Top 5 Skin Diagnoses Vary by Ethnicity in Study

BY DAMIAN McNAMARA
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MIAMI — Unique structural and functional differences between the skin of black and white patients might help explain differences in the top five dermatology diagnoses for each ethnicity, according to study data presented at an international symposium sponsored by L'Oreal Institute for Ethnic Hair and Skin Research.

Prior to this study, the most recent survey of cutaneous diseases in black Americans was published more than 2 decades ago (Cutis 1983;32:388-90), said Dr. Amanda B. Sergay, a third-year dermatology resident at St. Luke's–Roosevelt Hospital Center in New York City.

Dr. Sergay and her associates, including principal investigator Dr. Andrew F. Alexis, retrospectively compared the diagnostic codes for 1,074 black and white patient visits treated at the Skin of Color Center at St. Luke's–Roosevelt Hospital Center, New York City, from August 2004 to July 2005. When ethnicity was unclear, the patient's own description was used.

Acne vulgaris was the most common diagnosis in both groups (ICD-9 code 706.1). "The pathophysiology of acne is not thought to differ between races or ethnicities," she said at the symposium, which was also sponsored by Howard University.

Acne and dyschromia (code 709.09) are so common that they accounted for almost 50% of black patient visits (Cutis, in press: November 2007). Black patients also were commonly diagnosed with contact dermatitis and other eczema, unspecified cause (code 692.9), alopecia (code 704.0), and seborrheic dermatitis (code 690.1).

After acne vulgaris, the most common diagnoses in white patients were a lesion of unspecified behavior (code 238.2), benign neoplasm of the skin of the trunk (code 216.5), contact dermatitis or other eczema, and psoriasis (696.1).

In black patients, dyschromia and alope-

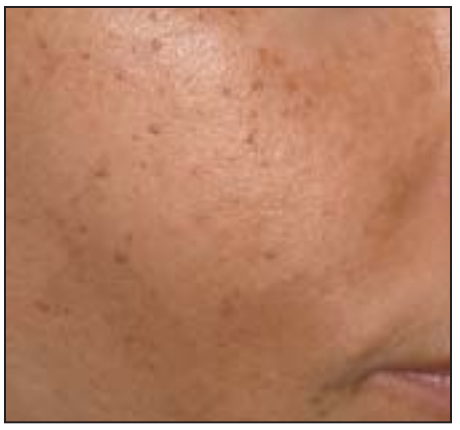
cia made the top-5 list, but they were not among the top 10 diagnoses for white patients, Dr. Sergay said. The dyschromia diagnoses included postinflammatory hyperpigmentation and melasma.

"Postinflammatory hyperpigmentation is a common sequela of cutaneous injury or irritation in skin of color," Dr. Sergay said. It can also result from pseudofolliculitis barbae, which is more common in black than in white patients because of structural differences in the hair follicle and shaft.

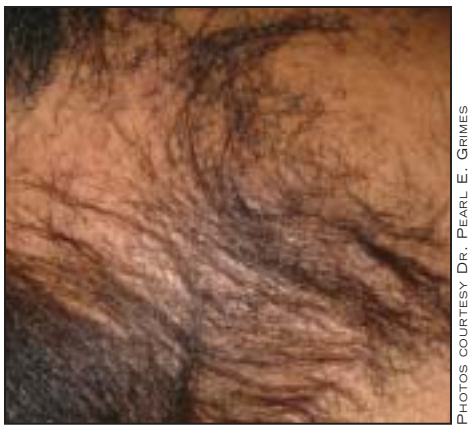
The higher incidence of alopecia in black patients could be partially explained by the fact that there are fewer elastic fibers in black skin to anchor hair follicles to the dermis (Dermatol. Clin. 1988;6:271-81). Chemical and physical hair care practices may also contribute to alopecia, as could the significantly lower total hair density and number of hair follicles in black patients, compared with whites (Dermatol. Clin. 2003;21:595-600; Arch. Dermatol. 1999;135:656-8).

Racial variations in skin physiology may also lead to differences in eczema prevalence, Dr. Sergay said.

The single-center source of information was a limitation of the study, as was potential selection bias from participating physicians, she said, adding that categorization of patient ethnicity by a physician or assistant is less reliable than self-reporting. ■



Melasma, a skin pigmentation disorder, manifests as dark spots on the face.



PHOTOS COURTESY DR. PEARL E. GRIMES

Blacks' skin physiology and hair-care practices make them prone to alopecia.

Few Seek Medical Advice for Problems Linked to Hair Care

MIAMI — Many black women experience adverse events and dissatisfaction stemming from their hair care practices, but few seek medical advice, results of a survey presented at an international symposium sponsored by L'Oréal Institute for Ethnic Hair and Skin Research indicate.

"A few years ago, I noticed scalp and hair conditions were a common complaint among black women in my practice," said Dr. Maria C. Rios, a clinical dermatologist in Montevideo, Uruguay. Physicians "need to recognize scalp and hair conditions associated with some procedures used by this ethnic group."

All 42 adult women (aged 18-60 years) surveyed used chemical or physical hair straightening techniques. Hair and scalp disorders occurred in 70% of respondents.

Following a physical examination and clinical photography, each woman completed a brief questionnaire, noting how satisfied they were with the ethnic or natural aspect of their hair, hair care practices, and any clinical presentations related to hairstyle management. The majority, 37 women, reported dissatisfaction with the ethnic aspect of their hair. A total of 26 reported a history of dermatologic lesions or other scalp/hair conditions.

Twenty women experienced irritant contact dermatitis after use of a chemical relaxer. Nine used a commercial brand and 11 used a product with "banana extract." Although participants reported great hair straightening results with banana extract, all who used it experienced stinging, burning, itchiness, flaking, and/or pain, Dr. Rios said at the meeting, which was also sponsored by Howard University.

Seven women reported scarring alopecia; five attributed the condition to chemical use, one to thermal hair treatment, and another to both practices. Three participants reported nonscarring alopecia related to their hair care.

One of the 26 women experienced allergic dermatitis after use of a chemical relaxer and hair dye at almost the same time, Dr. Rios said. A total of six women experienced burns, four from chemicals and two from hair ironing. A total of 16 women reported temporary hair loss and breakage. Interestingly, only four of these women sought medical advice.

—Damian McNamara