PRACTICE POINTER

Skin camouflage

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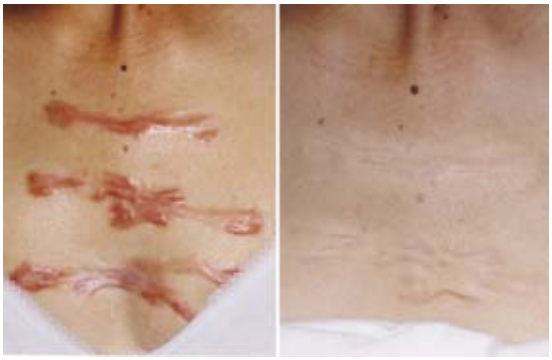
Skin camouflage can play an important part in improving wellbeing for patients with permanent or chronic skin problems

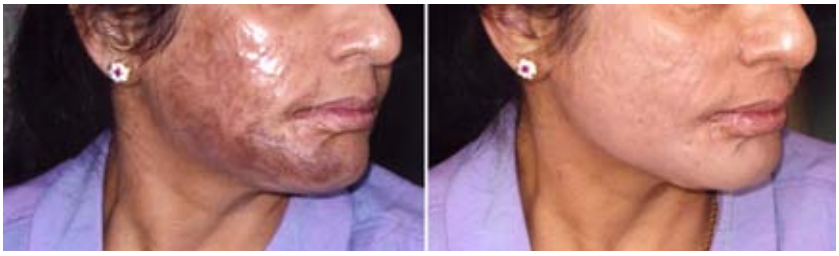
A Health Care Needs Assessment, *Skin Conditions in the UK*, estimated that skin problems account for about 10% of a general practitioner's surgery time and 6% of hospital outpatient referrals.[1] According to the British Association of Dermatologists (www.bad.org.uk, July 2011), 15% of the population per year will be seeking help from their general practitioner for a skin condition, and most patients will have their skin disorder diagnosed and treated in primary care.[1 2] As many as 30% of these patients also experience psychological distress owing to perceived disfigurement.[3] This can affect quality of life and ability to participate in work and social activities, which in turn can affect the quality of life of their family members.[4] For those with permanent or chronic disfigurement, use of skin camouflage can help a patient to adjust to an altered image and regain their self esteem by creating a sense of personal wellbeing.[5]



Keloid before (left) and after (right) camouflage

Which patients might benefit from skin camouflage?

For skin camouflage to be applied safely, the skin needs to be sealed, healed, and non-infectious, which rules out its use in many skin conditions seen in primary care.[6] *The Monthly Index of Medical Specialities* (*MIMS*) lists the conditions suitable for skin camouflage as port wine stain, vitiligo, and scarring (see table), but it overlooks other conditions in which these products may be suitable and beneficial. For example, beauticians and make-up consultants traditionally advise that patients with acne and rosacea should not cover up their skin with any cosmetic preparation, especially when it contains oils and waxes. However, a 2005 clinical report on acne treatment found that patients with inflammatory eruptions, including those with typical rosacea and mild to moderate acne, psychologically benefited from wearing skin camouflage.[7] During the study, inflammatory eruptions decreased, and quality of life indicators such as reoccurrence, appearance, frustration, embarrassment, being annoyed, and feeling depressed showed significant improvement. A research report about patients with keloid and hypertrophic scarring concluded that those with scar tissue 5 cm in length were particularly concerned with their appearance, regardless of whether the scar was immediately visible or hidden by clothing (Scar Information Service www.scarinfo.org; research sponsored by Smith and Nephew undertaken by Entri Research, 1999).



Facial burn before (left) and after (right) camouflage

Skin camouflage agents listed in *MIMS*

Brand	Foundation	Size (price)	Finishing/ fixing powder	Size (price)	Indication
Covermark	10 shades	15 mL (£11.32)	1 shade	50 g (£11.32)	Concealment of scars, birthmarks, vitiligo
Dermacolor	150 shades	25 mL (£8.10)	7 shades	60 g (£6.55)	Concealment of scars, birthmarks, vitiligo
Keromask	9 shades	15 mL (£5.68)	1 shade	20 g (£5.68)	Concealment of scars, birthmarks, vitiligo
Veil	40 shades	19 g (£20.62), 44 g (£30.68), 70 g (£38.74)	1 shade	– (£22.62)	Masking of scars, birthmarks, vitiligo

Details correct July 2011. £1=$1.6, €1.2.

What is para-medical skin camouflage?

At first there would appear to be little difference between over the counter corrective make-up and skin camouflage products—both set out to achieve the same result, which is to hide erythema, hyperpigmentation and hypopigmentation, unwanted tattoos (from radiography treatment), and scarring. However, products designed for skin camouflage differ from normal cosmetics in that they are very durable, lasting 8 to 16 hours before they need to be reapplied, and, when correctly applied, they make the camouflaged area water resistant. Skin camouflage products are designed to mimic and blend in with the natural skin colour, while the structure of the skin will remain unchanged. Service providers are careful not to use the words "make-up" and "cosmetics" when discussing skin camouflage. The term "skin camouflage" is non-exclusive, whereas "cosmetics" and "make-up" can create anxiety for those who would not normally wear decorative cosmetics.[6]

Where can patients obtain skin camouflage products?

The brands of skin camouflage currently listed in the *Drug Tariff*, *MIMS*, and *BNF* are available in the United

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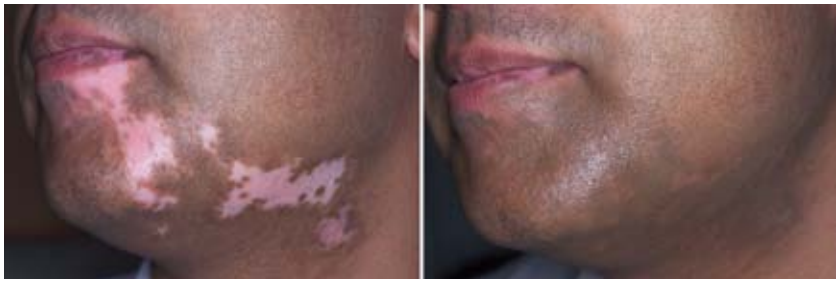
Previous articles in this series

- Persistent vaginitis (*BMJ* 2011;343:d7314)
- Diagnosing and investigating adverse reactions in metal on metal hip implants (*BMJ* 2011;343:d7441)
- How to minimise risk of acquiring tuberculosis when working in a high prevalence setting (*BMJ* 2011;342:d1544)
- Identifying and managing deprivation of liberty in adults in England and Wales (*BMJ* 2011;342:c7323)



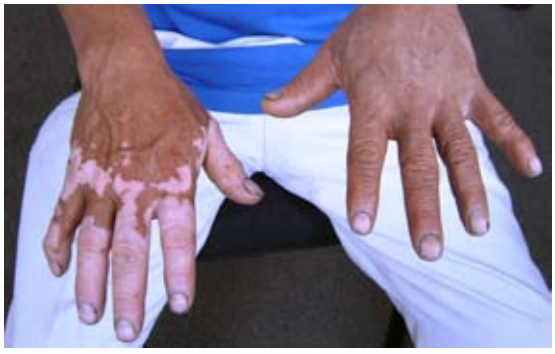
Facial vitiligo before (left) and after (right) camouflage

Kingdom on National Health Service prescription at the healthcare adviser's discretion. These brands can also be readily obtained privately through the internet and mail order, and can be ordered off prescription at a chemist.

How is skin camouflage used?

The usual method of application uses simple techniques to apply a fine layer of camouflage cream, followed by a setting powder. Although the products contain sun protection, additional (oil-free) sunscreen can be applied under and over the camouflage. The patient's normal make-up can be worn over their camouflage, and topical medication (including silicone gel scar treatment) or emollients can be applied before the camouflage.

Brands of skin camouflage vary in texture, slip, durability, and sun protection factor, which means one product may be better than another for a certain skin type and condition or more suitable for a patient's lifestyle. Before issuing the patient with any product, it is important to achieve an acceptable match between their unaffected skin colour and a camouflage cream. If no single colour is suitable, two can be mixed together.



Vitiligo of hands before and after camouflage

Port wine stain before (left) and after (right) camouflage

The British Association of Skin Camouflage recommends that users remove their camouflage on a daily basis. However, the organisation has not received any reports that camouflage cream and powder, when correctly applied, encourage comedones or worsen scarring or skin conditions.

Camouflage services are not readily available in primary or secondary care, but can be sought privately through the British Association of Skin Camouflage, the Skin Camouflage Network, and the Red Cross Camouflage Service (see box). The British Association of Skin Camouflage has trained members worldwide.

The British Association of Skin Camouflage is the only organisation that trains professionals for both NHS and private practice, and its graduates use both prescription and over the counter products. The Red Cross trains volunteers who work within the NHS and consequently uses only prescription products. We recommend that primary care services consider employing a member of staff who is trained to consult with patients requiring skin camouflage. During a consultation, the patient should be taught the correct procedure for applying the products, maintenance during their use, and methods of effective removal. A model for such a service is established at the Vitality Community Dermatology Service in Birmingham, which employs a specialist dermatology nurse to advise patients on skin camouflage (see box).

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Patienct consent: Images supplied by British Association of Skin Camouflage, which obtained patient consent for publication.

A NURSE SPECIALIST'S PERSPECTIVE

Skin camouflage is provided as part of the community dermatology service. I usually meet the patient in the dermatology clinic before their specific camouflage appointment. This provides the opportunity to introduce myself, to inform them about skin camouflage, and to manage their expectations.

The patients appreciate the "one stop" service; they do not have to wait for a further referral to the hospital, as they are booked in for the next available camouflage appointment. If the patient requires a routine dermatology review, the camouflage appointment can be arranged to coincide with this, thus avoiding multiple attendances. If the patient is not due for a review but expresses concerns about their condition or the management, then these would also be addressed during the camouflage consultation.

Camouflage consultations take up to one hour. In addition to educating the patient about the use of camouflage, the consultation provides the opportunity to offer further support and education about their underlying condition.

Providing the service in house benefits the patient, as they are treated holistically and the camouflage is offered as part of a management plan. It is rewarding to see the patient leave happier and with increased confidence after a successful consultation.

Julie Panter, dermatology nurse (BASC graduate), Vitality Dermatology Practice, Birmingham, UK

RESOURCES FOR PATIENTS

British Association of Skin Camouflage (www.skin-camouflage.net)—national and international provider of training for medical professionals and qualified beauticians (NHS and private practice)

British Red Cross Skin Camouflage Service (www.redcross.org.uk)—trains volunteers for the NHS

Skin Camouflage Network (www.skincamouflagenetwork.co.uk)—national association of practitioners in skin camouflage (does not provide training)

These organisations also offer an internet, postal, and telephone help line for patients, healthcare professionals, and others with questions about skin camouflage

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A PATIENT'S JOURNEY

Facial disfigurement

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This is one of a series of occasional articles by patients about their experiences that offer lessons to doctors. The *BMJ* welcomes contributions to the series. Please contact Peter Lapsley (plapsley@bmj.com) for guidance.

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Previous articles in this series

- Gambling addiction (*BMJ* 2011;343:d7789)
- Sir Karl Popper, swans, and the general practitioner (*BMJ* 2011;343:d5469)
- Living with alkaptonuria (*BMJ* 2011;343:d5155)
- Amyloidosis (*BMJ* 2011;343:d6326)
- Facial disfigurement (*BMJ* 2011;343:d5203)

Krysia Saul, who was severely disfigured by a dog attack at age 5, describes the process of coming to terms with her appearance and others' attitudes

Essex, 1955, approaching my sixth birthday; dad had agreed to do some carpentry work in our landlady's house, so I accompanied him. While he worked I explored the grounds looking for chickens. No chickens, but an Alsatian dog, chained since a puppy to his kennel. On that day the dog broke free and attacked me. It tore the skin from my back, pierced a lung, and savaged my right cheek, leaving a ragged hole from my ear to the corner of my mouth through which my tongue and teeth were visible.

I was rushed to Mount Vernon Hospital, then one of the few specialist centres for reconstructive surgery. I was not expected to survive, and treatment focused on keeping me alive. Surgeons had no experience of this kind of trauma or of the surgical techniques required to reconstruct my face. Initially they patched my face with a skin graft from my leg so that my cheek looked like one of Dad's darned socks.

Later, when my face had grown to its adult size, a pedicle flap was taken from my stomach and placed over the graft—a process that took several operations, each requiring a long stay in hospital. Journeys to the hospital by public transport seemed lengthy and arduous; my parents rarely visited because the travelling costs were so high. I read voraciously, acquiring the vocabulary of a much older child; my resilience is probably rooted in this phase of my life.

Most of the operations occurred throughout my time at junior school, when I must have looked like a patchwork doll. I became an object of curiosity and felt uncomfortable with others' attitudes towards my appearance. At a bus stop, two women remarked that I shouldn't be allowed out in public; another whispered that I should have been put down at birth. Outside a shop, a woman wearing dark glasses stared persistently, unaware that I could see her looking at me. Though hot with embarrassment, I glared back. Nowadays I smile if someone stares; they usually smile back or look away. To those who continue to stare I laughingly offer a photograph to remember me by—which leaves them feeling uncomfortable, not me. Naughty, though!

To compensate for lost schooling, I spent the last years of my education at a boarding school, where I felt comfortable because no one paid any attention to my scar. But starting work marked the beginning of a deep self-consciousness. Travelling to London meant my using public transport, a journey I hated. On trains and buses I rushed to a window seat, so that my "good" side was visible to anyone sitting next to me. Some people stared behind their newspaper; others gazed with hostility as though I had done something to deserve my face. I read a book, did a crossword, pretended to be asleep, and hid beneath swathes of hair deliberately grown long—anything to avoid the public gaze.

People's experience of visible difference and of dealing with it varies widely. Initially, I sought to achieve the flawless face portrayed in contemporary romantic novels through surgery. The final operation, instigated by me, was not a success, largely because of my unrealistic expectations. I reluctantly concluded that nothing would fully restore my face, so I had better learn to live with it.

Psychosocial support was never offered as an option. My general practitioner knew nothing about skin camouflage products and had little time for my concerns about self image. He even commented that I should be grateful to be alive at all. Yet camouflage became an important coping strategy, helping me literally to face the world with confidence, to express my identity, underpinning more sustaining coping behaviours and

A CLINICIAN'S PERSPECTIVE

I am not Krysia's doctor: I was her colleague and am a general practitioner and an educator. Krysia asked me to write this companion piece not only to add a doctor's perspective, but also to reflect on how we might improve the skills of health professionals in interacting with people with disfigurement. But, having written that sentence, I am reminded of Krysia's preference for the term "living with visible difference" as being a more inclusive and less value-laden description than disfigurement. When I first began working with Krysia at a UK medical school, of course I noticed her facial appearance but was not going to mention it, in the same way that I would not pass comment about someone with a missing limb or obvious neurological deficit. In social and (non-clinical) work circumstances we learn to notice but not question, certainly at least not until we have built a trusting and mutually respectful relationship. In our clinical roles, however, when we first meet a new patient we have to decide whether to ask and what to explore.

As a general practitioner the first consultation may be about symptoms or problems that seem unrelated to the disfigurement. Do we wait until the patient mentions it, perhaps when asked about their medical history? Or do we probe, potentially ineffectively, by asking: is there anything else you want to discuss? But this reflects on us, as health professionals, seeing the disfigurement as a problem, which it perhaps is not for the patient. However, in the early stages of a post-traumatic event like Krysia's, we need to be aware that there may be help we can offer. Patients may ask for help; if they do not, then we need to have the right words ready. We risk labelling someone like Krysia as being defined by her appearance. If we do decide to probe, we need to have some solutions available such as referral for camouflage for example, or the suggestion of a local self help group. And if we don't know of any possible solutions, we need to promise to find out, and follow-up on this promise. We must also remember that disfigurement is not always apparent—for example, a mastectomy, or severe scarring.

I have learnt a lot from Krysia about Changing Faces and resilience. As doctors we are never totally off duty and our interactions with people in situations outside the surgery add to our experience of human life and adversity. The patient centred approach (including exploring ideas, concerns, and expectations) is obviously still applicable when interacting with patients with similar needs to Krysia's—she writes eloquently of her unrealistic expectations at one point in her journey. We cannot help rewrite expectations unless we know what they are.

Recruiting simulated patients with visible difference for generic consultations (that is, not specifically involving the "disfigurement") will help students and junior doctors practise how to approach such patients and ask questions. Simulated consultations may also address the disfigurement directly to allow learners to explore expectations and discuss strategies.

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resilience. In my experience general practitioners know little about camouflage but will refer patients with disfigurement for surgical intervention. Some regard self image as a more difficult problem to resolve than disfigurement, as though they were separate issues.

In mid-1960s in Britain cosmetics generally, and camouflage products specifically, were neither as fashionable nor as accessible as in America. I researched the topic among the few beauty magazines available and wrote letters to "experts" and editors. I travelled to Scotland to visit Doreen Trust, who was born with a facial birthmark, and was the only person promoting camouflage makeup at that time. Camouflage products were not widely promoted, were expensive, and were available only by post from London. They came with little guidance, and early applications were frustrating, unpredictable, and time consuming. Dreadful colours, thick messy creams—facial Polyfilla. I cried for hours striving for the desired look. Today, several excellent brands are available on prescription and over the counter, and the British Association of Skin Camouflage provides training and support. Using camouflage routinely is a mixed blessing. Although it undoubtedly eased my transition from adolescent to adult in a society quickly becoming obsessed with facial perfection, successful application requires time, practice, and a good skin care regime. Users may become psychologically dependent on them but NHS-prescribed camouflage products are dermatologically tested and afford protection from the sun and harmful pollutants.

As a young adult I was anxious that my make-up would wear off, and I avoided social activities involving water, even though camouflage is waterproof when correctly applied. The prospect of sleeping with a guy raised concerns about the "big reveal." At what point in a relationship did one confess to looking worse without make-up, and how was I to "face up" the following morning? I slept with my make-up on and rose early to cleanse and reapply my face—which meant keeping my "kit" close by or ensuring that "sleeping" took place in my house. Intimacy and relationships pose substantial challenges for people with visible difference; especially if (as in the case of a former boyfriend) one's partner is obsessed with perfection. Nothing about me pleased him: my legs were too fat, my bust too small, and of course that scar was such an embarrassment. Worse, he wanted a naturally perfect face, free of blemish and artifice!

Some people are extraordinarily blunt and don't mince their words. Curiosity about my scar is understandable, but I bristle when asked, "What's wrong with your face?" That word "wrong" incenses me. There is nothing "wrong" with my face, although it is different. I tend to respond by playing dumb: "I give up, what is wrong with my face?" "What happened to your face?" comes a close second, though I also tell a nice story about the time I was tracking crocodiles on the Limpopo . . .

Healthcare professionals can also be insensitive. Comments like, "What an interesting scar," and, "What have you been up to then?" seem remarkably imperceptive to me. A psychologist suggested that, "People would soon get used to your scar without camouflage," unaware that it's not other people's feelings I'm concerned about. Healthcare professionals sometimes trivialise concerns that are related to appearance, and approaching a general practitioner may require some mental preparation. Although disfigured, I am not ill, and I do not regard myself as a patient, but when visiting my general practitioner about skin problems even I feel compelled to legitimise the consultation through illness—as if mental wellbeing were less important.

FURTHER READING

The British Association of Skin Camouflage (http://www.skin-camouflage.net)—provides a comprehensive service for people who are interested in para-medical skin camouflage

The British Red Cross (www.redcross.org.uk/What-we-do/Health-and-social-care/Social-support-in-the-UK/Skin-camouflage)—the charity has a team of trained volunteers who can teach people how to self-apply specialist cover creams

Changing Faces (www.changingfaces.org.uk)—a UK based charity giving support and information to people with disfigurements to the face, hands, or body, and their families

Few general practices display leaflets on appearance-associated ailments, voluntary groups, or psychosocial support, although some refer patients for counselling. However I doubt they refer patients to organisations like Changing Faces, a charity specifically established to support people with visible difference regardless of cause or condition. Recently treated for breast cancer, I was surprised how little attention was paid to the potential distress patients might experience from an altered appearance resulting from aggressive treatments. Nurses, attempting to make light of the side effects of treatment, can appear to be dismissive of anxieties about self-image that will vary with the individual. Patients investing heavily in their self-image might benefit from psychosocial support and camouflage.

Camouflage also helped me focus on more absorbing aspects of life such as marriage and academia. I came late to both. My husband, Norman, imbued me with emotional well-being and self-worth and academia with intellectual self belief. I would rush through my morning regime in order to finish that essay, write that paper, study for exams. Naturally, I would prefer to have no scar. But camouflage serves as a useful prop, part of my armoury against society's unseemly battle with youth and perfection without resorting to surgery, which can never restore me to "normal." It helps me portray externally the "me" that lives inside.

Competing interests: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, no other relationships or activities that could appear to have influenced the submitted work.

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Doctors' revalidation bags

GP appraiser Mayur Lakhani finds doctors' revalidation folders strangely evocative

I have been a GP appraiser for more than 10 years now. Appraisees have to deliver their folders to the appraiser's surgery. During this time, the packaging that these folders arrive in has fascinated me. Many folders arrive in shopping bags, which range from high street fashion brands to more stylish bags from Hermes and Selfridges and gift bags from national sporting events. Some are delivered simply as lever arch files held together with a rubber band. Others are torn foolscap wallet folders in flimsy supermarket plastic bags.

DUNCAN SMITH

The bags give a glimpse of the lives of the doctors preparing for appraisal and revalidation—bags that may reflect a doctor's lifestyle and what he or she had been doing recently. I remember an exotic hessian bag with a famous sari shopping mall logo, full of evocative eastern fragrances containing a superb folder of supporting information. As I retrieved it from the bag, I imagined the journey of the bag from the bazaars of the Indian subcontinent to the UK and a cold consulting room—perhaps describing the story of the movement of the doctor.

Another striking one was a large sparkling pink envelope—normally used for glitzy invitations. As I walked around with this pink "bling" in the practice and at home, people kept asking what the invitation or gift was. It seemed surreal that we were considering matters of livelihood and GMC registration with party envelopes.

The bags exemplify the diversity of the medical profession in origin, persona, interest, and styles. Now increasing numbers of doctors use paperless systems with electronic portfolios. All documentation will soon be electronic. I shall miss the vibrant and evocative bags.

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