Dermatological disease in the older age group: a cross-sectional study in aged care facilities

Maneka S Deo,1 Ngaire Kerse,2 Alain C Vandal,3 Paul Jarrett1,4

ABSTRACT

Objectives: To estimate the prevalence of dermatological disease in aged care facilities, and the relationship between cognitive or physical disability and significant disease.

Setting: 2 large aged care facilities in Auckland, New Zealand, each providing low and high level care.

Participants: All 161 residents of the facilities were invited to participate. The only exclusion criterion was inability to obtain consent from the individual or designated guardian. 88 participants were recruited—66 females (75%), 22 males (25%) with average age 87.1 years (SD 5.5 years).

Primary and secondary outcome measures: Primary—presence of significant skin disease (defined as that which in the opinion of the investigators needed treatment or was identified as a patient concern) diagnosed clinically on full dermatological examination by a dermatologist or dermatology trainee. Secondary—functional and cognitive status (Rehabilitation Complexity Scale and Abbreviated Mental Test Score).

Results: 81.8% were found to have at least one significant condition. The most common disorders were onychomycosis 42 (47.7%), basal cell carcinoma 13 (14.8%), astreotoxic eczema 11 (12.5%) and squamous cell carcinoma in situ 9 (10.2%). Other findings were invasive squamous cell carcinoma 7 (8%), bullous pemphigoid 2 (2.3%), melanoma 2 (2.3%), lichen sclerosus 2 (2.3%) and carcinoma of the breast 1 (1.1%). Inflammatory disease was more common in those with little physical disability compared with those with serious physical disability (OR 3.69; 95% CI 1.1 to 12.6, p=0.04). No significant association was found between skin disease and cognitive impairment.

Conclusions: A high rate of dermatological disease was found. Findings ranged from frequent but not life-threatening conditions (eg, onychomycosis), to those associated with a significant morbidity (eg, eczema, lichen sclerosus and bullous pemphigoid), to potentially life-threatening (eg, squamous cell carcinoma, melanoma and breast cancer). Those with less significant physical impairment were found to be at greater risk of inflammatory dermatoses.

INTRODUCTION

Residents in long-term residential care for older people are a vulnerable group in the community that is growing with ageing of the population. In New Zealand (NZ), the 65+ age group will form 23% of the population by 2036,1 and therefore the requirements for residential care will increase as the proportion of the older people in the population rises.

Older people living in long-term residential care may face multiple barriers to receiving appropriate care for dermatological disease not least of which include physical disease and cognitive deficits. Aged care facilities may not have optimal surroundings in which to undertake a comprehensive skin check, primary care physicians may lack dermatological training or confidence in dermatological examination and visits to such care facilities by dermatologists may be infrequent, although these factors will vary from country to country. In addition, older individuals may also have difficulty in obtaining transportation to dermatology clinics or face...
financial barriers to accessing care in the private health sector. In NZ, it is not routine for specialist dermatological care to be provided in the setting of an aged care facility; rather, specialist dermatological care is accessed outside the facility, in the public or private sector out-patient clinics.

There are several studies on the prevalence of dermatological disease in the older people but none from NZ. The data that exist suggest a high prevalence of both inflammatory dermatoses and skin cancer.2–5 In a study published in 2005 carried out in Tampa, Florida, the most common dermatological diagnosis was ‘pruritus and other related diseases’ but basal cell and squamous cell carcinoma were also recorded.6 A review of 61 reports from 12 countries examining the prevalence of skin disease among older people in different clinical environments reported a 57% prevalence of onychomycosis affecting nursing home residents.7

Skin disorders can significantly limit quality of life and, in the cognitively impaired, symptoms such as pruritus and pain may lead to behavioural disturbances. Older people with dermatological disease experience a higher rate of depression.8

Managing skin cancer in the setting of a long-term residential care facility in the face of multiple comorbidities can be challenging, as treatment decisions will differ compared with a young and healthy patient. Greater knowledge about the burden of disease in this vulnerable group will lead to better planning and delivery of dermatological care. This study sought to investigate the prevalence of dermatological conditions in residential care and test the hypothesis that those with the greatest physical or cognitive impairment would have the greatest dermatological disease burden.

**Aims and hypotheses**

The study aimed to estimate the prevalence of newly diagnosed dermatological disease in two aged care facilities and to examine the hypotheses that there was an association between cognitive or physical disability and undiagnosed dermatological disease in this population. In NZ, the elderly who reside in these facilities are usually either significantly physically and/or cognitively impaired.

**METHODS**

**Design**

A cross-sectional survey was conducted in two aged care facilities.

**Participants and recruitment**

All 161 residents of two large aged care facilities in South Auckland, NZ, were invited to participate in the study between December 2012 and November 2013. These facilities were selected as they provided low level care (where residents are partly mobile and require assistance with instrumental activities of daily living (IADLs) and one or two basic activities of daily living (ADLs), called rest homes in NZ, hostels in Australia, residential homes in the UK, assisted living in the USA to high level care (where most residents are dependent on 24 h nursing care and are dependent in most ADLs), called hospital level care in NZ, nursing homes in the UK, the USA and Australia. The residents were approached by letter and by personal invitation from the staff and researchers. However, if the resident was not able to give consent to the study, the next of kin or legally designated enduring power of attorney was approached. The consent included a request to undertake a genital examination, which could be declined or accepted. A genital examination was not undertaken or discontinued if it was deemed to be too distressing for the resident. The consent also permitted access to the clinical records.

**Disease outcomes**

The primary outcome was defined as the presence of any significant skin disease. A significant condition was defined as a dermatological disease that in the opinion of the investigators needed treatment or was identified during the assessment as a patient concern. A first set of secondary outcomes were defined as presence of a significant skin disease in one of the following categories: solar damage-related condition; infection or infestation; inflammatory disease; congenital disease; circulation or vascular disease; apocrine or sebaceous disease; immunobullous disease; any other disease. The disease subgroups consisting of all tinea, and of all eczema, respectively, were also added to the list of secondary outcomes.

**Disability risk factors**

The cognitive assessment was undertaken using the Abbreviated Mental Test Score (AMTS), which consists of 10 questions to assess memory, a score smaller than 8 suggesting cognitive impairment.9 For analytical purposes, the AMTS was categorised into three groups (0–3=serious impairment, 4–8=impairment and 9–10=no impairment). The physical assessment was by the Rehabilitation Complexity Scale (RCS) validated and used previously in residential care research in NZ to reflect physical disability.10–14 The RCS assesses 19 functions of older people among which are mobility, use of toilet, dressing, self-care appearance and showering/bathing. Each component is graded and the final figure is a summation of all the grades with a score of 19 the least disability and 76 the highest disability. The RCS was categorised into three groups (0–29=little impairment, 30–39=moderate impairment and 40+=serious impairment). Individual items of the RCS were also examined as specific risk factors.

**Assessments**

All the assessments were undertaken by a dermatologist (PJ) or a senior trainee (MSD) and all significant dermatological diseases were recorded. All significant dermatological diseases were reported by letter to the
primary care physician and access to publically funded treatment was made available if needed.

Statistical analysis
Descriptive analyses were carried out. Inferential analyses were carried out using logistic regression. Each disease category (including the primary outcome of ‘any disease’) was dichotomised and regressed on each of the two categorised risk factors. Both risk factors, as well as their interaction, were fitted together in other models. Results were reported as newly diagnosed disease ORs under serious versus low or no impairment, along with 95% CIs.

The potential confounders identified a priori were gender, age group and aged care facility. Age group and facility were considered distal risk factors compared with impairment level, and were not retained for adjustment. Gender was assessed as a potential confounder for each outcome and impairment type combination by considering the relative difference between the adjusted and unadjusted log-OR estimates associated with impairment and the significance level of the added gender term. Any relative difference of 10% accompanied by an observed significance level of 0.20 or less led to the reporting of a gender-adjusted OR. Participant records with missing AMT or RCS information were removed from the analysis set for the affected analyses only.

As further exploratory analyses, hypothesised relationships between specific disease categories and individual items on the RCS were also examined, as well as interactions between cognitive and physical disability as disease category predictors. Unadjusted observed significance levels were reported. The level of significance where applicable was set at 5% against two-sided alternatives, with a Bonferroni adjustment accounting for the two primary hypotheses used in the sample size calculation. Data were analysed using SAS software (SAS V9.3 for Windows).

RESULTS
Patient characteristics
There were a potential 161 residents, and in total 88 patients were examined (50%). The average age was 87.1 years (SD 5.5 years) and 55 patients consented to a genital examination. The study group was comprised of 66 females (75%) and 22 males (25%). Eighty-two participants were of European ethnicity (93.2%), two of Maori ethnicity (4.6%) and two participants were of Asian/Indian ethnicity (2.8%) (table 1).

The results relating to AMTS were as follows: 21 participants (25.9%) were designated as having no impairment, 35 participants (43.2%) had impairment and 25 participants (30.9%) had serious impairment (table 2).

The results relating to the RCS were as follows: little impairment was recorded in 42 participants (47.7%), moderate impairment in 18 participants (20.5%) and serious impairment in 28 participants (31.8%). The Spearman correlation coefficient between the AMTS and RCS was −0.63 (95% CI (−0.74 to −0.47); table 2).

Dermatological diseases
Eighty-eight residents were examined and 72 (81.8%) were found to have a significant dermatological disease. The number of diagnoses and their frequency are summarised in table 3.

The dermatological disorders are summarised in table 4. The most common disorders were onychomycosis 42 (47.7%), basal cell carcinoma 13 (14.8%), asteotitic eczema 11 (12.5%) and squamous cell carcinoma in situ 9 (10.2%). Other significant findings were invasive squamous cell carcinoma 7 (8%), bullous pemphigoid 2 (2.3%), lichen sclerosus 2 (2.3%) and carcinoma of the breast 1 (1.1%). Of those who consented to the genital examination, two were found to have lichen sclerosus.

Confounding by gender
Adjustment by gender caused relative changes of 10% or less in the ORs for both mental and physical impairment, and significance for gender of more than 0.20, in all but two combinations of outcomes and impairment. The exceptions were the combinations of the infection/infestation outcome with both types of impairment. The relative changes in OR exceeded 70%, and the significance of gender was 0.01 in both cases. Gender-adjusted impairment ORs were not significantly different from 1 in either case.

Association of disease groups with cognitive or physical disability
A comprehensive analysis was undertaken to examine groups of diseases, as well as specific diseases against the AMT and RCS total and specific scores. No associations were found between total dermatological disease burden...
and cognitive impairment (OR 1.5, 95% CI (0.30 to 7.4), p=0.88, no impairment vs serious impairment, any diagnosis) or physical impairment (OR 0.92, 95% CI (0.27 to 3.2), p=0.97, little impairment vs serious impairment, any diagnosis). However, examination of all inflammatory diseases showed that those with the least physical impairment had more inflammatory disease than those patients with the most physical impairment (OR 3.69, 95% CI (1.08 to 12.61), p=0.04). Significantly, more inflammatory disease was found in those with less physical impairment. Separate items of the RCS examined showed that those who were independent in self-care (compared with those that were dependent), and independent in toileting (compared with dependent) were more likely to have eczema. Separate items of the RCS indicating awareness and increased night care also showed that those who were fully aware and did not need night care were more likely to have eczema. The relevant findings are summarised in table 5.

**DISCUSSION**

There is a significant burden of unrecognised and inadequately treated dermatological disease in older people living in aged residential care facilities. This study did not show the expected correlation between dermatological disease burden and physical or cognitive ability but showed a significant association between being physically independent and having inflammatory skin disease. A potential explanation is that those residents needing and receiving a higher level of attention by the attending staff because of a significant physical disability had a greater level of incidental observation, and therefore treatment of dermatological conditions. This hypothesis is consistent with high-quality care. Additionally, it is encouraging that in this study, no cases of scabies were diagnosed. Potentially, better education of residents and assistance with application of creams for those who carry out self-care may be important. In addition, those residents with a mild physical disability who may be perceived by the residential care staff to be more independent in self-cares than those with a significant disability may require more help from the staff than anticipated to reduce their inflammatory disease burden. Since this study suggests that those with less severe physical disability are at greater risk of dermatological disease, this group may benefit from periodic skin reviews.

The aged care facilities were not randomly selected but chosen because they gave access to significant numbers of patients with a spectrum of physical and

---

**Table 3** Number of dermatological diagnoses

| Number of dermatological diagnoses | Frequency | Per cent |
|------------------------------------|-----------|----------|
| 0                                  | 15        | 17.1     |
| 1                                  | 26        | 29.6     |
| 2                                  | 24        | 27.3     |
| 3                                  | 14        | 15.9     |
| 4                                  | 6         | 6.8      |
| 5                                  | 3         | 3.4      |

**Table 4** Summary of all diagnoses

| Diagnosis                  | N   | Per cent |
|----------------------------|-----|----------|
| Infections                 |     |          |
| Onychomycosis              | 42  | 47.7     |
| Candida/intertrigo         | 9   | 10.2     |
| Tinea pedis                | 5   | 5.7      |
| Tinea corporis             | 3   | 3.4      |
| Folliculitis               | 1   | 1.1      |
| Tinea cruris               | 1   | 1.1      |
| Total infections           | 61  |          |
| Inflammatory               |     |          |
| Eczema asthotic            | 11  | 12.5     |
| Eczema lichen simplex chronicus | 5  | 5.7      |
| Eczema varicose            | 4   | 4.6      |
| Psoriasis vulgaris         | 3   | 3.4      |
| Chondrodermatitis helicis nodularis | 2  | 2.3      |
| Eczema contact irritant    | 2   | 2.3      |
| Psoriasis scalp            | 2   | 2.3      |
| Eczema contact allergic    | 1   | 1.1      |
| Eczema discoid             | 1   | 1.1      |
| Eczema seborrhoeic         | 1   | 1.1      |
| Psoriasis pustular localised | 1  | 1.1      |
| Total inflammatory         | 33  |          |
| Solar damage and skin cancer |   |          |
| Squamous cell carcinoma (in situ) | 9  | 10.2     |
| Squamous cell carcinoma (invasive) | 7  | 8        |
| Actinic keratosis          | 4   | 4.6      |
| Atypical/naevus exclude melanoma | 3  | 3.4      |
| Malignant melanoma         | 2   | 2.3      |
| Porokeratosis              | 1   | 1.1      |
| Basal cell carcinoma       | 13  | 14.8     |
| Total solar damage and skin cancer | 39 |          |
| Circulatory/vascular       |     |          |
| Capillaritis               | 2   | 2.3      |
| Ulcers venous              | 2   | 2.3      |
| Ulcers arterial            | 1   | 1.1      |
| Ulcers mixed               | 1   | 1.1      |
| Ulcers pressure            | 1   | 1.1      |
| Total circulatory/vascular | 7   |          |
| Apocrine/sebaceous         |     |          |
| Acne excoriee              | 3   | 3.4      |
| Immunobullous              |     |          |
| Bullous pemphigod          | 2   | 2.3      |
| Congenital                 |     |          |
| Ichthyosis NOS             | 1   | 1.1      |
| Other                      |     |          |
| Vitiligo                   | 3   | 3.4      |
| Lichen scroerus            | 2   | 2.3      |
| Breast cancer              | 1   | 1.1      |
| Epidermoid cyst            | 1   | 1.1      |
| Favre-Racouchot syndrome   | 1   | 1.1      |
| Web space fissuring        | 1   | 1.1      |
| Total other                | 9   |          |

NOS, not otherwise specified.
cognitive disease, ranging from low to high level care. Half of the potential patients were not enrolled due to a combination of inability to obtain suitable consent, frailty, declining participation and difficulty scheduling convenient appointment times. These factors may have lead to selection bias towards those with dermatological symptoms, those who had received less recent dermatological care and/or those patients who were expected by their next of kin to be more amenable to undergoing examination, although bias may well have lain in the other direction. Nevertheless, the gender and ethnic characteristics of the study group suggest that the findings are likely to be generalisable to a number of centres. Additionally, the diagnoses were made on a clinical basis but by a dermatologist working closely with a dermatology trainee. All significant diagnoses were reported to the general practitioner. The remit of the study did not permit laboratory testing.

Older people living in aged care facilities have a significant incidence of undetected disease, and with anticipated demographic changes, there will be challenges managing this problem both for the patient and dermatologist. There may be benefit from provision of visiting specialist services to this group. Alternatively, teledermatology could be considered. Those who were more independent in residential care had more inflammatory skin disease, suggesting that greater treatment of inflammatory skin disease was offered to those with greater dependency.

CONCLUSION

There was a high rate of undiagnosed and untreated dermatological disease in the study population with 81.8% having one or more significant finding. The disease types varied from the frequent but not life-threatening (eg, onychomycosis), to those associated with a significant morbidity that may be hidden from carers (eg, lichen sclerosus), to potentially life-threatening (eg, squamous cell carcinoma, melanoma and breast cancer). In this study, over 25% of the residents had three or more dermatological diagnoses. Those with less physical disability had a higher rate of inflammatory dermatoses. No significant association was found between dermatological disease and level of cognitive impairment.

Acknowledgements The authors wish to thank the senior management of the aged care facilities for permission to examine the residents and the residents for participation. They also wish to thank Mr Ben Elliott, student at University of Auckland, for summation and assistance with statistical analysis of the data.

Contributors All of the listed authors meet the ICMJE criteria for authorship. MSD contributed to study design, acquisition of data, interpretation of data, drafting article and final approval. NK contributed to conception and design, interpretation of data, revising the article and final approval. PJ contributed to study design, analysis of data, revising the article and final approval. ADV contributed to conception and design, data acquisition, analysis and interpretation, drafting and revising the article and final approval.

Funding Ko Awatea Centre for Health System Innovation and Improvement, Middlemore Hospital, Auckland, New Zealand.

Competing interests None declared.

Ethics approval New Zealand Health and Disability Ethics Committees of the Ministry of Health (reference number 12-NTA-36).

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement No additional data are available.

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

REFERENCES

1. Government NZ. National Population Projections: 2011(base)–2061. 2012 (18 May 2014). http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationProjections_HOTP2011.aspx
2. Smith DR, Sheu HM, Hsieh FS, et al. Prevalence of skin disease among nursing home patients in southern Taiwan. *Int J Dermatol* 2002;41:754–9.

3. Kiliç A, Gül U, Aslan E, et al. Dermatological findings in the senior population of nursing homes in Turkey. *Arch Gerontol Geriatr* 2008;47:93–8.

4. Yap KB, Siew MG, Goh CL. Pattern of skin diseases in the elderly seen at the National Skin Centre (Singapore) 1990. *Singapore Med J* 1994;35:147–50.

5. Liao YH, Chen KH, Tseng MP, et al. Pattern of skin diseases in a geriatric patient group in Taiwan: a 7-year survey from the outpatient clinic of a university medical center. *Dermatology* 2001;203:308–13.

6. Norman RA. Geriatric dermatology. *Dermatol Ther* 2003;16:260–8.

7. Smith DR, Leggat P. Prevalence of skin disease among the elderly in different clinical environments. *Aust J Ageing* 2005;24:71–6.

8. Kim EK, Kim HO, Park YM, et al. Prevalence and risk factors of depression in geriatric patients with dermatological diseases. *Ann Dermatol* 2013;25:276–84.

9. Hodgkinson H. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1:233–8.

10. Kerse N, Butler M, Robinson E, et al. Wearing slippers, falls and injury in residential care. *Aust N Z J Public Health* 2004;28:180–7.

11. Bonita R, Broad JB, Richmond DE, et al. Dependency levels of people in aged care institutions in Auckland. *N Z Med J* 1990;103:500–3.

12. Bonita R, Broad J, Richmond DE, et al. A profile of the 7500 people in aged-care institutions in Auckland. *N Z Med J* 1990;103:553–5.

13. Booth T. *Home truths: old people's homes and the outcome of care*. Aldershot, UK: Gower Publishing, 1985.

14. Flicker L. Clinical issues in aged care: managing the interface between acute, subacute, community and residential care. *Aust Health Rev* 2002;25:136–9.

15. Rubegni P, Nami N, Cevenini G, et al. Geriatric teledermatology: store-and-forward vs. face-to-face examination. *J Eur Acad Dermatol Venereol* 2011;25:1334–9.

16. McGoeyst ET, Oakley A, Rademaker M. Waikato teledermatology: a pilot project for improving access in New Zealand. *J Telemed Telecare* 2015;21:414–19.