

Emergent and Urgent Dermatology, Eruptions, and Wound Care

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POMA District 8
February 3, 2019

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Disclosures

- Dr. Drew is a consultant for AbbVie, Inc., Sun Pharmaceutical Industries, Ltd, Pfizer, Inc., Centocor Biopharmaceutical, Ortho Pharmaceutical Corp., Galderma Laboratories, LP, Medimetrix Pharmaceuticals, Inc., and Novartis Pharmaceuticals Corp.

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Acute Cutaneous Lupus



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Acute Cutaneous Lupus



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Acute Cutaneous Lupus

- ANA positive, Anti Ro, La Positive
- Photo distributive
- Need Systemic Work up
- Initial tx, systemic corticosteroids, SPF
- Antimalarials following negative G6PD

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Subacute Cutaneous Lupus



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Subacute Cutaneous Lupus Erythematosus

- ANA negative, Ro and La positive
- Fewer systemic symptoms
- Less systemic co morbidities
- Corticosteroids and steroid sparing agents, spf

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Discoid Lupus



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Discoid lupus

- ANA, Ro and La negative
- Usually not systemic
- Scarring and Scaling alopecia
- Photo distributed
- Treatment include systemic, topical and intralesional corticosteroids, steroid sparing agents

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Acral Lentiginous Melanoma



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Acral Lentiginous Melanoma

- Highest morbidity and Mortality of the Melanomas
- Due to delay in Diagnosis
- Bob Marley's demise
- Breslow depth
- Work up and wide excision based on Breslow depth
- FSE monthly by patient, quarterly by physician
- Excision, not biopsy

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Congenital Nevus



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Congenital (Hairy) Nevus

- Very low malignant risk
- High parental concern
- Watch for changes

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Bullous Pemphigoid



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Bullous Pemphigoid

- Differentiate from Pemphigus, a far more serious Dx
- H & E and DIF biopsy
- Systemic corticosteroids
- Steroid Sparing agents
- Often burns out

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Stasis dermatitis



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Stasis dermatitis

- Chronic
- Circulatory Compromise
- Compression Essential
- Work up for Co morbidities
- Prevention of Ulcerations

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Necrotic Ulcers



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Leg Ulcers

- Leg ulcers are symptoms, not diagnoses
- treatment based on etiology
- biopsy if treatment not effective
- work up for co morbidities (malignancy, trauma, diabetes, PVD, abuse, et al)

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The magic changing ink



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Dermatomyositis



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Dermatomyositis

- Classic but subtle clinical presentation, including Heliotrope rash, shawl sign, gottron's papule
- Work up essential: CK, Aldolase, LDH, etc
- 50% with associated malignancy
- Biopsy confirmation
- Treatment systemic corticosteroids, steroid sparing agents, spf, others

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Pyogenic Granuloma



Etiology often trauma and microtrauma. Surgical treatment

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Foreign Body Granuloma



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Foreign Body Granuloma

- History of injury important
- Can be recent, usually remote

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Erythema Multiforme Minor



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Erythema Multiforme Minor

- Usually due to Drug reactions or HSV
- Treatment directed at etiology
- Palms, soles, mucous membranes.
- Often recurrent, esp if HSV induced
- Avoidance of offending drug (sulfonyl ureas, bactrim) and/or supressive anti virals

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EM Major/SJS



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Molluscum contagiosum



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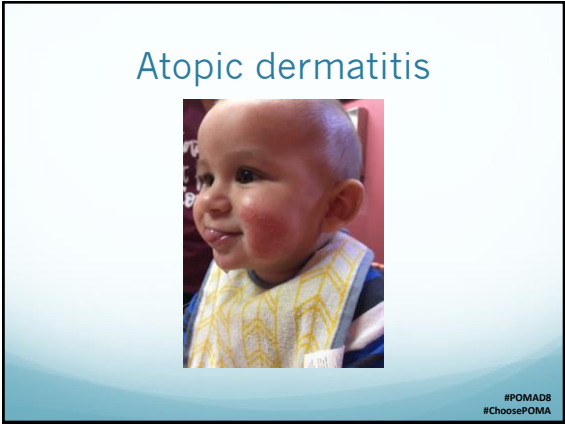
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Molluscum contagiosum

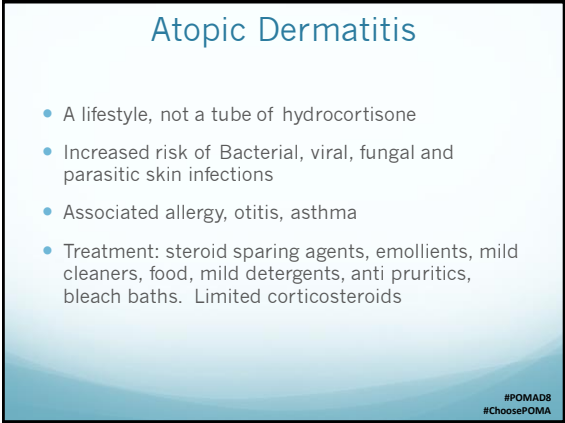
- In toddlers, almost always associated with atopic dermatitis.
- If fewer than 10, treat the AD first
- If greater than 10, treat the MC
- If associated with wrestling, sports, STD, treat the MC

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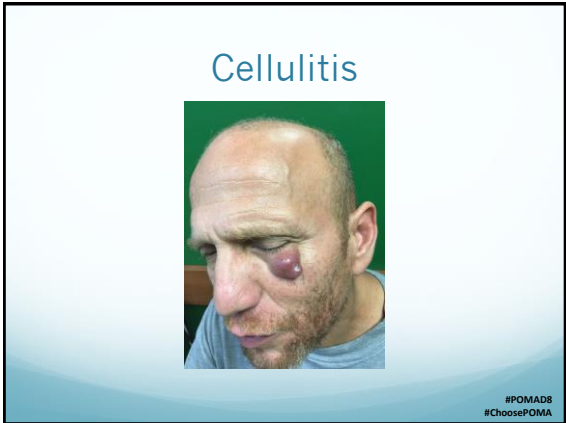
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Cellulitis

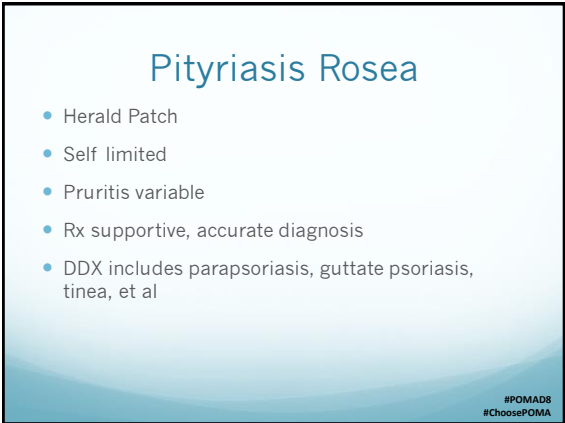
- Usually staph or strep
- Community acquired vs Hospital acquired MRSA
- Topical, oral, systemic antibiotics
- History of prior manipulation, puncture, penetration with home sterilized safety pins, awls, needles, razors

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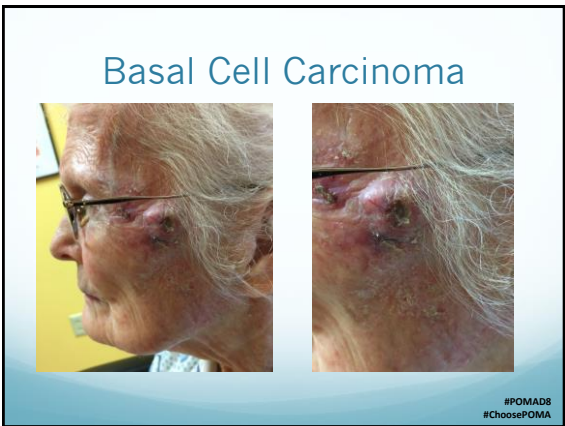
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Basal Cell Carcinoma

- Most common Human Malignancy > 1,000,000/year
- Rare metastasis
- Surgical excision is ToC
- Radiation, MOHS, ED&C, Imiquimod, vismodegib

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SCC



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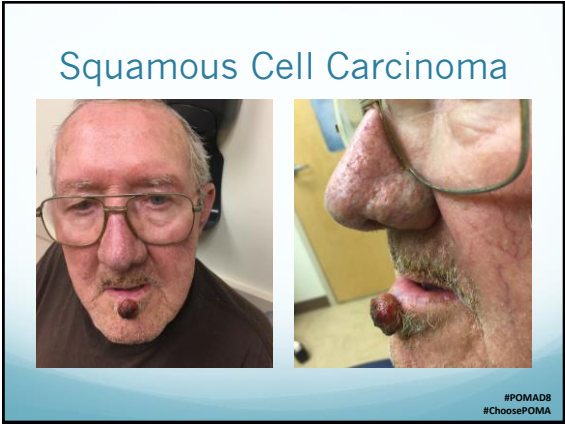
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Squamous Cell Carcinoma

- Slightly higher risk of metastasis, particularly of hands, face, scalp and neck
- Surgical treatment ASAP
- Clean margins
- SPF
- Frequent FSE
- In immunocompetent host, usually sun exposed

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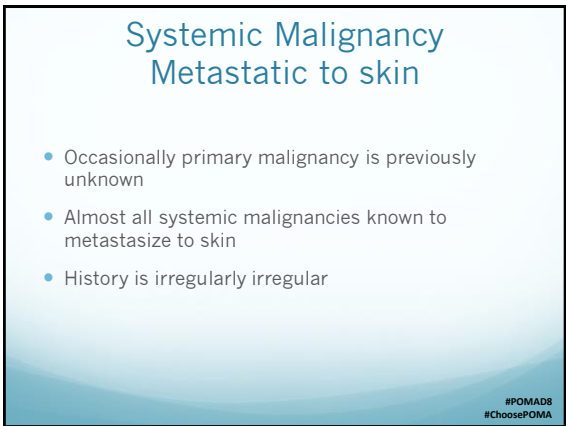
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Squamous Cell Carcinoma in the immunocompromised patient



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SCC in Immunocompromised patients

- Often in solid organ transplant patients, those on chemotherapy, or systemic immunosuppressants
- Metastatic rate higher
- Clinical presentation often more aggressive

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Granuloma Annulare



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Granuloma Annulare

- Distinct presentations in pediatrics vs adult pts
- Often confused with tinea (no scale with GA)
- Can be associated with DM

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Tinea Capitis with Kerion



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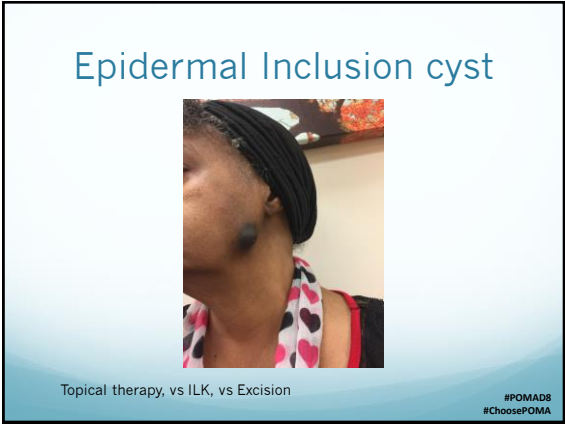
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Tinea Capitis with Kerion

- Epidermophyton, Microsporum and Trichophyton spp are causative organisms
- Usually associated with regional adenopathy
- Tinea capitis requires oral treatment
- Griseofulvin 20mg/kg x 6 weeks, terbinafine by weight
- Kerion is a late sequellae.
- Power of a Nickel (Powerofanickel.org) and DOcare

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Treatment Options for BSA > 10%

- Narrowband UVB
- Methotrexate
- Acetretin
- Apremilast (PDE 4 inhibitors)
- Biologics
- Combinaiton theraby

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Sebopsoriasis with Isomorphic phenoenon



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Pediatric psoriasis



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One month of adalimumab



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Compulsive excoriation



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Compulsive
Excoriation/Neurodermatitis

- Rarely a primary dermatitis
- Often require multidisciplinary approach
- Recognition of the patients participation in the disease
- Elimination of the picking/scratching/digging
- Often requires psychoactive agents (doxepin, fluvoxamine, benzodiazapines)

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Cutaneous Sarcoid



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Diabetic foot disease



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