Skin diversity descriptors guidance for healthcare professionals document 1

This document is designed to provide guidance on describing skin conditions across a broad spectrum of skin tones.

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Skin diseases addressed: Acne vulgaris, atopic eczema, pityriasis rosea, lichen simplex chronicus, nodular prurigo, pseudofolliculitis barbae
Descriptions appropriate for: Healthcare professionals. Other versions can be found here.

Improving skin disease descriptors in dermatology

Describing rashes accurately is critical for making the correct diagnosis. In dermatology, the words used to describe rashes and lesions (meaning areas of skin affected by a skin disease) originated in Western Europe in the 18th century, at a time when dermatology was being established as a distinct medical speciality. Given the historical origins of dermatology, the descriptors that are currently routinely used for rashes/lesions are biased, catering mostly to people of European ancestry, with lighter skin tones. This presents significant challenges and limitations when these descriptors are used universally, applying to people from diverse geographic ancestral backgrounds, with a wide spectrum of skin tones. This spectrum of skin tones is far broader than currently recognised by commonly used classification systems.

For example, certain rashes/lesions are described as being ‘erythematous’ in colour. This refers to a symptom called ‘erythema’ (from the Greek for ‘red’), which is a change in colour of an area of skin, caused by increased blood flow in certain capillaries. Symptoms may even be described as ‘salmon-coloured’, for example, in psoriasis. Such descriptors are of limited usefulness when applied to individuals with darker skin tones, in whom redness may not be so easily appreciated or for whom colour may take on a different appearance.

It is therefore vital that the language used for describing rashes/lesions in dermatology is updated, to be inclusive and reflective of the UK’s ethnic diversity.

The British Association of Dermatologists (BAD) has assembled an international group of dermatologists, with extensive experience in treating people with darker skin tones (including Dr Ophelia E. Dadzie (UK), Prof Ncoza Dlova (South Africa) and Dr Antoine Petit (France)) to tackle this issue, with a view to updating current skin descriptors used in dermatology, with new descriptors that are applicable to all ethnicities. This document is part of this work.

FOR HEALTHCARE PROFESSIONALS			
Condition	**General Symptoms**	**What it looks like in richly pigmented skin**	**What it looks like in lightly pigmented skin**
Acne vulgaris	• Asymptomatic • May be painful (nodules, large pustules) • Some patients complain of itch (especially in richly pigmented skin) • Some patients may complain of hyperpigmented 'spots' and/or uneven skin tone (especially in richly pigmented skin)	Primary lesions • Comedones (closed and/or open), Hyperpigmented macules • Papules • Pustules • Nodules Colour • Skin-coloured, hypermelanised/ hyperpigmented • Erythema is difficult to discern Secondary changes • Excoriation • Hypermelanised/ hyperpigmentation • Scarring, including keloid/hypertrophic scars Distribution • Face, upper chest, upper back (seborrhoeic distribution) and also • Upper arms • Thighs & buttocks Comment • Steroid-induced acne • Pomade acne • In people of non-European ancestry, peculiar varieties of acne include steroid induced acne, occurring in the setting of misuse of skin lightening agents, and so called 'pomade' acne. The former presents as monomorphic papules and/or pustules primarily on the face, while the latter presents with the primary lesions of acne, however	Primary lesions • Comedones (closed and/or open) • Papules • Pustules • Nodules Colour • Erythematous Secondary changes • Excoriation • Scarring, including keloid/hypertrophic scars Distribution • Face, upper chest, upper back (seborrhoeic distribution) and also • Upper arms • Thighs & buttocks

		this is located predominantly on the forehead. In this setting, there is often a history of use of petrolatum-based products for greasing the scalp.	
Atopic eczema	• Itchy, dry, scaly and/or thickened skin • May also be weepy skin	Primary lesions • Patches & plaques with ill-defined borders and symmetrical distribution • In children of African descent, micropapular (known as “follicular”), lichenoid/psoriasiform or nummular patterns are classically frequent Colour • Variable degrees of dyspigmentation (both hyper and hypopigmentation) • Erythema is difficult to discern Secondary changes/ complications • PIH may last long after the eczema has cleared and be a source of concern for affected patients • Lichenification, crusting and scales are also features depending on the type of eczema, i.e. whether acute, subacute, or chronic Distribution • Cheeks, head and convexities in young infants, then typically flexural sites in older children and adults Comment • Changes in temperate climate • May be worse in summertime by hot weather	Primary lesions • Large patches & plaques with ill-defined borders and symmetrical distribution Colour • Variable degrees of redness (erythema) Secondary changes/ complications • Lichenification, crusting and scales are also features depending on the type of eczema, i.e. whether acute, subacute, or chronic Distribution • Cheeks, head and convexities in young infants, then typically flexural sites in older children and adults Comment • Changes in temperate climate • Usually worse in wintertime by dry, cold weather

Pityriasis rosea	• Often asymptomatic • Sometimes may present as mild to moderate pruritus/itch • The rash may also be preceded by a pre-eruptive phase with nonspecific manifestations, such as fever, headache and upper respiratory tract symptoms and arthralgia	Background • Usually adolescents or young adults • Topography/distribution • Mainly affects the trunk and proximal limbs. Lesions follow the lines of cleavage resulting in a 'Christmas tree' pattern at the back. "Herald patches": • Approximately 50% of patients describe a first stage with one or a few large 'herald' patches on the trunk or proximal leg • Followed a few days later by crops of new lesions Dimorphism • Two kinds of fine brown or dark brown lesions: large (#2 cm) annular oval patches with discrete squamous collarette and smaller papulosquamous lesions Colour • Skin coloured or brown • Erythema is difficult to discern Secondary changes/ complications: • It may heal with either PIH or hypopigmentation lasting for weeks or even months Comment • Disease spontaneously heals over weeks (8-12 weeks) • Recurrence rate is low (approximately 4%) • The erythematous or rosy colour is not evident in darker skin tones and hence the term pityriasis rosea is	• As per richly pigmented skin, however lesions are erythematous, usually with a pink hue

		not relevant nor descriptive in dark skin • There may be other variants – so-called atypical forms. Published literature suggests these atypical forms may be more common in richly pigmented skin-like profuse micropapular, vesicular, facial involvement, inverse type.	
Lichen simplex chronicus	• Unremitting itchy, thickened skin	Primary lesions • Patches or plaques • Lichenification (thickening) of the skin is a prominent feature, with accentuation of skin markings • It may be associated with nodules or papules depending on the chronicity Colour • Usually hyperpigmented; patches of achromia may occur after excoriations due to scratching the skin. • Erythema is difficult to discern. • If it occurs in genital area the lesions may appear white and macerated due to moisture. Secondary changes/ complications • Variable degrees of dyspigmentation, i.e. hyperpigmentation, may be observed as part of post inflammatory hyperpigmentation (PIH), as well as post-erosive hypopigmentation Distribution • Any part of the skin may be affected	• As per richly pigmented skin, but erythema may be more visible compared to darker skin

Nodular prurigo	• Unremitting itchy skin	Primary lesions • Nodules, papules • (Firm lichenified and dome-shaped) Colour • Usually, hyperpigmented may be skin coloured and achromic in the centre after excoriation • Erythema is difficult to discern Secondary changes/ complications • Some may be excoriated and infected (please note that nodular prurigo is rarely superinfected compared to eczema) Distribution • Any site	• As per richly pigmented skin, but erythema may be more visible compared to darker skin
Pseudofolliculitis barbae	• Asymptomatic • Itchy and/or burning, pustules or excoriations • Often within 24-48 hours of shaving • Spots in the beard region	Primary lesions: • Perifollicular papules • Papules or pustules with embedded hairs may be seen with close inspection Colour • Skin coloured, brown, or dark brown • Erythema is difficult to discern Secondary changes • Hypermelanised/ hyperpigmentation • Scarring, such as hypertrophic, keloid scars • Infection-pustules, crusting Site • Beard region-specifically lower face, submental and anterolateral neck regions • Spares areas involving upper lip region	• As per richly pigmented skin, however primary lesions are erythematous and post-inflammatory hyperpigmentation is not a prominent feature

		Comment • May develop in other areas of body often shaved- axillae, pubis, legs, groin, scalp (occipital scalp- • folliculitis (acne) keloidalis nuchae)	