Our Dermatology Online

Case Letter

Cultural and aesthetic considerations in patients with skin of color

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Sir,

Culture is influenced by the prevalent art, customs, religion and social institutions in an environment. As the population continues to evolve, the world is becoming more multicultural and, vice versa, cultures are becoming more multiethnic. By the year 2050, approximately 50 percent of the US population will be people with skin of color, demonstrating the importance of cultural sensitivity and awareness on the lives of our patients [1].

Religion is a significant component of cultural practice. For example, Muslim women who wear headscarves require a private establishment for their haircuts. These establishments are far and few in Western countries, and most Muslim women therefore develop expertise in cutting and styling their hair at home. As hair stylists are often the scouts for abnormal hair loss and complications of daily styling, such as traction alopecia, early stages could therefore be missed resulting in late presentation to a dermatologist and subsequently, irreversible scarring. The same applies to men wearing turbans.

In patients of African descent, certain hairstyles such as braiding and cornrows are practiced from childhood. Caregivers experience unnecessary judgement if their child's hair is deemed 'messy', resulting in braids often being done too tight. With these repeated insults, patients are predisposed to traction alopecia and possibly central centrifugal cicatricial alopecia (CCCA) [2]. Alternatively, chemical relaxers have been found to be associated with the development of uterine cancer in the postmenopausal population [3].

East Asians have a more prevalent culture of wearing sun-protective clothing compared to Asian Americans [4]. This leads to implications in research as studies examining skin cancer in East Asia may not reflect the lifestyles and risk of Asian Americans, thus underestimating the frequency in the latter. Regarding sunscreen and many cosmetic therapies, Hispanics/Latinx represent the "heaviest buyers" in skincare yet many feel underrepresented in the media [5]. Additionally, there is room for growth in the formulation of sunscreens for patients with skin of color as the absence of a residue, low price and suitable SPF and broad spectrum coverage are important factors for patients [6].

It is always an important reminder to keep an open mind and ask a patient to identify their most important concern. A woman wearing a Niqab may have multiple cosmetic concerns but her most important may be the lifting of the brows, the presence of tear troughs, or the health of the hands and nails, as these are the areas seen by most of the people that she interacts with. The psychosocial impact and stigmatization of skin conditions in different communities is also important to remember. While the scientific research and cultural awareness towards vitiligo is increasing, in South Asian communities, it is still unfortunately associated with significant ostracization. The role of psychodermatology should therefore be addressed in these consultations with a low threshold for psychiatric referrals.

The structural competencies that influence the social determinants of health also need to be heeded. Factors such as transportation, housing instability, and the distribution of how skin diseases present in

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different skin types all affect the care that is provided to patients. For example, patients living in highly segregated communities were significantly associated with a higher odd of developing atopic dermatitis [7]. Different measures to address these inequities include redistribution of resources to directly and indirectly increase the accessibility of care to underserved populations. Direct measures include establishing clinics in underserved communities, and indirect measures include standardized skin of color training throughout residency programs.

In conclusion, cultural competence is increasingly mandated in the context of dermatology consultations and should be compounded by cultural humility to address the lifelong dynamism of identities and eliminate our own implicit biases.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

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