

Review Article

AESTHETIC SKIN CARE IN GERIATRICS: OPPORTUNITIES AND CHALLENGES IN ENHANCING QUALITY OF LIFE IN OLDER ADULTS

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ABSTRACT: The rapidly aging population creates new demands for comprehensive healthcare, including aesthetic dermatology. Physical appearance directly influences psychological well-being, self-confidence, and quality of life in older adults. This review aims to analyze the role of aesthetic skin care in geriatrics, identify the boundaries between appropriate needs and excessive interventions, and highlight the risks of complications as well as physicians' responsibilities in ensuring safety; We systematically synthesized and analyzed medical literature published between 2015 and 2025 related to skin aesthetics, geriatrics, and elderly healthcare. PubMed, Scopus, and Google Scholar were searched using the following keywords: "geriatrics dermatology", "skin aesthetics", "aesthetic skin care", "elderly dermatology", "cosmetic dermatology," "aesthetic interventions complications elderly", "quality of life", "skin care elderly", "complications", "physician counseling"; Evidence indicates that aesthetic skin care significantly improves psychological health, quality of life, and social connectedness in older adults. However, complication risks are heightened due to multimorbidity, long-term medication use, and age-related physiological changes of the skin. Ethical considerations and the distinction between appropriate and excessive interventions must be carefully addressed in clinical practice; Aesthetic skin care in geriatrics represents an inevitable trend but requires cautious implementation. Physicians play a pivotal role in counseling, preventing complications, and selecting appropriate interventions to optimize both medical benefits and humanistic values in the comprehensive care of older adults.

Keywords: Geriatric dermatology; Aesthetic skin care; Quality of life; Complications; Physician counseling

1. INTRODUCTION

Global population aging is progressing at an unprecedented rate, generating increasing demands for comprehensive healthcare among older adults. Within this context, aesthetic skin care not only contributes to improving physical appearance but also enhances psychological well-being and social connectedness. A quasi-randomized study conducted among elderly residents in Japanese nursing homes demonstrated that daily facial skincare significantly improved body image, self-esteem, and mental health [1]. Similarly, a 13-week group-based beauty program in Taiwan was shown to reduce depressive symptoms and improve perceptions of aging in older participants [2].

Nevertheless, aesthetic interventions in elderly populations require careful consideration. Aging skin exhibits numerous physiological alterations, including subcutaneous fat loss, skin laxity, deep wrinkle formation, and dyspigmentation [3], along with common dermatologic conditions such as dermatitis, infections, and edema, particularly in multimorbid patients [4],[5]. These factors substantially increase the risk of complications if interventions are undertaken without adequate assessment and professional counseling.

Accordingly, the role of physicians, especially geriatricians and dermatologists, becomes crucial. Clinicians must distinguish appropriate needs from excessive demands, provide evidence-based counseling, and ensure safety, thereby preventing potential harm to this vulnerable population. Evidence from Japan has highlighted that structured skincare interventions not only improve psychological health but also elevate overall quality of life in older adults [1], with similar benefits reported in other countries when interventions are conducted with prudence.

2. MATERIALS AND METHODS

2.1. Objectives and research questions

This review aimed to address three primary questions: (1) What recent scientific evidence (from 2015 onwards) exists regarding the impact of aesthetic skin care on the quality of life of older adults? (2) How can the boundaries between appropriate interventions and excessive procedures be defined? (3) What are the potential complication risks and the role of physicians in counseling and ensuring safety? Clearly formulated research questions were designed to enhance the systematic approach and focus of this review.

2.2. Literature search

A literature search was conducted in PubMed, Scopus, and Google Scholar databases, limited to studies published from 2015 to the present. The main search terms included the following combinations: "geriatrics dermatology", "skin aesthetics", "aesthetic skin care", "elderly dermatology", "cosmetic dermatology", "aesthetic interventions complications elderly", "quality of life", "skin care elderly", "complications", "physician counseling".

Inclusion criteria comprised original research articles, review papers, case reports, and clinical practice guidelines related to aesthetic dermatology and geriatrics; publications dated 2015 onwards; and studies reporting outcomes related to quality of life, complications, or physician counseling.

Exclusion criteria included studies published before 2015; those focusing primarily on cosmetic dermatology in younger populations; and studies lacking clear data or not directly relevant to elderly populations.

This article was designed as a narrative review with a structured literature search rather than a full systematic review. The search process followed predefined inclusion and exclusion criteria to enhance transparency and reproducibility, but no formal meta-analysis was conducted.

3. DISCUSSION

3.1. Recent evidence on the impact of aesthetic skin care on quality of life in older adults

Cutaneous aging is accompanied by epidermal barrier dysfunction, chronic low-grade inflammation (inflamm-aging), xerosis, and chronic pruritus. These factors are closely associated with diminished quality of life (QoL) and functional impairment in older people. Recent reviews and updates emphasize that barrier disruption promotes systemic low-grade inflammation. At the same time, xerosis and pruritus are highly prevalent in older adults, reducing QoL through sleep disturbance, excoriation, secondary infections, and restricted social participation. This provides a sound biological rationale for targeted skincare interventions (moisturization, barrier repair, anti-pruritic strategies) as part of patient-centered geriatric care [6],[7],[8].

Clinically measurable effects have been demonstrated in small- to medium-scale but methodologically rigorous trials, indicating that skincare or so-called “therapeutic beauty” interventions can improve body image, mood, and perception of aging. A quasi-randomized trial in elderly female nursing home residents in Japan showed that twice-daily facial care over three months significantly improved scores on the Cutaneous Body Image Scale, suggesting psychosocial benefits from a simple, low-cost intervention [1]. Similarly, a 13-session group-based beauty program in Taiwan for individuals ≥ 65 years improved perceptions of aging and reduced depression, with effect directions consistent with prior observational data despite modest sample size [2].

Furthermore, structured skin care programs in long-term care facilities implemented as quality-improvement process models have demonstrated potential to enhance skin health and safety (reducing moisture-associated damage and dermatologic adverse events), thereby indirectly improving QoL through symptom relief and ease of care. A feasibility and intervention-mapping study described replicable care packages that may be scaled up [9],[10].

From the patient perspective, patient-reported outcome measures (PROMs) such as the Dermatology Life Quality Index (DLQI) and FACE-Q provide validated tools to quantify subjective benefits following skincare or aesthetic procedures. FACE-Q Aesthetics has been widely applied across minimally invasive procedures and cosmetic surgeries, demonstrating reliability, validity, and sensitivity to change; in phase 3 trials, significant improvements were observed in satisfaction with appearance and psychological well-being post-intervention. In parallel, DLQI remains a reference standard in dermatologic research. However, certain analyses highlight high rates of “not relevant” responses in specific conditions, suggesting that PROM selection should be tailored to older populations [11],[12],[13].

Overall, evidence from 2015–2025 supports the notion that aesthetic skin care, from barrier-focused regimens and “therapeutic beauty” programs to minimally invasive procedures, can improve multiple QoL domains (body image, emotional well-being, social functioning) in older adults. Nonetheless, larger randomized controlled trials (RCTs) and standardized PROM reporting by age group are needed to strengthen the evidence base [1],[2].

3.2. The boundary between “appropriate” and “excessive” interventions: ethical frameworks and body dysmorphic disorder screening

Recent ethical analyses highlight the principles of proportionality (benefit–burden balance), non-maleficence, respect for autonomy, and transparency of benefits and risks. An intervention is considered “appropriate” when the expected benefits (psychological relief, improved social functioning, increased confidence, reduction of dermatologic symptoms) outweigh costs and risks. Conversely, warning signs of “excessive” intervention include unrealistic expectations, procedural dependency, pursuit of harmful beauty standards, or demands driven by misinformation and social pressure. Updated recommendations urge aesthetic practitioners to reaffirm professional integrity and

avoid performing unnecessary or patient-detrimental procedures [14],[15].

Screening for body dysmorphic disorder (BDD) serves as a “safety checkpoint” prior to any aesthetic intervention, particularly in older adults who may experience loneliness or underlying depression. A 2023 evidence review recommended the use of BDDQ/BDDQ-DV (BDD Questionnaire/BDDQ-Dermatology Version) or the Dysmorphic Concern Questionnaire (DCQ) screening tools due to their feasibility outside psychiatric settings [16]. A 2024 meta-analysis confirmed that BDD is prevalent among aesthetic clients and associated with poor satisfaction after procedures. Accordingly, in geriatric aesthetic practice, we recommend brief BDDQ-DV screening; if positive, interventions should be deferred, and psychological counseling or referral initiated. Even in negative cases, a “cooling-off period” should be implemented for high-risk decisions [17].

Shared decision-making (SDM) helps define the boundary of “adequate, appropriate, safe.” Subclinical cognitive impairment is not uncommon in individuals ≥ 65 years. Studies in elective surgery populations demonstrate that SDM is both feasible and measurable, while the American Geriatrics Society (AGS) position statements emphasize individualized, goal-concordant care. In practice, clinicians should assess decision-making capacity, involve family when desired, employ decision aids and accessible educational materials, and document treatment goals clearly (e.g., “reduce xerosis/pruritus and enhance social engagement” rather than “completely erase wrinkles”) [18],[19],[20].

Independent ethics reports further recommend mandatory reflection periods, standardized informed-consent processes, and oversight of social media marketing to curb unrealistic expectations, factors that may disproportionately affect older adults [21].

3.3. Risks of complications in aesthetic interventions among multimorbid elderly patients and the guiding role of physicians

Biological background of aging and multimorbidity

Aging skin is thinner, drier, lipid-depleted, and exhibits impaired local immunity with inflamm-aging, leading to increased sensitivity to irritation, delayed wound healing, easy bruising, and higher susceptibility to infection. Multimorbidity and polypharmacy (particularly photosensitizing or photoallergic agents such as amiodarone, thiazides, and fluoroquinolones) further increase the risk of adverse events with laser/light-based therapies and post-procedural sun exposure. Therefore, thorough medication review, proactive patient education on photoprotection, and careful adjustment of procedural parameters are mandatory [22],[7],[23].

Dermal fillers (HA fillers) and vascular events

Vascular occlusion following filler injection, though rare, is a severe complication that can result in ischemia, skin necrosis, or blindness. Recent consensus statements and guidelines emphasize a prevention–early recognition–management approach: understanding vascular “danger zones,” avoiding large bolus injections, using low injection pressure, considering cannulas in appropriate tissue planes, and vigilant monitoring for early ischemic changes. In suspected cases, high-dose hyaluronidase with repeated, widespread infiltration should be promptly administered, with adjunctive soft tissue support. Ocular involvement requires emergency management. Doppler ultrasound can serve as a supportive diagnostic tool. This issue is particularly critical in elderly patients, whose soft tissue is thinner and vasculature more fragile [24],[25],[26].

Botulinum toxin in older adults

Updated evidence suggests that the overall safety profile of botulinum toxin type A (BoNT-A) remains favorable in individuals aged ≥ 65 years, provided appropriate indications, dosing, and technique are observed. Nonetheless, caution is warranted regarding ptosis, dry eye (especially in patients with ocular comorbidities), neuromuscular disease, and the need for individualized dosing regimens due to age-related changes in muscle mass and soft tissue anatomy [27],[28].

Bleeding–bruising and anticoagulant/antiplatelet therapy

Experience from dermatologic surgery highlights that in most cases, anticoagulant or antiplatelet therapy should be continued during minor dermatologic–aesthetic procedures, as bleeding events are generally mild and manageable, whereas discontinuation significantly increases thromboembolic risk. Prospective studies and systematic reviews confirm that bleeding events remain rare and largely minor, even in patients on multiple hemostasis-altering agents. For patients on direct oral anticoagulants (DOACs), recent dermatologic surgery reviews favor continuation or minimal adjustment, combined with meticulous hemostatic technique, compression, and patient education. Decisions should be individualized, based on procedure type, thrombotic versus bleeding risk scores, and close collaboration with prescribing physicians. The 2022 CHEST guidelines on perioperative antithrombotic management provide a useful reference framework when considering more invasive interventions [29],[30].

Pre-procedural geriatric assessment: frailty and functional capacity

Frailty is a strong predictor of postoperative complications, mortality, and loss of independence across surgical specialties, as confirmed by systematic reviews and meta-analyses. Although most aesthetic procedures are low risk, the use of Comprehensive Geriatric Assessment (CGA) and the 5-item Modified Frailty Index (mFI-5) can be valuable to stratify risk, optimize pre-procedural care (xerosis/pruritus management, nutritional optimization, glycemic control), and guide postoperative planning. Evidence from elective surgery cohorts indicates that CGA can improve selected outcomes without causing harm [31],[32].

The physician’s guiding role: practical recommendations

First, counseling should be structured into key steps: (i) identify patient priorities (functional–social–psychological), emphasizing goal-concordant care and respect for personal values; (ii) screen for BDD and underlying depression/anxiety to ensure psychological suitability for aesthetic procedures; (iii) evaluate frailty and skin status (xerosis, pruritus, chronic dermatoses [33], (iv) review medications, including photosensitizers and anticoagulants, as these can significantly affect procedural safety; (v) implement SDM with a “stepwise plan”, beginning with barrier-focused, reversible, and biologically safe measures, advancing to minimally invasive procedures only when benefits are clear and risks acceptable.

Second, baseline PROMs such as DLQI and FACE-Q should be recorded and re-assessed post-intervention, both to quantify benefit and to manage expectations [11].

Third, patient education and complication monitoring are essential: early recognition of ischemia after filler injection, 24–48 h emergency contact lines, and detailed hemostasis plans for anticoagulated patients. Current consensus recommendations on filler complications, including hyaluronidase protocols, should be incorporated into standard clinical operating procedures [26].

Synthesized evidence from 2015–2025 indicates that: (i) aesthetic skin care in older adults has both biological and clinical justification for QoL improvement, particularly through barrier restoration, pruritus reduction, and support of body image/social functioning; (ii) the distinction between appropriate versus excessive intervention is best achieved via psychological screening, SDM, and focus on meaningful outcomes; (iii) although complication rates are low for minor procedures, a “long tail of risk” persists (e.g., filler vascular occlusion, bleeding/bruising, photosensitivity) that necessitates systematic prevention strategies. Continuing anticoagulation is generally safer than interruption, while CGA facilitates patient selection and optimization. A stepwise intervention approach, prioritizing reversible and biologically safe measures before escalating to invasive options, aligns with geriatric principles, maximizes benefit, minimizes harm, and preserves dignity and autonomy in older adults [1],[20].

Clinical implications

Training programs for aesthetic physicians should incorporate geriatric principles, frailty assessment, and psychological screening. Standardized counseling protocols

should be developed, emphasizing shared decision-making and realistic goals. Multidisciplinary collaboration between dermatology and geriatrics is recommended to optimize patient safety and outcomes.

Limitations

This review has several limitations that must be acknowledged. First, although a systematic search of major databases (PubMed, Scopus, Google Scholar) was conducted, only articles published from 2015 onwards were included. While this approach ensured the currency of the evidence, it may have excluded earlier foundational studies that remain of scientific value.

Second, most existing studies on aesthetic skin care in older adults involve small sample sizes, short follow-up durations, and are largely observational or feasibility trials, with few large-scale RCTs. Consequently, the strength of evidence linking aesthetic interventions to improvements in quality of life remains modest.

Third, there is heterogeneity in outcome measurement tools: some studies employed generic QoL instruments (e.g., DLQI), whereas others utilized aesthetics-specific measures (e.g., FACE-Q). This lack of standardization complicates direct comparisons and limits the ability to synthesize findings across studies.

Fourth, this article primarily focused on three central themes: impact on quality of life, the boundary between appropriate and excessive interventions, and complication risks, while other important aspects, such as cultural and social determinants, gender differences, and economic implications, were not explored in depth.

Finally, as a current concept review, this work is largely narrative and descriptive rather than quantitative (meta-analysis). As such, it may be subject to selection bias and is dependent on the quality of reporting in primary studies. Therefore, the conclusions presented should be interpreted with caution, and further research, particularly large-scale, multicenter clinical trials, is warranted to strengthen the current evidence base.

4. CONCLUSION

Aesthetic skin care in geriatrics is emerging as an important component of comprehensive elderly care strategies. Recent evidence demonstrates that interventions ranging from simple barrier-focused regimens to minimally invasive procedures can yield significant benefits in body image, psychological health, and QoL. However, the distinction between appropriate needs and excessive interventions must be carefully recognized and managed, especially in vulnerable populations with psychological or social fragility. Concurrently, the elevated risk of complications due to age-related skin physiology and multimorbidity underscores the pivotal role of physicians in counseling, screening, and ensuring patient safety. An integrated, individualized, and evidence-based approach will be essential to maximize benefits while minimizing risks in this rapidly evolving field.

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