Dermatologic Urgencies and Emergencies

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Red Flags in Dermatology Warranting a Dermatology Consult:

1. Blisters, Desquamation, and Erosions
2. Painful/Dusky Skin
3. Mucosal involvement
4. Rapidly progressive ulcerations
5. Rapidly progressive purpura or necrosis
6. Erythroderma (red and/or scaly all over)

Blisters, Desquamation, Erosions

1. SJS/TEN and Erythema Multiforme
    a. Painful dusky skin with formation of erosions, blisters, or sloughing
    b. Look for hemorrhagic crusting of the lips**
    c. SJS/TEN
        i. due to drug culprit:
            1. Allopurinol
            2. Seizure meds
            3. Antibiotics (especially Bactrim)
            4. Nevirapine
            5. NSAIDs
        ii. In kids, children's Motrin (and less commonly Tylenol) is one of the most common culprits
        iii. If you are suspicious, stop any possible offending med immediately
        iv. Treatment is supportive (until further evaluated by dermatology)
    d. Erythema Multiforme
        i. Tends to have more targetoid dusky plaques as compared to SJS (which tends to have more sheet-like sloughing of skin), but sometimes can be difficult to tell the difference
        ii. If heavy mucosal predominance in a child, can be induced by mycoplasma pneumonia – check mycoplasma serology and if elevated titers can treat with abx
2. Bullous Pemphigoid
    a. Most common autoimmune blistering disease
    b. Patients are usually 60 or older
    c. Present with scattered tense blisters
    d. Treatment is with high dose prednisone
    e. Topicals: triamcinolone 0.1% ointment (454g jar) twice daily is commonly used
3. Staphylococcal Scalded Skin Syndrome
    a. Kids (extremely rare in adults)
        i. Due to a staph exotoxin (kids immature kidneys are unable to clear the exotoxin as compared to adults)

   ii. Very superficial desquamation, predominantly in the folds* (ie neck, axillae, antecubital fossa, groin)
   iii. Look for perioral and periocular crusting (usually yellow crusting)*
   iv. Perform culture swab from all areas of crusting
   v. Requires admission, start on iv nafcillin
4. Herpes Zoster
   a. Look for blisters in a dermatomal distribution
   b. Disseminated zoster can occur in patients who are immunosuppressed
   c. Unroof the blister with a 15 blade, perform HSV 1+2 PCR and VZV PCR (usually a send out)
      i. PCR is preferred over culture (higher sensitivity and specificity)

<u>Rapidly Progressive Ulceration</u>

1. Pyoderma Gangrenosum

- Rapidly progressive ulceration that usually starts with gun-metal grey pustules that coalesce to form cribiform ulcerations, with overhanging/undermined borders
- Associated with underlying systemic disease in about 50% of cases (think about PG in a patient with underlying IBD or hematologic myeloid malignancy – ie AML)
- Tissue culture (via bedside biopsy is usually performed to rule out infection)
- Treatment is via high dose steroids or high dose cyclosporine
- Avoid pathergy (ie debridement could make worse)

<u>Rapidly Progressive Purpura or Necrosis</u>

1. Palpable purpura
   a. What we see in leukocytoclastic vasculitis (“LCV”)
      i. Usually presents with palpable purpura on the lower legs
      ii. Common to see this in patients who have been in the hospital, sick, on many different medications, etc.
      iii. Perform a ROS to inquire whether any other organ systems could be involved (ie any joint pains, blood in stool, etc. – usually this is apparent clinically if so)
      iv. If mild and localized to lower legs, can treat with topical steroids
      v. TAC 0.1% ointment and clobetasol ointment (stronger) are usually used
   b. IgA vasculitis (“HSP”)
      i. This is a variant of LCV with IgA deposition on DIF
      ii. Think about IgA vasculitis if the palpable purpura extends above the waist, and is forming blisters/vesicles*
      iii. Significant in adults because they can have renal involvement (sometimes severe) – check kidney function and UA (look for hematuria, proteinuria)
2. Retiform/stellate purpura
   a. Often times starts as dusky purple areas of skin that begins to form necrotic eschars, often in a stellate/retiform/net-like pattern
      i. This pattern signifies that something is occluding the blood vessels
   b. Examples include:
      i. Calciphylaxis:

1. Uremic calciphylaxis: Most common, patients on dialysis
2. Non-uremic calciphylaxis: patients usually have risk factors: obesity, recent prednisone use, recent warfarin use, heavy EtOH use, low albumin (including anorexia)

ii. Antiphospholipid syndrome
iii. Purpura fulminans (pt with bacterial sepsis)
iv. Cholesterol emboli syndrome (tends to present with a showering phenomenon – ie intermittent livedo)
    1. Pt with history of recent procedure within past few months: ie cardiac cath, arteriography, peripheral interventions, intraaortic balloon pumping, and cardiac/vascular surgery)
v. Angioinvasive fungal infections
    1. Think about this in any patient with neutropenia (usually patients who are on chemotherapy)
        a. These infections are rapidly progressive and deadly. If you have a patient with neutropenia who develops retiform purpura, a dusky scab, etc – take this seriously!
    2. Think about this in any patients who are severely immunosuppressed (ie recent MVA in the ICU, someone in the ICU on dialysis, vent)
vi. Cryoglobulinemia
vii. Heparin/warfarin necrosis (uncommon)

<u>Erythroderma</u>

- Red/ scaly all over
- Common causes include:
    - Drug Rashes
        - Morbilliform Drug Eruption (most common)
            - Various causes (antibiotics are common)
            - Usually about 1-2 wks after starting a new drug
        - DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms)
            - Presents later, usually 4-6 weeks after starting a drug
            - Common culprits:
                - Vancomycin, Minocycline, Dapsone, allopurinol, abacavir, seizure meds, sulfonamides
            - Labs: eosinophilia, leukocytosis, transaminitis
            - Watch kidneys, liver
            - Stop any possible offending meds
            - Exam: look for facial swelling, facial crusting, and lymphadenopathy (cervical most common) in addition to a morbilliform drug rash
            - Treatment: high dose steroids
    - Atopic Dermatitis
        - Severe atopic dermatitis can become very severe and involve the entire body
        - Pt has usually had a history of eczema for many years before it gets to this point
        - Pt is often non-compliant with topicals at home
        - Treatment: commonly with TAC 0.1% ointment (make sure to rx the 1 lb jar) applied to all skin covered with sauna suit. Perform bacterial culture swab to rule out secondary staph infection (common in these patients, treat

accordingly), prednisone can be done in severe cases ie 0.5-1mg/kg/day tapered over 3-4 wks. *quick tapers can cause worse rebound

- Erythrodermic psoriasis