Common Dermatologic Presentations in the Acute Care Setting

Kim Ceci
June 15, 2011
CASE 1

- Very pruritic eczematous-like rash
- Small papules, vesicles or bullae that can be confluent
- +/- Inflammation with erythema, edema, oozing or crusting
- Localized but can spread
- Delayed hypersensitivity reaction
Allergic Contact Dermatitis

- Determine offending agent
- Occupational exposure?
- Avoid agent, protective gear/products, allergen testing if agent unknown

**Acute Tx:**
- Cold compresses/baths + cornstarch & baking soda
- Oral antihistamines for pruritis

**Mild/Localized Tx:** Corticosteroid ointment/gel

**Severe Tx:** Systemic corticosteroid + taper

**Poison Ivy:** Zanfel binds allergen

**Antibiotics** if superimposed infection
CASE 2

- Itchy or tingling to severe lancinating pain, tenderness, dysesthesias, paresthesia or hypersensitivity
- Unilateral rash eruption 1-5 days later
- Erythematous macules and papules spreading anteriorly along involved nerve segment
- Transform over next 24h to vesicles on erythematous base lasting 3-5 days
- Evolve to pustulation, ulceration, and crusting
Herpes Zoster

- Treat if 72hr or less since onset rash
  - Valtrex 1000mg TID x7d
  - Famvir 500mg TID x7d
  - Acyclovir 800mg 5 times a day x7d

- Analgesics: NSAIDs, opioids
  - Gabapentin 900mg x1 to decrease pain severity
  - Amitriptyline 25mg QD x90days to decrease risk for postherpetic neuralgia in 60 or older

- Hutchinson’s sign
  - Ophthalmology consult!

- Caution! - until all lesions crusted
CASE 3

- Extreme pruritis, excoriations of the scalp primarily in girls 3-12 years old
- Oval light gray nits found on inspection of scalp
- Secondary impetigo or furunculosis can occur
Pediculosis

- Nix (1% permethrin shampoo)
- Severe/resistant Tx:
  - Add Bactrim 5mg/kg BID x10d, or
  - Elimite (5% permethrin cream) overnight
  - Ovide (0.5% malathion lotion), no hairdryer/curling iron
  - Ivermectin 200-400 mcg/kg PO x1 repeated after 7-10d
- Disinfect sheets/clothing
- Nit removal
- OTC alternative: HairClean 1-2-3
- Head shaving effective
- Pubic lice - same tx, should prompt STD workup, treat partner
CASE 4

- Extremely friable red or yellow papule or polyp, bleeds with every slight trauma
- Crusted sometimes purulent appearing collection of well-demarcated, red granulation tissue arising from a moist, sometimes hemorrhagic, skin ulceration, often with a collarette of scale at the base
Pyogenic Granuloma

- Minority will involute spontaneously in 6 mo
- If <0.75cm - cauterize w/ silver nitrate stick until completely discolored - use 1% epi + lido
- If pedunculated - ligate w/ absorbable suture
- Cover w/ Keflex 500 TID x3-4d to prevent secondary cellulitis for wound on distal extremity
- Epulis gravidarum - gingival lesion during pregnancy, spontaneous resolution after delivery
- Appears neoplastic in nature or recurrent, extensive lesion - Derm Referral!
CASE 5

- Intense pruritis
- Short elevated gray threadlike serpiginous tracks w/papule or vesicle present at end of burrow
- Usually at interdigital web spaces, volar aspects of wrists, axillae, olecranon area, nipples, waistline, genitalia and gluteal cleft
Scabies

- Elimite (5% permethin cream) overnight, w/ 2nd tx 1 week later
- Ivermectin PO 0.2mg/kg once
- Pregnant and Infants: 5% or 10% precipitated sulfur in petrolatum QHS x3 nights (odor + stain)
- Pruritis: antihistamines, prednisone if severe
- Disinfect sheets/clothing/towels
- Treat close physical/sexual contacts +/- symptoms
CASE 6a

- Tick bite 5-10 days prior to start of symptoms
- Initial: fever, N/V, myalgia, arthralgia, fatigue
- Erythema migrans = usually round to oval, well-demarcated median diameter 15cm, pathognomonic, 1-16w after bite
  - Annular homogenous erythema in 60%
  - Central erythema in 30%
  - Central clearing in 9%
- Multiple lesions in up to 50% signify disseminated infection
CASE 6b

- Tick bite 1-2w prior to start of symptoms
- Initial: fever, chills, severe HA, myalgias
- Subtle small flat pink non-pruritic blanching spots on wrists, forearms, ankles ~2-5d after symptoms
- Maculopapular petechial rash involving palms and soles with centripetal pattern of spread ~6 days after symptoms begin
- 10-15% may never get rash
Tick Bite

- Tick attached:
  - Removal: Glove up, use narrow forceps, grasp tick closest to skin, firmly pull straight up, tick mouth parts will release
  - Lidocaine
  - Save in alcohol for identification
  - Scrape any remaining fragments away with No. 15 scalpel

- Advise on prevention

- Do NOT use heat/occlusion/caustics for removal or use bare hands
Lyme

- <72 hours *Ixodes* tick: minimal risk for disease transmission - no need for prophylaxis
- <72 hours + engorged *Ixodes* tick: give doxycycline 200mg x1 prophylactically
- >72 hours attached, rash or signs/symptoms:
  - Doxycycline 100mg BID
  - Amoxicillin 500mg TID or 50mg/kg for pregnant/nursing women or children <8 yo
  - Cefuroxime 500mg BID if allergy
  - Duration 10-21 days
RMSF

- Wood tick or dog tick, if removed - very low risk of disease transmission
- Empiric therapy based on clinical judgement and epidemiological setting
  - Doxycycline 100mg BID or 2.2mg/kg if <45kg
  - Chloramphenicol 50 mg/kg divided QID for pregnant women
- Duration: 5-7 days
CASE 7

- Very pruritic, worrisome spreading rash
- “Athlete’s foot”: interdigital, moccasin or vesicobullous, often fissuring, scaling with underlying pink to red skin
- “Jock itch”: erythematous scaling eruption often annular +/- pain on inguinal folds, inner thighs, perineum & buttocks
- “Ringworm”: erythematous flat scaling annular eruption with central clearing with raised borders advancing circumferentially, vesicles or pustules can formed if inflammed
Tinea

- Tx: BID application of Terbinafine, Clotrimazole 1%, or Miconazole 2% in cream, spray, lotion, powder, applied 2cm past border of lesion
- Duration: Must continue 7-14d after resolution to prevent relapse except if Lamisil used
- Extensive/Severe Tx: PO Terbinafine 250mg daily x2w, Ketoconazole 200mg daily x4w, or Fluconazole 150mg weekly x2-4w
- If secondary skin infection: Domeboro compresses, topical Bactroban or systemic ABX depending on severity
- If inflammed/weeping lesion: consider Lotrisone along with wet compresses
- Remember: Corticosteroid alone decrease symptoms but allow increased fungal growth
- Advise: Non-occlusive footwear, loose/no undergarments of absorbent cotton, dry skin well
Tinea

- **Tinea capitis:**
  - Requires systemic tx (griseofulvin)

- **Tinea versicolor:**
  - Misnomer
  - Lipophilic yeast not dermatophyte
  - Asymptomatic but cosmetically unpleasant with irregular patches varying pigmentation, lighter in summer, darker in winter
  - Tx: Nizoral 2% Ketoconazole shampoo 5 min daily x3d
  - Recurrence 80% in 2 yrs - can treat monthly with Nizoral or Selsun shampoo
  - Alternatives include antifungals previously discussed
CASE 8

- Intense pruritis
- +/- history of precipitating agent/event in immediate or recent past, more often patient only has rash
- Non-tender, sharply defined, slightly raised, blanching wheals surrounded by erythema, usually circular or as incomplete rings, central erythema may appear more pale in comparison to surrounding area, anywhere on body
- Transient - no more than 8-12 hours, but can be replaced with new lesions in different locations
- +/- angioedema, N/V/abd pain, anaphylaxis
Urticaria

- First assess airway and breathing!!!
- If respiratory tract involved:
  - Oxygen + IV access
  - Epinephrine 0.3mg SC or IM, Q10min until symptoms subside
  - NS boluses if hypotensive
  - Benadryl 50mg IV or IM for pruritis
  - Solumedrol 40mg IV decreases possibility for relapse
- Admit to observe if anaphylaxis or severe angioedema
- Provide Epi-Pen and encourage Med-Alert bracelet
Urticaria

- Attempt to determine precipitating cause then AVOID agent (most remain undetermined)
  - Stings, drugs, herbs, vitamins, foods especially containing dyes, nitrates, nitrites, sulfites, MSG, aspartame
- H1-blocker for next 48-72 hours
- H2-blocker can improve clearing
- Prednisone burst to decrease recurrence

Chronic/Resistant:
- Consider TCA (Doxepin 10-50mg QHs)
- Consider Leukotriene modifier (Singulair 10mg Qd)
- Allergist referral

Angioedema alone: Think ACE(-) or hereditary angioedema

Painful urticaria +fever/arthralgias: Think infection or illness
- i.e. collagen vascular disease w/vasculitis, anicteric hepatitis, CMV, or infectious mono