

Women's Dermatologic Diseases, Health Care Delivery, and Socioeconomic Barriers

THE ARCHIVES OF DERMATOLOGY JOINS JAMA in dedicating our March issue to women's health¹ to commemorate the first International Women's Day, March 8, 1910. In 1945, the Charter of the United Nations affirmed the principle of sex equality, and in 1995, the Beijing Conference and Platform for Action recognized that the empowerment of all women is the most effective way to promote health, especially the prevention of human immunodeficiency virus and AIDS.² In this editorial, we define the dermatologic diseases of women and their relevance in the broad context of worldwide women's health and discuss how women's health is influenced by cultural and social norms.

WOMEN AND DERMATOLOGIC DISEASES

Women's health issues in dermatology include diseases that affect women because they are related to the menstrual cycle, pregnancy, childbirth, and/or menopause. The management of dermatologic disorders in a woman who is pregnant or likely to become pregnant differs from the management of the same disease in a man. Some diseases may occur only in women, including those affecting the genitalia or breast, and other diseases are documented to be significantly more prevalent in women. These diseases are more likely to appear during certain decades of a woman's life (**Table**). All of these issues must be carefully assessed as the practicing dermatologist cares for women.

Articles in this issue on diseases that occur only in women are those about vulvar disease,³ skin disorders of the female breast,^{4,5} and female pattern hair loss.⁶ We have also included articles on diseases that occur more commonly in women (eg, erythromelalgia,⁷ lupus erythematosus,⁸ disseminated granulomas annulare,⁹ scleroderma, and Raynaud phenomenon) and X-linked dominant disorders (eg, CHILD [congenital hemidysplasia with ichthyosiform erythroderma] syndrome¹⁰). The sexual dimorphic prevalence of autoimmune disease, such as systemic lupus erythematosus, is explained by the influence of sex hormones on acquired immunity.¹¹

From a public health perspective, the unusual dermatologic diseases discussed in this issue of the ARCHIVES pale in comparison with the larger women's health concerns that span a woman's life cycle and include malnutrition in young girls, cervical and breast cancer in middle-aged women, and osteoporosis and potential bone fractures in older women. However, for each woman with a rare skin disease whose dermatologist struggles to provide care, the

Table. Usual Age of Onset of Dermatologic Diseases More Common in Women

Stage of Life/Age	Disease and Female-Male Ratio of Occurrence
Birth	Hemangioma, 3:1 X-linked dominant disorders
Childhood	Coup de sabre, facial hemiatrophy, 7:1
Adolescence: menarche	Deliberate tanning Folliculitis on legs from hair pulling Linear scleroderma, 2.6:1 Nail dystrophy, allergic contact dermatitis, and infections from prosthetic fingernails
20-29 y	Raynaud phenomenon, 4:1 Contact dermatitis from cosmetics Erythema nodosum Photoaging Pregnancy: chloasma, pruritic urticarial papules of pregnancy, herpes gestationis
30-39 y	Discoid lupus erythematosus, 3:1 Hand dermatitis Hirsutism Melanoma Melasma
40-60 y: Menopause	Systemic scleroderma, 4:1 Dermatomyositis, 3:1 Female pattern hair loss Mammary Paget disease Subacute cutaneous lupus erythematosus, 7-9:1 Rosacea conglobata, fulminans Varicose veins
>61 y: Senescence	Lichen sclerosus, 6:1 Sjögren syndrome, 9:1 Vulvodynia

therapeutic responses described in this issue offer hope for an improved quality of life. For example, a woman with erosive lichen planus of the anogenital region may have difficulty walking, urinating, defecating, and having sexual intercourse. She needs symptomatic relief. Her physician also needs to know which treatment has the best chance of success and the complications of such treatment. The study by Cooper and Wojnarowska³ makes it possible to tell her that about 70% of patients gain relief of symptoms following 3 months of treatment with topical ultrapotent corticosteroids. Other unique therapeutic examples from this issue include dapsone to treat a patient with lupus profundus,⁸ etanercept to treat disseminated granulomas annulare,⁹ a topical gel of amitriptyline and

ketamine for relief from the pain of erythromelalgia,⁷ and oral finasteride to treat female pattern hair loss.⁶

DERMATOLOGIC HEALTH CARE DELIVERY TO WOMEN

Women's dermatologic health extends to the delivery of dermatologic health care to women and the cultural and socioeconomic forces that shape women's behavior which cause them to seek care. Although there are disparities in access to health care in the United States, generally women visit their physicians more frequently than men do. The hypothesis is that access to routine gynecologic and obstetric care for women helps them develop familiarity with the health care system and contributes to women mediating health care for the family. The socialization of men in some western countries may deter them from seeking health care.

In this month's ARCHIVES, Federman and colleagues¹² examine our role in providing quality health care for women. Female veterans receiving health care in a Veterans Administration medical center report a low (18%) incidence of full-body skin screening by their primary care physician even though 79% of patients associated such a screening with physician thoroughness and only 15% reported embarrassment. Primary care physicians may be allocating precious health care resources to those older than 60 years and those with a history of skin cancer. Implementing the American Cancer Society recommendation that patients older than 40 years have annual full-body skin screening for skin cancer¹³ may not be possible because there are not enough skilled clinicians to perform such large numbers of skin cancer screenings. Physicians are not reimbursed for this service. The reluctance expressed by 78% of female patients surveyed to have full-body skin examinations performed by physicians of the opposite sex is another barrier to care.¹² Training physicians and nurses to offer patients the choice of a same-sex physician may alleviate the discomfort of those who express reluctance.

Standards of beauty vary across different cultures and periods. Cultural norms place more emphasis on a woman's youthful, beautiful appearance than on a man's. Children's toys, cartoons, and storybooks reflect the ideal of physical perfection that adults seek. Women and men grow up immersed in this subliminal culture, but girls respond differently to the ideal and unattainable appearance of their Barbie dolls than boys do to their G.I. Joe action figures. In the United States, nearly 90% of all cosmetic procedures are performed on women.¹⁴ Women become consumers of an amazing array of devices and substances to enhance their youthful beauty.

Consumer demand propelled the use of Botox injections to treat wrinkles, and it became the most commonly performed nonsurgical cosmetic procedure in 2004 (2 837 346 botulinum toxin A injections, followed by 1 411 899 laser hair removal procedures).¹⁴ In this issue, articles on botulinum toxin A¹⁵ and polyglactic acid implants¹⁶ explore the technique and benefits of aesthetic procedures, and a pilot study¹⁷ reports the probable mechanism of action of intralesional phosphatidylcholine lipolysis.

Among those seeking cosmetic procedures, approximately 10% are women with body dysmorphic syn-

drome.¹⁸ Dermatologists are more likely to see women with dysmorphic syndrome because these patients perform repetitive behaviors such as skin picking.¹⁹ The delusional state of some skin pickers is recognized by the former name of this disorder, *dermatologic hypochondriasis*.²⁰ In this issue, Meehan et al²¹ report on the treatment of delusions of parasitosis with olanzapine. Recognizing patients with delusions of parasitosis is usually not difficult, but identifying those with distortion and preoccupation with appearance (ie, the body dysmorphic syndrome) can be very challenging and makes treating such patients difficult because of their unrealistic expectations.

PREVENTING DERMATOLOGIC DISEASES IN WOMEN

Although occupational hand eczema may occur at any age and in either sex, it is most commonly observed in women. Hairdressers are at risk for 2 of the leading occupational dermatoses, irritant and allergic contact dermatitis of the hands. In the Danish population-based study²² in this issue, the most severely affected occupations were kitchen workers, cooks, and hairdressers. The study by Khumalo et al²³ also confirms the increased risk of allergic contact dermatitis in hairdressers. Those with lower socioeconomic status are particularly vulnerable, with a high risk of prolonged sick leave, job change, and the loss of their job.²² Patients with atopic dermatitis also fare poorly. By counseling a young patient with atopic dermatitis about the potential impact of different types of future employment, dermatologists might encourage a teen from an economically disadvantaged family to consider learning secretarial skills rather than attending beauty school or working as a cook.

Similarly, dermatologists may play a role in vaccinating female preteens and teens before their first sexual encounter. Preteens and teens cease having regular care from pediatricians but may see dermatologists for the treatment of plantar warts, acne, or eczema. Sexual transmission of the human papilloma virus (HPV) leads to persistent infection with oncogenic viruses, which is a risk factor for cervical cancer in women.^{3,24} After years of dedicated research, medicine is on the cusp of being able to prophylactically immunize adolescent women before sexual exposure and thereby potentially modify this risk factor.²⁵ As we consider prevention of dermatologic diseases, such as HPV infection, in women, it is important to recognize that this depends on changing societal norms and expectations.

SOCIOCULTURAL BARRIERS TO WOMEN'S HEALTH CARE

Health care cannot improve for many women as long as the worldwide threats of domestic violence, illegal abortion, sexually transmitted diseases, and genital mutilation remain. Ironically, these issues have less to do with actual women's diseases than with societal pressures and cultural norms. When women or girls are not highly valued and have little political or economic power, the health care system makes little to no effort to reach them. For example, in many African and Middle Eastern coun-

tries, women must obtain their husband's permission to seek health care.²⁶ Cultural and social norms, including education and financial status, strongly influence women's health care status. Women who are on the social and economic margins of society are often denied access to basic human rights, including equality, education, physical integrity, health care, and economic security.

In the Greco-Roman tradition, a woman was regarded as the property of her father and then of her husband until she died.²⁷ The Judeo-Christian religion established the notion of wife as the property of her husband in the last of the Ten Commandments: "Thou shalt not covet thy neighbor's house, thou shalt not covet thy neighbor's wife . . . nor anything that is thy neighbor's" (Exodus 20: 17). In this tradition, the wife is equivalent to a piece of property. Hinduism provides scriptural sanction for *sati*, the practice of widow burning: "Let these women, whose husbands are worthy and are living, enter the house with ghee (applied) as corrylium (to their eyes). Let these wives first step into the pyre, tearless without any affliction and well adorned" (Rig Veda: X.18.7). Patriarchy continues in Islam: "Men are the protectors and maintainers of women . . ." (Koran, Surah an-Nisa: 34).

Although sex-based persecution takes many forms, certain common threads are woven on the warp of religious tenets. When women are viewed as the property of the men in their family, the owners of the property have the right to decide its fate; thus, women become a commodity to be exchanged. Women and girls, as opposed to men and boys, often suffer violence at the hands of family members within the private sphere of the patriarchal home. Honor crimes, bride price, domestic violence, incest, female genital mutilation, forced marriage of children, and widow rituals are tied to notions that men own the bodies of the women in the family. The choices women make with regard to their bodies are not their own but rather are a reflection of the values of the family and the larger cultural and/or religious community.

Securing women's health means broad-based social transformation of complex sexual and cultural mores that must involve men in approaches that collide with social convention, political sensitivity, and religious doctrines. As women assume leadership positions in medicine around the world, we have the opportunity to influence the health care of all women by tackling sociocultural ideas. The work that lies before us in this century is to achieve the health care emancipation of women in all nations.

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