As a multicultural society, the UK has a diverse population with a range of skin colours and hair types. Consequently, nurses must be able to complete a physical skin assessment of all skin types, irrespective of colour. Joseph Manning explores the ways in which patients with dark skin and dermatological disorders present with different clinical signs to those with light skin.

The nursing assessment for patients with dark skin and a dermatological disorder is also described

**KEY WORDS**
- Dark skin
- Dermatology
- Assessment

The UK has a multicultural population with a range of skin colours and hair types. Dermatological disorders affect up to 33 per cent of the population, and cause severe problems for about 10 per cent of cases (All Parliamentary Group on Skin, 1997).

The detrimental effects of dermatological disorders include social isolation and stigma (Lewis-Jones, 2000). In order to minimise these negative effects it is important that patients are assessed and diagnosed efficiently and with compassion so that they can be treated appropriately.

Many dermatological disorders that affect people with light-coloured skin also affect people with dark skin. However, some of these diseases present differently or ‘atypically’ in a patient with dark skin (Lang, 2000). It is important that nurses are aware of these differences when they assess patients.

**How to assess a patient who has dark skin and a dermatological disorder**
The patient is assessed in the same way as any other. The assessment provides a basis for the diagnosis, management, and nursing care the patient will receive.

The assessment is holistic because it is imperative when planning care that the needs of the whole person are taken into account. For example, it is important to consider cultural factors associated with exposing the patient’s skin.

It is evident from clinical practice that there are very few skin assessment tools that take the colour of the skin into consideration. However, tools can be adapted to meet the needs of the patient.

It is crucial to understand and use the correct terminology to describe lesions on the skin (Table 1). This ensures that the assessment can be interpreted and understood by all health care professionals and provides a standard language for documentation.

**The nursing assessment** This comprises four main areas (Lawton, 2001): 
- A detailed history of the patient’s skin condition. This should include information on its duration, occurrence, and any variations;
- A general assessment of the patient. This identifies data about her or his state of mind, physical abilities, cultural needs, and physiological status. This information will have implications for the patient’s care plan and will highlight any other conditions she or he may present with;
- An assessment of the patient’s knowledge. This gives an indication of what the patient knows about her or his dermatological disorder;
- A specific physical assessment of the skin and hair. This provides essential information about the dermatological conditions that are present and the treatment that is required. Hair type is related to race and this also needs to be considered. For example, Afro-Caribbean hair can be easily damaged by heat and chemicals.
Physical assessment of the skin It is important when carrying out an assessment to make physical contact with the patient. By touching, you will be able to feel the texture and temperature of the skin. You will also begin to break down the physical isolation the patient may feel because of her or his condition (Lawton, 2001).

Key areas that need to be considered when carrying out a specific physical assessment of a patient with dark skin include coloration, shape and distribution, and the character of the dermatological disorder.

- **Coloration** Colour is the main area in which dermatological conditions present differently in dark-skinned patients. Therefore, when a dark-skinned patient presents with a skin disorder, the assessment of the colour of the affected skin must be meticulously carried out.

  For example, lesions that appear red or brown on light skin (Fig 1), often present as black or purple on dark skin (Fig 2). It is important that the assessment is carried out in good natural light (Lawton, 2001; Lawrence and Cox, 1993) to avoid any alteration of the colour that may occur under synthetic lighting.

  It can be helpful to start with an examination of an area of the body that is of normal colour and not affected by the dermatological disorder. This will be useful for the purposes of comparison and will help to highlight any abnormal coloration.

- **Shape and distribution** The shape of the area or lesion must be defined. It is important to describe whether the lesion is large or small, what formation it is in – for example, in a circle (annular) or in a line (linear) – and whether the lesions are raised or flat. The location of the dermatological condition on the body must be noted.

<table>
<thead>
<tr>
<th>NAME</th>
<th>PRESENTATION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macule</td>
<td>A flat, circumscribed area of altered skin colour: brown, red, or white</td>
<td>Pityriasis versicolor</td>
</tr>
<tr>
<td>Papule</td>
<td>Small, elevated, palpable, circumscribed, usually &lt;5mm in diameter</td>
<td>Scabies</td>
</tr>
<tr>
<td>Nodule</td>
<td>Elevated, palpable, firm, circumscribed, and &gt;5mm in diameter</td>
<td>Erythema nodosum</td>
</tr>
<tr>
<td>Plaque</td>
<td>Elevated, palpable, flat-topped, rough, superficial papule that is</td>
<td>Psoriasis</td>
</tr>
<tr>
<td></td>
<td>&gt;2cm in diameter. Papules can coalesce to form plaques</td>
<td></td>
</tr>
<tr>
<td>Wheal</td>
<td>Elevated, irregular area of cutaneous oedema: red, pale pink, or white</td>
<td>Urticaria</td>
</tr>
<tr>
<td>Vesicle</td>
<td>Elevated, circumscribed, superficial fluid-filled blister that is &lt;5mm in</td>
<td>Herpes simplex</td>
</tr>
<tr>
<td></td>
<td>diameter</td>
<td></td>
</tr>
<tr>
<td>Bulla</td>
<td>Vesicle that is &gt;5mm in diameter</td>
<td>Bullous pemphigoid</td>
</tr>
<tr>
<td>Pustule</td>
<td>Elevated, a collection of pus</td>
<td>Impetigo</td>
</tr>
<tr>
<td>Scale</td>
<td>Thickened, flaky exfoliation, irregular, dry/oily. Silver, white, or tan in colour</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Crust</td>
<td>Dried serum, blood or purulent exudate, slightly elevated, variable size</td>
<td>Impetigo discoid</td>
</tr>
<tr>
<td>Excoration</td>
<td>Loss of epidermis caused by scratching</td>
<td>Atopic eczema</td>
</tr>
<tr>
<td>Lichenification</td>
<td>Rough, thickened epidermis, accentuated skin markings due to scratching</td>
<td>Lichen simplex</td>
</tr>
</tbody>
</table>

(Adapted from Lawton, 2001; MacKie, 1991)

**REFERENCES**


**FACT FILE WOUND CARE SUPPLEMENT**

This article was produced with assistance from the British Dermatological Nursing Group
documented. This will identify whether the condition is specific to a certain area or generalised across the body and will give clues to the cause.

**Condition and character** The affected area must be inspected in order to identify the type of lesions present (Table 1). Each disorder or condition is unique and may consist of several types of lesions. It is essential to state whether all of the lesions are the same (monomorphic) or whether there are several types of lesion (polymorphic).

**Key differences when assessing dark skin** The most obvious way that dark skin differs from light skin is change in pigmentation. These can be categorised into three groups: normal variants, primary conditions, and secondary conditions (Table 2). Normal variations in pigmentation include demarcation lines, which are areas of hyperpigmentation (a darkening of the skin), and changes in nail or oral pigmentation, which can include the formation of longitudinal dark bands in the nail plate (Lawrence and Cox, 1993).

**Documentation** All findings must be documented clearly using appropriate terms and highlighted on a body plan (Lawton, 2001). It is important to document on the body plan any other findings such as scars, demarcation lines, or amputations (Lawton, 1998).

**Evaluation of treatments** Before treating a patient’s dermatological condition it is important to consider the implications of the treatment. It is especially important to consider the effects that the treatment will have on skin pigmentation. Certain treatments may have adverse effects causing hypopigmentation (a lightening of the pigment of the skin) or hyperpigmentation.

For example, hypopigmentation can be caused by steroid injections, and the use of psoralens and oestrogens can result in hyperpigmentation. Both are highly noticeable on dark skin and this can have detrimental effects on the patient (McMichael, 1999).

Similarly, certain types of hair can be affected by some treatments. Afro-Caribbean hair is susceptible to chemical and heat damage. It is important that the patient is fully informed of the type of treatment, what it entails, and the effects it may have on hair and skin.

**Conclusion** There are key differences in presentation of dermatological disorders in dark skin as opposed to light skin. Health professionals must be aware of the differences in dark-skin pigmentation and hair types, normal changes in dark skin, and changes in colour and presentation associated with dermatological disorders.