Chief Complaint: Dermatitis

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- Dr. Cervantes disclosed that she has no financial relationships with any ineligible organizations or commercial interests.

By completing this educational activity, the participant should be better able to:

1. Develop a screening protocol to identify patients with risk factors for developing hypothyroidism, order appropriate laboratory tests to diagnose hypothyroidism, and diagnose subclinical hypothyroidism.
2. Prescribe appropriate pharmacotherapy for patients with hypothyroidism and monitor patients accordingly.
3. Identify a diversity of tissue compartments in which hypothyroidism is consequential.

General term meaning inflammation of the skin

Approach to Dermatitis

History	Onset, duration, pattern, associated symptoms, previous skin diseases, previous episodes, contacts, travels, activity, drugs, habits, previous treatments, any response to the treatment
Skin Exam	Features of lesions and location
General Exam	Associated symptoms to rule in/out

Most Common Dermatitis

- Atopic Dermatitis
- Seborrheic Dermatitis
- Contact Dermatitis (allergic vs. irritant)

Atopic Dermatitis

- ITCH THAT RASHES
- Chronic inflammatory condition with relapsing itchy and scaly plaques secondary to immunologic, genetic and environmental factors
- Commonly associated with Asthma and Allergies
- Children: 10-30%
  - 85% have symptoms <1 yo
  - 95% have symptoms <5 yo
- Adults: 1-2%

- PRURITUS, main symptom
- Increase risk to develop contact dermatitis and seborrheic dermatitis
- Clinical Presentation: age dependent
  - Neonate: face and scalp +/-alopecia
  - Infant: face, arms & legs
  - Older children & adults: flexural surfaces, face, neck

- Acute
  - Erythema, vesicles, bullae, weeping, crusting
- Subacute
  - Scaly plaques, papules, erosions
- Chronic
- Lichenification, scaling, hyperpigmentation

- Clinical Diagnosis
  - History & Physical
  - Lab tests (only in special cases)
    - Bacterial culture if secondary infection suspected
    - HSV PCR for eczema herpeticum
    - KOH to r/o tinea
    - Scraping to r/o scabies
    - Skin biopsy

Differential Diagnosis

- Contact Dermatitis
- Tinea
- Impetigo
- Psoriasis
- Scabies
- Seborrheic Dermatitis
- Keratosis Pilaris

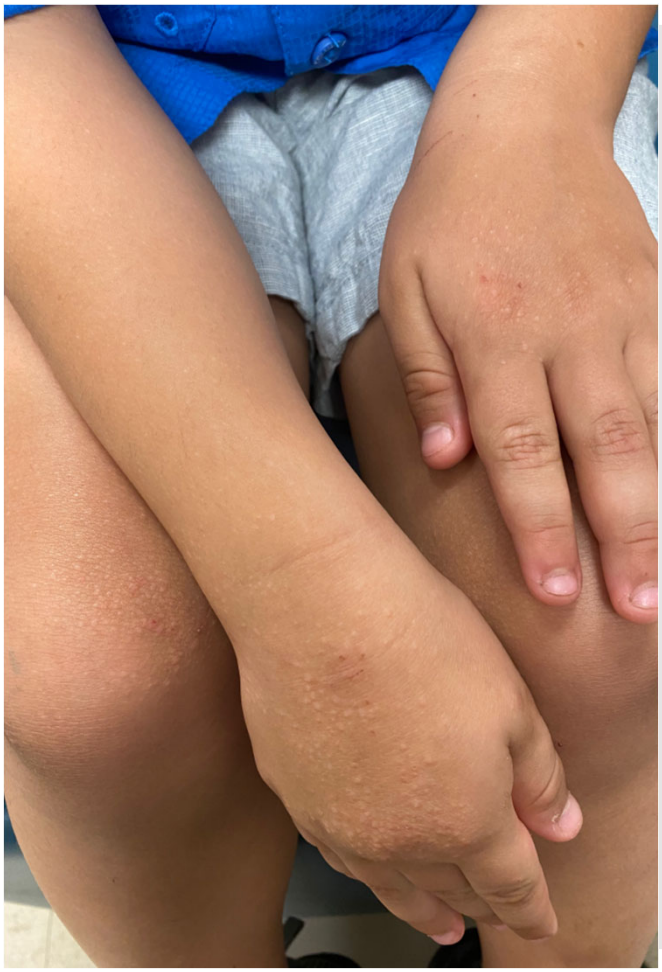
Recommendations

- LIBERAL emollient use
  - ***Glazed Donut Look***
- Hypoallergenic soaps & detergents
- Lukewarm showers/baths <10 min
- Colloidal Oatmeal baths
- Bleach Baths no longer recommended
- Wet Wraps
- Avoid known allergens and irritants
  - Fragrances, Wool, Extreme temperatures, Foods

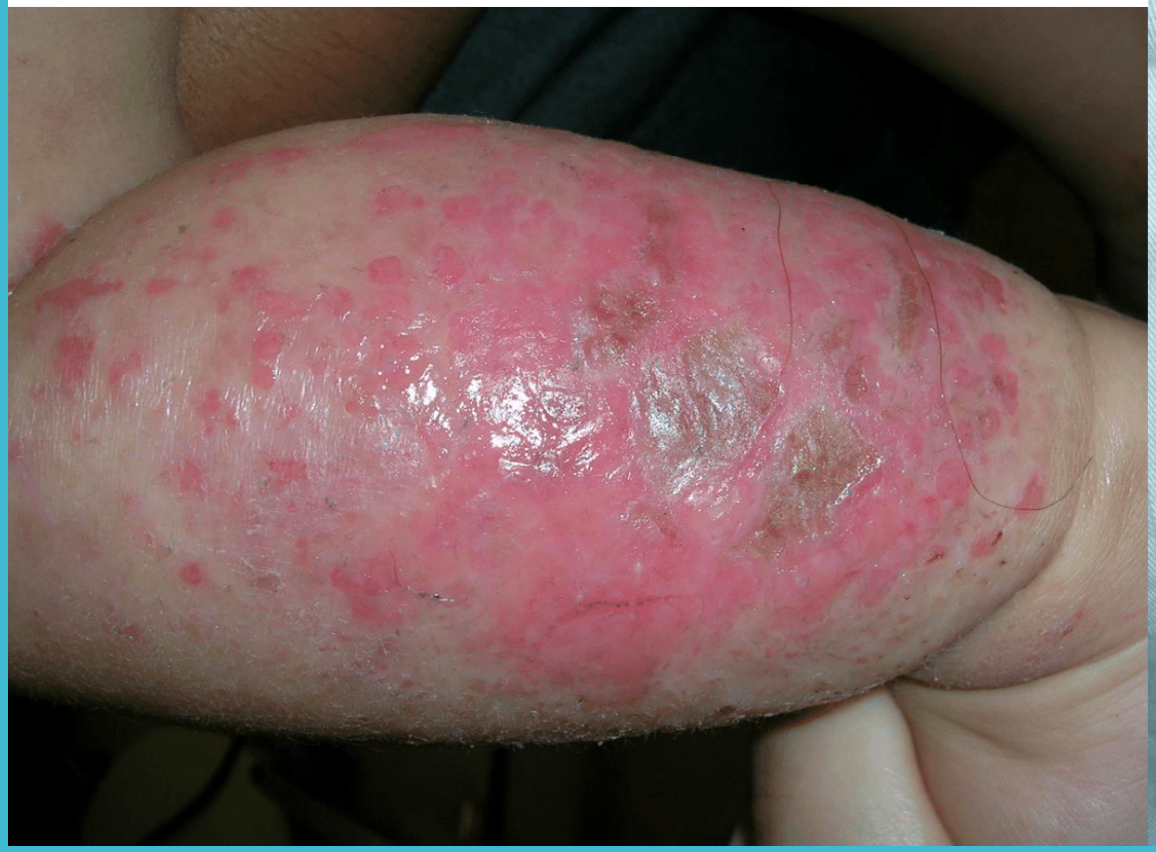
Treatment

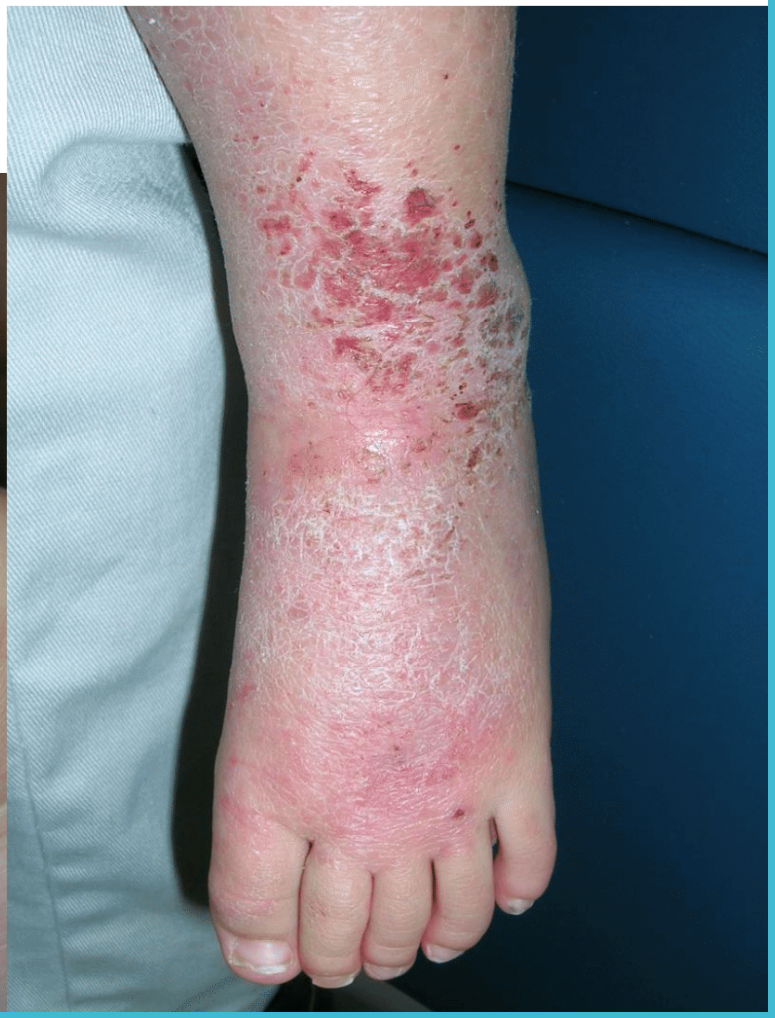
- Topical
  - Steroids
  - Calcineurin inhibitors
  - Crisaborole
  - JAK inhibitors
- Systemic
  - Immunosuppressants
    - Oral: Prednisone, Cyclosporine, Methotrexate
    - Injectable: Dupilumab, JAK inhibitors
- Oral antihistamines- pruritus control
- Phototherapy
- Hospitalization for severe cases

- Failed topical steroids
- Failed Crisaborole
- Responded well to Calcineurin inhibitors



Oral cephalexin bid is good choice





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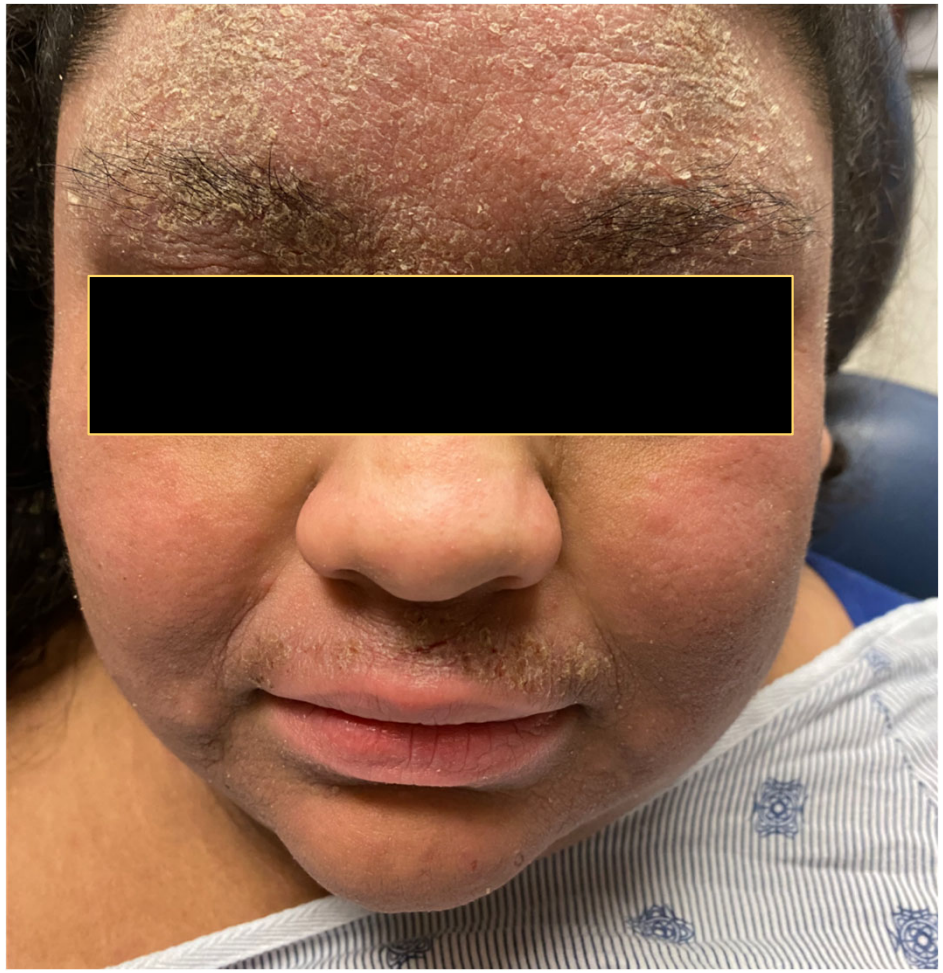
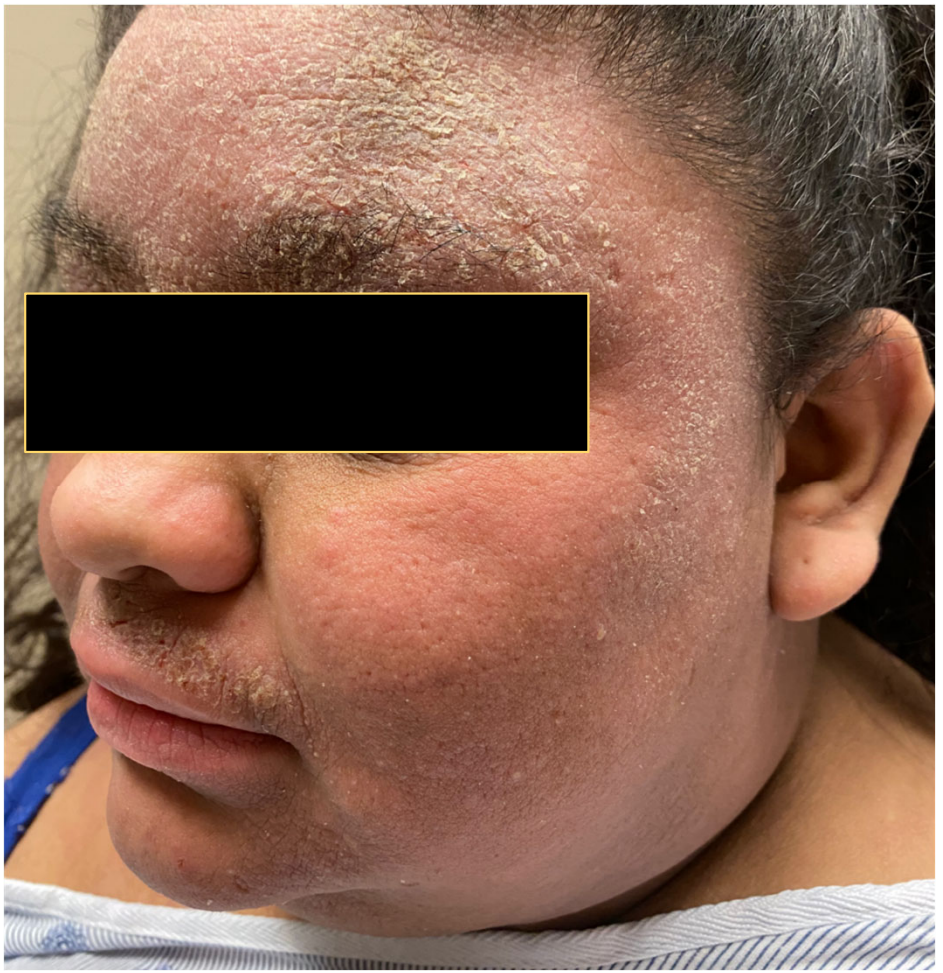
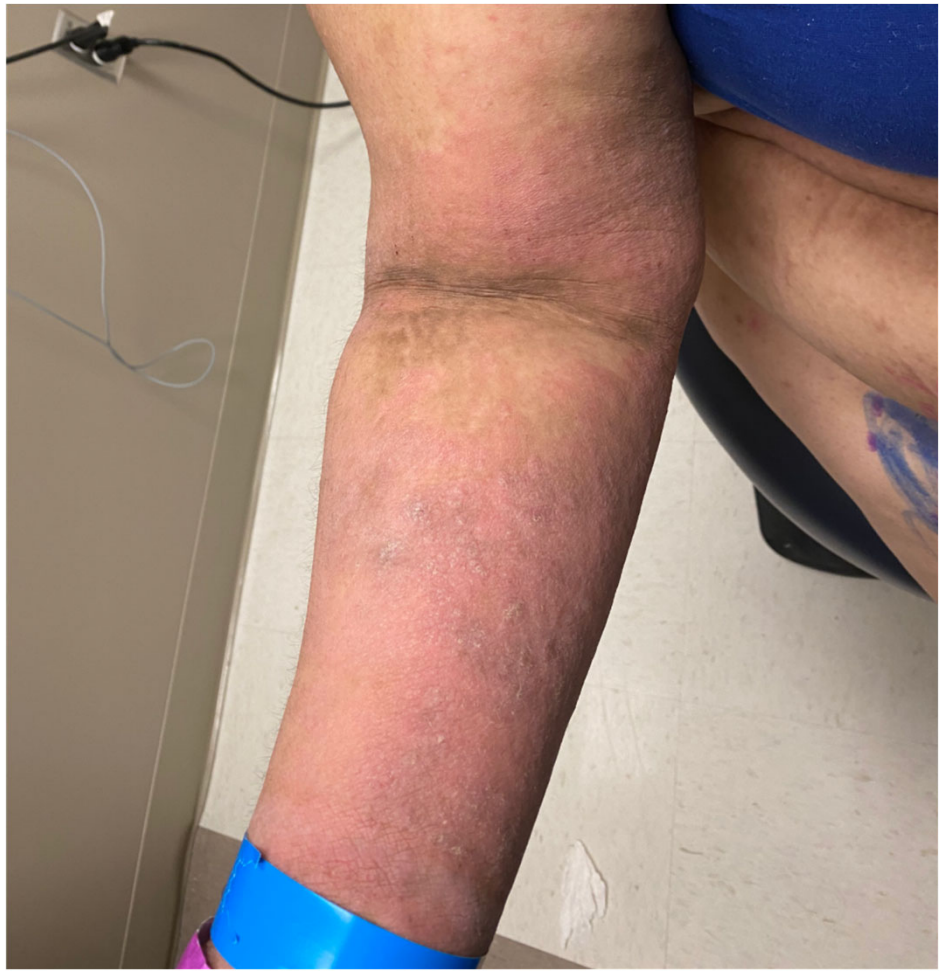
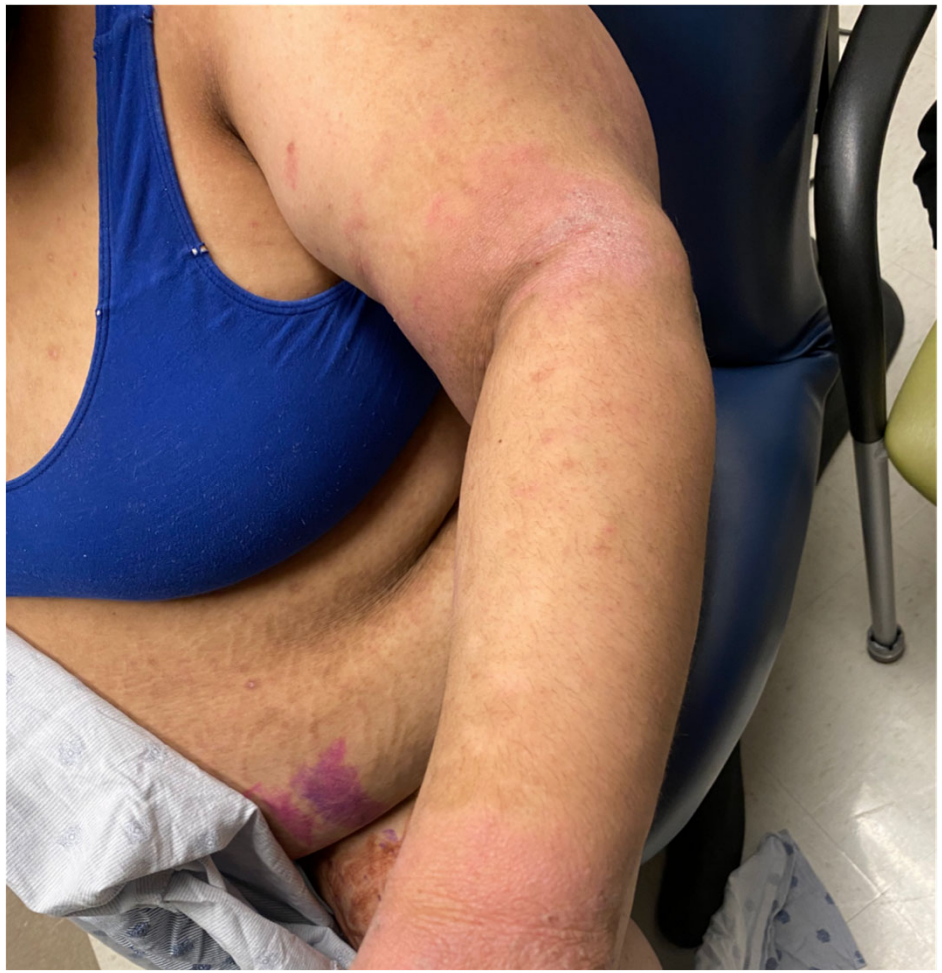
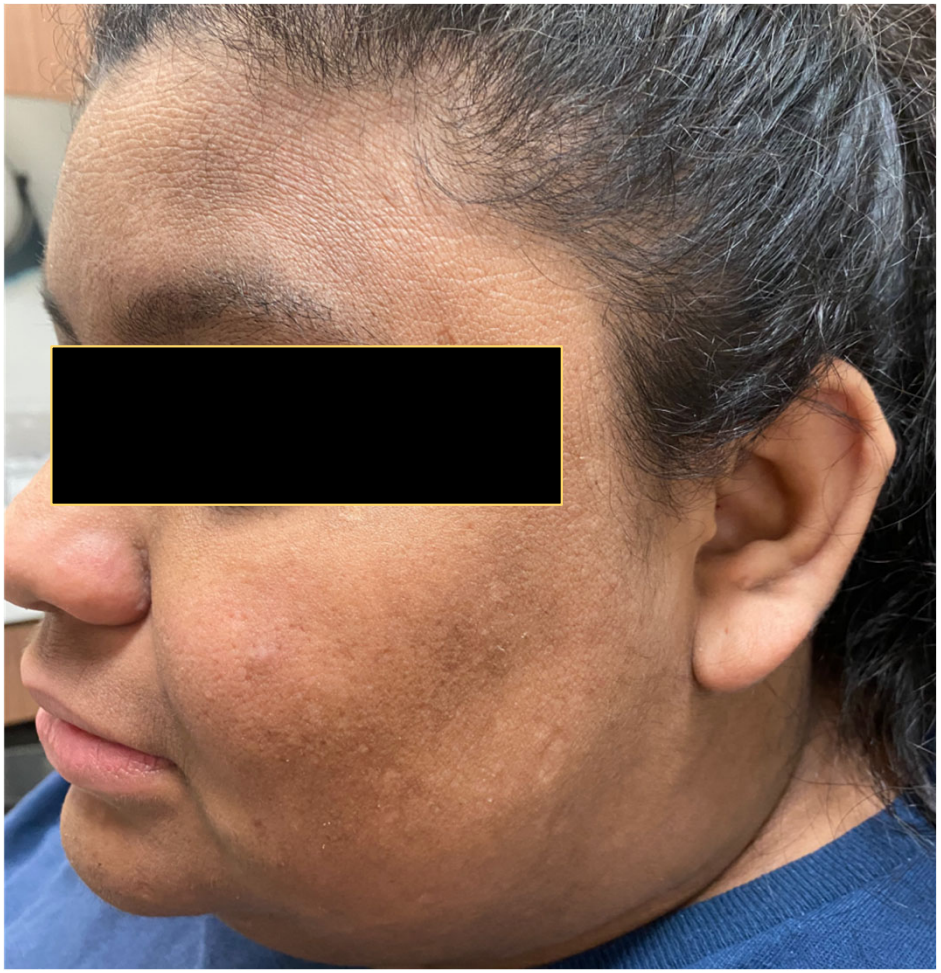
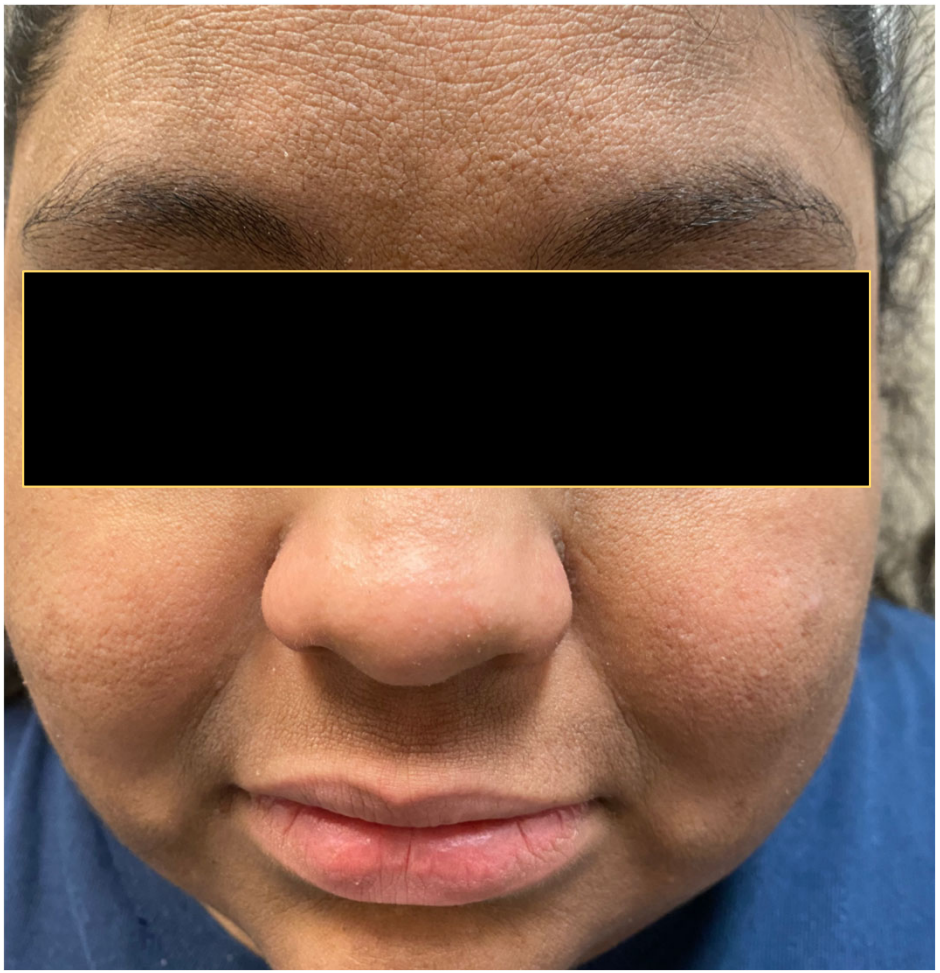


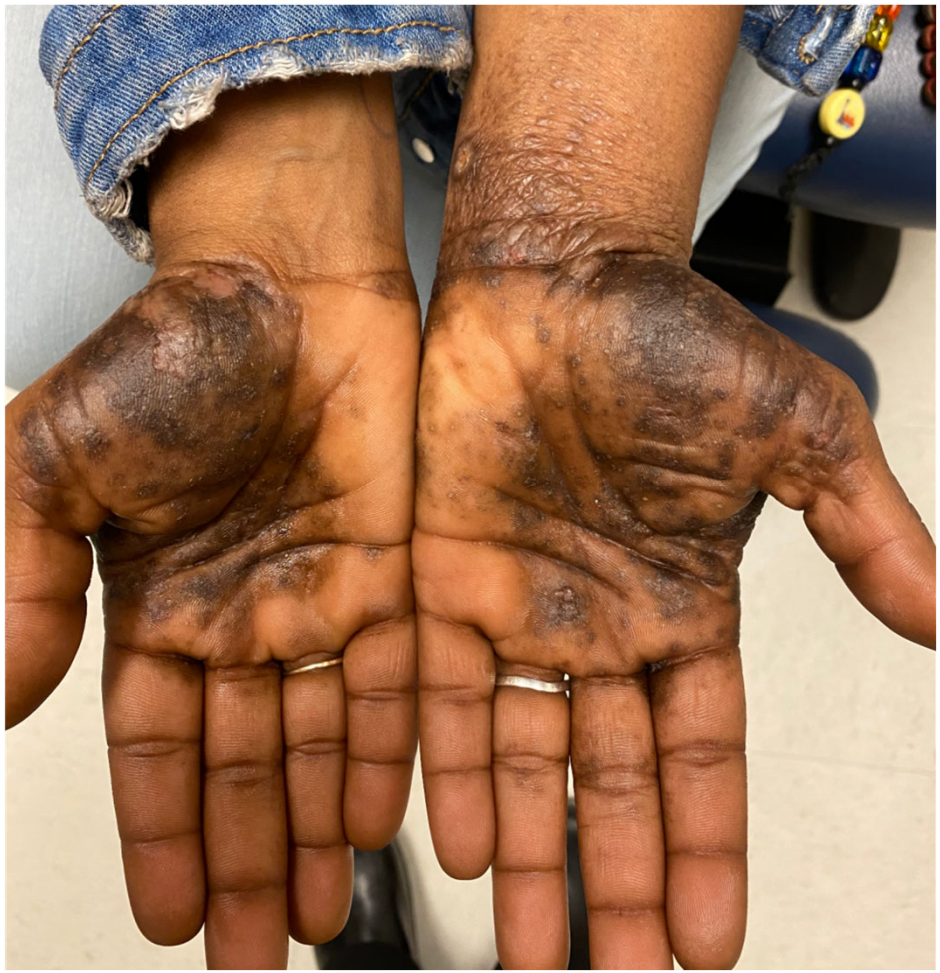


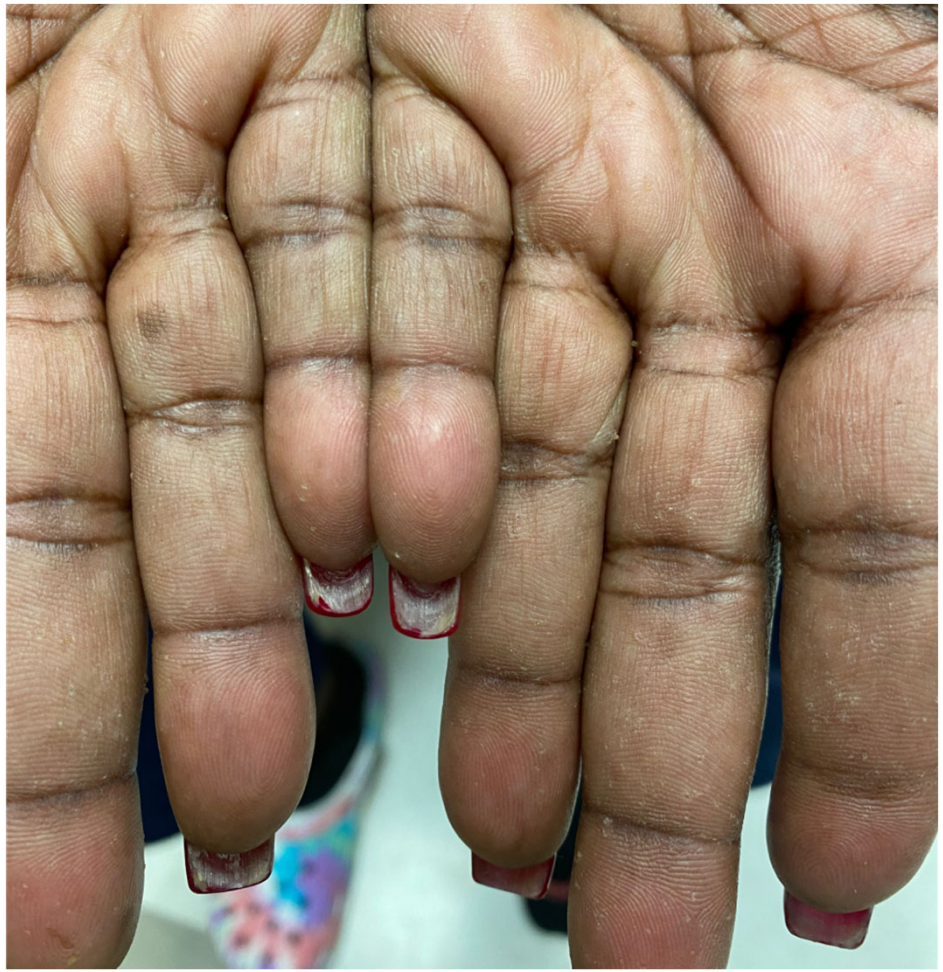


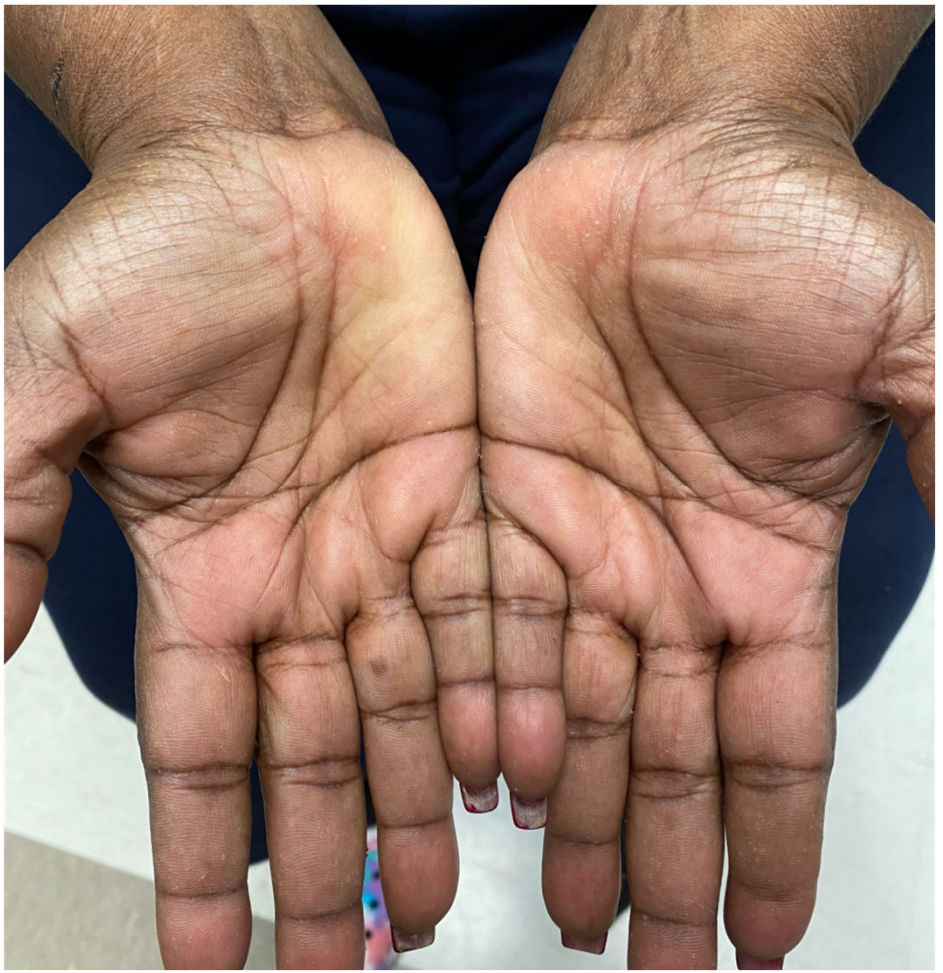




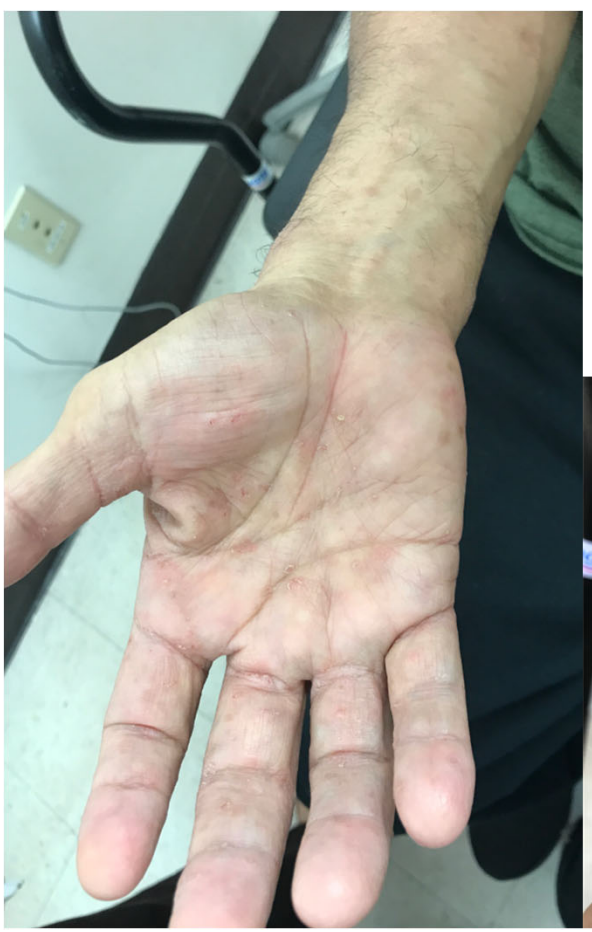


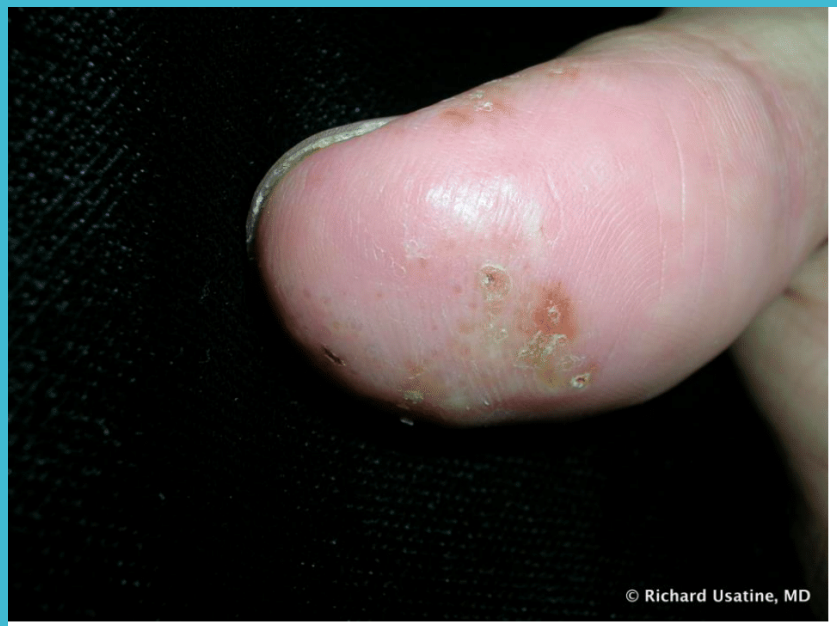






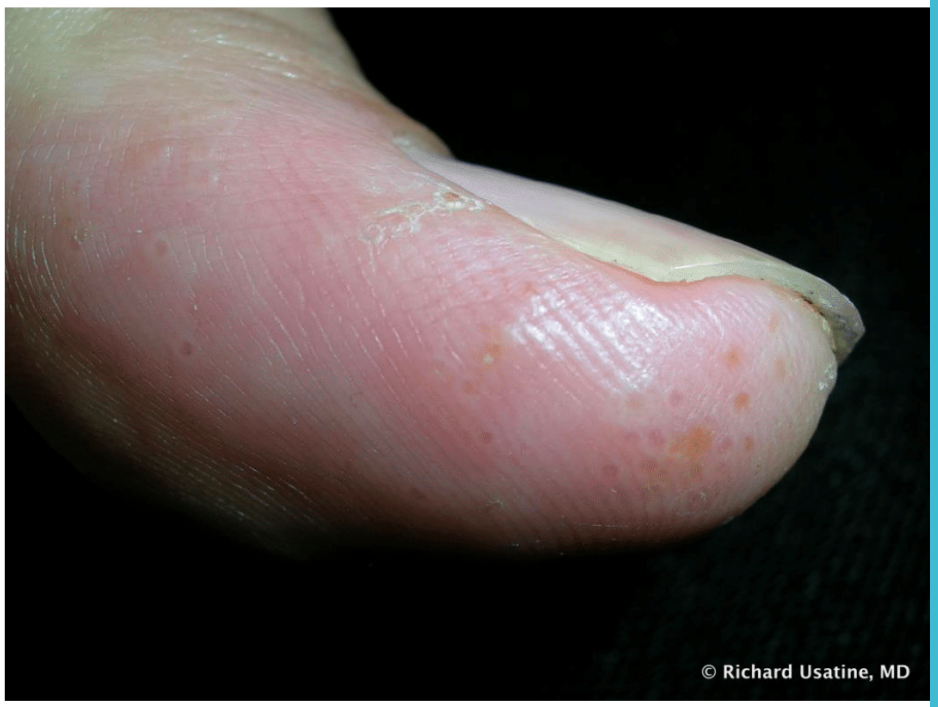
Scabies





Dyshidrotic eczema

Tapioca vesicles



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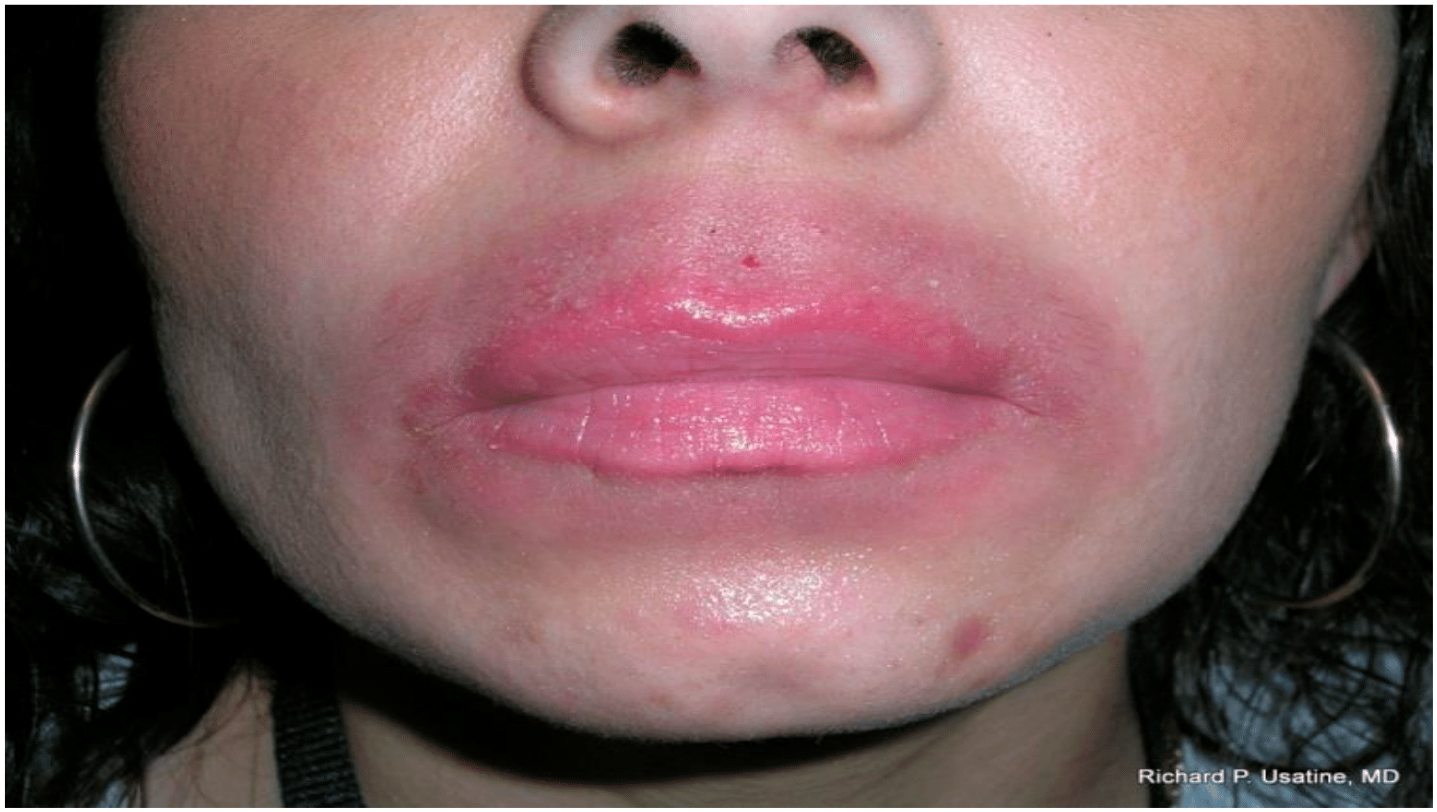
Lip Licker Dermatitis
ICD



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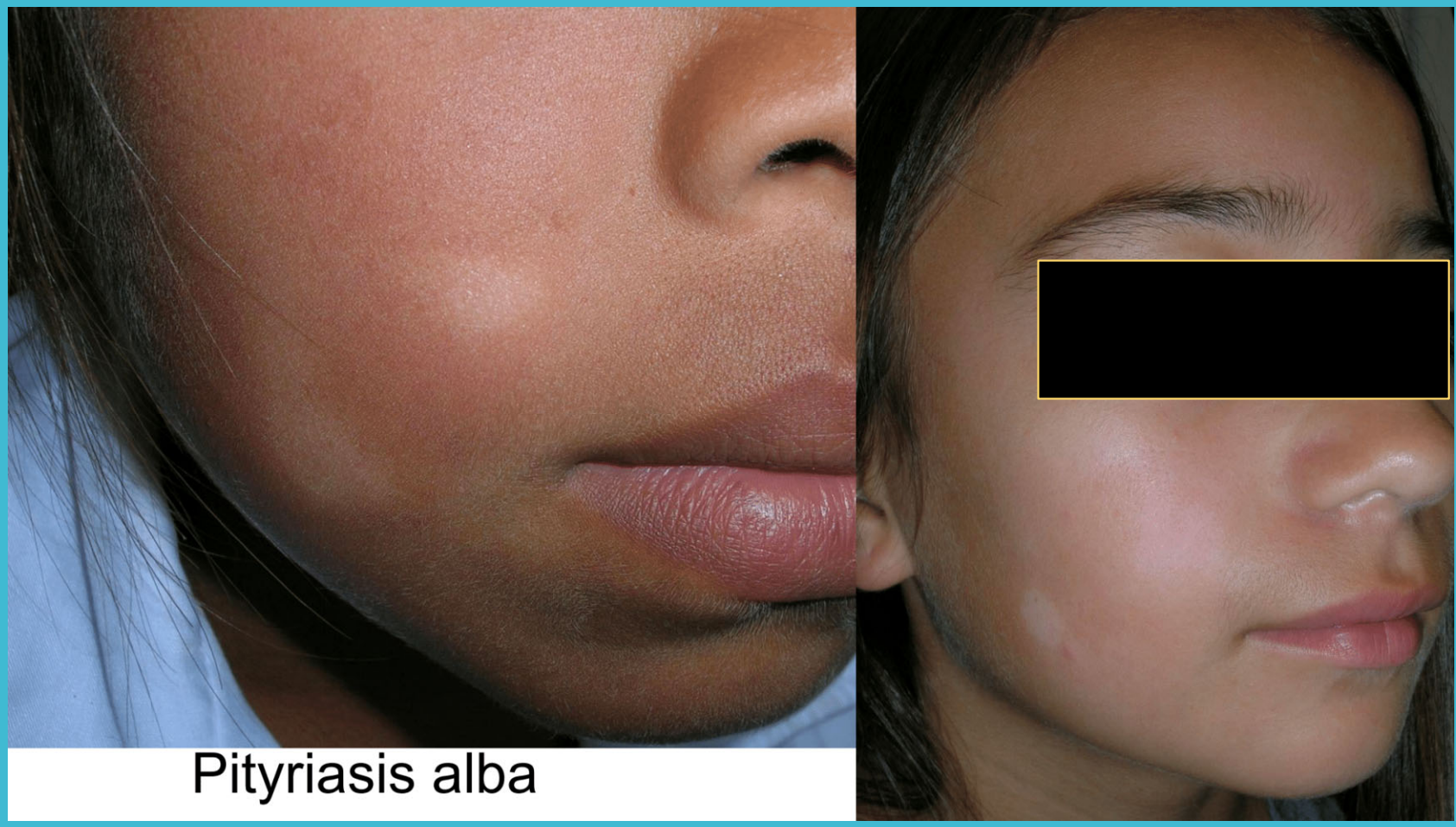

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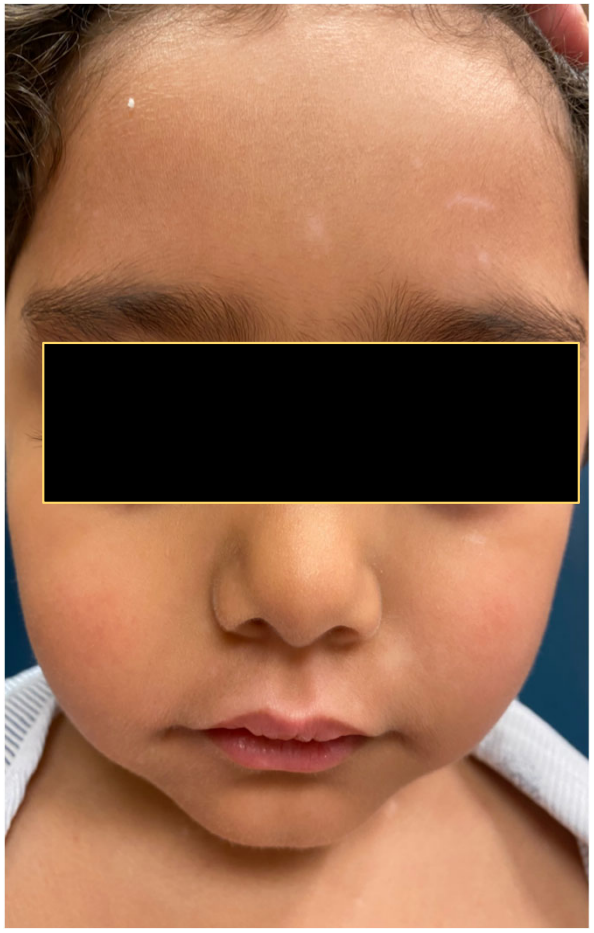
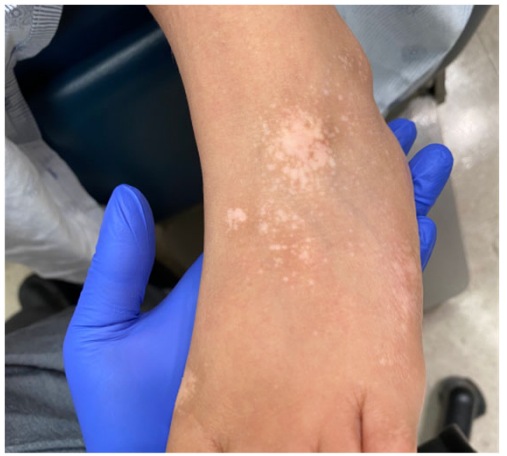
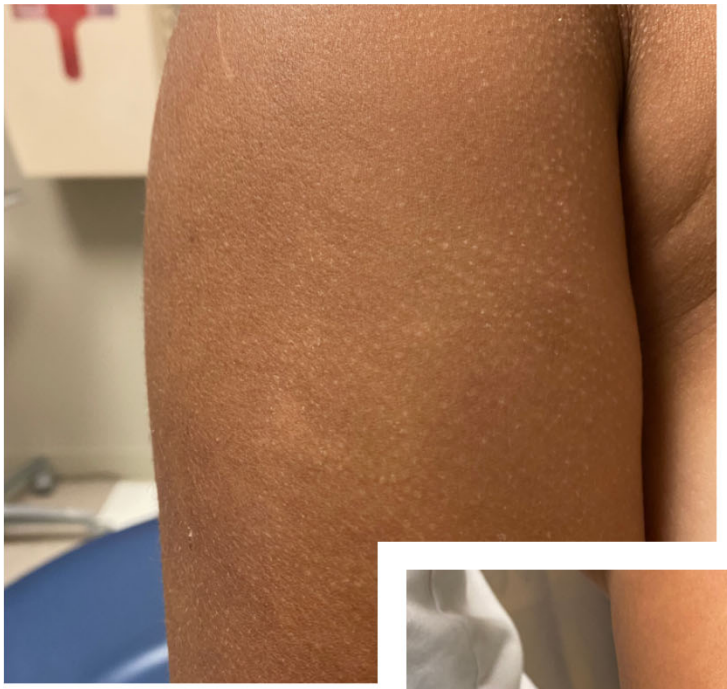
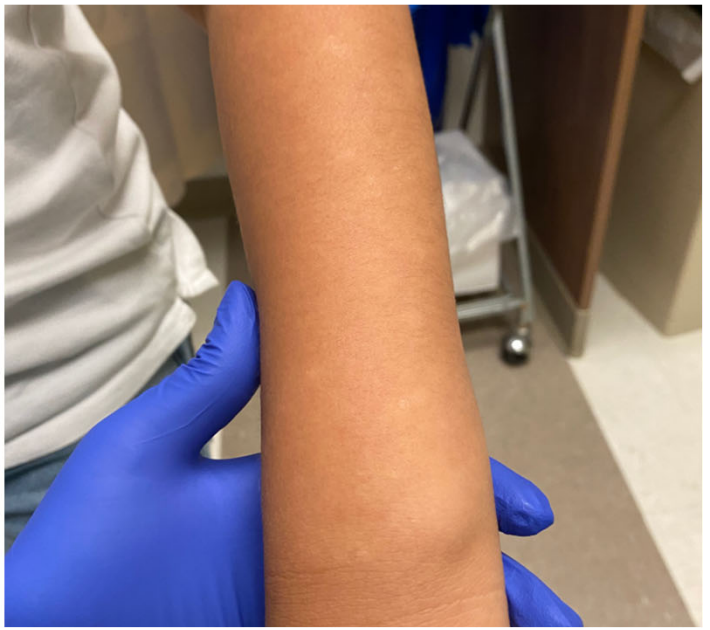
Vitiligo



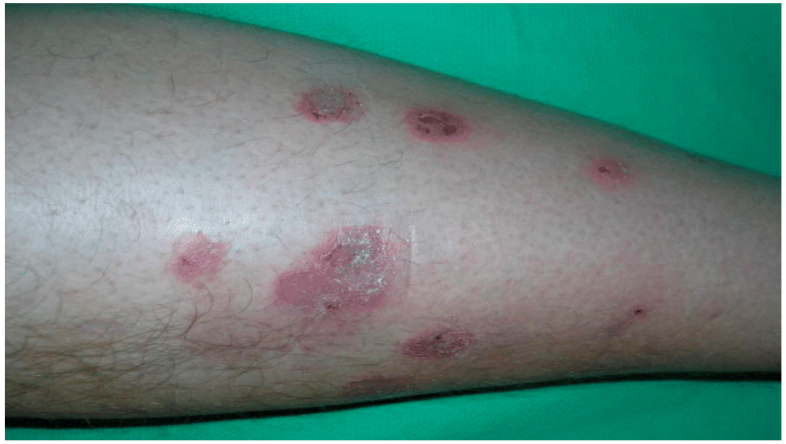


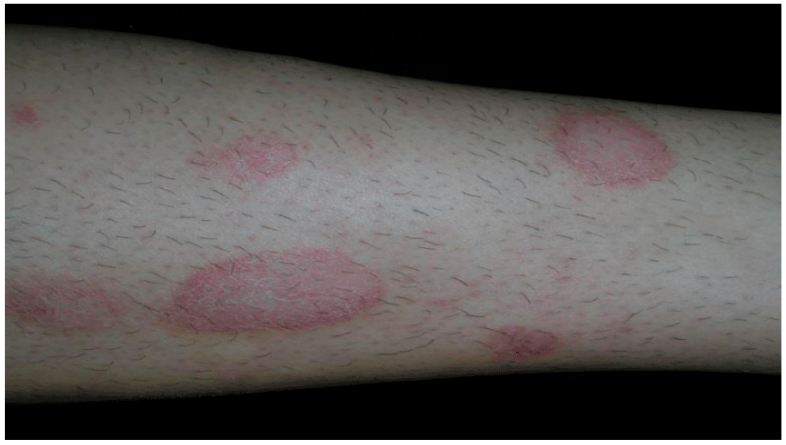
Keratosis Pilaris & Pityriasis Alba

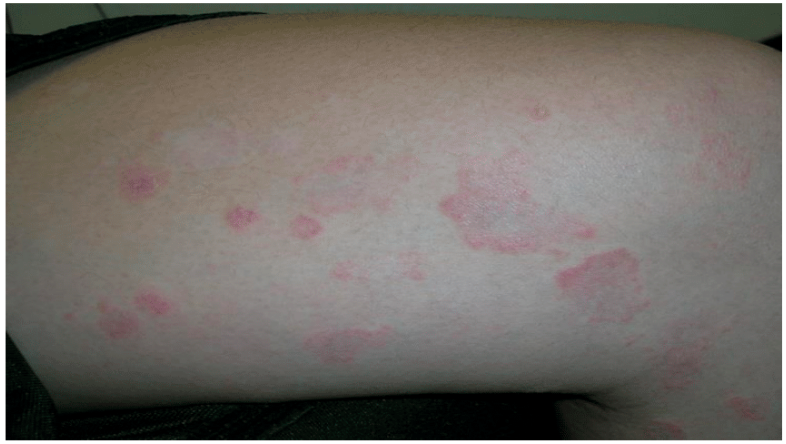


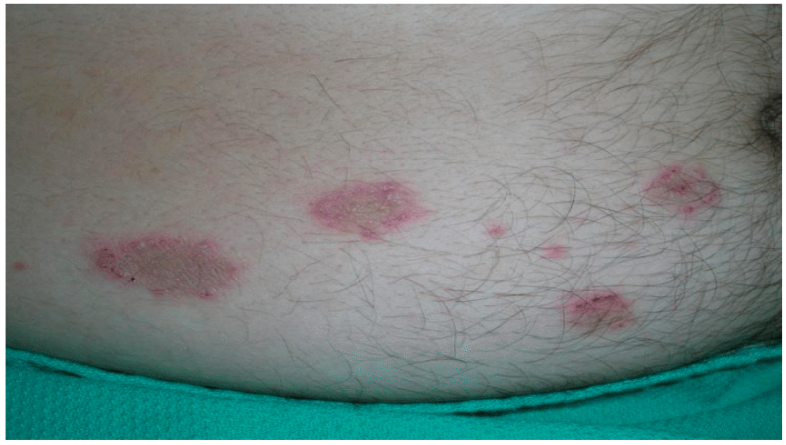


Nummular eczema









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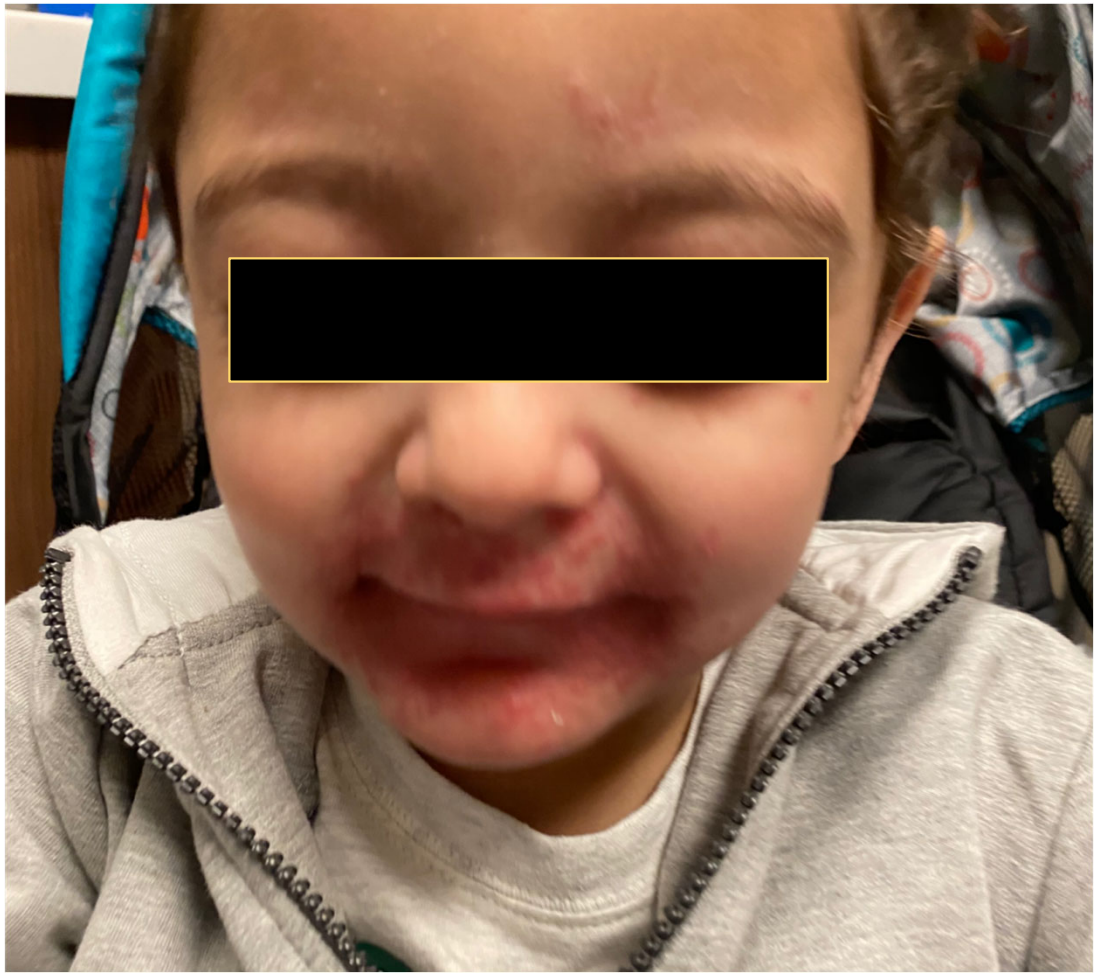
Steroid Phobia

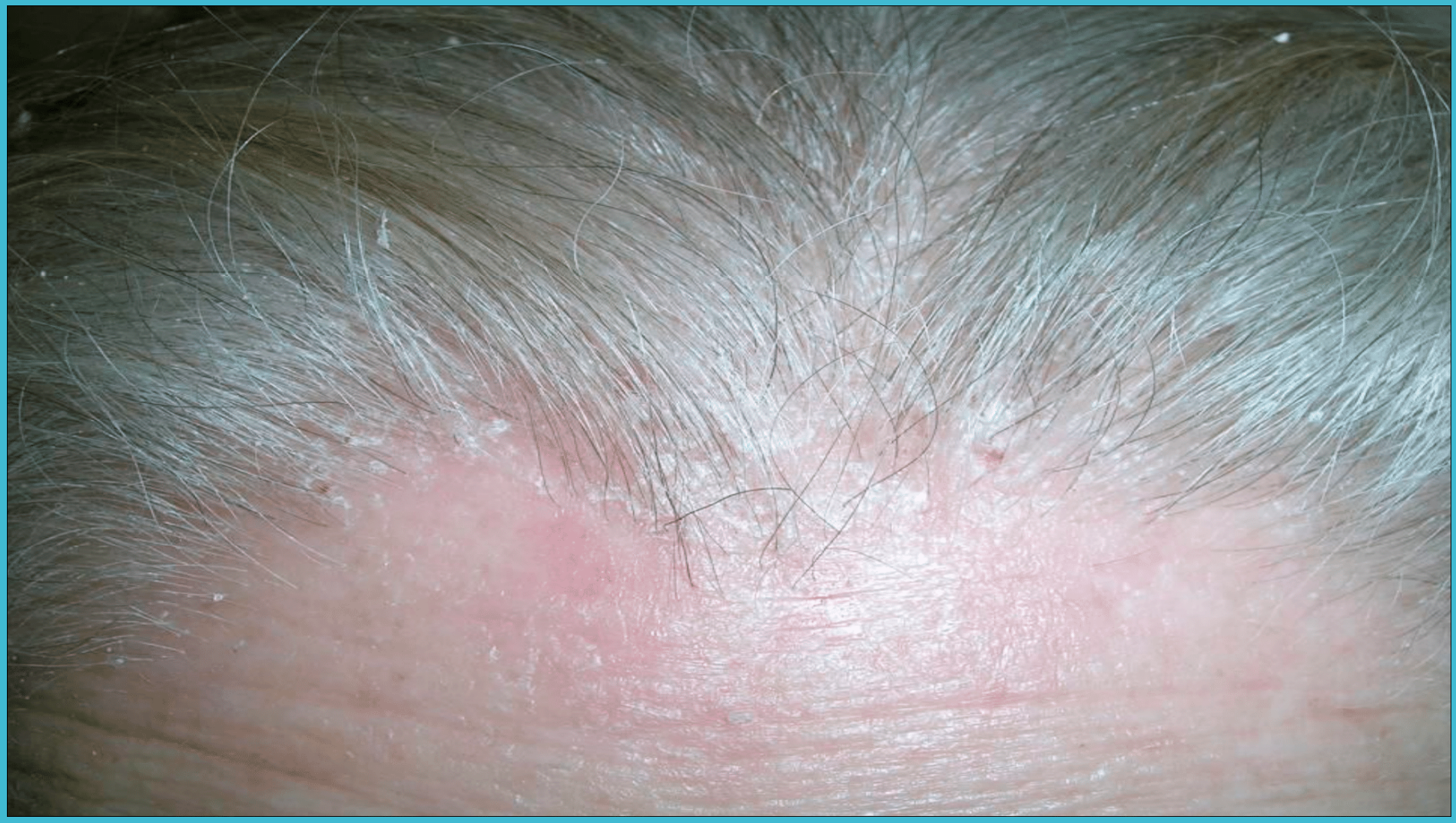
- Get over it!!!
- Educate your patients, parents, grandparents
- Face: Hydrocortisone 1- 2.5%, Desonide 0.05%
- Body: Triamcinolone 0.1%, Clobetasol 0.05% if severe
- Ointment > Cream > Lotion > Solution
- Alternatives
  - Coconut oil
  - Sunflower Seed Oil
  - Indigo compound
  - Oral Hemp Seed Oil
  - Black Tea Compresses
  - CBD



- Mom refused steroids from PCP.
- Would not be swayed.
- Improved with Crisaborole.

- Sebum rich areas
- Pityrosporum sp. (Malassezia)
- Neonates → Adults
- Dry, itchy, red, flaky, greasy scalp

- Clinical diagnosis
- KOH
- Consider HIV testing if high risk
- Commonly found in Acne-prone patients, elderly & neurological disorders: CVA, Parkinson's disease



Courtesy of Richard Usatine, MD

Differential Diagnosis

- Scalp Psoriasis
- Perioral Dermatitis
- Rosacea
- Tinea Versicolor
- Allergic Contact Dermatitis
- Atopic Dermatitis

Treatment for Pityrosporum

- Shampoo
  - Ketoconazole Shampoo
  - Ciclopirox Shampoo
  - Selenium Sulfide
  - Pyrithione zinc
- Topical Antifungal
  - Ketoconazole, econazole, clotrimazole
- Oral
  - Fluconazole

Treatment for Inflammation

- Topical Steroid
  - Hydrocortisone, Desonide for face
  - Fluocinonide, clobetasol for scalp

Cradle Cap

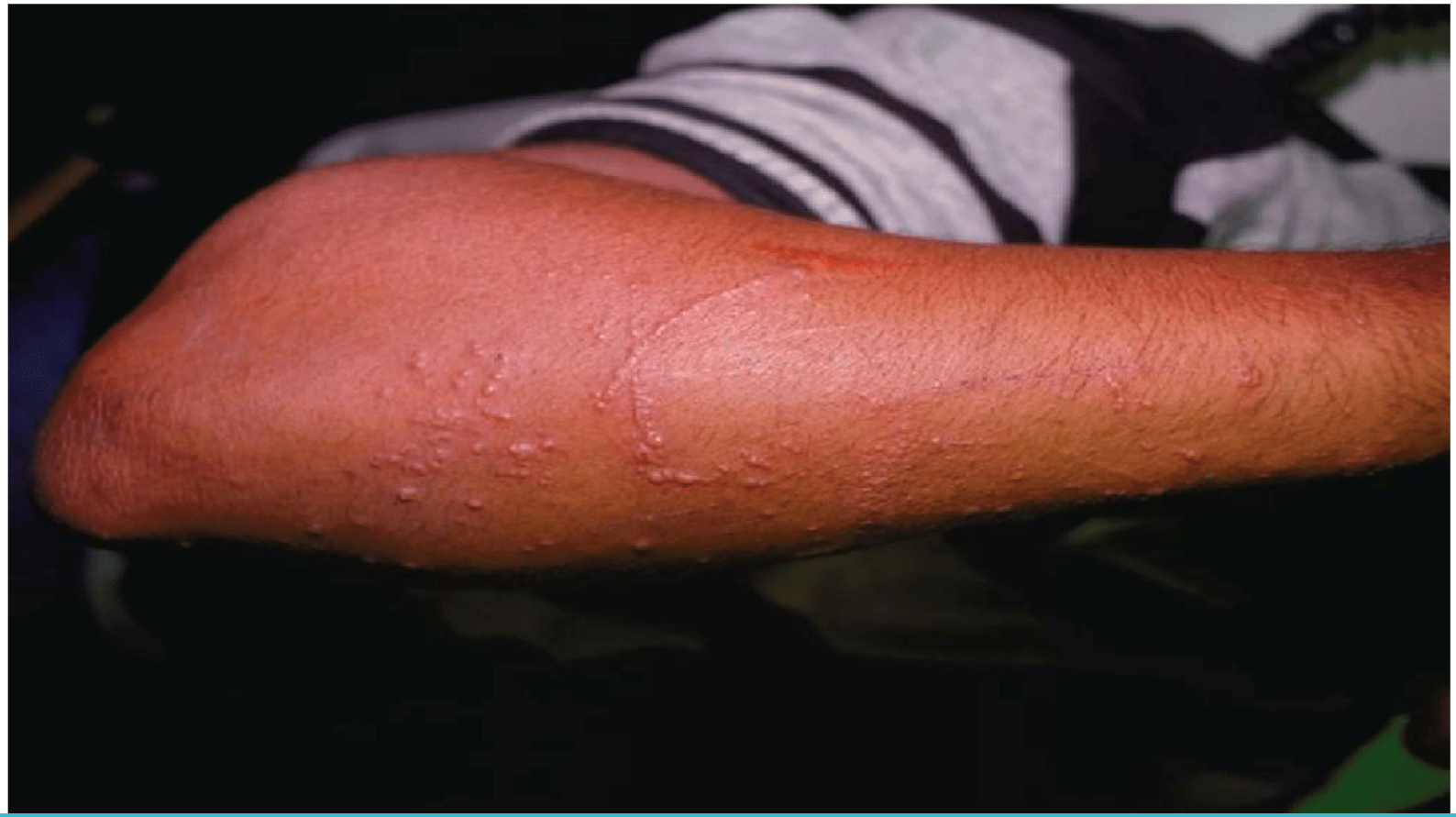
How do you tell the patient to use the products?

- Lather Medicated Shampoo into scalp for 5 minutes before rinsing
- Alternate with dandruff shampoo of choice
- Use foam from scalp to wash face (nasolabial folds, brows, beard) & ears if also affected
- May follow with Conditioner to hair not scalp
- Wash hair on patient's schedule
- African American Hair: Zinc Based shampoo + Ciclopirox
- Topical steroid: nightly, max twice a day
- Face: alternate topical steroid & topical antifungal

Contact Dermatitis (Allergic vs. Irritant)

- Hypersensitivity type IV→ Allergen activates T-cell response
- Multiple exposures
- Common Allergens
  - Urushiol (Poison Ivy, Sumac)
  - Nickel
  - Fragrance
  - Metal
  - Neomycin
  - Adhesive
  - Oxybenzone (sunscreen)
  - Formaldehyde-releasing preservative polypropylene (facial mask)

POISON IVY



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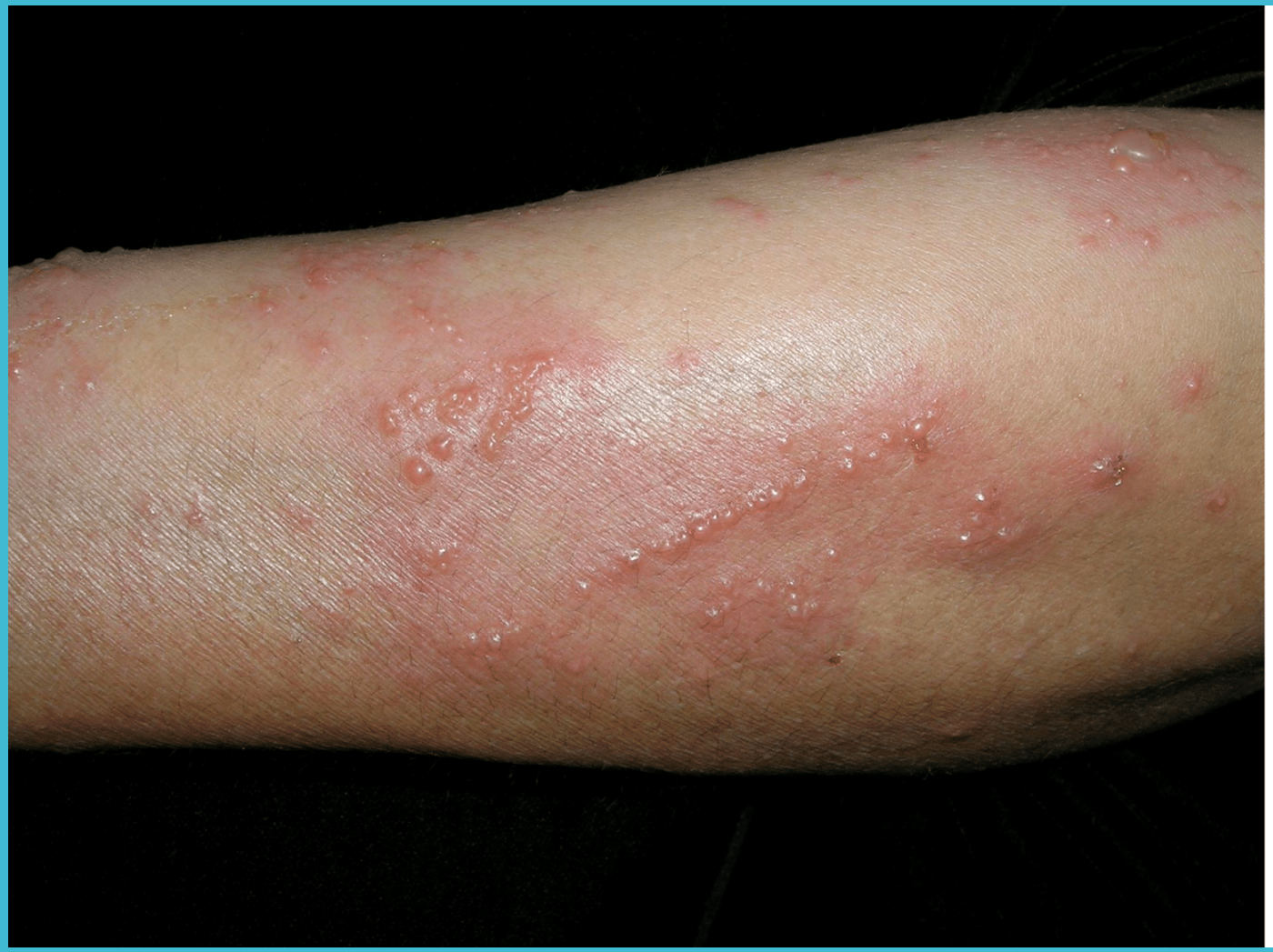
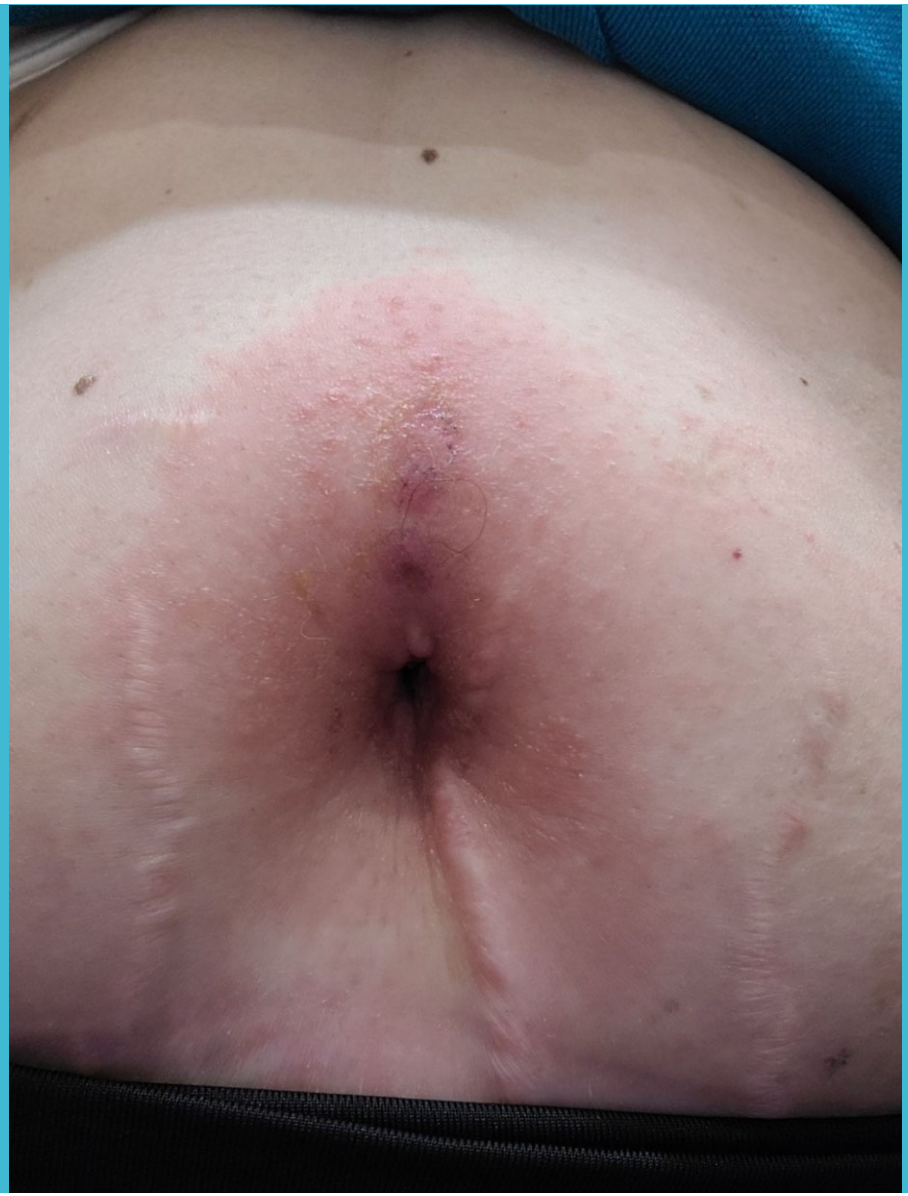


Poison ivy

line of vesicles

Courtesy of Richard Usatine, MD

Nickel Allergy

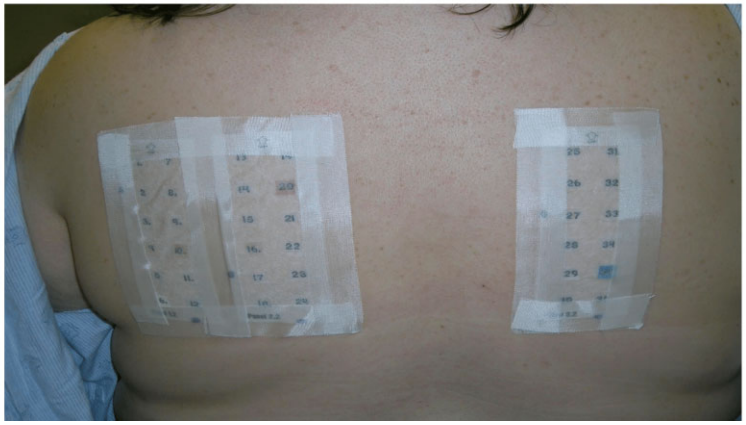


- Acute
  - Erythema, vesicles, bullae, oozing, crusting
- Subacute
  - Scaly plaques, erosions, crusts
- Chronic
  - Scaling, lichenification, fissures, cracks
- Geometric Shape
- Photo activated
- Activity related

- Direct Chemical or physical toxic effect to keratinocytes
- Most common 80% of contact dermatitis
- Begins with burning or stinging feeling
- Common on hands, eyelids, lips
- Everyone is susceptible
- Previous history of atopic dermatitis
- Occupational related
  - Housekeepers, janitors, healthcare workers, electrician, nail techs, mechanics

- Water
- Soap
- Detergents
- Alcohol
- Solvents
- Adhesives
- Friction

"T.R.U.E. Test"



Clinical diagnosis

H&P

Contact Patch Testing

True Test x 35 or more advanced if needed

KOH to r/o tinea

Courtesy of Richard Usatine, MD

Differential Diagnosis

- Atopic Dermatitis
- Nummular Eczema
- Dyshidrotic Eczema
- Arthropod Bite Reaction
- Psoriasis
- Seborrheic Dermatitis
- Secondary Syphilis
- Tinea

- Avoid Offending Agent
- Protective Barriers
- Topical Steroids, Calcineurin Inhibitors
- Phototherapy
- Antihistamines for pruritus
- Systemic steroid for severe cases

Take Home Points

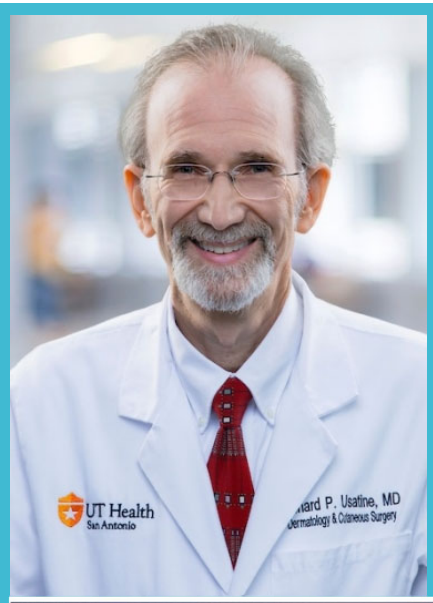
- AD = ITCH that RASHES
- NO to steroid phobia, use with caution
- Ask the right questions
- Mindful of different hair types and practices

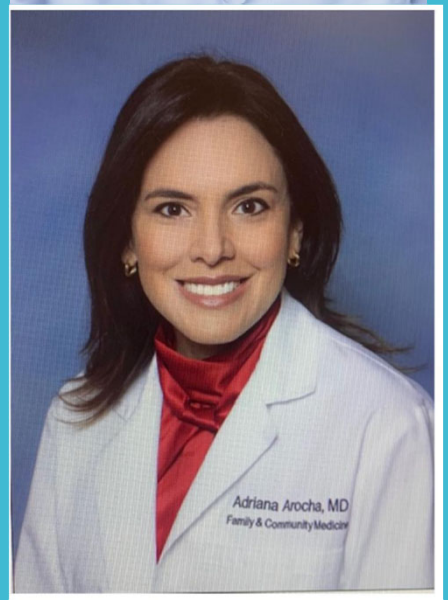
Thank you for your attention!! :)

Acknowledgements

Dr. Richard Usatine

Dr. Adriana Arocha






Question
Time!

References

- Richard P. Usatine, MD; Family Medicine 3rd edition 2019
- VisualDx.com
- Ali Alikhan and Thomas L.H. Hocker, MD Review of Dermatology 1st edition 2017
- Mark G. Lebwohl, MD Skin Diseases 4th edition 2014