Differences in Perceptions of Beauty and Cosmetic Procedures Performed in Ethnic Patients

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The United States has become progressively more multicultural, with the non-Caucasian ethnic population growing at record rates. The US Census Bureau projects that, by the year 2056, greater than 50% of the US population will be of non-Caucasian descent. Ethnic patients have different cosmetic concerns and natural features that are unique. The cosmetic concerns of ethnic patients also differ as the result of differences in skin pathophysiology, mechanisms of aging, and unique anatomic structure. There is no longer a single standard of beauty. We must now adapt to the more diverse population and understand how to accommodate the diversity of beauty in the United States. Ethnic patients do not necessarily want a Westernized look because what constitutes beauty is determined by racial, cultural, and environmental influences. We as leaders in skin care must understand these differences and adapt our practices accordingly. This article will focus on the differences in aging in different ethnic populations and highlight procedures unique to skin of color.

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The term ethnic skin has been used in the medical literature to describe skin of color, traditionally of Fitzpatrick skin types III-VI. Similar terms used include dark skin, brown skin, and pigmented skin. These terms do not define any particular race, ethnicity, or culture, nor do they adequately describe all skin types and pigmentations. Among African Americans there is wide range of skin pigmentation. There are also differences in skin pigmentation among Asians in Japan and China as compared with slightly darker skin types in Koreans and people of South-East Asia, such as Thailand, Singapore, and Cambodia. Skin-type definition initially proposed by Fitzpatrick does not adequately define the multicultural variations we see every day. Until a more inclusive term is defined, we will use the term “ethnic skin” in this article to refer to patients with pigmentation darker than that of Caucasian race (Table 1).

Up until the late 1990s, most of the literature published on cosmetic procedures focused on Caucasian patients. In addition, cosmetic industries developed most of their products for the Caucasian consumer. In recent years, more ethnic patients are requesting cosmetic procedures and there is an increasing demand for anti-aging products and services. According to the American Society of Plastic Surgery, there has been a 457% increase in nonsurgical cosmetic procedures between the years 1997 and 2007; ethnic minorities comprised 22% of all cosmetic procedures, which is an increase from 17% in 2001.

Ethnic patients have natural features that are unique and thus have different cosmetic concerns. The cosmetic concerns of ethnic patients differ as the result of differences in skin pathophysiology, mechanisms of aging, and unique facial structure. For example, photoaging in the African-American population is not as pronounced as that seen in Caucasian patients, yet dyschromia is a significant problem in this subset of patients. The cosmetic industry is beginning to understand these distinctive features and is developing a large market of products for the ethnic patient.

There is no longer a single standard of beauty. We must now adapt to the more diverse population and understand how to accommodate the diversity of beauty of persons of different ethnic populations and highlight procedures unique to skin of color.
different ethnicities in the United States. Ethnic patients do not necessarily want a Westernized look because what constitutes beauty is determined by racial, cultural, environmental influences. As leaders in skin care, we must understand these differences and adapt our practices accordingly. This article will focus on the differences in aging in different ethnic populations and highlight procedures unique to skin of color.

Skin Differences Among Ethnic Groups

There has been expanding research on the fundamental differences in skin structure and function of different ethnic groups. However, categorization of these differences into a classification system has been difficult with growing variations in pigmentation because of racial mixture. The classification of skin of color was originally developed by Fitzpatrick as the Fitzpatrick Skin Phototype System (Table 2). This system defines skin type based on reaction to ultraviolet (UV) radiation. Other skin classifications have been proposed, such as the Lancer Ethnicity Scale, which calculates healing efficacy and time in patients undergoing cosmetic laser or chemical peel procedures (Table 3). Other systems have been designed to define skin color but have limited clinical usage.

There have been several studies in which the authors examined at intrinsic differences in skin structure in different ethnic groups. The most significant difference between people of color and Caucasians is the amount of melanin in the skin. The major determinant of skin color is the activity of melanocytes, ie, the quantity and quality of pigment production, not the density of melanocytes. Melanosomes, located in the cytoplasm of the melanocyte, are the site of melanin production.

### Table 1 Ethnic Groups That Comprise Persons Defined as Having “Ethnic Skin”

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino or Hispanic</td>
<td>Persons of Spanish and indigenous Central/South American descent, including Central Americans, South Americans, and Caribbean-American persons of Spanish descent, including Cuban, Puerto Rican, and Dominican</td>
</tr>
<tr>
<td>East Asian</td>
<td>Chinese, Japanese, Korean</td>
</tr>
<tr>
<td>Southeast Asian and Pacific islander</td>
<td>Filipino, Vietnamese, Cambodian, Thai, Malaysian, Laotian, Burmese, Hmong descent, Polynean, Micronesian</td>
</tr>
<tr>
<td>Australoid</td>
<td>Australian aborigine, Melanesian descent (new the Republic of Guinea, Papua, Solomon Islands)</td>
</tr>
<tr>
<td>Native Americans</td>
<td>More than 560 recognized tribes, including Inuit.</td>
</tr>
<tr>
<td>East Indian</td>
<td>Indian, Pakistani, Bangladesh, Sri Lanka</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>Iranian, Iraqi, persons from Saudi Arabia and the Arabian Peninsula (including Kuwait, Bahrain, Oman, Qatar, the United Arab Emirates, Yemen), Lebanese, Afghani, Jordanian, Syrian, Israeli, Turkish, North African (Egypt, Morocco, Algeria, Libya)</td>
</tr>
</tbody>
</table>

Traditionally, there are 9 geographic races, each with particular genetic similarities. These geographic races include Europeans (which include Middle Eastern and Mediterranean persons), Eastern Indians, Asians, American Indians, Africans, Melanesians, Micronesians, Polynesians, and Australian Aborigines. We modify these schema into categories in which, ethnic persons share similar anatomic characteristics.

### Table 2 Fitzpatrick Skin Phototype System

<table>
<thead>
<tr>
<th>Skin Phototype</th>
<th>Reaction to Moderate Sun Exposure*</th>
<th>Skin Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Burn and no tan</td>
<td>White</td>
</tr>
<tr>
<td>II</td>
<td>Burn and minimal tan</td>
<td>White</td>
</tr>
<tr>
<td>III</td>
<td>Burn then tan well</td>
<td>White to light olive</td>
</tr>
<tr>
<td>IV</td>
<td>Tan, minimal to no burn</td>
<td>Light brown</td>
</tr>
<tr>
<td>V</td>
<td>Tan, no burn</td>
<td>Brown</td>
</tr>
<tr>
<td>VI</td>
<td>Tan, no burn</td>
<td>Dark brown</td>
</tr>
</tbody>
</table>

*Thirty minutes unprotected sun exposure in peak season (spring or summer) depending on the latitude.

### Table 3 Lancer Ethnicity Scale (LES)

<table>
<thead>
<tr>
<th>Geography</th>
<th>Fitzpatrick Skin Phototype</th>
<th>LES Skin Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons of African background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central, East, West African</td>
<td>V</td>
<td>5</td>
</tr>
<tr>
<td>Eritrean and Ethiopian</td>
<td>V</td>
<td>5</td>
</tr>
<tr>
<td>North African, Middle East Arabic</td>
<td>V</td>
<td>5</td>
</tr>
<tr>
<td>Sephardic Jewish</td>
<td>III</td>
<td>4</td>
</tr>
<tr>
<td>Persons of Asian background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese, Korean, Japanese, Thai, Vietnamese</td>
<td>IV</td>
<td>4</td>
</tr>
<tr>
<td>Filipino, Polynesian</td>
<td>IV</td>
<td>4</td>
</tr>
<tr>
<td>Persons of European background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Celtic</td>
<td>I</td>
<td>1</td>
</tr>
<tr>
<td>Central, E. European</td>
<td>III</td>
<td>2</td>
</tr>
<tr>
<td>Nordic</td>
<td>I-II</td>
<td>1</td>
</tr>
<tr>
<td>N. European (general)</td>
<td>I-1-2</td>
<td>1-2</td>
</tr>
<tr>
<td>S. European, Mediterranean</td>
<td>III</td>
<td>3-4</td>
</tr>
<tr>
<td>Persons of Latin/Central/South American background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central/South American Indian</td>
<td>IV</td>
<td>4</td>
</tr>
<tr>
<td>Persons of North American background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Native American (including Inuit)</td>
<td>II</td>
<td>3</td>
</tr>
</tbody>
</table>

biosynthesis. Melanosomes are transferred from the dendrites of the melanocyte into neighboring keratinocytes of the epidermis. Variation in skin color is dependent on the number, size and aggregation of the melanosomes within the keratinocyte. Dark-skinned black patients have singly dispersed, large melanosomes that contain more melanin compared with smaller aggregated melanosomes containing less melanin in lighter-skinned persons. Once transferred to keratinocytes, melanosomes are also degraded more slowly in darker skin (Fig. 1).

On a molecular level, there are defined pigmentation genes, such as tyrosinase-related protein family members, melanocyte-stimulating hormone, melanocyte-stimulating hormone receptor, and the melanocortin-1-receptor that also contribute to the difference in pigmentation among ethnicities. Tyrosinase-related protein 1 has been shown to increase tyrosinase activity, melanin synthesis, and melanosomal size. Increase in tyrosinase activity and melanin production can explain why the same number of melanocytes in different skin types results in differential responses to UV light. Similarly, melanocyte-stimulating hormone increases DNA repair proteins, which protects against sun-induced DNA damage in darker-skinned patients.

Early studies have suggested that the thickness of the skin is the same in light and dark skin; however, darker skin types have may have more cornified cell layers and greater lipid content compared to white stratum corneum. Black skin has been found to have more and larger fibroblasts, smaller collagen fiber bundles, and more macrophages than white skin. A review of differences in skin structure and function has been conducted by one of the authors and has been summarized in Table 4.

### Table 4 Objective Differences in Skin Structure and Physiology Based on Race

<table>
<thead>
<tr>
<th>Evidence Supports</th>
<th>Insufficient Evidence* for</th>
<th>Inconclusive:</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Increased melanin content and melanosomal dispersion in persons of color</td>
<td>Racial differences in:</td>
<td>Racial differences in:</td>
</tr>
<tr>
<td>● Multinucleated and larger fibroblasts in black persons compared with white persons</td>
<td>Skin elastic recovery/extensibility</td>
<td>TEWL</td>
</tr>
<tr>
<td>● pH black &lt; white skin</td>
<td>Skin microflora</td>
<td>Water content</td>
</tr>
<tr>
<td>● Larger mast cell granules, increased PLS, and increased tryptase localized to PLS in black compared with white skin</td>
<td>Facial pore size†</td>
<td>Corneocyte desquamation</td>
</tr>
<tr>
<td>● Variable racial blood vessel reactivity</td>
<td></td>
<td>Lipid content</td>
</tr>
</tbody>
</table>

PLS = parallel-linear striations; TEWL = trans-epidermal water loss.


*Skin elastic recovery/extensibility, skin microflora, and pore size were labeled as “insufficient evidence for” racial differences rather than “inconclusive” because only 2 studies or fewer examined these variables.


**Aging in Different Ethnic Groups**

Aging has many etiologic contributions. Genetics, gravity, behavior, and environment all play an important role in the aging process; however, a majority of the visible cutaneous signs of aging are the result of UV exposure. Dyschromia, crow’s feet, and perioral and other facial rhytides can occur decades earlier in fair-skinned individuals as compared with age-matched persons with darker skin.
The way in which aging is defined in the medical literature is also quite varied. The Glogau classification of facial photoaging is a commonly used parameter among dermatologists (Table 5). There is heavy emphasis on rhytidosis in this classification scheme; however, there are significant structural changes that play a significant role in the aging face that are not accounted for with this classification system. The development of a tear-trough depression, loss of cheek fat, prominence of the jowls, and deepening of the various facial folds, such as the nasolabial fold and marionette lines are some of the common structural changes in the aging face. Aging of the neck is associated with loose skin, platysmal bands, and transverse folds. This section will highlight differences in photoaging and structural aging in ethnic populations.

### Photoaging

Photodamage is defined as prematurely aged skin resulting from the effects of UV radiation. It is characterized by coarse and fine wrinkling, mottled pigmentation, sallowness, textural roughness, and telangiectasia. Histologic features include epidermal and dermal thinning, loss of polarity of epidermal cells, and keratinocyte atypia. Dermal features include elastosis, degeneration of collagen and anchoring fibrils.

Photoaging is arguably the most significant concern of cosmetic patients. However, it is not as prominent in skin of color, particularly in those populations with darker skin. Photodamage in Caucasian patients results in rhytides, skin laxity, sallowness, solar lentigines, seborrheic keratoses, and dyschromia. Ethnic patients have increased epidermal melanin and a thicker dermis, thereby revealing less photodamage than their age-matched lighter-skinned counterparts. Darker skin types have fewer rhytides but with photodaging develop mottled pigmentation, texturally rough skin, dermatois papulosa nigra and seborrheic keratoses, and solar lentigines.

There are well-defined racial differences in melanosome size, distribution, and melanization of the skin. Skin of color has the benefit of additional melanin and different packaging and distribution of melanosomes that reduces transmission of UV light. Kaidbey et al and others showed that increased melanin acts as a UV filter, with 5 times as much UV light reaching the upper dermis of white patients as compared with black patients. African Americans develop less solar elastosis, and the increased melanin content in dark skin protects against actinic damage and nonmelanoma skin cancers. The timing of photoaging also differs among fair-skinned and dark-skinned individuals. Signs of photoaging are evident in the fourth decade in Caucasians; however, they may not be visible until the fifth or sixth decade in darker ethnic persons.

Nouveau-Richard et al evaluated 160 Chinese and 160 Caucasian French age-matched women (average age 20-60 years of age) for signs of aging, including facial wrinkles (crow’s-feet, glabella, and perioral wrinkles) and pigmented spots. The groups did not differ in the assessment of lifelong exposure to the sun. This study revealed that wrinkle onset is delayed by 10 years in Chinese women as compared to French Caucasian women. However, pigmented spot intensity was much more prevalent in Chinese women.

Morizot et al evaluated the differences in the appearance of aging, in more than 500 age-matched women from Japan (Sendai) and France (Paris). The groups displayed no difference with respect to age, smoking habits, of self-reported lifetime sun exposure. The results of this study showed that solar damage and rhytidosis occurred at an earlier age and were more severe in French women than Japanese women; however, pigmented spots occurred more and earlier in life in Japanese women than in French women. This study elucidated that intrinsic pigmentation alters signs of aging and of dyschromia.

Hillebrand et al also looked at differences in aging in 2 Japanese cities (Akita, 39 degrees N, and Kagoshima, 31 degrees N) to evaluate geographic location and photoaging. This study confirmed that photoaging occurred several years earlier in women from Kagoshima, a city closer to the equator and with more UV exposure. This study elucidates variability in aging manifestations within ethnicities as well as among different ethnicities.

Acceptable social norms among patients differ with regards to UV exposure. In the United States, many persons of all racial groups prefer the appearance of tanned skin (Although this perception may be beginning to change as more people are educated about the effects of UV exposure). However, around the world these perceptions differ. For example, in Asia and South-East Asia, many women much prefer extremely fair skin to tanned skin, and the cosmetic procedures performed reflect this attitude.

Treatments for photodamage in Caucasian patients may differ from those in darker skin types. The best evidence of topical treatment for signs of aging comes from literature on the use of topical tretinoin (all-trans-retinoic acid) in Caucasian patients. Tretinoin has been shown in well-controlled studies to reduce fine wrinkles, hyperpigmentation, and histologically provides a reduction in epidermal atypia and dysplasia, a reduction in melanin granules throughout

### Table 5 Glogau Classification of Facial Photoaging

<table>
<thead>
<tr>
<th>Type</th>
<th>Age (years)</th>
<th>Clinical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, no rhytides</td>
<td>20-30s</td>
<td>Minimal pigmentary change or rhytides, no keratoses</td>
</tr>
<tr>
<td>II, dynamic rhytides</td>
<td>Late 30-40s</td>
<td>Early senile lentigines, keratoses palpable but not visible, parallel smile lines begin to appear, dynamic rhytides</td>
</tr>
<tr>
<td>III, static rhytides</td>
<td>50 or older</td>
<td>Obvious dyschromia, telangiectasia, visible keratoses, static rhytides</td>
</tr>
<tr>
<td>IV, all rhytides</td>
<td>60-70s</td>
<td>Yellow/grey color of skin, previous skin malignancies, rhytides throughout</td>
</tr>
</tbody>
</table>

the epidermis, increased vascularity of the papillary dermis, and formation of new collagen. However, data also have confirmed its benefit in the treatment of dyschromia and fine wrinkling in Asian skin.

Structural Aging

Structural facial aging is caused by the volumetric loss of fat, skeletal resorption, and redistribution of skin and soft tissue. In the younger face, the superficial and deep fat is distributed evenly. As the face begins to age, fat atrophy and hypertrophy cause an irregular topographic contour to the face. Atrophy develops on the temples, cheek, and lateral chin; bone resorption of the mandible and loss of lip volume occurs; as well as increased shadowing under the eyes and sometimes increased protrusion of the infraorbital fat pads. All of these contribute to sagging of the overlying skin. The aging process also has ethnocentric variability. Traditional esthetic procedures should be modified to adapt to the patient’s ethnic background and unique facial structure.

Careful evaluation of facial proportions is necessary before any esthetic procedure is undertaken. This analysis should consider not only ethnocentric variations in facial structure and aging but also ethnically diverse perceptions of beauty. Anthropometry is the quantitative measurement and ratio of facial features; a quantitative standard of attractiveness. It is based on proportional relationships of the face known as the neoclassical cannons that have been studied and revised for hundreds of years.

Originally, proposed by Leonardo da Vinci, the face is divided into equal horizontal thirds: distance from the frontal hairline to the top of the brow, from the brow to the base of the nose, and from the base of the nose to the distal portion of the chin (Fig. 2). The facial proportions of the Caucasian patient as outlined in Table 6 adapted from the original article by Powell and Humphreys is defined by an oval face, prominent cheekbones, tapered jaw line, narrow nasal base, and thin lips. Another method used to calculate beauty with mathematical proportions is the concept of “phi,” the golden ratio. The ratio of 1:1.618 was described by ancient Greeks as a mathematical method to calculate optimal proportions for all structures in nature; some believe that the neoclassical cannons are modifications of phi. Dr Stephen Marquardt, a plastic surgeon, trademarked the “phi mask,” a facial mask of proportions that incorporates the 1:1.618 ratio to describe the most attractive face (Fig. 3). The phi mask has been applied to persons of all races and ethnicities. Matory, Holland, and Grimes have suggested that these defined proportions are not applicable to all ethnic groups. In recent years, esthetic surgeons are beginning to understand and modify these proportions to fit the widely diverse and structurally unique ethnic patient (Table 6). Marquardt himself has also modified the “phi mask” to apply to 3 different ethnic groups—Caucasian, Asian, and African—with the statement that more variations may be developed. Although discussion of all anthropometric measurements and facial structure is beyond the scope of this article, we attempt to highlight differences among ethnic groups.

African-American Facial Analysis

Although African-Americans do not develop as much UV-induced photoaging as Caucasian patients, given their in-

\[ \text{Figure 2} \quad \text{Caucasian woman, age 28. The face is divided into equal horizontal thirds: distance from the frontal hairline to the top of the brow, from the brow to the base of the nose, and from the base of the nose to the distal portion of the chin. (used with permission.)} \]

\[ \text{Table 6} \quad \text{Facial Analysis of Women of Different Ethnic Groups} \]

<table>
<thead>
<tr>
<th></th>
<th>Caucasian</th>
<th>African-American</th>
<th>Caribbean American</th>
<th>Central American</th>
<th>South American</th>
<th>Southern Chinese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizontal proportions</td>
<td>1:1:1</td>
<td>1:1.2:1.3 or 1:1.2:1.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasofrontal angle</td>
<td>125°-135°</td>
<td>127.6° or 136.8°-137.4°</td>
<td>110°</td>
<td>137°</td>
<td>136°</td>
<td>137.9° (119-166)</td>
</tr>
<tr>
<td>Nasofacial angle</td>
<td>36-40°</td>
<td>33.4° or 38.9°</td>
<td>41°</td>
<td>44°</td>
<td>46°</td>
<td>36.4° (20-46)</td>
</tr>
<tr>
<td>Alar width: Intercanthal distance</td>
<td>1:1</td>
<td>1:2:1</td>
<td>1.2:1</td>
<td>1:1</td>
<td>1.1:1</td>
<td>&gt;1:1</td>
</tr>
<tr>
<td>Columella:lobule</td>
<td>2:1</td>
<td>1.3:1 or 1:1.2 or 1:1.3</td>
<td>1.5:1</td>
<td>1.1:1</td>
<td>1.5:1</td>
<td>1.2:1</td>
</tr>
<tr>
<td>Nasolabial angle</td>
<td>90°-120°</td>
<td>73.9° or 85.6°-90.3°</td>
<td>110°</td>
<td>99°</td>
<td>100°</td>
<td>87.8° (55-108)</td>
</tr>
</tbody>
</table>


*Horizontal proportions derived from relationship of trichion to glabella, glabella to subnasale, subnasale to gnathion ratio.
creased skin melanin, there is pronounced sagging of the malar fat pads, soft-tissue laxity, and jowl formation of the mid face. Studies of facial analysis by Farkas et al.\textsuperscript{42} highlight the difference in facial structure in African Americans as compared with Caucasians (Table 6). African Americans have a broad nasal base, decreased nasal projection, bimaxillary protrusion, orbital proptosis, increased soft tissue of the mid-face, prominent lips, and increased facial convexity (Fig. 4).\textsuperscript{43} Further studies also revealed 2 types of African-American nasal structure, one with a high dorsum and one with a low dorsum, reflecting variability in interethnic facial structure.\textsuperscript{44}

\textbf{Latino Facial Analysis}

There is a wide variety of ethnicities comprising the term “Latinos” as previously mentioned. This diversity also plays a huge role in facial structure differences among ethnicities. Similar to African Americans, increased melanization provides enhanced protection against photoaging; however, Latinos do develop skin mottling, jowl formation, infraorbital hollowness, and shadowing.\textsuperscript{45} In persons of Mexican descent, the face is broad with prominent malar eminence, broad nose, widened alar base, short columella, horizontally oriented nostrils, and thick nasal skin.\textsuperscript{46,47} In Caribbean women, the anthropometric measurements are more similar.
to African-American women, whereas central and South American women often have similar anthropometric measurements to Caucasian women. Overall Hispanics have increased bizygomatic distance, bimaxillary protrusion, greater convexity angle, broader nose, broad rounded face, and a receding chin (Fig. 5).

Asian Facial Analysis

The aging face in the Asian population is significantly different than aging in Caucasian patients. Studies that have evaluated the Asian facial structure suggest that Asians have a weaker facial skeletal framework, which results in greater gravitational soft-tissue descent of the midface, malar fat pad ptosis, and tear trough formation. Shirakabe et al also propose that the facial structure and soft tissue of Asians is similar to that of an infant, including a wider and rounder face, higher eyebrow, fuller upper lid, lower nasal bridge with horizontally placed flared ala, flatter malar prominence and midface, more protuberant lips, and more receded chin (Fig. 6). The distance from the eyebrow to the upper-lid margin in Asians is much greater than in the Caucasians due to the fuller upper eyelid and to the narrower palpebral fissure. There is also more malar fat in the midface of Asians, moderate premaxillary deficiency, and more prominent soft tissue in the lips compared to Caucasians that have thinner lips and a more prominent chin. Additionally, Asians have a broad prominent forehead, wider intercanthal distance, short palpebral fissure, and a lack of supratarsal crease. Koreans also have wider lower face with recessed chin, and a wider mandibular angle.

A study by Biller and Kim, characterizing ideal nasolabial angle, nasal tip width, and location of eyebrow apex for Asian and white women, demonstrates that neither the ethnicity of the model nor the ethnicity of the volunteer evaluating the model played a significant role in determining the ideal angle or position of the above parameters. They found that, in general, a more lateral brow apex is preferable in younger faces, whereas a more medial apex is preferred in older faces. In addition, moderate nasolabial angles of 104 and 108 de-
gree and a nasal tip width of 35% of the alar base was most attractive in both ethnicities. The study supports some claims that beauty is considered innate and independent of culture; however, the study is limited by a small number of models (4), representing only 2 ethnicities. In addition, all the volunteers evaluating the models were from the United States, which may represent a more "westernized" ideal of beauty.

The aforementioned differences in facial structure as well as previously mentioned differences in photoaging have contributed to different esthetic procedures sought by patients in different ethnic groups. For example, with regard to blepharoplasty, in the Asian eye there is an absence of a superior palpebral fold, which produces a "single eyelid," the presence of an epicanthal fold, and more prominent periorbital fat pads, resulting in significantly different surgical approach. Moreover, Japanese women often like to preserve the greater of the epicanthal crease and opt for cosmetic procedures to restore a full-lid contour and prefer more thin lips. Ko

Dyschromia: Melasma and Postinflammatory Hyperpigmentation

Unfortunately, the same wonderful features of melanocytes that prevent photoaging can contribute to less-desirable properties in darker skin types that make them more reactive to inflammation resulting in dyschromia. The most common complaints of dark-skinned patients are the dyschromic disorders, mainly postinflammatory hyperpigmentation and melasma. Although many skin-lightening agents and procedures are available to these patients, it is important to have an open and realistic conversation with them about skin dyspigmentation and set realistic goals about therapy.

There are very complex cultural factors associated with skin dyspigmentation and skin bleaching. Westernized, and generally lighter-skinned, ideals of beauty stem from complex social and cultural paradigms as historically Europeans colonized and dominated every corner of the world. These ideals are beginning to change as racial intermixing has occurred and as persons of color continue to have a greater presence in leadership positions and in the media worldwide. Nonetheless, cultural beliefs valuing lighter skin still exist, especially in the Asian community. In Japan, great lengths are taken to achieve the ideal irojirō, or fair skin, with some bleaching creams even advertised to bleach the lips or nipples. One survey by Synovate found that 4 of 10 women in Hong Kong, Malaysia, the Philippines, and South Korea used a skin-whitening cream. It is estimated that in Asia more than 60 global companies are competing for a share of their US$18 billion dollar market. These ideals are inherent in old Japanese and Chinese proverbs that state that "white skin makes up for seven defects" (Japanese) and "white skin can cover 1000 ugliness" (Chinese). Even in countries where pigmentation among the inhabitants is quite varied, such as Brazil, the Dominican Republic, and India, lighter-skinned individuals are often predominate in the upper socioeconomic echelon as well as leadership positions in government.

A comprehensive level of understanding of these issues is necessary to address and treat patients with dyschromia.

Postinflammatory Pigmentary Alteration

Postinflammatory hyperpigmentation or hypopigmentation is a common consequence of many inflammatory skin conditions and treatment modalities in dark-skinned patients. Hyperpigmentation is caused by an increase in melanin production or an abnormal distribution of melanin pigment, whereas in hypopigmentation there is a decrease in melanin production. The etiology of this phenomenon in dark-skinned patients is still unknown; however, literature supports the hypothesis that it is secondary to cytokines and inflammatory mediators, such as leukotriene (LT), prosta-

Melasma

Melasma is common to many ethnic groups particularly Hispanics, African Americans, and Asians. It is an acquired disorder associated with multiple etiologic factors, including pregnancy, endocrine abnormalities, and oral contraceptive use. It often manifests as irregular, symmetric brown patches distributed over sun-exposed areas of the face. Woods-light examination aids in the distinction of epidermal-type vs. dermal-type melasma. There can also be mixed and indeterminate variations; all of which are based on the depth of pigmentation. Epidermal-type of melasma, is intensified by Woods light examination as there is increased melanin throughout the epidermis, whereas dermal melasma is not enhanced by Wood’s light examination. Although the etiologic role is unclear, there is some genetic predisposition to developing melasma. Grimes et al reported that melasma may be the result of hyperactive and hyperfunctional melanocytes causing increased melanin deposition in the epidermis and dermis. Studies have also implicated progesterone in the etiology of melasma because postmenopausal women on estrogen therapy do not usually develop melasma but those on estrogen/progesterone therapy often do.

It is imperative that the underlying cause of melasma or postinflammatory pigmen
tary alteration be eliminated, including sun avoidance, oral contraceptives, and photosensitizing drugs. Ethnic patients use sunscreen less than their age-matched fair skin counterparts. Sunscreen usage is im-


portant in not only skin cancer prevention and the prevention of photo-aging, but also vital to the prevention of dyschromia. Patients should be instructed to wear daily broadband-spectrum UVA-UVB sunscreens which include brookite and zincite. However, some formulations with zinc or brookite are less cosmetically acceptable to darker-skinned patients because they may leave a whitish or chalk-like hue on a darker-skinned individual; thus, the micronized forms of these ingredients may be preferable. Some sunscreens may be potent photosensitizers, such as sunscreens containing paraaminobenzoic acid, and should be used with caution because they may cause worsening dyspigmentation in the darker-skinned patient.

**Treatments for Disorders of Hyperpigmentation and Hypopigmentation**

Hydroquinones and other topical bleaching agents are the most commonly used treatments for melasma and postinflammatory hyperpigmentation. A thorough discussion of treatments for hyperpigmentation is provided in this journal in the article titled “Management of Hyperpigmentation” by Pearl Grimes. Although topical creams have been effective, in the authors’ experience, the most effective mechanism for treating dyschromia includes a combination of topical lightening agents, sunscreen, and sun avoidance and in-office procedures, including chemical peels. A summary of chemical peels in ethnic skin is presented in the sections to follow. Other treatments for dyschromia include microdermabrasion, and lasers. The use of lasers for dyschromia is discussed in further detail in this journal in the article titled “The Use of Lasers in Darker Skin Types” by Cyylburn Soden and Eliot Battle.

**Chemical Peels**

Chemical peels have been reluctantly introduced in to the armamentarium of cosmetic treatments in ethnic populations. Treatment of dyschromia with chemical peels has only recently been investigated. Chemical peels should be performed with great care and caution because the risk of hyperpigmentation and worsening of dyschromia is an all too common consequence and, thus, peels are often paired with topical regimens to minimize potential side effects. The physiological differences in darker-skinned patients mentioned previously, including increased reactivity of melanocytes, larger fibroblasts, and increased melanin content, are features that render increased susceptibility to scarring and dyspigmentation. Peels should be implemented in the treatment of melasma and postinflammatory pigmentation in patients who have tried and failed topical bleaching agents.

The approach to peels in darker skin types should be done with great caution. Patients should be pretreated with hydroquinone, azelaic acid 20% or kojic acid for several weeks before the peel and initial peels should be performed in the lowest concentration to assess sensitivity and reactivity of the skin. If tretinoin is used before peeling procedures, it should be discontinued 2 to 4 weeks before the peel because it enhances penetration of the peel and thus increases the risk of hyperpigmentation.

**Chemical peels are classified by their depth of skin penetration as superficial, medium-depth, or deep peels (Table 7). As the depth of the peel increases, so does the risk of dyspigmentation. Every patient regardless of pigmentation has a risk of dyspigmentation and scarring. Thus, it is best to start with superficial peels to minimize potential side effects in susceptible patients. For dyschromia, peels can be done in 2- to 4-week intervals for a series of 3 to 6 peels. If there is no reactivity and increased depth is indicated, titration of the strength is suggested in gradual degrees. Glycolic acid can be started at 20% to 30%, and titrated up to 50% and 70%. Salicylic acid can be started at 10% to 15% and titrated up to 20% to 30%. Gentle postpeel care with mild cleansers and emollients is also important to avoid any residual skin irritation and reactivity. Bleaching agents are then resumed after the peel.

Studies have shown significant benefits in the use of glycolic acid in darker-skinned patients for the treatment of melasma, acne, and postinflammatory pigmentary alteration. Both African-American and Asian patients in these studies had improvement in their skin dyschromias with minimal irritation and postpeel dyspigmentation when titrating doses of the peels were used. In a study by Grimes, salicylic acid was also beneficial in the treatment of postinflammatory pigmentation when used in 20% to concentrations for a series of 5 peels (2 20% and 3 30% salicylic acid peels). Peels were performed biweekly in titrating doses. Patients were pretreated for 2 weeks with 4% hydroquinone and minimal to mild side effects occurred in 16% of the patients which eventually resolved in 7-14 days.

Jessner’s is a superficial peel when used alone or is a medium depth peel when used with trichloroacetic acid. Lawrence et al. compared the efficacy of Jessner’s solution to 70% glycolic acid or the treatment of melasma in a split-face study of 16 patients. Of the total group, 5 were skin type IV and 3 were skin type V, and one was skin type VI. There was no statistically significant difference in improvement between

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**Table 7 Chemical Peels**

<table>
<thead>
<tr>
<th>Type of Peel</th>
<th>Depth</th>
<th>Peeling Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superficial</td>
<td>Stratum corneum to papillary dermis</td>
<td>Salicylic acid 5-20%, Jessner's solution (14% resorcinol, 14% salicylic acid, 14% lactic acid, ethanol)</td>
</tr>
<tr>
<td>Medium</td>
<td>Penetrates upper reticular dermis</td>
<td>Undiluted phenol 88%, Jessner’s 40-50% with TCA 35%, Glycolic acid 70% with TCA 35%</td>
</tr>
<tr>
<td>Deep</td>
<td>Mid- reticular dermis</td>
<td>Baker Gordon formula (phenol, croton oil, septisol, water)</td>
</tr>
</tbody>
</table>

TCA >50%
the 2 groups. There was no increased frequency of side effects in patients of skin types IV-VI with either treatment.

Trichloroacetic acid (TCA) is a common peel used in skin types I-III. Its use in darker skin types has been more limited as there are increased risks of post peel hyperpigmentation compared to salicylic acid and glycolic acid. TCA causes a concentration-dependent precipitation of epidermal proteins, causing sloughing and necrosis of the treated area. This peel may be used at concentrations of 10% to 30% if patients fail titrating doses of salicylic acid and glycolic acid peels, but with caution.

Chemical peels are a great adjunct in the treatment of photoaging and dyschromia in darker skinned patients. Mild superficial peels should be used and gradually titrated to optimal therapeutic benefit to minimize irritation and worsening dyspigmentation.

Lasers
Laser technology has advanced significantly in the last 5 years. Initially developed and used in skin types I-III, many lasers now have been developed and used widely in darker skinned patients. Ethnic patients and dermatologists have historically been hesitant to use lasers in darker skin types given risks of scarring and dyspigmentation. There is now more literature validating the efficacy and safety of lasers in darker skin types. Problems specific to ethnic patients conducive to laser treatment include hair removal, including that for pseudofolliculitis barbae, dermatosis papulosa nigra, photoaging, melasma, lentigines, nevus of Ota, Horii’s nevus, and tattoo removal. We briefly highlight lasers that have been studied in ethnic skin, however an in-depth review has been dedicated to this topic in this journal.

Pigment Lasers. The treatment of dyschromia in darker skin types is challenging. There is increased melanin in darker skin types. The absorption spectrum of the chromophore melanin is 250-1200 nm, and heavily pigmented skin contains more melanin, thus absorbing laser light high in the epidermis rather than allowing it to reach the deeper targets. This absorption in the epidermis is converted to heat which has to potential to cause epidermal damage and scarring. When comparable fluences are used, the less laser energy reaching the target chromophore in the deep dermis, the less efficacious the treatment. Newer laser devices with better surface cooling, longer pulse durations, and longer wavelengths are now in the armamentarium for safer and more efficacious use in the darker skinned patients.

Despite the increased safety, darker-skinned patients may require more treatments compared with fair-skinned patients and often have refractory skin conditions. Melasma, in particular, is often refractory to laser treatment because melanin incontinence and repackaging is often not altered by laser treatment.

Dermatosis papulosa nigra is common in many darker skin types and is often successfully treated with pigment lasers, such as the 532 nm KTP and 532-nm frequency-doubled Q-switched neodymium: yttrium–aluminum–garnet (Nd: YAG) lasers. Choosing a low fluence and small spot size limits scarring and surrounding epidermal damage. Light electrosurgery is also an effective treatment for this condition, with minimal side effects.

A common pigmentary abnormality in Asian and Hispanic patients is the dermal melanocytosis of the Nevus of Ota. Studies have shown benefits from Q-switched ruby, alexandrite, and 1064-nm Nd:YAG lasers. Although reported complication rates are low, similar precautions, including choosing a longer wavelength, longer pulse duration and the shortest fluence for the desired benefit are important to consider to limit epidermal injury.

Tattoo removal in darker-skinned patients is often associated with pigmentary alteration. A candid discussion about realistic expectations is necessary with every patient as treatment sites will have some level of pigmentary alteration. The best laser for blue/black tattoo removal in darker skinned patients is the Q-switched Nd:YAG as it has the longest wavelength resulting in the least risk of scarring and pigmentary alteration. For green/purple tattoos, the Q-switched alexandrite is often used and for red tattoos the 532-nm Q-switched Nd:YAG is the best option. These lasers are absorbed within the absorption spectrum of melain and once again increase the risk of hypopigmentation and scarring.

Vascular Lasers. Treatment of vascular lesions (port wine stains, telangectasias, hemangiomas, and veins) in darker-skinned patients is controversial because the absorption spectrum for hemoglobin is within the spectrum of the absorption spectrum for melanin. Scarring and epidermal damage is minimized by the use of lasers with longer wavelengths, such as the Nd:YAG laser. However, the greater the fluence needed to achieve the desired treatment effect, the greater the risk of epidermal damage. Although shorter-wavelength vascular lasers, such as the 595-nm pulse-dye laser, may also absorb melanin in addition to hemoglobin, their use may be required to achieve effective results. If the longer-wavelength lasers are ineffective, a test spot with the shorter-wavelength lasers should be tried first before treating the entire affected area.

Skin Rejuvenation. Skin rejuvenation with ablative resurfacing has been infrequently used in darker skin types because there are significant risks of scarring and dyspigmentation. Newer nonablative resurfacing devices are more favorable alternatives for skin rejuvenation in this population. Test spots should be performed in all patients. Patients are often pretreated with hydroquinone to minimize the risk of post-treatment hyperpigmentation, although the efficacy of prelaser hydroquinone is debated. Nonablative fractionated techniques, such as the Fraxel Restore device (Solta Medical, Hayward, CA) have been used in skin types III–VI for the treatment of rhytides, acne scarring, and pigmenitary changes with some success and minimal complications. Collagen remodeling is thought to occur with nonablative fractional resurfacing improving skin laxity without epidermal ablation limiting potential epidermal injury. Fraxel Restore is the only laser FDA approved for the treatment of melasma.
ated CO₂ lasers are beginning to be used in skin types IV and above, but with extreme caution.

Hair Removal. Ethnic patients frequently request hair removal procedures. Almost every skin type can be treated with hair removal lasers because side effects are minimized with long new longer wavelength lasers, long pulse duration, and effecting skin cooling. The diode and Nd:YAG lasers are the most effective wavelengths to treat darker skin types. Although there are risks of dyspigmentation, they are minimized with adequate precautions. Hair removal in patients with pseudofolliculitis barbae can also be very effective treatment and should be considered despite skin pigmentation. The long pulsed Nd:YAG is the treatment of choice for hirsutism and pseudofolliculitis barbae in African-American patients with Fitzpatrick skin types V and VI. The wavelength of the Nd:YAG (1064 nm) is at the end of the absorption spectrum of melanin. This wavelength is sufficient to achieve significant thermal injury in dark coarse hairs while sparing epidermal pigment. Additionally, the adjustable pulse width of long pulsed Nd:YAG laser allows the laser energy to be delivered over a longer period allowing for the heat to dissipate and sufficient epidermal cooling to occur. Challenges with the long pulsed Nd:YAG in darker skin types arise in those patients with dark skin but fine hair. In these patients, permanent hair reduction is more challenging because the fluence necessary to achieve permanent reduction of fine hair becomes risky. In these patients, it is important to educate the patient on the potential limitations of laser-assisted hair removal.

The risks of scarring and postinflammatory pigmen- tary alteration pose a therapeutic challenge in patients with ethnic skin. Although all lasers pose some threat of dyspigmentation and scarring, newer devices with longer wavelengths, more effective contact cooling and longer pulse durations have been developed making lasers safer for use in patients with darker skin. Complications are minimized with clinical experience and patients should be adequately educated about the risk benefit ratio, setting realistic goals, and the need for test spots.

Botox. The chemodenervation of skeletal muscles induced by Botulinum A exotoxin (BoNT-A) has been used for more than 20 years in the treatment of dynamic rhytides. Dynamic facial muscles result in rhytides and deep furrows in all ethnic skin types. The most common cosmetic uses of botulinum toxin are for the treatment of glabellar rhytides, forehead lines, and crow’s feet. Studies have illustrated similar benefits in ethnic patients with minimal side effects. In a study by Ahn, et al, BoNT-a (Botox, Allergan, Irvine, CA) was effectively used for the treatment of dynamic rhytides in the upper face of Asian patients. Although dermal thickness and fibroblast number may be increased in African Americans, possibly affecting botulinum toxin dosing and response, a study by Carruthers et al evaluating the use and dose of Botox in African Americans found that there were similar effects and doses used in African-American women compared to Caucasian patients. Similarly, Grimes and Shabazz also found that doses of both 20 and 30 U of BoNT-A demonstrate efficacy and safety in African-American women with skin types V and VI. Botox is used commonly in ethnic patients for dynamic rhytides, similar to its use in Caucasians, but has also been used in novel ways in ethnic patients for their unique cosmetic concerns.

In Asian patients, BTX-A can be injected in the lower eyelid to create a wider ocular aperture. This eyelid recontouring is done with very small amounts of the toxin, often 1-2 U of BTX-A into the mid lower lid. Flynn and Carruthers injected Botox into the orbicularis oculi of 15 women. One lower eyelid received 2 U subdermally in midpupillary line 3 mm below ciliary margin, whereas the opposite eye received 2 U in the lower eyelid with 12 U into the lateral crow’s feet (3 injections of 4 U each were placed 1.5 cm from the lateral canthus each 1 cm apart). Their results revealed that in 40% of subjects who had injection of lower eyelid alone there was an increased palpebral aperture, whereas 86% of subjects who had injection of the lower eyelid and the lateral orbital area had increased palpebral aperture. In this study there were no reported side effects, including ectropion, ptosis, dry eyes, or photophobia.

Facial beauty in Asian patients is also defined by delicate oval lower face structure. Korean patients often have a bony malar or mandibular prominence or masseter muscular hypertrophy giving their lower face a more squared appearance. When bony hypertrophy is the culprit, skeletal reduction surgery is the procedure of choice and is a popular technique in Asia. However, muscular hypertrophy and a prominent mandibular angle can be altered with chemodenervation of the masseter muscle. Approximately 25 U of Botox, 5 U/0.1 mL is injected at the inferior masseter border. Some practitioners will inject an additional 25 U injected per side at 1-week intervals to ensure optimal paralysis, with maintenance rejections at 6 and 8 months. Most patients will only require 2 to 3 consecutive treatments, and only patients who have residual masseter motion require reinjection. Side effects include mild fatigue with chewing and transient buccal weakness. It is important to only inject the lower portion of the masseter and avoid injection in the upper half to avoid complete masseter paralysis.

In Japan, calf hypertrophy is referred to as “daikon-ashi” and in Korea it is called “muu-dar.” Similar to masseter hypertrophy, injection of the gastrocnemius muscle with Botox causing a chemical denervation of the muscle can help decrease calf volume.

Injectable Filling Agents. The nonsurgical treatment of volume loss of the lower face is becoming increasingly common in ethnic patients. Darker-skinned patients develop significantly more volume loss in the lower face compared with deep furrows and rhytides of the lower face seen in Caucasian patients. There are many different soft-tissue fillers on the market, all of which have been safely used in darker-skinned patients. As with all procedures, there are risks of postinflammatory pigmen- tary alteration even after minor injection related trauma. With all soft-tissue augmentation products, the correct injection strategies, including tissue depth and
Body Image and Contouring

Body contours also have ethnic variation. Many Hispanic and African-American patients opt for fuller legs, thighs, and hips in comparison with more delicate and thinner contour preferred by Asian patients. Natural ethnic variations of the hips and thighs in African/African-American and Brazilian women have been embraced by these cultures with more cosmetic procedures being performed to enhance these features.

Tumescent liposuction is a common procedure among all ethnicities. Hypertrophic scars, keloids, and hyperpigmentation are risks in ethnic patients at cannula insertion sites. Ultrasound-assisted liposuction, laser-assisted liposuction, and selective cryolysis are more novel techniques, the efficacy of which, are still being studied in ethnic patients.109,110

Gluteal enhancement, initially popularized in Brazil, has been performed most commonly via use of implants and a combination of liposuction/autologous mini fat grafting procedures.111,112 Potential complications of excessive liposuction in the gluteal area are the banana fold and sensuous triangle deformity. The “banana fold”, or the infragluteal fold, is a fat deposit on the posterior thigh near the gluteal crease and parallel to it. The “sensuous triangle” is found at the junction of the lateral buttocaks, the lateral thigh, and the posterior thigh. Correction of these iatrogenic deformities via autologous fat transplantation has been described by Brazilian plastic surgeons.113

Methods for treating cellulite have also been described in ethnic patients, predominately in Brazil. Techniques for cellulite reduction include topical application of caffeine, botanic extracts, endermologie, mesotherapy, radiofrequency delivery, and subcision.114-118 A novel noninvasive technology for circumference and cellulite reduction is a device that combines Bi-polar radiofrequency, infrared Light, Vacuum and Mechanical Massage (VelaShape, Syneron, Inc., Irvine, CA). At the time of this writing, there are no published reports of the use of VelaShape in ethnic patients in peer-reviewed journals.119

Hair Transplantation

Hair transplantation is performed at a lower frequency in African-American men with male pattern hair loss in than in white men.120 It has also become more culturally acceptable for African-American men to shave their heads bare as a way to camouflage androgenetic alopecia. If hair transplantation is a consideration, caution must be taken in African-American men for development of keloids, particularly at the donor site. It is suggested that test grafts are performed with a 3 month wait before proceeding with procedure.

Modification in technique has been proposed for very curly hair in African Americans. Modifications include the use of larger 4-mm punch grafts and manual removal of the donor grafts instead of mechanical removal to prevent transection of the hair follicles.121 In addition, adding saline to the donor sites after infiltration with local anesthesia may help straighten the curly follicle and provide more viable hair for transplantation.122

Conclusion

The perception of beauty is determined by genetics, cultural, environmental, and historical influences. Skin of color comprises a phenotypically heterogeneous group of patients. Understanding unique differences in skin physiology, aging mechanisms, and treatment options are an important part of
the care of ethnic patients. Ethnocentric beauty is one that should be celebrated. More ethnic patients are requesting esthetic procedures than ever before, however they do not all necessarily desire “westernized” appearances. They often wish to enhance their culture-specific beauty. The understanding of these culture and ethnic-specific features is the first step in taking care of ethnic patients and using specialized esthetic approaches to their care.

References


Perceptions of beauty, cosmetic procedures in ethnic patients


