Practical Dermatology for the Internist

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Intertrigo or “yeasty rashes”

- IRRITANT DERMATITIS (moisture/friction) is primary cause, not yeast
- Topical nystatin and ketoconazole cream = WORTHLESS
- Low-med potency steroid or anti-inflammatory (tacrolimus or Hydrocortisone 2.5% to Triamcinolone 0.1%)
- Clotrimazole OTC or econazole but I often just give Fluconazole 200mg weekly for 2-4 wks, don’t worry about interactions with statins when infrequent/short pulse
- Silver sulfadiazine topically works pretty well too
- Resistant cases are usually anaerobic bacterial infections/swab or give augmentin
- Keep it dry! Blow dryer on cool setting, Zeasorb-AF powder, Interdry fabric, anti-perspirant (unscented Dove)
Seborrheic dermatitis

- Glabellar forehead, NL folds, beard, scalp
- Ketoconazole cream doesn’t really work
- Low potency steroid (HC 2.5% cream vs desonide, TAC 0.025%) for 7-10 days each month then 2x/wk for maintenance
- Tacrolimus if covered
- Sulfur products like prosacea/adult acnomel (OTC on amazon like de la cruz ointment)
- Vanicream Z-bar or H&S shampoo
- Weekly fluconazole also works
- Ketoconazole 2% shampoo for scalp/hair-bearing areas helps, rotate with an OTC like zinc, tar, sal acid
- Mometasone/betamethasone solution/lotion
Rosacea

- Classically little red pimples/pustules
- Metronidazole is usually first-line formulary and will work for most
- Ivermectin: script or compounded isn’t often covered
- JUST flushers (wouldn’t call this rosacea); IPL laser cosmetically is only effective treatment, topical Afrin preparations; but can have rebound
Perioral dermatitis

• Metronidazole doesn’t seem to work anymore
• Doxycycline 100mg qd or Azithromycin 3x/wk for 6 wks
• Mild cleansers, avoid moisturizers/oily topicals
• NO antiaging creams/retinoids
• People that get this multiple times probably have true rosacea, doxy 50 mg qd or 100mg x 6 wks a couple times a year is fine
Hybrid of rosacea/seb derm? Demodex?

- Ivermectin first, then
- Tacrolimus ointment or pimecrolimus cream especially if itchy
Solar/senile purpura/thin fragile skin

• Usually on arms: breakdown of collagen/elastin fibers, reduced oil production
• Easy bruising/tears, also dry/flaky/creepy
• Mild cleansers: Cetaphil/Cerave
• Sunscreen
• Dermend (arnica) for bruising
• Exfoliate 1-2x/wk or use keratolytic with urea, lactic acid, glycolic/salicylic or retinoid
• Arm guards/neoprene on Amazon
• Collagen supplements (Vital proteins scoop in coffee)
• If on face/chest “pinch purpura”, might run CBC, SPEP/serum light chains
What is the most common cancer associated with POEMS

1) Multiple myeloma  
2) Castleman’s disease  
3) Plasmacytoma  
4) Pancreatic carcinoma  
5) Monoclonal gammopathy of undetermined significance (MGUS)

POEMS: Rare paraneoplastic syndrome characterized by polyneuropathy, organomegaly, endocrinopathy/edema and monoclonal plasmaproliferative disorder

Skin changes include hyperpigmenatation and hypertrichosis
Hair loss (usually women)

- Frontal fibrosing alopecia/lichen planopilaris is epidemic (why??)
- Slow thinning with redness/itch, usually >65; finasteride 2.5mg/day, dutasteride 0.5mg/day
- Essentially nothing works to regrow hair, just trying to slow the process, personally I don’t think immunosuppressants are worth the risk for hair loss
- Send us alopecia areata (oval bald patches) for injections, new Jak/stat inh
- Its (almost) never thyroid but check ferritin, maybe Vit D
- Minoxidil 1.25mg works for most types like post-viral or after COVID a surgery, stress; and female pattern
- Collagen supplements, Vit D, Slow release Iron if ferritin less than 70
- Honestly nothing makes a significant difference clinically
- PRP can be done; $$ OOP
Thick toenails

• 50% of people age 50; 70% at age 70 and so on…
• Often not fungal (frictional) if just a couple of them
• Only offer oral therapy if symptomatic and proven fungal: trim off a sample of nail and send in a biopsy specimen for PAS stain (takes 2-3 days and often better than a culture)
• Pulse terbinafine 250mg for 10 days each month until 50+% of nail plate looks nml; labs after 2nd pulse if >50 and on other meds
• Itraconazole/Fluconazole can be pulsed for 7 days each month usually without having to check labs
• Urea 30-40%
• Dilute original Listerine and white vinegar soaks
Terbinafine toxicity

• Oral therapy with terbinafine is associated with elevations in serum aminotransferases in less than 1% of patients and the elevations are generally asymptomatic and resolve without stopping therapy. The estimated probability of developing elevated serum aminotransferase levels requiring stopping treatment is about 0.31% for 2 to 6 weeks' treatment and 0.44% for treatment longer than 8 weeks.

• Clinically apparent liver injury from terbinafine occurs rarely (1 in 50,000 to 120,000 prescriptions)

LiverTox: Clinical and Research Information on Drug-Induced Liver Injury [Internet]. Bethesda (MD): National Institute of Diabetes and Digestive and Kidney Diseases; 2012
1) Onychomycosis
2) Retronychia
3) Yellow nail syndrome
4) Psoriasis

- Retronychia
  - Looks like a mostly detached (especially proximally) plate just floating on the nail bed
  - Congenital malalignment of nail plate of great toe
  - Trauma/friction
  - Treatment is nail avulsion but usually grows back, I send to podiatry for destruction of matrix if painful
Tinea versicolor

• “Fawn” colored patches, scalyer when gently scraped
• Fluconazole 200mg (2 doses 1 wk apart)
• Won’t tan as well due to tyrosine inhibition
• Ketoconazole or Selsun shampoo 2x/wk as a body wash, beware, Selsun can cause chemical burns if left on too long
Erosio interdigitale blastomycetica

• White maceration between 4th and 5th toes
• Mixed infection of webspace
• Cryotherapy works great
Lichen sclerosus

- Vaginal itch in females: not likely to be 2/2 yeast in post-menopausal
- Women >> Men but can cause paraphimosis and adhesions (balanitis xerotica obliterans)
- Many advanced cases diagnosed, ask about itch or burning with urination (can also be perianal/fissures)
- Clobetasol OINTMENT bid for 6 wks then SLOOOOWLY taper to 2x/wk even if sx are gone (won’t cause thinning on mucosal skin)
- Can refer to PT for dilators and to Urology or Gyn for Mona Lisa Touch CO2 laser
- Associated with vulvar and penile carcinoma (SCC)
Herpes zoster

• Huge uptick in incidence since COVID pandemic (?)

• Still seeing it after vaccinations, often milder attenuated cases that look more like a single group of vesicles

• If classic presentation, I just treat with valacyclovir 1g TID x 1 wk as culture or PCR can take about that long to result

• Topical steroids help itch/pain

• Also lidocaine 4% OTC and Capsaicin
Sacral root HSV-2

• HSV-2, not “recurrent shingles”
• Sores at top of gluteal cleft (second most common location I see after labial)
• Valacyclovir 1-2g at first signs, repeat in 12 hrs or acyclovir 800mg TID x 2-5 days (men need longer)
• Can cause ulcers in bedridden/geriatrics
• Suppress with Valacyclovir 500mg qd or acyclovir 400mg bid
Warts

• In adults over 40, one of the hardest things to cure
• 40% salicylic acid has best cure rates
• Soak, apply, pare, repeat until gone
• Cryotherapy only helps recruit lymphocytes to the area, sometimes can stimulate immune response
• I sometimes inject candida, use compounded creams with 5-fu, cidofovir, imiquimod or podophyllin
• Heat therapy with heating pad (temp at 111-115) has shown benefit
Itchy skin (no rash)

- Subtle Hives or Dermatographia: Try antihistamines (non-drowsy OTC first), ok to go up to 2-3x dose on label
  - Labs (r/o liver/renal, hematological abnormalities), Vit D, Thyroid, Ferritin
  - R/o infection (UTI, sinus) or occult malignancy
  - New meds (amlodipine, HCTZ)?
  - Psychological stress/dementia/depression?
- Try topical steroids but often not effective
- CeraVe with pramoxine (red label)
- Gabapentin, low dose naltrexone, low dose prednisone
- Itchy scalp (no rash): probably cervical deg – acupuncture, PT, neurology
Notalgia paresthetica

- Unilateral itch (sometimes burny/creepy crawly), upper scapular back
- No rash or lesion usually seen (can look brownish)
- Probably due to a mildly irritated cutaneous nerve (thoracic compression)
- Capsaicin 5x/day for a week, then 3x/day at least for full month; after 4 months; 70-90% response rate
- Acupuncture, chiropractor, PT, yoga, massage
Urticaria/hives

• If less than 6 wks duration or known cause, NO WORKUP (usually post-viral)
• Claritin (fastest), Zyrtec (longest lasting), allegra (least drowsy), xyzal (works best) up to 3-4x labeled dose for acute cases
• Try NOT to use prednisone; rebound can be bad
• Topical steroids don’t help
• H2 blockers don’t help
• Sometimes I add montelukast or cyproheptadine TID, few can tolerate Benadryl, hydroxyzine or doxepin unless at night
• If persisting over 6 wks can get lab workup but it will be nml 99.9% of the time
• Vit D 5000IU/day for 3 months; then 1-2000 IU/day for maintainence
• Colchicine, dapsone, Cyclosporin, MTX, etc can be used
• Omalizumab for resistant cases but have to fail 2 months of high dose antihistamines to qualify (Allergy: Thornblade, not Cady)
Chronic Spontaneous Urticaria After COVID-19 Vaccine (or after active COVID)

- Most self-resolve but can last a year or more
- Treat similarly with non-drowsy antihistamines, don’t be afraid to push the dose

Case Reports Cureus
Erythema multiforme

- HSV infection or other virus
- Antibiotics (including erythromycin, nitrofurantoin, PCN, sulfas & tetracyclines)
- Anti-epileptics
- NSAIDS
- Vaccinations (most common cause in infants)

- Inflammatory bowel disease
- Hepatitis C
- Leukemia/Lymphoma
- Solid organ cancer malignancy
RIME (Like Erythema Multiforme) or Mycoplasma pneumoniae-induced rash and mucositis (MIRM).

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**Reactive Infectious Mucocutaneous Eruption Associated With SARS-CoV-2 Infection**

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[Author Affiliations | Article Information](https://jamanetwork.com/journals/jamadermatology)


COVID-19 Resource Center

As COVID-19, caused by SARS-CoV-2, spreads worldwide, various patterns of associated dermatologic diseases continue to emerge. Early reports classified multiple cutaneous manifestations of SARS-CoV-2 infection. In this article, we report the obser-

Figure 1. Initial Presentation 3 Days After Onset of Mucocutaneous Symptoms and 1 Week After Initial Anosmia and Ageusia


The patient was prescribed betamethasone valerate, 0.1%, ointment for the lips and penis, intraoral dex-

Figure 2. Mucositis

A, The patient experienced worsening mucositis and pain 10 days after initial anosmia and ageusia, at which time prednisone treatment was initiated. B, The mucositis had essentially resolved on follow-up 3 weeks after starting prednisone.
Drug/medication rashes

• SDRIFE: Symmetric Drug-related Intertriginous and Flexural Exanthema (Baboon syndrome)
• Cause: Usually Antibiotics, antifungals, chemo, supplements
• No systemic sx
• Antihistamines, emollients

Dangerous drug rashes (SJS-TEN)

• Acute onset after initiation of drug
• Develops over 24-48 hrs (if it has been going on a week or more isn’t going to be SJS/TEN)
• Involves 2 or more mucosal surfaces (lips/mouth/genitals, eyes)
• Neuroleptics/mood stabilizers/antibiotics (sulfa)

• Using more cyclosporin and etanercept for these than IVIG or steroids
• Just send them to us if questionable; usually need to go to UW or Utah for burn unit care
Rash of Immunosenescence

- Common in those >65
- Usually diffusely scaly/dry but sometimes looks like bug-bites
- Can be called prurigo nodules, papulareczema, dermal hypersensitivity
- Usually work-up for known autoimmune bullous disorders with biopsy/DIF (r/o bullous pemphigoid) but rarely pos; we treat the same way
- Prednisone temporarily helps
- Methotrexate
- Mycophenolate
- Dapsone
- NB-UVB
- Dupilumab is amazing (but poorly covered by medicare)
- Frustrating to treat because people don’t want to get regular labwork or be immunosuppressed
Grovers (transient acantholytic dermatosis)

- Pink scaly papules in a band around lower trunk (flanks, abdomen, back)
- Biopsy is diagnostic (acantholysis)
- Sweating exacerbates
- 50% terribly itchy; 50% no itch
- Triamcinolone 0.1% cream prn
- Sleep with synthetic fiber shirt or naked with fan/window open
- Sarna, Dermend cream
- Doxycycline 100mg once daily
- Acitretin or high dose Vit A
- NB-UVB (improves in summer)
Psoriasis

- 2% population
- Average age of onset 30 (can present at any age)
- Check nails for pits and scalp for plaques
- Topical steroids first-line (usually clobetasol)
- Calcipotriene not very effective
- 10% TBSA for systemic therapy or light
- Tar and sal acid OTC
- Methotrexate often required unless contraindications
- Infused biologics covered better than others for medicare
Lumps and bumps

• Cysts may or may not have a pore, usually easy to remove even scalp/neck, often have a smell or patients say they used to squeeze things out, feel more superficial

• Lipomas: larger than 3cm or on scalp/neck/deep on upper back/shoulder send to Gen Surg (often tethered, submuscular, hard to keep numb)
Inflamed/ruptured cyst

• Not infected, it is a foreign body reaction
• Can use a 4mm punch too to squeeze some of the purulent debris out, may have to pack with iodoform gauze
• if not too uncomfortable just leave it to reform and have them make excision appt in about 6-8 wks
• Doxycycline 100mg once daily for 6 wks can help inflammation
• Some inject Kenalog but I don’t
Digital mucoid cyst

- Clean with ETOH; poke with an 18-gauge needle, squeeze, looks like clear jelly with a little blood
- Wrap tightly for 2 wks (changing daily or whenever wet) use athletic tape or a coban torn in half
- Refer to hand/foot ortho if recurrent or just crazy-big but they still come back even after excision
- Sometimes I inject with Kenalog if they keep coming back or feel sore (probably helps the arthritis component); evidently freezing can also work but I don’t understand why and don’t do it
Dark toe/fingernails

• 99% of the time it is blood
• Biopsy has to be at nail matrix and ruins the nail forever
• Have to observe hemorrhages for growth (should move about 2mm in fingers and 1mm or less in toenails each month)
• History is everything
• Follow over time (like 3 mos)
• Photos, photos, photos
ABCDEs vs Ugly Duckling

• I counsel patients to look for a spot that is different than the others
• Either bright red or multiple colors, often flat things are perceived to be fine while bumpy growths are worrisome to patients (its usually the reverse)
• Most melanomas are Superficial Spreading type or start as in-situ/lentigo maligna which are flat sometimes for many yrs
Melanocytic lesions

- Doing your own biopsies may expedite care/surgery for cancers, also pays well ;-)  
- Flat ones can be shaved, just make sure you get completely under a raised one to avoid transecting melanoma; remove entire visible lesion if you can  
- I use flexible razor blades; just fold and break in half, pinch edges. No need to sterilize  
- Cauterize base, petrolatum for aftercare  
- Always take photo of site
Epic Haiku to add photos (iphone app)
Actinic keratoses

- 0.2% turn into SCC each year
- Fine to freeze a couple times if not bleeding/tender/indurated or thick crust (horn)
- I numb/curette a lot of the thick ones on scalp
- If more than 12 in one area, send in 5-FU twice a day for 2 wks for face (4 wks on arms/hands)
- Diclofenac 3% daily for 3 months (low irritation)
Basal cell carcinoma

- 3.6 million cases/year
- I’ve diagnosed them as young as age 18
- Any sore present >6 wks esp on face is suspect
- OK to do a shave biopsy (please photograph site with outline in marker) then send to us, sometimes saves time if it will need mohs and if you aim to scoop the whole lesion it is healed at the time on re-excision so hard to find later
- Haiku app phone
- I ED&C 95% of them on the trunk and extremities if superficial or small focally nodular (less than 1.0cm)
- Micronodular and infiltrative/sclerotic types excise with 0.4cm margin
Seborrheic keratoses

- BY FAR the MOST common reason for appts in >40 age group
- 100% benign, cosmetic unless inflamed/itchy/bleeding; don’t like the way they look/feel/bothersome=cosmetic
- This is an area you could increase your procedures with freezing (17110 for inflamed SK is $203)
- Also try 17% sal acid wart removing gel or am-lactin/urea preparations to help smooth
Delusions of parasitosis/Morgellons

- Often lots of skin lesions but they are ulcers/scabs from picking but they need Psych, we can’t help them
- Patients will use buzz-words like “worms/fibers coming out of skin” but also ears/nose/eyes/anus/vagina/nipples
- Matchbox or “bag” sign
- Often ask for ivermectin, permethrin
- Often professionals in medical field like Nurses, MAs, MDs, philosophy professors
- Anti-psychotics like pimozide, atypicals classically; they often won’t go to psychiatrist
- Trifluoperazine 1-2mg/at night. Sedating, less SEs than other anti-psychotics, also used for n/v with chemotherapy
Screening exams

- No set recommendations based on insurance or evidence
- “Adult general population screening for malignant melanoma is not supported or refuted by current evidence from RCTs.”
- There are 9600 dermatologists in USA; 268,000 PCPs, so we can’t see everyone with no h/o cancer every year
- Seems reasonable to have pts see us for screening exams once and if then every 2-5 yrs depending on risk factors or PRN new/concerning growths
- I like to see h/o melanoma yearly and h/o NMSCs q1-2 yrs (depending on #) for FBSE but will spot-check a worrisome lesion/area anytime (90% are SKs)
- Would ideally like to see patients stable on low-risk meds to refill through PCP (rosacea meds, HSV tx, eczema creams, etc).
- Personally my practice is transitioning away from acne/warts/SKs/tags/screening low risk people with FBSE screenings to high-risk cancers, acute and chronic severe rashes, autoimmune diseases, excisions

Contact dermatitis (poison ivy)
Erythema Ab Igne
Tinea
Raynauds
Porphyria cutanea tarda
Dermatomyositis
Nummular eczema
Leishmaniasis
MRSA impetigo
Psoriasis