Pearls for Every Day Dermatology Problems

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Oakview DERMATOLOGY

Objectives

- Increase your knowledge of topical steroids and their uses.
- Improve your treatment of seborrheic dermatitis
- Gain some treatment pearls for treating warts and molluscum contagiosum
- Develop a standard treatment plan for patients with urticaria
- Learn what patients need to be seen by dermatology and when to consider a referral
- Gain some dermatology pearls for everyday problems

Topical Corticosteroids Review

- Potency: Classes I → VII.
  - Class I -- the MOST potent
  - Class VI -- the LEAST potent prescription
  - Class VII – LEAST potent of all – these are OTC
- The appropriate potency required for treating individual disease varies. Best results occur when the appropriate strength is used for the SITE and DISEASE.
  - Side effects can occur when the strength is too strong for the area/disease being treated

Del Rosso, J & Fallon, S. Corticosteroids: Options in the era of steroid-sparing therapy. *Journ of Amer. Acad. of Derm.* 2005. p S50-S58.

Steroid Potency

Example of LOCATION based decision:

Thicker skin can tolerate and needs stronger potency steroids

Palms/Soles → Super potent – Class I & II

Legs/Arms → Mid-potency – Class IV & V

Face/Neck/Intertriginous → Low-potency – Class VI or VII

Examples of DISEASE based decision:

Psoriasis – thick plaques → Super-potent—Class I & II

Genital Lichen Sclerosis → Super-potent – Class I & II

Atopic Dermatitis (non-face) → Mid-potency – Class IV & V

Topical Corticosteroids

- Concentration- varies among classes and doesn't always tell you a lot
  - Class is always the best indicator of strength
  - Example: Fluocinonide 0.1% and Betamethasone Diproprionate 0.05% are both Class II steroids
- Make sure you are prescribing what you want– some sound similar
  - Betamethasone Diproprionate (Class II) & Betamethasone Valerate (Class V)
  - Fluocinonide (Class II) & Fluocinolone (Class V)

Topical Corticosteroids

- Vehicle is important
  - Ointments: Sometimes the ointment is stronger than the cream – but not always – so check!
    - Example:
      - Cutivate Cream/Lotion - Class V
      - Cutivate Ointment – Class III
  - Ointments are good for mucous membrane areas and for people with a lot of allergies
    - Only the steroid and petrolatum
  - Creams are more elegant – but can sting/burn due to preservatives

Corticosteroid Vehicle Cont'd

- Gels: Great for hair bearing areas or for quick application
- Lotions: Best for large area application
- Foams: Hair bearing areas
- Solutions: Good for compounding and for scalp
  - Be aware – not all solutions are created equal

Topical Corticosteroids

- Tachyphylaxis- the decrease in the responsiveness to a drug with long term use
  - Does it exist for topical steroids?[1]
  - Design treatment plans that are easy to use
- Occlusion – Increases the steroid potency
  - Can be used for clinical benefit
    - Saran Wrap
  - Can also unexpectedly cause side effects
    - Skin on skin

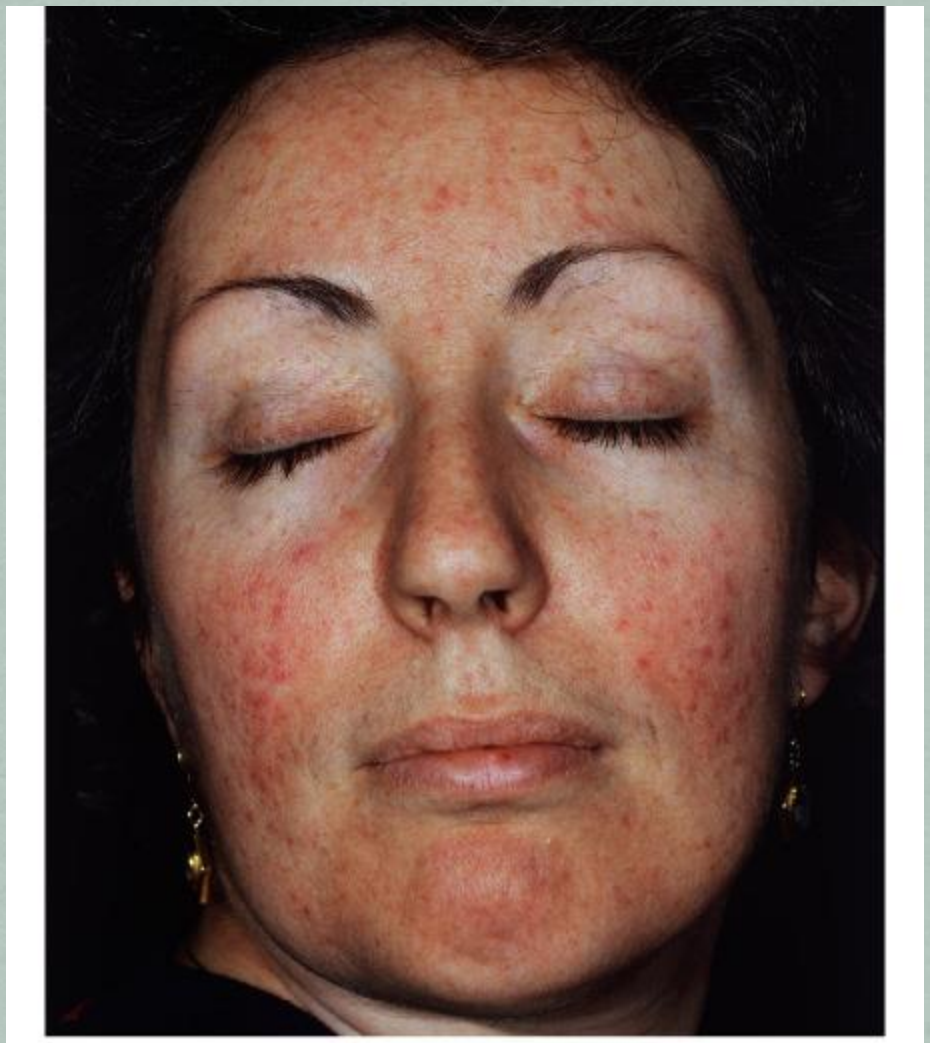
Miller JJ, Roling D, Margolis D, Guzzo C. Failure to demonstrate therapeutic tachyphylaxis to topically applied steroids in patients with psoriasis. J Am Acad Dermatol 1999;41:546-9.

Topical Corticosteroids

- What about systemic side effects from absorption of corticosteroids such as cataracts, growth retardation or Cushing's?
  - Can diabetics use topical steroids?
- But doc – the insert says I can only use the medicine for two weeks!! ---- Steroid Phobias
- What's with the tube size?

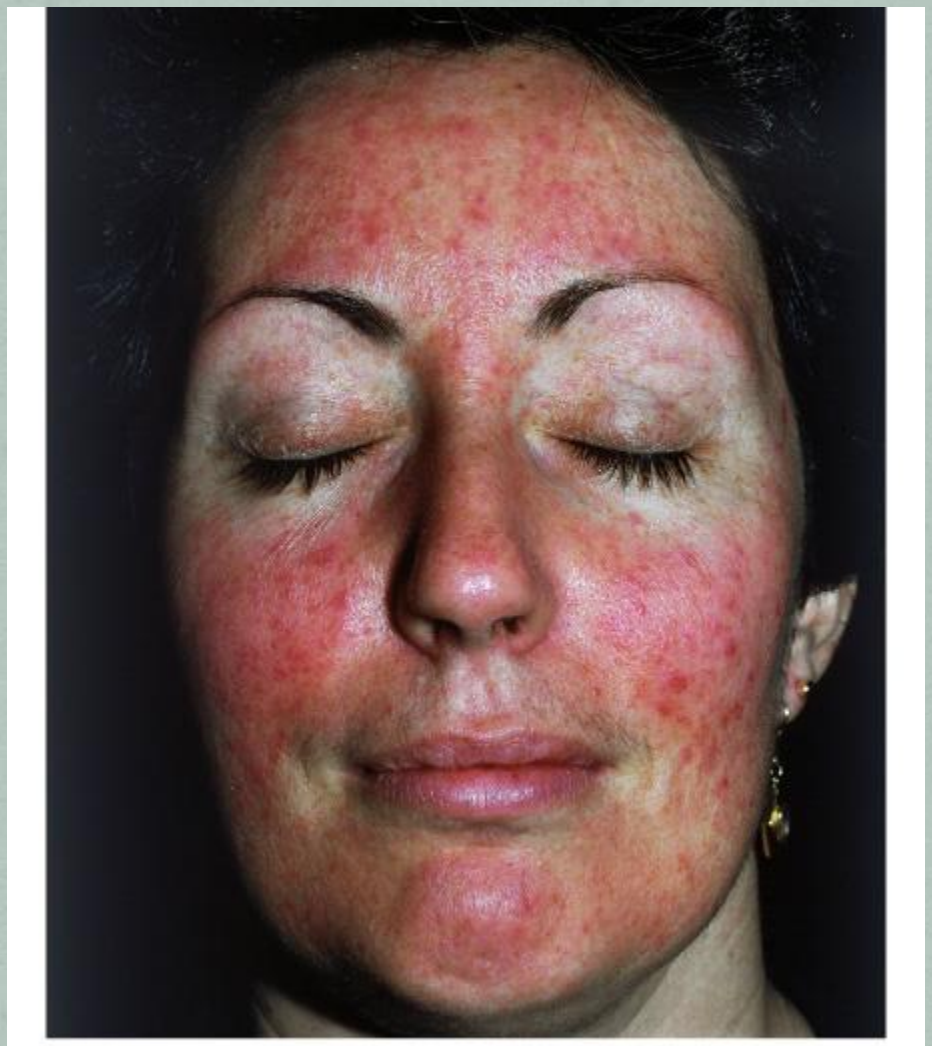
Charman CR, Morris AD, Williams HC. Topical corticosteroid phobia in patients with atopic eczema. Br J Dermatol 2000;142:931-6.

Adverse Reactions



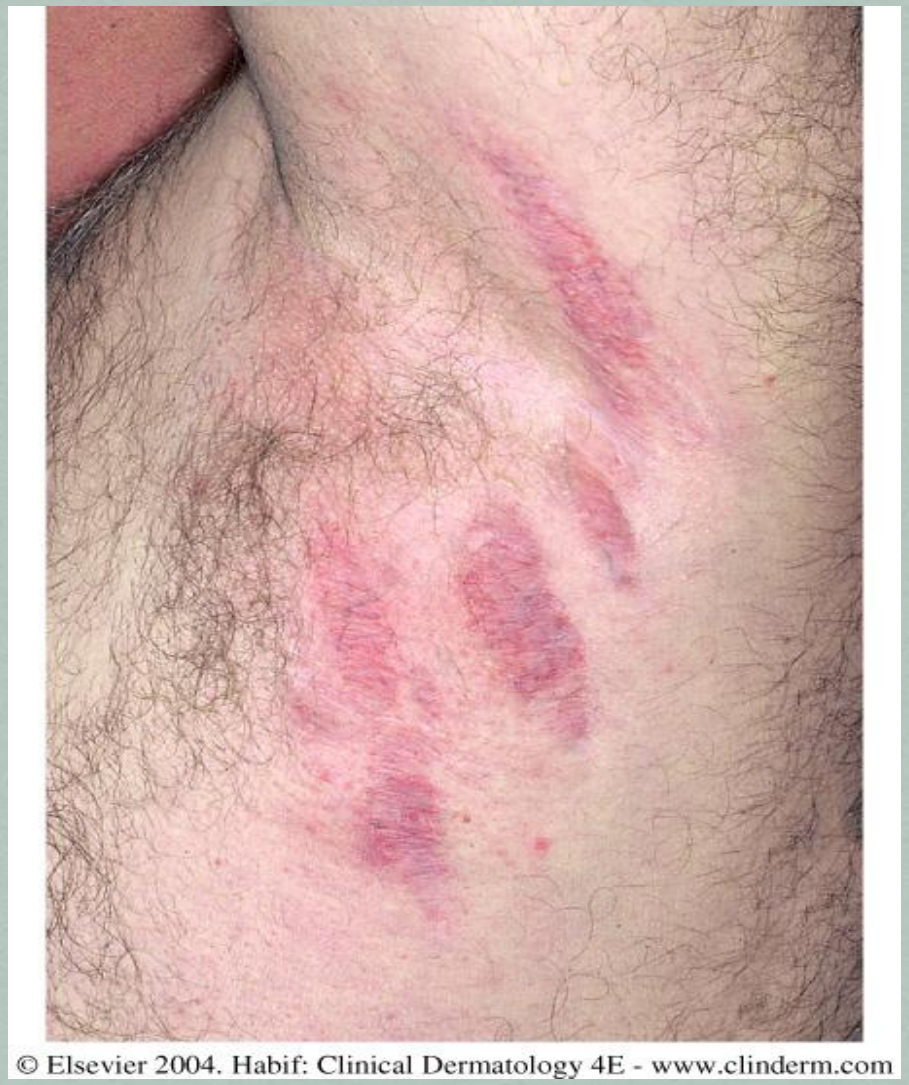
- Use can contribute to rosacea, perioral dermatitis, acne, and folliculitis

Adverse Reactions

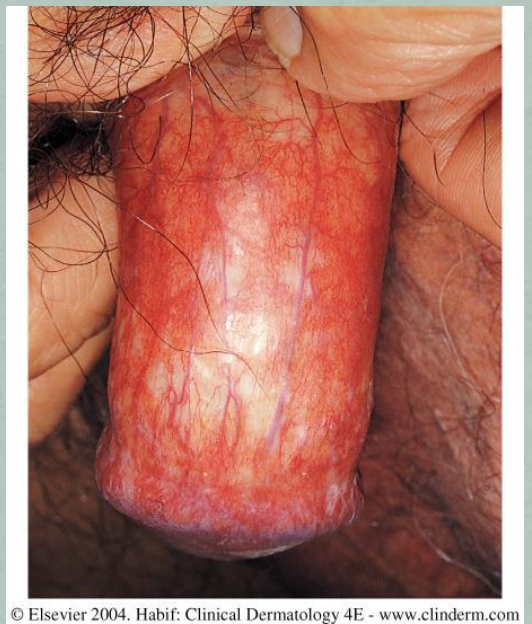


- Rebound phenomenon
  - Worsening of the existing condition after termination of topical corticosteroids
  - Mostly when inappropriately treating with steroids

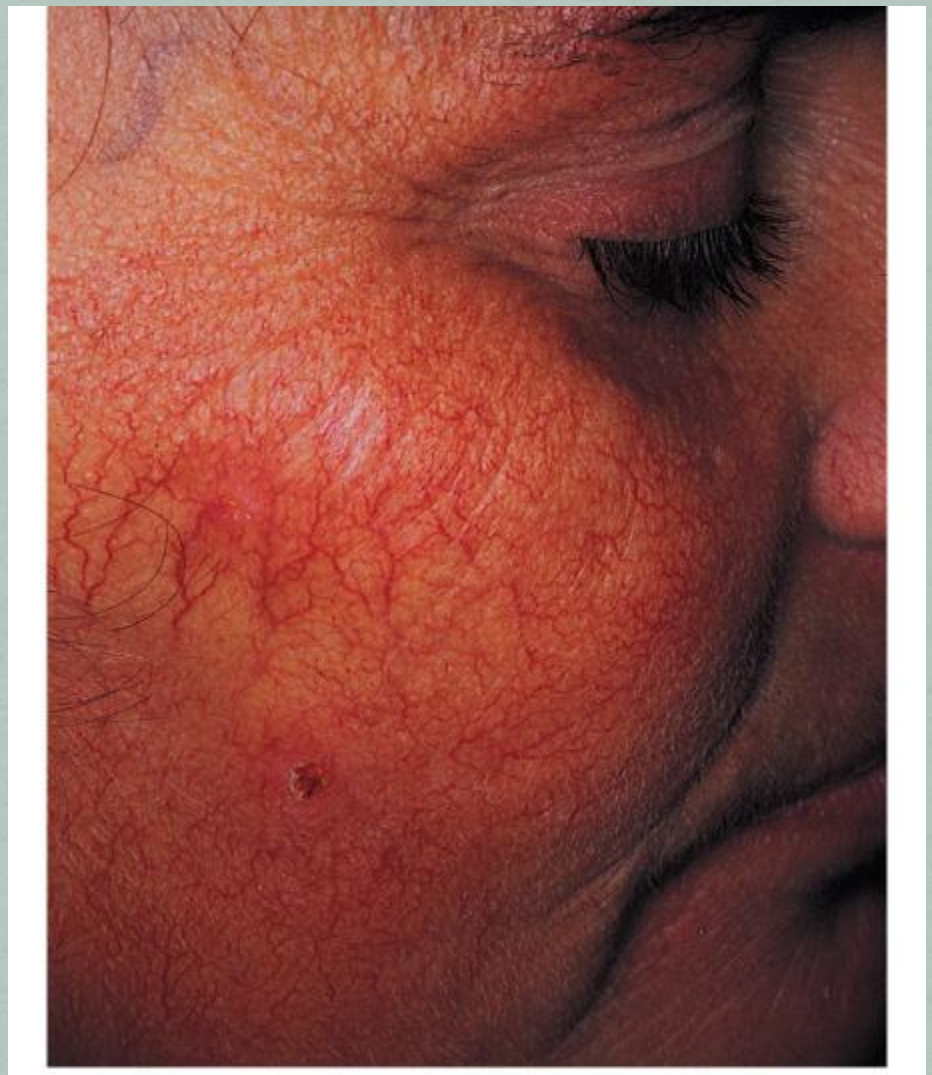
Adverse Reactions



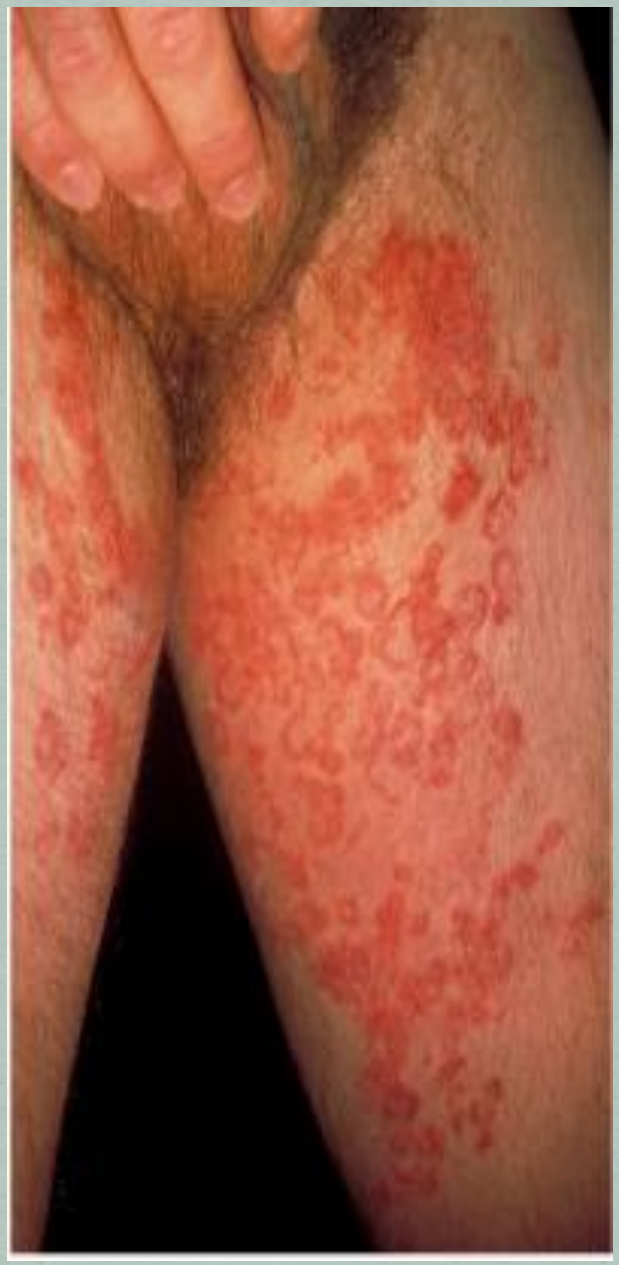
- Skin Atrophy
  - Telangiectasia, striae and even open sores



Adverse Reactions



- Atrophy: thinning of the epidermis and regression of dermal connective tissue
  - Long term constant use
  - Too strong a steroid for the area
  - Occlusion effects
  - Inappropriate use
  - Reversible in most cases



Adverse Reactions

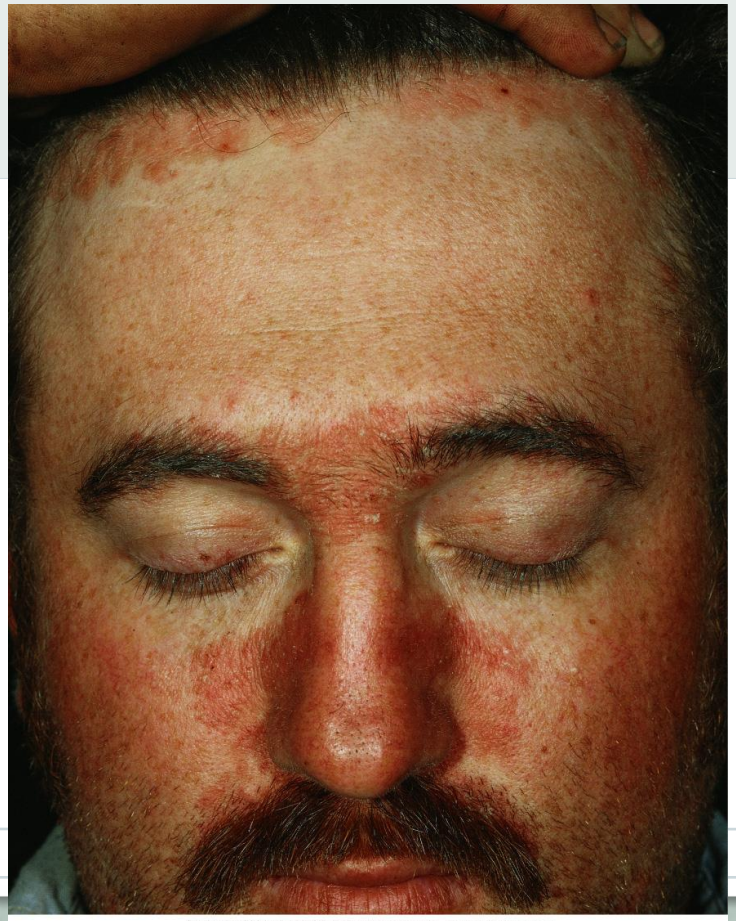
- Alteration of typical cutaneous infections
  - Tinea incognito
  - Scabies/impetigo incognito

Elsevier 2004 Habif: Clinical Dermatology 4E – www.cliniderm.com

Topical Corticosteroids

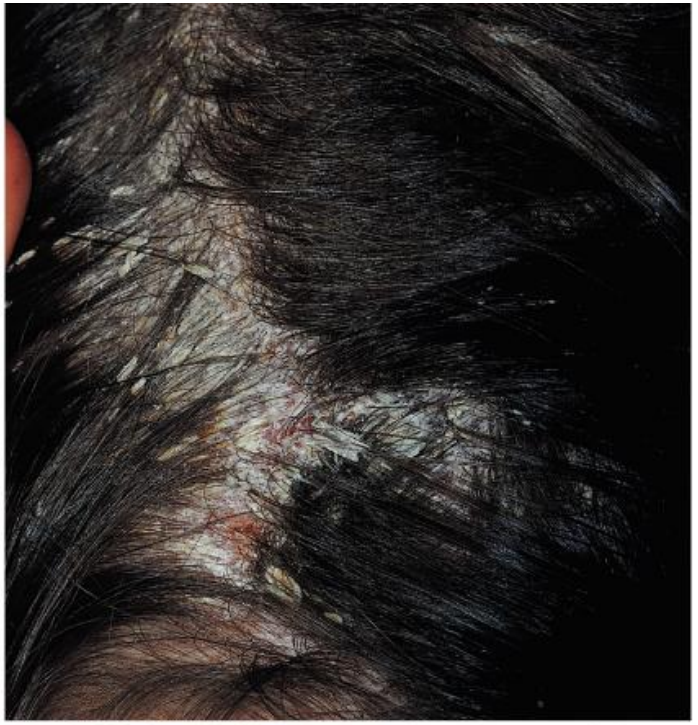
- Steroid allergy??
  - A small percentage of patients may actually be allergic to topical corticosteroids
    - There are several groups based upon allergy classification
    - Patients may be allergic to a component of the base or to the medication itself
    - Patch testing to determine sensitivity

Seborrheic Dermatitis



Seborrheic Dermatitis

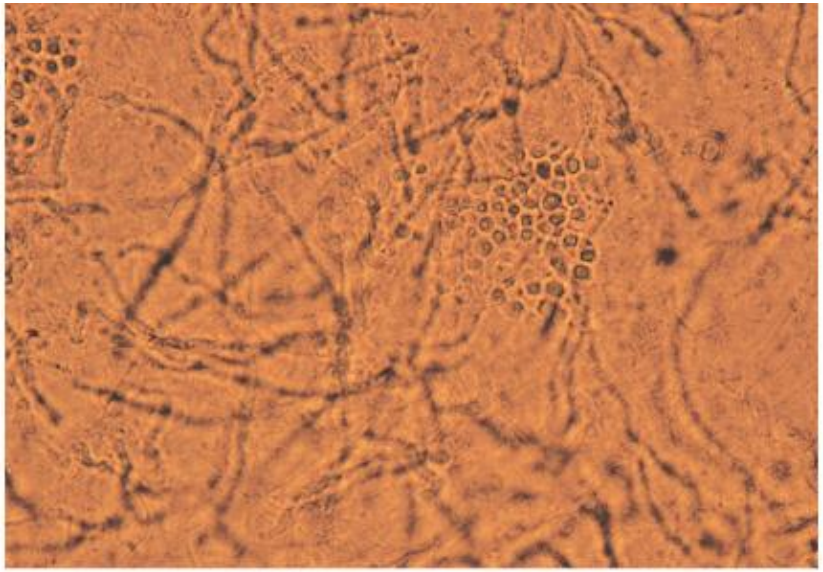
- Chronic relapsing skin condition
- Prevalence
  - 11.6% Overall – Dandruff
  - 2.8% - Severe
- No clear genetic predisposition
- Etiology: fungi of the genus malassezia (formerly called Pitirosporum ovale



Naldi L, Rebora A *Clinical practice. Seborrheic dermatitis.*:, The New England Journal Of Medicine, 1533-4406, 2009 Jan 22, Vol. 360, Issue 4

Malassezia

- Normal human flora
- Lipid-dependent – explains disease distribution
- *Malassezia globosa* and *Malassezia restricta* predominate
- Patients with Seb derm are thought to have higher *Malassezia* counts than healthy controls
- Fungal count diminishes as the disease improves

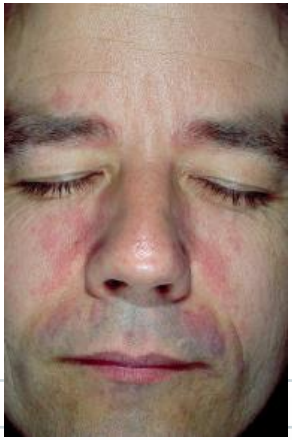


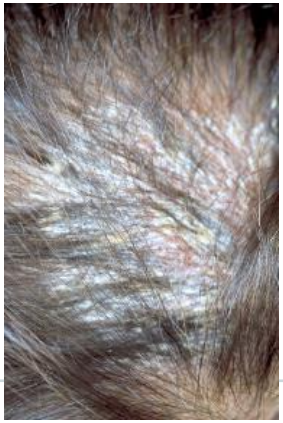
Elewski, Boni. Safe and Effective Treatment of Seborrheic Dermatitis. *Cutis,* 333-338, 2009 June, Vol 83.

Seborrheic Dermatitis - Clinical

- Scaling and poorly defined erythematous patches
- Large variations in extent of disease and morphology

Mild → Severe





Seborrheic Dermatitis Treatment Considerations

- There is no cure
- Need to set appropriate patient expectations
- Need to choose therapy based on location and patient preference
  - Many vehicles: Shampoo/foam/liquids/lotions/creams
  - Cost: OTC vs Rx
  - Ease of use

Seborrheic Dermatitis Treatment Options

- Topical antifungal agents
- Oral antifungals
- Topical corticosteroids
- OTC Shampoos
  - Keratolytics
  - Those with antifungal activity

Antifungals

- **Should be considered primary therapy**
- Ketoconazole, sertaconazole, miconazole, fluconazole
  - All species of *Malassezia* are susceptible to the azoles
- Oral antifungal therapy
  - Data on efficacy is limited
  - Long-term therapy is a dilemma

Naldi L, Rebora A *Clinical practice. Seborrheic dermatitis.*:, The New England Journal Of Medicine, 1533-4406, 2009 Jan 22, Vol. 360, Issue 4

Antifungals

* Ketoconzole
  - Available as a cream/shampoo/gel/foam
  - The "work-horse" of seb derm
  - Anti-inflammatory, anti-seborrheic effect, anti-fungal[1]
- Cyclopirox (Loprox)
  - Available as a gel/cream/shampoo
  - Broad-spectrum antifungal with anti-inflammatory effect[2]

1. Borgers, M. & Degreef, H. The role of ketoconazole in seborrheic dermatitis. *Cutis*. 359-363. 2007 October. Vol 80.
2. Elewski, Boni. Safe and Effective Treatment of Seborrheic Dermatitis. *Cutis,* 333-338, 2009 June, Vol 83.

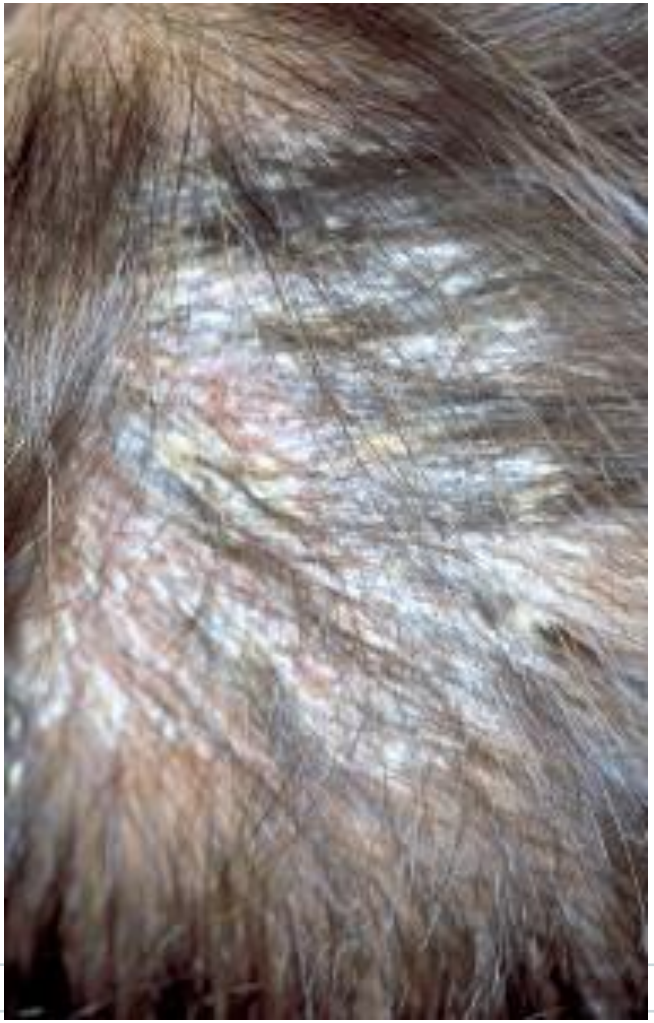
Topical Corticosteroids

- May be useful as adjunctive therapy
  - Often can control itching quickly
- Should NOT be mono-therapy
  - When used alone, there is quick reoccurrence once therapy is stopped
- Should use the lowest potency that is effective
- Consider location/vehicle

Elewski, Boni. Safe and Effective Treatment of Seborrheic Dermatitis. *Cutis,* 333-338, 2009 June, Vol 83.

OTC Shampoos

- Keratolytics
  - Neutrogena T Gel ® and T Sal, P&S ®, Denorex®
- Those with antifungal activity
  - Pyrithione zinc shampoos (Head & Shoulders ®)
  - Selenium sulfide shampoos (Selsun Blue ®, Extra Strength Head & Shoulders ®)



Treatment Pearls

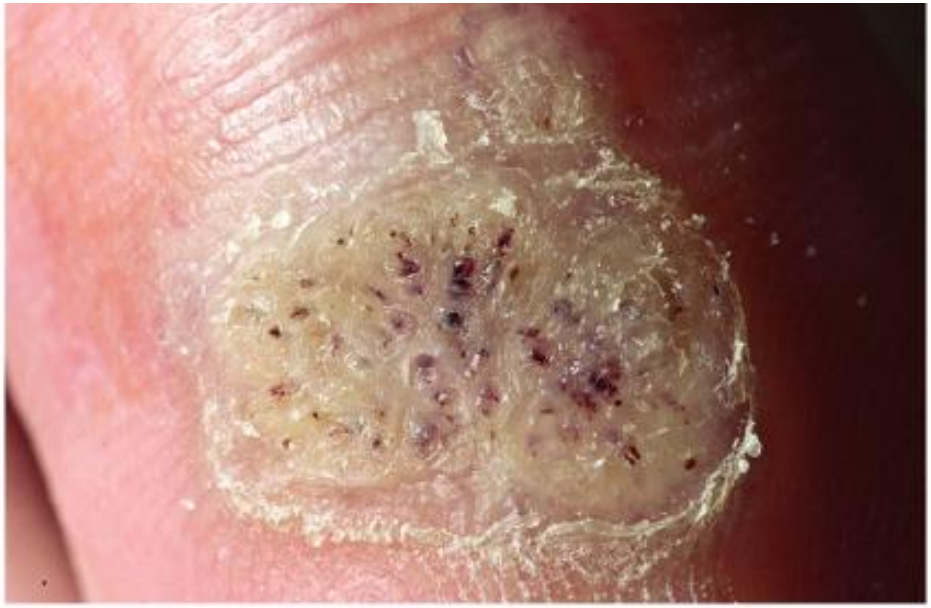
- Shampoos – must leave them on for 2-3 minutes for good effect

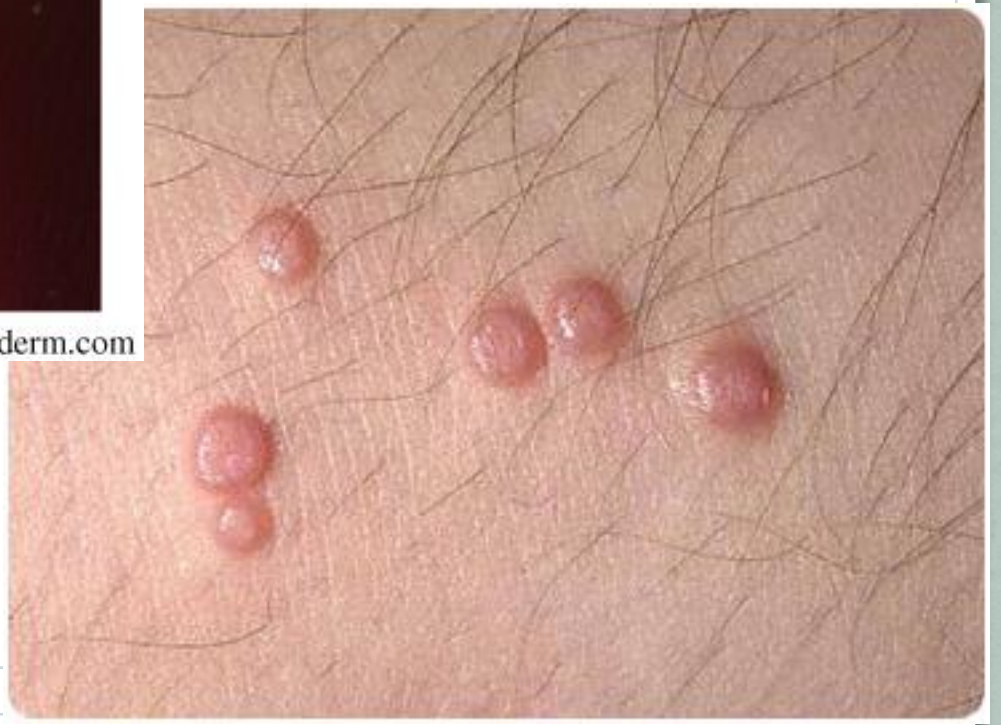
* Tar shampoos can discolor light/gray colored hair

- Women – watch for the wet ponytail or going to bed with wet hair

- Get rid of the scale – then address the inflammation (DermaSmooth Scalp Oil)

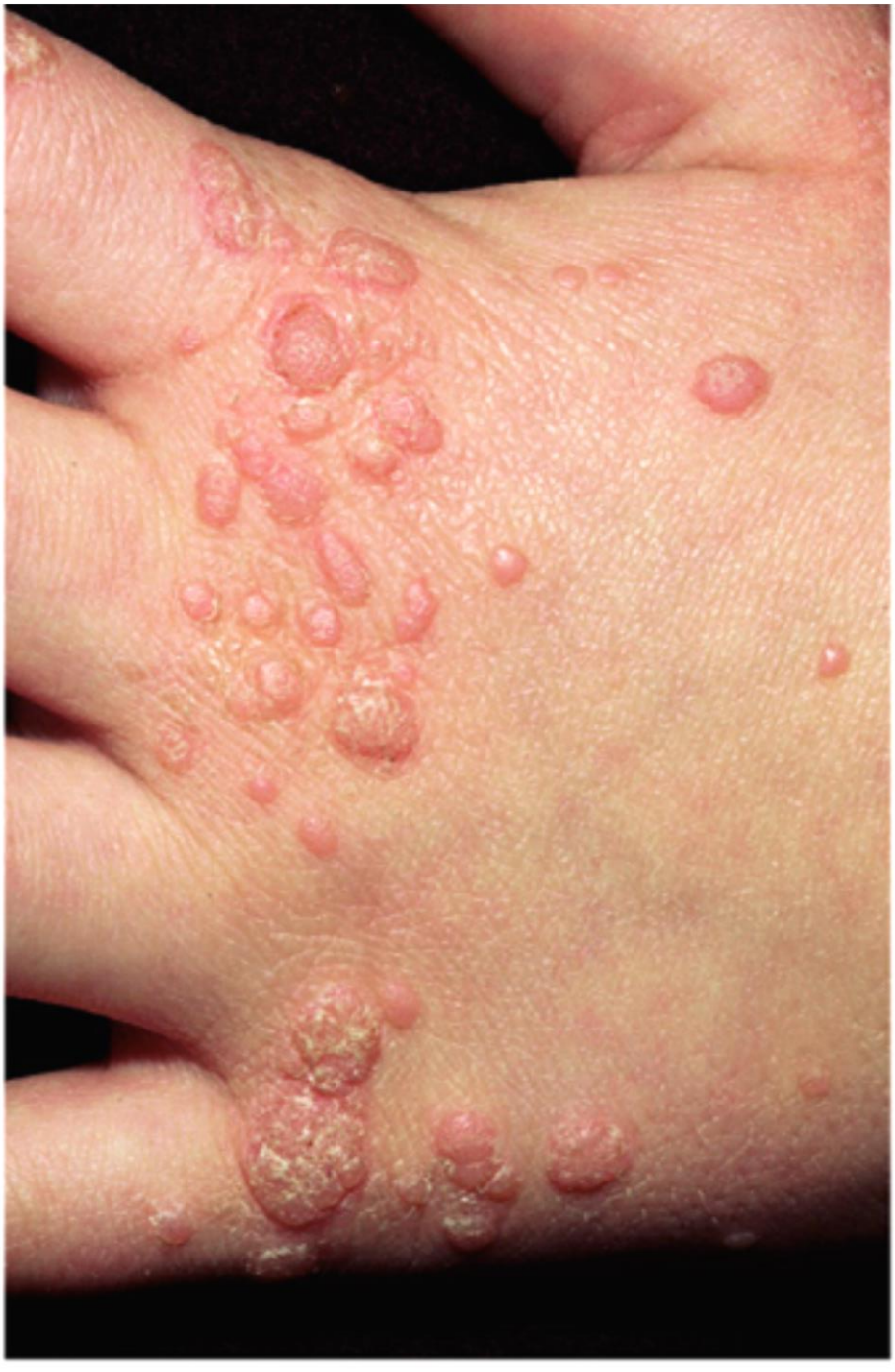
Warts and Molloscum





Warts

- 10% of children will be affected
- Peak incidence is between 9 and 16 years of age
- Most common sites are the hands and palms
  - Can occur anywhere
- Often develop at the sites of minor trauma
  - Nail biters!
- Can have significant psychosocial effects



er 2004. Habif: Clinical Dermatology 4E - www.clind

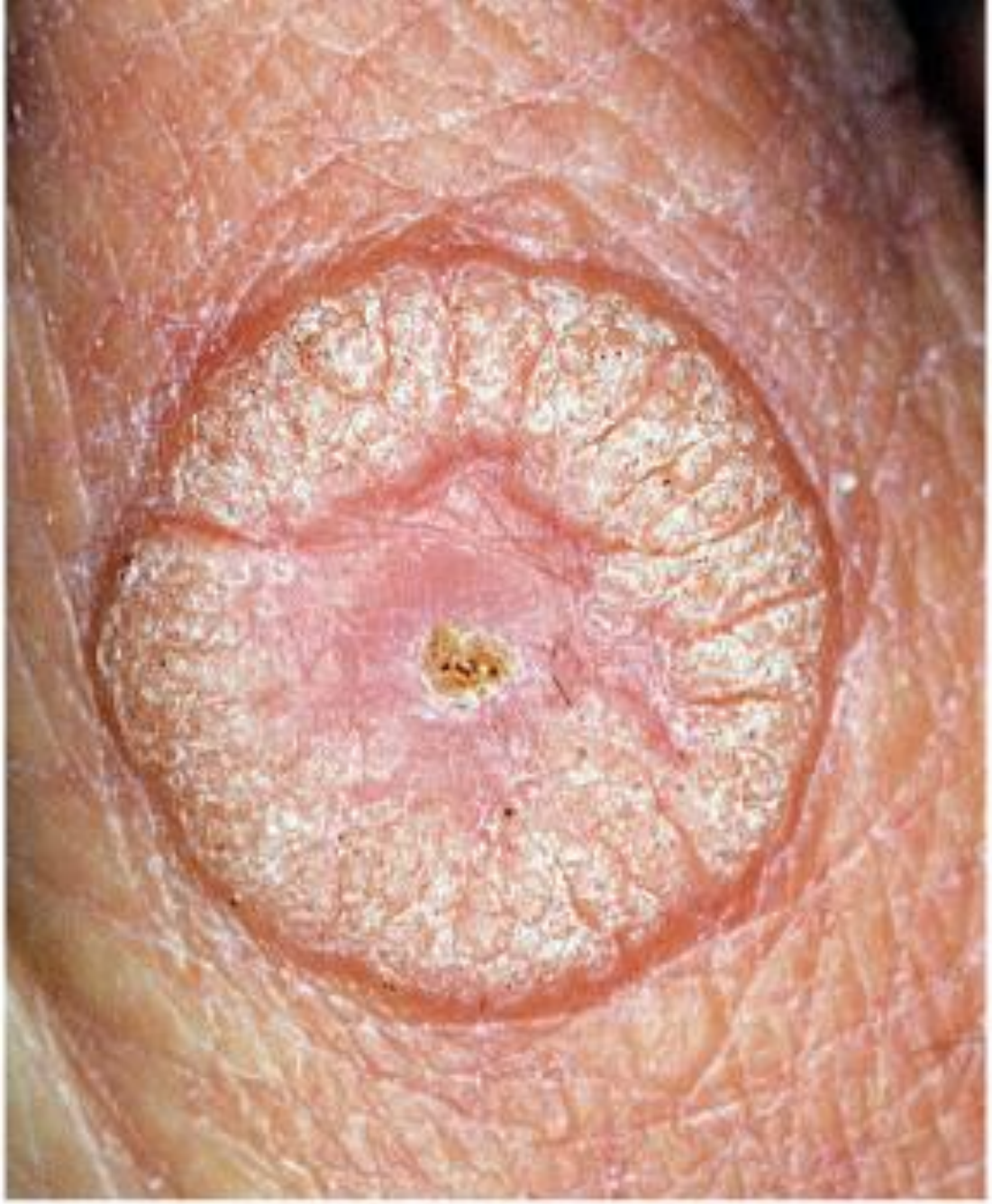
Warts

- Diagnosis – usually is clinical
  - Lack of skin lines
  - Pairing reveals pinpoint bleeding
  - Don't confuse with a clavus (corn)
- Warts can present for up to 18 months after inoculation
- Multiple variants (flat/plantar/filliform/genital/common)

Warts - Treatment

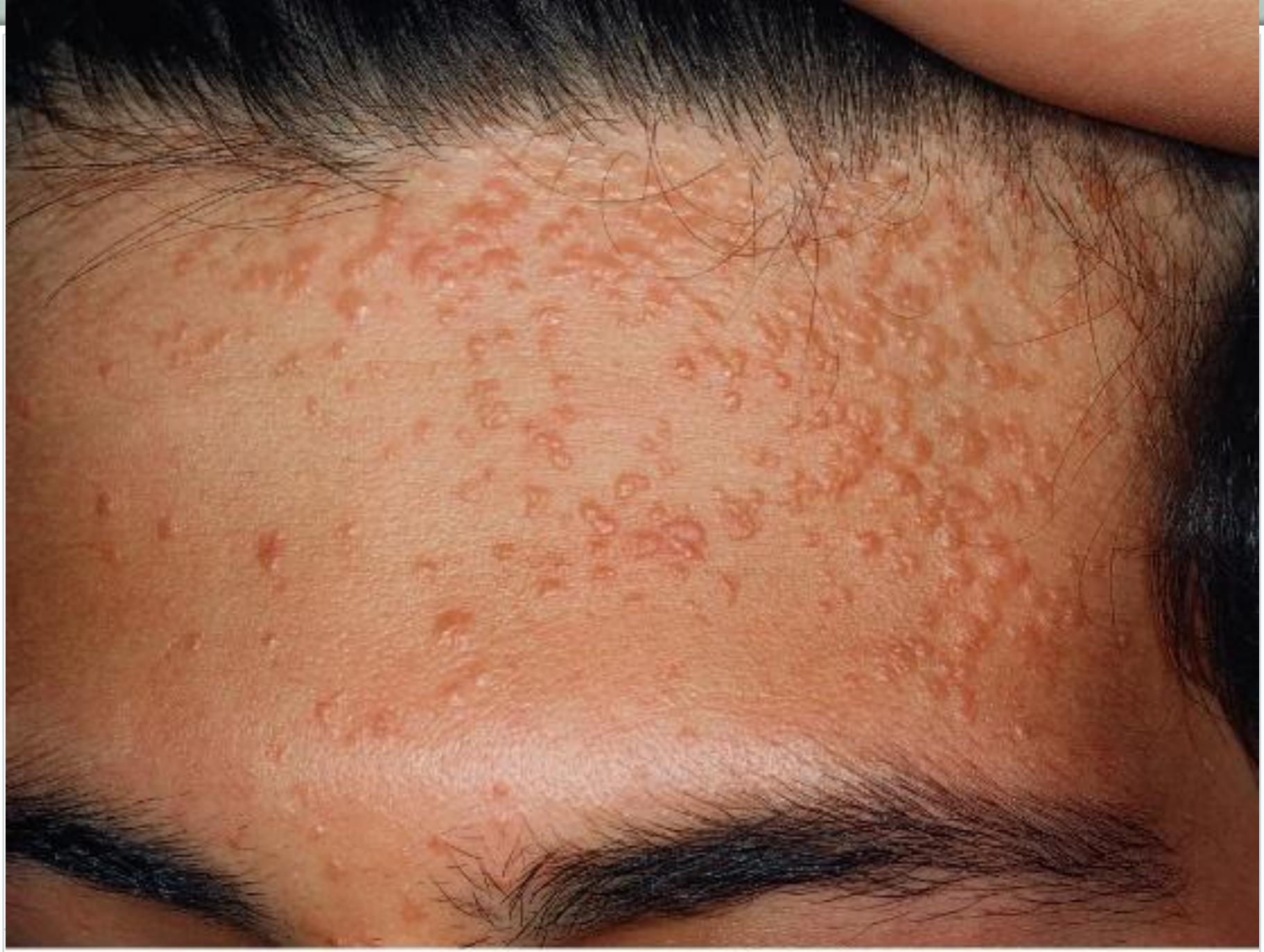
- Warts will drive you crazy!!!!
- Set appropriate expectations – it will help everyone to cope
  - Average number of treatments prior to clearance = 6
- Consider the patient's age/activities/ability for follow-through
- Is not treating an option??
  - 2/3 of warts will regress spontaneously over 2 years
  - What happens to the other 1/3????

Bellew, SG, et al. Childhood Warts: An Update. *Cutis*. 2004:73.379-384.



Wart Treatment

- Regardless of therapy choice, use frequent appointments spaced apart by no more than 3 weeks
  - Frequent low grade irritation is the most effective
- Options:
  - Liquid Nitrogen -- Cantherone
  - Salicylic acid -- Bleomycin IL
  - Imiquimod -- Topical retinoids
  - ED&C -- Laser
  - Contact sensitizing agents (DNCB, squaric acid)

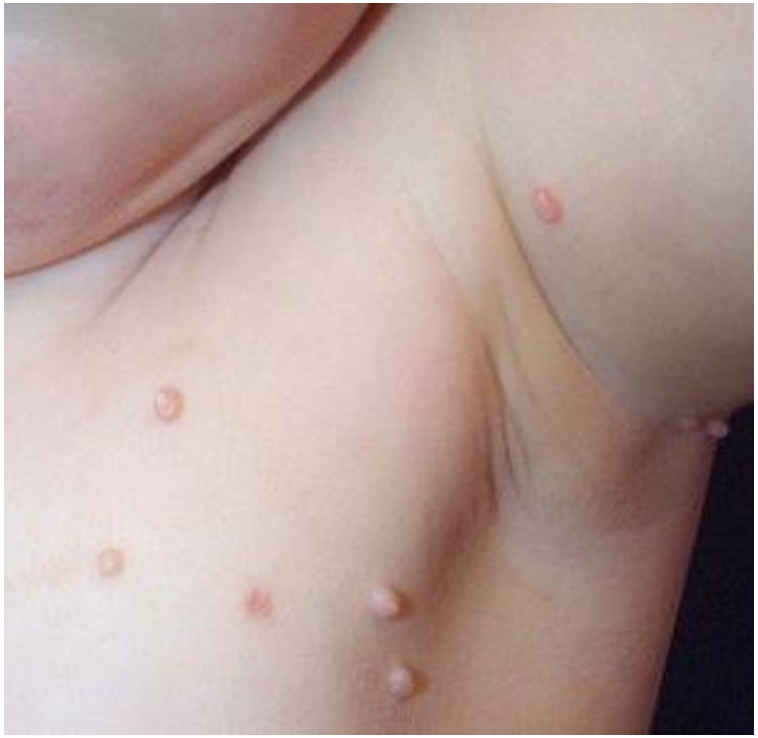


Wart Treatment Pearls

- With liquid nitrogen – pare down any hyperkeratotic lesions before treating
  - Keep the freeze ball to 1-2mm
- Only use imiquimod for "moist" warts
- Consider cimetide as adjunctive therapy in recalcitrant warts in children
  - Dosed at 25-40mg/kg daily
  - One study showed 80% cure rate at 8 weeks[1]
  - Other studies have shown no benefit
- Keep low level irritation going if at all possible
  - Duct tape, OTC salicylic acids, filing

Orlow SJ & Paller A. Cimetidine therapy for multiple viral warts in children. *J Am Acad Dermatol.* 193;28:794-796.

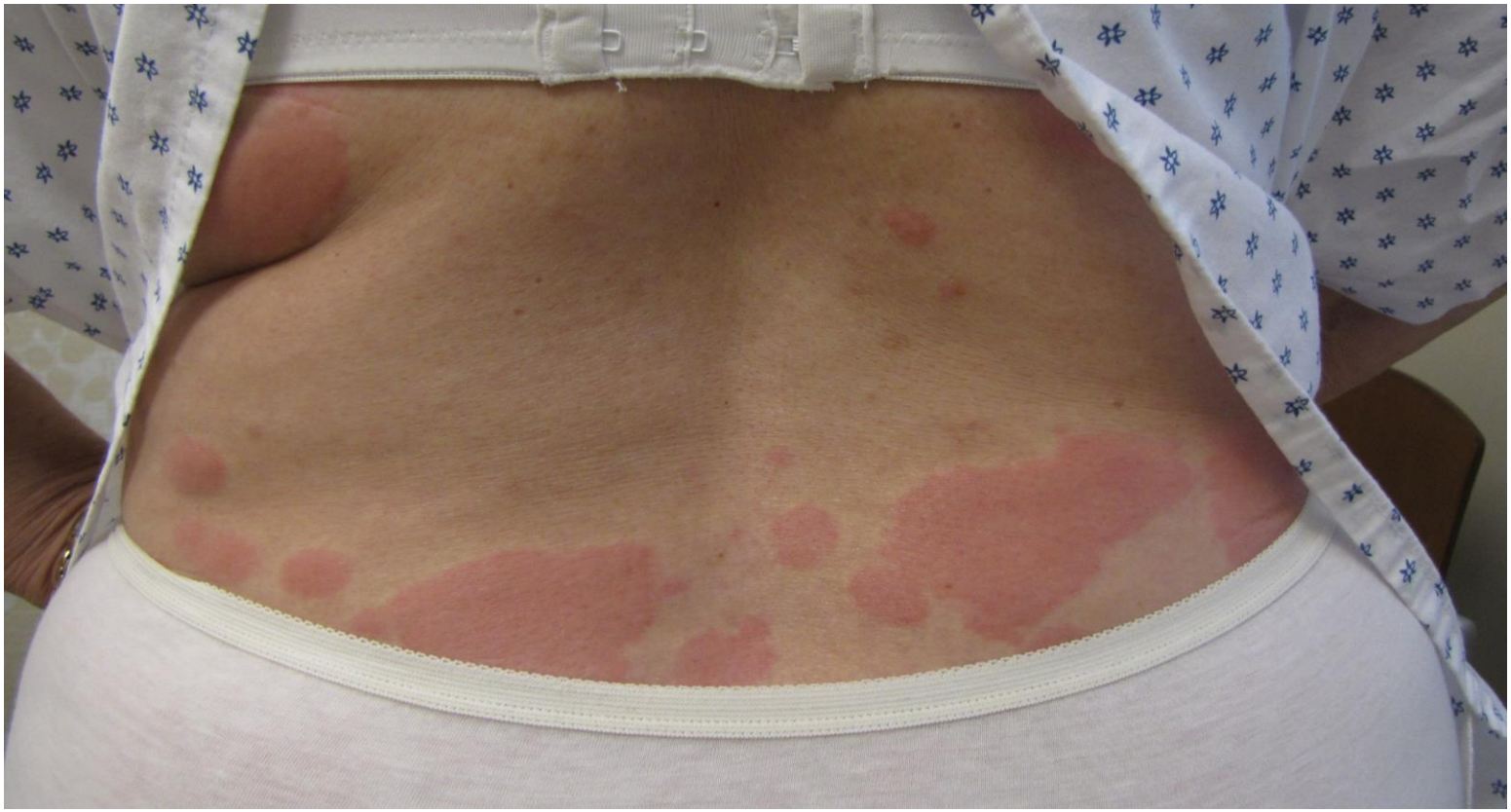
Molluscom

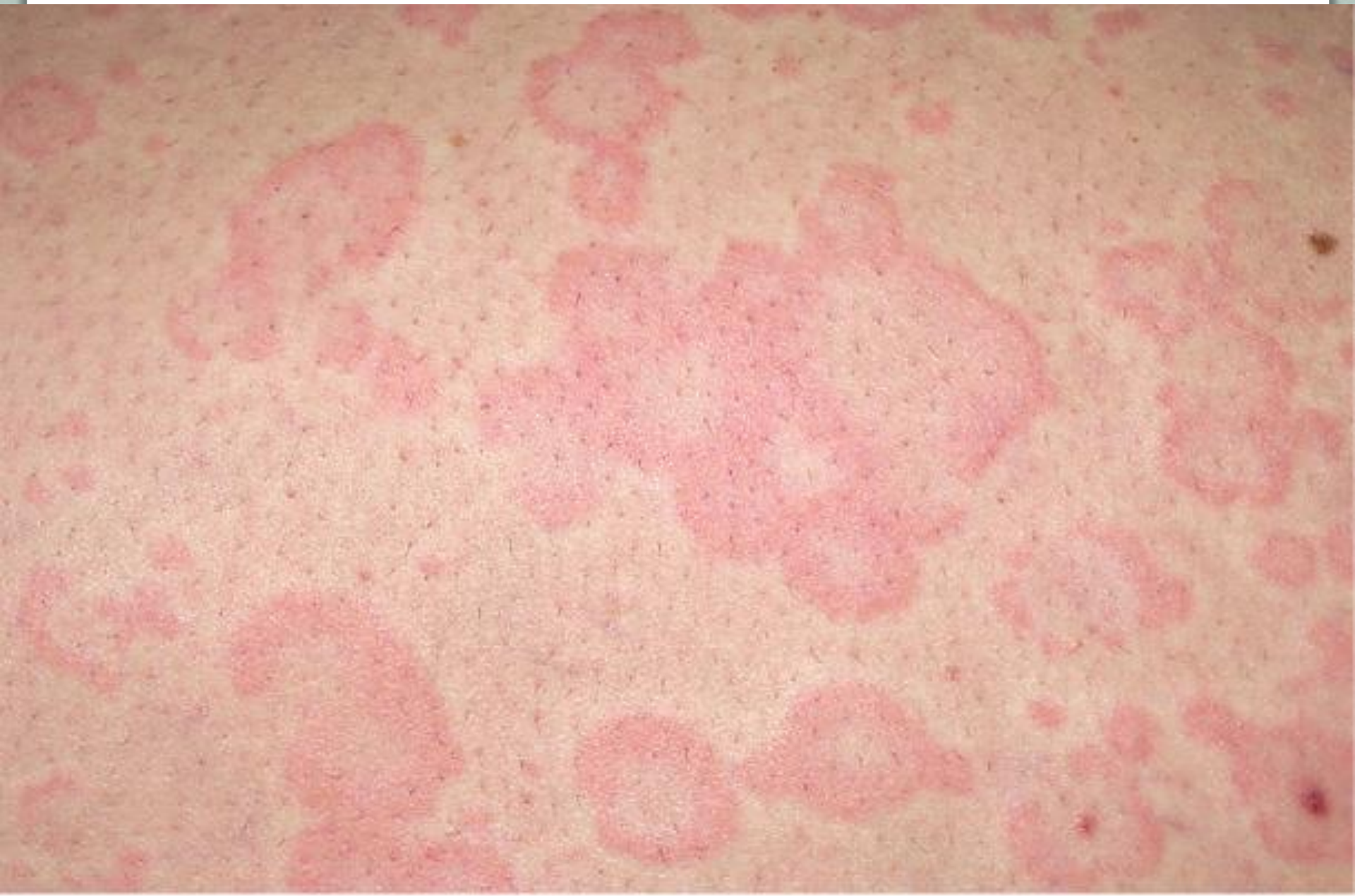


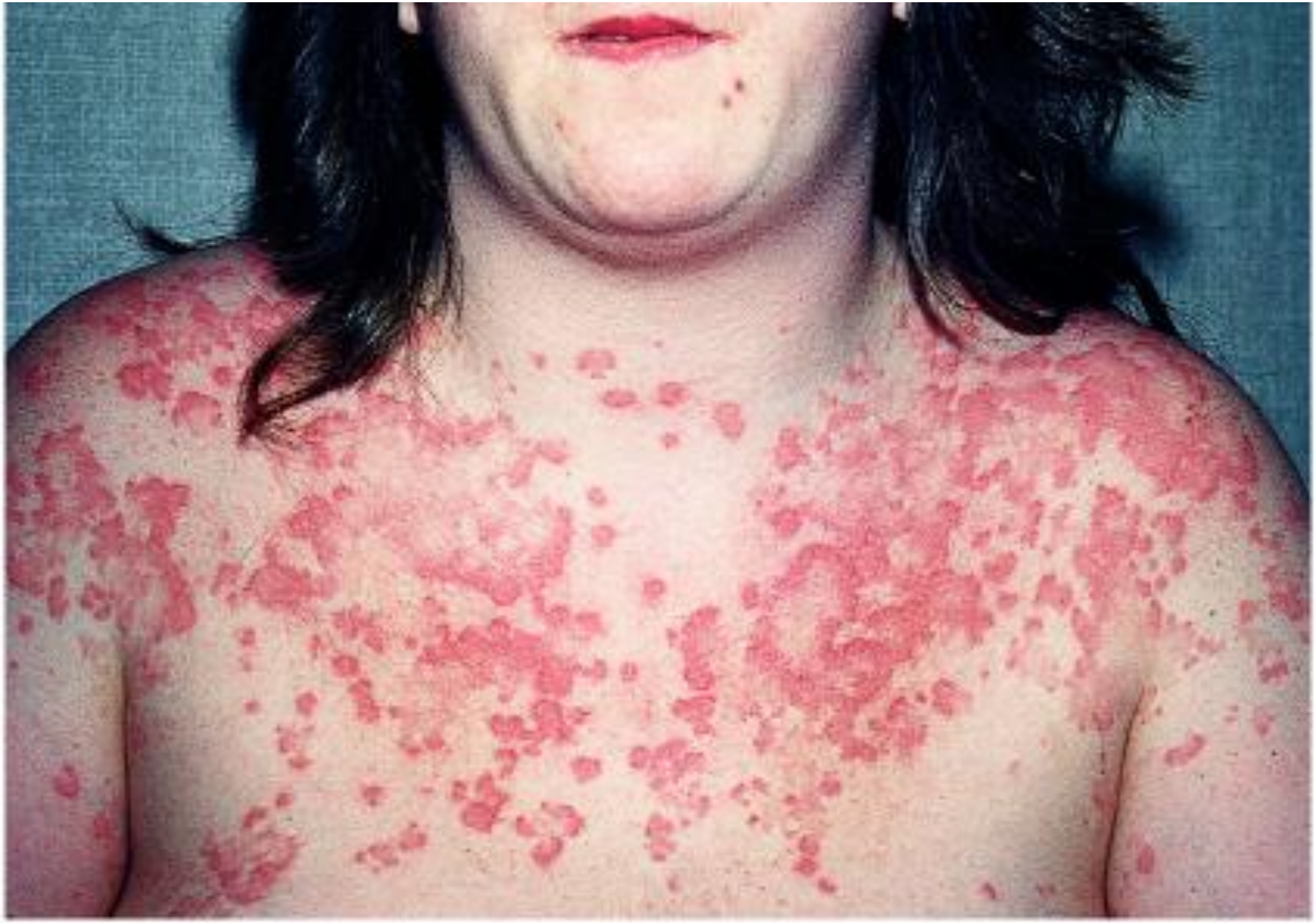
Most common in early school age children

Can itch! Kids scratch and spread the virus.

Urticaria (aka: Hives)





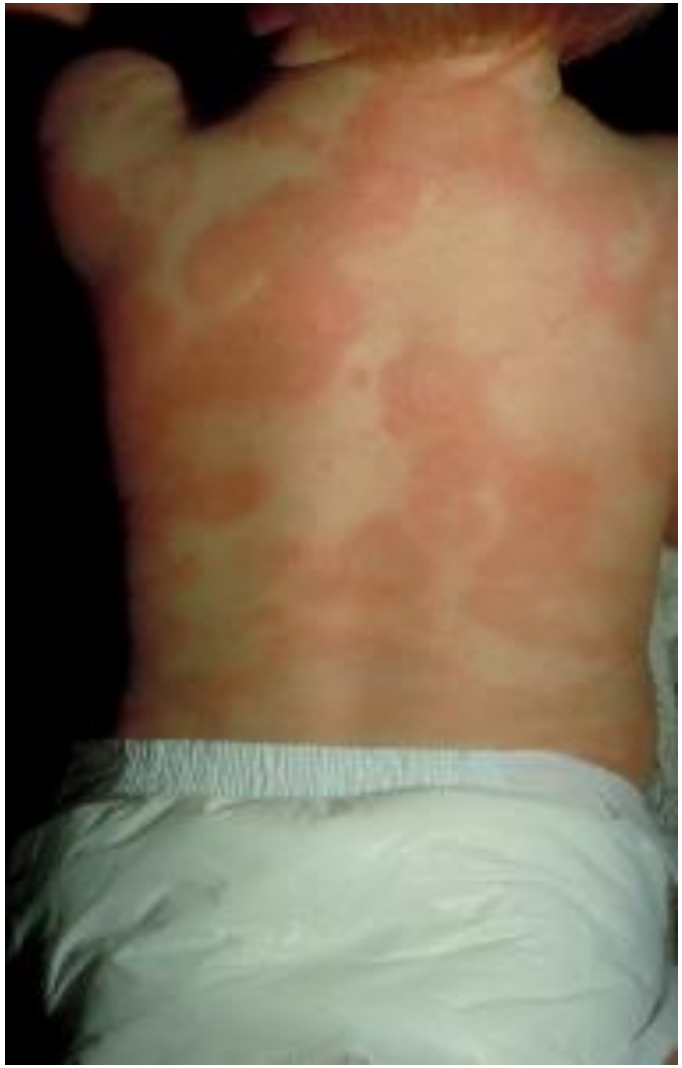


Urticaria

- Acute = less than 6 weeks
- Chronic = more than 6 weeks – hives at least twice weekly
- 50% of chronic urticaria cases resolve spontaneously within 6 months
  - Of those that don't, 40% will have urticaria 10 years later
- Vast majority of chronic urticaria cases will be idiopathic (50%), and a smaller subset will be chronic autoimmune related

Guldbakkek, KK & Khachemoune A. Etiology, Classification, and Treatment of Urticaria. *Cutis*. 2007:79.41-49.

- Urticaria affects 10-25% of the population at some point in their lives
- Acute urticaria is more likely to have an underlying etiology
  - Food or drug allergy most common
  - Need to R/O CTD, malignancies, infection
  - Allow ROS to guide the choice of testing
- Chronic Urticaria – is often found to be idiopathic
  - Followed by autoimmune, dietary, additives



H E Clive, et al. Chronic Urticaria. Journ of *Amer Acad Derm*. 2002: Vol 46 Numb 5 p645-657.

Urticaria – Treatment Pearls

- Oral steroids have more risk than benefit – and any benefit is very short lived
  - Work to achieve complete histamine blockade
- Histamine blockade may not be possible with only once daily dosing of 24 hour antihistamines
- Don't forget about H2 receptors
- Doxepin – it's not only for depression
- Sedating antihistamines - for sleep ONLY
- Try for COMPLETE suppression – then *slowly* taper off the medications

Top 10 Dermatology Pearls for Everyday Patient Presentations

Top Ten Dermatology Pearls

1. Always diagram out any biopsy of a possible skin cancer
   - You will be surprised at how well the aged population can heal!
2. Avoid combination antifungal/corticosteroid creams – Lotrisone
   - Can be using a MUCH stronger steroid than you truly want
3. If you choose to use oral steroids for skin rashes, use at least a 12-24 day taper
   - Rebound is a true concern
4. Have a dermatopathology lab that you can send to when needed
   - They can often help you differentiate between various types of rashes

Top Ten Dermatology Pearls

⑤ Have a "go to" for acne that is "multi-drug"

- Ex: An oral for the inflammation and a retinoid for the clogging

⑥ Generic and trade name products for dermatology are not always the same

- i.e. Solodyn and Minocycline

⑦ Help your pathologist out – given them as much information as possible even if it is descriptive

-- Garbage in – Garbage out

⑧ If a patient is on a biologic and they call for an acute visit - have a higher index of suspicion.

-- They are at a higher risk for a serious and strange infections

Top Ten Dermatology Pearls

⑨ *Bilateral* lower extremity edema, redness and warmth will nearly always be stasis dermatitis

-- Itching is a common complaint early

-- Bullae formation is possible

⑩ Scabs are not our friend!!

-- Moist wounds will heal better and prettier

-- Beware of recommending the use of triple antibiotic ointments due to risk of allergy– Vaseline should be your workhorse

Questions??