

Common Clinical Cases in Dermatology for the PCP

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Outline

- Case based presentation of common skin diseases.
- Recognizing skin diseases, their differential diagnosis and understanding a treatment algorithm – can refer at virtual any point in treatment ladder

Case 1: Eyelid Irritation

35 yo F with hx of sensitive skin, has streamlined skin care, recently started a tretinoin for anti-aging.

Now with itching, erythema, scale limited to eyelids



Eyelid Dermatitis

- Dermatitis = epidermal inflammation (spongiosis)
- Different types:
 - Allergic Contact Dermatitis
 - Irritant Dermatitis
 - Atopic Dermatitis
 - Seborrheic Dermatitis
- Mainstay of treatment for dermatitis = corticosteroids for controlling epidermal inflammation

We are...the steroid cream people

Cheaper/Effective Steroids

- Betamethasone Dipropionate **Augmented**
 - Solution (scalps) Fluocinonide/Clobetasol
 - Triamcinolone 0.1% (454 g!)
 - HC 2.5% (454 g!)
 - OTC Hydrocortisone 1%
-
- Be Generous – 60 or 90 g tubes! (Copays usually identical)
 - Beware of steroids in delicate areas
 - Beware of long term use

GENERIC NAME	EXAMPLES OF BRANDED PRODUCTS
CLASS 1—SUPER POTENT	
0.05% clobetasol propionate	Clobex® Lotion/Spray/Shampoo, Olux® E Foam, Temovate E® Emollient/Cream/Ointment Gel/Scalp
0.05% halobetasol propionate	Ultravate® Cream
0.1% fluocinonide	Vanos® Cream
CLASS 2—POTENT	
0.05% diflorasone diacetate	ApexiCon® E Cream
0.1% mometasone furoate	Elocon® Ointment
0.1% halcinonide	Halog® Ointment
0.25% desoximetasone	Topicort® Cream/Ointment
CLASS 3—UPPER MID-STRENGTH	
0.05% fluocinonide	Lidex-E® Cream
0.05% desoximetasone	Topicort® LP Cream
CLASS 4—MID-STRENGTH	
0.1% clocortolone pivalate	Cloderm® Cream
0.1% mometasone furoate	Elocon® Cream
0.1% triamcinolone acetonide	Aristocort® A Cream, Kenalog® Ointment
0.1% betamethasone valerate	Valisone Ointment
0.025% fluocinolone acetonide	Synalar® Ointment
CLASS 5—LOWER MID-STRENGTH	
0.05% fluticasone propionate	Cutivate® Cream/Cutivate Lotion
0.1% prednicarbate	Dermatop® Cream
0.1% hydrocortisone probutate	Pandel® Cream
0.1% triamcinolone acetonide	Aristocort® A Cream, Kenalog® Lotion
0.025% fluocinolone acetonide	Synalar® Cream
CLASS 6—MILD	
0.05% alclometasone dipropionate	Aclovate® Cream/Ointment
0.05% desonide	Verdeso™ Foam, Desonate Gel™
0.025% triamcinolone acetonide	Aristocort A Cream, Kenalog Lotion
0.1% hydrocortisone butyrate	Locoid Cream/Ointment
0.01% fluocinolone acetonide	Derma-Smoothe/FS® Scalp Oil, Synalar® Topical Solution
CLASS 7—LEAST POTENT	
2%/2.5% hydrocortisone	Nutracort® Lotion, Synacort® Cream
0.5- 1% hydrocortisone	Cortaid® Cream/Spray/Ointment and many other over-the-counter products

Special Creams for Special Sites

- Topical Calcineurin inhibitors – Better than vehicles in trials – but at what cost?
 - Black box warning: “Rare malignancies”
 - Tacrolimus (Protopic) **ointment** 0.03%, **0.1%** (\$70/60g @ Goodrx)
 - Pimecrolimus (Elidel) **cream** 1% (\$81/30g @ Goodrx)
- Topical JAK inhibitors – newly approved for Vitiligo, atopic dermatitis. Ruxolitinib (Opzelura), **\$2000/60 g**
 - Studies show superiority to placebo but there are no great head to head trials at present.
 - Risk of acne/folliculitis , concern for VTE/serious AE but low serum conc make serious heme AE unlikely.

Case 2

- 55 yo healthy man complaining of itching skin on his legs and flanks. Occurs every winter, this year is particularly bad.





Asteototic (Xerotic) Eczema

- Eczema of dry skin.
- Usually on shins, arms and flanks.
- Dry Skin Care
 - Short, cool showers
 - Limited gentle soap (e.g. Dove bar soap or Cetaphil cleanser).
 - Pat dry
 - Thick Creams in jars (e.g. Cerave or Cetaphil)
 - Triamcinolone 0.1% ointment for most inflamed areas.

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Other common eczemas: Nummular Dermatitis - worsens with age/dry skin/winter weather



Nummular Eczema:
Dry skin care
TAC

70 yo M, complaining of burning itching legs

70 yo M, hx of HTN/CHF
Was travelling, on feet
more than normal.

Worsening erythema on
the legs x 1 mo , trial of
10 days keflex without
improvement

No fever, no WBC

Itch/burning pain on lower
legs, presenting for dx/txt



Stasis Dermatitis

- Pathophysiology

- Dysfunction of the venous system (lack of pump of calf muscles, diseased valves in vein)
- Causes higher pressure in venous system -> backing up into the skin
- Fluid leaks into dermis, causes inflammation in epidermis.

- Epidemiology

- V Common 6% of people over 65
- F>M, obesity, hx of DVT, CHF, HTN

Stasis Derm



Stasis Dermatitis vs Cellulitis

Usually Bilateral
Itching rather than
tender
No fever/no
leukocytosis
Defects in skin
integrity, poor
vascular issues can
put at risk for
cellulitis.



Stasis Dermatitis: Management

- Ensure good pulses/arterial insufficiency not playing a role.
- Topical steroids for acute stasis - treats itch/inflammation. Typically Triamcinolone or Fluocinonide 1 wk on/1 wk off. Can use AmLactin lotion (not greasy) or Vaseline (greasy) for wk off
- Compression is mainstay of treatment
 - Start with 12-15 mm Hg.
 - Can get several pairs from Amazon for <\$20
 - Increase as tolerated
- Consider vascular c/s for ?EVLA

Other common eczemas

22 yo F gardening over the weekend, now with itchy linear and arcuate vesicular plaques on the arms/legs. Hx of ACD to poison ivy in past. Can't sleep, miserable.



Allergic Contact Dermatitis

ACD: Natural course is 2-3 wks of rash

*Class I Steroid (Diprolene BID)

*Antihistamines as sleep aid/less itch at bedtime -
Hydroxyzine 25-50 qhs

*Avoid oral CS when possible - avoid medrol dosepack
b/c of certain rebound - consider pred 40 x 1 wk, pred 20
x 1 wk, stop.

I've tried and tried but my patient with dermatitis is STILL itchy!

- Is there rash where patient is itchy? Is the itch driven by rash or is the itch neurogenic in origin.
- Could the rash be drug related? New drugs in last year?
- Is there a metabolic cause for itch: DM, CRI, Hepatitis/Liver dysfunction, Malignancy - Lymphoma CXR, MM SPEP, UPEP.
- Is there evidence for allergic/atopic process: Eosinophilia/IgE level
- Biopsy for chronic, persistent itchy rash

Treating my itchy older patients

- If there is no underlying process/persistent itch/rash:
- Consider treating scabies empirically to exclude scabies (Permethrin 5% neck down x 2 treatments 1 week apart)
- Empiric topical steroids
- Consider low dose gabapentin for itch (off label) sedating/increase fall risk – start low @ 100 qhs
- Can consider SC dupilumab il-4/il-13, dermatitis, prurigo nodules, itch

Masqueraders of Dermatitis

54 yo M otherwise well

3 mo hx of pruritic buttock rash



Case 2 Hx

3 months ago, presents to PCP for perianal itching: Given nystatin for fungus.

Dermatophyte ->Anti-Fungal

Candidal ->Nystatin

1 month ago urgent visit to PCP – TAC 0.1% cream + bactrim

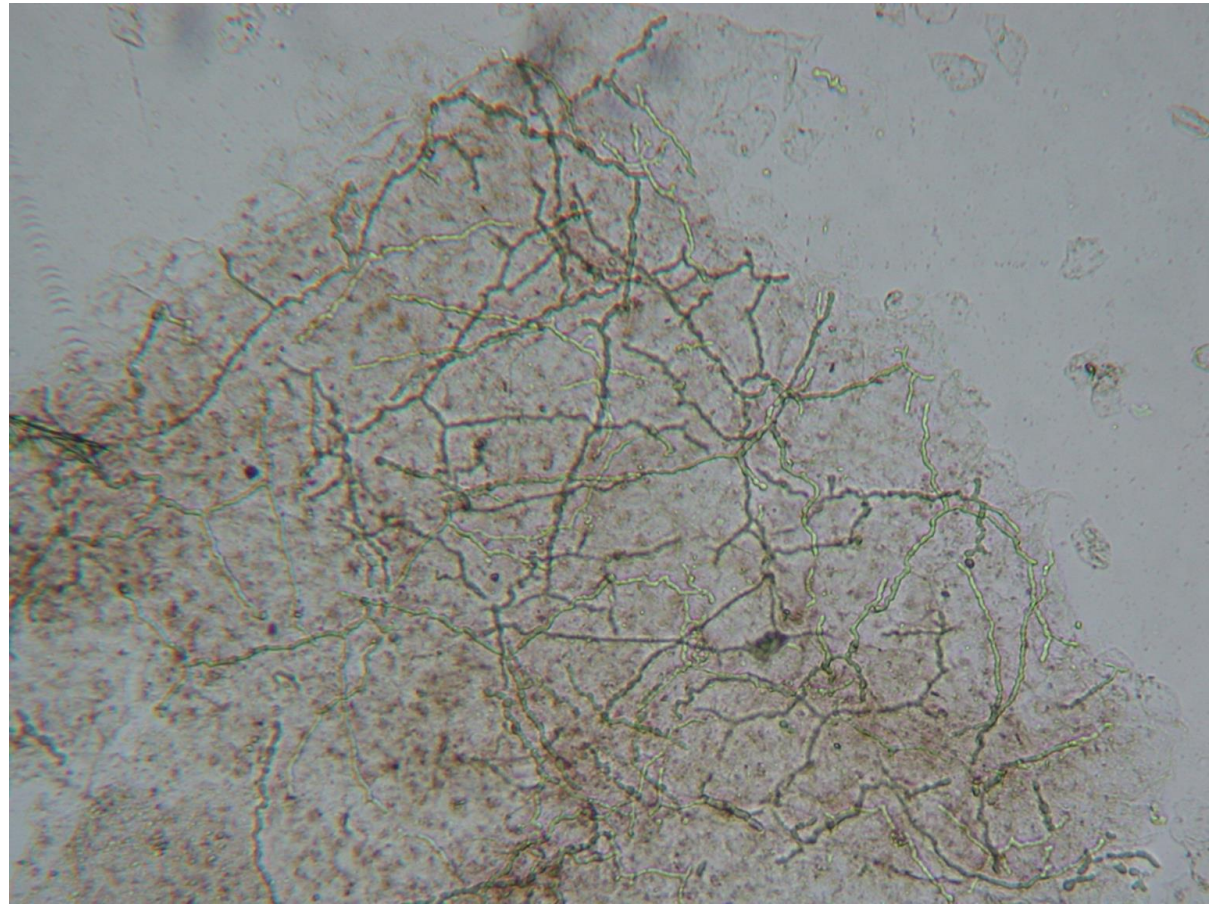
Initially improved/ then recurred

Sent to Derm

KOH Prep

Diagnostic to
differentiate tinea
v dermatitis.

If not interested in
doing prep, can
put scale
between 2 slides
and send out to
micro



Tinea Corporis

- Tinea = Dermatophyte Infection
 - T. Rubrum, M Canis, T Mentag are common causes
 - Txt:
 - *OTC Clotrimazole 1% Cream (Amazon 5x30g \$6!)
 - OTC Terbinafine (Amazon Lamisil AT– \$12/30 g tube)
 - *Rx Ciclopirox cream 0.77 % (\$25/15g tube, \$136/90g)
 - GOODRX is very useful for topical medication, common carve-out in insurance policies.

Tinea - same management, different sites



Masquerader of Dermatitis

Chronic itch and rash on the hand, axilla and groin in 18 yo F with no hx of dermatitis





Treatment of Scabies

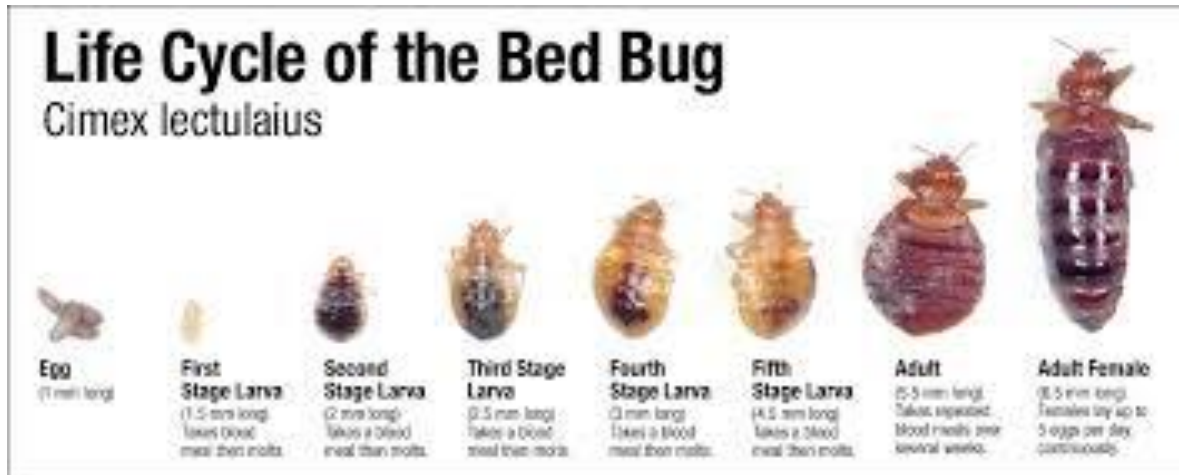
- Be wary of new itch, especially without hx of eczema, especially with any hx of travel
- Permethrin 5% neck down x 2 treatment, 1 week apart.
- Treat all members of household
- Itch can take 4-6 weeks to manifest after exposure.

Masquerader of Dermatitis

22 yo F just returning from Paris, has new rash, concerned for scabies



Bedbugs



Bedbug Treatment

- Bedbugs do not solely reside in mattresses, can live in walls, furniture, adjacent apartment
- Cannot throw out mattress and wash clothes and be done.
- Profession exterminator is required, usually treated with permethrins, although resistance is increasing
- Newer techniques of using heat to treat larger areas

Case 3

- 60 yo M with h/o scaling in nasolabial fold, dandruff. Given Ketoconazole cream and shampoo by PCP. Mild relief but still very bothered by redness and pruritus. He presents for further treatment.

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Seborrheic Dermatitis

- Common (3% prevalence), ?Hypersensitivity to malassezia yeast.
- Ketoconazole shampoo or cream sometimes works as monotherapy. (?Anti-inflam vs Anti-fungal)
- When fails, advance to Hydrocortisone 2.5% cream (\$12/30 g) for facial involvement (RCT 88% clear vs 42% vehicle) and Fluocinonide sol'n (\$100/60 mL) for scalp.
- Consider Salicylic Acid Shampoo (e.g. T/Sal) shampoo for scale
- Tar products work (e.g. T/Gel) but patients often find unpalatable

Case 1

- 35 yo M bothered by stubborn scaling plaques on elbows/knees/gluteal cleft.
- Mildly pruritic.
- Tried aquaphor/vaseline/gold bond lotion all without much change

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<http://dermis.net>

Don't forget areas to look



Topicals for Plaque Ps

- Class I steroids (eg betamethasone dipropionate augmented or clobetasol)
 - Ointment works best but will get clothes and bedding greasy
 - Cream is a good compromise
 - Lotion/Gel less occlusive, less effective
- Scalp
 - Clobetasol sol'n (\$50/50 mL) or foam (\$300/100 g).
- Intermittent use (Up to 2 wks per month) caution with folds, head/neck, groin, areas at high risk for atrophy.

Psoriasis or Psoriatic Arthritis?

- 5-10% of patients with psoriasis have psoriatic arthritis.
- Distal arthritis, characterized by involvement of the DIP joints
- Asymmetric oligoarthritis
- Symmetric polyarthritis
- r/b/a of treatment changes markedly for PsA. Refer to rheumatology for dx/txt.

Inverse Psoriasis



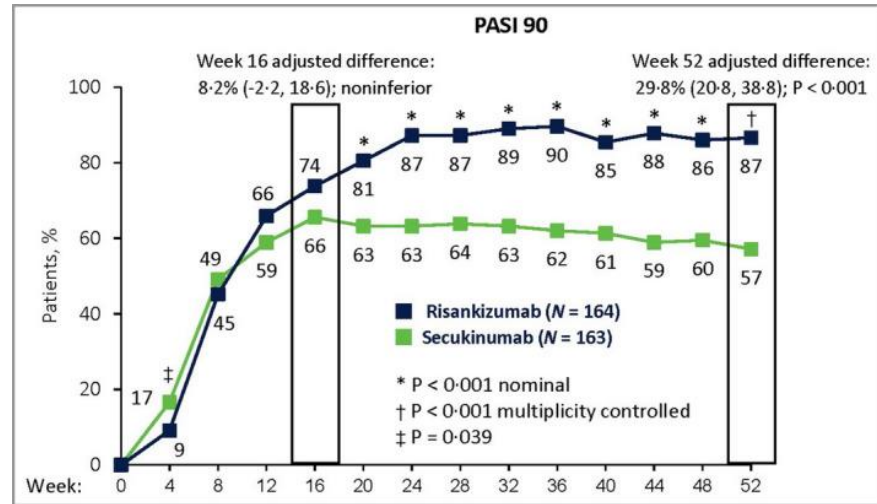
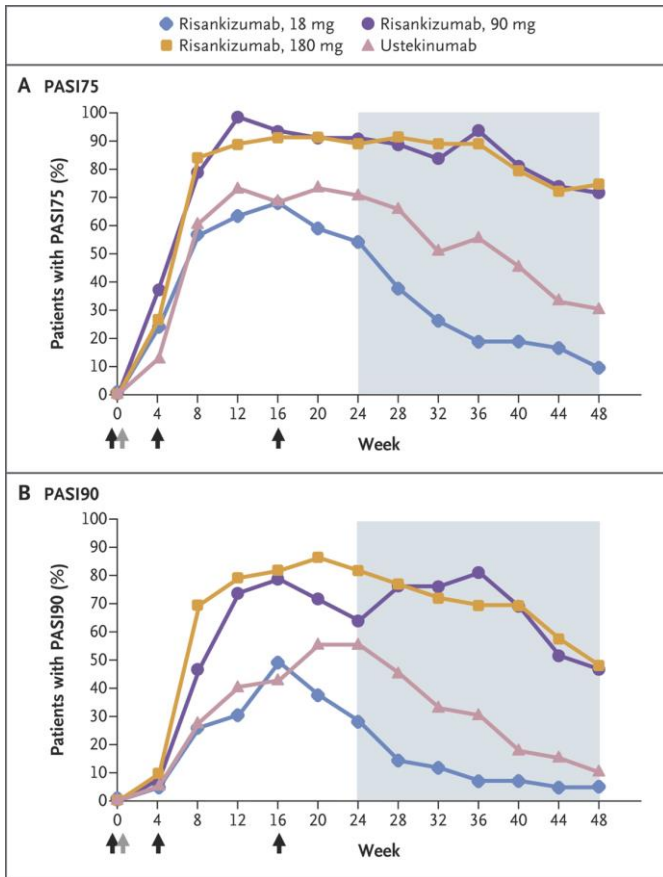
Inverse Psoriasis Treatment

- Can use brief pulses of topical steroids (triamcinolone 0.1% cr) usually mixed with clotrimazole as fungal ppx.
- Tacrolimus ointment is a good option as well

Biologics for Extensive Psoriasis

- Consider referral to dermatology
- Insurance used to be required to try/fail PO systemic agent like MTX, acitretin, Cs - this has changed.
- TNFs often still considered first line for PsA
- For plaque Ps, IL-17/IL-23 have shown superior efficacy to TNFs, and several studies have suggested newer agents are less immunosuppressive (eg complications due to TB reactivation compared to TNFs)

IL-17/IL 23 have impressive outcome data



Before starting a biologic...

- Serologies - be wary of immunosuppression worsening underlying infection: HIV, Hep B (can reactivate), Hep C, Spot TB – are vaccinations up to date.
- LFTs, renal fxn, CBC w/ diff
- Cancer history
- IBD Hx with IL 17