EMIRATES FAMILY MEDICINE SOCIETY CONGRESS

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2022 | DUBAI | UAE

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MINISTRY OF HEALTH & PREVENTION

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EMIRATES FAMILY MEDICINE SOCIETY
شعبة الإمارات لطب الأسرة

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EMIRATES MEDICAL ASSOCIATION

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DUBAI

5TH EMIRATES FAMILY MEDICINE SOCIETY CONGRESS

IN PERSON March 10 to 12

VIRTUALLY March 14 to 17

2022

INTERCONTINENTAL DUBAI FESTIVAL CITY

Dermatology

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AdventHealth Winter Park Family Medicine Residency Program

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Clinical Professor, LLU-COM

Lecture topics

1. Acne/Rosacea
2. Cancers
3. Papulosquamous eruptions

Dermatology terms

- Macule – flat lesion < 1 cm
- Patch – flat lesion > 1 cm
- Papule – raised lesion < 0.5 - 1 cm
- Plaque – raised lesion > 0.5 - 1 cm
- Vesicle – fluid-filled blisters < 0.5 cm
- Bulla – fluid-filled blisters > 0.5 cm
- Pustule – pus-filled blisters

Get to the Noun

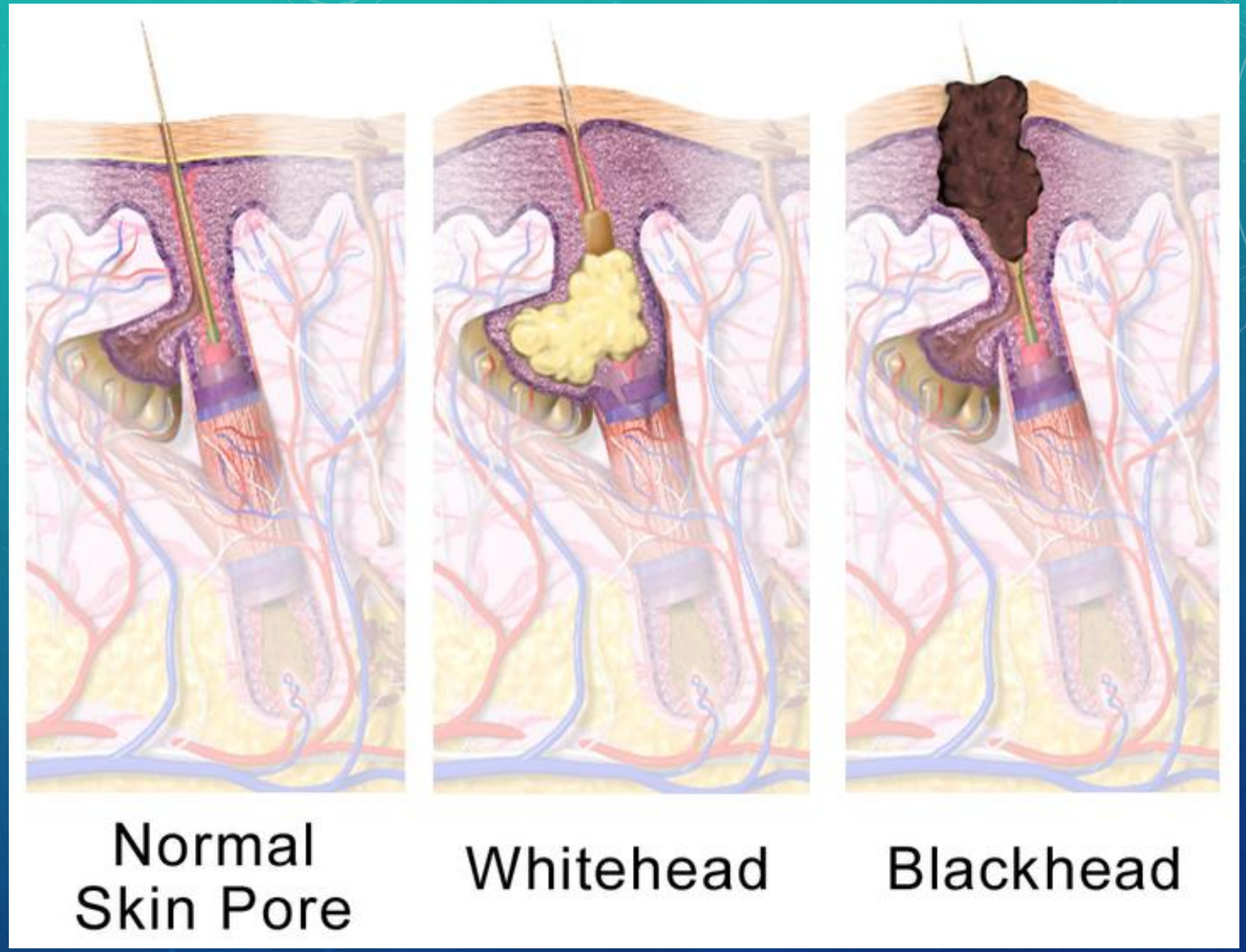
- “It’s an erythematous, papular, excoriated, lichenified …” THING
- Erythematous ***papule***
- Lichenified ***plaque***
- Getting to the noun gives a Ddx
- Papule → …
- Vesicle → …

Acne Vulgaris

Acne Vulgaris - Pathophysiology

1. Androgen-mediated stimulation of the sebaceous gland
2. Abnormal keratinization leading to follicular plugging – comedo formation
3. Proliferation of Propionibacterium acnes within the follicle
4. Inflammation
5. Genetics, stress, and diet may also play a role

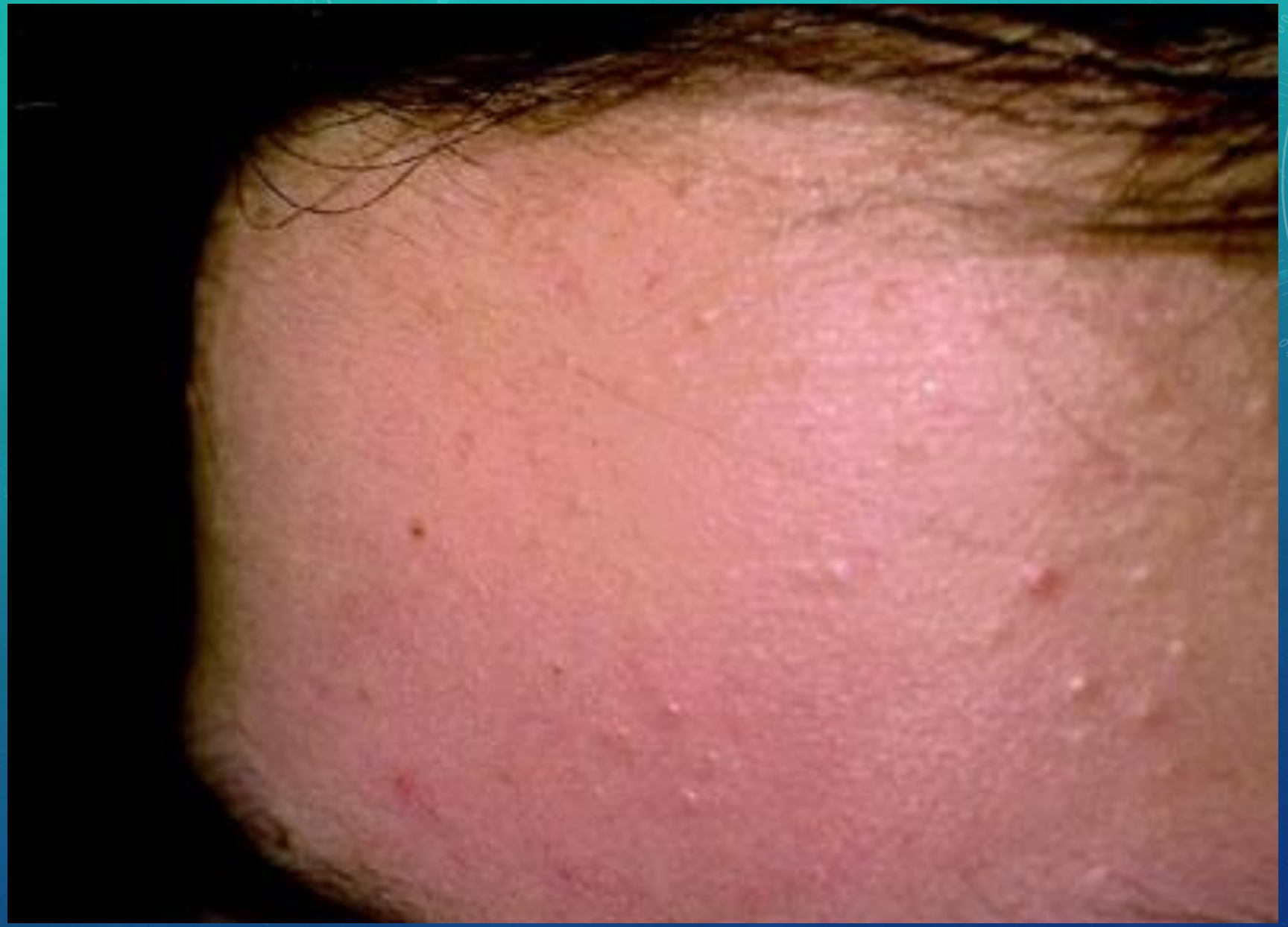
Haider A, Shaw J, *Treatment* of Acne Vulgaris, JAMA. 2004;292:726-735


Normal
Skin Pore
Whitehead
Blackhead

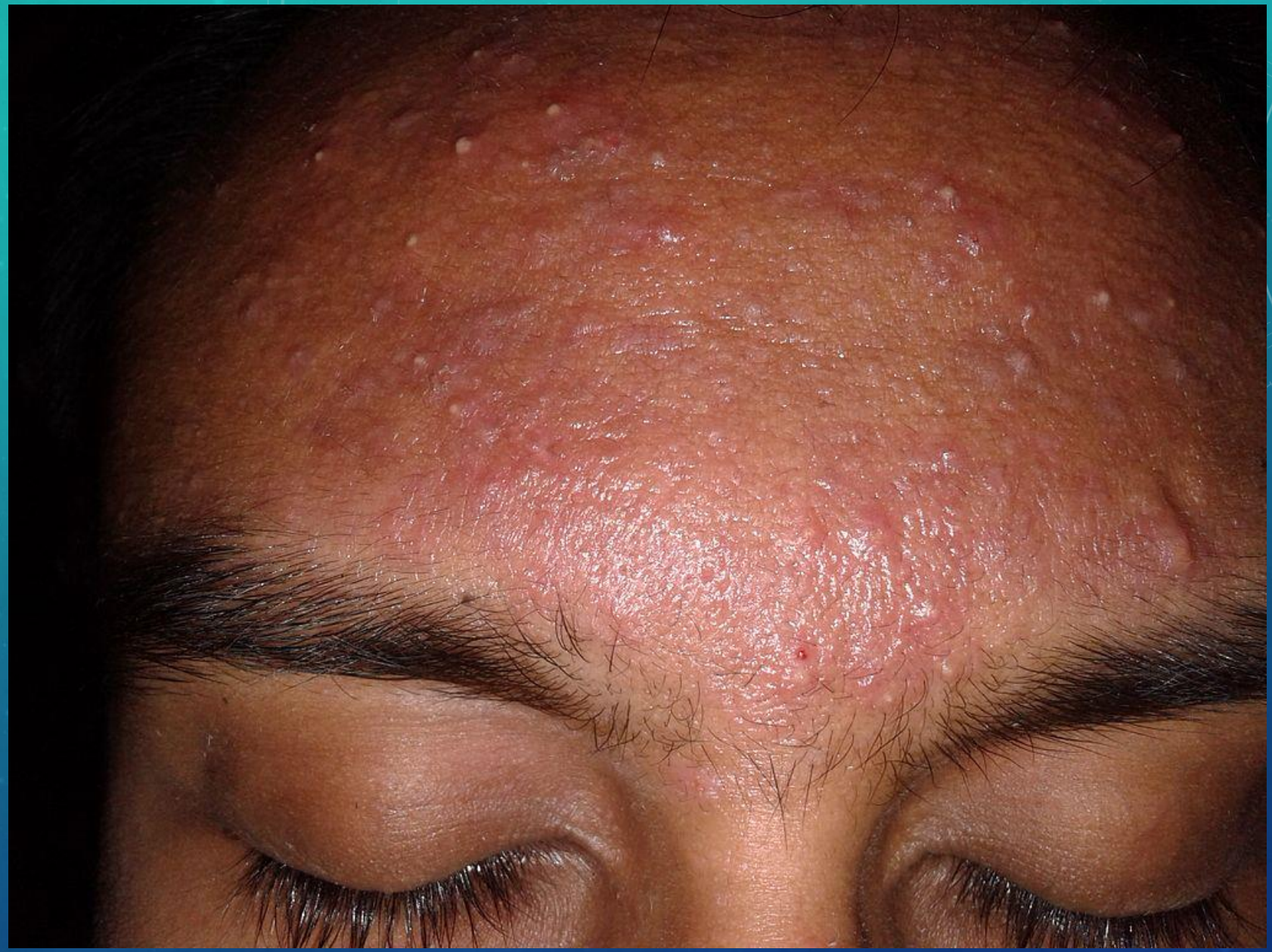
Acne Classification

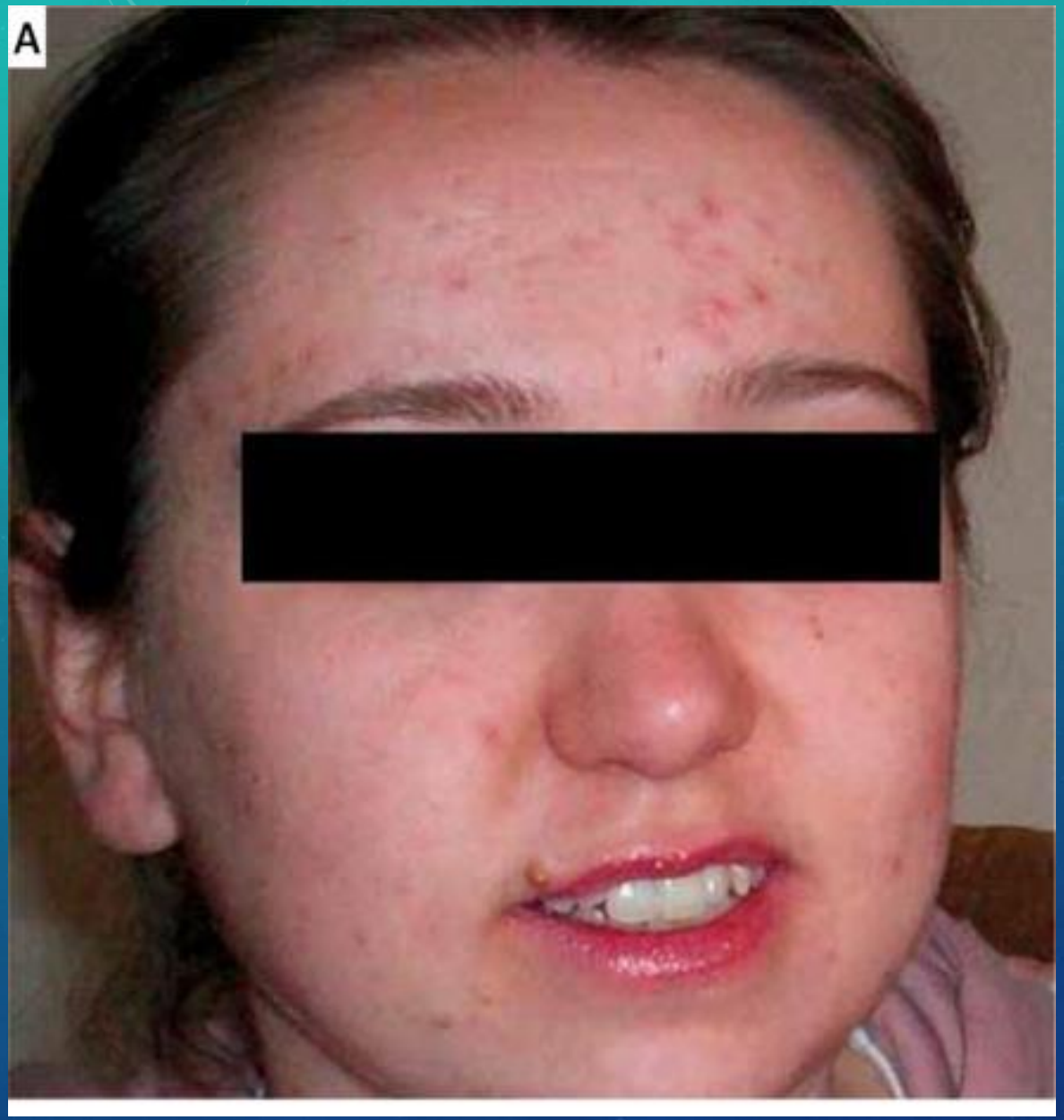
- Comedomal acne (no inflammation)
- Inflammatory acne (papules and pustules):
  - Mild to moderate severity
  - Moderate to Severe inflammatory acne
  - Severe Papulonodular Acne

Comedomal Acne



Inflammatory Acne (papules and pustules), mild to moderate severity

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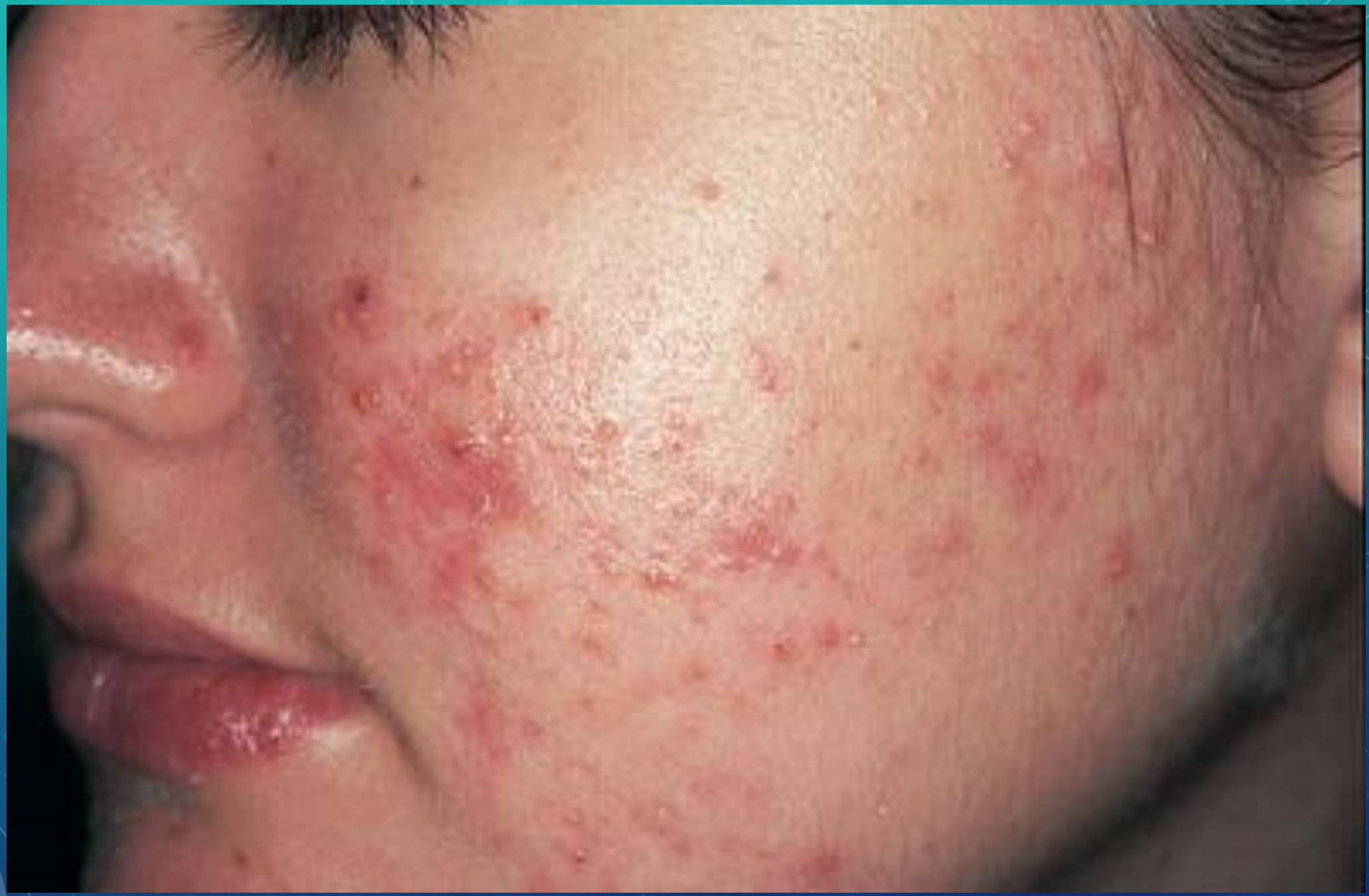
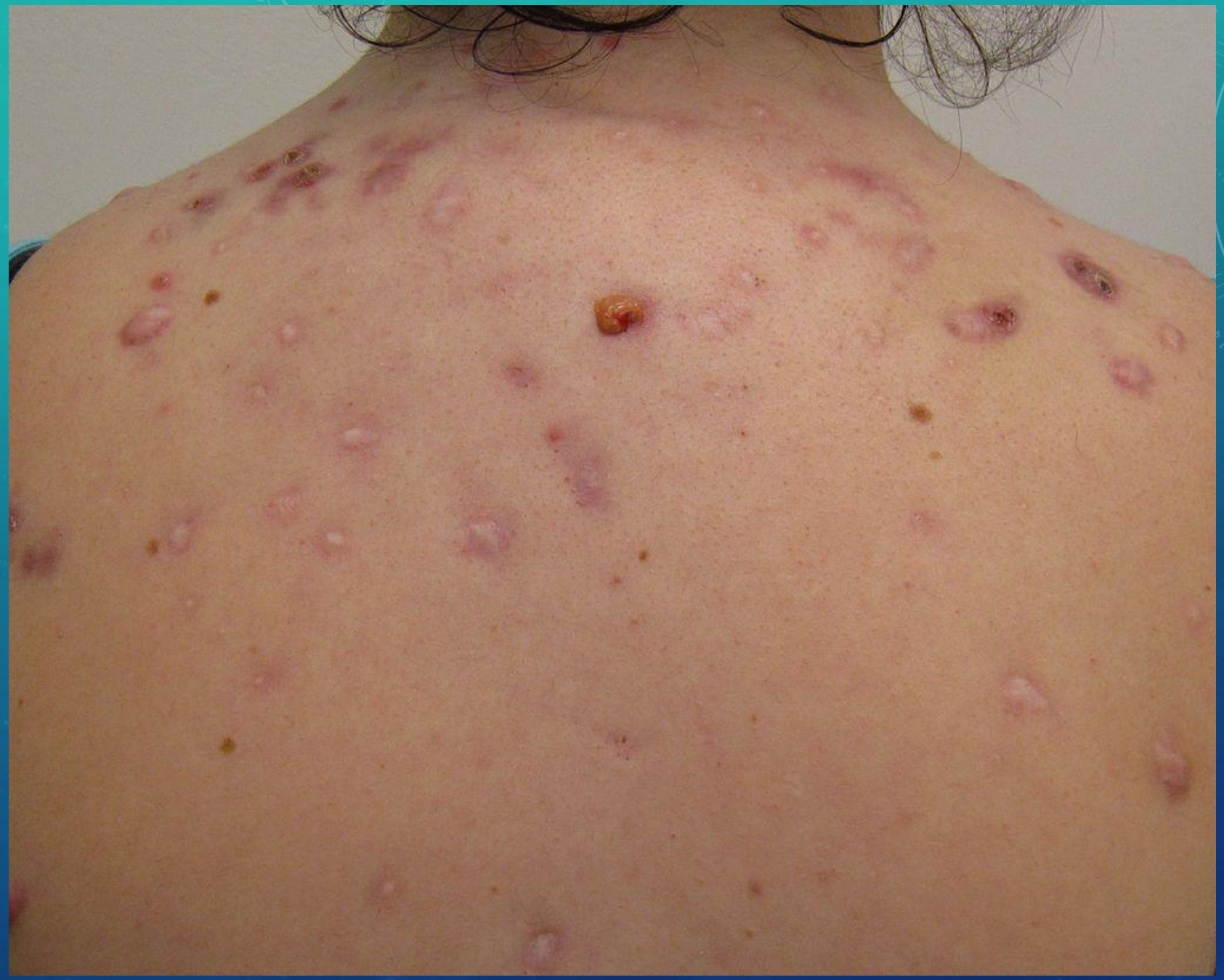
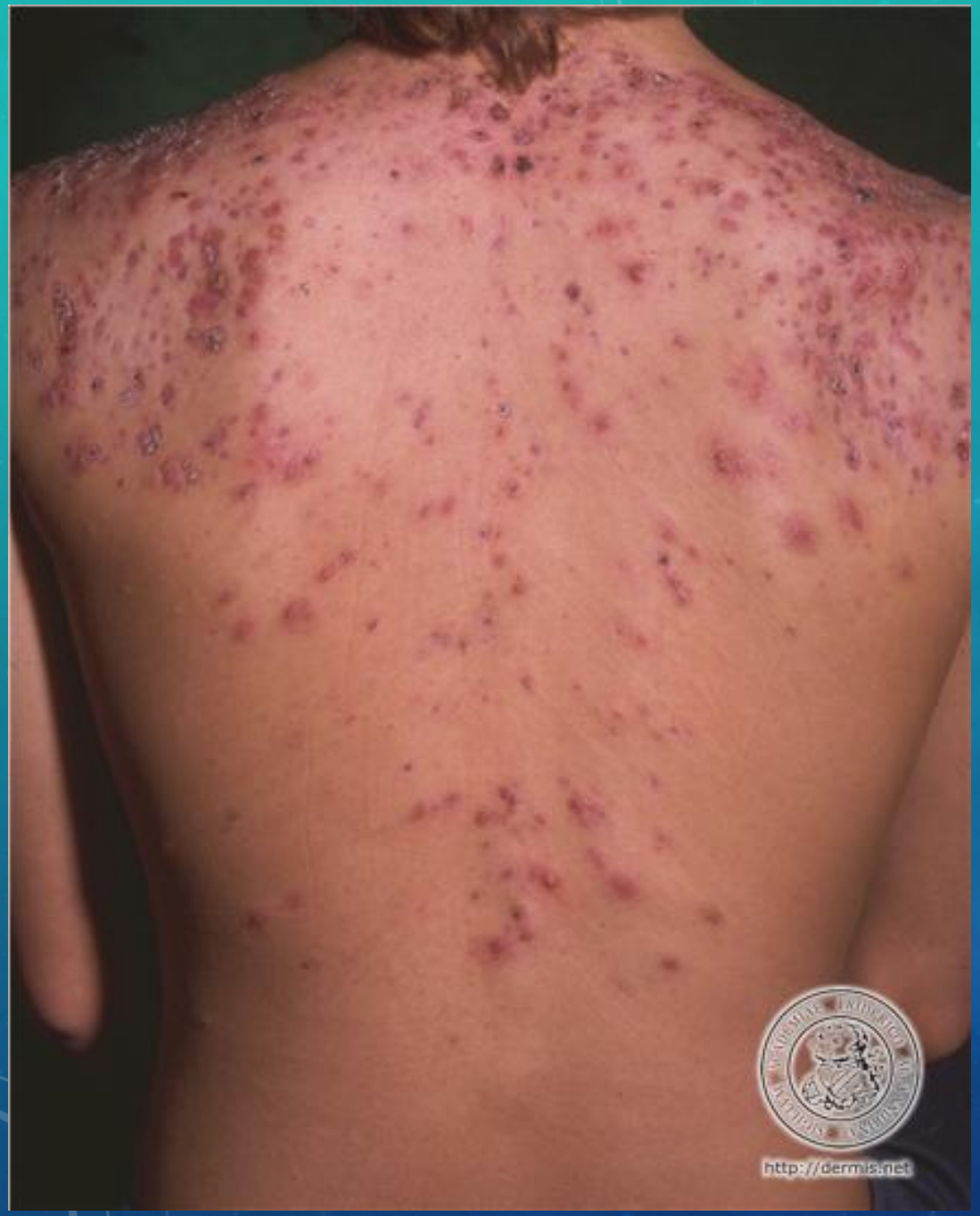
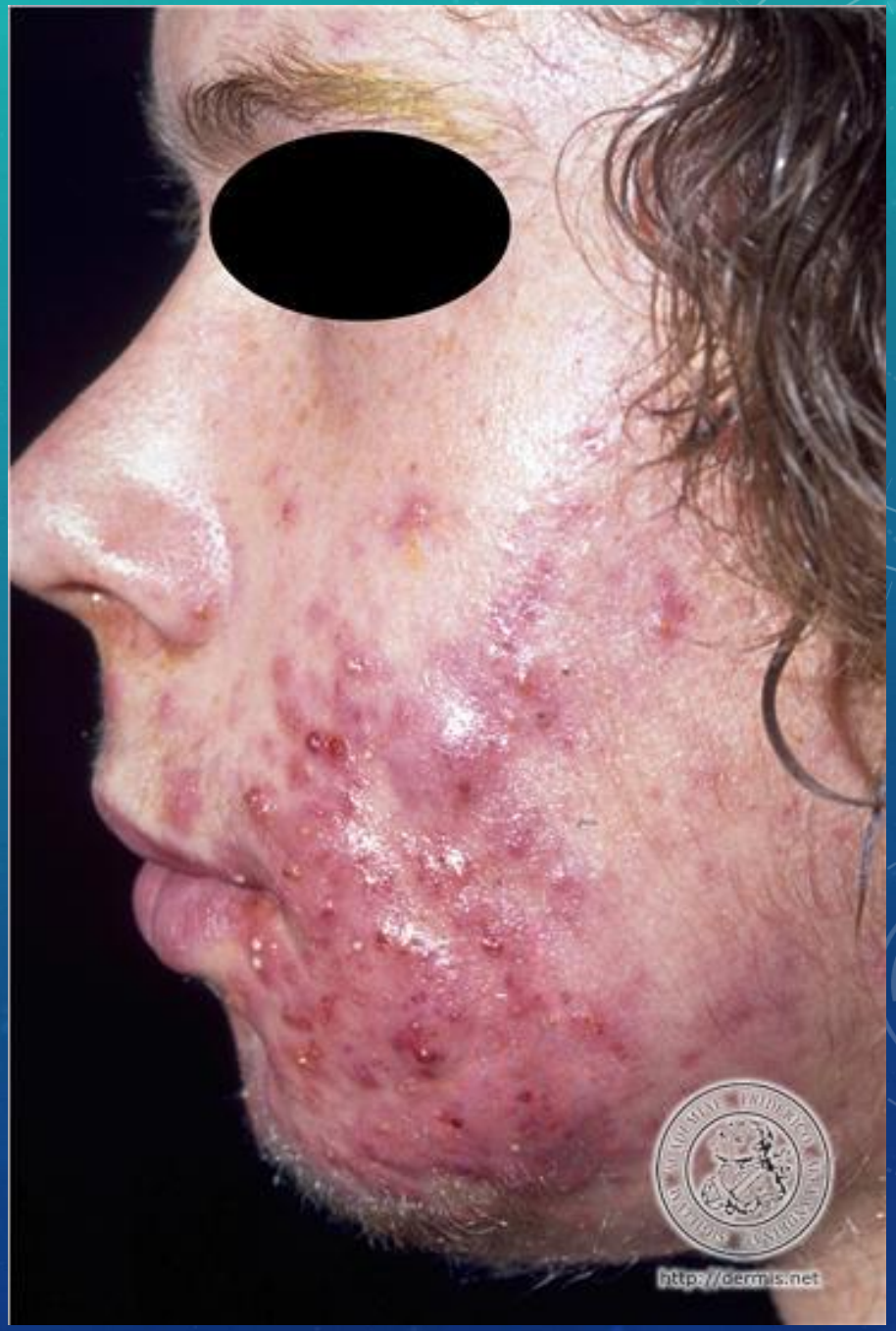
Moderate to Severe Inflammatory Acne





Severe Papulonodular/Cystic Acne

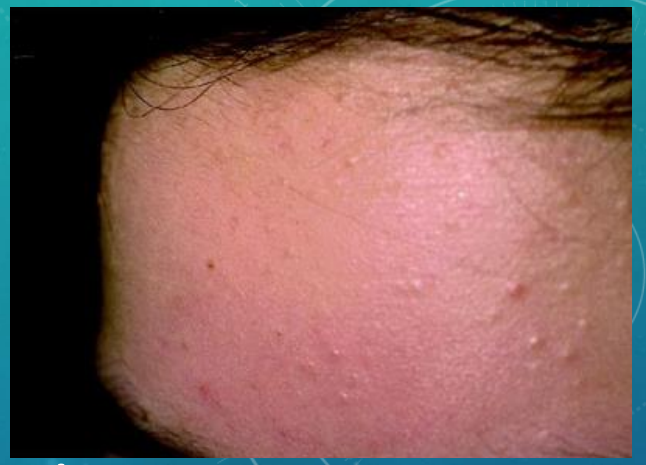

http://dermis.net


http://dermis.net

A patient has mild comedomal acne. What is the best initial therapy for this condition?

A. Topical tretinoin apply to affected area qHS
B. Oral doxycycline 50 mg daily
C. Benzoyl peroxide applied bid
D. Isotretinoin for 12 weeks

Treatment – Comedomal Acne



- Topical retinoids are the mainstay of therapy
- Decrease formation of comedomes and reduce inflammation
  - Tretinoin: Retin-A, not isotretinoin/Accutane ($40-68)
  - Adapalene ($90)
  - Tazarotene ($113)
- Treatment response of 40 – 70% within 12 weeks.
- Use a small pea-sized amount, apply the to affected areas at bedtime.

American Academy of Dermatology Acne Vulgaris Guideline, J Am Acad Dermatol.May 2016;74(5):945-973.e33
Haider A, Shaw J, *Treatment* of Acne Vulgaris, JAMA. 2004;292:726-735

Benzoyl peroxide

- Over-the-counter
- Antimicrobial
- Does NOT induce resistance
- Consider using in addition with any long term topical or oral antibiotic

Treatment – Inflammatory Acne Mild to Moderate

- Topical antibiotics are the treatment of choice
  - Benzoyl peroxide
  - Azelaic acid: pregnancy category B (Azelex and Finacea)
  - Clindamycin
  - Erythromycin
  - Dual agents combining benzoyl peroxide with clindamycin or erythromycin
- Current recommendations suggest combining topical antibiotics with topical retinoids if tolerated by the patient.

Treatment – Inflammatory Acne Mild to Moderate

- Response to topical antibiotics
  - 30 to 80% improvement
  - 8 to 12 weeks of therapy

A 23 yo female presents with acne that you stage as moderate to severe inflammatory acne. There are no scars. What is the best therapy for this degree of acne?

A. Topical retinoic acid to affected area at bedtime
B. Isotretinoin daily for 20 weeks
C. Benzoyl peroxide topically bid
D. Doxycycline 50 mg daily

Treatment – Inflammatory Acne Moderate to Severe

- Oral antibiotics are first line therapy having both antimicrobial and anti-inflammatory properties
  - Tetracyclines:
    - Tetracycline
    - **Doxycycline (preferred over tetracycline)**
    - **Minocycline (preferred over tetracycline)**
  - Erythromycin recommended less often secondary to resistant P. acnes
- Consider benzoyl peroxide to help reduce resistance

Treatment – Inflammatory Acne Moderate to Severe

- Response to oral antibiotics
  - 64% to 86%
  - 6 to 8 weeks of therapy

Treatment – Inflammatory Acne Moderate to Severe

- Doxycycline
  - 50 to 100 mg daily to bid
  - 20 mg per day has been studied and is effective
  - Side effects include GI upset, more chance at photosensitivity than TCN.
  - Doxycycline may be taken with food.
  - Do not use in children less than 8 years old

Treatment of Severe Papulonodular Acne

- Oral isotretinoin/Accutane is the drug of choice.
- It is used by itself except with women using oral contraceptives (OC).
- Dose is 1 mg/kg per day for 20 weeks or a total cumulative dose of 120 mg/kg.
- 80 to 90% success rate.

Isotretinoin

- It is a known teratogen, pregnancy category X
- Major malformations occur in 40% of infants exposed in the first trimester.
- Women need two negative pregnancy tests before commencing a course of therapy, and monthly thereafter
- Women need two forms of contraception during Rx.
- Women need to sign a consent form for treatment.
- Physicians currently need to be registered with iPLEDGE to prescribe.

Women with acne

- For women with acne who desire birth control, oral contraceptives (OCs) are an excellent choice.
- OCs approved for acne in the USA include:
  - Orthotricyclin
  - Estrostep
  - Yaz
  - Others-35 ☺
- Expected improvement from OCs alone is 40-70%.

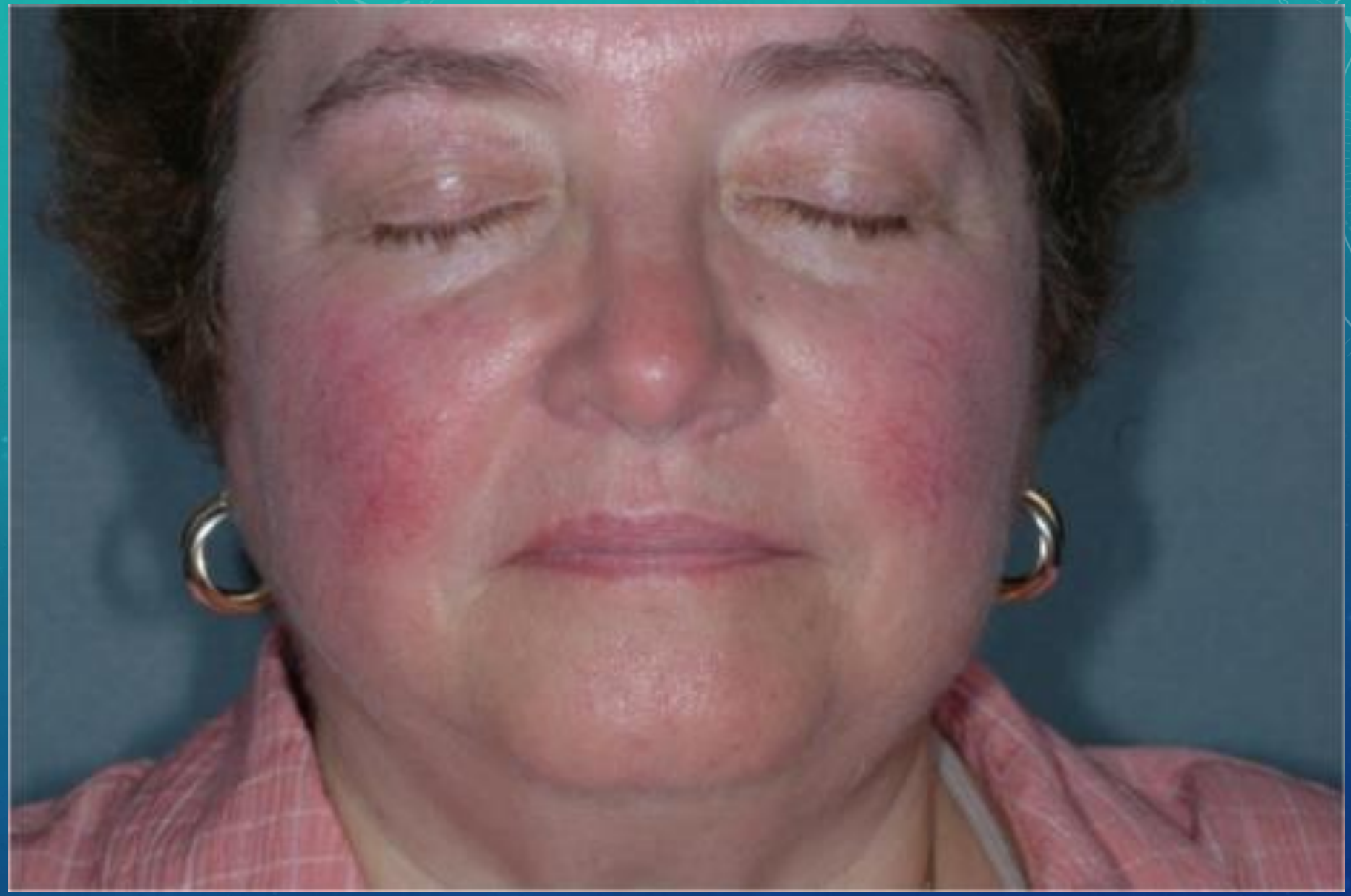
Acne - Treatment Summary

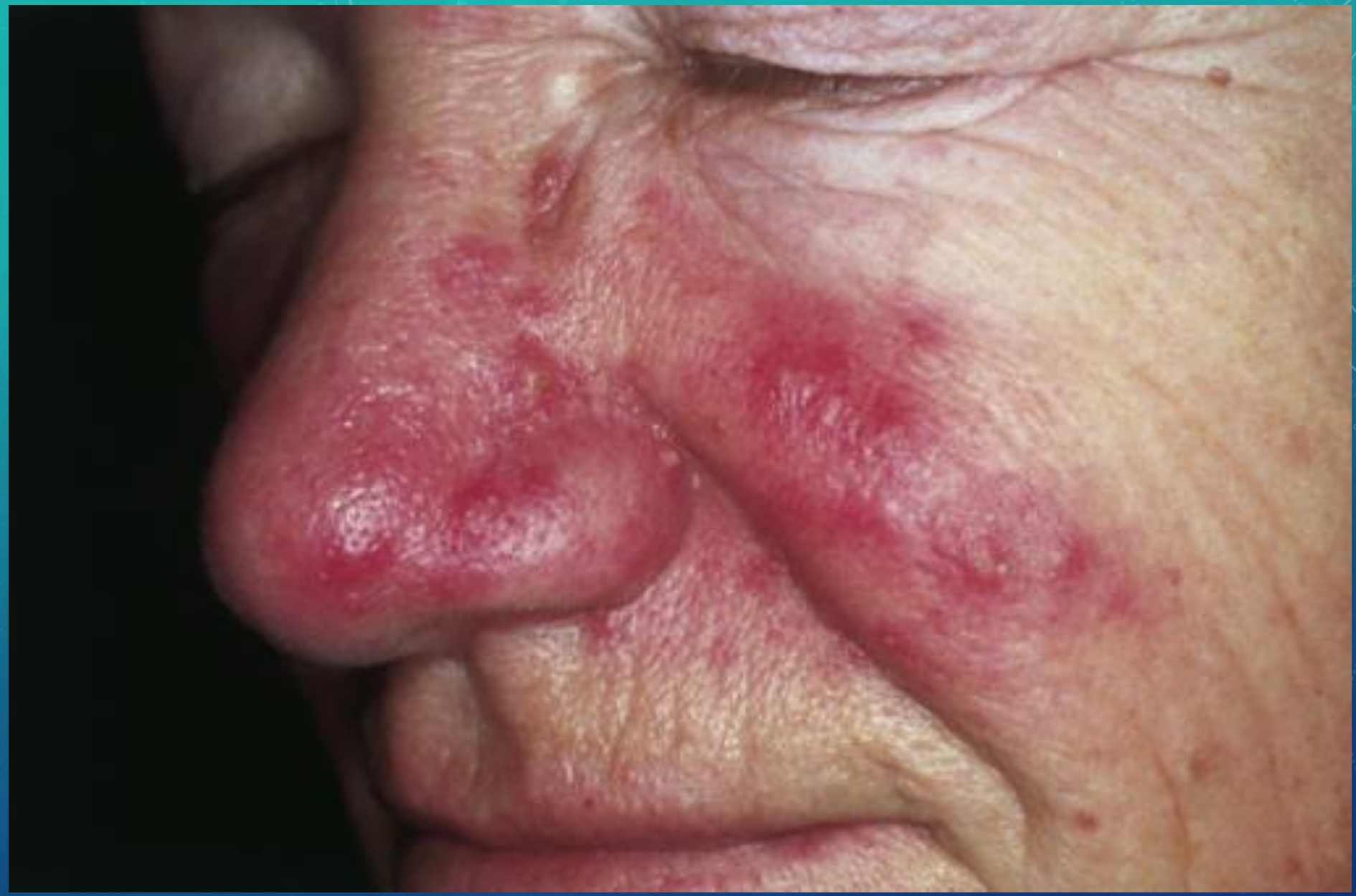
- Comedomal acne
  - Topical retinoids
- Mild to moderate acne
  - Topical retinoids with topical antibiotics/benzoyl peroxide
- Moderate to severe acne
  - Topical retinoids with oral antibiotics/benzoyl peroxide
- Papulonodular/scarring acne
  - Isotretinoin
- Maintenance
  - Topical retinoids +/- benzoyl peroxide +/- topical antibiotic

Rosacea

Rosacea

- Chronic facial skin condition of unknown cause
- Location - Central face
  - Transient or persistent erythema, flushing, warmth
  - Telangiectasia
  - Inflammatory papules and pustules
  - Hyperplasia (thickening) of connective tissue





Treatment

- Avoid triggers
- Mild cleansers, moisturizers, photoprotection with hats and SPF 30 sunscreens

Treatment

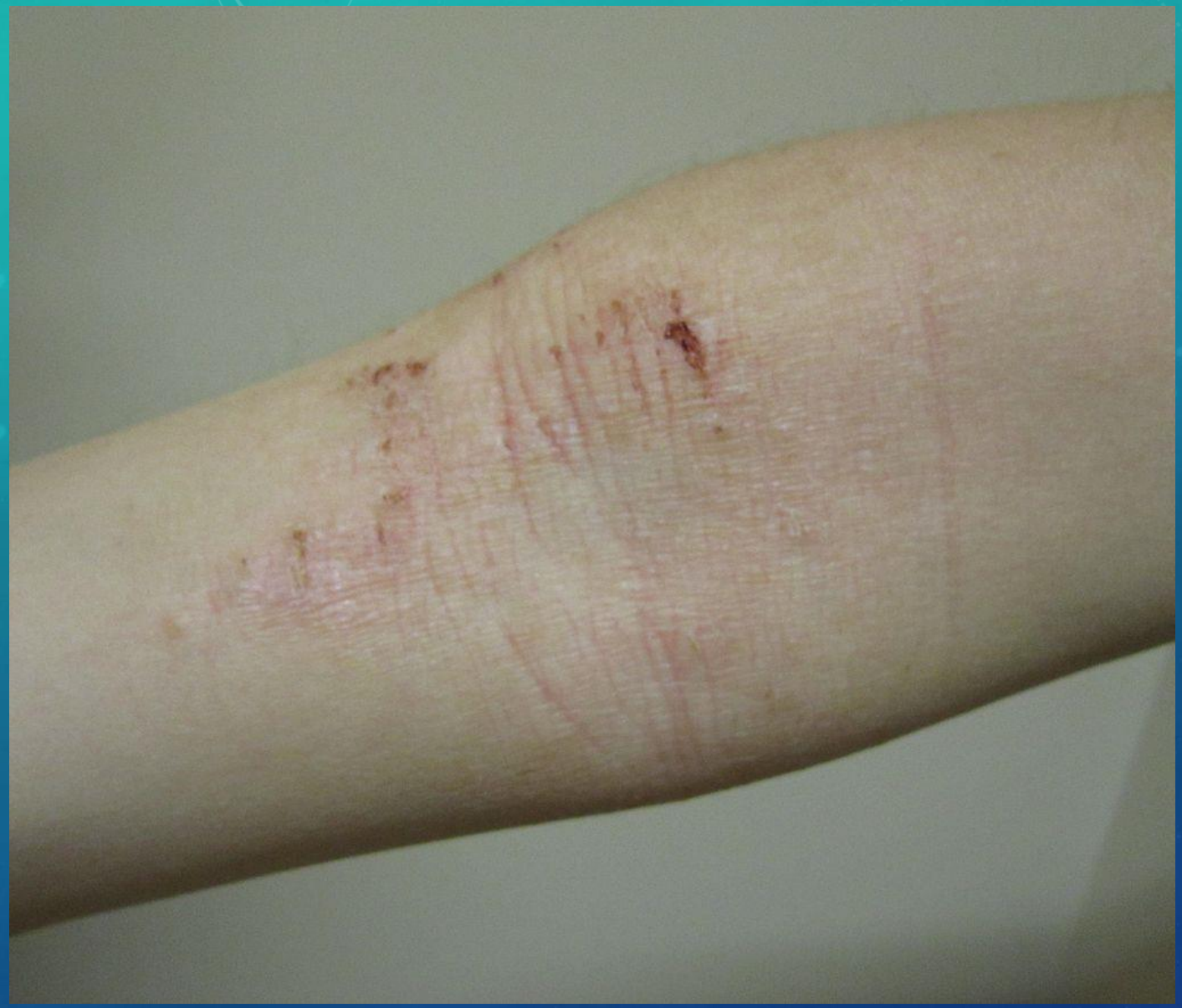
- Topical metronidazole
- Azelaic acid
- Brimonide, topical alpha-blocker to reduce erythema
- Oral doxycycline 20 mg bid and higher
- Phymatous Rx - Laser, light-based therapies
- Ocular sx – lid hygiene, topical cyclosporine, Abx

Atopic Dermatitis/Eczema

Atopic Dermatitis

- Chronic pruritic skin condition, flexural creases, lichenification over time
- “The scratch that itches”
- Onset usually before 2 years of age
- Only 10% diagnosed after age 5
- 30% of children with atopy develop asthma

Berke R, Singh A, Guralnick M. Atopic Dermatiis: An Overview. AFP. 2012;86(1):35-42

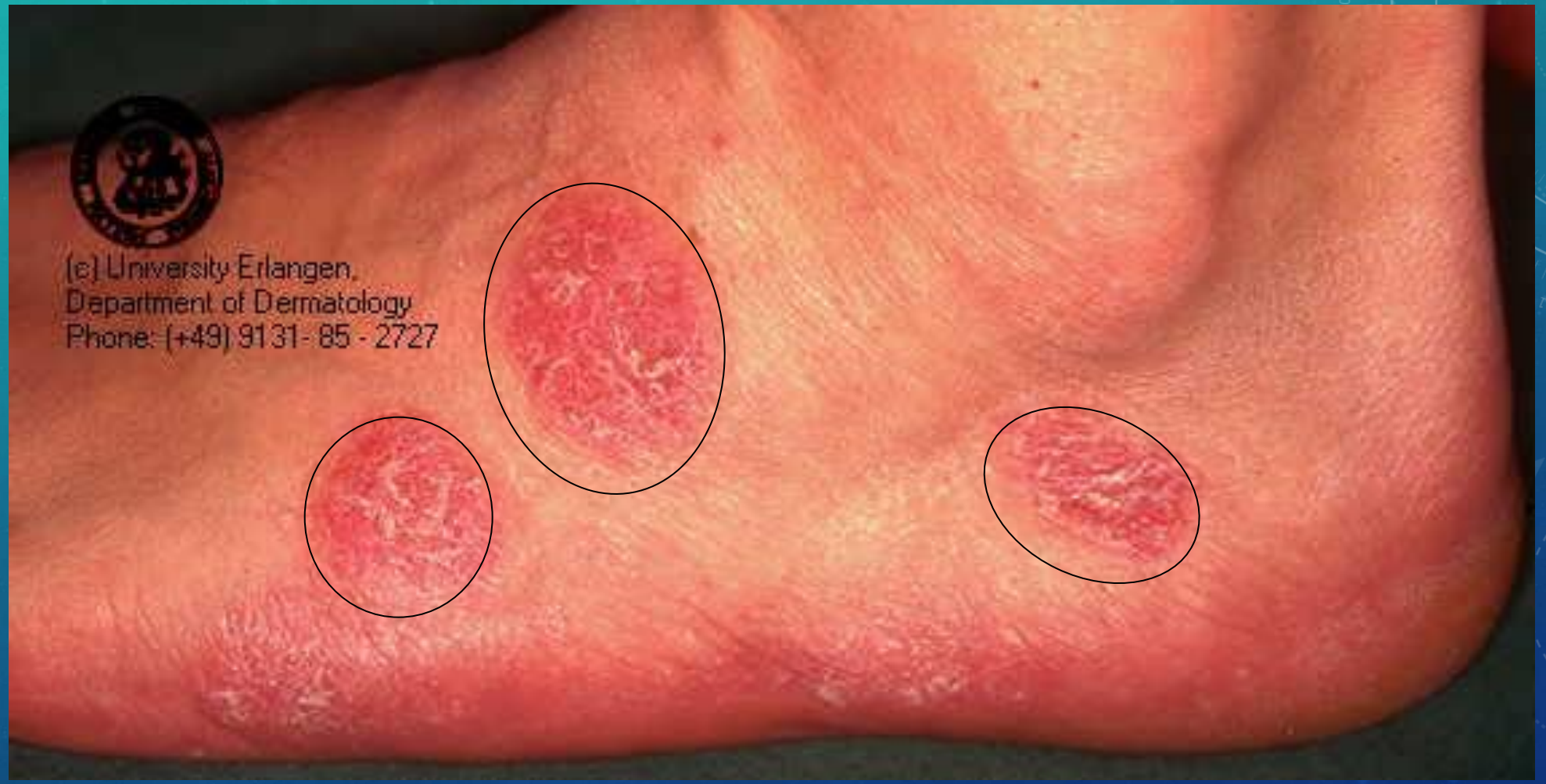


Atopic Dermatitis

- Regular use of emollients after bathing
  - Wet wrap therapy for recalcitrant disease
- Topical steroids are main treatment
- Calcineurin inhibitors are second line
  - Tacrolimus ($34) and pimecrolimus ($97)
  - Black box warning – skin cancers and lymphoma

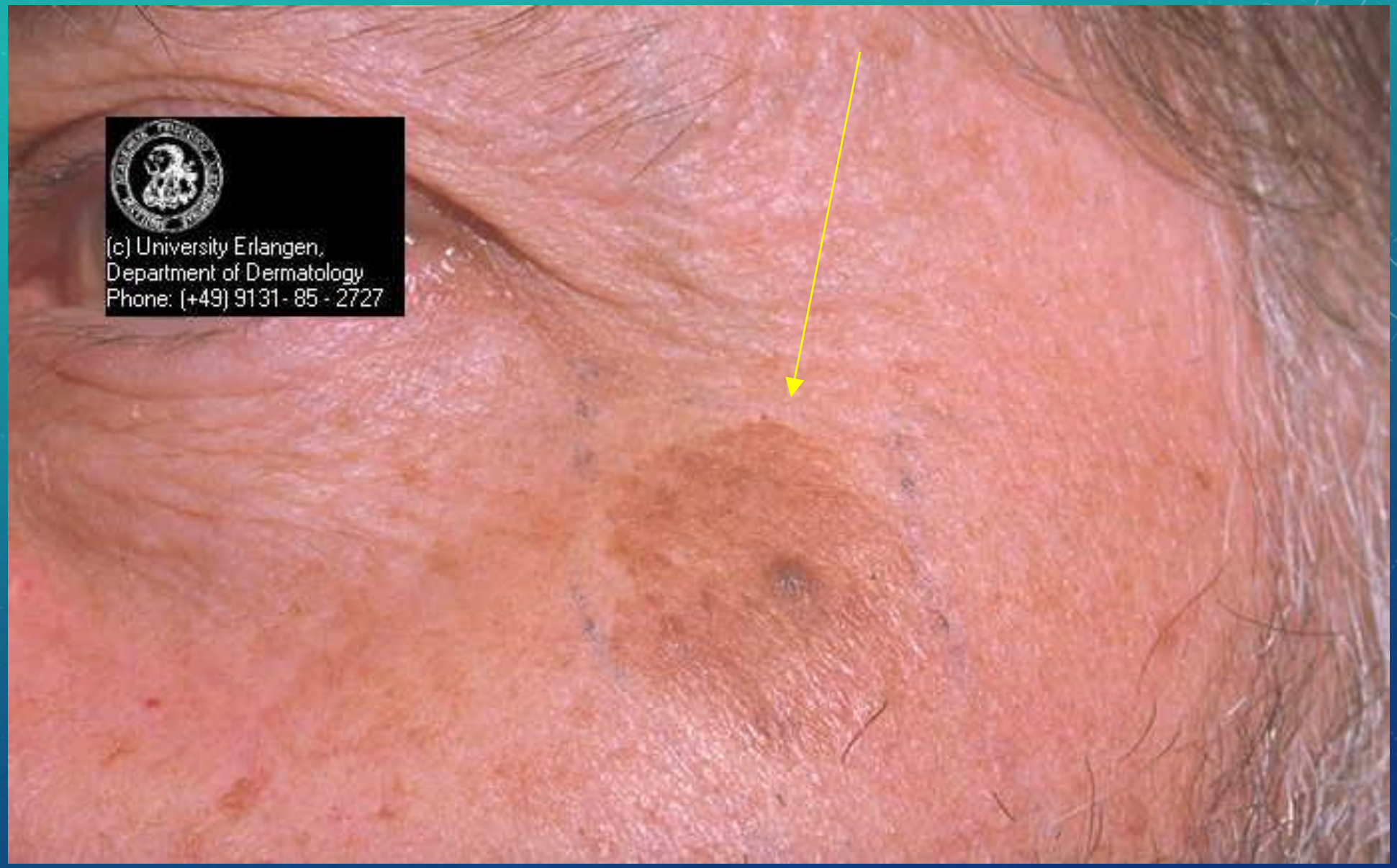
Management of Atopic Dermatitis: Guideline from the American Academy of Dermatology. J Amer Acad Derm;2014:February.

What type of eczema is this?



Nummular eczema

Doctor, these bumps have been growing on me for the past 5 years and I’m tired of them.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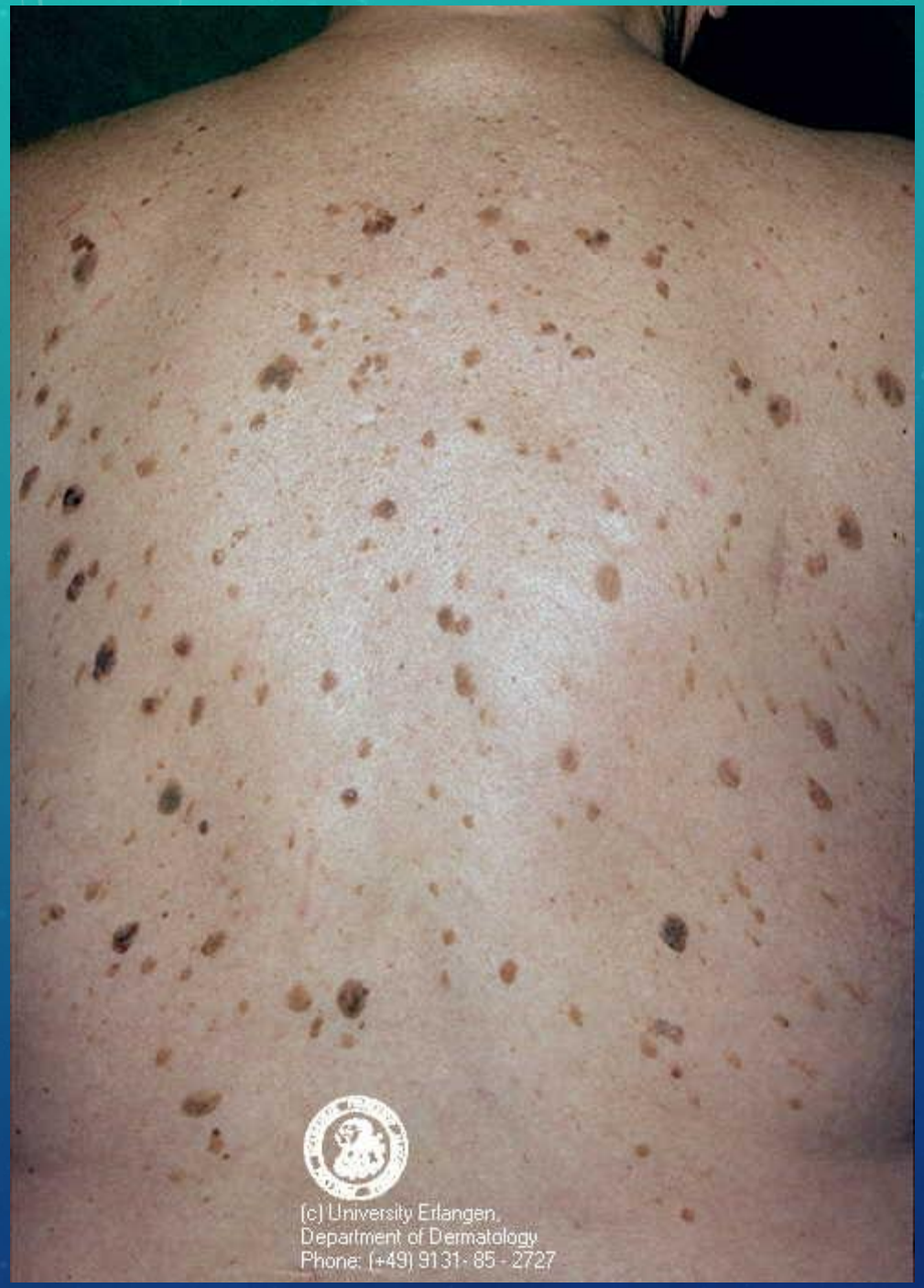
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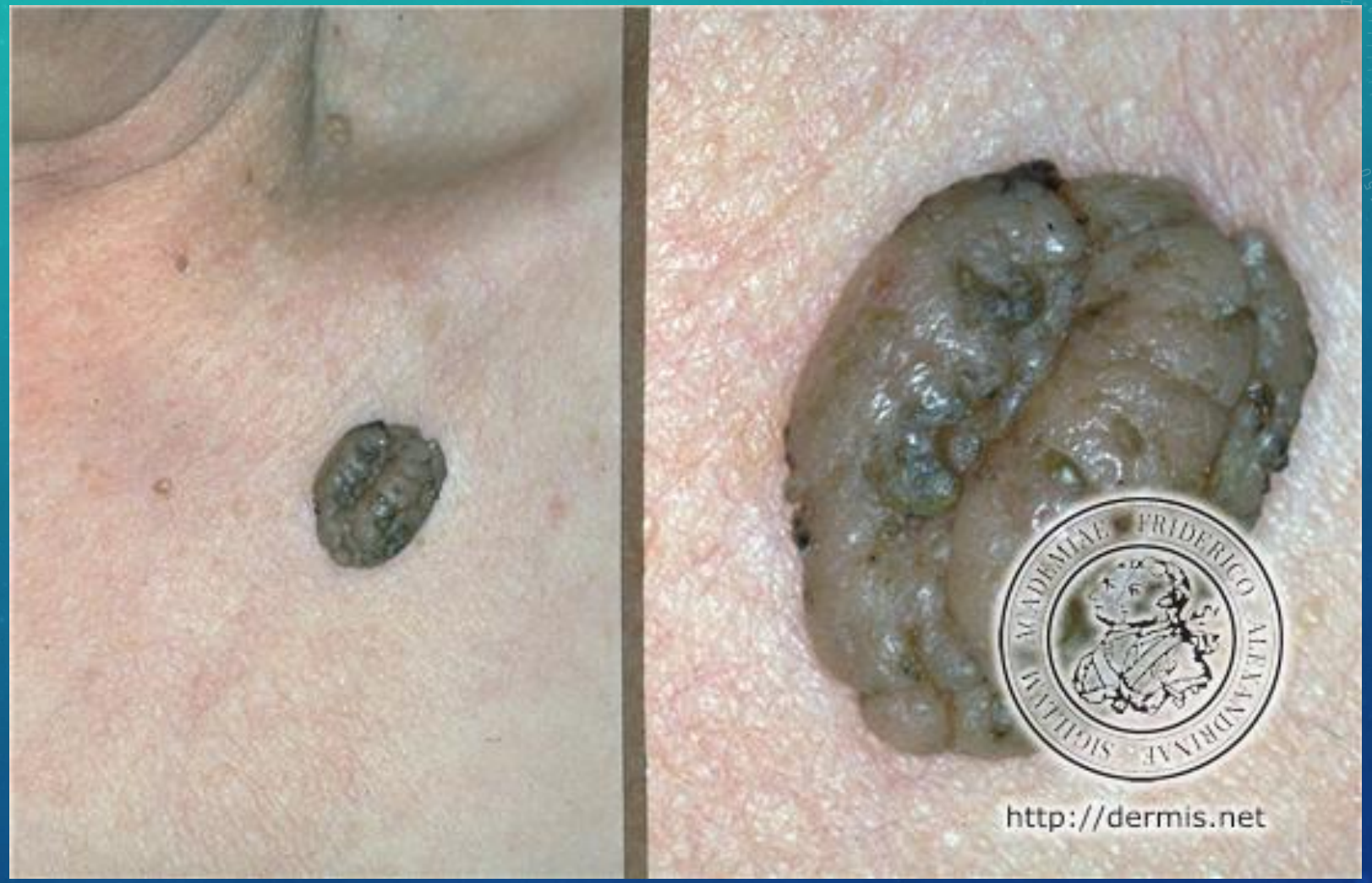
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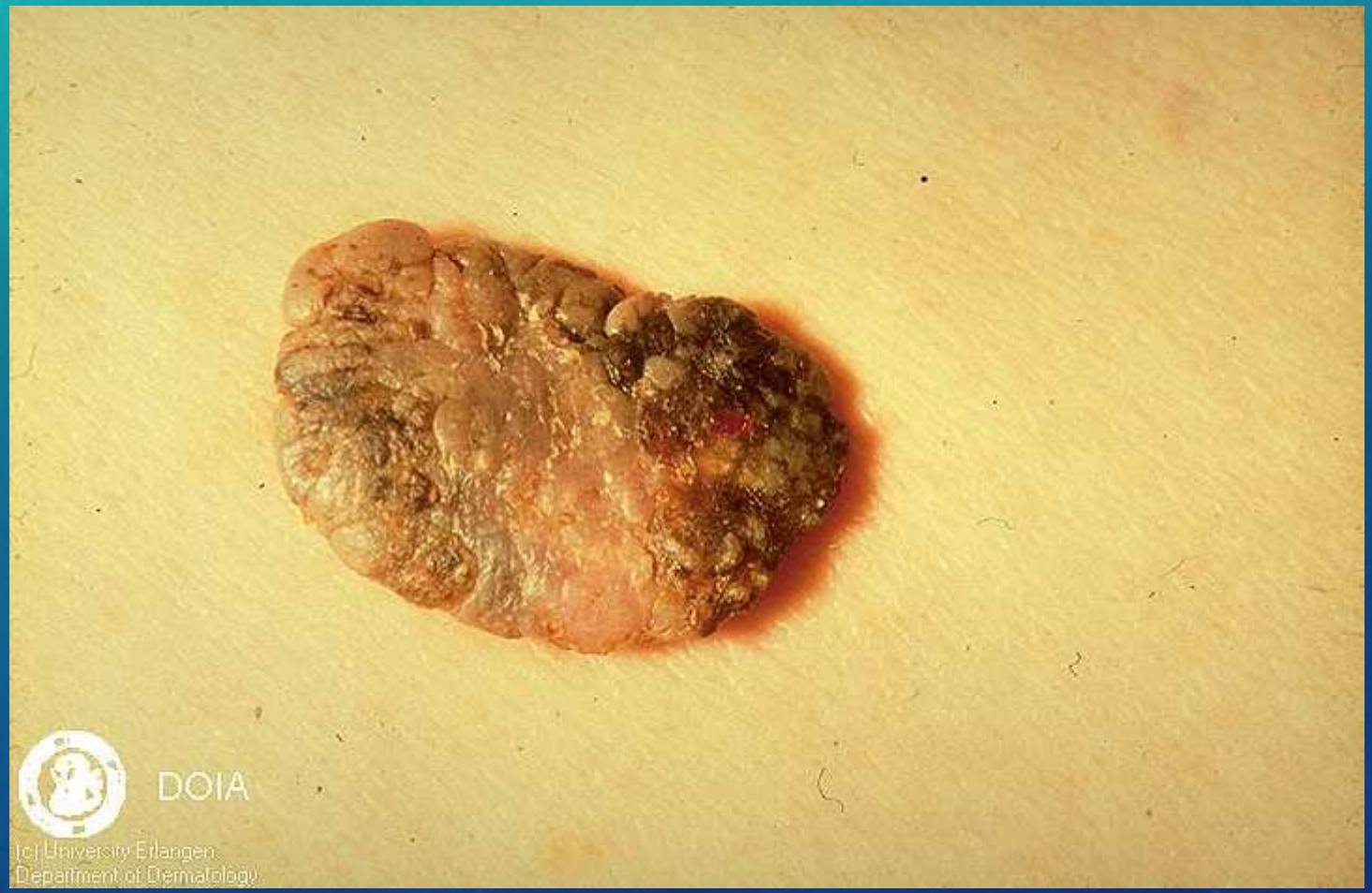
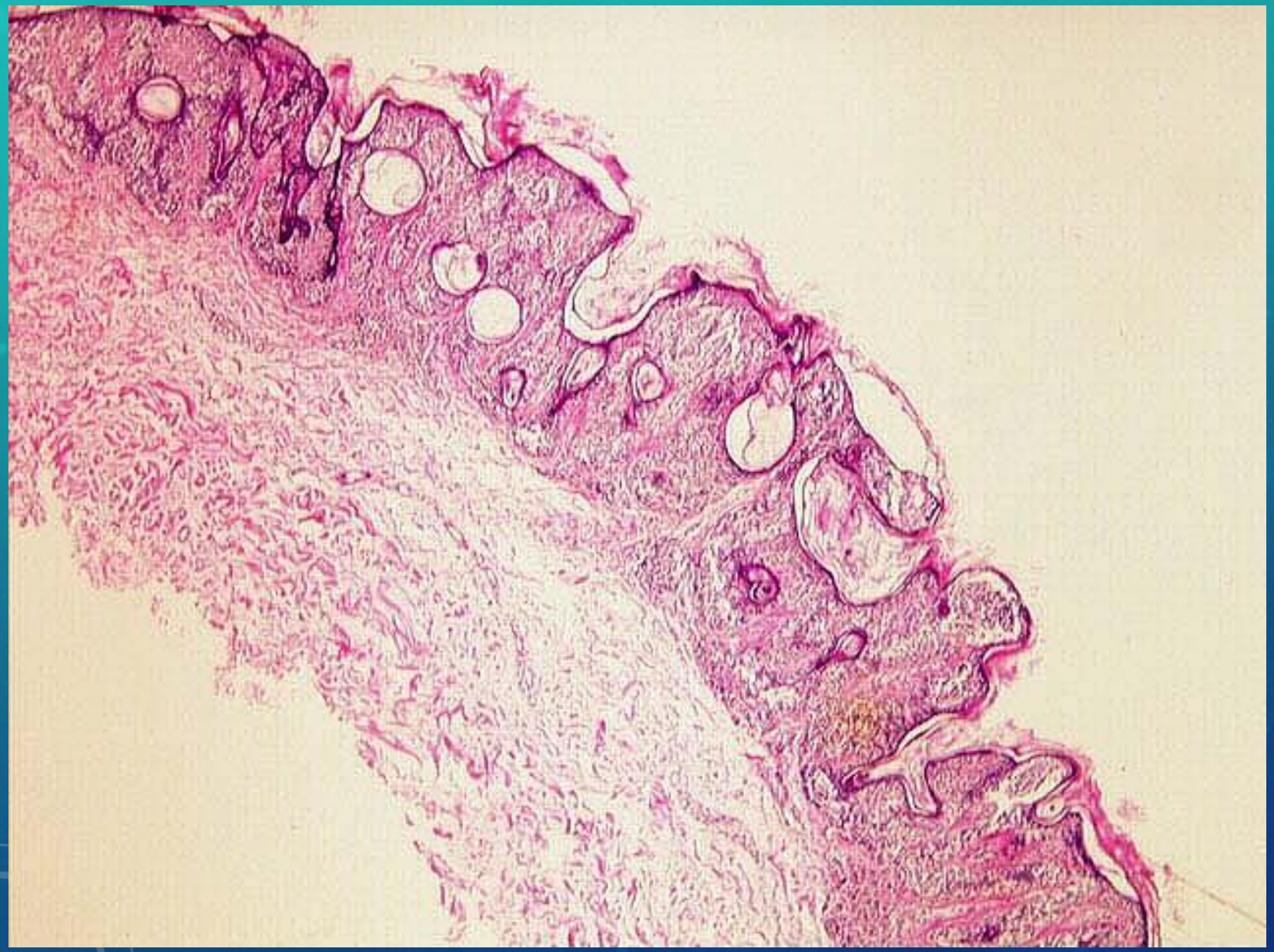
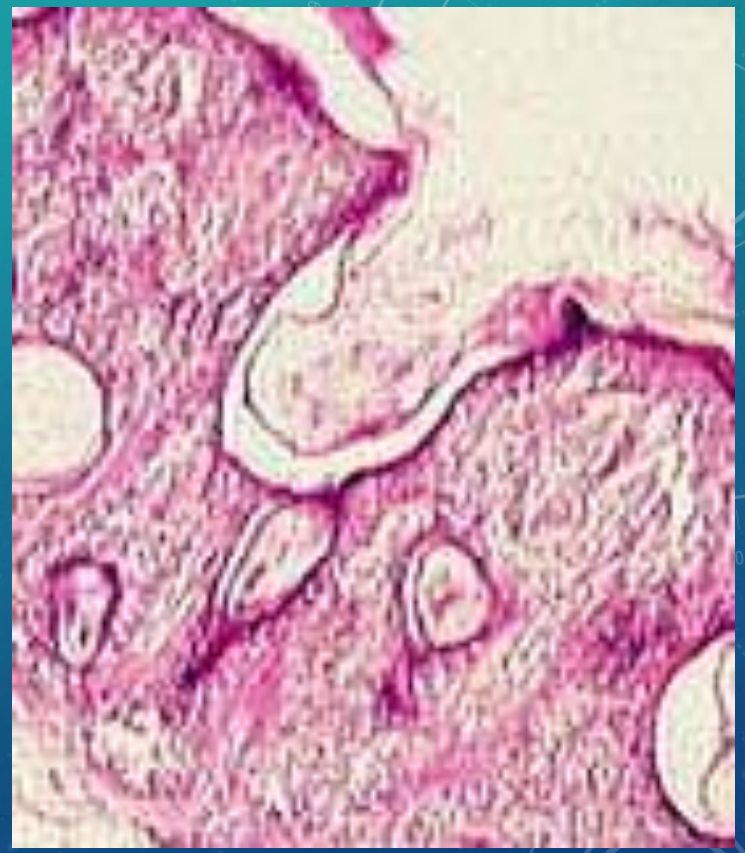
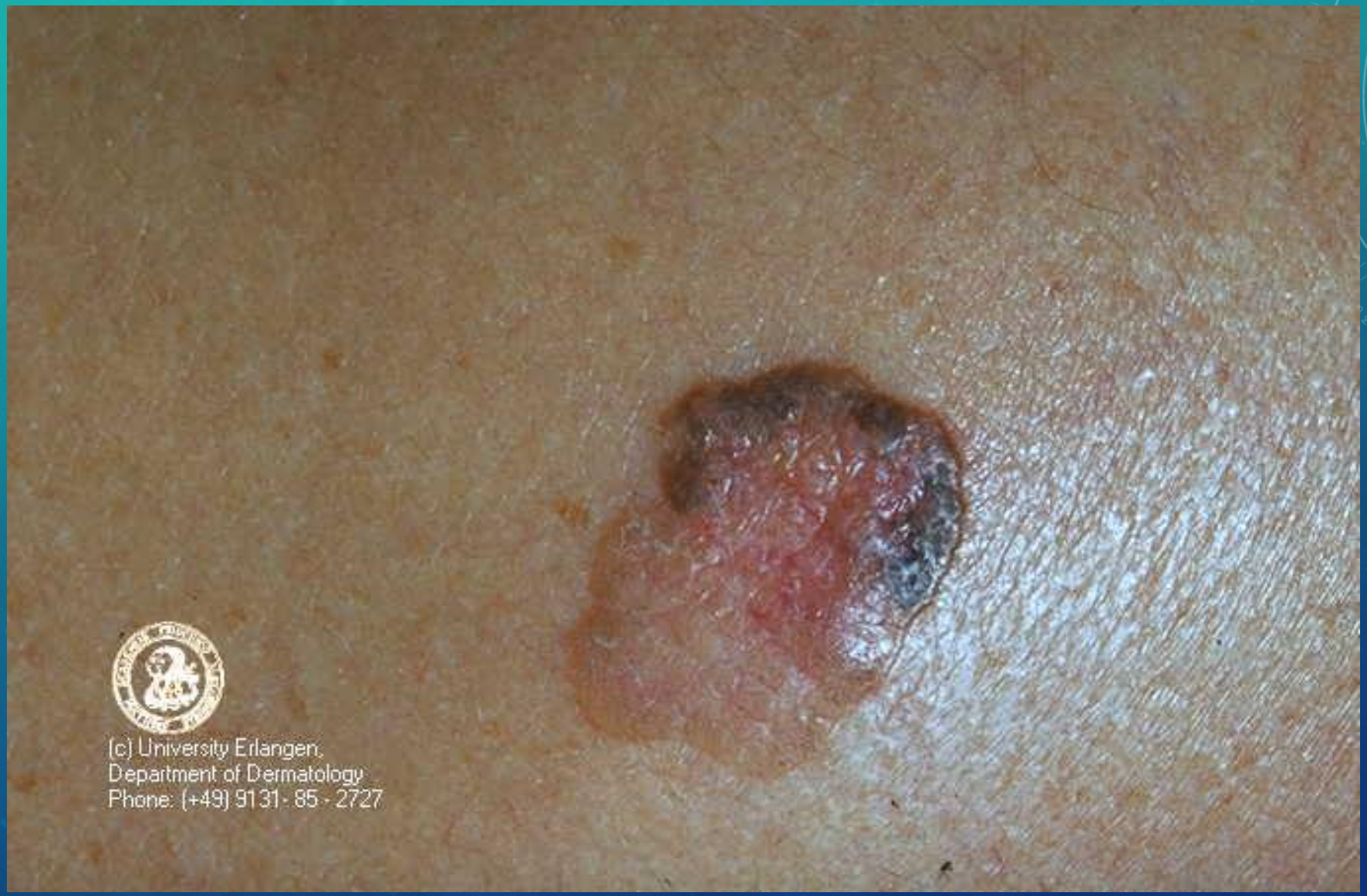
Seborrheic Keratosis





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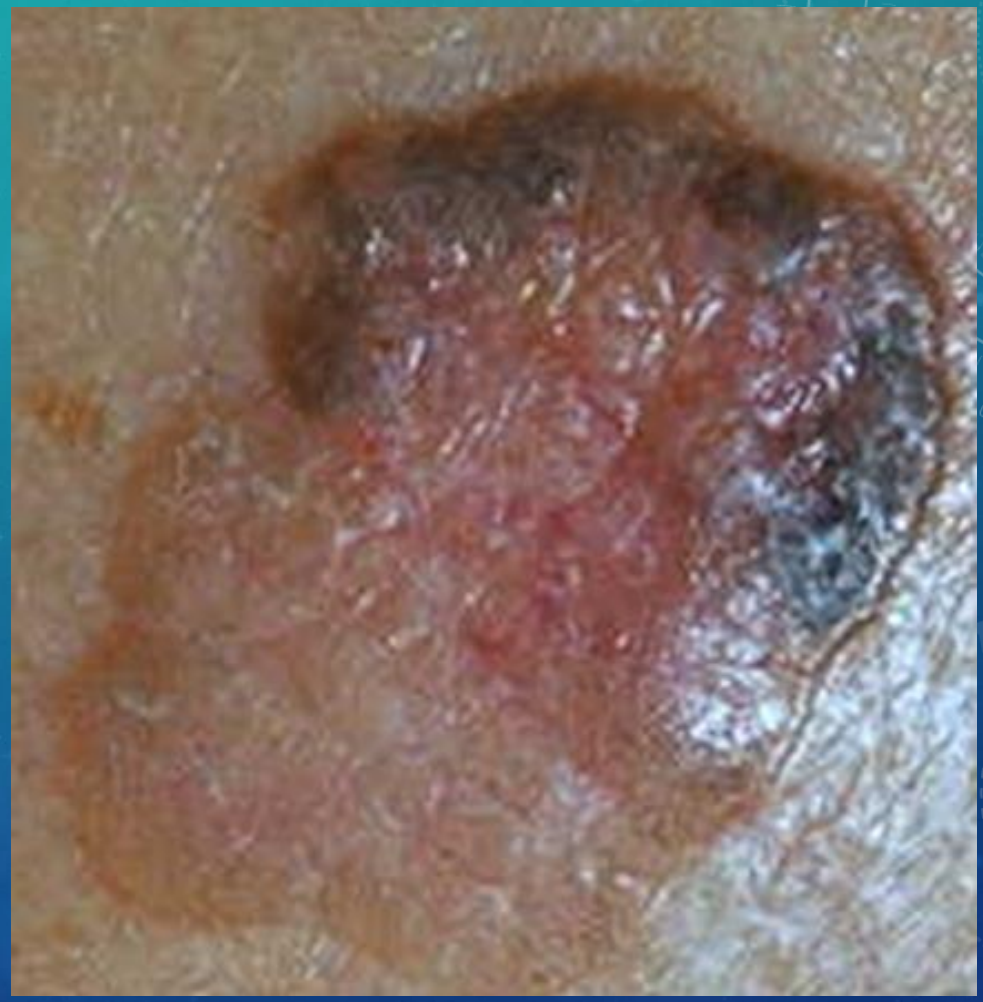
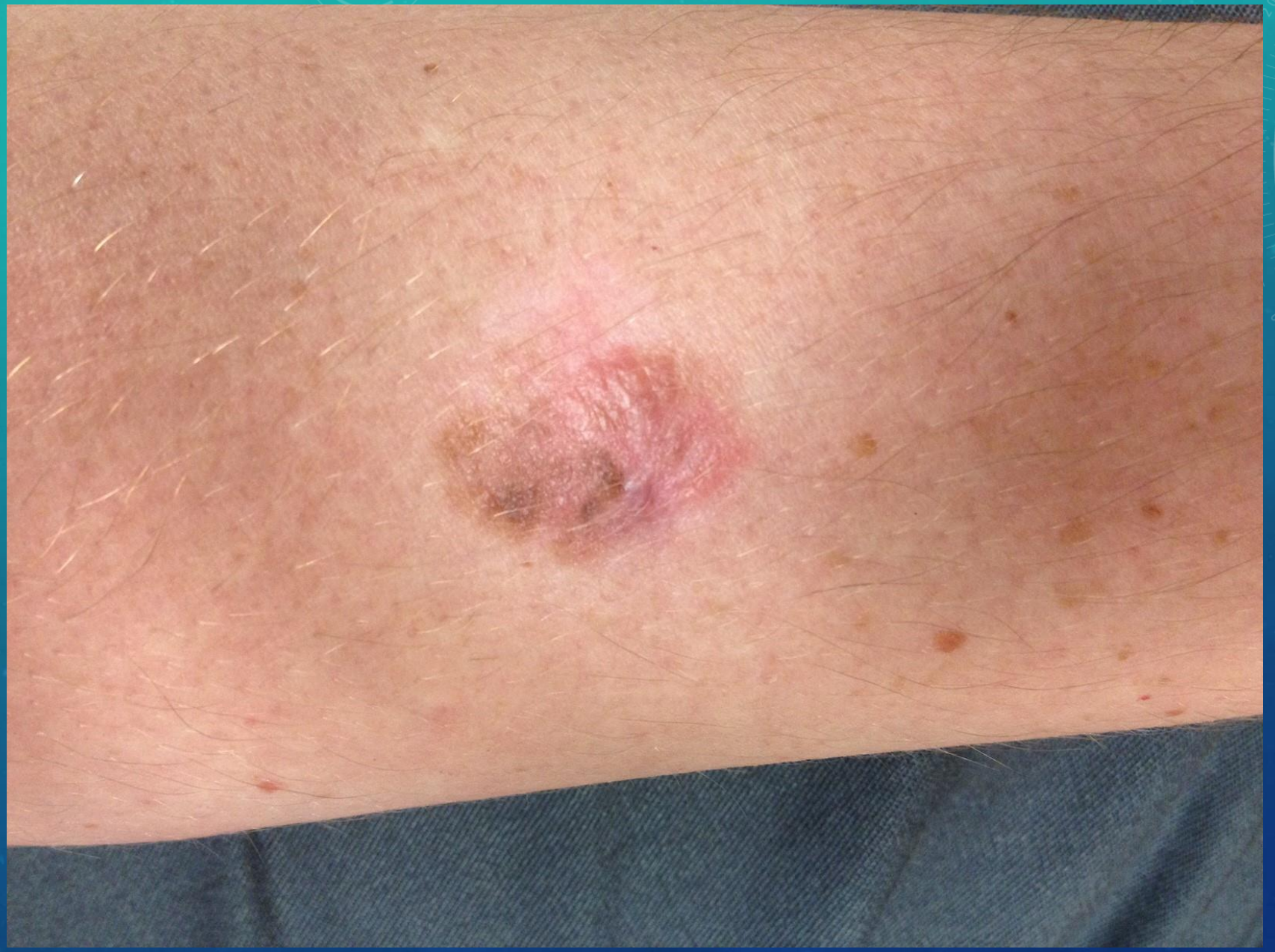
Seborrheic Keratosis

- Waxy surfaced
- “Stuck on” appearing
- Slow growing
- Can excise/freeze/curette
- They are benign

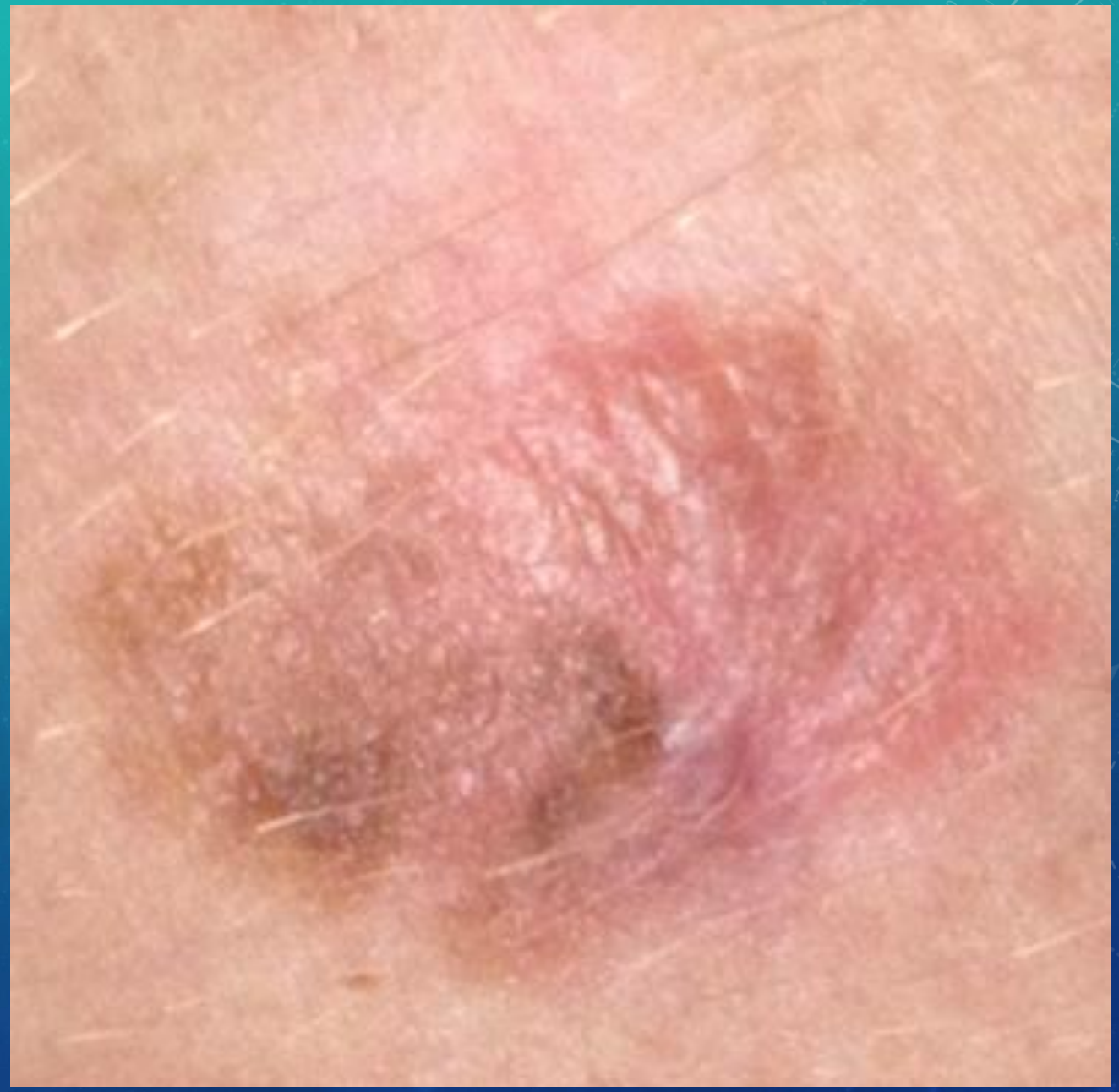
Differential Dx?

- Seborrheic Keratosis
- Compound/dermal nevus
- Granuloma annulare
- Basal cell cancer
- Melanoma
- Other tumor

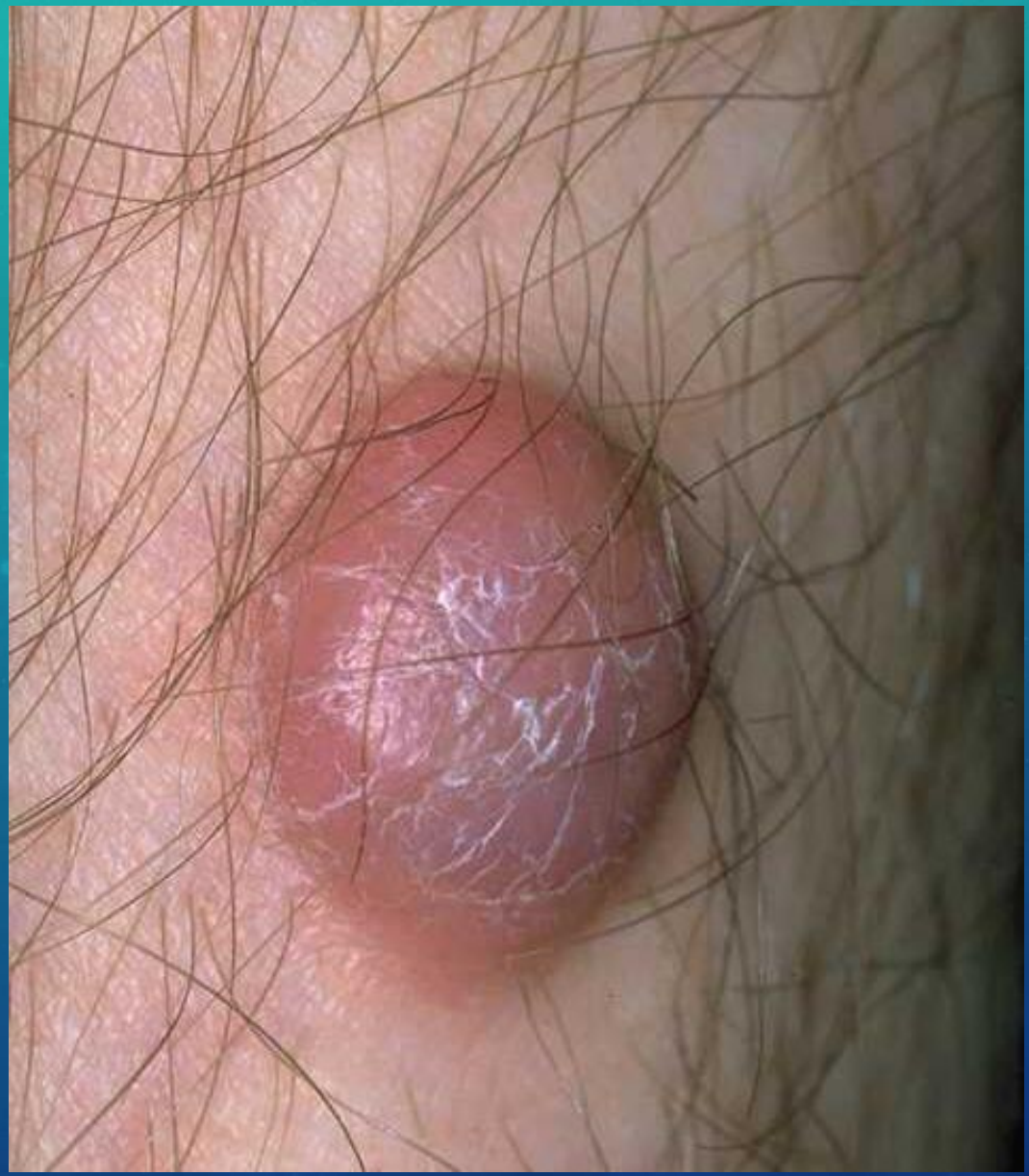


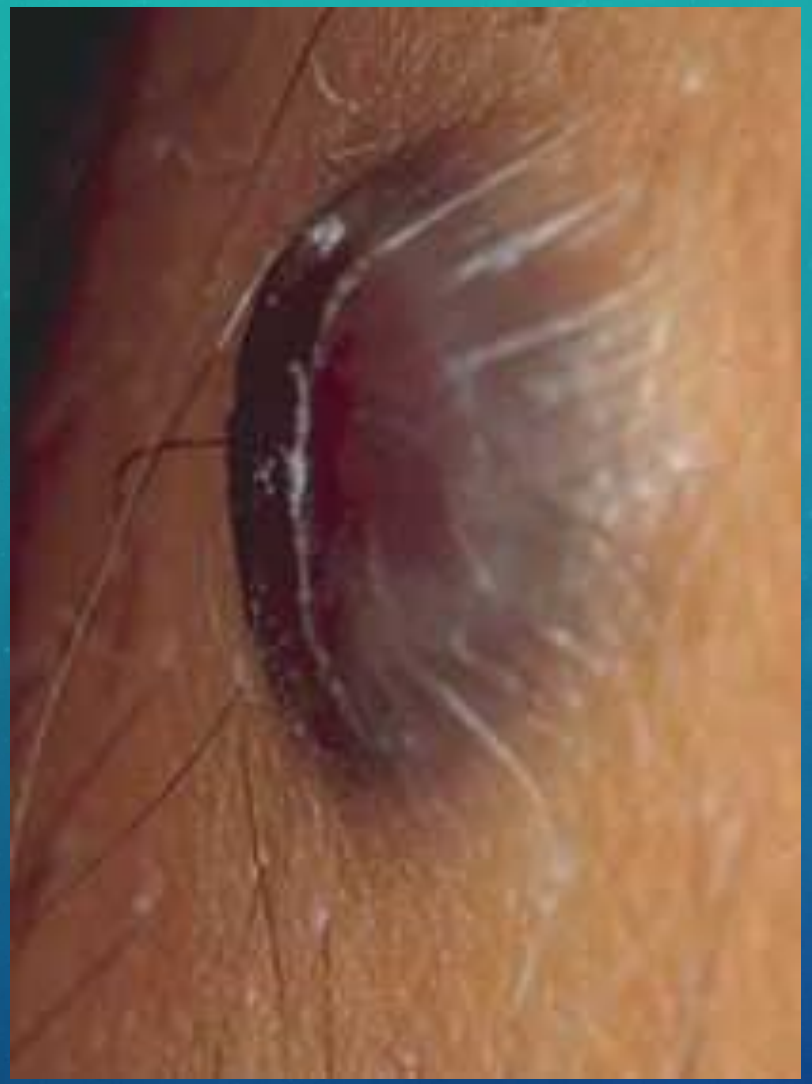


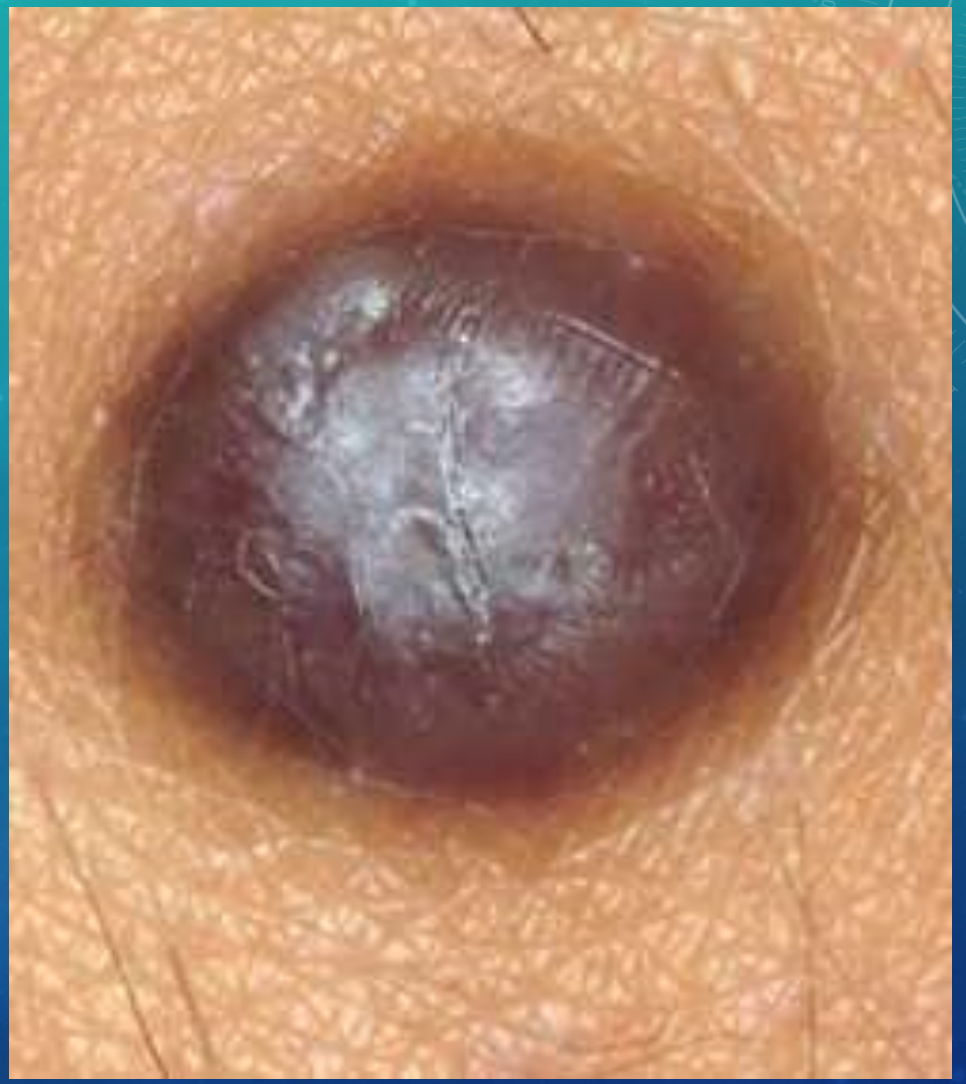
Melanoma

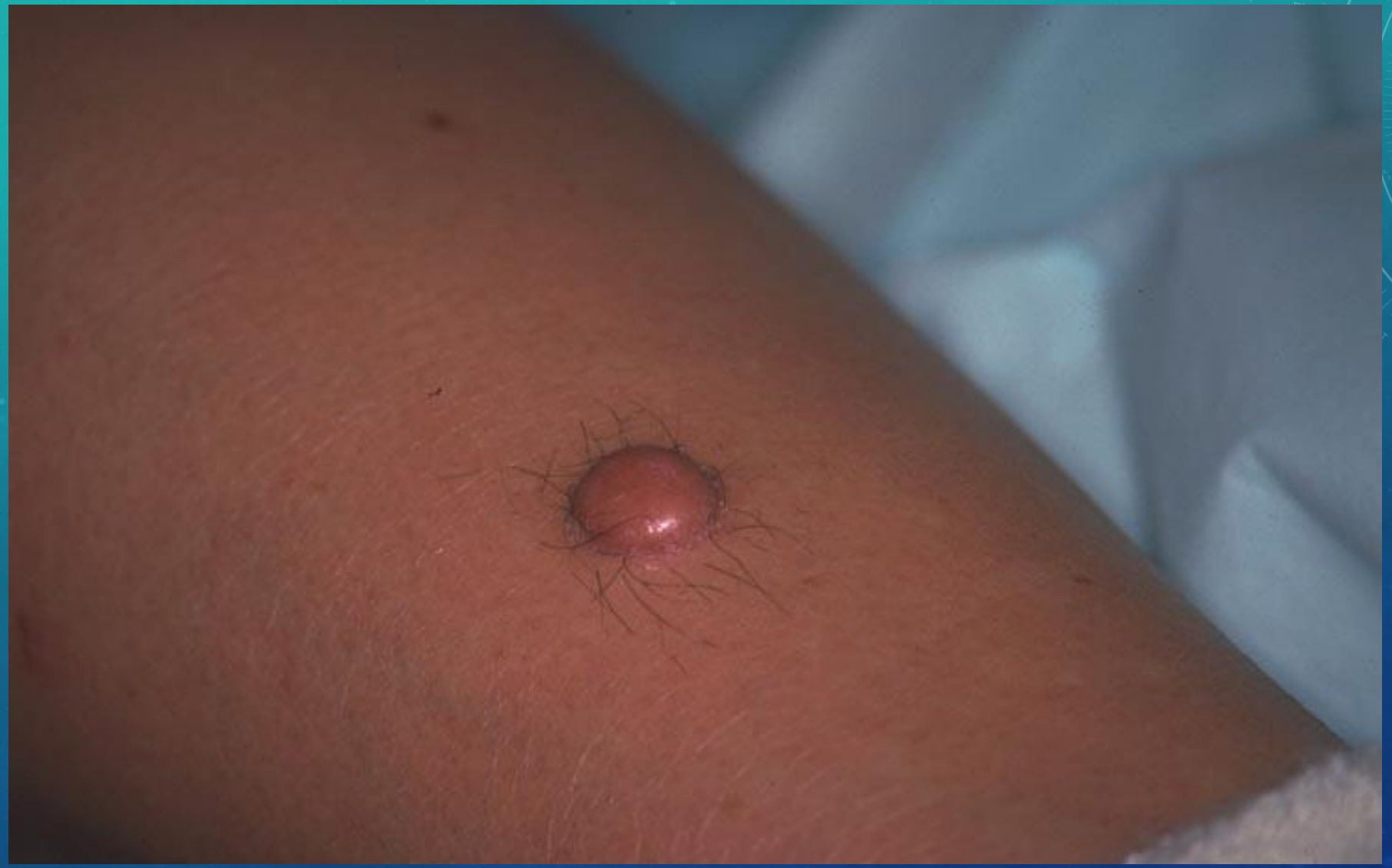


Tiger Cowries



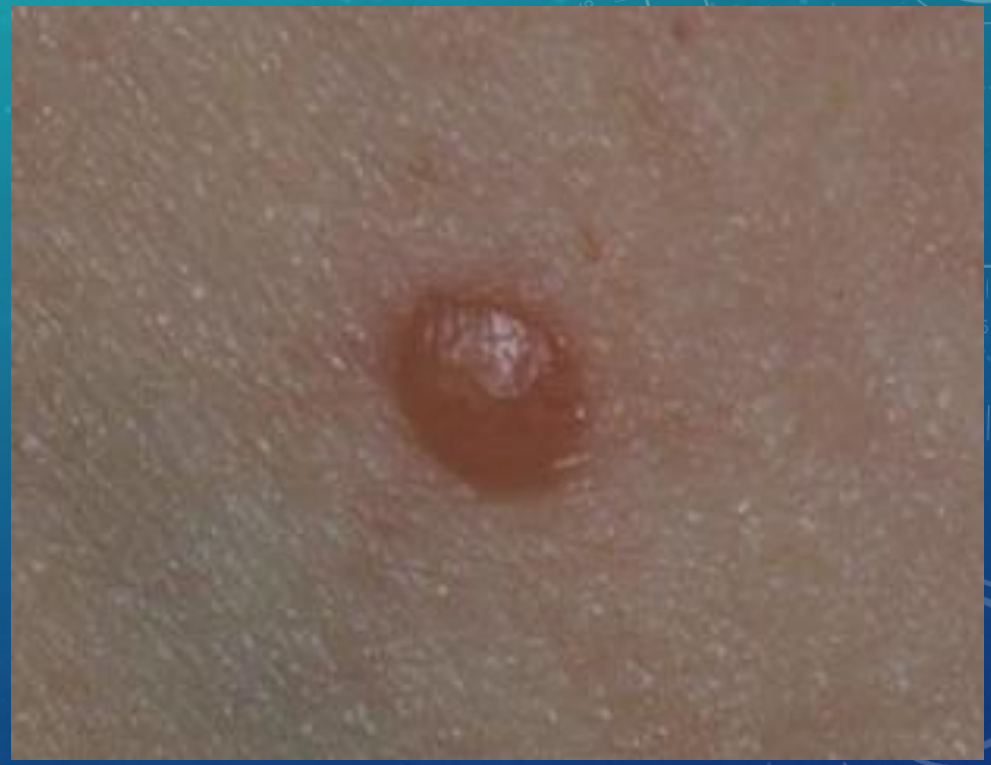






These skin lesions are examples of:

A. Lipoma
B. Neurofibroma
C. Dermatofibroma
D. Seborrheic keratosis



Diagnostic clues

- Positive dimple sign
  - When the tumor is gently squeezed from the sides, it dimples down below the skin
  - Like an iceberg, the majority of the tumor is below the level of the skin
- Commonly occurs on the legs, especially in women
- Usual pigmentation is darker than surrounding skin

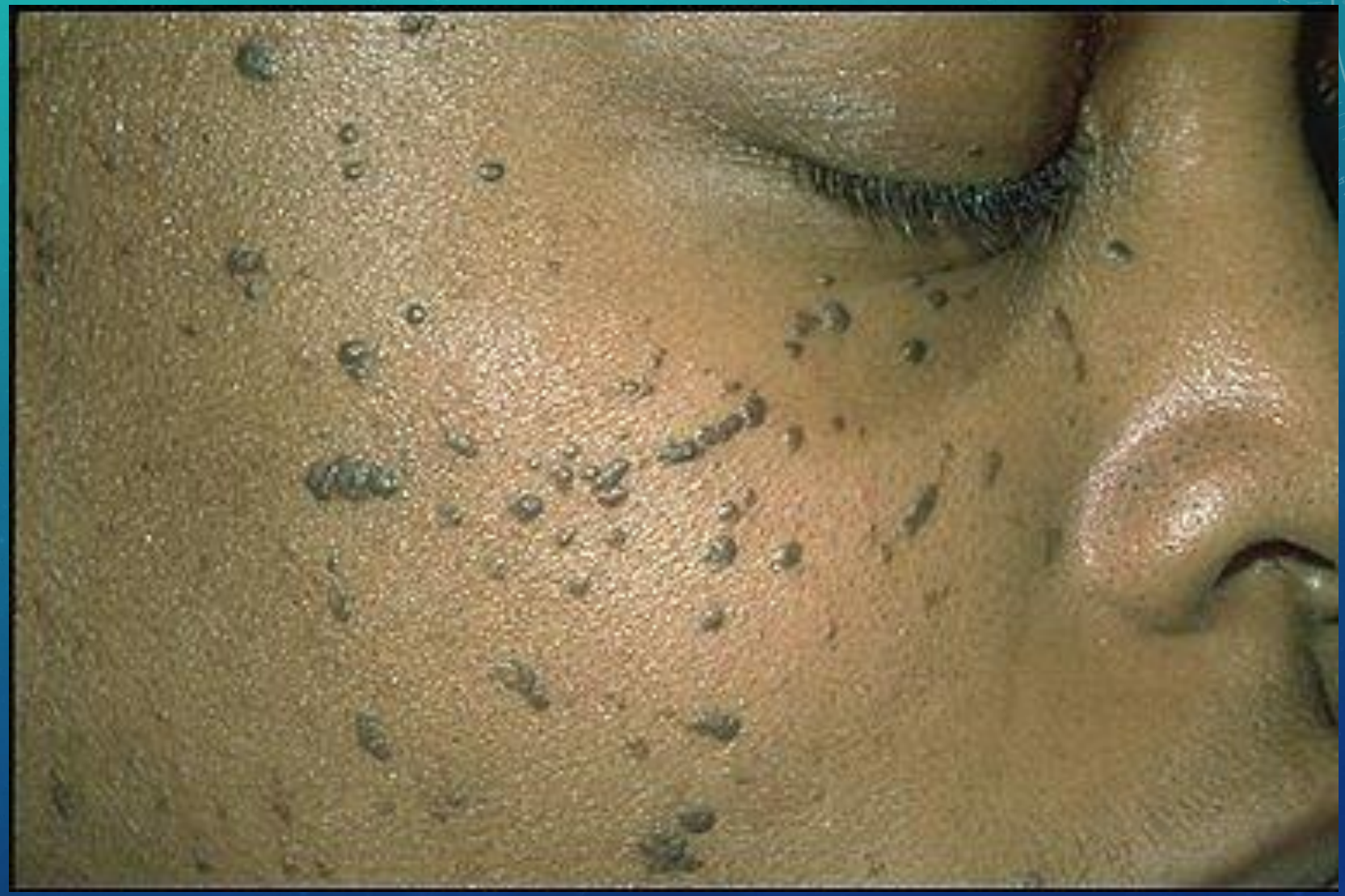
Treatment for dermatofibroma

- Aggressive reassurance
- Excisional biopsy if the lesion is irritating or concerning.

Golden Cowry


What are these lesions?

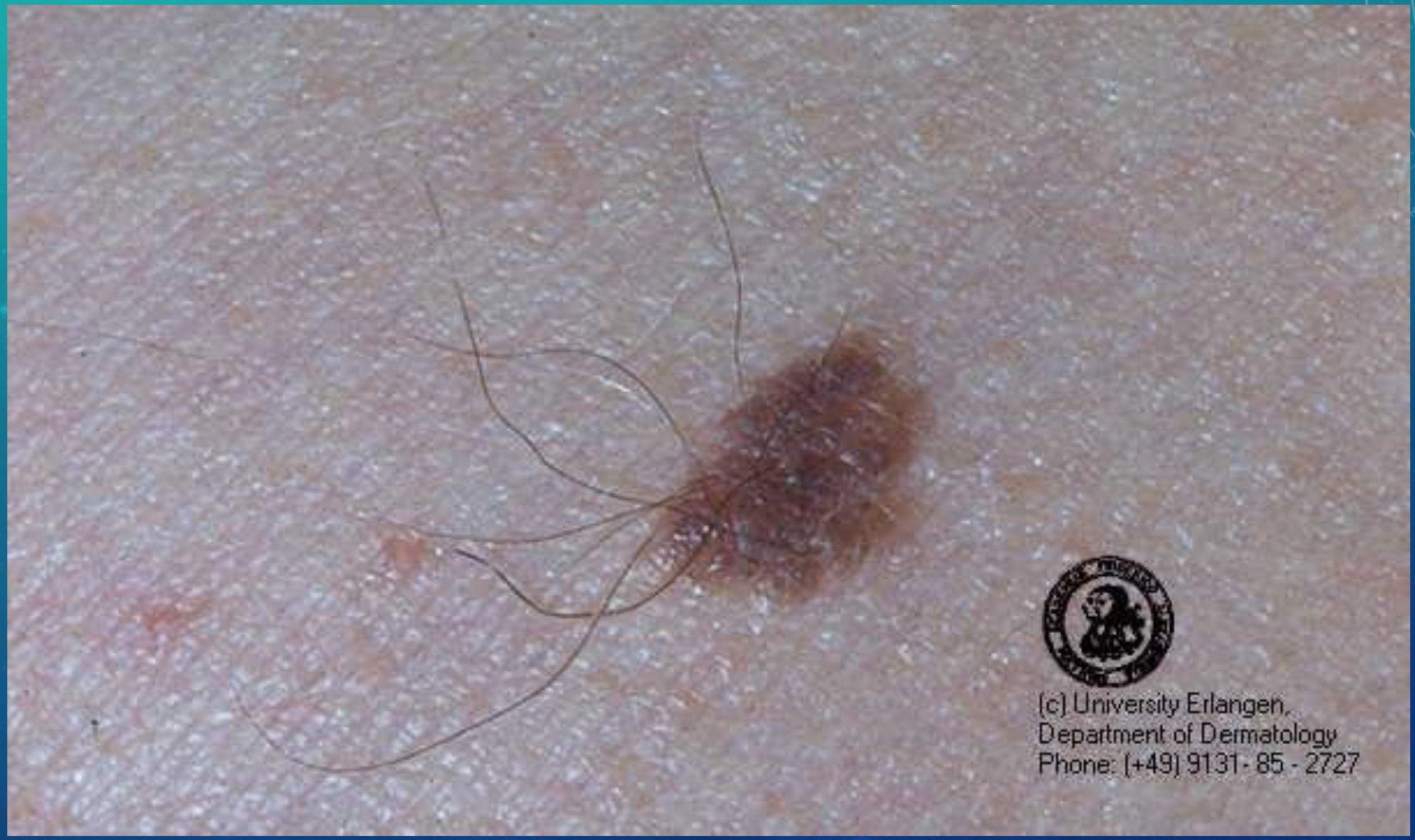
Dermatosis papulosa nigra



Dermatosis Papulosa Nigra Treatment

- Aggressive reassurance
- Can excise PRN
- I use a pair of sharp scissors and pickups without anesthesia to cut these off.
- The anesthesia hurts more than the scissors do.
- If using liquid nitrogen, be aware of potential post-procedural hypo-/hyperpigmention.

Tortoise cowry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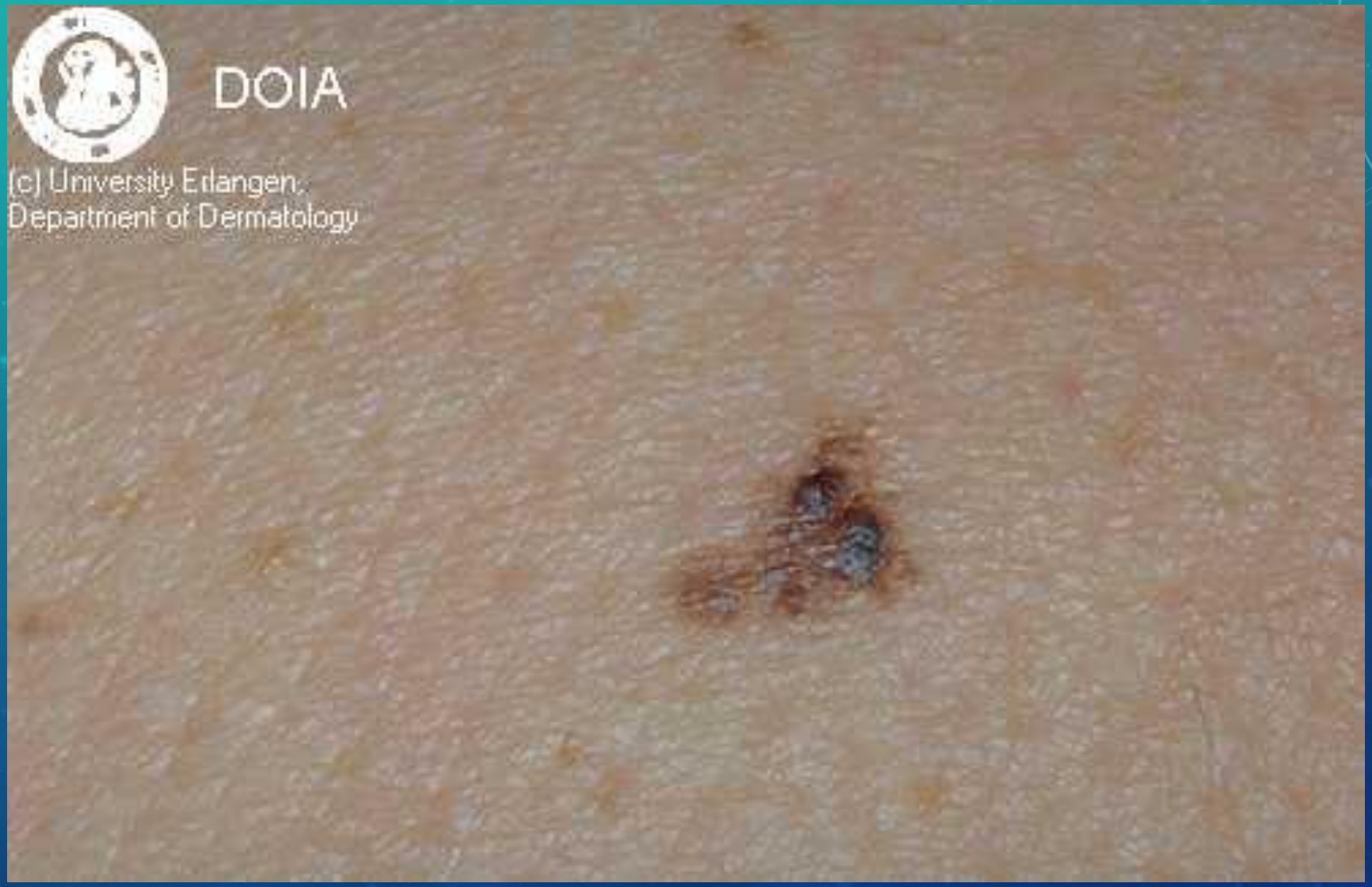
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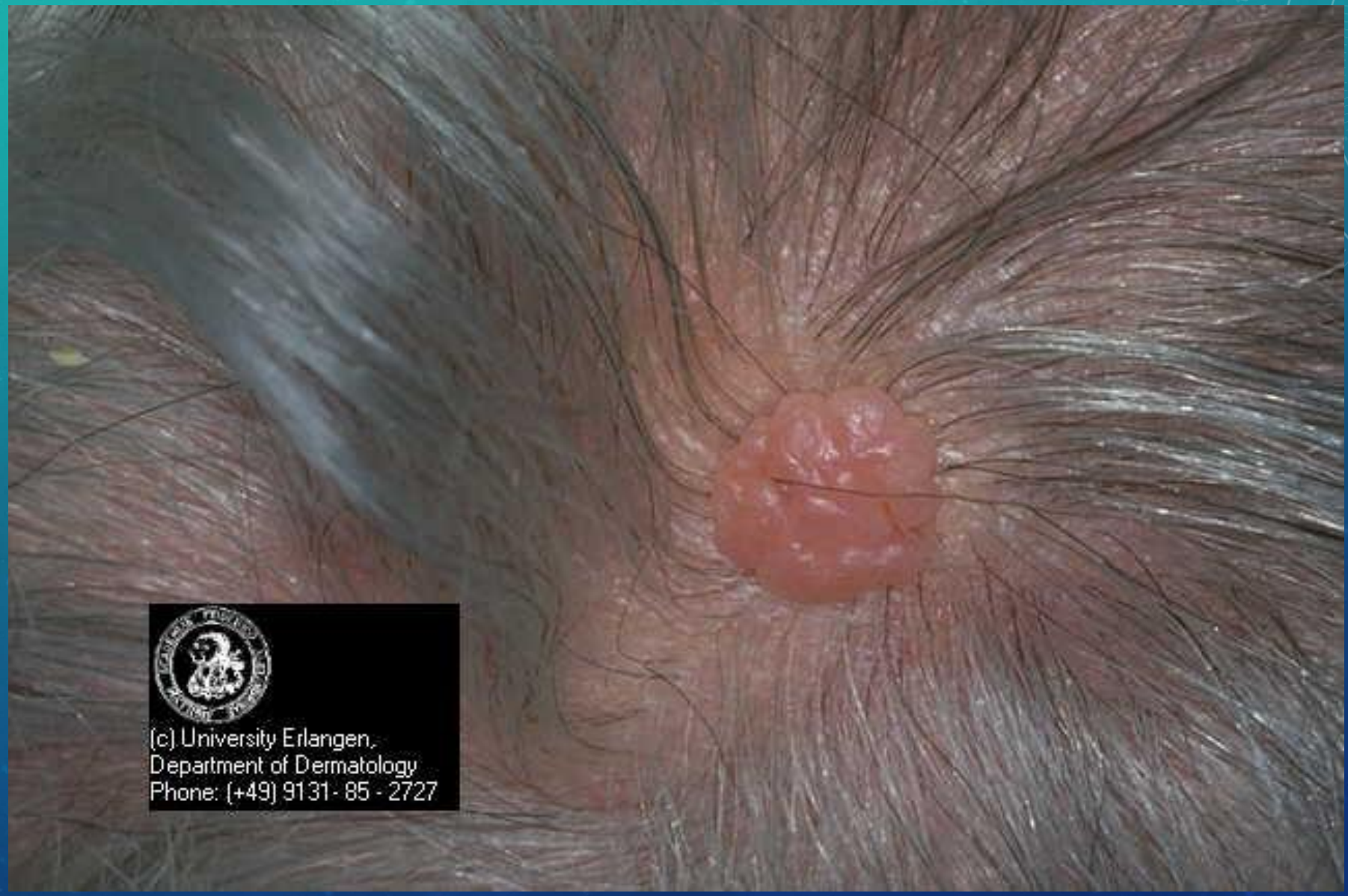
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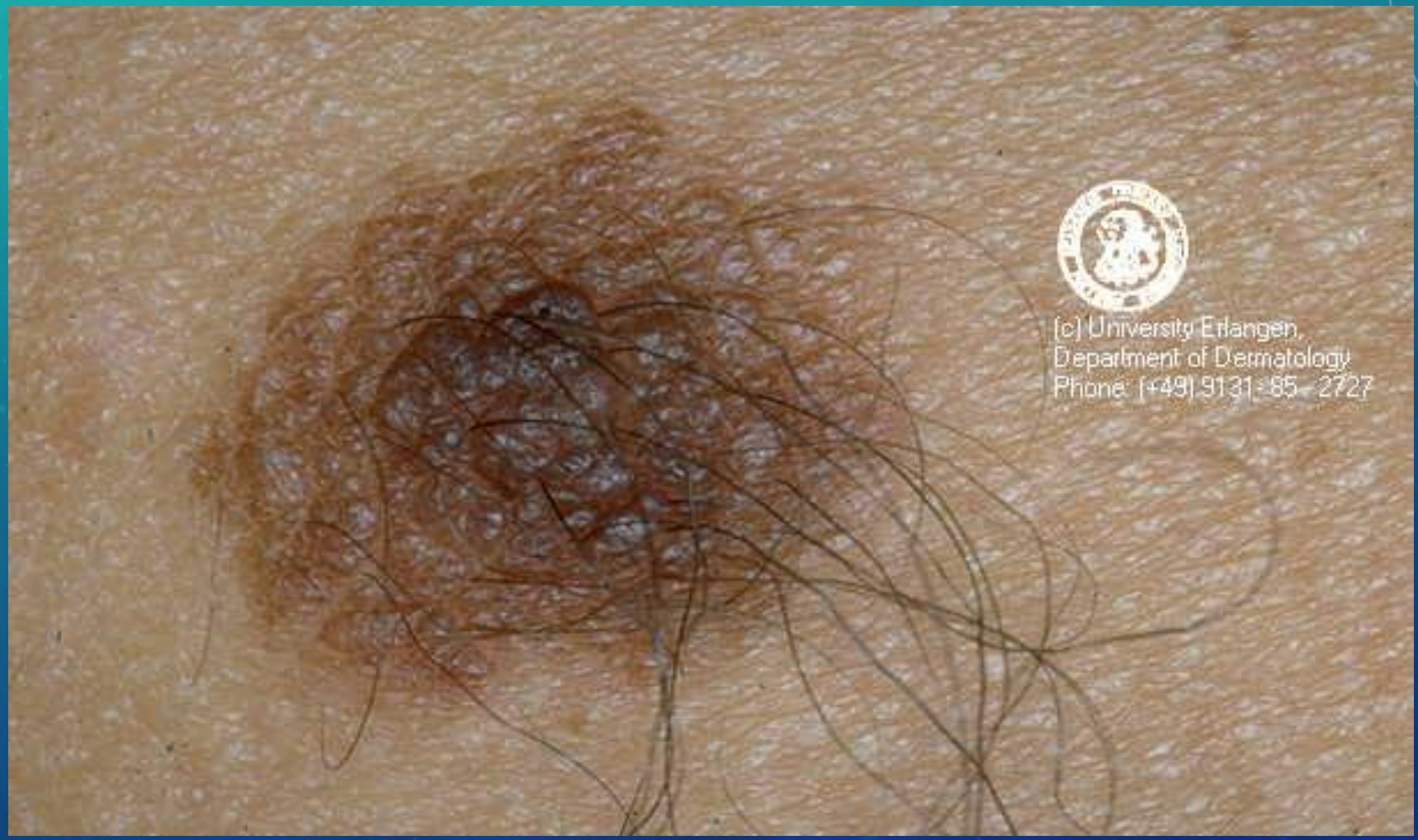
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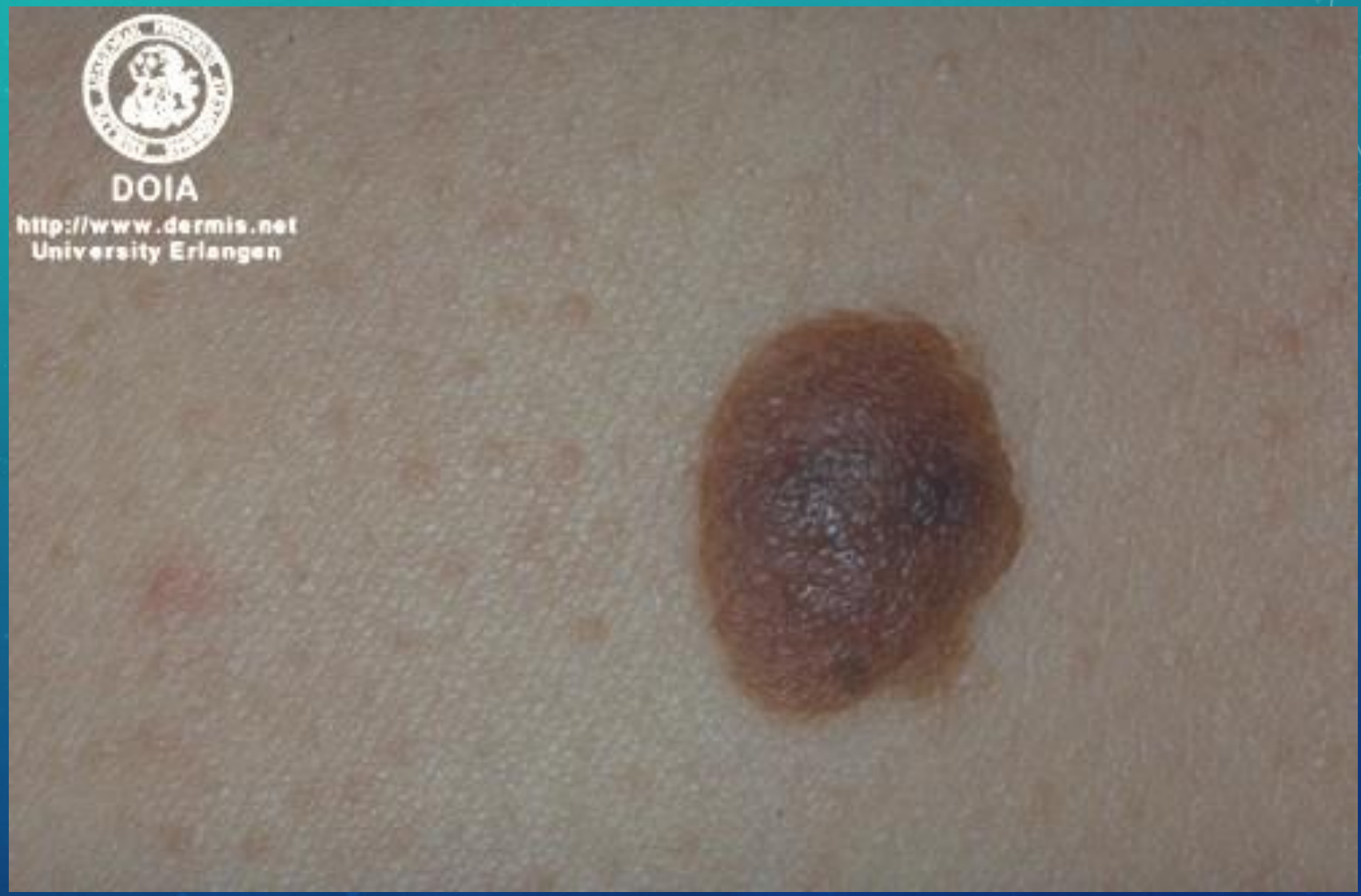
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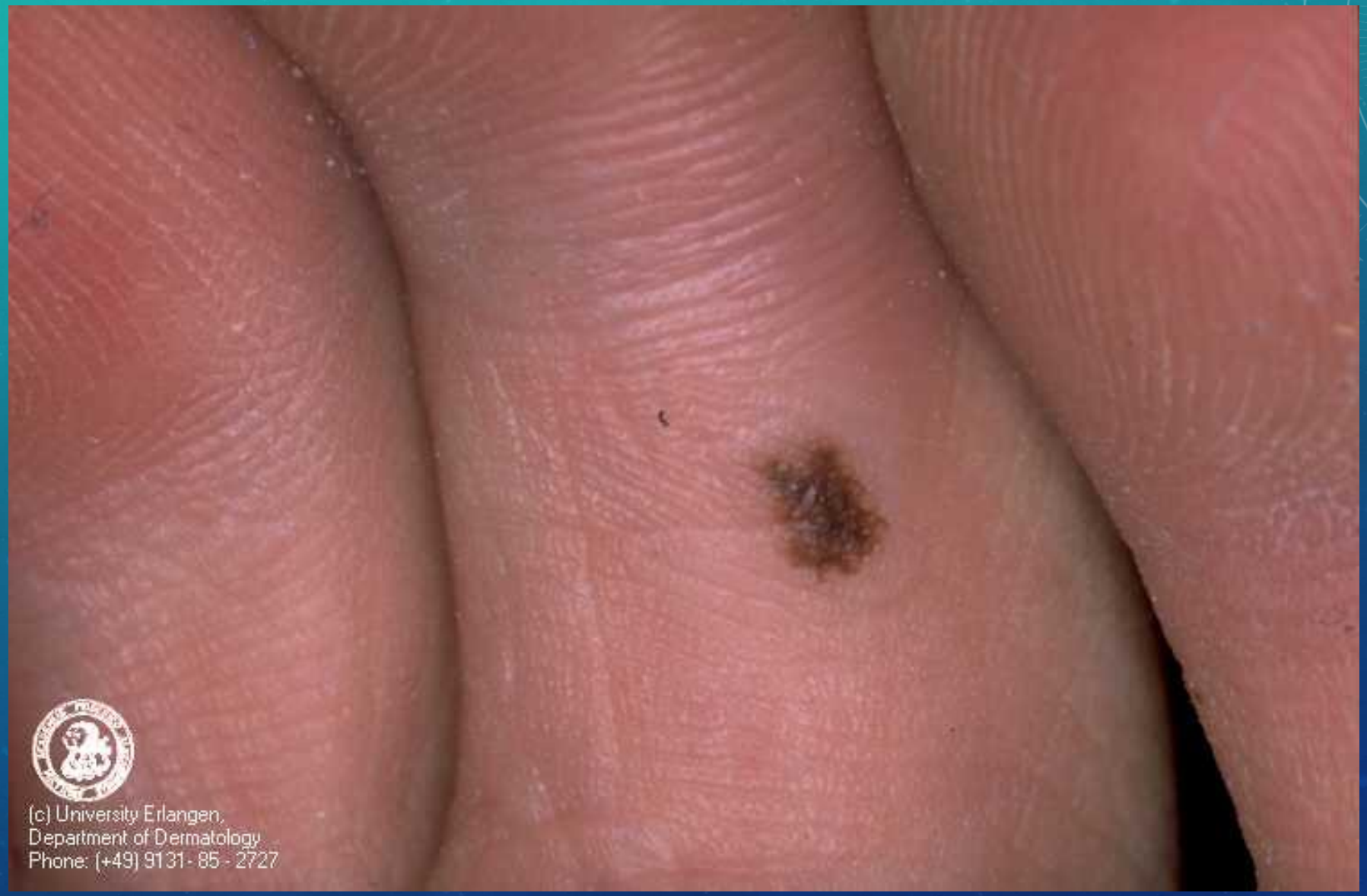
Well, doctors, what are these bumps? Remember, these have pigment

- Nevi aka “moles”
- Cancers: melanoma, BCC, SCC?
- Dermatofibroma
- SK, seborrheic keratosis
- Others
- If in doubt, consider biopsy

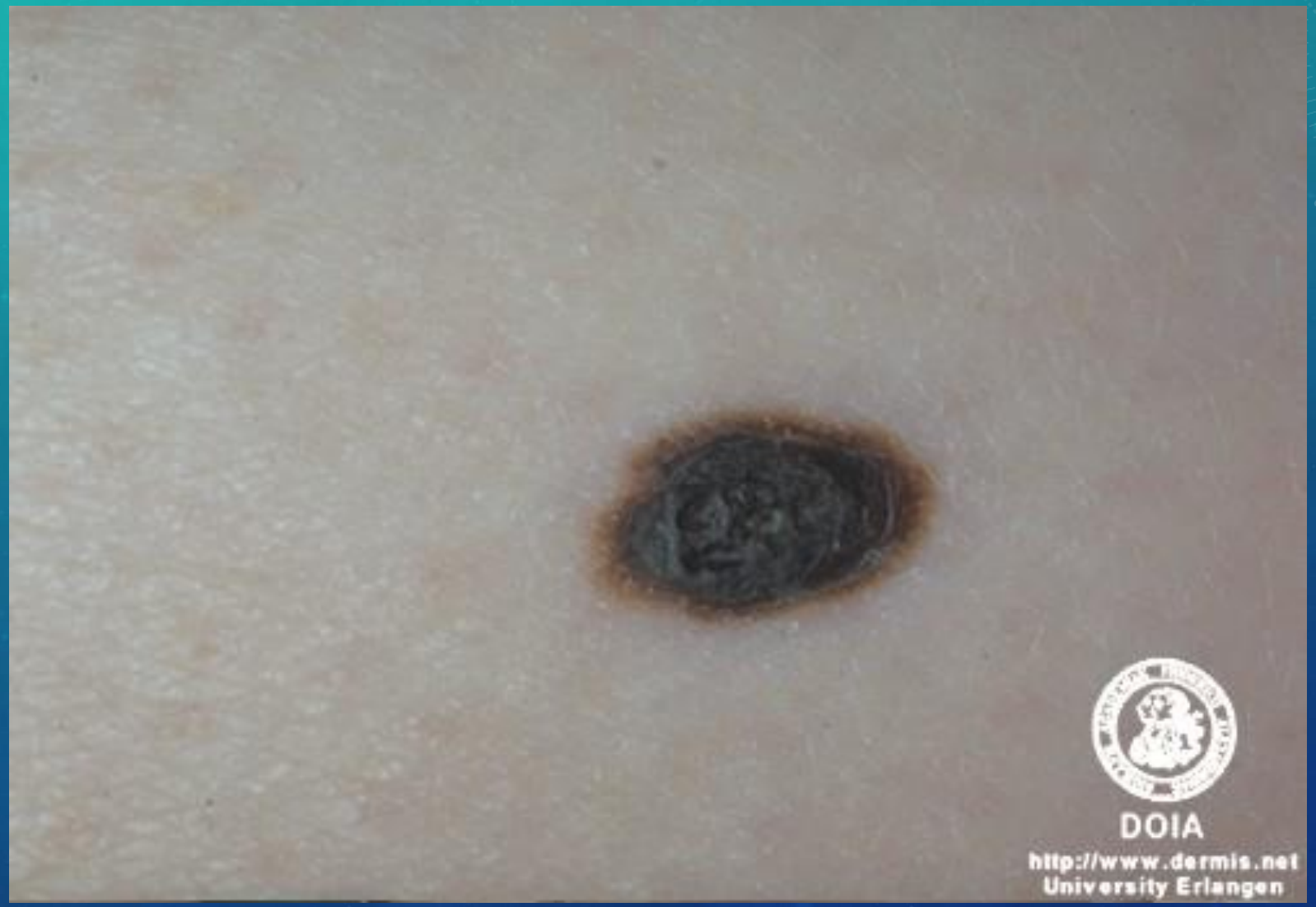
Nevi – three types

- Junctional – cells are at the dermoepidermal junction above the basement membrane. Flat lesions.
- Compound – cells are both above the basement membrane and in the dermis. Slightly raised lesions.
- Dermal – cells are only in the dermis. Raised lesions.

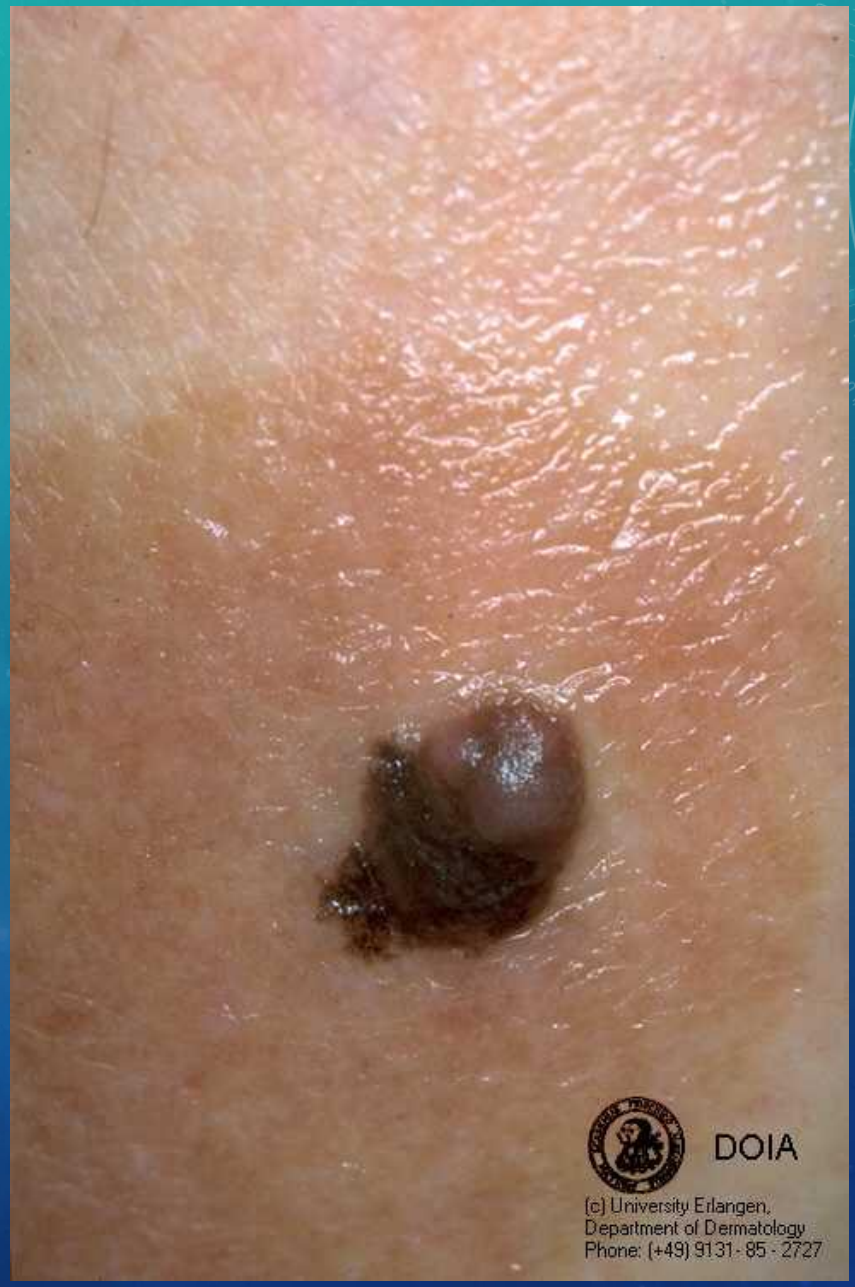
Junctional nevus



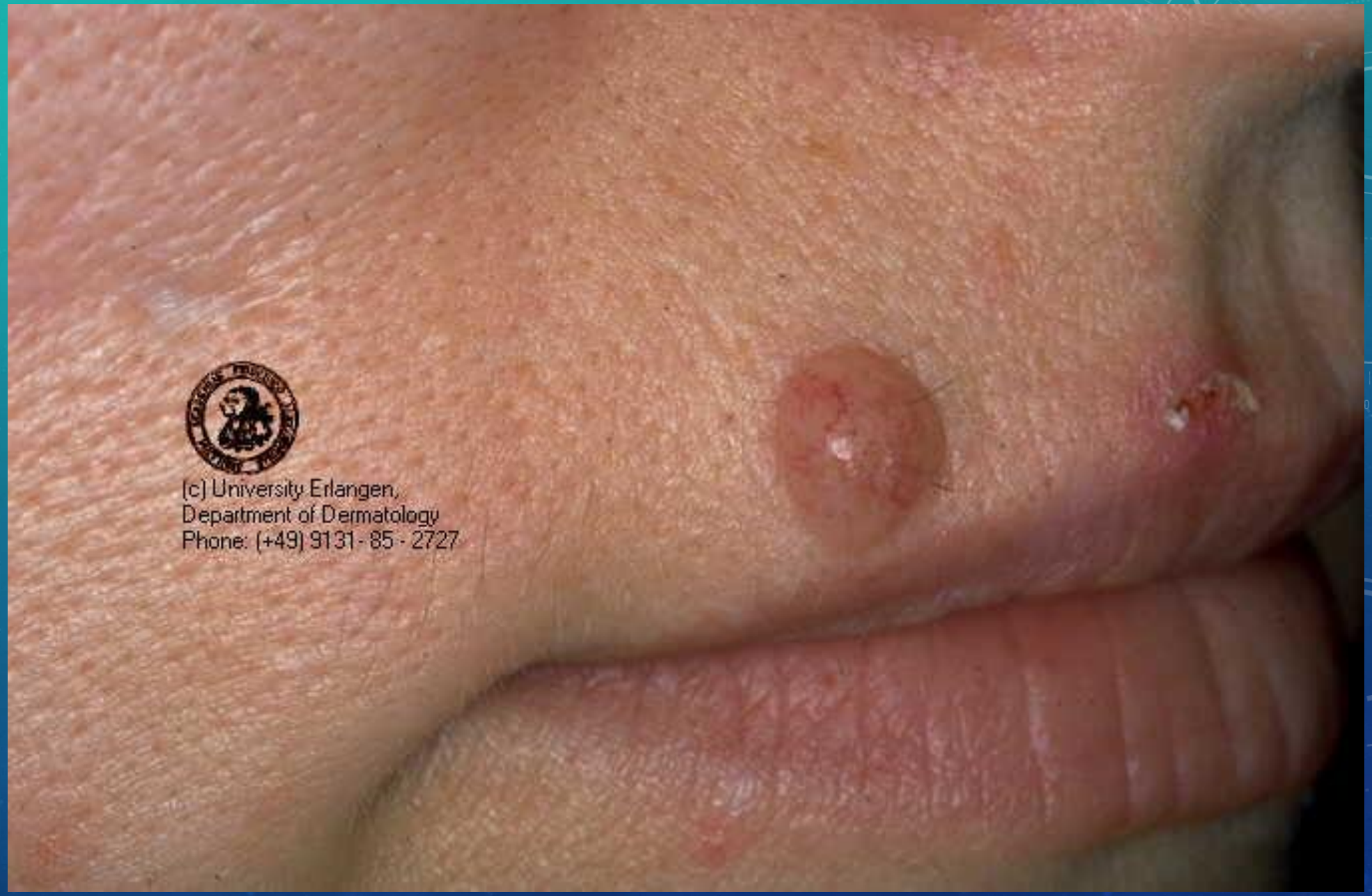
Junctional Nevus



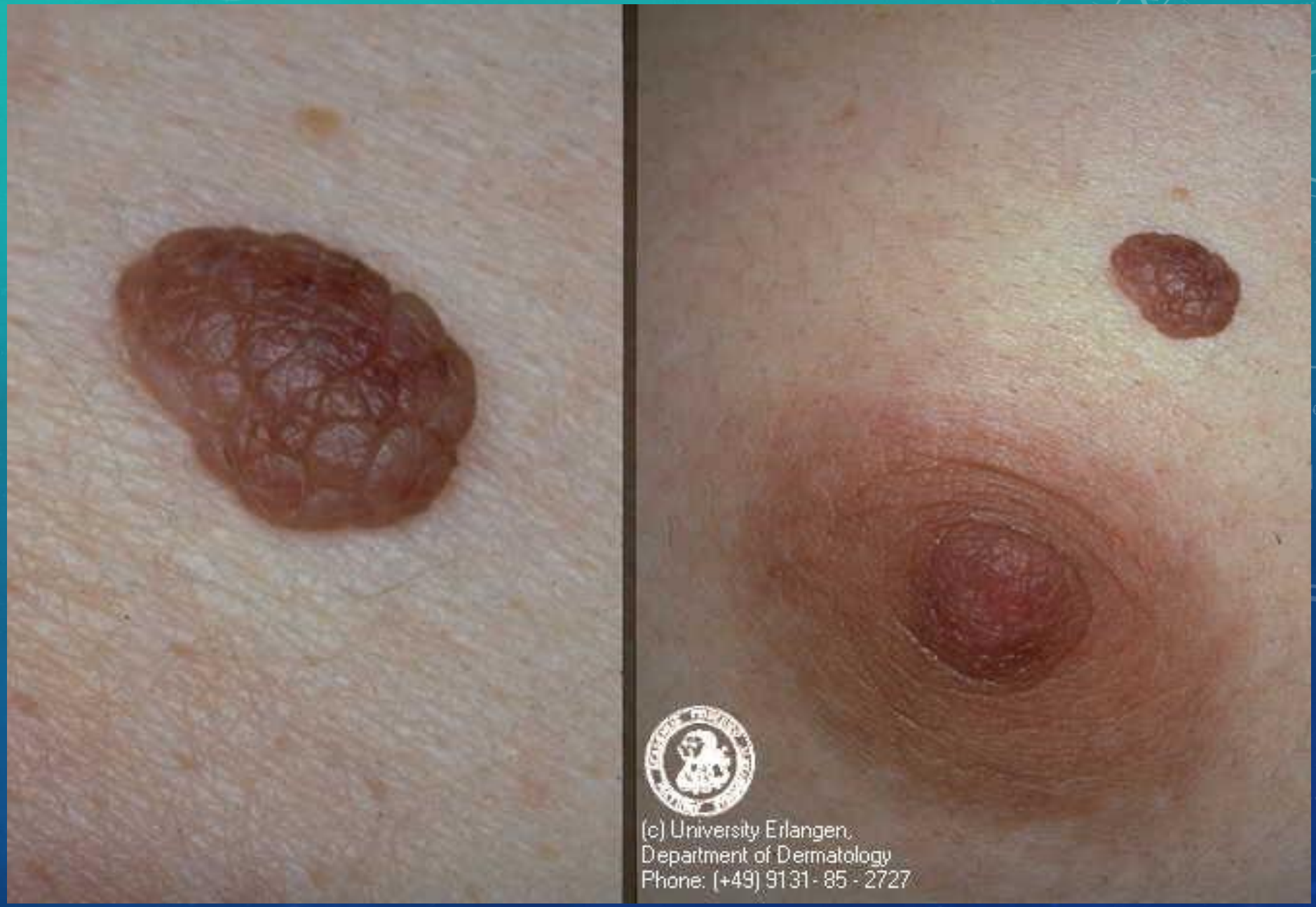
Compound Nevus



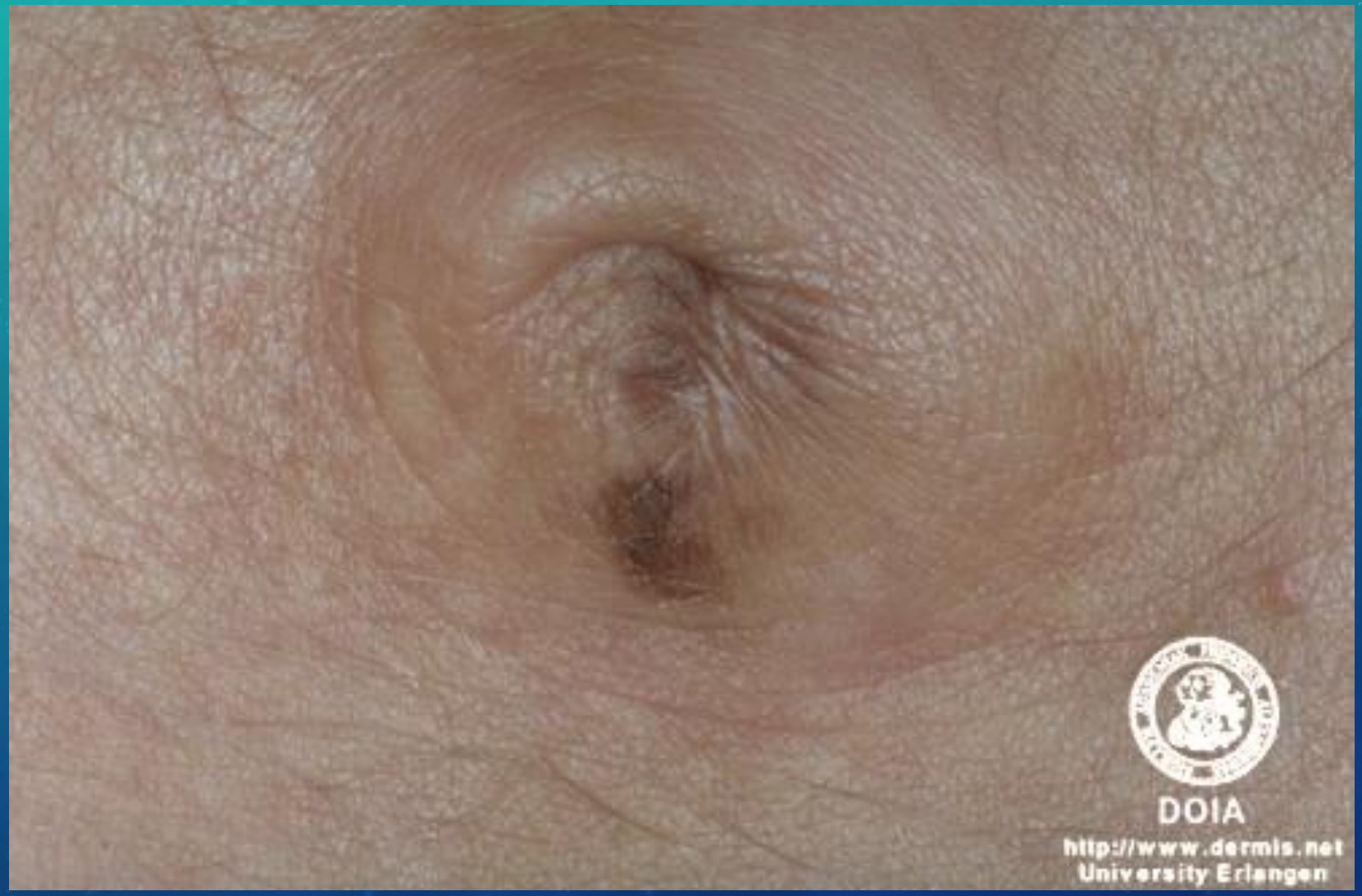
Dermal Nevus



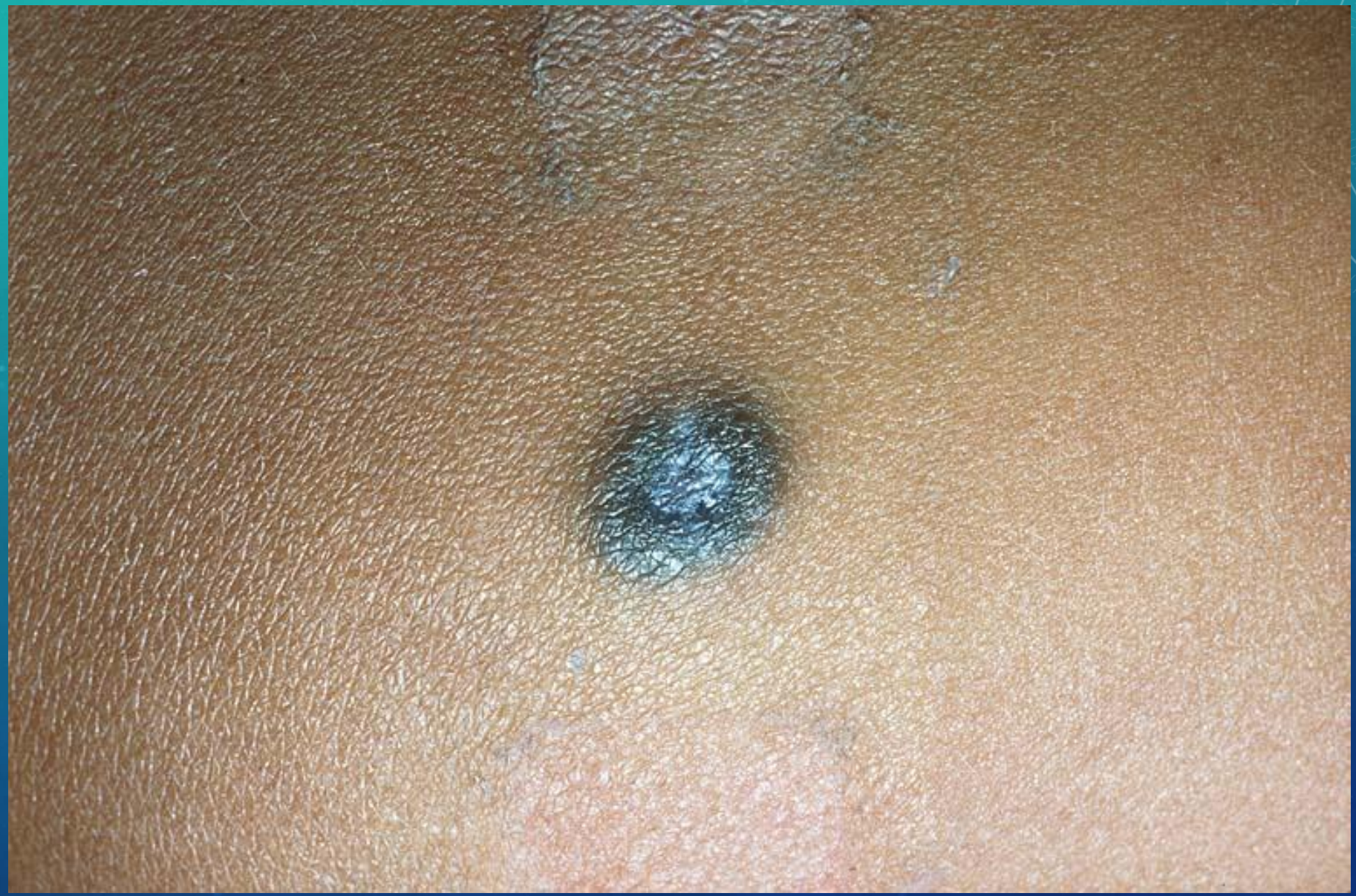
Dermal nevus

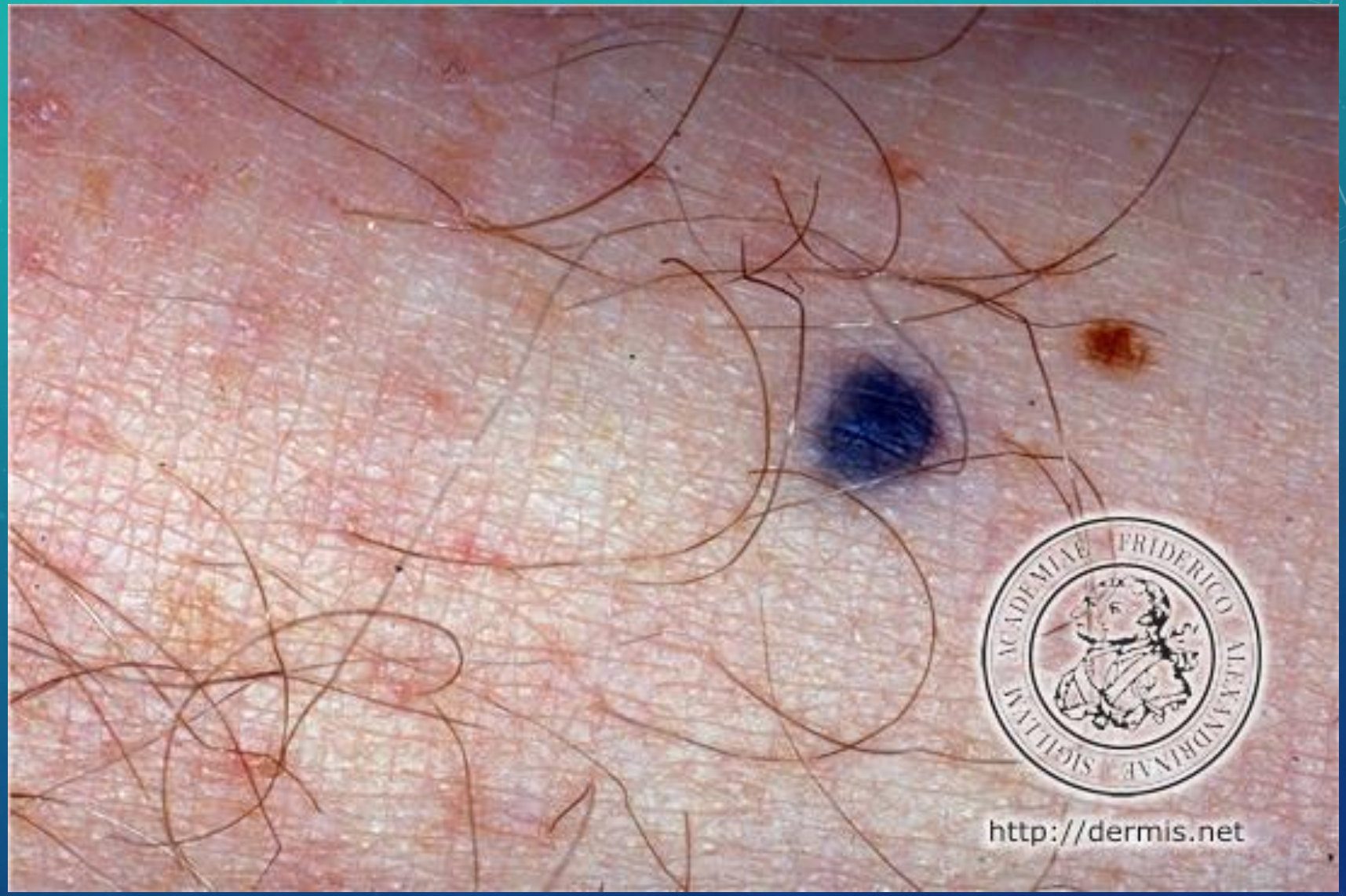


The dreaded black hole belly-button nevus



Here’s a special variety of mole

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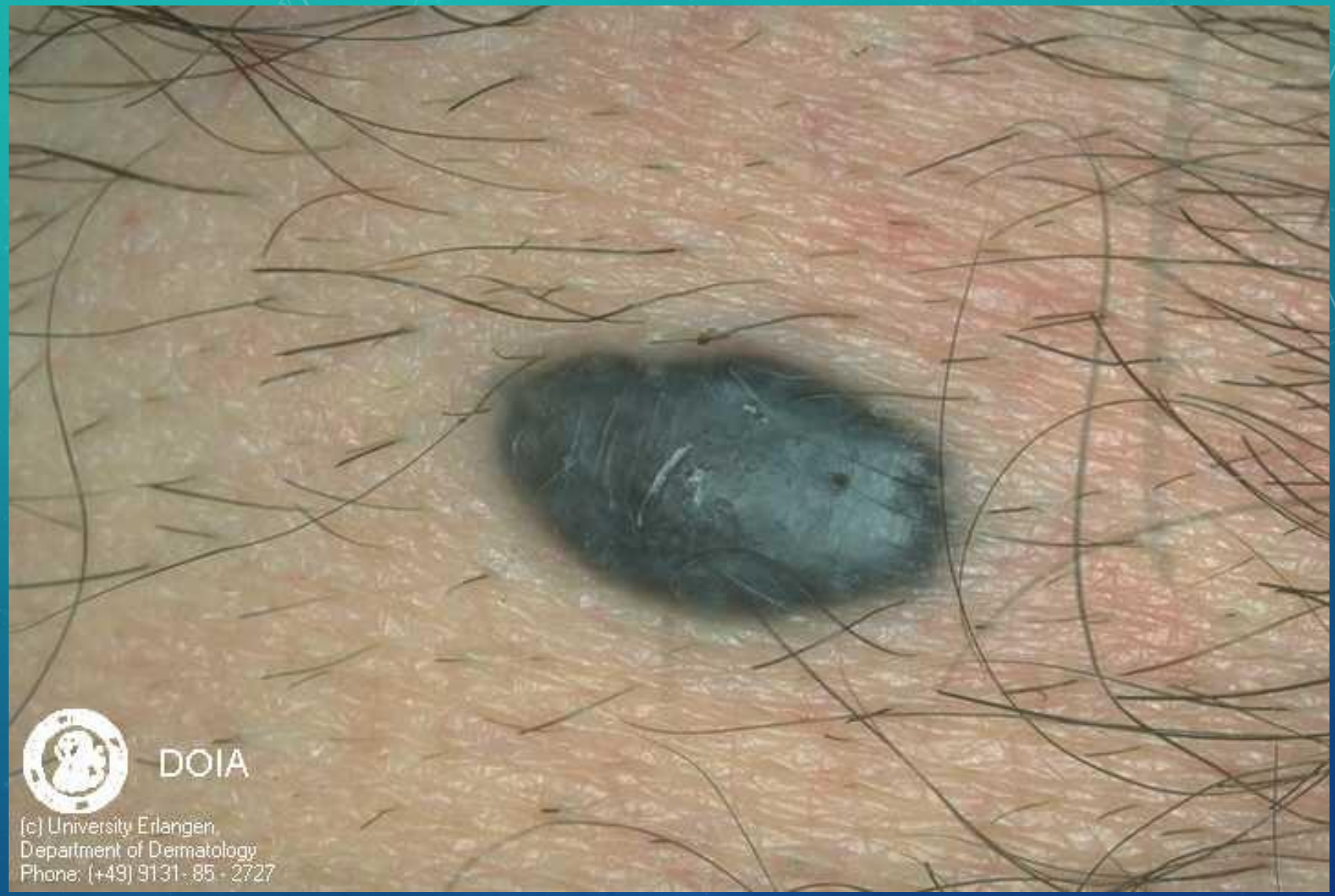
http://dermis.net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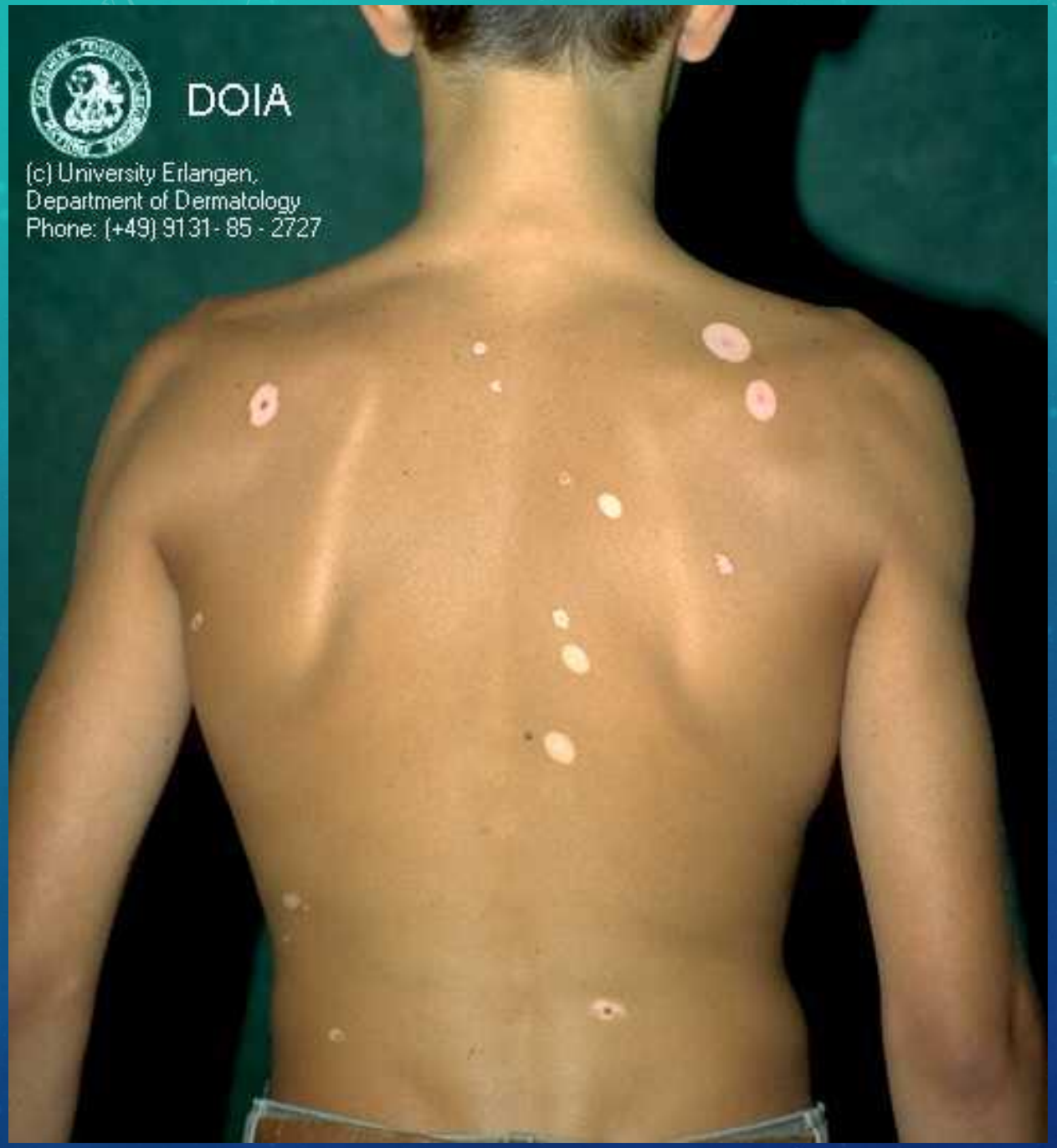
Phone: (+49) 9131 - 85 - 2727

Blue Nevus

Are these lesions running circles around you? Try this one on for size.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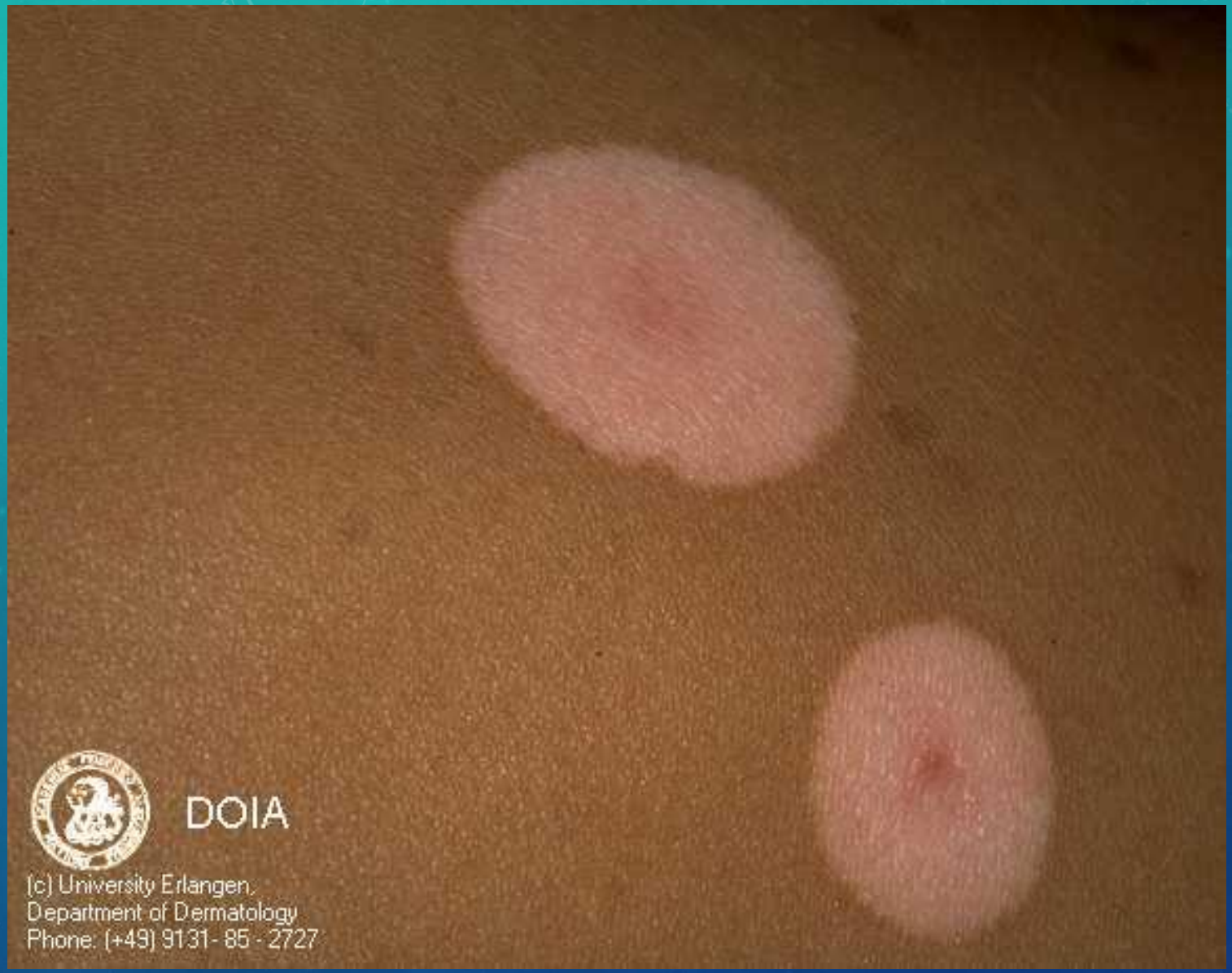
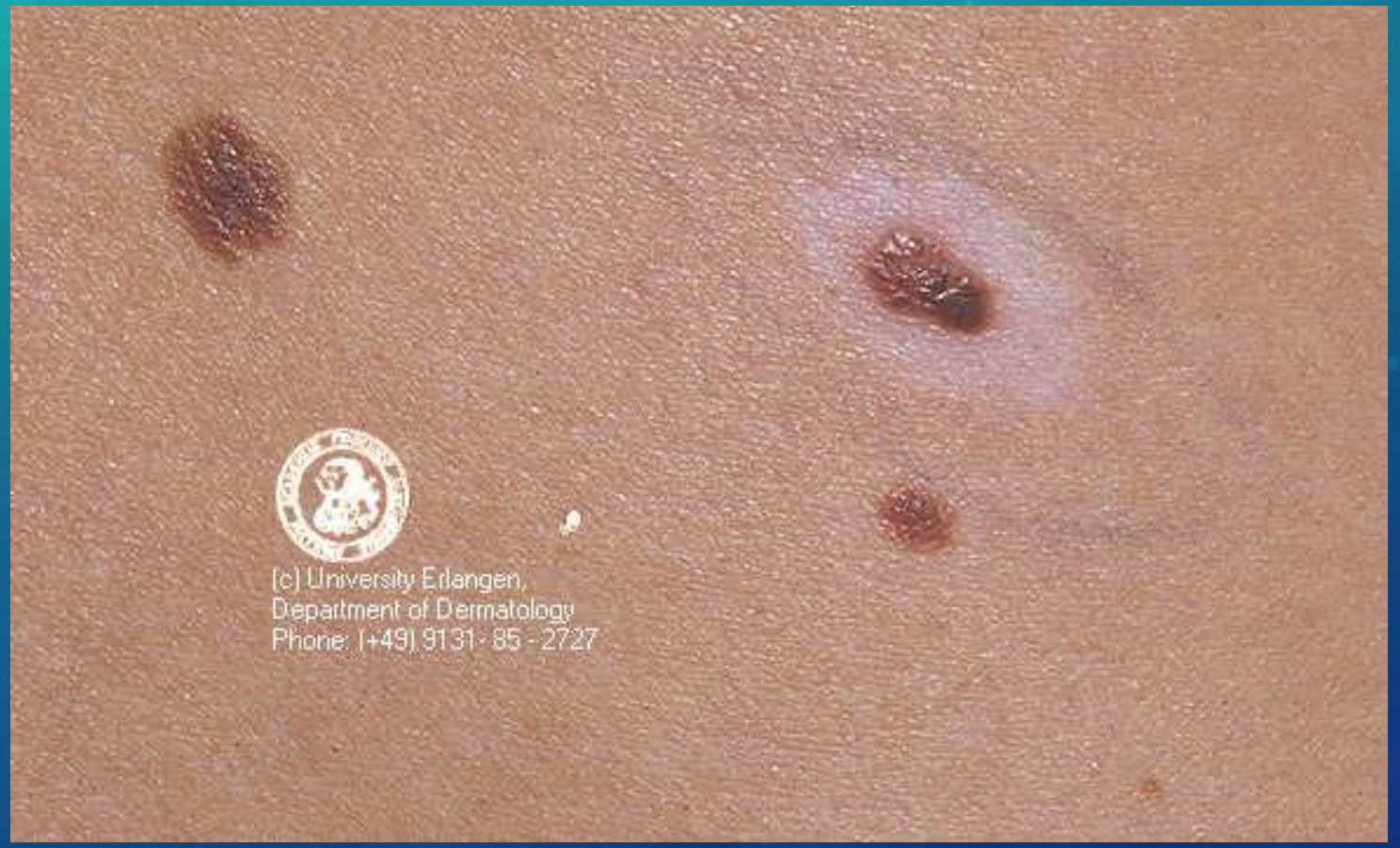


And these are…?

Halo nevus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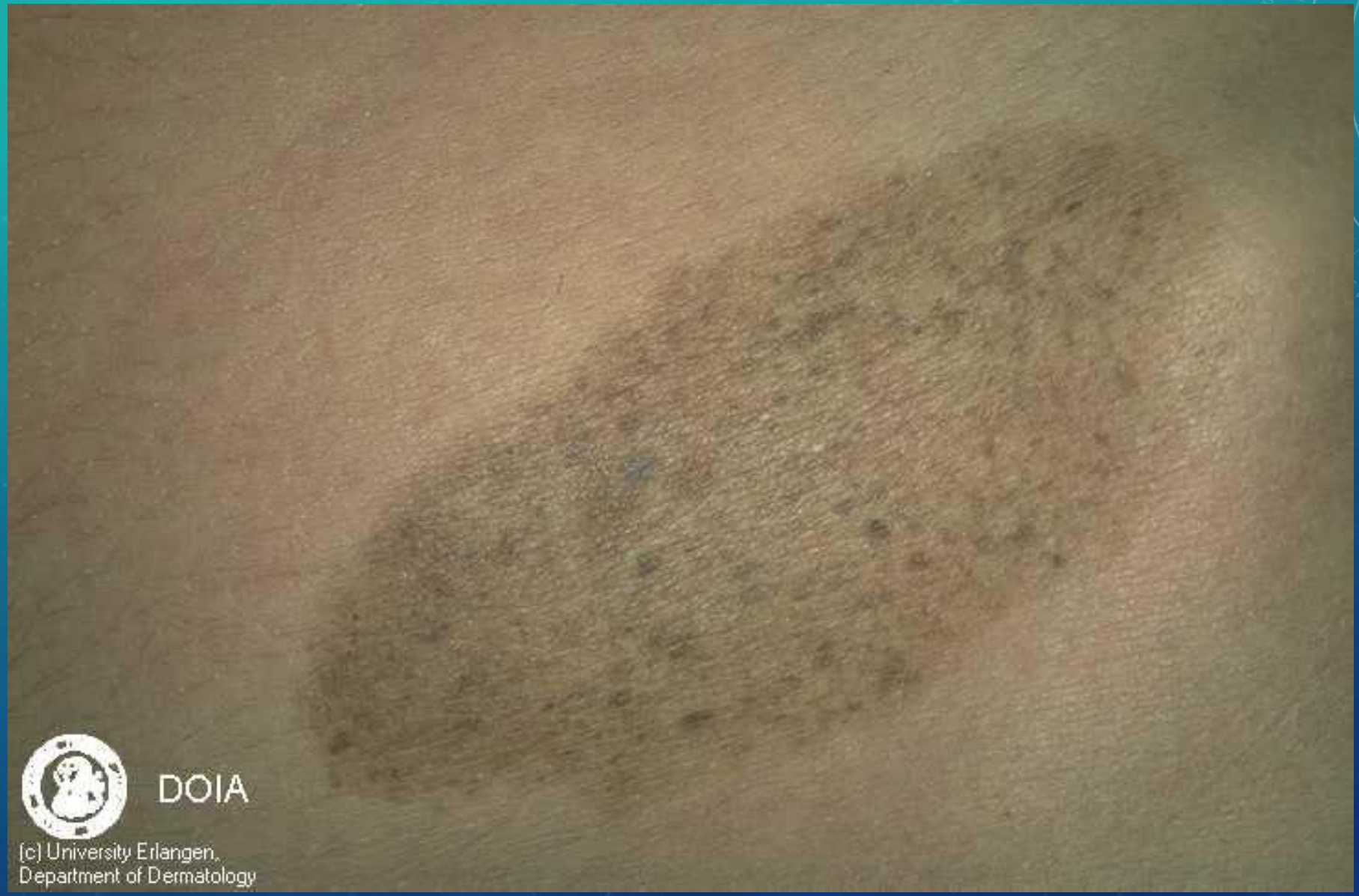
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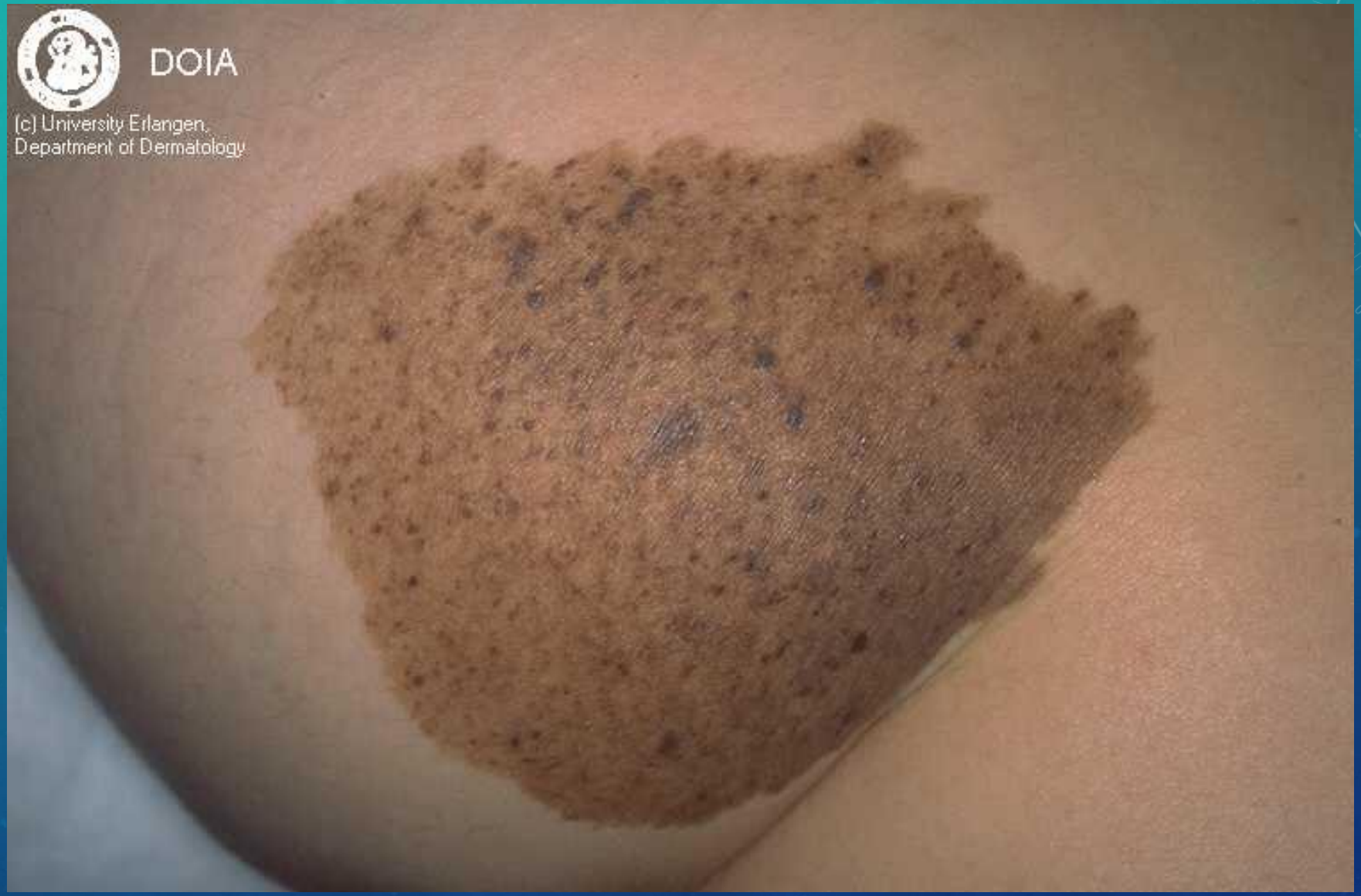
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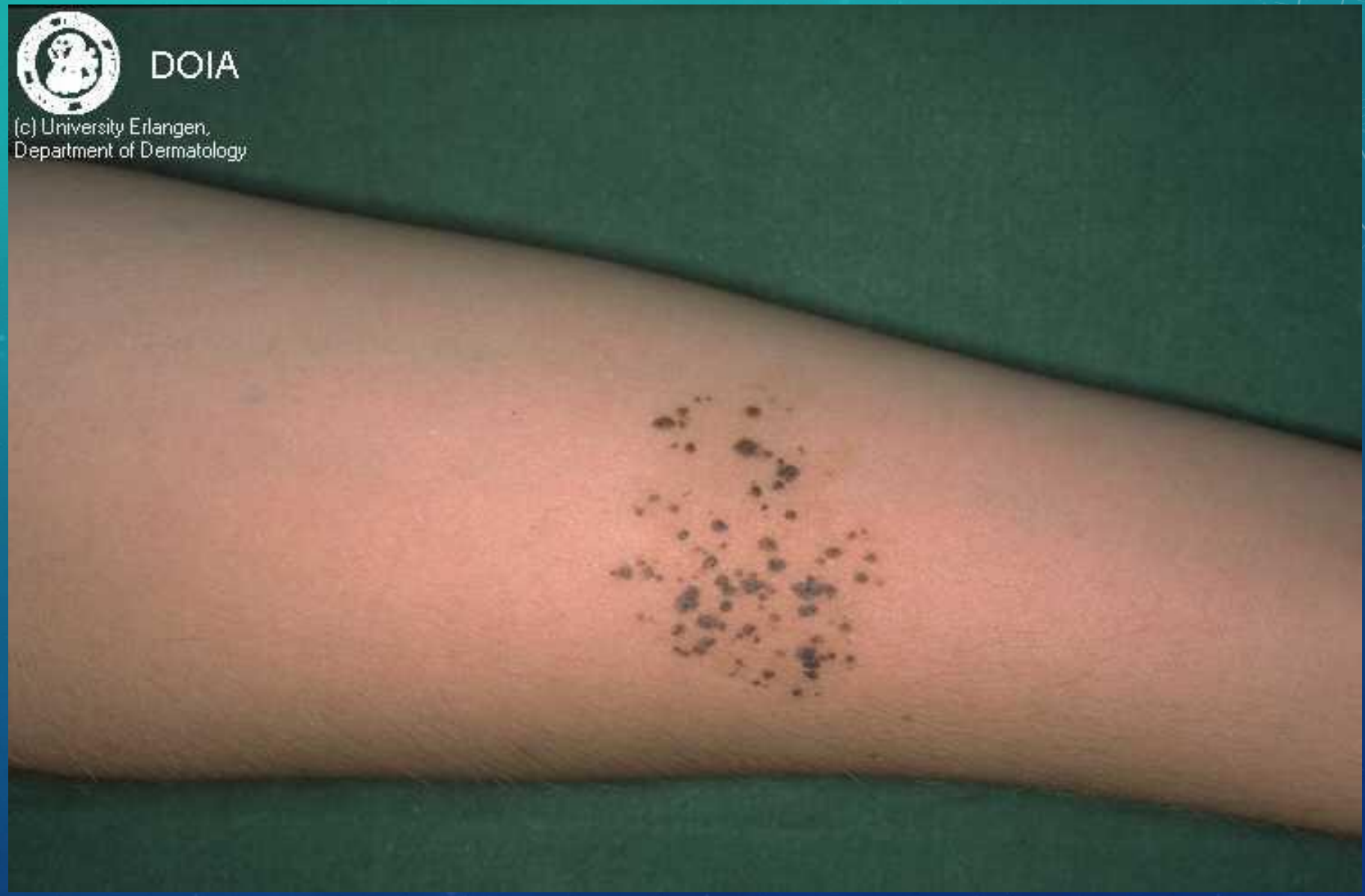
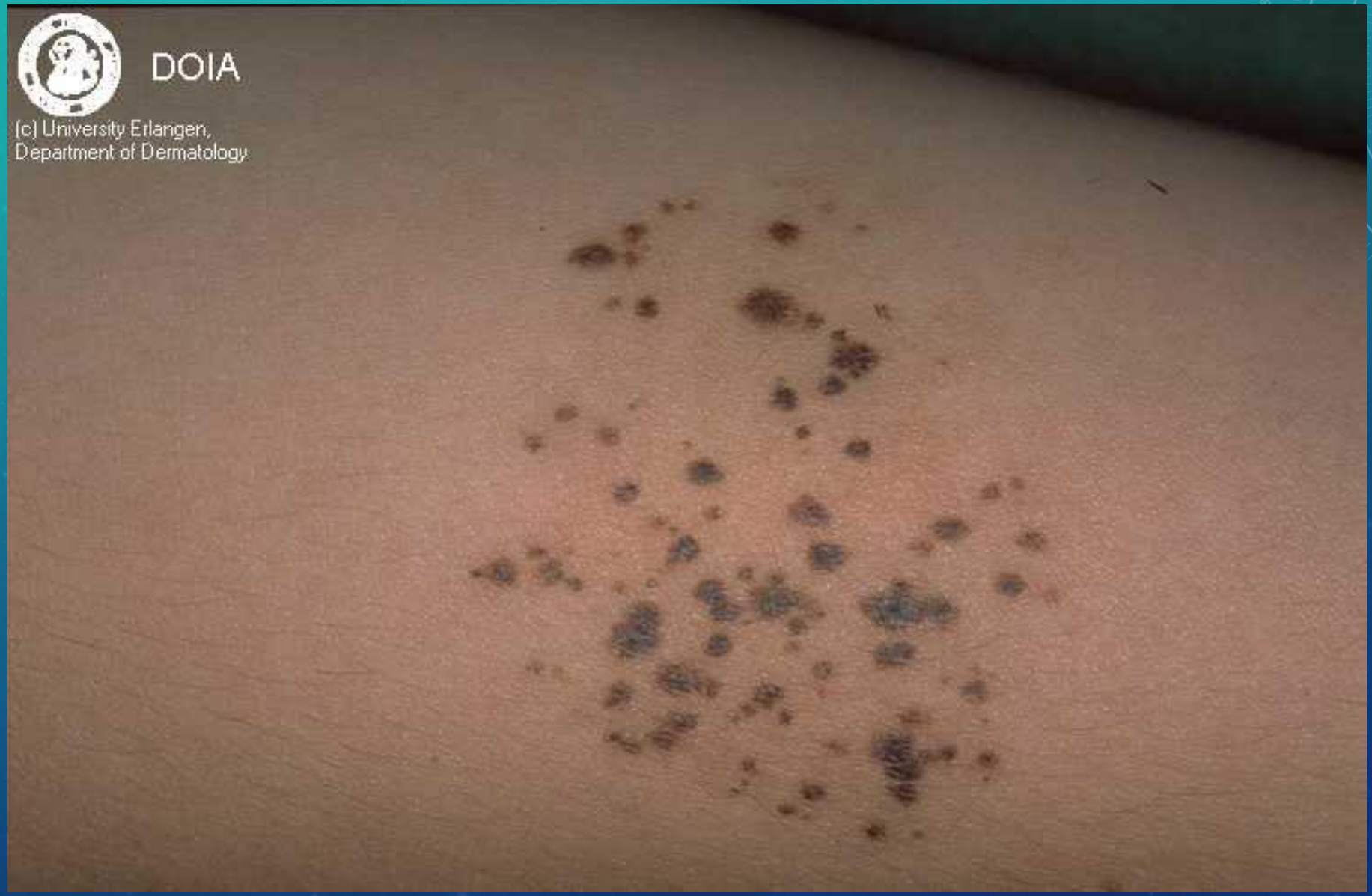
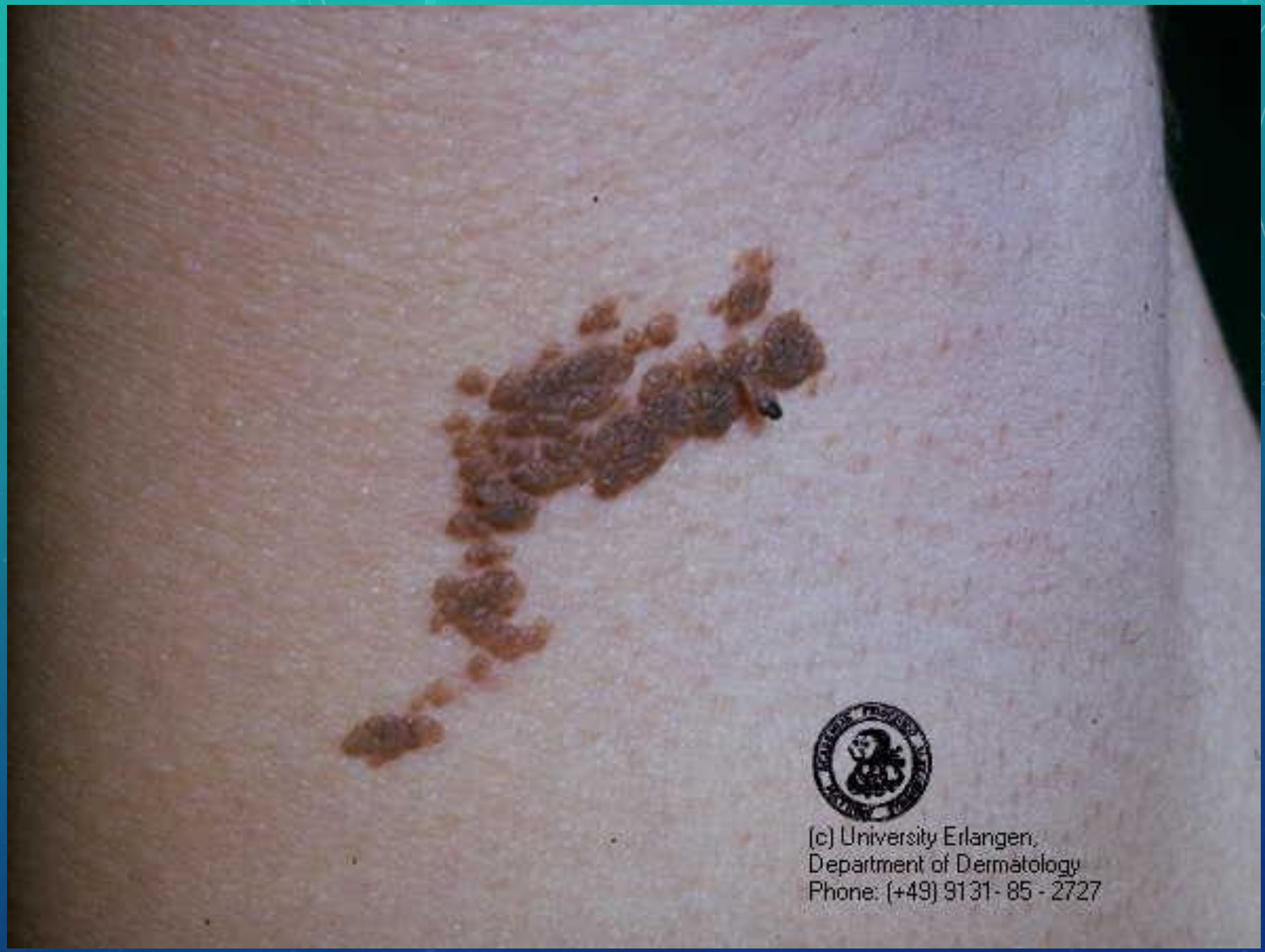
And this is …?



Nevus Spilus

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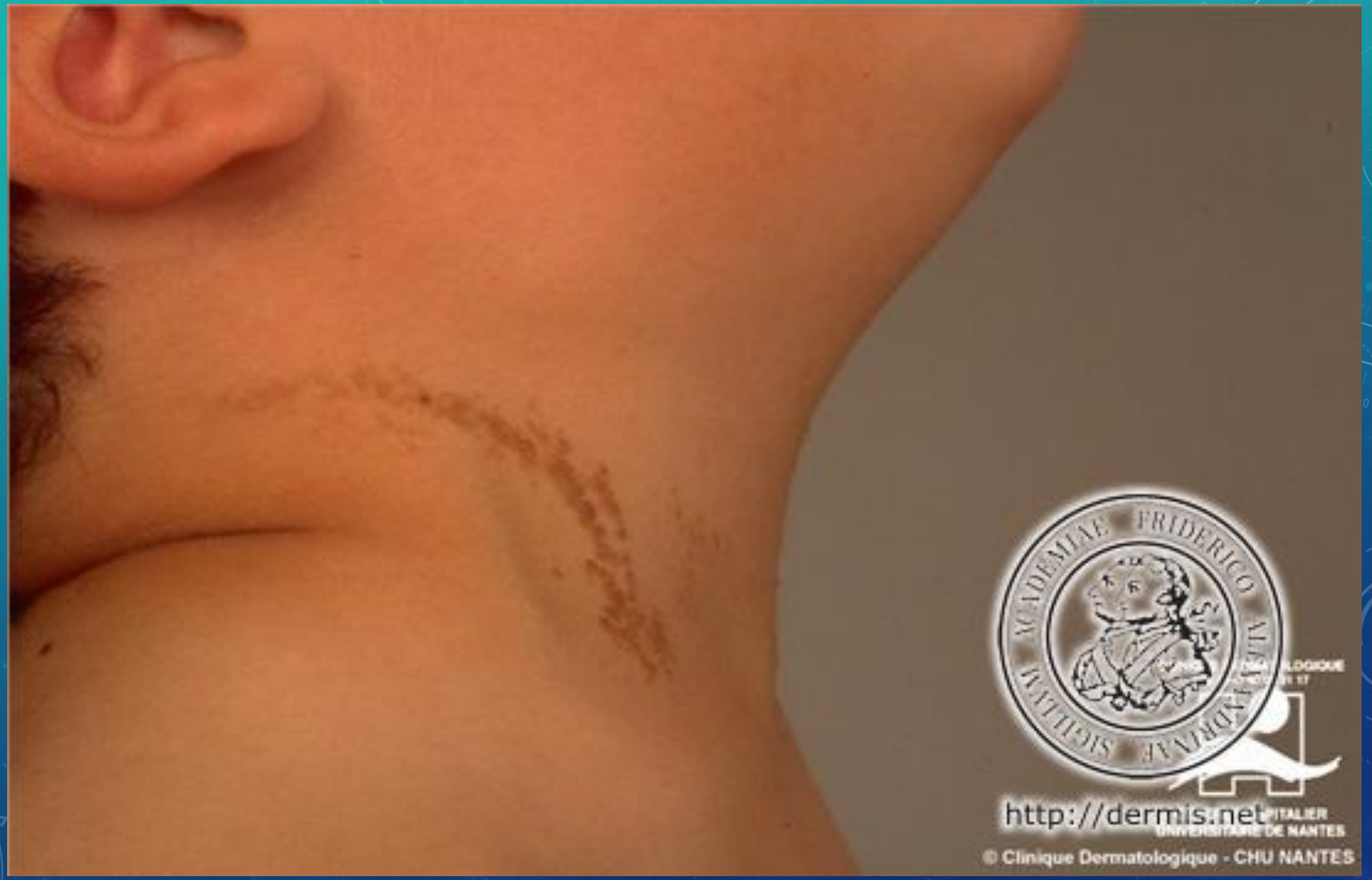
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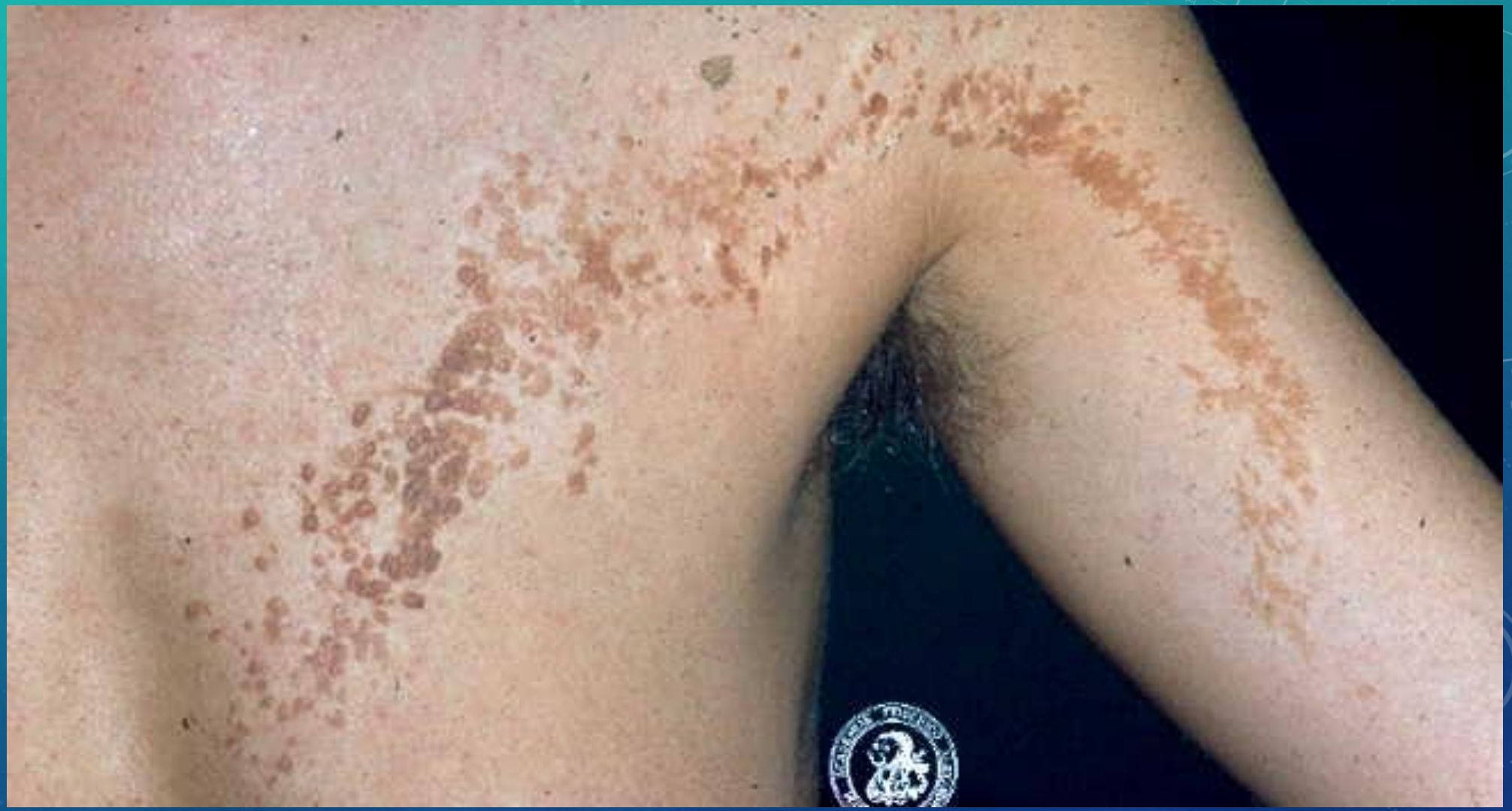
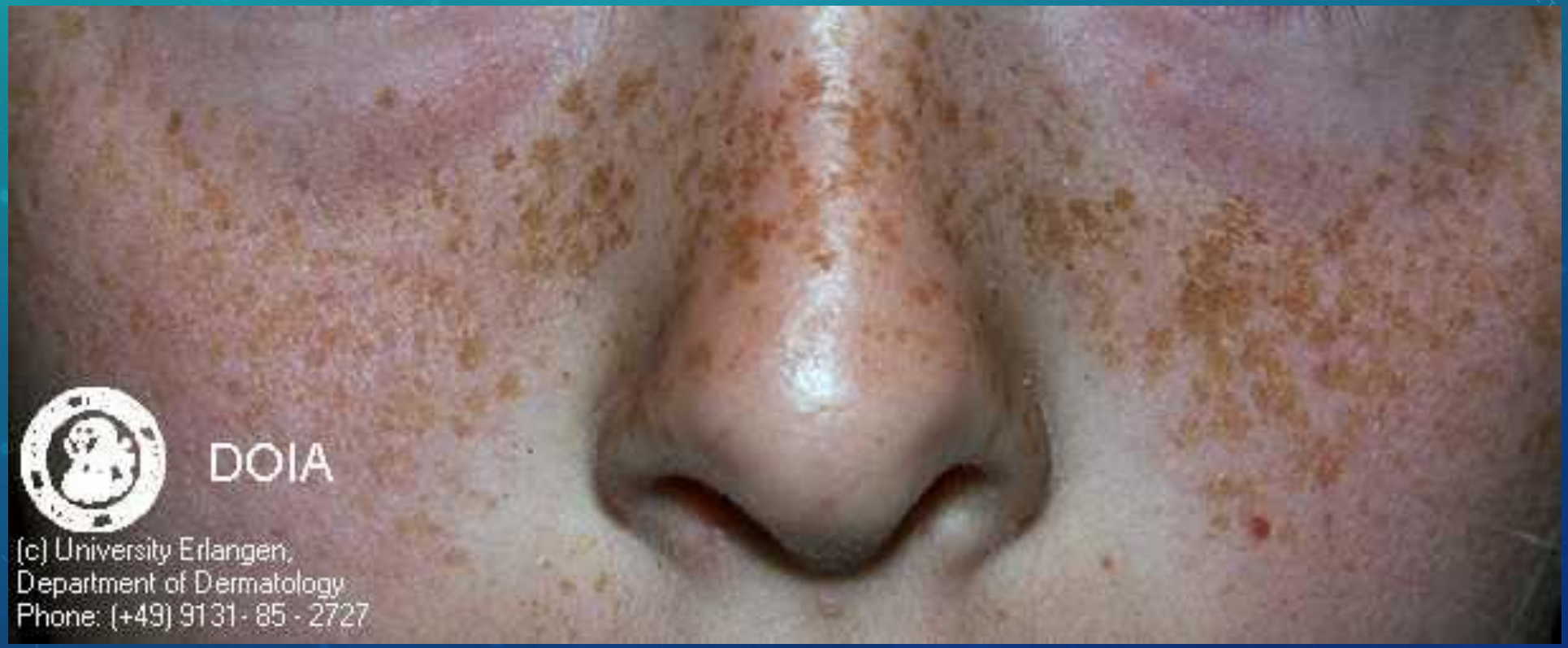
(Linear) Epidermal Nevus



What are these common splotches called?

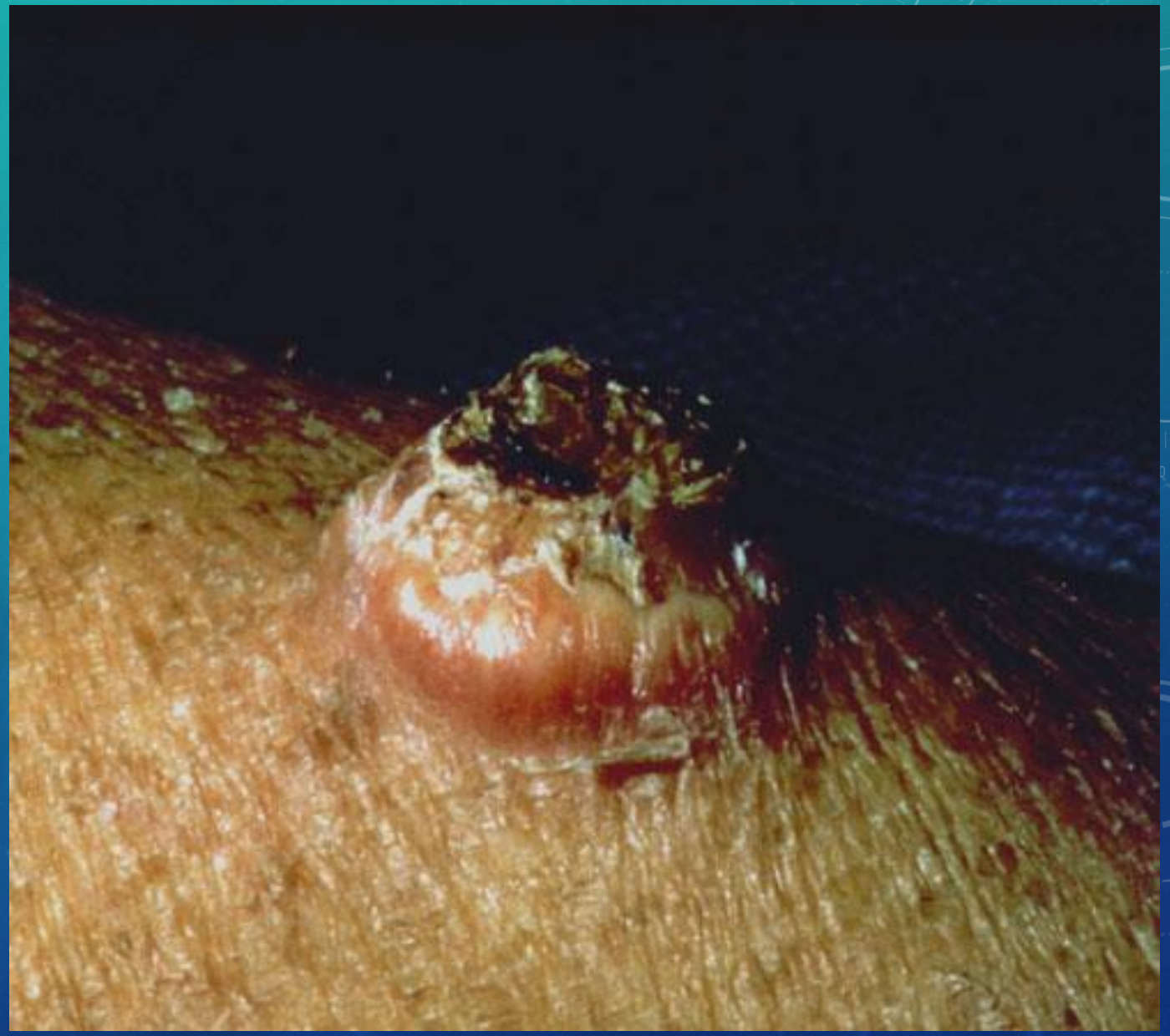
Ephelides … AKA Freckles

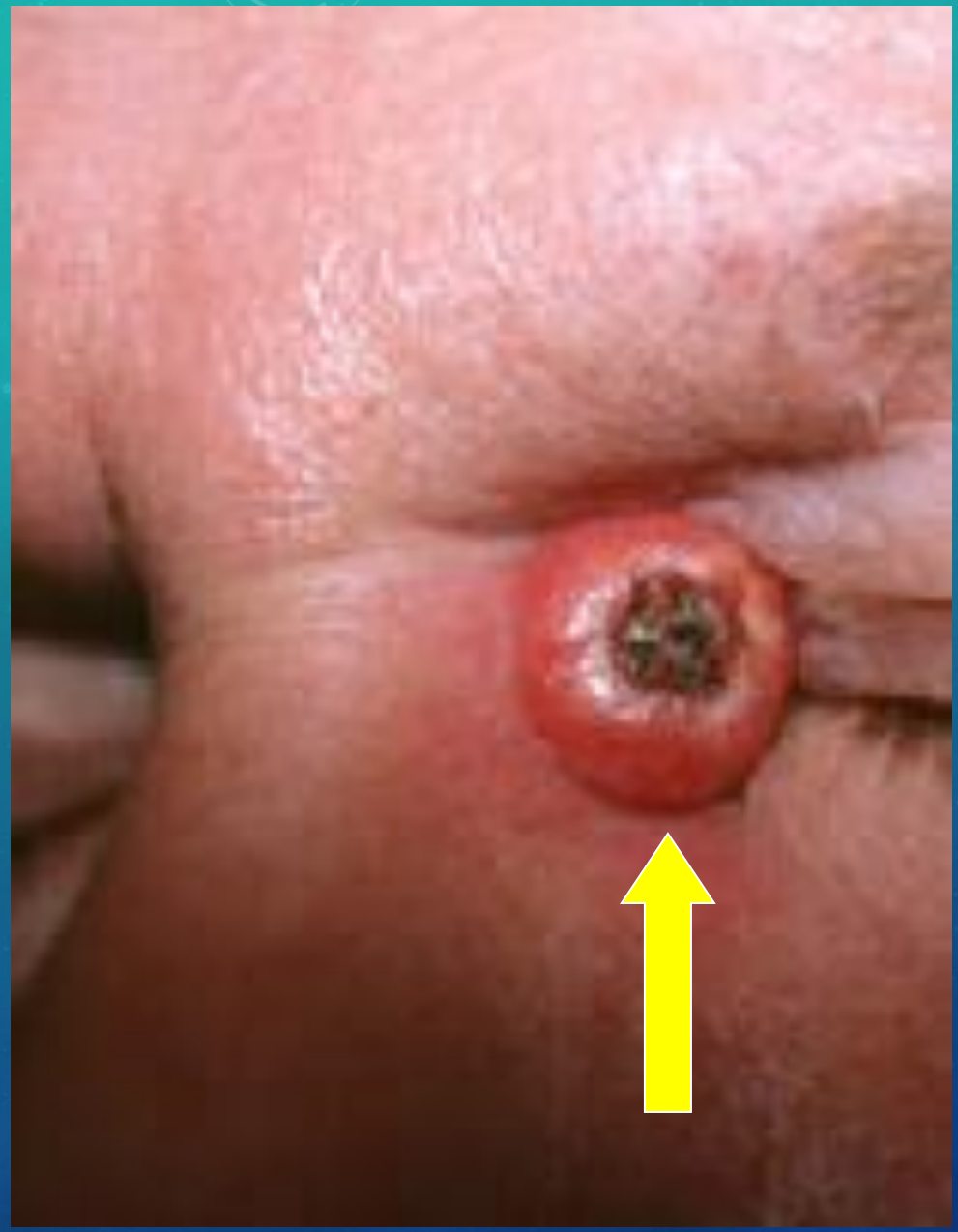


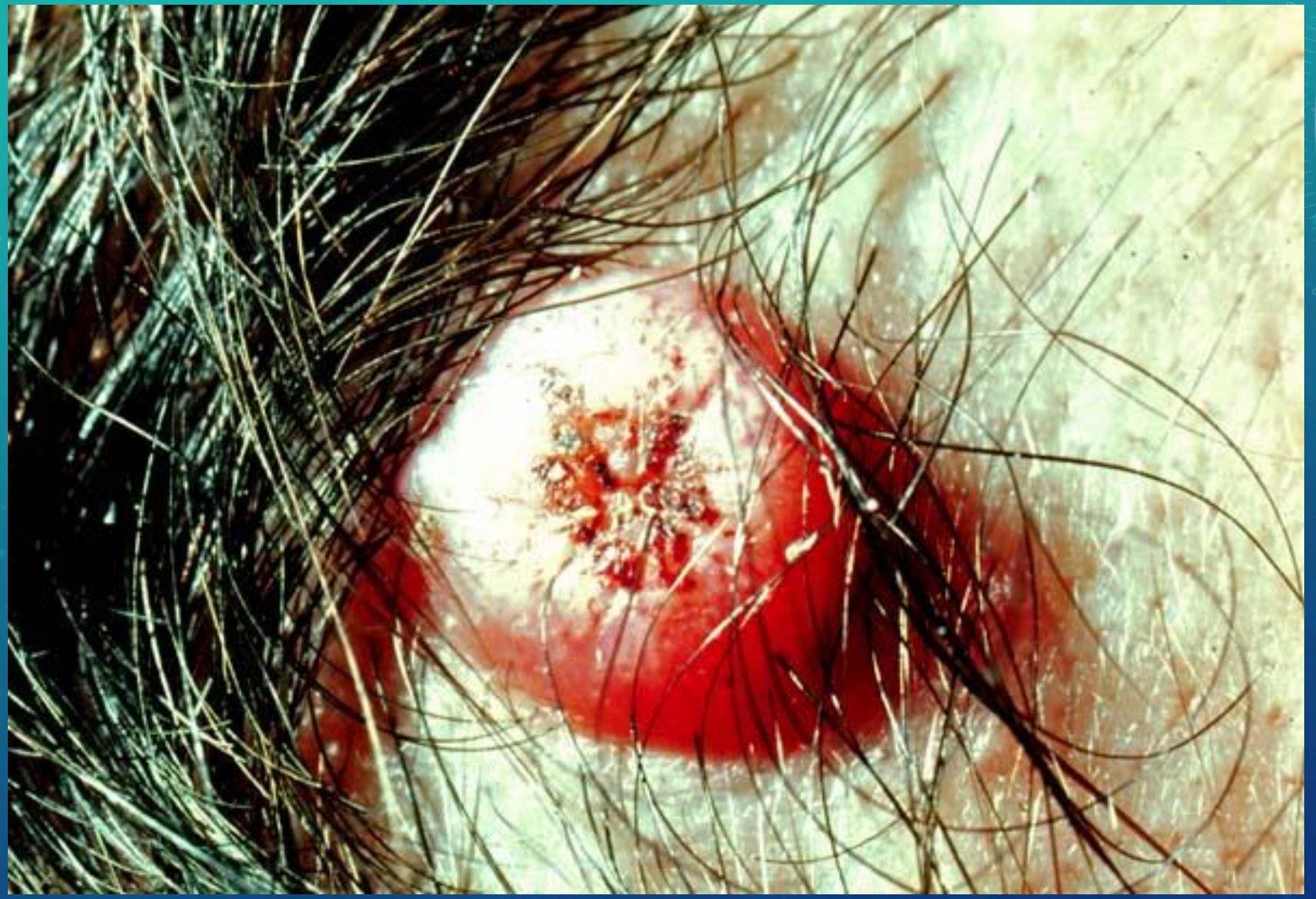
Asellus cowrie

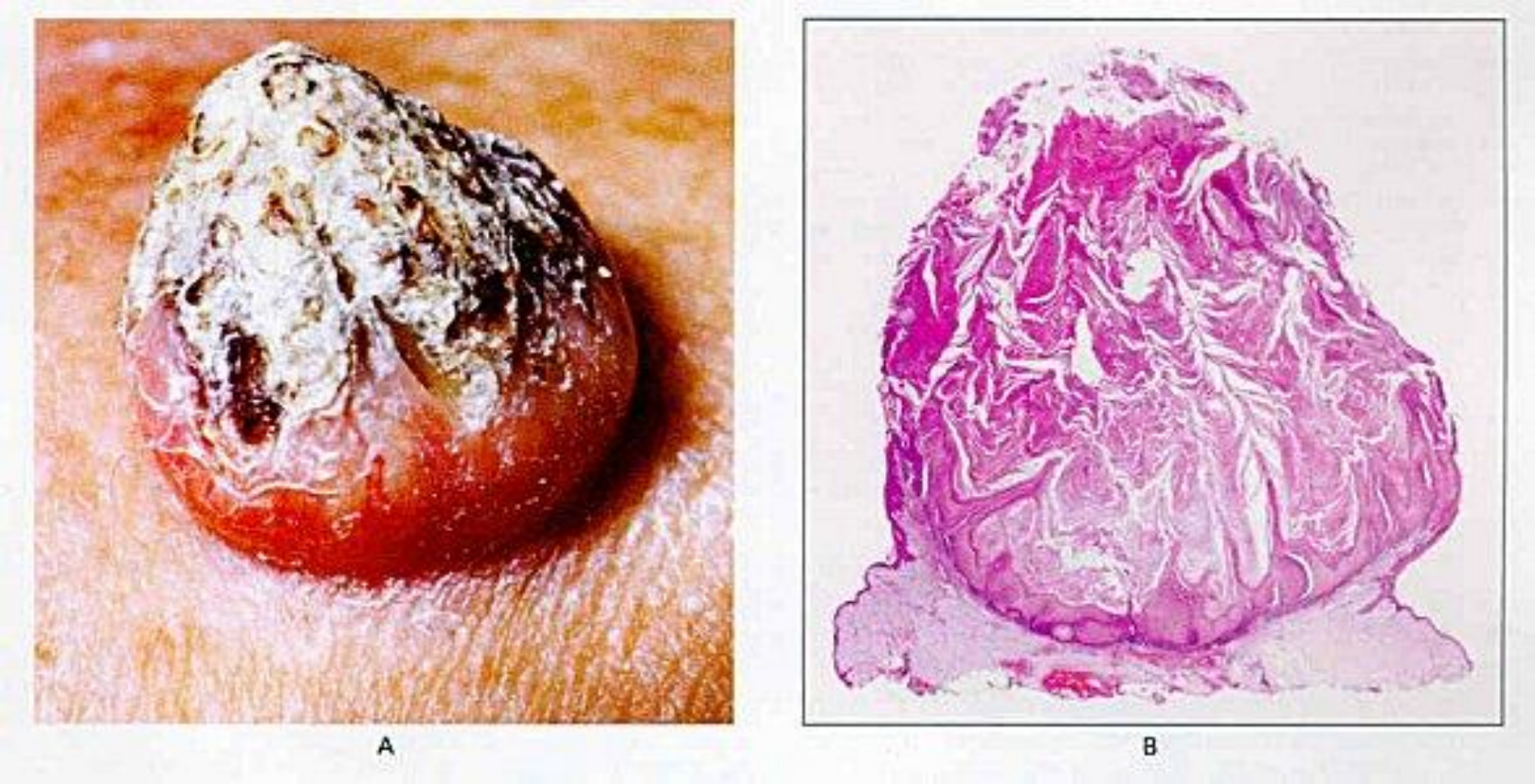
Hx: Appearance over 6-7 weeks

Normal skin previous





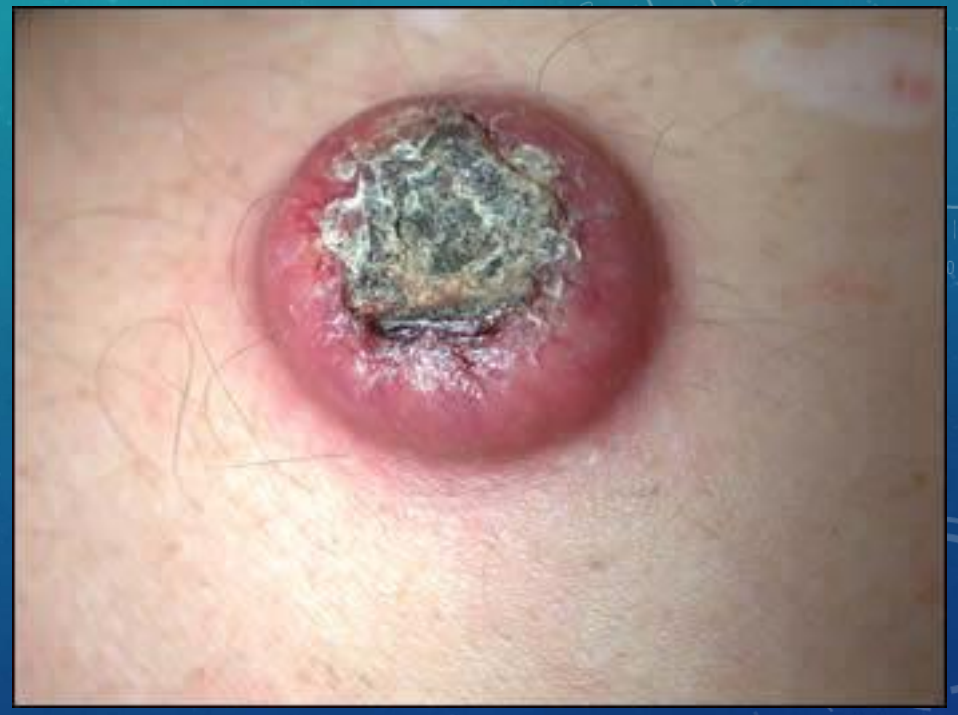




Looks like a volcano, doesn’t it?
So what could it be?

This lesion is most consistent with:

A. Keratoacanthoma
B. Basal cell cancer
C. Melanoma
D. Pyogenic granuloma



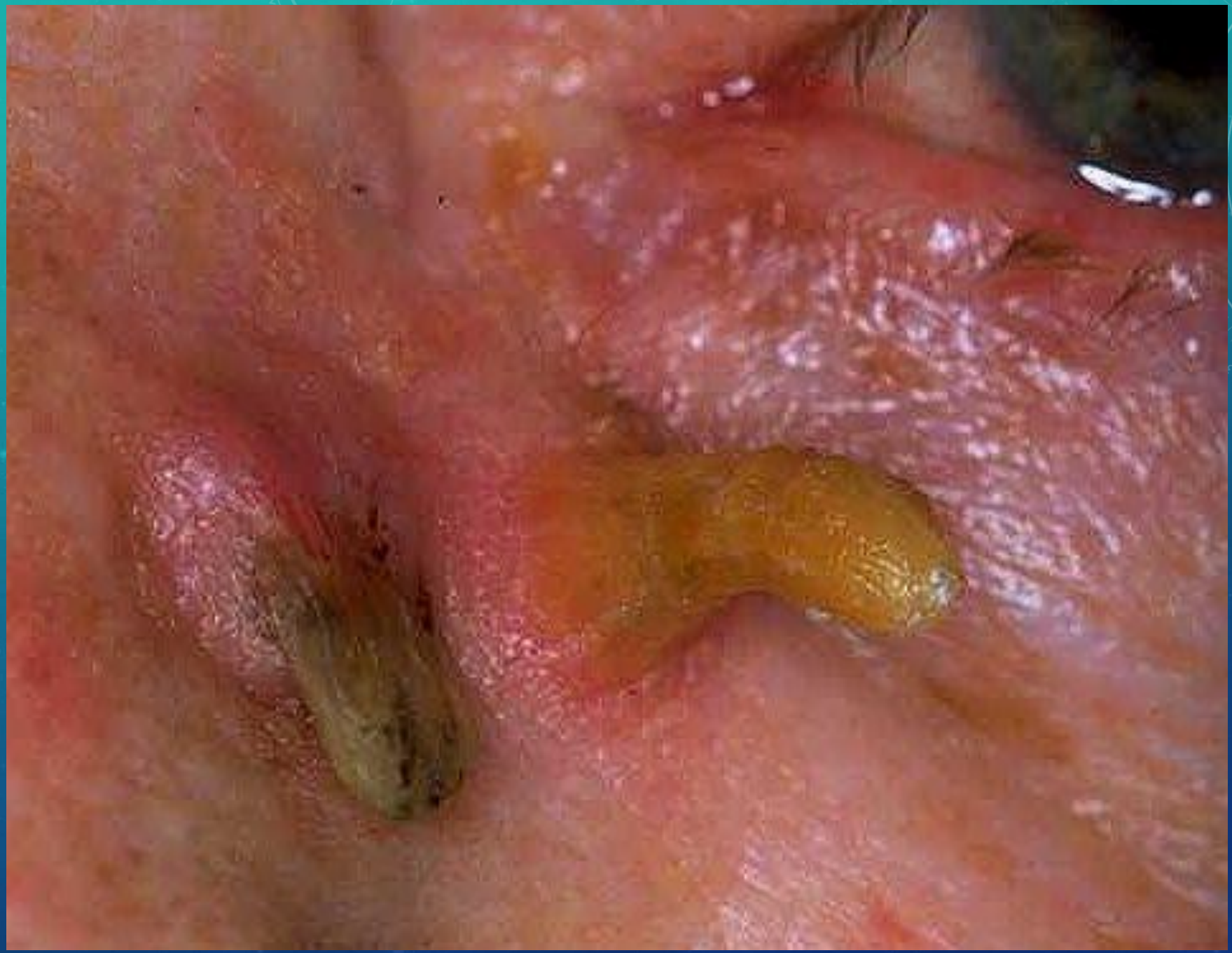
Diagnostic clues

- Rapid appearance over 6-8 weeks
- Central keratin core, like a volcano
- Usually appear in sun exposed areas
- More common in men

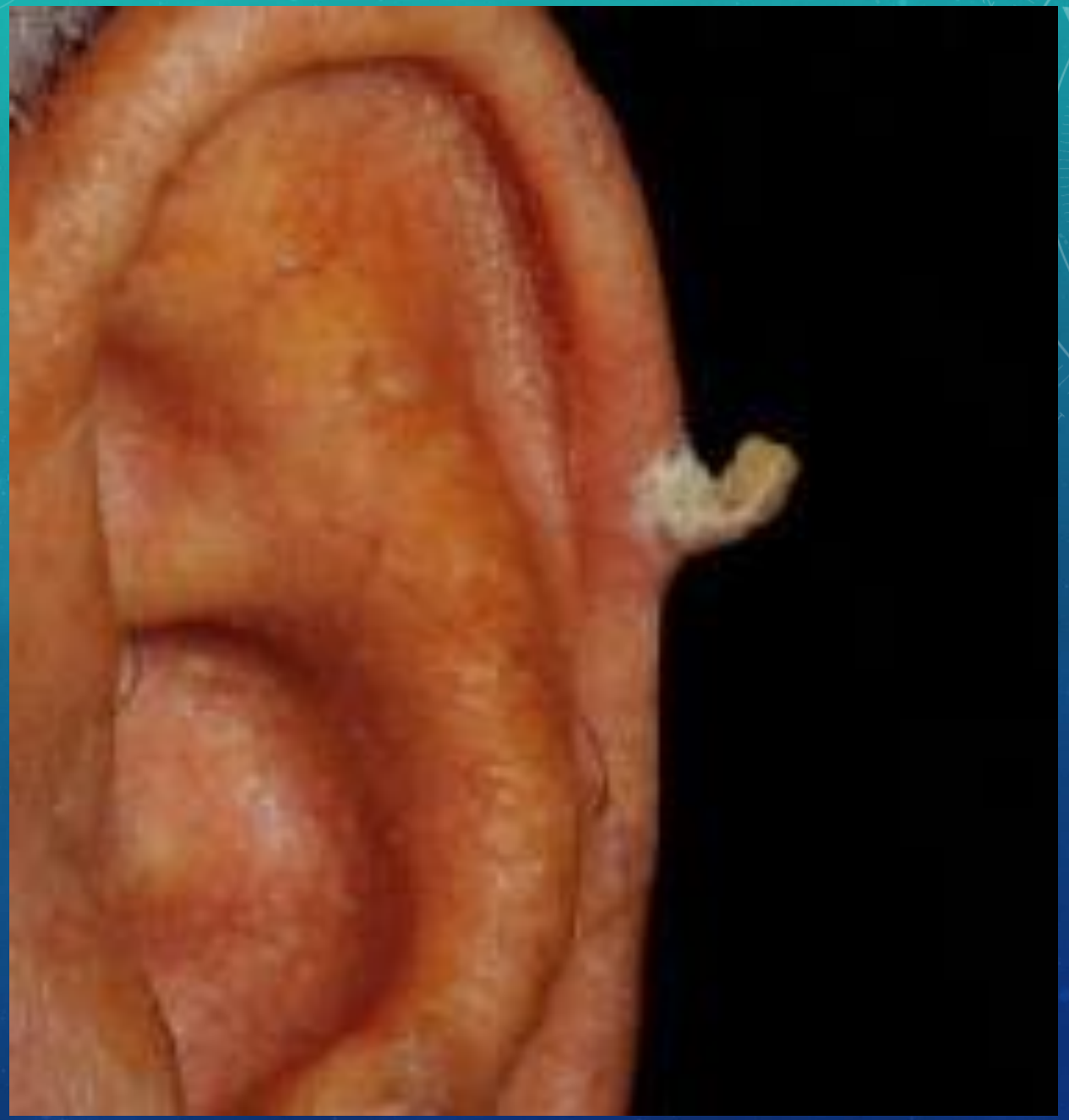
Treatment of keratoacanthoma

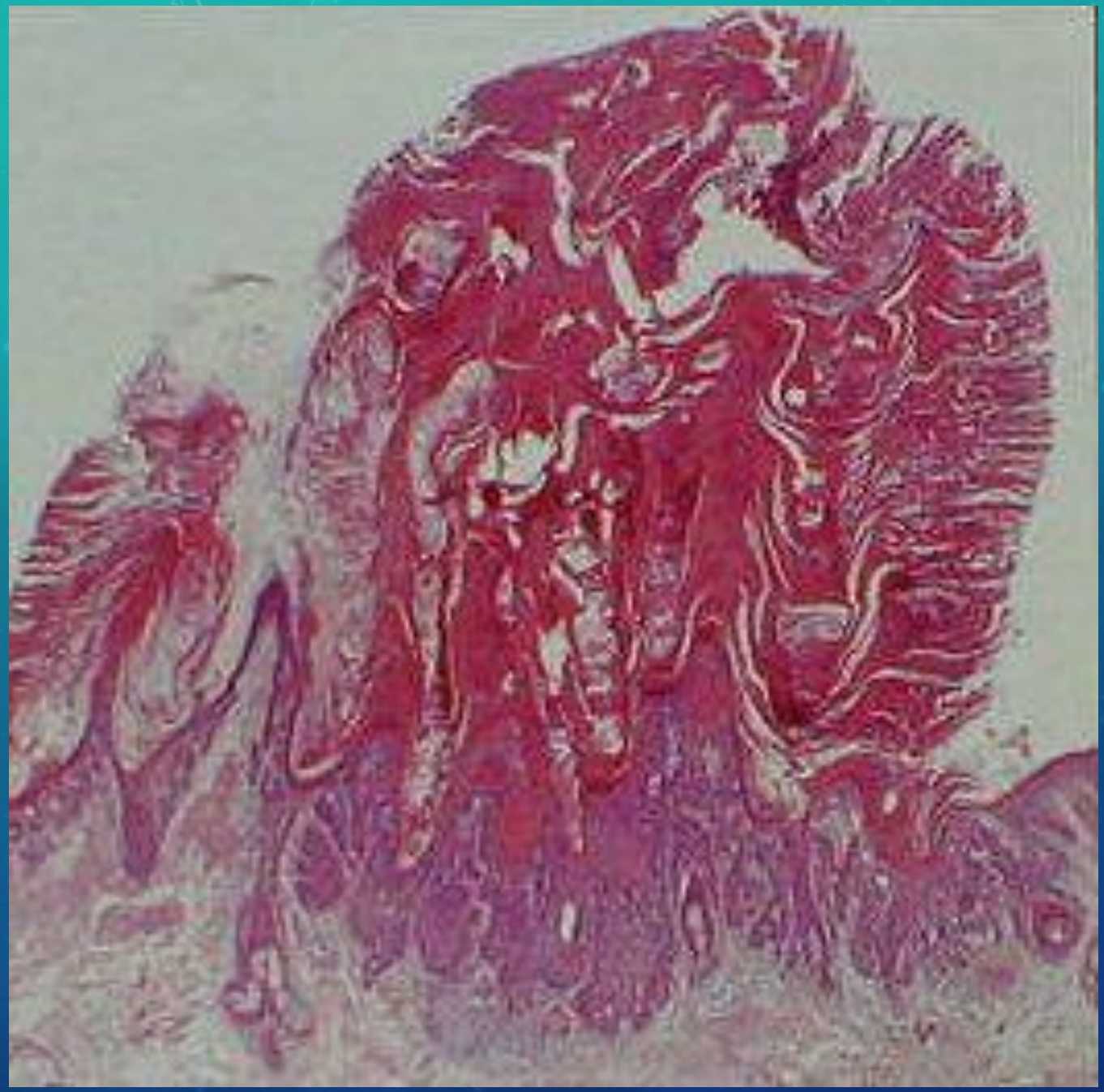
- KA is now classified as a type of squamous cell carcinoma: SCC-KA type
- Excise completely with 4-5 mm margins
- The history is key to making the diagnosis in that these **lesions appear rapidly**; they are not slow growing.

Here's a "horny" critter



Cutaneous horn



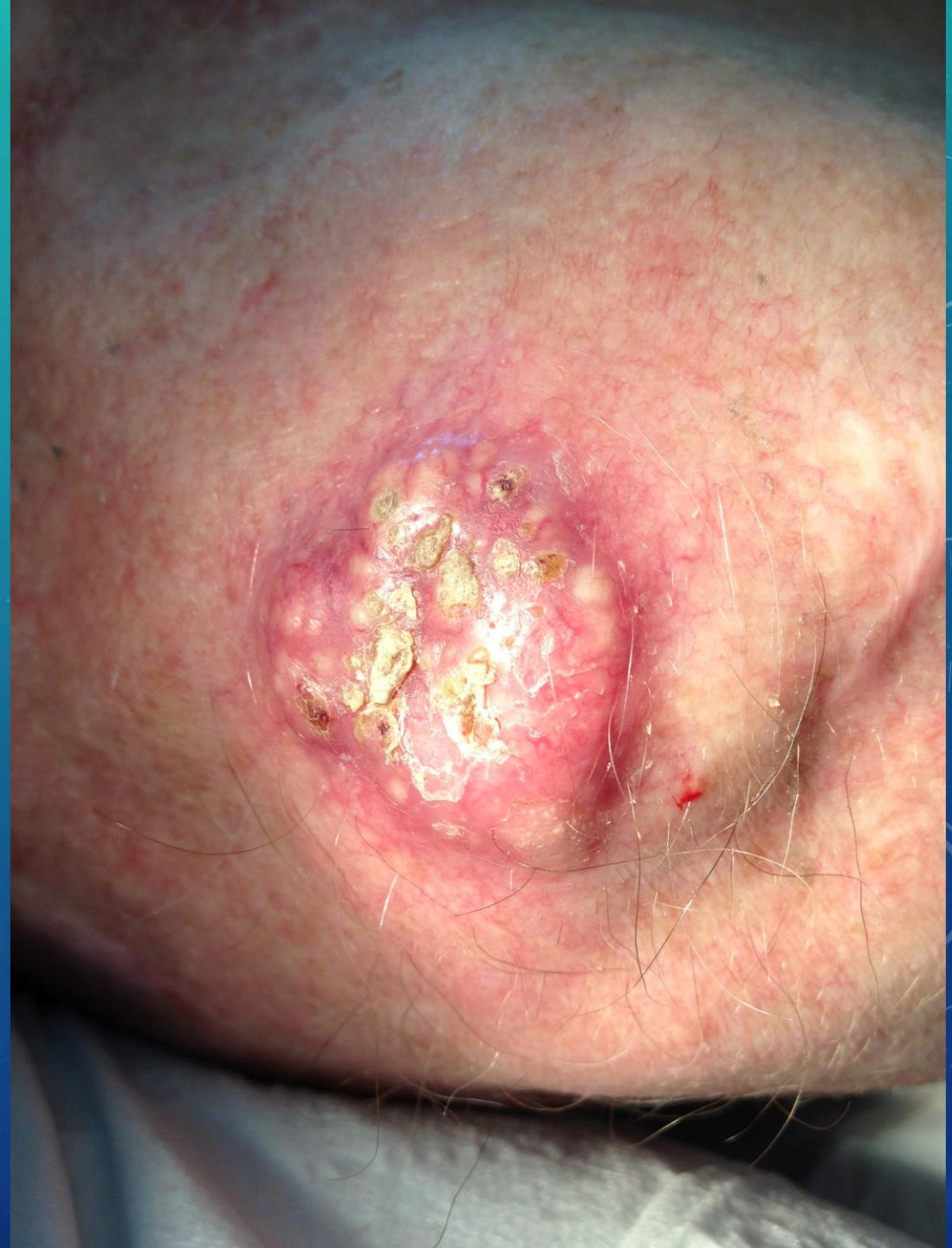


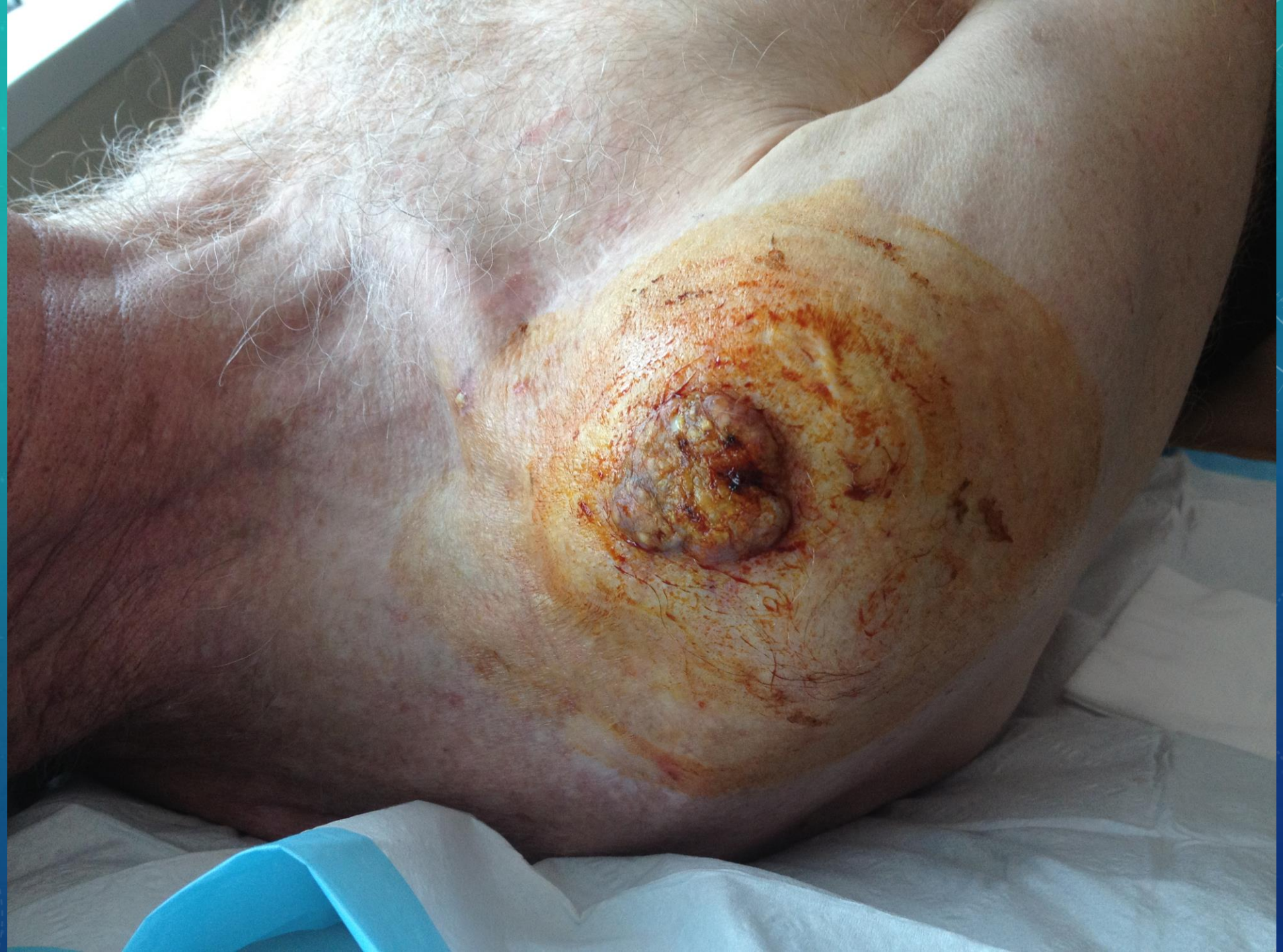
Cutaneous Horn

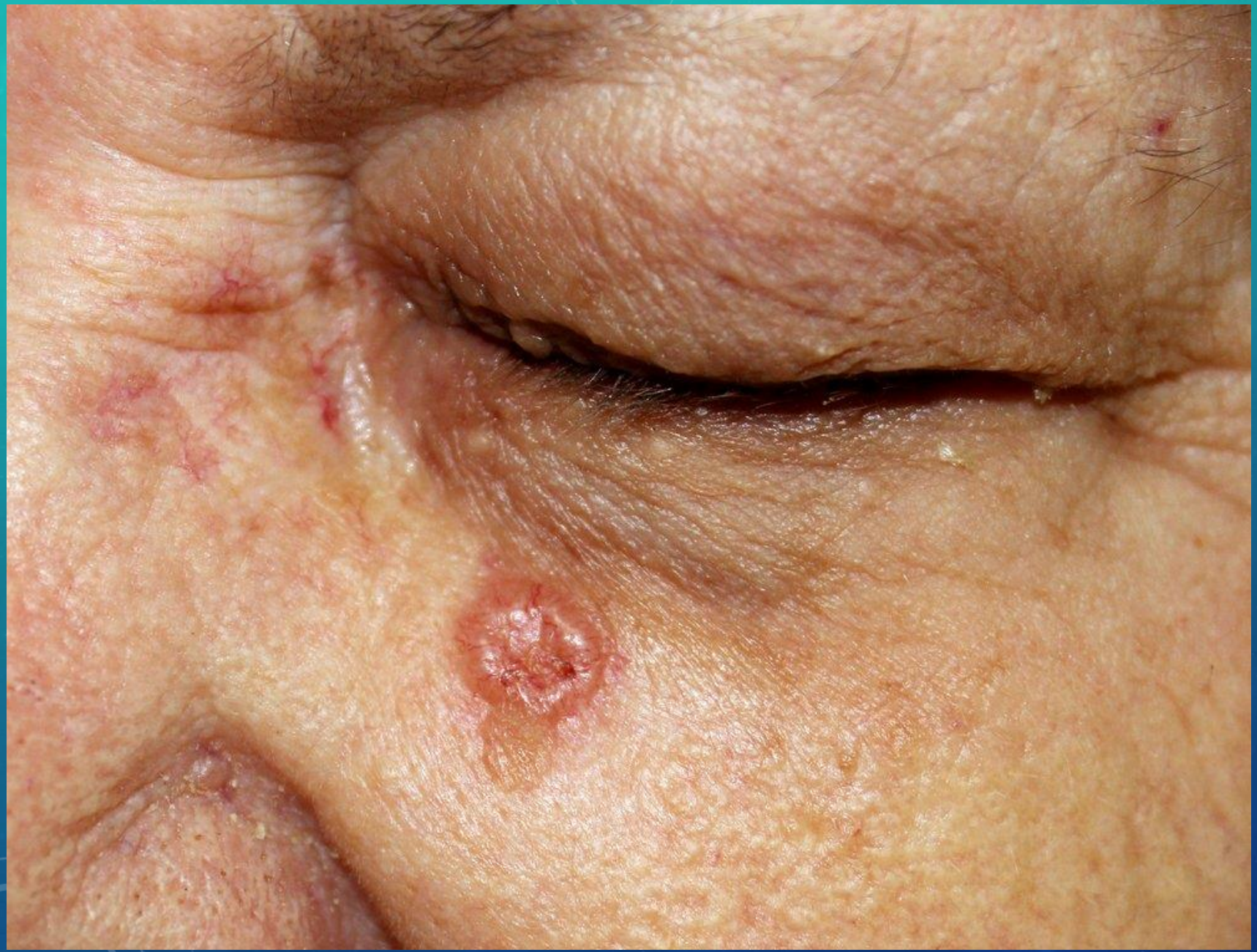
- Sharply excise these and send them for pathology to check for squamous cell cancer at the base.

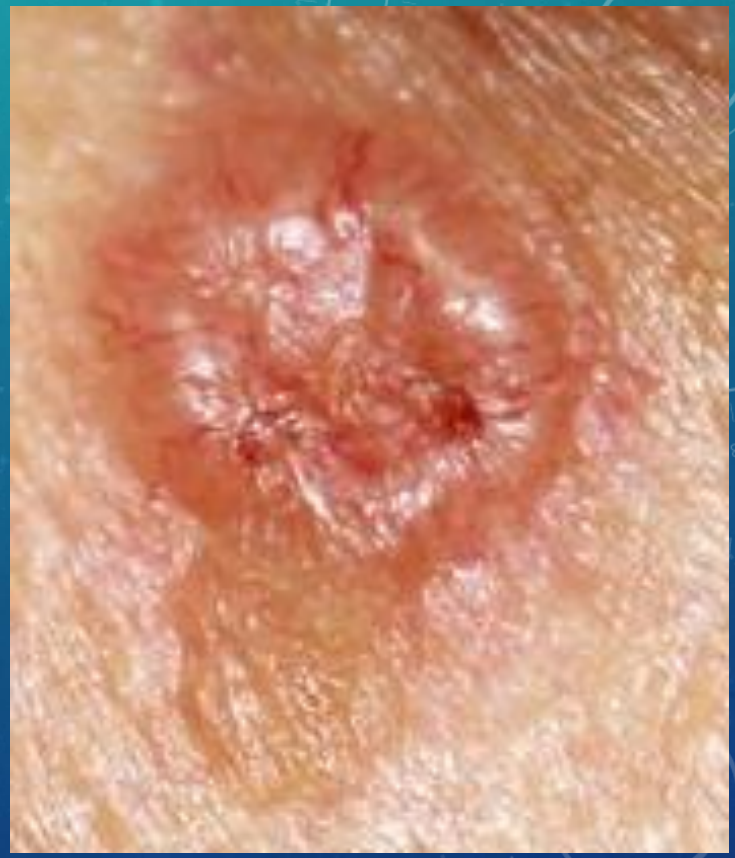
66 yo male with a large mass on his right shoulder for months/ years? What is the most likely diagnosis?

A. Smoldering abscess
B. Basal cell cancer
C. Squamous cell cancer
D. Infected lipoma



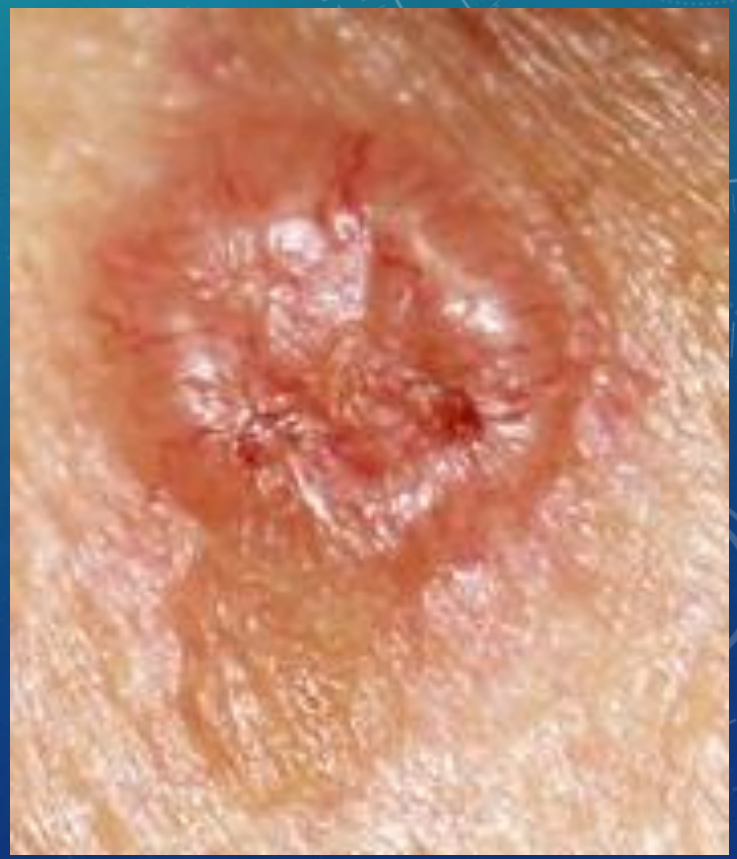


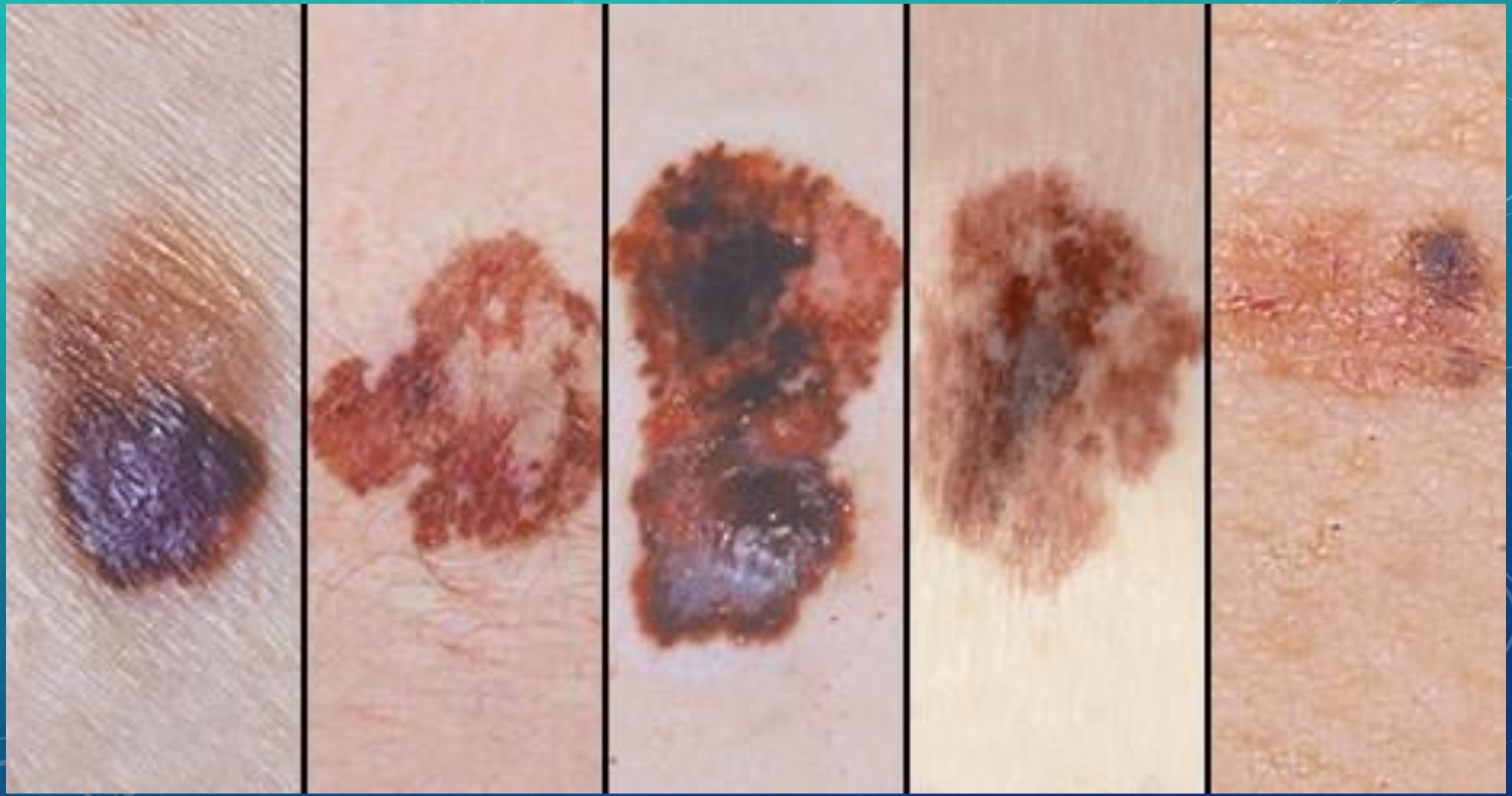


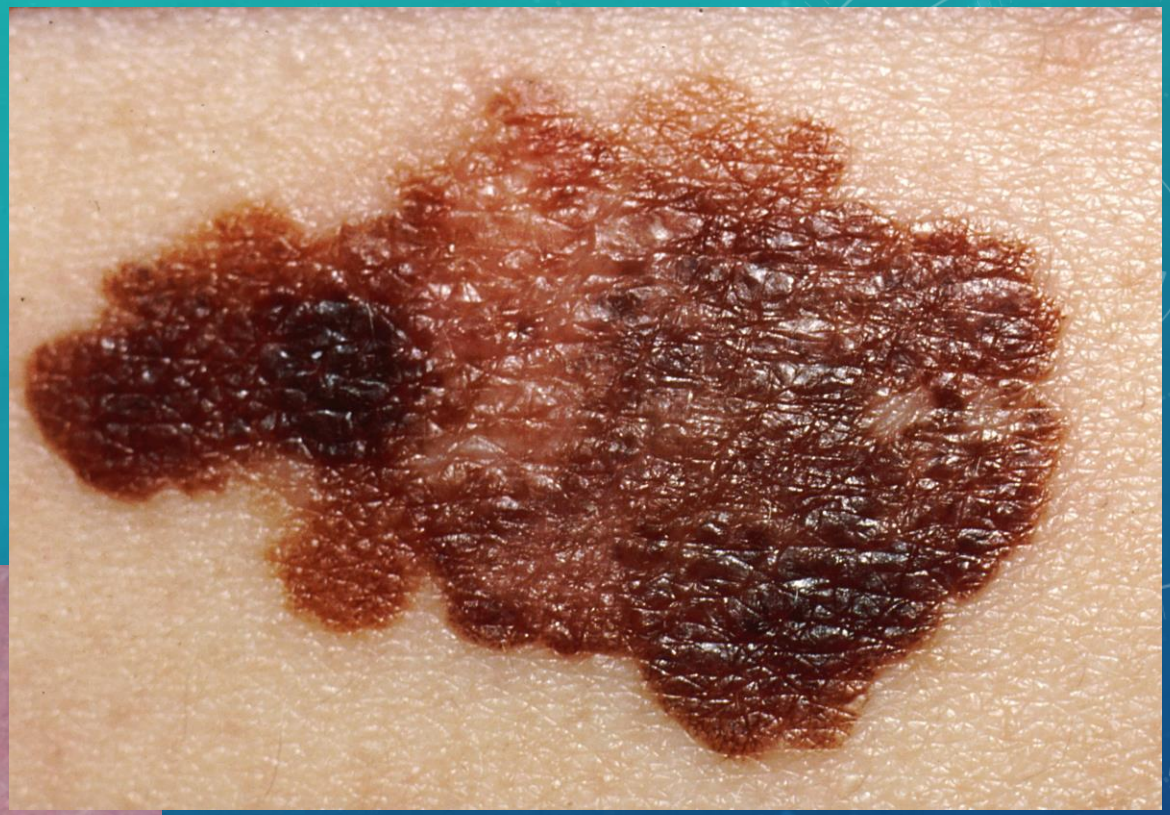


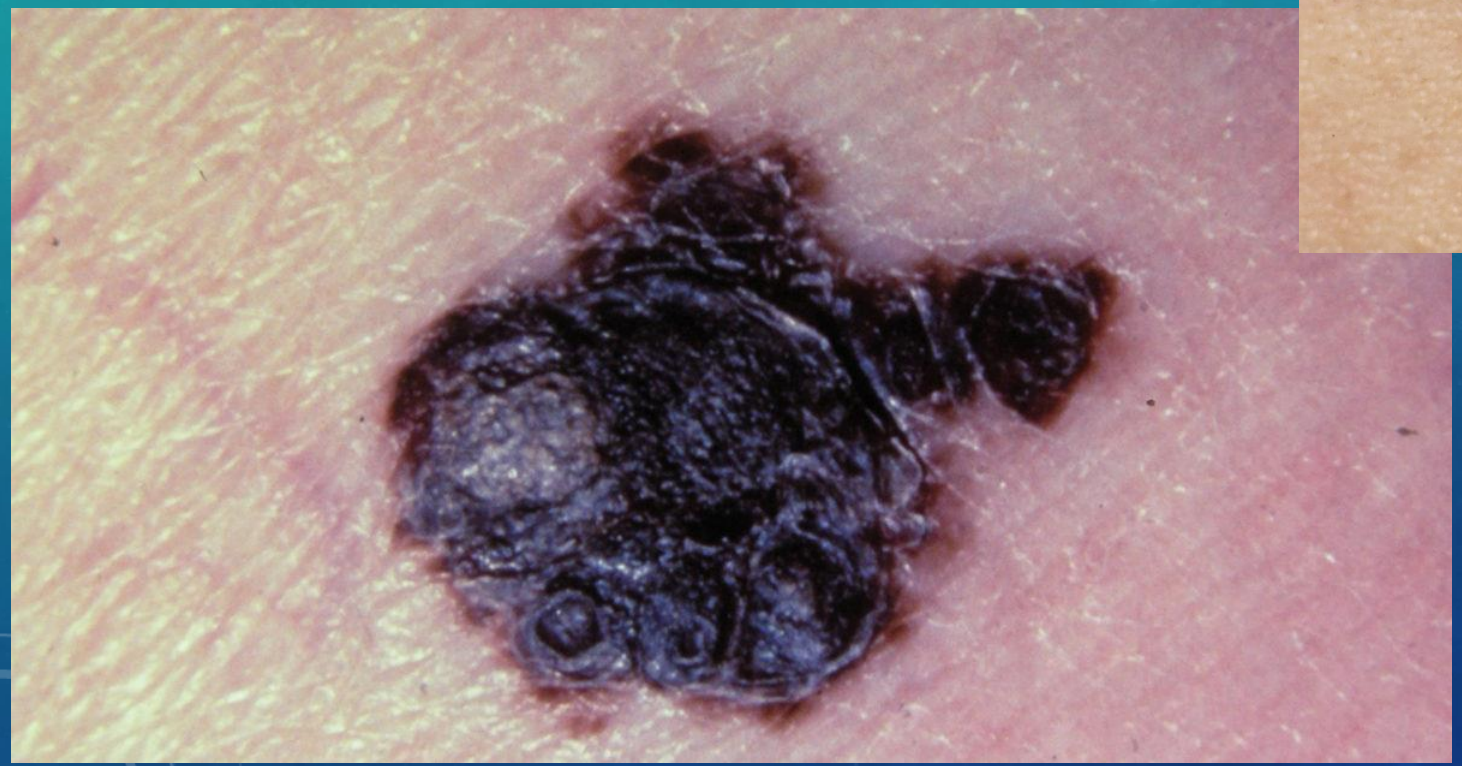
65 yo female with lesion below her left eye for 2 years. What is the most likely diagnosis?

A. Basal cell cancer
B. Squamous cell cancer
C. Amelanotic melanoma
D. Seborrheic keratosis in evolution



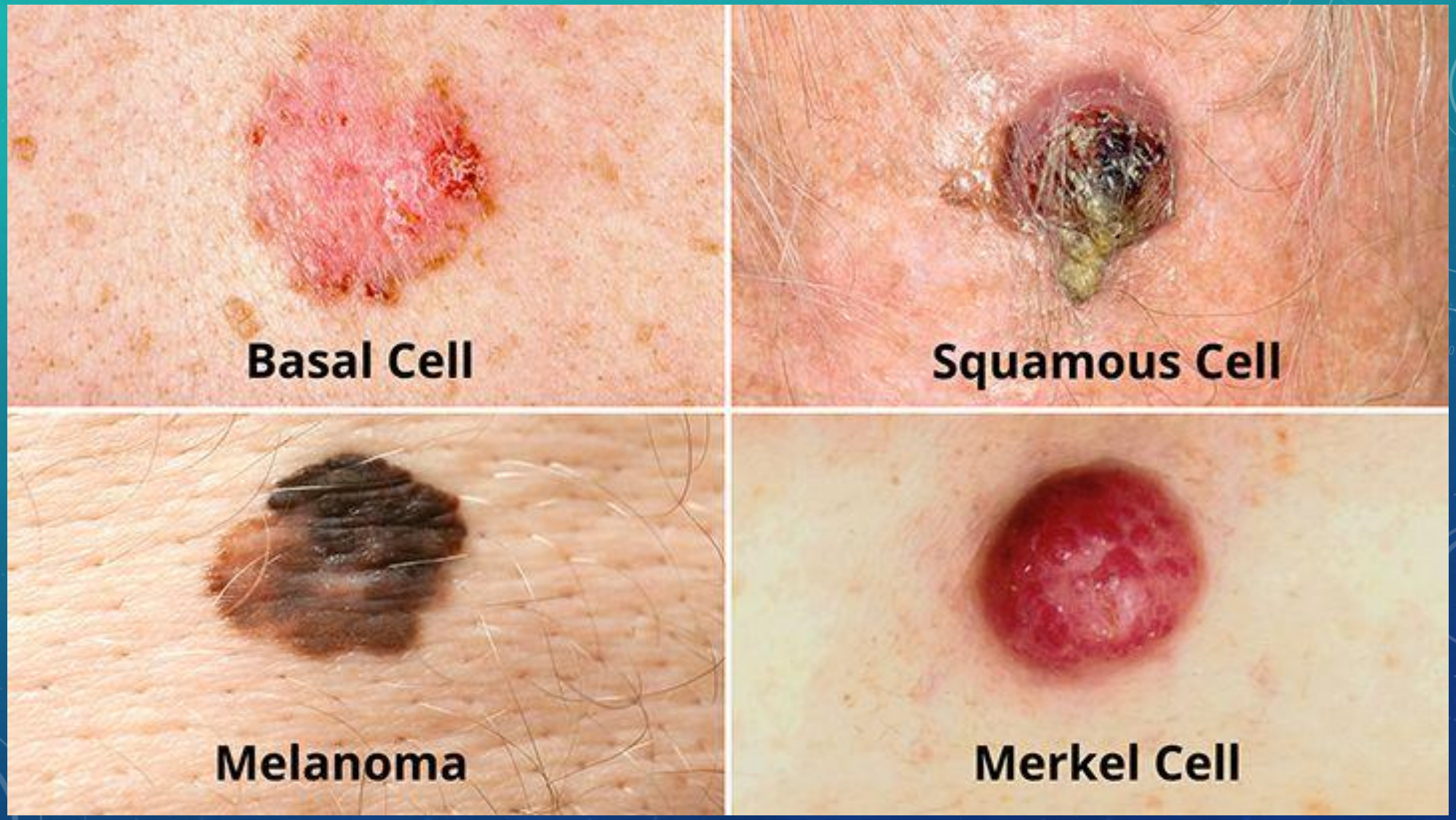






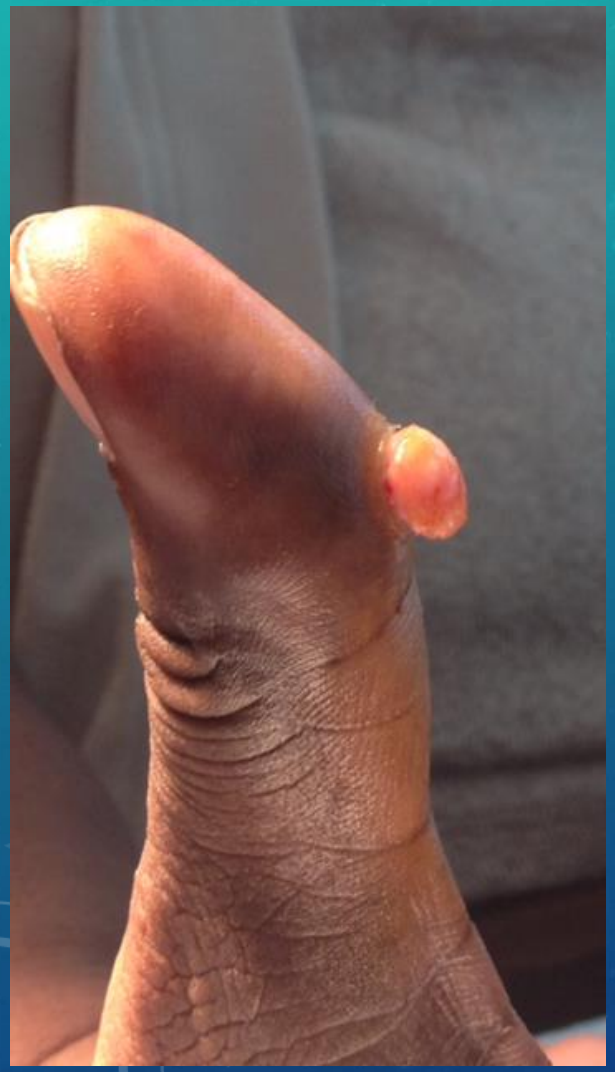
Melanoma ABCDEs

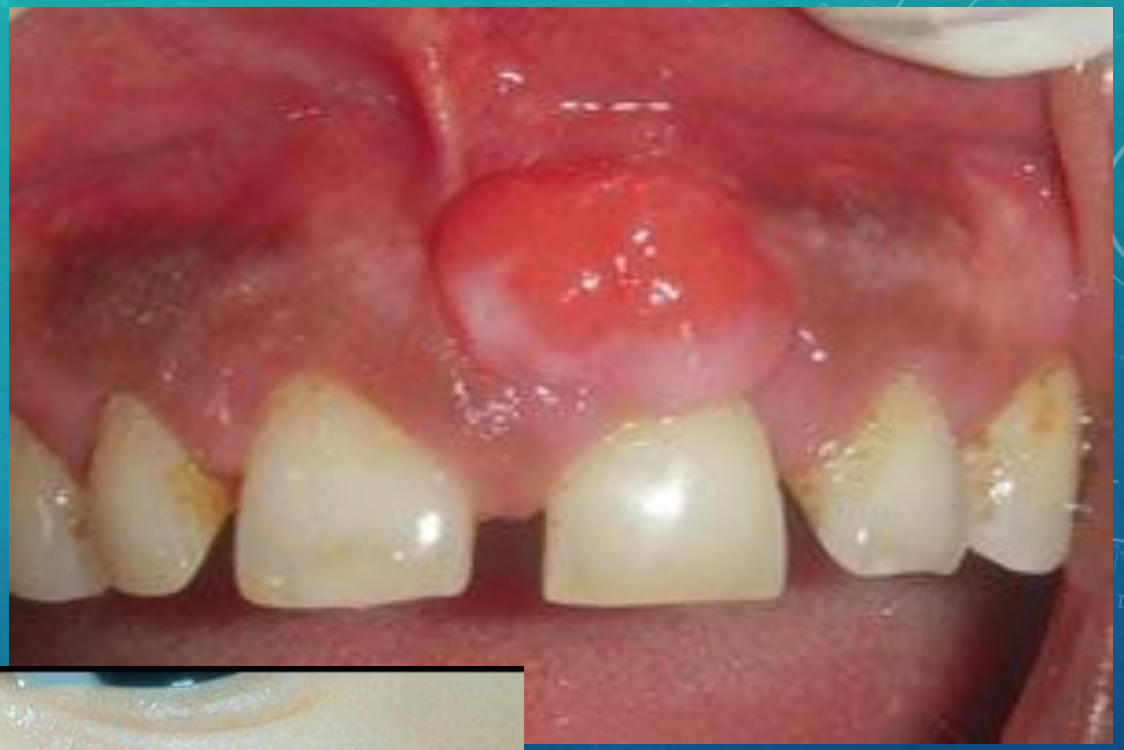
- Asymmetry
- Border irregularity
- Color variegation (different colors)
- Diameter > 6 mm – the diameter of a pencil eraser
- Evolution – changing lesion

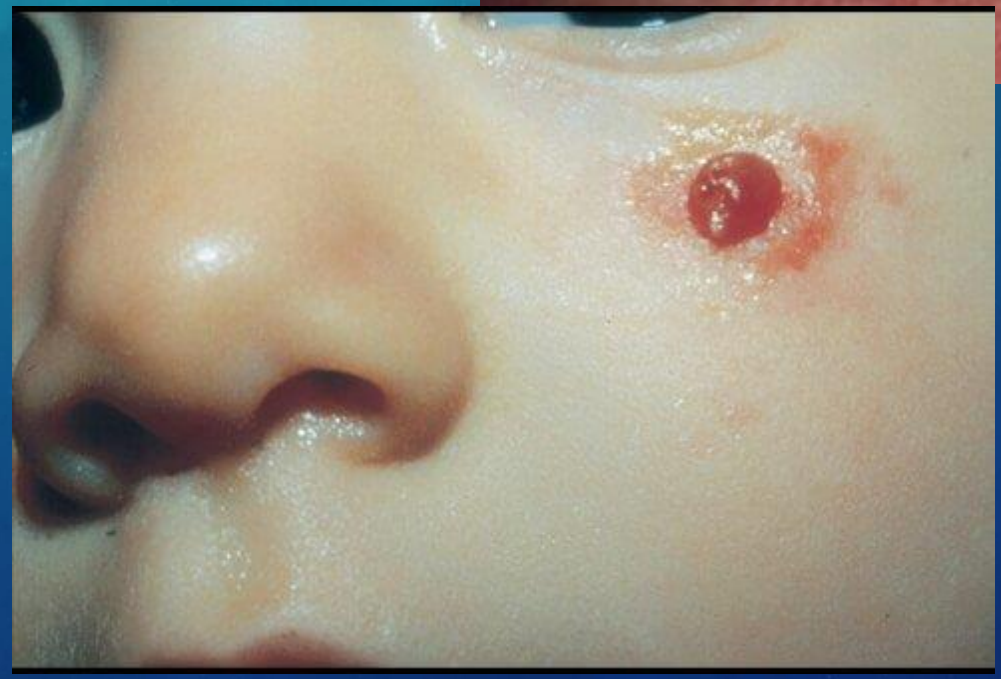

Basal Cell
Squamous Cell
Melanoma
Merkel Cell

Sieve cowry

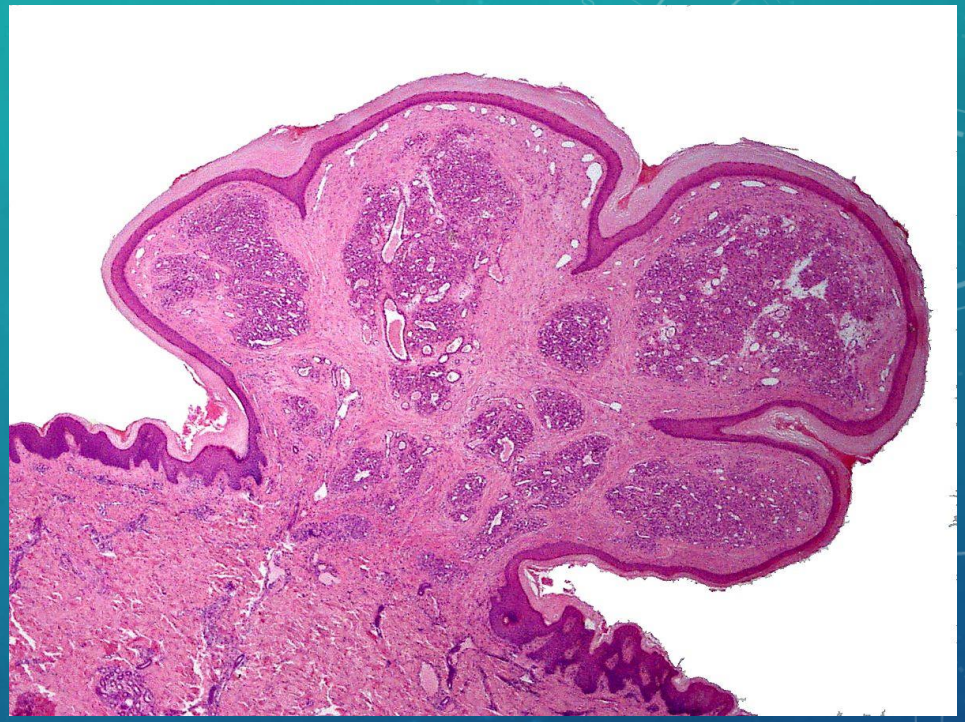
Pyogenic granuloma



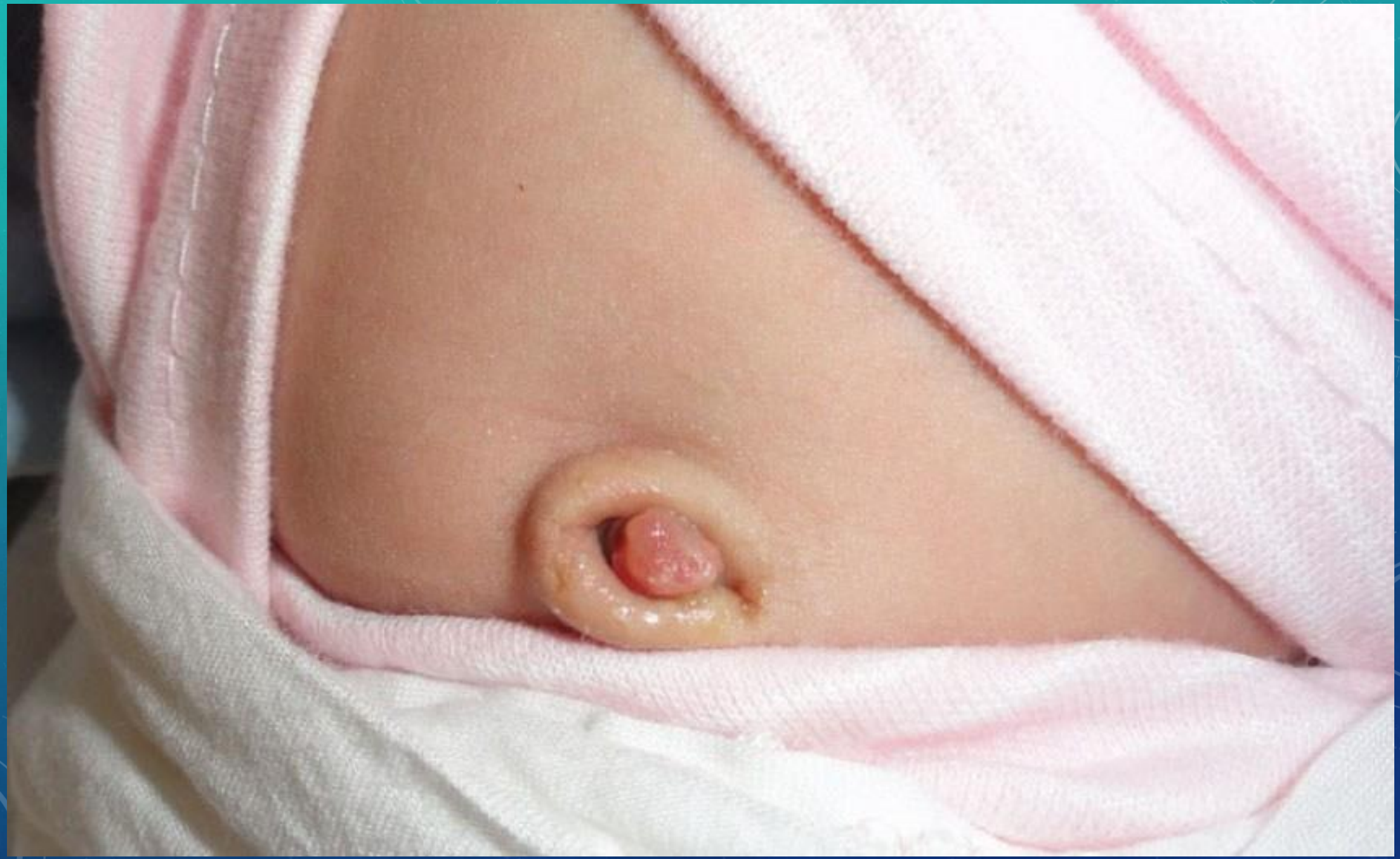




Pyogenic granuloma



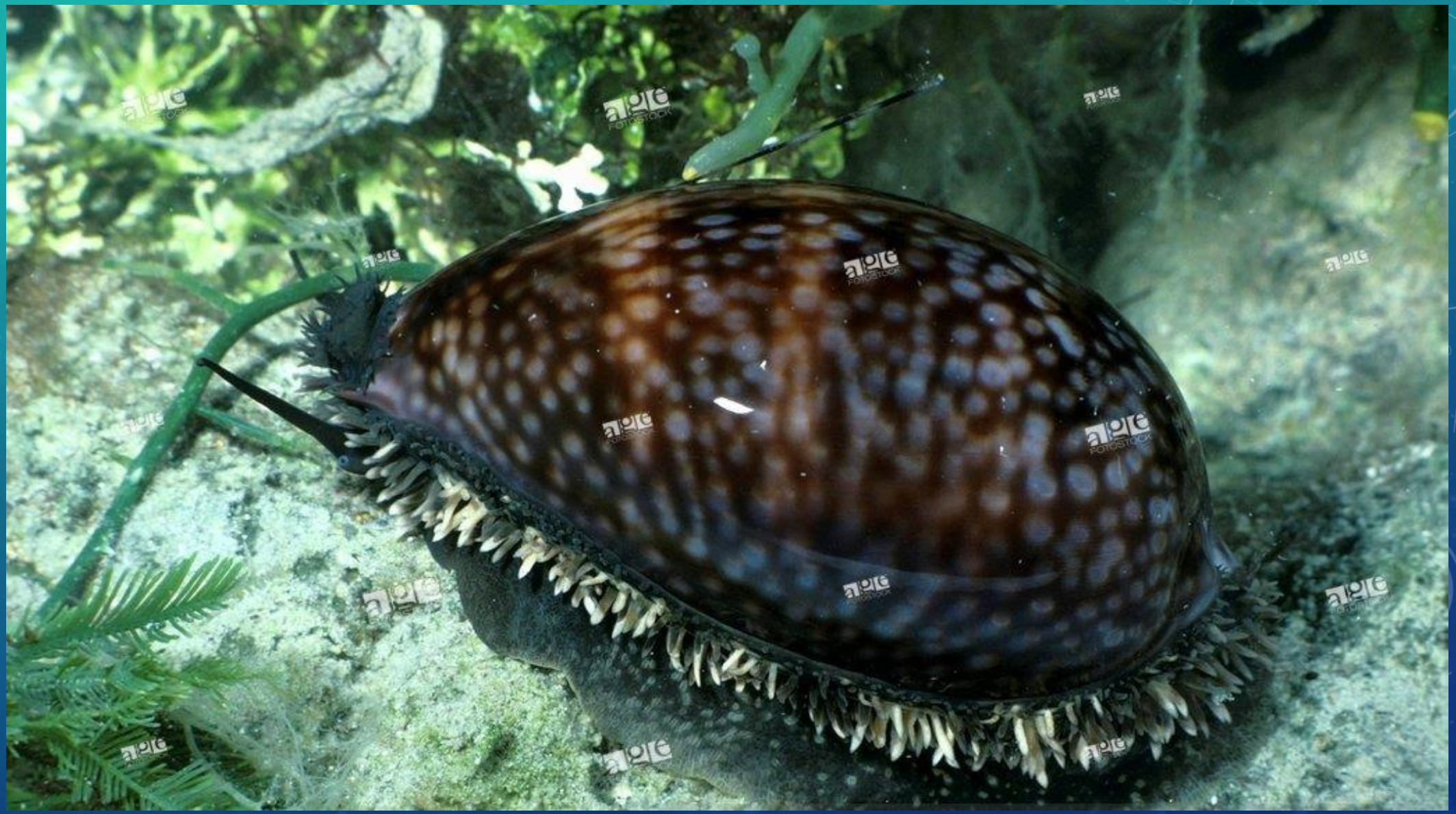
- Short time to appear
- Often recedes spontaneously
- Mucus membranes – oral and vaginal
- If bothersome of diagnosis unclear, excisional biopsy



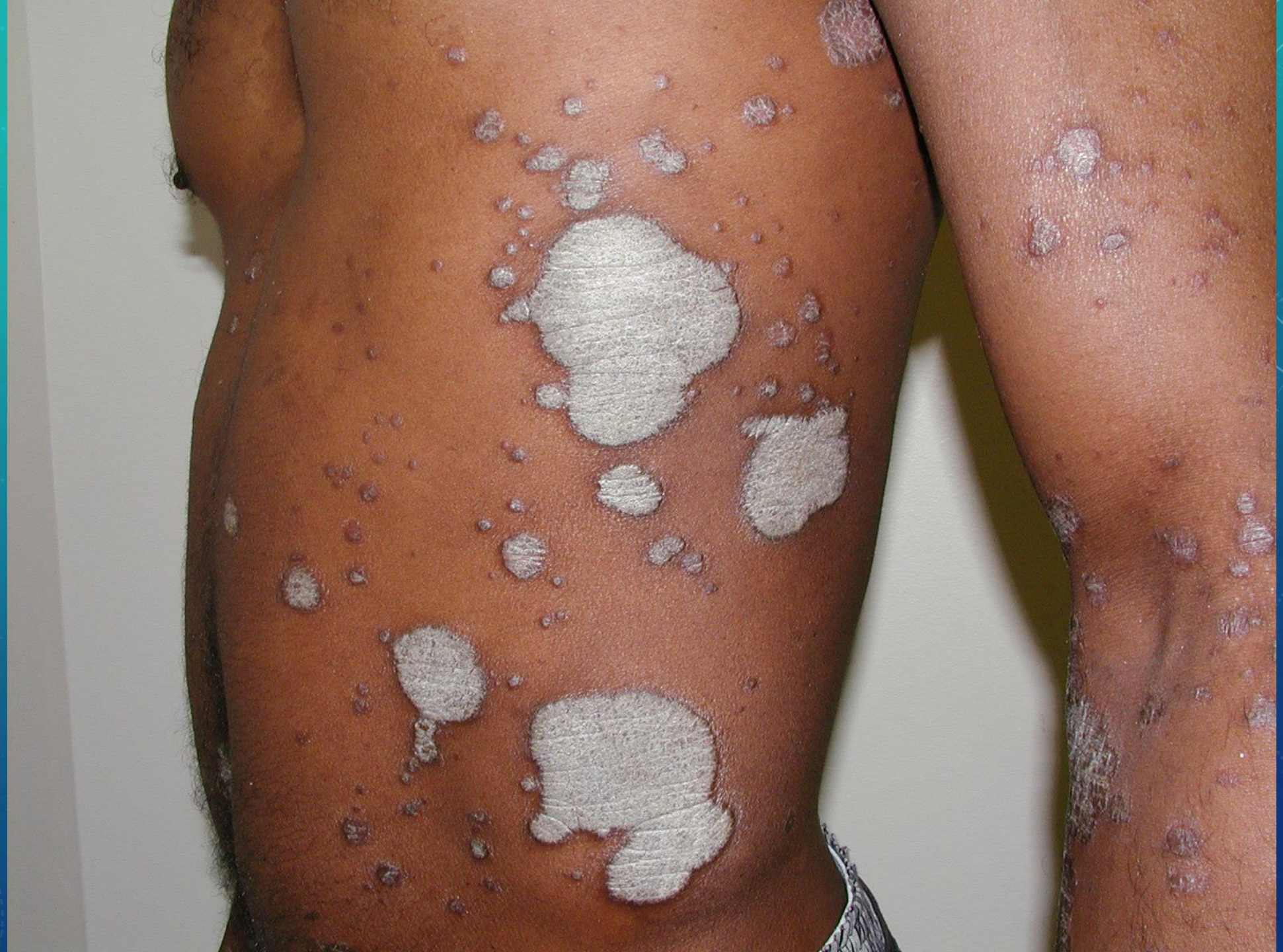
Umbilical granuloma

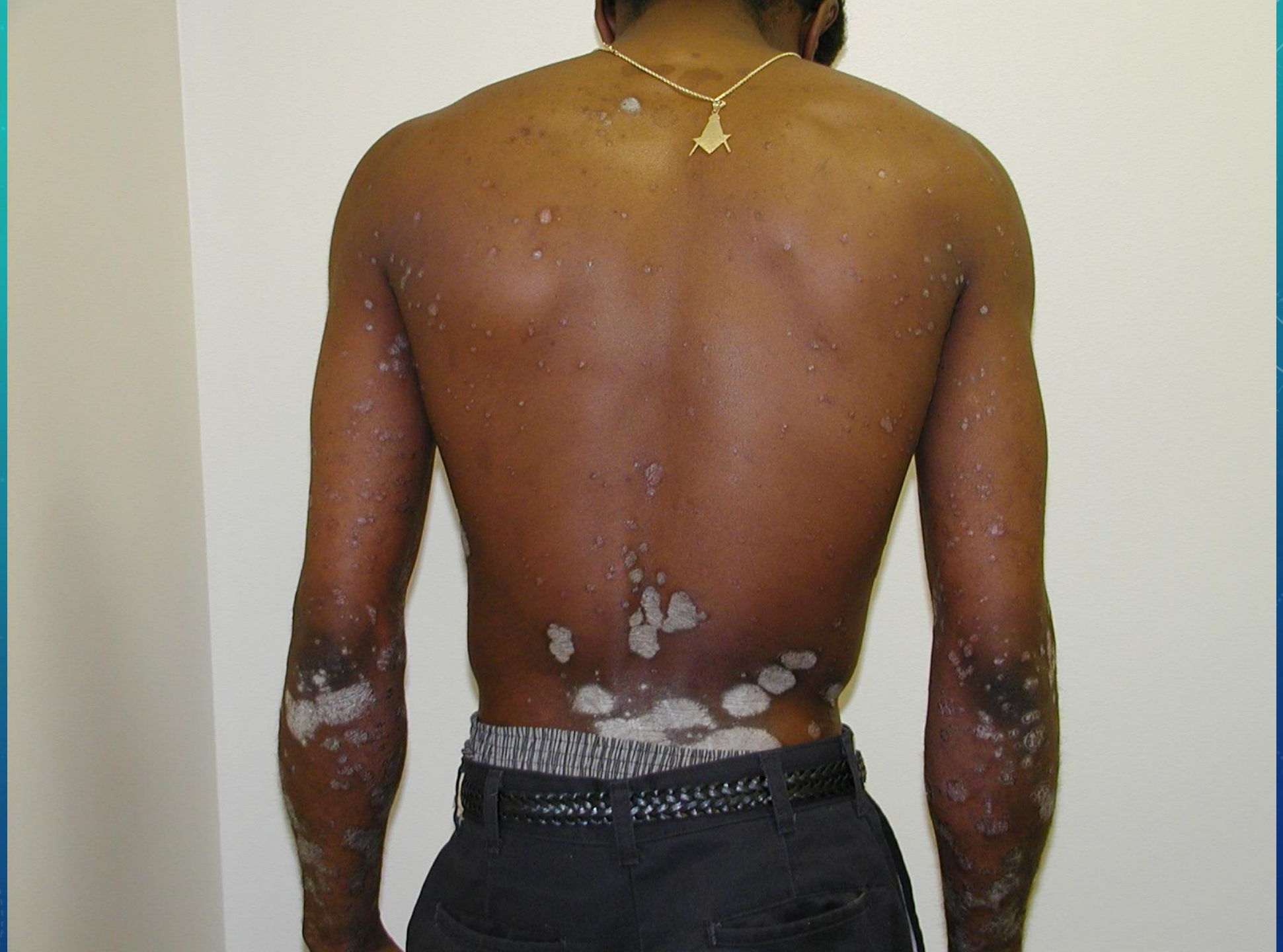
- Treat conservatively
- May use silver nitrate sticks prn
- Rarely, a suture may be tied at the stalk or the lesion excised

Deer cowrie

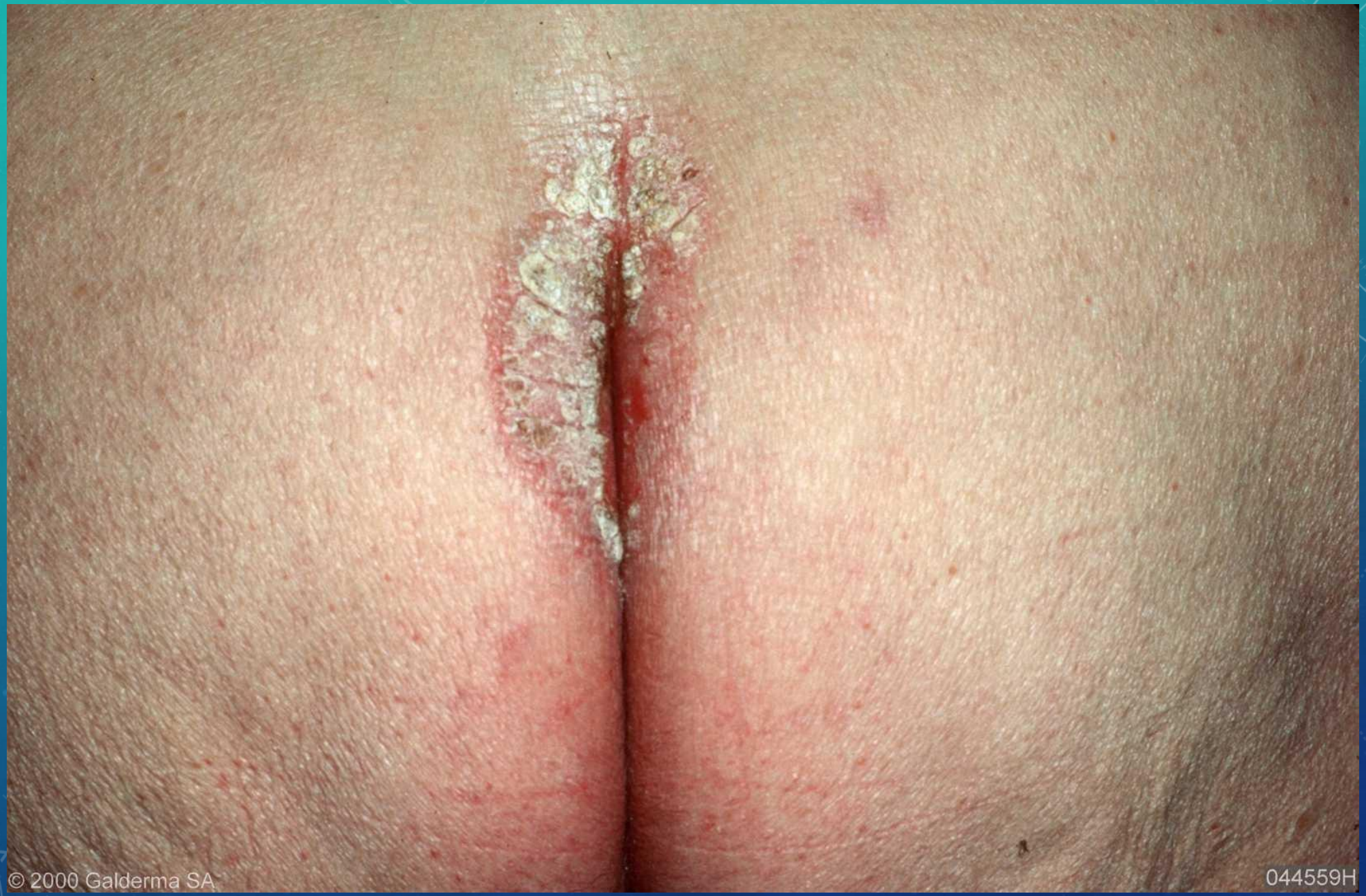


Doc, I have this thick silvery rash on my skin...





Psoriasis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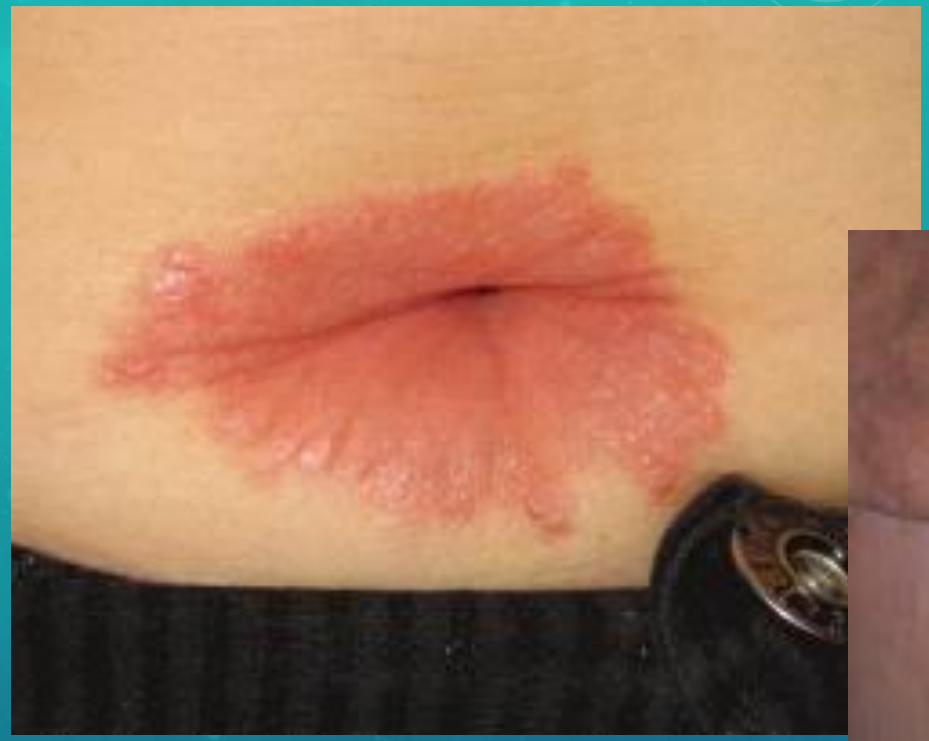

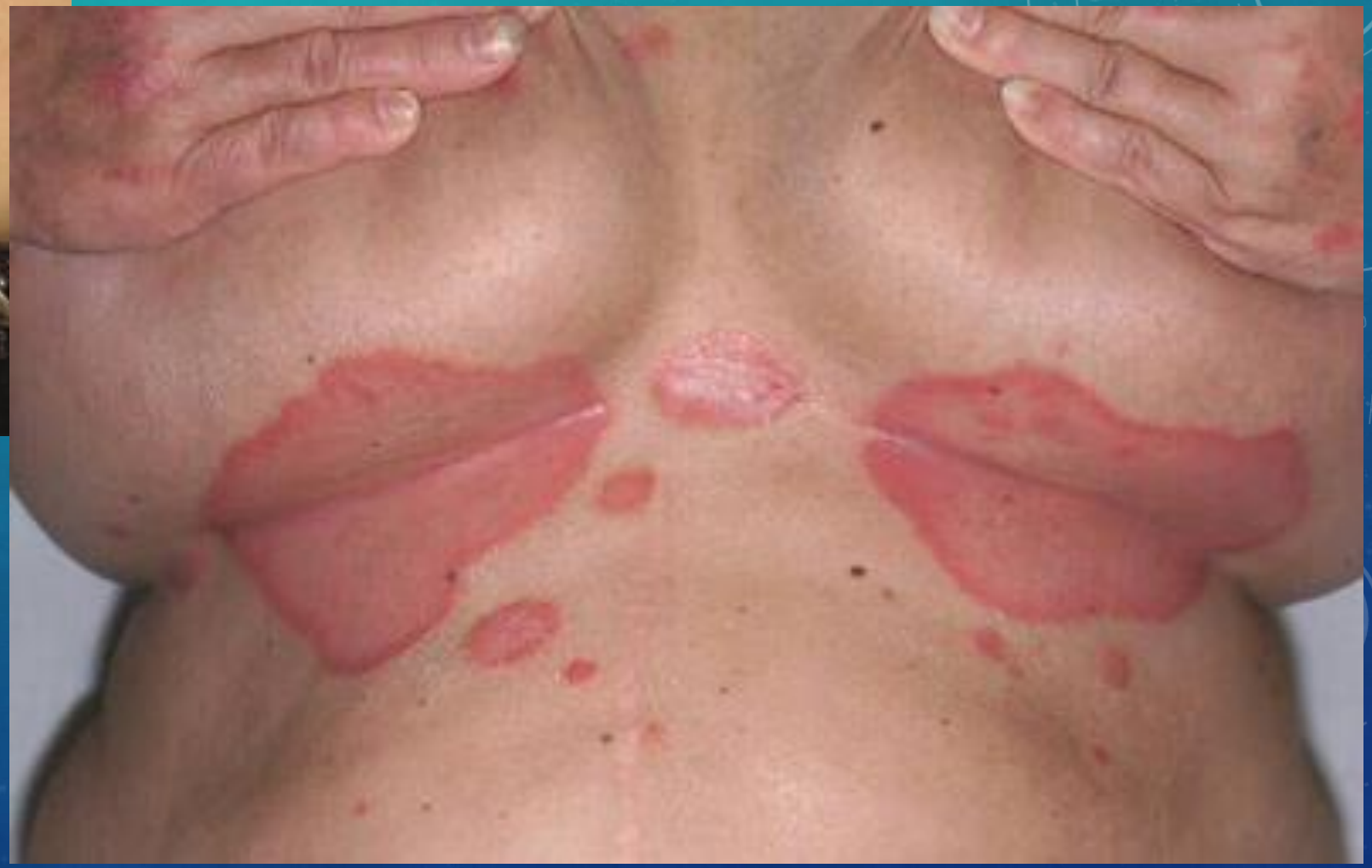

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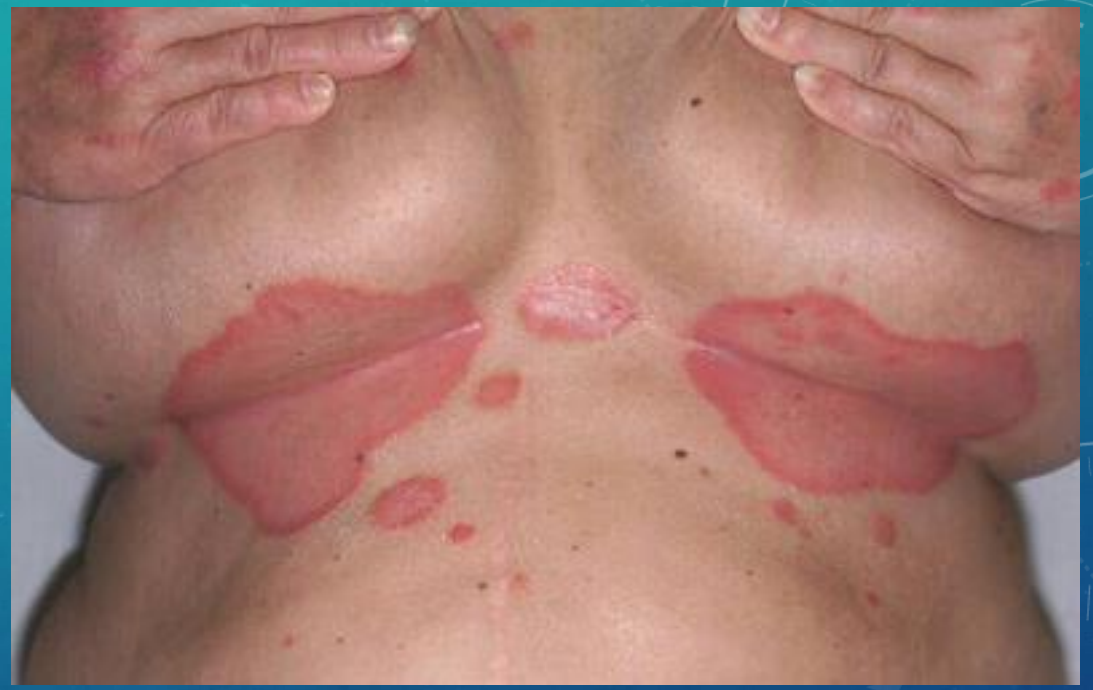
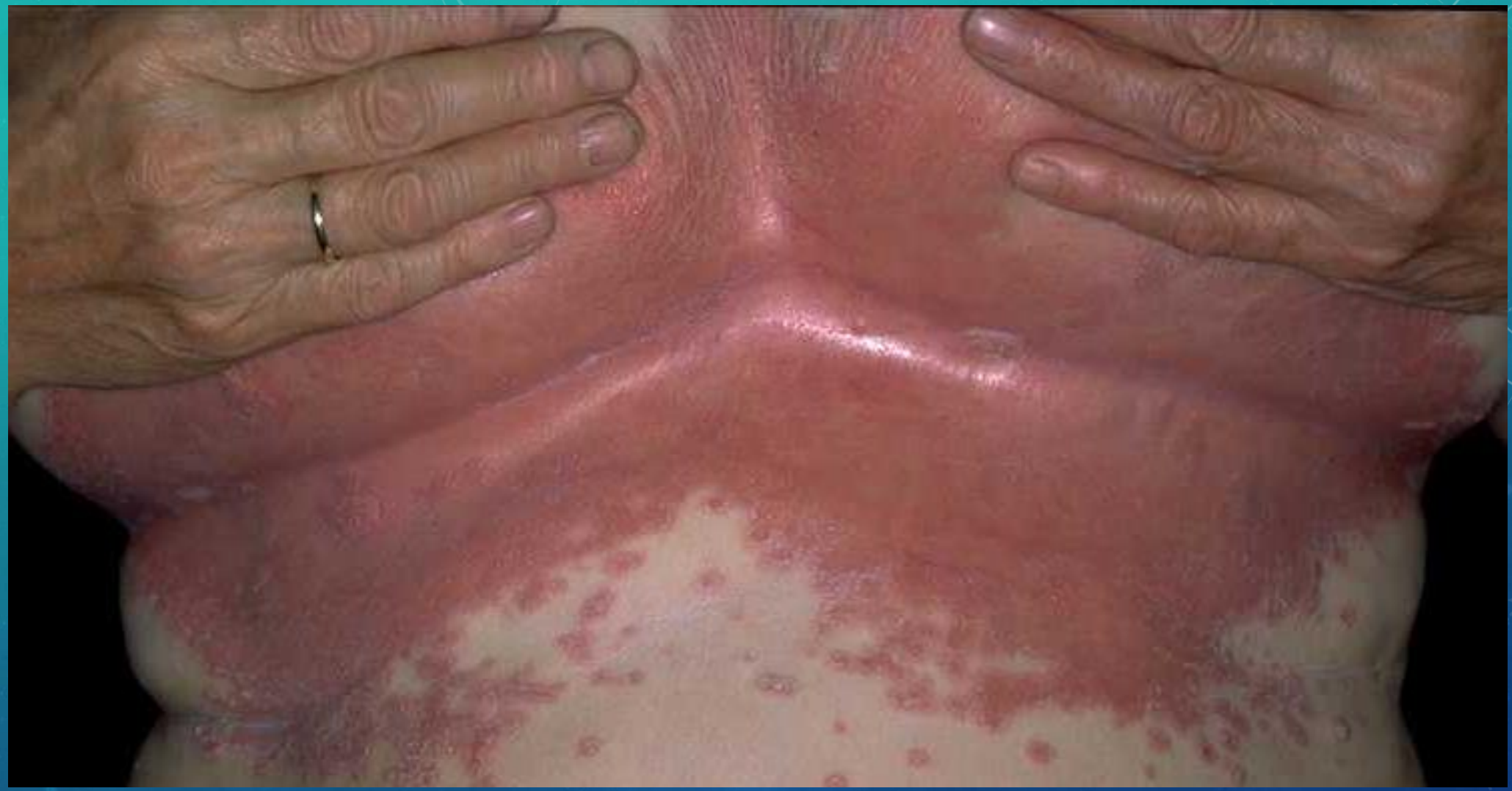


A. Seborrheic dermatitis
B. Inverse psoriasis
C. Candidal intertrigo
D. Cutaneous T cell lymphoma (mycosis fungoides)

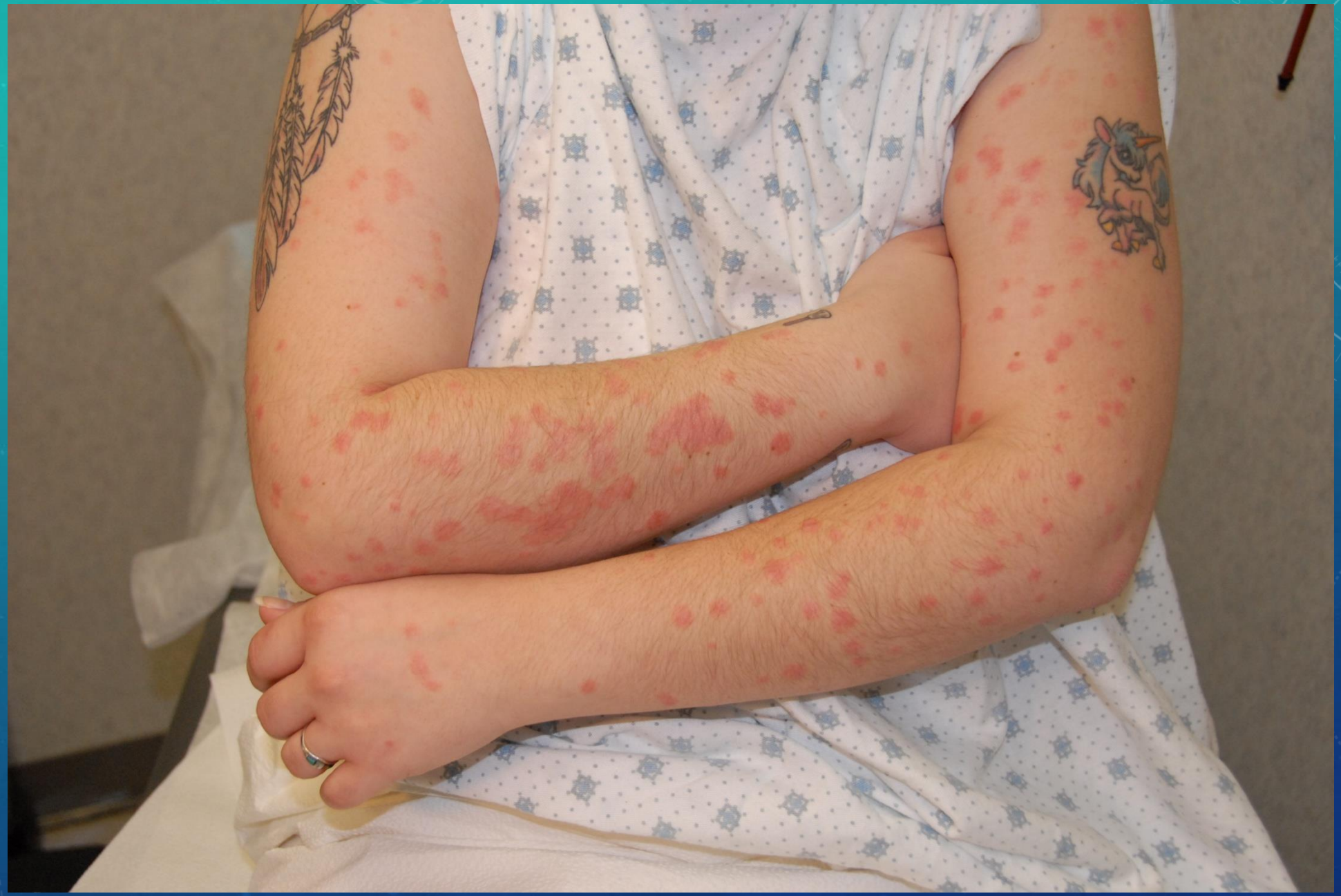


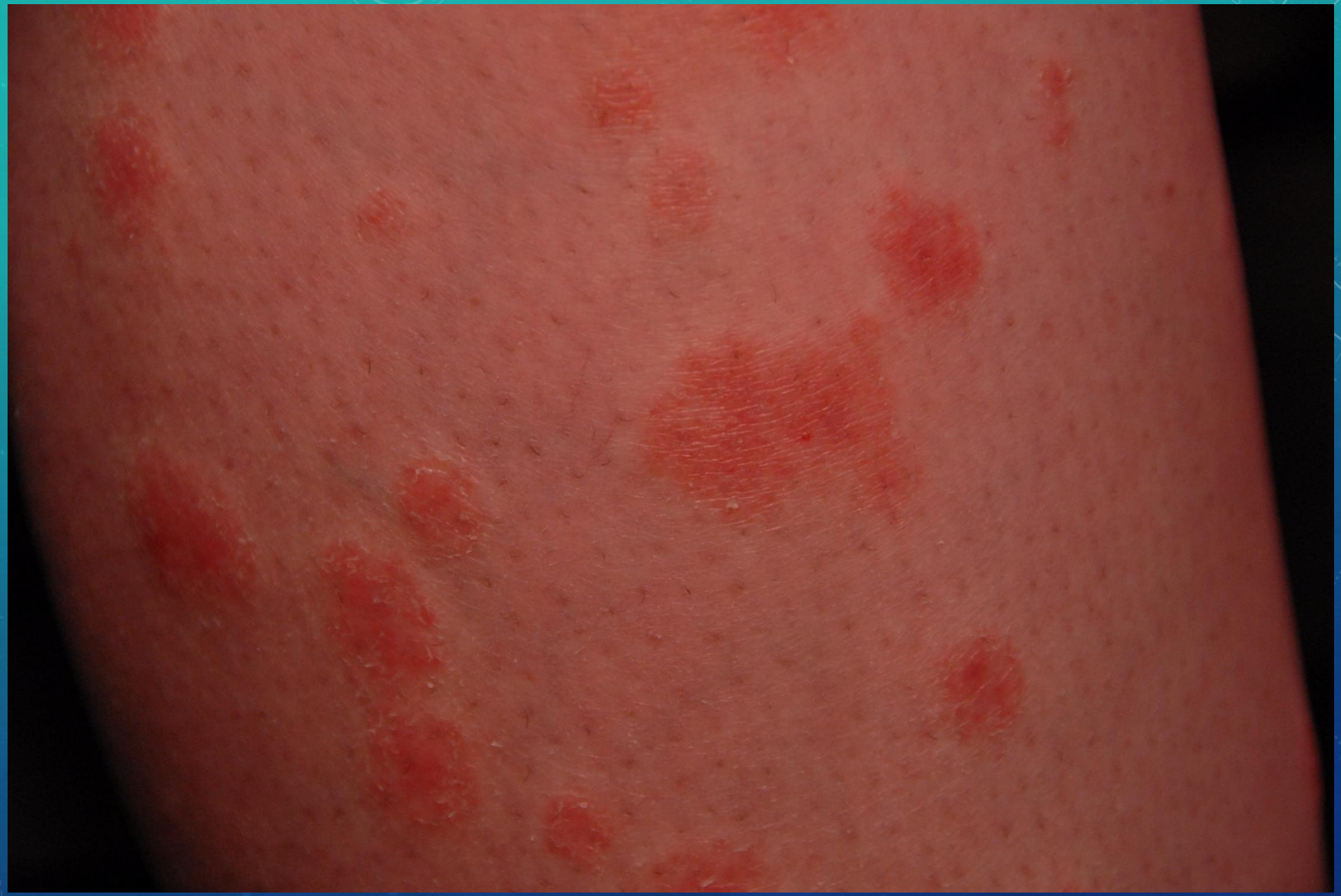
Psoriasis treatment

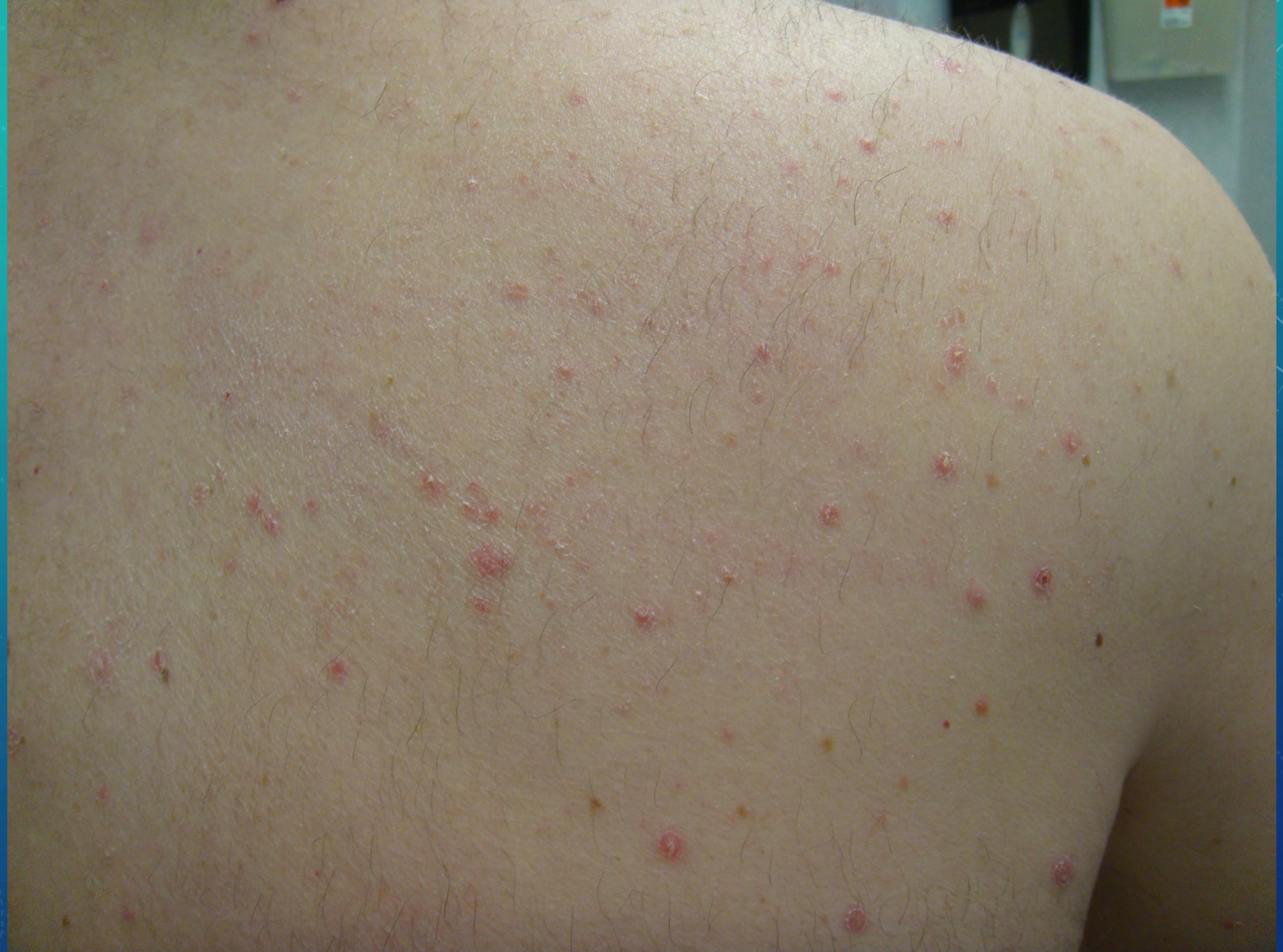
- Consider dermatology consult
- High potency topical steroids: group 1 often needed
- PUVA, UVB and tar
- Immunomodulators
  - (e.g., methotrexate, cyclosporine)
  - Biologic agents
    - TNF alpha inhibitors: etanercept, infliximab
    - Monoclonal Abs: against interleukins or TNF-α

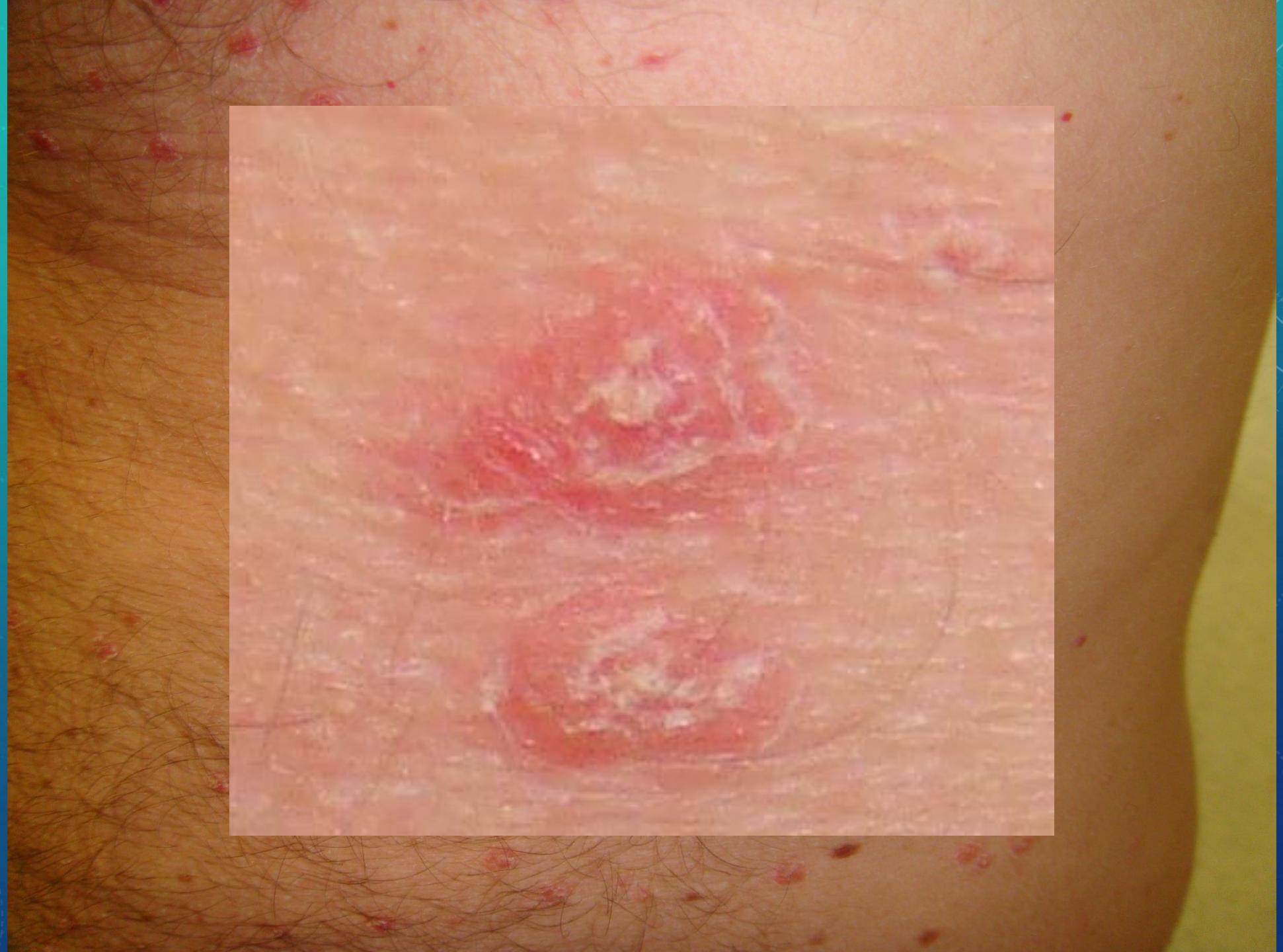
Psoriasis - systemic effects

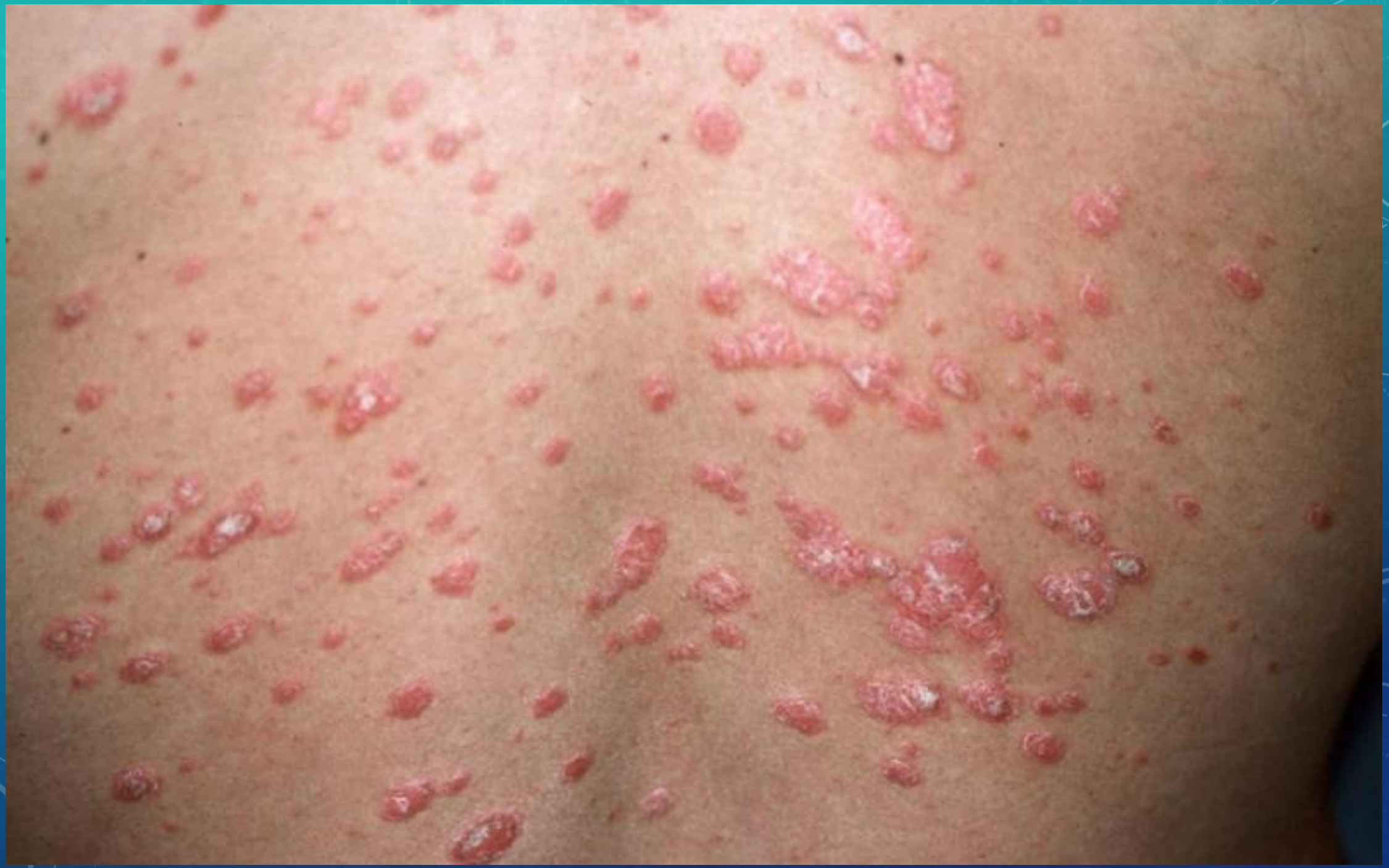
- Psoriatic arthritis, classically at the sacro-ileac joint
  - Seronegative spondyloarthritis
  - Negative for Rheumatoid factor = sero(-)
- Cup in saucer deformity of distal finger tufts
- Digit swelling, dactylitis





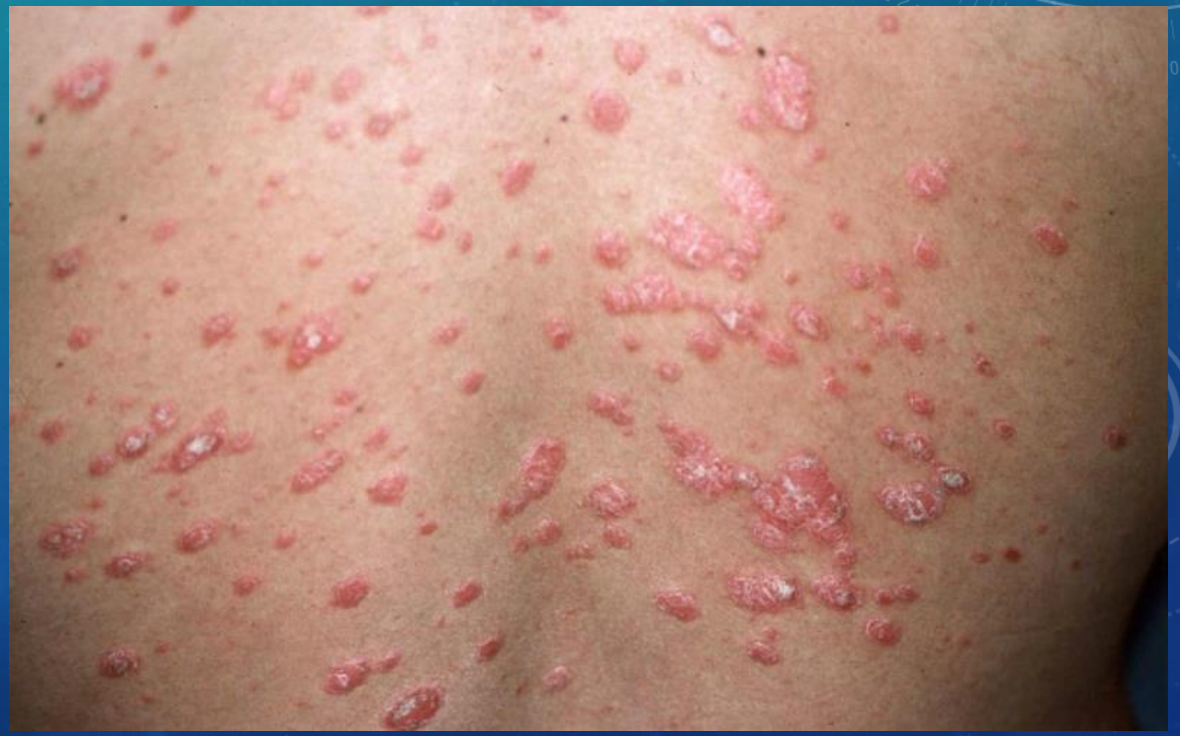




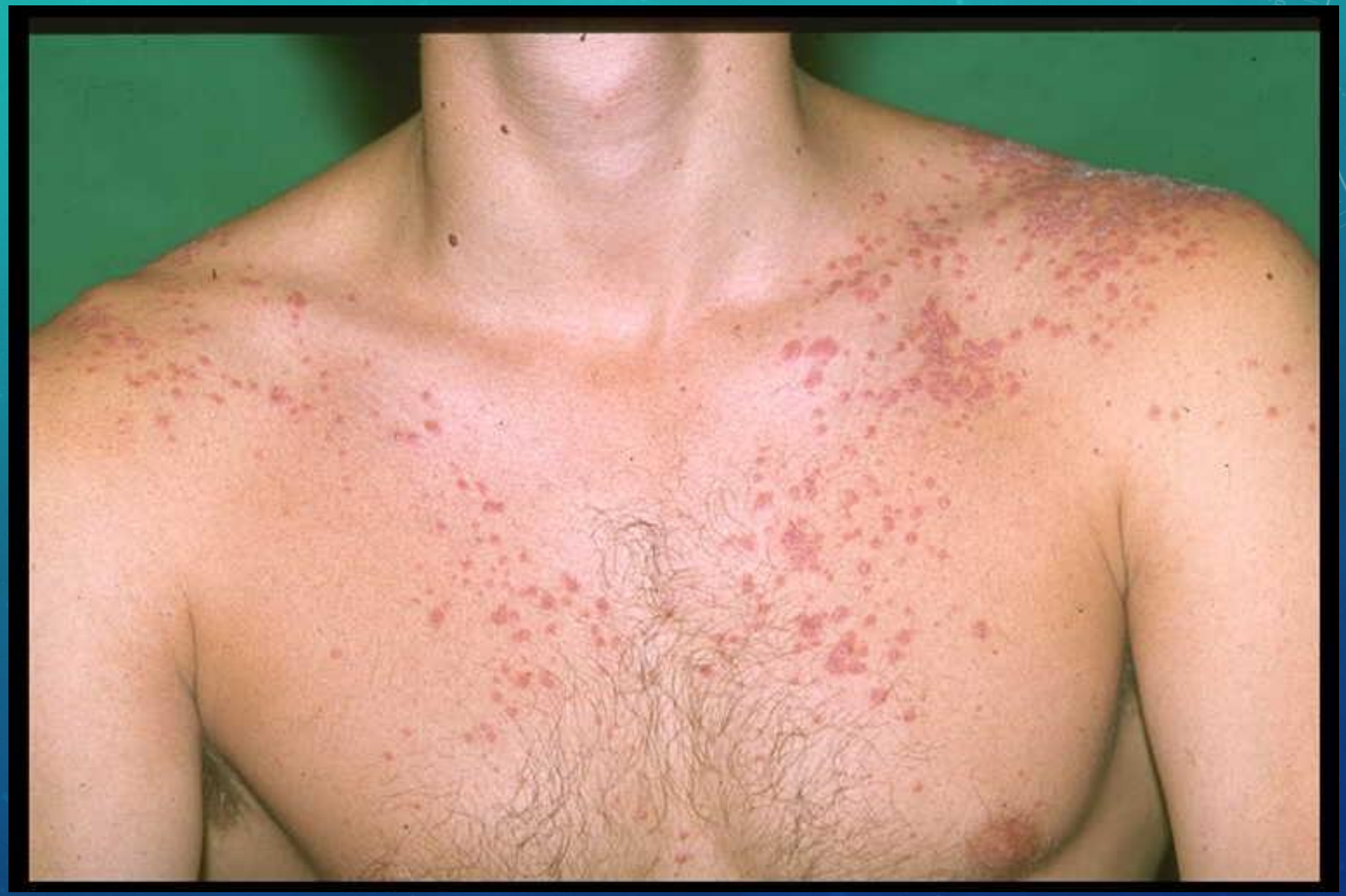


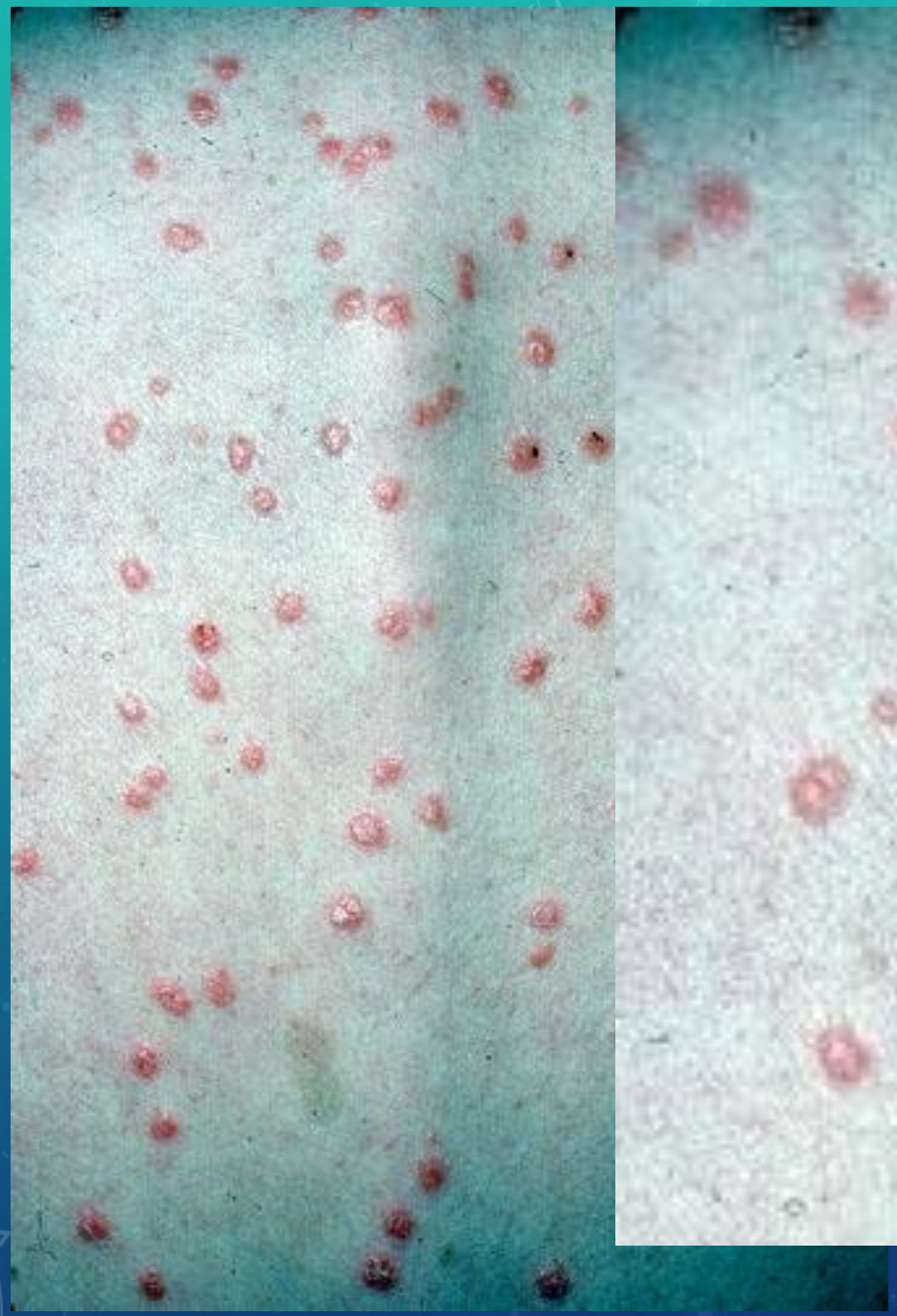
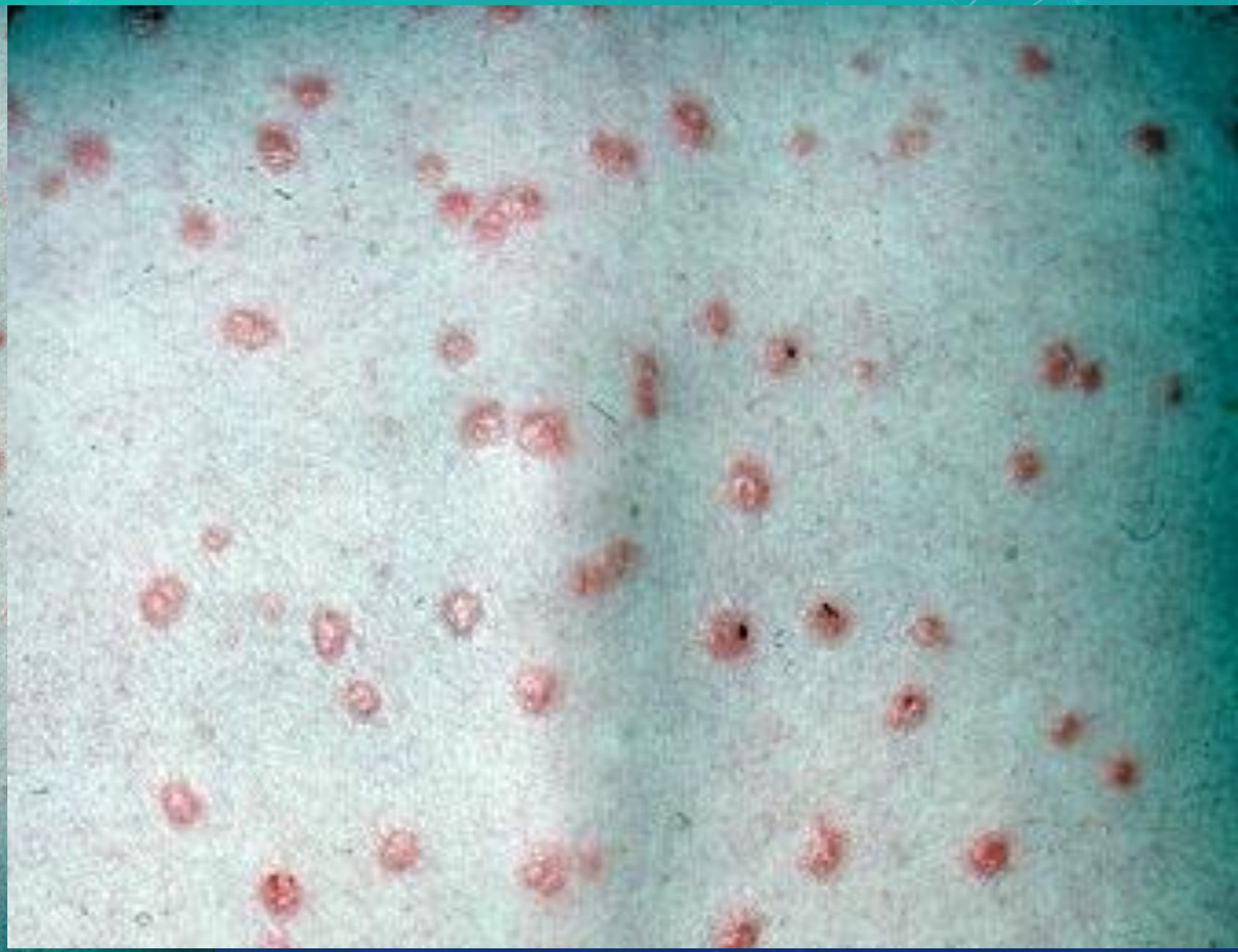
Patient with sore throat last week and now with a diffuse rash.

A. Generalized lichen planus
B. Guttate psoriasis
C. Varicella (chicken pox)
D. Pityriasis Rosea



Guttate Psoriasis



Guttate psoriasis – diagnostic clues

- GP spares the palms and soles (vs secondary syphilis)
- Guttate pattern is classic
  - Water droplets sprinkled on skin
- Central scale

Guttate Psoriasis

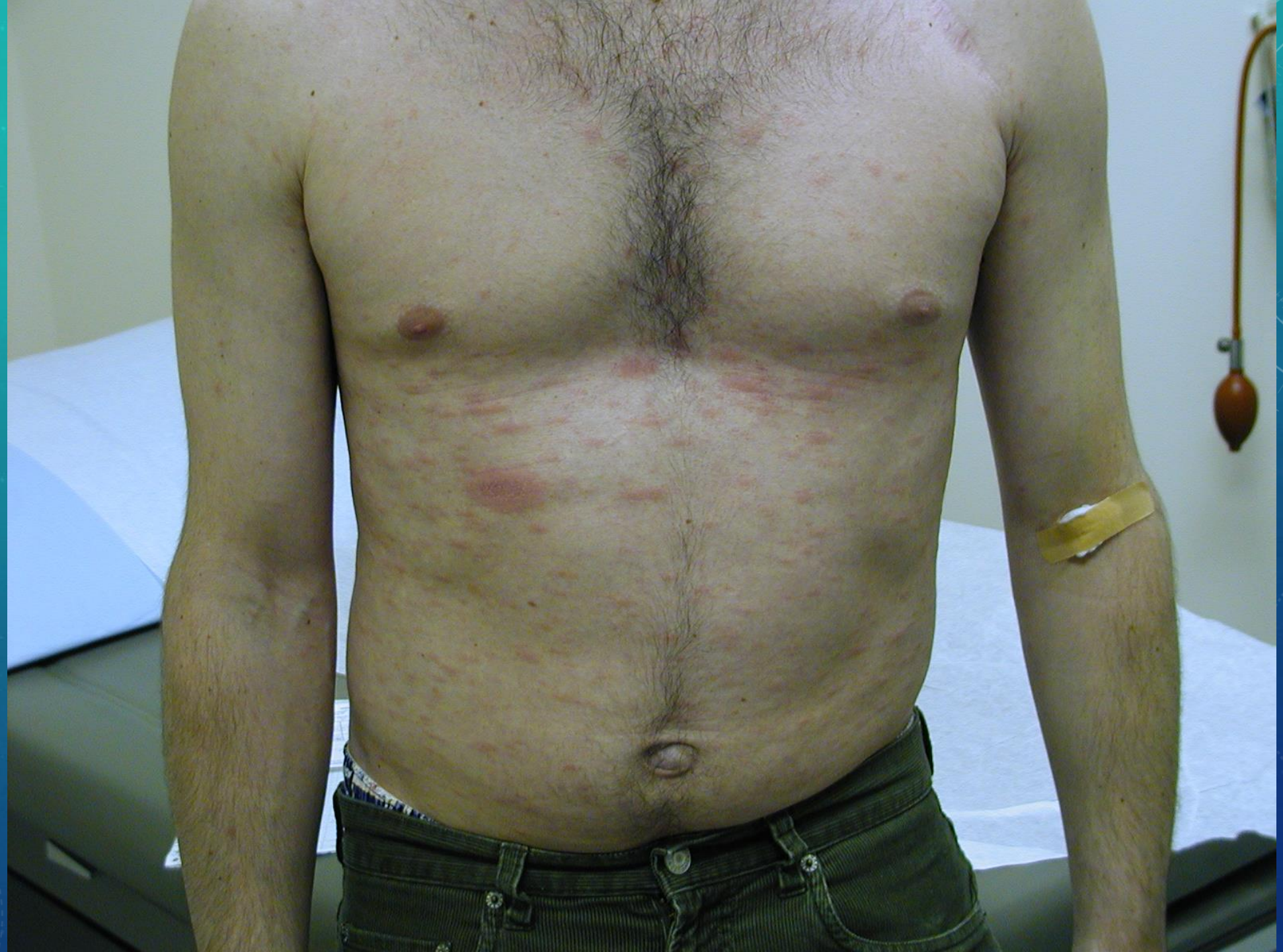
- GP is strongly associated with a preceding or concurrent GABS infection.
  - 70-80% patients
- Immune reaction to infection.
- A genetic predisposition plays an important role

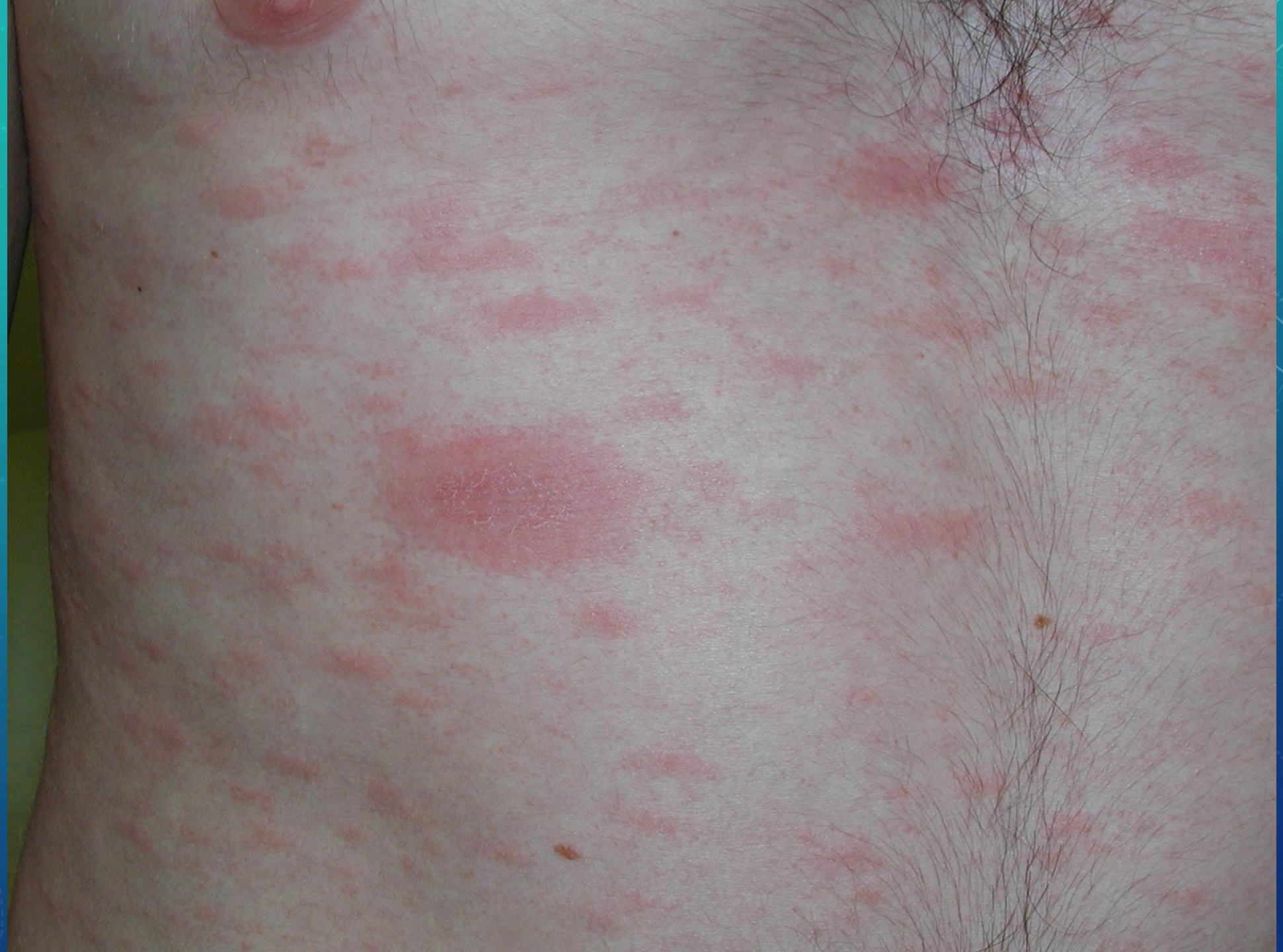
Telfer NR, Chalmers RJ, Whale K, et al. The role of streptococcal infection in the initiation of guttate psoriasis. Arch Dermatol. 1992;128(1):39

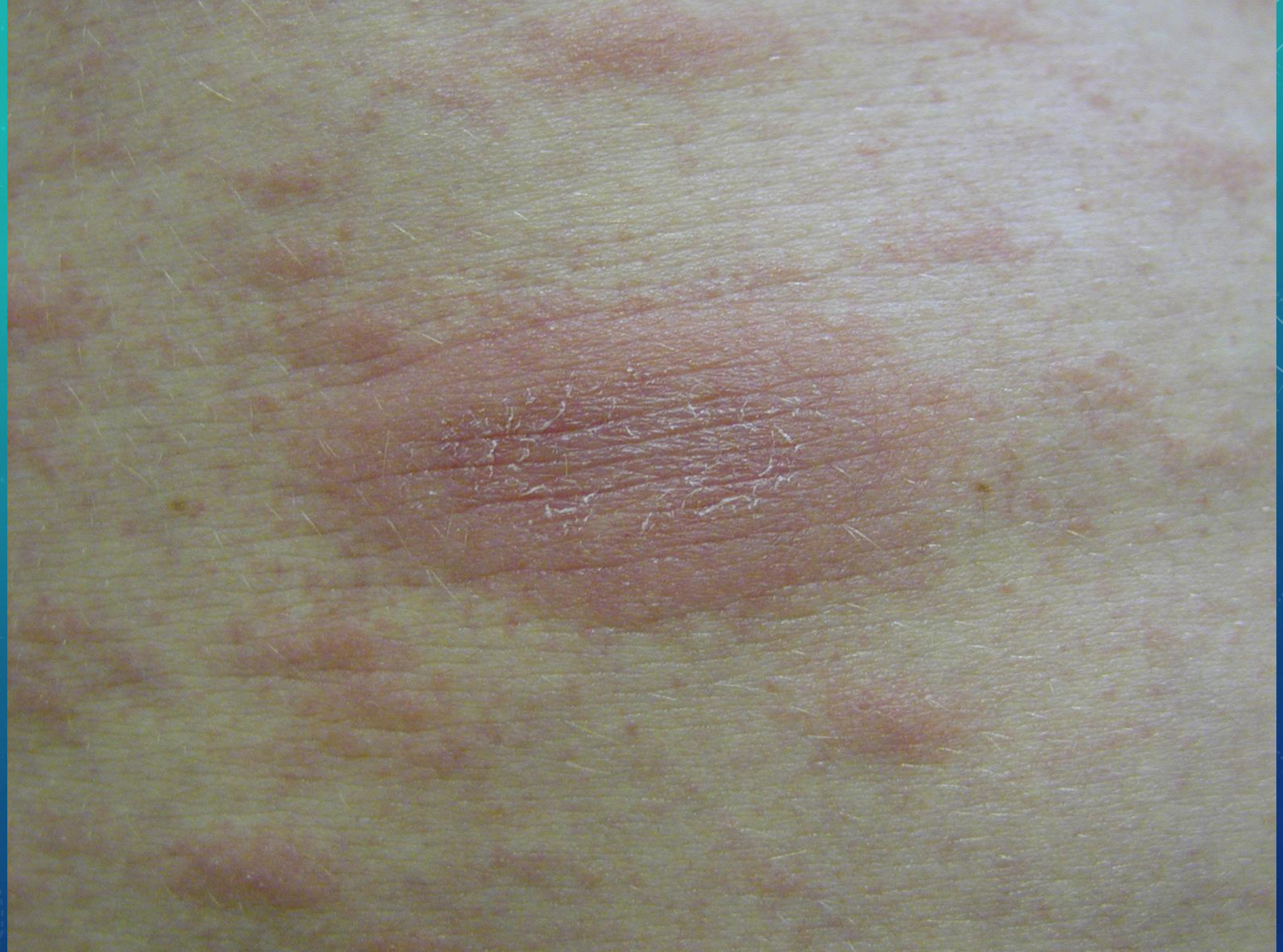
Guttate Psoriasis - treatment

- Reassurance and emollients
- Topical steroids
- UVB phototherapy
- Systemic agents are rarely necessary
- Empiric treatment for streptococcal infection and tonsillectomy for recurrent attacks

Flamingo tongue







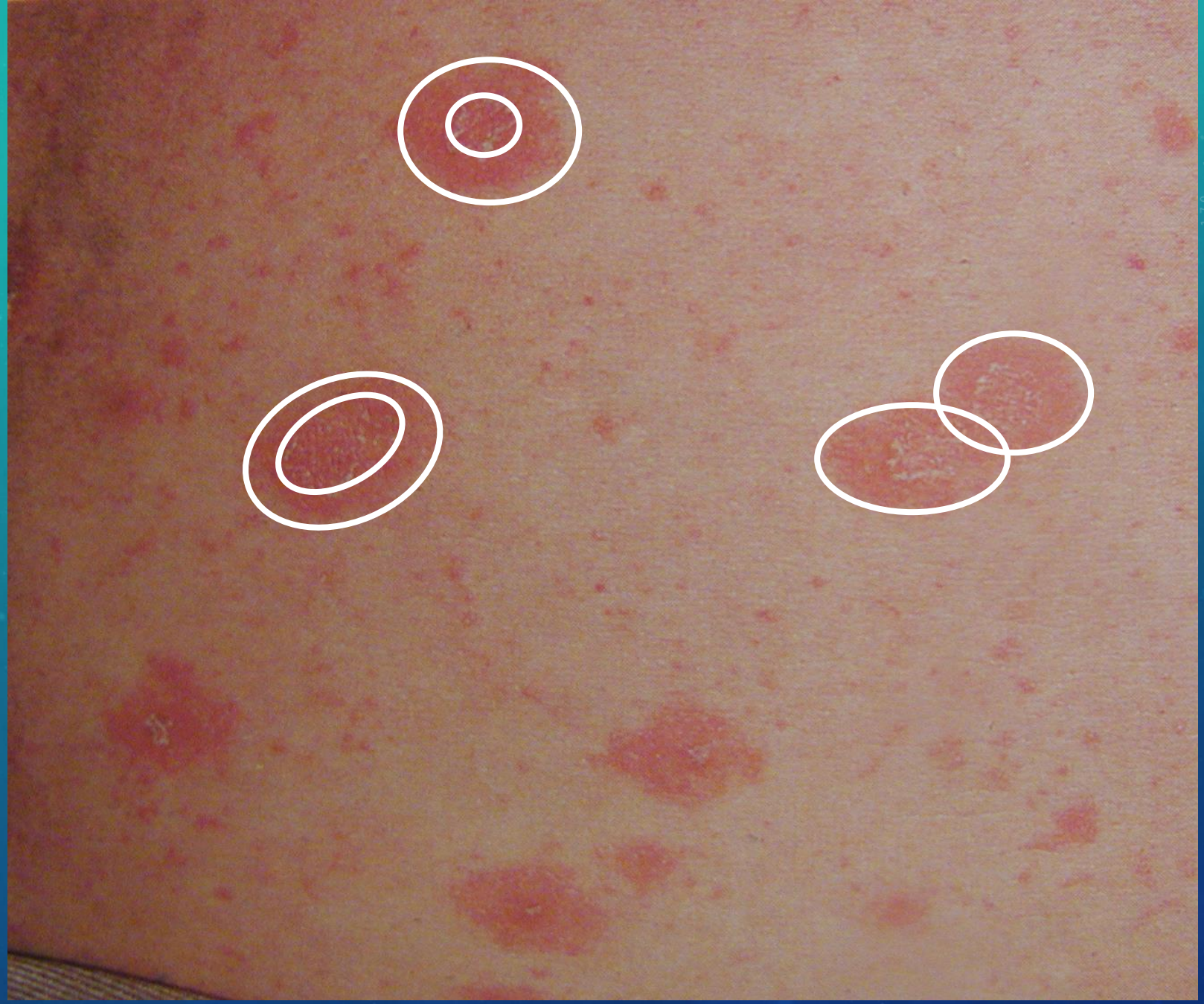
What eruption might this be?

A. Erythema marginatum

B. Secondary syphilis

C. Nummular eczema

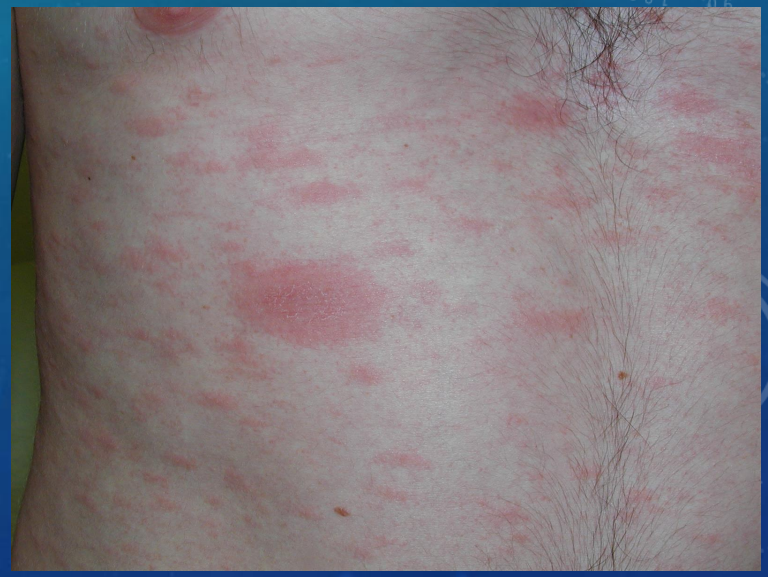
D. Pityriasis rosea



Pityriasis Rosea

Pityriasis Rosea

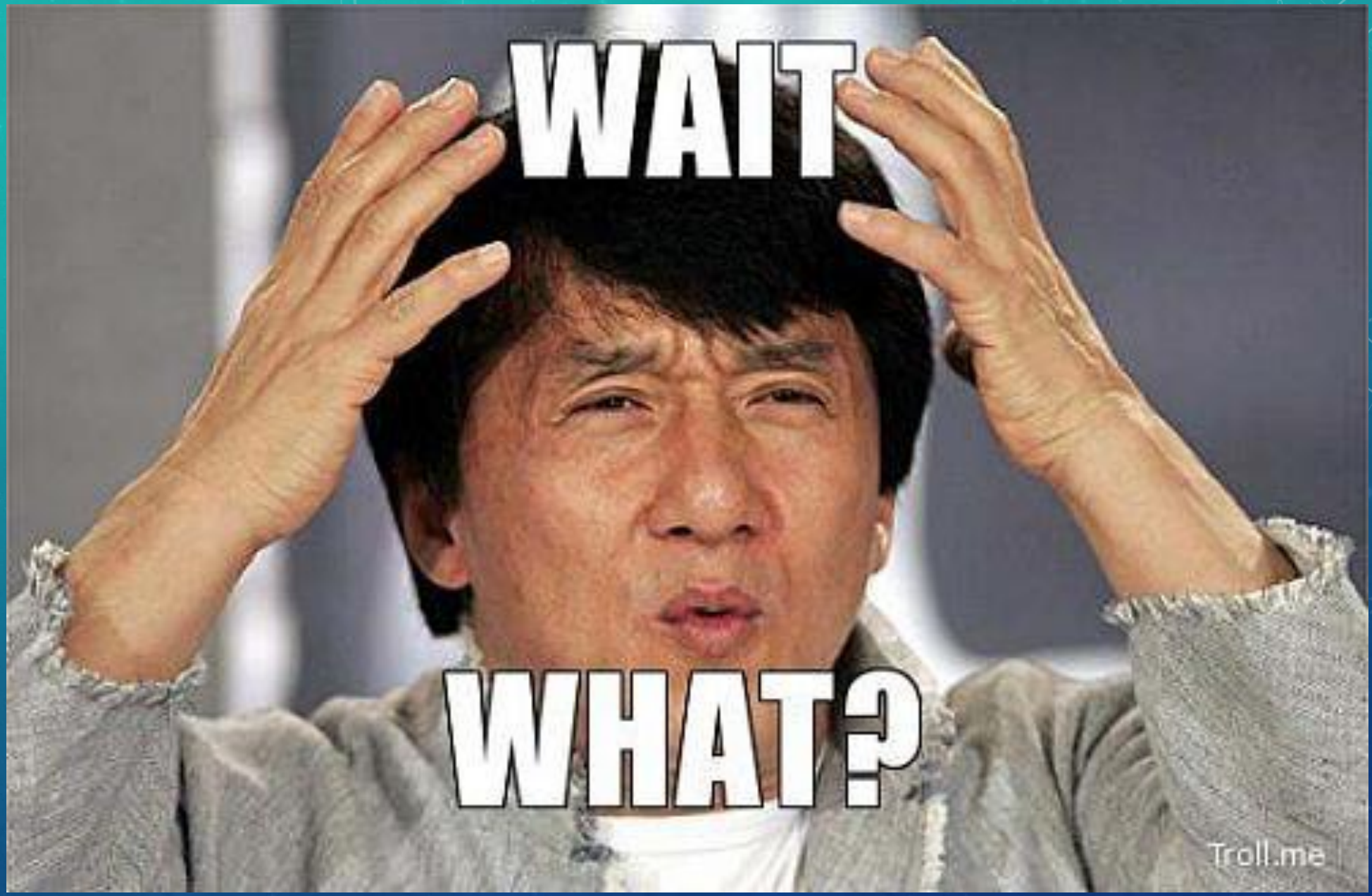
- Papulosquamous eruption of undetermined cause
- May have a herald patch initially
- Oval papules and plaques
- Collarette of scale
- Lesions follow Langer's lines
  - Christmas tree pattern on the back



Stuhlberg D, Wolfrey J, Pityriasis Rosea, Am Fam Physician 2004;69:87-92,94

Etiologies

- Purported viral etiology
- Some recent data has suggested Human herpes virus (HHV) 7


WAIT
WHAT?
Troll.me

Human Herpes viridae

- HSV 1 and 2: Oral and genital herpes
- HHV 3: Varicella-Zoster
- HHV 4: Ebstein-Barr
- HHV 5: Cytomegalovirus
- HHV 6: Roseola
- HHV 7: virus in search of a disease … PR?
- HHV 8: Kaposi’s sarcoma

Pityriasis Rosea - Treatment

- Aggressive Reassurance
  - This will go away ☺
- Medications:
  - Antihistamines
  - Topical steroids
  - Systemic steroids
- Usually resolves in 1-2 months. The pigmentary changes may take longer to resolve.

Antibiotics for PR

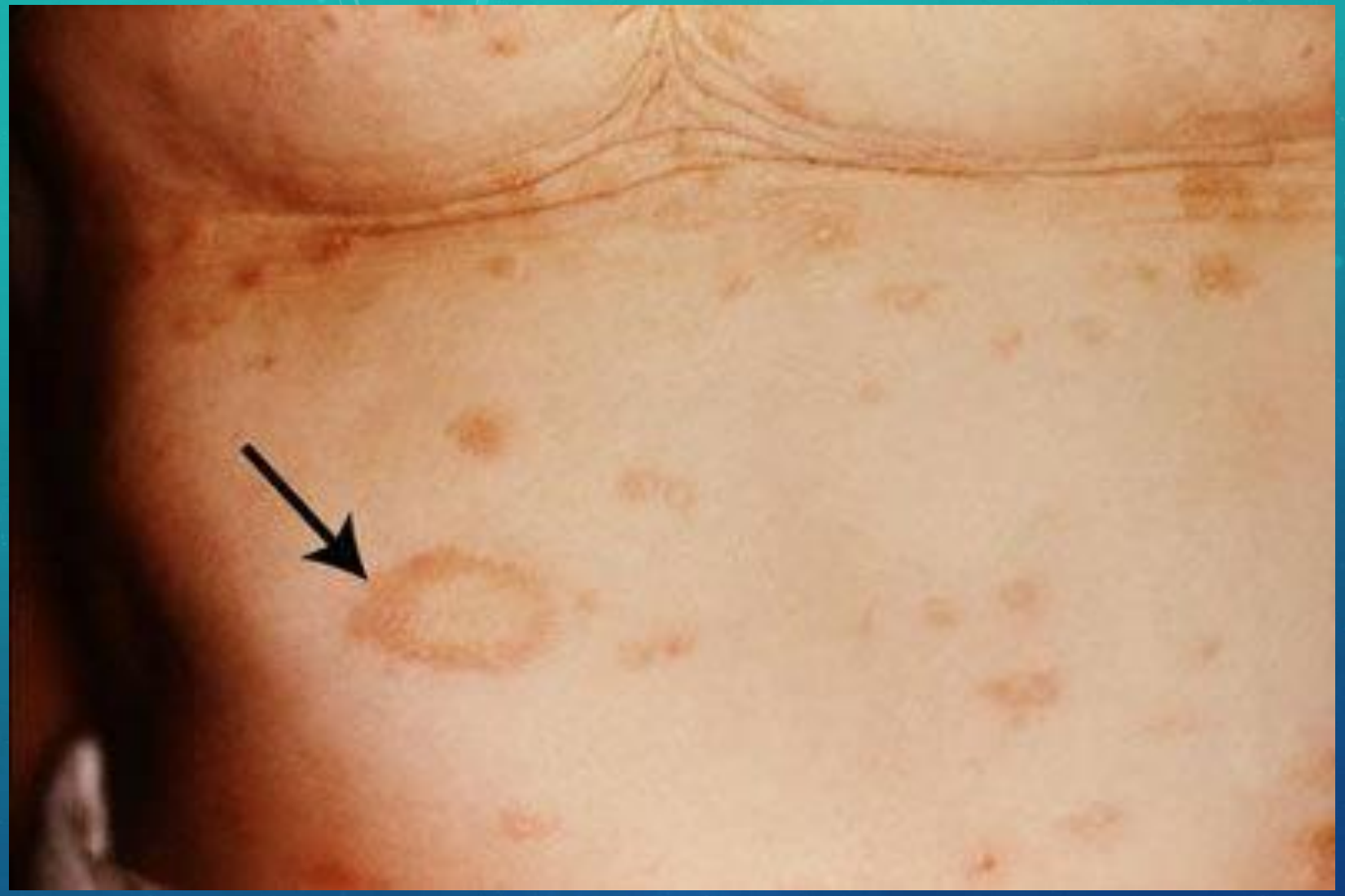
- Early data suggestive of potential benefit from erythromycin
- Data for newer macrolides, azithromycin and clarithromycin, not supportive of benefit
- Recent data using acyclovir suggests benefit

Acyclovir

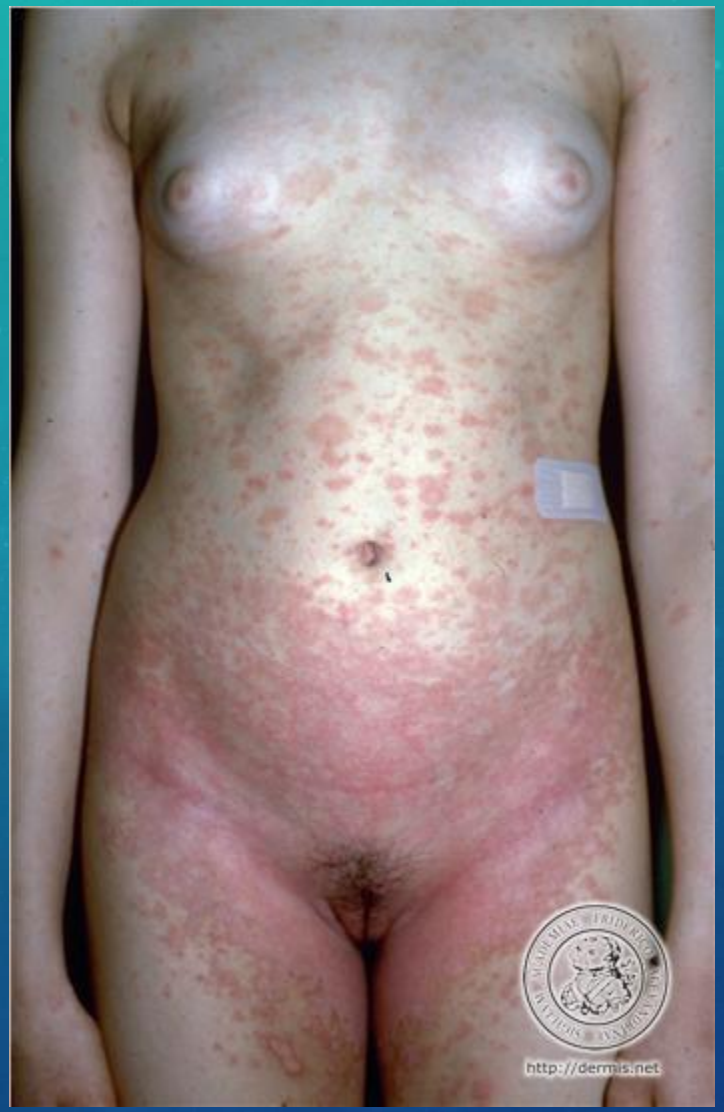
- Randomized trial of 64 patients with PR Rx'd with 400mg 5xdaily for 1 week
  - At two weeks, erythema reduced in 79% treated vs 27% in untreated patients
  - At four weeks, erythema reduced 93% reduction vs 61% in untreated patients
  - Difference no longer significant at four weeks
- Second trial 38 patients treated with 800mg 5xdaily for 1 week vs 30 patients treated with vitamin C (no placebo)
  - At one week, erythema was reduced 53% in treated vs 10% in untreated patients
  - At two weeks, erythema was reduced 87% in treated vs 33% in untreated patients

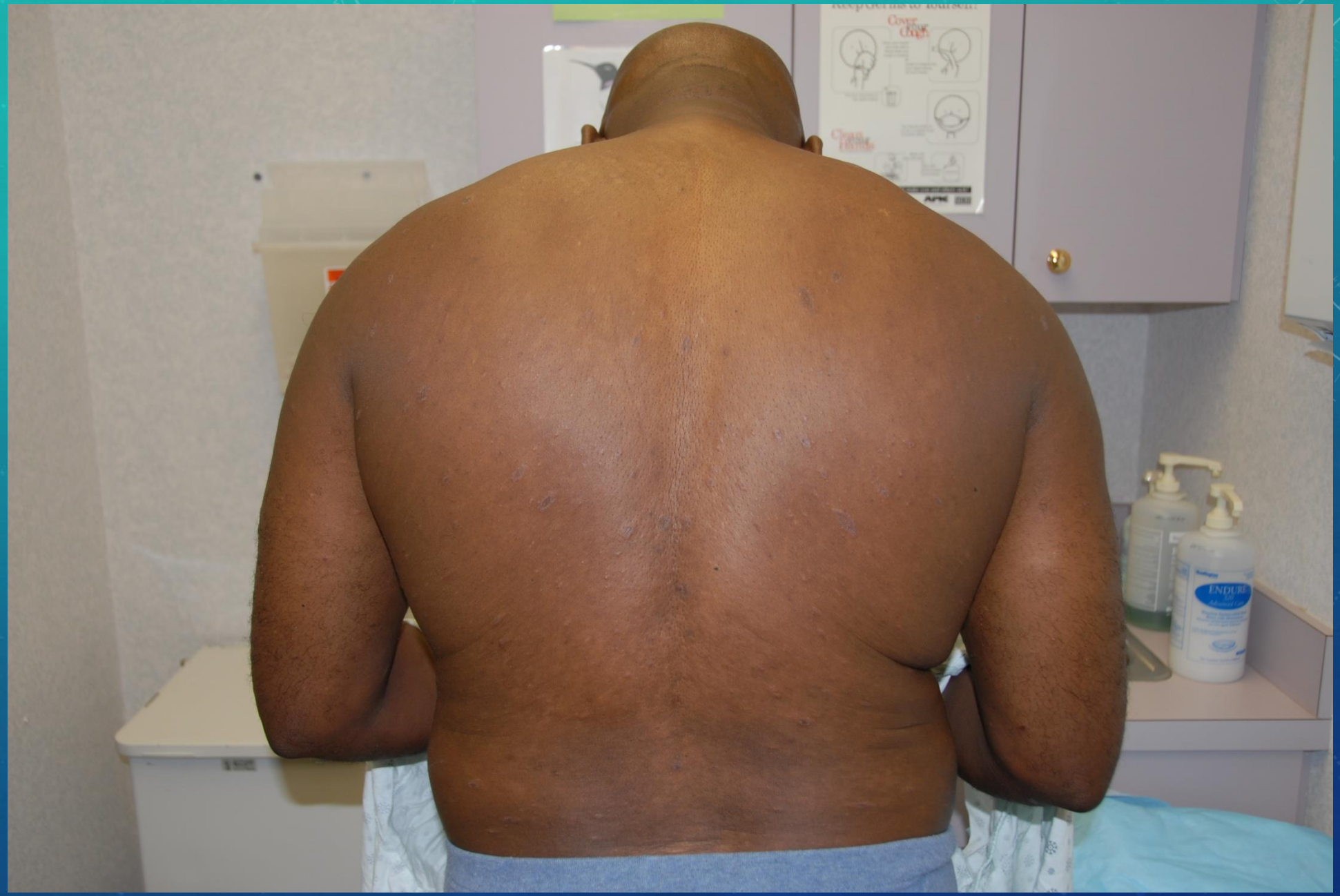
Rassai S, Feily A, Sina N et al. Low dose of acyclovir may be an effective treatment against pityriasis rosea: a random investigator-blind clinical trial on 64 patients. J Eur Acad Dermatol Venereol. 2011;25(1):24

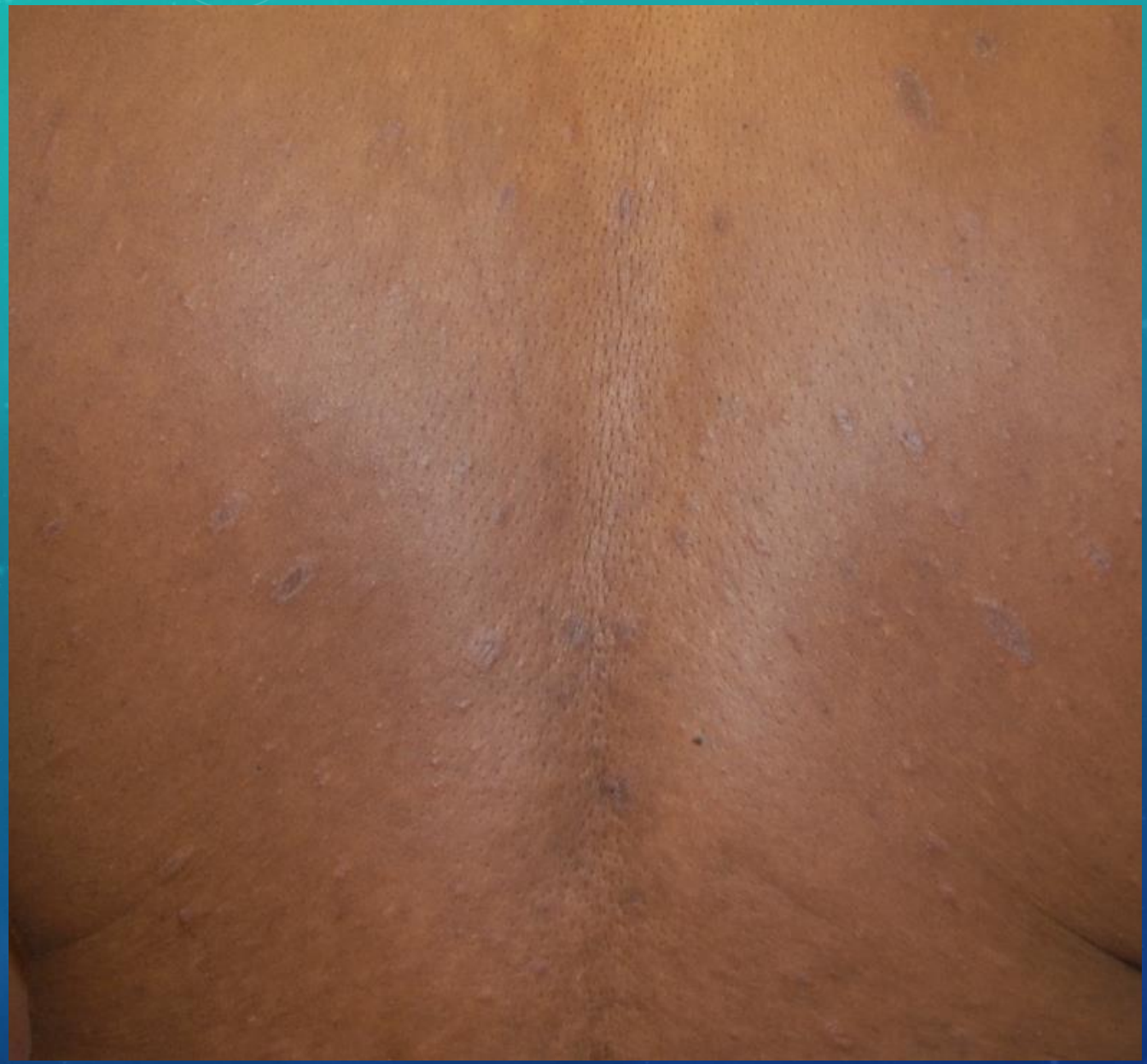
Ganguly S. A Randomized, Double-blind, Placebo-Controlled Study of Efficacy of Oral Acyclovir in the Treatment of Pityriasis Rosea. J Clin Diagn Res. 2014 May;8(5):YC01-4. Epub 2014 May 15

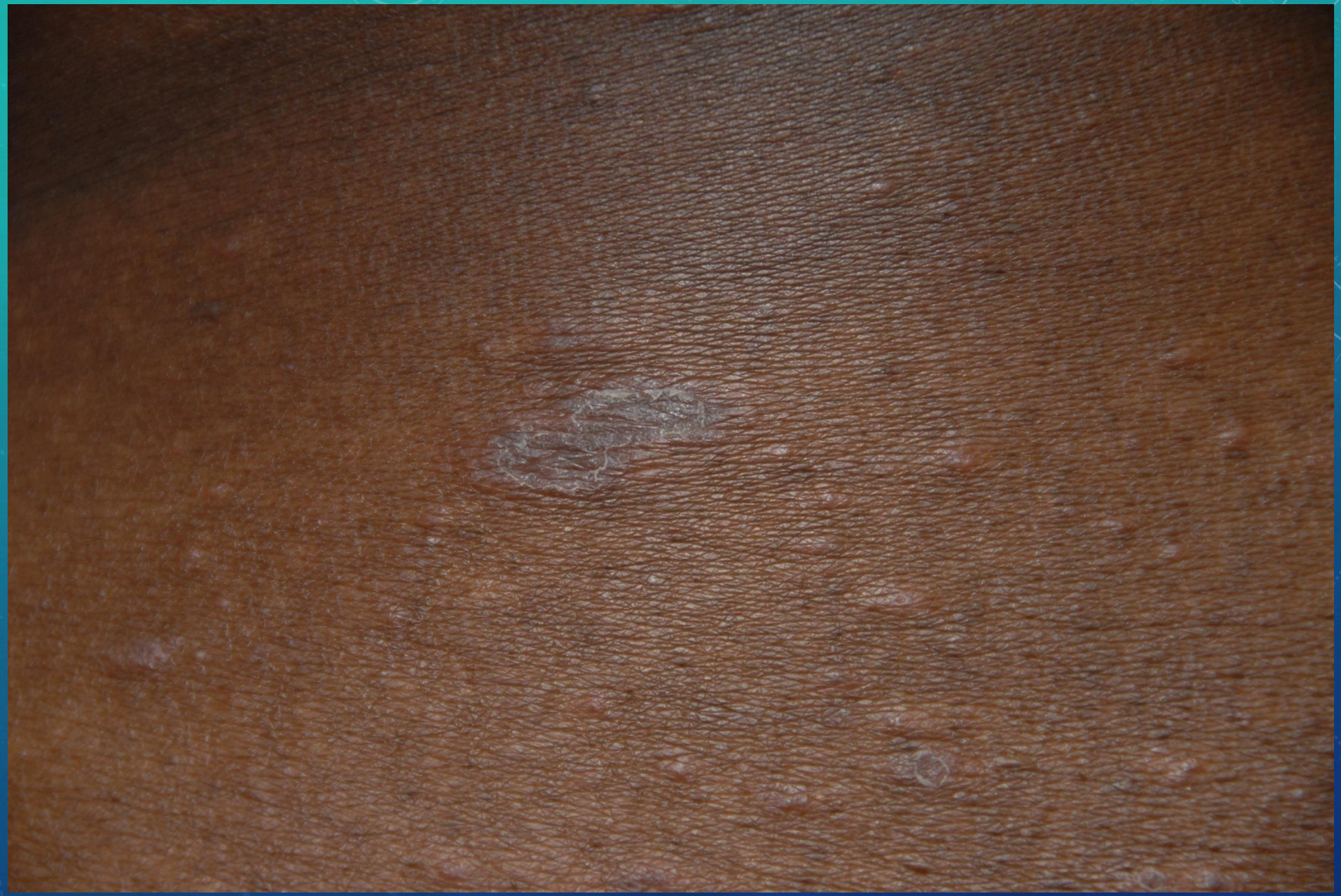


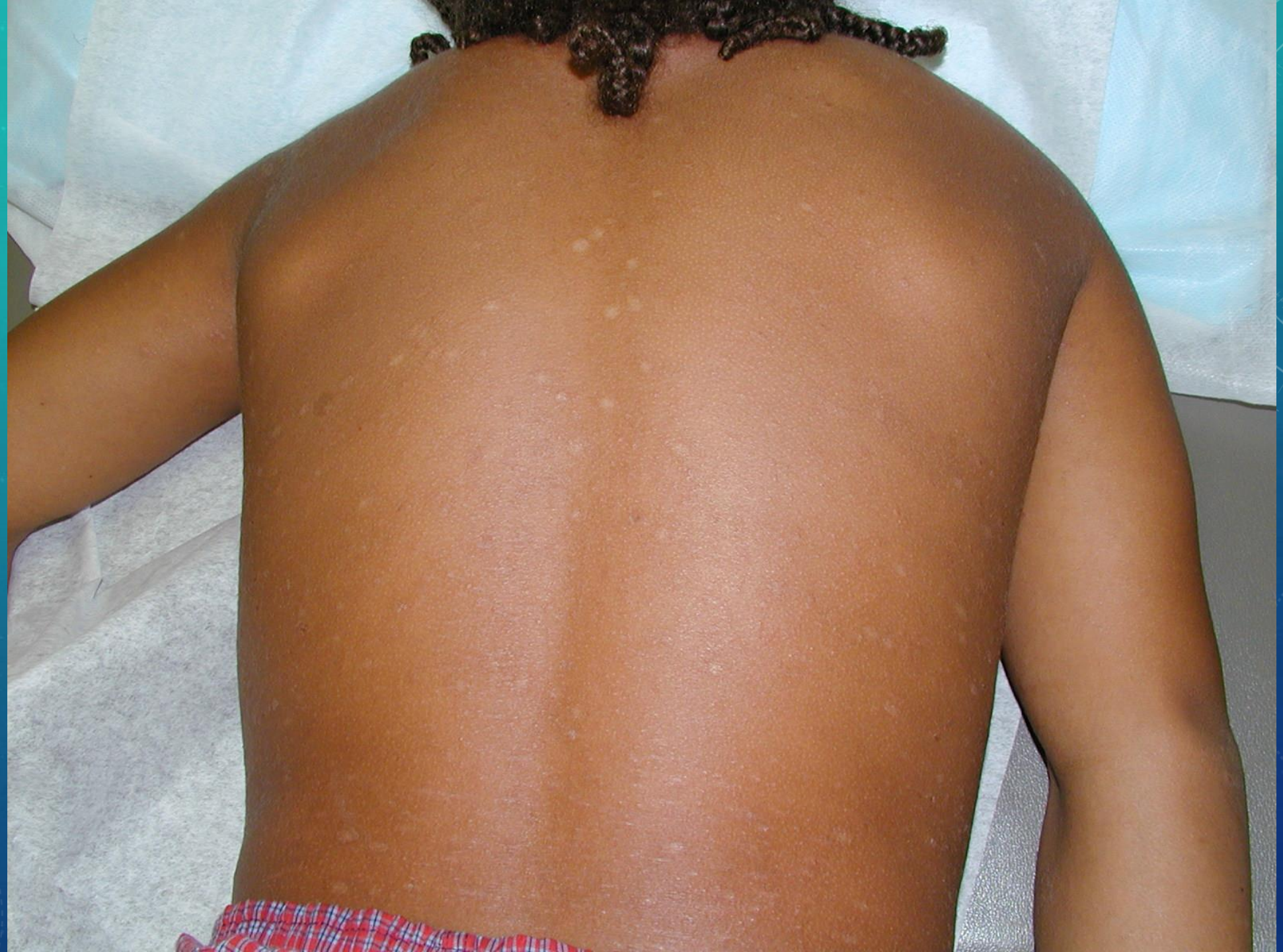
Herald patch

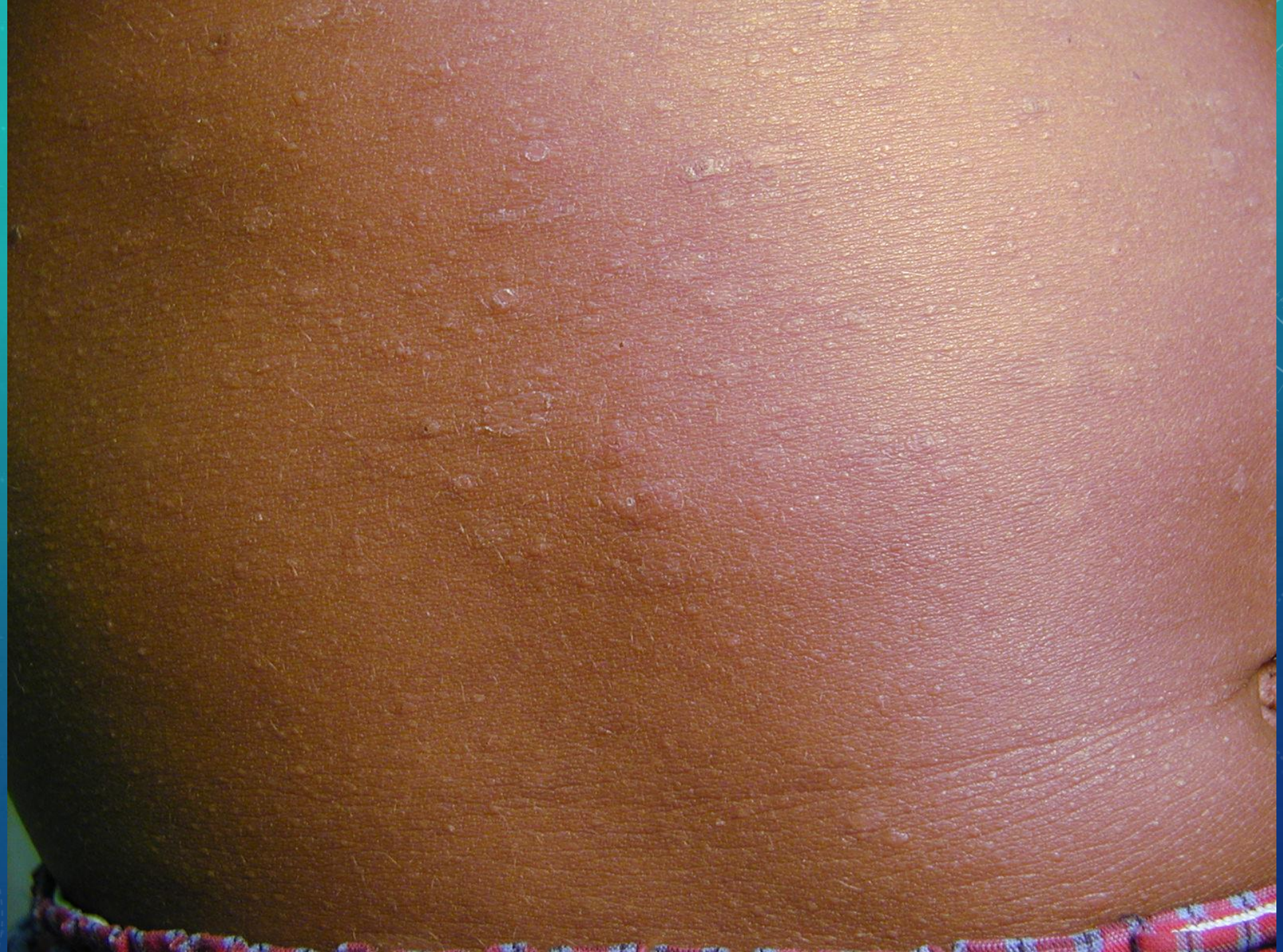

http://dermis.net

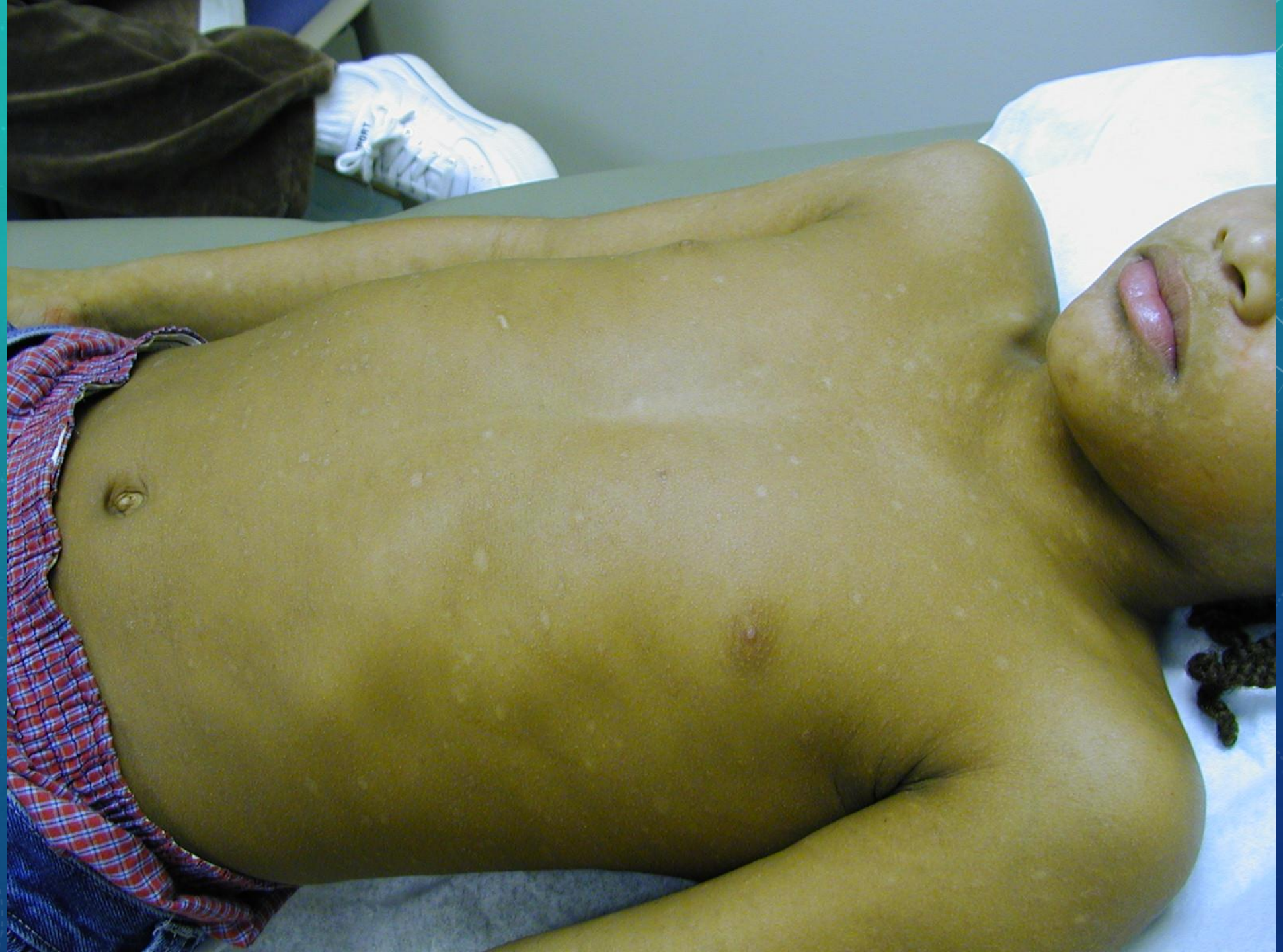

ENDURE

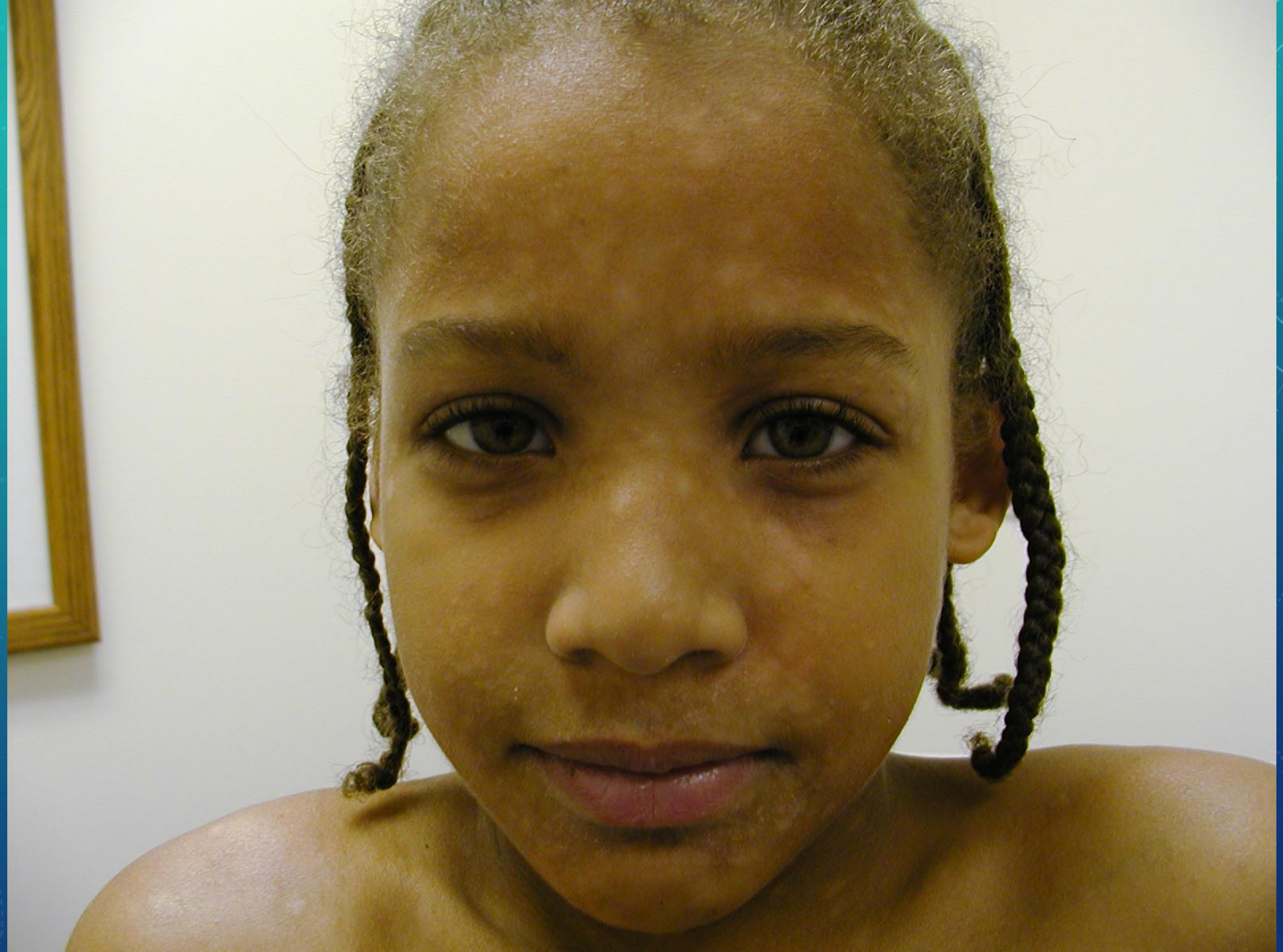


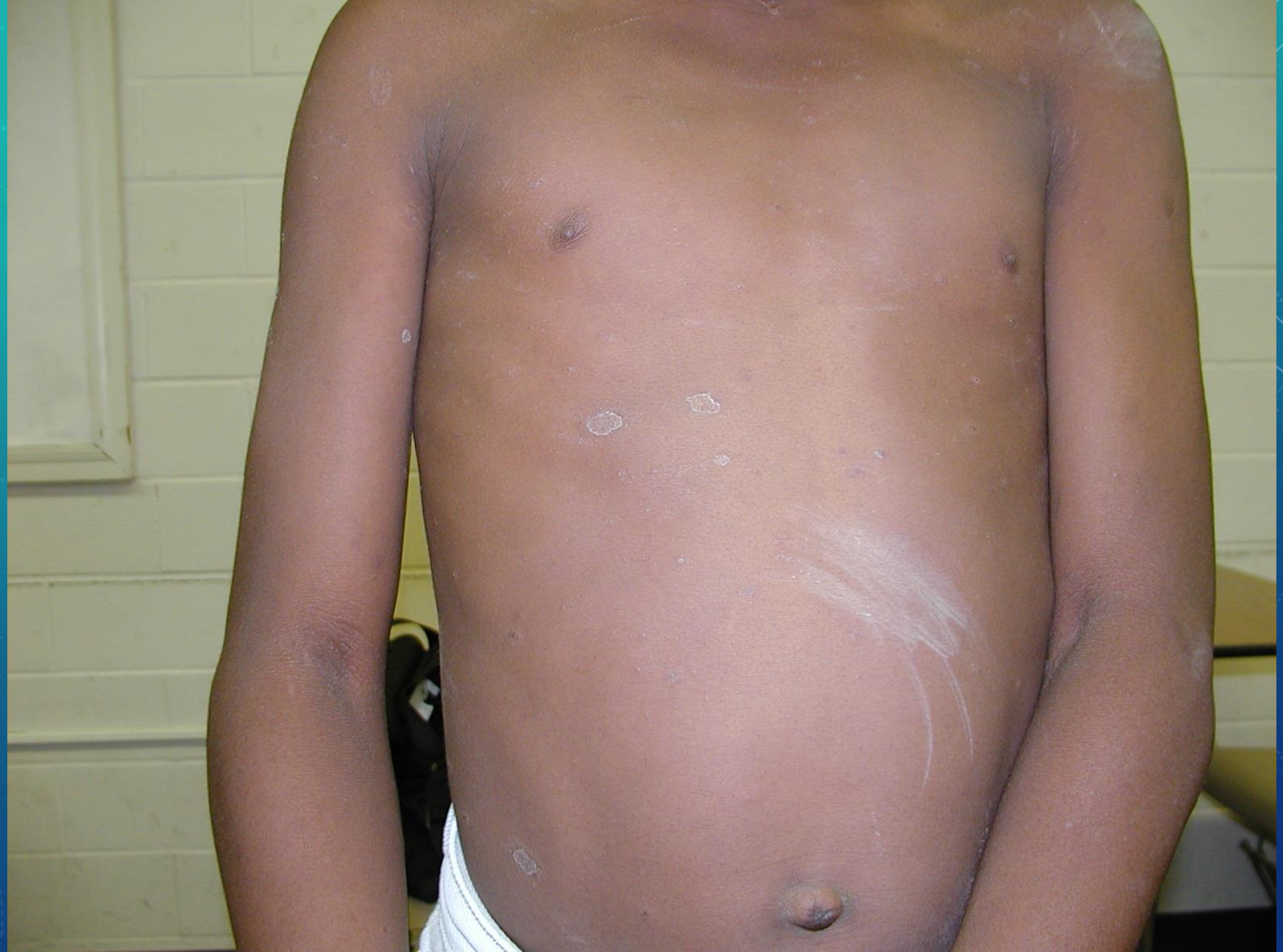


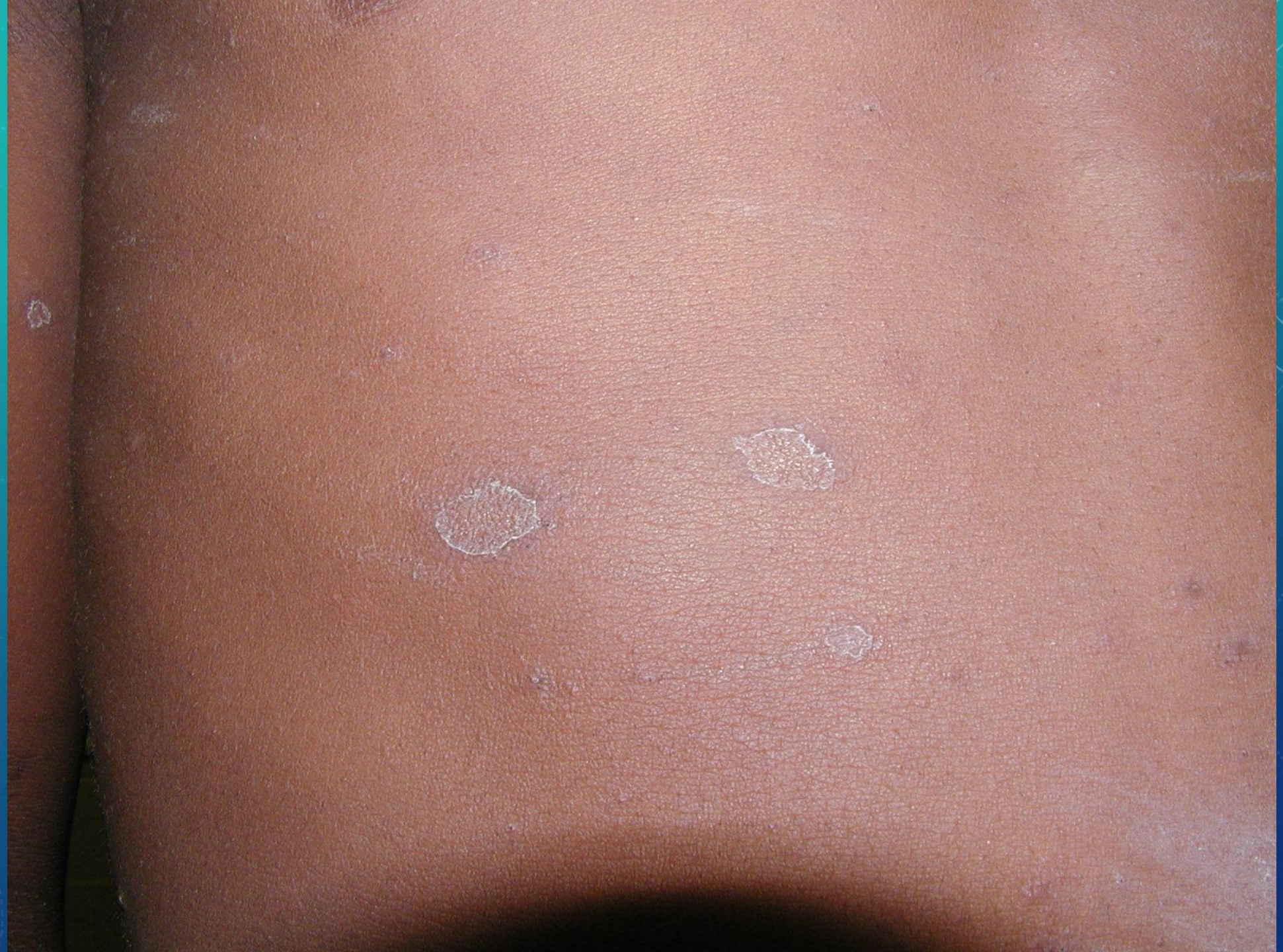




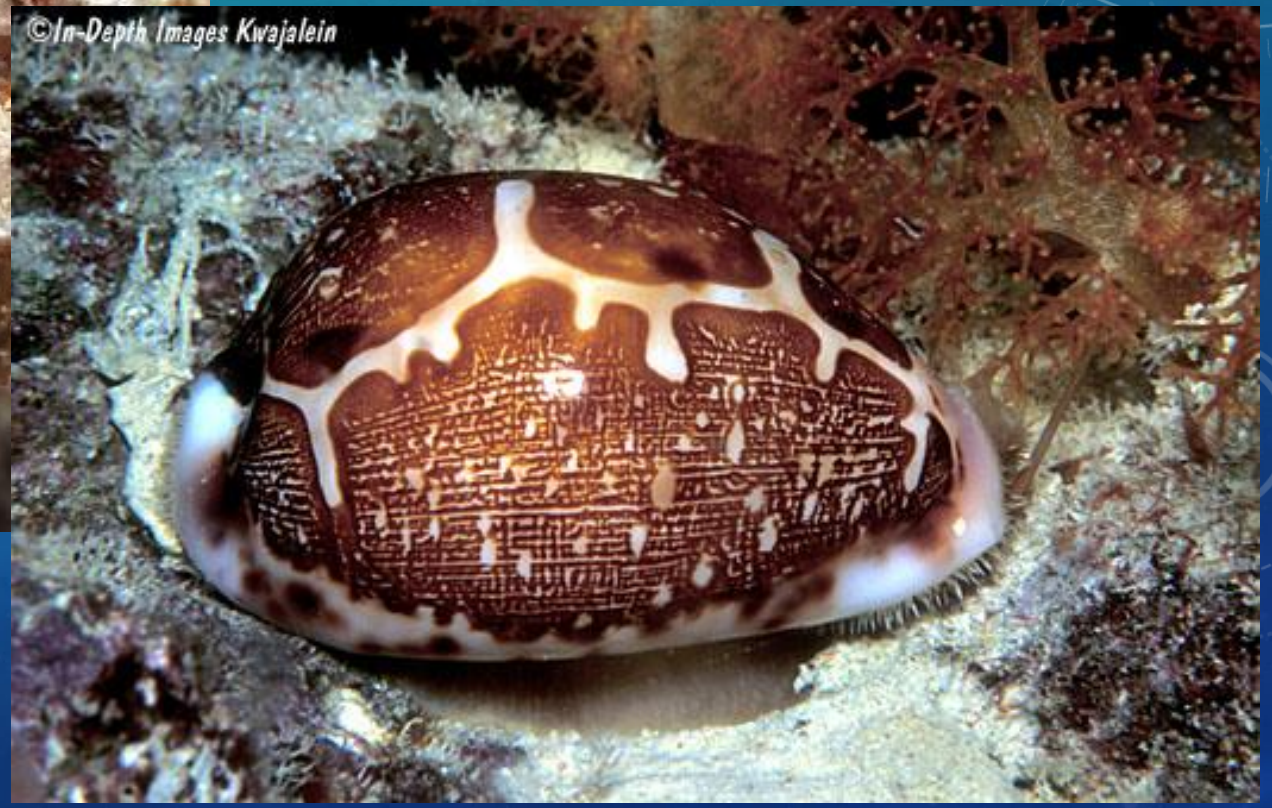


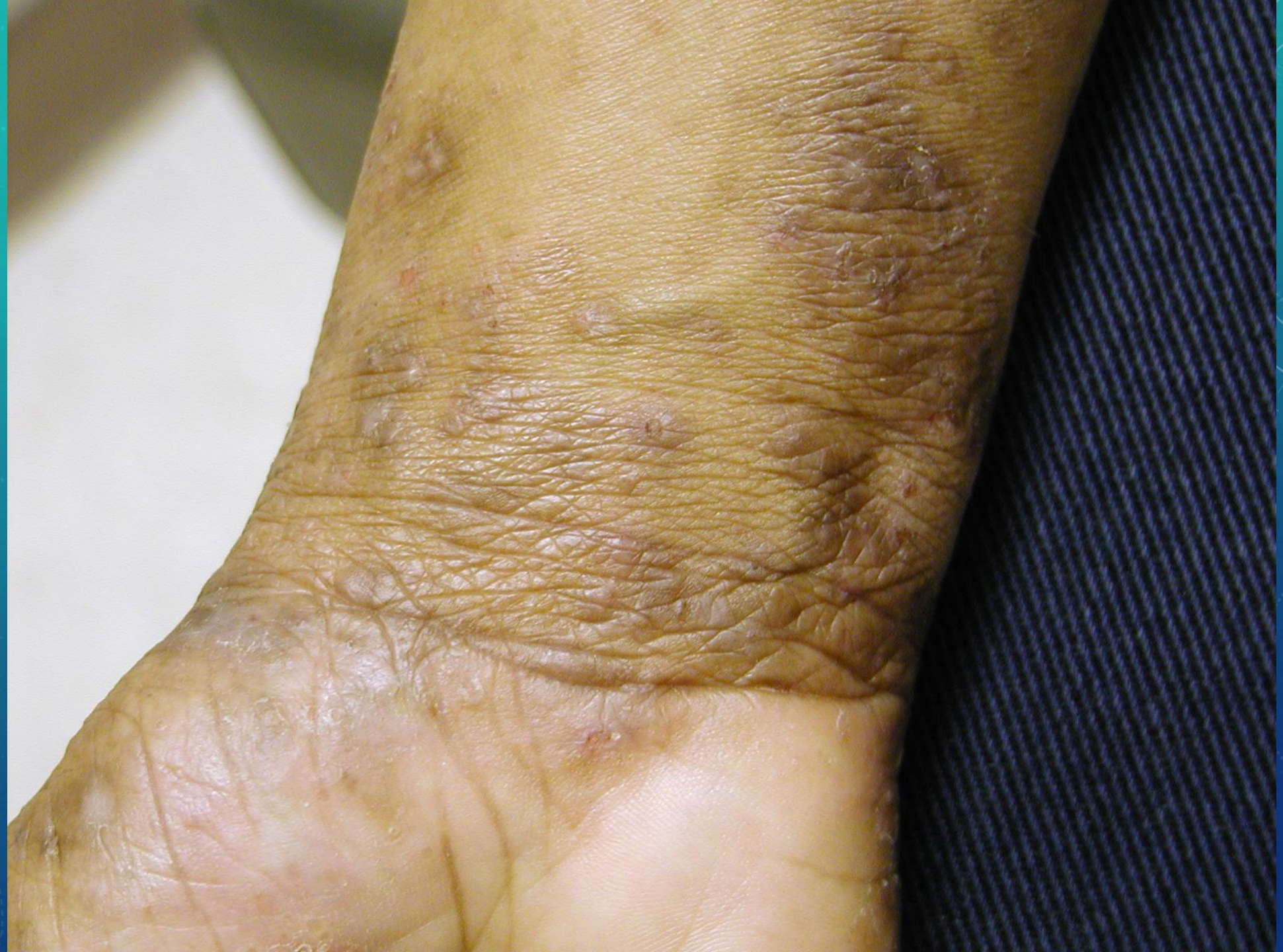


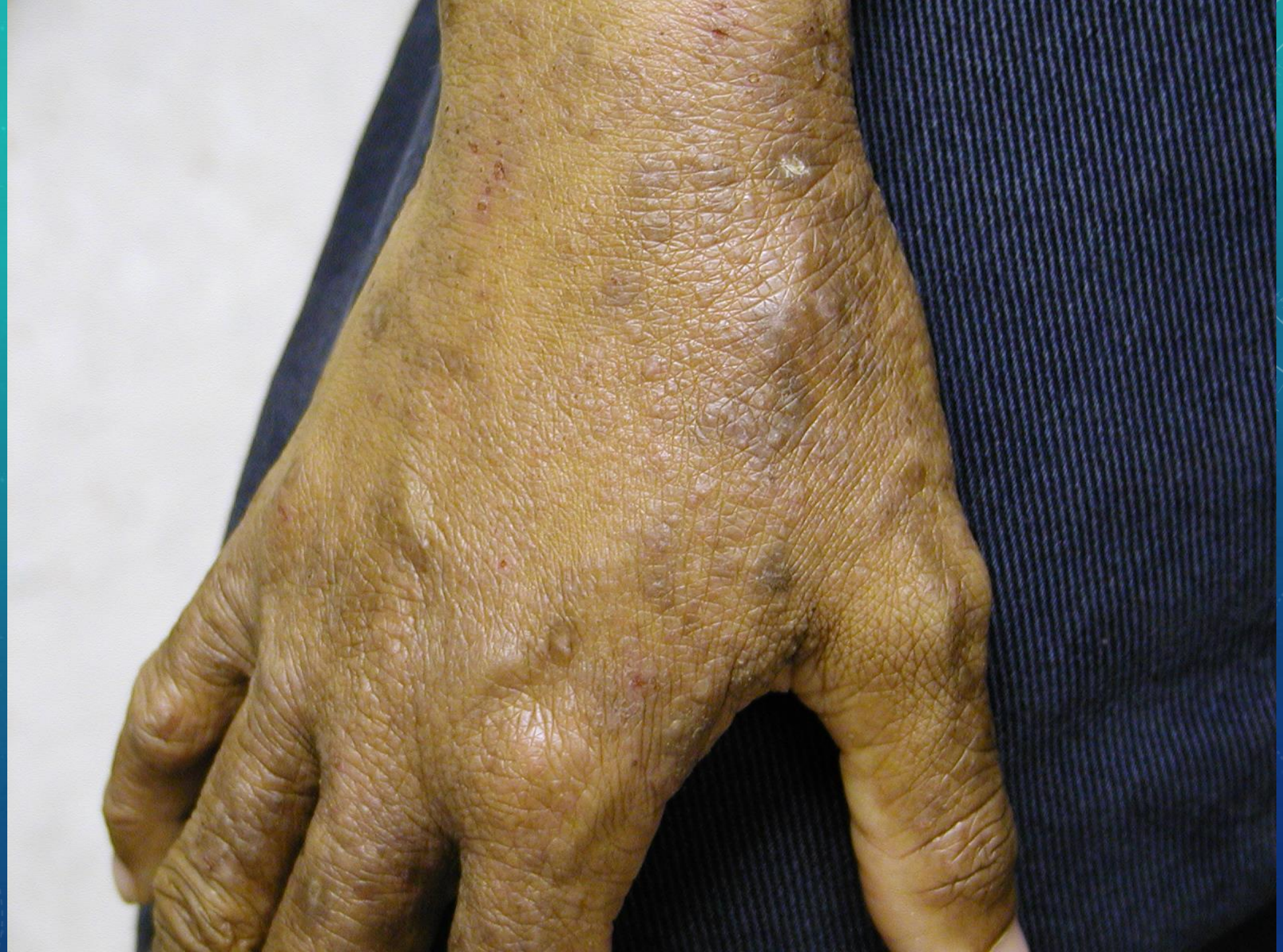


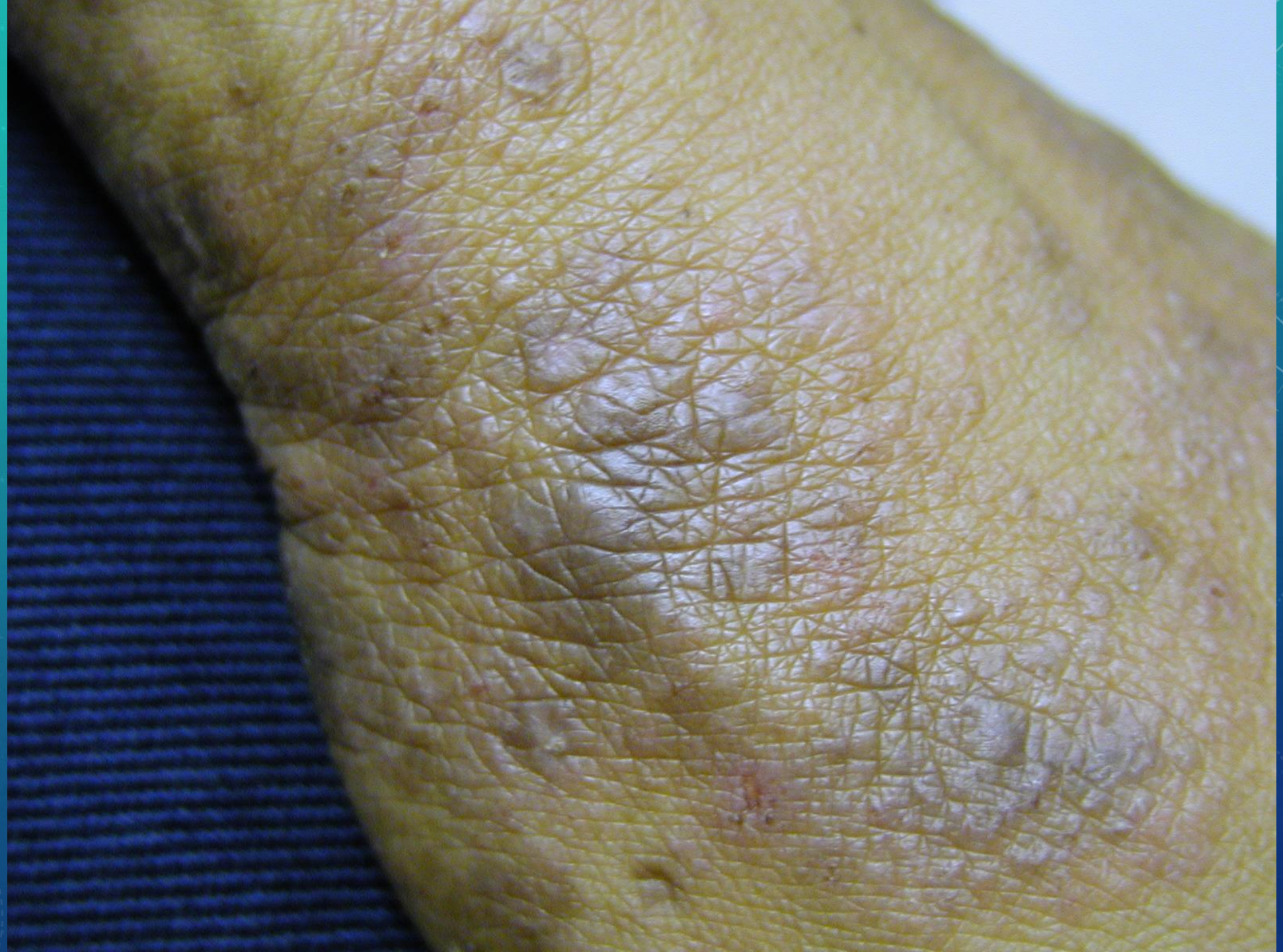


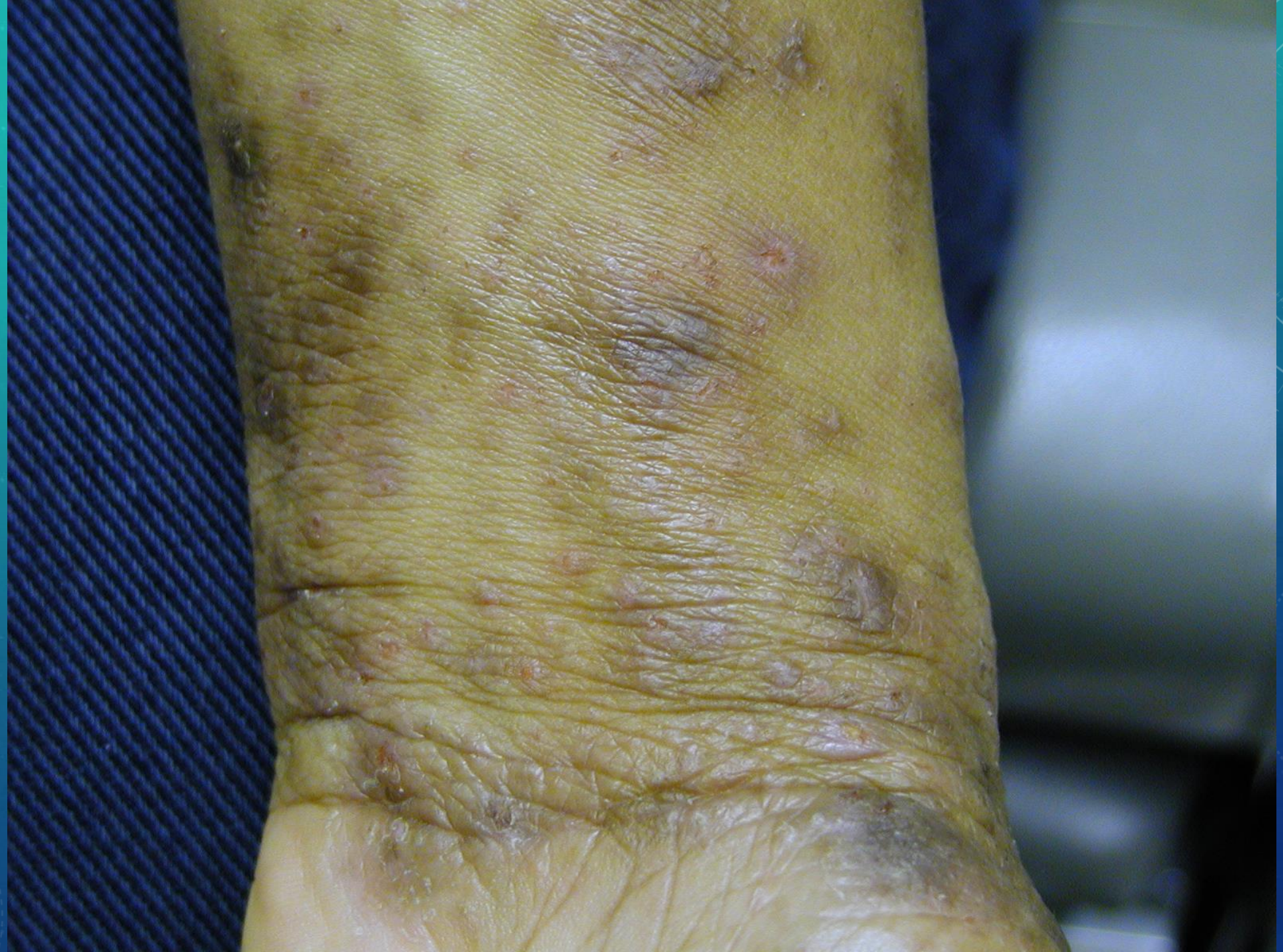
Map Cowrie

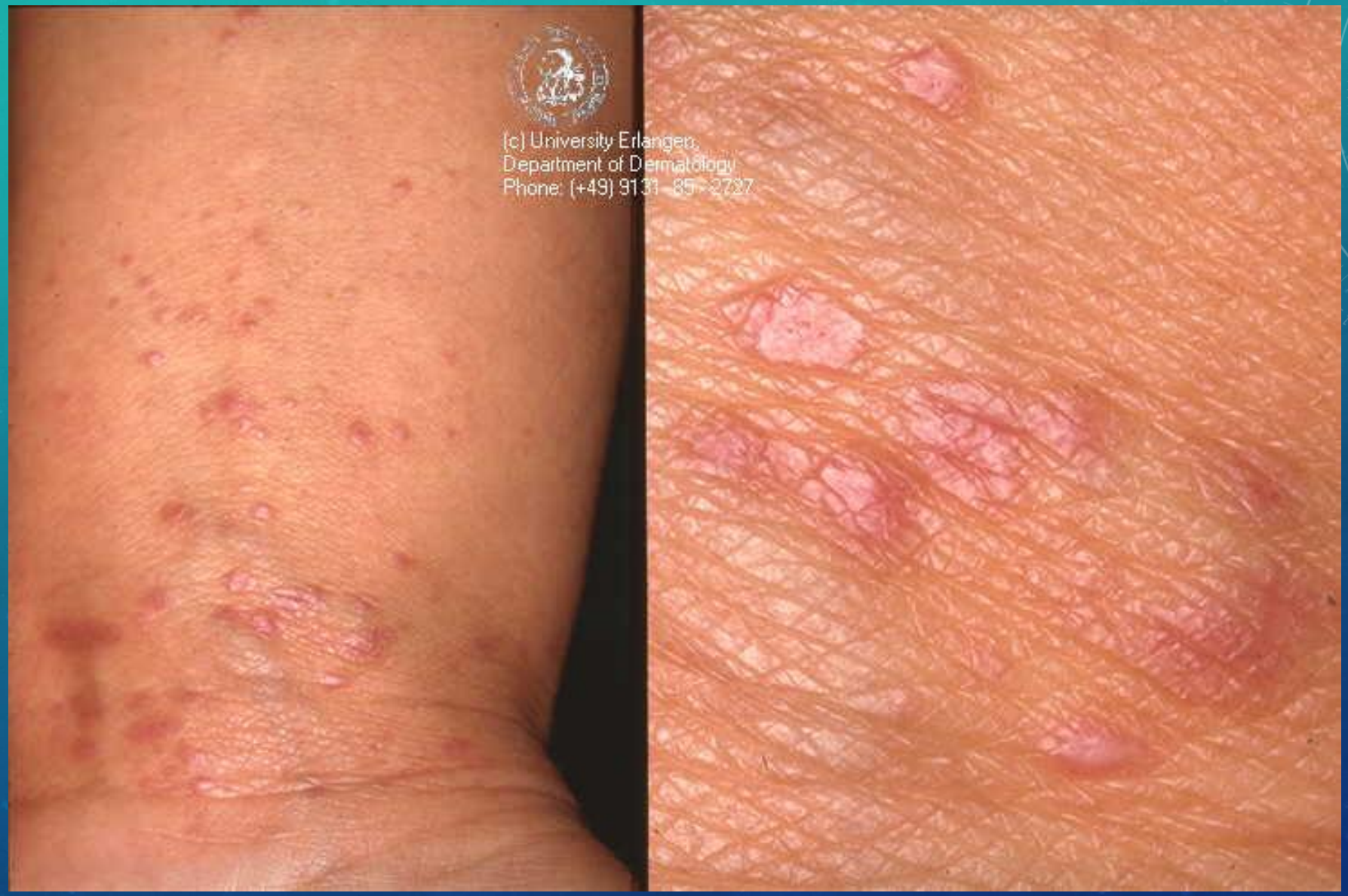






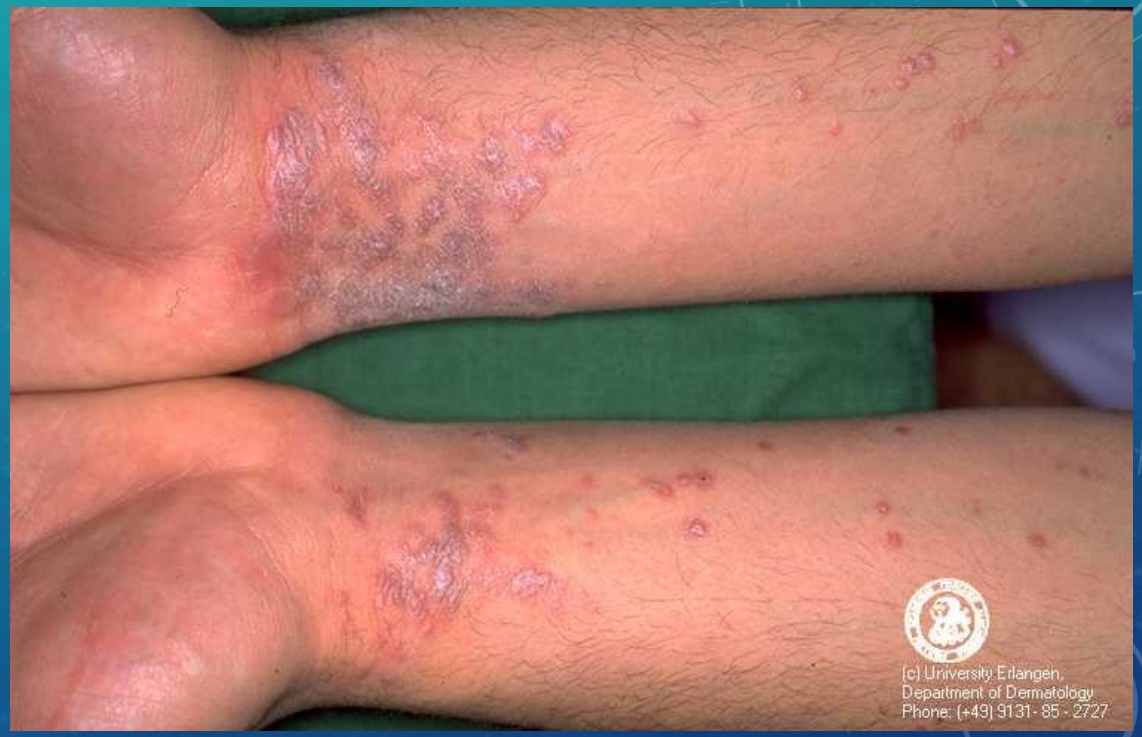


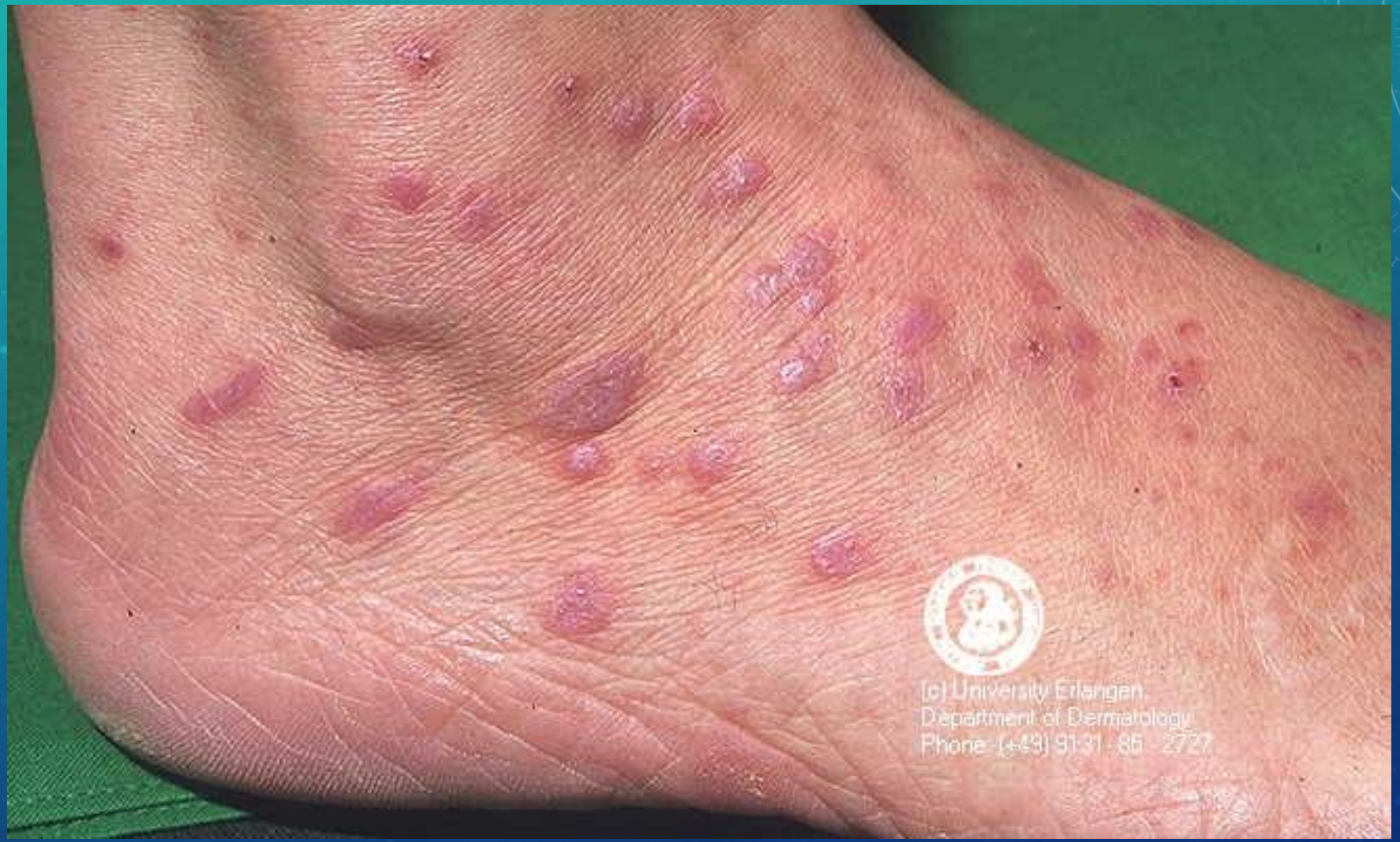



(c) University Erlangen,
Department of Dermatology
Phone: (+49) 9131 - 85 - 2727

What is the most likely diagnosis for this itchy rash on the volar aspect of the wrists?

A. Lichen planus
B. Secondary syphilis
C. Granuloma annulare
D. Rocky Mountain spotted fever

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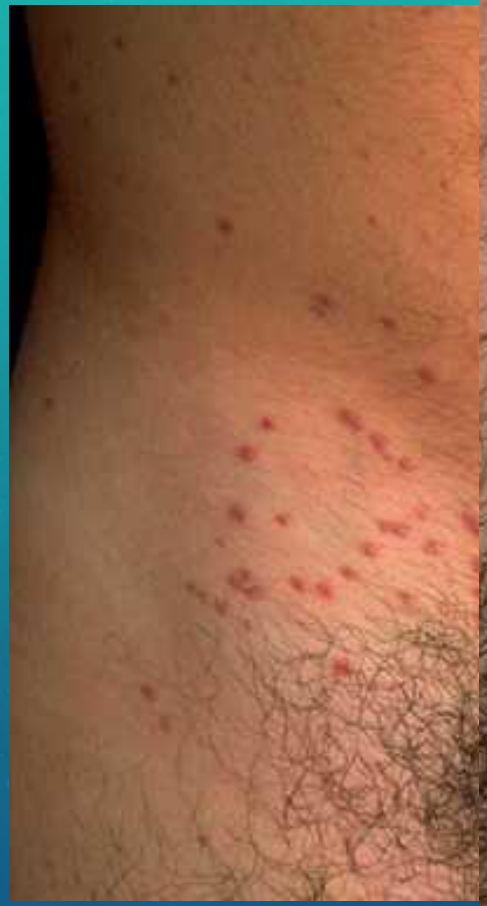
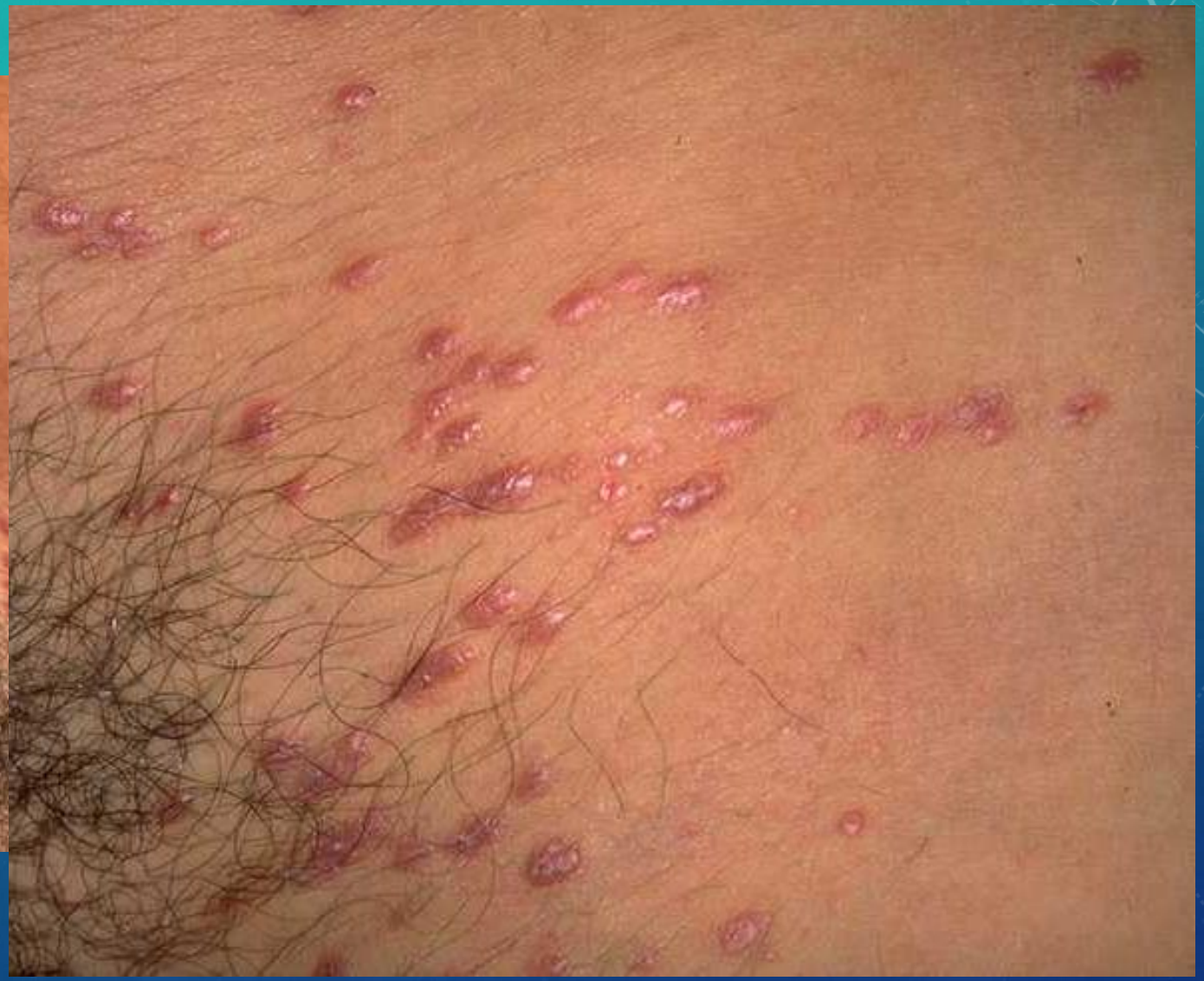
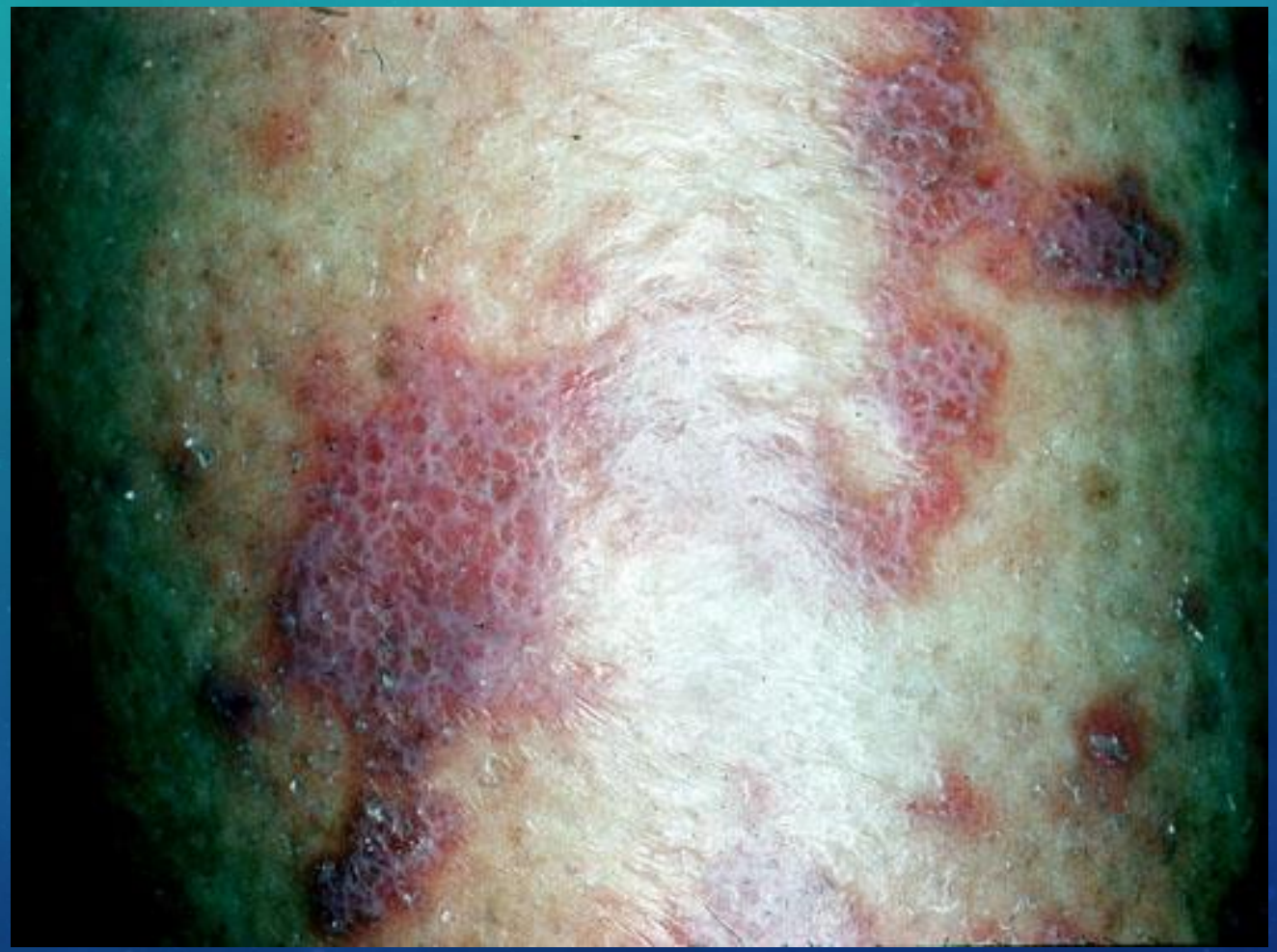
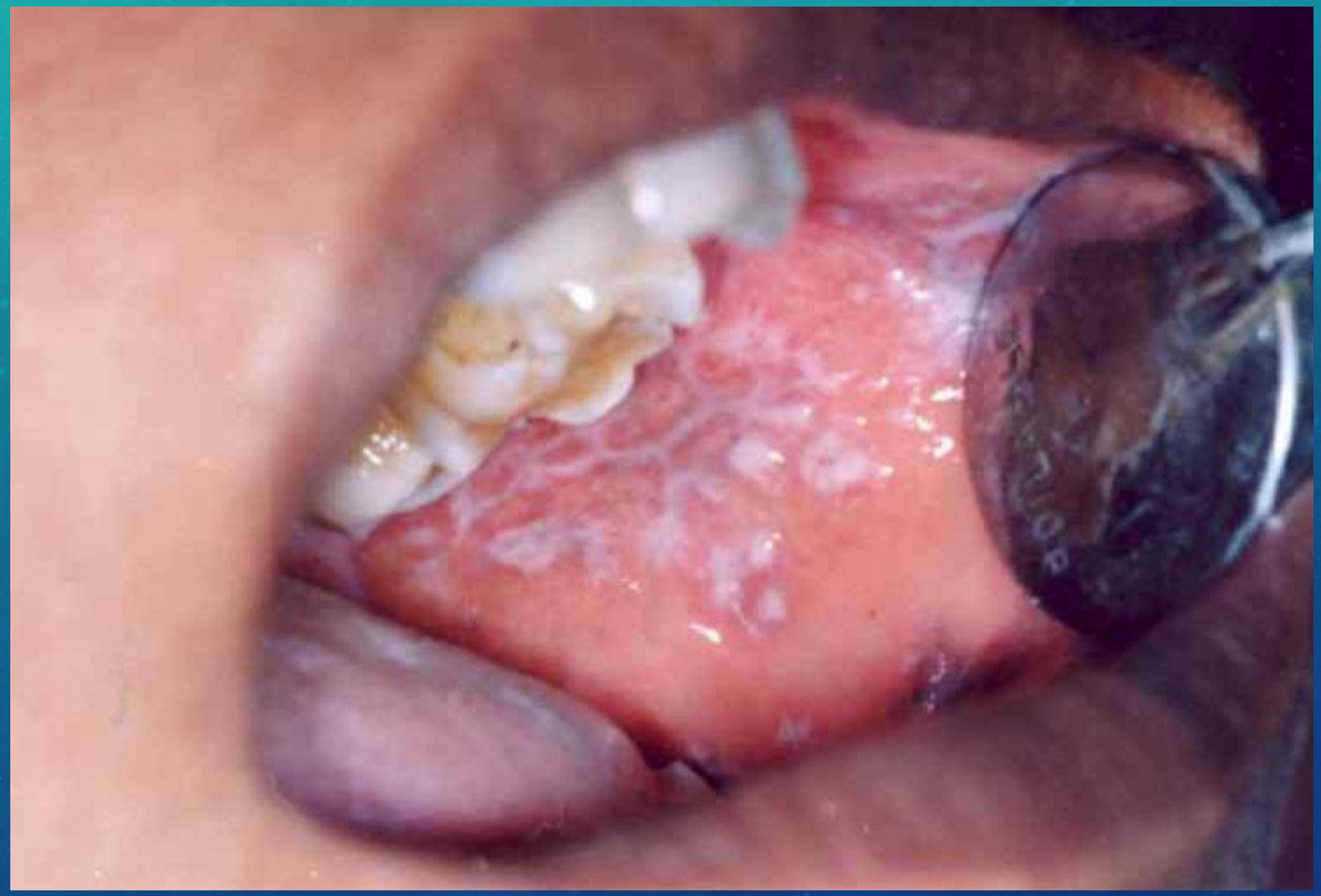


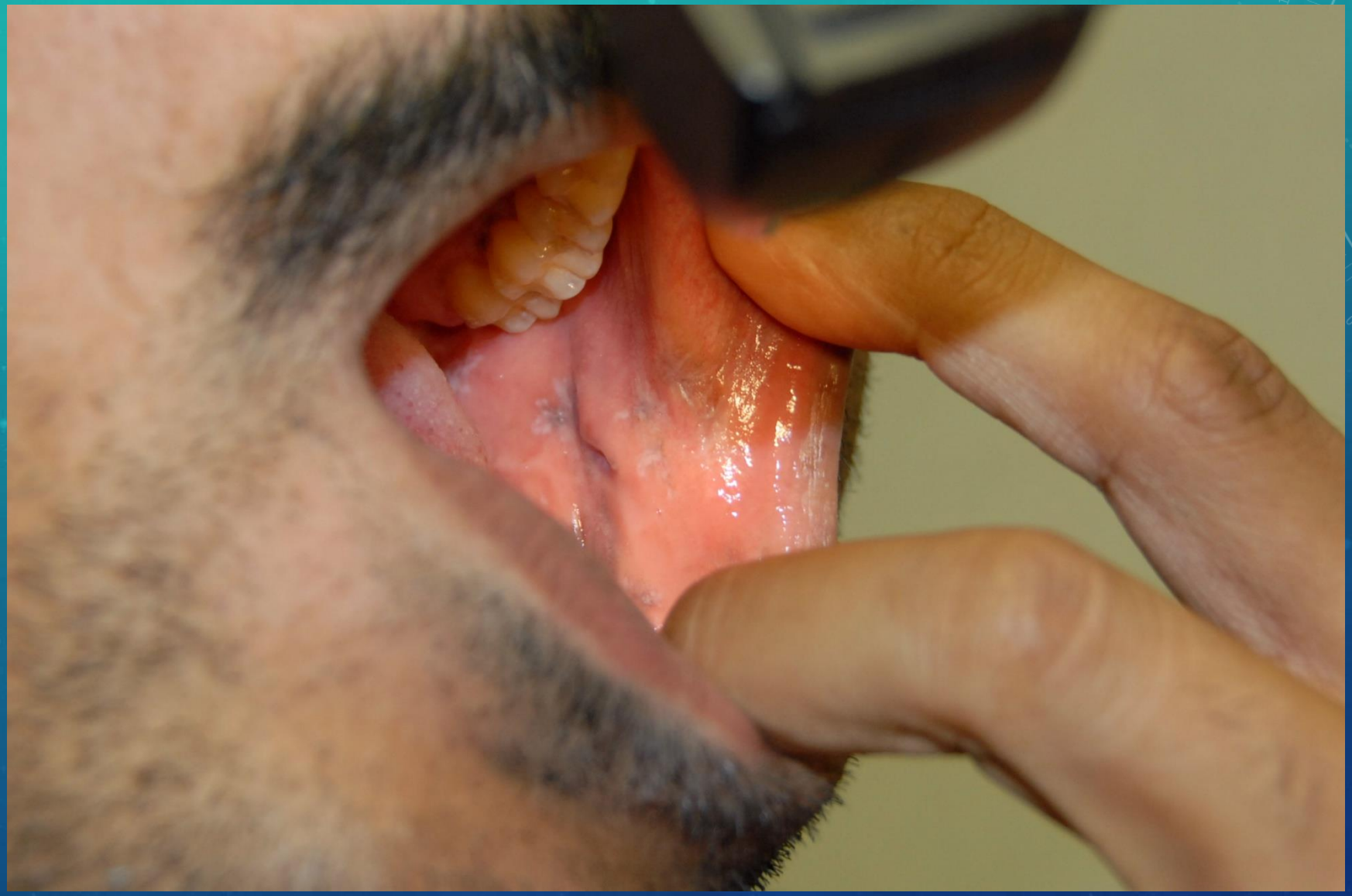


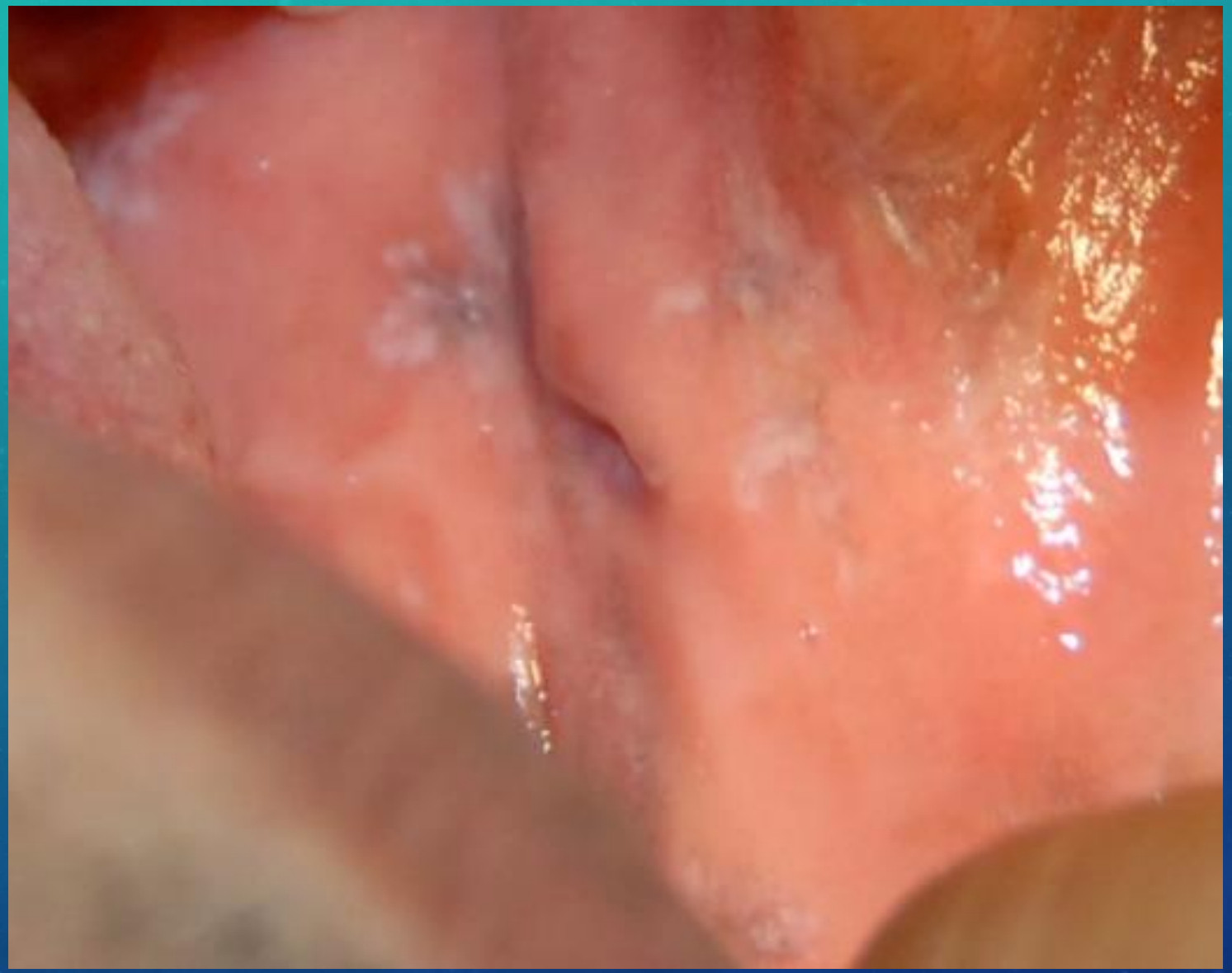
Wickham’s Striae – skin and oral



Wickham’s Striae







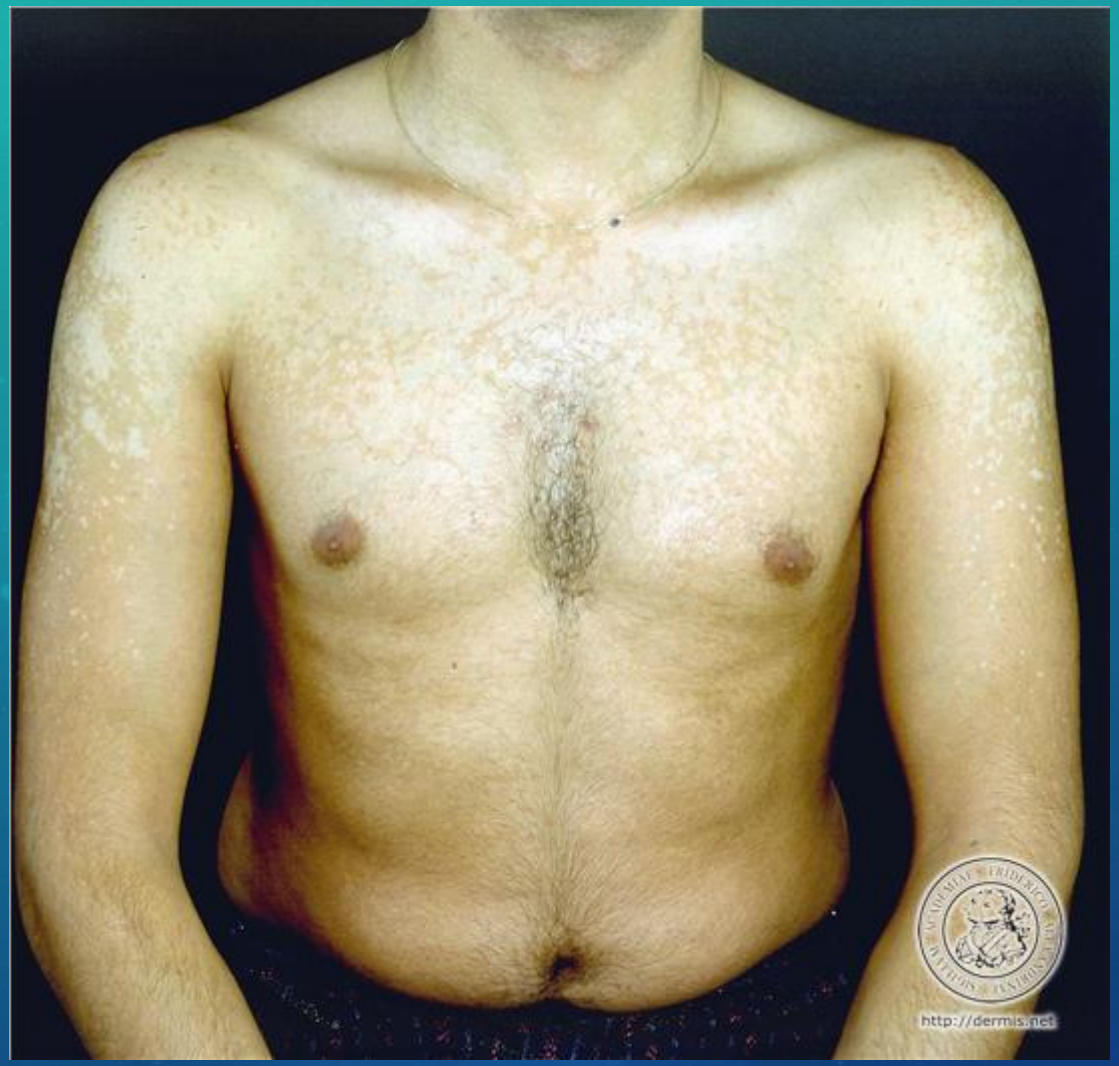
Lichen Planus

- Purple
- Pruritic
- Polygonal
- Planar
- Papules and plaques
- It’s not PUPP (pruritic urticarial papules and plaques of pregnancy)

Lichen Planus
Treatment

- Topical steroids, high potency initially
- Intralesional steroids
- Antihistamines
- PUVA for generalized LP
- Kenalog in orabase for oral lesions on buccal mucosa (Wickham's striae)

Zebra or Measled cowrie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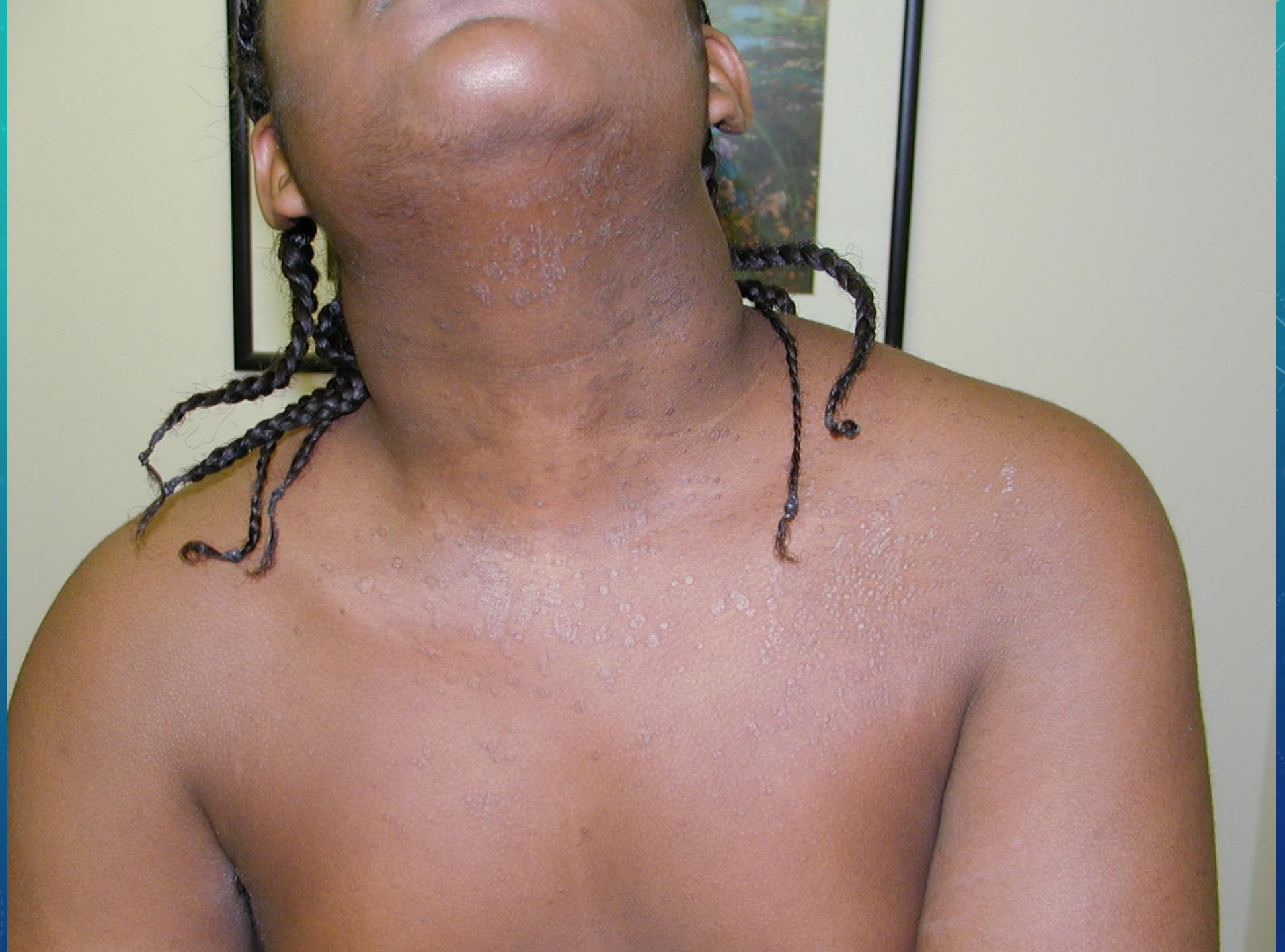
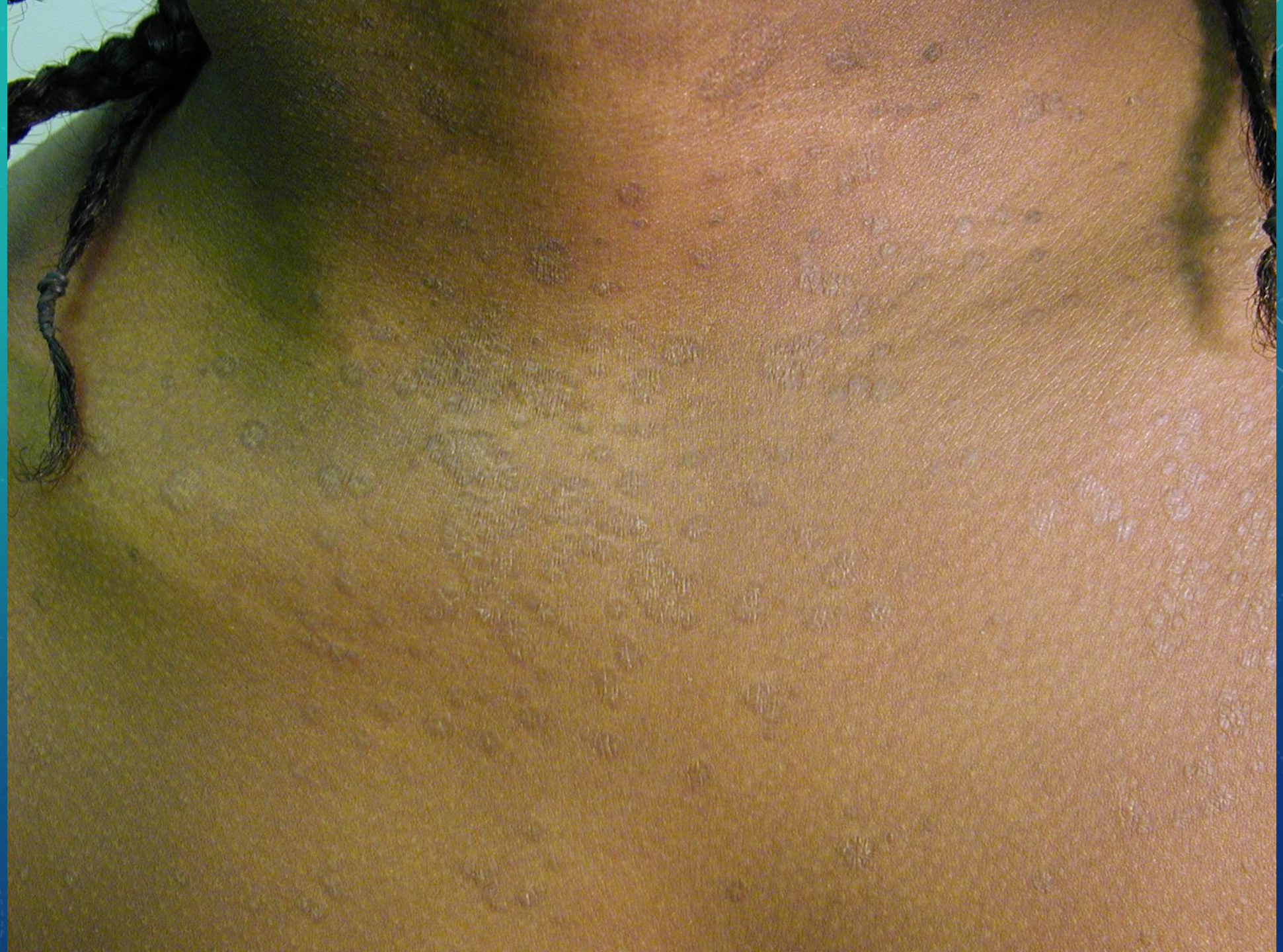
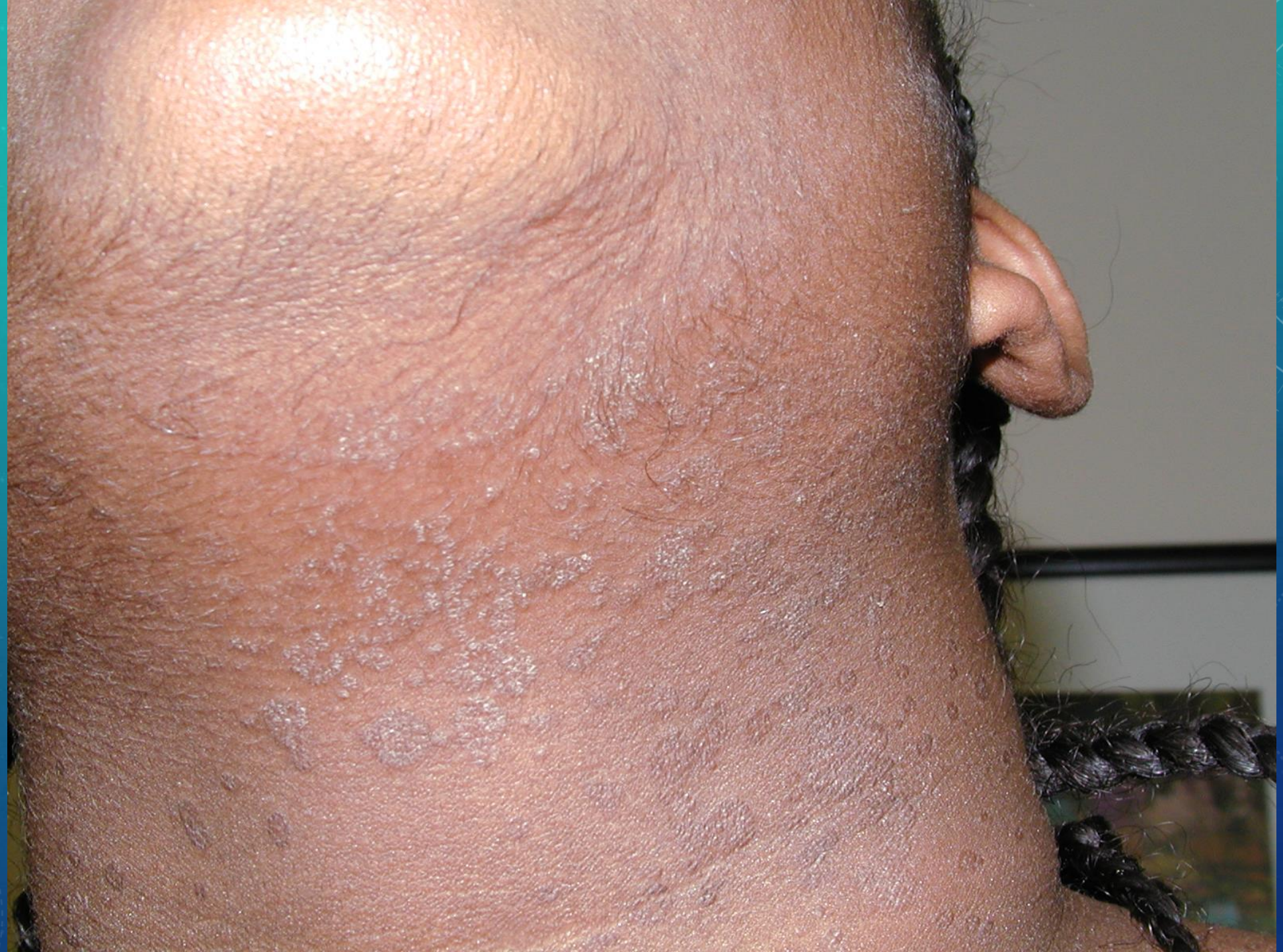
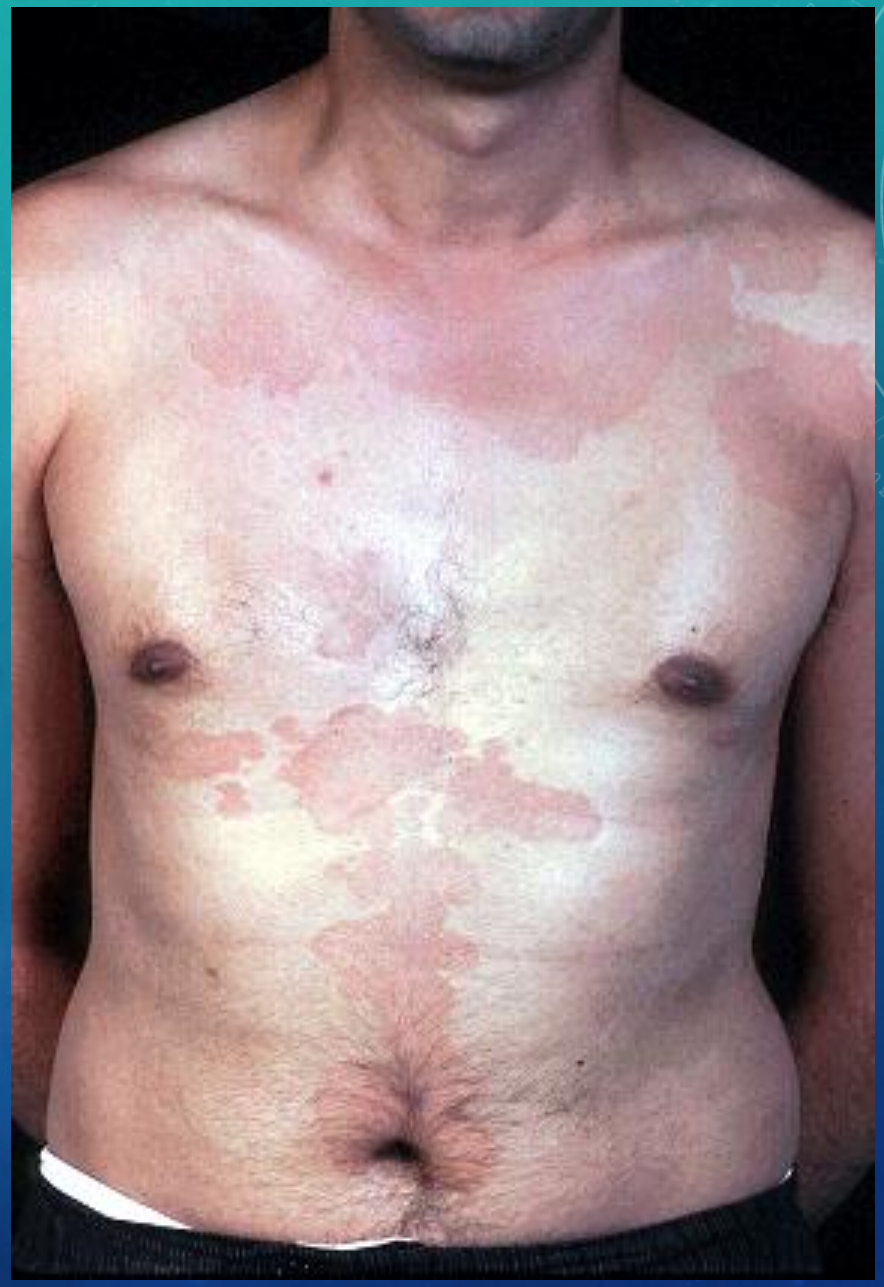






Tinea versicolor



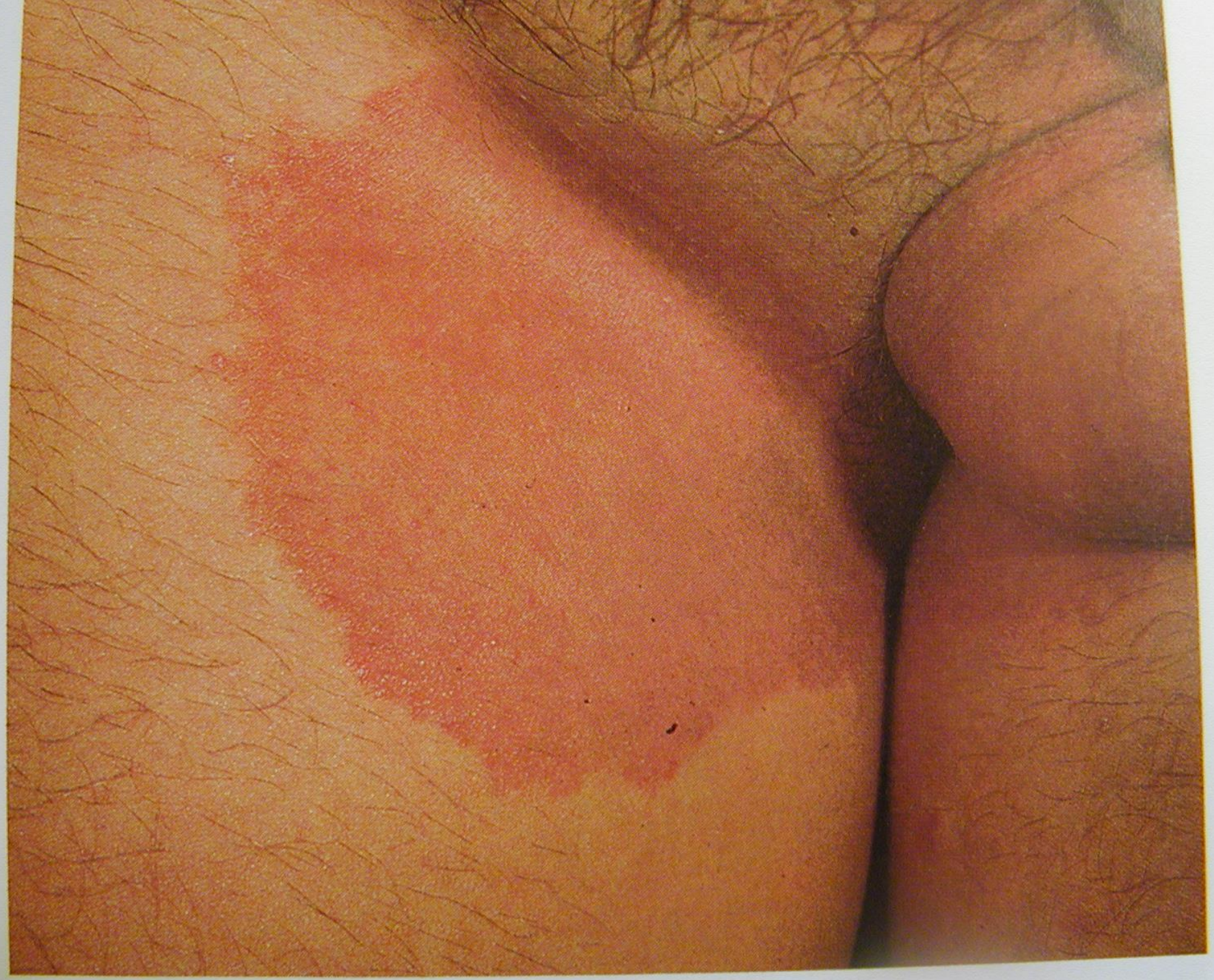
Meatballs

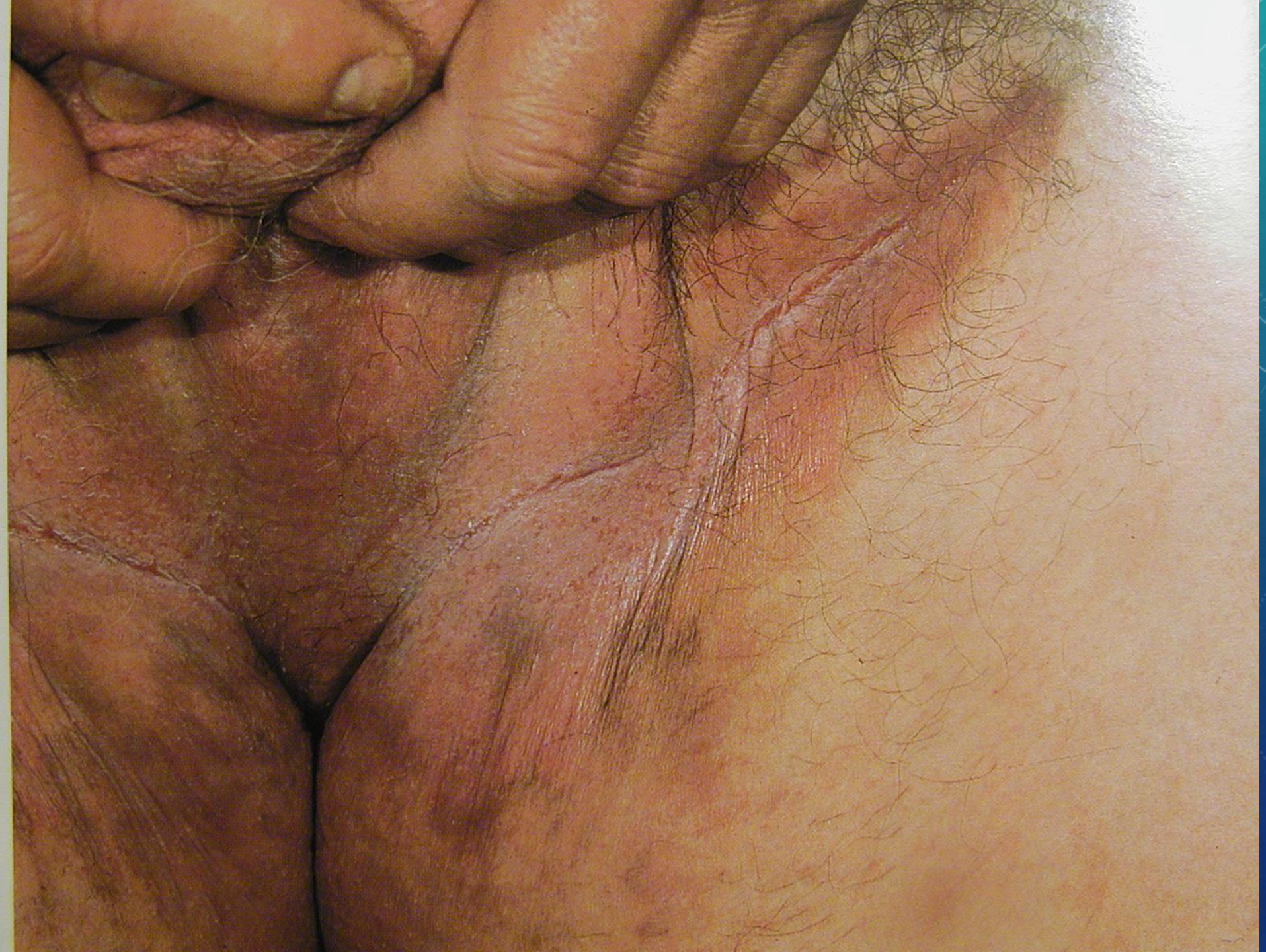
Spaghetti

Malassezia furfur

Tinea Versicolor - treatment

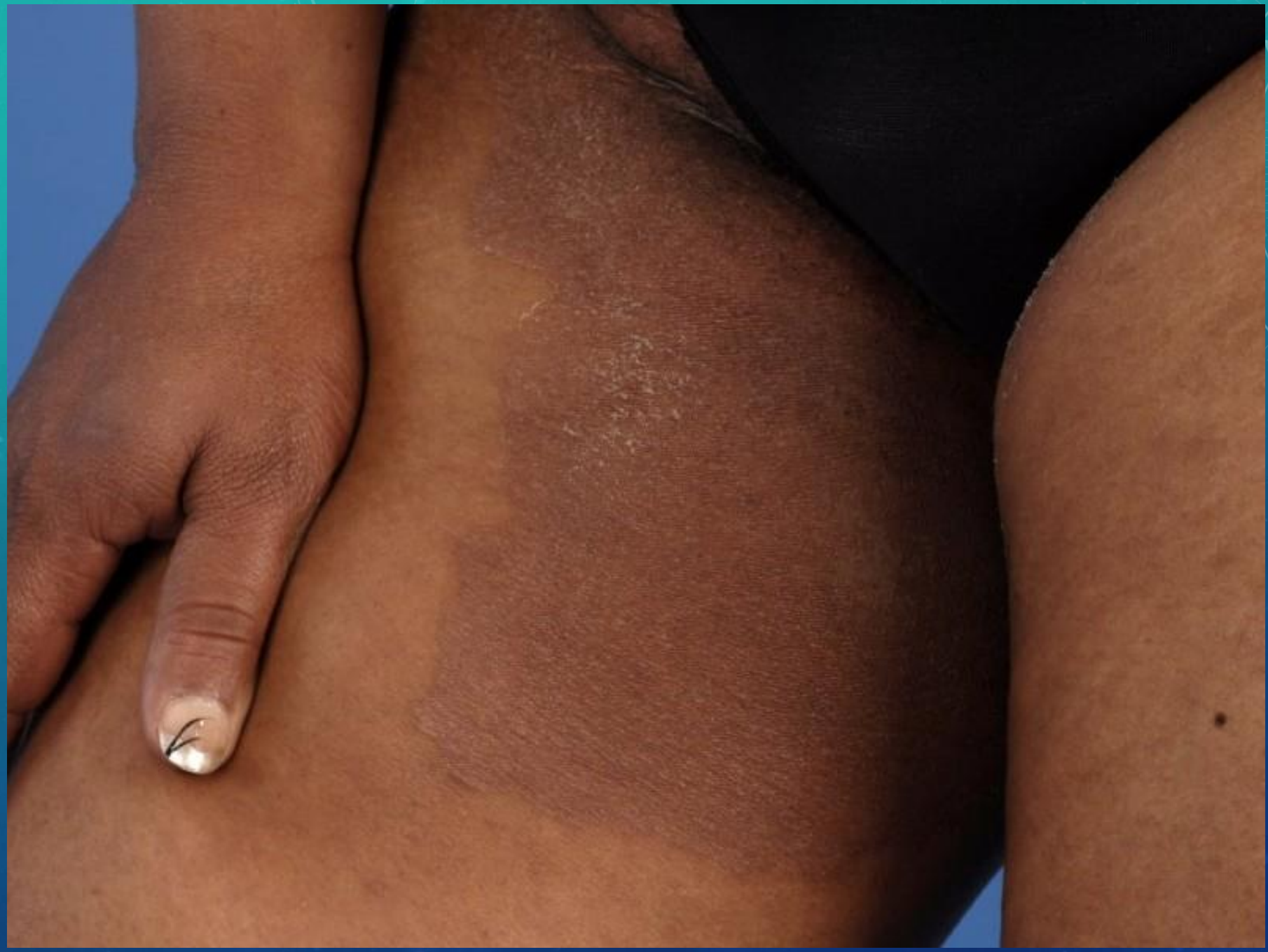
- Topical antifungals 70-80% cure rate
  - Apply for 2 weeks
- Oral antifungals
  - Ketoconazole 200-400mg daily for 5 days
    - 90-95% cure rate at 4 weeks
  - Single dose fluconazole 150mg
  - Single dose itraconazole 400mg
- Ketoconazole 2% shampoo
  - Wash daily – single application or three days worth

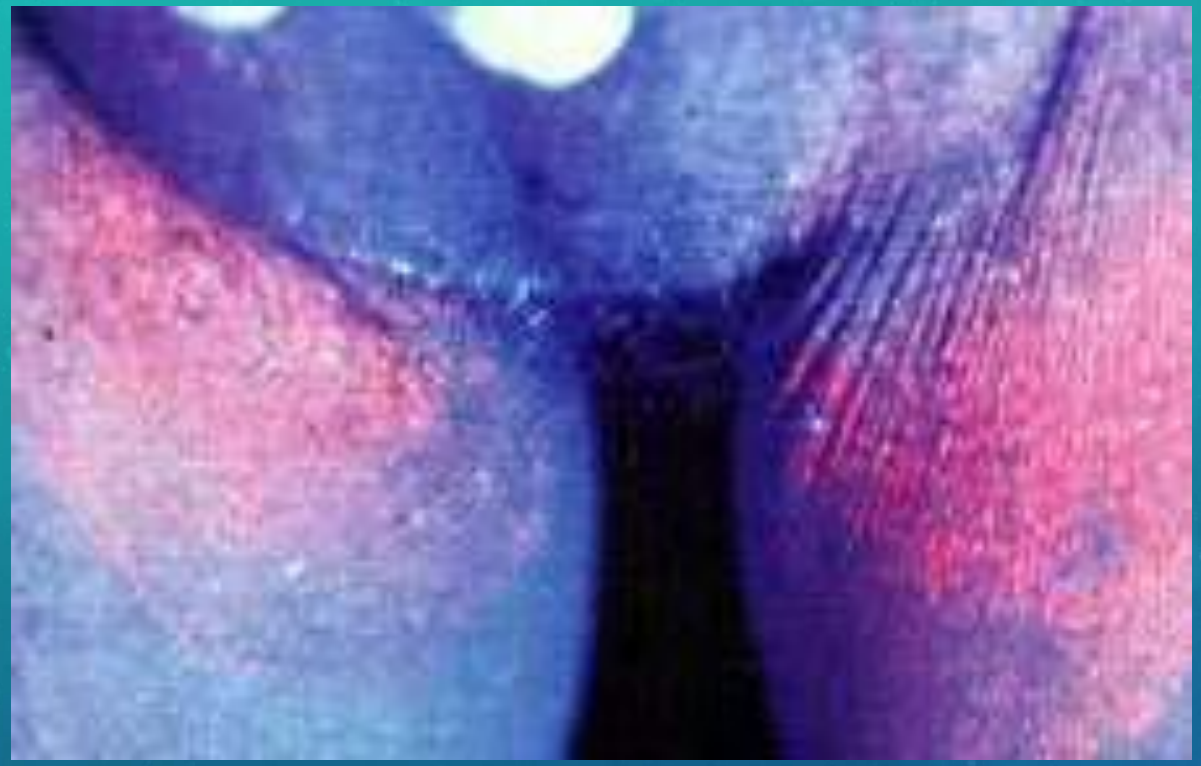


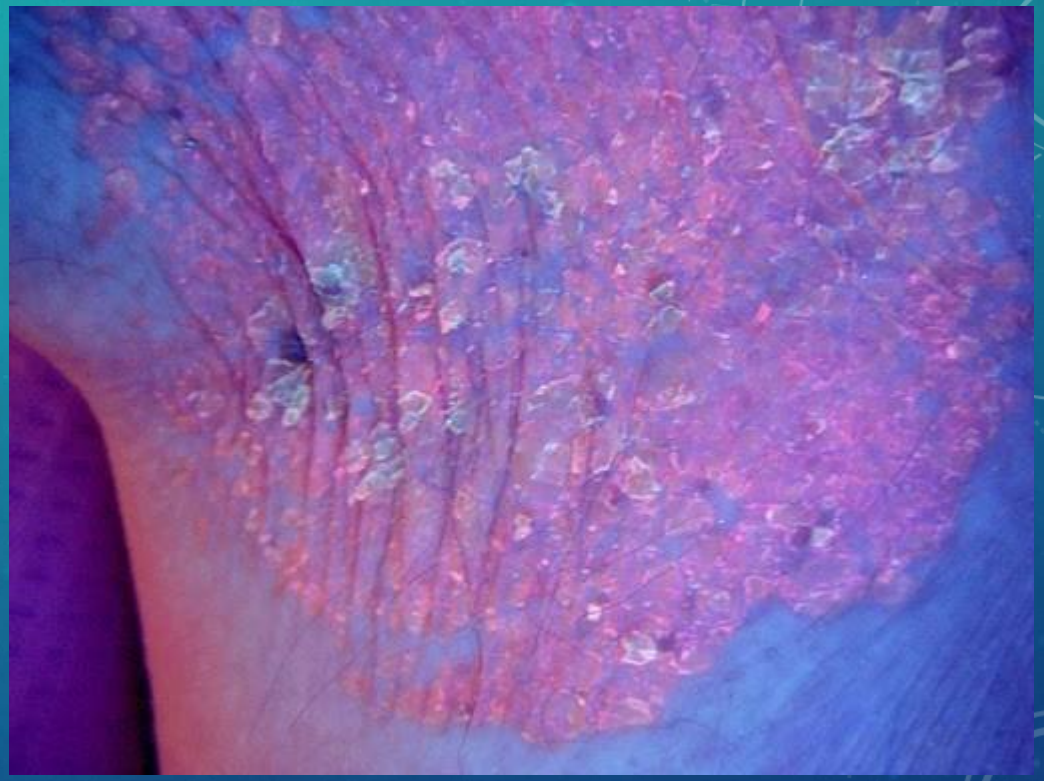


Tinea cruris

- Treat with topical or oral antifungals.
  - Clotrimazole 1% cream bid for 2-4 weeks
  - Econazole 1% cream qday x 2 weeks
  - Ketoconazole 2% crm qday x 2 weeks
  - Nystatin topical bid x 2 weeks
  - Many others: terbinafine, tolnaftate, ciclopirox, miconazole
  - For historical purposes: gentian violet
- May combine with a steroid
- Do not use steroid alone – will worse fungal skin infections







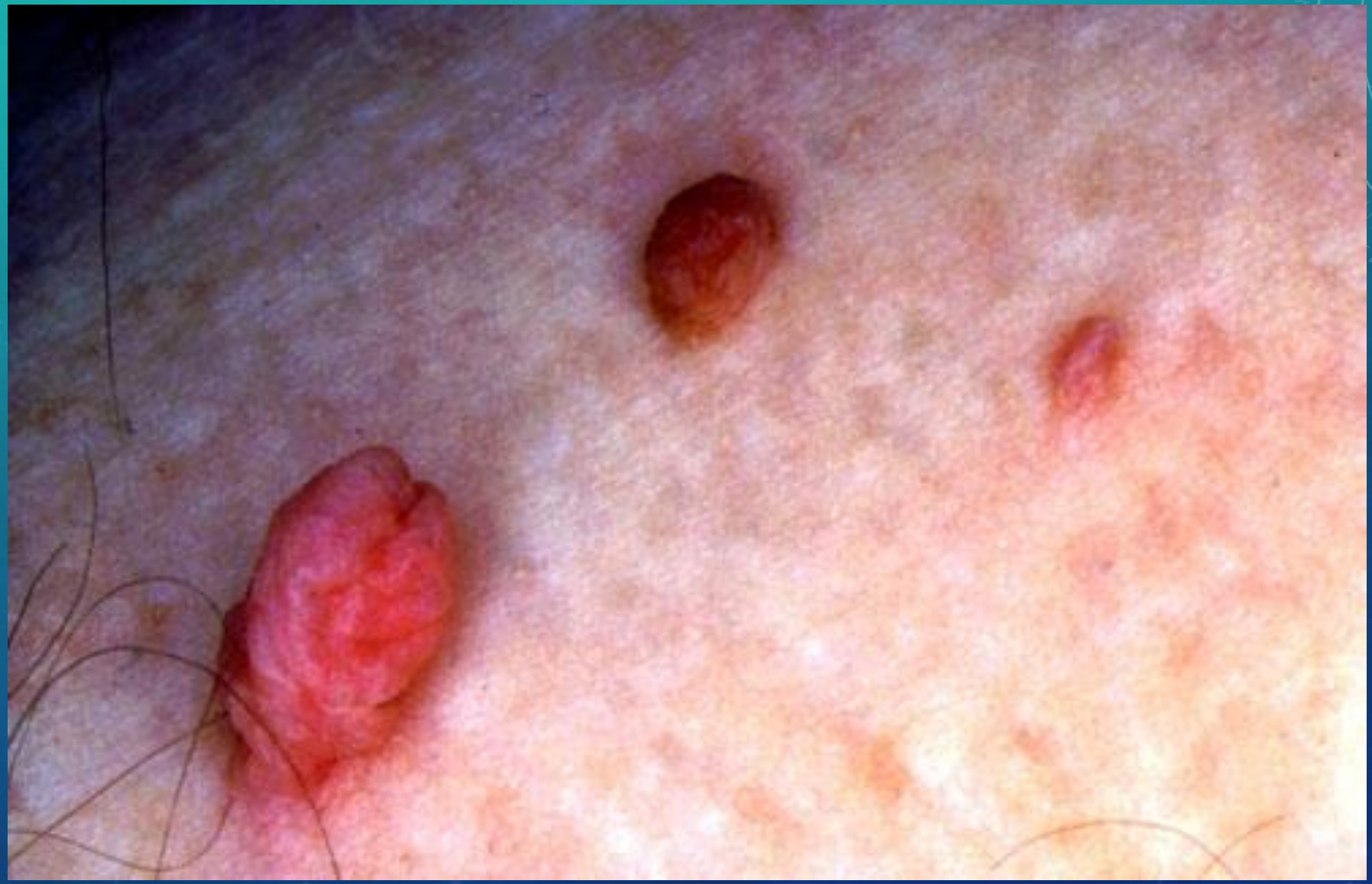
Erythrasma

Erythrasma

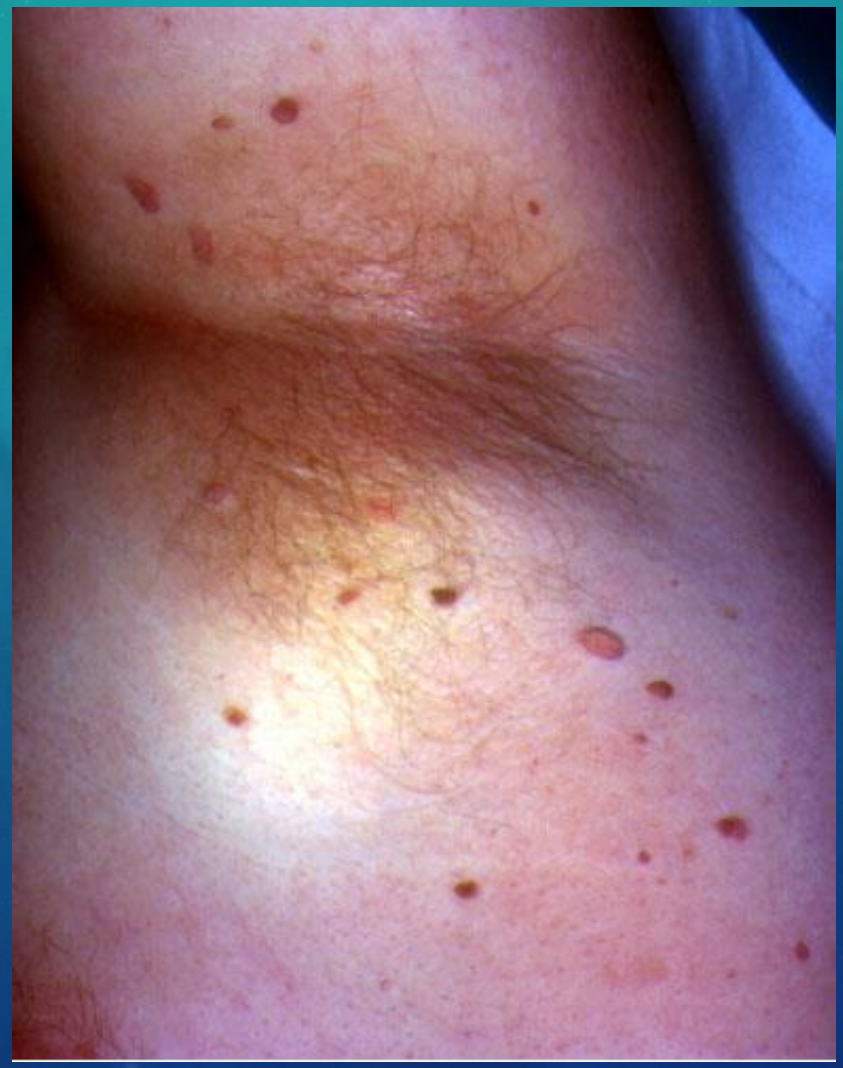
- Classically, this is the “resistant tinea infection.”
- If suspicious, use a Wood’s lamp to exam
- Caused by Corynebacterium minutissimum
- Treated with topical clindamycin or erythromycin for two weeks, or with oral clarithromycin or erythromycin oral for two weeks

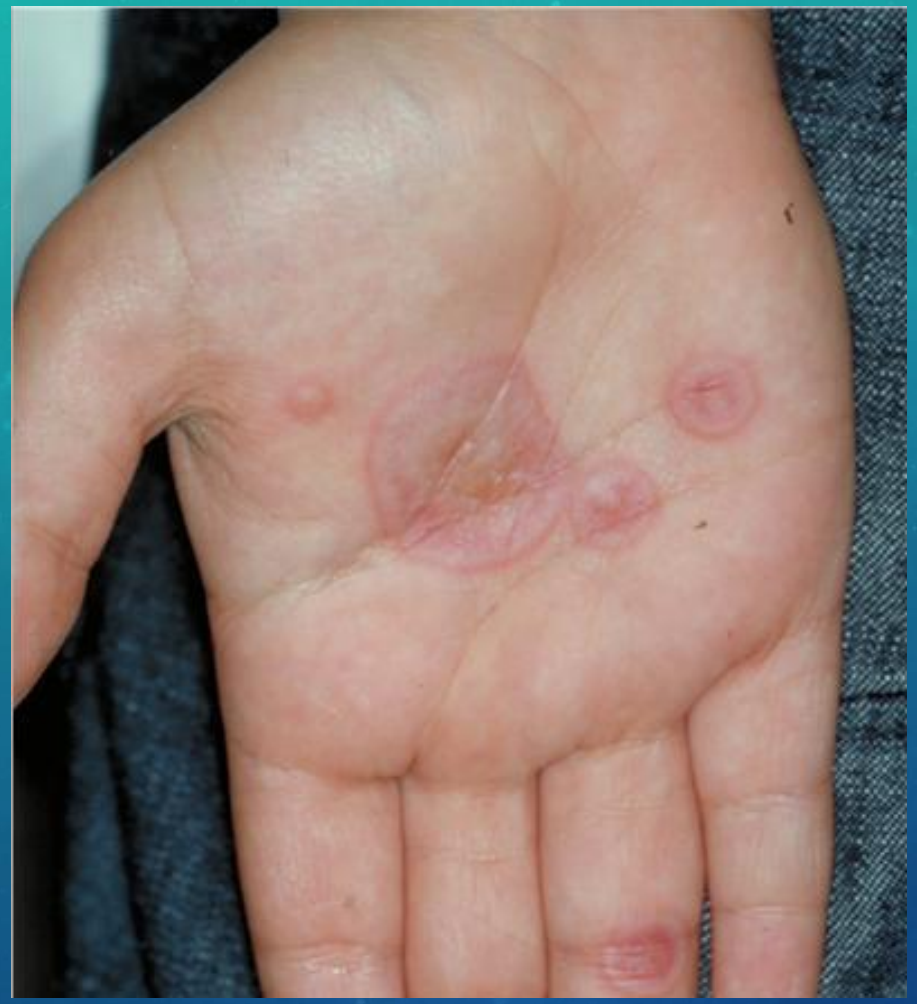
Zigzag cowry

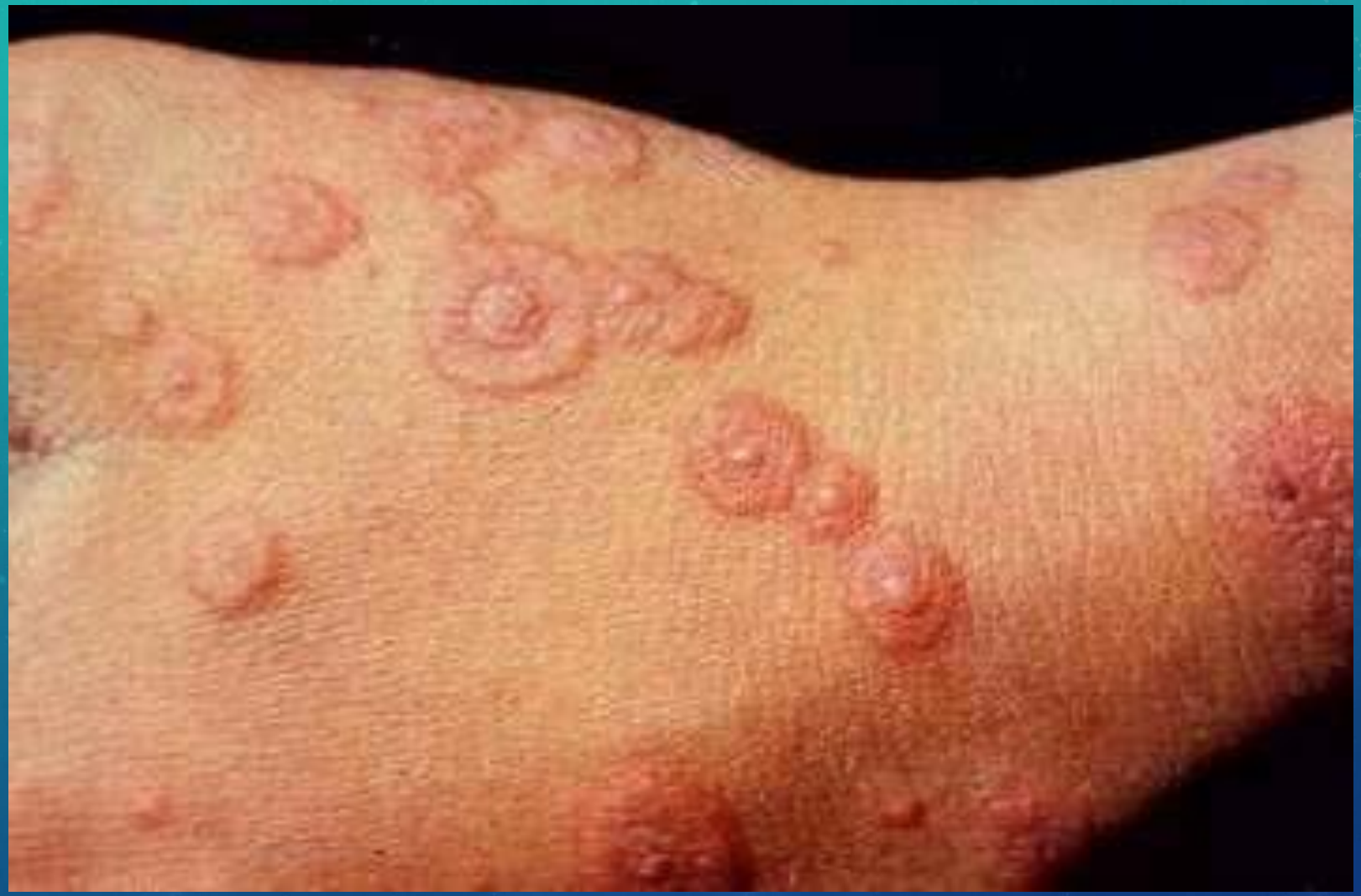
What are these nuisances?



Acrochordon (A.k.a. Skin tag)

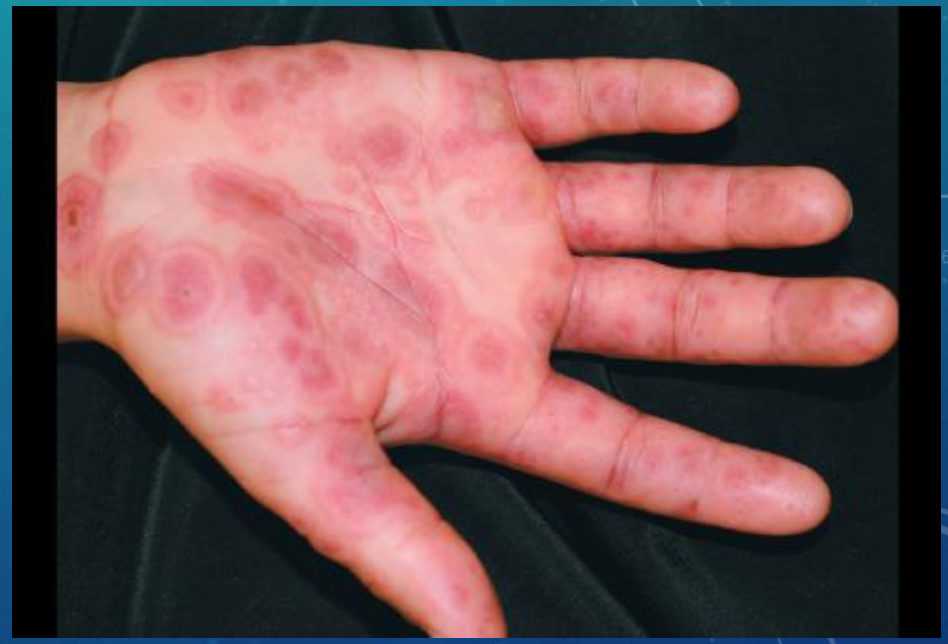


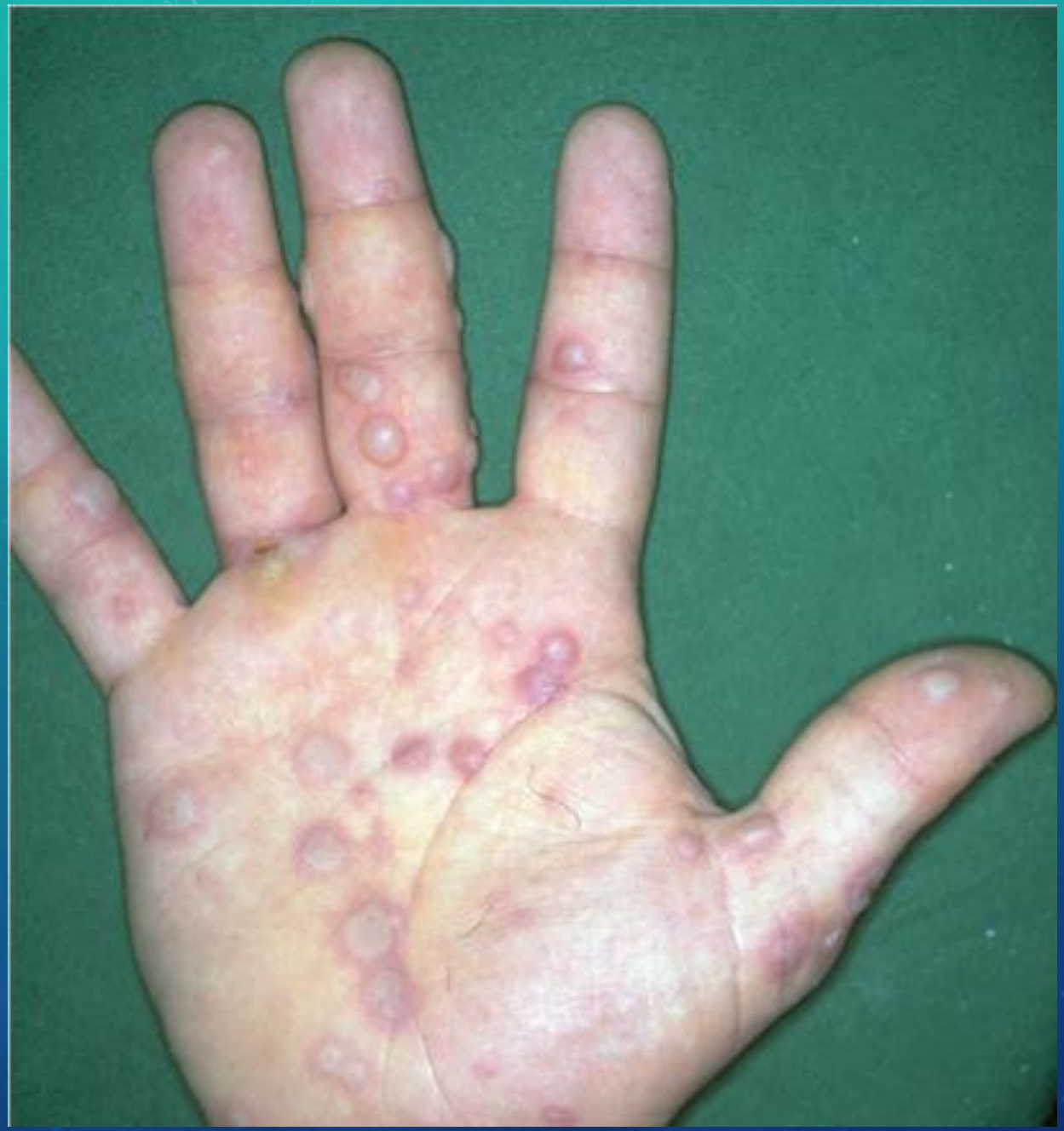




This skin eruption is most consistent with:

A. Erythema migrans
B. Erythema multiforme
C. Rocky Mountain spotted fever
D. Bullous tinea corporis

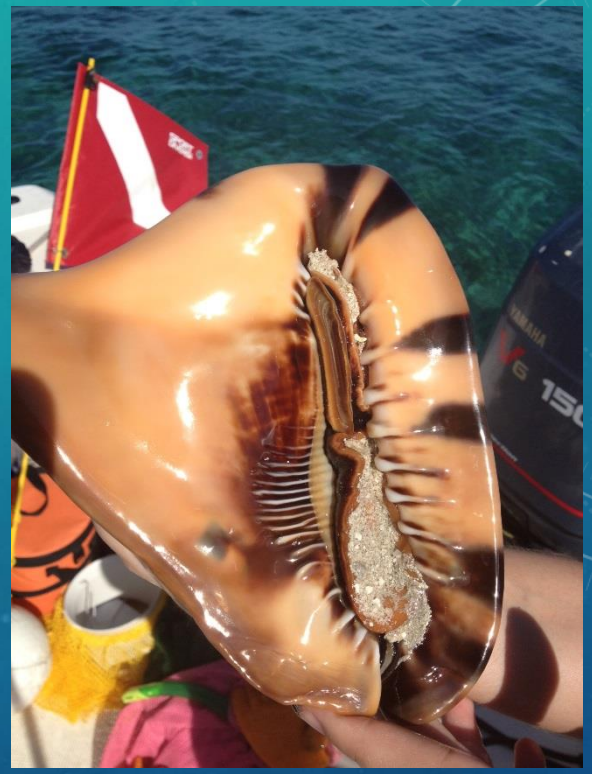




Erythema multiforme

- Associated with herpes simplex , mycoplasma pneumonia, and drug hypersensitivity.
- Typical target lesions.
- Usually spares oral mucosa versus Stevens-Johnson syndrome or the more severe toxic epidermal necrolysis
- Treatment
  - Remove any causative agents/drugs
  - Antihistamines
  - Topical and systemic steroids
  - Antivirals

Lamoreux M, Sternbach M, Hsu W, Erythema Multiforme, Am Fam Physician 2006;74: 1883-8



Thank you for your attention

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