Physiological Changes in Skin in Pregnancy

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Opinion

The woman's skin may undergo a number of changes during pregnancy, including physiological, pathological, or reversals of prior pathologies. 90% of pregnant women experience skin changes, according to the literature. Therefore, a variety of causes, including hormonal alterations, particularly those involving oestrogen and progesterone, might result in physiological changes. Additionally, physiological changes for foetal growth necessitate the modification of processes including vasodilation and skin distension. We can categorise the changes as physiological dermatological changes during pregnancy, specific dermatoses during pregnancy, dermatoses affected by pregnancy, and the last of which is more common than the others. Additionally, certain dermatoses, such as gestational pemphigoid, gestational prurigo, and polymorphic eruption of pregnancy, only manifest during pregnancy and are brought on by it. For individuals affected by pregnancy, on the other hand, there may be a pattern of improvement or deterioration of the dermatological condition as a result of pregnancy, such as lupus, psoriasis, atopic dermatitis, and acne. When it comes to the physiological ones, they are often self-limiting and benign changes that result from the hormonal and physical changes that occur during pregnancy. We can categories the changes as physiological dermatological changes during pregnancy, specific dermatoses during pregnancy, dermatoses affected by pregnancy, and the last of which is more common than the others. Additionally, certain dermatoses, such as gestational pemphigoid, gestational prurigo, and polymorphic eruption of pregnancy, only manifest during pregnancy and are brought on by it. For individuals affected by pregnancy, on the other hand, there may be a pattern of improvement or deterioration of the dermatological condition as a result of pregnancy, such as lupus, psoriasis, atopic dermatitis, and acne. When it comes to the physiological ones, they are often self-limiting and benign changes that result from the hormonal and physical changes that occur during pregnancy. Compared to the rate of 87.95% discovered in a study conducted in the central west region of Brazil, hyperpigmentation afflicted 78.6% of the patients. Regional differences, such as more sun exposure, can be used to explain this difference. Additionally, the second trimester in our study was the main trimester of onset, followed by the third. This may be because the placenta starts secreting excessive amounts of oestrogen and progesterone after 8 weeks of pregnancy. As a result, this hyperhormonal condition promotes melanin formation in regions with melanocytes that are more estrogen- and progesterone-sensitive. Compared to a study in India with n = 605 and a percentage of 77.4% for nipple involvement and 68.7% for linea alba, this situation had a higher percentage of nipple involvement. A hypermelanosis called melasma is defined by a clinical pattern of symmetrical, reticular lesions and persistent light brown to dark brown hyperpigmentation in photoexposed areas, especially the face. Between 36.4% and 70% of people have chloasma. In this study, a prevalence rate of 32.8% was discovered in the population under study, while a lower rate was later discovered in the literature. Its etiopathogenesis involves a number of factors that have been linked to the disease aggravation, including sun exposure, oral hormonal contraception, hormone replacement therapy, cosmetics, photosensitizers, pregnancy, and stress-related symptoms. The thenar and hypothenar eminences of the pregnant woman's palm are frequently affected by palmar erythema, which is a well-known primary physiological finding in pregnancy and typically consists of a non-painful, symmetrical, non-pruritic, non-scaly, somewhat warm erythema. 17.5% of the population under investigation had palmar erythema. With a prevalence of 43.5% in the population investigated, a comparable study conducted in Pakistan produced different results. However, a study conducted in India with a prevalence of 8% produced more comparable findings. Since palmar erythema is easier to see in lighter skin, this variation in results can be explained by the various cutaneous features of the groups investigated. Increased levels of circulating oestrogens, which are known to have a vascular proliferative impact and increase endometrial capillary density and consequently increase blood volume, appear to be associated with the pathophysiology of palmar erythema during pregnancy. Obstetric usage, arterial hypertension, perhaps preeclampsia, maternal obesity, and use of contraception are risk factors for the development of this dermatological alteration. Adipose tissue generates and secretes angiogenic factors, which are connected to the development of superficial venous and artery plexuses in the palm, in relation to maternal obesity. Contrarily, the usage of contraceptives amplifies estrogen vascular impact. Last but not least, systemic vasodilation is the cause of the connection between Palmar erythema and arterial hypertension and Preeclampsia.

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