mean creatinine level (106.9 ± 46.7) compared to those with idiopathic pruritus (78.3 ± 20.1, p = 0.010). Conversely, the mean glomerular filtration rate (GFR) was significantly lower in the non-idiopathic pruritus group (59.0 ± 24.9) than in the idiopathic pruritus group (86.3 ± 22.6, p = 0.000) (Table 4). These findings suggest a potential association between pruritus and impaired renal function. It is very vital to say, that although the Urea levels where slightly elevated in the non-idiopathic pruritus group, it was not statistically significant (Table 4).

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Table 4: Relationship between pruritus, biochemical parameters, Haemogram, physical parameters and Renal Ultrasound.

Variables	Idiopathic pruritus n=27	Non-idiopathic pruritus n=76	Test Statistics (t)	*P value*
Packed cell volume	38.3±4.6	38.8±4.4	- 0.491	0.667
Age	43.6±15.5	62.6±15.0	- 5.517	0.000
Total cholesterol	4.2±1.8	5.4±1.6	- 3.061	0.006
Triglycerides	0.7±0.4	1.1±0.8	- 3.339	0.045
HDL	1.5±0.5	1.6±0.7	- 0.798	0.316
LDL	2.4±1.5	3.1±1.5	- 2.083	0.067
Urea	3.4±1.6	3.5±1.7	- 0.274	0.797
Creatinine	78.3±20.1	106.9±46.7	- 4.328	0.010
Uric acid	0.3±0.1	0.3±0.1	0.000	0.031
Serum Glucose	5.2±0.8	5.8±1.9	- 2.249	0.154
Heart rate	80.9±13.7	80.9±14.9	0.000	0.993
QTc	408.4±36.0	424.1±40.0	- 1.889	0.146
R1+SIII	1.1±0.6	1.2±0.7	- 0.711	0.835
Neck Circumference	36.1±3.4	36.1±3.6	0.000	0.999
Systolic BP	118.5±10.4	140.5±22.1	- 6.811	0.000
Diastolic BP	73.0±9.0	83.9±12.9	- 4.785	0.001
Waist Hip ratio	0.88±0.05	0.90±0.08	- 1.504	0.245
Body surface area	1.7±0.2	1.7±0.2	0.000	0.362
Rt kidney volume	60.6±14.5	67.4±78.1	- 0.725	0.739
Left kidney volume	60.0±11.4	75.3±96.0	- 1.363	0.541
Body mass index	26.6±5.4	28.1±6.4	- 1.179	0.358
Pulse pressure	45.5±10.0	56.6±17.8	- 3.956	0.009
Glomerular filtration rate (GFR)	86.3±22.6	59.0±24.9	5.247	0.000
TG-HDL ratio	0.56±0.3	0.77±0.5	- 2.580	0.085

Note that packed cell volume, uric acid, urea, lipids, age, anthropometric and electrocardiograph variables were comparable between those with and without pruritus.

DISCUSSION

Pruritus is a common feature of many skin diseases; fortunately, these dermatoses have distinct diagnostic features that permit prompt treatment and relief of the pruritus. Generalized pruritus (GP) not accompanied by any visible causative skin disease is frequently encountered in the skin clinic in Ogbomoso, Oyo state Nigeria which by extrapolation are many in the community. A host of disorders have been associated with pruritus[22-24] and adequate checklists have been suggested by the authors for investigations of these patients.

Pruritus not associated with obvious skin disease is a major problem in Ogbomoso which was similar to what is found in other dermatology clinic across the country.

This study showed predominantly female with pruritus in about three quarter of the participants while the rest one quarter of the participants were pruritus in male. A similar study found women affected than men, and female sex was associated with an increased but non-significant risk for incident of chronic pruritus during the past 12-months.[25] Most available studies in Nigeria, Africa and globally rarely consider relationship between sex of subjects and pruritus. Both the frequency and the causes of chronic itch depend on age, predisposition like atopy, underlying diseases, ethnicity, climate/humidity, and especially access to the regional healthcare system.[26–28]

The prevalence of itch appears to differ worldwide.[26,27,29] Prevalence of pruritus in this study is 41.9% which is more than the prevalence by Heidelberg Pruritus Prevalence Study which showed a prevalence of 13.5%. This could be due to variation in sample size and the methodology used in either study.

The significant findings (0.017) of eight subject with pruritus and underweight found out of ninety subjects with pruritus and no underweight compared to three subjects with underweight out of 140 subjects without pruritus could possibly be due to those with pruritus secondary to underlined chronic kidney disease from hypertension, diabetes or other co-morbidity in these

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subjects. Because of anorexia and poor dietary intake, some of these subjects will ultimately present with underweight. This study findings make it different from other study that mainly laid emphasis on aetiology of the pruritus rather than accompanied complication like underweight. Depression due to frustration from itching could also eventually affect the appetite of this subject which could lead to underweight. About 30 subjects out 73 were found to present with depression compared with 24 out of 119 subjects though not statistically significant (0.265). Palpitation and breathlessness were found to be statistically significant at 0.048 and 0.005 respectively in subject with pruritus. This could be due to pruritus that resulted as a complication of co-morbidity like hypertension, diabetes, primary glomerulonephritis, pyelonephritis among others which could culminate in chronic kidney disease of which cardiovascular complications like palpitation and cardiac decompensation could result in dyspnoea in exertion in addition to cutaneous manifestation like uraemic frost, dry skin and eventual pruritus.[17] Intermittent claudication was found in less than two third of subjects with pruritus among those with pruritus and no intermittent claudication while about one third of subjects without pruritus but has intermittent claudication were found out of those without pruritus and no intermittent claudication. This finding was not statistically significant (1.000). Literature search for association between pruritus and intermittent claudication yielded no significant findings which make this study a novel one.

The characteristic findings of pruritus in this index study revealed about forty- two subjects with acute pruritus while about sixty-one subjects presented with chronic pruritus. Acute pruritus was defined as < 6 weeks while chronic pruritus occurs after > 6 weeks. Different living conditions and rituals in human beings as well as migration also contribute to acute and chronic itch.[29,30] Dermatological diseases have a worldwide distribution, but their prevalence is related to the geographical location. For example, otomycoses is much more frequent in subtropical and tropical climate[31] and does hardly contribute to the differential diagnoses of chronic itch in countries with Western lifestyle. Scabies is considered to be the most frequent cause of acute itch but rather rare in chronic though with advent of triple action agents used in the emerging economic nations scabies has been found to be chronic skin disease in such clime. Scabies was recently added to the World Health Organization's list of neglected tropical diseases (NTDs), and its occurrence has been increasing in poor countries, countries with low standard of living, and especially in times of wars, migration, and in reception centers for asylum seekers.[32] As infections and infestations are more prevalent in subtropical and tropical countries, scabies is a major cause of acute itch in these countries but is considered to be a less frequent cause in Western countries that are more affected by chronic itch. All this may explain why itch is mentioned as a global burden of skin diseases, also in the elderly.[33,34]

About forty-nine subjects of the 103 identified in this study with pruritus were found to have rash which could be due to primary skin diseases such as eczema, papulosquamous disorder, infective skin lesions such as scabies among others which is similar to previous studies findings.

Climatic association with pruritus such as heat and cold was found to be significant in subjects with heat compared to those with cold and pruritus. In previous studies different living conditions and rituals in human beings as well as migration also contribute to acute and chronic itch.[29,30] In a study conducted by Olumide and Oresanya in about 6% of study cases, general pruritus was thought to be due to intolerance to environmental heat.[35]

Pruritus aggravated by use of sponge and relieved without its use along with pruritus worsened and relieved by bathing with cold and warm water identified in this study were similar to previous findings of aquagenic pruritus aggravated by use of hard sponge along with bathing with cold water and relieved by avoiding or use of soft sponge along with bathing with warm water. Olumide and Oresanya found 21% bath-related pruritus, which was thought to be due to intolerance to the temperature of the bath water, over-alkalinization of the water, histamine released by excessive friction from coarse local sponge, and excessive dryness of the skin from regular and frequent use of soaps.[35]

Antihistamine use in over ninety percent of patient with acute and chronic pruritus were found to be relieved of their pruritus in this study. Such antihistamines include

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sedatives and non-sedatives. The few percentages without significant relieve from antihistamine possibly has background co-morbidity such as chronic kidney disease secondary to complicated hypertension, diabetes among other chronic diseases. In a study done by Weisshaar. E common treatments like antihistamines do not relieve itch, even in combination.[36,37] This finding was contrary to our study. This could possibly be due to variation in sample size and research methodology adopted.

About one third of subject with pruritus in this study were found with one or two chronic disease(s) such as hypertension, diabetes or chronic kidney/heart disease. Complication from such chronic disease could result in acute or chronic pruritus as observed in previous studies.[19]

Regarding the degree of pruritus, majority of subjects with pruritus were found to have mild degree of pruritus which could last < 6hours. Such disorder includes urticaria or some drug reaction which disappear on its own or with discontinuation of such medication. More than a quarter of subjects with pruritus were found to have moderate to severe pruritus. This group of people include those with primary skin disorder like eczemas, contact dermatitis, papulosquamous disorder or some drug reactions like erythema multiformes, Steven Johnson syndrome or TENS. Above patient may require hospital admission or in some cases intensive care management to avoid mortality. A study by Weisshaar. E found chronic urticaria affecting about 1% of the world population, presenting with severe itch, and constitutes a global burden .[38] Non communicable diseases such as hypertension or diabetes could lead to pruritus with moderate to severe pruritus which are difficult to manage due to complication of such chronic disorder like uraemia of which renal replacement therapy may be necessary to enhance the quality of life of such individual. In a previous study itch is prevalent in chronic diseases, especially in western societies. Chronic itch in patients with end-stage renal disease (ESRD) is a considerable problem, and regional differences need to be considered because in (developing) countries, patients have limited access to hemodialysis (HD) with differing dialysis quality standards. There are no epidemiological studies on itch HD in developing countries because this treatment is hardly available. A representative cross-sectional prospective prevalence study on chronic itch in HD patients [German Epidemiological Hemodialysis Itch Study (GEHIS)] showed chronic itch to affect 25.2% (point prevalence) of HD patients.[39]

The quality of life of about two third of respondents with pruritus in this study was found to affects their sleep mildly, moderately or severely. The leisure of the respondents were affected by pruritus in about a third of them while subjects' ability to attend to errands and school runs were affected in about one third each with pruritus either moderately or frequently. In previous studies pruritus, especially chronic itch, strongly reduces health-related quality of life (HRQOL).[26, 27, 29, 40–42] Chronic pruritus can be an additional burden in chronically ill patients leading to an additional reduction in QOL and affecting mortality in patients.[40–42]

Relationship of pruritus with biochemical parameters, haemogram, physical parameters and renal ultrasound performed in this study make this study a unique one especially as a cross- sectional community study when compared to other similar study done in the past in emerging economy world which are mostly hospital retrospective study. The following were found to be statistically significant in relationship with pruritus; age of respondents, serum total cholesterol and triglycerides, creatinine, uric acid, systolic and diastolic blood pressures, pulse pressure and GFR of the respondents. These findings could be related to complications which some of the subjects have developed as a result of the background chronic diseases like hypertension or diabetes which ultimately affect respondent's kidney functions, blood pressure, biochemical parameters and in some cases haemogram.

Previous studies could not review most of the parameters discussed above due to limited resources for such investigations especially in low to middle socio-economic environments where this study was performed. In a previous study chronic pruritus can be a symptom or precursor of another (frequently) severe disease[43] but diagnostics are limited and not accessible in most countries; for example, radiological diagnostics and allergy testing are not reimbursed in many countries or excluded in insurance policy.[44,45]

Strengths and limitations of the study:

This is one of the few community-based cross-sectional studies on pruritus in Africa incorporating clinical,

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biochemical, haemogram, and imaging data, which provides a broader understanding compared to typical hospital-based or retrospective studies.

The research outlines prevalence, risk factors, and impacts of both acute and chronic pruritus, making targeted interventions and understanding of etiological factors possible in similar environments.

Assessment of pruritus' effect on quality of life and daily functioning, using validated indices, supplies actionable data for patient care and spotlights the significant burden of chronic itch.

As a cross-sectional design, the study can only show associations, not causality, between pruritus and risk factors.

Reliance on self-reported symptoms and questionnaires introduces risks for recall and reporting bias, possibly distorting estimates for pruritus prevalence, severity, and comorbidities.

The single-center focus (Ogbomoso) may limit generalizability; sociocultural and environmental factors may differ elsewhere.

Like other pruritus studies, there is a lack of validated clinical tools or biomarkers for measurement, and some systemic causes may be overlooked or mis-classified due to limited resources.

Some confounders such as full psychiatric evaluation, detailed medication histories, and nuanced secondary causes might not have been fully controlled because of typical constraints in low-resource community studies.

Implications of the findings of the study:

Chronic pruritus is common and significantly impairs quality of life, particularly among individuals with chronic illnesses, but often goes under-recognised and under-treated in primary and specialty care settings. These findings highlight the urgent need to integrate pruritus assessment into chronic disease clinics, promote behavioral and community education, and adopt multidisciplinary care approaches to address its diverse causes and impacts. There remains a need for larger, well-designed studies to better understand and guide management of pruritus in developing countries.

CONCLUSION

The result of this study had ultimately provided answers to the prevalence, aetiology and impacts of pruritus on quality of life among these subjects. Stressing that the presence of chronic diseases can results into pruritus and thus affects the quality of life of individuals with such condition.

Declarations: The ethical approval was obtained from the Bowen University Teaching Hospital ethical review board. All participants provided written informed consent before their inclusion in the study. All guidelines per Helsinki's declaration and good clinical practice guidelines were followed. The Bowen University Teaching Hospital, Ogbomoso Research and Ethics Committee (NHREC/12/04/2012) approved the research protocol.

Authors' Contribution: GMI (Conceived and designed the study, approved the design and implementation, coordinated and supervised data collection, drafted the initial article and critically reviewed and revised the draft. She is the corresponding author), POA(Approved the design and implementation of the study and critically reviewed and revised the draft), OOO(Approved the design and implementation of the study, coordinated, supervised data collection and critically reviewed and revised the draft), AOO (Approved the design and implementation of the study, coordinated, supervised data collection and critically reviewed and revised the draft), OAA (Approved the design and implementation of the study, coordinated, supervised data collection and critically reviewed and revised the draft), OKI(Coordinated, supervised data collection and critically reviewed and revised the draft and involved in data analysis and interpretation. She is the corresponding author). AOS contributed to editing and proofreading of this write up.

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