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"CAO GIÓ," CUPPING, AND SOUTHEAST ASIAN CULTURAL LITERACY IN DERMATOLOGY

"I grew up recognizing the bright red streaks of cạo gió on my relatives and on my own skin, a familiar sign that someone was fighting a cold or shaking off fatigue. So, when I later learned while reading case studies in dermatologic journals that these same marks were sometimes misinterpreted as signs of abuse in medical settings, I felt a strange mixture of recognition and unease. In Vietnamese households, cạo gió -- literally "scraping the wind" -- is a familiar ritual of care, performed with camphor oil (dầu gió) and a coin, believed to restore balance and drive out illness [1]. To us, it was ordinary, comforting, and healing.

Outside the clinic, I've grown used to the puzzled looks from others, especially non-people of color, who have seen these same markings on me or on my Southeast Asian friends. The confusion is almost predictable -- an uneasy attempt to map these unfamiliar markings onto a framework that assumes irregular or "artificial" skin changes as a signal for physical harm, particularly when seen on children or adolescents. And I can understand how, in clinical practice, that same uncertainty can escalate. The history and literature both show how these practices have been misinterpreted, revealing the real risk when clinicians are not taught to recognize cultural dermatologic patterns.

Coining (cạo gió), cupping (giác hơi), and other related Southeast and East Asian healing practices have centuries of history, yet they often collide with assumptions embedded in Western medical training. For dermatology providers -- who may encounter these markings in referrals or as the first point of contact -- the stakes are particularly high. Misinterpreting the characteristic linear purpura, ecchymoses, or therapeutic erythematous streaks of coining as signs of physical harm can lead to what the literature terms "pseudobattering," a misdiagnosis of abuse rooted in cultural misunderstanding. These errors can trigger unnecessary investigations, fracture patient trust, and retraumatize families already navigating the vulnerabilities of illness, migration, systemic racism, and cultural mismatch. Yet overcorrection carries its own danger: if we dismiss all patterned skin findings as cultural, we risk overlooking genuine maltreatment.

This tension has deep historical roots. Southeast Asian healing traditions have long been vulnerable to misinterpretation in U.S. medical settings. Coining in particular offers dermatology providers a unique opportunity to recognize culturally patterned skin findings. Since the resettlement of Southeast Asian refugees in the late 20th century, clinicians have repeatedly misread coining, cupping, and similar practices as signs of child maltreatment, leading to Child Protective Services investigations [2,3,4].

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These cases highlight a recurring pattern of cultural misunderstanding. They also reinforce medical mistrust between families of color and the U.S. healthcare system -- creating yet another barrier to seeking care.

Why do these misunderstandings persist? Part of the answer lies in the stories Western medicine has long told about the skin. For centuries, European dermatology -- and the cultural ideals that shaped it -- promoted an epidermal schema in which healthy skin was expected to be unblemished, uniform, and pristine. As Claudia Benthien and Thuy Li Nguyen Tu note, this aesthetic ideal became intertwined with moral judgment: marks on the skin signaled disorder, pathology, or wrongdoing [4]. Within that framework, linear erythematous streaks or patterned ecchymoses are almost immediately interpreted as trauma and abuse.

But in Vietnamese, Cambodian, Lao, Chinese, and other Asian households, these markings carry a different narrative. Although influenced in part by colonial medical encounters, coining and similar practices have endured as expressions of therapeutic intent -- warming the body, improving circulation, releasing “trapped wind,” and caring for loved ones. What appears alarming through a Western clinical gaze may be instantly legible to those raised within these traditions.

Dermatology has a meaningful opportunity to shift this dynamic. By educating ourselves about cultural healing practices -- and their dermatologic presentations -- we can prevent misdiagnoses, reduce unnecessary trauma, and strengthen rapport with patients who are already marginalized and underrepresented. We must also recognize that some families turn to these practices not only out of cultural continuity, but because affordable, accessible healthcare remains out of reach. Cultural competence, then, is inseparable from health equity."

References:

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