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Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with top tips from experts about what they should know about specific, key subject areas by the time they complete their residency.

Eczematous diseases

Andrew F. Alexis, MD, MPH

1. Broaden your color palette when assessing eczema in richly pigmented skin types (skin of color).

Looking for shades of red in the background of richly pigmented skin can result in under-diagnosis or under-appreciation of the severity of eczematous disorders in skin of color. In this population, the "erythema" may look purple/violet, reddish-brown, or gray-brown.

References:

1. Kaufman BP, Guttman-Yassky E, Alexis AF. Atopic dermatitis in diverse racial and ethnic groups-Variations in epidemiology, genetics, clinical presentation and treatment. Exp Dermatol. 2018 Apr;27(4):340-357.

2. Calibrate your eyes when assessing erythema in higher skin phototypes.

To better assess the severity of erythema in skin of color (particularly in Fitzpatrick skin phototypes V and VI), I recommend "calibrating" your eyes by first assessing non-lesional skin and then comparing it to lesional skin. Taking a "delta" of the color differences helps to better appreciate the severity of erythema or hyperchromia in clinically active areas.

References:

1. Kaufman BP, Guttman-Yassky E, Alexis AF. Atopic dermatitis in diverse racial and ethnic groups-Variations in epidemiology, genetics, clinical presentation and treatment. Exp Dermatol. 2018 Apr;27(4):340-357.

3. When treating seborrheic dermatitis in women of African ancestry (whose natural hair is Afro-textured) be sure to design a regimen that is compatible with the patient's hair care practices.

Due to structural differences in the hair shaft as well as practical considerations pertaining to the length of time involved in hair washing and subsequent styling, hair washing frequency among black women tends to be less than in individuals with naturally straight hair (e.g. once weekly or once every two weeks on average). More frequent hair washing is not only time consuming and often impractical, but can also lead to hair dryness and fragility — especially with medicated shampoos typically prescribed for seborrheic dermatitis. Therefore, in my experience, recommending a medicated shampoo once weekly and then asking the patient if that frequency works well for them is a culturally sensitive way to approach this. Then, prescribing a "leave on" topical corticosteroid in a vehicle that the patient finds acceptable is important for treatment as needed throughout the week.

References:

1. Elgash M, Dlova N, Ogunleye T, Taylor SC. Seborrheic Dermatitis in Skin of Color: Clinical Considerations. J Drugs Dermatol. 2019 Jan 1;18(1):24-27.

4. Seborrheic dermatitis in skin of color can present with hypopigmented patches without visible scale.

Recognizing this sometimes subtle presentation is important. I like to differentiate it from vitiligo with a Wood's light during the initial examination. Looking for hypopigmentation in the typical seborrheic areas of the face including the palpebral area and medial cheeks is helpful when presented with a patient who complains of dry or sensitive skin on the face (including those that may report flaring after using topical retinoids or benzoyl peroxide agents for acne). The scale may me masked by moisturizers or simply not present at the time of clinical presentation, and erythema may not be seen. Treatment with topical calcineurin inhibitors or the topical PDE4 inhibitor crisaborole for 8-12 weeks typically results in resolution of the pigment change. Topical antifungal creams can be used as an alternative if the above are not covered.

References:

1. Elgash M, Dlova N, Ogunleye T, Taylor SC. Seborrheic Dermatitis in Skin of Color: Clinical Considerations. J Drugs Dermatol. 2019 Jan 1;18(1):24-27.

5. Sensitivities to specific contact allergens can vary in frequency by race or ethnicity.

This is likely due to differences in culturally determined exposure patterns rather than genetic differences. In a study from the North American Contact Dermatitis Group, positive patch tests to p-phenylenediamine occurred in 7.0% of blacks vs 4.4% in whites ($P<0.001$), whereas positive patch tests to fragrances occurred in 12.12% of whites vs 6.77% of blacks ($P<0.0001$). Other significant differences were found between groups.

References:

1. Deleo VA, Alexis A, Warshaw EM, Sasseville D, Maibach HI, DeKoven J, Zug KA, Belsito DV, Fowler JF Jr, Marks JG, Mathias CG, Pratt MD, Rietschel RL, Storrs FJ, Taylor JS, Zirwas M. The Association of Race/Ethnicity and Patch Test Results: North American Contact Dermatitis Group, 1998-2006. Dermatitis. 2016 Sep-Oct;27(5):288-92. DR

If you have suggestions for topics or content for Clinical Pearls, contact Dean Monti at **dmonti@aad.org**