DISEASE IN SKIN OF COLOR

By Joe Monroe, PA

“DARK SKIN” DEFINED

• FITZPATRICK SCALE: TYPE III - VI
• TYPE I = FAIREST, TYPE VI = DARKEST
• IT'S NOT HOW YOU LOOK, IT'S HOW YOU RESPOND TO UV EXPOSURE
• "BURNS EASILY, NEVER TANS" = TYPE I
• "TANS EASILY, Seldom Burns = TYPE III
• TYPE VI = EGGPLANT COLORED BLACK

SKIN TYPES

• I – VI = VERY FAIR TO VERY DARK DARK
• A CONTINUUM OF RESPONSES TO UV EXPOSURE
• MANY IMPLICATIONS FOR SKIN DISEASE
“DARK” PATIENTS

• COULD BE HISPANIC/AFRICAN MIX
• MANY NATIVE AMERICANS, ASIANS, INDIANS, ETHIOPIANS, Eritreans
• THE HISTORY IS WHAT REALLY COUNTS
• MANY TYPE IV AND V’S NEVER GET IN THE SUN, LOOK PALE, BUT COULD TAN
• EG, VIETNAMESE, PHILLIPINOS

PINK/RED = PURPLE/BROWN

• PIHyper COMMON IN DARK SKIN
• ECZEMA, ACNE, LICHEN PLANUS = EXAMPLES
• BURNS, OTHER TRAUMA DO THE SAME
• CAN LAST YEARS

HYPERPIGMENTATION

• DOESN’T HAVE TO BE BROWN
• BLUE DISCOLORATION CAN RESULT FROM MEDS (COLOIDAL SILVER, GOLD SALTS, MINOCYCLINE)
• DISCOLORATION CAN RESULT FROM DISEASES eg HEMOCHROMATOSIS, WILSON’S DISEASE, ADDISON’S
• CAN HAPPEN IN FAIR-SKINNED PATIENTS
POST-INFLAMMATORY HYPERPIGMENTATION

- Often becomes “the problem” in the patient's mind
- The only way to lighten it is to treat the underlying condition
- Fade creams, such as hydroquinone 4% creams, can help, as can sunscreens
- Patients need patience, education

HISTOLOGICALLY

- No increase in #s of melanocytes in dark patients
- Instead, it's the number, size, and distribution of melanosomes (pigment granules) within keratinocytes that make for dark skin
- An evolutionary adaptation to sun exposure?

HYPOPIGMENTATION

- Partial or total
- Total pigment: vitiligo, LS&A, morphea
- Can be iatrogenic
- Tends to be permanent while hyperpig. usually temporary
PIHypo from Vitiligo?
VITILIGO?
• WOOD’S LAMP ACCENTUATES VITILIGO, NOT MERE PIHypo
• BIOPSY SOMETIMES NECESSARY
• TREATABLE, EARLY ON

PIHypo Secondary to Scratching

LICHEN PLANUS
*PIHypo secondary to LP
*Penile, puzzling, purple, pruritic, papular, plaquish, polygonal, planar
PIHypo Secondary to DLE

SCALP DISORDERS
- INCLUDING ALOPECIA, CELLULITIS, OTHER INFLAMMATORY DZ’S
- REFER TO DERMATOLOGY WHEN POSSIBLE
- BIOPSY IF YOU CAN, +/- CULTURE
- "PROCESSING" AND HAIR TYPE COUNT
- BUT JUST PRONE TO VARIOUS DZ’S

SCALP DISORDERS
- ACNE-LIKE ERUPTIONS EG DISSECTING CELLULITIS
- SCARRING ALOPECIA
- TRACTION ALOPECIA
- SEBORRHEA
- CENTRAL CENTRIFUGAL ALOPECIA
- FOLLICULAR DEGENERATION SYNDROME
PI HYPER

- Common after acne, eczema, burns, neurodermatitis, contact dermatitis
- Where whites would turn pink, dark skin turns darker
- Does not = scarring but can be quite persistent

POST-INFLAMMATORY HYPERPIGMENTATION

DISCOID LUPUS

*Patulous follicular orifices
*Does not turn into SLE
PAPULOSQUAMOUS DISEASES

- SEBORRHEA
- PSORIASIS
- TINEA CORPORIS (DERMATOPHYTOSIS) aka “ringworm”

SEBORRHEIC DERMATITIS

SEBORRHEIC DERMATITIS
Tinea Face II

Atopic Dermatitis
- Extremely common, becoming more common (15% of newborns)
- Bilateral, symmetrical eczema
- Excoriated, hyperpigmented
- Belt buckle, earrings, jeans snap
- + Fam & personal atopic history
- Extensor > flexural in dark patient

Infantile AD
ATOPIC DERM

- Nearly all are allergic to nickel.
- Nickel exposure is not the cause, but can make it worse.
- Not diet-related, though many AD pts have food allergies.
- Stress, dry skin, scratching all make it worse.
- Colored, scented products = a no-no.

NICKEL ALLERGY PLUS AD

ATOPIC DERMATITIS

- Hyperpigmentation very distressing.
- Will only fade with successful treatment of AD.
- Need pt ed regarding darkening.
- Prevention >> treatment.
- (Elidel, Protopic + Moisturizer)
LICHEN NITIDUS

DYSCHROMIA FROM DRUGS
- MINOCYCLINE
- SILVER, GOLD SALTS
- AMIODORONE
HYPERPIGMENTATION FROM MCN

CAROTINEMIA
DZs FAVORING DARK SKIN

- SARCOID
- LUPUS
- ATOPIC DERMATITIS
- ALOPECIA
- SCALP DISORDERS
- DYSCHROMIA
- KELOID FORMATION

SARCOID VS LUPUS

- AKA SARCOID
- INFLAMMATORY REACTION TO UNKNOWN ANTIGEN, WITH GRANULOMATOUS TISSUE REACTION (NON-CASEATING)
- CAN BE PURELY CUTANEOUS, OR SYSTEMIC
- CAN INVOLVE LUNGS, KIDNEYS, ETC
- FAR MORE COMMON IN AFRICAN-AMERICANS THAN IN AFRICAN BLACKS OR IN WHITES

SARCOIDOSIS

- AKA SARCOID
- INFLAMMATORY REACTION TO UNKNOWN ANTIGEN, WITH GRANULOMATOUS TISSUE REACTION (NON-CASEATING)
- CAN BE PURELY CUTANEOUS, OR SYSTEMIC
- CAN INVOLVE LUNGS, KIDNEYS, ETC
- FAR MORE COMMON IN AFRICAN-AMERICANS THAN IN AFRICAN BLACKS OR IN WHITES
SARCOID DIAGNOSIS

- Usually requires biopsy
- Tissue pattern differs from other granulomatous diseases
- e.g., leprosy, GA, fungal
- Annular periocular lesions = common
- Just have to think of it to dx it

LUPUS

- Can be cutaneous, systemic, or both
- More common in women of color
- Wide variety of presentations incl. discoid favors sun-exposed skin
- Butterfly rash = uncommon
- Odd scaly rashes on sun-exposed skin of young women (ears, face) = classic
- Needs biopsy to diagnose

DISCOID LUPUS
**KELOIDAL TENDENCIES**

- **TRUE KELOID** = IRREGULAR, OBSCURES ORIGINAL TRIGGERING LESION/WOUND
- CONTINUUM: NORMAL SCARRING, HYPERTROPHIC SCARRING, KELOID
- WORSE IN PATIENTS WITH DARK SKIN
- MORE LIKELY ON CHEST, DELTOIDS, EARLOBES, OVER JOINTS, SHOULDERS

**KELOID TREATMENT**

- AVOID ELECTIVE SURGERY (any invasive procedure) TO HIGH RISK AREAS
- SURGICAL EXCISION but..........  
- INTRALESIONAL INJECTION WITH STEROIDS (10-40 MG/CC) GIVES TEMPORARY RELIEF (2 – 6 MONTHS)
- CAN SOFTEN WITH LN2 BEFORE INJ.

**PRAYER RUG SPOT?**
ACRAL LENTIGINOUS MELANOMA

- Palms, Soles, Nail Beds
- Mucous Membranes
- The least pigmented areas
- Not in sun-exposed skin
- Poor prognosis due to delay in diagnosis and treatment

ACRAL LENTIGINOUS MELANOMA

- Occur most often in people of color, who are at low risk overall.
- Bob Marley died from ALM under toenail, diagnosis delayed, patient in denial.
- Mostly flat
- Account for 3 – 10 % of all MM
ALM ASIAN FEMALE

MELANOMA

- Melanocytes migrate from neural crest to epidermis, can stop anywhere along the way
- Primary melanomas can develop in the lung, in the colon, and on non-sun-exposed skin
- Pro/Con re: role of sun in ALM

MELASMA

- Far more common in this group
- Darker skin + estrogen + sun + gender = recipe for melasma
- Hard to treat, harder to keep it away because sun protection = a must, forever
- Can be lasered, but.........
MELANONYCHIA

• MORE COMMON IN DARKER PATIENTS
• SLENDER, SMOOTH EDGES, LACK OF CHANGE = ALL GOOD
• STAINING OF ADJACENT CUTICLE = BAD SIGN

MELASMA
MISCELLANEOUS

- DON’T FORGET SYPHILIS, ESPECIALLY FOR WIDESPREAD RASHES
- PEARLY PENILE PAPULES
- RETICULATED PAPILLOMATOSIS
- HIRSUTISM

HIRSUTISM