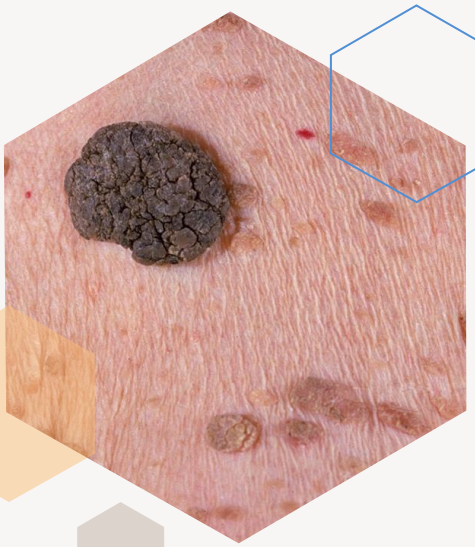
Skin Changes in Geriatric Patients: What's Normal, What's Not, and What We Can't Miss



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Viewpoints presented are my own and should not be considered to represent those of the VA

Learning Goals:

By the end of this lecture, participants will be able to:

- Distinguish normal age-related skin changes from pathologic findings
- Identify common benign, premalignant, and malignant skin lesions in older adults
- Recognize red-flag features requiring urgent escalation
- Apply a standardized escalation framework across care team roles
- Improve early detection while avoiding unnecessary referrals

Why Skin Assessment in Geriatrics Matters

- Skin disease is one of the most common reasons older adults seek medical care
  - Unlike many other health issues, they can see these problems
- Incidence of skin malignancy rises sharply with age
- Older adults are more likely to present with advanced stage malignancies
- Skin findings can be an indicator of systemic disease
- Skin diseases contribute to:
  - Infection risk
  - Hospitalizations
  - Functional decline
  - Reduced quality of life

What Normal Aging Skin Looks Like

Key Changes:

- Thinning, translucency
- Xerosis (dryness)
- Increased fragility
- Delayed healing

Why?

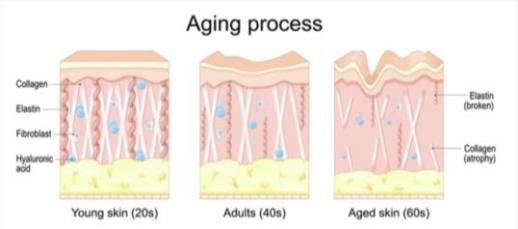
- ↓ Epidermal turnover
- ↓ Collagen & elastin
- ↓ Sebaceous/sweat glands
- Impaired immune surveillance (immunosenescence)

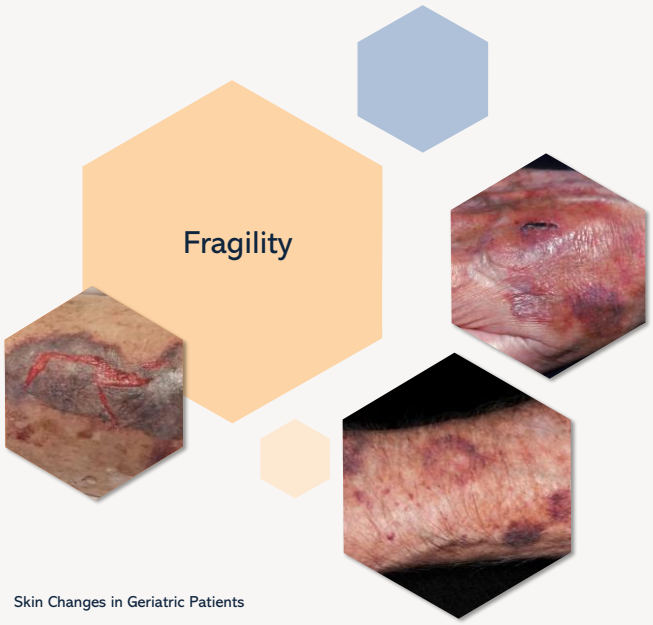
You need to know what normal is to know what's not normal.

Common Skin Changes in Geriatric Patients:

Atrophy (thinning):

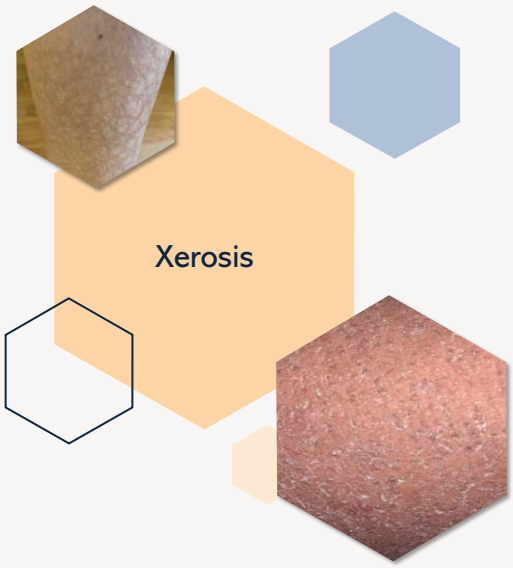
- "Crepey" texture, loose and sagging
- Veins can become much more prominent on the hands and arms
- Many patients bothered by appearance, but not dangerous
  - Little supportive evidence for any topical or oral supplements to improve elasticity or appearance





Fragility:

- Thinning skin from loss of collagen and UV exposure
- Leads to increased incidence of:
  - Skin tears
  - Bruising
    - Senile (Actinic) Purpura
      - Purple ecchymoses commonly on the forearms/hands
      - Only mild trauma needed
  - Poor/delayed wound healing



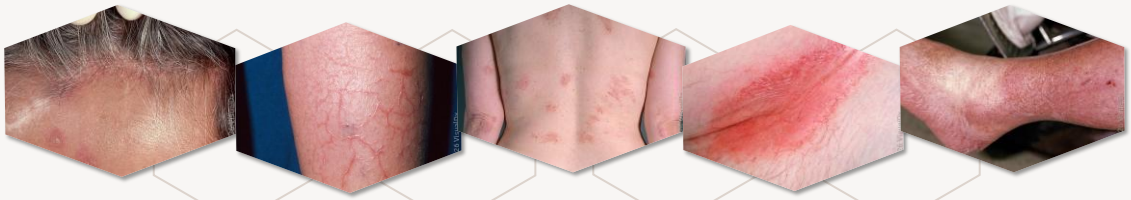
Xerosis (Dry Skin):

- The MOST COMMON skin condition in geriatric patients
- Can be pruritic (very, or not at all)
- Creates increased risk for:
  - Skin breakdown
  - Rashes
  - Infection
- When to worry:
  - Symptomatic, intractable, and/or associated with secondary changes (rashes or wounds)
- Key educational points:
  - Contrary to popular belief, skin hydration can't be improved with increased water intake!!
  - Habitual application of moisturizing cream, with options for keratolytic or emollient

Dermatosis Neglecta:

- More than simple dry skin
- Caused by inadequate exfoliation
- Buildup of skin cells, sebum, sweat, and normal skin flora (bacteria and sometimes yeast)
- More common in individuals with physical limitations or mental health conditions
- Will often not be able to be removed with soap and water, but isopropyl alcohol works well
  - Encourage gentle friction with regular bathing routine

So Many Rashes, So Little Time



Seborrheic Dermatitis

- "Dandruff on steroids

Primarily found: scalp, brows, ears, alar creases, beard.

Asteatotic Eczema

- "Cracked riverbed"

Primarily found: lower legs, but can occur on arms and trunk

Nummular Eczema

- VERY pruritic!
- Coin shaped

Primarily found: extensor surfaces

Intertrigo

- Can burn, sting, itch
- Caused by moisture & friction

Primarily found: Intertriginous regions (i.e. skin folds)

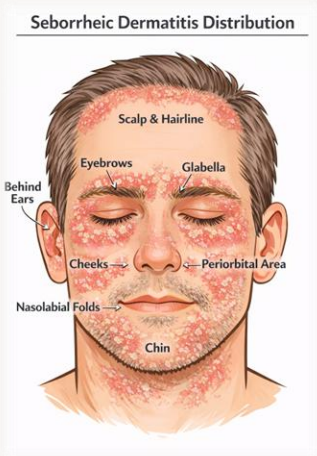
Stasis Dermatitis

- Texture and color changes
- Can develop ulcers

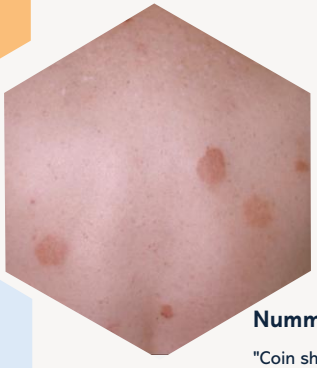
Primarily found: ankles, lower legs, sometimes dorsal feet

Seborrheic Dermatitis

- VERY common
- Can occur throughout the lifetime, but increases significantly in 5th and 6th decades
- Can feel itchy and irritated
- Most common on the scalp, ears, and face, but can occasionally be seen on the trunk, underarms, and groin
- OTC or Rx anti-dandruff shampoos are helpful
- Avoid chronic topical steroid use!



Rashes of Dry Skin



Nummular Dermatitis

"Coin shaped" scaly plaques

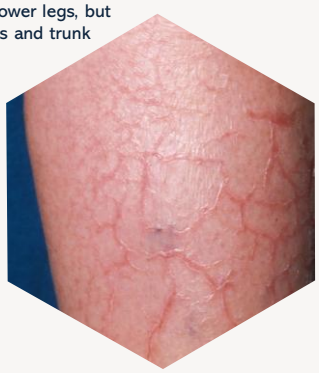
Usually very itchy!

Dry skin management principles

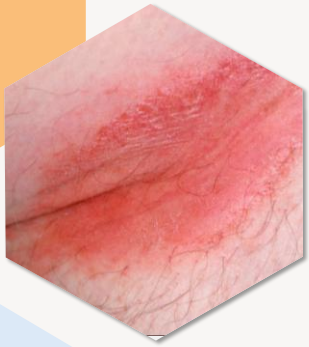
Asteatotic Eczema

Dry "cracked riverbed" appearance

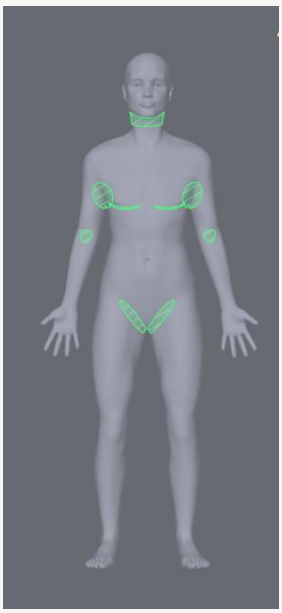
Primarily found: lower legs, but can occur on arms and trunk



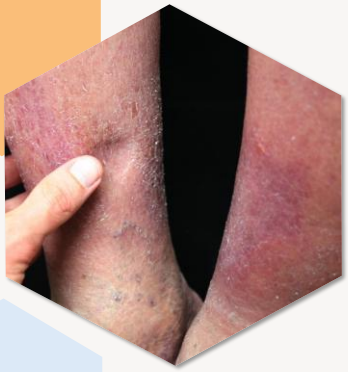
Intertrigo



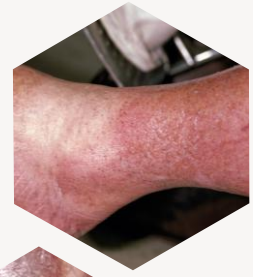
- Inflammatory condition in skin creases/folds: underarms, groin, infrabreasts, neck, pannus
- Worse with increased moisture, friction, and heat.
- Redness with possible maceration and/or skin breakdown
- Irritation and burning
- Can be secondarily infected with bacteria or yeast
- Behavior modifications is mainstay of prevention, but this may require brief use of topical steroids

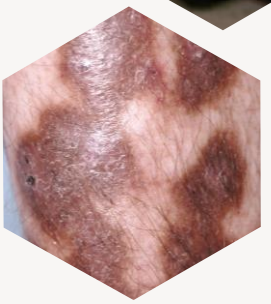


Stasis Dermatitis



- "Venous stasis dermatitis" or "stasis eczema"
- Scaly rash that can be itchy and/or irritated
- Found on the lower legs, ankles, and dorsal feet in people with reduced vein functioning / edema
- Risk for ulcerations!!
- Dark pigmentation called hemosiderin deposition is not necessarily active rash, but can mask it
- Compression stockings (if able), moisturization, topical steroids

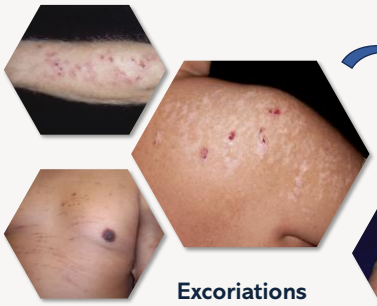




Pruritus (Itching)

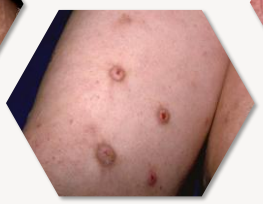
- Itching is common, with many possible causes
  - Can be multifactorial, but xerosis is the leading contributing factor
- It's a source of significant morbidity
- May occur with or without visible rash
- Secondary changes to the skin from scratching are NOT the same as active rash!
- If no visible rash, think:
  - CKD, liver disease, nerve conduction changes, thyroid dysfunction, iron deficiency, medication effects, hematologic malignancy
- Red flags:
  - Generalized pruritus without rash
  - Severe nocturnal itching
  - Unintentional weight loss, fevers, night sweats
  - Pruritus refractory to emollients>2–4 weeks
  - Signs of infestation (burrows, multiple affected residents)
  - Jaundice, dark urine, pale stools

Pruritus Without Rash Can Look Like...



Excoriations

- Scratches on the skin
- Active wounds +/- scabs
- Healed areas appear pink, white, or hyperpigmented

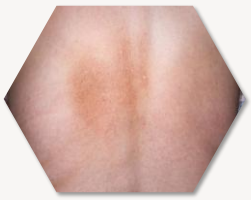


Prurigo Nodularis

- Chronic scratching, picking, rubbing the same spot
- Prurigo nodule become EXTREMELY pruritic

Lichen Simplex Chronicus

- Commonly on the head/neck, groin/genitals, and lower legs
- Chronic scratching thickening of the skin, to a leathery texture and appearance



Notalgia Paresthetica

- Localized itching between the shoulder blades
- Chronic scratching causes hyperpigmentation

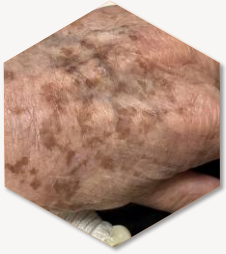
Benign Pigmented Lesions

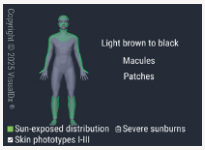
Solar Lentigines

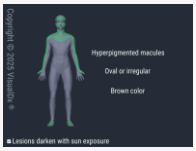
"Sun Spots" or "Liver Spots"

Occur in sun exposed areas

Most are benign (but they have the potential to become malignant)





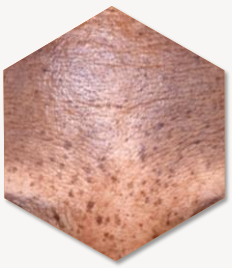


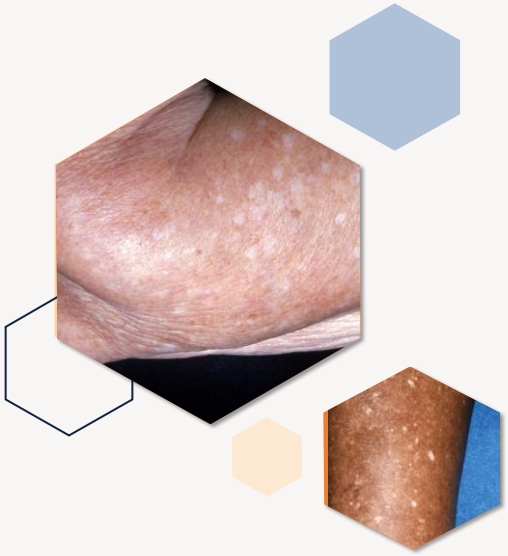
Feature	Solar Lentigines	Ephelides (Freckles)
Melanocyte number:	Increased	Normal
Melanin production:	Increased	Increased
Rete ridges:	Elongated, clubbed	Normal
Epidermal hyperplasia:	Often present	Absent
Solar elastosis:	Common	Absent / Minimal
Persistence:	Permanent	Seasonal
Age association:	Older adults	Childhood

Ephelides

"Freckles"

Less common than lentigines, but often coexist





Guttate Hypomelanosis

- "Confetti-like" spots that are lighter than surrounding skin tone
- Especially found on the arms and legs, occasionally the trunk (areas of chronic sun damage).
- Rarely seen on the face
- They don't grow or change, but can be more noticeable when skin is tanned

Benign Skin Growths

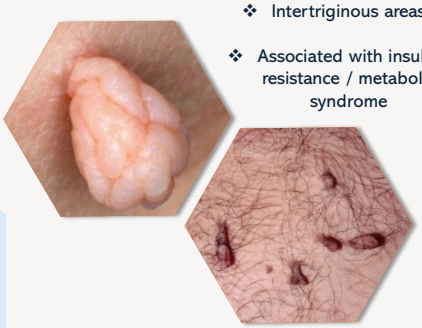
Seborrheic Keratoses

- "Barnacles"
- Not related to UV exposure
- Tend to be hereditary
- Can occur anywhere EXCEPT: lips, palms, soles

Benign Skin Growths

Skin Tags

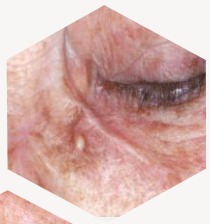
- Intertriginous areas
- Associated with insulin resistance / metabolic syndrome



Hemangiomas

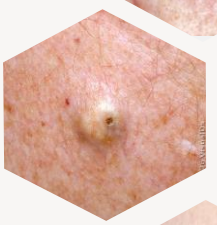
- "Cherry angiomas"
- Often called "red moles" by patients

Benign Skin Growths



Milia

- Small (1–2 mm), white or yellow keratin cysts
- Common on face (especially periocular)
- Benign, stable --> cosmetic



Cysts

- Firm, mobile subcutaneous nodule
- Central punctum often visible
- Common on face, neck, trunk
- May become inflamed or rupture with trauma

Dilated pores of Winer

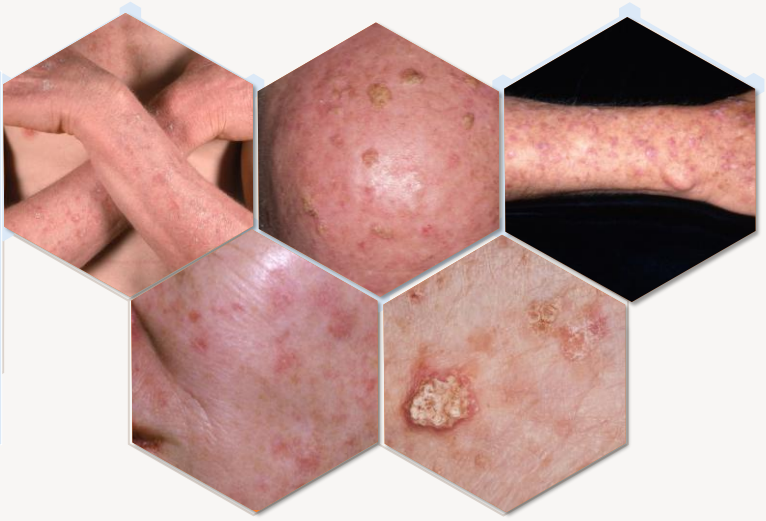
- Large solitary “blackhead-like” opening
- Often on face, neck, or back
- Keratin plug within widened follicle
- Can be expressed, but will re-fill

Pre-malignant and Malignant changes in Geriatric Skin:

- Actinic Keratoses (AKs)
- Basal Cell Carcinomas (BCCs)
- Squamous Cell Carcinomas (SCCs)
- Melanoma Variants
- Zebra Diagnoses Not To Miss

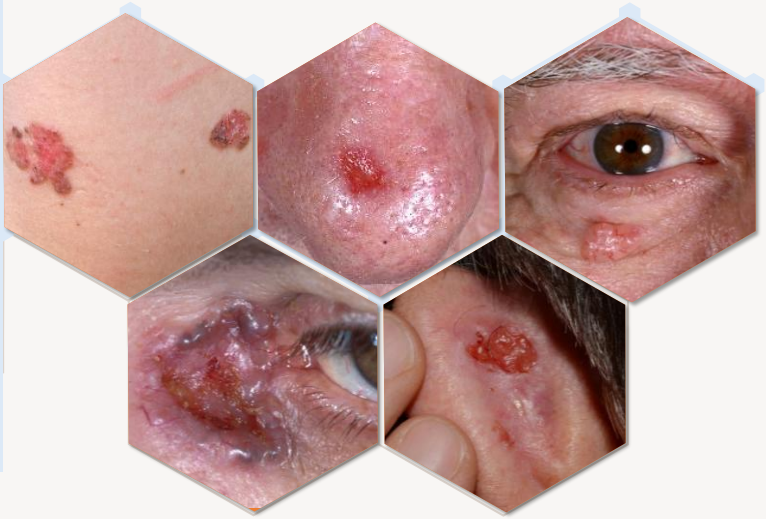
Actinic Keratoses (AKs)

- Considered precancerous
  - Risk of transformation to skin cancer
- Caused by chronic UV damage
- Varying degrees of scale – subtle to hypertrophic
  - Hypertrophic AKs can be difficult to differentiate from SCC clinically



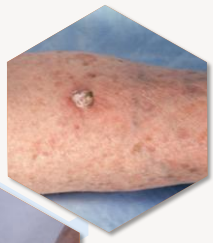
Basal Cell Carcinomas (BCCs)

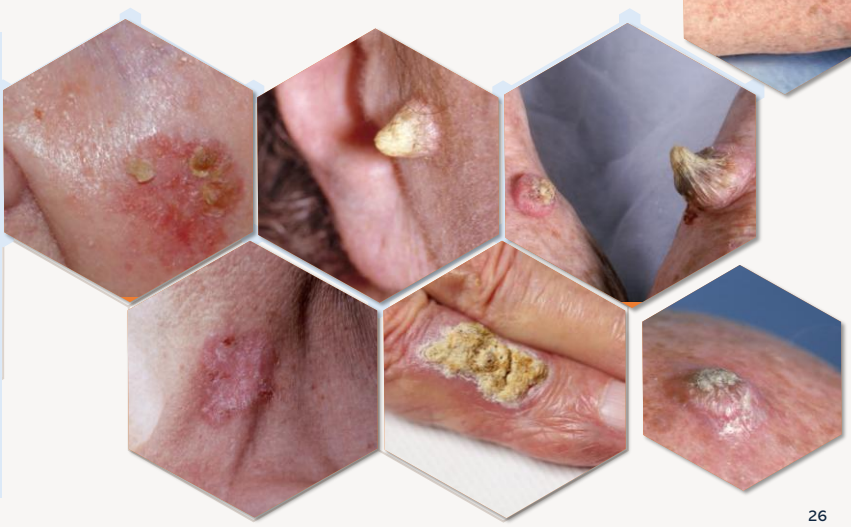
- Most common type of skin cancer
- Rarely metastasizes, but is commonly locally destructive
- Common subtypes:
  - Superficial
  - Nodular
  - Infiltrative / Morpheaform
- Hallmarks:
  - Slow growing
  - "Non-healing" wound
  - Bleed easily
  - Rolled borders
  - Can be pigmented



Squamous Cell Carcinomas (SCCs)

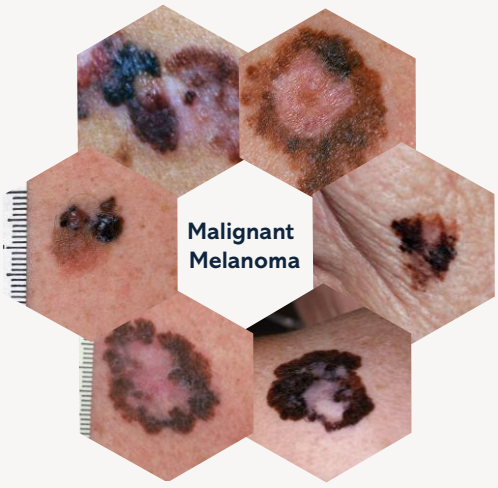
- Second most common type of skin cancer
- Common subtypes:
  - Superficial (Bowen's)
  - Invasive
  - Keratoacanthoma type
- Risk factors:
  - UV damage (# of AKs)
  - Fair skin type / freckling
  - Immunosuppression
  - Exposures (chemicals, smoking)
  - Scars or non-healing wounds



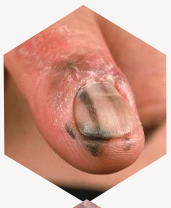


Melanoma

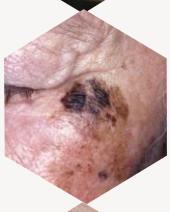
- The "Big Bad Scary" cancer
- Subtypes / classifications:
  - Superficial (MIS)
  - Nodular
  - Lentigo maligna
  - Acral / nail
  - *Amelanotic
- Risk factors:
  - UV damage
  - Strong family history
  - High number of nevi



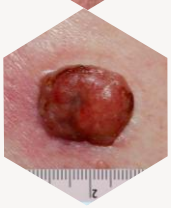
More obvious presentations that many would recognize as concerning



Acral / Nail

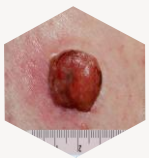


Lentigo Maligna



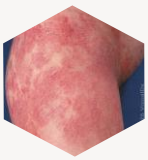
Amelanotic

Zebra Malignancies



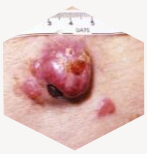
Amelanotic Melanoma

- Almost no brown pigment --> pink, red, or close to skin-colored
- Can resemble BCC, SCC, or pyogenic granuloma



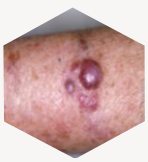
Cutaneous T-Cell lymphoma (CTCL/Mycosis Fungoides)

- Many different presentations, but most common is chronic persistent "eczema-like" patches/plaques
- Often on the trunk and in sun-protected areas (hips/saddle bags)



Merkle Cell Carcinoma

- Rapidly growing, firm, red/purple nodule
- Typically on sun-exposed skin (head/neck)
- Can be painless
- More common in immunosuppressed patients



Angiosarcoma

- Rare, but aggressive
- Bruise-like patch, or dilated vessel-like plaque

Delayed diagnoses in older adults

Delayed diagnoses is multifactorial:

- Patient level factors:
  - Changes attributed to "just aging"
  - Generational beliefs - "if it doesn't hurt, it's not serious."
  - Cognitive impairments, patients less likely to self-report
- Disease level factors:
  - Blunted symptomology
  - Lesions hidden in in less visible areas
- System level factors:
  - Multiple comorbidities competing for attention
  - Time-limited visits / problem-focused encounter

EARLY DETECTION IS A TEAM SPORT!

- Nursing & MAs: early visibility during vitals, wound care, bathing
- Primary care clinicians: opportunistic skin checks amid chronic care
- Home health & LTC staff: longitudinal view → notice subtle change
- Caregivers & family: trusted reporters of "this looks different"

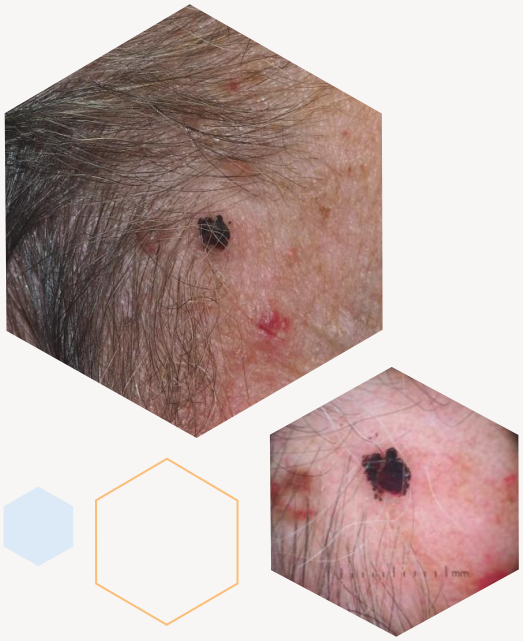
Clinical Rules That Prevent Missed Cancer

1. **Non-healing = treat as malignant until proven otherwise**
2. **New 'mole' after 50 deserves examination**
3. **Bleeds, grows, or hurts = escalate**
4. **Ugly duckling beats pattern recognition**

Clinical case

- 03/2024: 79 y/o male presents to his PCP with multiple concerns, including a lesion on the right temple x 3 months reported as itchy. He is referred to Teledermatology.
- 04/2024: Telederm read as possible non-melanoma skin cancer, or mechanical trauma. Recommendation for shave biopsy within 30 days.

What do you notice?

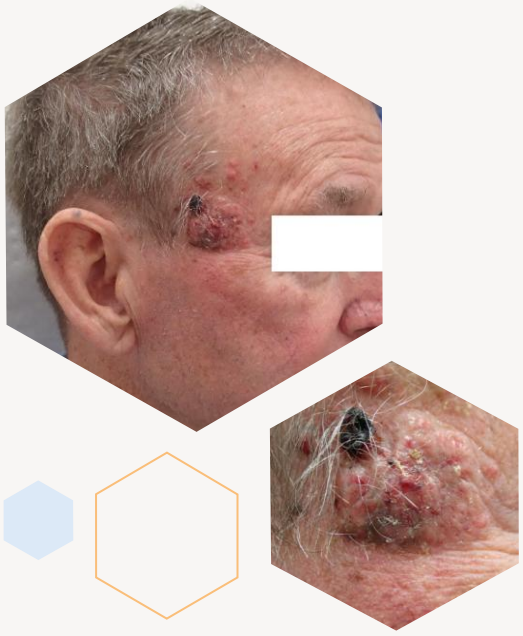


Clinical case

- 06/2024: Patient is seen in Dermatology for recommended biopsy, with noted rapid growth/evolution of the lesion with the following exam:

"Right temple: 3.0 x 2.5 cm pink/tan/brown shiny plaque, at the superior/lateral aspect is a 8 x 6 mm dark black hemorrhagic crust. There are several shiny pink papules ranging from 3-5 mm in size scattered superiorly. Overall, the affected region measures 5.0 x 3.5 cm."

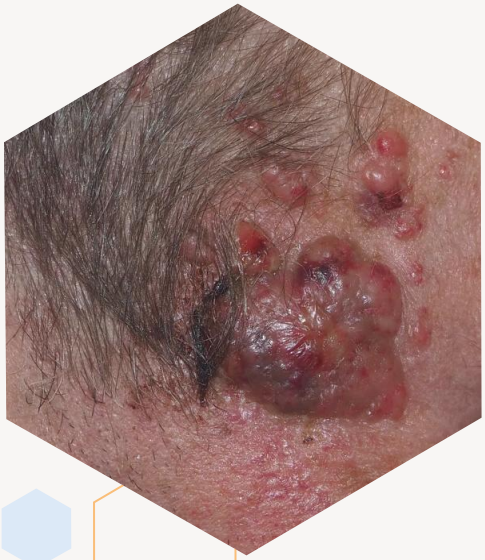
- Shave biopsy performed with differential listed as: Merkle cell vs melanoma vs SCC vs angiosarcoma



Clinical case

- 06/2024: Eight days later the patient presents to PC for rapid regrowth of the lesion in the previously biopsied area. Is sent for same day Telederm.

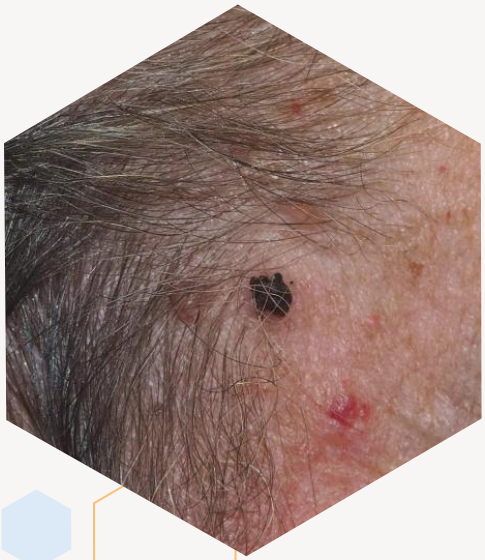
" (Condition 1) Differential Diagnosis:
1. *merkel cell carcinoma*
2. *melanoma*
3. *metastatic tumor from other source*
4. *atypical mycobacterial or fungal infection"*



Clinical case (cont)

- 06/2024: Pathology results received four days later confirm melanoma.

Final Diagnosis
Skin, right temple, shave biopsy
- Malignant melanoma with the following features:
1. Histologic subtype: Nodular.
2. Approximate Breslow thickness: At least 2.0 mm, see comment.
3. Clark's Level: At least IV, see comment.
4. Ulceration: Present.
5. Mitotic rate: 8/mm2.
6. Lymphocapillary invasion: Not identified.
7. Satellitosis: Not identified.
8. Perineural invasion: Not identified.
9. Lymphocytic infiltrate: Present, non-brisk.
0. Regression: Not identified.
1. Margins: Peripheral and deep margins involved by invasive melanoma.
2. Melanoma in situ: Not definitively present.
3. Stage: At least pT2b (per AJCC 8th edition), see comment.



Clinical case (cont.)

- Patient was referred to Fred Hutch with recommendation for immunotherapy prior to surgical management.
- 07/2024: CT showed right temporal scalp lesion and small indeterminate lung nodules.
- 11/2024 Multiple immunotherapy regimens trialed with continued clinical growth, finally with tumor response to 3rd line treatment.
- 02/2025: Repeat CT showed small skin lesion (6 x 3 mm) on the right temple, no evidence of subcutaneous involvement, without lymphadenopathy
- 02/2025: Wide local excision completed with residual primary disease found, but negative SLNB

Thank you!