COMMON GP PRESENTATIONS IN DIVERSE SKIN TYPES - BY DR DAMI JAGUN
A Summary

Introduction

- 24% of GP consultations are skin presentations
- Most common dermatological presentations in primary care
    - Eczema
    - Infections
    - Benign lesions
- Most common dermatological presentations in secondary care
    - Acne
    - Psoriasis
    - Skin cancer

Atopic dermatitis

- Chronic itchy inflammatory skin condition
- Risk factors
    - Family history of atopy
    - Environmental
    - Stress
    - Overheating
    - Irritating detergents
- With skin of colour in mind
    - There is an additional papular/ follicular eczema variant which is common in skin of colour
    - Skin of colour is more likely to get post inflammatory changes - hyperpigmentation, hypopigmentation, depigmentation
    - Pityriasis alba (hypopigmented ill defined macules or patches) are also common
    - Appearance of eczema is more mauve coloured in acute cases, and hyperpigmented in chronic cases
    - Lichenified eczema takes on a tree bark appearance on skin of colour
    - Erythrodermic eczema may be hard to see - ask what their normal skin colour is
- Management
    - Emollient and steroid
    - Wet wraps
    - Oral steroid for very severe cases

Psoriasis

- Chronic immune mediated inflammatory skin condition
- Interestingly absent in Eskimos and Australian Aboriginals
- Affects skin (extensor surfaces, intergluteal cleft), scalp, nails and joints
- Presentation in skin of colour
    - The erythema may be subtle
    - There may be hypochromic regions

- Management
    - Topicals - emollients, steroids, vitamin D analogues, coal tar, salicylic acid, retinoids
    - Phototherapy - PUVA, nbUVB
    - Systemics - methotrexate, acitretin, ciclosporin, fumaric acid esters
    - Apremilast

Acne

- Interestingly virtually absent in Kitvan Islands (Papua New Guinea) and Eastern Paraguay
- With skin of colour in mind
    - There is often subclinical inflammation - what appears as mild acne shows severe inflammation histologically
    - Post inflammatory hyperpigmentation and keloid scarring is common
- Management
    - Treat concurrent acne and post inflammatory hyperpigmentation - topical azelaic acids or retinoids

Pityriasis versicolour

- Chronic non contagious benign fungal skin infection
- With skin of colour in mind
    - In addition to the erythematous variant, there is a hypopigmented and hyperpigmented variant in skin of colour

Pityriasis rosea

- Acute self limiting rash thought to be due to HHV-6/7 virus, vaccination or drugs - starts as a macule or papule which expands to become a plaque with raised borders then a generalised rash after 1-2 weeks
- With skin of colour in mind
    - May appear grey or violaceous as opposed to rose or salmon coloured in lightly pigmented skin
    - Shows extremities predominance (with face and scalp being involved) as opposed to the truncal predominance in lightly pigmented skin
    - Central necrotic hyperpigmentation is common in skin of colour
    - There is an additional papular variant in skin of colour
- Management
    - Self limiting - consider emollients, oatmeal baths
    - Antihistamines or topical steroids if symptomatic

Seborrhoeic keratosis

- Benign neoplasms of the epidermis
- With skin of colour in mind
    - Almost always appears dark brown or black in richly pigmented skin as opposed to variety of colours in lightly pigmented skin (yellow, grey, skin coloured, brown, black)
- Management
    - Conservative management
    - Cryotherapy - risk of hypopigmentation in skin of colour
    - Curettage and cautery - risk of hypopigmentation in skin of colour
    - Electrodessication

<u>Longitudinal melanonychia vs nail melanoma</u>

- Longitudinal melanonychia
    - Pigmented band extending from the nail matrix to free edge of the nail due to active melanocytes - normal physiological variation where melanin production is greater than degradation
    - Presents in 50-90% of black individuals over 50
    - Management
        - Reassure and monitor with high quality photographs
- Nail melanoma
    - Thick pigmented band, usually single band, may extend into the skin
    - Hutchinson's sign is usually present
    - Has ABCDEF of malignancy - asymmetrical, irregular borders, irregularly pigmented, large diameter, changes over time

<u>Seborrhoeic dermatitis</u>

- Inflammatory condition that affects sebum rich areas of the body e.g. face, scalp, neck, upper chest and back
- Common in infants and adults
- Presentation varies from dandruff (uninflamed) to widespread greasy scaly rash
- May lead to erythroderma in severe cases
- With skin of colour in mind
    - Active plaques may be hypopigmented or hyperpigmented in skin of colour
    - There may be a papular or annular pattern in skin of colour
- Management
    - Infantile
        - Wash scalp with baby shampoo or emollient then use brush or fine toothed comb to remove scales
        - Consider clotrimazole 1% cream BD-TDS or miconazole 2% cream BD for up to 4 weeks
        - Consider hydrocortisone 1% OD-BD for up to 2 weeks
    - Adult seborrhoeic dermatitis
        - High fruit intake and stress reduction
        - Keratolytics for descaling e.g. salicylic acid
        - Antifungal shampoo or creams - rinse off after 5 minutes
        - Mild topical steroid or calcineurin inhibitor

Key Takeaways

- Skin presentations make-up ¼ of all GP consultations
- Many dermatological conditions present differently in skin of colour
- There may also be additional and specific complications in skin of colour

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Written by: Lamisa Ahmed , Ezigbo Iyamah, Vaseharan Suntharan and Dr Jagun

Common community (GP) presentations in diverse skin types - Dr Jagun