Another Rash ?

Objectives

- At the completion of this session the learner will be able to:
- 1. Identify common skin rashes seen in dermatology
- 2. Differentiate between rashes that require urgent treatment and those that require monitored therapy.
- 3. Determine an appropriate treatment plan for common rashes

Financial Disclosures and COI

- The speaker is on the advisory committee for:
- ABVIE
- CELGENE
- LILLY
- NOVARTIS
- PFIZER
- VALEANT

Significance

- Dermatologic conditions are the number one reason to enter ambulatory walk in clinics
- The skin it the largest organ of the body and frequently is a measure of what is occurring internally

Take a good history

- Duration
- What did it look like in the beginning and how has it progressed?
- Does anyone else in your immediate family or workers have a similar rash?
- Have you been ill and in what way?
- What have you treated the rash with prescription or over the counter medications?

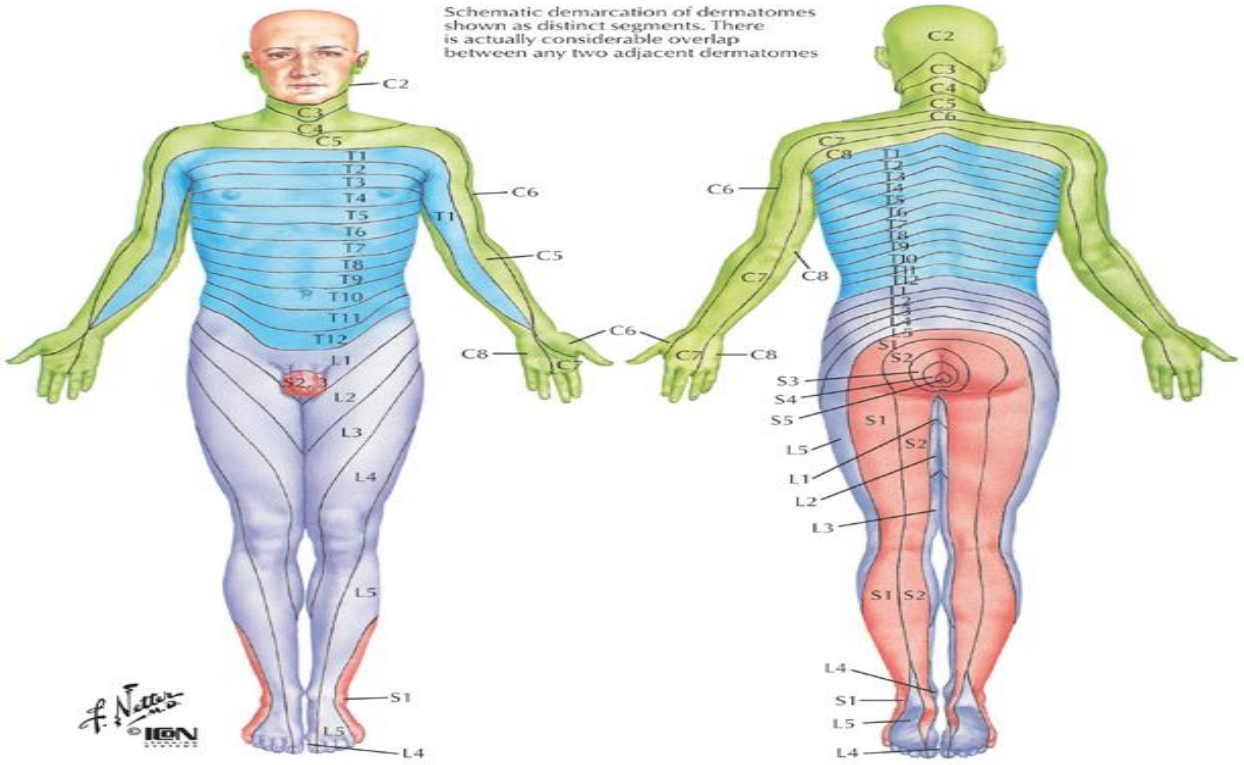
Take a good history

- Have they seen anyone and what diagnosis where you given?
- What is your medical history?
- What medicines do you take?
- Does it itch, hurt, scale, or asymptomatic? Give it a scale.
- How did it begin and what does has it changed (tie this into treatment history)?
- Is the patient sick?

What does it looks like?

- Macule vs. Patch
- Papule, nodule, pustule, tumor
- Vesicle or Bulla
- Petechial or purpura
- Indurated vs. non-indurated
- Is it crusted…deep or superficial
- What pattern…. Blaschkos vs. dermatome,, symmetrical, central vs. caudal, reticular, annular vs. linear
- Pigment, vascularity

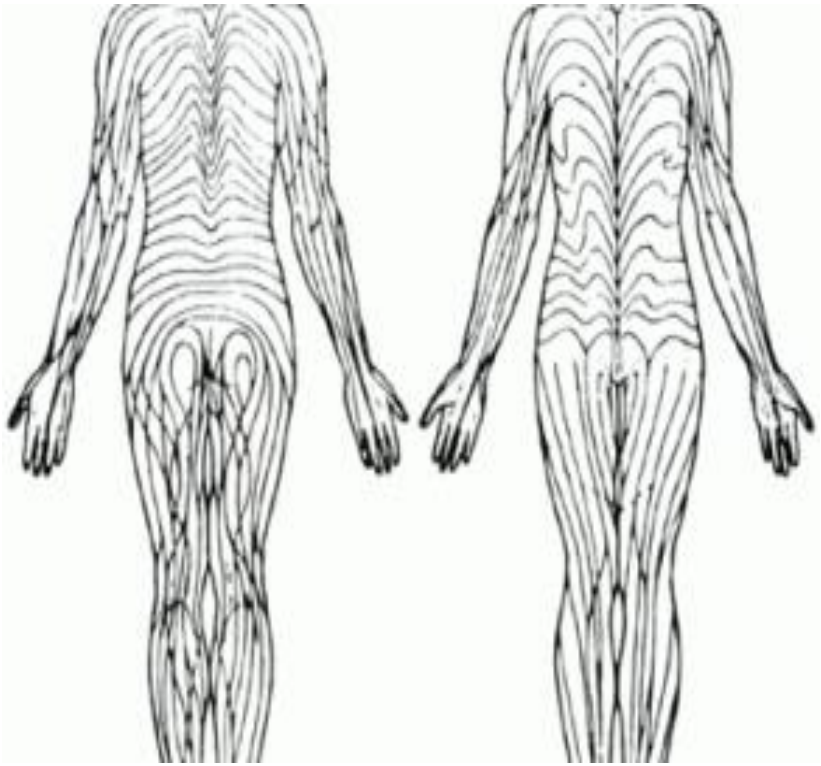
Dermatomes



Levels of principal dermatomes

C5	Clavicles
C5, 6, 7	Lateral parts of upper limbs
C8, T1	Medial sides of upper limbs
C6	Thumb
C6, 7, 8	Hand
C8	Ring and little fingers
T4	Level of nipples
T10	Level of umbilicus
T12	Inguinal or groin regions
L1, 2, 3, 4	Anterior and inner surfaces of lower limbs
L4, 5, S1	Foot
L4	Medial side of great toe
S1, 2, L5	Posterior and outer surfaces of lower limbs
S1	Lateral margin of foot and little toe
S2, 3, 4	Perineum

Blascko's Lines



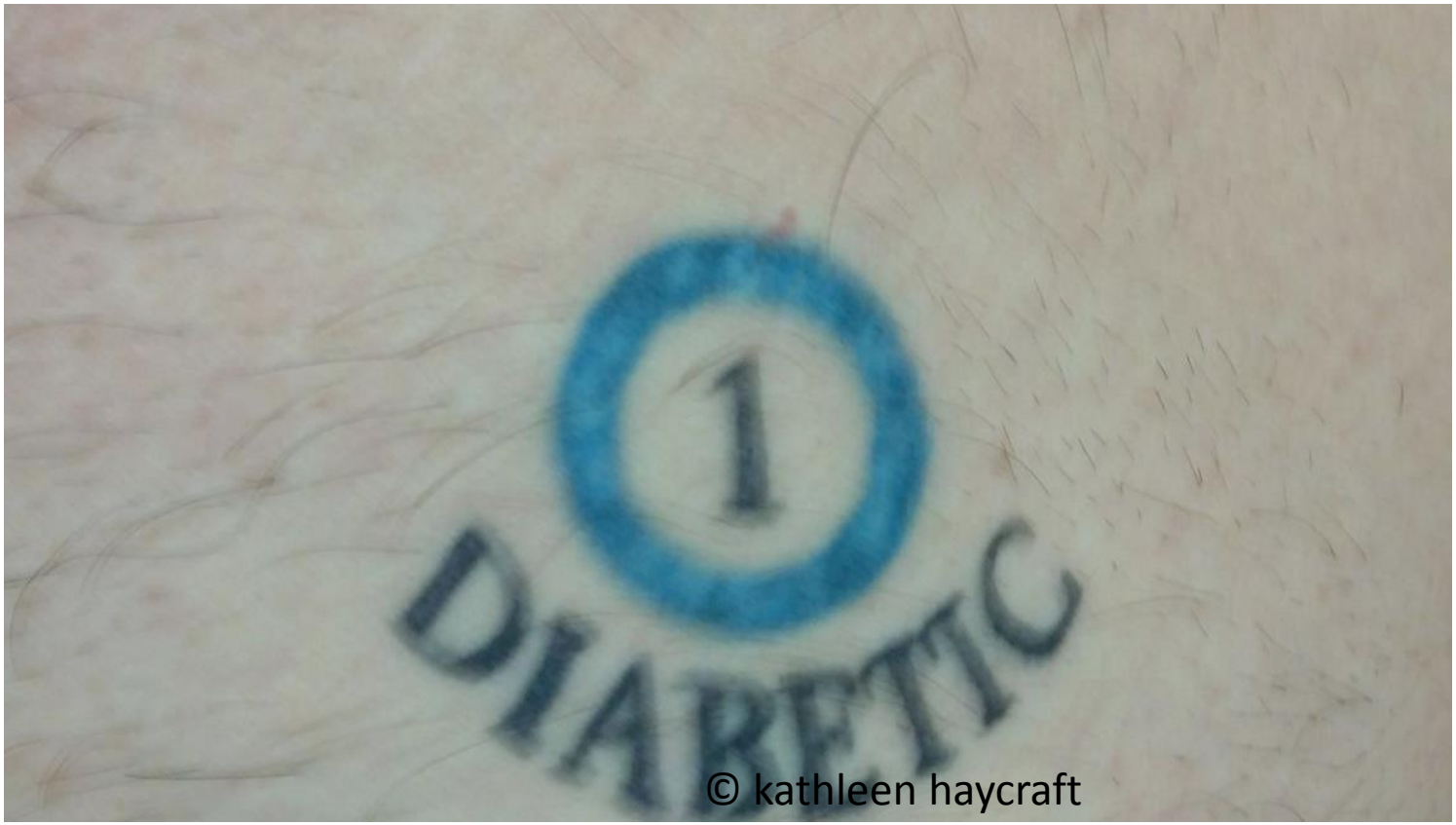
A day with dermatology

- Dermatology is very visual….look think and make an impression.
- Dermatology is also very tactile. Use your hands. Use your sense of smell.
- Listen and evaluate and re-measure your impression.

Pearls

- If the rash is symmetrical…think bug or drug.
- When biopsy…know what you are looking for to do the correct technique.

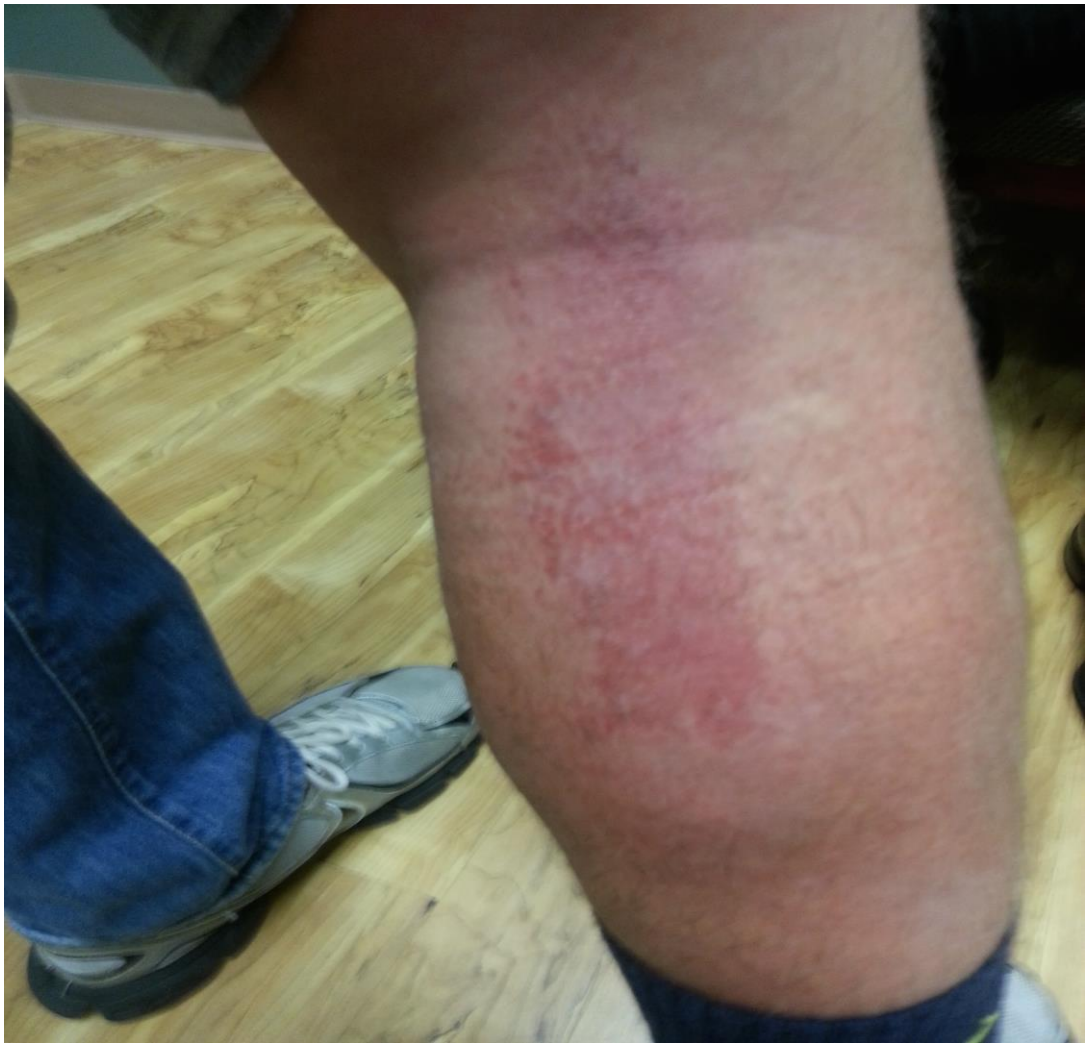
A Tattoo I approve of



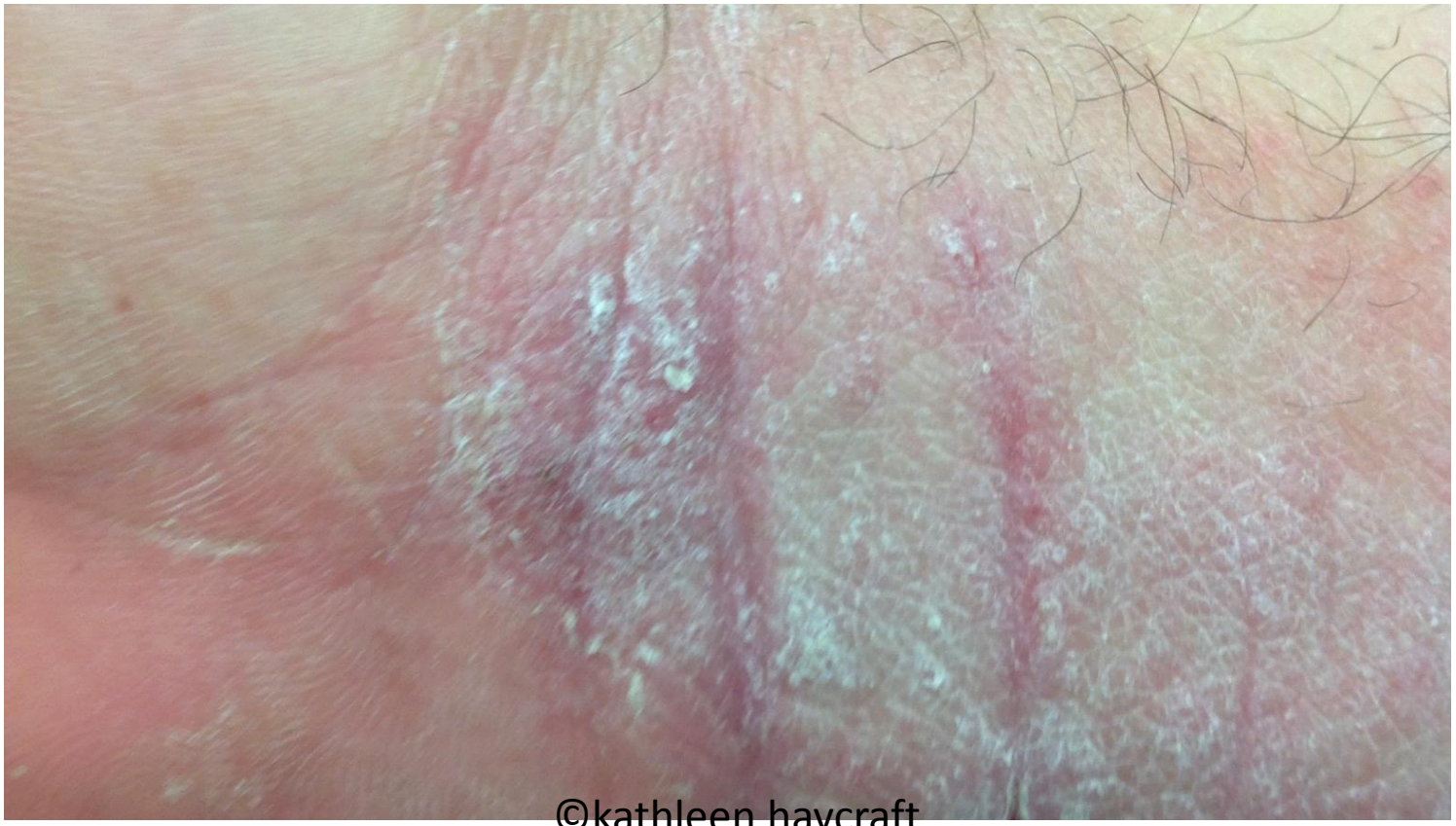
The random days of rashes

- These cases were all listed at the front desk as “rash”

It has been itching here for a few months



I itch all over



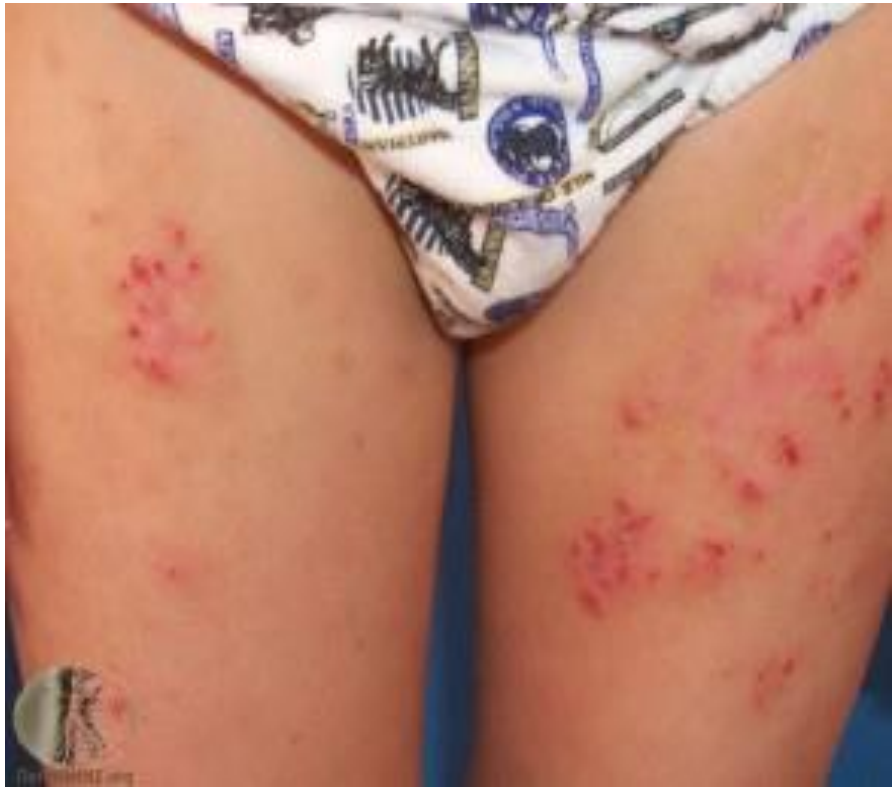
Dermatitis ?allergic/contact/irritant or eczema

- This is chronic lichen simplex..note cracking and thickening of skin that spares the fissures.
- May be a fine rash or may be a thickened rash…the itch that rashes. Control the itch and you will control the rash

Controlling the itch

- High dose antihistamines 4 to 8 times dose for allergies, if this does not work, consider doxepin or gabapentin
- Steroid with wet soaks ..moisturize with tepid water apply .1% triamcinolone ointment and apply wet wash cloth, towel or PJs for 10 to 15 minutes.
- Topical agents TCIs such as pimecrolimus (Elidel) or tacrolimus (Protopic) bid these may sting the first few days
- Eucrisa (crisaborole) is a new phosphodiesterase inhibitor
- Moisturization
- Gentle soap
- Free detergent
- Bleach water baths…1/2 cup bleach to FULL tub of water. Add bleach after tub is full
- Light box or sunlight
- Variety of allergy testing (prick, blood or patch?)

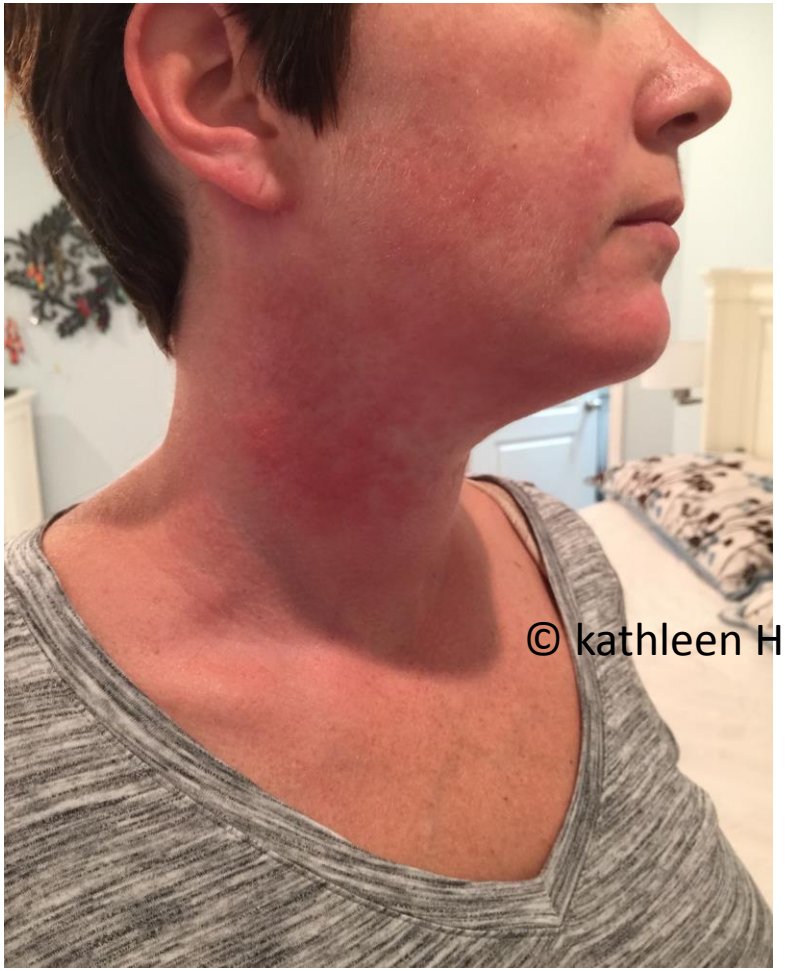
Atopic Dermatitis



Pathophysiology

- Mutation of Filaggren gene, impaired natural moisturizing factor in the skin, environmental conditions, 85% risk of identical twin, staph trigger, hygiene hypothesis
- Associated with allergies, asthma and esophageal mutation
- If you have children with atopy, future children should be thoroughly moisturized
- Game changer with dupulimab…Dupixent
- Treat with similar treatments as for itch

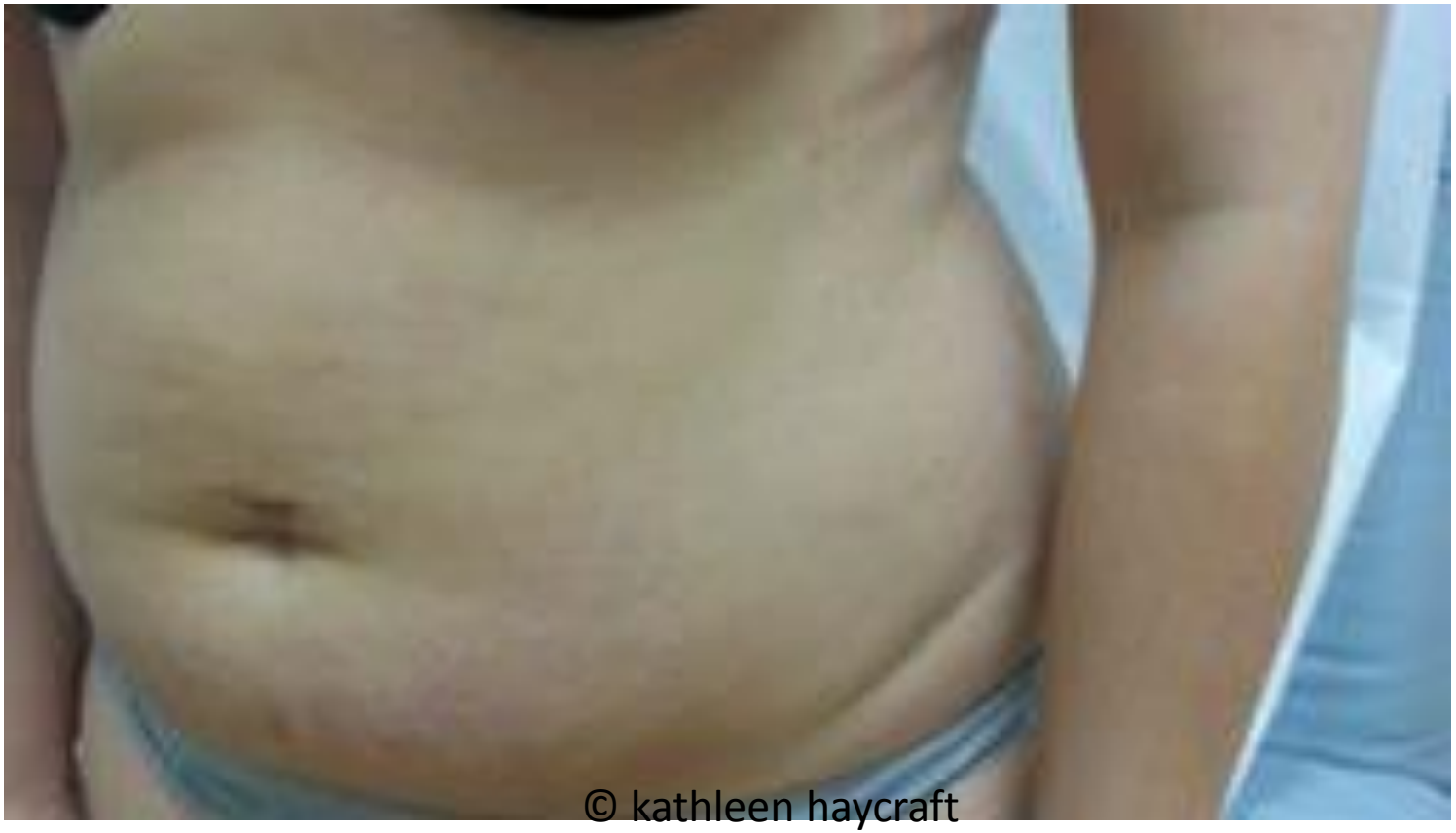
Started new med and used sunscreen burning rash on sun exposed skin



Differential

- Drug was certolizummab (Cimzia)
- Sunscreen was a chemical base
- Biopsy favored drug induced photo sensitivity
- Drug changed and the condition resolved
- With sun exposure think: photosensitivity, polymorphic light eruption or connective tissue diseases e.g., lupus (adverse reaction of cerolizumab)

These bumps really itch



History

- Itchy especially at night and itches intensely.
- Has used Cortaid (flurandrenolide tape)and antihistamines and nothing works.

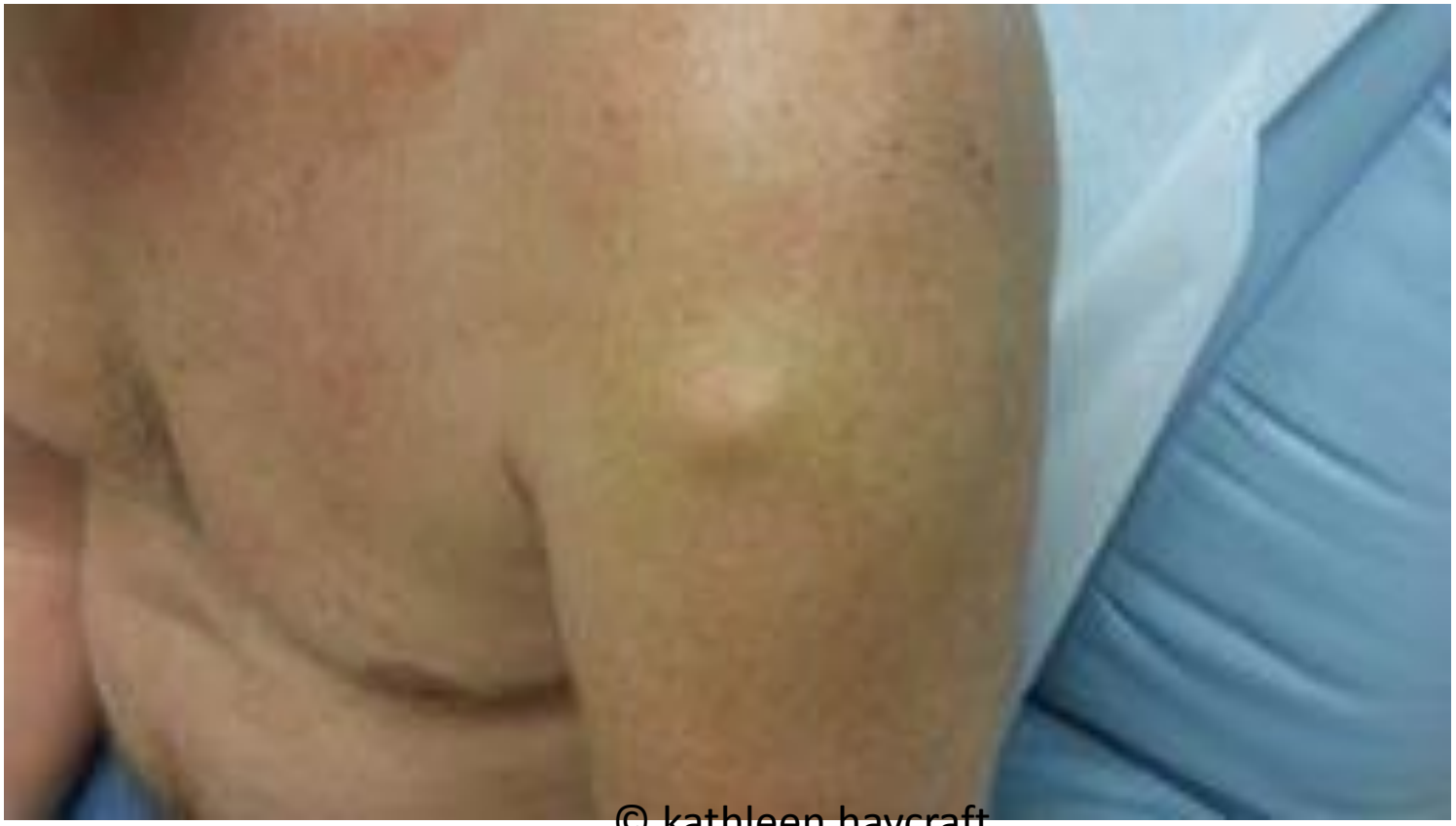
Diagnosis and Treatment

- Scabies An assumption of a rash on the trunk in middles age with intense itching at night
- Axillary if common with infants
- Loves the umbilicus and interdigitary areas in most ages
- If you see intense scaling in elder or immunosuppressed consider Norwegian crusted scabies….teaming with scabies and highly infectious.

Treatment

- Treatment:
  - 5% permethrin cream
  - 25% benzyl benzoate
  - 10% sulfur
  - 10% crotamiton cream
  - 1% lindane lotion
  - Oral or topical ivermectin

This bump keeps growing



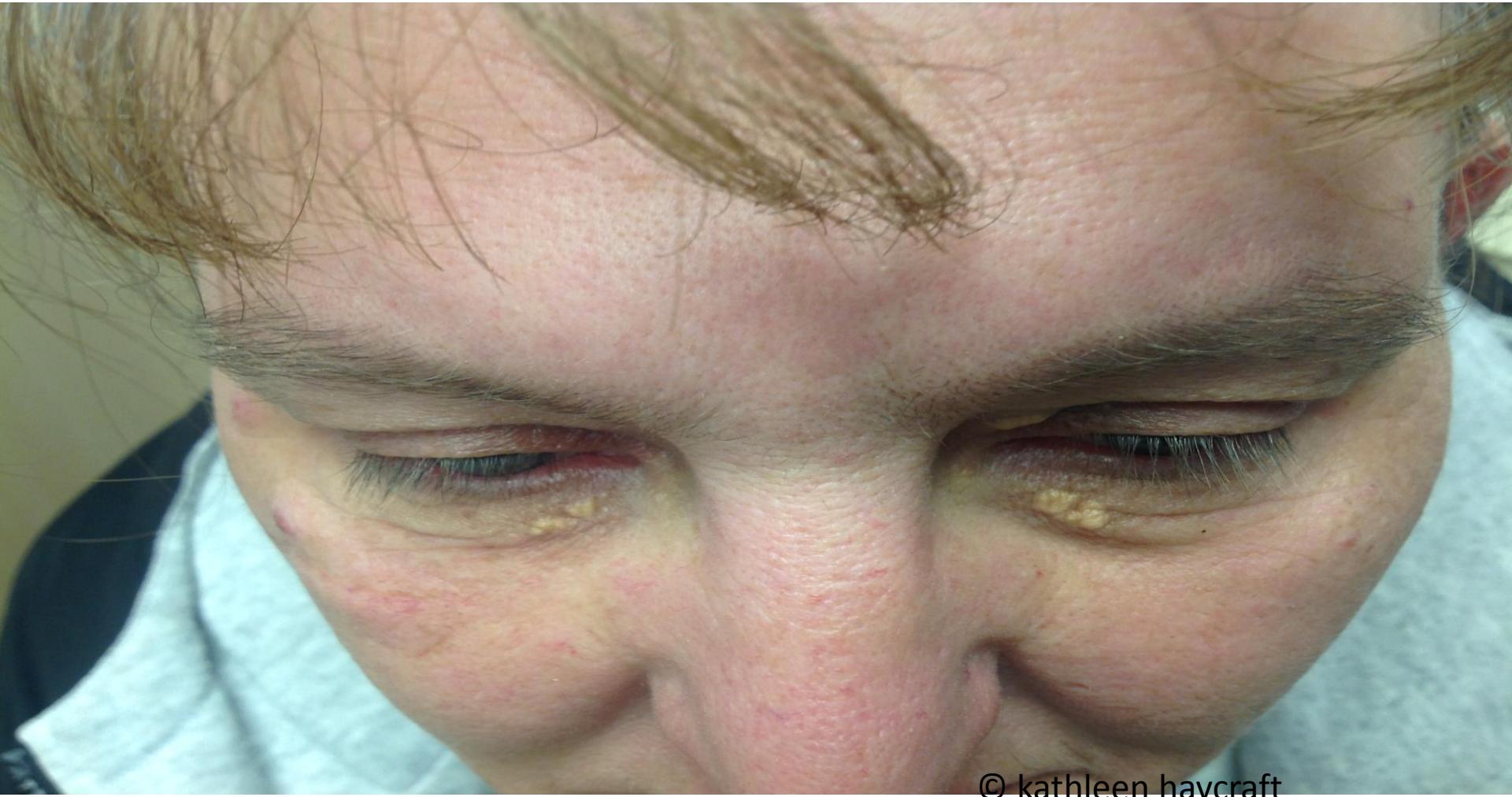
Symptoms

- Palpable and firm edges (unless repeatedly manually expressed)
- Very mobile
- May have history of forceful expression of cheesy white or yellow material
- THESE ARE NOT INFECTIOUS

Diagnosis and Treatment

- Epidermoid Cyst
- I & D (don’t recommend as some have squamous cell cancer) or elliptical or punch excision.
- If inflamed cyclins (due to their anti-inflammatory effect
- Laser

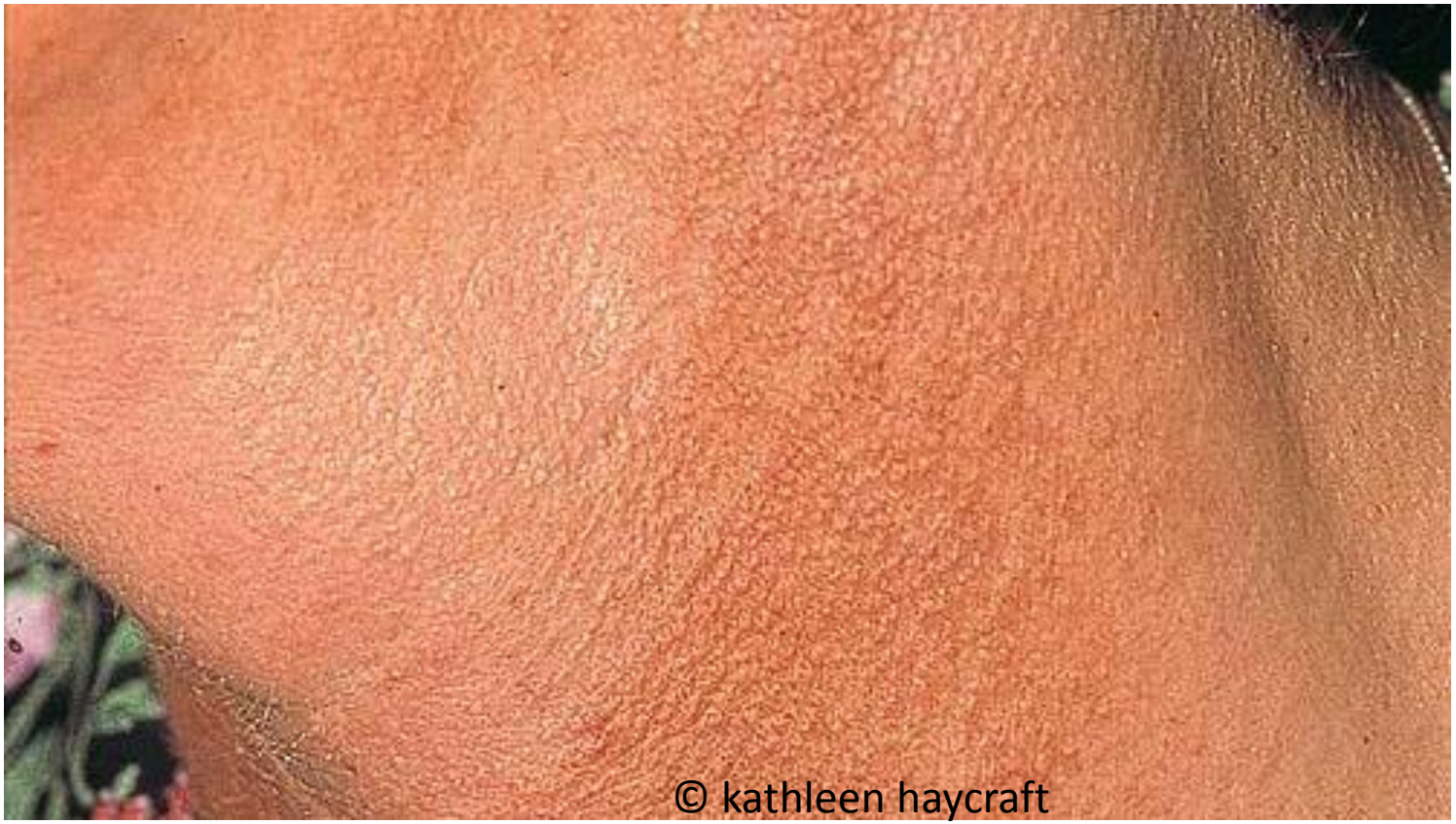
These bumps have to go



Xanthelsma vs Xanthoma

- Associated with high lipid level with xanthoma not xanthelesma
- Treatment of high cholesterols with statins or diet and exercise
- Excision may lead to scarring and recurrence

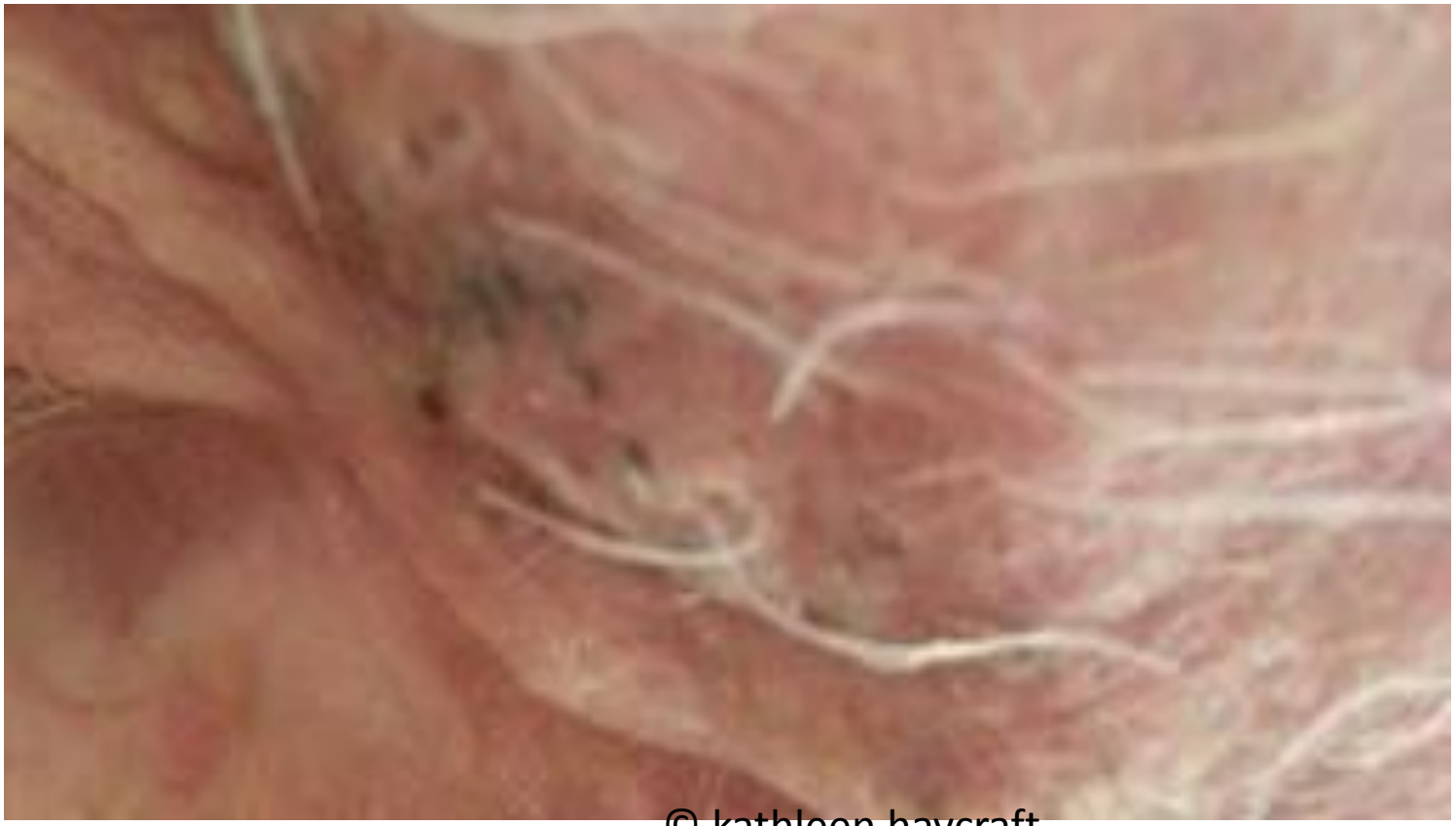
This funny rash is on my neck



Poikiloderma of Civatte

- Peels and hydroquinoine may fade
- Exfoliants e.g., alpha hydroxy and tretinoin
- IPL
- Sunscreen, Sunscreen, Sunscreen
- Potent topical Vitamin C

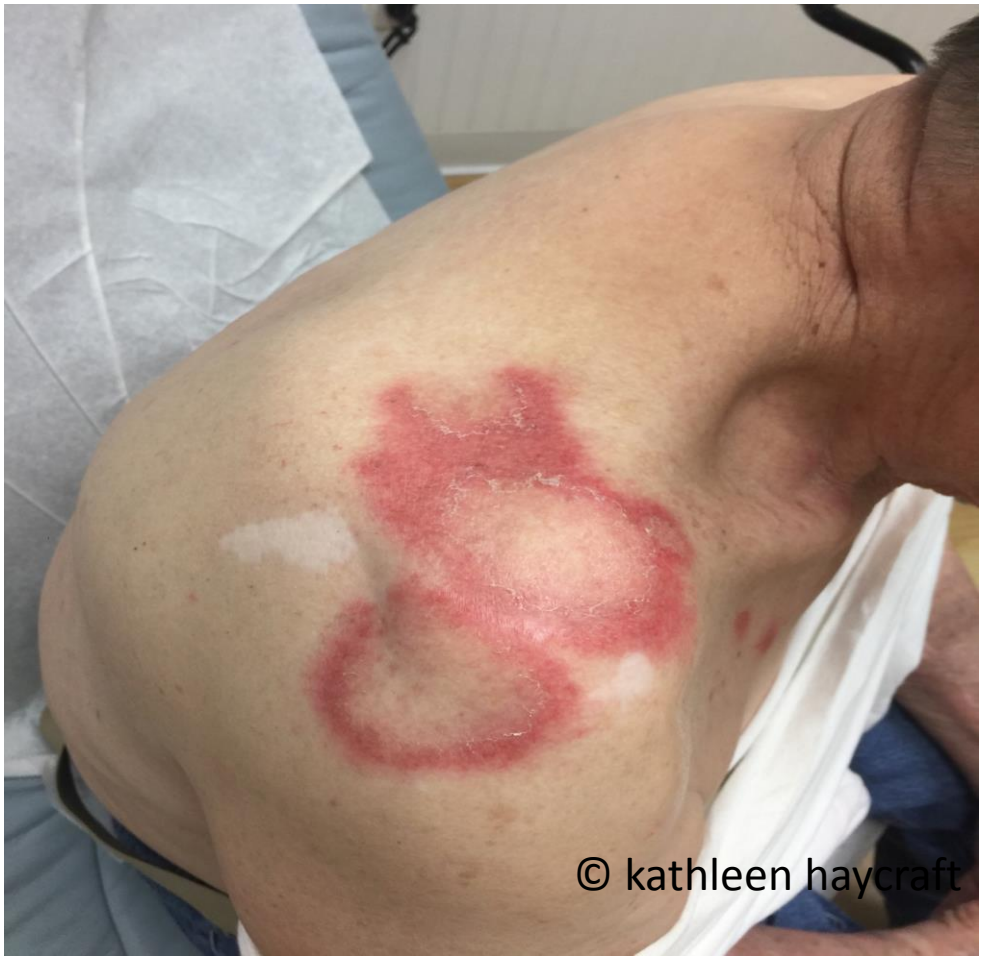
I can’t stand these bumps on my eyelids



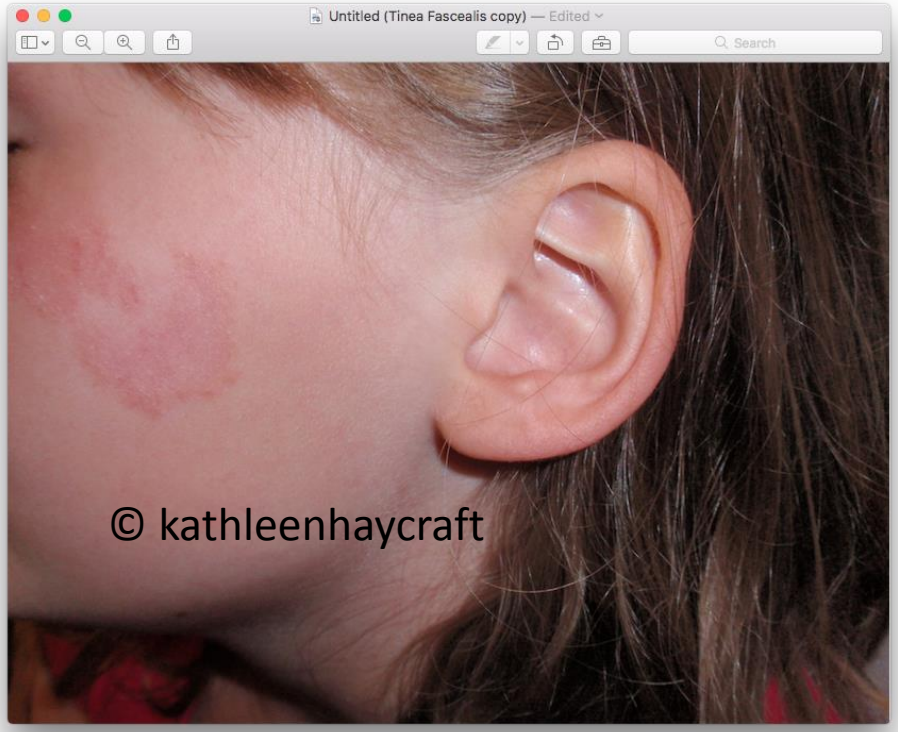
Actinic Comedones

- Sunscreen
- Stop smoking
- Retinoids
- Extraction

Keeps getting bigger and itchy



Tinea


Untitled (Tinea Fascealis copy) — Edited
Search
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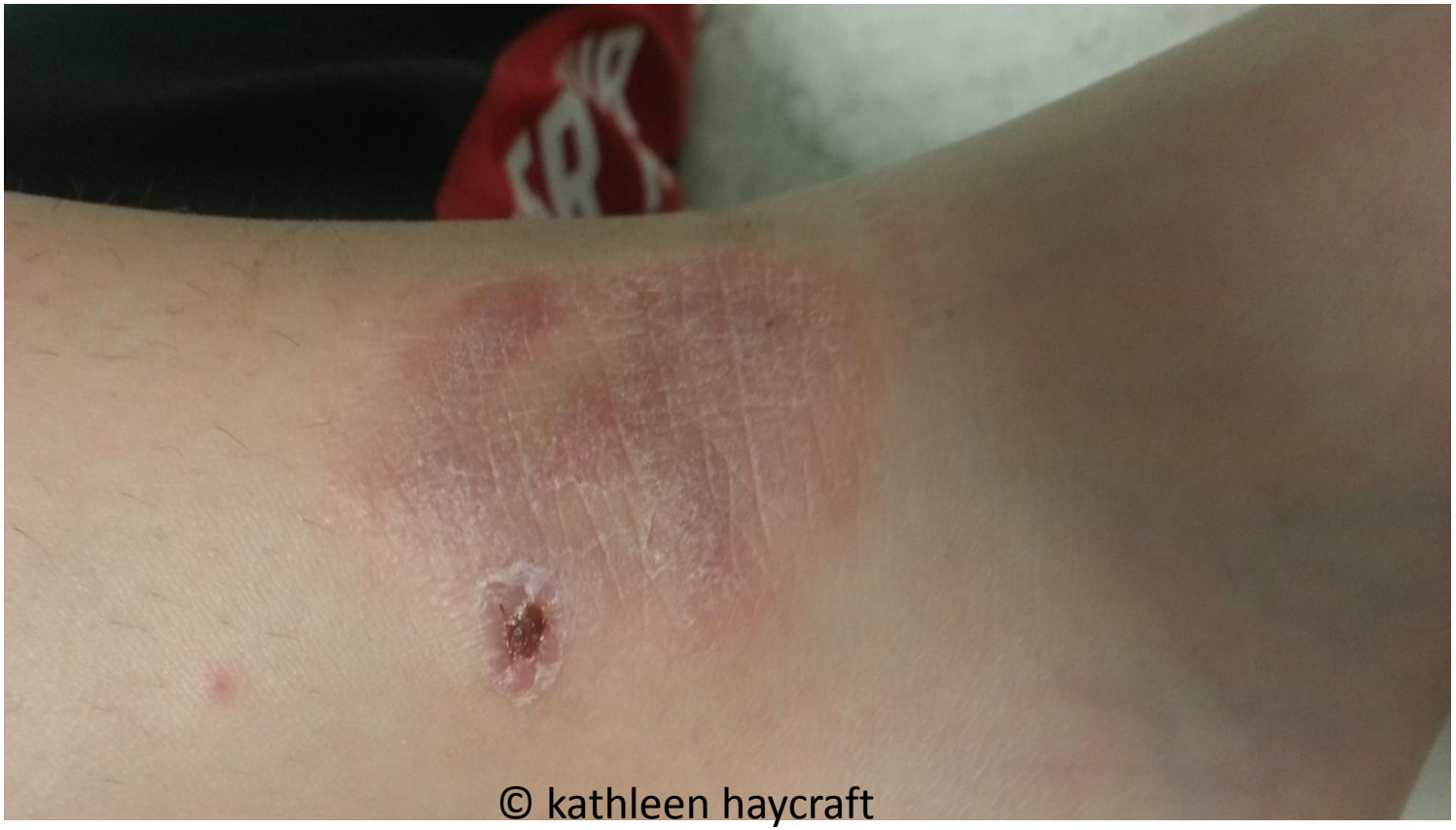
Tinea treatment

- Treat the itch with antihistamines
- White vinegar 1 TBSP with 2 cups tepid water soak for 15 minutes dry and put on azole cream
- Tinea capitis and faciei may require oral treatment with fluconazole or lamisil
- DO NOT TREAT WITH STEROIDs

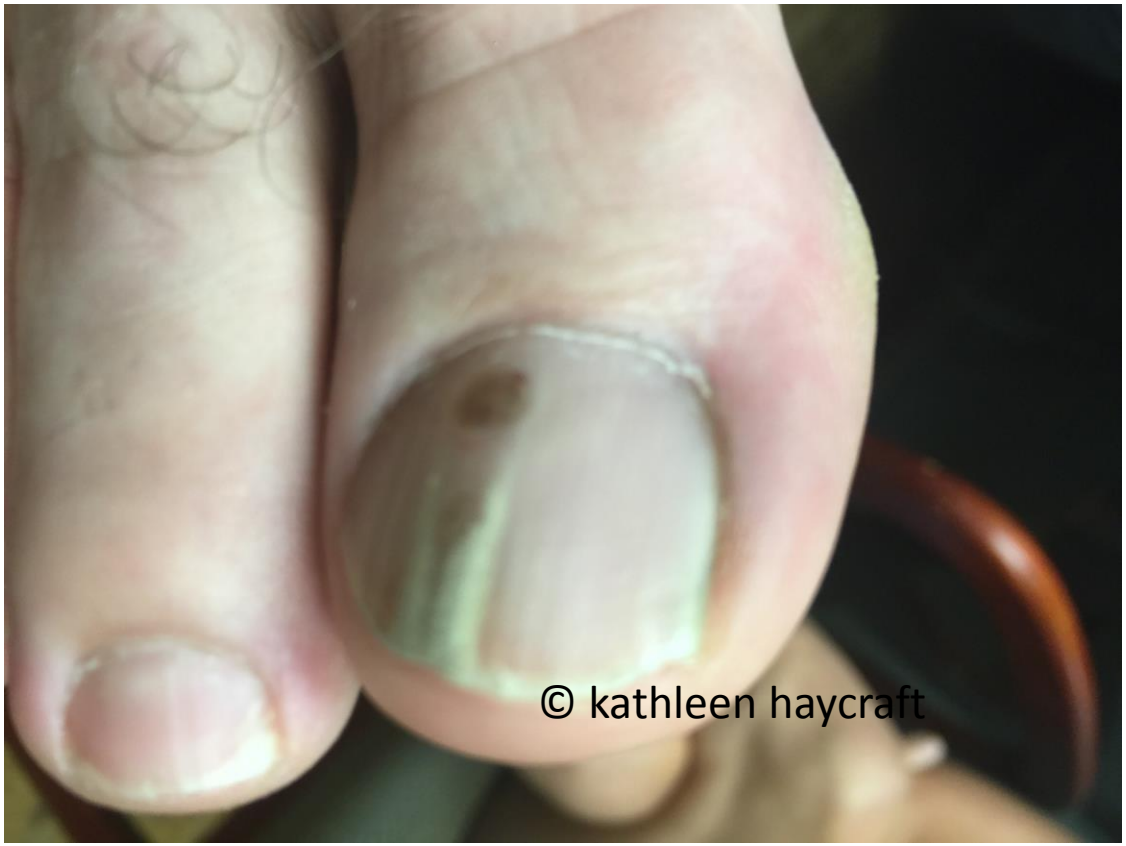
This is itchy and started as a pimple



Majocchis granuloma

- Punch biopsy may consider DIF to rule out connective tissue disease.
- Oral terbinafine for 4 to 8 weeks or fluconazole for similar treatment
- AVOID STEROIDS

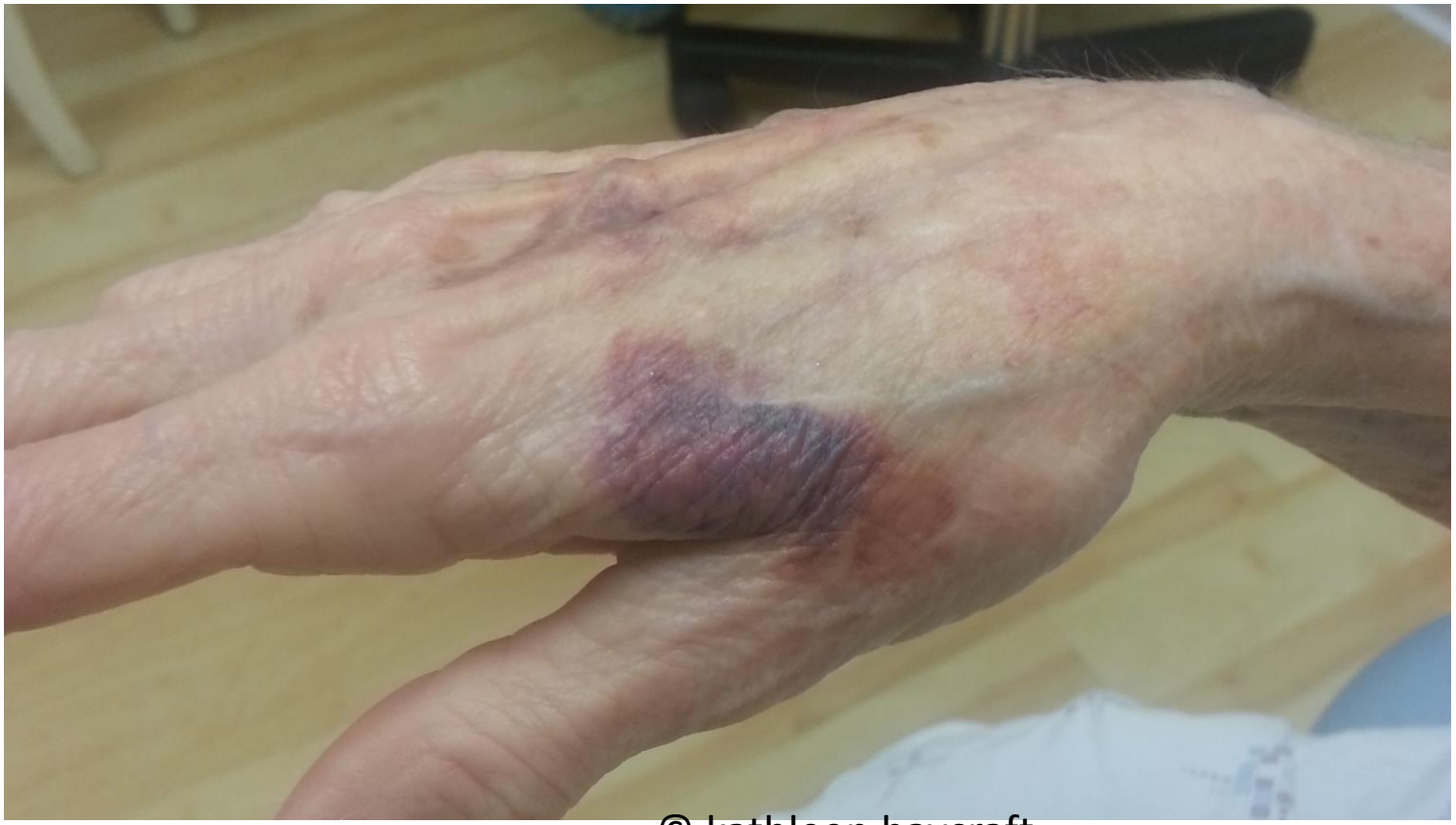
Onychomycosis usually will find tinea pedis



Onychomycosis

- Can do nail clipping to prove
- Topical laquers: boron, azole, thymol, ciclopirox
- Look and treat for tinea pedis
- Don’t forget the shoes
- May need oral terbinafine

I hate this bruise



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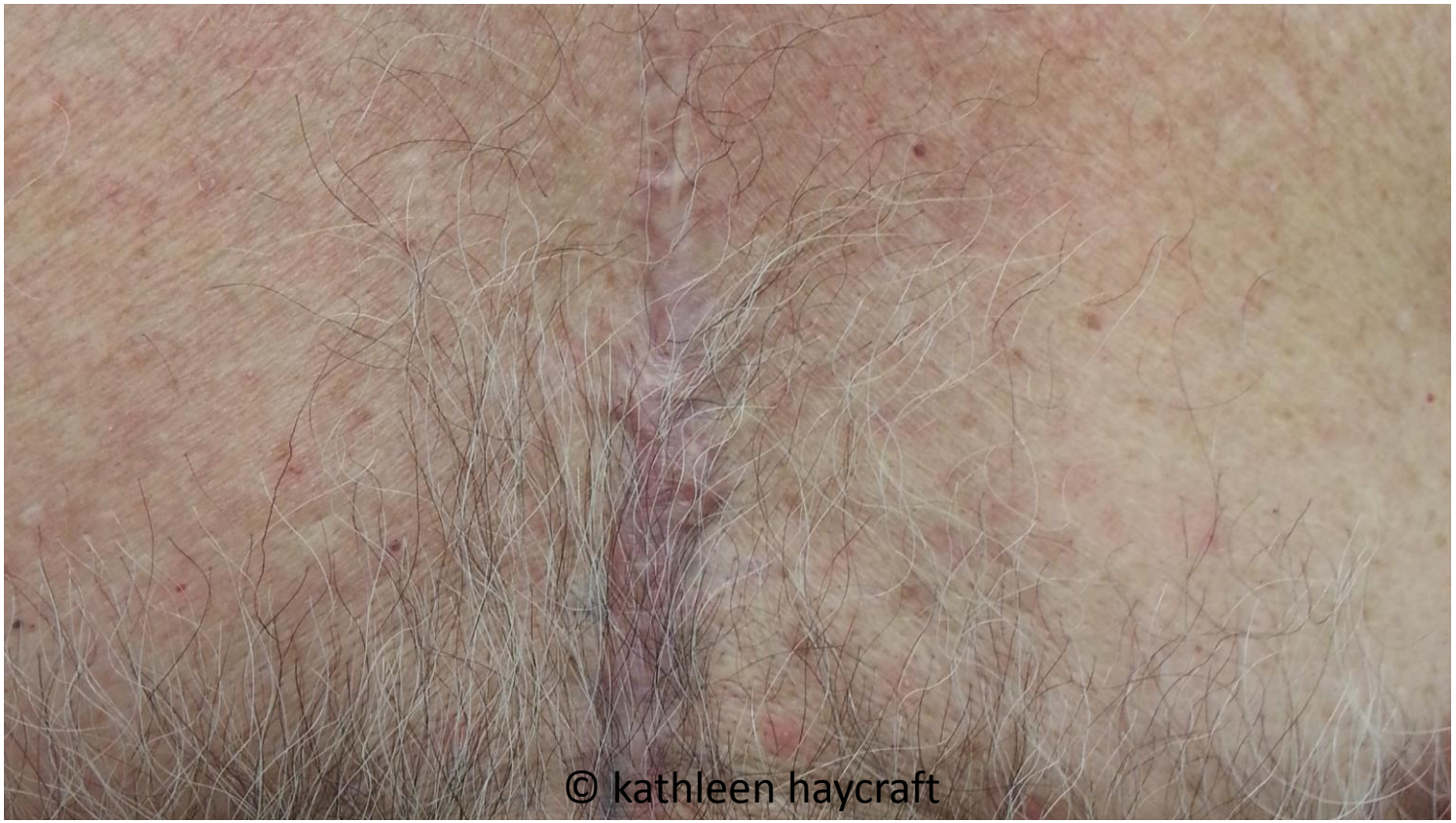
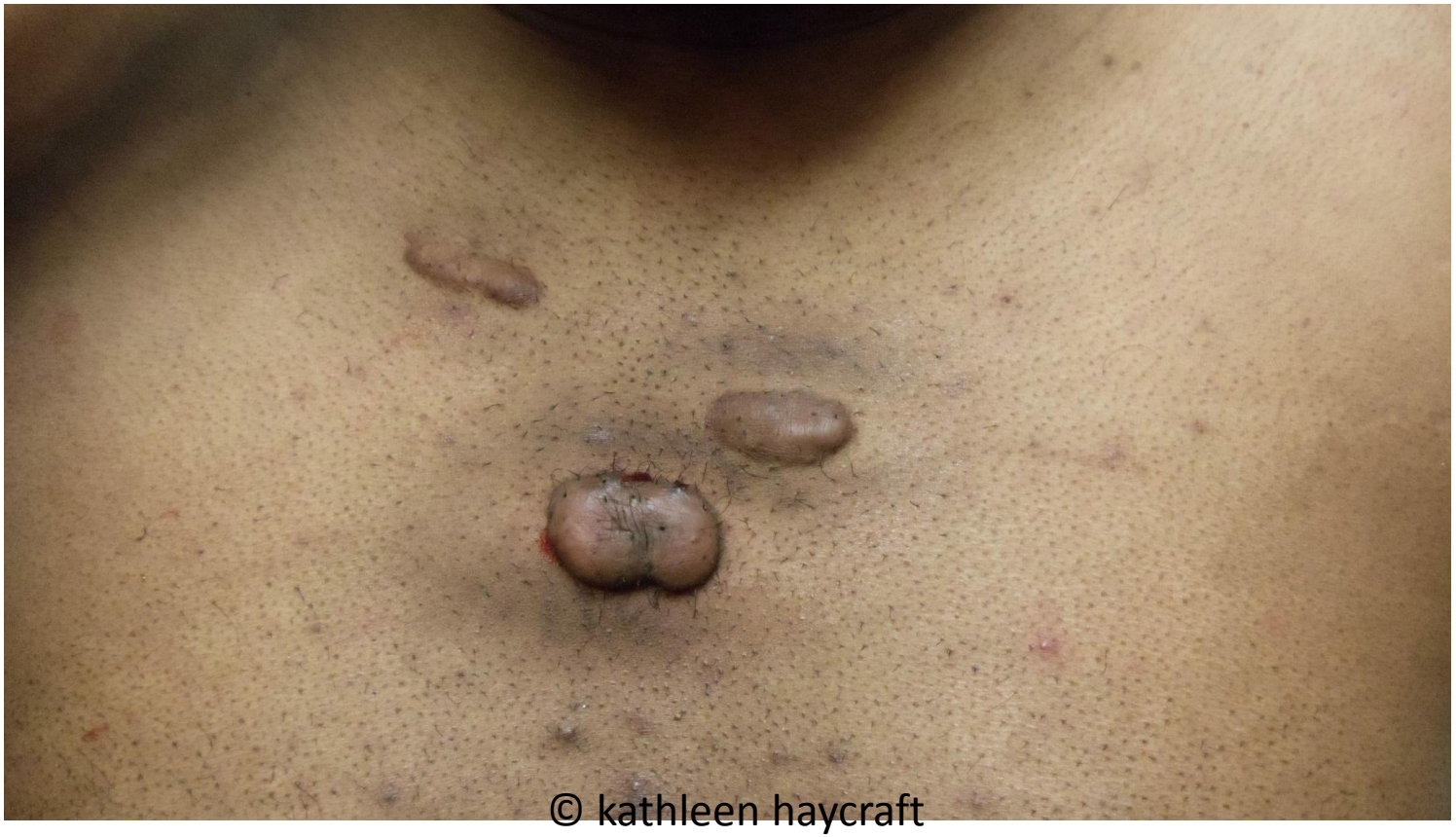
Actinic Purpura

- Solar damage
- OTC products
- Often use a cream with arnica montana

This is growing after my heart surgery is it cancer



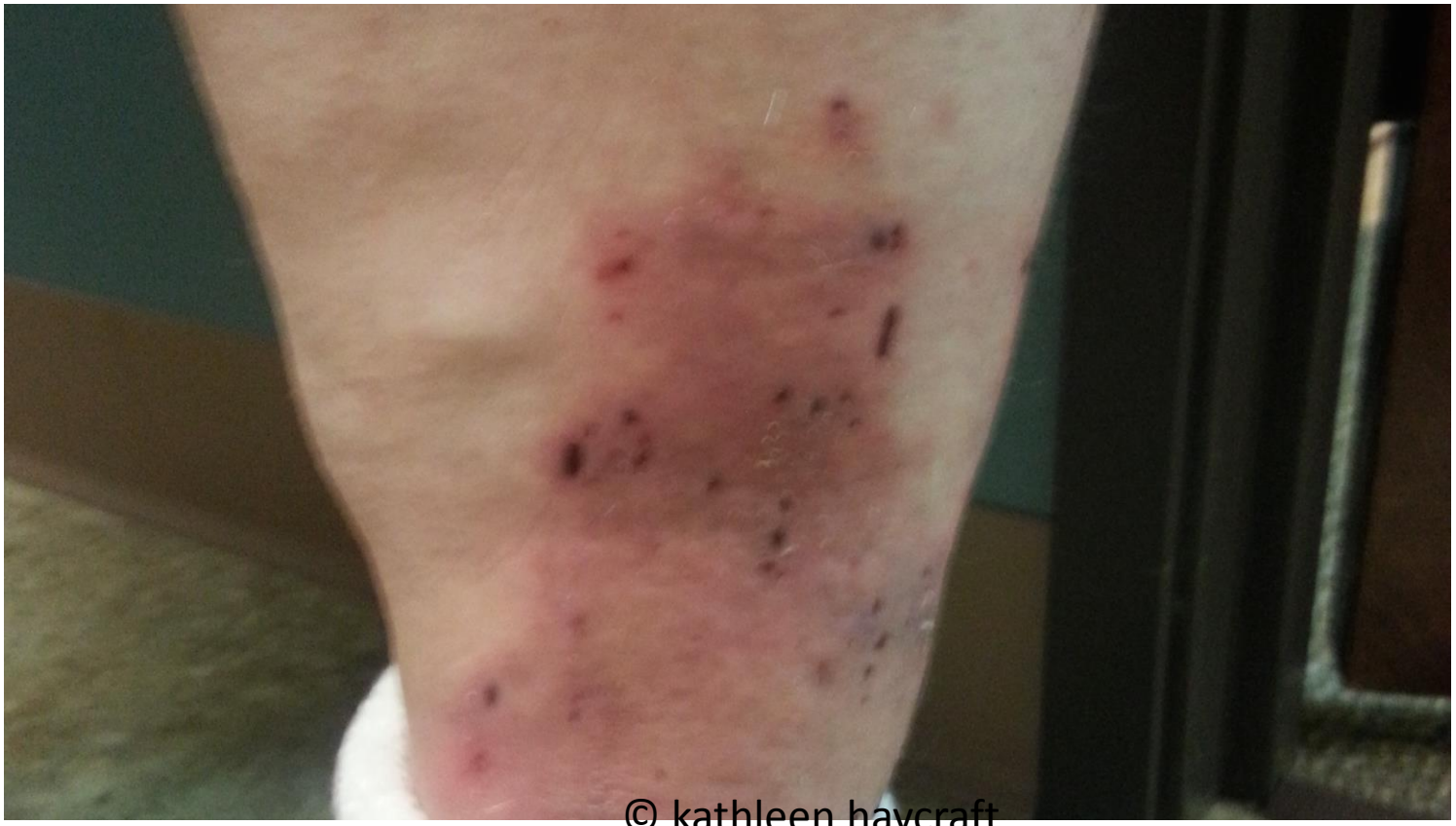
I have these since I have had acne



Keloid/Hypertrophic Scar

- Histologically different
- Clinically a hypertrophic scar stays within its boundaries but a keloid extends beyond its original scar site
- LN2
- TAC injection
- Silicone gel or patch
- Laser

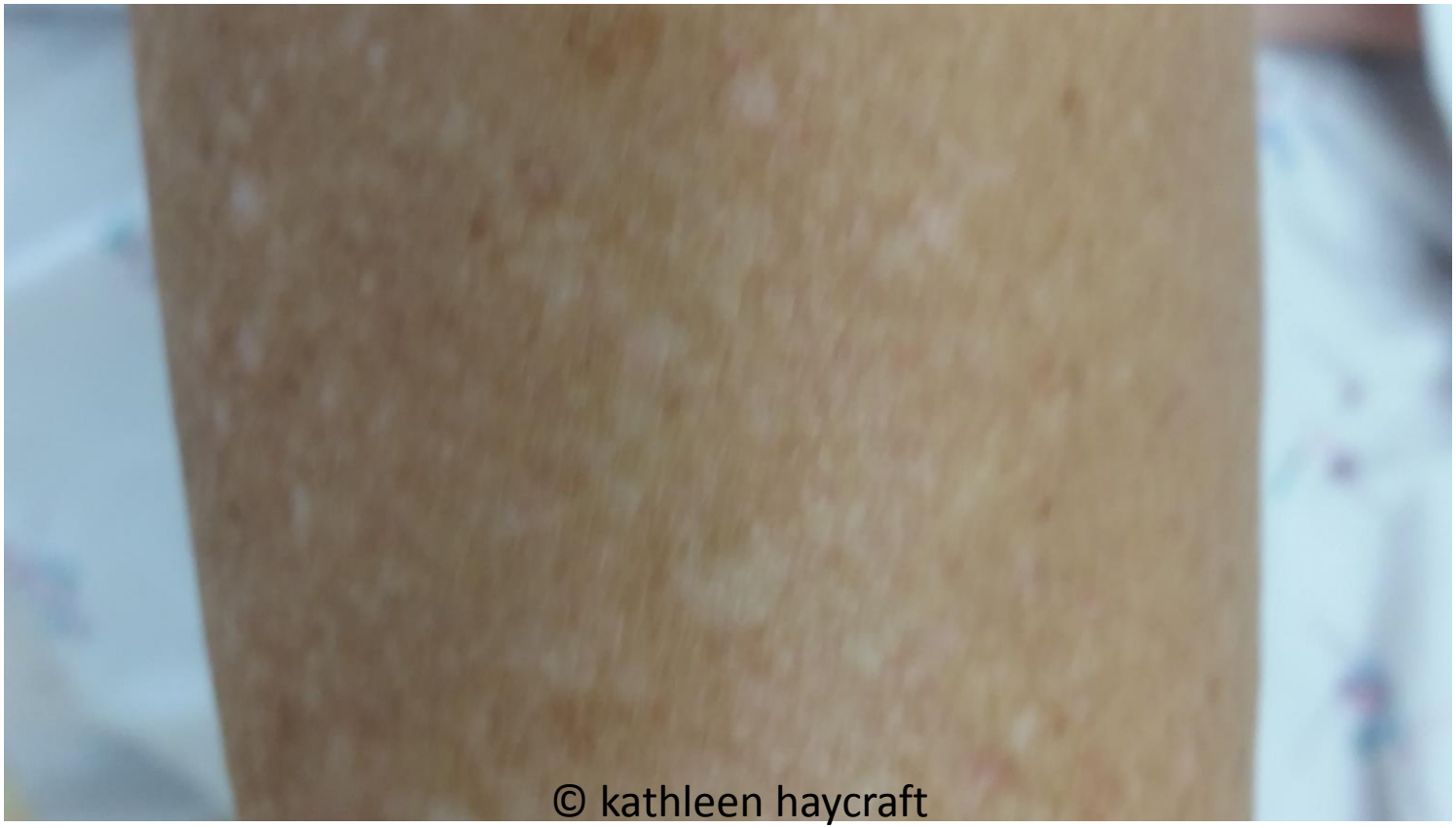
This is ugly



Venous Stasis Dermatitis

- Compression is imperative
- Unna boots are still usefully
- Referral for varicose vein repair
- Statins regardless of lipid levels
- Assess for secondary infection however this is rare and always culture ideally with a tissue culture before treating
- If ulcerated, silver products or umbilical cord tissue
- Steroid and moisturizers

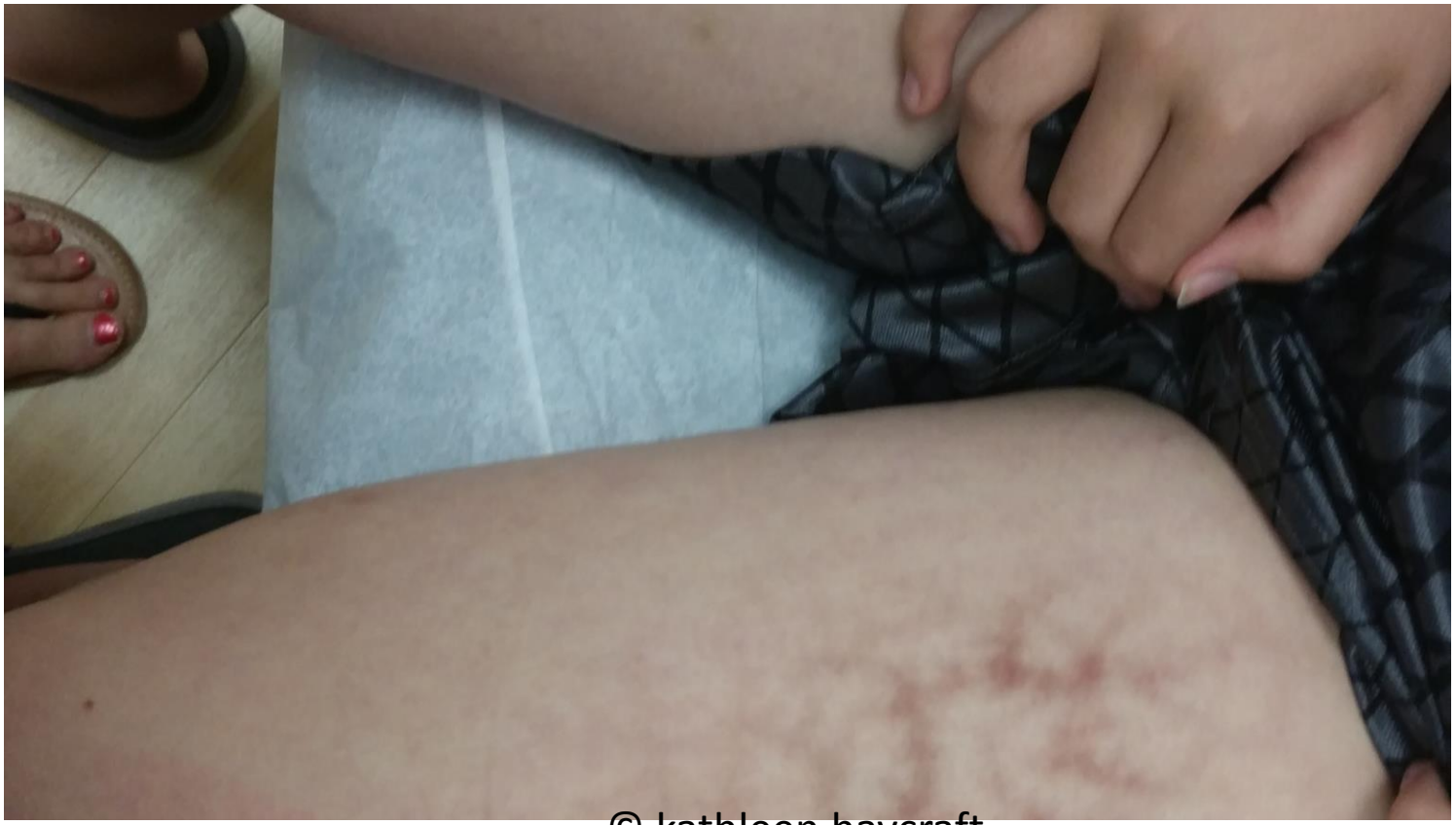
I have these white spots can you make them go away?



Idiopathic Guttate Hypomelanosis

- Damage from long term sun exposure and melanocytes have been “blasted”
- SUNSCREEN, Sunscreen, sunscreen
- IPL and Peels may be of some help

Why does my son have this sudden mark?



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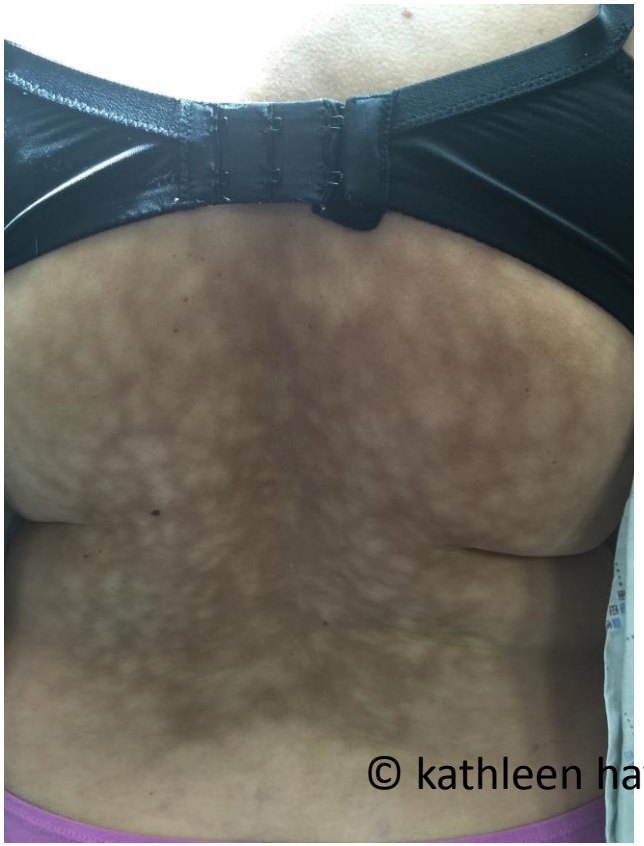
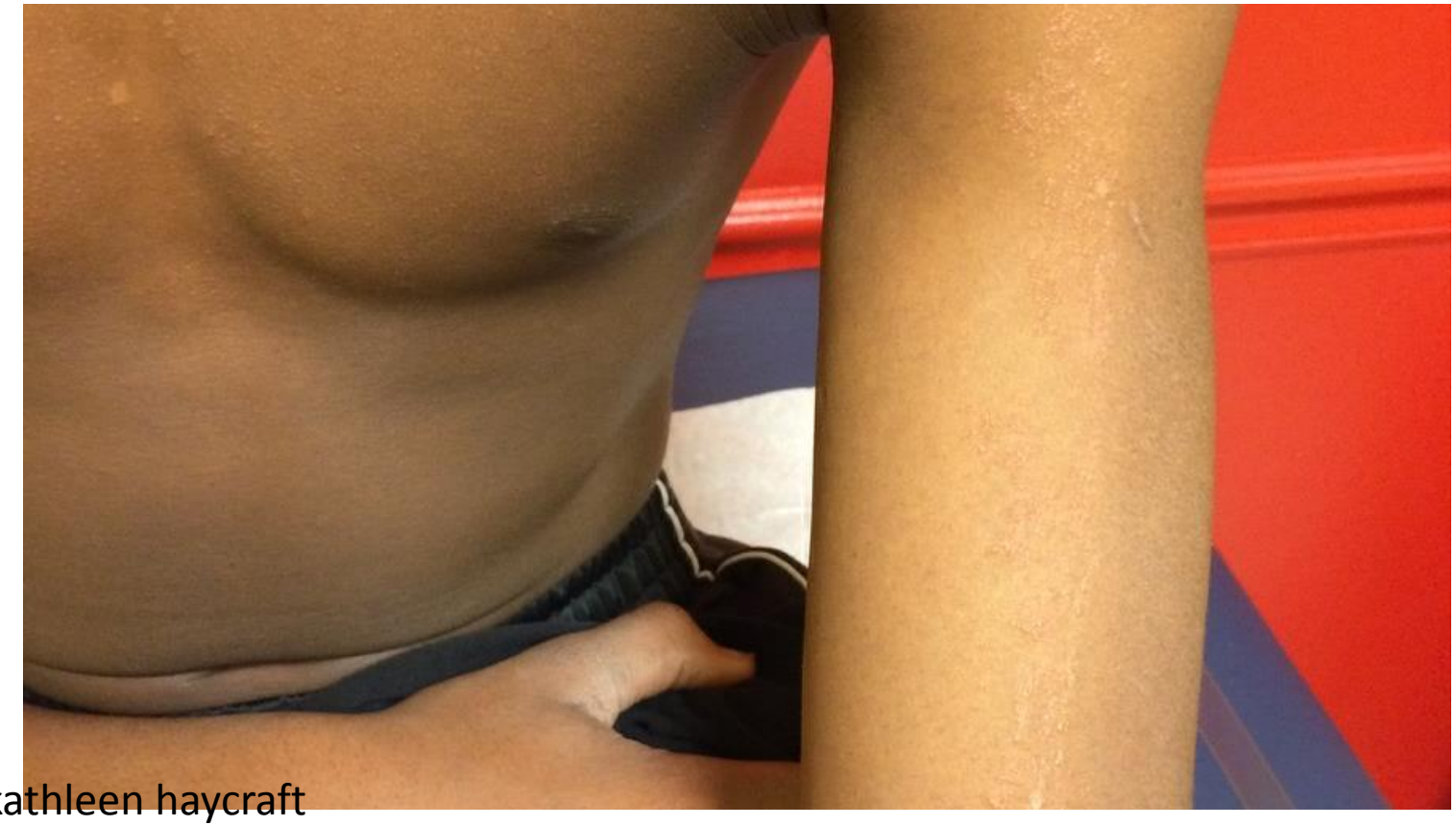
What do you think this patient is doing?



Erythema Ab Igne

- Due to heat
- This patient had been using his computer/game station and the power source was on this side.
- Remove heat and skin will usually return to normal in 6 months to a year.
- Sunscreen as sun will increase the likelihood of permanent hyperpigmentation

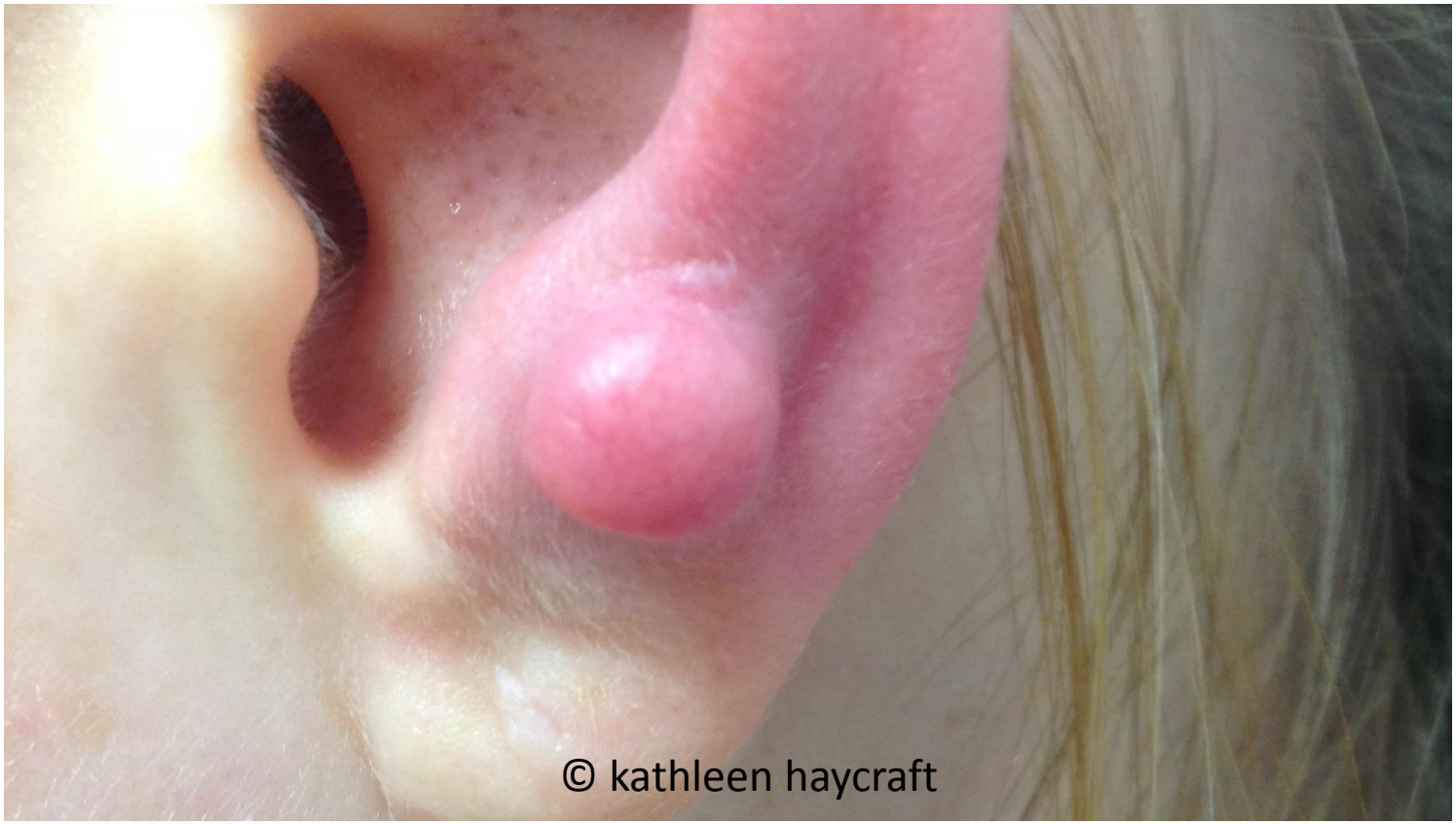
I got a call from a pediatric nurse asymptomatic line



Unilateral Thoracic Exanthem

- Usually asymptomatic but is variable.
- Usually has a virus preceding. Take the history as usually has had a URI
- Resolves without treatment
- Reassurance

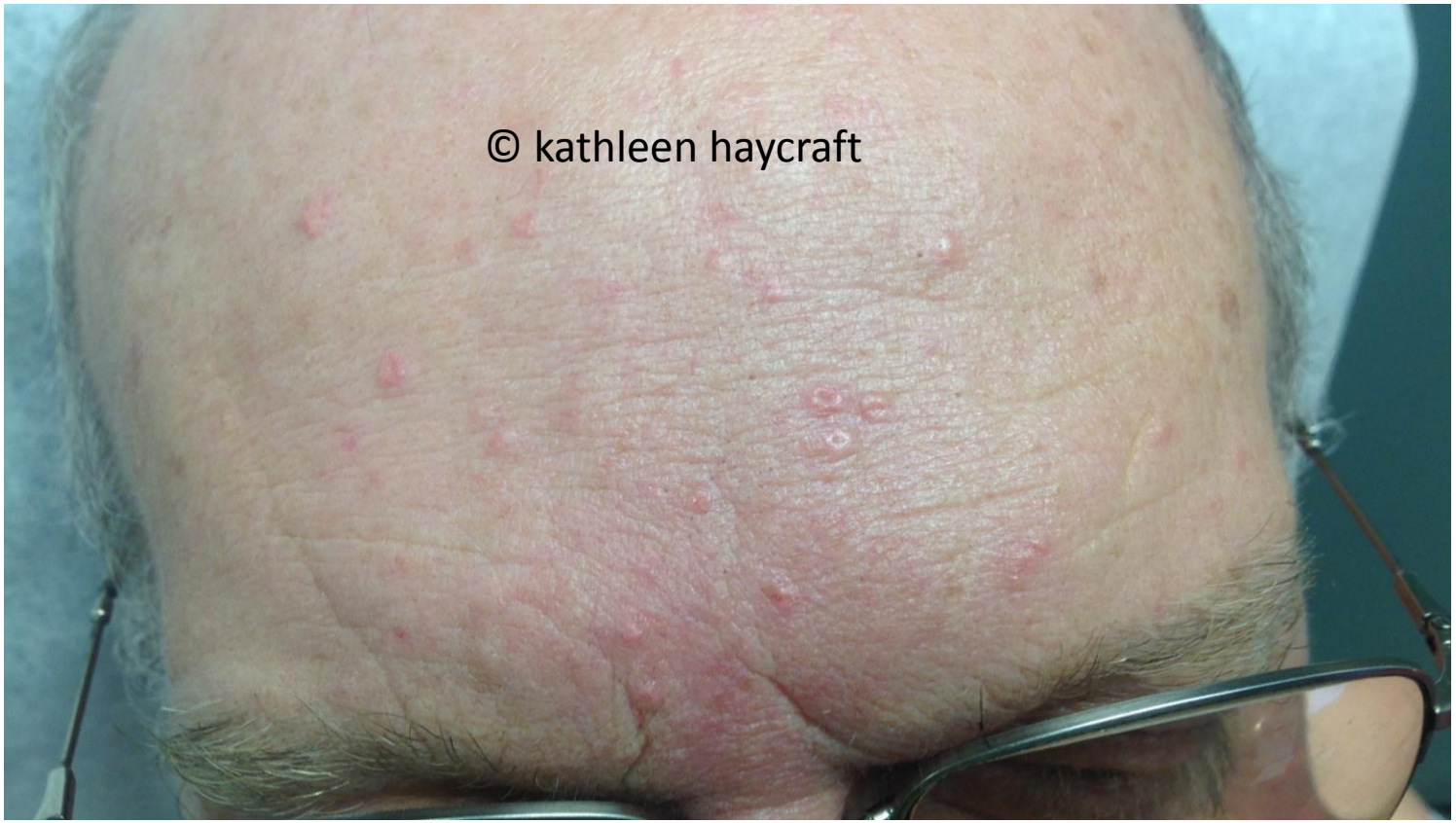
This doesn't hurt but is a big bump



Keloid after ear piercing

- Never excise as it will worsen
- Send to a dermatology…may excise with imiquimod
- Triamcinolone injection followed by LN2

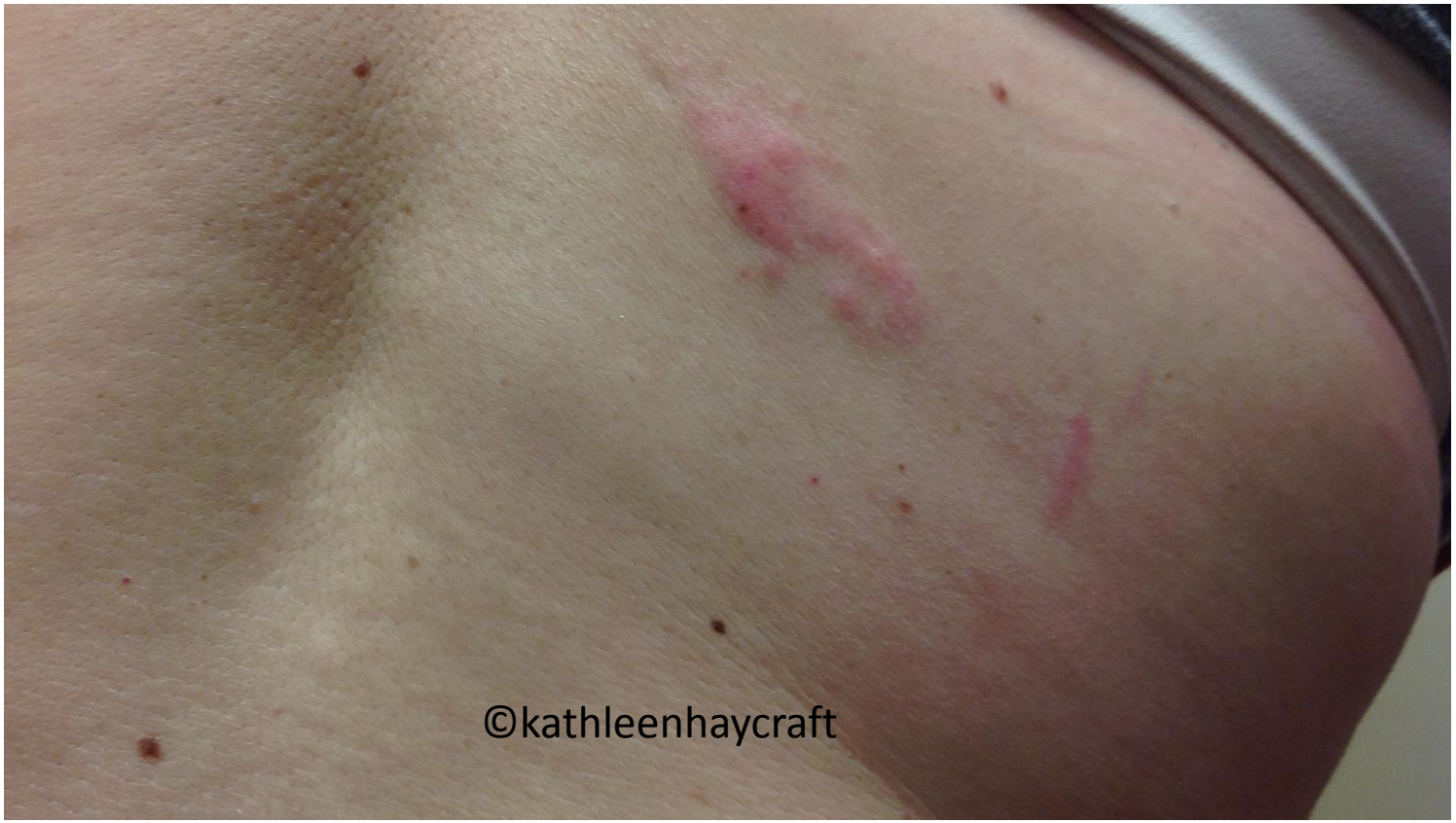
I have these painless bumps on my forehead



Sebaceous Hyperplasia

- Retinoids. Oral use of isotretinoin for 2 to 4 months. This population is older so lipid risk is of concern
- Do not excise
- IPL or Laser

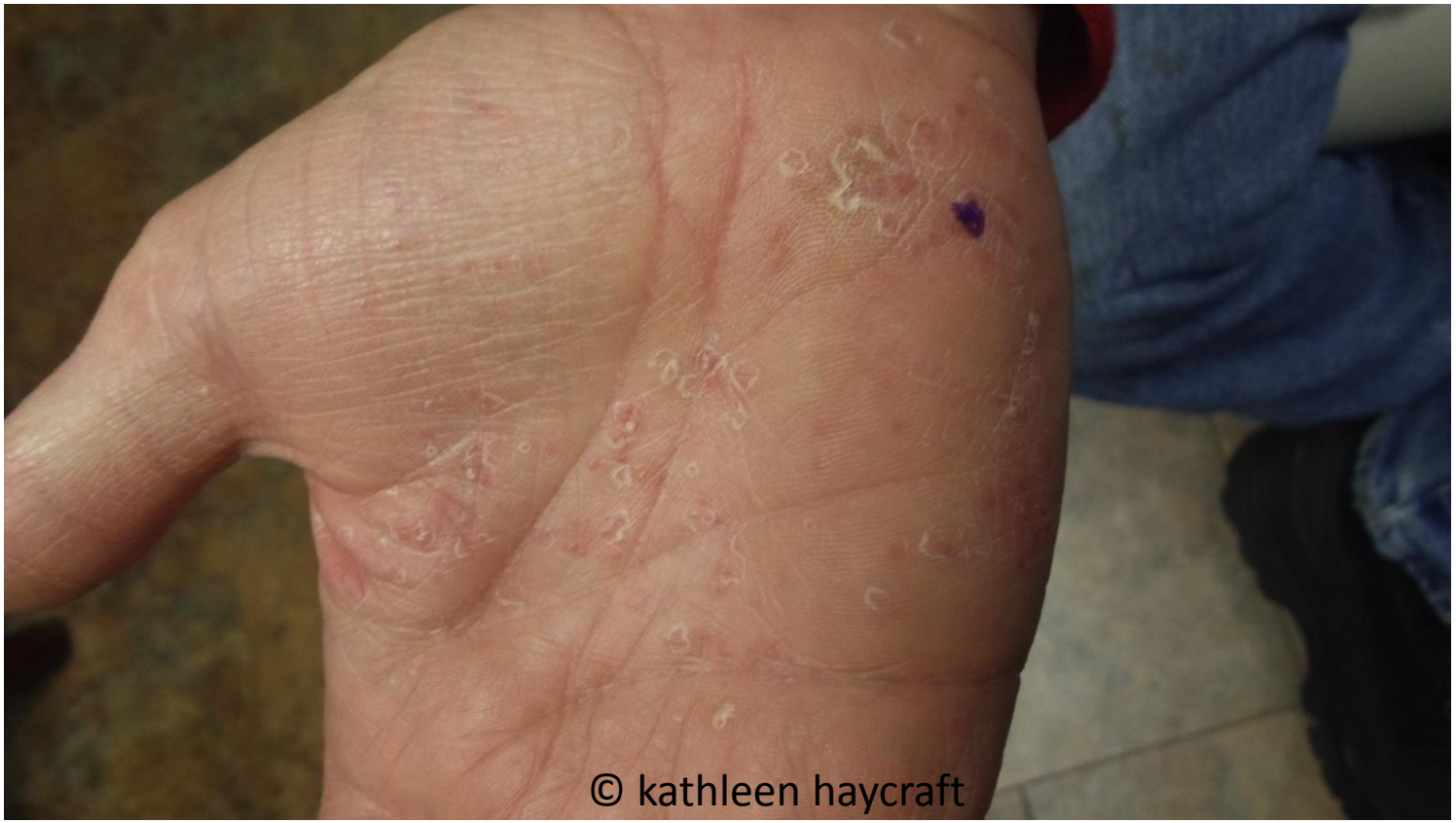
This hurts and itches and has been here for 4 days



Herpes Zoster

- Pain usually precedes rash. Some may have itch. Pain is usually “burning”
- Is not a bilateral rash
- Early phases treat with antivirals
- Steroids in some cases
- Important to turn off the pain switch with lidocaine patches or gabapentin

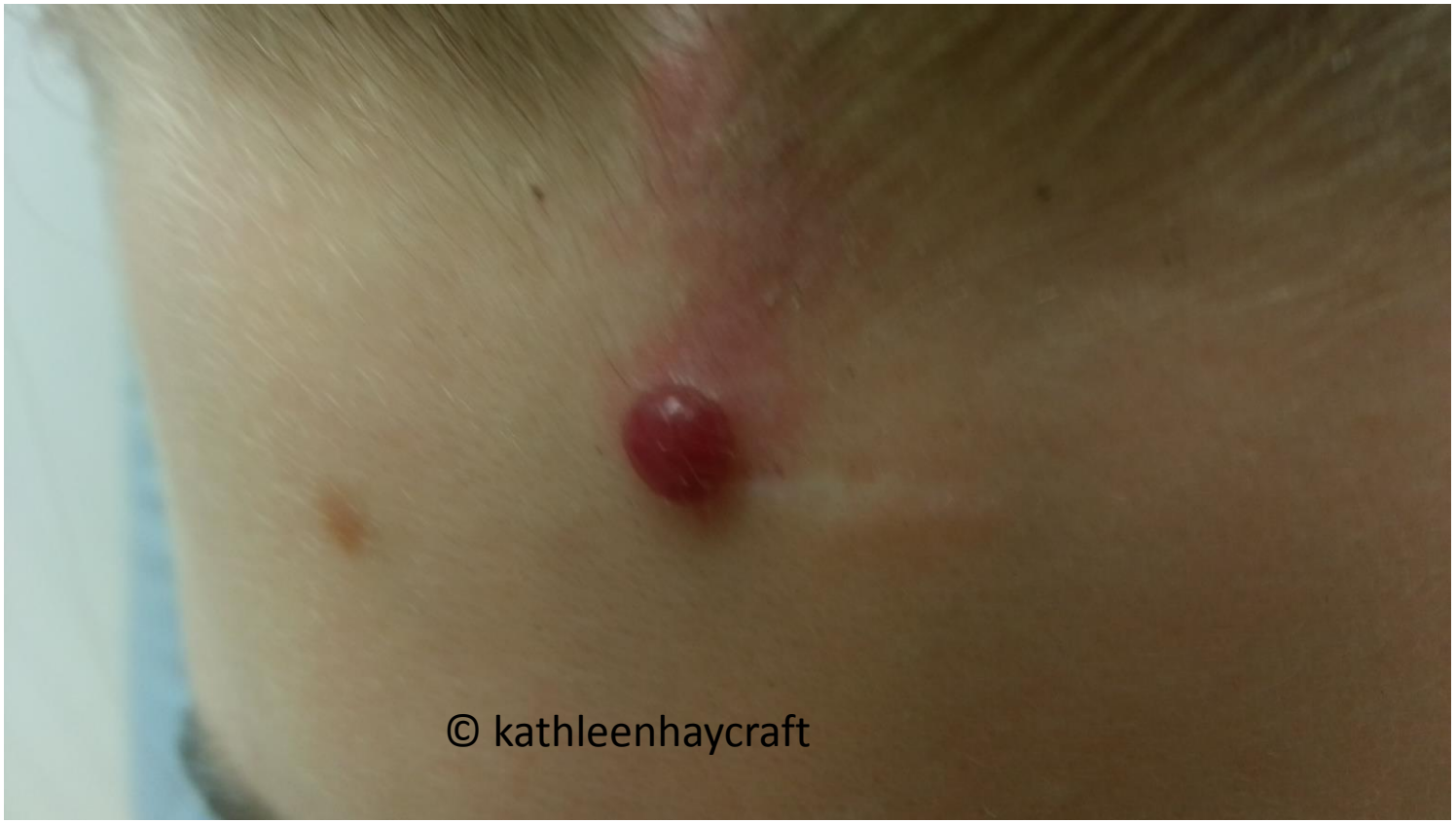
I have an itchy rash that won't go away



Id/Dyshidrotic Eczema

- Differentiate
- If Id treat the primary fungal source
- If eczema, steroid creams, moisturization, gentle soaps, free detergent, TCI, gloves (either physical or barrier) and generous use of antihistamines

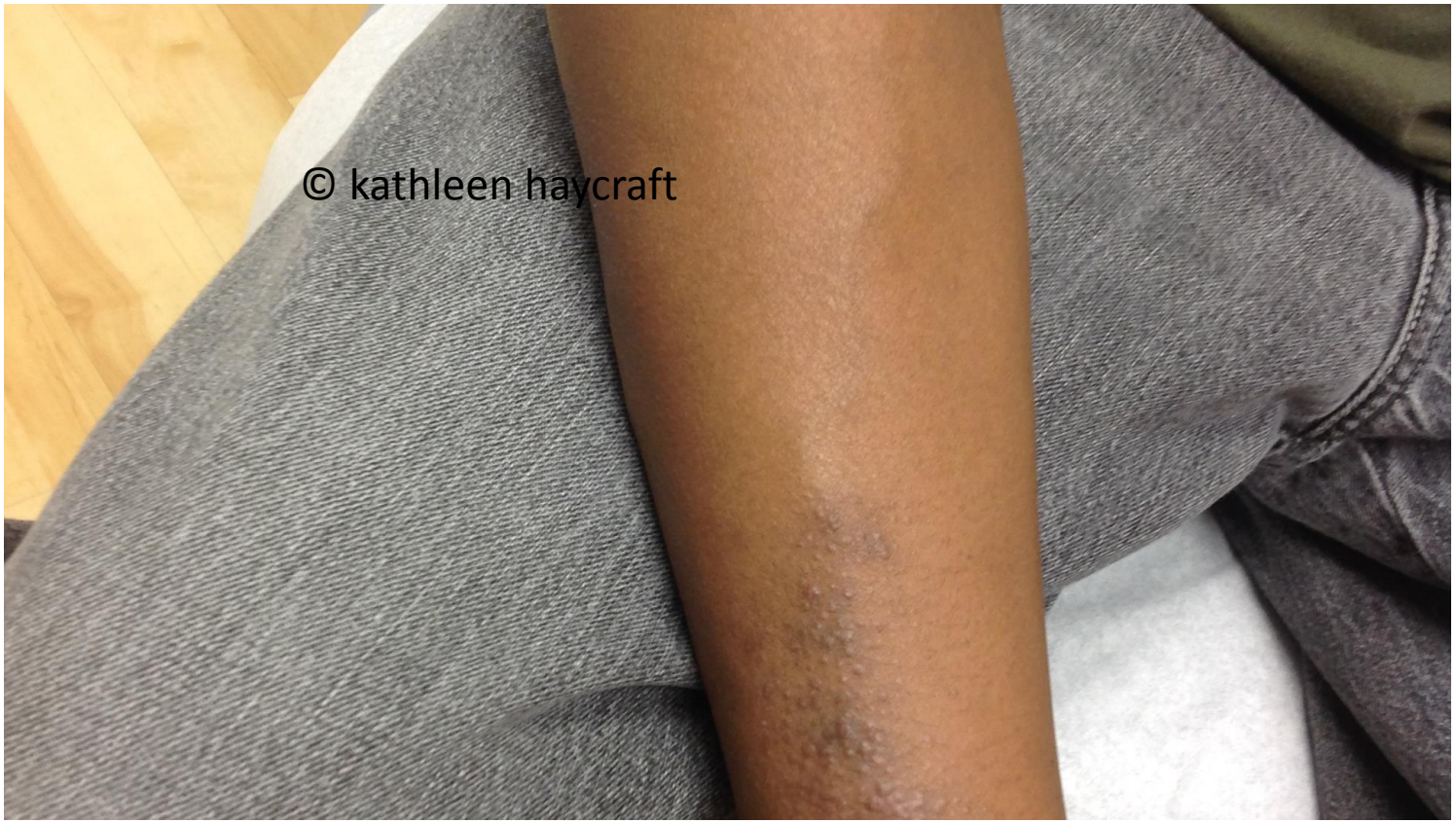
This bump keeps bleeding



Pyogenic Granuloma

- Note the collarate. An excessive response of tissue healing.
- Shave and hyfrecate base.
- May reoccur

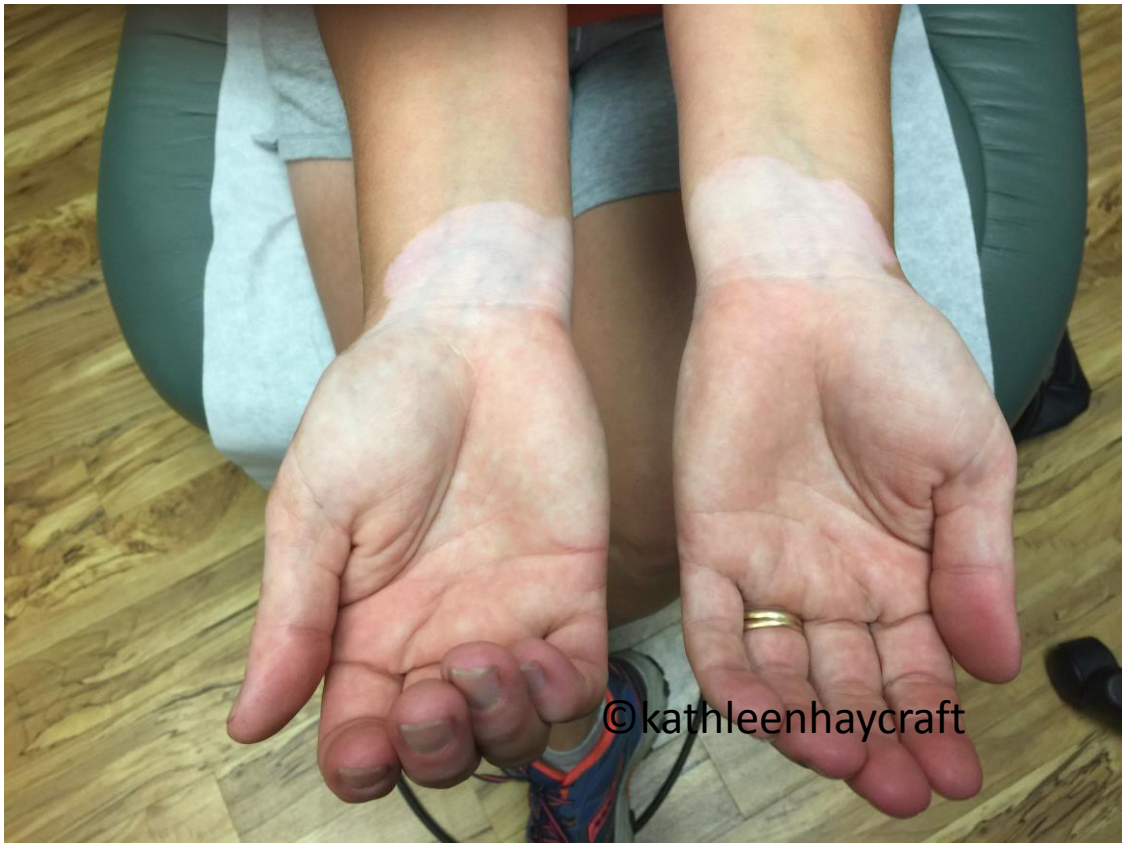
I have this itchy rash



Interesting patient had a fistula above the rash

- Example of venous stasis

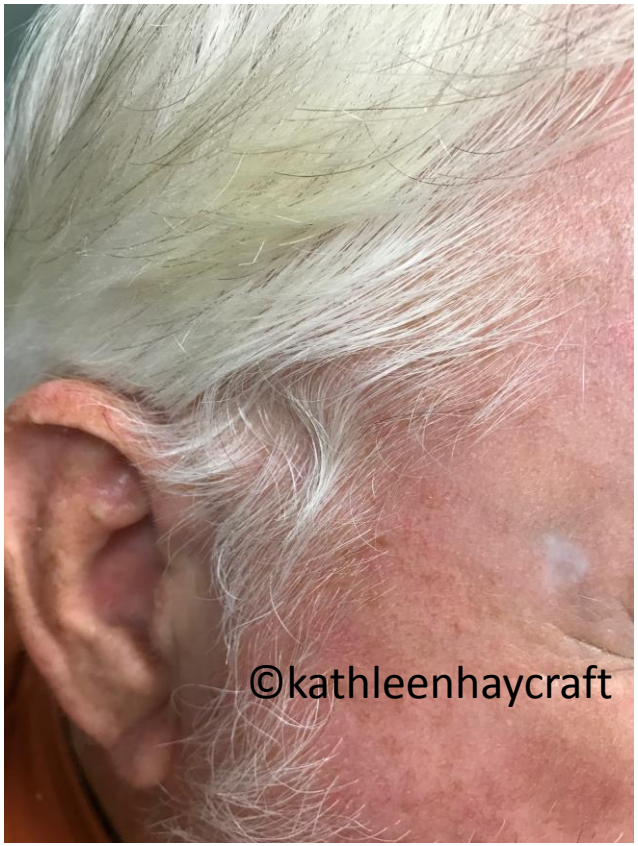
Vitiligo



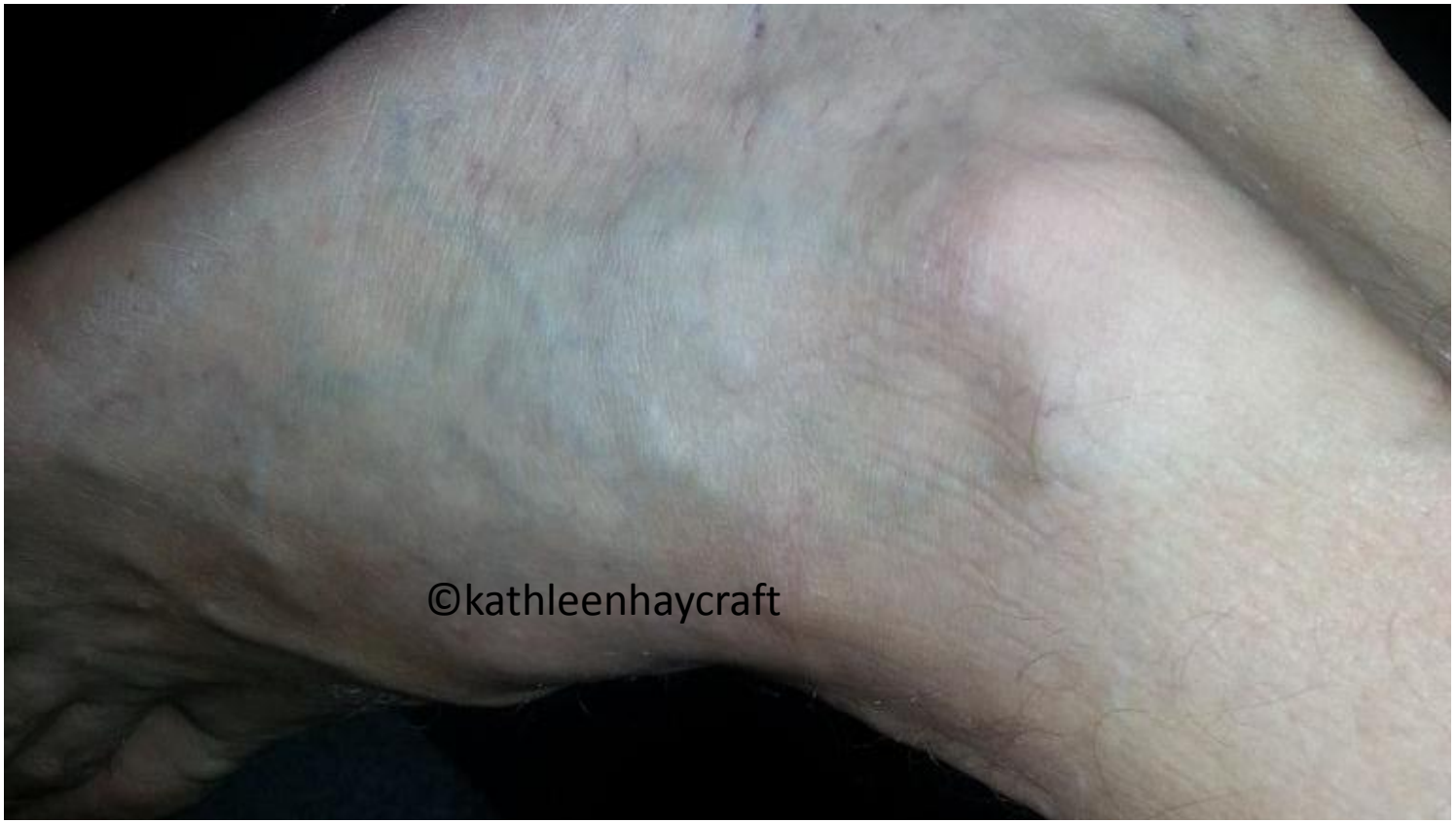
Vitiligo

- Immune system attacks the melanocyte
- Central is easier to treat
- Excimer laser, topical steroid, TCI, Oral steroid

Vitiligo due to Nivolumab



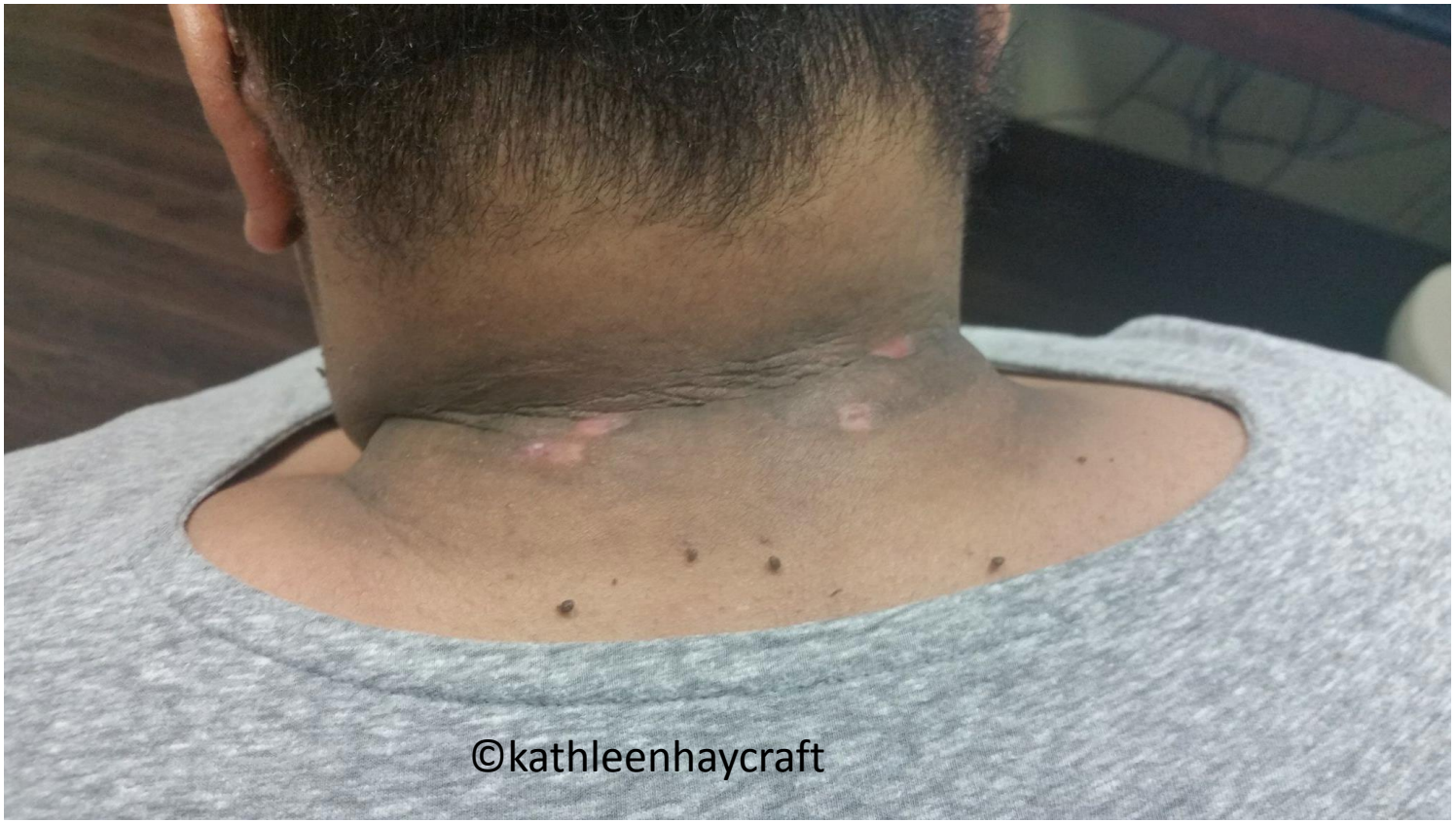
This rash is ugly but doesn't itch or hurt



Stucco Keratoses

- Variant of seborrheic keratosis
- Do not require treatment
- Patient can scrub off with pumice bar after moisturization

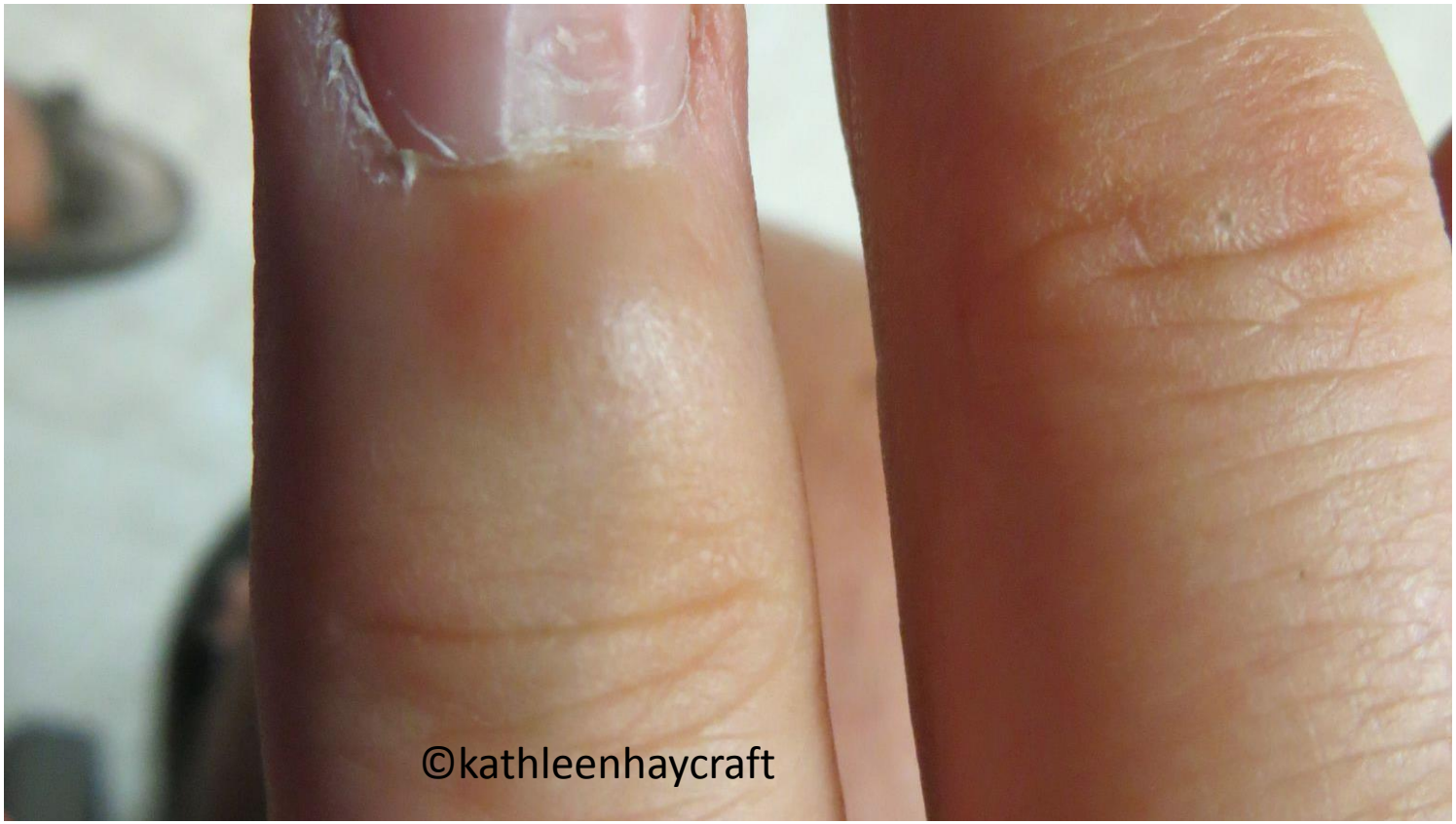
This seems so dirty



Acanthosis Nigricans

- Seen as a normal variant but may be a marker of diabetes, thyroid and other endocrine disease. Test if felt to be a high risk.
- Weight loss, exercise, antiseptic soaps, amlactin or lac-hydrin
- Do not underestimate the power of Mediterranean diet and exercise on the skin

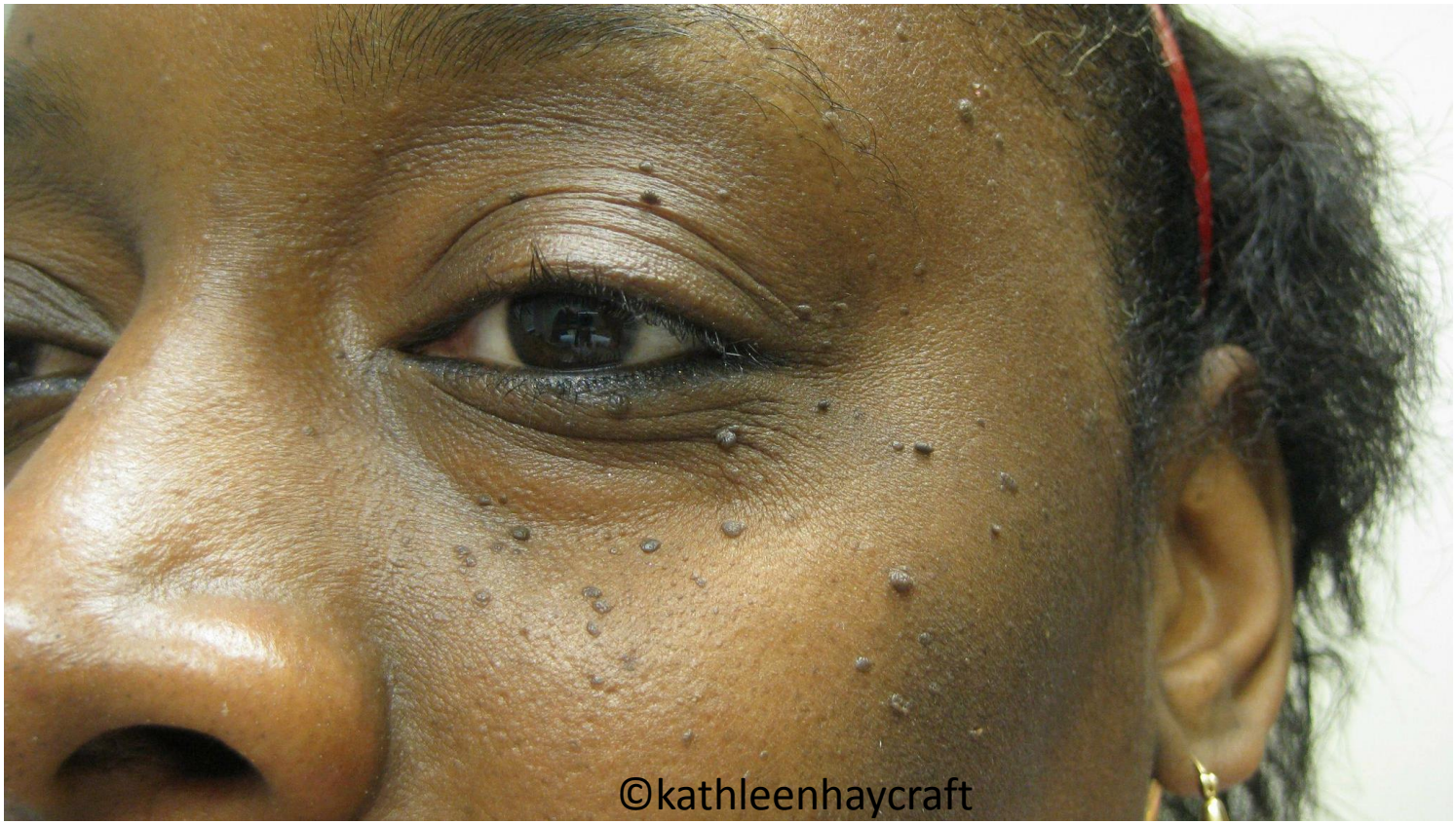
This bump is cancer I think



Digital myxoid cyst

- Palpable firm edge near a joint on the finger
- Variant of ganglion cyst
- LN2 or excision
- Does not require treatment

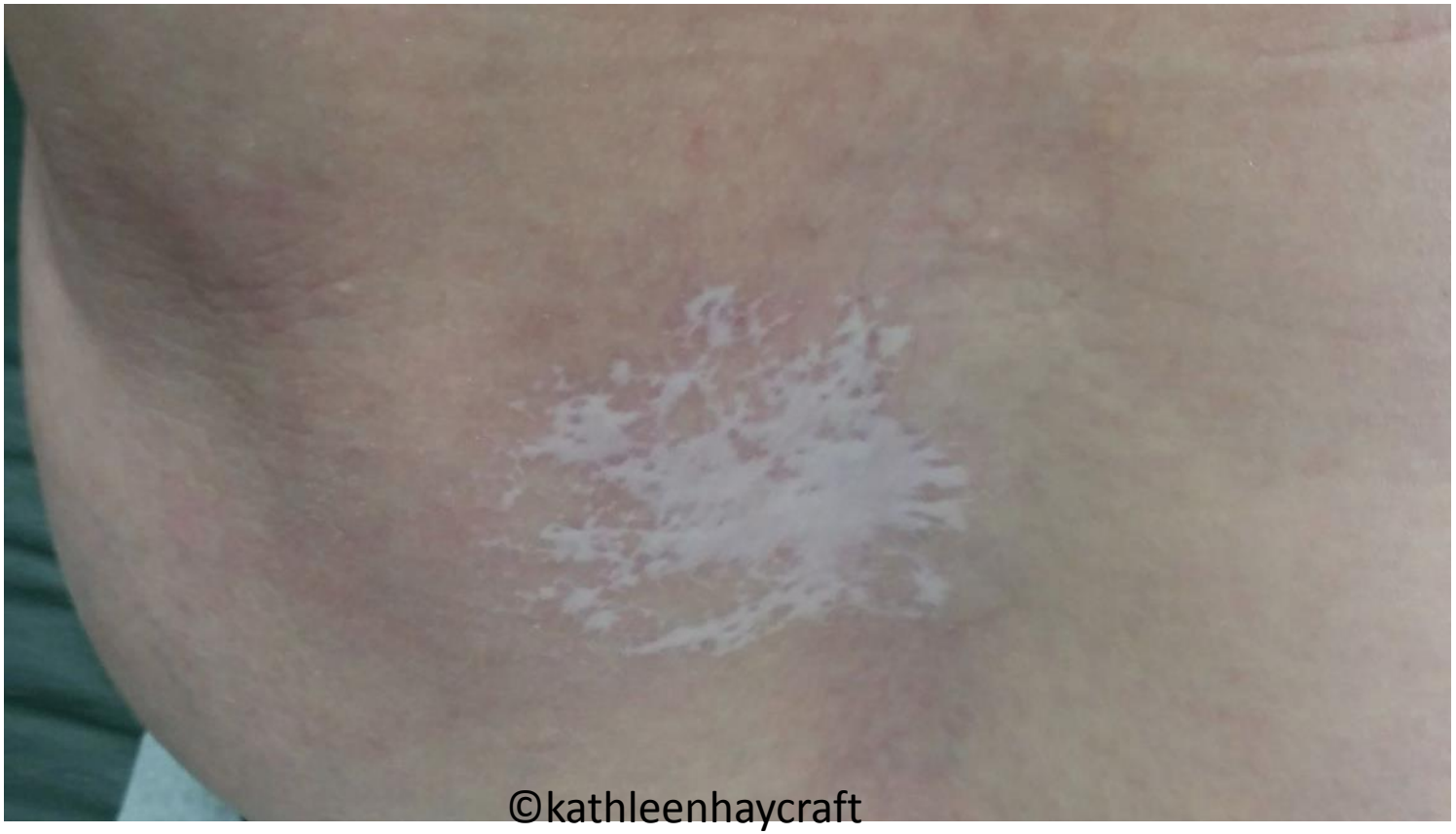
I don’t like these bumps



Dermatosis Papulosa Nigricans

- Variant of SK
- Difficult to treat as it may cause hypopigmentation

Can you remove this?



Cicatrix post herpes shingles

- Scarring is in a classic pattern.
- Laser may be helpful

Rash keeps growing on my fingers

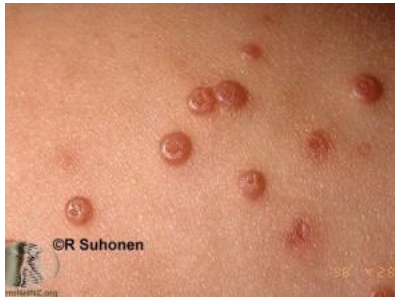
Pathophysiology

- Due to HPV
- Risk factors include working with red meat, smoking, public showers, eczema/dry skin, lowered immune system
- Approximately 130 subtypes of HPV most common are 2 and 4
- HPV invades the basal cell layer of the skin may have latency before hyperkeritinization and vessel growth
- Many types of warts: genital, oral, cervical, genital, flat warts

Wart Treatment Options

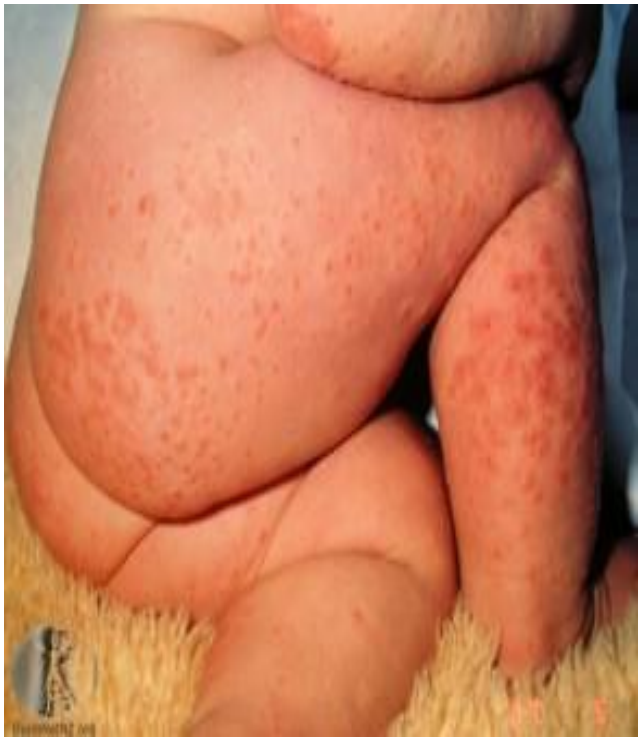
- LN2 only if curetted and lidocaine if necessary
- Cantherone Plus
- Candid
- Imiquimod
- Bleomycin injections
- EDCT, laser, surgery
- OTC wart treatments in between treatments

Molloscum Contagiosum



- Due to pox virus
- Treat or not to treat
- Cantherone or glycolic acic

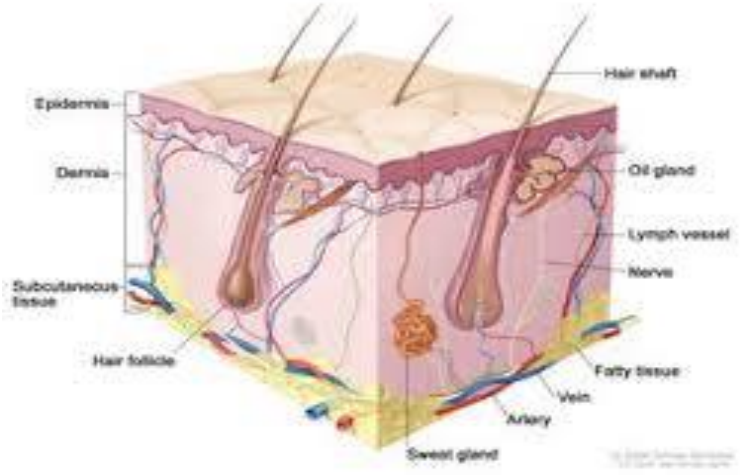
Giananni Crosti



- May have been ill
- May be nearly any viral from Hep B to Hep C to HIV enterovirus, EBV, RSV, CMV
- Last about 6 to 12 weeks
- Molloscum may appear similar but never this wide spread

Acne

Pathophysiology



Increase hormones increase oil and increase P Acnes
this causes redness and inflammation
Increase in keratinocytes proliferation that cause blockage of sebaceous ducts
Chronic inflammation of sebaceous units

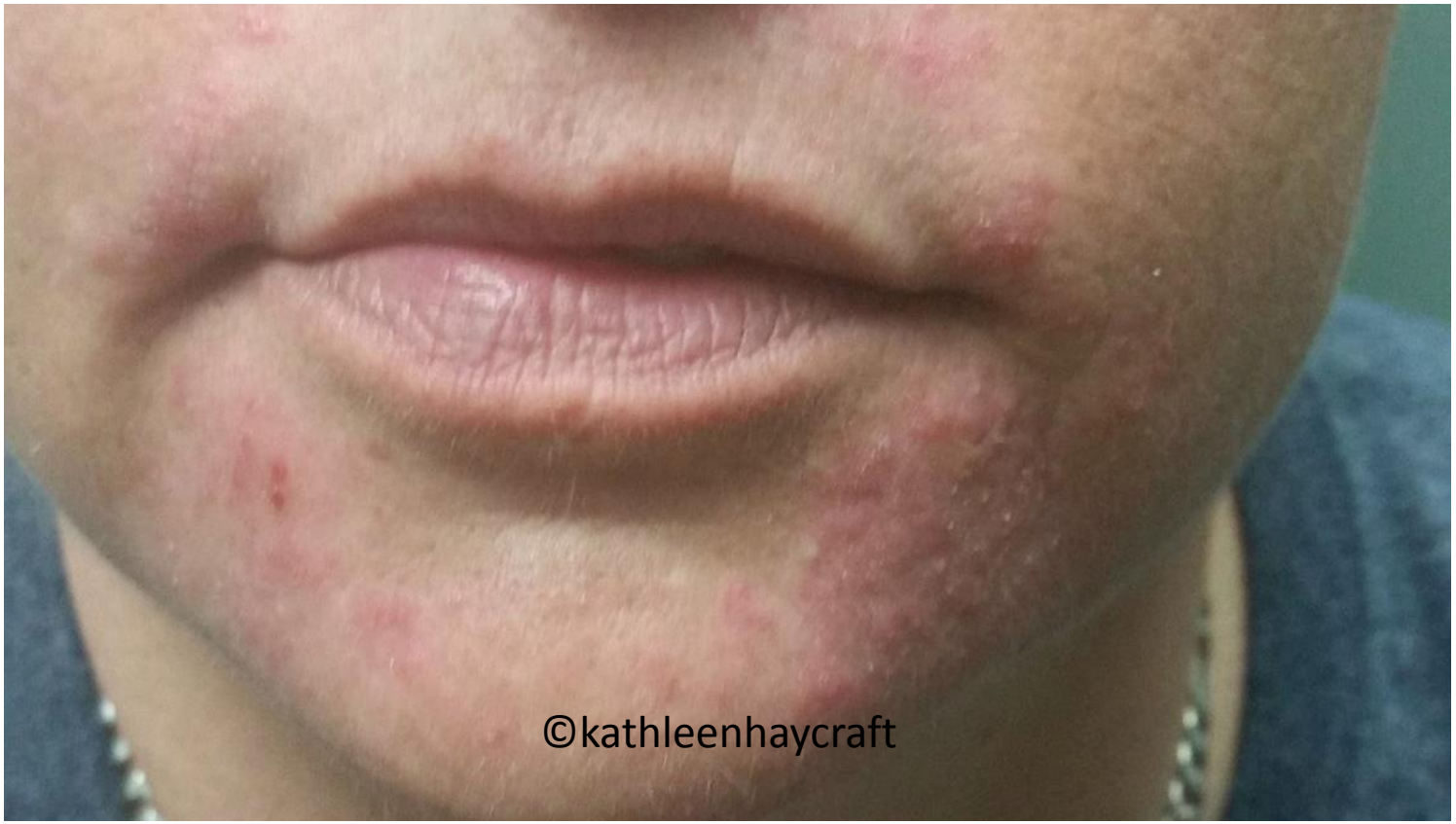
Treatment of Acne

- Retinoids are the mainstay
- Cleanse face gently at night with cleanser gently dry and apply retinoid brush teeth then apply moisturizing lotion
- Oral cyclins should be limited to 2 to 4 months. Extended release lower dose important option Doxy may cause photosensitivity, Mino may cause lupus like reaction and pseudotumor cerebri, generics may not be given with dairy. Both if lodged in esophagus may cause severe chest pain and bleeding. In pregnancy give zithromycin

Treatment of Acne continued

- When discontinuing oral antibiotics use topical benzoyl peroxide combination
- Salicylic acid is helpful
- OCP is helpful If flare around menses, consider 3 month cycles
- Consider spironolactone and isotretinoin
- Laser for post inflammatory changes
- If under age of 7 refer to endocrinology
- Neonatal acne if frequently yeast and clotrimazole will work

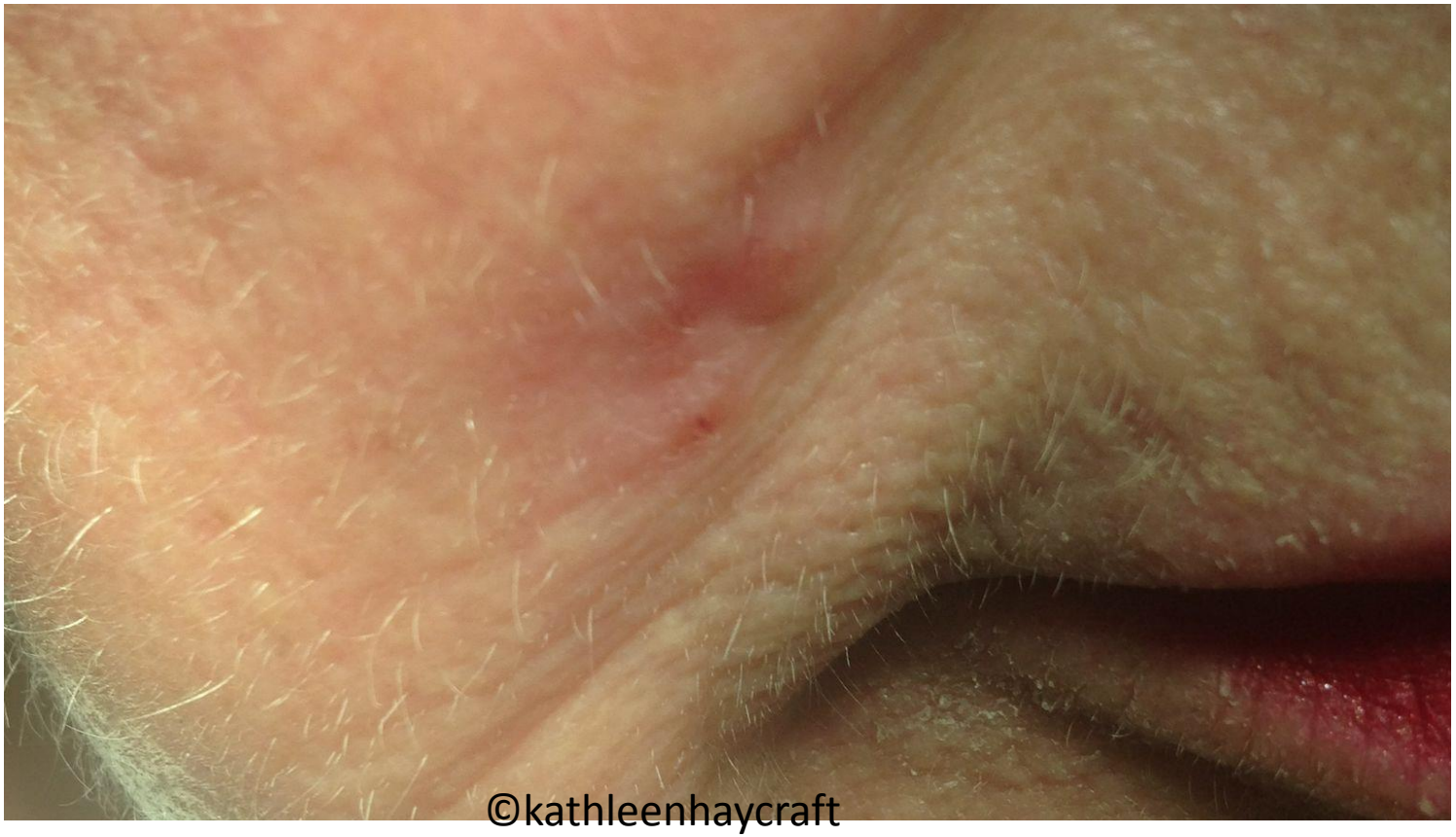
I have been using an ointment to try and clear this up



Perioral Dermatitis

- Inflammatory rash
- Note perioral sparing.
- May be a precursor of rosacea
- Frequently exacerbated by topical steroid use. ALWAYS AVOID STEROID USE
- 1 to 2 months of cyclins and TCI will clear

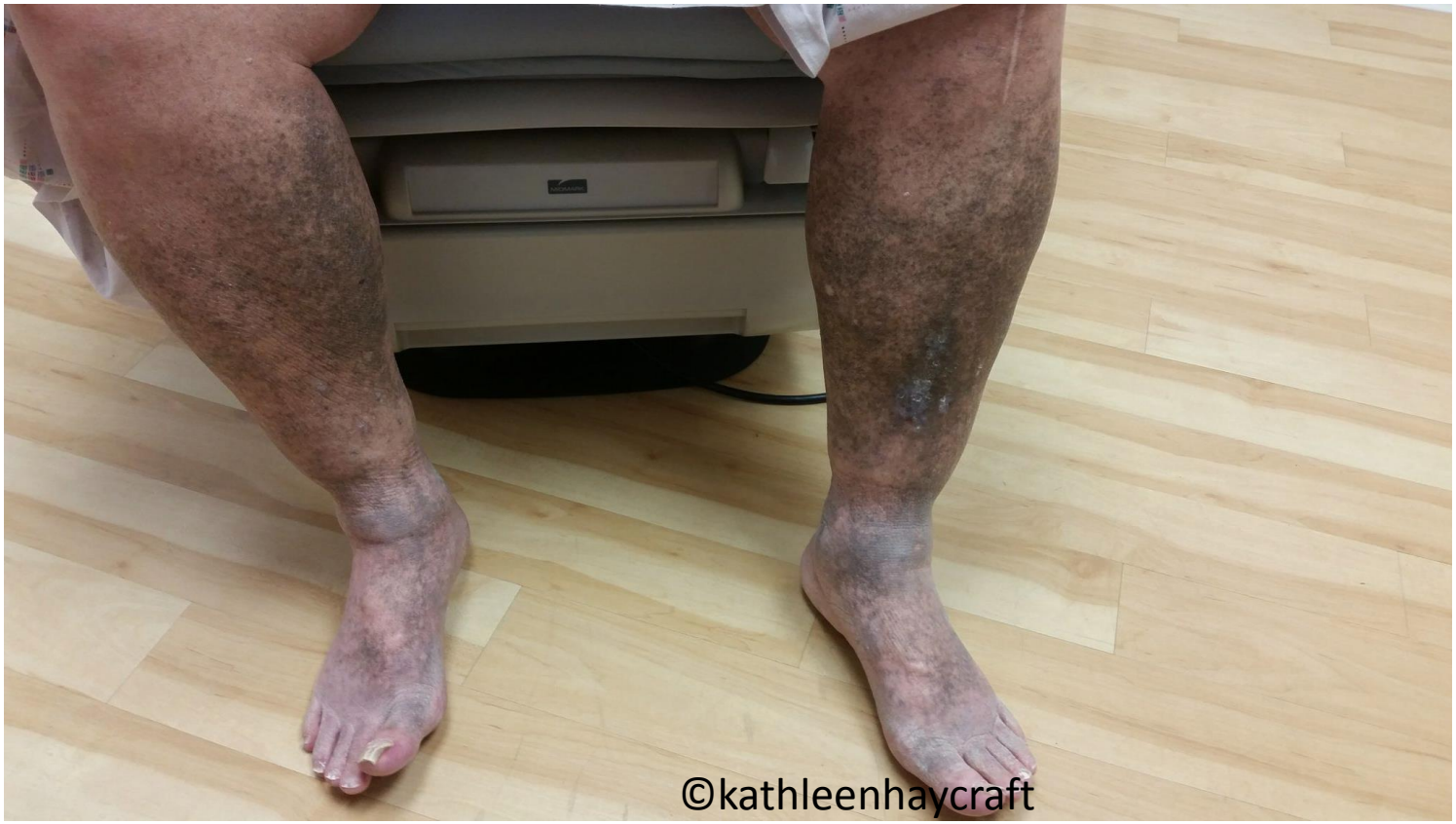
I am getting pimples at my age



Rosacea

- Is an inflammatory disease of the central face
- ETR to papular pustular to granulomatous and ocular may occur at any point
- Treatment based on stage and range from vasoconstrictors, to cyclins, to metronidazole, to ivermectin, to IPL
- Chronic
- Need to be aware of triggers

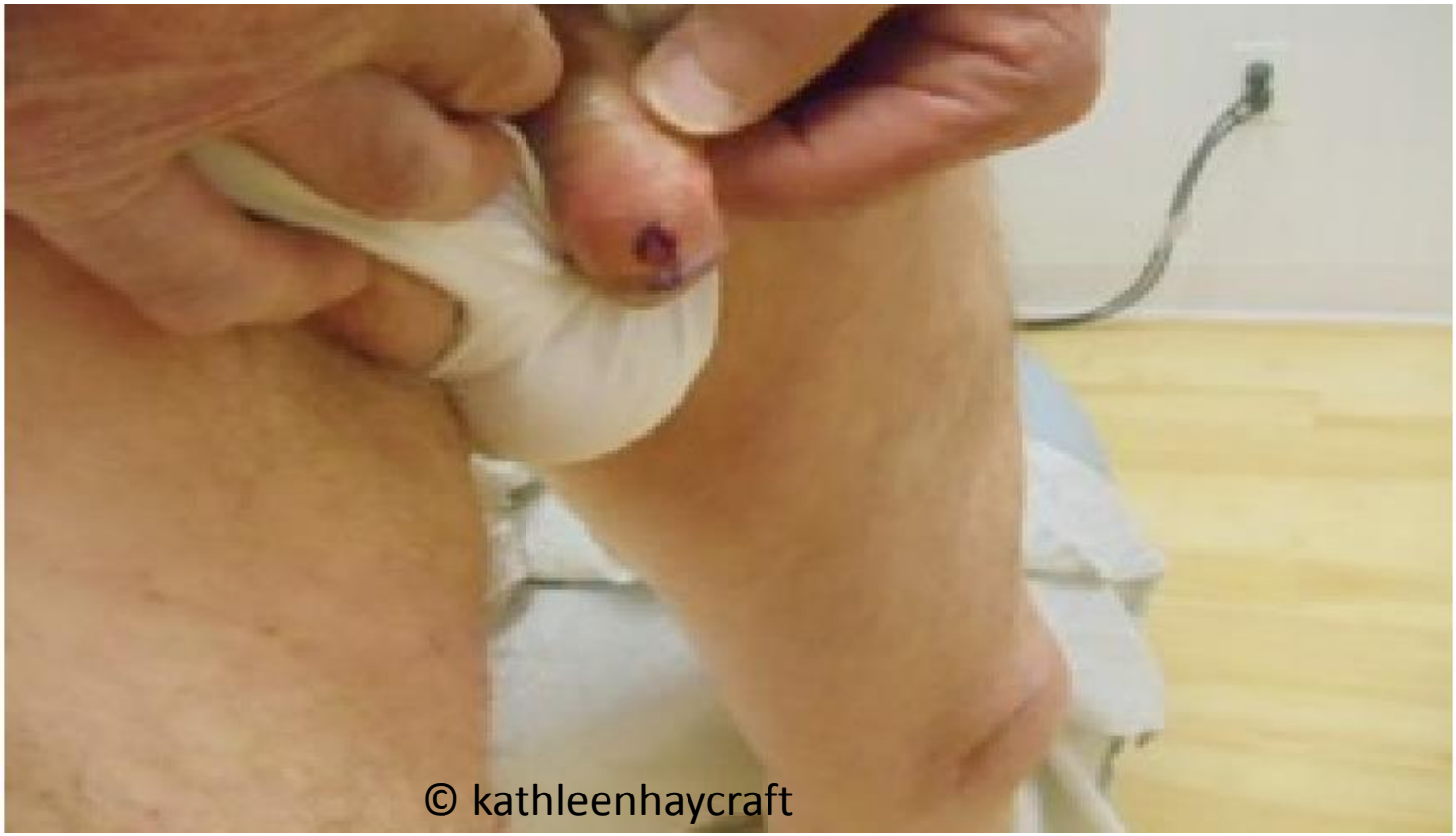
My legs are blue



Blue pigmentation due to minocycline

- The dangers of long term minocycline use.
- May or may not reverse after discontinuation.
- Amiodaraone, antipsychotics, seizure meds can cause hyperpigmentation
- Steroids can cause hypopigmentation and vessel formation with fat atrophy
- Nsaids and others can cause fixed drug eruption

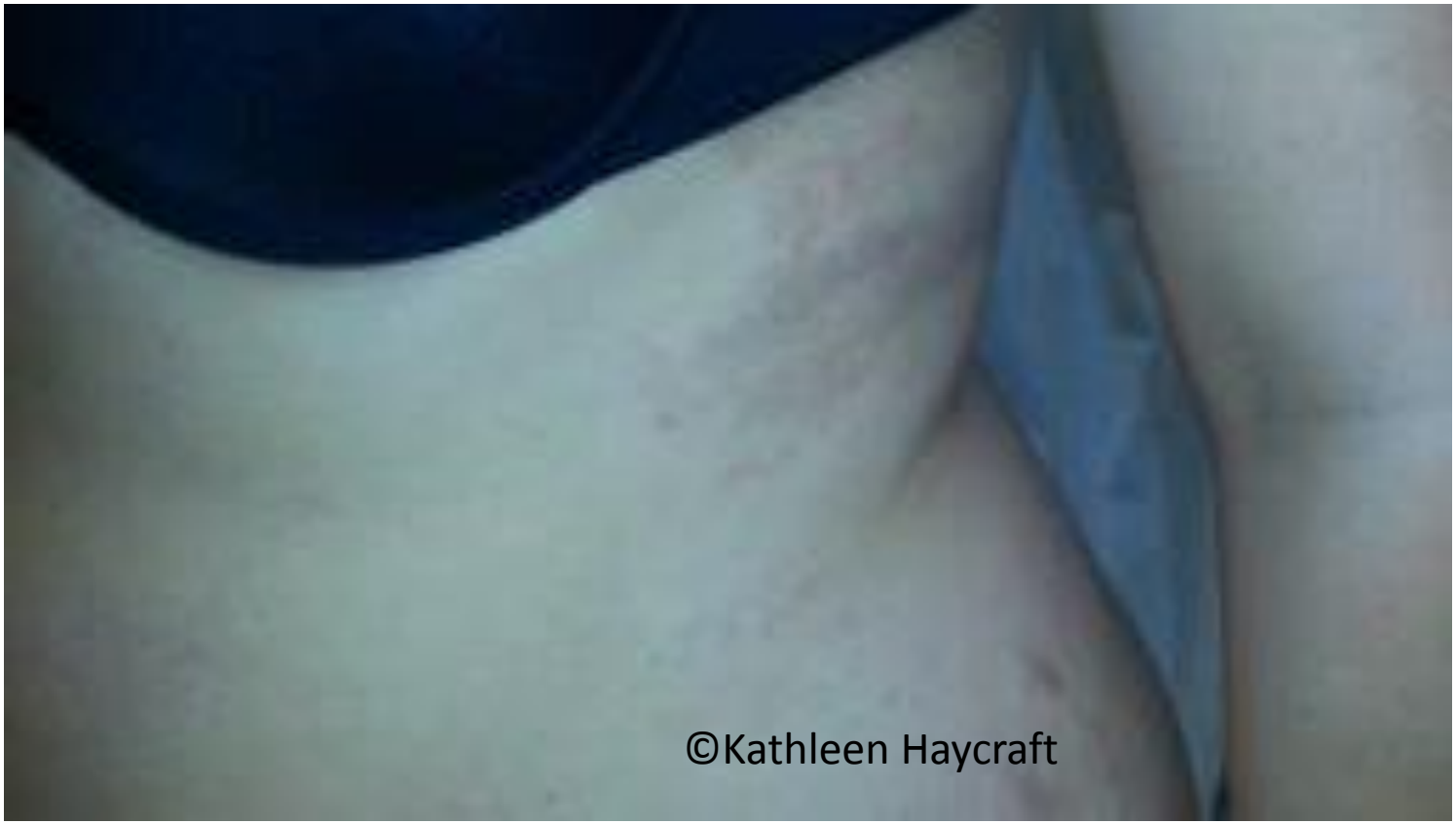
I have this sore on my penis that won't go away



Zoon's balantis

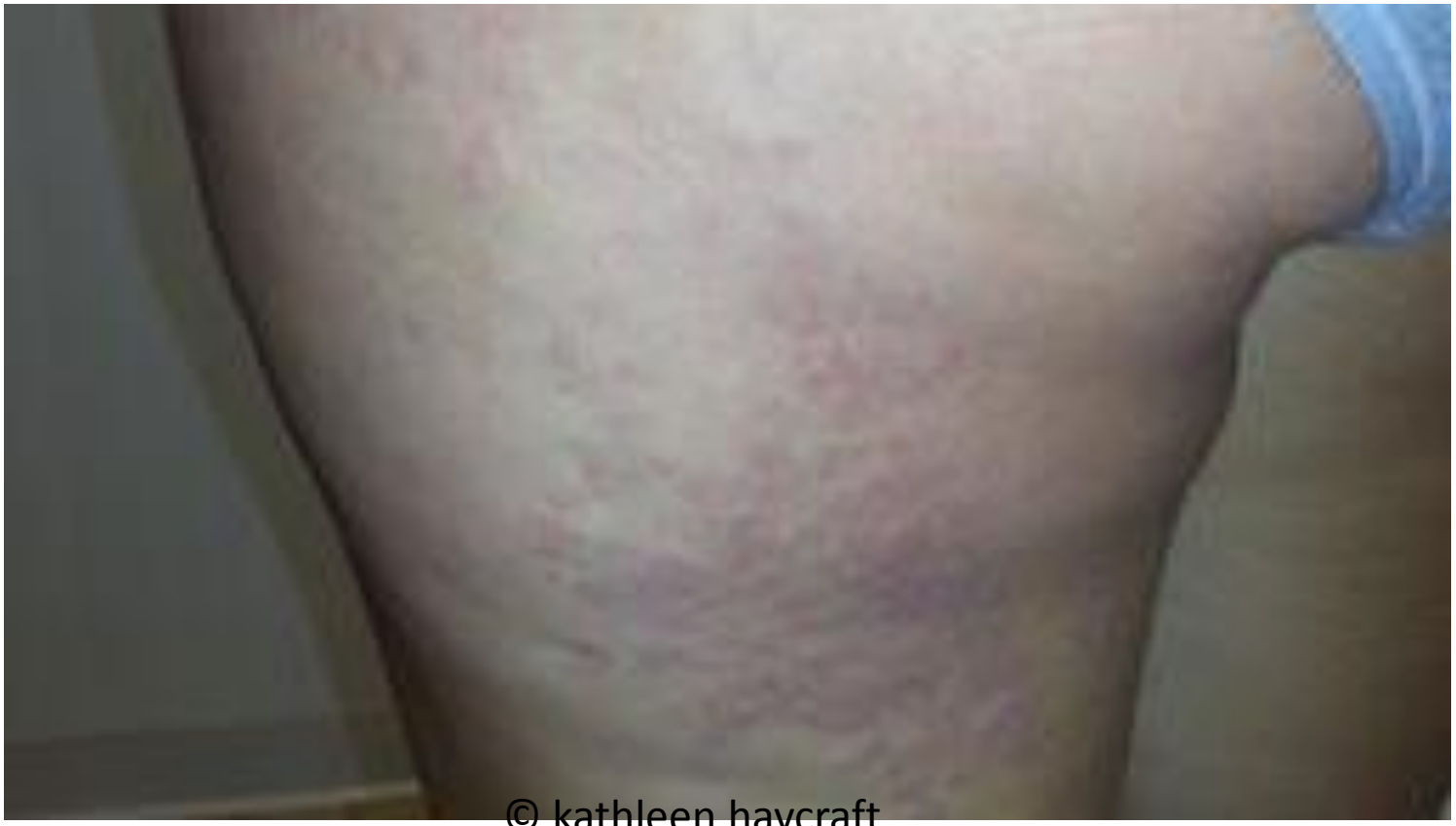
- Not cancer
- Inflammatory condition
- Responds to TCI and steroids
- Referral usually wise as cannot rule out squamous cell cancer without a biopsy

Interesting Cases



- This patient was placed on the schedule as a “rash”. When queried she has had the rash all of her life and wants to know if it is cancer.
  - Note the distribution pattern.

Cont:On my back of legs too

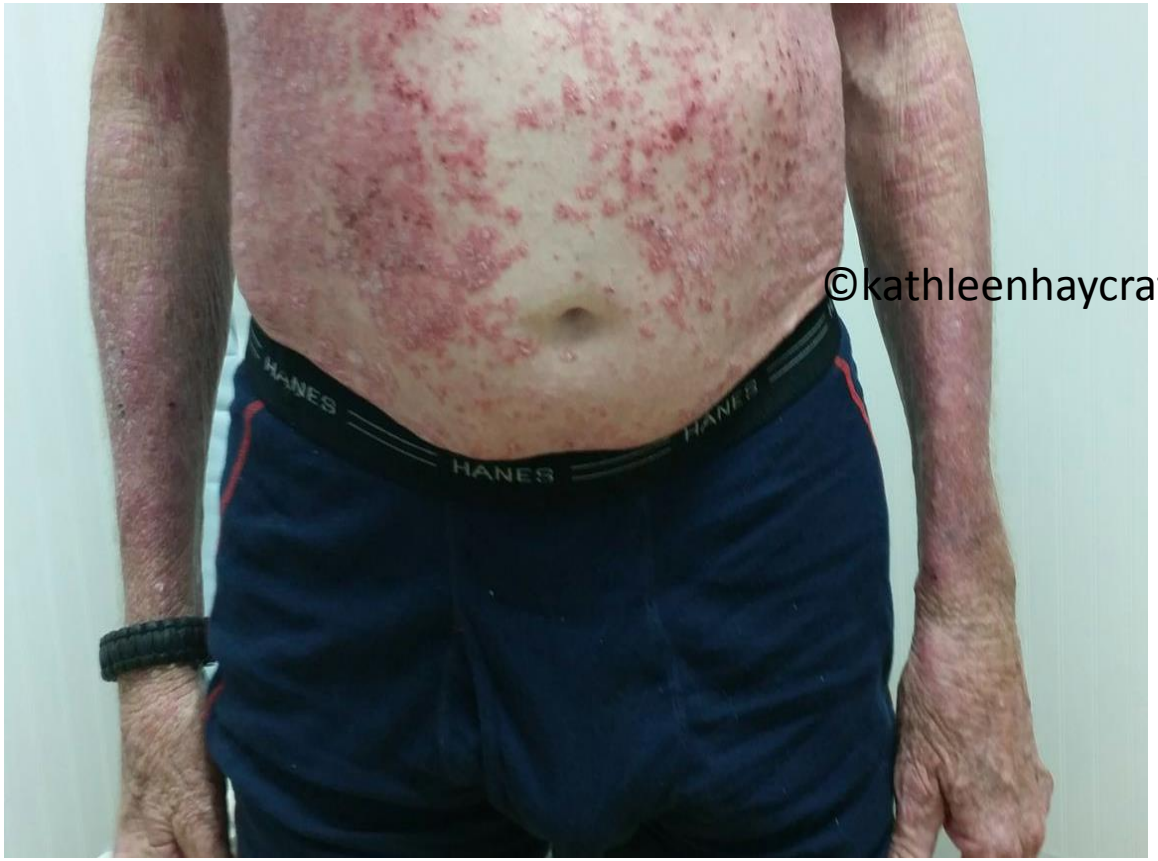


And further down my leg

AVM

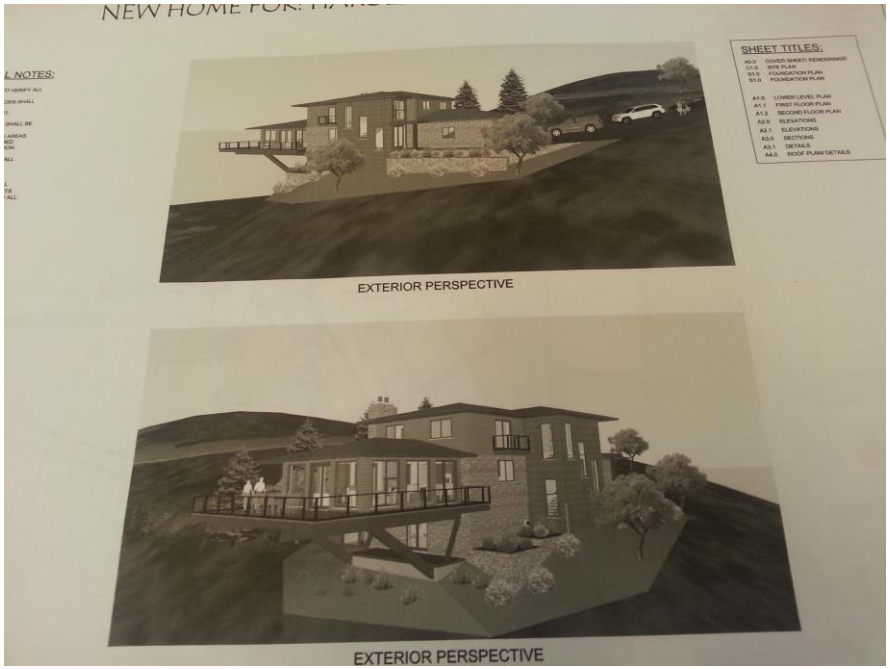
- Congenital arteriovenous malformation that follows Blaschko's line.
- A form of cutaneous mosaicism.
- IPL, PDT, Laser

Rash all over, chills, feel sick



- These are my patients who have entrusted me with their photos.

Our plans in life



This is my real life

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Thank you.

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