

Editorial

Ethnic dermatology

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We, as Muslims, have a very clear concept about the origin of races as Allah Almighty in His Holy Book Quran says, “O mankind, we have created you from a male and a female and made you races and tribes, that you may know one another; the noblest among you, in the sight of God, is the one most God fearing of you; God is knowing, Aware (Ch. 49, Verse 13). The concept of human races was first developed in the 18th century to help understand evolution and human variation. Anthropologists, based on genetic data, propose the ‘single origin model’ of *Homo sapiens* evolution.¹ The diversification into the three major races i.e. Negroid, Caucasoid and Mongoloid, each with distinctive characteristics of skin and hair – occurred about 110,000 to 40,000 years ago. The Skin Phototype (SPT) system has been used classically by dermatologists to categorize all people (from type I to VI), including those with pigmented skin. This system, developed by Fitzpatrick, is based on the reactions or vulnerability of various types of skin to sunlight and ultraviolet radiation (UVR).² At one end of the spectrum are persons with oculocutaneous albinism and SPTs I and II who have limited tanning potential. On the other hand of spectrum are SPTs IV to VI who have full tanning potential without sunburn.

People with skin of color constitute a wide range of racial and ethnic groups - including Africans, African Americans, African Caribbeans, Chinese and Japanese, Hispanics and certain groups of fair-skinned persons (e.g. Indians, Pakistanis, Arabs) [Figure 1]. The majority of these people can be categorized as SPTs IV, V and VI. An individual with an olive skin tone, also characterized as beige or lightly tanned, is classified as having type IV skin; those with brown skin as type V; and black skin as type VI.^{2,3}

Ethnic differences in skin properties may explain racial disparities seen in dermatologic disorders and provide insight into appropriate differences in the management of these disorders. However, these differences have not been widely investigated by objective methods and the data are often contradictory. On the basis of available literature so far, few definitive conclusions can, however, be made about racial and ethnic differences in skin structure, physiology, and dermatologic disorders. These include differences in epidermal melanin content, melanosome dispersion, hair structure, fibroblast and mast cell size and structure in people of color compared with fair-skinned persons.⁴⁻⁷ These differences could at least in part account for the lower incidence of skin cancer and a lower incidence and different

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Figure 1 People from different ethnic (racial) groups

presentation of photoaging in certain people of color compared with fair-skinned persons.⁸⁻¹⁰ On the other hand, a higher incidence of pigmentation disorders and of certain types of alopecia in people with skin of color compared with those of other ancestry may also be explained logically.^{11,12}

These differences, which emerged during the latest stages of evolution, could probably be the result of both genetic and environmental factors.³ However, these biologic or genetic factors are not the only ones impacting, cultural practices also can have a significant influence and can be associated with certain dermatological disorders. Despite these acknowledged differences, racial classifications are more or less arbitrary. Furthermore, variation between individual members of a racial or ethnic group may at times assume greater importance than interracial variation in its impact on health and disease.^{3,4,7}

In clinical practice, acne and eczema are generally the two most common disorders in dark populations followed by pigmentary disorders and alopecia. Alopecia is largely attributed to cultural hair-grooming techniques. Among pigmentary disorders, postinflammatory hypopigmentation is a

common complication seen in skin of color from numerous inflammatory diseases i.e. seborrheic dermatitis, pityriasis alba, atopic dermatitis, irritant and allergic contact dermatitis, sarcoidosis, lichen striatus, secondary syphilis, tinea versicolor, diaper dermatitis, and discoid lupus. Hypopigmentation has been described from contact with phenolic detergents.¹⁰⁻¹⁴

Medical and surgical therapies may be different in non-Caucasian populations for diseases of skin and hair than in Caucasian populations. Newer treatment modalities such as lasers require knowledge of proper parameters as well as knowledge of adverse reactions in darker skin.^{4,15} Eighty percent of the world's population consists of individuals with pigmented skin. Darker skin differs from Caucasian skin in its reactivity and disease presentation. Although some research to enhance understanding of ethnic skin has been undertaken, significant work remains to be performed in the area of ethnic skin disorders to properly manage dermatoses in the non-Caucasian population.

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Manuscript Submission

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