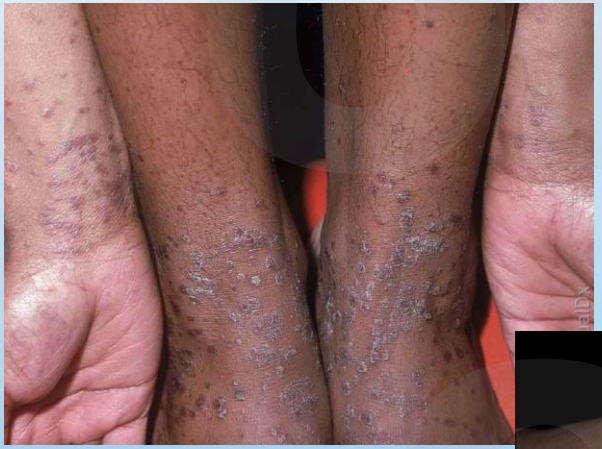
Papulosquamous Dermatoses: *Don't (Do?) Make A Rash Decision*

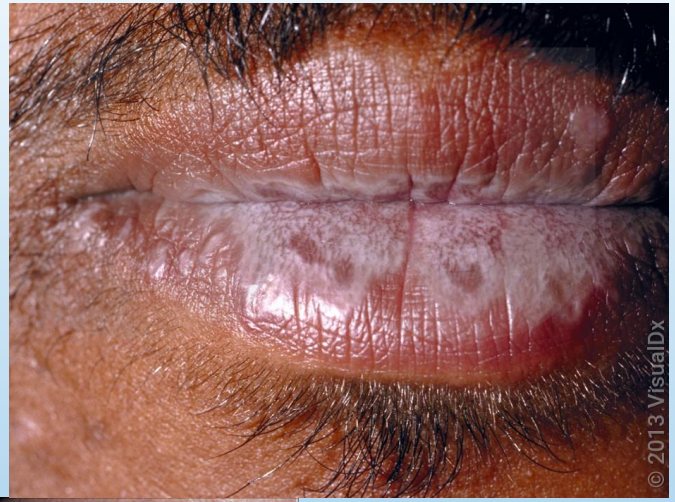
PRESENTED BY: Lara Clayton, PA-C, Assistant Professor in Dermatology

Papulosquamous and eczematous rashes

- Red, pink, purple papules or plaques with scale
- Heterogenous group of disease
  - Lichen planus
  - Psoriasis
  - Pityriasis rosea
  - Tinea/Candidiasis
  - Eczemas/dermatitis
    - Atopic dermatitis
    - Contact dermatitis
    - Lichen simplex chronicus
    - Nummular dermatitis
    - Dyshidrotic eczema
    - Seborrheic Dermatitis
  - Many others

Case 1

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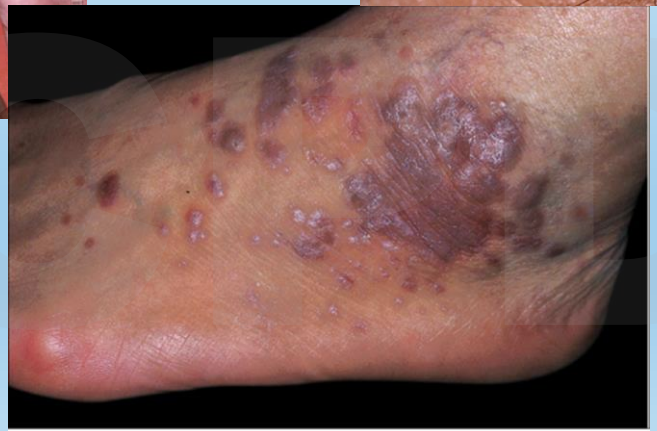
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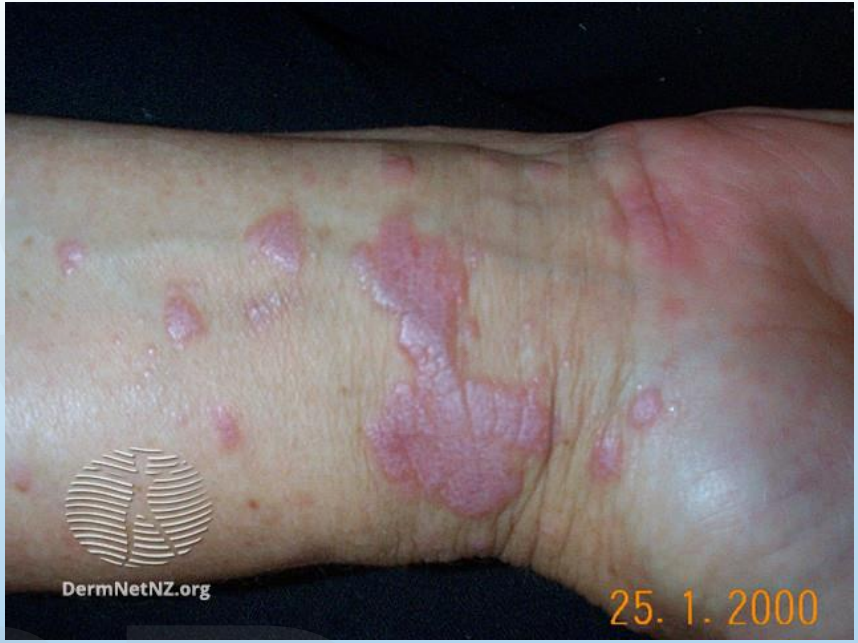
Lichen planus

- Autoimmune disorder in the skin, nails, mucosa
  - T cell mediated autoreactive disease against keratinocytes whose self antigens have been changed (trauma, infection)
- Etiology: Unclear (maybe viruses, contact allergens, medications, stress, physical injury, genetic)
- 40's-60's but can occur at any age
- No predilection for sex or ethnicity
- 1% of population
- Medications (captopril, enalapril, labetalol, propranolol, methyldopa, calcium channel blockers, NSAIDs, hydroxychloroquine, thiazide diuretics, etanercept, infliximab, gold)

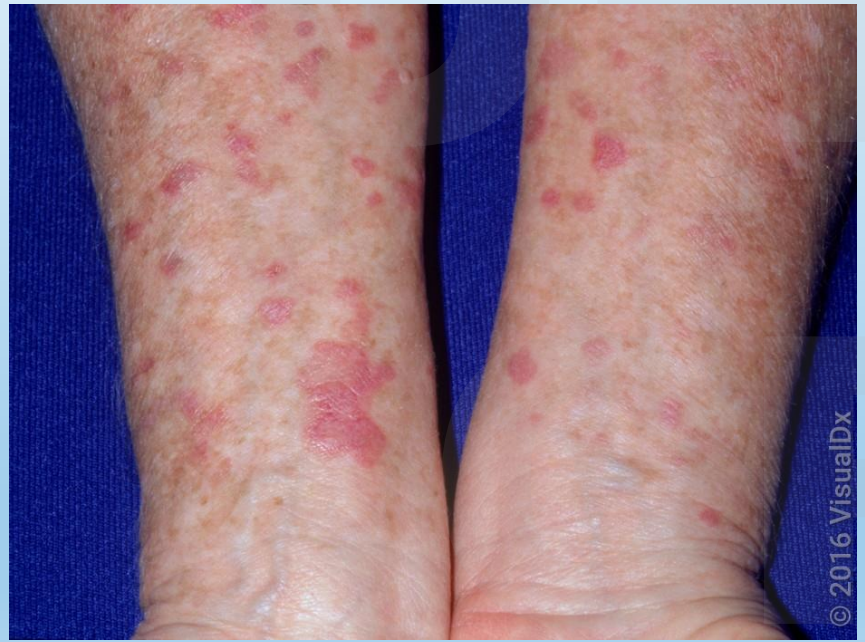
Lichen planus

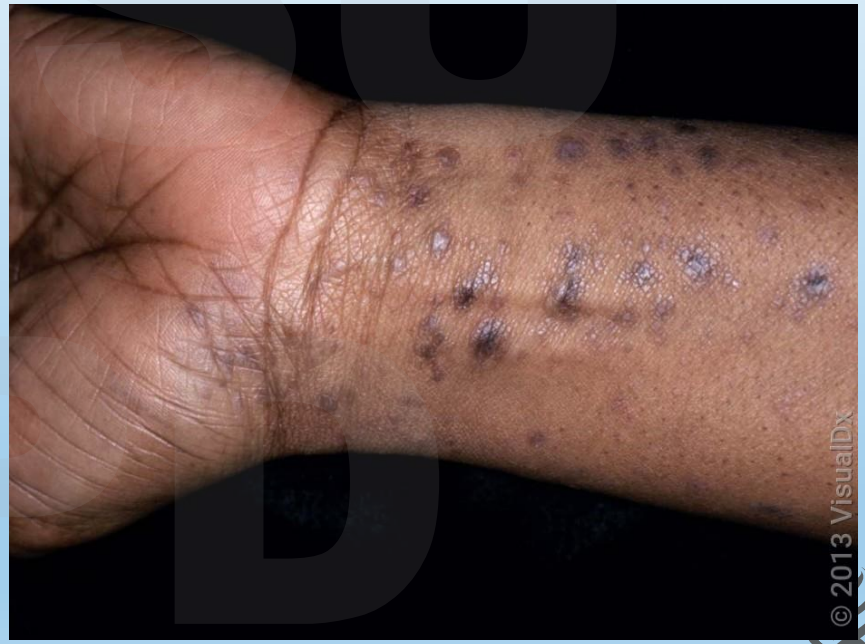
- pruritic, flat-topped, polygonal, pink to purple papules/plaques that are localized most commonly along the volar wrists, forearms, shins, ankles, and hands/feet, but may be widespread
  - Oral & genital LP
  - Lichen planopilaris
  - Nails
- 6 Ps: purple, planar, polygonal, pruritic, papules, and plaques
- Worse with trauma (Koebnerization)
- Wickham striae



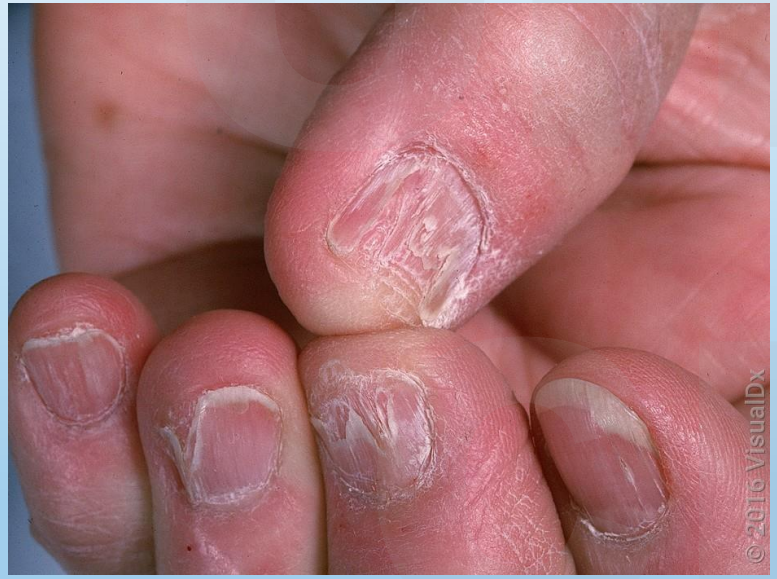
DDX: lichenoid drug reaction, lupus, pityriasis lichenoides chronica, contact dermatitis, GVHD, granuloma annulare…

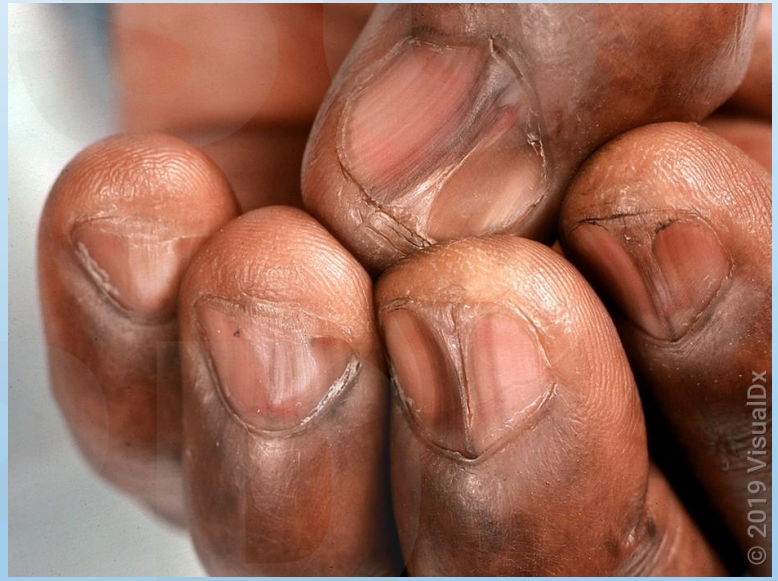
Lichen planus





Lichen planus (nails)





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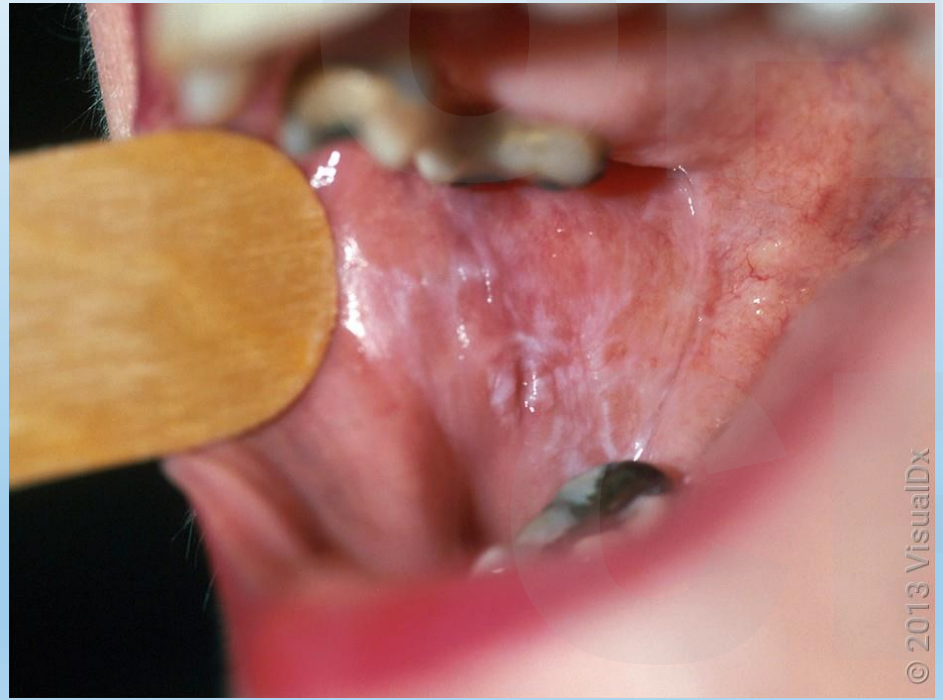
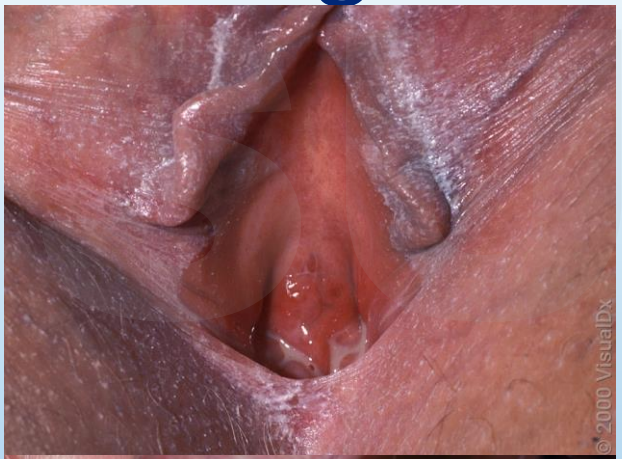
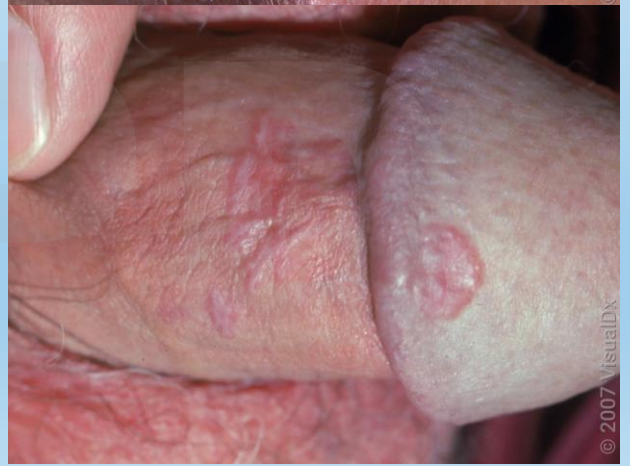
Lichen planus (oral and genital)







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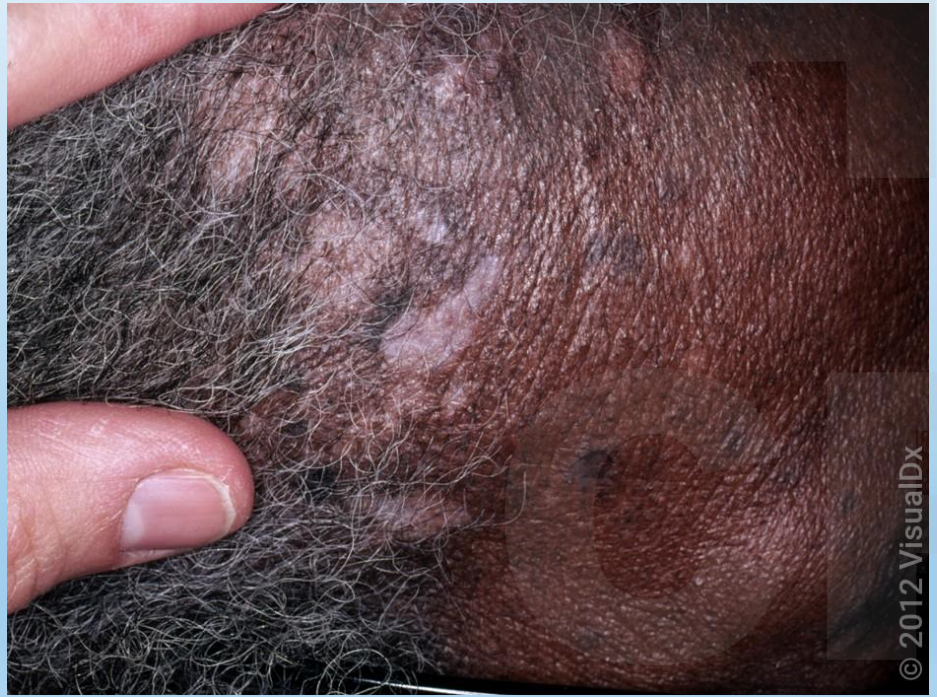
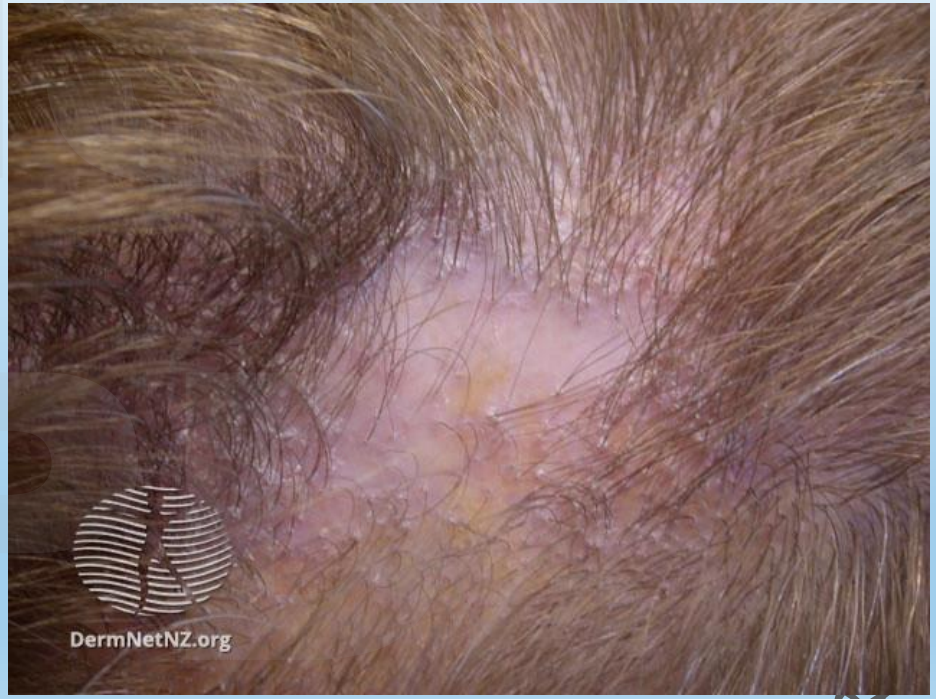
Lichen planopilaris





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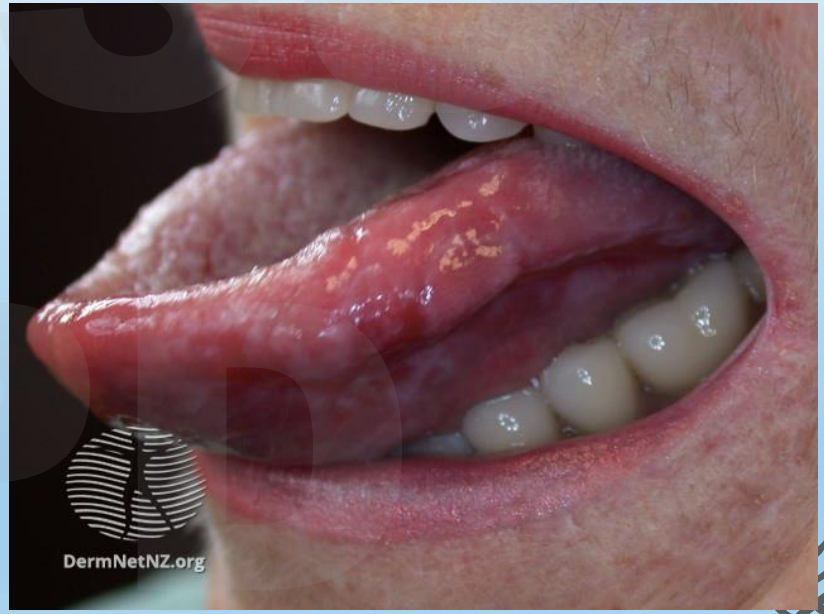
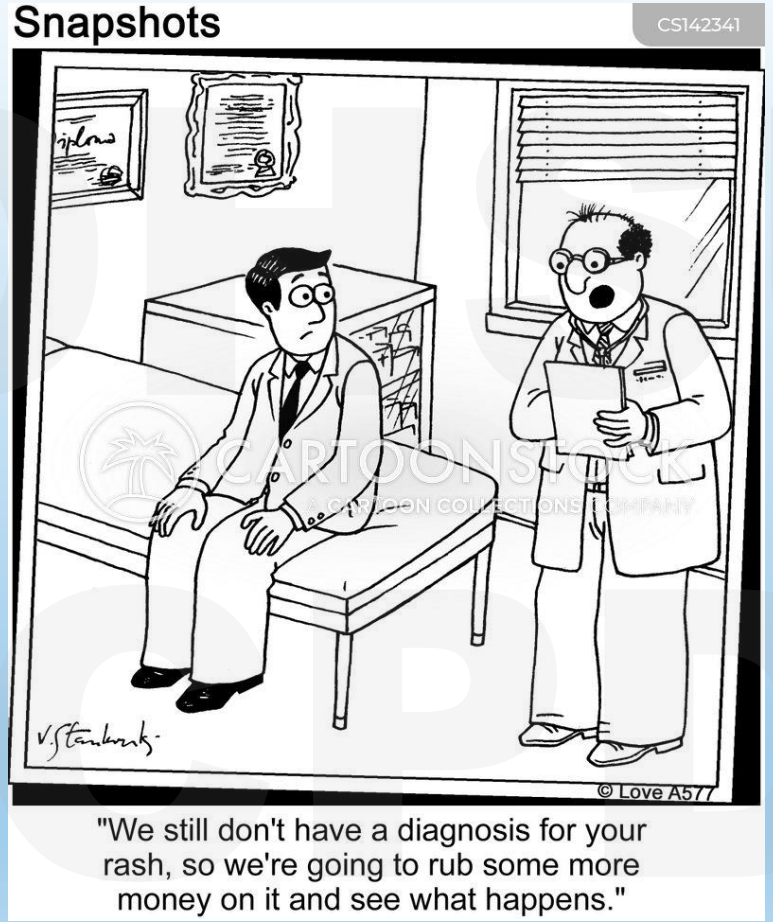
Lichen planus Work-up

- History & physical
- Biopsy to confirm
- Drug list
- Consider Hep B&C, LFTs
- Patch test?

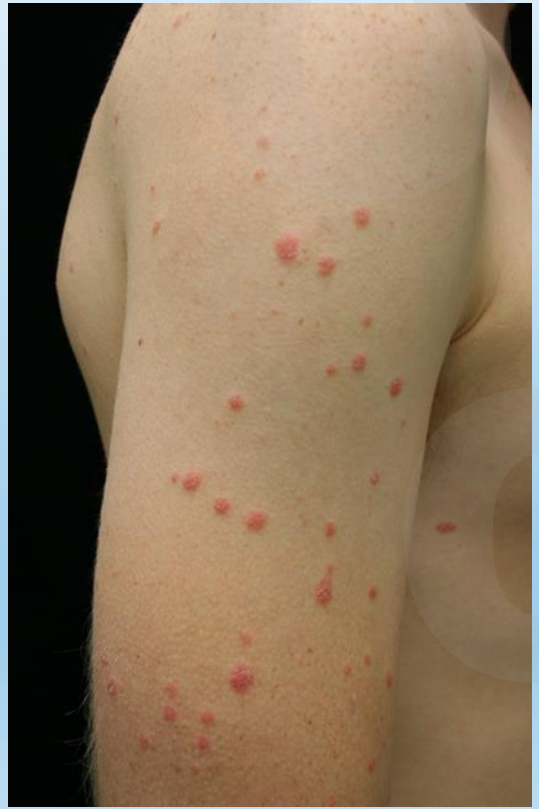


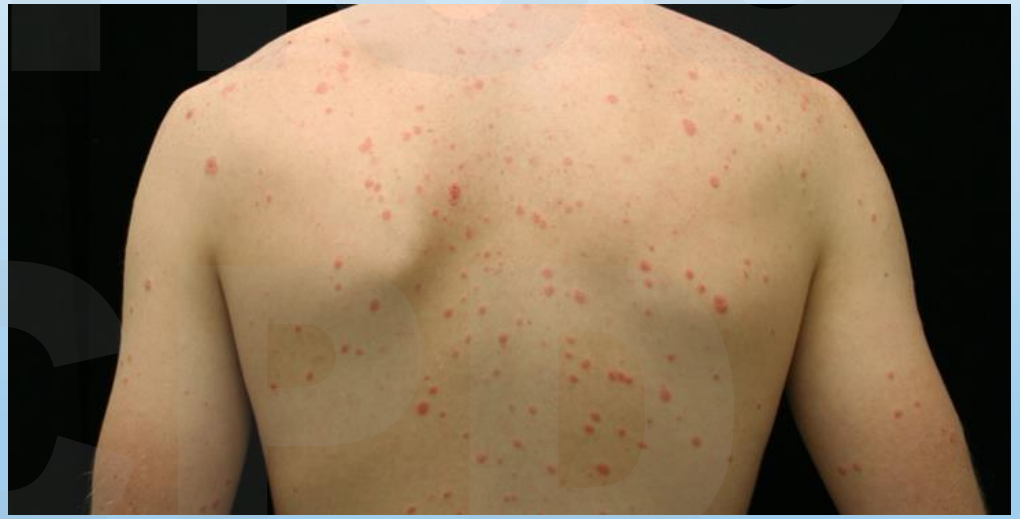
Lichen planus: Treatment

- Stop offending medication
- Control pruritus
- Topical Steroids
- Tacrolimus
- Intralesional steroids
- Oral prednisone, acitretin, hydroxychloroquine, methotrexate, phototherapy

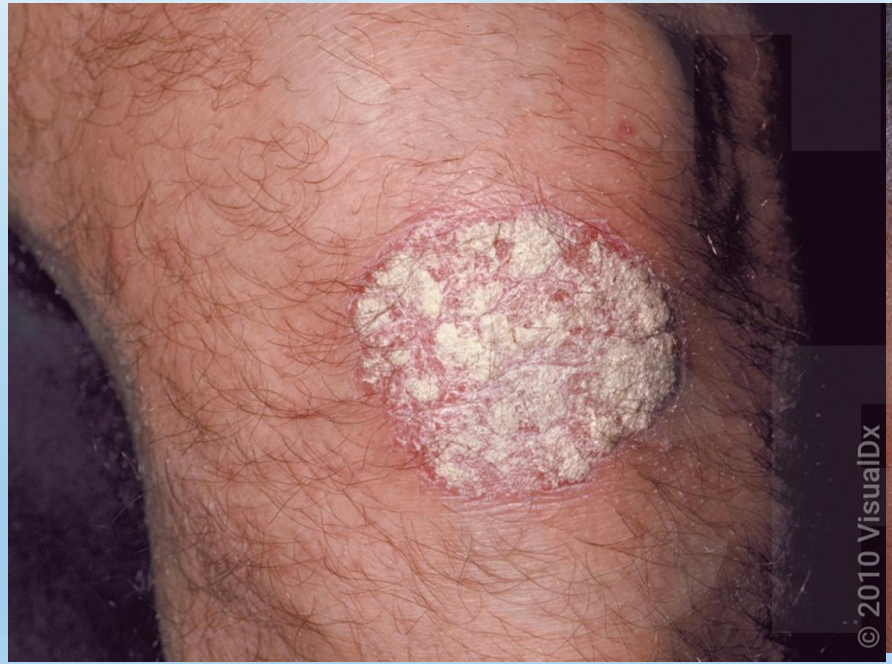

Snapshots
CS142341
© Love A577
"We still don't have a diagnosis for your rash, so we're going to rub some more money on it and see what happens."

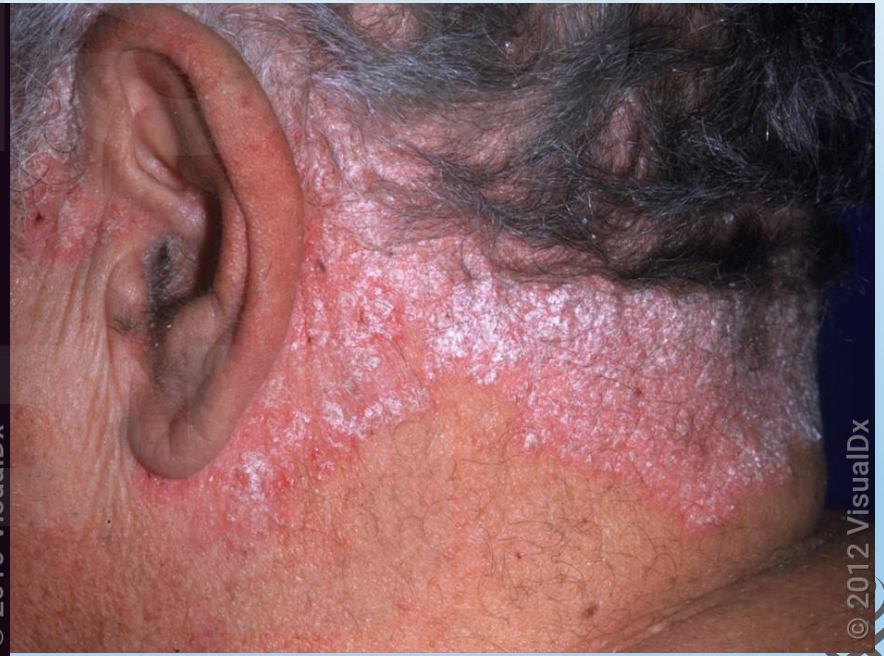
Case 2a





Case 2b





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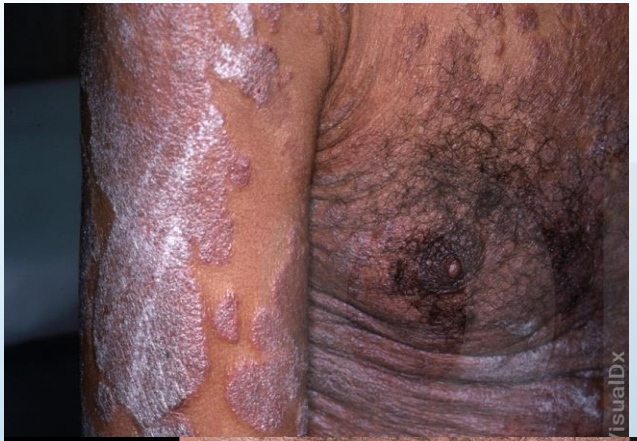
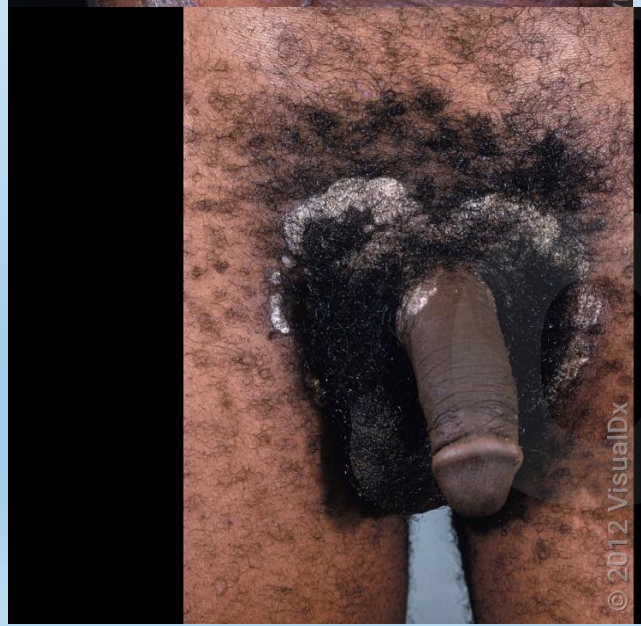
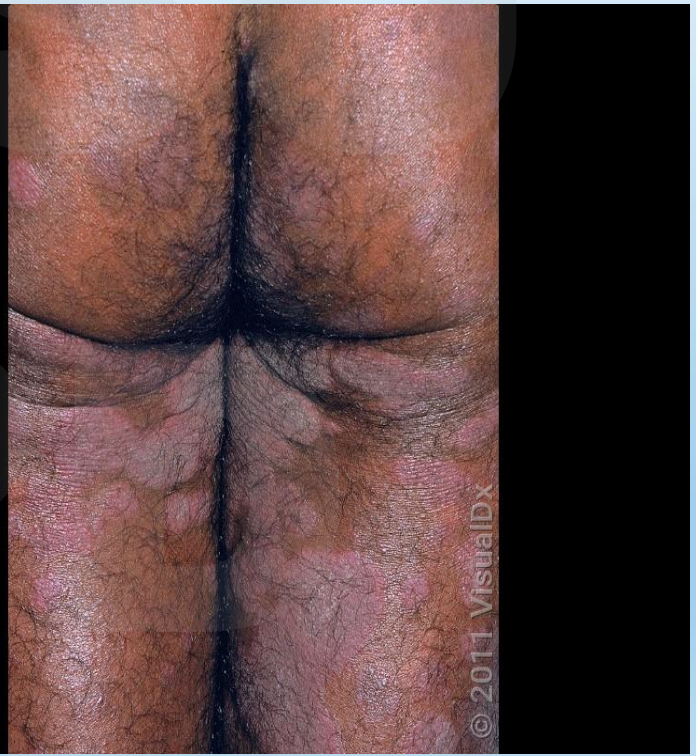
Case 2c







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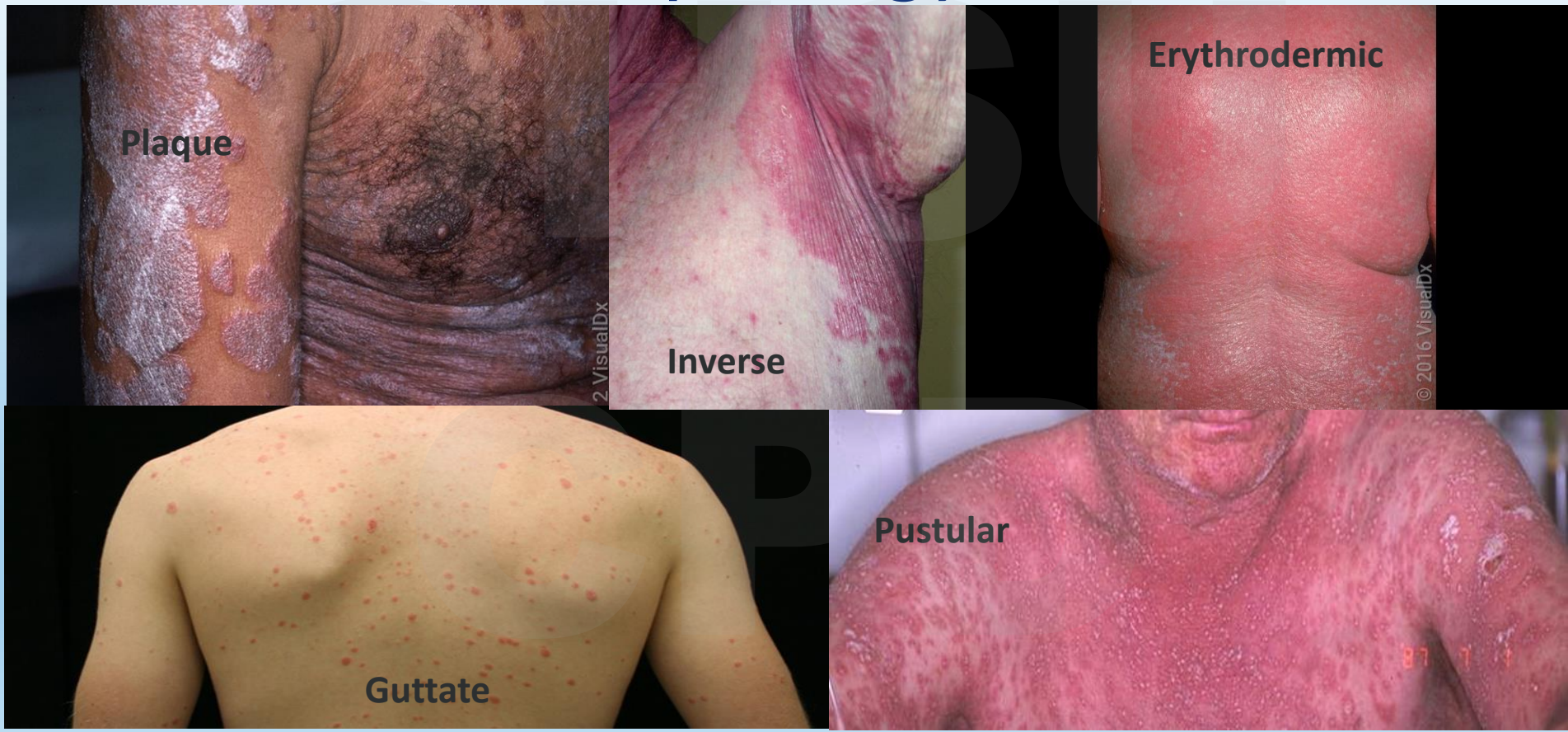
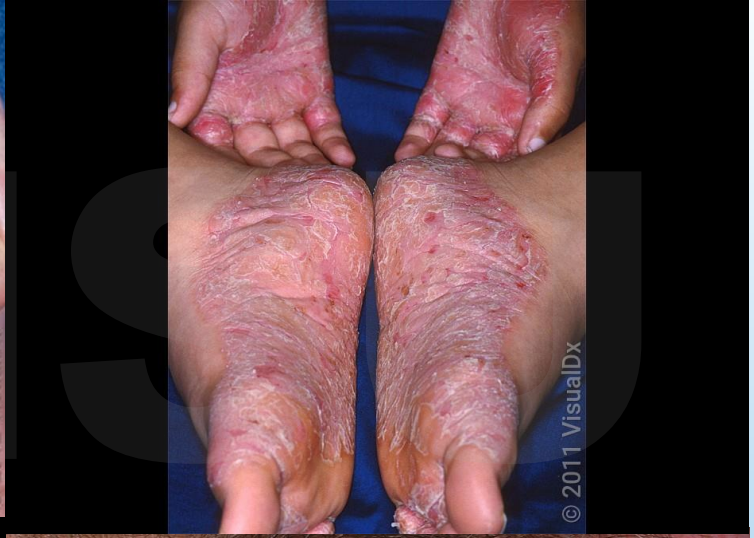
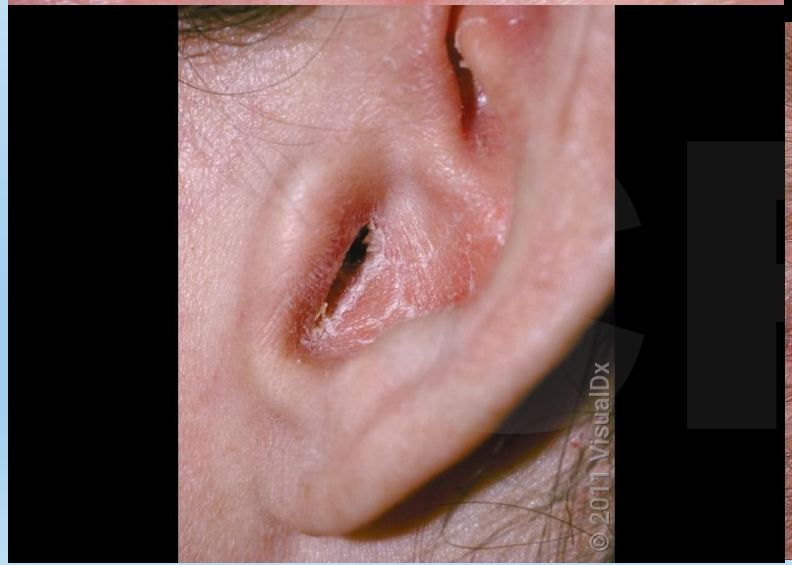
Psoriasis

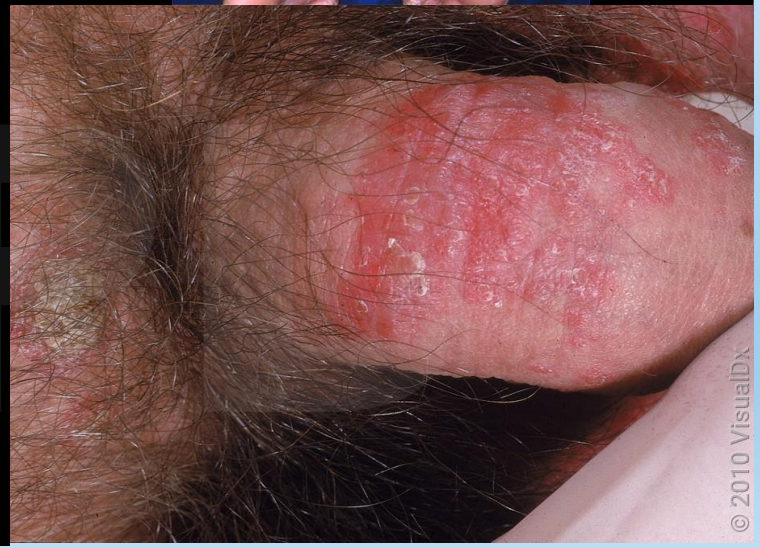
- Chronic, immune mediated inflammatory skin disease with well demarcated plaques
  - T cell driven involving cytokines TNF alpha, IL-23
- Polygenic: 30% of patients have a first degree relative with psoriasis
- Triggers: Strep, HIV, medications
- Common, 2% population
- Onset 20-30 years and 50-60 years but can occur at any age
- Clinical diagnosis but can be confirmed with biopsy

Psoriasis: Morphology









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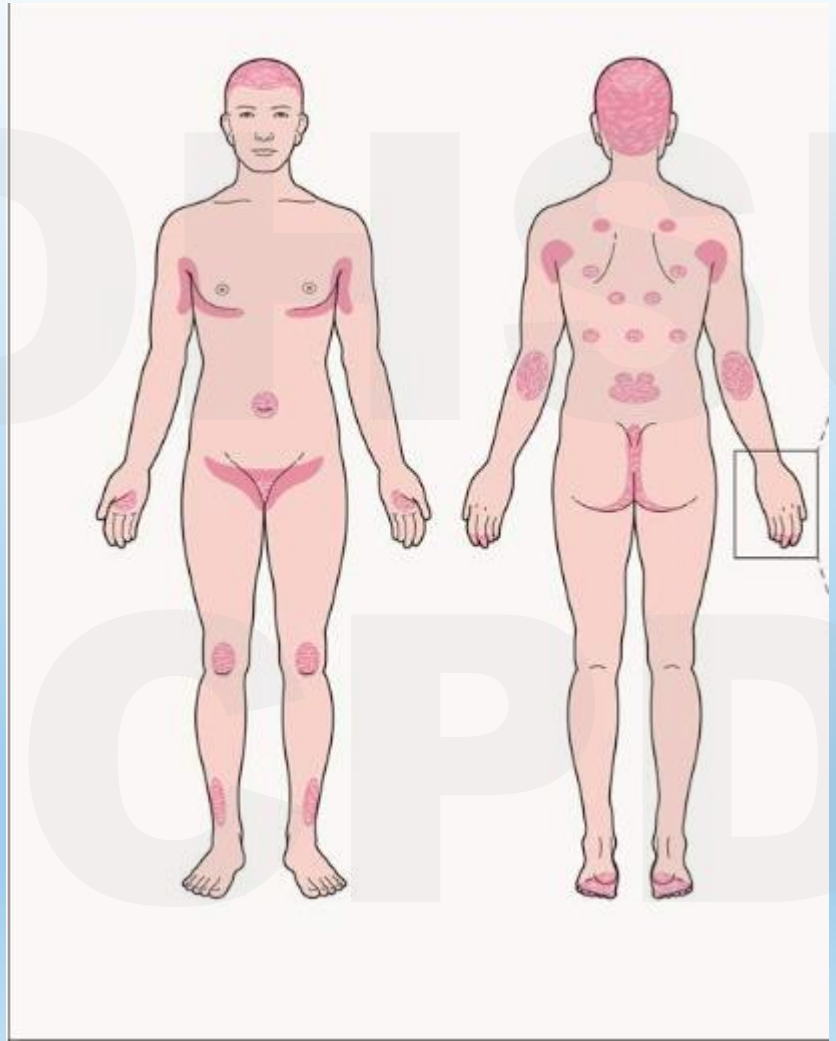


Psoriasis

Factors that worsen psoriasis

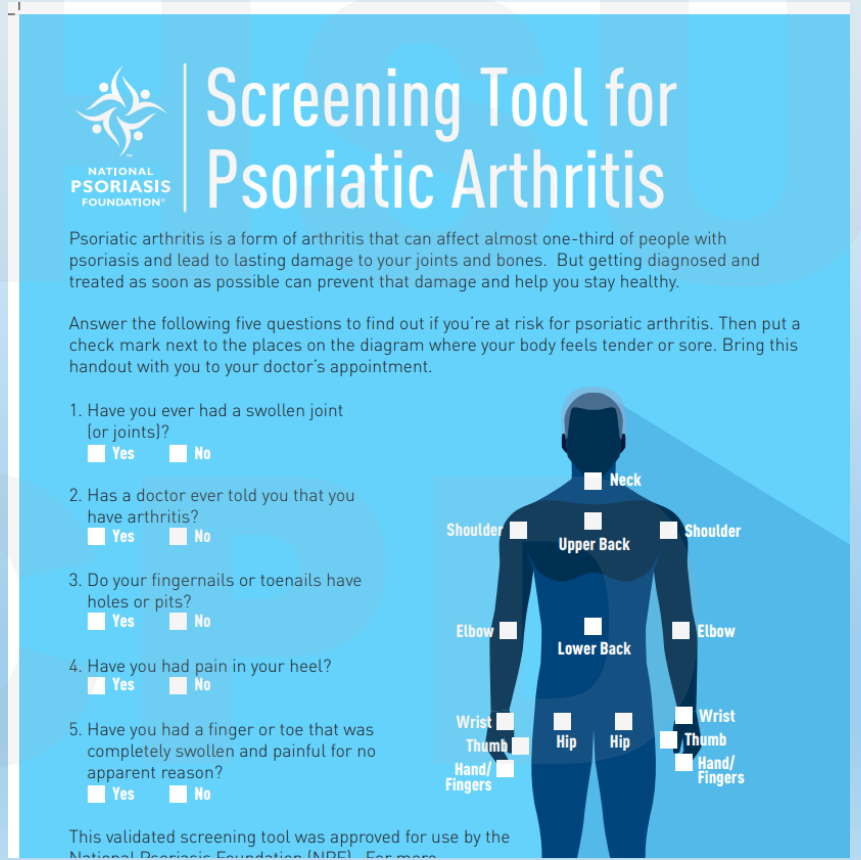
- Obesity
- Smoking
- Strep
- Alcohol
- Stress
- Physical injury
- Medications
- Stopping steroids

Diseases associated with psoriasis

- Inflammatory arthritis
- IBD
- Uveitis
- Celiac disease
- Metabolic syndrome
- Fatty liver disease
- Cardiovascular disease
- Psychological disorders
- Malignancy
- Obesity
- Smoking
- Alcohol abuse
- Skin Malignancy

Psoriasis: The Joint

- 85% of patients: psoriasis precedes joint symptoms
- 30% of people with psoriasis will have joint disease



NATIONAL PSORIASIS FOUNDATION

Screening Tool for Psoriatic Arthritis

Psoriatic arthritis is a form of arthritis that can affect almost one-third of people with psoriasis and lead to lasting damage to your joints and bones. But getting diagnosed and treated as soon as possible can prevent that damage and help you stay healthy.

Answer the following five questions to find out if you're at risk for psoriatic arthritis. Then put a check mark next to the places on the diagram where your body feels tender or sore. Bring this handout with you to your doctor's appointment.

1. Have you ever had a swollen joint (or joints)?
   ☐ Yes ☐ No
2. Has a doctor ever told you that you have arthritis?
   ☐ Yes ☐ No
3. Do your fingernails or toenails have holes or pits?
   ☐ Yes ☐ No
4. Have you had pain in your heel?
   ☐ Yes ☐ No
5. Have you had a finger or toe that was completely swollen and painful for no apparent reason?
   ☐ Yes ☐ No

This validated screening tool was approved for use by the

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Psoriasis: The Burden

- 50% surveyed in the United States indicated they would rather have a medical condition generally considered more dangerous, such as hypertension or asthma, than a skin condition like psoriasis.
- 82.9% of patients often or always felt the need to hide their psoriasis
- 74.3% claimed that their self-confidence was often or always affected by their psoriasis
- 45.7% were often or always depressed because of their psoriasis
- 82.9% would often or always avoid activities like swimming and sports because of their psoriasis
- 35.3% were often or always inhibited in their sexual relationships because of their psoriasis
- 22.9% stated that psoriasis affected their choice of career

Weiss et al, JAAD, 47, 512 2002

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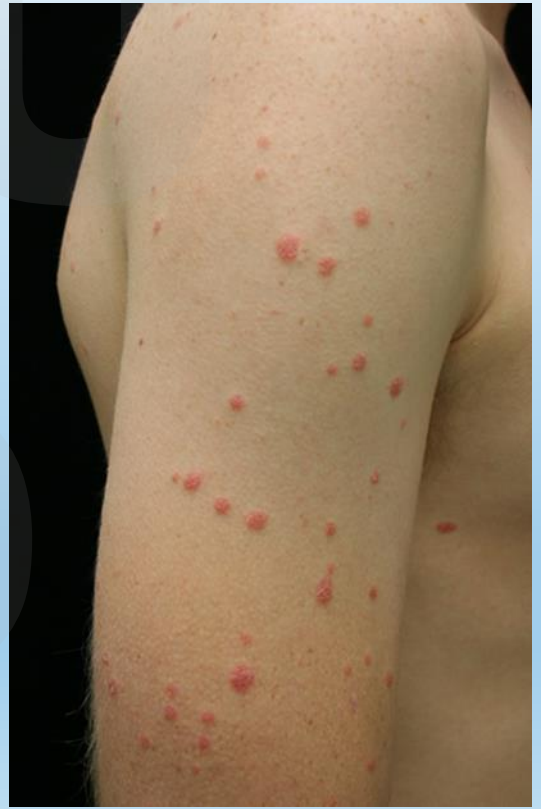
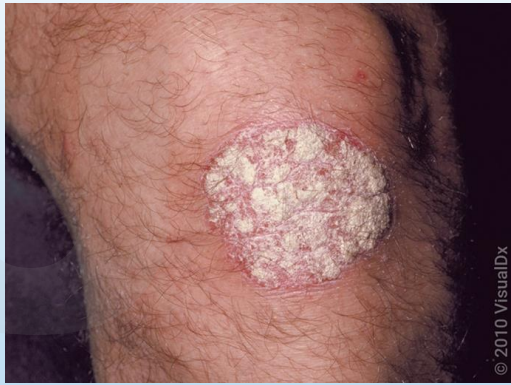
Guttate Psoriasis: Case 2a

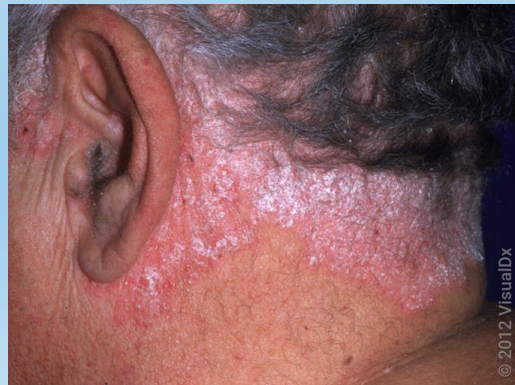
- Ask about sore throat or exposure to strep and treat
- Ask about medications (systemic steroids, beta blockers, lithium, antimalarials, interferon, NSAIDS
- Biopsy?
- ASO titer, anti-DNase B titre.
- Treatment
  - Phototherapy
  - Mid potency steroids
- Clears 3-4 months; however 25% can evolve to plaque psoriasis
- DDX: pityriasis rosea, syphilis, ID reaction to tinea, small plaque parapsoriasis



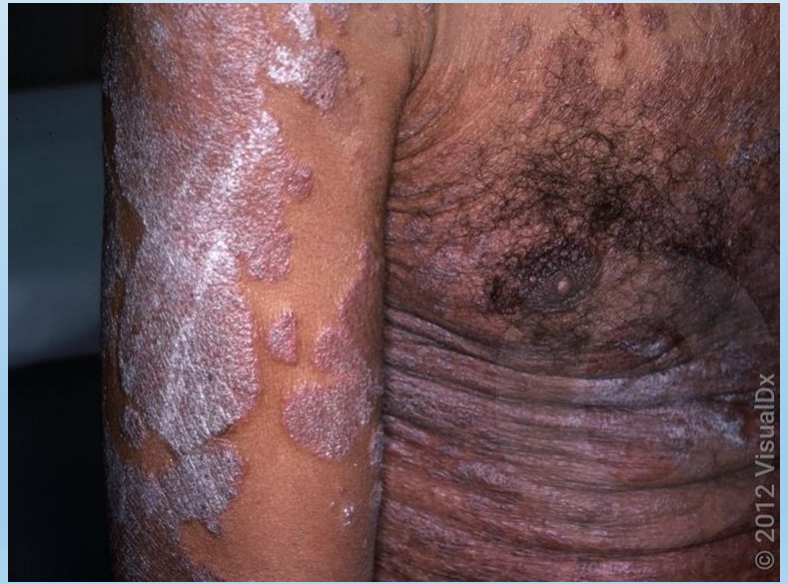
Plaque Psoriasis: Case 2b

- Most common form
- Well demarcated erythematous plaques: bilateral symmetric
- Auspitz sign
- Koebner phenomenon
- Examine: hands, feet, face, scalp, genitals
- Treatment:
  - Emollients
  - Topical steroids- mid to high TS for torso, arms and legs and low potency for intertriginous or facial involvement
  - Calcineurin inhibitor (tacrolimus, pimecrolimus)
  - Vitamin D analogue (calcipotriene)
  - Excimer





Severe Plaque Psoriasis: Case 2c



- >30% BSA
- Affecting groin, hands, feet
- Affecting QOL

Treatment:

- Phototherapy
- Oral (methotrexate, acitretin, cyclosporine, apremilast (Otezla)
- Biologics
  - Humira
  - Enbrel
  - Remicade
  - Stelara
  - Cosentyx
  - & more

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Dermatology Life Quality Index (DLQI)

AAC # _____ **Date:** _____ **Provider:** _____

Name: _____ **DOB:** _____ **Diagnosis:** _____ **Score:** _____

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK.
Please check (X) one box for each question.

1. Over the last week, how **itchy, sore, painful** or **stinging** has your skin been?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□		
2. Over the last week, how **embarrassed** or **self-conscious** have you been because of your skin?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□		
3. Over the last week, how much has your skin interfered with you going **shopping** or looking after your **home** or **garden**?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
4. Over the last week, how much has your skin influenced the **clothes** you wear?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
5. Over the last week, how much has your skin affected any **social** or **leisure** activities?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
6. Over the last week, how much has your skin made it difficult for you to do any **sport**?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
7. Over the last week, has your skin prevented you from **working** or **studying**?	Yes	□		
	No	□	Not relevant	□
If "No," over the last week how much has your skin been a problem at **work** or **studying**?	A lot	□		
	A little	□		
	Not at all	□		
8. Over the last week, how much has your skin created problems with your **partner** or any of your **close friends** or **relatives?**	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
9. Over the last week, how much has your skin caused any **sexual difficulties**?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□
10. Over the last week, how much of a problem has the **treatment** for your skin been, for example by making your home messy, or by taking up time?	Very much	□		
	A lot	□		
	A little	□		
	Not at all	□	Not relevant	□

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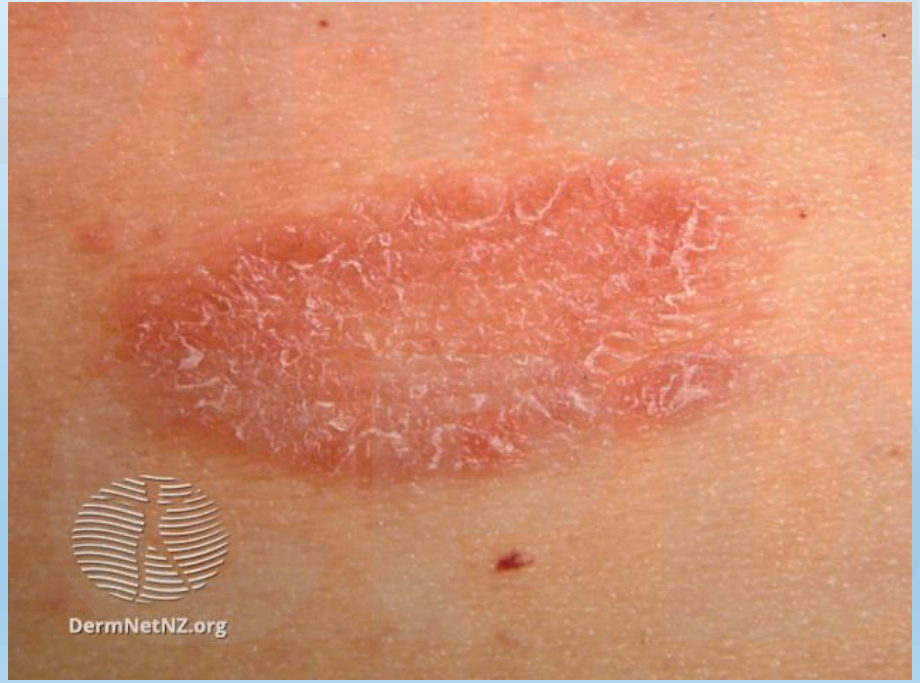
BUT YOU WOULD HAVE ALREADY SEEN MY RASH, YEAH? IT WAS HUGE ON INSTAGRAM LAST WEEK..

Case 3



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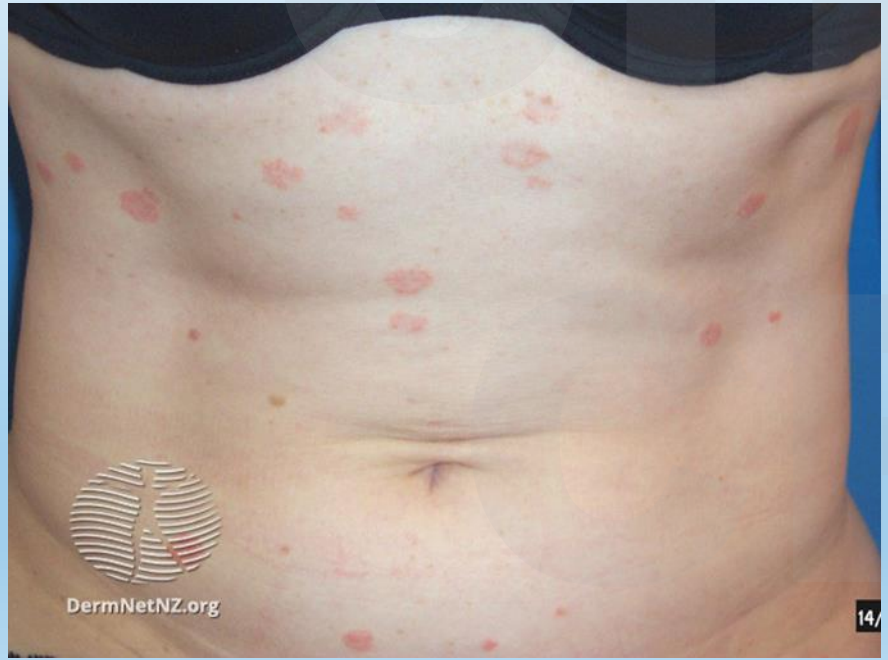
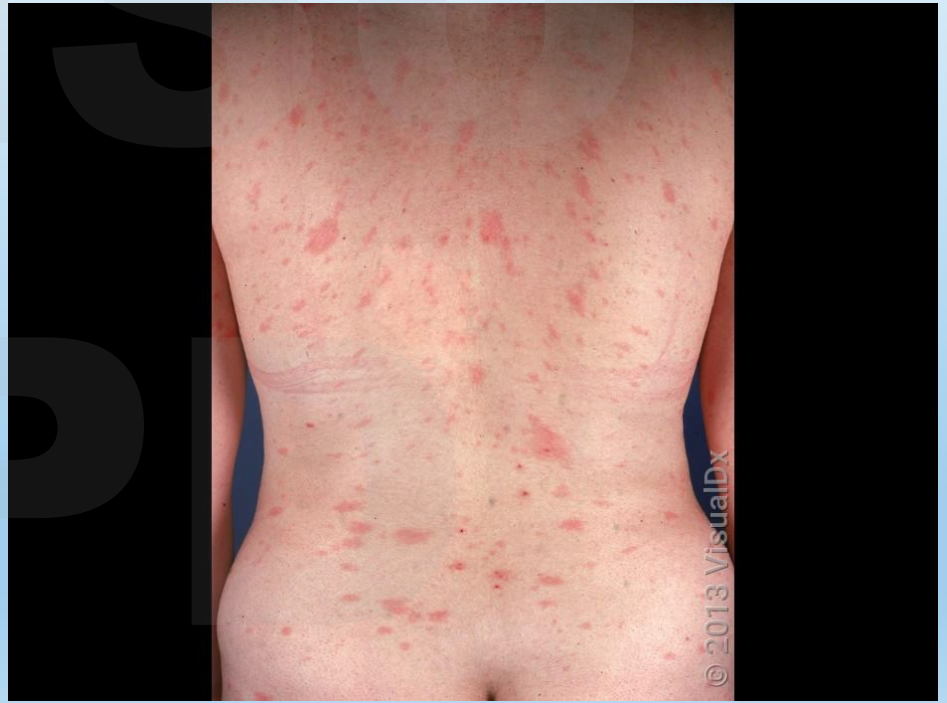
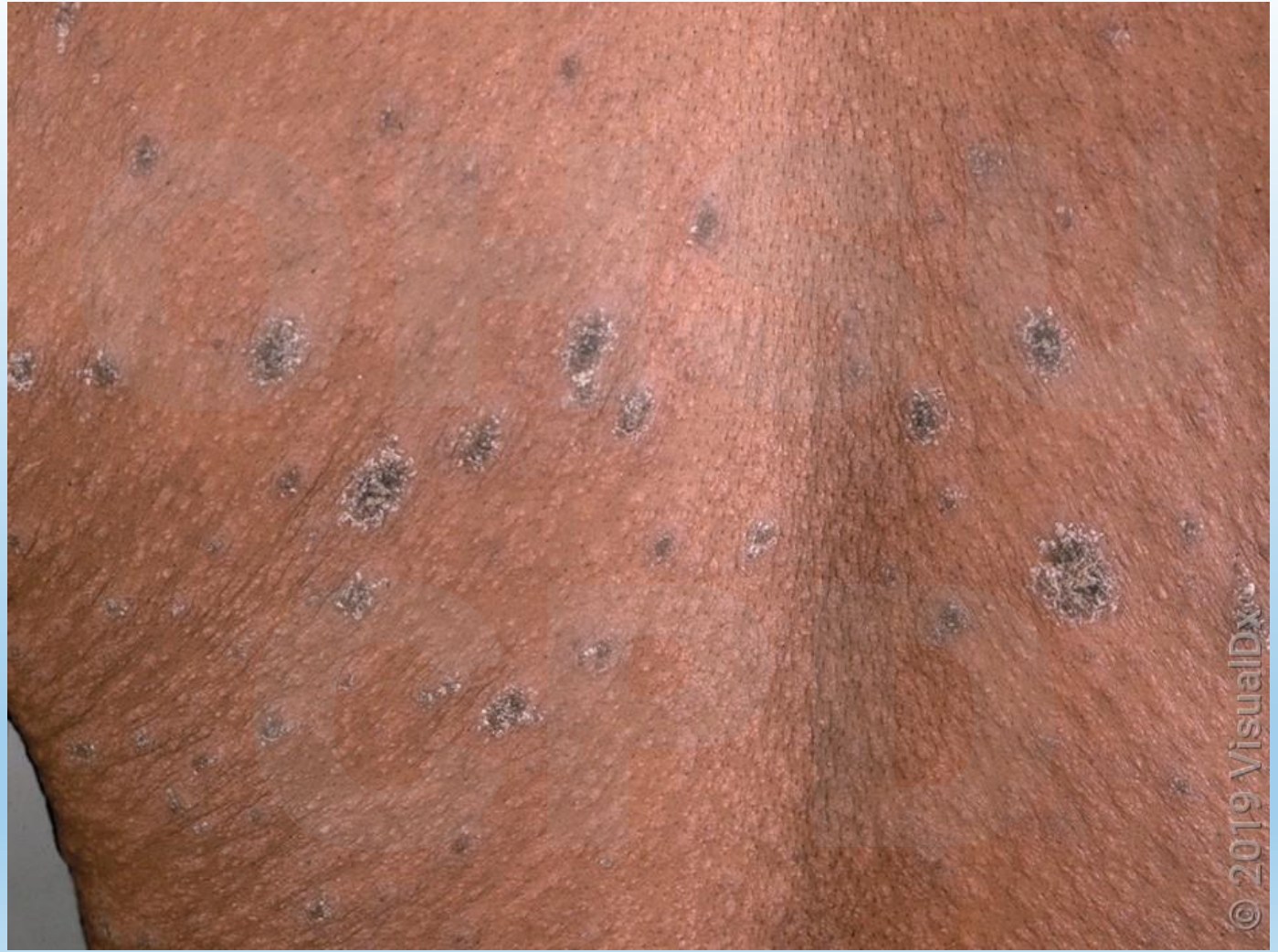
Case 3







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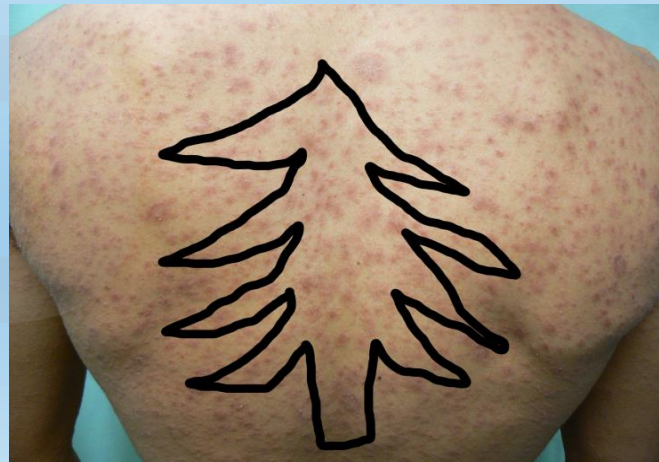
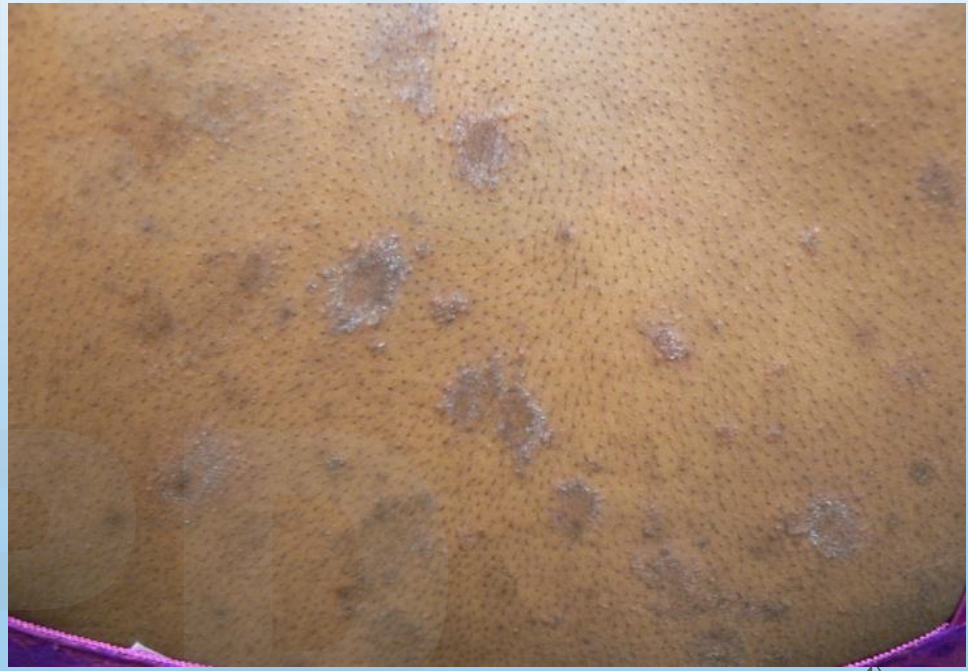
Pityriasis rosea

- Acute eruption thought to have a viral trigger
- Peaks in late teens and 20's
- Herald patch appears 1-20 days before generalized rash
  - 2-5cm in diameter
  - Scale just inside the edge of the plaque and central clearing
- Generalized rash
  - Chest, back >upper arms, thighs, >>neck
  - Spares palms, soles, face, scalp
  - Rash follows skin tension lines
  - Fir tree "Christmas Tree"



Pityriasis rosea

- Clinical diagnosis
- Asymptomatic but can have itching
- Viral symptoms can be present
- Mean duration is 5 weeks. 80% resolve within 8 weeks. Recurrence is rare.
- 25% would like treatment for pruritus
- Treatment: topicals (antipruritic lotions, steroids, phototherapy, erythromycin, azithromycin, acyclovir
- DDX: tinea, guttate psoriasis, secondary syphilis, pityriasis lichenoides chronica, nummular dermatitis, drug eruption



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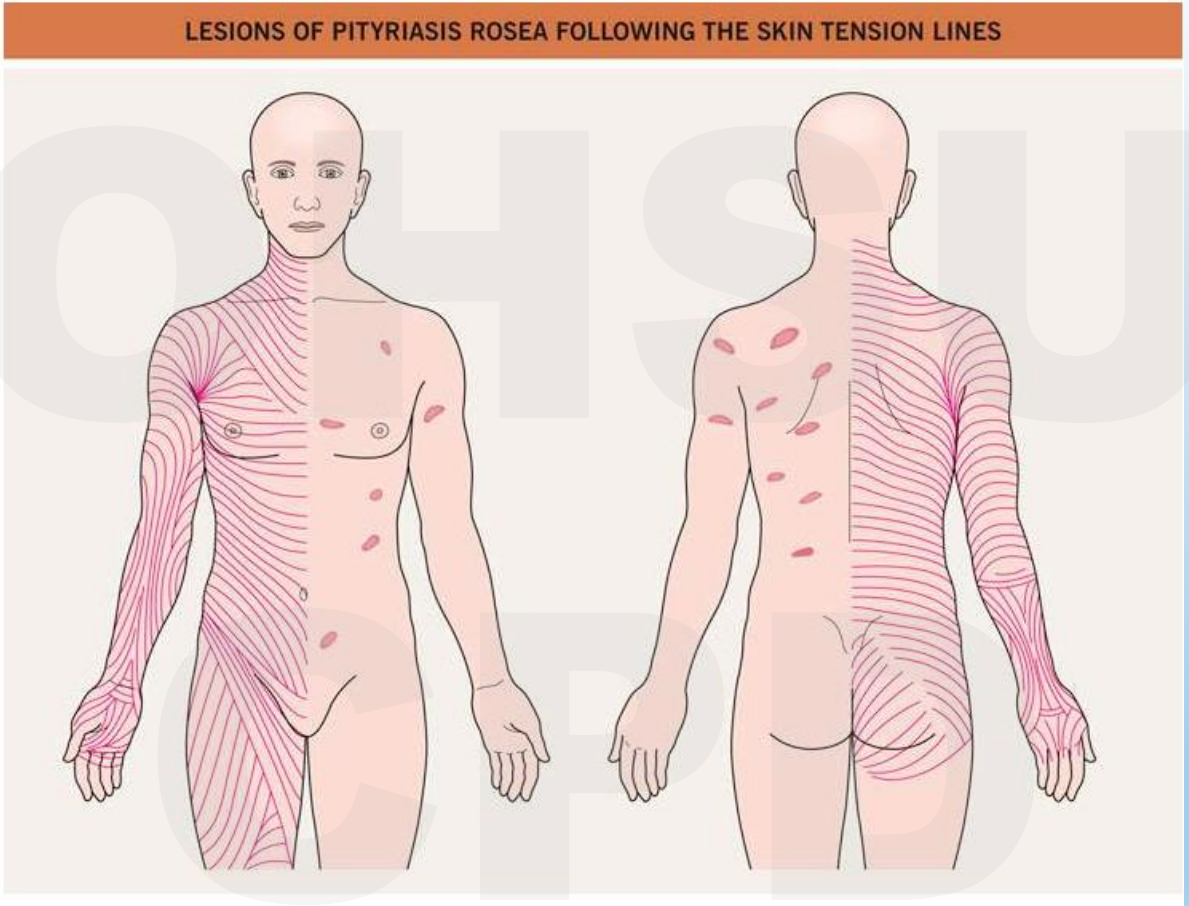
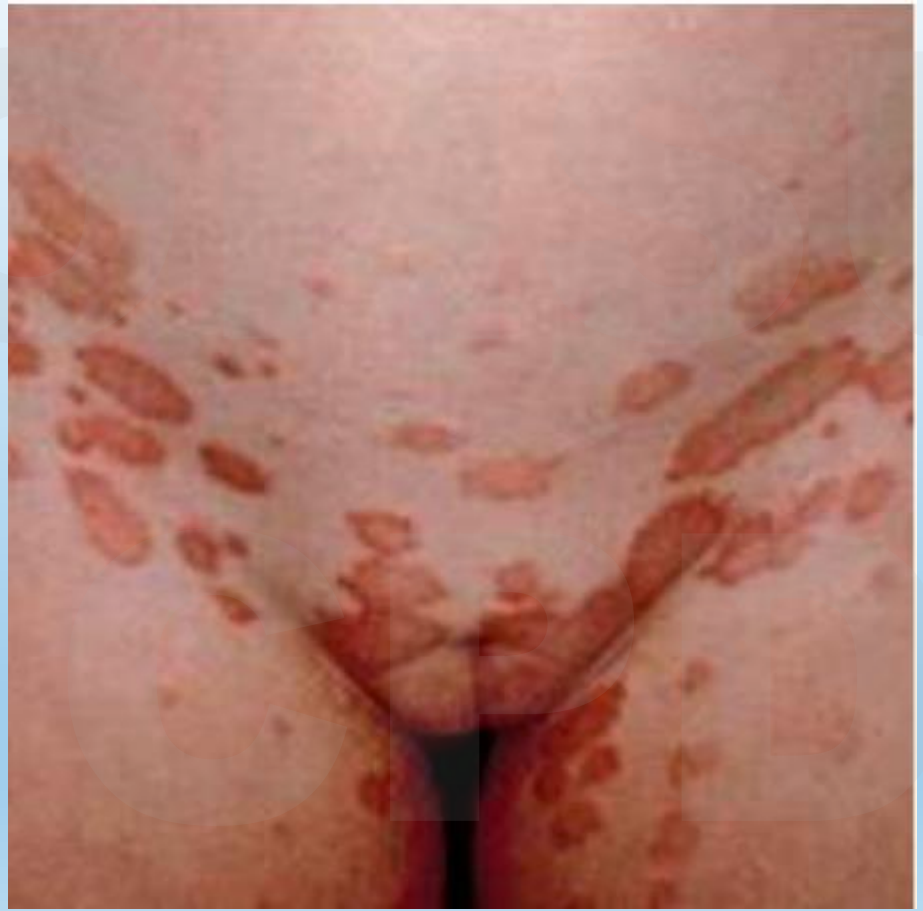
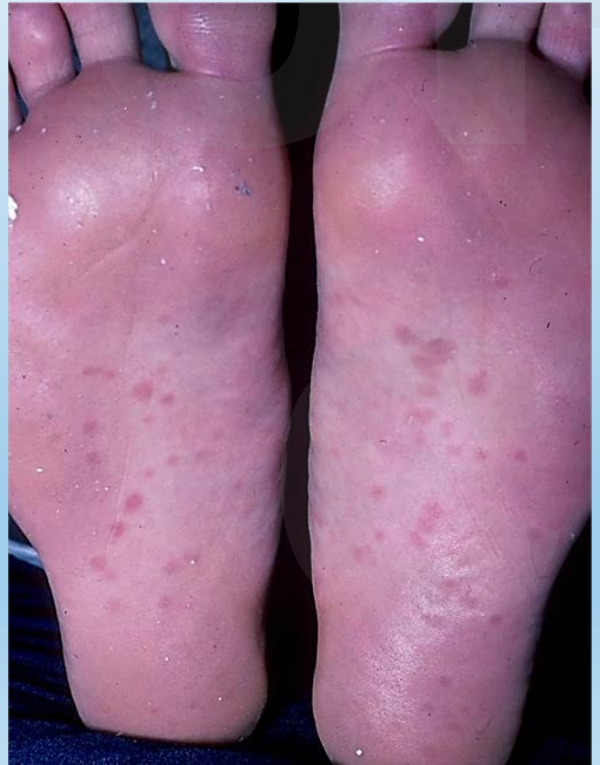
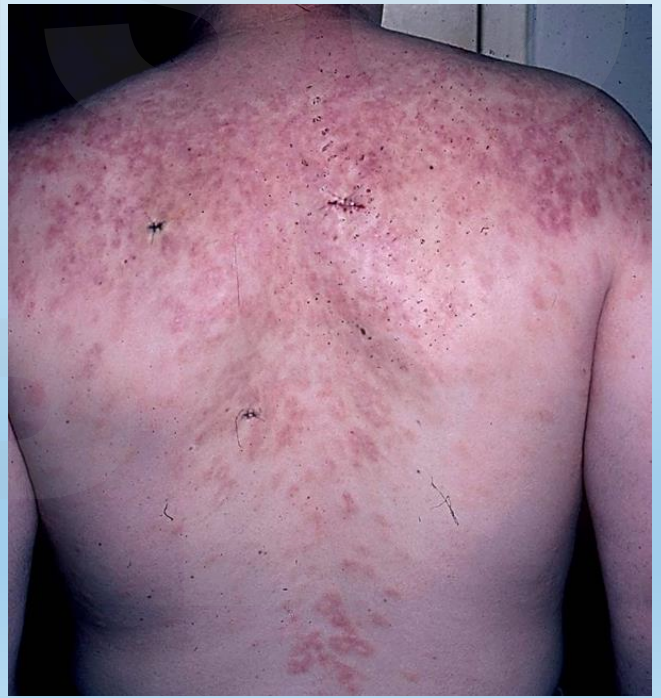


Lesions of PR follow the skin tension lines: These lines are often referred to as Langer lines of cleavage. The long axis of the individual lesions aligns with these lines.



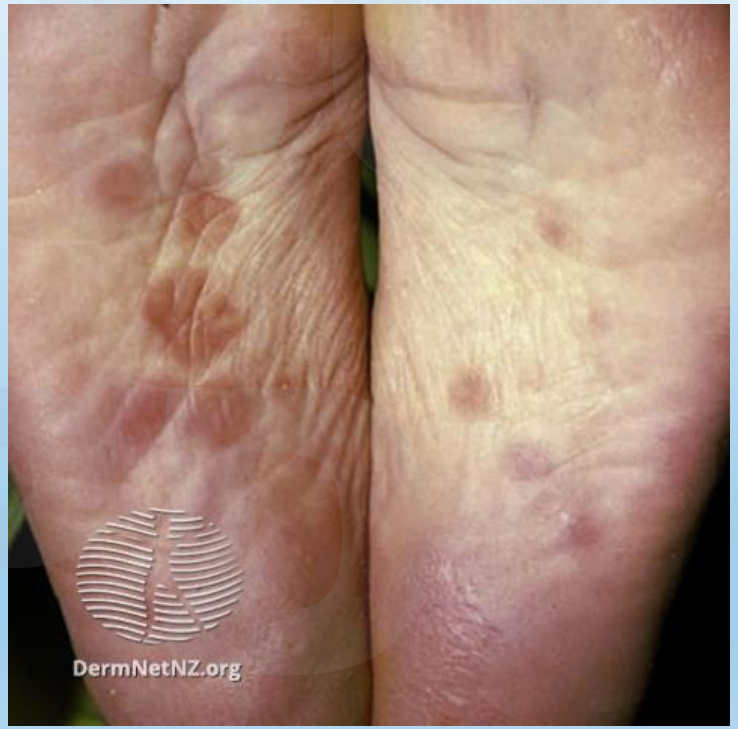
What about “Pityriasis rosea” on the palms/soles?





Secondary Syphilis

- Should be on the DDX for new onset scaly rash
- Papulosquamous eruption similar to PR
- Prodrome of malaise, fever, neck stiffness, myalgias, arthralgias
- Ask about history of a painless chancre on genitals
- Draw RPR
- IM PCN



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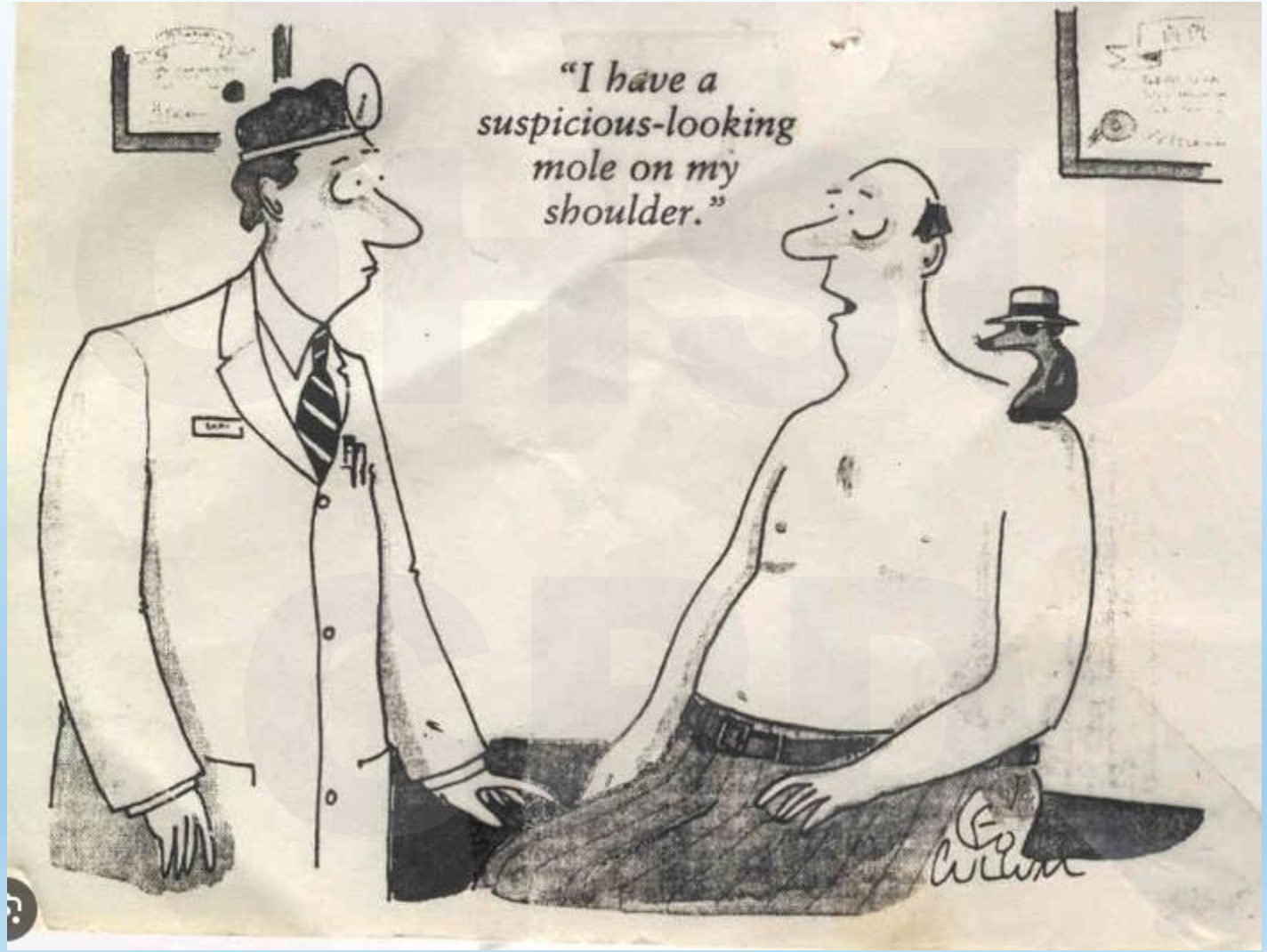
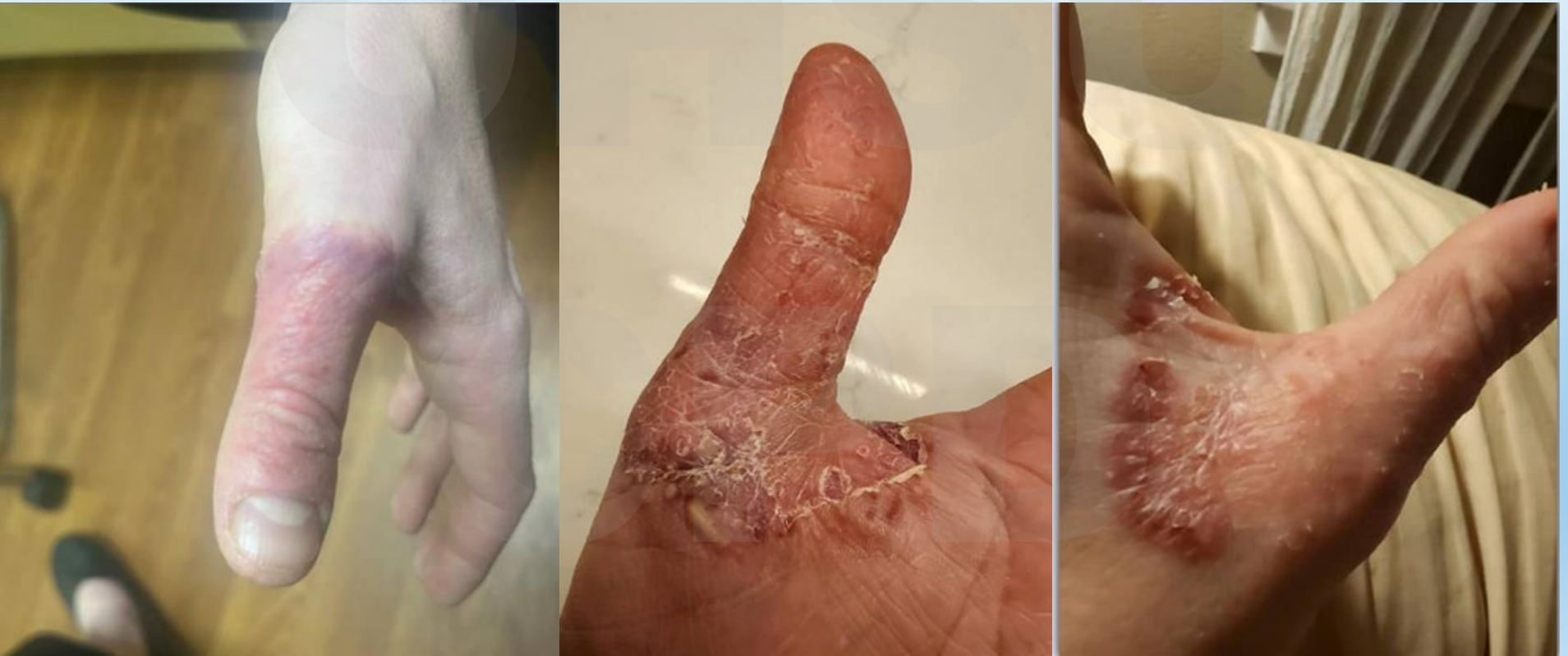
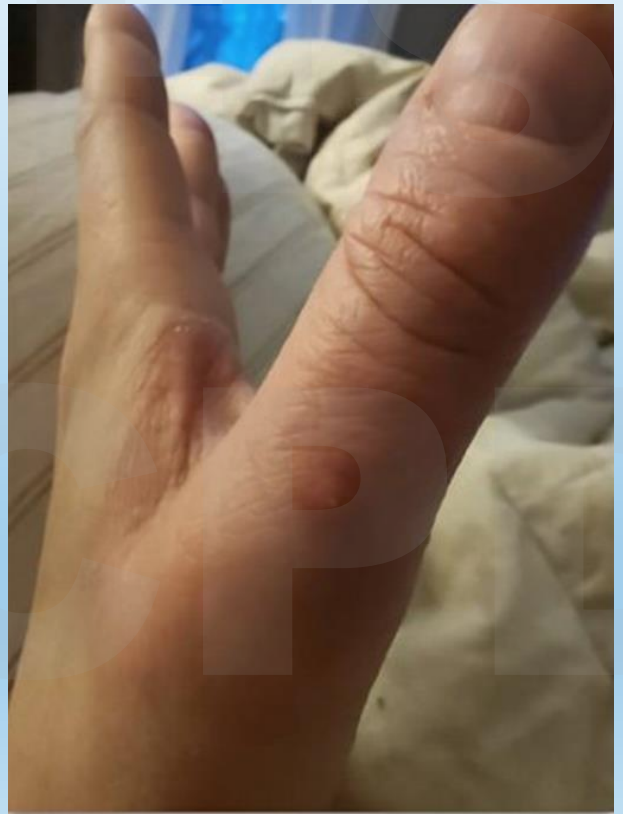
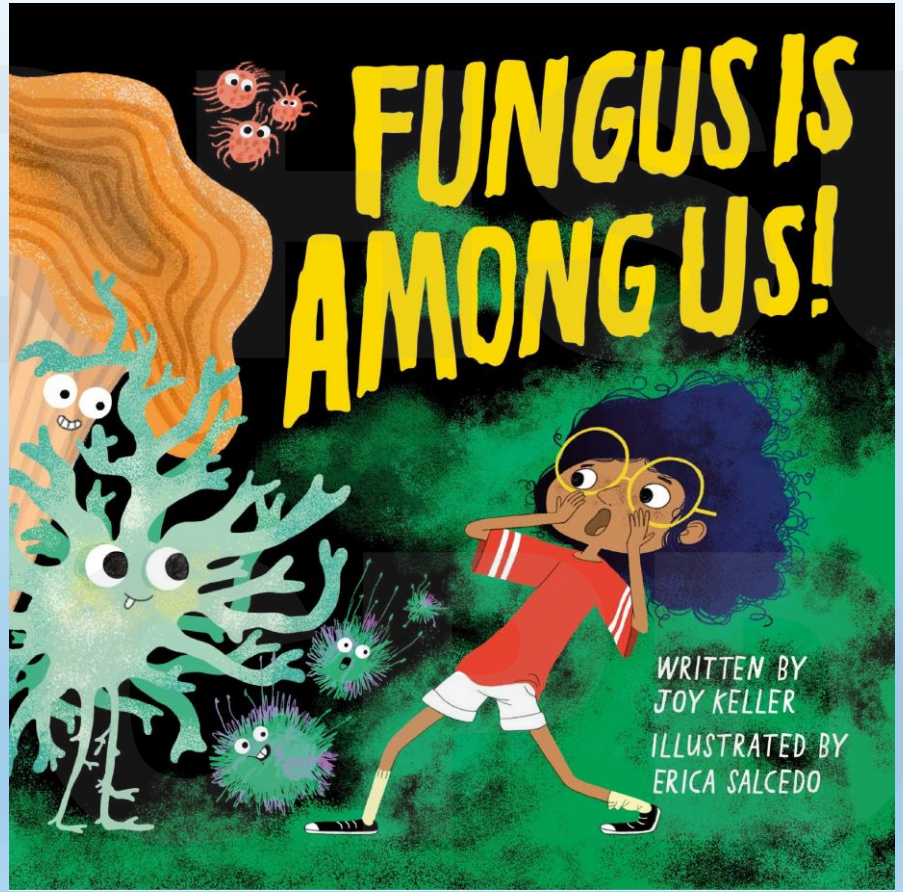

"I have a suspicious-looking mole on my shoulder."

Case 4: Progressing Hand Dermatitis

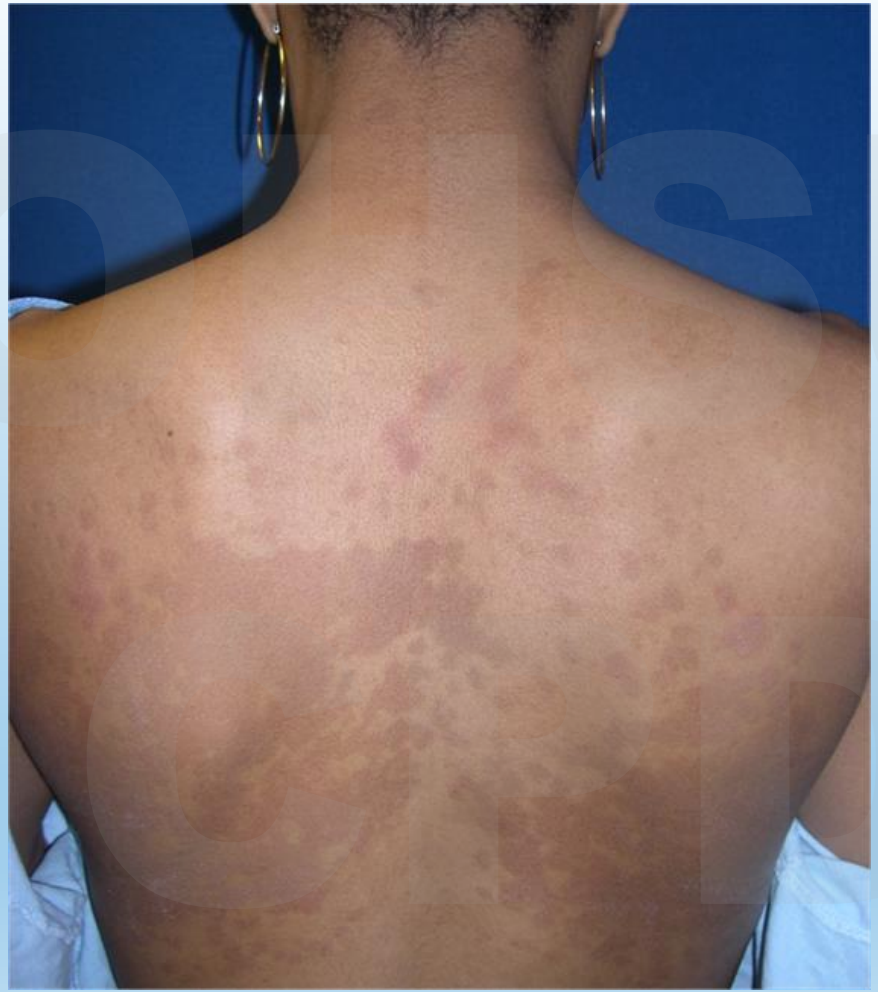


2 weeks later



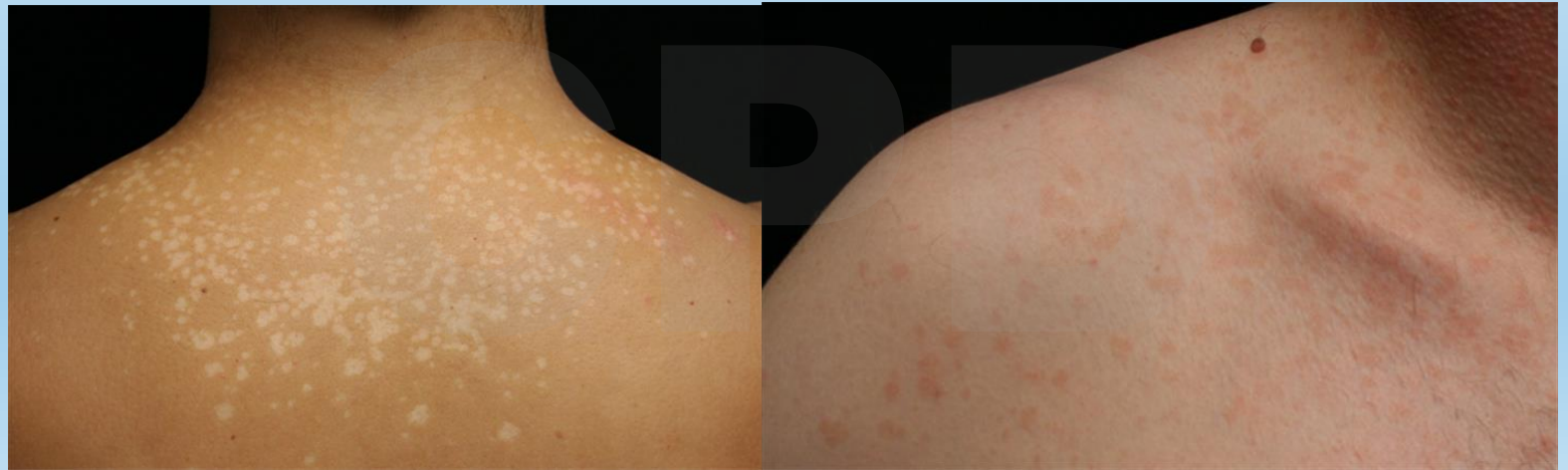

FUNGUS IS AMONG US!
WRITTEN BY JOY KELLER
ILLUSTRATED BY ERICA SALCEDO

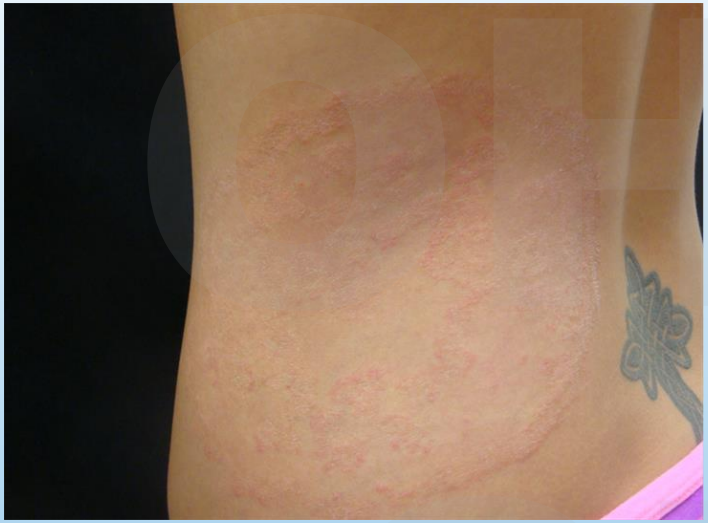
OHSU



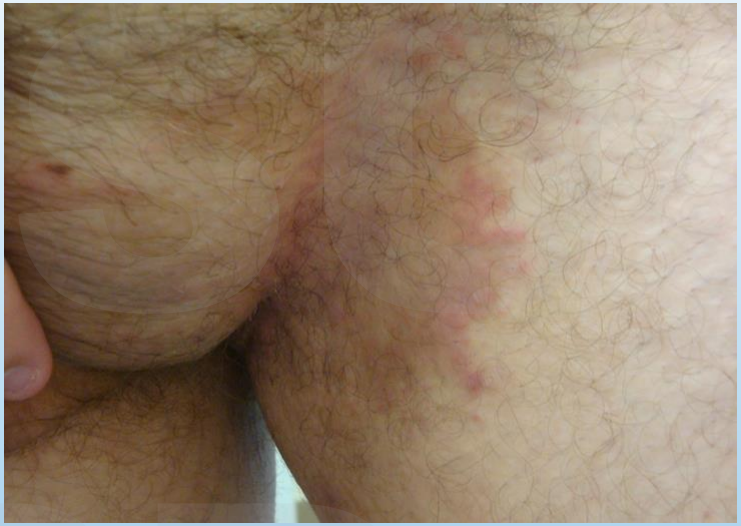
Tinea versicolor

- Not caused by dermatophyte.
- Malassezia
- Well demarcated hypo or hyper pigmented macules and patches on the trunk, arms (salmon pink, tan, brown)
- Use 15 blade to appreciate scale
- +KOH: “spaghetti and meatballs” short hyphae and round spores
- Treatment: selenium sulfide shampoo (5-7min), Ketoconazole shampoo (10 min). Ketoconazole cream 2-4 weeks





Tinea corporis



Tinea cruris

KOH+

Terbinafine Cream BID x 4-6 w (2nd line clotrimazole, miconazole)

Can do oral for 2 weeks if extensive

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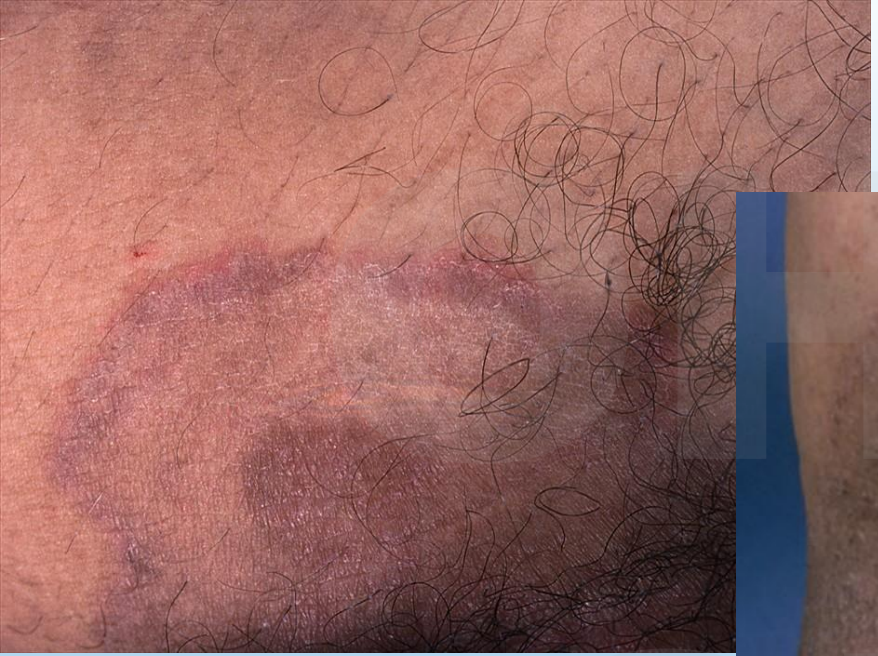

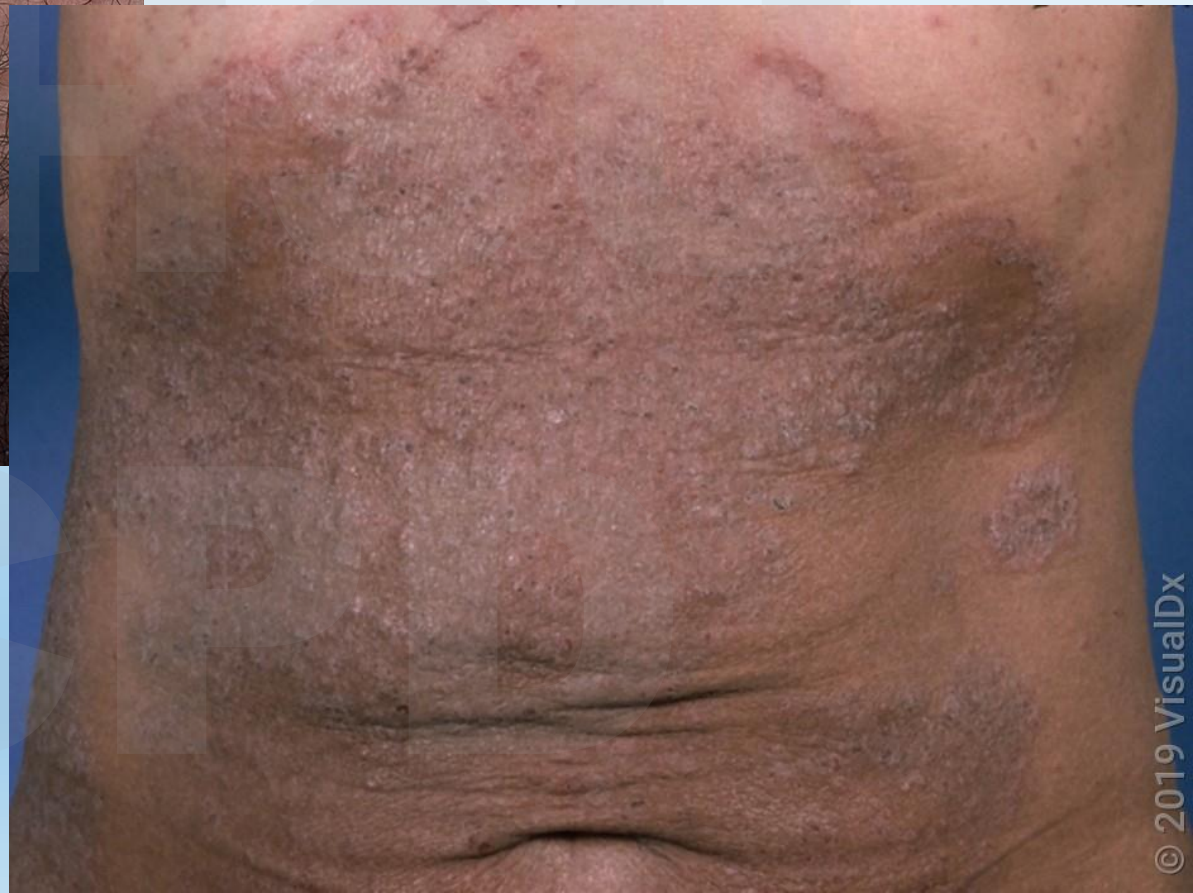
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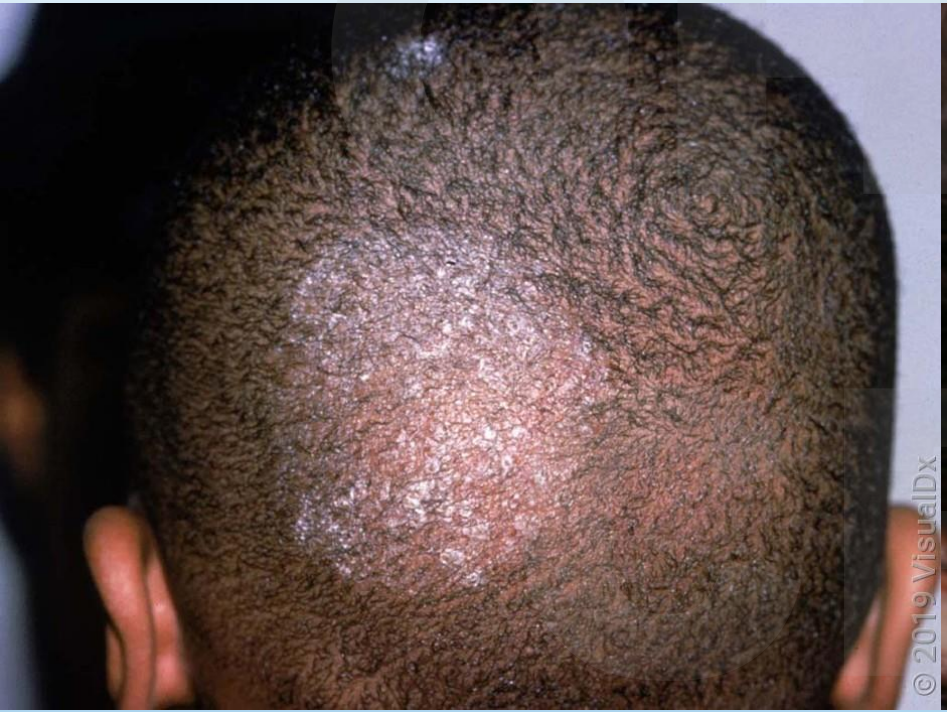
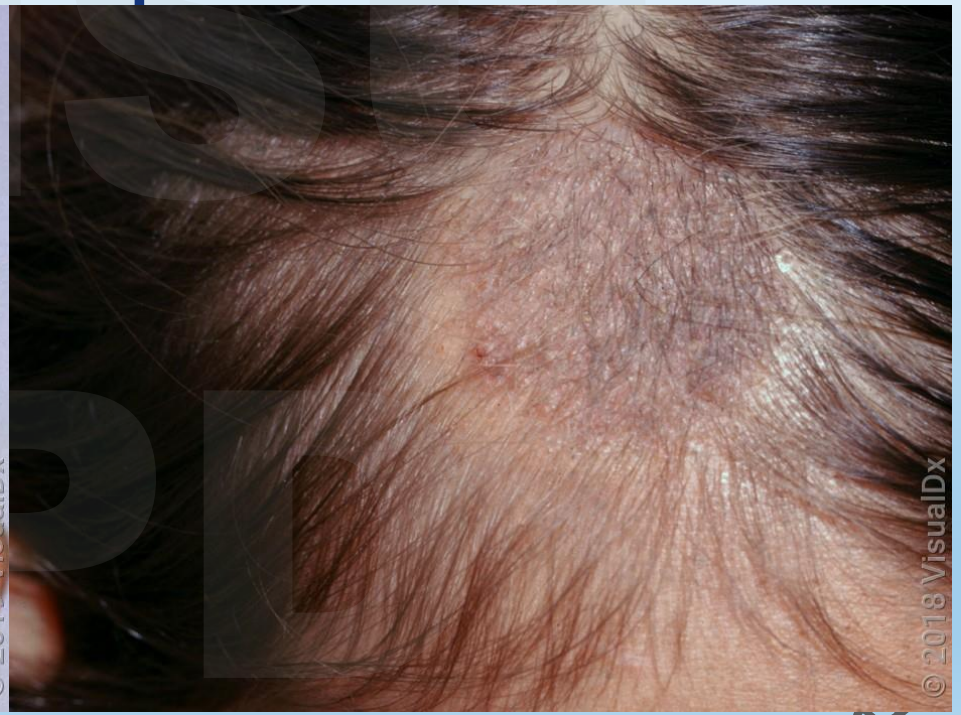
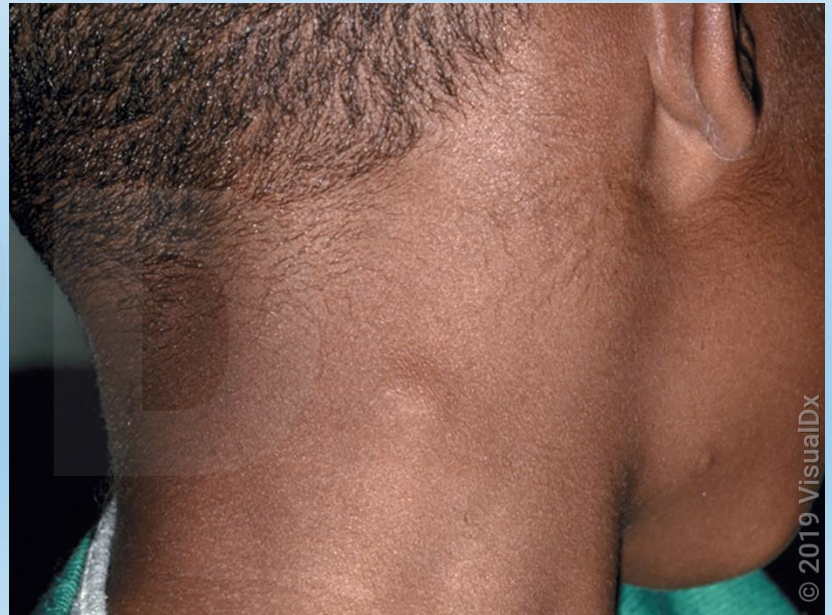
Tinea Capitis



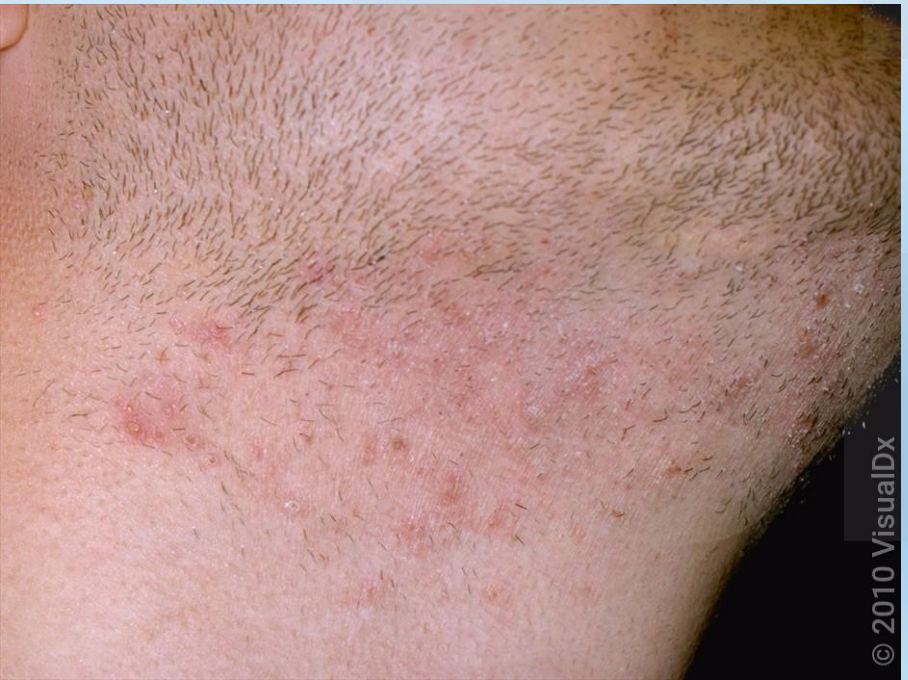


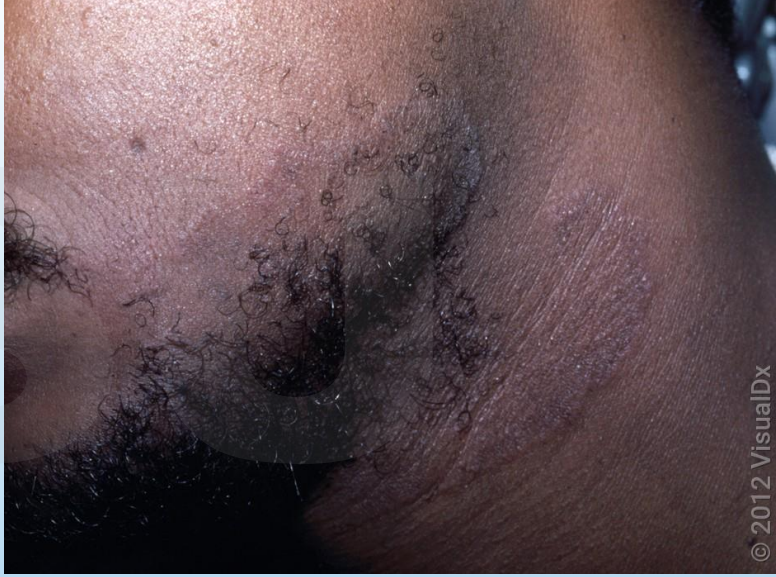
Tinea Capitis

- Child with scaly alopecia on scalp
- History!
- Trichophyton tonsurans & Microsporum canis.
- Perform fungal culture
- Tx: oral terfinafine (4-6 weeks+) or grisoefulvin (8+ weeks)
  - Add antifungal shampoo



Tinea Barbae





- Papules, pustules, nodules in beard
- History!
- Trichophyton
- Perform KOH
- Tx: terbinafine (2-4w)

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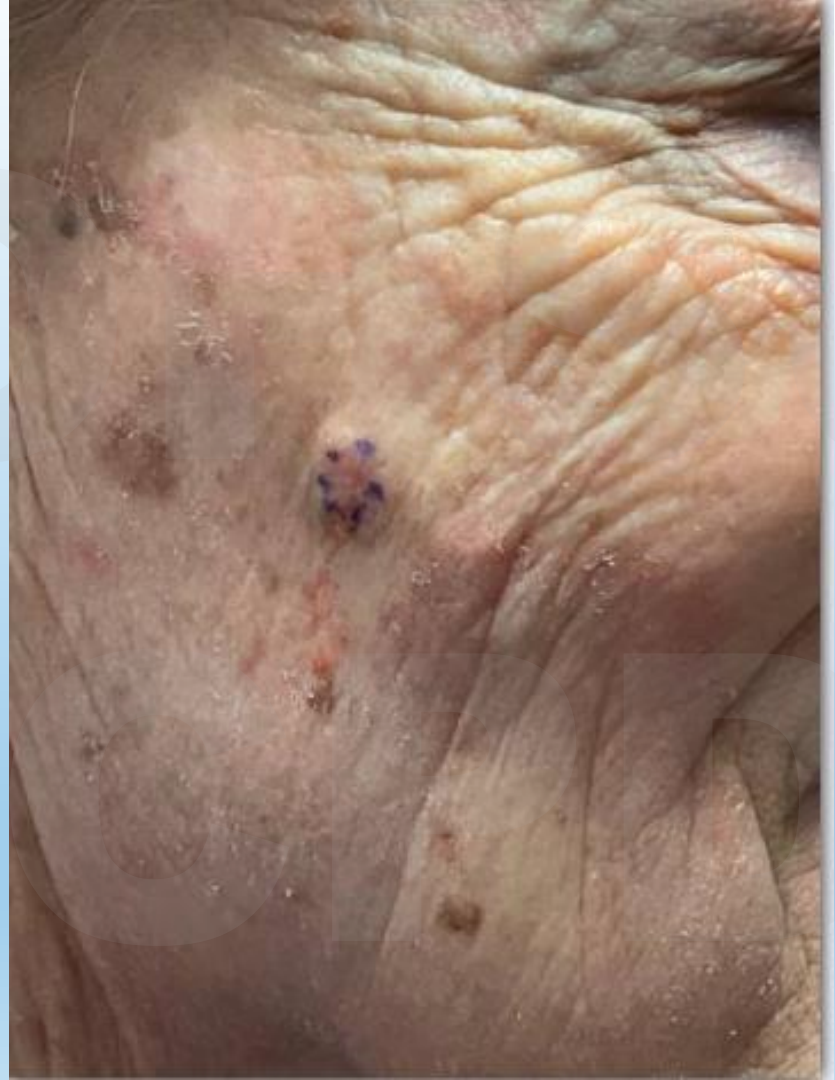
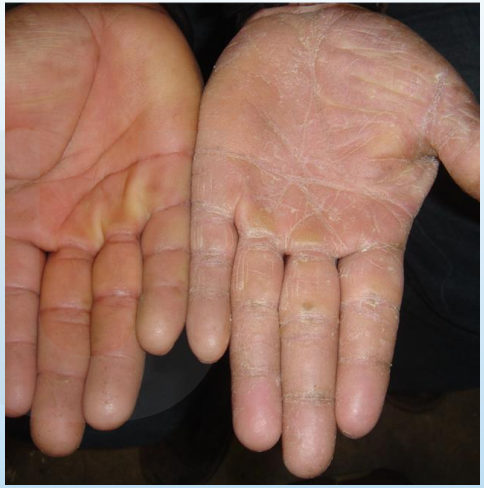
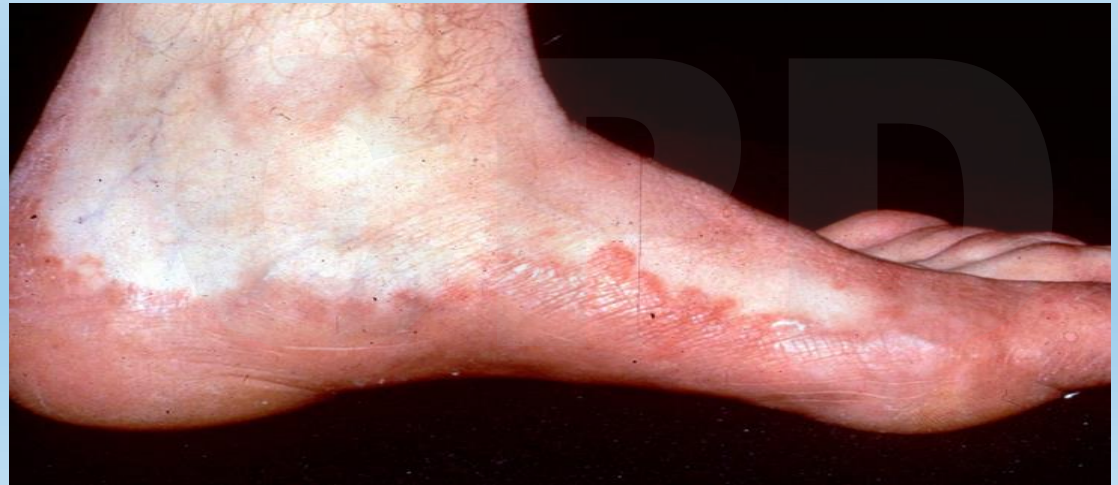


Tinea pedis



- One hand, two feet
- Trichophyton rubrum
- Warm environments (public showers)
- 4 types: interdigital, moccasin, vesicular, ulcerative



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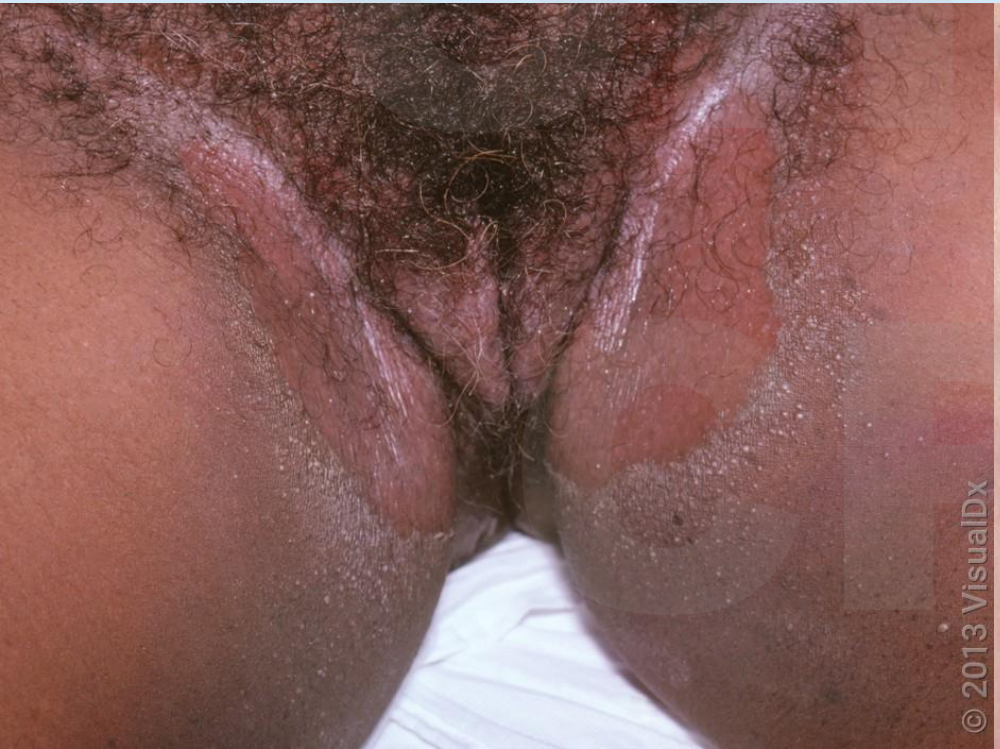
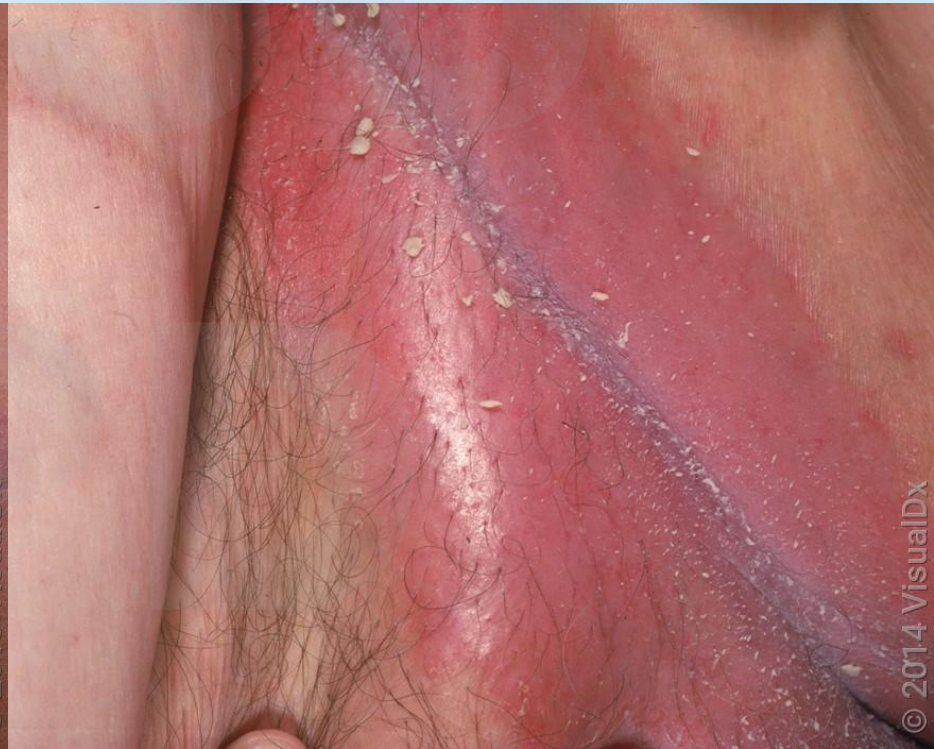
Tinea Pedis Treatment

- Start terbinafine (fungicidal) cream twice daily for 2-4 weeks
- Fungistatic: clotrimazole and miconazole
  - 4-6weeks

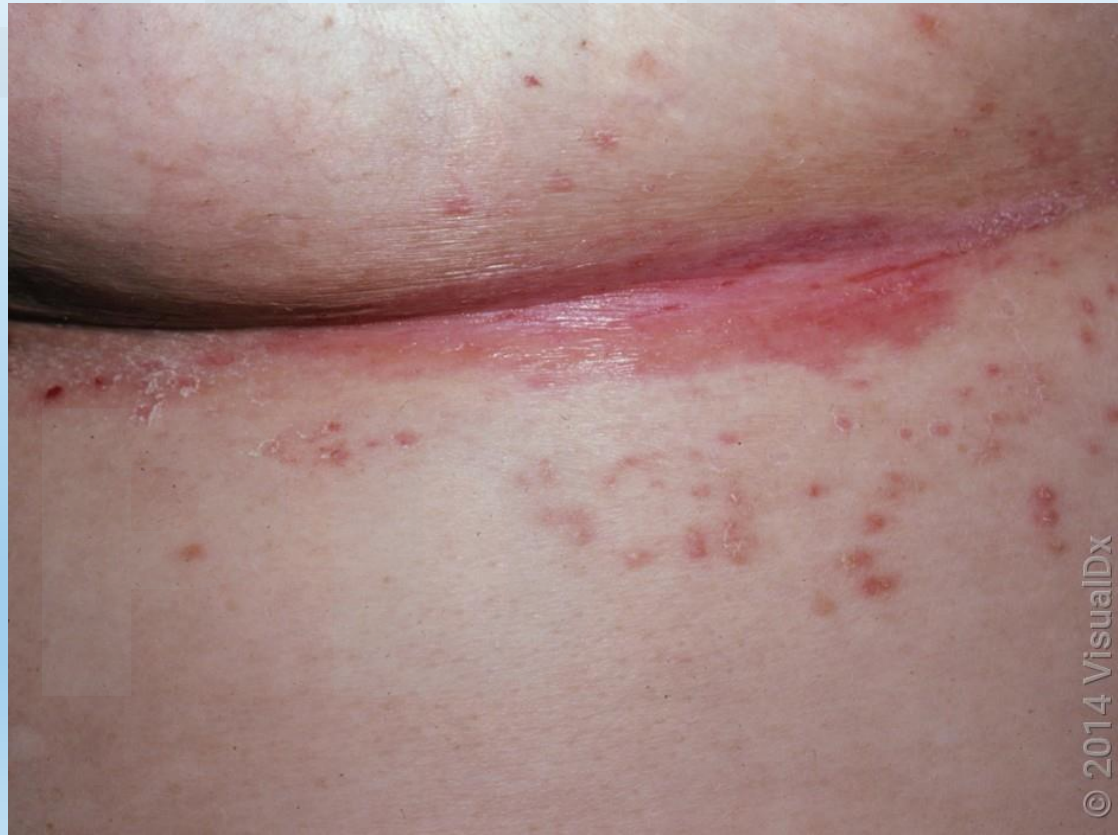
Candidiasis

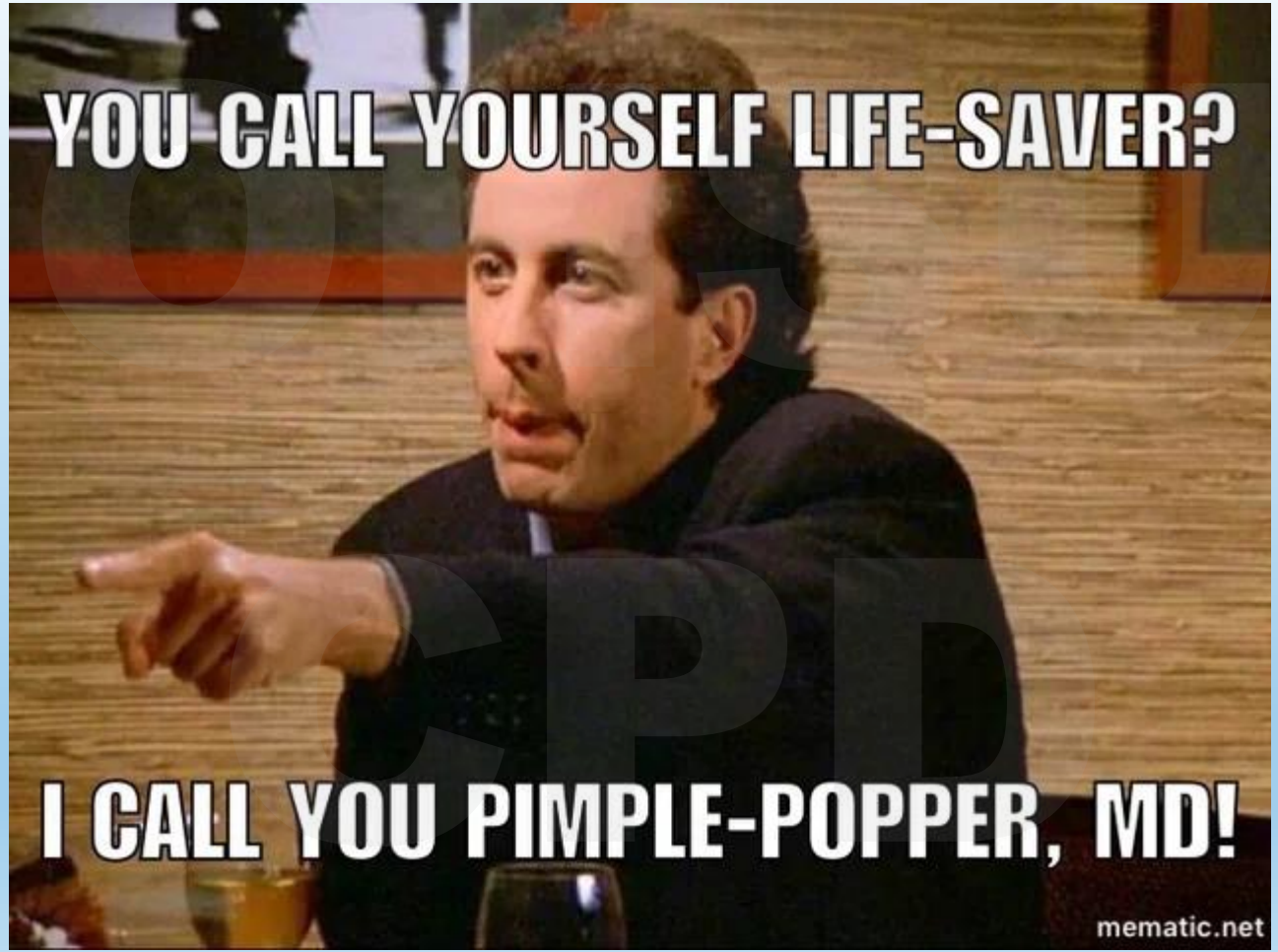




Candidiasis

- Intertriginous erythema and satellite pustules
- Clinical Dx but can do KOH to see pseudohyphae , budding yeasts
- Treatment
  - miconazole twice daily
  - Zeasorb powder for maintenance
  - Oral fluconazole




YOU CALL YOURSELF LIFE-SAVER?
I CALL YOU PIMPLE-POPPER, MD!
mematic.net

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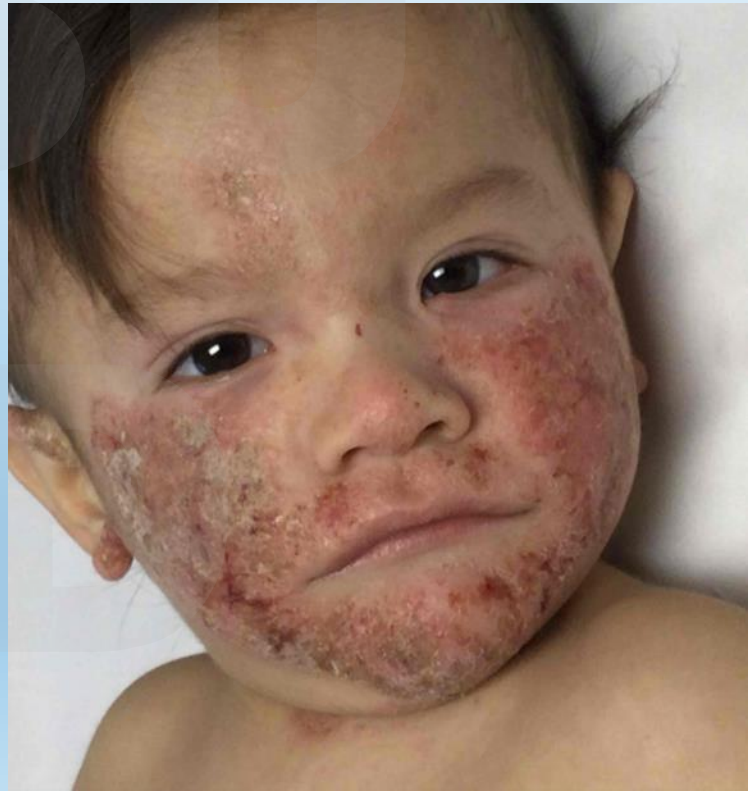
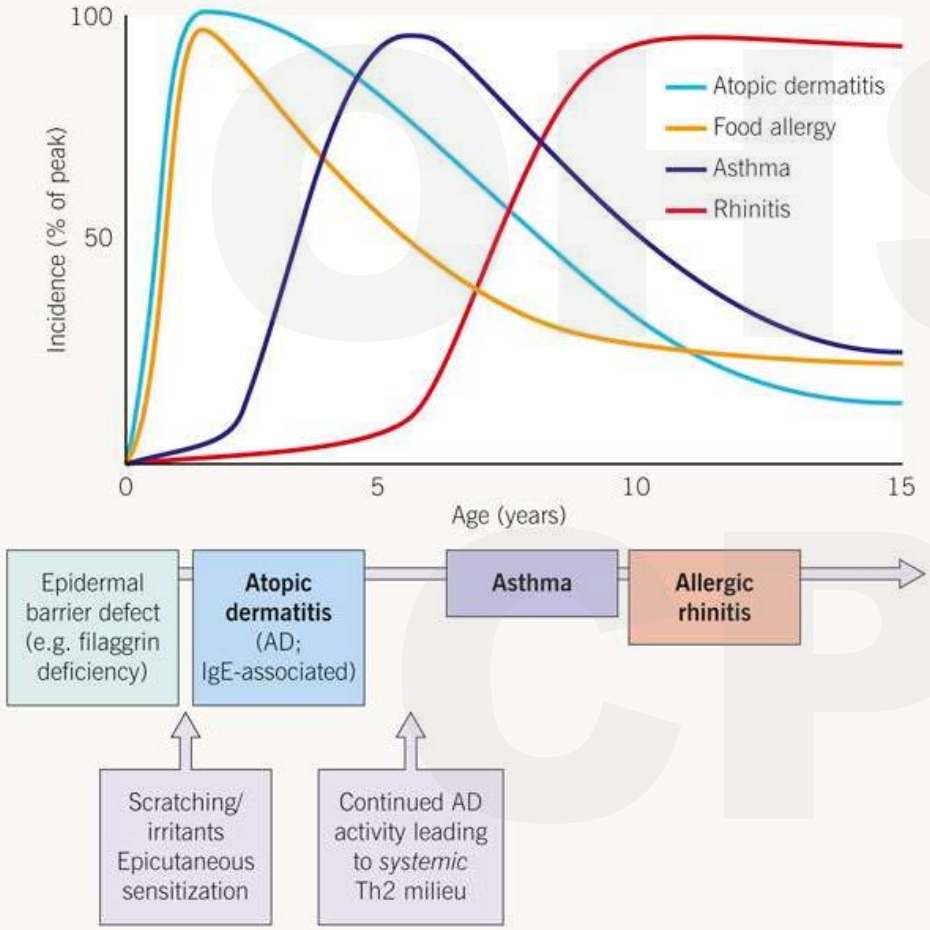
Atopic Dermatitis: Case 5

Eczema from the Greek word *ekzein*
"to boil, effervesce"

- *Red irritated plaques that weep*
- *"the itch that rashes"*
- *Chronic relapsing course*
- *AD sequelae*

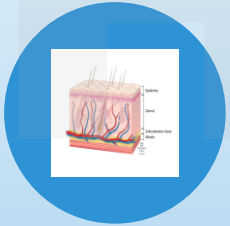


THE ATOPIC MARCH



AD: Epidemiology

- The onset of AD typically occurs in infancy or childhood, with more than 50% of patients developing the condition before age one and 85% before age five
- Higher incidence in urban and higher income
- **late-onset type** : defined as AD that starts after puberty
- **senile-onset type** : an unusual subset of AD that begins after 60 years of age



IMMUNE DYSREGULATION

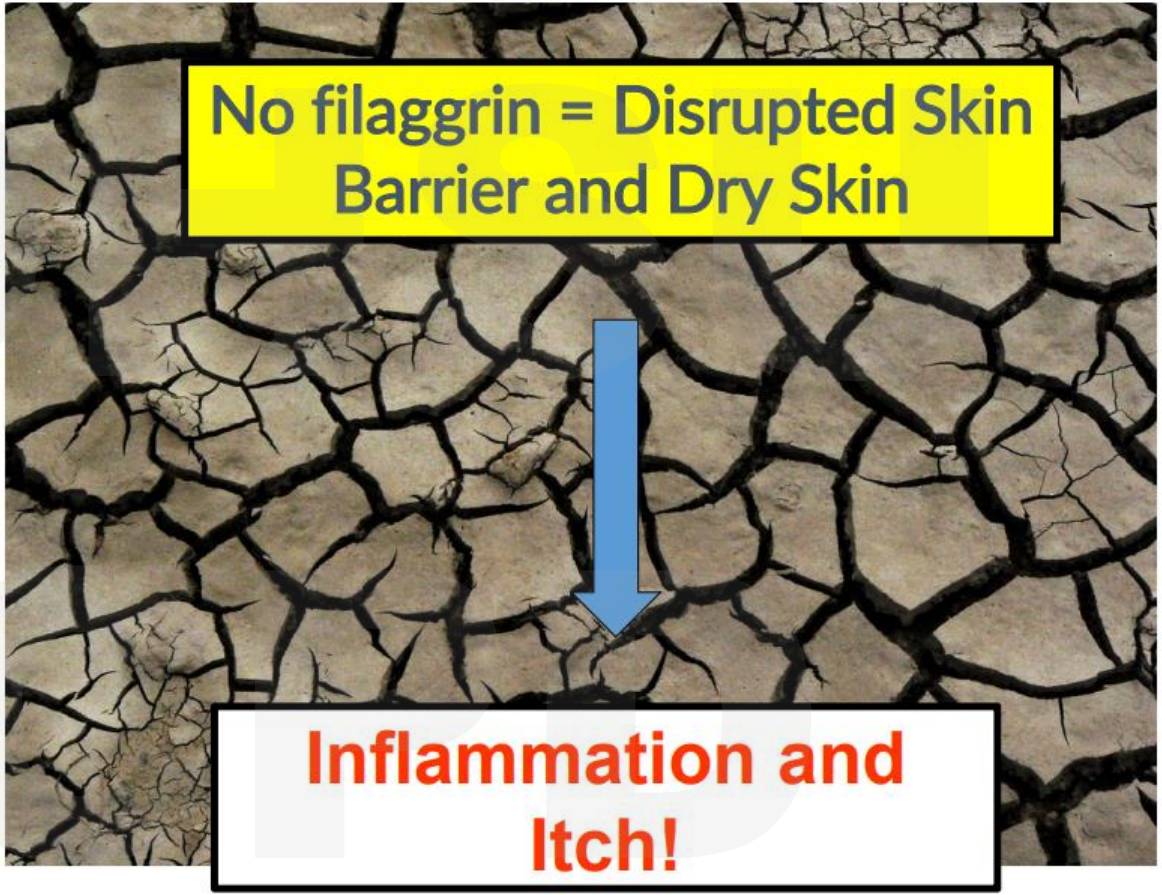
FAMILY HISTORY (GENES)

MUTATIONS IN FILAGGRIN

Pathogenesis

What does Filaggrin do?
Filament Aggregating Protein

Thank you to: Susan Tofte, DNP, MS, FNP-C



Thank you to: Susan Tofte, DNP, MS, FNP-C

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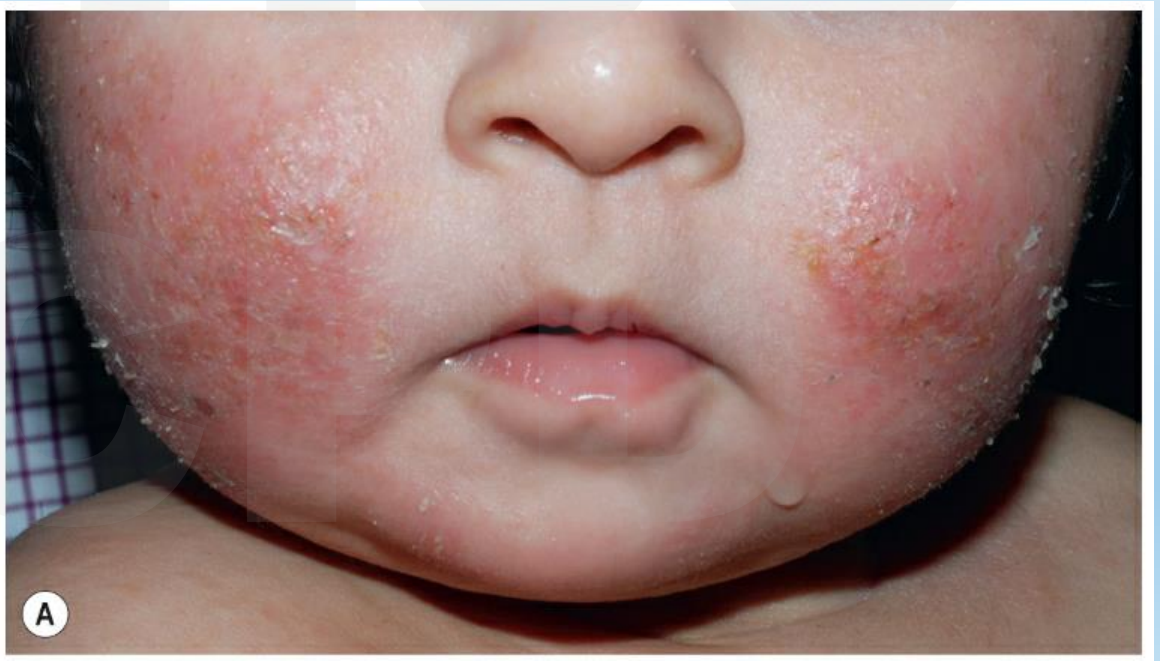
Signs and Symptoms

- ITCHY!
- Erythema
- Scaling and dryness
- Weeping
- Lichenification



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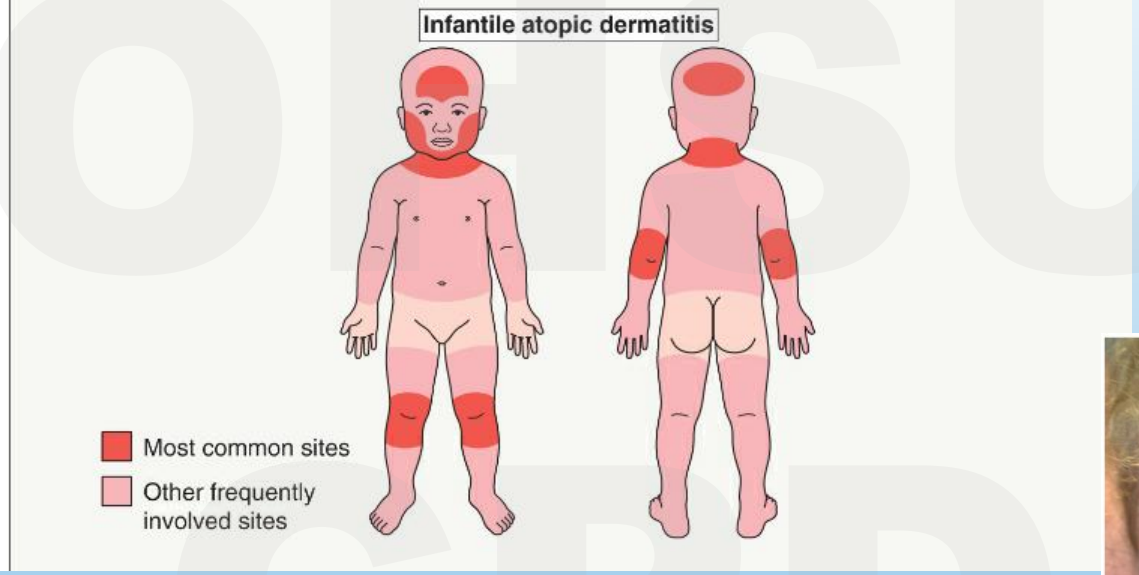
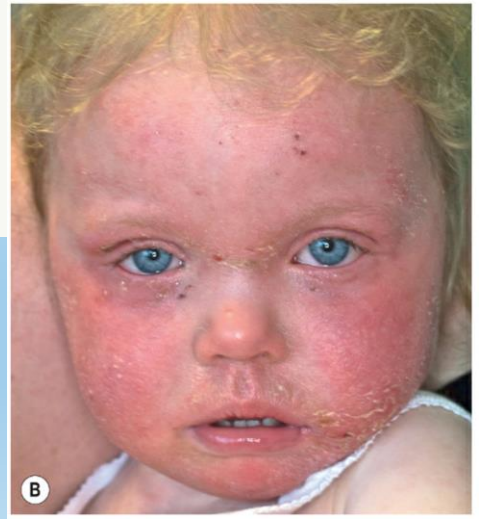
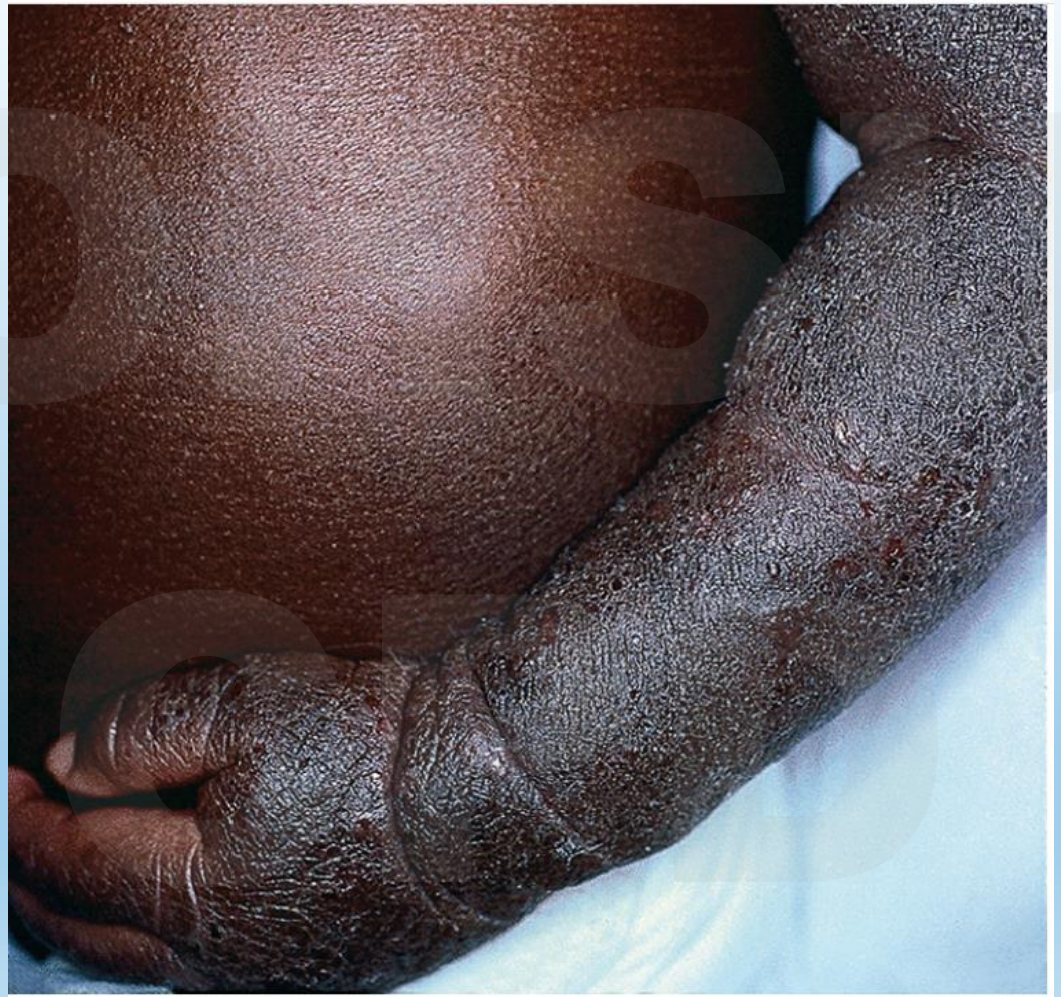
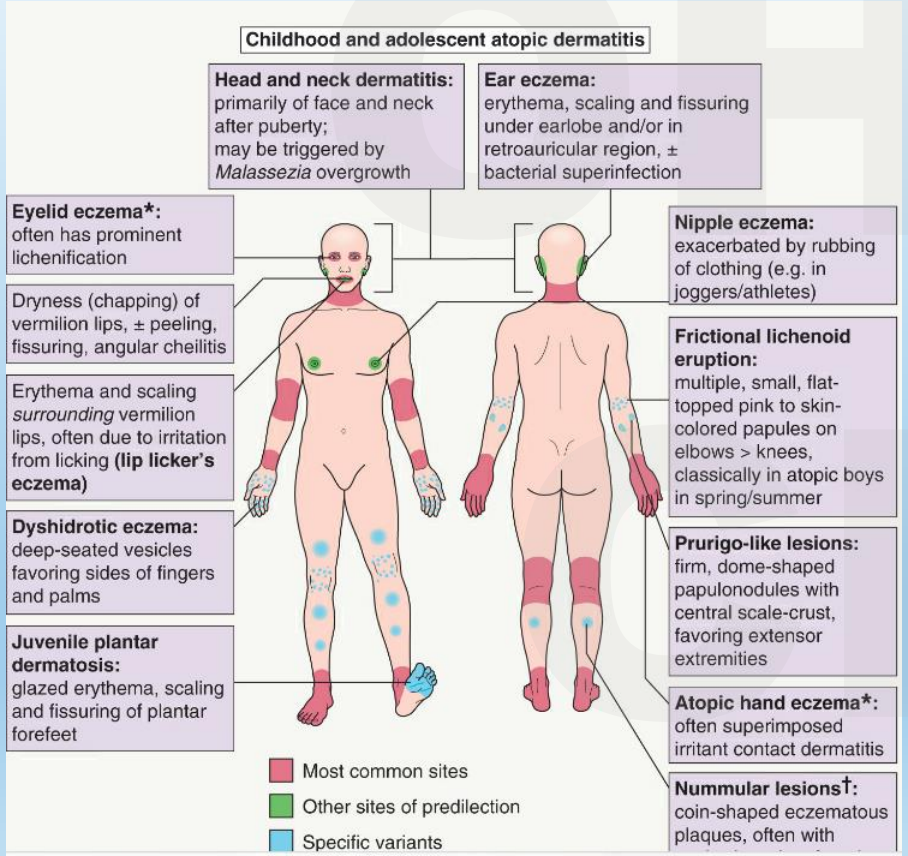
DISTRIBUTION PATTERNS OF ATOPIC DERMATITIS AND REGIONAL VARIANTS

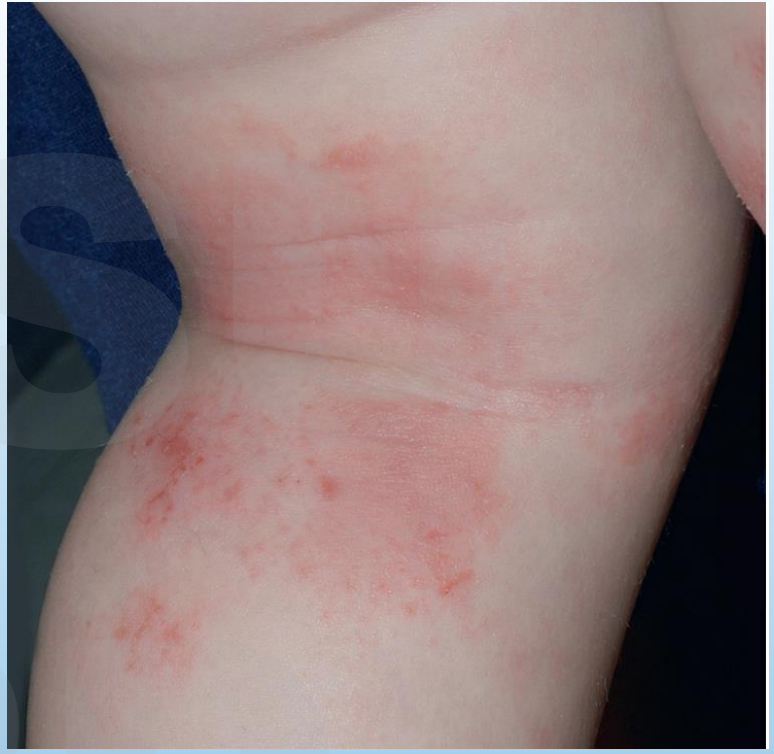




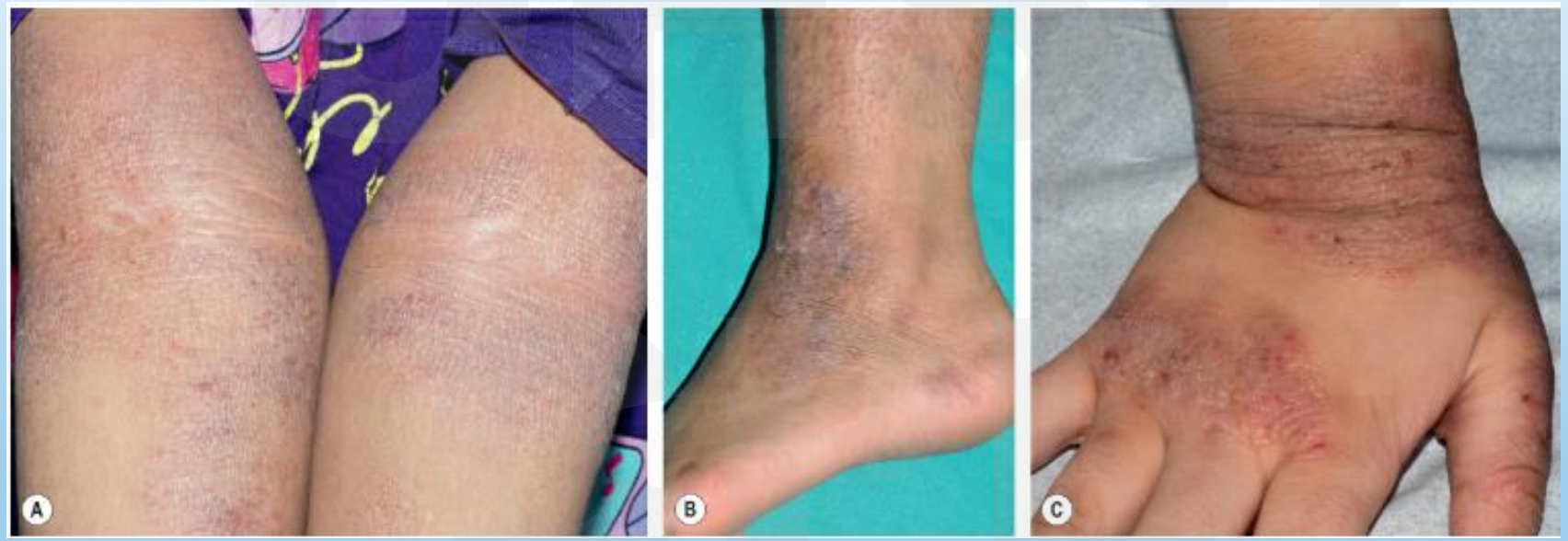


Childhood and adolescent AD





Childhood AD



Acta Dermatovener (Stockholm) Suppl. 92: 44–47, 1980

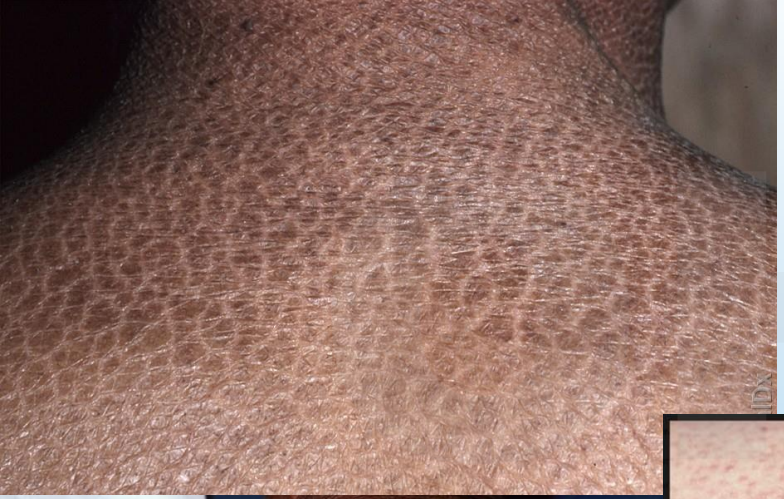
DIAGNOSTIC FEATURES OF ATOPIC DERMATITIS

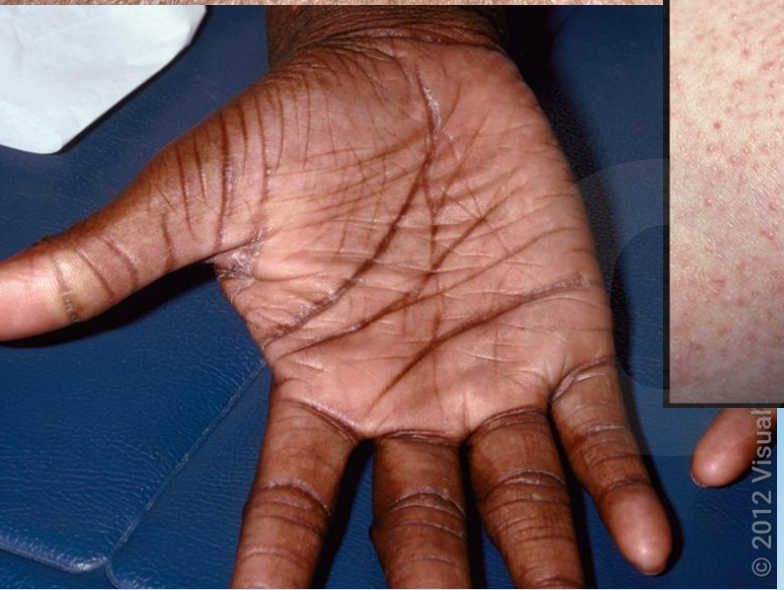
Jon M. Hanifin[1] and Georg Rajka[2]

[1]*Department of Dermatology, University of Oregon, Health Sciences Center, Portland, Oregon, USA and* [2]*Department of Dermatology, University of Oslo, Norway*

Must have 3 or more basic features:
- Pruritus
- Typical morphology and distribution:
  - Flexural lichenification or linearity in adults
  - Facial and extensor involvement in infants and children
- Chronic or chronically-relapsing dermatitis
- Personal or family history of atopy (asthma, allergic rhinitis, atopic dermatitis)

Plus 3 or more minor features:
- Xerosis
- Ichthyosis/palmar hyperlinearity/keratosis pilaris
- Immediate (type I) skin test reactivity
- Elevated serum IgE
- Early age of onset
- Tendency toward cutaneous infections (esp. *Staph. aureus* and *Herpes simplex*)/impaired cell-mediated immunity
- Tendency toward non-specific hand or foot dermatitis
- Nipple eczema
- Cheilitis
- Recurrent conjunctivitis
- Dennie-Morgan infraorbital fold
- Keratoconus
- Anterior subcapsular cataracts
- Orbital darkening
- Facial pallor/facial erythema
- Pityriasis alba
- Anterior neck folds
- Itch when sweating
- Intolerance to wool and lipid solvents
- Perifollicular accentuation
- Food intolerance
- Course influenced by environmental/emotional factors
- White dermographism/delayed blanch

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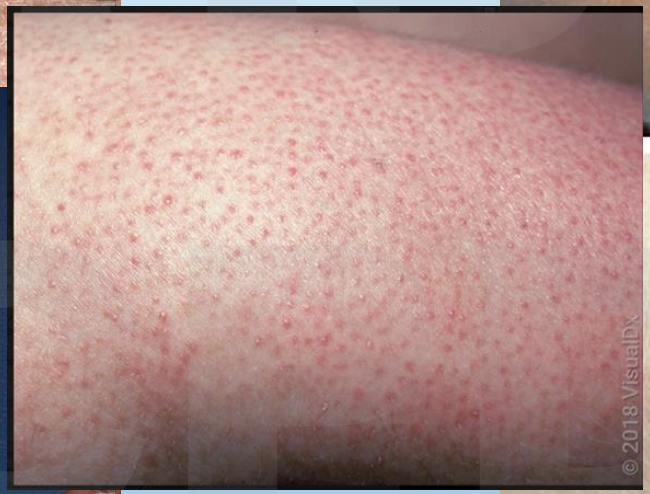
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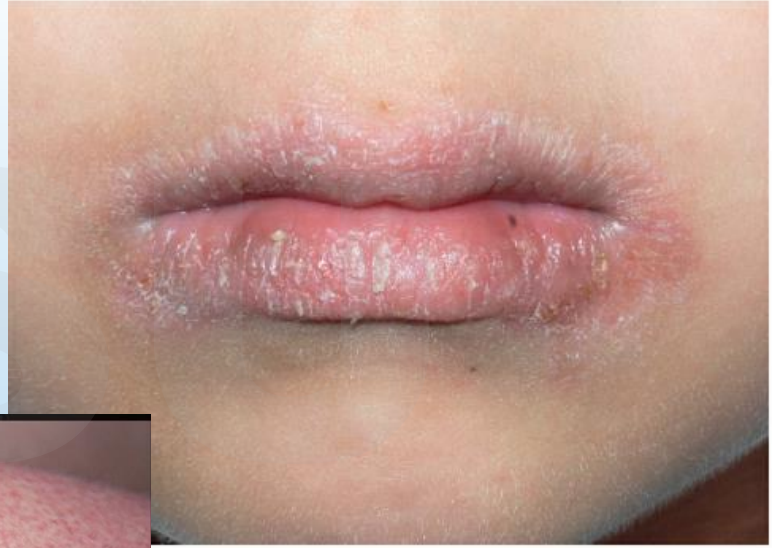
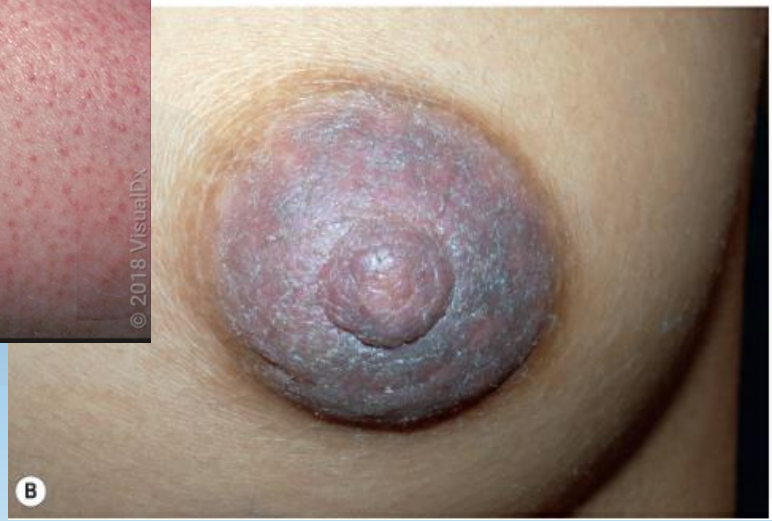



B

Differential Diagnosis

- Seborrheic Dermatitis
- Contact dermatitis
- Psoriasis
- Nummular dermatitis
- Asteatotic eczema
- Lichen simplex chronicus

Immunodeficiencies

- Wiskott–Aldrich syndrome
- Hyperimmunoglobulin E syndromes
- IPEX (immune dysregulation,
- polyendocrinopathy, enteropathy, X -linked) syndrome and IPEX-like condition
- Omenn syndrome

AND OTHERS…

Infestations and Infections

- Scabies
- Tinea
- HIV associated dermatoses
- Mucocutaneous candidiasis
- Impetigo
- Syphilis
- HTLV-1-associated “infective dermatitis

So many others:

- Nutritional deficiencies
- Langerhans Cell Histiocytosis
- Dermatitis Herpetiformis
- Drug eruptions
- Lymphoma

Treatment and Management

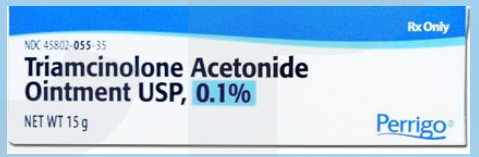
- Induce remission: treat to “put out the fire”
- Maintenance: continue to treat to reduce flares
- Rescue: Rescue flares quickly

Induce Remission

- Baths-they are good! But…
  - Limit soap to only the necessary areas
  - Soak and smear (within 3 minutes)
  - Bland emollient at least twice daily
  - ~limit to 15-20 min
  - warm water…not hot!

Induce Remission

- Mid potency steroid for non facial AD applied twice daily until clear and then continue twice weekly for maintenance.
- They will flare again and when they do—rinse and repeat!
- Show them how much ointment to apply and where
- Prescribe an appropriate quantity
- Address steroid phobia
- Look out for infection!



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Induce Remission

- Hands/feet/scalp: Strong steroid eg Clobetasol ointment
- Body: mid potency eg Triamcinolone ointment
- Face/neck/axilla/groin: low potency eg Hydrocoritsone 2.5%

Maintenance

- Twice weekly mid potency steroid (body)
- Twice weekly low potency steroid (face/neck/groin)
- Continue proper bathing and emollient

<u>Avoidance of Irritants/triggers</u>

- Extreme temperatures
- Irritants
  - Wool
  - Detergents
  - Sweat
- Infections (Staph aureus, HSV, Molluscum, URI)
- Dust mites
- Pollen
- Stress
- Foods

Maintenance: non-steroid

- Utilize nonsteroidals:
  - ✓ Elidel (Pimecrolimus)
  - ✓ Protopic (tacrolimus)
  - ✓ Eucrisa (crisaborole) (Infants ≥3 months)
  - ✓ Topical ruxolitinib is a Janus kinase (JAK) inhibitor approved
  - ✓ Roflumilast cream 0.15%, six years and older
  - ✓ Roflumilast cream 0.05%, two to five years
  - ✓ Tapinarof cream

Observational Study › J Am Acad Dermatol. 2020 Aug;83(2):375-381.
doi: 10.1016/j.jaad.2020.03.075. Epub 2020 Apr 1.

No evidence of increased cancer incidence in children using topical tacrolimus for atopic dermatitis

Amy S Paller [1], Regina Fölster-Holst [2], Suephy C Chen [3], Thomas L Diepgen [4], Craig Elmets [5], David J Margolis [6], Brad H Pollock [7]

Affiliations + expand

PMID: 32246968 DOI: 10.1016/j.jaad.2020.03.075

Free article

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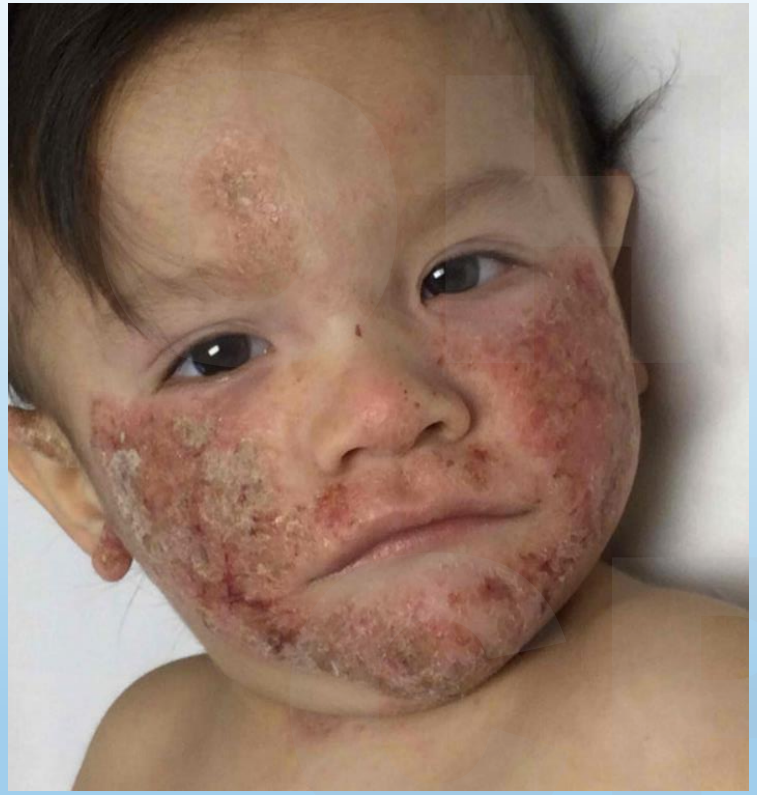
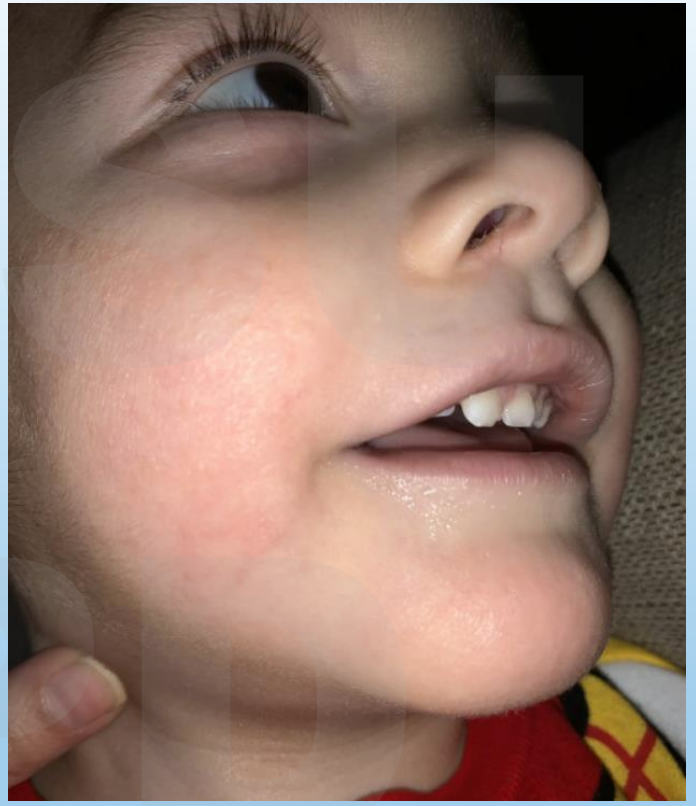
Maintenance: non-steroidals

- They can be used on eyelids/face/genitals
- Work best when skin is not inflamed
- Can have some stinging (can place in refrigerator)
- Use as a maintenance (on non-inflamed skin)
- Helpful when a patient isn't staying clear on twice weekly steroid





Systemic treatment: Methotrexate

- Common to have insurance want this as first step
- Need to monitor CBC/CMP monthly for first 3 months
- Typically 15mg/kg per WEEK with daily folic acid
- Takes time ~3+ months
- Side effects: cytopenias, liver toxicity, pulmonary fibrosis as major SE and also nausea, oral ulcers as other potential SE

Systemic treatment : Cyclosporine

- Start at 5mg/kg day
- Monitor Blood Pressure
- Labs (CMP, CBC, Magnesium, uric acid, lipids)
- Avoid grapefruit juice, NSAIDS
- Can interact with statins
- Treat no longer than 6 months

Systemic Treatment: Dupilumab

- Human IgG4 receptor monoclonal antibody that inhibits IL-4 and IL-13
- FDA approved down to 6 months for severe AD
- Approved as adjunct therapy for asthma and chronic allergic rhinosinusitis w/ nasal polyps, prurigo nodularis, BP, and more!
- Sub-q injection; weight based
- Most common side effects: conjunctivitis , head and neck dermatitis, injection site reactions

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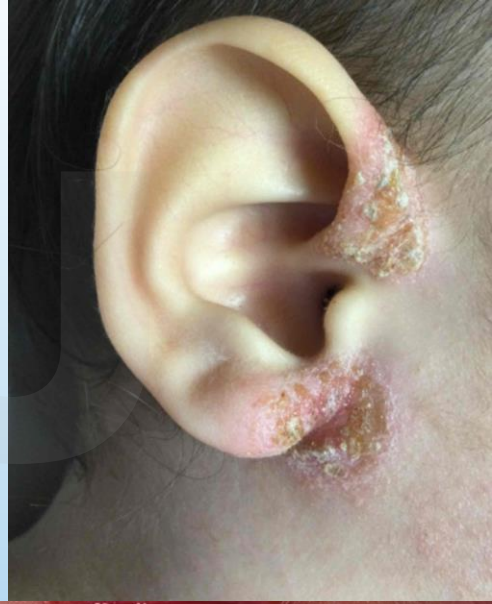
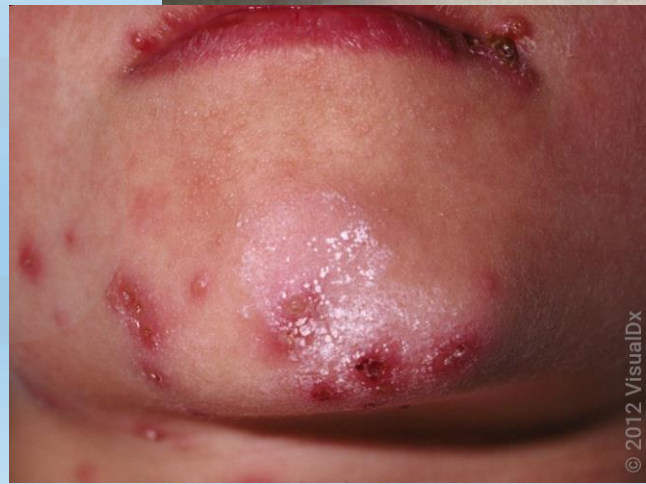
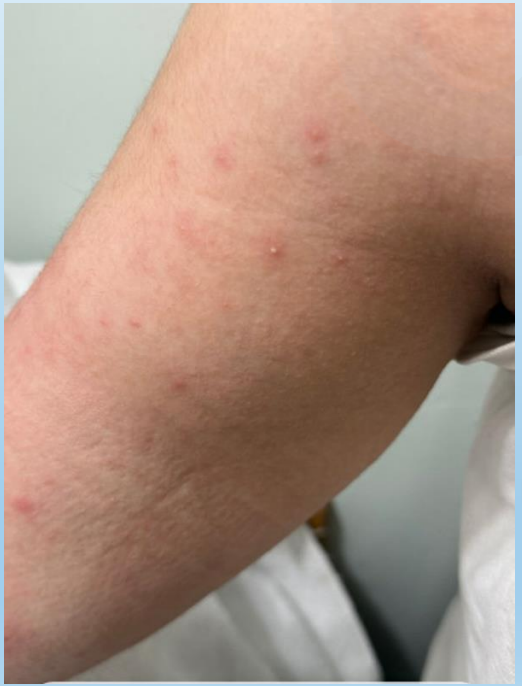
Other treatments

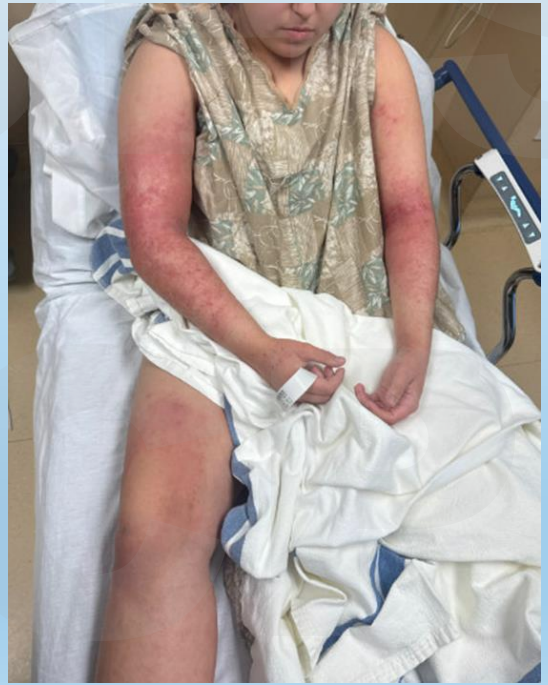
- Phototherapy
- Wet Wraps
- Antibiotics
- Antivirals

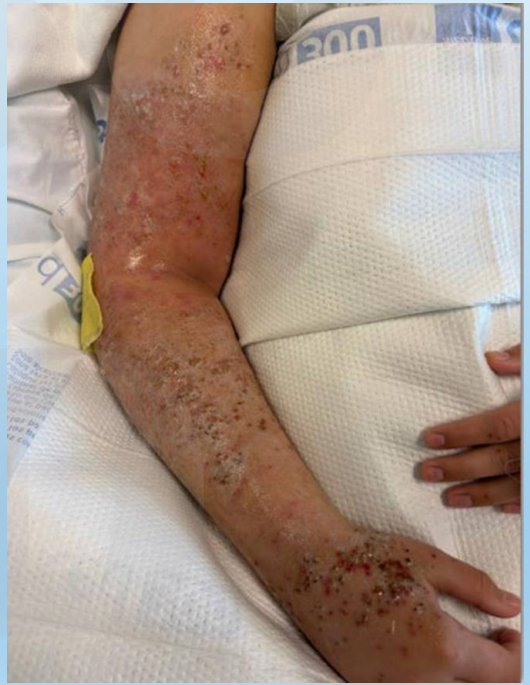




Thursday, Saturday, Tuesday







Other Treatments

- 12 + Years old:

Tralokinumab

- human immunoglobulin G4 (IgG4) monoclonal antibody that binds to IL-13
- upper respiratory tract infection, injection site reaction, asthma, and headache

Lebrikizumab

- a humanized IgG4 monoclonal antibody that binds soluble IL-13

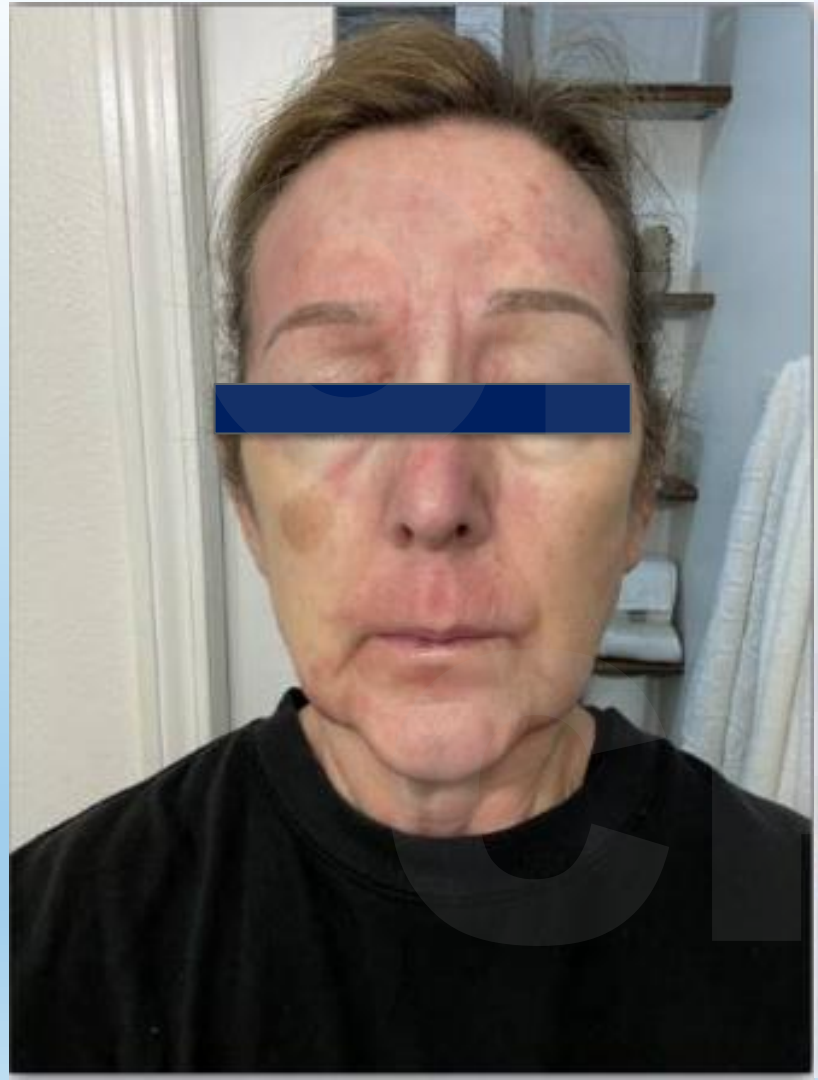
Nemolizumab

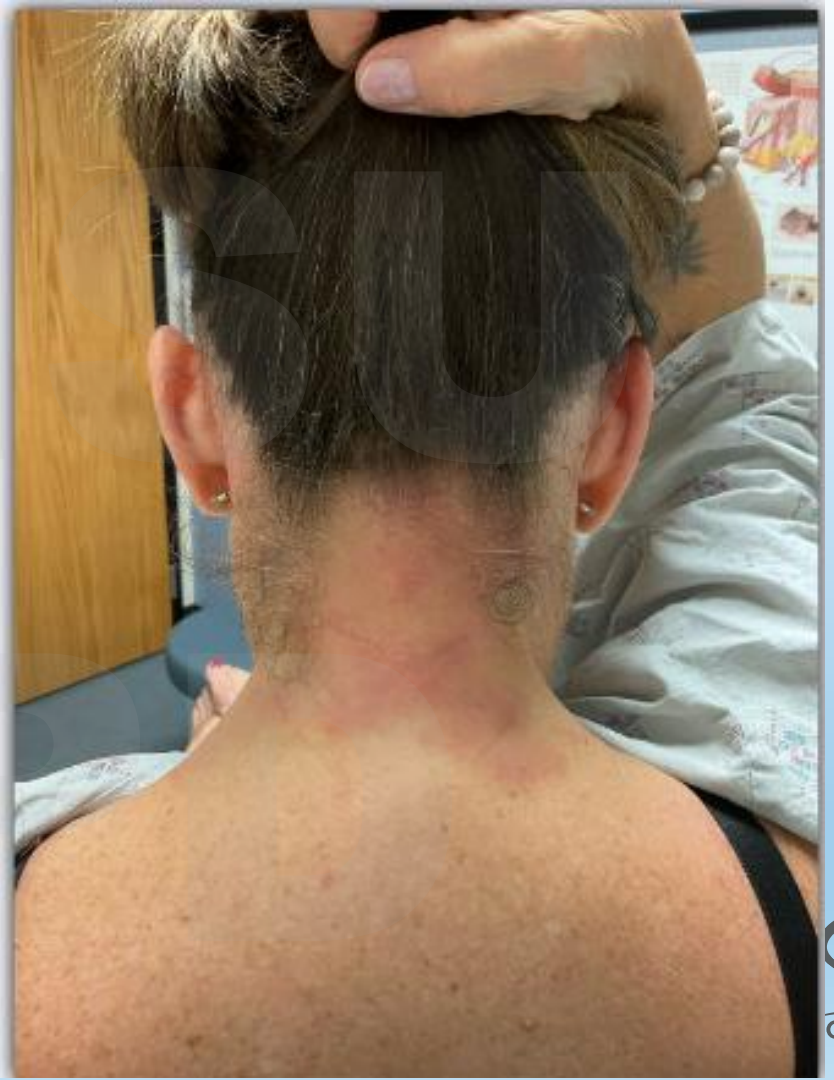
- humanized monoclonal antibody against the receptor of IL-31

Jak Inhibitors

12+ years old

- Janus kinases (JAKs) are a family of intracellular enzymes (JAK1, JAK2, JAK3, and tyrosine kinase 2 [TYK2])
- these are necessary for signaling inflammatory cytokines, including IL-4 and IL-13
- Upadacitinib, Abrocitinib, Baricitinib
- acne, headache, nasopharyngitis and upper respiratory tract infection, and creatine phosphokinase (CPK) elevations

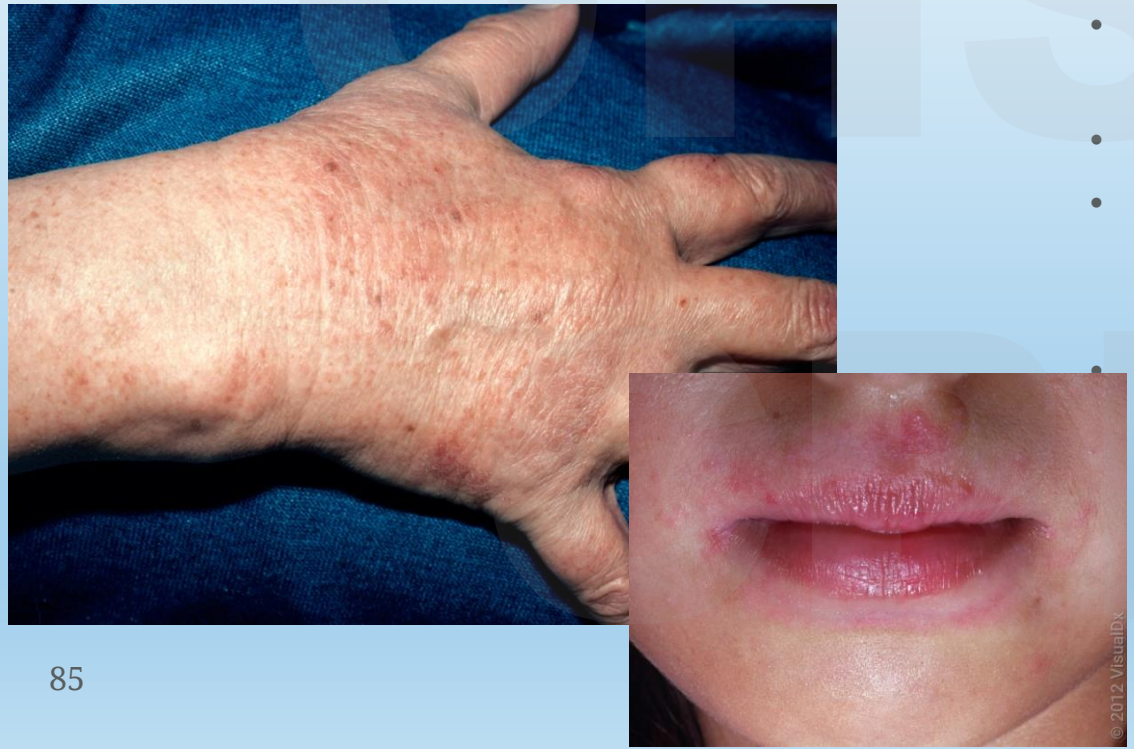




Contact Dermatitis

- ICD (irritant contact dermatitis)
  - 80% of cases
  - Caused by a topical and physical irritant to epidermis
  - Commonly occupational
- ACD (allergic contact dermatitis)
  - Delayed hypersensitivity reaction to a substance
  - Ex: Poison Ivy

Irritant Contact



- Non-immunologically mediated
- Erythema, lichenification, fissures, scaling, vesicles
- Most commonly affects the hands
- Lip licker's dermatitis
- Common causes: soaps, wet work, petroleum, oils, coolants
- **Tx**: avoidance of triggers, emollients, topical steroids

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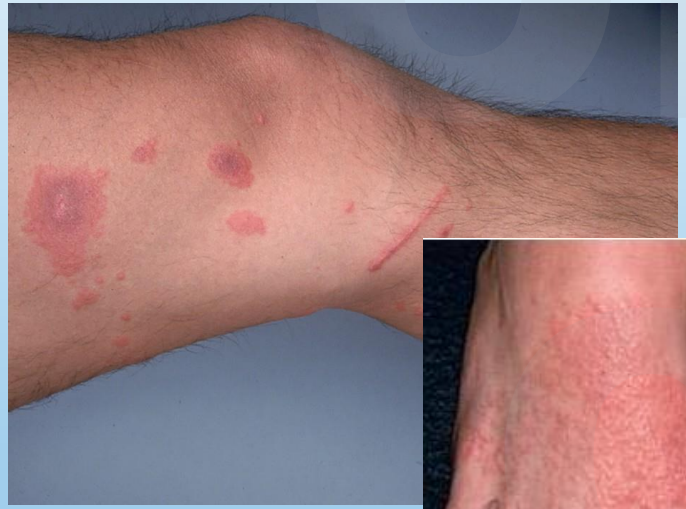
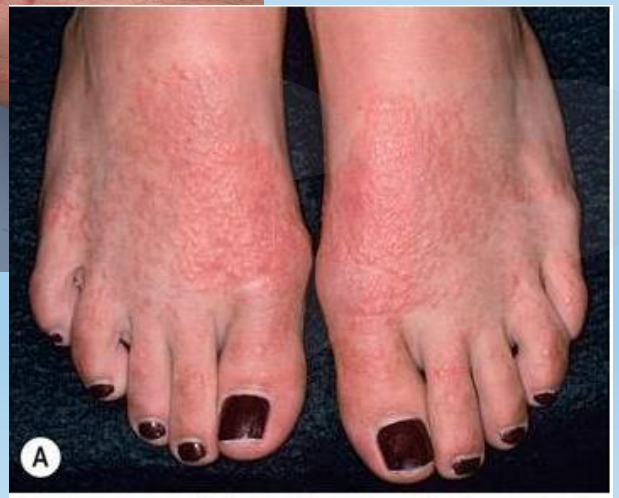
Allergic Contact



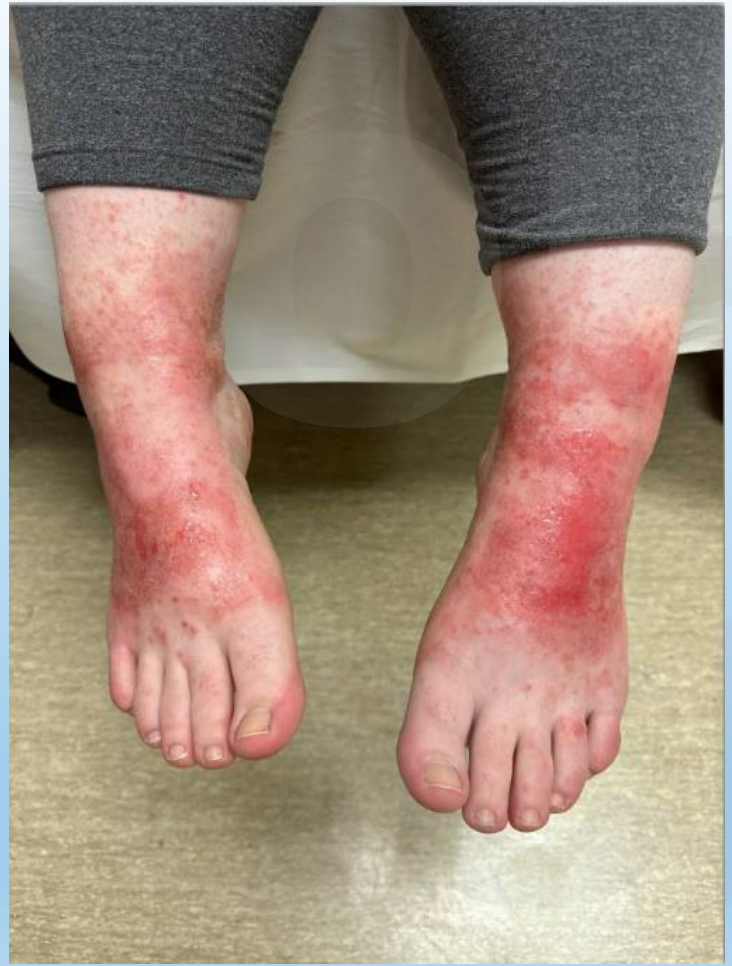


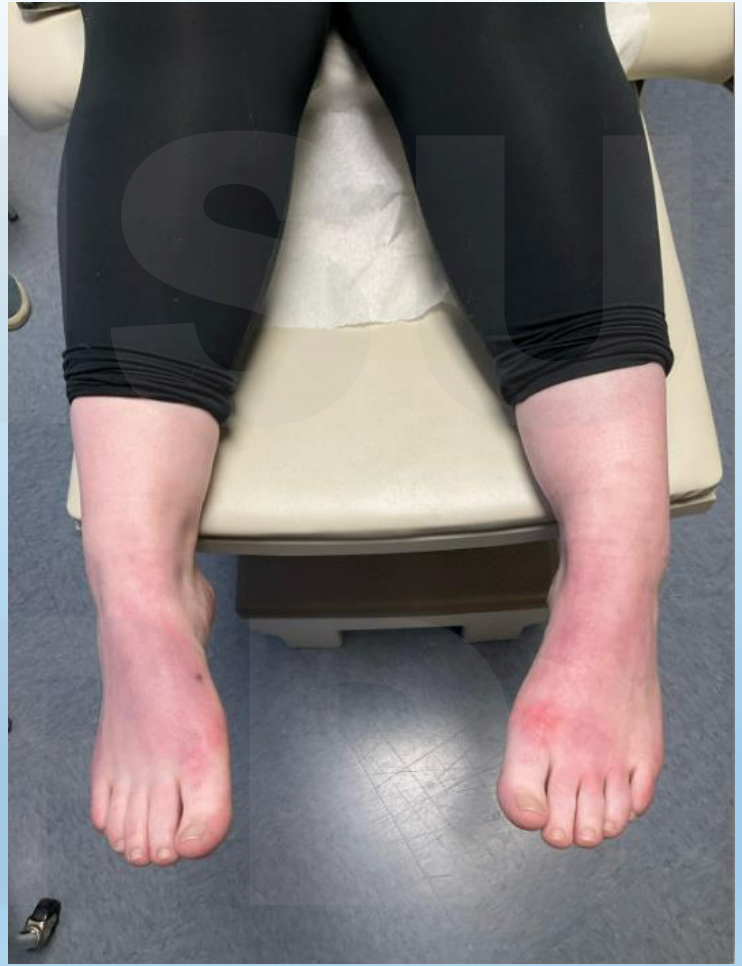
- Delayed-type (type IV) hypersensitivity reaction
- Intense pruritus during the acute phase
- Well demarcated and localized
  - Autosensitization with extension from the original site
- Erythema, edema, vesicobullae, oozing, lichenification

Common allergens: metals (nickel), fragrances, preservatives, topical antibiotics, plants, airborne, sunscreens

Work-up: thorough history, patch testing

Tx: avoidance, topical and systemic corticosteroids





Thank you!