Atopic Dermatitis in Skin of Colour

A quick-reference guide based on the HealthCert Education webinar presented by Dr Stephanie Rea, in collaboration with CeraVe. **Watch replay >**

At a glance

Atopic dermatitis (AD) can look very different in skin of colour. Reliance on the "classic" red, flexural eczema pattern may lead to under-recognition, delayed diagnosis, and undertreatment.

The key clinical challenge: In darker skin types, inflammation is often less visibly erythematous and may instead present with:

- Hyperpigmentation or hypopigmentation
- Follicular papules
- Papular or discoid (nummular) eczema
- Lichenification (skin thickening)
- Extensor rather than predominantly flexural involvement

The key management principle: Restore the skin barrier early and consistently through appropriate skincare and emollient use, alongside anti-inflammatory treatment when required.

Why it matters

Atopic dermatitis is not simply a cosmetic condition.

Patients with skin of colour may experience:

- Significant itch and sleep disturbance
- Reduced quality of life and self-esteem
- Social stigma related to visible skin changes
- Increased risk of secondary bacterial infection
- Long-term pigmentary changes following inflammation

Early recognition and treatment can reduce both disease burden and complications.

Clinical clues: How AD may present differently

Don't rely on redness alone

Inflammation may appear:

- Brown, violaceous, or hyperpigmented rather than bright red
- Subtle despite significant symptoms
- Difficult to appreciate visually without considering history and morphology

Common morphologic patterns

Follicular eczema

- Small follicular papules
- Often more prominent in darker skin types

Papular eczema

- Multiple itchy hyperkeratotic papules
- May occur on the trunk, flexures, or extensor surfaces

Lichenified eczema

- Thickened skin with exaggerated skin markings
- Often reflects chronic scratching and the itch-scratch cycle

Pityriasis alba

- Poorly defined hypopigmented, slightly scaly patches
- Commonly seen in children
- Frequently mistaken for fungal infection

Discoid (nummular) eczema

- Coin-shaped, scaly plaques
- Can be intensely pruritic and frequently secondarily infected

Practical diagnostic tips for GPs

Ask yourself:

- Is the patient describing significant itch despite minimal visible redness?
- Are pigment changes masking active inflammation?
- Is chronic scratching causing lichenification?
- Could this be a morphologic variant of eczema rather than another diagnosis?

Consider important differentials

Depending on presentation, consider:

- Tinea
- Lichen planus
- Lichen nitidus
- Scabies
- Folliculitis
- Cutaneous T-cell lymphoma (particularly in older adults with new-onset eczema)
- Drug eruption

Management pearls

Prioritise barrier repair

Barrier dysfunction is central to AD.
Recommend:

- Soap-free cleansers
- Fragrance-free products
- pH-neutral skincare
- Regular emollient use, even when skin appears clear

Emollient adherence matters more than perfection

Patients are more likely to use products they find acceptable.

- Creams and lotions may be preferred in warmer climates
- Ointments may provide greater moisturisation but are not always acceptable to patients
- The "best" moisturiser is often the one the patient will use consistently

Consider ceramide-containing moisturisers

Ceramides help restore barrier function and may:

- Reduce transepidermal water loss
- Improve skin hydration
- Support recovery of the damaged epidermal barrier

Watch for infection

Be alert for:

- Oozing or crusting lesions
- Rapid worsening of eczema
- Secondary bacterial infection, particularly Staphylococcus aureus

For highly inflamed, crusted lesions:

- Consider skin swabs (MC&S)
- Treat infection promptly
- Escalate anti-inflammatory treatment as clinically indicated

When to refer

Consider dermatology referral when:

- Diagnosis is uncertain
- Disease is moderate-to-severe
- Symptoms remain uncontrolled despite appropriate topical therapy
- Frequent infections occur
- Systemic therapy may be required

Key message

> In skin of colour, atopic dermatitis is often more recognisable by its morphology, pigmentation changes, and itch than by erythema. Maintaining a high index of suspicion, recognising common variants, and prioritising barrier repair can substantially improve outcomes for patients.

Next steps



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