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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Closing the Gaps in Atopic Dermatitis: Screening & Diagnosis in Patients with Skin of Color

Announcer:
Welcome to ReachMD. This medical industry feature titled, Closing the Gaps in Atopic Dermatitis: Screening & Diagnosis in Patients with Skin of Color, is sponsored by AbbVie US Medical Affairs.

Personal opinions and thoughts are Dr. Shi's own. Dr. Shi serves as a paid consultant for AbbVie.

Dr. Vivian Shi:
Atopic dermatitis, or AD for short, is one of the most common chronic inflammatory skin diseases in America.
It has a U.S. prevalence rate of 12 percent among children and 7.2 percent among adults.[3,4]

AD prevalence also varies according to ethnic and racial backgrounds, affecting a disproportionately larger percentage of African American and Asian American patients compared to European American patients.[5,6]

This disease is frequently associated with allergic and non-allergic comorbidities.

Inflamed skin causes itching, pain and discomfort, which can impact sleep quality and create emotional burdens of the disease that can lead to anxiety and depression.[7] Patients with AD may also be at risk of skin-related infections[1,2], lymphoproliferative malignancies[2], cardiovascular and metabolic disorders[2], autoimmune diseases[3,8], gastrointestinal issues[2,9], and bone and joint complications.[9]

Food allergy[1], asthma[1,2], allergic rhinitis[1,2], and eosinophilic esophagitis are the most common comorbidities in the atopic family.

In addition to the occurrence of comorbidities, other psychosocial, economic, and lifestyle factors can also add to the overall burden of living with AD.

On the surface, the cycle between itching, consequent scratching, and exacerbations from this disease may cause bleeding, oozing, cracking, flaking, and drying, which can worsen an already defective skin barrier and lead to significant pain and discomfort.[10]

But diving a little deeper, patients with AD may also struggle with numerous psychological and socioeconomic impacts of the disease, such as mood and sleep disorders, increased risk of hospitalizations, and worsening sense of overall well-being. And this can be a cascade into broader-reaching burdens for patients such as magnified healthcare costs[11], impaired productivity at work or school[10,11], diminished relationships[10], and several other quality of life impacts.[10,11]

AD-associated itch scratch cycle is not only burdensome in itself, but it can be a trigger for many other AD-related consequences. And that makes successful treating a priority in managing of AD.

But like many other diseases, effective treatment requires an appropriate diagnosis. And this can be challenging in AD because this skin disease has a heterogeneous presentation and distribution.[3]

As we know, AD lesions can affect many parts of the body, including the face, neck, arms, hands, legs, and feet. The classical presentation includes pruritus, eczematous lesions, and dry skin of the flexural surfaces, including creases of the elbow, knees, wrists,

and ankles.[12]

But the diagnostic challenges go beyond AD lesion distribution. There are other significant barriers that we need to take into account, namely:

- access to care for AD patients,
- recognition gaps in the unique presentations of the disease, and
- underestimation of disease severity, all of which may contribute to inadequate treatment.

Likewise, for racial and ethnic minorities, there are additional factors contributing to misdiagnosis of AD, including:

- common under-representations of these patient populations in research studies, as well as
- nuances in AD presentation for non-white ethnic groups that are largely overlooked in the literature.

Taken together, these challenges may lead to underdiagnosed and misdiagnosed disease for people of color, which is enormously impactful when we recall the higher prevalence rates in AD in African American and Asian American patients.

So let's examine some of the key differences in presentation that can be overlooked, starting with "erythema" which presents differently in more pigmented skin compared to fair skin.

In fair skin, this is usually identifiable by reddish or pinkish lesions.

However, erythema in darker patients can appear violaceous and may be missed completely. Additionally, darker skin has a higher risk of post-inflammatory dyspigmentation.[5]

In Asian skin, erythema may appear purple, brown and bruise-like rather than the salmonish colored erythema seen in white skin.

When looking for signs of Atopic Dermatitis in patients with skin of color, particularly in darker skin tones, look for potential lichenification or skin thickening, accentuation of skin lines, or excoriation.[5] Patients may also present with perifollicular accentuation, scattered and distinct papules, known as papular eczema. Other common AD features in darker skin types include diffuse xerosis, Dennie-Morgan lines, hyperlinearity of the palms, prurigo nodularis, and post inflammatory dyspigmentation.[5]

In Asian patients, the main clinical characteristics of AD include well-demarcated lesions, scaling, lichenification, and histologic characteristics include epidermal hyperplasia, frequent hyperkeratosis, and greater acanthosis.[5] These clinical and histologic features are similar to the presentation of psoriasis in white individuals.

Awareness of these key differences in clinical presentation across ethnic and racial groups is an important step in to helping to improve our diagnosis and treatment of this disease and reducing its many burdens on our patients.

Announcer:
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