COMMON SKIN PROBLEMS—Steven E. Prawer, MD, Clinical Professor of Dermatology, University of Minnesota Medical School, Minneapolis

Acne vulgaris: *grade 1*—comedones (*ie*, whiteheads, blackheads); most common form; best treated with comedolytic agents, *eg*, Retin-A (tretinoin), Differin (adapalene), and Tazorac (tazarotene); avoid these agents in adults because of drying effects; patients bathe with mild soap (*eg*, Cetaphil) and apply lotion in morning; *grade 2*—characterized by comedones and papules (pimples); if papules few, have patient use comedolytic agents at night and apply topical antibiotic (*eg*, Cleocin T [clindamycin], Benzamycin [benzoyl peroxide and erythromycin], or BenzaClin [clindamycin and benzoyl peroxide]) in morning; if patient has many pustules, consider topical antibiotic (*eg*, tetracycline); if patient fails to respond, consider doxycycline or minocycline; *grade 3*—comedones, papules, and pustules; if not responsive to doxycycline or minocycline, consider amoxicillin or trimethoprim-sulfamethoxazole (Septra, Bactrim); *grade 4* (*acne fulminans)*—cystic acne; typically occurs on trunk, chest, and back; lesions can erode into bone; consider referral to dermatologist for treatment with Accutane (isotretinoin)

Rosacea: presents with telangiectasia; flare factors include sun, cold, spicy foods, and alcohol ingestion; MetroGel (metronidazole) effective but drying; newer agents include MetroCream, MetroLotion, and Noritate (varieties of metronidazole); give tetracycline if papules or blepharitis develop

Psoriasis: typically presents with well-demarcated, scaly plaques; trauma, *eg*, scratching, produces lesions (Koebner's phenomenon); *localized to elbow*—apply Cordran (flurandrenolide) tape at night and remove in morning; superpotent corticosteroids (*eg*, Temovate [clobetasol], Ultravate [halobetasol], or Diprolene [betamethasone]) often helpful, but avoid use >1 mo; new treatment combination of Dovonex (calcipotriene) during week with superpotent corticosteroid on weekend; *feet*— initially treat with superpotent steroid, then switch to Lidex (fluocinonide) or Diprosone (betamethasone); *scalp*— associated with extensive scaling; Derma-Smoothe (fluocinolone) helpful (remove in morning and shampoo with Neutrogena T/Gel, Pentrax, or Ionil T Plus [contain coal tar]) or Neutrogena T/Sal Therapeutic Shampoo (contains salicylic acid); *guttate psoriasis*—development of papulosquamous lesions 1-2 wk after streptococcal infection, especially if family history of psoriasis; *generalized psoriasis*—treatment modalities include corticosteroids; if widespread, avoid potent medication by giving triamcinolone ointment or Dovonex; if patient fails to respond, consider referral to dermatologist for UV-B, psoralen-UV-A irradiation (PUVA), methotrexate, cyclosporin, or new retinoid drug (*eg*, etretinate, Soriatane [acitretin]); *children with psoriasis*—speaker uses mild steroid (*eg*, hydrocortisone [Westcort, Locoid), alclometasone [Aclovate]); avoid more potent agents because of absorption

Seborrheic dermatitis: associated with greasy scales; typically on preauricular or postauricular areas (sometimes inside ear), scalp, face, chest, scrotum, or groin; characterized by pink, scaly patches; treat with steroid without fluoride (can cause perioral dermatitis), *eg*, Westcort, Aclovate, or desonide

Pityriasis rosea: thought to be caused by virus; typically lasts 6-8 wk; not contagious; can improve with exposure to UV light

Lichen planus: demonstrates Koebner's phenomenon; characterized by small purple papules; usually responds to steroids (*eg,* Lidex, Cyclocort [amcinonide])

Xerosis (dry skin): especially common in elderly people who live in cold climates; characterized by thick scales on skin, pronounced on legs; advise patients to start applying moisturizer as soon as they begin using heaters in winter; use mild soap (*eg,* Cetaphil, Oilatum) and moisturizer (*eg,* Lac-Hydrin and AmLactin [contain lactic acid]); associated with nummular eczema (treat with steroid ointment)

Dyshidrotic eczema: caused by plugged eccrine glands; triggers include hot, humid weather, latex gloves (cause excessive sweating), and stress; treatment includes Lidex or Cyclocort gel (drying)

Atopic eczema: typically in children 6-9 mo of age; usually starts on face and spreads to antecubital fossae or popliteal fossae; treat with topical steroids; if no response, consider use of tacrolimus (Protopic; new immune-system modulator); 25% of atopic eczema may persist into adulthood (treat with steroid ointment)

Contact dermatitis: due to exposure to poison oak, poison ivy, or poison sumac; vesicles or papules in line; if localized, give topical steroid (cream or gel, avoid ointment); if generalized, give systemic prednisone (treat for 2 wk to prevent rebound); *comment*—if rash occurs on top of feet, think contact dermatitis, not tinea

Corticosteroids: *ultrahigh-potency agents—eg,* Ultravate, Temovate, Diprolene; should not be used for more than 2-3 wk; *high-potency drugs*—indicated if steroids still needed after course of ultrahigh-potency drug; *eg,* Elocon (mometasone), Diprosone, Lidex, Florone (diflorasone), Cyclocort; *midpotency or low potency drugs*—safe for children with lesions on face; *eg,* Westcort, Locoid, Aclovate, Tridesilon (desonide), over-the-counter (1%) hydrocortisone; side effects include hirsutism, perioral dermatitis (with potent steroids that contain fluoride), follicular papules in occluded, hair-bearing areas (*eg,* groin), skin atrophy in occluded area (*eg,* axilla, groin), ecchymosis

Tinea versicolor: fungal; lesions typically brown or red in whites and hyperpigmented or brown in blacks; treat localized lesions with topical antifungal agents (*eg,* Nizoral [ketoconazole]); if generalized, give Nizoral tablets (excreted through eccrine glands; have patient work out 2 hr after dose, and not wash for 12-24 hr to allow medication to kill fungus in eccrine glands; effect lasts approximately 1 yr)

Tinea pedis: presents as "moccasin skin," vesicles, or bullae on bottom of feet or between toes; treat with topical antifungals, alternating shoes from day to day, medicated powder (*eg,* Zeasorb-AF [miconazole]) or sprays (*eg,* Lamisil [terbinafine]) on feet, shoes, and socks

Topical antifungal drugs: Tinactin (tolnaftate), Halotex (haloprogin) early drugs, followed by Loprox (ciclopirox); first- generation azole antifungal drugs (1970s; inhibit ergosterol synthesis) include Lotrimin (clotrimazole) and Micatin (miconazole); second-generation agents include Spectazole (econ-azole) and Vagistat-1 (tioconazole); third-generation agents include Nizoral, Exelderm (sulconazole), and Oxistat (oxiconazole); *comments*—limit use of Lotrisone (contains betamethasone) to 2 wk to prevent atrophy

Tinea unguium (onychomycosis): *distal lateral*—most common type; occurs distally under nail, grows proximally to nail plate; thick, yellow or brown infection; *proximal*—starts proximally under lunula of nail fold and grows distally; white; hallmark of HIV infection; *superficial*—surface of nail crumbly; may be sign of HIV infection; *granulomatous*—rare; seen in patients with chronic mucocutaneous candidiasis or chronic paronychia; thick granulomas on all nails

> Treatment: griseofulvin and Diflucan (fluconazole) hydrophilic, ineffective; newer agents Sporanox (itraconazole) and Lamisil lipophilic, more effective (give for 3 mo, stays in nail for 9 mo); watch for drug-drug interactions with Sporanox

Urticaria (hives): difficult to find cause (frequently drug, food, infection); treat with first- and second-generation antihistamines; speaker uses Vistaril (hydroxyzine) at night or Claritin (loratadine), Zyrtec (cetirizine), or Allegra (fexofenadine)

Alopecia: *alopecia areata*—autoimmune disease; autoantibodies attack skin and hair, causing localized areas of hair loss; sometimes associated with other autoimmune disorders, *eg*, thyroid disease; may respond to topical steroids or steroid injections; *alopecia totalis (entire scalp) and alopecia universalis (entire body)*—treatment difficult; try Rogaine (minoxidil) or skin irritant (*eg*, anthralin)

Impetigo: honey-colored, crusted lesions; frequently seen in spring and summer; due to staphylococci, streptococci, or both; treat with Bactroban (mupirocin) tid

Folliculitis (sycosis barbae): small pustules in hair-bearing areas; very common; treat with tetracycline or Cleocin T solution; irritated by shaving, have patient switch to electric razor

Ecthyma: deep erosion or ulcer in skin; treat with Keflex (cephalexin), second-generation cephalosporin, or dicloxacillin; for patient with penicillin allergy, use erythromycin or Zithromax (azithromycin)

Multiple warts: consider referral to dermatologist; Cantharone (cantharidin) works well; Aldara (imiquimod) approved for genital and rectal warts (and used “off label” for others); *flat warts (verruca plana)*—if on face, avoid liquid nitrogen spray due to risk of scarring; consider Retin-A or Differin gel

Molluscum contagiosum: sexually transmitted in adults; occur near genitalia, especially in suprapubic area; treat with liquid nitrogen or Cantharone (treatment of choice in children)

Herpes simplex: group of vesicles on red base; treat adults with Valtrex (valacyclovir) or Famvir (famciclovir); for children, use Valtrex, Famvir, or consider topical antiviral Denavir (penciclovir; speaker prefers to Zovirax; must be applied during prodrome)

Herpes zoster: infection in trigeminal nerve; Valtrex and Famvir work well; if ophthalmic involvement, try prednisone and refer to ophthalmologist; if in child or if >10 lesions beyond dermatome, work up for underlying lymphoma or leukemia; for pain, try capsaicin, topical lidocaine, antidepressant drugs

Questions and answers: *workup for large melanoma on chest for 5 yr, 20-lb weight loss,*

no insurance, and negative magnetic resonance imaging (MRI)—if melanoma excised and lymph nodes negative, prognosis excellent; if lymph nodes positive, consider clinical trial of interferon or vaccines; *effect of Differin on keratinocytes and aging skin*—tretinoin appears more effective in treating wrinkles; *sun protection program*—sunscreen safe for all infants >6 mo of age; older patients should use sunscreen with sun protection factor (SPF) greater than or equal to 30; sun-sensitive patients should avoid sun from 10 AM to 4 PM ; use sunscreens with both UV-A and UV-B protection

ACNE VULGARIS—Lawrence A. Schachner, MD, Professor of Dermatology and Pediatrics, and Director, Division of Pediatric Dermatology, University of Miami School of Medicine, Miami

Myths held by teenagers concerning acne

Case of boy 15 yr of age: presented in office with depression; papular, pustular, and nodular lesions of face and chest beginning at 11 yr of age; now has scarring lesions on back

Stages of acne

Etiology: speaker believes distinct anatomic alteration; follicular canal running from sebaceous gland to skin has "too sticky and retentive a lining" (retention hyperkeratosis; target of Retin-A); linked to chemotactic substance produced by *Propionibacterium acnes*

Mechanisms involved in development of acne lesions

What to tell teenagers about acne: dispel myths that certain foods, poor hygiene, or sex contribute to acne; explain how acne develops; advise therapeutic goal to prevent physical and psychologic scars; warn about side effects of acne treatments and how to minimize them; *comment*—provide personalized handouts

Benzoyl peroxide: "go low" (initial dose 2.5 mg) and "go slow" (15 min at first, then increase to 1 hour)

Retin-A: "best of the comedolytics"; "low potency, low application"; potential side effects irritation, photosusceptibility, hyperpigmentation; 0.1% gel or 0.25% cream; apply at bedtime to minimize photosusceptibility

Cleocin and erythromycin: topical antibiotics; Cleocin associated with rare reports of bloody diarrhea and pseudomembranous colitis; speaker prescribes frequently

Benzamycin: anti-inflammatory and anticomedonal; must be refrigerated; helps prevent need for oral antibiotics in papular or pustular acne

Tetracycline: effective against inflammatory acne only; potential side effects photosensitivity, irritation, vaginal candidiasis

Accutane: effective in treating nodular cystic acne; usual course of therapy 4-5 mo; benefits may last 6 mo to life; anticomedonal, antipapulopustular, antinodulocystic; highly teratogenic (requires scrupulous birth control); affects bones, joints, and lipids;

associated with “almost universal” dryness of eyes and skin; speaker doubts drug induces depression or suicide; expensive; decrease incidence of side effects (*eg*, granulomatous or exacerbated acne) by starting with low dose and increasing to maximum dose in 1 mo; if patient still has significant acne after 2 courses, place him or her on monthly pulses of Accutane; long-term continuous use can result in skeletal changes

Approach to therapy: *comedonal acne*—start with tretinoin; comedone extraction sometimes indicated; *multinodular disease*—Retin-A plus benzoyl peroxide; add topical or oral antibiotic if poor response; *severe acne*—use benzoyl peroxide, antibiotic (*eg*, doxycycline, Minocin [minocycline], Bactrim), and tretinoin; injection of cystic lesions; *severe nodulocystic acne*—usually requires Accutane

Problem areas in treating acne: lack of compliance; starting with drug regimens that are too strong (leads to irritation); *comments*—dispel illusions of “quick fix”; tell patient it will take at least 4-6 wk to get better; stress potential drug side effects; provide written handouts containing treatment schedule

New drugs: *Azelex (azelaic acid)*—anticomedonal, anti-inflammatory; good agent for patients who develop hypersensitization or hyperpigmentation while on benzoyl peroxide or retinoid drug or from their disease; synergistic efficacy with other topical antibiotics; also effective for treating rosacea; *Differin*—retinoid derivative; anti-inflammatory, helpful in reducing comedonal and inflammatory acne; *Retin-A Micro Gel*—associated with less irritation and better compliance than Retin-A; “start low”; good drug for adolescents; *Tazorac*—acetylenic retinoid derivative; anticomedonal, anti-inflammatory, and antiproliferative; approved for psoriasis and acne; available in 2 strengths (0.05% and 0.1% gel), less irritation with lower strength; apply to skin for 2 min initially, and gradually increase length of exposure time (speaker seldom advises >5 min); can be used as monotherapy or with topical or oral antibiotics