

Color Me Healthy: Patient-Centered Care in Skin of Color

Dermatologists' approaches to treating darker skin types aren't color blind...yet.

By 2050, more than 50 percent of the US population will have skin of color. As it stands, skin of color patients are the majority in California, New Mexico, and Texas, and soon will be the majority in Arizona, Nevada, Georgia, New York, and Florida, the Skin of Color Society reports.

This means that all dermatologists must become more proficient at diagnosing and treating cosmetic and medical concerns in patients with skin of color STAT. While much progress has been made, there still remain unmet needs and unanswered questions when it comes to skin issues in this population. Experts from the Skin of Color Society convene yearly to update the media on progress and issues affecting these patients. Here's where we stand in 2017.

MICRO-NEEDLING

Where we are: Micro-needling is used to treat scarring, melasma, skin rejuvenation, acne vulgaris, and primary hidradenoma in the skin of color population, says Nada Elbuluk, MD, FAAD, assistant professor at the Ronald O. Perleman Department of Dermatology at New York University Langone Medical Center in New York City. And because it doesn't target melanin the way lasers do, there aren't side effects like hyperpigmentation.

Babar K. Rao, MD, FAAD, a clinical associate professor of dermatology at Weill-Cornell Medical School in New York City and Founder and Director of Rao Dermatology NY, agrees. "The data shows us that micro-needling can be effective in darker skin types without causing hyperpigmentation," says Dr. Rao, also a clinical professor of dermatology at Rutgers-Robert Wood Johnson Medical School in Piscataway Township, NJ.

What we still need to learn: "We can enhance topical drug delivery with microneedling, but we don't know the effects of topicals when they go deeper into the skin layers or what products are safe and effective to use in this way," Dr. Elbuluk says.

SKIN CANCER RISK AND MORTALITY

Where we are: The five-year survival rate for African



Drs. Alexis, Taylor, McMichael, Perez, Rendon, and Desai (left to right) at the Skin of Color Society Media Day.

Americans with malignant melanoma is 78 percent. It's 86 percent for Hispanics and 85 percent for Asians. The five-year survival rate for malignant melanoma is 92 percent for whites. The incidence of melanoma is increasing in all Hispanics, more markedly in those of Puerto Rican and Mexican descent, says Maritza I. Perez, MD, FAAD, a clinical professor of dermatology at Mount Sinai Icahn School of Medicine in New York City.

What we still need to learn: "We don't know if this is a result of genetics, delayed diagnosis, or both," says Marta I. Rendon, MD, FAAD, the founder and director of the Rendon Center for Dermatology & Aesthetic Medicine in Boca Raton, FL. What's more, Dr. Perez adds, "the role of ultraviolet light in malignant melanoma development in people of color is unclear given frequent location of non-sun-exposed sites."

"It's important for dermatologists to realize that people with skin of color can, and do, get skin cancer," says Susan Taylor, MD, FAAD, associate professor of dermatology at the Perleman School of Medicine of the University of Pennsylvania in Philadelphia. "These patients should be advised to wear sunscreen on a daily basis with at least 30 SPF, and dermatologists should do regular screening exams in these patients with par-

ticular attention paid to palms, soles, fingernails, toenails, and mucosal membranes.”

SELF DIAGNOSIS APPS

Where we are: “There are many skin apps to help patients treat themselves, but none of these apps are objective enough to be used by patients with skin of color yet,” Dr. Rao says. This is also true of teledermatology services. “You can see a rash in lighter skin, but in darker skin, you can’t always see inflammation or redness,” he says. Moles may also not be visible with these technologies.

What we still need to learn: Apps and services that are truly color blind are needed to allow skin of color patients to benefit from these high-tech services, Dr. Rao says.

PIGMENTATION ISSUES

Where we are: This is a huge issue in skin of color patients, experts agree. Hypopigmented disorders (tinea versicolor, sarcoidosis, mycosis fungoides, pityriasis alba), depigmented disorders (vitiligo), and hyperpigmented disorders (melasma and post-inflammatory hyperpigmentation commonly due to acne) fall under the umbrella of pigment disorders. Melasma treatments can include azelaic acid, kojic acid, zinc, and hydroquinone. Triple combination therapy with hydroquinone, retinoids, and topical steroids is the first line treatment for melasma today, Dr. Rendon says. For vitiligo, options include doing nothing, topical therapy including steroids or vitamin D analogues, calcineurin inhibitors, depigmentation, systemic treatment, phototherapy, surgery, and/or psychotherapy. Often a combination of these therapies is needed to address vitiligo, says Seemal R. Desai, MD, FAAD, a clinical assistant professor of dermatology at the University of Texas Southwestern Medical Center in Dallas and the founder and medical director of Innovative Dermatology in Dallas.

What we still need to learn: “Some of the lasers target melanin and this is still tricky in darker skin types. New ways of treating redness and melasma in darker skin are still needed,” Dr. Elbuluk says. “Dermatologists need to be aware that skin of color can react differently and be more conservative with energy-based treatments,” she says. “If hesitant, reach out to an expert and always do a test spot first,” she says. “When adverse effects do happen, they take much longer to treat and it’s a frustrating process for patients and doctors.”

Dr. Rendon agrees: “These patients are at higher risk for keloids, scarring, hyper and hypopigmentation and — depigmentation, which is even harder to treat.”

Patient expectation management matters when treating melasma in skin of color, Dr. Desai says. “Melasma is a chronic disease. It is not something that will go away. It is always lurking in the background. Tell patients ‘you will look better and feel better, but it will always be there and long-term

treatment with topicals is needed.’” More research is needed on glutathione, which assists in converting eumelanin to pheomelanin. It is still controversial due to bioavailability, but there have been some promising results in studies, he says.

Most insurers don’t cover the cost of phototherapy for vitiligo because they feel it’s solely a cosmetic concern. “We need to do more quality of life studies on pigment disorders. This will really help with payers and legislative officials,” he says.

CHEMICAL PEELS

Where we are: Chemical peels get a bad rap when it comes to treating pigment abnormalities in skin of color. If utilized correctly, chemical peels can be an effective treatment option for patients of color, Drs. Desai and Rendon say. When using any chemical peel modality in skin of color, “it is important to pretreat the skin with hydroquinone and retinoids for four weeks. This is crucial,” Dr. Desai says.

What we still need to learn: “Education is warranted,” he says. “The pretreatment message is not getting out, and the lack of pretreatment is responsible for many of the bad results seen in patients treated at med spas,” Dr. Desai says.

CENTRAL CENTRIFUGAL CICATRICAL ALOPECIA (CCCA)

Where we are: CCCA is almost exclusively seen in women of African ancestry and we believe this is due to common hair care practices coupled with genetic predispositions, explains Andrew Alexis, Director of the Skin of Color Center in New York, where he is also an associate professor of dermatology at the Icahn School of Medicine at Mount Sinai. It often travels with traction alopecia. Symptoms range from none to severe pruritus and pain. The mechanism of scarring is unknown, he says. “Early detection is the key because the earlier we start treatment, the better the prognosis,” he says. “On careful exam of the scalp, we can detect the beginning of scarring before it becomes a large patch devoid of hair.”

What we still need to learn: The average lag time between onset of CCCA and time of diagnosis is approximately 4.5 years. “We can do better,” says Amy McMichael, MD, a professor of dermatology at Wake Forest Baptist Medical Center in Winston Salem, NC. Dr. McMichael is currently conducting a retrospective study of 15 patients staged at beginning and end of treatment with intralesional Kenalog, topical steroids, +/- minoxidil. After treatment 33.3 percent had decreased severity scores, 53.3 percent had increased severity scores and 13.3 percent had no change in severity scores. “Counseling women on the dangers associated with some common hair practices must also take center stage,” she says. ■

The 13th Annual Skin of Color Society Symposium will take place in Orlando, FL on March 2 at the Hyatt Regency Orlando. For more information, visit skinofcolorsociety.org.