Skin cancer is the most common form of cancer in the United States. Although skin cancer is less common in persons of color than in Caucasians, the rates of morbidity and mortality associated with skin cancer often are significantly greater in darker-skinned ethnic groups. This article reviews special considerations in the approach and management of nonmelanoma skin cancer in patients of color.

Basal Cell Carcinoma (BCC)

The classic presentation of a solitary pearly papule with rolled borders and central ulceration may occur in persons of color, but pearly borders and surrounding telangiectasia may be difficult to appreciate in darker skin tones (Fig. 1). Although BCC does occur in sun-exposed areas; in skin of color, it is seen with increasing frequency at nonsun-exposed sites and often presents in an atypical manner, making diagnosis challenging. Physicians should therefore consider taking a biopsy of any suspicious or nonhealing lesion in persons of color. Histologically, pigmented BCC occurs more frequently in persons of color. The differential diagnosis of BCC in persons of color includes blue nevus, seborrheic keratoses, lupus erythematosus, trauma (curling iron burn), sarcoid, and nevus sebaceous (Fig. 2).

Studies have documented the correlation of BCC in African Americans to UV light exposure; however, persons of color often have a false sense of security with regard to awareness of skin cancer risk and tend not to follow sun-protection guidelines proposed in skin cancer campaigns aimed at high-risk patients. Persons of color also have an increased incidence of medical conditions, such as diabetes, hypertension and lupus, necessitating the use of photosensitizing medications. These combined factors support the need for better counseling, patient education, and perhaps a distinct skin cancer awareness campaign directed toward skin of color.

Squamous Cell Carcinoma (SCC)

SCC is the most common cutaneous malignancy in African Americans and the second most common cutaneous malignancy in Caucasian, Japanese, and Chinese patients (BCC being the most common NMSC in the latter). Although actinic keratoses, the precursor lesions to SCC, are seen commonly in Caucasians and Japanese patients, they tend not to occur in African Americans. SCC, which occurs in sun-exposed and nonsun-exposed areas with equal frequency in Caucasians, is 8.5 times more likely to occur in nonsun-exposed areas of African Americans, in areas such as the
lower extremity and anogenital region,\textsuperscript{18,19} suggesting that UV radiation plays less of a role in the development of SCC in African Americans. Mortality rates of African Americans with SCC are as high as 29\% and may be related to delayed diagnosis of tumors in nonsun-exposed areas as well as potentially more biologically aggressive tumors.\textsuperscript{20} Although Bowen disease (SCC \textit{in situ}) is less common in African Americans (Figs. 3 and 4), it often occurs on the lower extremity as a hyperkeratotic plaque.

Risk factors for SCC in persons of color include chronic inflammatory and scarring processes, such as lupus, radiation sites, burn scars, hidradenitis suppurativa, and cutaneous ulcers.\textsuperscript{14} The decreased survival rate of SCC in African Americans warrants vigilant surveillance and biopsy of any nonhealing lesion associated with a chronic inflammatory process. Patients with cutaneous chronic inflammatory disease should be counseled regarding their increased risk for SCC and advised to seek medical attention for any nonhealing lesion.

**Hypopigmented Mycosis Fungoides**

Hypopigmented mycosis fungoides, a variant of cutaneous T-cell lymphoma, occurs almost exclusively in persons of color and almost twice as often in African Americans than in...
Caucasians. It presents as ill-defined hypopigmented patches in patients who often have an eczematous history (Fig. 4). The differential diagnoses of hypopigmented mycosis fungoides include Tinea versicolor, Pityriasis alba, Tinea corporis, vitiligo, and postinflammatory hypopigmentation. Biopsy should be considered in patients of color unresponsive to standard therapies for the aforementioned conditions or who have an unexplained exacerbation of their disease process. Diagnosis often requires several serial biopsies.

**Treatment of NMSC in Persons of Color**

Treatment options do not differ from those used in Caucasian patients; however, because of the increased risk of keloid formation in persons of color, caution must be taken to minimize tension on surgical wound closures. Erythematous hypertrophic scars in light-complexioned persons of color (skin types IV) may be treated with the pulsed dye laser. This author uses Cynosure 595 nm, 10-mm spot, 0.5-ms pulse duration and fluences of 3-6 J, with fading witnessed in 1 to 3 treatments. When treating precancerous lesions, this author avoids use of liquid nitrogen in persons of color in favor of imiquimod in effort to avoid posttreatment loss of pigment associated with liquid nitrogen.

**Conclusions**

Skin cancer does occur in persons of color, although less commonly than in Caucasians. Persons of color are more likely to die from their disease when compared with their Caucasian counterparts. This disparity may be attributable to delayed diagnosis as well as more biologically aggressive tumors. Little is known regarding the sun-protective behaviors of persons of color, many of whom have a false sense of security regarding their skin cancer risks. Public awareness skin cancer campaigns directed at persons of color should consider skin cancer surveillance and counseling as they do with Caucasian patients.

**References**


**Nonmelanoma skin cancer in persons of color**