Practical Solutions to Common Skin Problems

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Disclosures

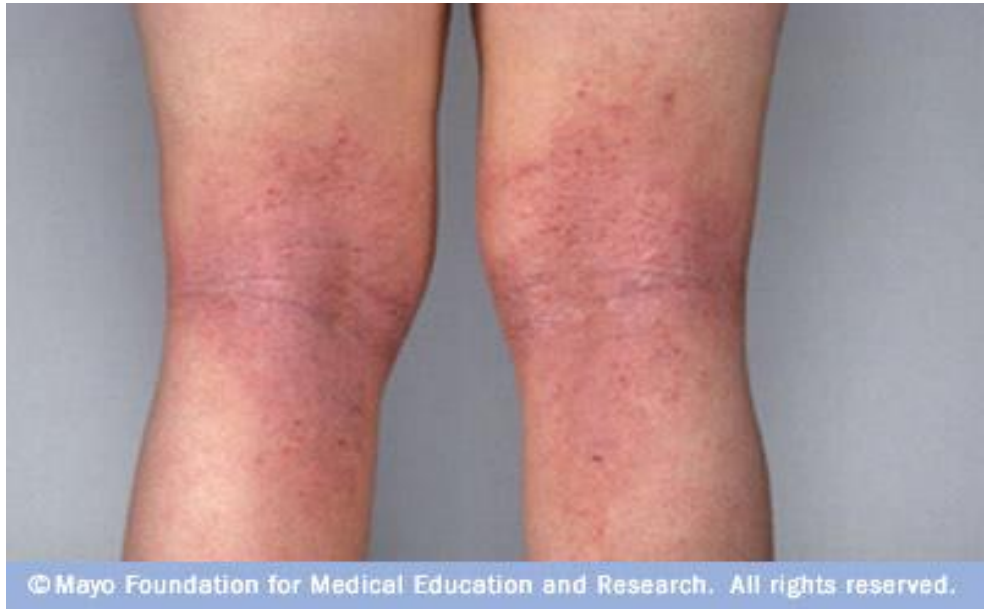
None

Learning objectives

- Recognize and provide initial treatment for atopic dermatitis
- Recognize extra articular manifestations of psoriasis
- Counsel patients on effective sun protection

Case presentation

- 30 yo wm seen at first routine health visit to establish care. He has this rash on his LE. He says it is "always like this" and "nothing helps."
- "It's not a big deal, can I just get my inhaler refilled and my cholesterol checked?"



Poll: What is the diagnosis?

A) Psoriasis

B) Atopic dermatitis

C) Allergic contact dermatitis

D) Eczema herpeticum

E) Cellulitis

Answer: B) Atopic Dermatitis

A) Psoriasis

B) Atopic Dermatitis

C) Allergic Contact Dermatitis

D) Eczema Herpeticum

E) Cellulitis

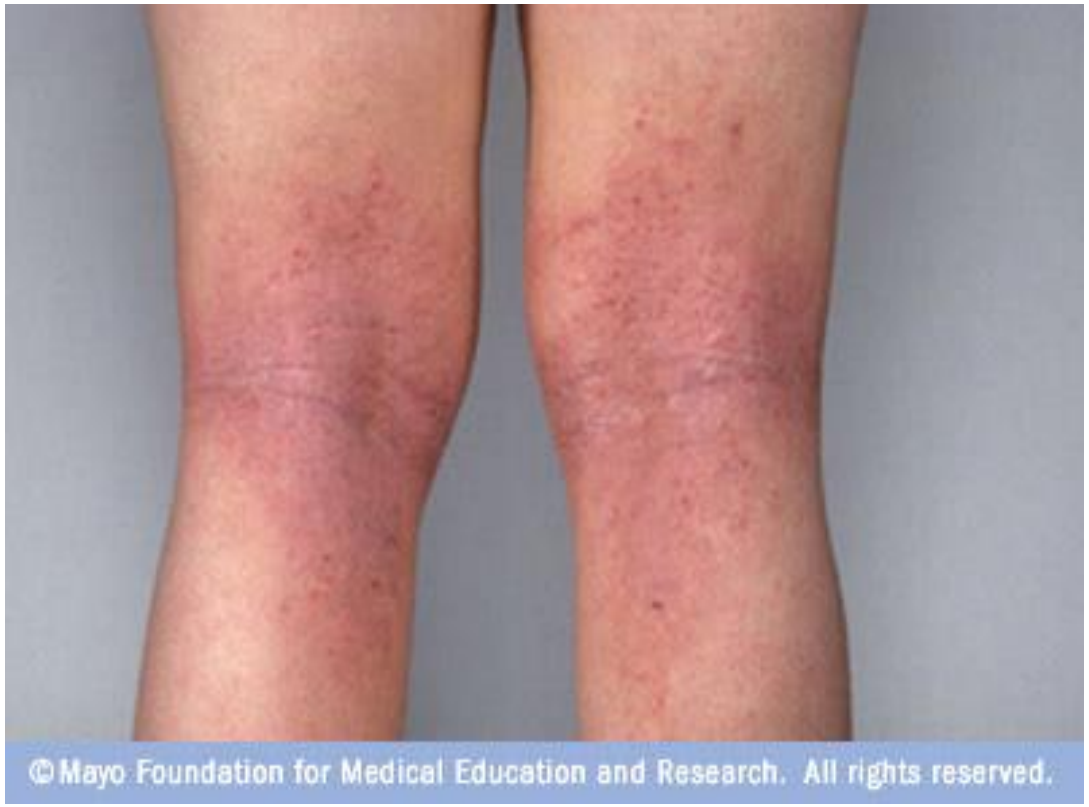
Eczema/Dermatitis

- Greek : “boiling”
- Many subtypes
  - Atopic
  - Allergic Contact
  - Xerotic
  - Dyshidrotic
  - Stasis
- Symptom: Itch, sometimes severe
- Presentation: Ill defined areas of scale, crust, fissures, erythema

Atopic Dermatitis/Atopic Eczema

- Part of Atopic Triad: asthma, eczema, hayfever
- History of triad, childhood atopy, FHx of atopy: "were you a rashy child?"
- Rash ITCHES so patients scratch and rub which thickens the skin
- Histology: lymphocytic spongiotic dermatitis, perivascular dermal infiltrate. Skin biopsy can be helpful if dx uncertain.
- Frequently “superinfected,” usually with Staphylococcus
- Both barrier dysfunction and altered T-cell function play a role

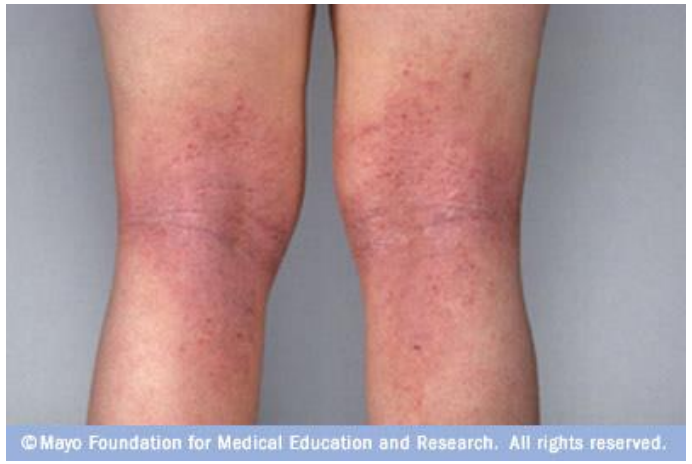
Atopic Dermatitis/Eczema



- Why does this matter to your patient's health?
- Chronic inflammation!
- No different that treating the asthma.
- Much improved QOL/sleep when itching stops

Poll: What would you prescribe for this pt?

- A) Triamcinolone Acetonide 0.1% Ointment BID for 14 days
- B) Cetaphil Cream BID for 14 days
- C) Clobetasol Ointment BID for 7 days
- D) Hydrocortisone 2.5% Ointment BID for 14 days
- E) Cephalexin 500mg Take one po QID for 10 days



ANSWER: A) Triamcinolone Acetonide Oint BID for 14 days

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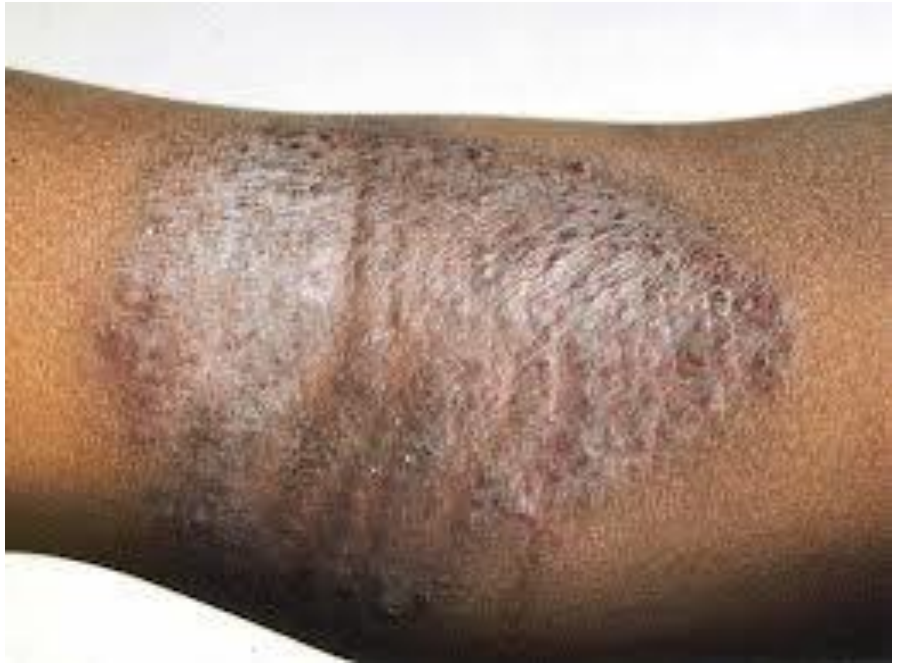
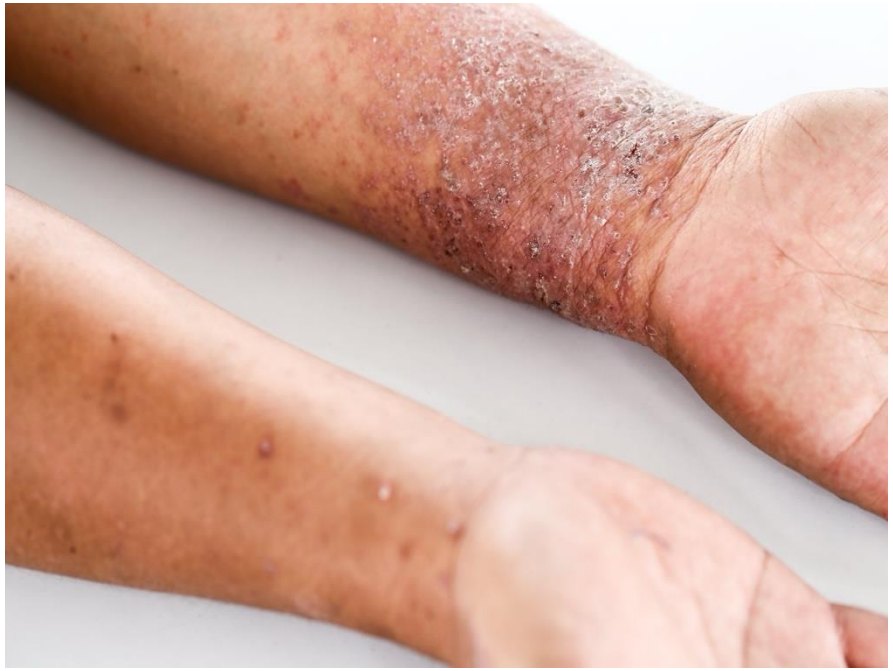
- B) Cetaphil Cream BID for 14 days
- C) Clobetasol Ointment BID for 7 days
- D) Hydrocortisone 2.5% Ointment BID for 14 days
- E) Cephalexin 500mg Take one po QID for 10 days
- OINTMENTS ARE STRONGER THAN CREAMS, DON'T CONTAIN POTENTIAL ALLERGENS OR IRRITANTS, AND HELP REPAIR BARRIER!

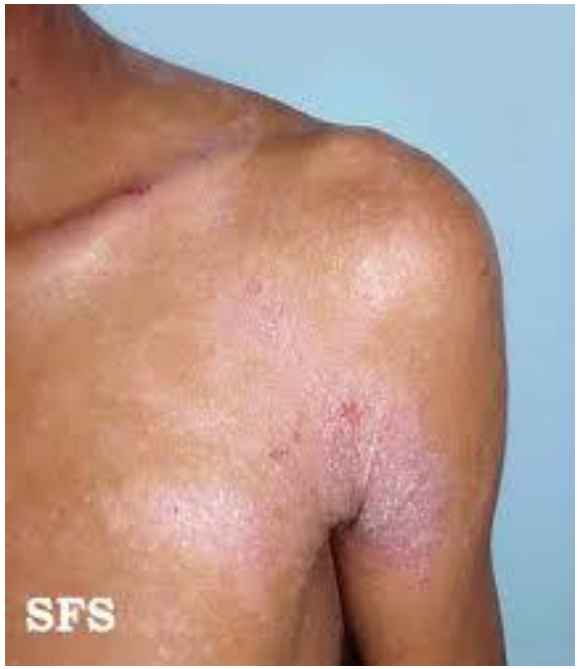
Atopic Dermatitis/Eczema

- May look dark/hyperpigmented on darker skin
- Thickened, "bubbling", ill-defined borders on flexural sites most commonly
- Patients often scratch throughout the visit, usually without noticing that they're scratching



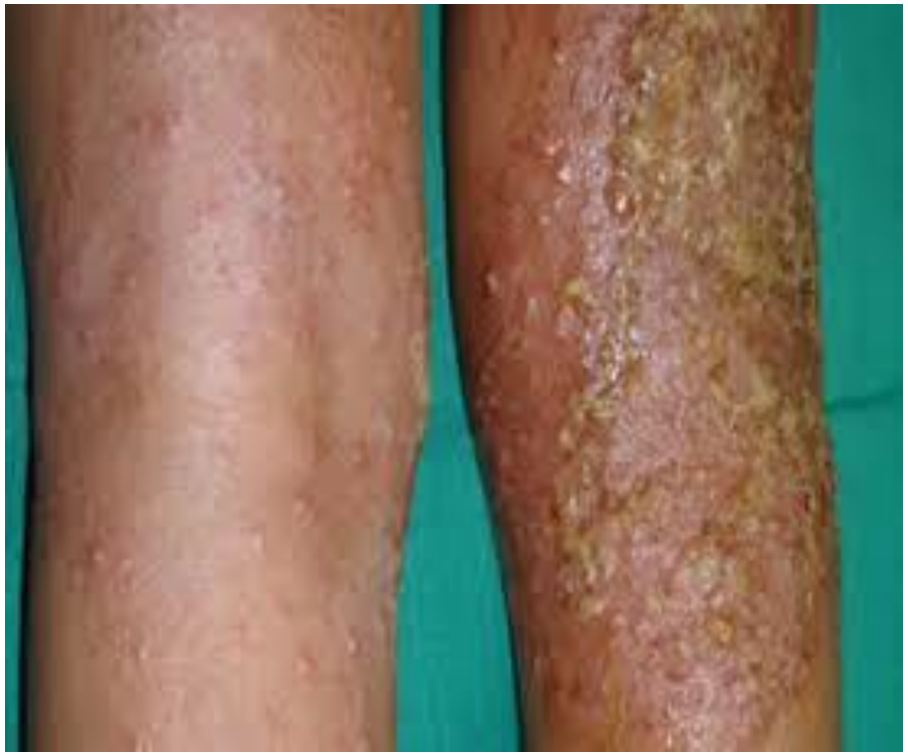
Atopic Eczema/Dermatitis



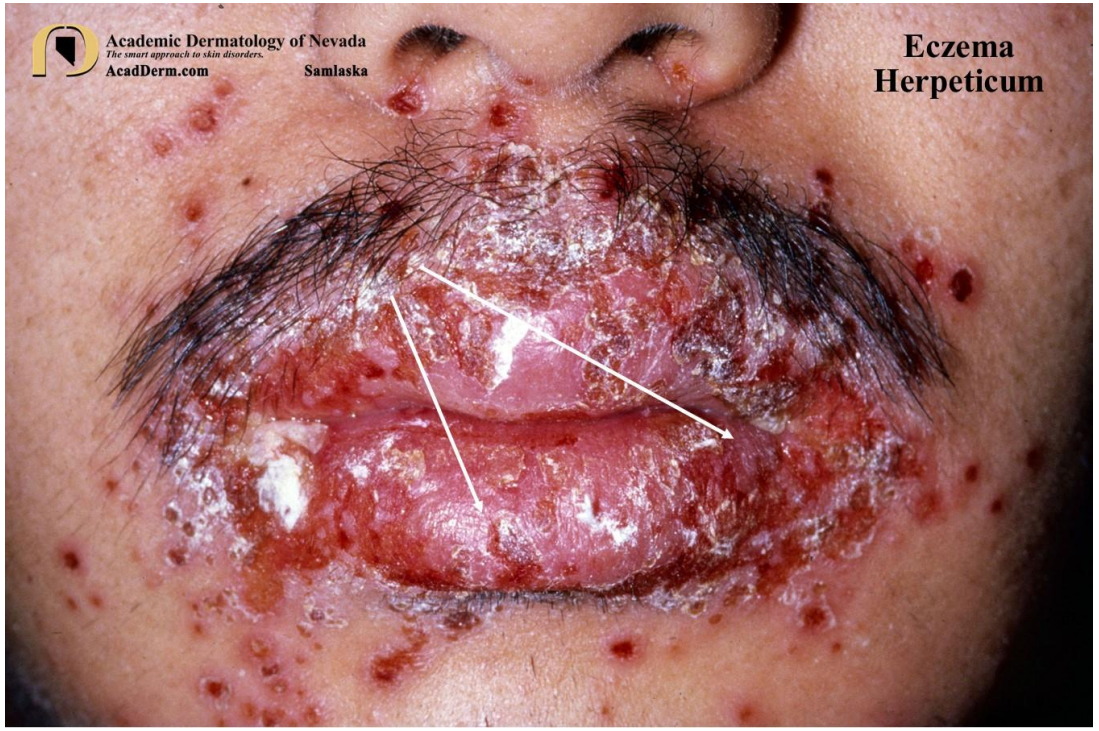


Eczema is Commonly Superinfected

- If “honey crusted,” weeping, blistered or tender:
- DO A CULTURE!!!
- It’s easy!
- Only a culture will tell you if it’s really infected and if you Rx'd correct agent
- If “punched out” ulcers, suspect HSV and culture for that, too



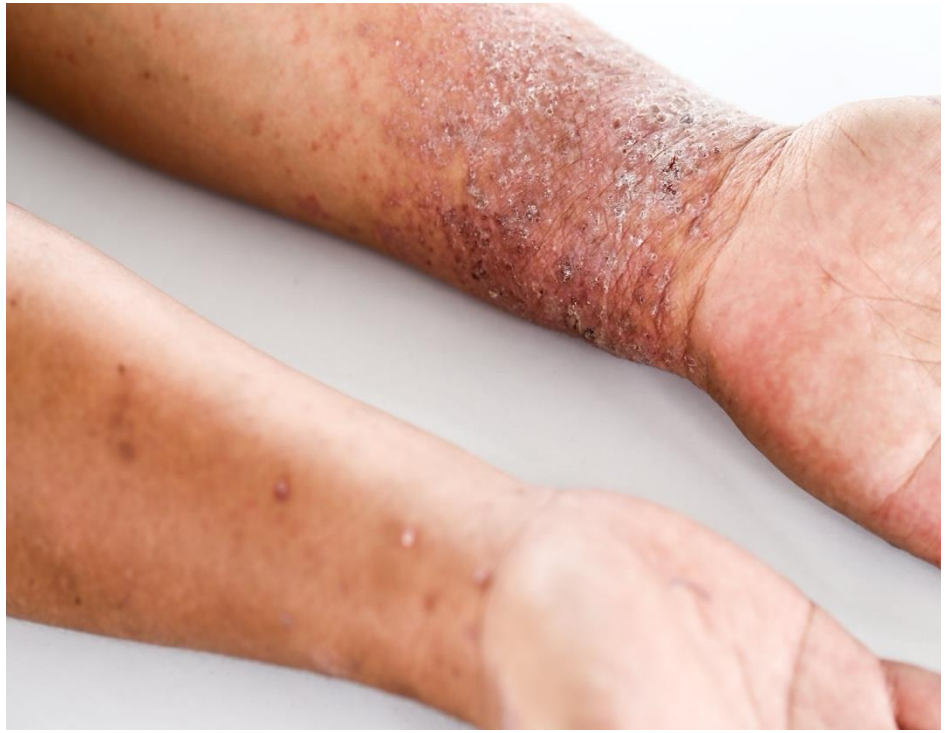
Eczema Herpeticum



- Indiviual, scattered, "punched out" ulcers
- Shaving spreads this infection
- Viral culture or PCR swab SEPARATE from bacterial culture
- Treat presumptively with valacyclovir or acyclovir while awaiting culture results

Treatment of Eczema

- Repair the Barrier
- Stop the inflammation
- Cx open skin lesions/Treat any infection
- Schedule close follow up
- Think of Allergic Contact Dermatitis
- Refer to Dermatology if not better with tx



Treatment of Eczema

- “Hydration and Lubrication”
- Topical treatments:
  - Face/skin folds: desonide 0.05%
  - Trunk/limbs: TAC or Lidex Oint
  - Tacrolimus/pimecrolimus(calcineurin inhibitors)Crisaborole cream (PDE4inhibitor)
- Let Culture guide ABx choice: OK to change ABx after initial Rx if needed
- Bleach baths(1/2c per tub) helpful in chronic eczema (grease upafterward!)

Hydration and Lubrication

- Hydrate skin with plain water. Immersion in a bath is best. If extensive open areas, add 1 cup kosher salt to the bath to ease stinging.
- 5-7 min soak. Longer than that removes lipid barrier.
- Comfortably warm water: not searing, not "lukewarm"
- NO or very little soap, only in armpits, groin, feet; only at very end of bath/shower. Rinse soap well.
- ONLY Dove Sensitive Skin, Cetaphil, or Vanicream soap

Hydration and Lubrication (con't)

- Minimal drying ("wrap towel around you and hang it up")
- Slather medications/lubricants on DAMP skin
- White petrolatum best, coconut oil (100%) for the "natural" people, Cetaphil cream, Vanicream, Cetaphil Restoraderm, Aveeno Eczema Care (listed $-$$$$ here)
- Easily demonstrated on the back of the patient's hand.
- Every patient with any skin disease should do this; so should most of us in Colorado!

Topical Corticosteroid Prescribing

- **LOW** potency for face, skin folds: hydrocortisone 2.5%, desonide0.05%
- **MID** potency for trunk, limbs, scalp: Triamcinolone acetonide 0.1%,0.5%, fluocinolone 0.05%, mometasone 0.1%. Rx solution for scalp.
- **HIGH** potency for hands, feet. Clobetasol/halobetasol proprionate0.05%, betamethasone diproprionate 0.05%, Fluocinonide 0.05%
- Make it a habit to Rx OINTMENTS and to use "Apply BID on DAMP skin for 14 days" as your SIG! T-cells take 14 days to calm down.

Topical Steroid Prescribing

- Volume to prescribe: 45 gms or more unless its just lips or eyelids (then 20 gm of low potency)
- Whole trunk: 180gm
- Whole body: 240gms
- Both hands or feet: 90 gms
- Scalp: 240cc of solution. Wipe off drips with wet cloth
- 1 copay regardless of volume written

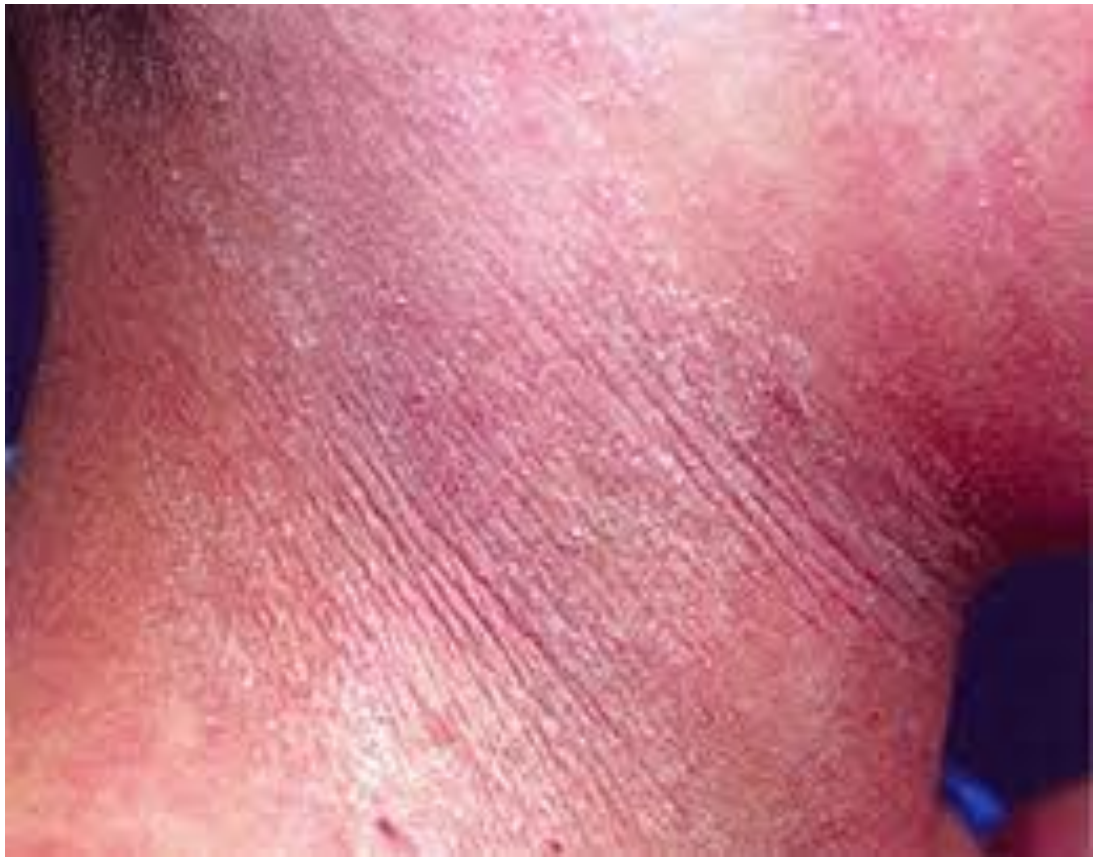
Proper TOPICAL STEROID USAGE

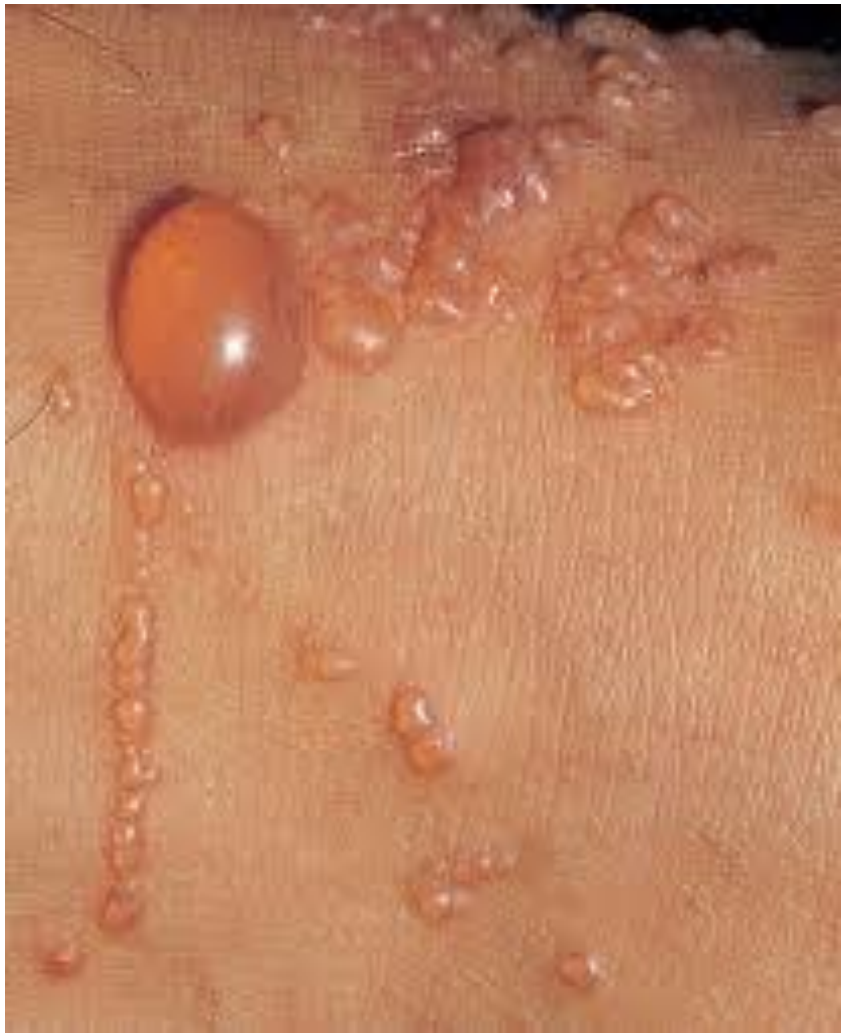
- TCS should be prescribed BID.
- Ointments are better than creams because they are stronger and generally don’t contain allergens
- Apply to DAMP skin for quickest relief
- Prescribe enough product! 180/240 gms. Ok to write for a refill.
- Don’t be afraid of steroid toxicity. The vast majority of patients grossly underuse their steroids. Atrophy is reversible when steroids are stopped.
- Schedule follow up in 1-2 weeks to see that treatment works.

Allergic Contact Dermatitis (ACD)

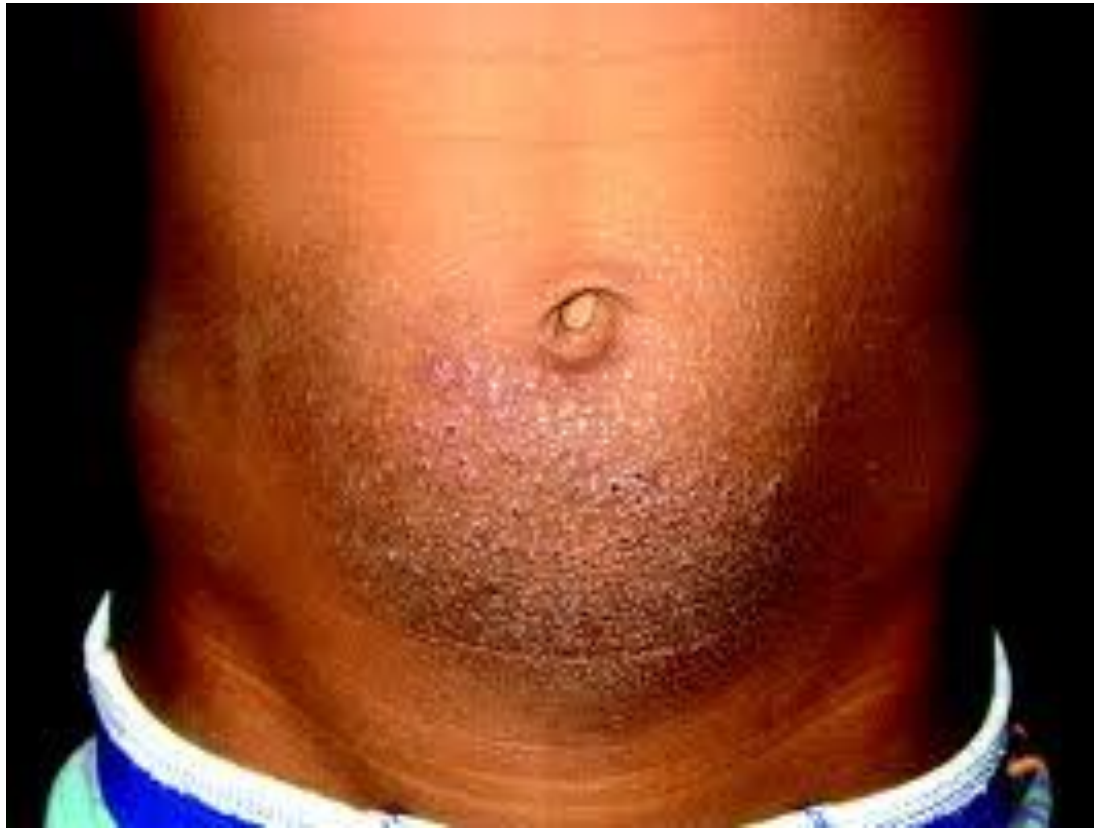
- Chronic eczema predisposes to ACD as open skin/"barrrier dysfunction" allows almost all molecules to become allergens
- Desperate people do desperate things to stop itching. Internet is full of lies/scams/nonsense
- Try to think of this in your differential dx if rash is recalcitrant to tx
- Nickel, Neosporin, lanolin, fragrance, propylene glycol, cocomidopropyl betaine, methylisothiazolinone are all common causative allergens. I always ask "what have you tried on this?" and "Have you used any Neosporin or antibiotic ointment?"

Allergic Contact Dermatitis

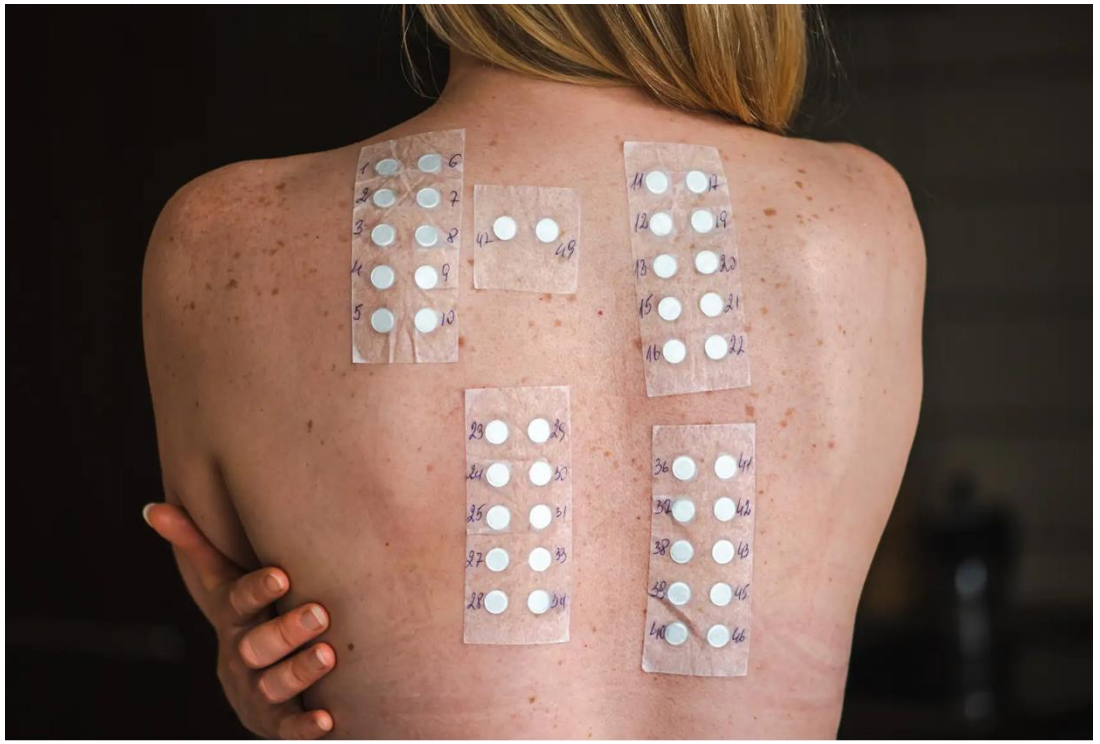




Allergic Contact Dermatitis



Allergic Contact Dermatitis



Allergic Contact Dermatitis

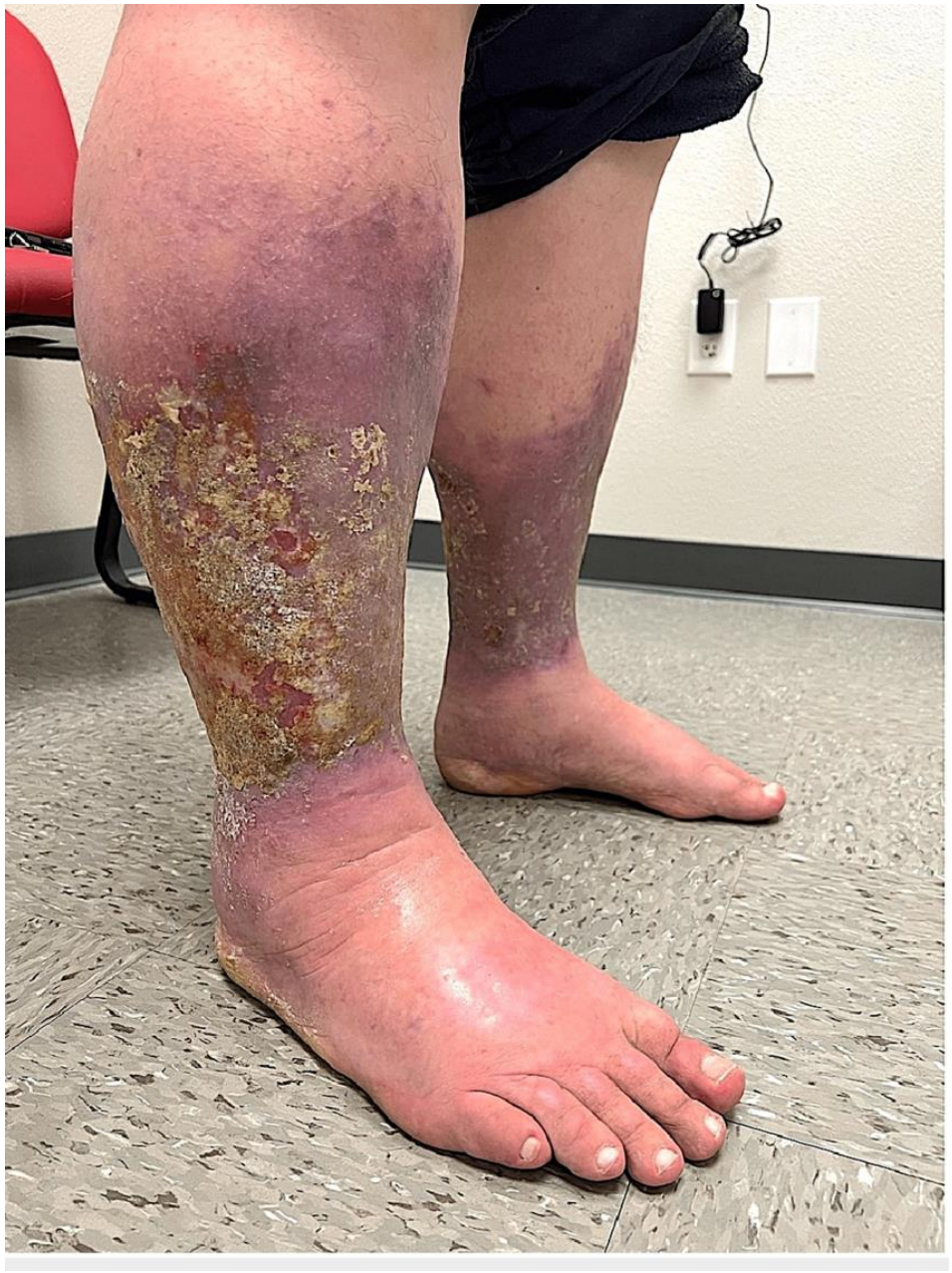
- Patch testing will delineate allergens
- Avoidance of allergen/s will radically improve rash
- Avoidance is difficult with some allergens (fragrance, preservatives)
- Patients add allergens over time. May need repeat patch testing.
- Steroids can act as allergens
- Vaseline, water, platinum are non-allergenic

When to Refer

- Your patient isn’t getting better with standard therapy
- Your patient is covered head-to-toe in rash
- You suspect an allergy to a topical or systemic agent
- You're lost, or baffled, or out of ideas

Stasis Dermatitis

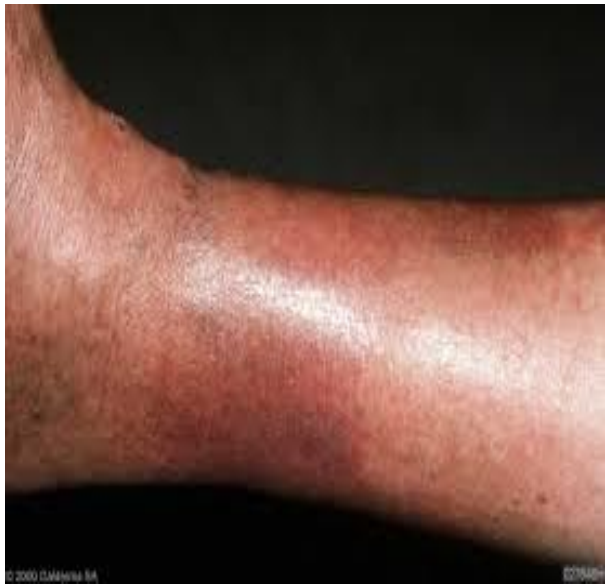
- 65 yo WM with complaints of itching rash on legs
- PE: Overweight, NAD. Non-toxic, afebrile.
- Dry scales fall to floor when he raises his pant legs and lowers his socks
- 2+ pitting edema
- R LE weeping straw colored fluid



Stasis Dermatitis

- Commonly missed, or called “bilateral cellulitis”
- Skin is red, warm, swollen; may blister and weep
- But it ITCHES
- Patient isn’t toxic/ill/febrile
- Very common and easy to diagnose if you know The Best Questions

Stasis Dermatitis



- Chronic venous stasis changes at medial ankles
- Edema
- No pain to touch (deep pressure might hurt due to edema)
- ITCHES or has minimal symptoms

The Best Questions for Stasis Dermatitis

- “Does it itch or does it hurt?”
  - If “Both:” Does it itch more or hurt more? Did it itch before it hurt?
- “How long have your legs looked like this? When did you last have normal legs?”
  - Cellulitis: hours-days
  - Stasis: weeks, months, years
- Are your legs thinner first thing in the morning?

Stasis Dermatitis

- Patient non-toxic/afebrile
- Normal CBC
- Rash ITCHES
- Commonly Bilateral
- Treat with elevation, compression/topical steroids (sometimes Abx if superinfected)
- Follow clinical course and Cxs

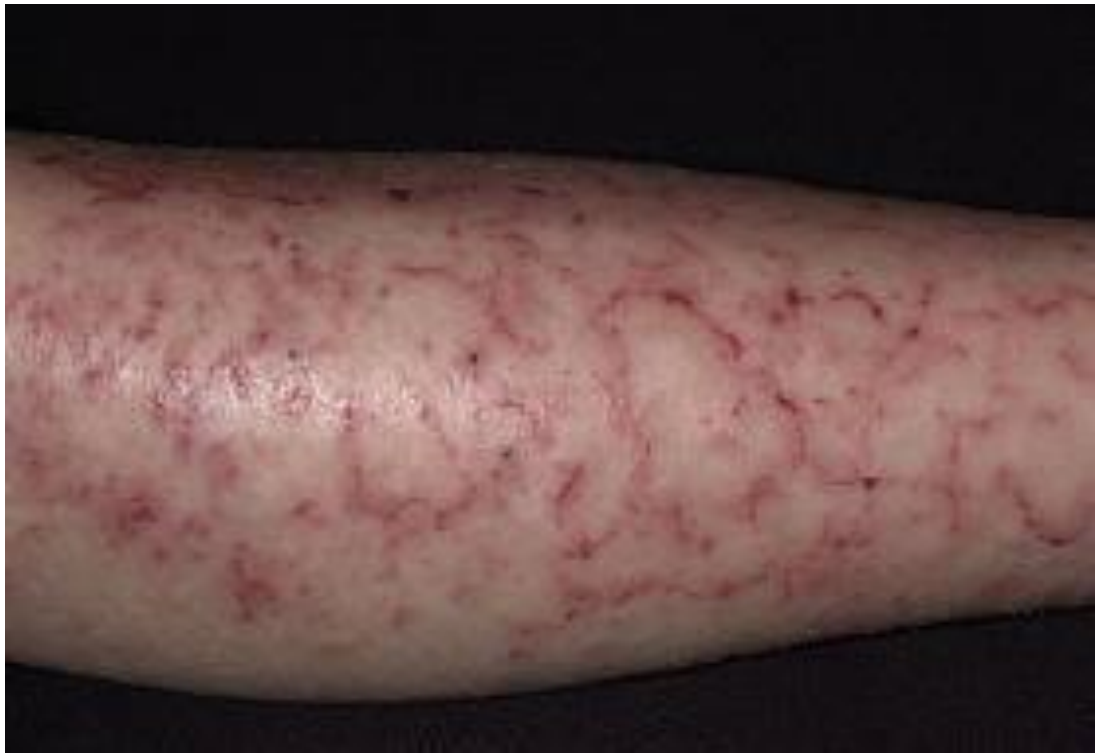
vs.

Cellulitis

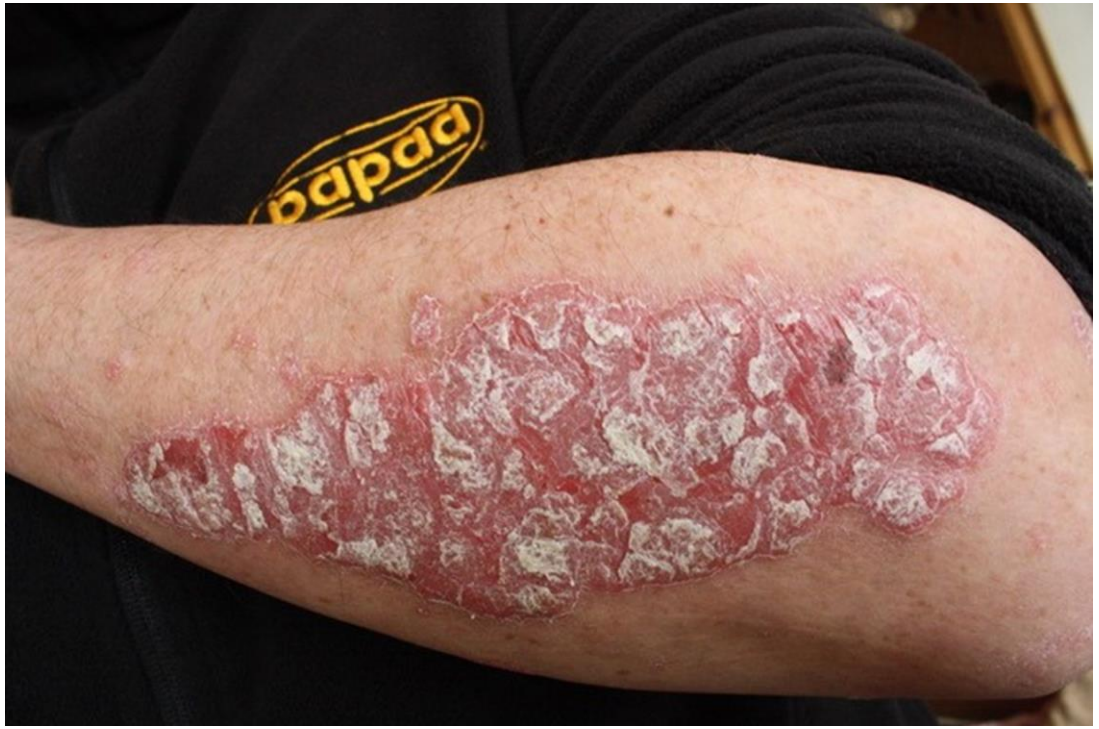
- Patient toxic/febrile
- Elevated WBC, left shift
- Rash HURTS
- Never Bilateral
- IV Antibiotics, occasional surgical decompression/debridement
- Follow clinical course and Cxs

Xerotic Eczema/Dry Skin Dermatitis

- Common in Colorado, the elderly, and men
- Skin looks like the desert in August
  - Flaky, shriveled, pink/red cracks
- ITCHES, burns
- Hospital “full body wipes” may cause
- Treat with Hydration/Lubrication and topical steroid OINTMENTS on damp skin



CASE



- 48yo WM with PMH significant for HTN, asthma, obesity, and OSA seen to establish care
- You see this rash on his B arms and knees.
- He says it is"always like this" and "nothing helps."
- "It's not a big deal, can I just get my inhaler refilled and my cholesterol checked?"

Poll: What skin disease is associated with an increased risk of coronary artery disease

- A) atopic dermatitis
- B) Neurofibromatosis I
- C) Psoriasis
- D) Herpes Simplex Types I and 2

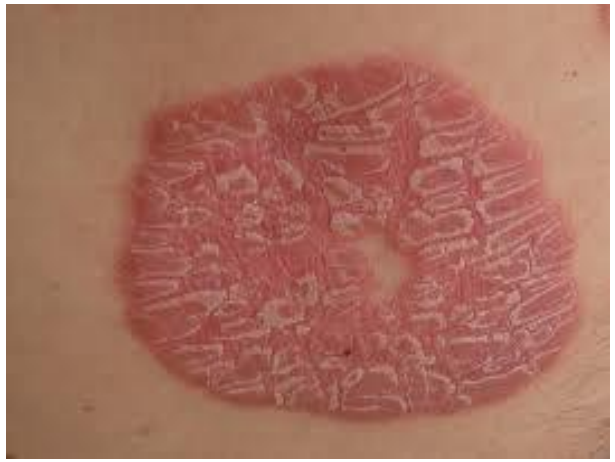
Answer: C) Psoriasis

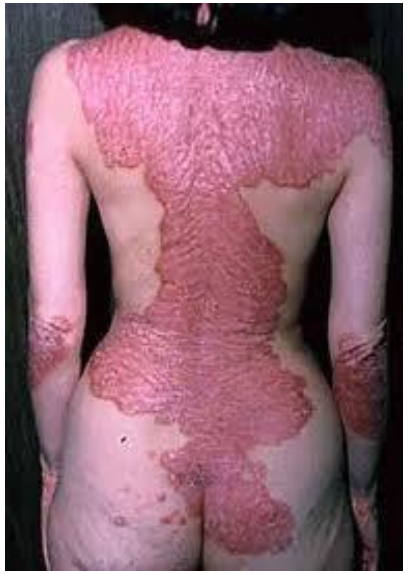
- Most common autoimmune disease in US
- 3.2% of US population
- 30% of patients will have psoriatic arthritis as well because psoriasis is a SYSTEMIC disease
- Increased risk of atherosclerosis (inflammatory pathways) equal to FH of CAD
- Severe psychosocial impact even when disease is limited
- Increasingly treatable to 100% clear skin with biologic medications

Psoriasis

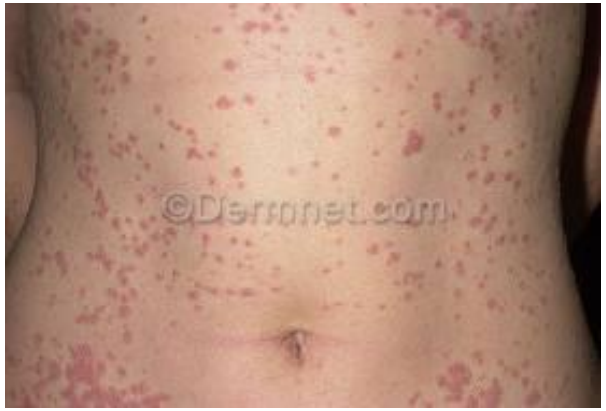
- Sudden onset, frequently after infection. FHx in 40%
- Well delineated plaques, heavy scale, pustules on palm, soles
- Elbows, knees, scalp, ears, nails (pits, oil spots, subungual hyperkeratosis), genitals, umbilicus, palms, soles, skin folds: LOOK AT whole skin! Patient in gown!
- ASK ABOUT ARTHRITIS (especially axial pain, heel pain, single swollen joint)
- Obesity, smoking, alcohol intake worsen disease
- Modify CAD risks, treat the psoriasis/inflammation

Psoriasis





Psoriasis



Psoriasis

Psoriasis Treatment

- Treatments aimed at reducing inflammation
- Most patients won’t use topicals for more than a few days
- Give adequate volumes of topical medications if you prescribe them, but this is a systemic disease, and systemic therapies should be considered
- ASK ABOUT ARTHRITIS!
  - "Do you have a stiff neck/back most mornings?” Pts blame pillow/mattress
  - "Do your heels hurt?"
  - "Have you had a single swollen joint and thought you must have 'done something to it' but didn't get hurt?"

Psoriasis Treatment

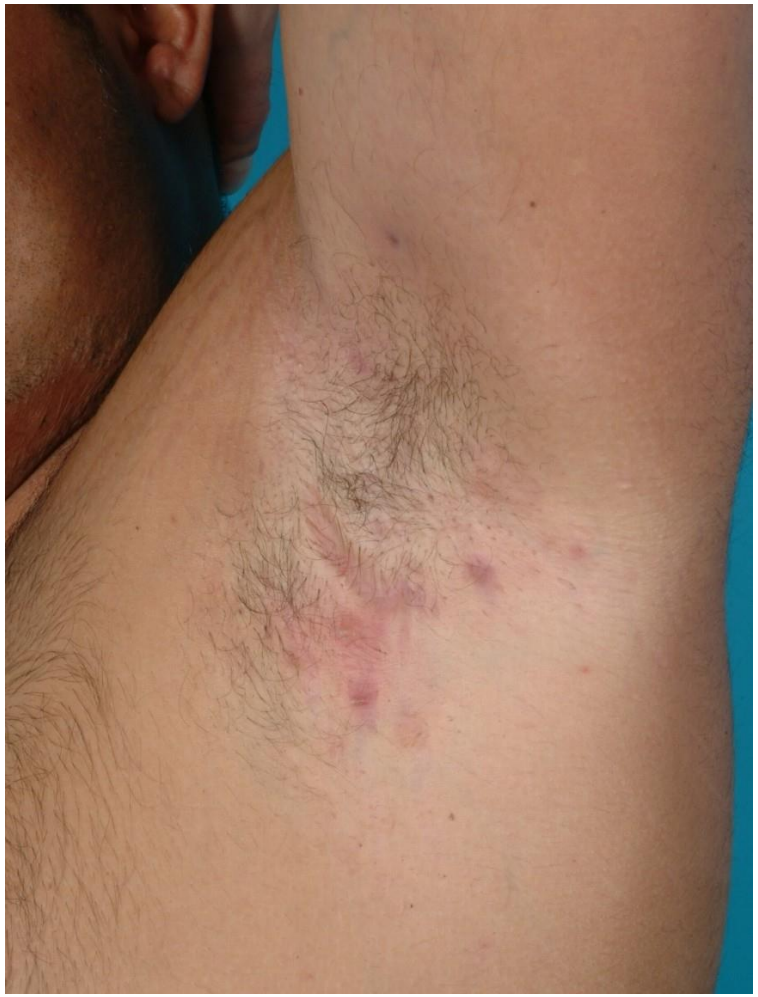
- Biologic medications have changed this disease immeasurably. Be hopeful with patients that we can clear their psoriasis! Long term studies show improved CAD risk on biologic medications
- Ask about psychosocial impact and walk a mile in the patient's shoes: Are they too embarrased wear a swimsuit or have sex with their partner?
- UV light, methotrexate, oral retinoids are old, sometimes useful alternatives, but used less frequently now
- ASK ABOUT ARTHRITIS: I in 3 will have it!
- Refer to Dermatologists who like treating psoriasis
- Great resource for patients and providers: NPF: www.psoriasis.org

You can prescribe biologic treatments for psoriasis

- TB is MAIN risk of this class and the only one I worry about
- ALL patients **MUST** be screened for TB before treatment and annually while on biologics
- Treat positive TB tests before starting biologics
- I repeat screening after travel to endemic areas
- Need to document extent of disease in the record before and during treatment (PASI score (Psoriais Area Severity Index), IGA (Investigator's Global Assesment). Both have calculators online.
- PA can be a nuisance. Pharma has this figured out and a local rep can always help you

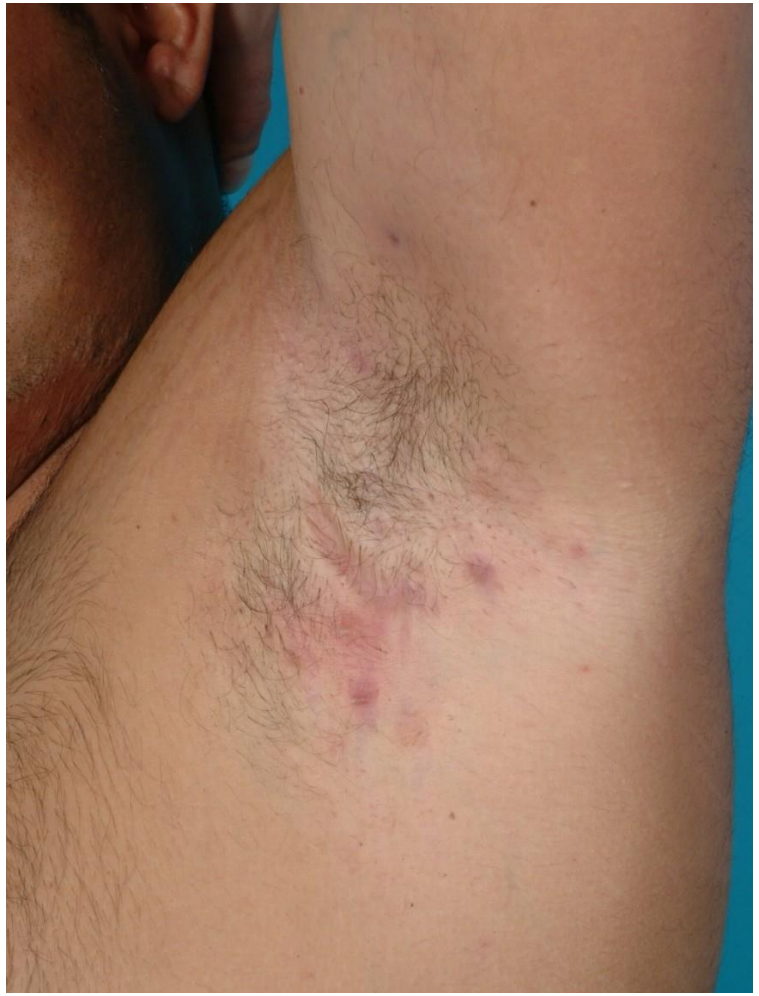
Case

- 48yo WM with PMH significant for HTN, asthma, obesity, and OSA seen to establish care
- You see this rash on his B axilla. He says it is "always like this" and "nothing helps."
- "It's not a big deal, can I just get my inhaler refilled and my cholesterol checked?"



Poll: What is This?

- A) Bacterial Folliculitis
- B) Varicella Zoster
- C) Razor burn/shaving rash
- D) Pseudofolliculitis Barbae
- E) Hidradenitis Suppurativa



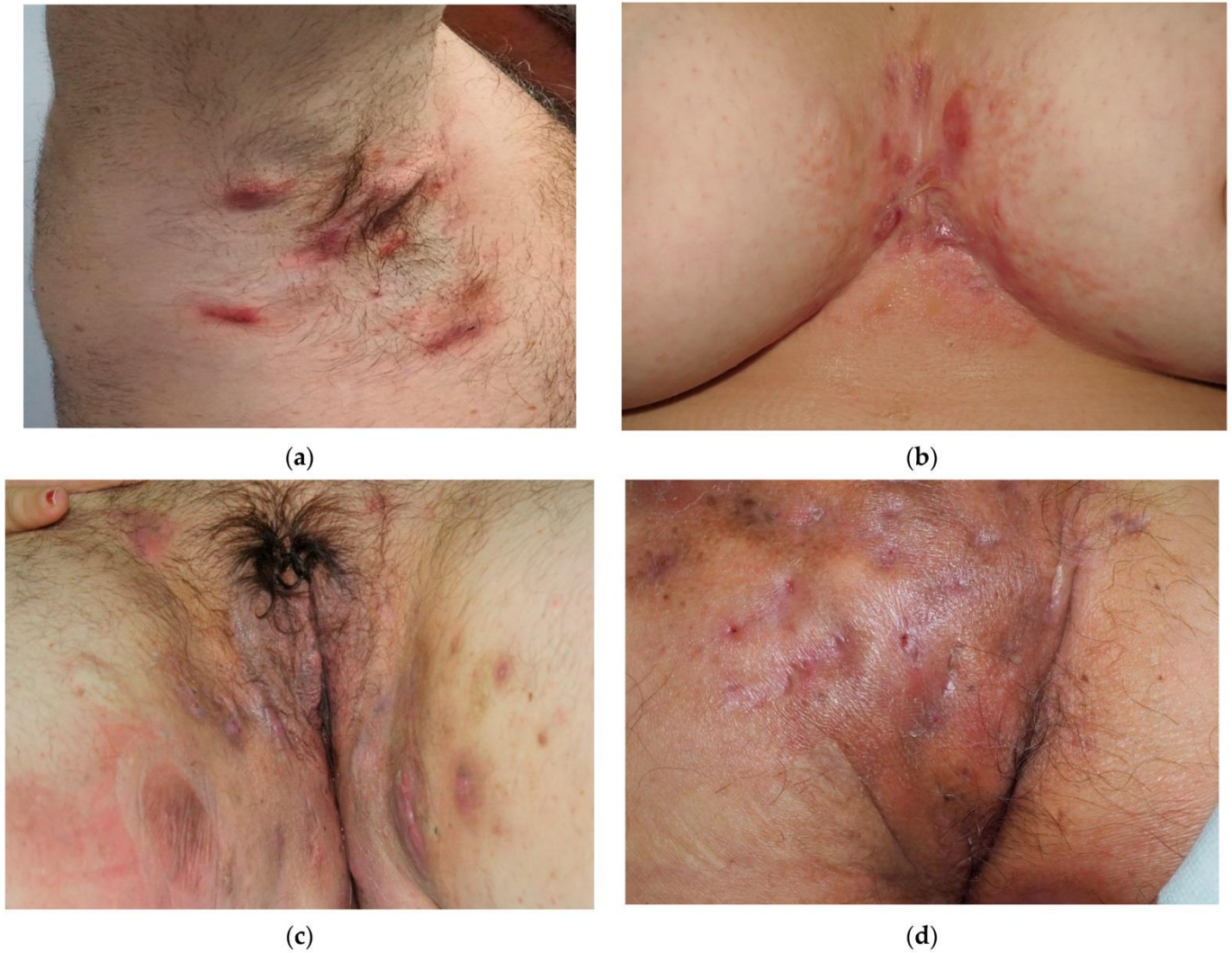
ANSWER: E) Hidradenitis Suppurativa

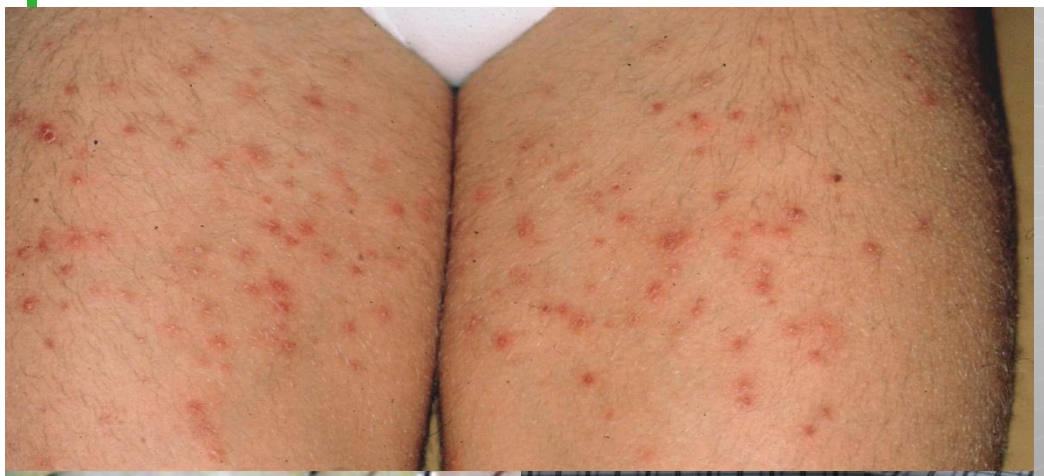
- Chronic auto-immune inflammatory disease characterized by cyclic inflammation of hair-bearing skin with pain, scarring, fistula formation
- Misnomer: this disease occurs in hair follicles, not sweat glands (but it is suppurative)
- Prevalence up to 0.4-4.1%, globally 0.99%
- More common in women, AA, obese patient, smokers
- Significant QOL impact

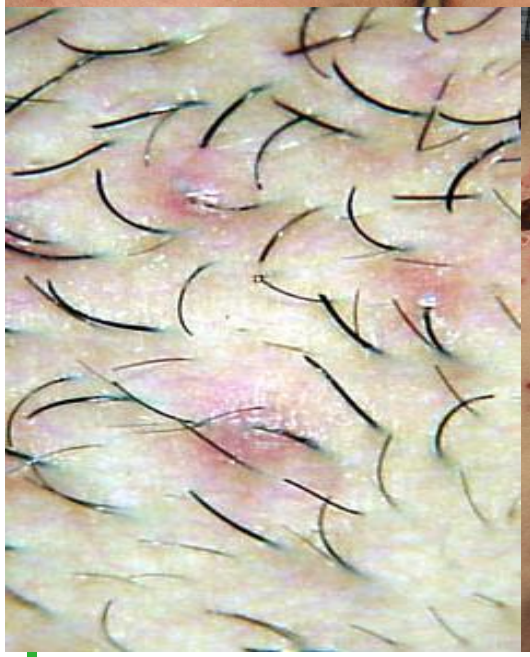
Hidradenitis Suppurativa

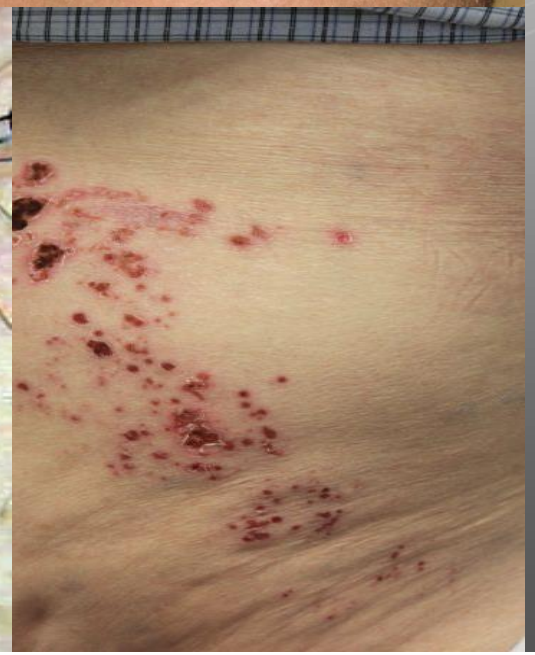
- Don’t accept the patient’s diagnosis! HS is NOT a “razor burn” or “ingrown hairs"
- Average time to diagnosis: 9 years! Average number of misdiagnosis: 3
- Average number of physicians seen: 3 (Primary care, Gyn, Surgery)
- History! "When did it start? Have you ever had a pilonidal cyst? How may episodes a year?"
- EXAMINE: B axillae, B groin, gluteal cleft, anus, inframammary creases and sternum, scalp

Hidradenitis Suppurativa









History: acute versus chronic, onset, pain, drainage, pilonidal cysts?
Exam: are fistulas present? Scarring? Can you see ingrown hairs?
Cultures: bacterial, viral can help. If sterile, strongly consider HS. Biopsy usually diagnostic.

Not Hidradenitis Suppurativa

Poll: What is the best wart treatment

A) Liquid nitrogen topically

B) Salicylic acid topically

C) Duct tape topically

D) Cantheridin topically

E) None of the above

ANSWER: E) None of the Above

- No treatment is better than another across populations/wart locations/trials of every kind
- All treatments about 20% effective during study period

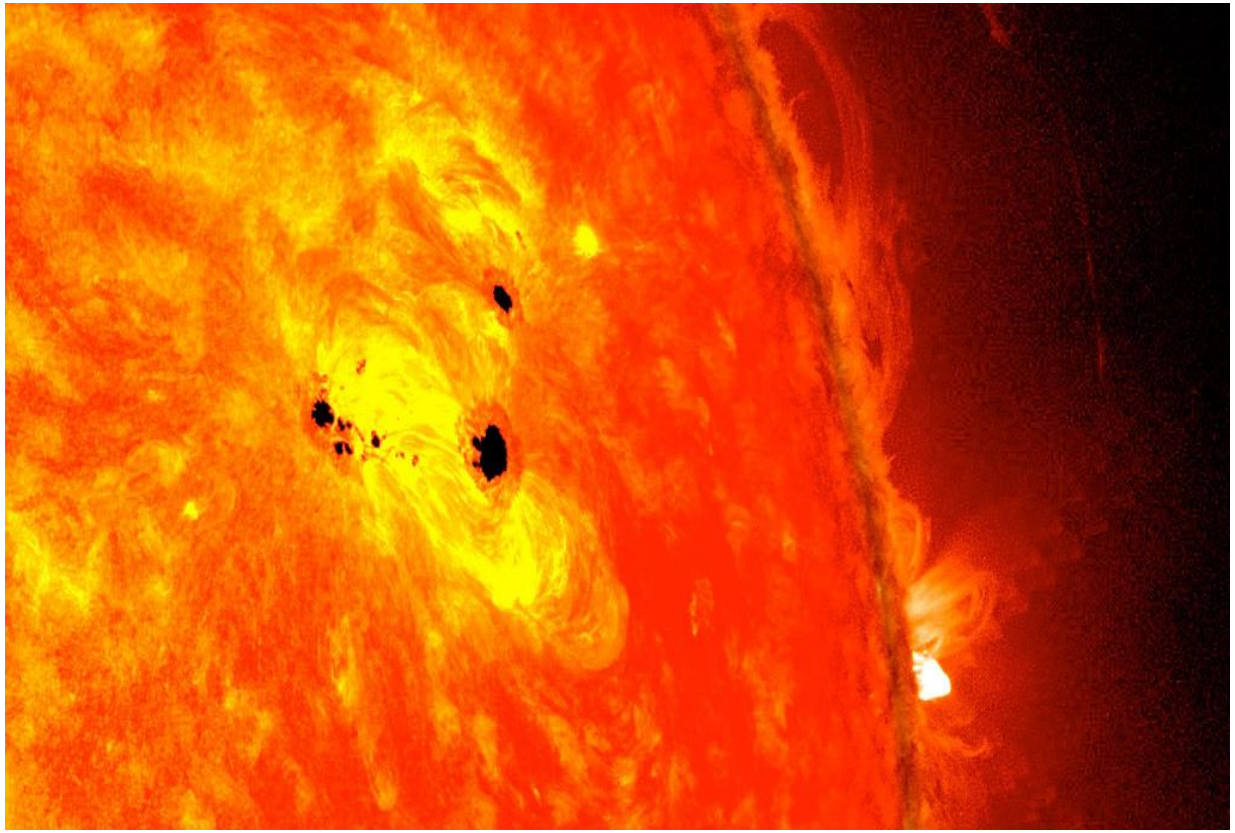
Warts

- Caused by Human Papilloma Virus: 200+ HPV types
- No current treatment kills HPV: Warts ”go away” when we get immune to the HPV subtype causing our warts
- No “seeds” or “roots:” virus lives in the epidermis
- ONLY immunity will result in disappearance of the wart
- Explain this to patient, then use whatever you like.
- HPV vaccines target specific high risk subtypes, but any wart can be a springboard for a discussion of HPV vaccination!

Therapeutic Options

- Liquid nitrogen topically: safe, painful, quick, reimbursed. Aim for 20-30 sec of freeze (not spray) time, 2-3 cycles. Consider letting patient apply it.
- Salicylic acid topically: safe, painless. Use adherent vehicle (not Compound W) daily, at bedtime, at bedside. File wart down weekly to remove dead tissue
- Duct tape topically: safe, painless, as effective as any other treatment. Five days on, 2 days off, file wart down after removing duct tape
- Cantheridin topically: Painless, not FDA approved. Apply in office, wash of 4-6 hours. Blisters can be painful, lance if so.
- ***Don’t do “surgery” on warts: it won’t kill the virus and can cause scars with warts in them***

Last Topic!



Poll: What does SPF 30 mean?

- A) the sunscreen protects me for 30 times longer than no sunscreen
- B) the sunscreen protects me for 30 minutes
- C) the sunscreen has 30 toxic ingredients
- D) the sunscreen has to be applied 30 minutes before going outside

ANSWER: A) 30 times longer than no sunscreen

- Sun Protection Factor: note the word "factor" here
- This is very confusing for patients, so better if you have a quick blurb/handout/statement
- If I am examining a tan or sunburned patient: "You're getting enough sun to cause skin cancer. Would you like some simple advice about sun protection?"

Sunscreen

- **Daily** use of SPF 30 or higher sunscreen cuts risk of skin cancer by 50%. That's half, folks.
- Sunscreens work to prevent burning, tanning, aging, cancer.
- No evidence to date that sunscreens are harmful to humans.
- Plenty of evidence to date that ionizing radiation from the sun is harmful to human skin. No such thing as a safe tan.
- Proper application AND REAPPLICATION are essential to proper use. Set a time on phone for 90 mins. 1 ounce sunscreen covers 1 avg adult one time. 4oz bottle should last 1 person 1 day at the beach.
- Sun avoidance and sun protection are the other cornerstones of skin cancer prevention.

Sun Protection/Sun Avoidance: Clothing

Sunscreen

- Most people don’t use enough, nor reapply frequently enough: that's why they are tan/burned.
- Higher SPFs give some small insurance against human failure. I buy SPF 50 and up.
- Buy product you like/will use, with a minimum SPF of 30. Daily use cuts skin cancer risk in half.
- Reapply within 2 hours (set a phone alarm). Tempus fugit.

Take Home Summary

- Don't overlook hydration and lubrication in treating eczema.
- Prescribe higher volumes of topical corticosteroids as ointments.
- Patients with psoriasis have elevated risk of cardiovascular disease and should be treated appropriately.
- Wear sunscreen of at least SPF 30 every day. Teach your patients to do the same.

Finally:

- Call for help if you're not sure. Dermatology is a "black box" specialty, so don't be shy about needing help.
- Science is your friend. Be a diagnostician!
- Thank you for your attention.
- Questions?

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