

# Rash Review: *Dermatology for the Advanced Practice Provider*

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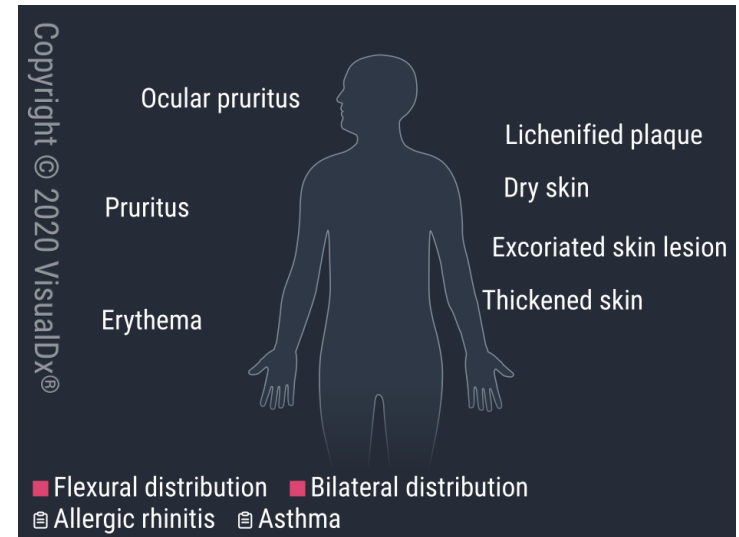


# Eczematous Disorders

- ▶ "Eczema"
  - Most common of all inflammatory skin diseases
  - General term for variety of disorders
  - Acute vs Chronic

# Atopic Dermatitis

- ▶ Disease of childhood?
  - Chronic condition
  - Impact on quality of life
- ▶ Presentation
  - Body Locations differ over time
  - Pruritus, inflammation, xerosis
  - Excoriations
  - Weeping, infections
  - Lichenification and scarring
- ▶ Triggers
  - Environmental factors
  - At home behaviors



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<https://www.visualdx.com/visualdx/diagnosis/?moduleId=101&diagnosisId=51378&imgSet=1>.

# Atopic Dermatitis

- ▶ Management
  - Bathing
    - Hydrate the skin and lock it in!
  - Emollients
    - Greasier the better!



1. Bobonich M, Nolan M. Eczematous Disorders. In: *Dermatology for Advanced Practice Clinicians*. 1st ed. Lippincott Williams And Wilkin; 2014:24-36.
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# Atopic Dermatitis



## ▶ Medications

- Topical Steroids
  - Gain Control of the flare
  - Potency depends on body area affected
- Topical Calcineurin Inhibitors
  - Tacrolimus (Protopic) and Pimecrolimus (Elidel)
    - Black Box Warning
- Anti-histamines
  - Sedating vs Non-sedating
  - Avoid topicals

# Atopic Dermatitis

- ▶ Medications (cont.)
  - Antibiotics
    - Keflex if acute
    - Doxycycline if recurrent
    - Topical Mupirocin if eczema is not flared
  - Oral Steroids
    - Prednisone taper over at least 6 days
    - Concurrent with topical steroids



# Atopic Dermatitis

- ▶ Potency and Vehicle
  - Very-high
    - Clobetasol
    - Halobetasol
  - High
    - Fluocinonide
    - Betamethasone
  - Intermediate
    - Triamcinolone
    - Mometasone
  - Low
    - Desonide
    - Hydrocortisone



# Nummular Dermatitis

## ▶ Presentation

- Common and Chronic
- Well demarcated annular (“coin shaped”), pruritic, erythematous papules and plaques





# Nummular Dermatitis

- ▶ Adults > Children
- ▶ BLE (men) and BUE (women)
- ▶ Triggers can vary
  - ▶ Environmental, infectious, allergic and irritant, history of venous stasis
- ▶ History of Atopy is not necessary
- ▶ Often mistaken for tinea or psoriasis



# Nummular Dermatitis

- ▶ Treatment
  - Emollients
  - Topical Steroids
    - Moderate–high potency
    - Ointment > cream



# Contact Dermatitis

- ▶ Eczematous dermatitis resulting from contact or exposure to external irritants or allergens in the environment.
- ▶ Irritant Contact Dermatitis
  - Non-immunologic disorder resulting from physical contact with skin barrier
  - ~80% of all CD
  - Virtually all people at risk of developing ICD
- ▶ Allergic Contact Dermatitis
  - Immunologic response with genetic pre-disposition

# Irritant Contact Dermatitis

- ▶ Responsible for majority of occupational skin dermatoses
- ▶ Infants and the Elderly
- ▶ Due to exposure or repeated exposure of offending agents
  - Water is the most common offender!
    - “universal solvent”



# Irritant Contact Dermatitis

## ▶ Presentation

- Intensity and clinical signs depends on:
  - Properties of substance
  - Degree of skin barrier at time of exposure
  - Environmental factors
- Onset is rapid



# Irritant Contact Dermatitis

## ▶ Acute ICD

- Develops within minutes–hours
- Sharply demarcated erythematous plaques, edema and bullae possible
- Stinging, burning – think chemical burns



# Irritant Contact Dermatitis

## ▶ Chronic ICD

- Multiple sub-threshold contacts when the skin does NOT have ample time between exposure to recover and restore the normal skin barrier function
- Sx:
  - Erythema without distinct demarcation
  - Scaling, vesicles, lichenification, hyperkeratosis



# Irritant Contact Dermatitis

## ▶ Considerations

- Further testing may be helpful
  - KOH, biopsy, Patch Testing
- Significant impact on life/lifestyle

## ▶ Treatments

- Topical steroids
  - Keep use limited
  - Potency of TCS dependent on affected area(s)
- Prevention Education
  - Encourage self-advocacy



# Allergic Contact Dermatitis

- ▶ ~20% of all CD's
- ▶ Allergen specific reaction
  - Examples: allergy to jewelry, poison ivy rash, lanolin



# Allergic Contact Dermatitis

## ▶ Presentation

- Well demarcated, pruritic, eczematous plaques
- Edema, vesicles, weeping possible
- May become chronic (lichenified and scaly)
- Typically a localized reaction, depending on causative agent



# Allergic Contact Dermatitis

## ▶ Treatment

- Avoid the allergen 😊
- Patch Testing
  - Identify, eliminate, avoid
  - TCS may be used to aid in clearance of residual dermatitis
  - Can take 6 weeks to resolve even once offending agent is identified



# Asteatosis Dermatitis

- ▶ *"Eczema craquelé"*
- ▶ Severely dry skin that is inflamed and fissured
- ▶ Adulthood > Childhood
- ▶ Men > Women
- ▶ "Winter Itch"
- ▶ Numerous outside influences
  - Cold/dry weather, lack of moisturizing, UV exposure, excessive use of soap and water, perfumed soaps, habitual scrubbing



# Asteatotic Dermatitis

- ▶ Presentation
  - Pruritus, burning, dry, scaling, superficial cracks
  - “dry riverbed” appearance
  - Mildly erythematous
  - No vesicles, bullae, pustules



# Asteatotic Dermatitis

## ▶ Treatment

- Emollients
  - Ointments > creams > lotions
  - Urea and lactic acid containing moisturizers can be helpful
- Mid-potency TCS to decrease inflammation
- Recurrence is common



1. Bobonich M, Nolan M. Eczematous Disorders. In: *Dermatology for Advanced Practice Clinicians*. 1st ed. Lippincott Williams And Wilkin; 2014:24–36.

2. Craft N, Fox LP, Goldsmith LA. Eczema craquelé. VisualDx. Accessed September 19, 2023. <https://www.visualdx.com/visualdx/diagnosis/?moduleId=101&diagnosisId=51385>.

# Dyshidrotic Dermatitis

## ▶ Presentation

- Clear–white small vesicles
  - “Tapioca Pearls”
- Pruritus, burning initially
- Scaling occurs once vesicles resolve
- Hands and feet
  - May extend to lateral surfaces
  - Spares dorsal aspects



# Dyshidrotic Dermatitis

- ▶ Mostly Idiopathic
- ▶ Not related to sweat gland activity
- ▶ Triggers:
  - Stress
  - Fungal infection
  - ID reaction
  - Drug reaction



1. Bobonich M, Nolan M. Eczematous Disorders. In: *Dermatology for Advanced Practice Clinicians*. 1st ed. Lippincott Williams And Wilkin; 2014:24–36.

2. Cohen JM, Schaffenburg W, Burgin S. Dyshidrotic dermatitis in adult/child. VisualDx . Accessed September 19, 2023.  
<https://www.visualdx.com/visualdx/diagnosis/?moduleId=101&diagnosisId=51388>.



# Dyshidrotic Dermatitis

## ▶ Management

- Avoid Triggers/Irritants
- High Potency TCS
  - BID x2 weeks
  - Transfer to Calcineurin Inhibitor
  - Antihistamines can be helpful
  - Oral steroids for severe cases



# ID Reaction

- ▶ Inflammatory Dermatitis
  - Body's response to an infection, inflammatory condition, or substance/drug/allergen/irritant.
  - “Auto-sensitization” or “Disseminated Eczema”
  - Commonly seen in patients with contact dermatoses
- ▶ Pathogenesis
  - Poorly understood
  - Immune mediate response?
    - Fungus seems to be common trigger

# ID Reaction

## ▶ Presentation

- Poorly demarcated eczematous plaques, papules, vesicles
- Extremities, face, and occasionally trunk
- Reaction location may vary – near infection or remote to infectious site
- May take days to weeks to develop
- Spreads until underlying condition is treated



# ID Reaction

- ▶ Management
  - Treat underlying infection
  - TCS may provide some relief
    - Use is controversial as they may suppress cutaneous immune system and allow further spread of cutaneous infection
- ▶ Self-limiting condition



# Lichen Simplex Chronicus

- ▶ “Neurodermatitis”
- ▶ Chronic disorder resulting from excessive scratching & rubbing of the skin
- ▶ Adults > adolescents
- ▶ Commonly seen in those with a history of atopic dermatitis and anxiety



# Lichen Simplex Chronicus

## ▶ Presentation

- Develops in response to pruritus from a primary process like AD, bug bite, psoriasis, stress, etc.
- Hyperpigmented, thick, lichenified plaques
- Leathery in appearance
- Easy to reach areas
  - Back of neck, arms, legs, vulva/scrotum, perianal area



# Lichen Simplex Chronicus

- ▶ Management:
  - Perpetuation of the itch–scratch cycle can be further aggravated by stress/anxiety. However, this is the key to stopping the issue at hand.
  - Emollients
  - TCS (high potency)
  - Intralesional kenalog injections
  - Referral to psych if OCD/Anxiety is primary component



# Seborrheic Dermatitis

- ▶ Recurrent papulosquamous disorder
  - Erythema with waxy/yellow scaling
- ▶ High Prevalence
- ▶ “Dandruff” = most mild form
- ▶ Men > Women
- ▶ Increased Prevalence
  - Down Syndrome
  - Parkinson Disease
  - Neurological Disorders (Mood disorders, stroke victims, head and neck injuries, immunocompromised)





# Seborrheic Dermatitis

- ▶ Common Triggers:
  - Medications, seasonal changes, sunlight, heat, topical hair products
- ▶ Associated with normal yeast on skin (*Malassezia*), increased sebum production
- ▶ Presentation:
  - Erythema with dry, moist, or adherent scale
  - Scalp, forehead, eyebrows/glabella, nasolabial folds, ears/post-auricular areas



# Seborrheic Dermatitis

- ▶ Treatment
  - Azole Antifungals
    - Ketoconazole cream and/or shampoo
  - OTC products
  - Lather for 5–10 minutes prior to rinsing!



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# Pityriasis Rosea

- ▶ Common, self-limiting, papulosquamous dermatosis
- ▶ Affects young, healthy individuals
- ▶ More common in Spring and Fall
- ▶ Suspected to have viral etiology
  - Association with human herpes virus 6 & 7



# Pityriasis Rosea

## ▶ Presentation

- ~2–4cm solitary erythematous patch/plaque precedes eruption (Herald Patch) which occurs within days–weeks
- Multiple pink, round/oval papules and plaques with fine “collarette scale” on border
- Symmetrical distribution on the trunk, following skin tension lines
- Face, palms, soles typically spared
- ~25% experience pruritus
- Few experience flu-like symptoms

# Pityriasis Rosea

## ▶ Management

- Symptomatic Care
- Anti-histamines
- UVB
- Resolution in 6–8 weeks

## ▶ Special Considerations

- Pregnancy
  - Association with HHV 6&7
  - Premature delivery and fetal demise have been observed in pregnant women with PR – especially within first 15 weeks gestation
  - Refer to OB
    - Possible treatment with acyclovir



# References

1. Bobonich M, Nolan M. Eczematous Disorders. In: Dermatology for Advanced Practice Clinicians. 1st ed. Lippincott Williams And Wilkin; 2014:24–36.
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# Questions!?

