RECOGNIZING COMMON SKIN CONDITIONS
Perioral Dermatitis
Perioral Dermatitis

- Predominately seen in females ranging in age from 16 to 45 years old.
- Also seen in infants and toddlers due to excess moisture from drooling or pacifier use; make sure to rule out bacterial and fungal component.
- Can also be seen periocular but much less common and more difficult to treat.
Potential Causes

- Unknown etiology.
- Potentially aggravated by:
  - Potent topical (fluorinated) glucocorticoids; nasal steroids; ocular steroids, and steroids used in airway diseases.
  - Fluoride toothpaste; cinnamon and peppermint; over moisturizing.
Signs and Symptoms

- 1-2 mm erythematous confluent papules and satellite papules; less common pustules, no comedones.
- May appear eczematous with fine scale.
- Typically starts unilateral and spreads symmetrically periorally, at the nasal creases and nasolabial folds sparing the vermillion border of the upper and lower lip.
Perioral Dermatitis

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Perioral Dermatitis

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Perioral Dermatitis
Periorbital Dermatitis
Therapeutic Options for Perioral Dermatitis

AVOID TOPICAL STEROIDS

- Oral doxycycline or minocycline 100mg qd to bid
- Topical metronidazole 1% qd
- Azaleic acid (Finacea qd to bid in combo with metrogel)
- Topical Sodium Sulfacetamides (cleansers/lotions)
- Erythromycin 2% qd – bid
- Ketoconazole Gel (Xologel)
Contact Dermatitis
Contact Dermatitis

- **Irritant Contact Dermatitis**
  - Caused by a chemical irritant.
  - Can be acute or chronic.
  - Confined to the area of exposure.

- **Allergic Contact Dermatitis**
  - Caused by an allergen that elicits a Type IV (cell-mediated or delayed) hypersensitivity reaction.
  - Dependent on sensitization of the individual.
  - May spread beyond affected sites.
Irritant Contact Dermatitis
Irritant Dermatitis

- Most common form of occupational skin disease accounting for up to 80%.
- Ask your patients what kind of work they do?
  - Housekeeping, hairdressing, medical, construction, electrical, mechanical, floral/landscaping, food industry, bartending, printing/exposure to paper products or ink, fishing, painting, metal work
Agents and Factors that cause ICD

- Abrasives, cleaning agents, hand sanitizers, solvents, oxidizing agents, plants, animal secretions, powders, dust, soils, excessive exposure to water.

- Patients with a history of atopy; lighter skin types; temperature and humidity; mechanical irritation.
Signs and Symptoms of ICD

- Burning, stinging, itching, pain.
- Erythema, painful fissures, vesicles and bulla, dryness, hyperkeratosis, papules and pustules, erosions, lichenification.

Acute ICD

- Erythema, edema, acute bullous, burning and pain.
- Due to acute exposure of chemicals, oils, and solvents.
ICD from Garlic
ICD from Cement
Bullous ICD
Chronic ICD

- Hand Dermatitis – most common chronic ICD, which occurs in combination with ACD due to sensitization.

- Airborne ICD – found on face, neck, anterior chest, and arms. Caused by dust and volatile chemicals. Distinguish from photoallergic contact dermatitis.

- Pustular and Acneiform ICD – May target follicles and be papulopustular. May result from metals, mineral oils, greases and solvents.
Airborne Dermatitis
Management of ICD

- Removal of noxious substance or irritant.
- Wear protective clothing and eyewear.
- Wash with water or neutralizing solution right after contact.
- Barrier creams (cerave, hylatopic plus foam or cream).
- Change of job may be necessary.
Treatment of ICD

- Topical steroids (Class I most effective), oral (2-week course) or IM steroids depending on severity
- Tacrolimus or pimecrolimus for chronic ICD – maintenance therapy
- Lubricants/barrier creams
- Keratolytic creams
- PUVA therapy (chronic conditions)
Allergic Contact Dermatitis
Allergic Contact Dermatitis

- Delayed, cell-mediated hypersensitivity reaction.
- Symptoms begin from 48h to days after contact; it may even take months of exposure for symptoms to appear.
- The first symptoms is typically severe itching; sometimes burning and stinging can occur too.
Characteristic Skin Findings

- Acute – edema, erythema, vesicles, papules, erosions, or crusts.
- Subacute – plaques with mild erythema, dry scales, small round pointed firm papules.
- Chronic – plaques of lichenification, scaling, excoriations, firm papules and pigmentary changes.
- May be isolated to the area of exposure or spread to other areas.

Patch Testing (Tru Test)

- Wait until dermatitis has subsided for at least 2 weeks.
- Should be performed on a uninvolved site.
- Stop oral antihistamines, oral steroids and topical steroids to the area patch test will be applied.
- Positive response should elicit erythema, papules and possibly vesicles.
Top 10 Most common allergens

- Nickel sulfate (metals of clothing, jewelry) (#1)
- Neomycin sulfate (contained in cream/ointment)
- Balsam of Peru (topical medications)
- Fragrance Mix (fragrances and cosmetics)
- Thimerosal (antiseptics)
- Sodium gold thiosulfate (medication)
- Formaldehyde (disinfectants, curing agent, plastic)
- Quaternium-15 (disinfectant)
- Cobalt chloride (Cement, oils, eyeshades)
- Bacitracin (ointments and powders)
Hypersensitivity Reactions from Patch Test
Nickel Allergy
Nickel Allergy
Shoe allergy
ACD
Allergic Reaction to Poison Ivy
Lichen Simplex Chronicus
and
Prurigo Nodularis
Lichen Simplex Chronicus (LSC) and Prurigo Nodularis (PG)

- Localized areas of hyperkeratosis and hyperpigmentation.
- Causes from chronic itching, rubbing or picking due to chronic pruritus, inflammation or a habit.
- Associated with Atopic Dermatitis and atopy.
- PN can also be associated with neurosis.
Lichen Simplex Chronicus
Prurigo Nodularis
Acanthosis Nigricans
Acanthosis Nigricans

- A velvety thickening and hyperpigmentation of the skin.
- Commonly seen around the neck, axillae and other body folds.

Etiology

- Hereditary
- Endocrine disorders (such as diabetes, PCOS, Addison’s)
- Obesity
- Drug administration
- Malignancy (paraneoplastic, adenocarcinoma of gastrointestinal or genitourinary tract)
Acanthosis Nigricans
Acanthosis Nigricans
Course and Prognosis

- Seen in puberty, may regress as patient gets older.
- Look for underlying endocrine disorder.
- Diet and exercise; loss of weight.
- Discontinue causative drug.
- Look for underlying malignancy.
Treatment

- Treat underlying disorder
- Weight loss and diet
- Topical medications that can help; mainly cosmetic options
  - Azaleic acid
  - 4% Hydroquinone
  - AHAs
  - Low dose tretinoin
  - With all the above topical treatment options, warn against possible irritation
  - Explain all therapies are considered off-label

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Pityriasis Rosea
Pityriasis Rosea

- An acute exanthematous eruption.
- Self-limiting (6 to 12 weeks duration).
- Commonly confused as Tinea Corporis, especially in the beginning of eruption when only the primary patch appears called a “Herald’s Patch”.
- Herald patch precedes full eruption by 1 to 2 weeks; herald patch is seen in 80% of patients.
Pityriasis Rosea

- Distribution: truncal in a “Christmas Tree” pattern and proximal aspects of arms and legs.
- Appearance: oval, salmon to dull pink fine scaly patches and plaques.
- Pruritis: none; mild to severe.
- May follow and upper respiratory infection.
- Not contagious.
Pityriasis Rosea
Herald Patch
Pityriasis Rosea
Management and Treatment

- Reassurance
- Oral antihistamines
- Antipruritic lotions
- Topical steroids
Lichen Planus
Lichen Planus

- Acute or chronic inflammatory dermatosis involving skin, nails and/or mucous membranes.
- Flat-topped, pink to violaceous, shiny pruritic polygonal papules and plaques.
- Wickham’s striae: milky white reticulated lines.
- The Four P’s
  - Pruritic
  - Polygonal
  - Purple
  - Papule
Causes of Lichen Planus

- Idiopathic
- Cell-mediated Immunity
- Drugs, metals, infection (Hepatitis C)
Lichen Planus

- Wickham’s striae seen with a magnifying glass and application of mineral oil.
- Common areas of distribution: flexor wrists, lumbar region, shins, scalp, glans penis, mouth.
- Examine inside the mouth at the mucous membranes (40% – 60% occurrence).
- Can also effect scalp showing atrophy and nails with destruction of nail fold and bed with longitudinal splintering, atrophy, and pterygium formation.
Lichen Planus

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Wickham’s Striae
Lichen Planus of the Nails

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Lichen Planus of the Scalp showing atrophy
Management and Treatment

- Topical steroids (sometimes under occlusion on thicker and harder to manage lesions)
- Intralesional kenalog injections (4mg/cc to 10mg/cc)
- Topical oral triamcinolone (ie. oralone)
- Systemic therapy
  - Cyclosporine
  - Oral Prednisone
  - Systemic Retinoids (soriatane)
  - Phototherapy
Granuloma Annulare
Granuloma Annulare

- Potential self-limited (may last several years and in some cases may last a lifetime); asymptomatic to having mild symptoms of itching and/or burning, chronic dermatosis of the dermis.
- Annular and semicircular plaques with central regression or depression.
- May be skin-colored, pearly white, pink, reddish to brown in color.
- Feels firm, smooth and rubbery with no scale.
- May be localized or disseminated.

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Granuloma Annulare

- Seen most commonly on distal extremities, near joints, palms and soles, and buttocks.
- The disease will disappear in 70% of patients in 2 years, but recurrences are common.
- Not a marker for internal disease.

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Granuloma Annulare

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Granuloma Annulare
Treatment Options

- Reassurance
- Topical steroids
- Intraleisional Kenalog injections (4mg/cc)
- Tacrolimus
- PUVA therapy for disseminated disease
- TNF-inhibitors (such as Enbrel and Humira have shown improvement in some cases)
Vitiligo
Vitiligo

- Affects 1% of the population.
- 50% of cases begin between the ages of 10 to 30.
- Genetic.

Pathogenesis (Three Theories)

- Autoimmune: destroyed by certain lymphocytes.
- Neurogenic: interaction between melanocytes and neurons.
- Self-destruct hypothesis: melanocytes are destroyed by toxic substances formed as part of normal melanin synthesis.
Vitiligo

Potential Precipitating factors

- Trauma – Koebner phenomenon
- Illness
- Emotional stress
- Sunburn
- Thyroid Disease
- Addison’s Disease
Vitiligo

- Wood’s Lamp Examination can be helpful in lighter skin types and in sun-protected areas of darker skin types to evaluate macules.
- Vitiligo affected areas will emit a blue-white light with sharp margins.
- Clinical diagnosis.

Wood’s Lamp

To use a Wood’s Lamp

- Must be in a completely dark room
- Examiner must adapt to dark room; may take up to twenty minutes
- Warm up wood’s lamp for at least one minute and hold light 10-12 cm from the skin
- All ointments, creams and medicines must be wiped from the skin prior to uses

Vitiligo
Management/Treatment

- Sunscreen SPF >30 with both UVA/UVB protection
- Cosmetic Coverup
- Repigmentation
  - Topical steroids (short-term use)
  - Immunomodulators (Tacrolimus)
  - PUVA in combination with topical or oral methoxypsoralen
  - Narrow UVB (Excimer laser)
Management/Treatment

- Minigrafting
- Depigmentation
  - Bleaching normally pigmented skin
    - Monobenylether of hydroquinone 20% (MEH)
Vitiligo

Before Excimer Laser treatment

During Excimer Laser Treatment
Vitiligo
Vitiligo

Sunburn appearance during excimer laser treatment

Brown speckling

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Alopecia Areata
Alopecia Areata

- Localized loss of hair in an annular pattern without any visible inflammation (completely smooth); most common area affected is scalp.

- Alopecia Totalis
  - Total absence of terminal scalp hair.

- Alopecia Universalis
  - Total loss of terminal body and scalp hair.

Alopecia Areata

- Autoimmune disease.
- Can be associated with other autoimmune disorders and endocrine disorders.
- May show gradual loss over weeks to months.
- Patches may be stable and spontaneously resolve.
- Asymptomatic.
Alopecia Areata
Nail Involvement

- Fine pitting (hammer brass) of dorsal nail plate
- Trachyonychia (rough nails)
- Onychomadesis (separation of nail from matrix)
Localized Alopecia Areata
Alopecia Totalis
Alopecia Areata
Management/Treatment

- Topical Steroids (superpotent agents may be effective)
- Intralesional injections with 4mg/cc IL Kenalog or 3mg/ml IL triamcinolone acetonide
- Systemic glucocorticoids
- Tacrolimus
- Potential new therapeutics in the near future

QUESTIONS???