

Primary Care Dermatology for Skin of Color

MAFP October's Virtual CME Session

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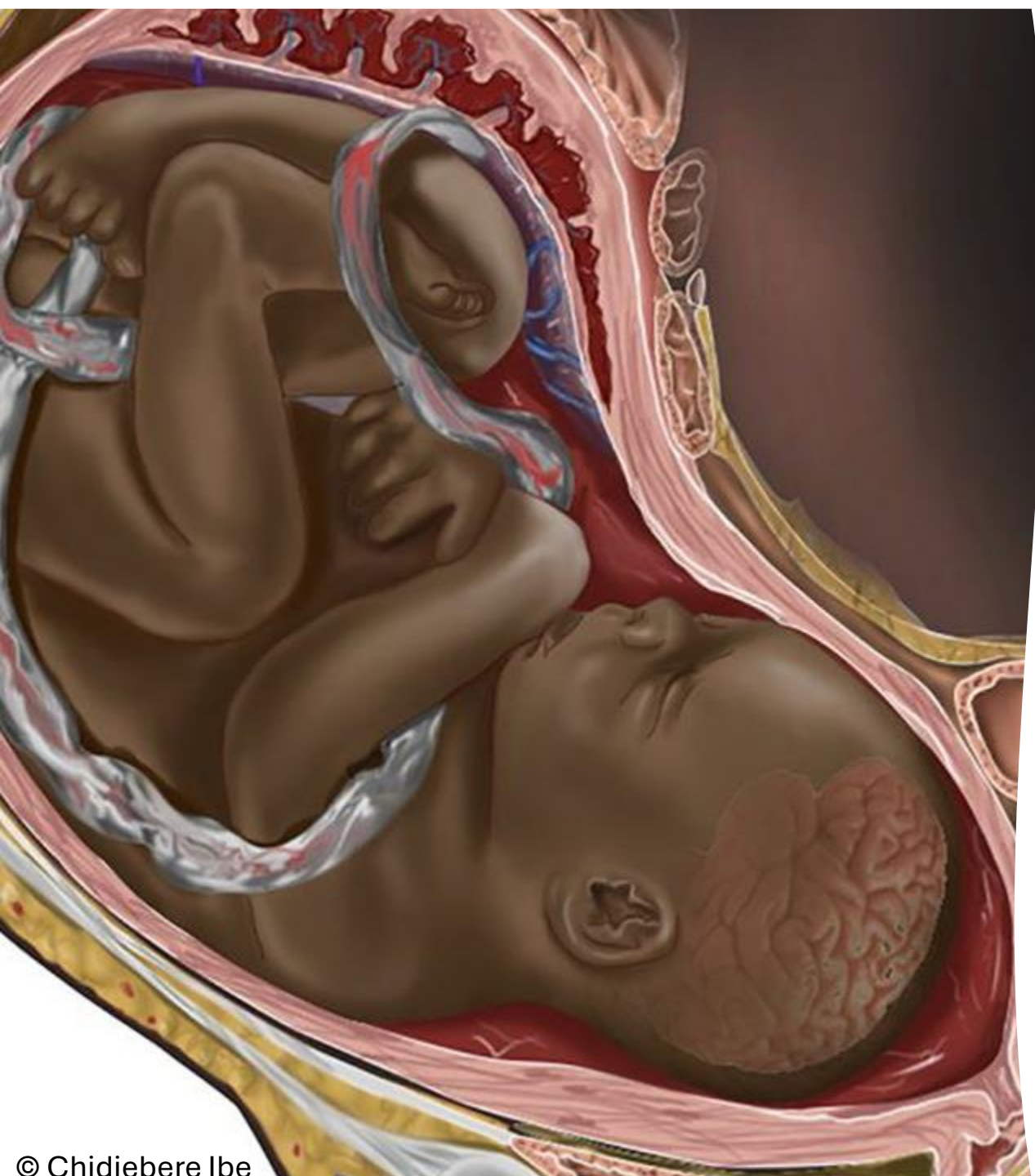
University of Pittsburgh School of Medicine

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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





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

The Fitzpatrick Scale



- Skin color classification based on propensity for photodermatitis
- The scale should not be used as a surrogate marker for race and ethnicity
- Race is a social construct: human-invented classification system
- There are no racial differences in the number of pigment-producing cells (melanocytes)

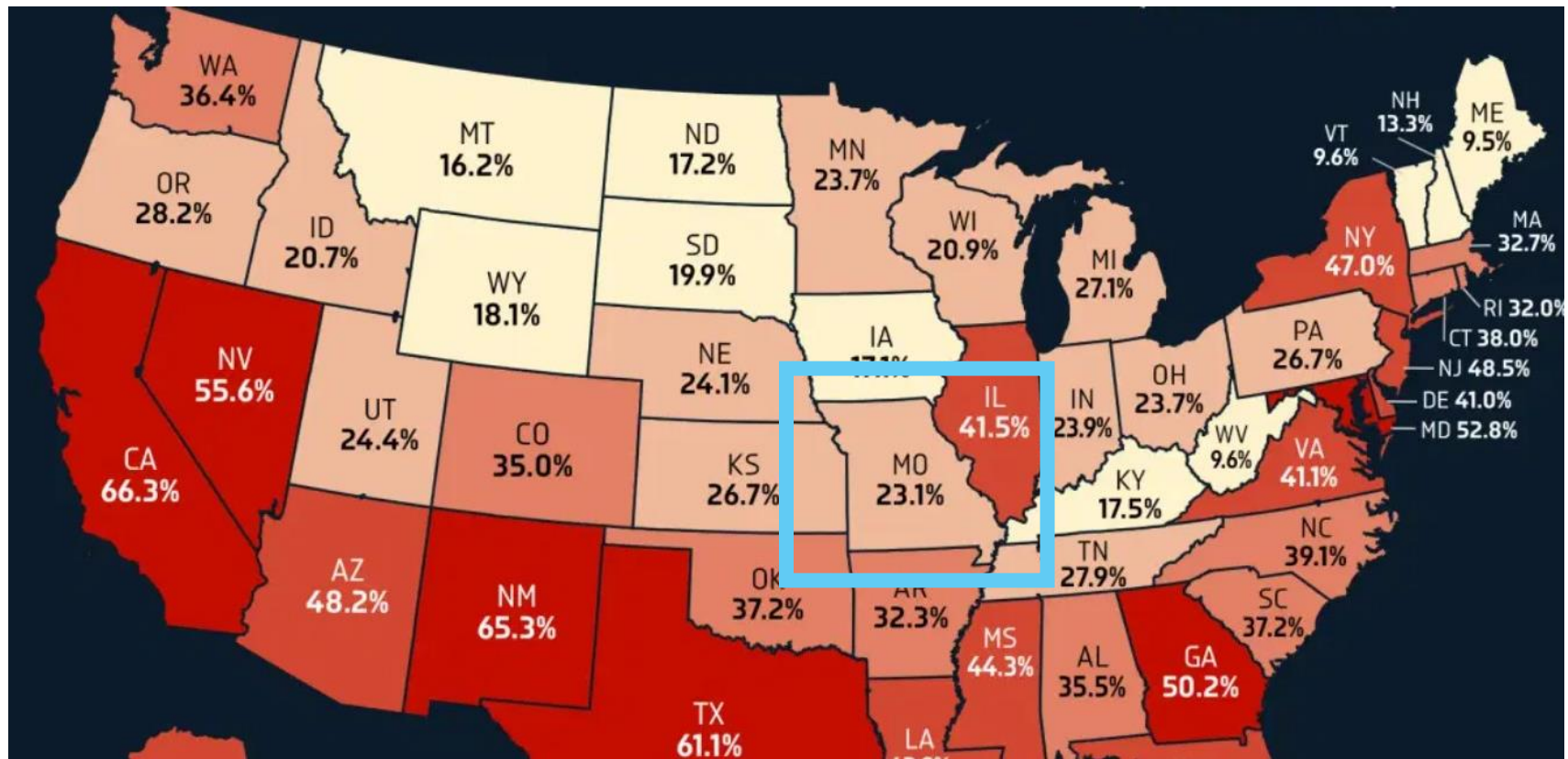
Monk Skin Tone Scale



- Dr. Monk created this scale to promote inclusivity
- Goal to improve AI/machine learning applications
- Could help reduce unintended algorithm bias

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.



- 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

Increasing Skin of Color Population

Dermatological health disparities are common

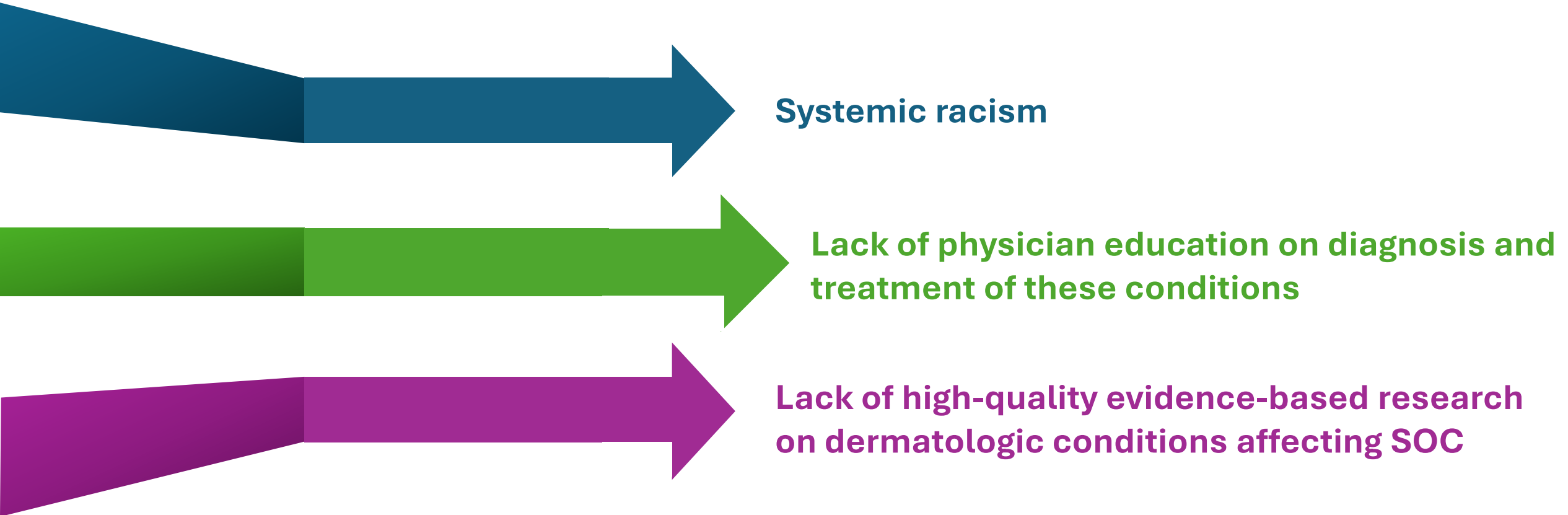
- AA patients with atopic dermatitis were less likely to receive desonide, topical calcineurin inhibitors, crisaborole, and dupilumab compared with White patients.¹
- Latinx patients with acne were less likely to receive tretinoin compared with non-Latinx patients.¹
- AA patients were less likely to receive biologics for psoriasis compared with White patients.²
- Melanoma 5-year survival was 93% in White patients and 73% in AA patients.³

¹Bell MA, Whang KA, Thomas J, Aguh C, Kwatra SG. Racial and ethnic disparities in access to emerging and frontline therapies in common dermatological conditions: a cross-sectional study. *J Natl Med Assoc.* 2020;112(6):650–653.

²Brown SG, Cobb CBC, Harvey VM. Racial and ethnic health disparities in dermatology. *Dermatologic Clinics.* 2023;41(2):325-333.

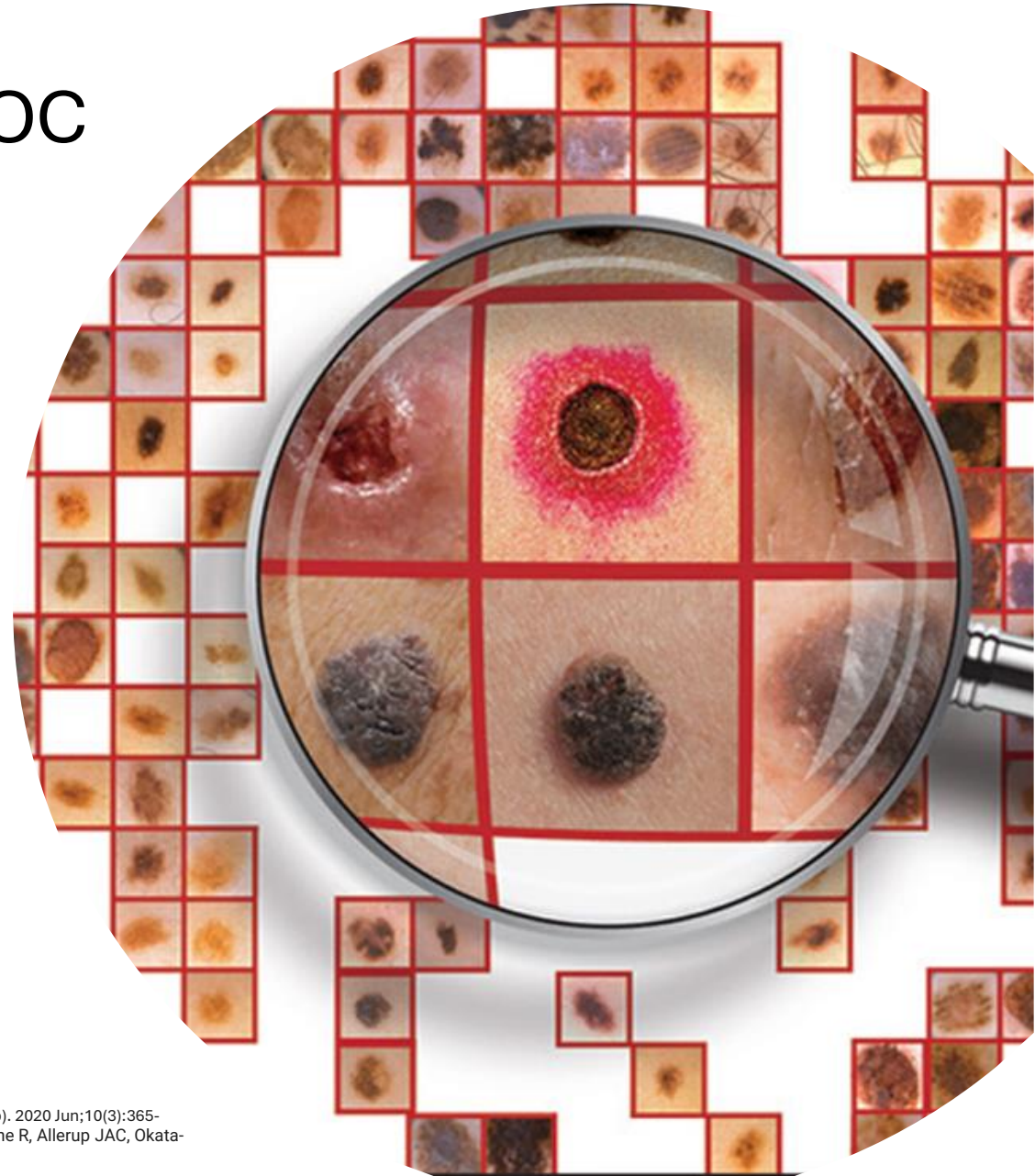
³Surveillance, Epidemiology, and End Result Database. Browse the SEER cancer statistics review: 1975-2017. Accessed March 2, 2021. https://seer.cancer.gov/csr/1975_2017/browse_csr.php

Why do these disparities exist?



New diagnostic options still lacking in SOC

- Artificial intelligence algorithms perform worse on lesions in SOC
 - Underrepresentation of SOC in datasets
 - Concerns about models generalizing to SOC



Cautionary Slide

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



Rosacea



- Can use diascopy to better visualize telangiectasia in SOC patients

Atopic Dermatitis



Melanoma?



A

Melanoma?



B

Melanoma?



C



Talon noir



**Acral lentiginous
melanoma**



Melanonychia



Nail diagnoses

- Differential includes subungual melanoma and subungual hematoma
- Hutchinson's sign

Acral Lentiginous Melanoma

- AA patients are more likely to present with late-stage disease and higher rates compared to White patients
- Misdiagnosis may contribute to further delay in treatment



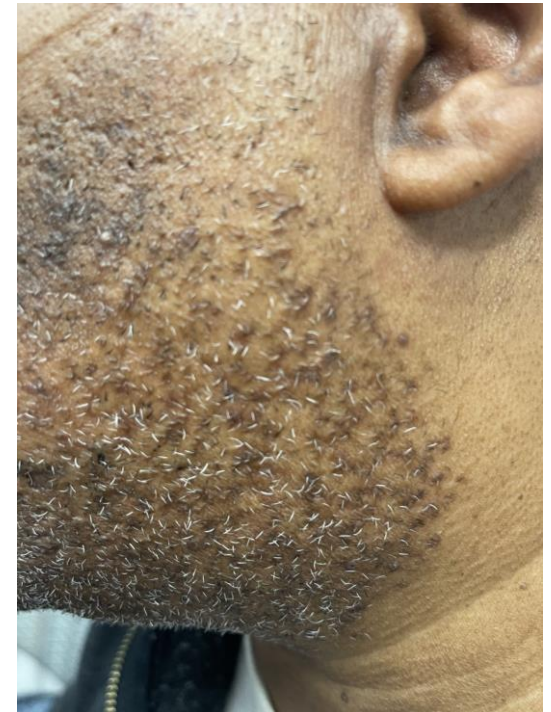
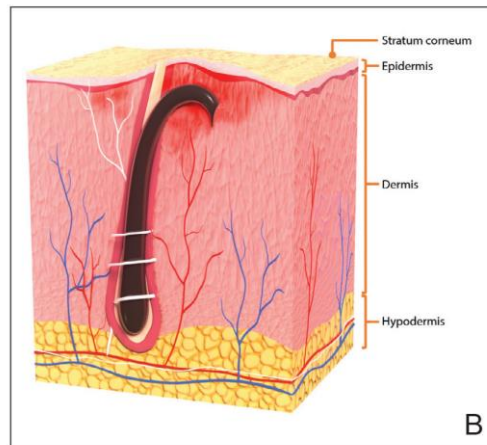
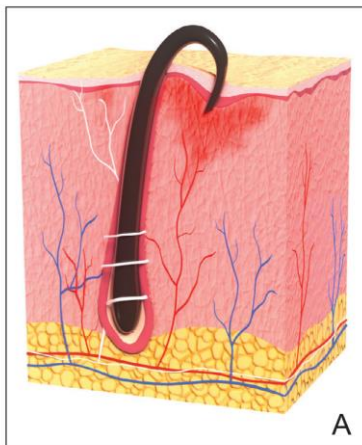
Common Dermatological Conditions in SOC

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

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

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



Pre-shave

Use a gentle cleanser to cleanse and exfoliate the skin

Apply a warm washcloth to the area for 5-10 minutes

Apply moisturizing shave cream or gel

SHAVE



- Electric razors (cut areas more evenly, straight, and not as close)
- Razors with skin guards (reduces tug and pull)
- Don't shave over the same area twice
- Don't pull the skin taut
- Take short strokes
- Apply gentle pressure to the skin
- Don't use razors more than five times

Rinse the skin

Apply moisturizer

After-shave

Massage skin in circular manner and repeat 12 hours later

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

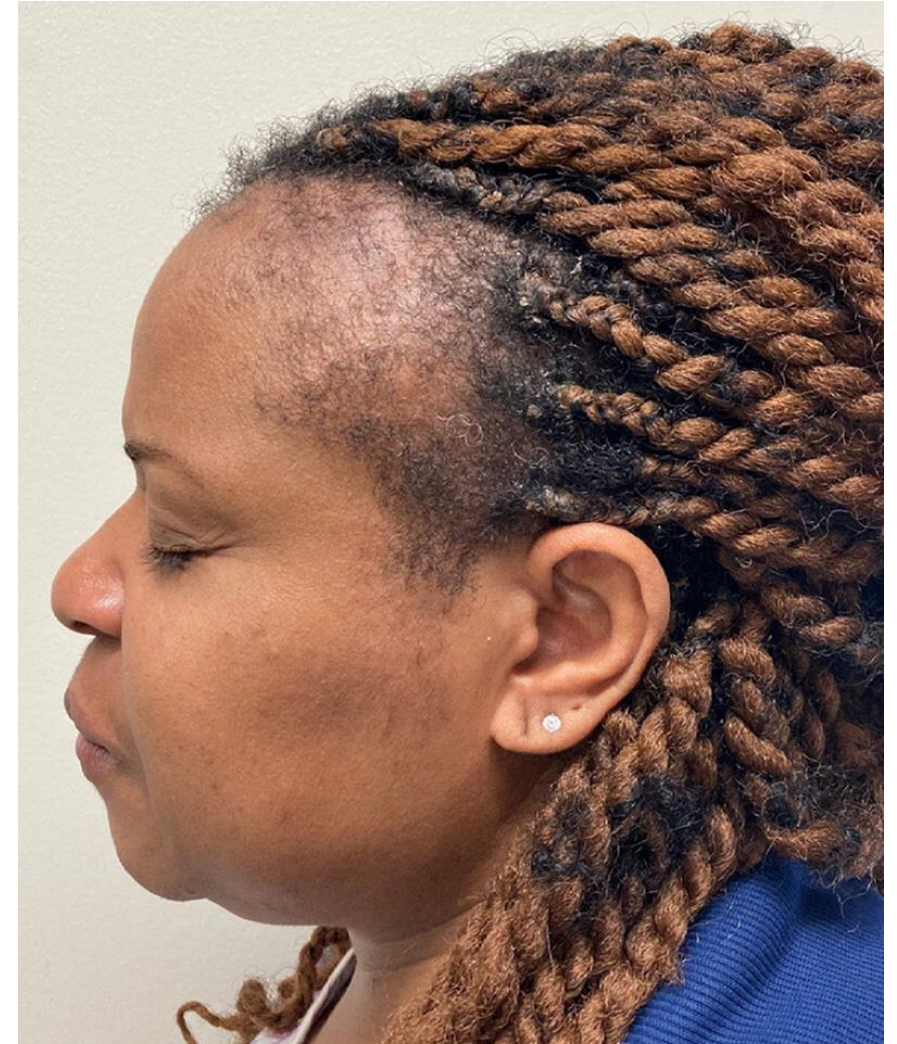


Traction Alopecia

Prolonged tension on the hair follicle

Most obvious around marginal hairline

1/3 AA women have traction hair loss





Follicular papules



Fringe sign

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

Keloids

- Scars that are shiny, thick, fibrous nodules
- SOC patients are 15X 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)



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



Hidradenitis Suppurativa (HS)

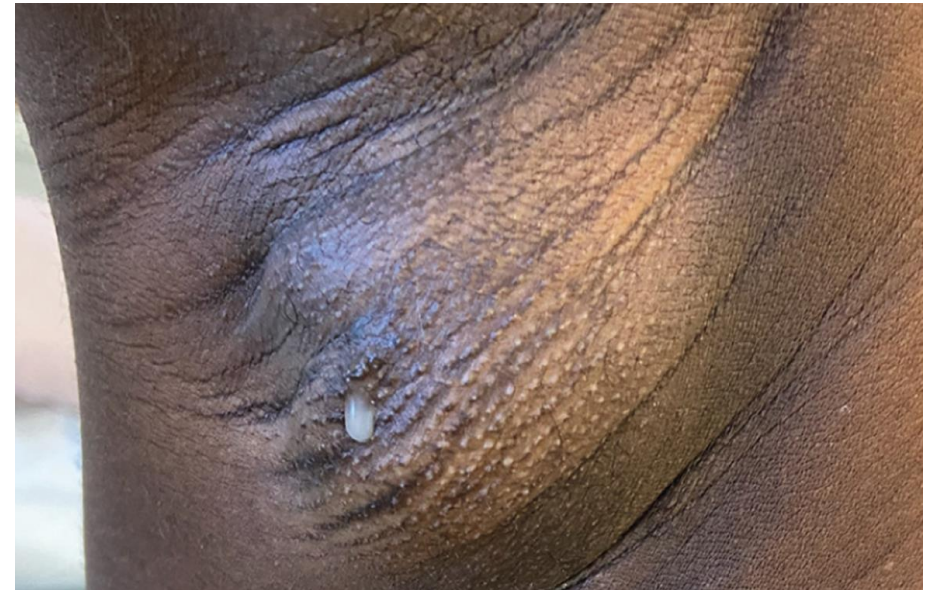


Hidradenitis suppurativa (HS)

- Systemic inflammatory disorder with skin manifestations
- Follicular occlusion disorder causing painful nodules and sinus tracts
- Commonly affects areas where skin touches skin
- Black 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

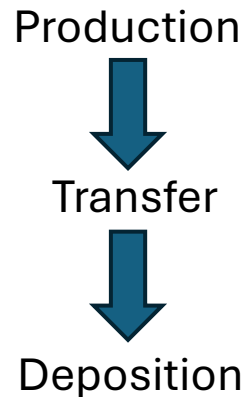
Hidradenitis Suppurativa Treatment

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



Post Inflammatory Hyperpigmentation (PIH)

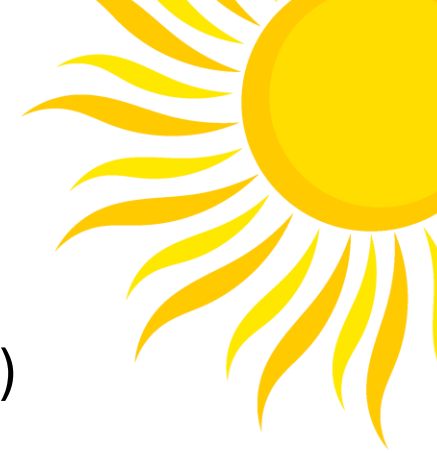
- Excessive melanin deposition in the dermal layers
- More pronounced and persistent in SOC
- Common causes include acne, atopic dermatitis, and PFB
- Resolution can take months to years
- Treat the underlying diagnosis **first**



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**

Importance of Sunscreen



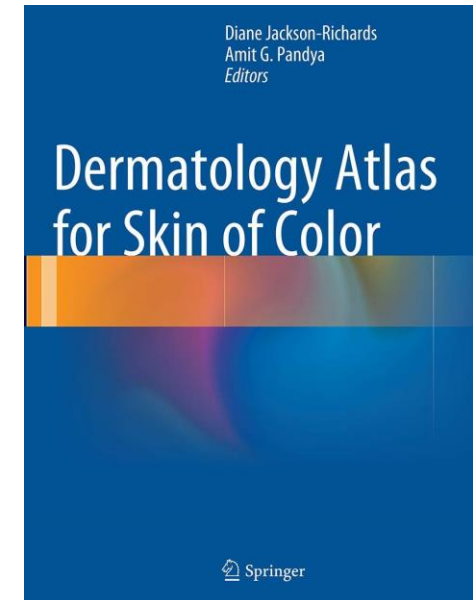
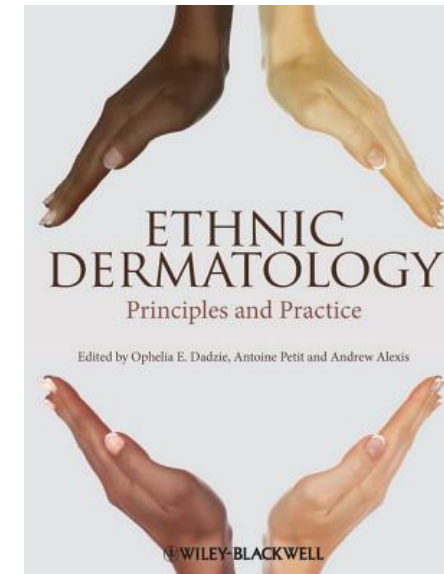
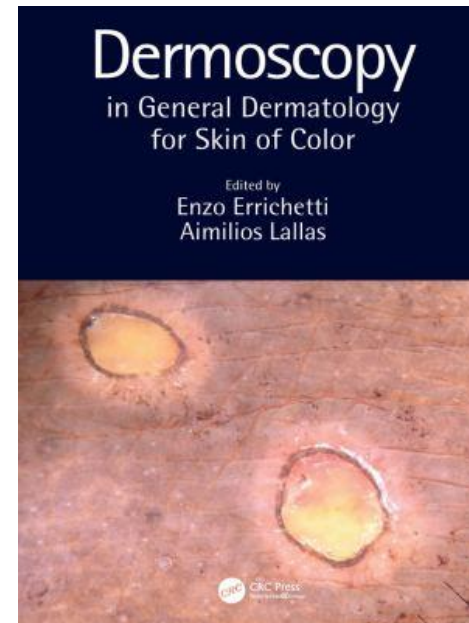
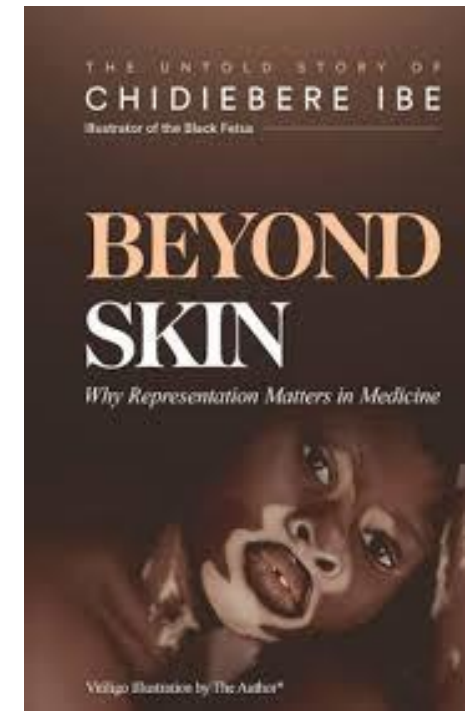
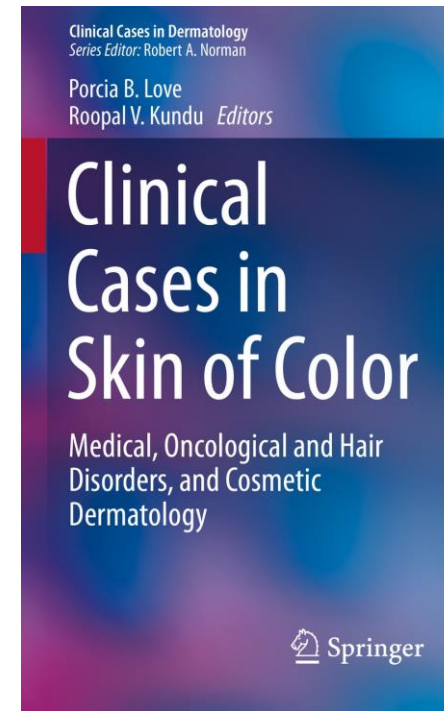
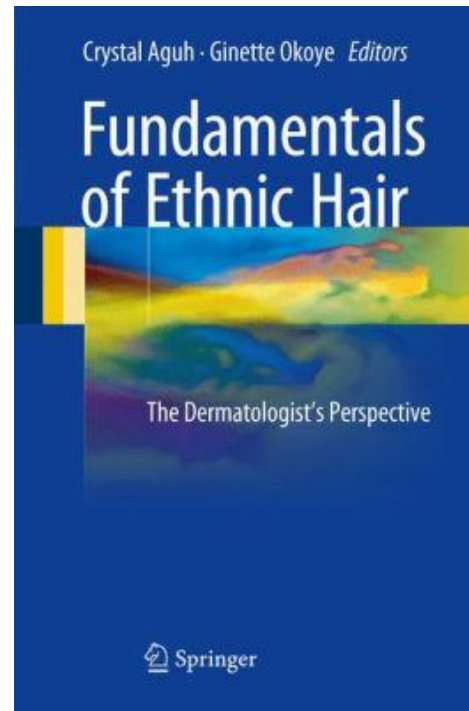
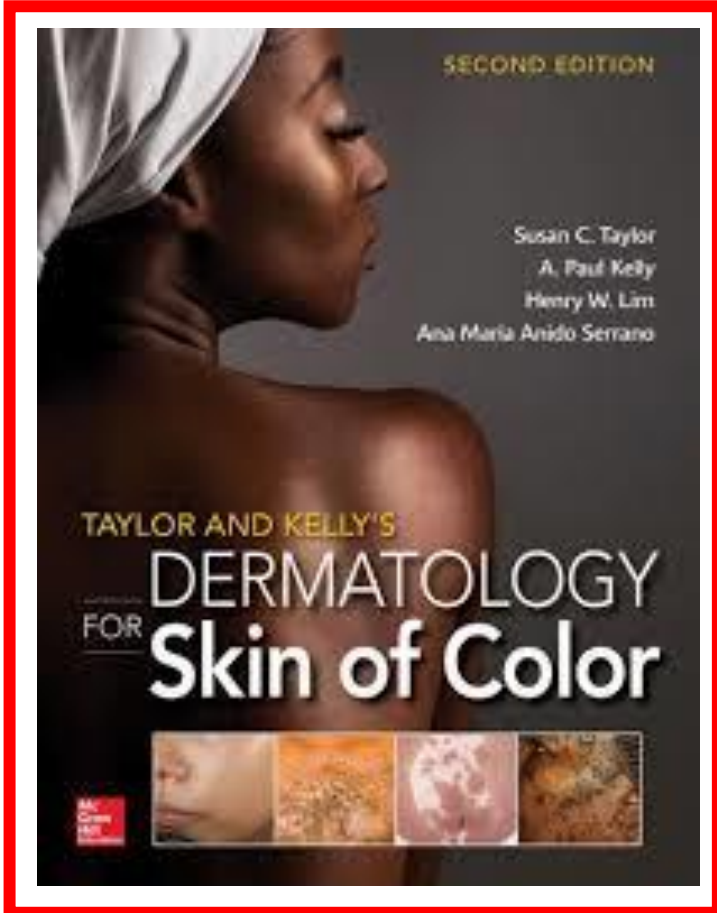
- Especially important for photo exacerbated conditions (melasma and PIH)
- Broad spectrum (UV-A and UV-B) and VL coverage with at least **SPF 30+**
- Physical or mineral sunscreens can leave a **white cast**
 - Active ingredients: zinc oxide +/- titanium dioxide
 - Tinted (iron oxide) sunscreens can 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 (we don't know the if there are adverse health effects)



Educational Resources

- VisualDx: FM department is working on EHR integration
- American Academy of Dermatology skin of color curriculum

Resources



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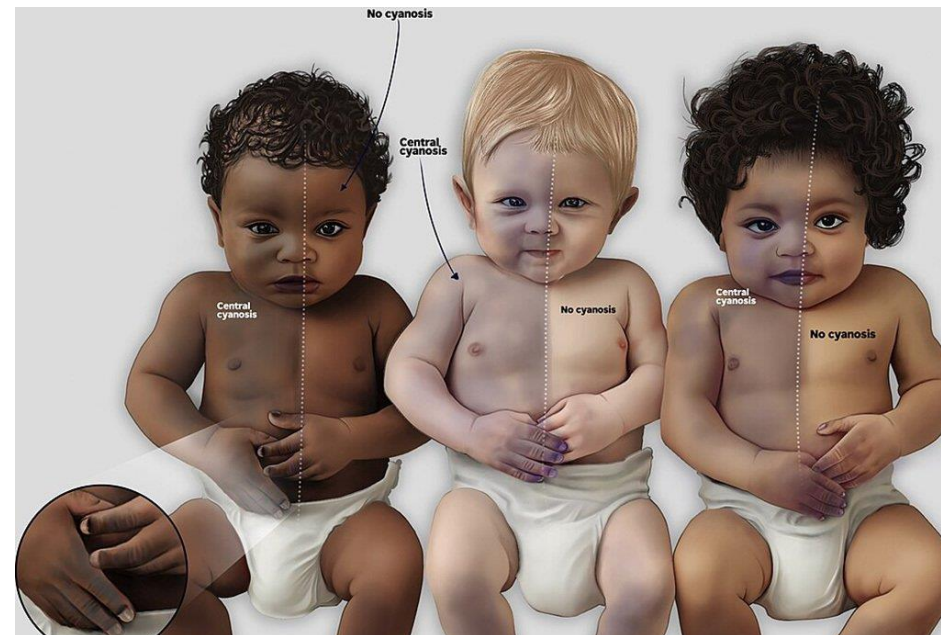


Image credit: Chidiebere Ibe

Any questions?