BEAUTY

Why Dark Marks Behave Differently in Darker Skin

Pigment changes can look similar but behave very differently, making the right name-and realistic expectations-more useful than a crowded skincare routine.

The mark that stayed behind

The spot that started as a blemish is flat now. The irritation has settled. Yet a brown or grey mark remains, sometimes becoming more noticeable than the original problem. On darker skin, this aftermath can be persistent, difficult to treat and easy to mistake for an entirely different pigment condition.

Skin colour comes from melanin, made by specialised cells called melanocytes. If those cells become damaged or unhealthy, melanin production can change. Too much can darken an area; too little can lighten it. Pigment changes may affect one patch or much more of the body, so "pigmentation" is a description, not a single diagnosis.

Post-inflammatory hyperpigmentation (PIH) is one important part of this picture. It can affect every skin type but has a heightened tendency to occur in darker skin tones. In a 2024 systematic review focused on skin of colour, 89% of studied cases followed an inflammatory condition and 83% involved the face.

That helps explain why treating the colour alone can miss the story. If a dark patch followed inflammation, it is not simply an unwanted surface stain. It is the visible aftermath of something that happened in the skin-and the evidence suggests there is no uniformly reliable way to erase it.

Similar colour, different stories

Melasma is another common source of dark patches, especially in people with darker skin types. It is acquired, chronic and prone to returning. Estimates in a 2022 systematic review ranged from 8.8% to 40%, depending on the population's ethnicity and geographical area. The range is wide, but the message is clear: melasma is common and stubborn.

It can also carry more emotional weight than the word "pigmentation" suggests. Reviews describe effects on self-esteem and quality of life. That matters because recurring facial

colour changes are not frivolous concerns, even when they are physically harmless. You see them whenever you see yourself.

Not every pigment change is dark. Vitiligo is a long-lasting autoimmune disorder in which immune cells attack and destroy melanocytes, producing milky-white patches. These often appear symmetrically, such as on both hands or both knees, although a less common segmental form affects one side or area of the body. Hair and the lining of the mouth or nose can also lose pigment.

A changing coloured spot may instead be a mole. Moles form when melanocytes grow in clusters, and most people have between 10 and 40. Most are ordinary. But a mole that looks unusual, grows, changes colour or outline, or changes in another way should be checked by a health professional. Pigment is not a category you can safely diagnose by shade alone.

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The evidence is less tidy than the shelf

The treatment evidence for PIH in darker skin is sobering. A 2024 review covering 48 studies and 1,356 people found no robustly effective option across the available approaches. Topical retinoids were the most frequently reported intervention, with partial improvement in 85% of participants. With laser therapy, 66% had partial improvement.

Laser was the only intervention associated with complete clearing in a subgroup, affecting 26% of treated participants. But some people experienced worsening PIH after treatment. That is the tension running through this subject: a more intensive procedure is not automatically a more dependable answer, especially when the outcome you fear is more pigment.

For melasma, the evidence is stronger for certain topical medicines. A 2021 review of 113 studies involving 6,897 participants found that hydroquinone alone and a triple-combination cream containing hydroquinone, tretinoin and a corticosteroid were the most effective and best-studied options. Chemical peels and laser- or light-based procedures produced mixed results and carried a higher risk of adverse effects than topical treatments.

Those findings still do not turn melasma into a solved problem. Studies were often small, used different designs and lacked long-term follow-up. Recurrence remained high across treatment groups in another systematic review, although double and triple combinations generally performed better than single therapies. The honest promise is not permanent removal. The evidence does not support one.

More intervention is not always more certainty

Chemical peels occupy an awkward middle ground. A 2024 review of 24 studies, involving 1,075 participants, concluded that peels could be safe and effective for melasma and found glycolic acid the safest and most effective peel studied. But the researchers could not combine the results in a meta-analysis because the studies differed too much.

That does not directly cancel the earlier review finding that peels were equal or inferior to topical treatments. It changes the emphasis. Peels may help, but the evidence does not establish that they outperform the best-studied creams. They can also cause irritation, dryness, burning, redness and PIH-the very colour change a person may be trying to improve.

Oral tranexamic acid has shown promising results for moderate or severe recurrent melasma. Yet reviews also report systemic side effects and say that more research is needed on long-term safety and effectiveness. This is not a casual skincare add-on. It belongs in an individual medical discussion, particularly because melasma treatment should be matched to the subtype.

Food supplements do not provide a neat escape from those trade-offs. A 2024 review of 21 intervention trials associated tomato and lycopene supplementation with reduced skin pigmentation and some measures of light-related skin damage. But those trials studied photoprotection and photoageing in healthy participants, not treatment of PIH, melasma or vitiligo. That is an interesting result, not permission to substitute a supplement for a diagnosis.

Monday takes one clear question

Your next step is not to collect three actives and a peel. It is to work out which problem you are actually looking at. A lingering mark after inflammation, recurring melasma, a milky-white patch and a changing mole may all be described as pigmentation, but the evidence points to different explanations and different conversations.

If a mole is changing in size, colour, outline or another way, arrange a professional check rather than experimenting on it. New or rapidly spreading loss of colour also moves this beyond a cosmetic decision: vitiligo can progress quickly, and people with it may be more likely to have other autoimmune disorders.

For persistent dark patches, ask a clinician to name the likely condition before discussing procedures. For suspected melasma, reviews support examination that helps identify the subtype before choosing treatment. Then ask the hard question: "What is the evidence that this option works better than a topical treatment for my type of pigment change?"

That Monday step takes an appointment and one sentence prepared in advance: "This patch began or changed like this, and I want to know what it is before I treat the colour." You do not need a longer routine yet. You need the right name for the mark.

Where this comes from

- Skin Pigmentation Disorders

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/skinpigmentationdisorders.html
- Moles

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/moles.html
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- Chemical Peels for Melasma: A Systematic Review.

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  Journal of cutaneous medicine and surgery, 2024 · https://pubmed.ncbi.nlm.nih.gov/39075672/