Primary Care Dermatology in Skin of Color

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Disclosures

I have no financial disclosures or conflicts of interest with the presented material.

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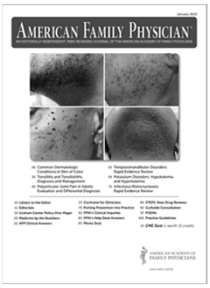
Learning Objectives

- Examine factors that contribute to skin of color health disparities
- Discuss common dermatological conditions in skin of color
- Identify skin of color educational resources



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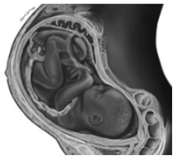
Skin of Color (SOC) Definition

Skin of color refers to a diverse population of racial and ethnic backgrounds, including but **not limited to** those who identify as Black or African American, American Indian or Alaska Native, Asian American, Pacific Islander, Latinx, and Middle Eastern or North African



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Skin of Color and Race

- Race is a social construct: human-invented classification system
- There are no racial differences in the number of pigment-producing cells (melanocytes)
- Some dermatologic conditions present differently in darker skin tones
- Diagnostic bias can delay recognition or treatment

Understanding skin of color enhances diagnostic accuracy, reduces disparities, and improves patient trust

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Importance of dermatology education in primary care

- Skin conditions account for 8 – 12% of all diagnoses seen by family medicine physicians
- During a 2-year period, 37% of patients will present to their PCP with at least one skin complaint, and 59% of these patients will list a skin concern as their chief complaint
- Family medicine residents correctly diagnosed 48% of skin conditions compared to 93% by dermatologists

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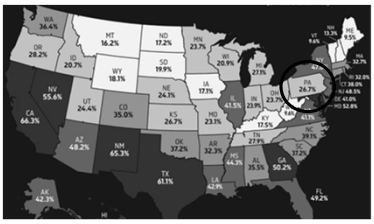
Increasing Skin of Color Population



- By 2045, non-Hispanic White people will no longer be the majority population in the US
- SOC already comprise the majority in California, New Mexico, Nevada, Texas, and Georgia

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Dermatological health disparities are common

- AA patients with atopic dermatitis were less likely to receive desonide, topical calcineurin inhibitors, crisaborale, and dupilumab compared with White patients
- Latinx patients with acne were less likely to receive tretinoin compared with non-Latinx patients
- AA patients were less likely to receive biologics for psoriasis compared with White patients
- Melanoma 5-year survival was 93% in White patients and 73% in AA patients

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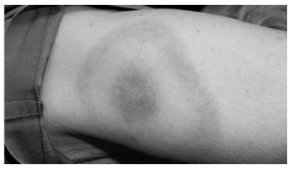
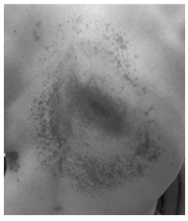
Cautionary Slide

- Often dermatological conditions are labeled as “classic”
- Location, morphology, symptoms are important
- Don’t just rely on color





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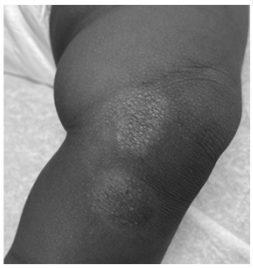
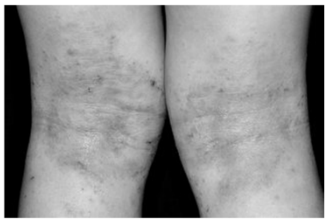
Atopic Dermatitis





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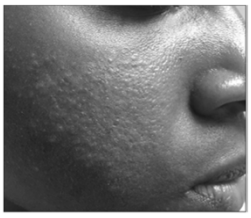
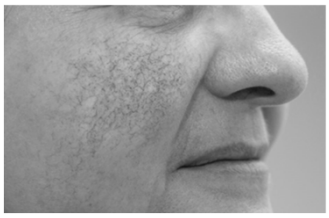
Rosacea





Can use diascopy to better visualize telangiectasis in SOC patients

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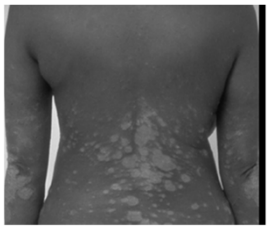
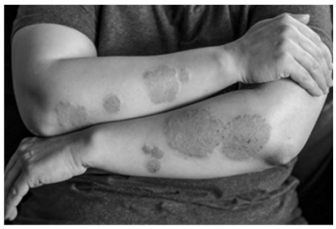
Psoriasis





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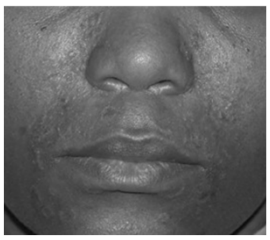
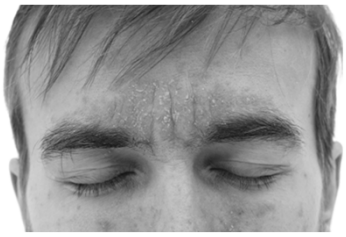
Seborrheic Dermatitis





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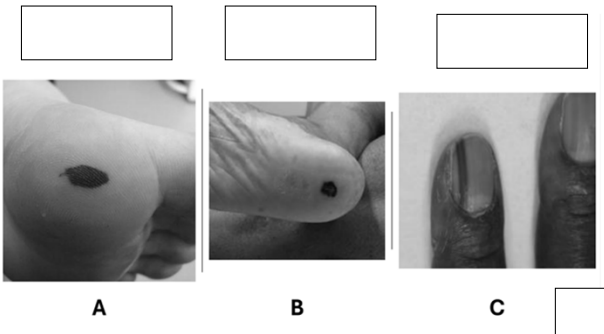

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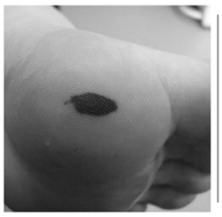

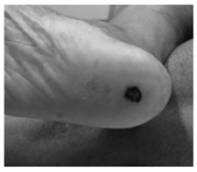

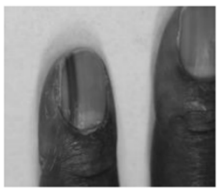

Talon noir

Acral lentiginous melanoma

Melanonychia

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Common Dermatological Conditions in SOC

- Sarcoidosis
- Atopic dermatitis
- Acne keloidalis nuchae
- Dermatosis papulosa nigra
- Lupus
- Melasma
- Psoriasis
- Vitiligo
- Central cicatricial alopecia

- Pseudofolliculitis barbae
- Traction alopecia
- Keloids
- Hidradenitis suppurativa
- Post-inflammatory hyperpigmentation

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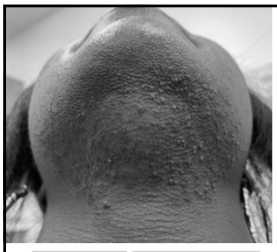
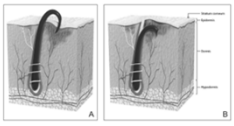
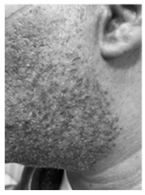




Pseudofolliculitis Barbae (PFB)

- Presents with follicular papules or pustules several days after shaving
- Anterior + lateral neck are most affected (any areas with thick coarse hair)
- 45 – 83% of AA men have PFB
- Pigmentary sequelae is common



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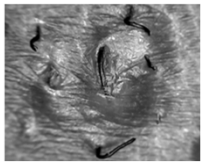
PFB Treatment

- Topical low-dose steroids and topical calcineurin inhibitors
- Benzoyl peroxide washes
- Topical diclofenac to reduce inflammation
- Consider chemical depilatories
- Chemical exfoliants: glycolic acid 7%, retinoids
- Laser hair removal is definitive treatment



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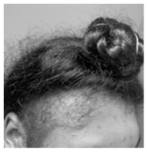
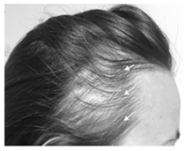
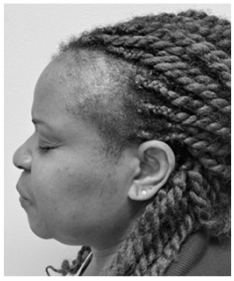
Traction Alopecia

- Prolonged tension on the hair follicle
- Most obvious around marginal hairline
- 1/3 AA women have traction hair loss







Dakkak M, Fonda KM, Lanney H. Hair loss: diagnosis and treatment. 2024;110(3):263-269.
James L. Cohell RN, Fox IL. Traction alopecia in black male patients. J Am Board Fam Med. 2007 Sep-Oct;20(5):489-9

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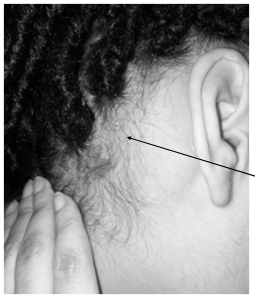

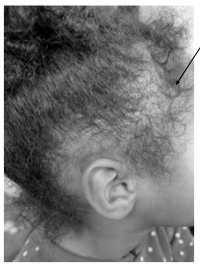

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Traction Alopecia Treatment

- Minimize* offending traction
- Minimize long-wear hair gel products that contain alcohol
- Avoid heat around the hair line
- Increase hair moisturization
- Topical or intra-lesional corticosteroids if evidence of inflammation
- Physician-perceived hair loss severity does not correlate with the patient's hair loss severity or its effect on their quality of life

Reid EE, Haley AC, Bonnicksa JH, Rademaker A, West DP, Colavincenzo M, et al. Clinical severity does not reliably predict quality of life in woman with alopecia areata, telogen effluvium, or androgenic alopecia. J Am Acad Dermatol 2012;66:e67-e102

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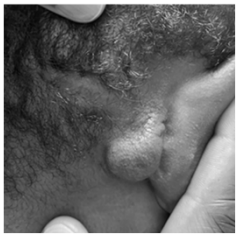
Keloids

- Scars that are shiny, thick, fibrous nodules
- SOC patients 5 times more likely to develop keloids
- 80% of patients report pain and itching
- Can take up to 12 months to develop after inciting event
- Keloids are different from hypertrophic scars
- Important to discuss when considering surgical procedures
- Avoid unnecessary surgery (risk-benefit shared decision making)



Keloids

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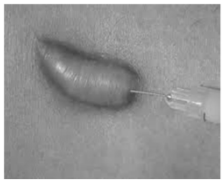
Keloid Treatment Options

- Excision, but high rate of recurrence
- **Intralesional corticosteroids** is treatment mainstay
- Cryosurgery
  - Reserved for small keloids
  - Dyspigmentation side effects
- Pulsed dye laser treatment



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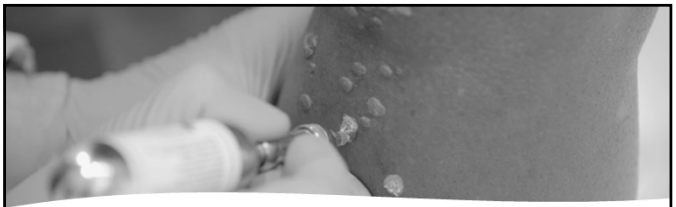

Skin Procedures

- Many procedures carry more dyspigmentation risks for SOC
- Every mole, skin tag removal can cause dyspigmentation
- Liquid nitrogen treatment can leave hypopigmentation
- Electrocautery is less likely to leave dyspigmentation
- Important to perform procedures with the right techniques and equipment
- Education and shared-decision making is important

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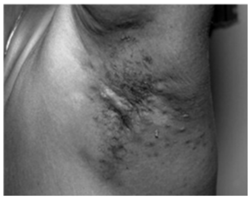
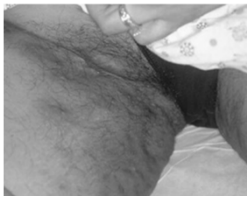
Hidradenitis Suppurativa (HS)





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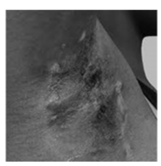
Hidradenitis Suppurativa (HS)

- Systemic inflammatory disorder with skin manifestations
- Follicular occlusion disorder causing painful nodules and sinus tracts
- Commonly affects areas where skin touches skin
- AA patients have 2-3X higher incidence than White patients
- Average 7-year delay in diagnosis
- Strong association with tobacco use
- Can drastically affect patient's quality of life



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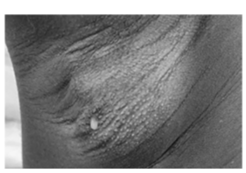
Hidradenitis Suppurativa Treatment

- Topical antiseptics (hibliclens, chlorhexidine)
- Topical antibiotics (clindamycin 1% bid X 12 weeks)
- Topical resorcinol 15%
- Intralesional corticosteroid injections
- Doxycycline X 3 months
- Rifampicin + clindamycin
- Hormonal therapies if cyclic flares



A Practical Guide for Primary Care Providers on Timely Diagnosis and Comprehensive Care Strategies for Hidradenitis Suppurativa. Garg, Amit et al The American Journal of Medicine, Volume 136, Issue 1, 42 – 53

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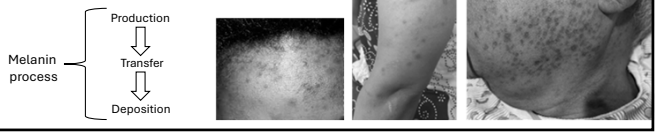
Post Inflammatory Hyperpigmentation (PIH)

- Excessive melanin deposition in the dermal layers
- More pronounced and persistent in SOC
- Common causes include acne, atopic dermatitis, and PFB
- Resolution can take months to years
- Treat the underlying condition **first**



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PIH Treatment Options

- Hydroquinone 4% (gold standard): 3 – 6 months maximum
- Retinoids (adapalene, tazarotene, tretinoin): targets all 3 pathways
- Azelaic acid 10 – 20% (good for acne and rosacea)
- Salicylic acid 10 – 20%: anti-inflammatory
- Oral tranexamic acid
- Other options: kojic acid, licorice root, Vitamin C, niacinamide, soy
- Dermatology referral: chemical peels, picosecond lasers
- **Sunscreen**

Post-inflammatory hyperpigmentation: A comprehensive overview - Journal of the American Academy of Dermatology (jaad.org)

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Importance of Sunscreen

- Especially important for photo exacerbated conditions (melasma and PIH)
- Broad spectrum (UV-A and UV-B) and VL coverage with at least **SPF 30+**
- Physical or mineral sunscreens can leave a **white cast**
  - Active ingredients: zinc oxide +/- titanium dioxide
  - Tinted (iron oxide) sunscreens can minimize the white cast and provide VL protection
  - Better for sensitive skin, patients with PIH, patients with acne, and children
- Chemical sunscreens absorb UV rays and converts them into thermal energy
  - Common active ingredients: avobenzone, octinoxate, oxybenzone
  - Easier to apply and does not leave a white cast
  - More water and sweat resistant
  - Chemicals do pass into the bloodstream

Sunscreen Selection - Skin of Color Society
Song H, Beckles A, Sutaria P, Porter ML. Sunscreen recommendations for patients with skin of color in the popular press and in the dermatology clinic. Int J Womens Dermatol. 2020 Nov 10;7(2):165-170.

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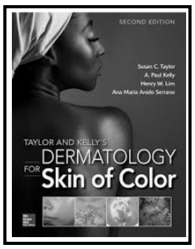
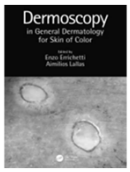
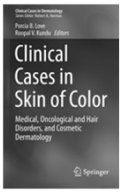
Resources







- VisualDx: opportunities for EHR integration
- American Academy of Dermatology skin of color curriculum

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Learning Objectives

- Examined factors that contribute to skin of color health disparities
- Discussed common dermatological conditions in skin of color
- Identified skin of color educational resources

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Thank you

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Please take a moment to complete the session evaluation.

Your input is important!

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