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DERMATOLOGICAL CONDITIONS IN SKIN OF COLOUR:

A Practical Guide for Healthcare Professionals

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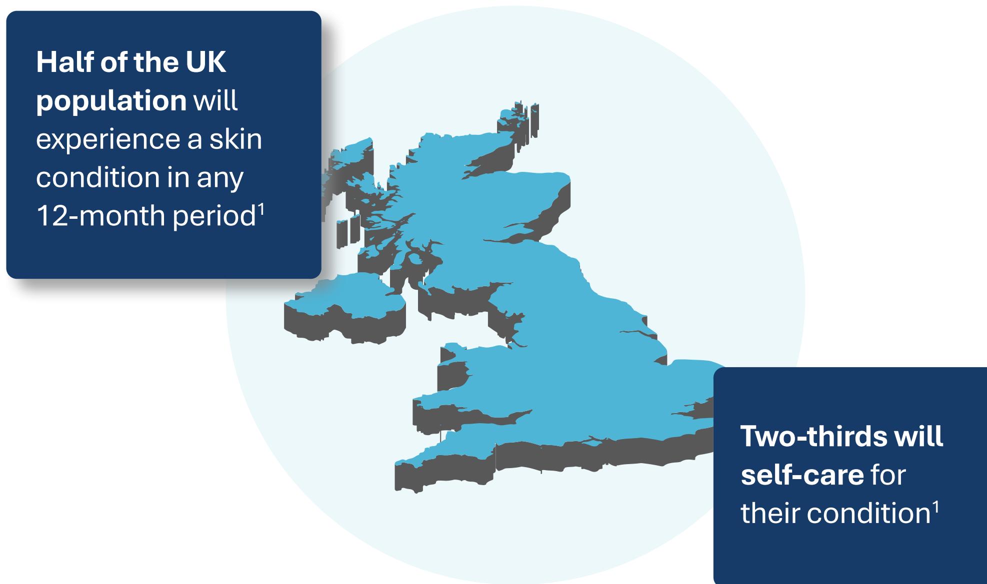
ALLIANCE

Introduction

Skin of Colour (SOC) is a broad term that refers to populations with skin tones darker than Caucasian.

It encompasses people from a wide range of racial and ethnic backgrounds, including those who identify as Black/African, Hispanic/Latina/o/x/e, Asian/Pacific Islander, Native American/Native Alaskan, Indigenous Australian, Middle Eastern, or biracial/multiracial.

Understanding the dermatological implications of SOC is critical in clinical practice. Approximately half of the UK population will experience a skin condition in any 12-month period, and approximately two-thirds will self-care for their condition.[1] However, many gaps have emerged regarding knowledge of conditions that occur in SOC populations, making recognition and appropriate management essential for healthcare professionals.



The clinical challenges

Identification

Many skin conditions are more difficult to identify in SOC populations due to differences in presentation.[2-6] The hallmark sign of inflammation, erythema, is often difficult to detect in darker skin tones, leading to underdiagnosis and delayed treatment.[3-6] Studies show that hospital admissions are up to six times higher in patients of colour,[4,6] highlighting the serious consequences of these diagnostic and treatment delays.

Educational gaps

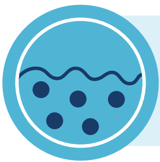
Racial bias in medicine is well documented, and teaching on dermatological conditions in SOC is significantly underrepresented in both medical education and research.[6-13]

- In a 2013 survey, almost half of dermatologists report they have not received enough training on treating skin disorders in patients with skin of colour.[14]
- A 2023 single-centre study revealed that medical students have lower diagnostic accuracy and confidence when observing photographs of skin conditions in darker skin tones, suggesting this might be a common occurrence across medical training.[15]
- Inadequate representation of different races and ethnicities remains a persistent problem in national and international clinical trials.[14,16]

These biases in teaching and training have contributed to delays in diagnosis and appropriate treatment in SOC, ultimately leading to greater morbidity and mortality.[4]

Physiological differences in Skin of Colour

Across skin colours, there are significant physiological differences that contribute towards the variation in presentation, severity, and outcomes of dermatological conditions.



Melanin production

Melanin is present in varying degrees within the human body and is responsible for eye, hair and skin colour.

Production of melanin is increased in SOC.[17] More melanin is protective against UV damage[17] but also predisposes to disorders of pigmentation, such as post-inflammatory hyperpigmentation or hypopigmentation and scarring, including keloid scarring.[2,18,19]

The skin barrier

In SOC there are physiological differences that can leave the skin barrier more vulnerable.[20]

Darker skin tones have a denser stratum corneum, reduced ceramide levels, and exhibit greater trans-epidermal water loss (TEWL).[20,21] These factors can contribute to dry skin, itchiness, and related conditions.

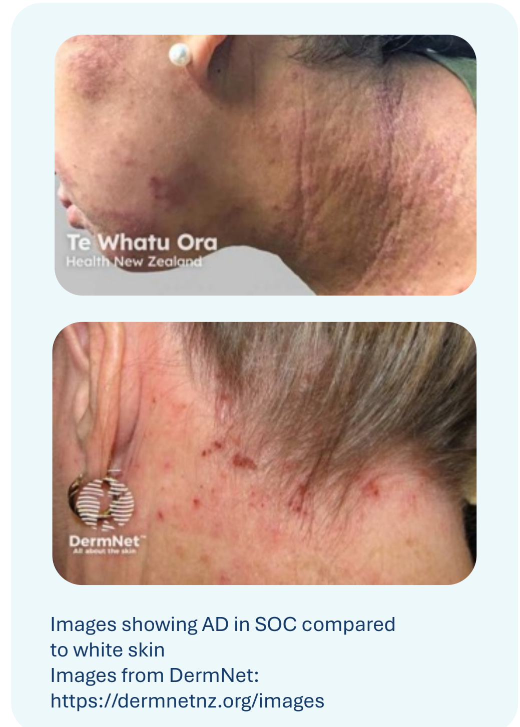
Hair follicles

Hair follicles play an important role in the absorption of treatments that are applied topically.[22]

Hair follicles in SOC have a smaller size and density, which may impact absorption of topical products, and are more prone to accentuation (inflammation).[22,23]

Atopic Dermatitis

Atopic dermatitis (AD), often referred to as eczema, is a chronic disease that causes inflammation, redness, and irritation of the skin.[24]



Images showing AD in SOC compared to white skin
Images from DermNet: https://dermnetnz.org/images

Clinical presentation in SOC

- Grey, reddish-brown, purple, or purplish-grey discolouration.[25]
- Reverse flexural pattern (affecting extensor surfaces rather than flexures).[26]
- Prominent hyperkeratosis and follicular accentuation.[27]
- Discoid or follicular patterns.[28]
- More severe pruritus leading to lichenification.[25]

Treatment approach

Emollients:
Recommended by NICE as the foundation of AD management.[29]

- Avoid products with urea, glycerine, or propylene glycol in those with sensitive skin such as Asian populations.[27]

Topical corticosteroids and calcineurin inhibitors:[27,30]

- Effective across all skin types but higher risk of hypopigmentation in SOC. Ensure adequate hydration with emollients, such as Hydromol are continued.[29,31,32]

Other treatment options that may be suitable include:

- Phototherapy, systemic treatments and targeted biologic therapies, however, there are limited data on biologic agents in patients with SOC.[27,30]

When to refer[33,34]

Refer for a routine dermatology appointment if:

- The diagnosis is, or has become, uncertain.
- Current management has not controlled eczema satisfactorily (for example the person is having one to two flares per month), or the person is reacting adversely to many emollients.
- Facial eczema has not responded to appropriate treatment.
- Treatment (application) advice is needed (for example bandaging techniques).
- Contact allergic dermatitis is suspected (for example if there is persistent eczema or facial, eyelid, or hand eczema). See the NICE CKS topic on Contact Dermatitis for more information.

- There is recurrent secondary infection.
- Eczema is assessed as causing significant social or psychological problems (for example sleep disturbance).

Refer to immunology, dermatology, or paediatrics if a food allergy is suspected and the expertise to diagnose and manage food allergy is not available in primary care.

Refer to a clinical psychologist, people whose eczema is controlled but whose quality of life and psychological well-being have not improved (this may not be directly related to the severity of the eczema).

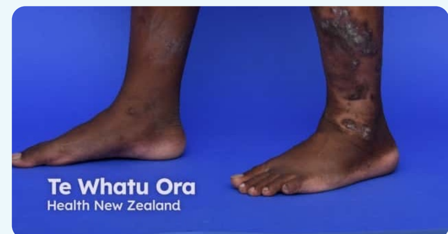
For more detailed information on AD diagnosis and treatment options, please refer to the CPD accredited Skin of Colour Learning Module on page 9

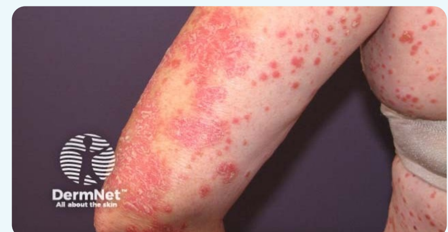
Psoriasis

Psoriasis is a chronic, immune-mediated inflammatory disease typically characterised by patches of raised abnormal skin.[35]

Clinical presentation in SOC

- Erythema may be absent or appear violaceous/dark brown.[36]
- Thicker plaques with increased scaling.[37]
- More widespread distribution.[36,37]
- Frequent scalp involvement in Asian and Black patients.[38]
- Active inflammation may be mistaken for post-inflammatory hyperpigmentation.[36]





Images showing psoriasis in SOC compared to white skin
Images from DermNet: https://dermnetnz.org/images

Diagnostic tips

Look beyond erythema for:[36]

- Nail abnormalities (pitting, onycholysis).
- Well-defined scaly plaques in typical distributions (scalp, extensor surfaces, intergluteal cleft).

Treatment approach

First-line excluding scalp and nail psoriasis:[39,40]

- Emollients, such as Hydromol, are recommended by NICE and PCDS as baseline therapy.
- Coal tar preparations.
- Once daily combination treatments (i.e. corticosteroid and vitamin D analogues).

For widespread unstable psoriasis of erythrodermic or generalised pustular types
Treat as a medical emergency with same-day specialist assessment.[41]

For more detailed information on psoriasis diagnosis and treatment options, please refer to the CPD accredited Skin of Colour Learning Module on page 9

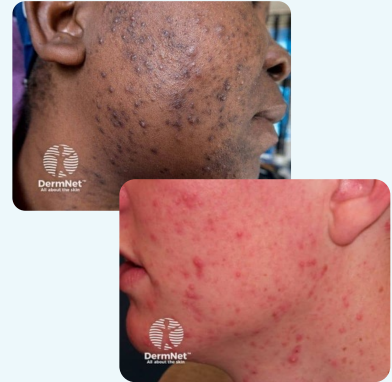
Acne Vulgaris

Acne is a common inflammatory skin condition[42] that affects individuals of all races and ethnicities,[43] with the highest incidence in the teenage population.[42]

Clinical presentation in SOC

While comedones appear similar across skin tones, key differences in SOC include:[44-47]

- Inflammatory lesions appear dark brown or purple rather than red.
- Post-inflammatory hyperpigmentation (PIH) is prominent and persistent.
- Higher risk of keloid scarring (jawline, chest, back).
- Pomade acne (from the use of oily hair products) is more common.



Images showing acne in SOC compared to white skin
Images from DermNet: https://dermnetnz.org/images

Treatment approach

Topical therapy: as an adjunct for severe acne and as a first-line monotherapy for mild-to-moderate acne:

- These include topical retinoids, azelaic acid and benzoyl peroxide, in addition to topical antibiotics.[46,48]
- NICE recommends 15-20% azelaic acid and topical retinoids for early treatment in SOC as this targets both acne and PIH simultaneously.[48]
- Topical retinoids, benzoyl peroxide and azelaic acid can cause dryness and irritation. Consider initially using less frequently and for shorter periods of time.[46]
- Emphasise daily sunscreen use to prevent further pigment darkening.[46]

Other treatment options:[46]

- Oral antibiotics, typically used with topical retinoids or benzoyl peroxide.
- Combination therapies e.g., combined retinoid and benzoyl peroxide/antibiotics.
- Systemic therapies for moderate-to-severe cases.
- Hormonal therapies for women (combined oral contraceptives, spironolactone).

Skincare advice:[46]

- Non-comedogenic moisturisers.
- Gentle cleansing.
- Sun protection is essential.

For more detailed information on acne diagnosis and treatment options, please refer to the CPD accredited Skin of Colour Learning Module on page 9

Rosacea

Rosacea is a common skin condition which frequently starts with an inclination to blush or flush easily, with a warm sensation on the face tending to persist over time and possibly becoming constant.[49,50] Rosacea is traditionally considered a condition of fair skin and is underdiagnosed in SOC.[51,52]

Images showing rosacea in SOC compared to white skin
Images from DermNet: https://dermnetnz.org/images

Clinical presentation in SOC

Classic flushing and erythema are difficult to detect. Look for:[50,52,53]

- Sensation of facial warmth.
- Dry, inflamed patches of darker skin.
- Dusky brown discoloured skin, usually in the centre of the face.
- Papules and pustules resembling acne.
- Yellowish-brown papules around mouth/eyes.
- Skin thickening on nose and medial cheeks (phymatous changes).

Diagnosis[52]

- A thorough patient history is necessary in SOC and patients should not only be screened for cutaneous symptoms but also ocular symptoms.
- Look for non-classic signs – dry skin, oedema, hyperpigmentation, also skin thickening on the nose and medial cheeks.
- Use a dermatoscopy to help identify telangiectasia (broken capillaries).

Treatment approach[52,54]

First-line therapy depending on phenotype and severity based on NICE guidelines:

Topical:

- Ivermectin for papulopustular rosacea.
- Oral propranolol for transient facial flushing.
- Brimonidine for persistent erythema.

Oral therapy:

- Oral antibiotics (in combination with topical ivermectin).
- Isotretinoin as second-line option.

Other options:

- Laser and light-based therapies can be effective but carry PIH risk.
- Surgical treatments.

Skincare advice:[52]

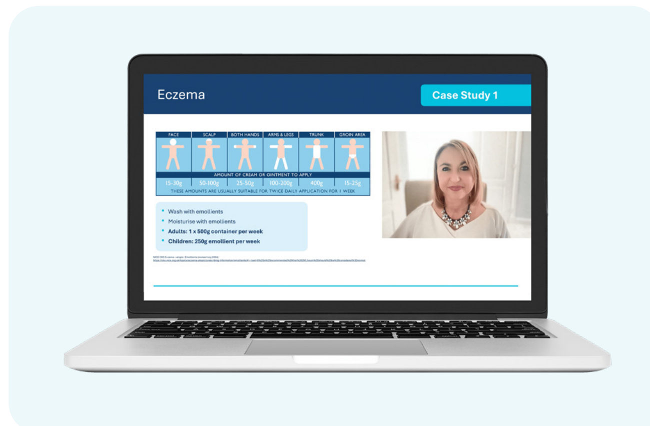
- Avoid harsh, alkaline soaps.
- Silicone-based moisturiser daily.
- Daily sunscreen (darker skin still requires sun protection).

For more detailed information on rosacea diagnosis and treatment options, please refer to the CPD accredited Skin of Colour Learning Module on page 9

CPD Certified Skin of Colour Learning Module

Available online at the Alliance HCP Academy

For more information on SOC, please visit our online CPD-accredited learning module on **Dermatological Conditions in Skin of Colour**, featuring Dr Catherine Fernando, a GP with a special interest in dermatology.



The complete module includes

- What SOC really means, and why it matters
- How SOC is underrepresented in research and education
- Key physiological and clinical differences between skin tones
- Condition-specific diagnosis tools for SOC
- Real-world case studies on a variety of dry skin conditions, including eczema
- Pre- and post-module quizzes to track your progress
- Downloadable summary infographic
- Certificate of completion and CPD credits

To access full content please register here or scan the QR code below.

Conclusion

Improving dermatological care for patients with SOC requires awareness, adjusted clinical skills and cultural sensitivity. While diagnostic challenges exist, understanding the physiological differences, varied presentations and treatment considerations outlined in this guide will help with diagnosis and treatment - playing a crucial role in reducing health inequalities and improving outcomes for all patients, regardless of skin colour.

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