Taking care of men’s skin problems—giving advice to men and boys

To coincide with Men’s Health Week, which runs this year from 14 to 20 June, Christine Clark explains what pharmacists can do to help men care for their skin, and says that it is never too early to start getting healthcare messages across men.

Male skin is usually thicker, oilier and hairier than female skin. Broadly speaking it is subject to the same genetic variations and environmental influences as female skin. However some problems occur more commonly in men. Others, such as those linked to facial shaving and the male genitalia, occur only in men. Some fungal infections occur more commonly in men, acne affecting the chest and back can be a particular problem and the changing pattern of skin cancers gives special cause for concern in men.

We know that men have a different approach to healthcare from women and, as the 2007 report on men and pharmacy noted, men do not necessarily feel comfortable in the female-oriented atmosphere of a community pharmacy. The provision of malespecific information was recommended as one way of communicating important healthcare messages to men.

Cancer Research UK recently announced that the mortality rate for men with malignant melanoma had doubled in the past 30 years. In the late 1970s fewer than 400 men died each year from malignant melanoma and now the figure is more than 1,100. The rate of mortality increase among men over 65 has increased five-fold during this period (from 3.0 per 100,000 in 1971 to 15.2 in 2008). Nevertheless, more than half the deaths occurred in men under the age of 70 years, some only in their 20s.

Melanoma is regarded by many as an avoidable and curable condition. It is avoidable because the major factors that contribute to its development are well known. It is curable because, if detected early while the tumour is still thin, it can be removed and the prognosis is good.

The key measure in melanoma prevention is avoidance of excessive exposure to ultraviolet light. Some groups of individuals are at higher risk than others — those with a personal or family history of melanoma and those who have atypical mole syndrome make up one group and those with a pheno-
undertake self-examination and seek medical advice for suspicious lesions, eg, a mole that starts to change shape, colour or size. One problem here is that the most common site for melanoma is men on their backs, and so a second person might be needed to help with the check.

Other types of skin cancer — non-melanoma skin cancer (NMSC), basal cell carcinomas (BCCs) and squamous cell carcinomas (SCCs) — are also UV-induced and they are much more common than malignant melanoma. About 80 per cent of skin cancers are BCCs. BCCs are slower growing and can be successfully removed, but if they are numerous this can be disfiguring on the face, scalp etc.

Messages about sun protection need to be given to men, especially those in high-risk groups, because the figures clearly show that men’s skin does not have any magic, inbuilt protection. One thing that makes it difficult to communicate the message is the 10 to 20 year time lag between exposure and the development of skin cancers; the present sharply rising incidence of skin cancer is attributed by many to the rise in popularity of package holidays in the 1970s.

The key messages are:

- Avoid sun when it is most intense, cover up and wear a hat with a wide brim.
- Use a broad spectrum sunblock that protects against both UVA (the ageing rays) and UVB (the burning rays) high factor sunscreen. Ideally this should have a minimum four-star rating for UVA and a minimum SPF 15 for UVB. Apply plenty, but do not use sunscreen to stay out in the sun longer, and reapply after swimming.
- Protect young children — start good habits in boyhood.
- Identify men who have had organ transplants (eg, kidney) — immunosuppressed people are at higher risk than others.

Fungal infections (feet and groin)

Fungal skin infections are common. They are caused by dermatophytes and yeasts that thrive in warm, moist environments and so the feet and groin areas are typical sites for infection. Athlete’s foot is the commonest type of fungal infection in humans. It is estimated to affect 15 per cent of the population and 1.2 million people in the UK are believed to have fungal infection of the toenails.

Dermatophyte infections invade keratinous tissue such as skin, hair and nails. Athlete’s foot (tinea pedis) is caused by dermatophyte infection. Typically it starts as itchy, macerated skin between the toes, commonly affecting the fourth/fifth toe web space. It can spread to involve all the toe spaces, the skin over the toes. Chronic infection of the sole of the foot often appears as fine, dry, powdery scaling. It is made worse by occlusive footwear (trainers, rubber boots) and is spread by contact with infected skin scales in shared washing facilities, swimming baths etc.

If the condition is not treated it can spread to other areas of the body: groin infection (tinea cruris) is three times more common in men than in women. It can also affect the toenails (tinea unguium). Tinea cruris (also known as jock itch, dhobie itch, crotch itch or crotch rot) presents as an itchy, erythematous rash with a well defined scaly edge. It affects the upper, inner thighs, pubis and anal region but rarely involves the penis or scrotum. Tinea corporis can cause similar lesions on the skin in other areas. The lesions tend to enlarge slowly, while clearing from the middle, leaving a typical ring-like appearance (hence the old name “ringworm”). Infection of the toenails (tinea unguium) causes thickened, crumbly, discoloured nails. The changes start at the free edge of the nail and it rarely affects all the toenails.

Topical treatments for dermatophyte infections

Athlete’s foot, ringworm and groin infections can all be treated with topical creams, gels, sprays or powders. There are two types of topical antifungal products — imidazole derivatives ( clotrimazole, miconazole, ketoconazole, sulconazole, econazole) and terbinafine (an allylamine). Allylamines have a fungicidal action whereas azoles are fungistatic. Although overall cure rates have been similar in some trials, allylamines take effect more quickly and require shorter treatment times.

The most common problem in the management of athlete’s foot is poor adherence to treatment. When treatment starts the itching and inflammation subside in a few days, but treatment should be continued for one to two weeks to ensure that the infection is eradicated. The antifungal cream, gel or spray should be applied to both feet, between and over the toes, the soles and sides of the feet. The single application treatment Lamisil Once could increase the effectiveness of treatment. This product is a liquid that is painted on to the feet and forms an invisible, water-resistant film on the skin, which acts as a drug reservoir. High levels of terbinafine persist in the stratum corneum for 13 days. Overall, this treatment is as effective as a one-week treatment with terbinafine cream. Lamisil Once must be painted on both feet, between the toes, on the sides and soles, and allowed to dry. The feet should not be washed for 24 hours after application.

Additional important messages are:

- Prompt, effective treatment can head off problems later; undertreatment can result in ongoing problems.
- Warm, moist conditions encourage the growth of dermatophytes and so measures to keep the feet and body fold cool and dry are important (cotton socks, cotton underwear, loose clothing, etc).
- Fungal spores on skin flakes can spread the disease to others and can reinfect the patient so towels should not be shared, underwear and socks should be changed frequently and old training shoes should be discarded.

Acne

Common acne (acne vulgaris) affects approximately 80 per cent of young adults between the ages of 12 and 24 years. The incidence of acne peaks at 18 years of age and it usually continues for four or five years. Experts believe that the prevalence of acne among older people is increasing, although the reasons for this are uncertain.

Acne has been described as “an inflammatory disease, characterised by embarrassment, shame, guilt, anxiety, depression, frustration, anger and pimpls”, emphasising that both the skin disease and its profound psychological impact need to be taken into account. Most acne sufferers self-diagnose and self-treat with over-the-counter products. However, young men tend not to seek treatment for acne as readily as young women — and may not admit that large areas of the chest or back are affected. There are many reasons for encouraging young men to seek advice and treatment for acne sooner rather than later. The severity of a patient’s acne is

Acne affects 80 per cent of young adults between 12 and 24 years
Acne is more common in smokers and residues in food might account for some. Recently it has been suggested dioxin-like compounds in cigarette smoke. This may be related to dioxin-like compounds in cigarette smoke. Young men need to know that effective treatments are available for acne and it is not “wasting the doctor’s time” to ask for a suitable prescription treatment. They should also be advised that topical treatments must be applied to the whole of the acne-prone area and treatment must be continued for at least two months. Trials of topical products show that improvements are still occurring after 12 weeks of treatment.

**Shaving problems**

Red, raised bumps and ingrown hairs, irritation, or rashes in the beard area are all problems that can be associated with shaving. They are most common in men who have curly facial hair, especially those of African-Caribbean descent. It is estimated that up to 80 per cent of African-Caribbean men suffer from shaving problems.

**Barber’s rash** (sycosis barbae, folliculitis), is caused when the hair follicles become infected with *Staphylococcus aureus*, commonly carried in the nasal passages. The infection leads to redness, itching, and small, pus-filled blisters.

**Razor bumps** (shaving rash, pseudofolliculitis barbae, PFB) are not infective in origin but a foreign body inflammatory reaction surrounding ingrown facial hair. It can also develop into full-blown folliculitis. Ingrowing hairs occur spontaneously in curly haired individuals but can also occur in others when the shaving technique results in the hair being cut below the skin surface. Folliculitis is treated with systemic antibiotics. Pseudofolliculitis can be treated by adopting a good shaving technique to avoid cutting the beard hairs too short. If the skin is very irritated a period of not shaving can also help. In the long term, good skin care and good shaving technique usually solve the problem (see Panel).

**Proper shaving technique helps to avoid skin problems**

**Good shaving technique**

Ideally, the shaving process should cut hairs off flush with the surface of the skin, with minimal friction and irritation to the surrounding skin.

Shave when the hairs have been wet for five minutes (eg, at the end of a shower). Wet hair is much softer and easier to cut than dry hair.

Shave in the direction of hair growth (usually with downward strokes), and minimise repeated strokes. Although this will not give the closest shave, it reduces the risk of ingrown hairs, cuts and irritation.

Shave with the skin in a neutral relaxed position and avoid stretching the skin taut as far as possible.

Aim for a close shave, but not too close. Alternatively, use an electric razor that cuts the hair a little longer or use a barber’s clipper (with clipping guard) to prevent shaving closer than 1mm cut of whisker hair.

**References**