Clinical nuggets for common rashes

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Clinical nuggets for:

- Tinea versicolor
- Seborrheic dermatitis
- Scabies
- Granuloma annulare
- Palmoplantar pustulosis
- Rhus dermatitis
Tinea Versicolor

- A very common, benign, superficial cutaneous fungal “infection”
  - *Malassezia sp*
  - Found in 18% of “uninfected” infants and 90-100% of adults
- Affects ~2-8% of the population
- Ages 15-24 years
  - when the sebaceous glands are more active
- Hypopigmented or hyperpigmented macules and patches on the chest and back
- May chronically recur in patients with a disposition to develop this
- Fungus is localized to the stratum corneum
Tinea Versicolor
Tinea Versicolor: Arriving at the Diagnosis?

- KOH prep
  - Time consuming
  - Need a microscope (+/- CLIA certified lab)

- Culture?
  - Virtually impossible
The Clinical Nugget: Diagnosing Tinea Versicolor

“Evoked scale sign”
- Stretch the macule/patch
  - T versicolor will always scale when released
- Scrape with a #15 blade or edge of a glass side
  - Should also elicit scale

The Clinical Nugget: Diagnosing Tinea Versicolor

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[References]
Treating Tinea Versicolor

- PO Ketoconazole - be wary of black box warning!
  - Liver injury, adrenal insufficiency, and drug interactions
  - FDA warning (9/2013):
    - “Nizoral oral tablets should not be a first-line treatment for any fungal infection. Nizoral should be used for the treatment of certain fungal infections, known as endemic mycoses, only when alternative antifungal therapies are not available or tolerated.”

- Fluconazole PO 150- to 300-mg weekly dose for 2-4 weeks
- Itraconazole 200 mg/d for 7 days
Treating Tinea Versicolor

- For prophylaxis:
  - Ketoconazole 2% shampoo as a wash (scalp and affected areas) TIW
  - Can also use 2% cream TIW based on patient preference

- Skin color alterations routinely take 1-2 months to resolve
Diagnosis?
Seborrheic Dermatitis
Seborrheic dermatitis

Also caused by Malassezia

**Clinical Nuggets:**

1. Worsens with T-cell deficiency (HIV) and neurological disorders (particularly Parkinsons)

2. Rash distributed on sebum rich areas of the body

3. Erythema with greasy scale
   - Varies in symptoms
   - Worse in winter/early spring
Seborrheic dermatitis

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Seborrheic Dermatitis
Treatment of Seborrheic dermatitis

- Face/body:
  - Topical steroids for short term uses
    - Flares: hydrocortisone or desonide BID x 1-2 weeks
  - Antifungals:
    - Ketoconazole shampoo or cream

- Scalp:
  - Antiseborrheic shampoos in rotation (selenium sulfide, zinc pyrethione, ketoconazole, salicylic acid, tar)
    - Change type of shampoo every other week
      - Tar: stinks and stains hair
      - Salicylic acid: great for scale; not so great for inflammation
  - Topical steroids
    - Most people tolerate a solution better than a cream or oil!
      - Clobetasol solution QHS x 2 weeks
      - Fluocinonide, fluocinolone also come in solutions
Scabies

- Eggs
- Feces
Clinical Scabies Nugget: _______
Clinical Scabies Nugget: Burrows vs?
Scabetic burrows

- Short serpiginous track in superficial epidermis
- Look in web spaces, flexor wrists, elbows, belt area
- Burrows are pathopneumonic for scabies, but...
  - they are hard to find with the naked eye
Examples of scabetic burrows
Examples of scabetic burrows
The Clinical Nugget: Genital Nodules

- Pruritic papules and vesicles on the scrotum and penis in men and areolae in women are highly characteristic.
- Also seen on buttocks or axillary folds.
- Firm, red-brown, >0.5 cm, oval shape.
The Clinical Nugget: Genital Nodules

- Pruritic papules and vesicles on the scrotum and penis in men and areolae in women are highly characteristic.
Scabies

- “Animal scabies” (mange) mites may result in transient symptoms in humans, but they are not a cause of persistent infestations

- Most transmission is from direct and prolonged skin to skin contact with an infected individual
  - Fomite transmission, such as infested bedding or clothing, is possible but rare
  - More common in crusted scabies

- Treatment:
  - Permethrin 5% cream to neck down; repeat in 7 days
    - All whom live in the house need to be treated!
      - These are often “carriers” and can be asymptomatic
  - Must also concomitantly wash all bedding/clothing in hot water
    - What can’t be washed should be set aside in a garbage back for 7 days
diagnosis???
diagnosis???
Palmoplantar Pustulosis

- Localized pustular psoriasis to hands/feet
- Sterile creamy- to yellow- pustules with erythema and scaling
  - “Lakes of pus”
- The Clinical Nugget:
  - Brownish-red macules at sites of resolving lesions
Palmoplantar Pustulosis

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  - Pustules on soles and/or palms with brownish/red macules = palmoplantar pustulosis
Palmoplantar Pustulosis

- Never on dorsal hands
- Can have pruritus, pain and burning
- Few patients (only 5-20%) have typical psoriasis plaques elsewhere
- Most often happens in people with a smoking history
  - ~80% are smokers at onset
  - Smokers have 7x the risk of developing
Palmoplantar Pustulosis Treatment

- Cochrane review from 2009:
  - Topical steroid with occlusion
    - Clobetasol BID x 2 weeks, then TIW x 2 weeks; repeat cycle
  - Oral retinoids
  - PUVA (oral psoralin + UVA phototherapy)
  - Re:PUVA
Diagnosis?
The Clinical Nugget:
- Looks like tinea WITHOUT scale
Granuloma annulare

- Dermal papules and annular plaques
  - No surface change or scale (unlike tinea)
  - Start small, but can expand to up to 5 cm in diameter
- Most commonly on the dorsal surfaces of the feet, hands, and fingers, and on the extensor aspects of the arms and legs
  - Can become generalized
- Relatively common disease that occurs in all age groups
  - Rare in infancy
Granuloma Annulare
Generalized Granuloma Annulare

- Up to thousands of papules and plaques that involve multiple body areas
- Lesions tend to be symmetrically disposed over acral areas and the trunk
- Rarely, the head, palms, soles, and mucous membranes are involved
Generalized Granuloma Annulare

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- Can be associated with diabetes (type 1 > II) and dyslipidemia

Treatment of Granuloma Annulare

- Localized granuloma annulare is not often symptomatic and it has a tendency towards spontaneous resolution (within 2-3 years)
  - Reassurance is often all that is necessary
  - Potent topical steroids x 4-6 weeks or IL steroids

- Generalized granuloma annulare is more often treatment resistant and can be very bothersome
  - Rifampin at 600 mg, ofloxacin at 400 mg, and minocycline hydrochloride at 100 mg monthly for 3-6 months


- Dapsone, hydroxychloroquine
Differential Diagnosis?
Rhus Dermatitis
(Toxicodendron Allergic Contact Dermatitis)
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Poison Ivy
Poison Ivy – Clinical Nugget #1?
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Geographical appearance

“An Outside ➔ In Job”
Toxicodendron
Allergic Contact Dermatitis

- Irritant: Urushiol
  - poison ivy, poison oak, and poison sumac
- Clinical Nugget #2-
  - Although technically not Toxicodendron species, urushiol is also found in mango peels and Japanese lacquer trees and can incite a similar clinical picture.
Toxicodendron
Allergic Contact Dermatitis

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“Mango allergy: The fruit that destroyed my face”
Toxicodendron
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- Type IV delayed hypersensitivity reaction

- Lesions generally appear within 12-48 hours
  - Range: 8 hr – 14 days
  - New lesions may continue to appear for up to 2-3 weeks.
  - Fluid from the vesicles of a poison ivy rash does not contain urushiol and is not a source for new lesions
Rhus Dermatitis
Treatment of Rhus Dermatitis

- Topical steroids + antihistamines
- *Clinical Nugget #3:*
  - *Prednisone taper*
Treatment of Rhus Dermatitis

- Topical steroids + antihistamines

Clinical Nugget #3:

- Prednisone taper – MUST be done over >14 days, otherwise the patient will flare badly!
Questions

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