

SEVEN SKIN CONDITIONS

A Handbook for the Non-Dermatologist

Provided by the
Department of Dermatology
University of Michigan Medical School

SPECIAL NOTE:

There are so many common skin problems in the world! To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for common problems that have not been evaluated and previously treated. Patients' personal physicians are the best source for such evaluations and therapies. This booklet provides helpful hints for successfully treating common conditions. Medicine is an art, and the field is constantly changing; please review current techniques and drug labeling as needed.

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Acne vulgaris

Description

Acne is most commonly seen during the teenage years, but can be seen in adults and young children as well. There are several types of acne, including comedonal, inflammatory, and nodulocystic. Comedonal acne consists of both closed comedones (whiteheads) and open comedones (blackheads). Inflammatory acne is erythematous and can be papular, pustular, or nodular. More inflammatory acne is known as nodulocystic acne, and consists of deeper nodules and cysts. Overlap is common.

Diagnosis

Closed or open comedones, inflammatory papules, pustules, nodules, cystic lesions.

Most commonly found on the face, shoulders, and chest.

Most commonly in males and females 13-24 years of age.

Treatment

ALL ACNE TREATMENTS TAKE WEEKS TO MONTHS TO WORK--- THEY ARE PREVENTING NEW LESIONS MORE THAN THEY ARE TREATING CURRENT ONES, SO RESULTS TAKE TIME.

- For comedonal acne, the most effective therapy is a topical retinoid (retinoic acid .025%) or retinoid derivative (retinoic acid, adapalene, and tazarotene). Used at bedtime.
- For inflammatory acne, topical antibiotic agents such as clindamycin, benzoyl peroxide/clindamycin or benzoyl peroxide/erythromycin combinations, sodium sulfacetamide, azelaic acid, salicylic acid BID should be added into the treatment regimen.
- For areas on the back and chest, use of a benzoyl peroxide wash can also be helpful.
- **For nodulocystic acne, oral antibiotics should be initiated that cover *P. Acnes*. Common antibiotics that can be used include minocycline, doxycycline, tetracycline, and Keflex. If a three month course of one antibiotic does not result in any significant change, switching to another antibiotic can be helpful.**
- For acne associated with menstrual cycles or in women with other signs of androgen excess, low-estrogen oral contraceptive pills can be a helpful adjunctive treatment. Ortho TriCyclen is one such agent.
- If different combinations of topical therapies for inflammatory acne do not result in any significant change, oral antibiotic therapy would be an appropriate next step (same agents as above). Remember that oral antibiotics do not show an improvement until 6 to 8 weeks of therapy.

Accutane is reserved for acne resistant to previous treatment, and requires careful monitoring of labs, pregnancy status, appropriate contraceptive use, and evaluation for side effects including vision changes, mood changes, suicide risk, and joint/muscle aches. UM physicians must follow the requirements set by ECCA and the pharmacy, including a specific consent form, available on the web at:

1. Clinical Guidelines for Prescribing Isotretinoin (Accutane) in Reproductive-Aged Women.

<http://www.pharm.med.umich.edu/di/clinical/accutane/AccutaneGuidelines%200102.pdf>

2. Consent Form for Patients (or parents of minors) Using Accutane.

<http://www.pharm.med.umich.edu/di/clinical/accutane/AccutaneConsent%200102.pdf>

3. Accutane Pregnancy Prevention: Overview - Flow Chart of the Process.

<http://www.pharm.med.umich.edu/di/clinical/accutane/Accutane%20flow%20chart%2001201.pdf>

For additional materials to comply with labeling, contact 1-800-93ROCHE.

Eczema-- atopic, contact, and non-specific dermatitis

Description

An acute, sub-acute, or chronic itchy inflammation of epidermis and dermis, often occurring in person with family history of or personal history of atopy.

Diagnosis

In acute cases, lesions are ill-defined erythematous patches or papules often with scale and edema. Erosions may appear crusted. Excoriations can be present. Sometimes it is superinfected.

In chronic cases, lesions are lichenified - thick, hyperlinear skin secondary to scratching. Fissures, hair loss, and periorbital pigmentation possible.

These lesions are commonly found on flexures, sides of neck, face, wrists, and dorsa of feet. In the case of contact dermatitis, look for linear lesions often with blisters and sparing of covered areas.

Treatment

Acute: Oral anti-histamine for itching, copious use of emollients QID, and a potent steroid like Lidex (0.05% cream) for 2 weeks BID. For infants and young children consider hydrocortisone 2.5%.

Chronic: As above except use mid-potency steroid such as triamcinolone 0.025% cream, Cutivate 0.05% cream or Locoid 0.1% cream in 2 week bursts. Use Elidel (1% cream) or Protopic (0.1% ointment) if steroids insufficient. **Chronic dermatitis, as the name implies, is a long-term problem; switching corticosteroids, adding secondary therapies from time-to-time, etc., are useful in managing patients.**

Acute contact dermatitis: Use Prednisone approximately 2 week course from 40mg QAM tapering by 10 mg after every 3 days. Consider supplementing with a brief 2 week course of Class I steroid such as Temovate cream 0.05% BID but not in folds or on the face.

Secondary therapy: Consider therapy for superinfection such as oral antibiotics (e.g., Keflex, azithromycin). This may be helpful even when patients do not look grossly infected. UVA-UVB therapy, bursts of PO steroids for acute or chronic eczema, cyclosporine, and higher potency topical steroids may be used.

(Closely based on Color Atlas and Synopsis of Clinical Dermatology, 3rd Edition, by Fitzpatrick, et al.)

SPECIAL NOTE:

To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for eczema that has not been evaluated and previously treated. Patients' personal physicians are the best source for such evaluations and initial therapies.

Moles

Description

Moles appear during the first 20 years of life, although some may not appear until later in life.

Moles are not stable. They can grow and go through changes of maturation. Flat junctional nevi may be present at birth, but usually appear between 3 and 18 years of age. They vary in size and shape, and may have a fried-egg appearance with darker bulls-eye center. They grow in proportion to body growth during childhood and adolescence. During adolescence and adulthood, they may become raised compound or intradermal nevi. Moles may darken with exposure to sun, birth control pills, and pregnancy. This is a normal occurrence.

Diagnosis

The signs of benign nevi are uniform pigmentation, smooth regular border, and unchanging size and color.

The signs of malignant transformation are the ABCDs. A is for asymmetry of 2 halves of the nevus (benign lesions have two halves in any orientation that show symmetry). B is for border - irregular or scalloped border and signs of satellite pigmentation. C is for color changes or variegation in color, especially red, white, gray, or blue. D is for diameter, with diameter of greater than 6 mm more concerning. Other signs include enlarging size or surface changes such as scaling, erosion, oozing, crusting, ulceration, or bleeding.

The “ugly duckling” sign refers to a mole that looks different from the majority of other moles and should be removed to evaluate for melanoma. Clinically atypical nevi are less likely to be melanoma if other nevi on the same patient share similar features. If the patient has one mole different from all others, you might remove it by shaving or excision. But if a mole has “cousins” that look similar, the risk of cancer is low.

Treatment

- If a mole looks suspicious for melanoma, remove the mole with 2 mm margins. The lesion must be sent to Pathology.
- **If the lesion turns out to be a melanoma, not to worry as studies indicate there is no detectable risk of causing melanoma to metastasize by performing a shave or punch biopsy.**
- The pathology report may show normal (junctional, compound, or intradermal) nevi, various levels of atypia (slight, moderate, severe), or melanoma. Atypia is a precursor to melanoma, but is not yet melanoma.
- If a mole is normal, no further treatment is needed.
- If a mole shows slight or moderate atypia and margins are clear, no further treatment is needed. Patient should be asked to look for recurrence of pigment.
- If a mole shows slight or moderate atypia and margins are not clear, re-excise or re-shave to get around the lesion.
- If a mole shows marked or severe atypia or any degree of pathologist’s concern for melanoma, please refer to Skin Cancer and Dermatology (SCAD) clinic for further evaluation. If pathology states melanoma, refer to Melanoma Clinic in the Cancer Center.

SPECIAL NOTE:

There are so many moles in the world! To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for routine “mole checks” or “skin checks”. Patients’ personal physicians are the best source for such evaluations.

Rosacea

Description

Rosacea is a common skin disease that usually presents during the third or fourth decades with facial erythema, papules and pustules, telangiectasia, and eventually can result in diffuse hyperplasia of sebaceous glands and associated connective tissue. Women and people with lighter skin tones are more frequently affected. Rosacea is also usually seen in people who have incurred considerable sun damage.

Diagnosis

The initial signs include easy flushing with inciting factors such as emotional stress, temperature changes, spicy foods, but more commonly from food that are served too hot in temperature and caffeinated and alcoholic beverages. The erythema subsequently becomes persistent over the central face, spreading laterally to the ears, and rarely to the chest and back. Some patients will develop telangiectasia and erythematous papules, occasionally pustules, scattered over the nose, cheeks, and forehead.

While rosacea is frequently referred to as adult acne, comedones (blackheads) are not found in rosacea. Patients with rosacea can have ocular involvement manifesting as conjunctival irritation, grittiness, burning, and injection. Ophthalmic rosacea can include blepharitis, conjunctivitis, iritis, iridocyclitis, and keratitis. If a patient has ocular involvement beyond mild conjunctival erythema, refer the patient to Ophthalmology for evaluation and treatment. Severe rosacea can result in rhinophyma (bulbous nose), a condition that has been culturally associated with excessive alcohol consumption, although this may not be true in any individual patient.

Treatment

It is important to remember that the signs and symptoms of rosacea are slow to remit — or may never remit completely — even with a thorough regimen and a compliant patient.

- Daily sunscreen use, SPF 15 or greater, AND Topical medications including: metronidazole (MetroCream, MetroLotion, MetroGel, Noritate) or sodium sulfacetamide (Klaron lotion).
- Occasionally patients have good responses to Ovice wash, used in conjunction with Nicosyn.
- Anecdotal reports have indicated that oral nicotinamide can be useful.

Treatment for Severe Rosacea

- For patients with conjunctivitis, blepharitis, multiple papules/pustules, or rhinophyma: oral antibiotics, typically minocycline or tetracycline, for long-term courses are indicated. Start patients at minocycline 100mg or tetracycline 250mg PO BID. Two months is a minimum treatment; patient may end up taking the medication for years. When tapering, add topical treatments. When prescribing minocycline, warn patients about possible dizziness, headaches, and GI upset. If patients take minocycline with food, the nausea can be ameliorated. If a patient complains of mild dizziness, and does not have an occupation where dizziness could put him/herself or others in danger, then try to taper to a single 100mg dose QD. If a patient complains of moderate or severe dizziness or persistent headaches, then discontinue treatment. Long term use of minocycline can rarely lead to bluish discoloration of skin and nails.
- Other oral medications that have been found efficacious include metronidazole, doxycycline, and clarithromycin.

Treatment for Telangiectasia and Rhinophyma

- Telangiectasia will not remit with the above treatments. If the patient has considerable concern regarding the cosmesis of telangiectasia, referral to UM Cosmetic Dermatology & Laser Center for pulse-dye laser or electrocautery may be indicated. Be sure to advise the patient that this will not be covered by insurance, given its cosmetic indication.
- Rhinophyma can be treated by ENT or Plastic surgery, with surgical debulking, laser, or electrosurgery.

NOTE:

Many patients believe they have rosacea. Often they have “physiologic rosacea” – red cheeks and some flushing that is a bit beyond average. Many of these patients are of English, German, or Irish extraction. Although these patients typically receive topical rosacea therapy, it is difficult to change normal physiology.

Seborrheic Dermatitis

Description

Seborrheic dermatitis is a common process, present in 2-5% of the population. This process is commonly called “dandruff” in adults and “cradle cap” in infants. It may be present in individuals of all age ranges, with the two age peaks in the first 3 months of life and in the 4th-7th decade of life. The etiology of seborrheic dermatitis is uncertain. One proposed etiology suggests the causative role of *Pityrosporum ovale*, lipophilic yeast. Seborrheic dermatitis is also likely affected by factors such as hormones and stress.

Diagnosis

This condition presents as erythematous plaques with overlying yellow dry or greasy scales of various sizes. The most common sites of involvement include the scalp, eyebrows, nasolabial folds, lips, ears, sternal area, axillae, umbilicus and gluteal crease. In general, there is increased involvement at sites where the sebaceous glands are most active. Pruritus may be a common symptom.

Treatment

Shampoos: Apply and massage into scalp. Leave on for 5 minutes, and then rinse off. May use daily initially, and then use 2-3 times a week for maintenance once clear.

Over-the-counter shampoos

- Selenium sulfide 1% (Selsun Blue), pyrithione zinc 1% (Dandrex, Zincon, Head and Shoulders), pyrithione zinc 2% (DHS Zinc, Sebulon, ZNP Bar), coal tar (DHS Tar, Zetar), ketoconazole 1% shampoo.

Prescription shampoos

- Selenium sulfide 2.5% (Exsel, Selsun), ketoconazole 2% (Nizoral).

Topical Preparations: Apply to affected areas daily until clear, and then as needed.

Over-the-counter topical preparations

- Hydrocortisone 1% cream, miconazole 2% cream.

Prescription topical preparations

- Hydrocortisone 2.5% cream, fluocinolone acetonide 0.01% solution (Synalar)*, ketoconazole 2% cream (Nizoral), sodium sulfacetamide lotion (Klaron).

Topical preparations may be used as adjunct therapy to medicated shampoos in the treatment of seborrheic dermatitis.

*If using potent topical steroid preparations, advise patients to use them sparingly and to avoid excessive and prolonged use since this may lead to skin atrophy.

SPECIAL NOTE:

To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for seborrheic dermatitis that has not been evaluated and previously treated. Patients' personal physicians are the best source for such evaluations and initial therapies.

Skin Tags

Description

A skin tag (acrochordon) is a small, soft, flesh-colored to dark brown growth that is either sessile or pedunculated. It is not skin cancer and does not become skin cancer. Skin tags are more common with increasing age. They appear most often in skin folds of the neck, axillae, trunk, beneath the breasts and in the groin area. They can become irritated by clothing or jewelry rubbing against them, and patients often want them removed

Diagnosis

Diagnosis is usually done based on clinical appearance. They are small but can be up to 1 cm in diameter. They are skin-colored to brown in appearance and appear in skin folds, typically around the neck, armpits, beneath the breasts, or in the genital region. They are typically painless. As a result of twisting on the stalk, they may become inflamed or tender, or necrotic.

Pathology testing is not required if skin tags have a characteristic appearance. If a skin tag is immobile, is a different color than surrounding skin, is multicolored, or has raw or bleeding areas, consider sending the lesion for pathologic evaluation.

Treatment

- **Skin tags can usually be clipped off at the base using sharp scissors or a sharp blade. This method is best for tags with a thin stalk. No anesthesia is required, and lesions often do not bleed. If bleeding occurs, it can be stopped with aluminum chloride, light electrodesiccation, or sometimes with just a spot-size Band-Aid.**
- For lesions with a thicker stalk, local anesthesia is recommended.
- Some patients and some doctors prefer cryotherapy with liquid nitrogen. Liquid nitrogen can be applied using two cotton-tipped applicators to trap the tag or try pick-ups or forceps dipped in liquid nitrogen. Continue to apply liquid nitrogen until the tag is white. Allow the tag to thaw before repeating the process once.
- Large numbers of small tags may be treated quickly by electrodesiccation.

Secondary treatment:

- If skin tags do not clear with the first treatment, retreat.
- Some nevi may have a pedunculated base. If a pigmented skin tag is changing or symptomatic, review the ABCDs of melanoma and consider biopsy.

SPECIAL NOTE:

- 1) **There are so many skin tags in the world! To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for skin tag therapy. Patients' personal physicians are the best source for treatment of skin tags.**
- 2) **Treatment of tags without symptoms should be billed to the patient (advance notice required, with specific forms for Medicare patients).**

The Common Wart (Verruca Vulgaris)

Description

The common wart is a discrete, benign, epithelial hyperplasia that tends to manifest as papule and plaques with cleft surfaces. They are caused by certain types of human papilloma virus (HPV) that commonly infect keratinized skin, usually at sites of minor trauma.

Immunocompromise such as HIV disease or during immunosuppression following organ transplantation is associated with an increased incidence of and more widespread cutaneous warts.

Diagnosis

- Firm papules, 1-10 mm, rarely larger. The surface may be cleft or warty. Plantar warts (on the soles of the foot) are usually flat; they may coalesce into patches.
- Warts usually cause the normal skin lines to deviate around them.
- Characteristic red dots that represent thrombosed capillaries within the wart. May require paring to see.
- Sites of predilection, sites of trauma: hands, fingers, knees.

Treatment

- Duct tape occlusion QHS.
- Liquid nitrogen to wart q4-6 weeks until resolution.
- 40% salicylic acid plaster (Mediplast, available OTC). Have patient apply it continuously for 3 of every 4 days.

If no resolution after several months, additional modalities as follows:

- 40% salicylic acid plaster under duct tape occlusion QHS.
- Liquid nitrogen and after thaws, apply cantharidin collodion 0.7% application to lesions; cover with moleskin and keep dry for 3 days (if possible). Note: Cantharidin collodion may be available on a named-patient basis; contact our office for information on ordering it.
- Topical imiquimod (Aldara) QHS under occlusion in addition to liquid nitrogen therapy q4-6 weeks.

As a last resort for resistant lesions, candidal antigen injections can be performed, as well as electrosurgery (risk of increased scarring), and surgical excision (risk of increased scarring). Such treatments are performed only on highly selected patients in the Dermatology Department. Contact our chief nurse if you believe one of your patients qualifies; do not send a consult (see SPECIAL NOTE below).

NOTE:

Warts are gone when skin lines are not deviated. For plantar warts, proper assessment may require paring to avoid unnecessarily treating dead wart tissue.

SPECIAL NOTE:

To preserve appointments for patients who need dermatologic consultations, UM Dermatology does not accept patients for wart therapy. Patients' personal physicians are the best source for treatment of warts.