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Family Practice Program Info *Family Practice Accreditation Info*

DERMATOLOGY UPDATE

COMMON SKIN PROBLEMS —Charles E. Crutchfield III, MD, Clinical Associate Professor of Dermatology, University of Minnesota Medical School, Minneapolis, and Director, Crutchfield Dermatology, Eagan, Minnesota

Keratosis pilaris: affects ≈40% of population to some degree; new products for managing condition include Glytone keratosis pilaris treatment kit and 5% salicylic acid and 10% urea ointment (Kerasal); lotion in Glytone kit applied after bathing, Kerasal applied twice daily; other products include 12% ammonium lactate lotion (Lac-Hydrin) and ammonium lactate- parabens-light mineral oil (AmLactin)

Molluscum contagiosum: caused by poxvirus that immune system often does not recognize as foreign; eliciting strong immune response key to management; applying podofilox (Condylox) lotion on lesion every other night for 2 to 3 mo usually "melts away" lesion; *caveats*—even with therapy, new lesions can develop for up to 3 mo; scraping or freezing lesions sometimes helpful; *points*—advise children they can attend school as long as lesion covered and no direct skin contact with other children; advise parents that during podofilox therapy, lesion should be "pink to mildly red"; if lesion becomes blatantly red, reduce therapy to every third night or twice weekly; curettage helpful for treating older children

Hemangiomas: 30% go away by 3 yr of age, 50% by 5 yr of age, and 60% by 6 yr of age; 40% of children still have problem at 6 yr of age; untreated lesions leave "weird scars"; therapy recommended for visible areas and for lesions involving genitalia or rectum; therapeutic modalities include laser therapy and cryotherapy

Sunburns: apply class 1 or 2 corticosteroid gel to affected areas, except intertriginous areas and face and have patient take 1 to 2 aspirin tablets q8h for 1 wk; can give oral prednisone if blisters widespread; for face, apply lower-class corticosteroid (*eg,* hydrocortisone valerate [Westcort]) 3 times daily for 1 wk

Sun protection: wear tight-weaved clothing; 80% of lifetime sun exposure occurs before 21 yr of age; educate parents about protecting children from sun; encourage use of sunscreens, starting at ≈6 mo of age

Port wine stains: laser therapy effective

Spider nevi: small vascular proliferations on skin that refill quickly with blood after applying finger to skin; laser therapy effective

Moles: if vermillion border involved, refer to plastic surgeon; dermatoscope or epiluminescence microscope helpful in evaluating moles (apply small amount of oil to skin first); these instruments allow visualization of structures in dermis (helpful in deciding whether lesion benign or malignant and how to direct biopsy); always take 2 Polaroid camera shots of lesion (1 to 1 setting); save 1 for medical record and give other to patient (to follow lesion for changes)

Warts: caused by papillomavirus; help from immune system required to clear; irritation therapy helpful; *pearl*—soak area for few minutes, apply salicylic acid plaster (Mediplast) to lesion, then wrap area with duct tape; reapply Mediplast and duct tape once weekly; if wart fails to resolve in ≈1 mo, consider cryotherapy or laser therapy

Vitiligo: newly devised narrow-band UV-B phototherapy (290 to 320 nm) effective ≈70% of time (also effective for psoriasis and eczema); tacrolimus (Protopic) ointment and pimecrolimus (Elidel) 3 times daily effective ≈25% of time; for refractory cases, resort to narrow-band UV-B therapy

Atopic dermatitis: educate parents about chronicity of this condition (educational video available from speaker's Web site, www.crutchfielddermatology.com) *what to tell parents*—atopic eczema part of same gene family that causes allergic rhinitis, allergic conjunctivitis, and asthma; children with this problem almost always have family member with allergic condition; disorder chronic, waxes and wanes, and exacerbated by dry skin (stress importance of moisturization)

> Treatment: bathe atopic children daily or at least every other day with mild soap; after bath or shower, seal moisture with emollient, then apply nonsteroidal cream of choice (*eg,* Protopic, Elidel) 1 to 2 times daily; if flare develops, apply Westcort cream twice daily for 1 wk; for nighttime scratching, prescribe diphenhydramine (Benadryl) 1 to 2 teaspoons at night; *points*—advise parents most children outgrow problem by teen years; warn about increased risk for flares during illness

Cradle cap: prescribe fluocinolone (Synalar) solution, 2 drops twice daily (should clear condition); speaker dislikes medicated shampoos (not enough time to work)

Poison ivy (or oak) dermatitis: *warning*—"leaves of 3, leave it be"; *points*—linear blisters clinical hallmark; caused by allergic reaction to urushiol resin (plants that produce this resin include poison oak, poison ivy, and poison sumac); resin causes type 4 hypersensitivity reaction; natural enzymes of skin break down this resin after 4 hr (therefore, it will not spread after that time); resin on clothing and animal fur still can spread after 4 hr; sensitization required before blisters can develop (do not develop after first exposure); type 4 hypersensitivity reaction requires 18 days to play out; new over-the-counter product (Ivy Block; cream or lotion) forms complex with plant oil so not recognized by immune system; indicated for patients highly prone to reactions; *treatment*—apply corticosteroid gel tid for 3 wk; on face, use lower- class steroid; give oral prednisone in morning if dermatitis widespread (begin with 40 mg, then taper to 20 mg, and eventually 10 mg over 3 wk); *other remarks*—heavy detergent required to remove resin from animal fur; exposure to smoke from burning poison ivy (or oak) plants can adversely affect lungs

Psoriasis: triamcinolone 0.1% with 2% tar extract works in ≈50% of patients (provide patient with l-lb jar; apply after bathing); UV light also helpful; new biologic agents (*eg,* etanercept [Enbrel], alefacept [Amevive], efalizumab [Raptiva], adalimumab [Humira]) and infliximab (Remicade) also helpful in treating condition; *comment*—≈25% of patients with psoriasis develop psoriatic arthritis; requires early intervention to prevent progression

Acne: topical retinoids (*eg,* tretinoin [Retin-A, Avita], adapalene [Differin], tazarotene [Tazorac]) key agents for treating; other drugs include antibiotics and topical benzoyl peroxide; laser therapy recently approved (involves 4 to 6 sessions over 2 to 3 mo)

Mosquito bites: apply topical Westcort cream over bites, cover with band aid for 3 days, and prescribe Benadryl for 3 days

Tinea versicolor: advise patient infection causes skin discoloration and that during treatment it will become flaky and powdery; skin color usually returns to normal in 2 to 3 mo; can use ketoconazole (Nizoral) cream twice daily for 3 wk

Tinea capitis in small children: endemic; treat with griseofulvin 20 mg/kg, with maximum of 500 mg/day for 2 mo (refill required for second month); topical fluocinolone (Synalar) can help relieve itching; also treat fomites (replace all items that touch hair or place them in sealed plastic bag with 5 mothballs for 1 wk); ask all household contacts to use ketoconazole (Nizoral) shampoo; check for enlargement of nodes in back of neck; strongly suspect problem in black child <12 yr of age with scalp rash

"OH, BY THE WAY, DERMATOLOGY" —Jeffrey Meffert, MD, Program Director, Dermatologic Services, Uniformed Services Health Education Consortium, San Antonio, Texas

What speaker means by "oh, by the way, dermatology": patients casually mention skin problem while leaving office after receiving care for another medical problem

When "oh, by the way" really not significant problem: *scenario*—patient mentions (while leaving office) that he or she is going on cruise and wants latest drug to cure ugly toenails; *easy thing to do*—prescribe terbinafine (Lamisil), itraconazole (Sporanox), or ciclopirox (Penlac); problem is there are many reasons for ugly-looking nails; *best thing to do*—tell patient to schedule another appointment to deal with nails

When "oh, by the way" may be significant: *scenario*—patient causally requests refill of medication (*eg,* Westcort, Elidel, naftifine [Naftin]) to treat jock itch; *comments*—easy thing to do is to refill it one more time; worst thing to do is to give shotgun prescription for combination agents like triamcinolone and nystatin (Mycolog) or betamethasone and clotrimazole (Lotrisone); *best approach*—schedule appointment to examine intertriginous area carefully, then determine appropriate medication; causes of jock itch can include fungal infection, monilial infection, chronic irritant dermatitis, allergic dermatitis, psoriasis, premalignant lesions, and even malignant tumors; problem with indiscriminately treating jock itch with antifungals and corticosteroids is that they temporarily reduce symptoms because of their anti-inflammatory actions

Situation where "oh, by the way" can be absolute disaster: *scenario*—patient points to lesion or rash in hallway with poor lighting, and physician agrees simply to apply liquid nitrogen to it; *issues*—cryotherapy acceptable if patient has something like seborrheic keratosis; however, if patient has basal cell carcinoma or other low-grade malignancy, cryotherapy only partially treats; *points*—avoid freezing moles; evaluate lesions before treating

QUESTIONS AND ANSWERS —Dr. Meffert

Use of 5-fluorouracil (5-FU) in dermatologic practice: used by speaker for variety of problems, some of them off- label; *actinic keratoses*—5-FU approved by Food and Drug Administration (FDA); give twice daily for 3 to 4 wk; if patient develops "smoking holes," discontinue and switch to topical corticosteroids; *superficial basal cell carcinoma*—avoid 5-FU; *Bowen's disease (superficial squamous cell carcinoma)*—5-FU frequently used, often under occlusion to accelerate speed and intensity of effect; no longer used for treating scalp lesions (chemical peels used instead); *warts*—5-FU effective in treating (off-label use); apply under occlusion with band aid at night; especially effective for treating periungual warts; avoid use in young girls and fertile women; *comments*—speaker prefers older 5- FU preparation (Efudex) to newer (Carac); topical ketorolac not very effective

Multiple cysts on scalp: *pilar cysts*—account for most multiple scalp lesions; treated surgically; do not respond to isotretinoin (Accutane) or triamcinolone injections; *multiple cysts throughout body*—suspect Gardner's syndrome, genetic syndrome also associated with colonic polyps, many of which become malignant

Management of infected sebaceous cysts: usually more inflamed than infected; drain surgically if red and fiery; inject lesion with triamcinolone (Kenalog) if slightly irritated, then watch for scarring and recurrence; if cyst infected, drain it surgically and give antistaphylococcal antibiotic

Topical treatment of condyloma: treat with anything that works; freezing generally indicated if someone has just 1 or 2 lesions; *condyloma acuminata*—highly transmissible; speaker generally freezes them, then gives drugs; *medications*—topical Efudex occasionally used; synthetic podophyllin (Condylox) and imiquimod (Aldara; generally preferred); warn that "if a little bit is working, a lot is not necessarily better"; *Condylox*—generally given twice daily for 3 consecutive days; *Aldara*—given every other day or 3 times/wk (avoid daily use on genital skin); probably works little better than Condylox; preferred agent for condyloma acuminata; *comment*—laser therapy no longer used

> Condyloma about mouth, face, and nose: generally treat with Condylox or Aldara; warn patients these agents will make lesions look red and inflamed (same true for Efudex)

Keloids: first make sure patient has keloid; dermatofibrosarcoma protuberans (malignancy) may resemble keloid in early stage; *treatment*—difficult; duct tape occlusion works just as well as silicone sheeting; if keloids red, use pulsed dye laser to inject corticosteroid; avoid surgical excision (with few exceptions, *eg,* ear lesions); after excision, consider applying Aldara (≈50% effective)

BEWILDERING LESIONS —Dr. Meffert

Factors to consider in evaluation: *location*—most facial lesions benign, but do not miss malignant or premalignant lesions; *length of time lesion present*—acute lesions more likely benign, but there are exceptions; chronic conditions also can be benign, but also consider skin cancer and other long-standing conditions; *history*—often helpful, but disregard if it does not make sense; most cancerous lesions do not develop rapidly; one exception is keratoacanthoma (rapidly growing squamous cell carcinoma); *surrounding area*—if surrounding area erythematous, consider biopsy; *previous treatment*—if someone presents with cutaneous horn and claims it has been frozen several times, be more suspicious (biopsy indicated if lesion has been frozen and grows back)

Location issues: *dermatofibroma*—uncommon on arm; more common on other parts of body; *basal cell carcinomas*—can develop anywhere; now seen even in young people

Basal cell carcinoma: seldom fatal; deaths usually associated with improper care or patient neglect; lesions can become large; excise with 4-mm margins around lesion to get 90% to 95% cure rate

Age of patient: some lesions may "look okay" if they occur in children, but be suspicious of tumors if they develop in adults; *pilomatricoma*—common in children; surgical excision only effective therapy; *hemangiomas*—usually get large, then shrink in children; in adults, generally do not worry if they develop on trunk or abdomen, but be suspicious if they occur on nose

Appearance issues: *halo nevi*—usually not problematic unless they "look weird"; presence of multiple lesions may indicate immune reaction to melanocytes (total-body skin examination indicated)

Change issues: *bumps*—consider malignancy if bump has been present for long time, then suddenly ulcerates (ulceration and depth both have prognostic importance in evaluating melanomas); *pimples*—suspect cancer if "pimple" does not improve after 1 yr; *moles*—be suspicious of moles that have changed; *patches*—suspect problem if previously flat patch now raised

Educational Objectives

The goal of this program is to educate the listener about various cutaneous problems. After hearing and assimilating this program, the clinician will be better able to:

1. Diagnose and treat common skin problems (*eg,* keratosis pilaris, molluscum contagiosum, hemangiomas, port wine stains, moles, warts, vitiligo, cradle cap, psoriasis, acne, fungal infections).

2. Manage patients who have sustained sunburns, and provide advice for protecting skin from sun.

3. Care for patients who have developed poison ivy or poison oak dermatitis or who have been bitten by mosquitos.

4. Deal with patients who passively mention (upon leaving office after being treated for another problem) that they want a prescription for a skin problem.

5. Evaluate patients with bewildering skin lesions.

Discussed on This Program

Adalimumab [Humira]
Adapalene [Differin] Alefacept [Amevive]
AmLactin (ammonium lactate, parabens, light mineral oil)
Ammonium lactate [Lac-Hydrin]
Aspirin (many trade names)
Benzoyl peroxide (several trade names)
Ciclopirox [Loprox, Penlac Nail Lacquer]
Diphenhydramine HCl (several trade names)
Efalizumab [Raptiva]
Etanercept [Enbrel]
Fluocinolone acetonide [Derma-Smoothe/FS; Fluonid, Flurosyn, FS Shampoo, Synalar, Synalar-HP]
Fluorouracil (5-fluorouracil, 5-FU) [Adrucil, Carac, Efudex, Fluoroplex]
Griseofulvin microsize [Fulvicin U/F, Grifulvin V, Grisactin 250, Grisactin 500]
Hydrocortisone valerate [Westcort]

Imiquimod [Aldara]
Infliximab [Remicade]
Isotretinoin (13-cis-retinoic acid) [Accutane]
Itraconazole [Sporanox]
Kerasal (5% salicylic acid and 10% urea ointment)
Ketoconazole [Nizoral, Nizoral A-D, Nizoral Cream Shampoo]
Lotrisone (combination of betamethasone [as dipropionate] and clotrimazole)
Naftifine hydrochloride [Naftin]
Pimecrolimus [Elidel]
Podofilox [Condylox]
Prednisone (several trade names)
Salicylic acid (several trade names)
Tacrolimus (FK506) [Prograf, Protopic]
Tar extract
Tazarotene [Tazorac]
Terbinafine HCl [DesenesMax, Lamisil, Lamisil AT, Lamisil DermGel 1%]
Tretinoin (trans-retinoic acid; vitamin A acid) [Altinac, Atragen (investigational), Avita, Renova, Retin-A, Retin-A Micro, Vesanoid]
Triamcinolone (Kenalog, others)
Triamcinolone acetonide and nystatin (several trade names)

Suggested Reading

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Faculty Disclosure

In adherence to ACCME guidelines, the Audio-Digest Foundation requests all lecturers to disclose any significant financial relationship with the manufacturer or provider of any commercial product or service discussed. The following has been disclosed: Dr. Meffert recommends the off-label use of certain medications for treating skin problems

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