“Is it contagious?”

Kristin Rygg, MPAS, PA-C

Skin, Bones, Hearts & Private Parts

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Overview

- Hidradenitis Suppurativa
- Pityriasis Rosea
- Warts
- Molluscum
- Condyloma
- HSV
- Zoster
- Rhus derm
- Tinea Versicolor

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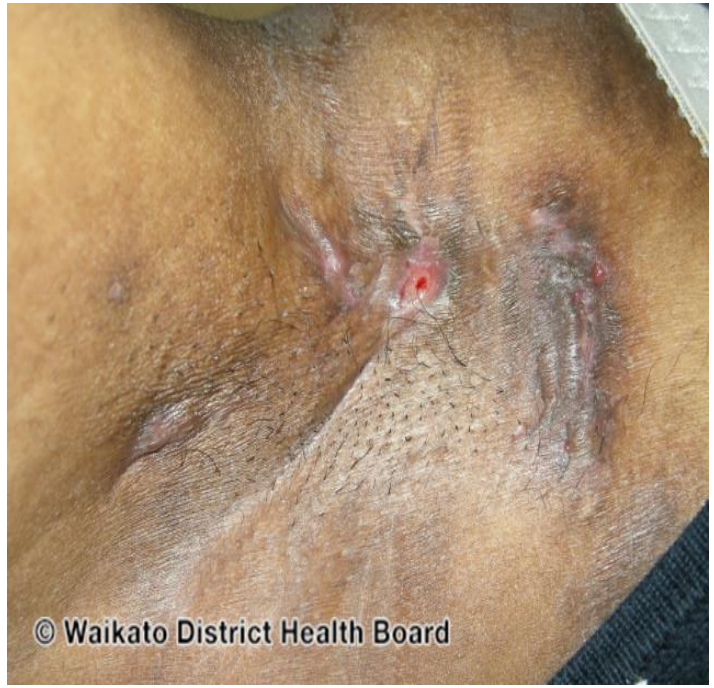
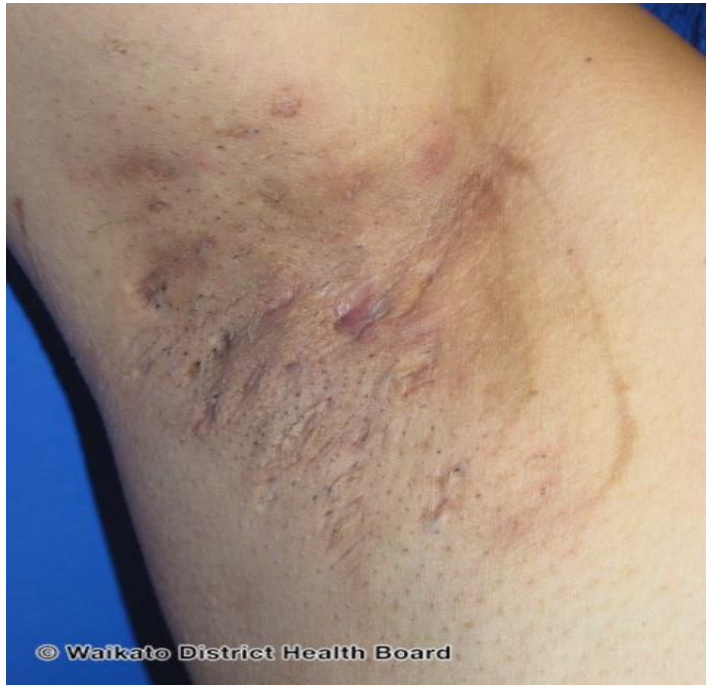
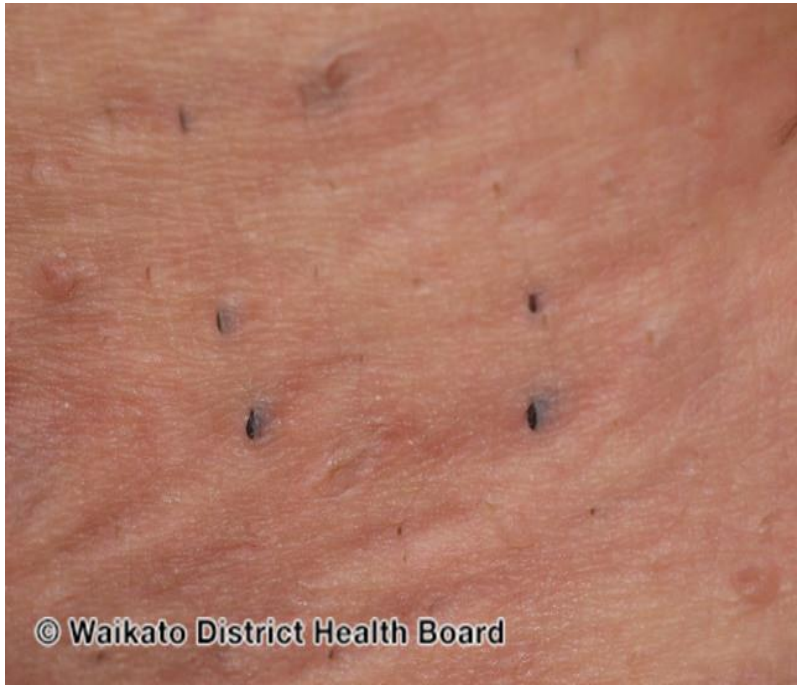
Hidradenitis Suppurativa (HS)







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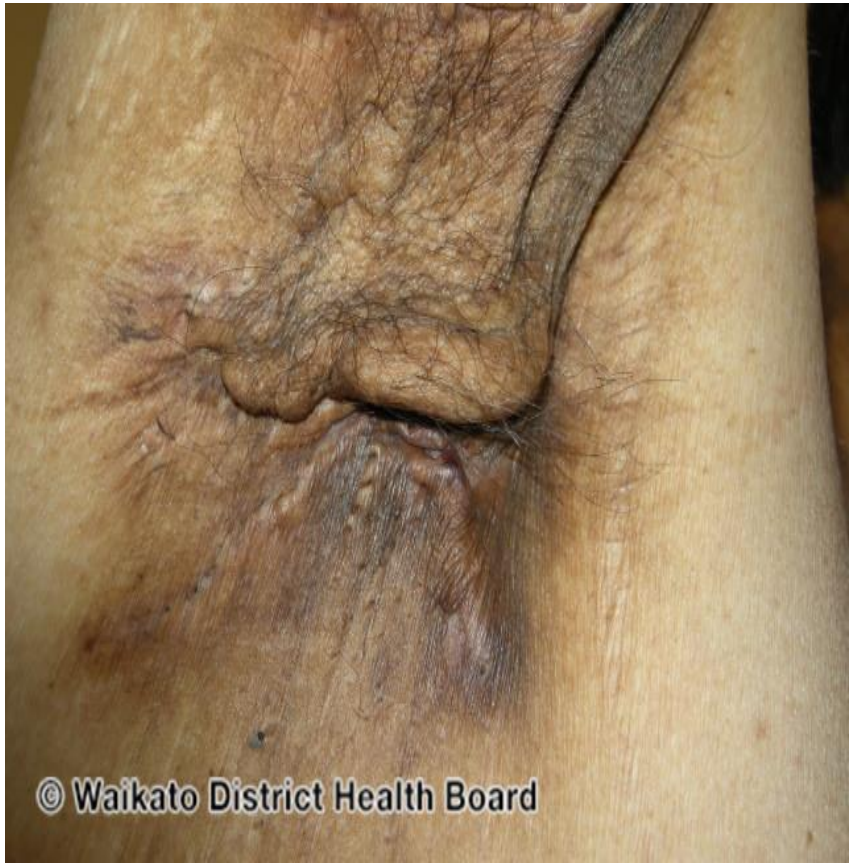
Hidradenitis Suppurativa (HS): Overview

- Acne Inversa (severe acne)
- Painful, inflamed nodules, abscesses, sinus tracts and scarring in the apocrine-gland bearing areas of the body (axilla, inguinal, anogenital)
- In dark skin, may appear dark brown, or violaceous gray
- Double comedones are pathognomonic
- Women > Men
- Adults, 3rd – 4th decades but can present in teens and twenties
- Socioeconomically disadvantaged
- Genetic predisposition



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HS: Common Complaints

- “I get these bumps” or “ingrown hairs”
- “I won’t wear a swimsuit.”
- “It hurts to sit.”
- “I won’t have sex.”
- “I can’t miss any more work.”

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HS: Pathophysiology

- Exact cause unknown - inflammatory process
- 4X higher incidence with Crohn disease
  - Also assoc. with DM, PCOS and obesity
- Genetics + Environment (smoking, skin occlusion)
- Follicular occlusion leads to rupture of the follicle with significant immune responses and development of painful nodules and abscesses
- Bacterial infection and colonization

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HS: Hurley Stages

- Stage I (mild)
  - Abscesses without sinus tracts/scarring
- Stage II (moderate)
  - Recurrent abscesses with sinus tracts/scarring
- Stage III (severe)
  - Multiple interconnected sinus tracts/scarring, diffuse involvement

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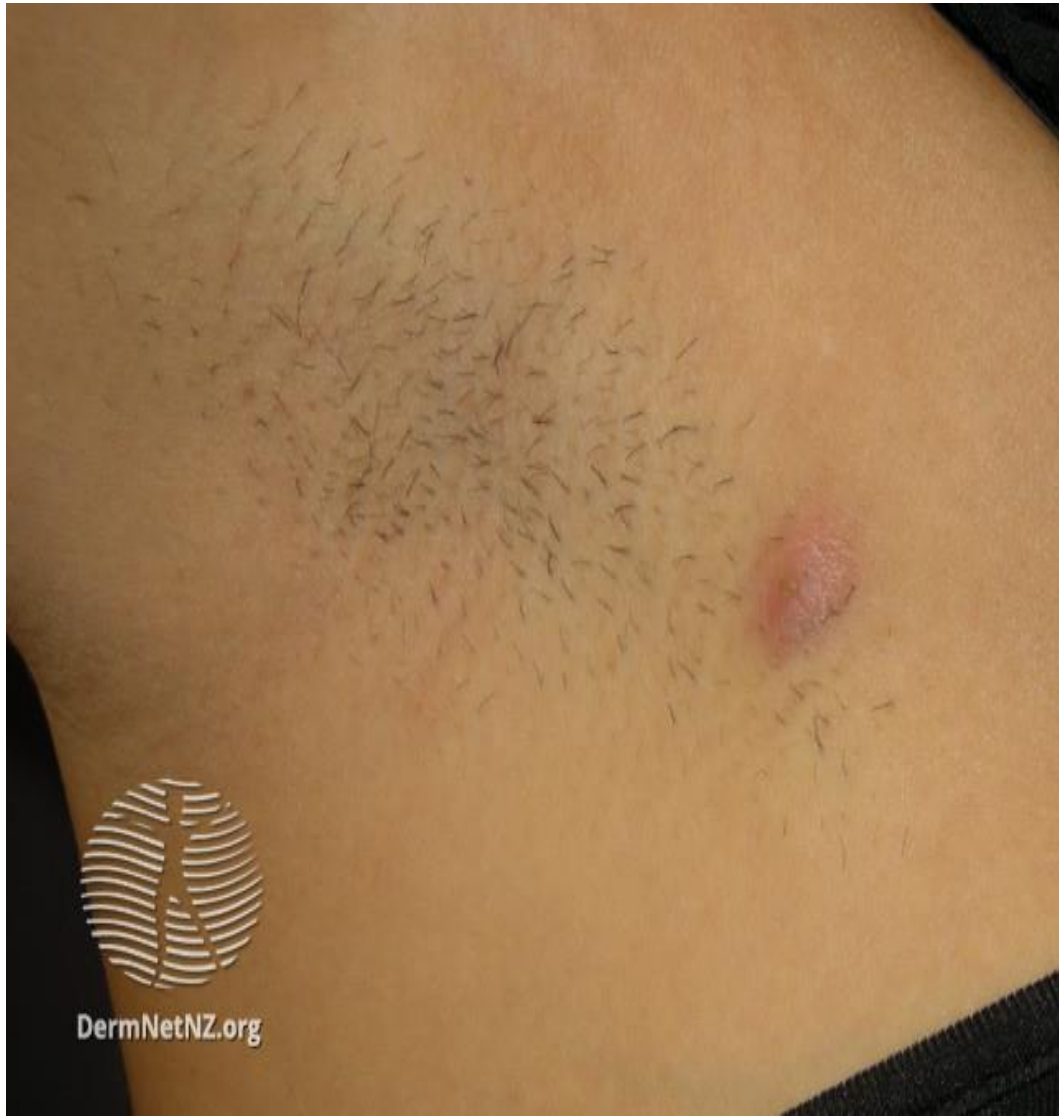
HS: Treatment

- Lifestyle Medicine
  - Screen for depression
  - Wear loose-fitting clothes
  - Weight loss
  - Smoking cessation
  - Laser hair removal
  - Empathy and compassion

- **Defer all treatment in pregnancy to OB
- **Consider early referral to dermatology
- **Must have high index of suspicion
- **Average delay in diagnosis - 7 years



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HS: Treatment (cont)

- Mild disease
  - Topical therapy - BPO, Hibiclens, topical clindamycin
  - ILK (2.5 – 5 mg/cc)

- Moderate disease
  - Topical therapy - BPO, Hibiclens, topical clindamycin
  - Oral antibiotics – Doxycycline
  - TNF Alpha Inhibitor (adalimumab), IL-17A (Secukinumab)

- Severe disease
  - TNF alpha inhibitor (adalimumab), IL-17A (Secukinumab)
  - Surgical procedures (deroofing, debridement, excision)

- **Treat underlying infection, consider culture

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HS: Biologic Adalimumab (Humira)

- TNF Alpha Inhibitor - Adalimumab
  - 12 yo and older
  - BBW for Malignancy and Serious infections
  - Ensure no CHF, Malignancy, IBD, CNS disorders nor demyelinating disease, Hepatitis, TB
  - Ensure all vaccines are UTD and give NO live vaccines
  - Check Labs before initiation and at least yearly
    - Yearly Quant Gold, HIV, Hepatitis panel, CBC with dif, CMP
  - 80 mg SC q2weeks
    - Start 160 mg SC on day 1, then 80 SC x 1 on day 15, then 80 mg SX q2 weeks on day 29

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HS: Contagious or NOT?

- NOT Contagious

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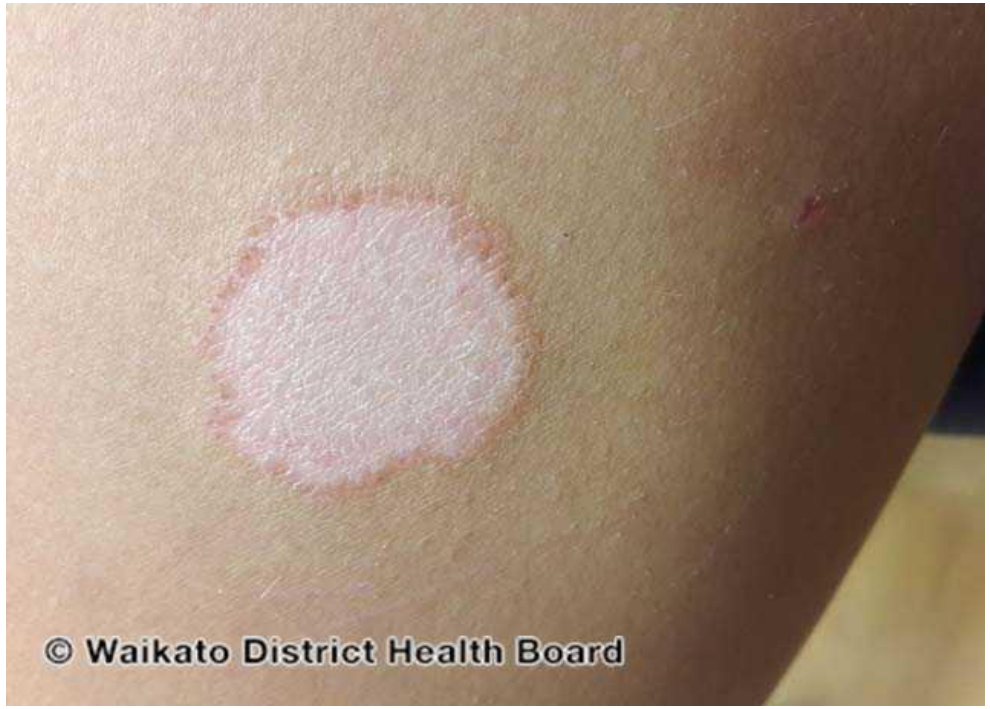
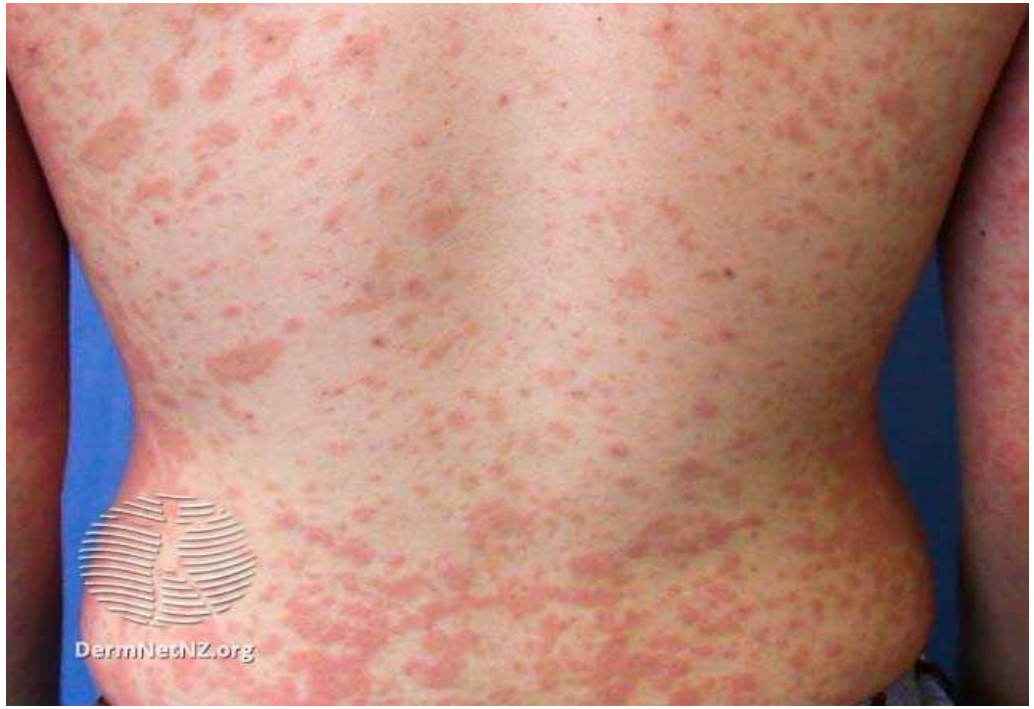
Pityriasis Rosea (PR)





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PR: Overview

- Acute exanthematous eruption
- Generally asymptomatic
  - Possible pruritis
  - May have flu-like symptoms or symptoms may precede eruption
    - HA, fever, cough, arthralgias, LAD, sore throat, GI upset
- Etiology uncertain
  - Viral, possible reactivation of HHV 6 & 7
  - May be drug induced
- Adolescents and young adults, but can occur at any age

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PR: Rash

- Primary phase - "**herald patch**"
  - Solitary, scaly, pink or flesh-colored annular patch
  - Peripheral scaling and central clearing
  - Generally, on trunk but may occur anywhere

- Secondary phase - "**Christmas Tree**"
  - Days to weeks after herald patch
  - Eruption of salmon-colored, oval patches
  - Follows **skin tension lines** on trunk and proximal extremities
  - In darker skin types - shades of purple, brown, gray or violaceous

*Inverse PR is similar but localized to groin and axilla

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PR: Treatment

- Self limited, generally up to 8 weeks, rarely recurs
- Most patients need reassurance only
  - Emollients
  - Mid-potency topical steroids
    - Triamcinolone lotion/cream BID up to 2 weeks
  - Antihistamines
    - Cetirizine 5-10 mg PO QD
    - Loratadine 10 mg PO QD
  - OTC anti-itch lotions
  - If constitutional symptoms or extensive disease
    - Consider acyclovir 400-800 mg 3-5 times daily x 1 week
- Biopsy, KOH if uncertain

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PR: Pregnancy

- Close follow-up with OB
  - Call to OB warranted
  - Increased risk of miscarriage
  - Careful with all topical and oral medications

- Patients with PR should ISOLATE from pregnant women

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PR: Contagious or NOT?

- Possibly
- Avoid pregnant women

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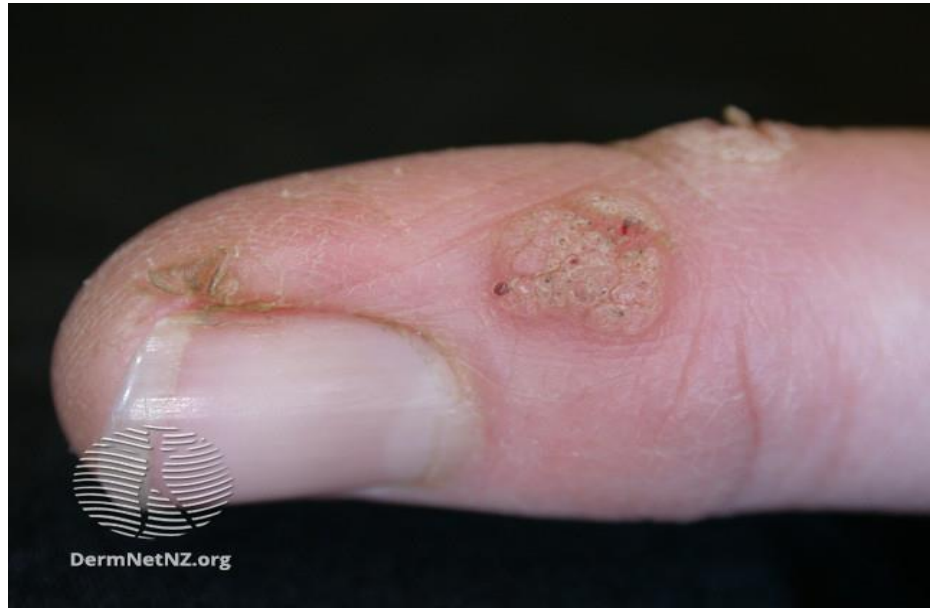
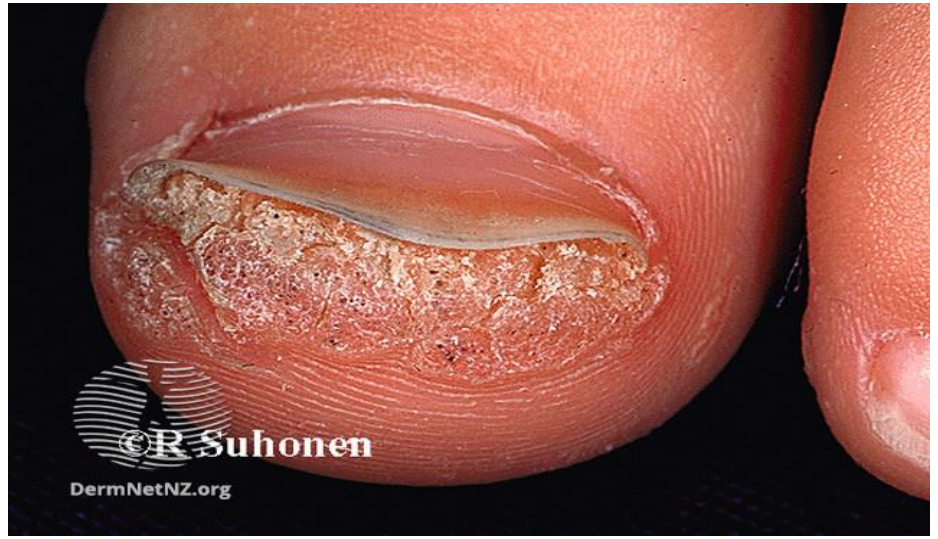
Warts: Overview

- Viral (HPV), transmitted by touch
- Fleshy, verrucous papules, may have black pinpoint vessels
- Frequently asymptomatic but may be painful, itch or spread
- Feet, hands, beard, legs
- Mandated Reporter
  - *If found in child's anogenital region, contact pediatrician





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Warts: Treatment

- Topical home treatment
  - OTC preparations
    - Corn and callus remover, Salicylic Acid, Duct tape
  - Retinoid (off label)
    - Adapaline (0.1%)
    - Age 12 and older
    - Apply thin film to AA 3x/week at night up to 16 weeks
  - Imiquimod (5%) cream (off label)
    - Age 12 and older
    - Apply thin film to AA 3x/week at night and wash off in 6-8 hours up to 16 weeks
    - Warn of Flu like reaction
- *Defer all treatment in pregnancy to OB

- In-office Treatment
  - Ln2 q2-4 weeks
  - Cantharadin (off label)
    - Age 12 and older
    - Short contact only
    - Treat few sites only
    - Never under occlusion
    - Weigh risks and benefits
      - Infection, pain, ulceration, scarring
  - Intralesional candida antigen (off label)
    - NO clinical studies
    - Q3-4 weeks up to 3 times
    - NEVER on digit
    - Weigh risks and benefits
      - Infection, pain, ulceration, scarring

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Warts: Contagious or NOT?

CONTAGIOUS

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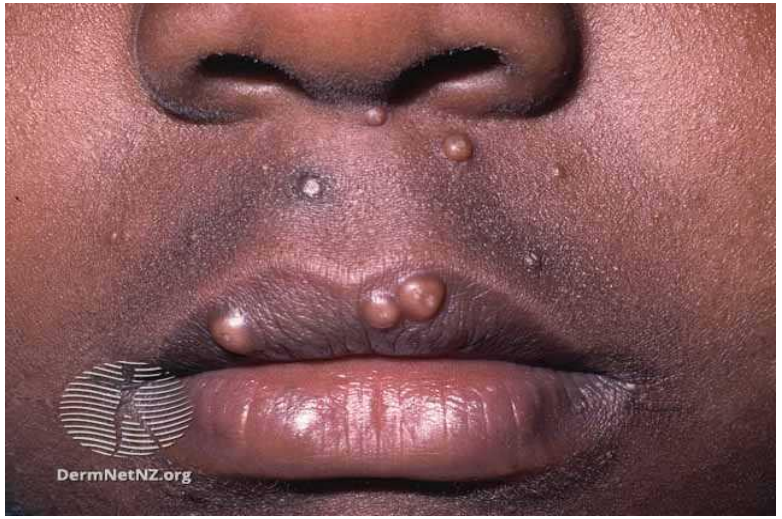
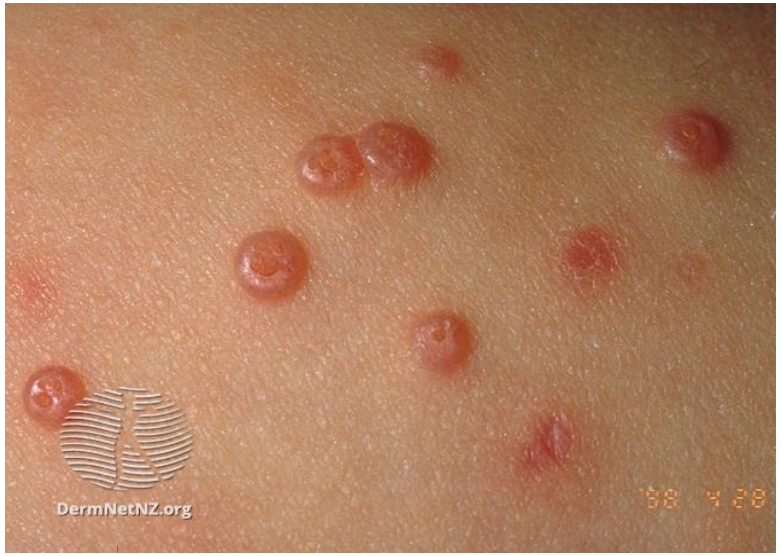
Molluscum Contagiosum (MC)

- Viral skin infection (pox virus), transmitted by skin to skin contact
- Pink or flesh colored, dome shaped, painless lesion with central dell 2-5 mm
- Easily transmissible and frequent self-inoculation
- Children, sexually active, immunosuppressed
- Mandated Reporter
  - *If seen in anogenital region in child, contact pediatrician.





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MC: Treatment

- Self-limited with spontaneous remission.
- Defer treatment to OB in pregnancy
- Any treatment may cause scarring

In-office Treatments

Any treatment may cause scarring

- Cantharidin topical solution 0.7%
  - FDA approved 2yrs and older
- Cantharidin (off label)
  - Age 12 and older
  - Short contact only
  - Treat few sites only
  - Never under occlusion
  - Weigh risks and benefits
    - Infection, pain, ulceration, scarring
- Ln2 q 2-4 weeks
- Curette

Home Treatments

Any treatment may cause scarring

- Retinoid (off label)
  - Adapaline (0.1%)
  - Age 12 and older
  - Apply thin film to AA 3x/week at night up to 16 weeks
- Imiquimod (5%) cream (off label)
  - Age 12 and older
  - Apply thin film to AA 3x/week at night and wash off in 6-8 hours up to 16 weeks
  - Warn of Flu like reaction
- Avoid co-bathing, fresh towels

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Molluscum: Contagious or NOT?

CONTAGIOUS

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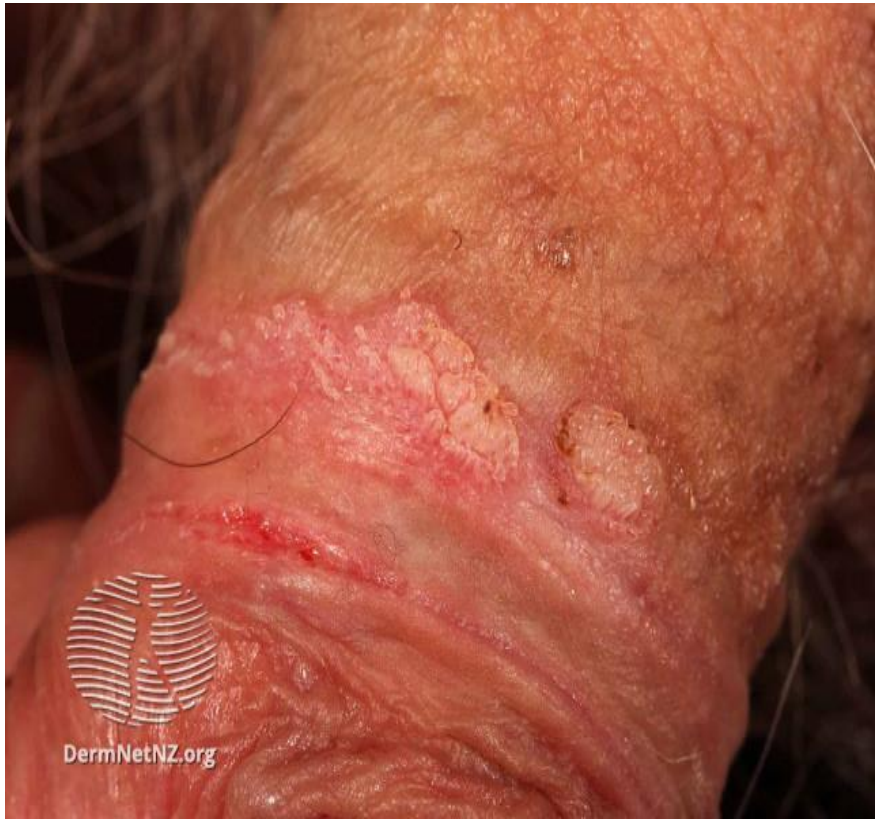
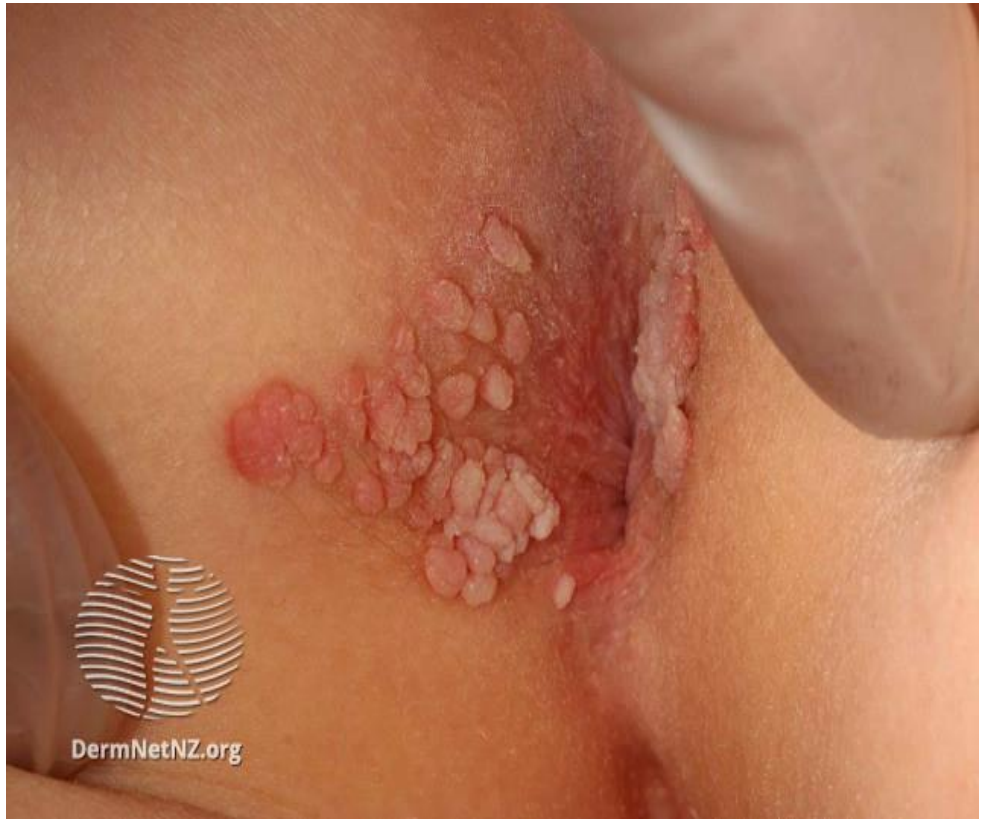
Condyloma





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Condyloma: Overview

- Most common STI
- Secondary to HPV
  - High-risk genotypes 16, 18, 31, 33, 35; low-risk 6 and 11
- Direct skin-to-skin contact, autoinoculation, fomite transfer
- Incubation 2-3 months up to 1 year
- Generally asymptomatic but may bleed, itch, dyspareunia
- Risk of malignant transformation
  - Immunosuppression increases risk

Condyloma: Appearance

- Found on anogenital, inguinal areas, back of throat
- 1-5 mm flat, papular, verrucous lesions
- Solitary, in groups/clusters or may coalesce
- Multiple colors
  - Pink, brown, flesh-colored, gray

Condyloma: Pregnancy

- Increased risk of quick growth and spread
- Presence often leads to cesarean
- Risk of maternal-child transmission
- Treatment deferred to OB

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Condyloma: Treatment

- Often clinical diagnosis
  - Biopsy if uncertain
- Most cases resolve on own within two years
- HPV Vaccination
- Smoking cessation
- Partner notification and evaluation
- Barrier protection
- STI screening
- Ensure pap smears UTD
- Consider gyn, uro, colorectal, ENT evals
- Concern for malignant transformation
- Counsel

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Condyloma: Treatment (cont)

- No clear treatment algorithm
  - Risk of depigmentation and scarring with all procedures and medications
  - Biopsy
  - Ln2 q 2-4 weeks
  - Cautery NOT recommended without proper smoke evacuator
  - Surgery evaluation
  - Vaccination

- Home treatment
  - Imiquimod (5%), Thin film to AA QHS 3x/week at night and wash off in 6-8 hours
    - Apply until clearance or up to 16 weeks
    - Avoid in pregnancy, avoid sexual contact
    - Flu like reaction
  - Podophyllotoxin (0.5%) gel, Thin film to AA BID x 3 days, stop for 4 days (x up to 4 cycles)
    - Avoid in pregnancy, avoid sexual contact

Condyloma: Contagious or NOT?

CONTAGIOUS

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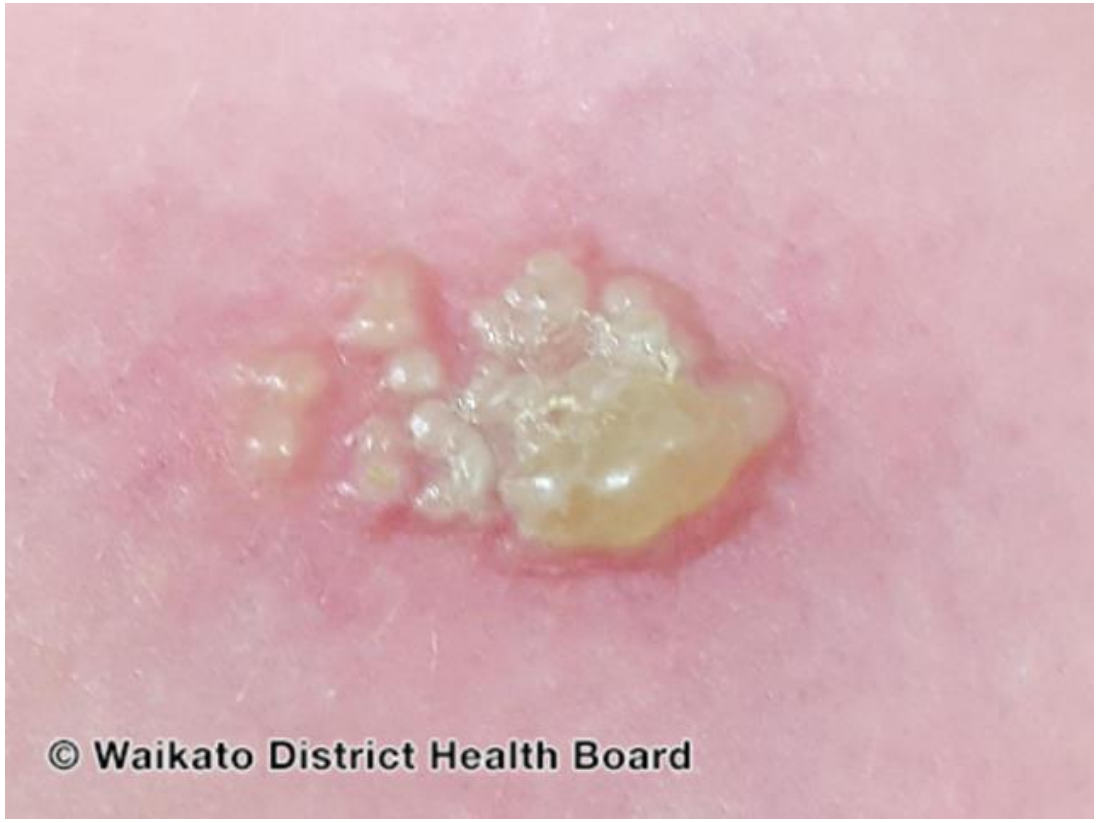
Herpes Simplex Virus (HSV)



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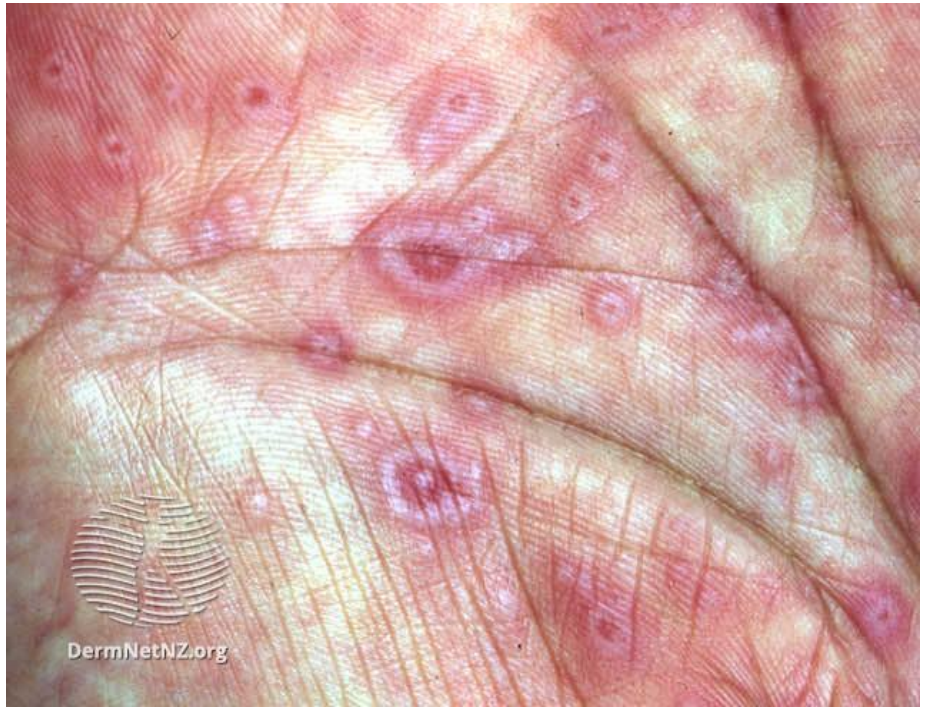
HSV: Overview

- Very common, spread by skin to skin contact
- Herpes virus
  - HSV-1 vs HSV-2
  - Labialis vs anogenital, crossover
- Latent vs active infection
  - Active infection generally lasts 1-2 weeks
  - Max viral shedding generally in first 24 hours
- Prodrome: pain, burning, stinging, tingle at lesion site
- Erythematous papules turn into thin-walled vesicles
  - May have fever, LAD, dysuria, flu-like illness

HSV: Additional Skin Infection Types

- Erythema Multiforme
- Herpetic Whitlow
- Herpes gladiatorum
- Eczema Herpeticum
- Zoster



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HSV: Treatment

- Herpes Labialis
  - Recurrence
    - Valacyclovir 2000 mg PO BID x 1 day with full glass of water
    - Treat ASAP
  - Suppression
    - Valacyclovir 500 mg PO QD with full glass of water.
    - Reassess treatment at 4 months

- Genital Herpes (immunocompetent)
  - 1st Episode
    - Valacyclovir 1000 mg PO BID x 7-10 days. Take all pills with full glass of water
  - Recurrence
    - Valacyclovir 500 mg PO BID x 3 days with full glass of water.
    - Treat ASAP
  - Suppression
    - Valacyclovir 1000 mg PO QD with full glass of water

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HSV: Treatment (cont)

- Alternative treatment and different dosing
  - Famacyclovir and Acyclovir
- Always ensure no drug-drug interactions
- Always ensure normal kidney function and dose adjust accordingly
- If immunosuppressed adjust doses and/or send to ID
- If pregnant call OB and defer treatment to OB

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HSV: Contagious or NOT?

CONTAGIOUS

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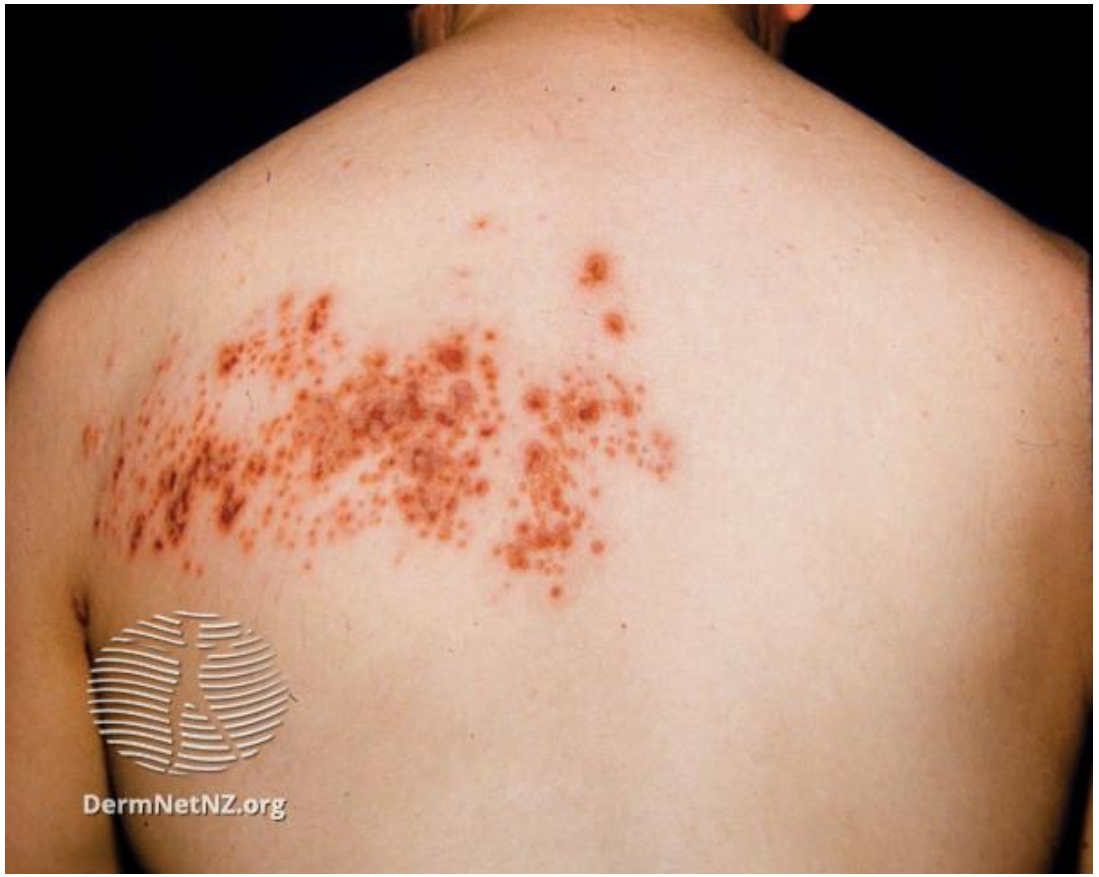
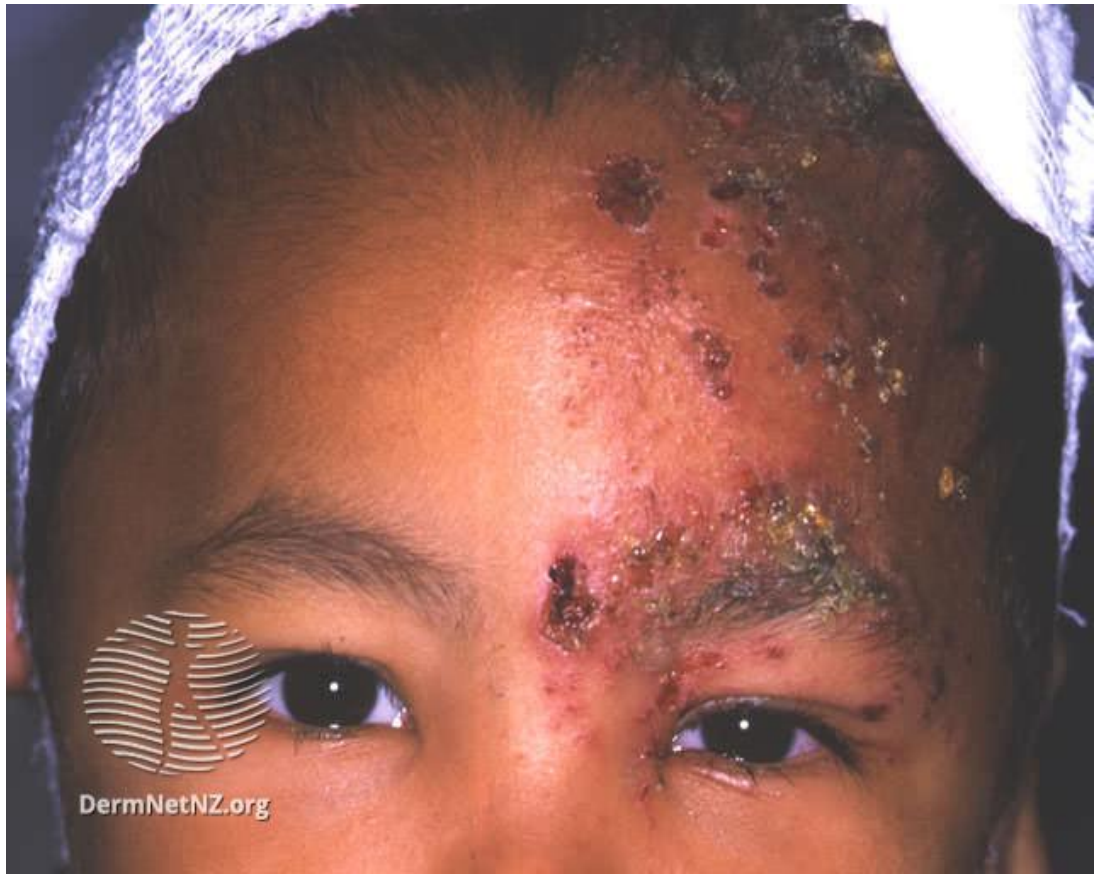
Herpes Zoster (Shingles)





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Herpes Zoster (Shingles): Overview

- Varicella-zoster virus
  - Causes chicken pox and zoster
- Due to reactivation of latent VZV
- Mostly occurs > 50 yo, but can occur at any age
- Prodrome may proceed rash
  - Generally 1-3 days
  - Flu-like illness, fever, chills, malaise, arthralgias, pain and/or itching across dermatome
- Rash
  - May occur anywhere on body
  - Erythema, vesicles, pustules, crusting, pain, itching
  - Unilateral, does not cross midline, follows dermatome
  - “Dew drops on a rose petal”
  - May have LAD

Herpes Zoster (Shingles): Treatment

- Initial Treatments (uncomplicated disease)
  - Treat ASAP up to 7 days after onset
  - Valacyclovir 1000 mg PO Q8 hours x 7 days (do NOT use in immunosuppressed)
  - Acyclovir 800 mg PO Q4 hours x 10 days
  - Famaciclovir 500 mg TID x 7 days
  - Pain control

- Treat secondary skin infections

- Risk factors for complications and/or chronic pain (PHN)
  - Immunosuppression, malignancy, advanced age, stress, recurrence
    - Disseminated Zoster
    - Consider prophylaxis in high risk populations
  - Hutchinson sign: Zoster on tip of nose (ophthalmic branch of trigeminal affected)
  - Must have high index of suspicion and treat ASAP!
  - If shingles is on face, make same day referrals to ENT and Optho
  - If severe disease, or multiple dermatomes, send to ER

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Herpes Zoster (shingles): vaccine

- Shingrix vaccination
  - CDC recommends for adults >50 yo, immunosuppressed > 19 yo
    - 90% effective in preventing zoster and PHN in immunocompetent
    - Two doses, 2-6 months apart
    - If recent shingles, wait til rash and symptoms are gone then vaccinate
    - If unsure if patient should get, review CDC clinical considerations
  - CDC recommends previously vaccinated with Zostavax upgrade vaccine
  - Contraindicated in pregnancy, severe illness

Zoster: Contagious or NOT?

Contagious (until crusted)

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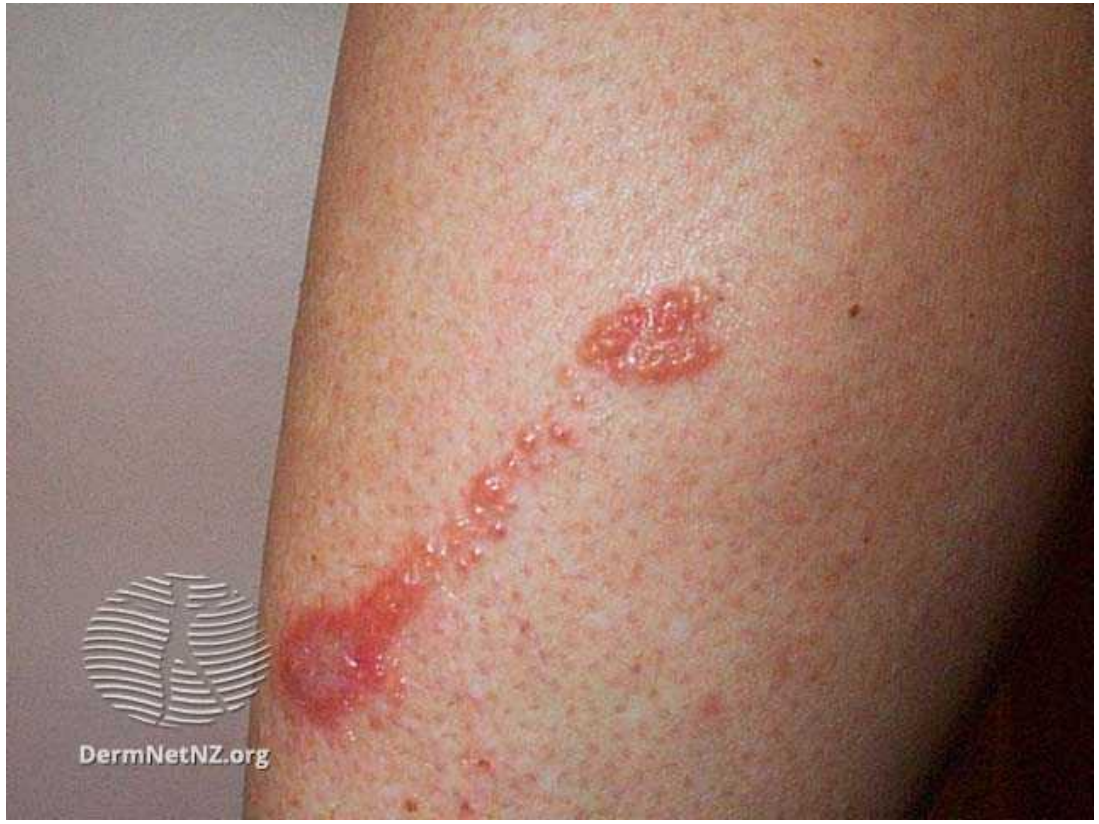
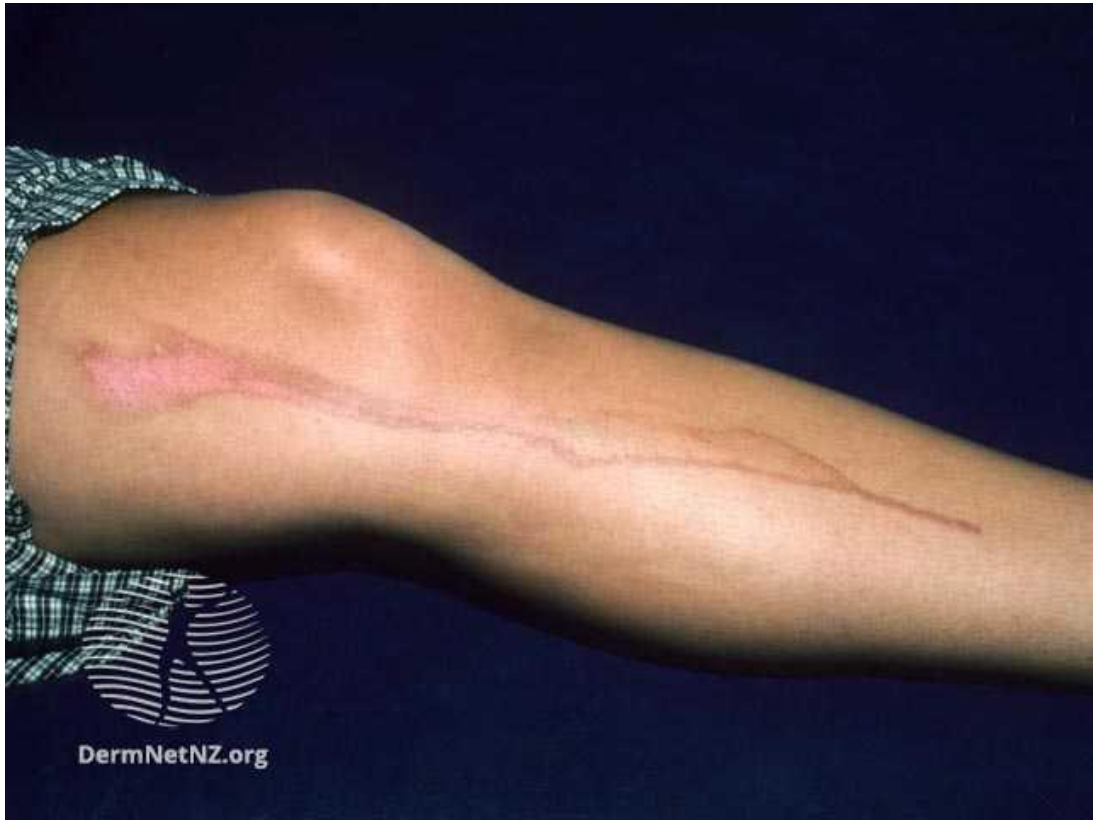
Rhus Derm





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Rhus Dermatitis: Overview

- Poison ivy, oak, sumac
- Contact dermatitis due to oil resin
- ~48 hours after exposure
- Occurs at site of contact as well as autoinoculation with unwashed resin
- Erythematous, linear plaques, frequently with vesicles and bullae
- Associated pain and intense itch

Rhus Dermatitis: Treatment

- Immediately wash area with soap and water
  - Wash clothing, furniture, shoes, gear, pets

- Oral Treatment (if large BSA or advanced disease)
  - Prednisone, 0.5 mg/kg QD with very slow taper over 14 days
    - do NOT prescribe Medrol dose pack
    - Beware of rebound rash

  - Oral Antihistimines
    - Cetirizine 5 mg PO Qday
    - Hydroxyzine 12.5-25 mg Q6-8 hours
    - Diphenhydramine OTC 25-50 mg PO Q6 hours or QHs.
    - Careful with sedation

- Treat secondary skin infections

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Rhus Dermatitis: Treatment (cont)

- Topical treatments (small BSA or minimal disease)

- Low-potency topical steroids (face, folds, genitals)
  - Desonide lotion/cream/ointment BID up to two weeks
  - Hydrocortisone 2.5% lotion/cream/ointment BID up to two weeks
  - Aclometasone 0.05 % ointment BID up to two weeks
  - Counsel on proper steroid use

- Medium to High-potency topical steroids (trunk, extremities)
  - Triamcinolone (0.1%) lotion/cream BID up to two weeks
  - Clobetasol (0.05%) lotion/cream BID up to two weeks
  - Counsel on proper steroid use

- Comfort treatments
  - Ice, tap water or Burrow compresses, colloidal oatmeal baths

Skin, Bones, Hearts & Private Parts

Rhus Derm: Contagious or NOT?

Contagious (resin)

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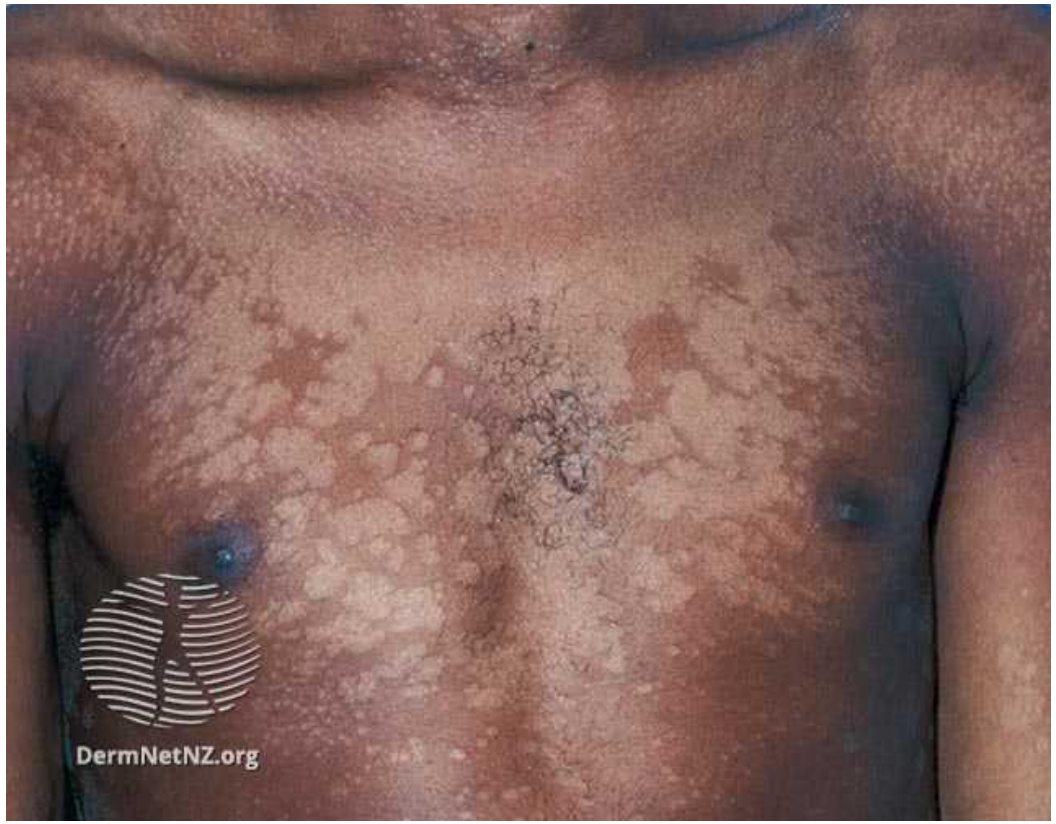
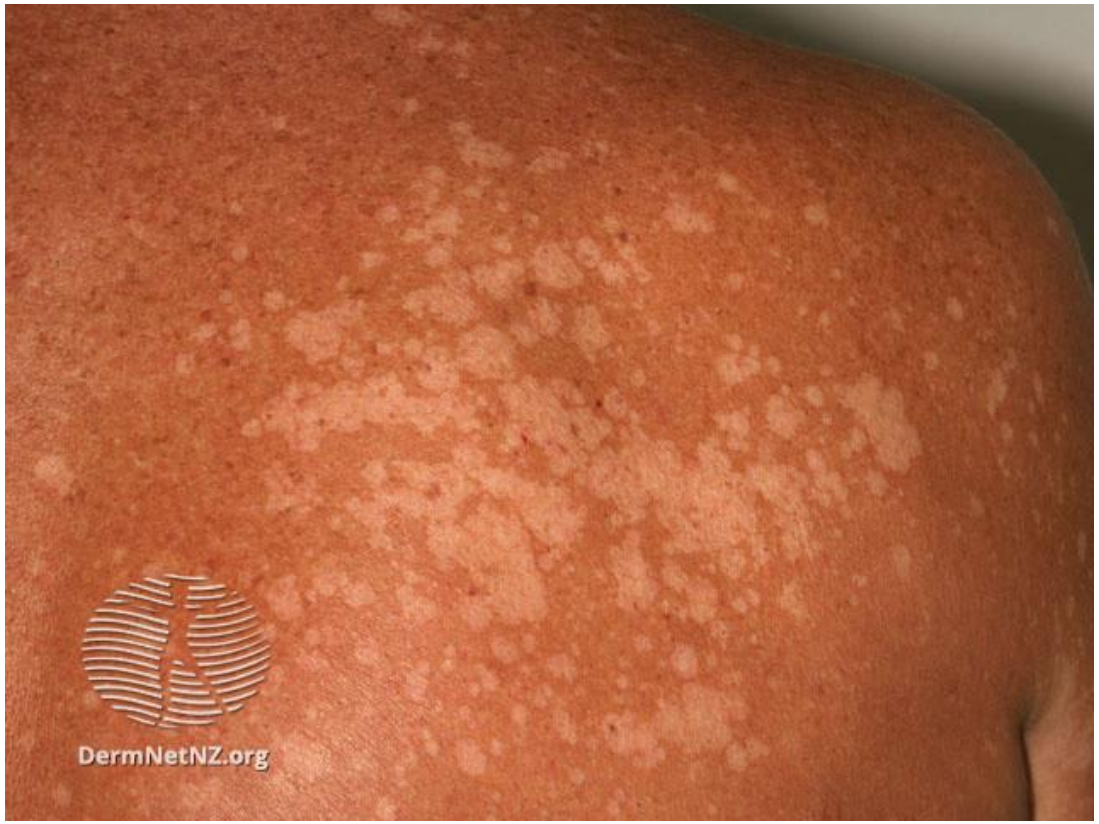
Tinea Versicolor





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Tinea: Types

- Tinea Versicolor
- Tinea Corporis
- Tinea Cruris
- Tinea Capitus
- Tinea Pedis
- Tinea Manus
- Tinea Faciei
- Majochi granuloma
- Tinea Nigra
- Etc.

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Tinea Versicolor

- Benign fungal infection
- Malassezia
- Conversion to filamentous form changes color
  - Pink, brown, hypo and hyper-pigmented
- Varying colors of macules, patches and plaques
- Trunk, arms, face, neck, suprapubic
- Generally no itch
- Heat, humidity, steroids, immunosuppression
- Generally begins in the warmest months

Tinea: Tests

- KOH

  “Spaghetti and meatballs”
- Biopsy

- Topical Treatment
  - Ketoconazole shampoo 2%. Let sit 5-10 min then rinse daily x 1- 4 weeks
  - Clotrimazole or econazole QD-BID x 1-4 weeks

- Oral Treatment
  - Fluconazole 300 mg by mouth QD x 2 weeks
  - Itraconazole 200 mg PO QD x 5-7 days
  - **Check drug drug interactions and note small risk of liver toxicity

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Tinea: Treatment

- Topical Treatment
  - Ketoconazole shampoo 2%. Let sit 5-10 min then rinse daily x 1- 4 weeks
  - Clotrimazole or Econazole QD-BID x 1-4 weeks

- Oral Treatment
  - Fluconazole 300 mg by mouth QD x 2 weeks
  - Itraconazole 200 mg PO QD x 5-7 days
  - **Check drug drug interactions and note small risk of liver toxicity
  - **Weigh Risks and Benefits of oral treatment

- Prevention
  - Keto 2% shampoo, ZNP 2% shampoo, Selenium Sulfide weekly

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Tinea Versicolor: Contagious or NOT?

NOT Contagious

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Pearls

- When in doubt, biopsy or refer to dermatology
- Always schedule timely return visit for patient
- Ensure if any worsening, they go to urgent care or ER
  - Including but not limited to fever, chills, night sweats, new or worsening symptoms
- Ensure proper steroid use with stop date
- Provide written instructions
- Always have a dermatology team you can call

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Q & A

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