Cutaneous Findings Encountered in the Outpatient Setting

Pityriasis Rosea

- Benign exanthem likely viral in origin
- Linked to URIs, can present in many family members
- Occasional pruritis (75%, severe in 25%)

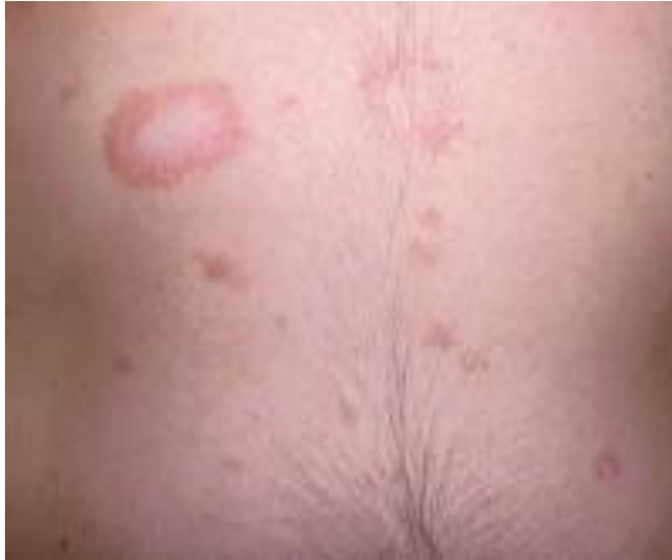
Pityriasis Rosea

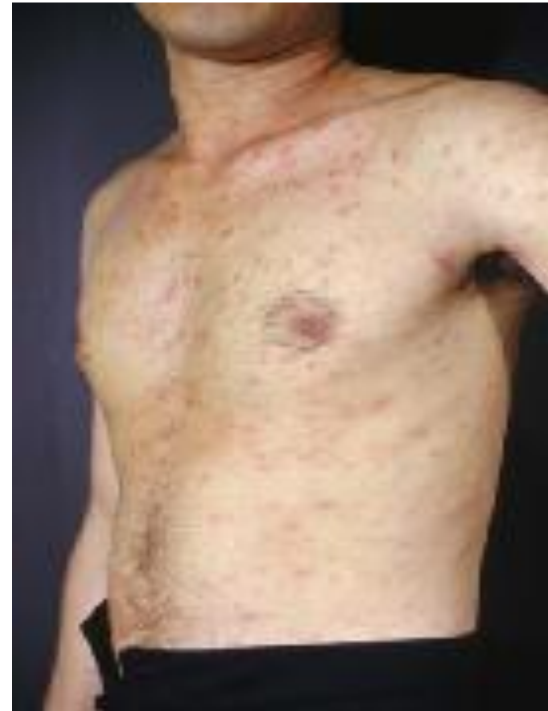
- Herald Patch
  - Single pink patch 2-10 cm in diameter
  - On neck or trunk with fine scale
  - Found in greater than 50% of patients
- Generalized Eruption
  - 1-2 weeks after appearance of herald patch
  - Salmon colored macules with fine scale
  - Organized in linear fashion along cleavage lines

Treatment

- Reassurance
- Pruritis relief – topical steroids, oral antihistamines, oatmeal baths
- NO USE for systemic steroids
- UVB light may be necessary
- Usually resolves by 12 weeks

Pityriasis Rosea





Seborrheic Dermatitis

- Papulosquamous disorder occuring on sebum-rich areas of face, scalp, trunk
- Intermittant active phases – burning, scaling, itching
- Can be complicated by secondary infections
- Activity increased in winter, early spring

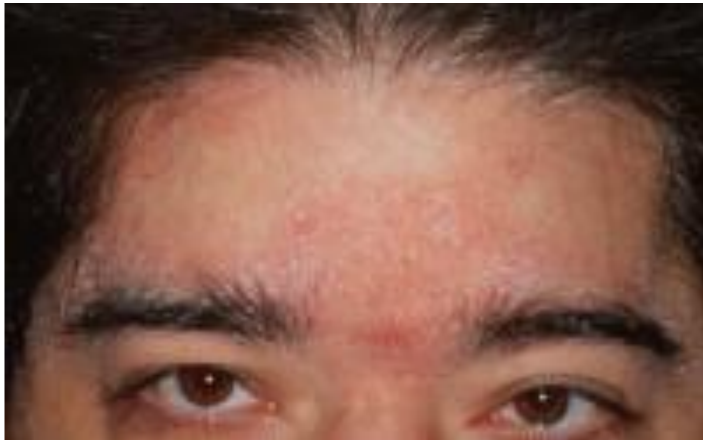
Seborrheic Dermatitis

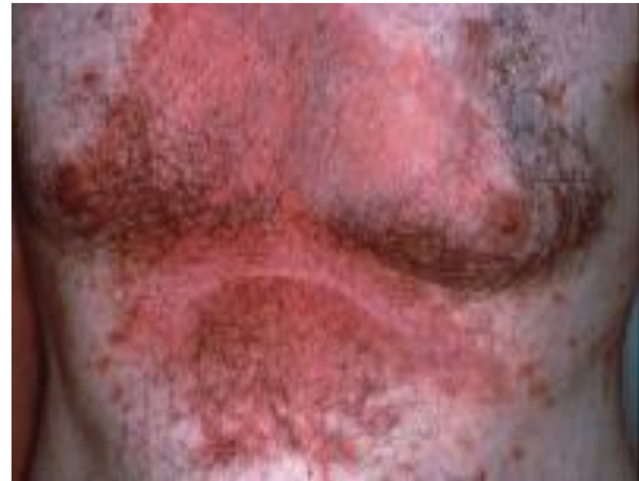
- Appearance varies from mild, patchy scaling to thick, adherent crusts
- Scaling over red, inflamed skin
- Hypopigmentation in dark-skinned races
- Distribution – oily and hair-bearing areas
- Typically an annular scaling

Treatment

- Early treatment of flares encouraged
- Topical steroids for short-term use ONLY
- Sulfur, sulfonamide preparations, ketoconazole gels
- Dandruff – long periods of lathering; shampoos with selenium, sulfer, zinc, salicylic acid

Seborrehic Dermatitis





Allergic Contact Dermatitis

- Initial Sensitization phase (10-14 days)
- T-cell mediated immune response
- Once sensitized – rash develops within hours to several days after exposure
- Can occur over existing skin pathology (i.e. neomycin rxtns on stasis ulcers)

Allergic Contact Dermatitis

- Pruritic papules and vesicles on an erythematous base
- Lichinified plaques may exist in chronic ACD
- Location can give important clues as to causation

ACD

- Hands: an important site of ACD, particularly in the workplace. Common causes include the chemicals in rubber gloves.
- Perianal: frequent in the perianal area as a result of the use of sensitizing medications and remedies (eg, topical benzocaine).
- Otitis externa: Topical medications
- Airborne ACD: Chemicals in the air. Usually occurs maximally on the eyelids, but imay affect other areas, particularly the head and the neck.
- Ophthalmologic: chemicals in ophthalmologic preparations may provoke dermatitis around the eyes.
- Hair dyes: Individuals allergic to hair dyes typically develop the most severe dermatitis on the ears and adjoining face rather than on the scalp.
- Stasis dermatitis and stasis ulcers: Individuals with stasis dermatitis and stasis ulcers are at high risk for developing ACD to topical medications applied to inflamed or ulcerated skin. May develop widespread dermatitis from topical medications applied to leg ulcers or from cross-reacting systemic medications administered intravenously. A patient allergic to neomycin may develop systemic contact dermatitis if treated with intravenous gentamicin.

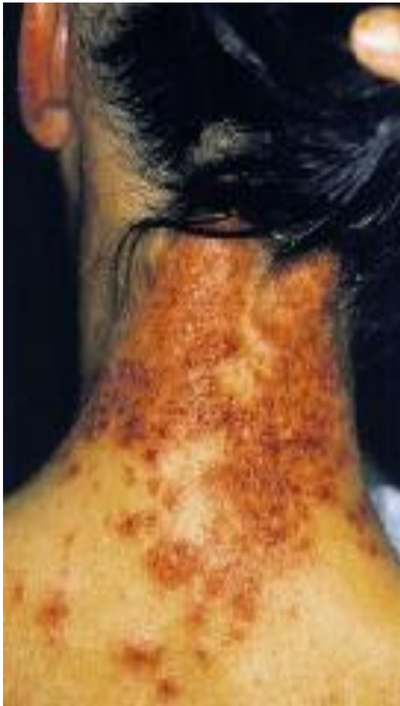
ACD

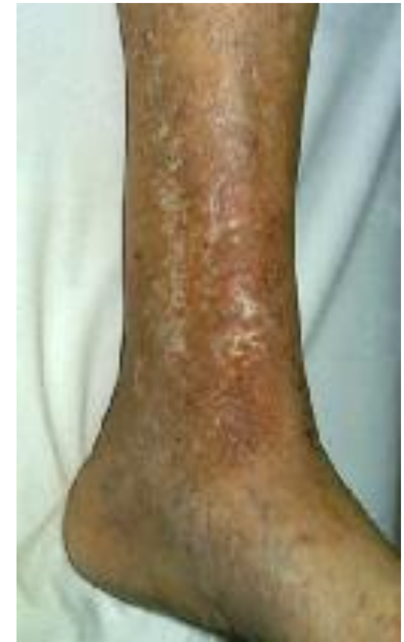
- 25 chemicals responsible for approximately ½ of all cases
- Poison ivy, nickel, chemicals in rubber gloves, dyes and chemicals in textiles, preservatives in moisturizers, cosmetics, topical meds, formaldehyde, fragrance, topical corticosteroids, neomycin, benzocaine, preservatives in sunscreen

ACD

- Can be diagnosed with Patch testing
- Treatment
  - Cool compresses, lukewarm oatmeal baths
  - Oral antihistamines
  - Corticosteroids
    - In severe cases – 2 weeks of po steroids starting at 40-60 mg and tapering
  - Immunosuppressive agents (Imuran, Neoral) may be needed in severe, recalcitrant cases

Allergic Contact Dermatitis





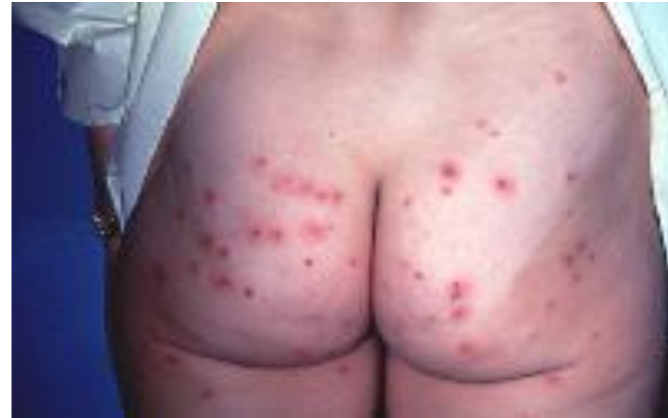
Folliculitis

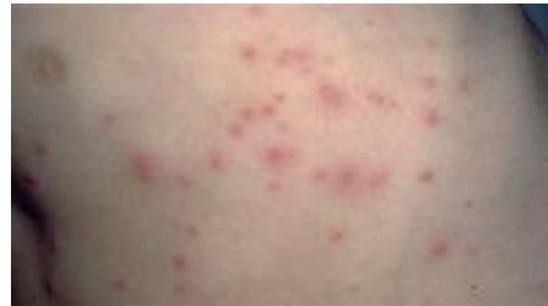
- Results from obstruction/disruption of hair follicles
- Can result from infection or physical/chemical irritation
- May cause mild discomfort/pruritis
- Lesion is papule/pustule with central hair
- May be bacterial (staphylococcal, gram negative), fungal (pityrosporum), viral (HSV), irritant

Folliculitis

- Can empirically treat based on history/physical exam
- If resistant to therapy, cultures, Gram stain, KOH prep, and biopsy are the diagnostic tests of choice
- Nasal culture of family members to look for *S aureus* colonization may be needed in chronic cases

Folliculitis





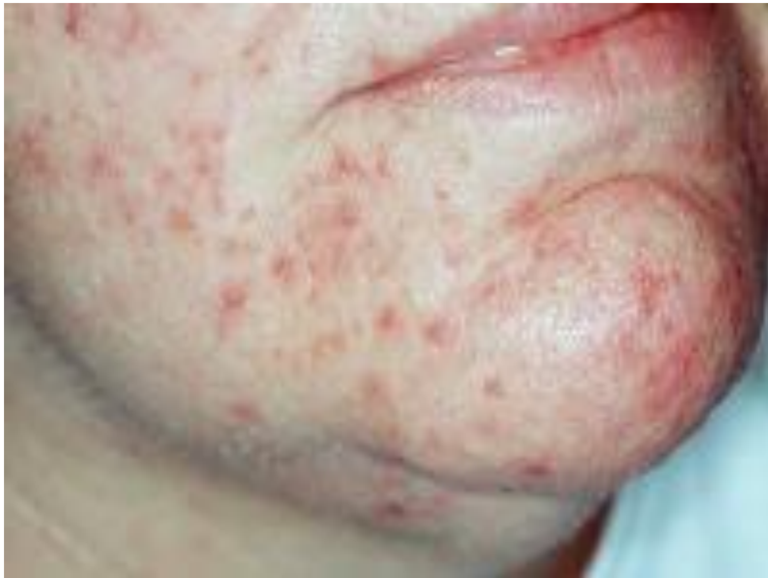
Rosacea

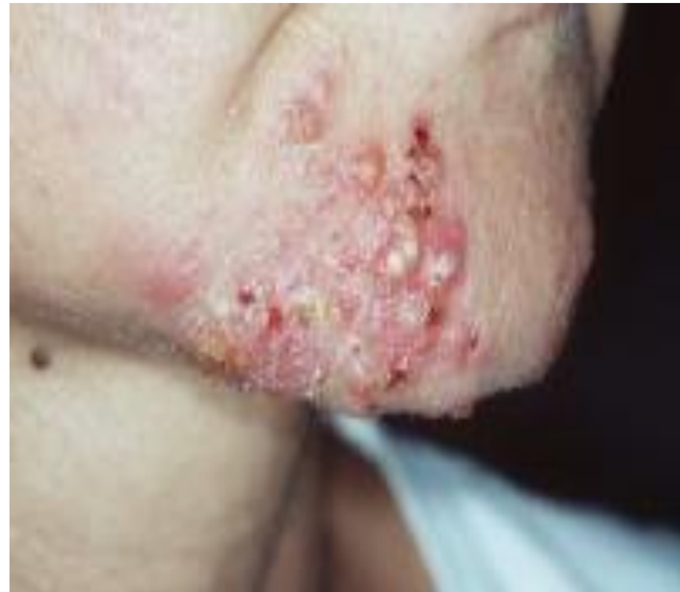
- Common condition -- facial flushing, erythema, telangiectasia, coarseness of skin, an inflammatory papulopustular eruption resembling acne
- Rhinophyma -- may occur as an isolated entity; can be disfiguring
- Lymphoedema may be marked periorbitally
- Ocular rosacea may be accompanied by conjunctival injection, and rarely, chalazion and episcleritis

Rosacea

- Treatment
  - Tetracycline 250 mg – 500 mg tid for acneiform lesions; treat 2-4 mos
  - Topical metronidazole
  - Accutane
  - Ocular rosacea – tetracycline for minimum of 3 mos

Rosacea





Tinea Corporis

- A superficial dermatophyte infection of the glabrous skin of the skin; inflammatory lesions and noninflammatory lesions
- Infection occurs through contact with infected humans, animals, or inanimate objects
- Pruritic annular plaque is characteristic of a symptomatic infection

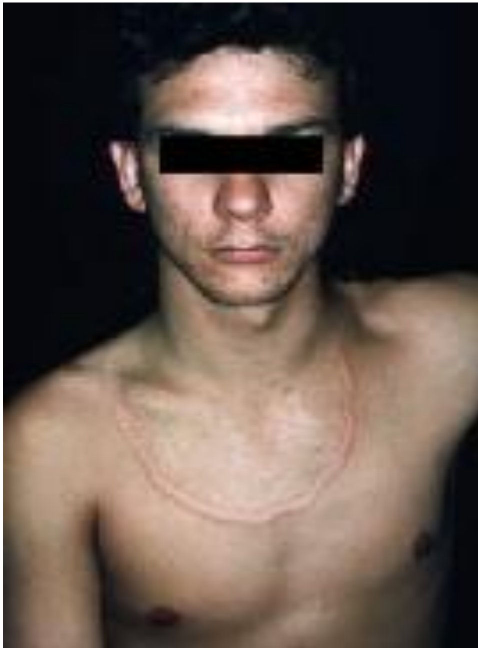
Tinea Corporis

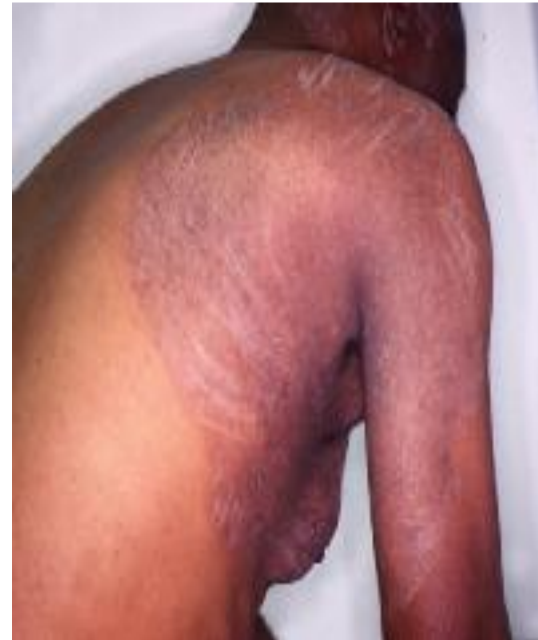
- Lesion typically begins as an annular, erythematous, papulosquamous lesion
- May grow rapidly; may become annular in shape after central resolution occurs
- Scaling, crusting, vesicle formation, and papules may also be present

Tinea Corporis

- Dermatophytes rarely invade living tissues
- Topical therapy is recommended for localized cases - should be applied to an area at least 2 cm beyond the edge of the identified lesion once or twice a day for at least 2 weeks
- Systemic therapy -- for cases of tinea corporis that are extensive, those that involve patients who are immunocompromised, or those that are not responsive to topical therapy

Tinea Corporis





Granuloma Annulare

- A benign inflammatory dermatosis -- dermal papules and annular plaques
- Its precise cause is unknown
- Asymptomatic cutaneous lesions
- Few to thousands of 1- to 2-mm papules or nodules that range in color from flesh-toned to erythematous

GA

- Hypothesized to be associated with tuberculosis, insect bites, trauma, sun exposure, thyroiditis, and viral infections, including HIV, Epstein-Barr virus, and herpes zoster virus
- Intralesional corticosteroid is the most uniformly successful therapy

GA

- Spontaneous resolution occurs within 2 years in 50% of cases, although lesions may last weeks to decades
- Recurrence, often at the same site, is noted in 40% of cases

GA