Let's Make a Rash Decision.

Kristin Rygg, MPAS, PA-C



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- University of Florida, College of Medicine 2008
- SDPA Director at Large, 2021-2023
- AAPA Huddle Representative, Dermatology, 2022
- Guest Faculty University of Colorado PA Program
- Pharmaceutical Speaker
- Denver, Colorado

Overview

- Steroids
- Contact Dermatitis
- Eczema / Atopic Dermatitis
- Psoriasis, guttate
- Drug eruption, EM, SJS/TEN

Steroid Classes

Class 1 Very High Potency Betamethasone dipropionate Clobetasol Difforasone diacetate 0.05% C O (diprolene) 0.05% C O Class 2 High Potency Amcinonide Betamethasone dipropionate 0.05% C O Class 3 High Potency Amcinonide Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Decoximetasone Difforasone dipropionate 0.1% O Class 3 High Potency Amcinonide Hakinonide 0.1% C L Dass 4 Mid Potency Betamethasone dipropionate 0.05% C (non-diprolene) Decoximetasone Difforasone diacetate 0.05% C Difforasone diacetate 0.05% C (non-diprolene) Difforasone diacetate 0.05% C Difforasone diacetate 0.05% C 0.05% C Difforasone diacetate 0.05% O 0.05% O Difforasone funcate 0.1% C 0.05% O Triameinolone 0.1% C 0.05% C Difforasone diacetate 0.05% C 0.05% O Difforasone diacetate 0.05% C 0.05% C Difforasone diacetate 0.05% C 0.05% C Difforasone diacetate 0.05% C 0.05% C Flucinolo	Medscape® www.med Class	scape.com Generic Name	Formulation
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- Ordere F - Form O - Ool J - Leffer O - Orderent O - Orderent		Hydrocortisone hydrochloride	0.25% C L, 0.5% C L O S, 1% C L O S, 2% L, 2.5% C L O S
C = Cream, F = Foam, G = Gel, L = Lotion, O = Ointment, S = Solution) = Cream, F = Foam, G = Gel, L =	Lotion, O = Ointment, S = Solution	

General adult use, but use caution

- Classes 1, 2: scalp, palms, soles
- Classes 3, 4, 5: trunk, extremities
- Classes 6, 7: face, folds, genitals

Infants/children

- Lowest potency steroid, least amount of time
- Be aware of peanut allergy

Steroid Pearls

- Judicious use
- Vehicle matters: solution, lotion, cream, ointment
- Know one-two steroids in each class
- Know when, where and how to use them
- When treating peri-orbital area always ensure no cataract/glaucoma
- Always put stop date on rx instructions
- Careful with moderate-to-large BSA
- Avoid occlusion
- Steroids can cause glaucoma, cataract, HPA axis suppression, striae, atrophy
- Ensure steroid is age appropriate. Kids are different.
- Never give steroid/antifungal combo

Approach to Rashes

- History is King
 - Age
 - HPI
 - ROS
 - Unadulterated version?
 - New or changed medications?
- Distribution
- Are they sick? Do they look toxic?
- Biopsy
- Treatment

Contact Dermatitis

• PICTURE

• PICTURE

Contact Dermatitis: Overview

- Allergic (ACD)
 - Delayed hypersensitivity reaction and worsens with exposure
 - Inflammatory response to antigen or irritant
 - Common allergens: nickel, acrylic, formaldehyde, fragrance, plant, neomycin, adhesives, oxybenzone, cobalt
 - Appears within 24-96 hours after exposure
- Irritant (ICD)
 - Occurs only in area of direct contact
 - Commonly caused by chemical
- May be difficult to discern type
- May be well-demarcated
- May be airborne, occupation induced

Contact Dermatitis (cont)

- Acute: clear, fluid-filled vesicles or bullae on erythematous and/or edematous skin; associated pruritis
- Subacute: formation of papules, pruritis
- Chronic: scaling, fissures, lichenification, pruritis

Contact Dermatitis: Treatment

- Stop/avoid offender
- Bland emollients
- Topical steroids
 - Body part specific, BID x 1-2 weeks. Stop 1 week. May repeat once.
- May use topical tacrolimus (BBW)
- Consider antihistamines
- Consider referral to allergy for <u>patch testing</u>

Eczema and Atopic Dermatitis

• PIC

• PIC

Eczema and Atopic Dermatitis: Overview

- Poorly demarcated, erythematous scaley patches, lichenification, excoriations, vesicles, hyper- or hypo-pigmentation
- Skin flexural surfaces (neck, acf and popliteal) but can be anywhere
- Pruritis
- Frequently associated with secondary infection
- Multifactorial: allergens, stress, genetics, atopy (asthma, allergic rhinitis, AD)
- Nummular eczema: variant of AD presents mostly 40-50's
 - Pruritis, coin-shaped patches with scale
- Clinical diagnosis but biopsy if uncertain

Eczema and Atopic Dermatitis: Treatment

- Topical therapies are first-line if limited BSA or minimal disease
 - Steroid (body part specific) BID x 2 weeks. Stop 1 week. Repeat once.
 - Tacrolimus or Pimecrolimus
 - BBW, greater than 2 yo
 - Crisaborole (2%) oint BID
- Systemic therapy for moderate-severe disease
 - Dupilimumab
 - Adult: Start 600 mg SC divided in 2 sites x 1 then 300 mg SC q2weeks
 - Pediatric: weight and age dependent
 - JAKS

Psoriasis and Guttate Psoriasis



Psoriasis and Guttate Psoriasis

PIC

• PIC

Psoriasis: Overview

- Chronic multisystem inflammatory disease that mostly affects skin and joints
- Classic disease
 - Pink to bright red well-demarcated plaques with silver scale o
 - Extensor surfaces of knees and elbows
 - Can present anywhere including scalp, umbilicus, gluteal cleft, trunk, nails, genitalia
- Inverse psoriasis
 - Shiny, glistening, pink red plaques in creases
- Guttate psoriasis
 - "Raindrop" papules and plaques on trunk and extremities
 - Frequently follows strep infections
- Koebner phenomenon new skin plaques due to trauma
- Clinical diagnosis, biopsy if uncertain

Psoriasis: PEST Score

Have you ever had a swollen joint (or joints)?

2. Has a provider ever told you that you have arthritis?

3. Do your fingernails or toenails have holes or pits?

4. Have you had pain in your heel?

5. Have you had a finger or toe that was completely swollen and painful for no apparent reason?

Psoriasis: Treatment

Topical therapies are first-line if limited BSA

- Steroid (body part specific) BID x 2 weeks. Stop 1 week. Repeat once.
- Betamethasone/calcipotriene (0.064%/0.005%) QD up to 8 weeks. Never on face/folds/genitals
- Roflumalast 0.3% QD, 18 yo and up, Contraindicated: hepatic impairment
- Tapinarof 1% QD, 18 yo and up
- Tacrolimus or Pimecrolimus
 - BBW, greater than 2 yo
- If extensive disease and/or positive PEST
 - Consider referral to dermatology and/or Rheumatology
 - Narrow-band ultraviolet B phototherapy
 - Consider biologics

Psoriasis: Treatment (cont)

- Old pills
 - Acetretin, MTX, Cyclosporin
- New pills
 - PDE-4 inhibitor (Otezla), kind-of Jak (Sotiktu)
- Biologics
 - TNF-Alpha, IL-17, IL-23
- Jaks

Psoriasis: Treatment (cont)

- Ensure NO history:
 - Malignancy, CHF, IBD, CNS or demyelinating disorders, TB, Hepatitis, immunosuppression, active infection
- Labs prior to starting any biologic and yearly
 - Quant gold
 - Hepatitis
 - CBC with diff
 - CMP
 - HIV
 - **ASO Titer
- **Warnings: Increased skin cancer risk, serious infection risk, malignancy

Drug Eruptions

• PIC

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Drug Eruptions: Types

- Fixed drug eruption
- Exanthematous drug eruption
- Drug-induced hypersensitivity syndrome (DIHS), also called Drug-related eosinophilia with systemic symptoms (DRESS)
- Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)
- Erythema multiforme

Drug Eruptions

- Immediate vs. Delayed Reactions
- Immediate occur less than 1 hour of the last dose
 - Urticaria
 - Angioedema
 - Anaphylaxis
- Delayed occur after one hour; usually occur after 6 hours and occasionally up to weeks or months
 - Fixed drug eruptions
 - Exanthematous eruptions
 - Systemic reactions (DIHS, SJS, TEN)

Drug Eruptions

- All types of drugs:
 - Instilled (eye drops, ear drops)
 - Inhaled (steroids, beta adrenergic)
 - Ingested (oral medications capsules, tablets, syrup)
 - Inserted (suppositories)
 - Injected (IM, IV)
 - Incognito (alternative substances "natural" medications, herbs, homeopathic, vitamins, over-the-counter, CBD)
 - Intermittent (any medications patients intermittently cough, cold, sinus, pain relievers, etc.)
 - **Ask if pills have changed size, dose, shape or color

Fixed Drug Eruption



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Fixed Drug Eruption: Overview

- Characterized by the formation of a single or few round or oval patches or plaques
- recur at the same site when re-exposure to the drug occurs
- Most frequently affects mouth, genitalia, face and acral areas but can occur anywhere
- Occurs from 30 minutes to 8 hours after ingesting drug if previously sensitized
- Lesions become raised and then eventually form bullae and erosions
- Not typically accompanied by systemic symptoms
- Healing phase often involves a violet hue; post-inflammatory hyperpigmentation

Fixed Drug Eruption: Common Offenders

- Phenolphthalein (laxatives)
- Tetracyclines: doxycycline, minocycline
- Metronidazole
- Sulfonamides (including Bactrim, sulfasalazine)
- Barbiturates
- NSAIDS
- Salicylates
- Yellow food coloring

Fixed Drug Eruption: Treatment

- Resolution of lesions occurs days to weeks after drug is discontinued
- If non-eroded treat with a potent topical corticosteroid ointment
- If eroded treat with a protective or antimicrobial ointment; keep covered until reepithelialized
- Symptomatic treatment for pruritis/pain
- Refer to dermatology or ER if widespread or generalized

Erythema Multiforme (EM)

• PIC • PIC

EM: Overview

- Immune-mediate skin reaction
- Self-limited
- Most commonly occurs < 40 years
- 90% associated with infections HSV, M. pneumoniae
- <10% caused by medications NSAIDS, antibiotics, antiepileptics
- Usually begin on extremities; may spread to trunk
- Distinct disease from Stevens-Johnson

EM: Overview (cont)

- Initially begins as pink or red papules that enlarge to become plaques
- May burn or itch
- Within 3-5 days, they develop into the classic **target** (iris) lesion: round lesion of 3 concentric circles including a dark center surrounded by a lighter pink ring. Both of those are surrounded by a red ring.
- Often no identifying cause
- May be associated with reactivation of HSV, other viral illness
- May have up to 6 episodes/year for a period of 6-10 years
- Prophylactic treatment if >5 episodes of HSV or EM per year
- Persistence is rare think IBD, malignancies

EM: Treatment

- Most cases require no further testing
- Labs to r/o other diagnoses
- Skin biopsy if unclear
- If caused by recent infection or medication, treat the infection or discontinue the drug
- If uncomplicated, treat symptomatically with topical steroids or antihistamines
- If HSV is causative agent oral acyclovir or valacyclovir

• PIC MORBILLIFORM RASH

- 90% of all skin drug reactions
- 2% of new prescriptions
- Limited to the skin
- Erythematous macules and papules appear on the trunk and spread to the extremities symmetrically
- May be accompanied by pruritus and mild fever
- Timing: 7-10 days after drug initiation in 1st episode; 24-48 hours in repeat exposures
- MORBILLIFORM RASH

- Beta-lactam antibiotics (penicillin, cephalosporins)
- Sulfonamindes
- Allopurinol
- Anti-epileptic drugs
- NSAIDS
- Others including herbal and natural therapies

- Resolves spontaneously after medication is stopped usually few days to 1 week
- May continue the medication safely if the eruption is not too severe and the medication has no effective substitution
- May experience scaling/desquamation in healing
- No long-term sequelae
- Treatment: topical steroids, emollients, oral antihistamines, reassurance
- Signals of more severe reaction:
 - Erythroderma
 - High fever
 - Any mucosal involvement
 - Skin tenderness
 - Blistering, Pustules
 - Evidence of other organ involvement (kidneys, liver, lungs, blood)
 - **ANY of the above signals more severe reaction

SJS/TEN

• PHOTO

• PHOTO

SJS/TEN: Overview

- Rare, acute, serious, **potentially fatal** skin reaction almost always to medications
- SJS < 10% BSA, TEN 10-30% BSA
- > 200 meds have been reported to be associated with SJS/TEN
 - 40% are antibiotics (frequently BACTRIM)
 - Usually systemic meds but has been reported with topicals
 - More often in drugs with long half-lives
 - Rarely associated with vaccinations

SJS/TEN: Overview

- **Prodrome** several days that resembles a URI or "flu-like illness" with fever, ST, runny nose, cough, red eyes, conjunctivitis, body aches
- Prodrome followed by abrupt onset of a tender/painful skin rash (dusky red to purpuric macules which look like target lesions) which progress to flaccid blisters. Begins on the trunk and spreads rapidly to face and limbs over hours to days.
- Usually reaches its maximum by 4 days.
- Nicolsky's sign: the necrotic epidermis detaches with lateral pressure

SJS/TEN: Mucosal Envolvement

- Often precedes skin eruption
- Frequently involves mouth, eyes and genital mucosa "hemorrhagic crusts of the lips"
- Eye involvement will lead to permanent sequelae including blindness

SJS/TEN: Common Offenders

- Sulfa antibiotics (Bactrim), sulfasalazine
- Tetracyclines
- Allopurinol
- Anticonvulsants (carbamazepine, lamotrigine, phenobarbital, phenytoin)
- NSAIDS
- Nevirapine

SJS/TEN: Treatment

- Dermatologic Emergency
- Early recognition and discontinuation of the offending med is critical
- Mortality 5-12% for SJS; > 20% for TEN
- Poor prognosis: increasing age, significant comorbid conditions (DM, HTN, HIV, immunocompromised)
- SCORTEN Criteria
- Supportive care in ICU or burn unit
- Multidisciplinary care derm, ophtho, CCM

Q&A