Common Dermatologic Infections

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IDEAS FOR 2017

- The talk was 57 minutes
- Consider taking out one of the cases
- Consider updating bedbugs in the news or even budbugs all together
- Will need to change to associate professor, hopefully
Case 1

- 50 year-old male presents with “itchiest rash ever” on his hands, wrists, axilla, periumbilical region, and groin
What would you do next?

A. Skin biopsy
B. Scabies preparation
C. Empiric topical steroids + antihistamine
D. Empiric topical antifungal
What would you do next?

A. Skin biopsy  
B. Scabies preparation  
C. Empiric topical steroids + antihistamine  
D. Empiric topical antifungal

Scabies prep - negative

This does not exclude scabies

Image courtesy of Dr. Luis Requena
Scabies infection

Burrowing of mite into skin

Hypersensitivity reaction

2-4 weeks

- "Itchiest rash ever"
- Finger webs, wrists, axilla, peri-umbilical, groin, breasts, spares face

• Asymptomatic
• Typical burden: 10-15 mites


Skin scraping

- Method:
  - Identify burrows
  - Apply a 1-2 drop of mineral oil to burrows and slide
  - Scrape with scalpel
  - Rub contents from scalpel onto glass slide
  - Apply cover slip

https://www.google.com/search?q=scabies+preparation&safe=off&source=l1280&bih=685#q=scabies+preparation+scalpel&safe=0
Skin scraping

- Frequently, testing is negative since
  - Burrows can be difficult to identify
  - Mite burden usually low

Positive skin scraping

Treatment options

- Antiscabetic therapy
  - Permethrin
  - Precipitated sulfur 5-10%
  - Ivermectin (systemic therapy)
  - Lindane
  - Crotamiton
  - Benzyl benzoate

- Systemic symptomatic treatment
  - Use topical steroids and antihistamines liberally

Topical treatment: Permethrin

- FDA approved for treatment of scabies (> 2 mo age)
- Pregnancy category B
- Formulation: 5% topical cream (Elimite)
- Treatment regime
  - Apply from neck down in the evening and leave on overnight
  - Repeat in 1-2 weeks
- Advantages:
  - Every effective
  - Few side effects
- Disadvantages/side effects
  - Erythema, burning upon application, contact dermatitis

Topical treatments: Sulfur

- 5-10% precipitated sulfur in petrolatum base
- Safe option in infants and pregnant women
- Applied 3 successive nights
- Advantages:
  - Safe with low toxicity
  - Inexpensive
- Disadvantages/side effects:
  - Irritation
  - Messy, malodorous, stains clothing


Oral treatment: Ivermectin

- Used off-label for treatment of scabies
- Treatment regimen: 200 mcg/kg x 1 and repeat in 1-2 weeks
- Advantages
  - Oral
  - Effective
- Disadvantages/side effects
  - Report of neurotoxicity -> death in 15/47 a long-term care facility residents over 6 months
  - Similar studies did not demonstrate these findings
- Caution when using in the elderly
- Do not use in children < 5 years due to theoretical neurotoxicity
- Avoid in pregnancy

CDC treatment guidelines

- Permethrin: medication of choice
- Ivermectin: failed treatment or cannot tolerate Permethrin

http://www.cdc.gov/parasites/scabies/health_professionals/meds.html

Additional clinical pearls

- After treatment, symptoms may worsen due to sensitization, not treatment failure
- Rule of thumb at UCSF: if not better in 3-4 weeks, consider an alternative diagnosis

Differential diagnosis: Pruritic erythematous papules

- Inflammatory skin disease
  - Dermatitis herpetiformis
  - Prurigo nodularis
  - Lichen planus
- Arthropod bites
  - Fleas, bedbugs, mosquitoes
- Drug reaction

https://expertconsult.inkling.com/
Differential diagnosis:
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Delaunay P et al. CID 2011;52:200;
Which of the following is a type of cutaneous lymphoma that can clinically resemble a scabies infestation?

- A. Mycosis fungoides
- B. Anaplastic T-cell lymphoma
- C. Marginal zone lymphoma
- D. Lymphomatoid papulosis
- E. Subcutaneous panniculitis-like T-cell lymphoma
If skin scrapping negative but high index of suspicion, empirically treat
If no improvement, consider skin biopsy to evaluate for other entities on differential diagnosis

Take home points
- Highest-yield place to detect mite is a burrow
- Mites usually not present within papules
- Scabies preparation often negative
- Might worsen before resolution
- Consider skin biopsy to evaluate for alternatives if no improvement
Take home points:
Differential diagnosis:
Pruritic erythematous papules

- Inflammatory skin disease
  - Dermatitis herpetiformis
  - Prurigo nodularis
  - Lichen planus
- Arthropod bites
  - Fleas, bedbugs, mosquitoes, scabies
- Drug reaction
- Lymphomatoid papulosis

Case 2

- 50 year-old HIV-positive male who is homeless gets admitted for pneumonia
- Internal medicine team notices he has widespread erythematous and scaly rash
- Dermatology consult
Diagnosis

A. Psoriasis
B. Eczema
C. Crusted (hyperkeratotic/Norwegian) scabies
D. Pityriasis rosea
E. Allergic contact dermatitis
Diagnosis

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D. Pityrasis rosea
E. Allergic contact dermatitis

Crusted (Hyperkeratotic) Scabies

- Clinical findings
  - Thick white plaques with fine scale ("white sand stuck on the skin")
  - Widespread

- Risk factors
  - Immunosuppression
  - Elderly
  - Impaired sensation

- Heavy-mite burden
- Easily transmitted
Crusted scabies

- Skin scrapping often positive
- Infection control challenge
- Treat with Ivermectin plus permethrin, more frequently

Differential diagnosis: Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema
- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
- Cutaneous lymphoma
  - Mycosis fungoides
Differential diagnosis:

Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema
- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
- Cutaneous lymphoma
  - Mycosis fungoides

Differential diagnosis

Erythrodermic psoriasis  Crusted scabies
Differential diagnosis

Erythrodermic eczema  Crusted scabies

Take home points

- Keep on differential diagnosis of papulosquamous eruption in older, debilitated or immunosuppressed patient
- Easily transmitted due to high mite burden
- Treat with ivermectin plus permethrin
Take home points:
Differential diagnosis: Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema
- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
- Cutaneous lymphoma
  - Mycosis fungoides

Case 3

- 35 year-old female presents with “round red circles” on her trunk and extremities
- Self-diagnosed as eczema
- Used husband’s eczema medication (topical steroid), but plaques worsened
What additional information should you seek?

A. Ask about recent tick bites
B. Take a sexual history
C. Perform a KOH preparation
D. All of the above
KOH prep of our patient

Diagnosis

- *Tinea corporis*
Tinea

- Superficial fungal infection
- Sites of infection:
  - Upper layer of the epidermis (stratum corneum)
- Causative organisms require keratin for growth

Trichophyton
Microsporum
Epidermophyton

Clinical manifestations

- Annular erythematous scaly papules and plaques
- Central clearing with “advancing border”
Atypical manifestations of tinea

- **Dermatophytic folliculitis**
  - Also called Majocci granuloma/tinea incognito
  - Often after Rx with topical steroids
  - Invasion of hair shaft
  - Absence of scale
KOH preparation

- Apply alcohol swab to AA
- Scrape scale onto glass slide
- Scrape scalpel onto slide
- Apply 1-2 drops of KOH
- Apply cover slip
- If KOH w/o DMSO, gently heat with alcohol lamp or lighter for 2-3 seconds
- Examine under low-power for hyphae


https://knol.google.com/k/will-johnson/ringworm-tinea-corporis-tinea-facies/4hmquk6fx4gu/634#
Treatment of tinea

- Limited superficial infection:
  - Topicals recommended
    - Clotrimazole, econazole, oxiconazole
    - Terbinafine
- Extensive infection, immunocompromised, or failed topicals:
  - Systemic therapy recommended (See Appendix A dosing regimens)

Additional clinical pearls

- Empiric treatment of a “rash” with a combination topical steroid/antifungal combination
- Treatment failure
- Alteration in clinical appearance, including dermatophytic folliculitis
- Skin biopsy useful if KOH difficult to interpret/negative but still high index of suspicion for disease/dermatophytic folliculitis possible

Differential diagnosis: Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema

- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
  - Crusted scabies

- Cutaneous lymphoma
  - Mycosis fungoides
Psoriasis

Psoriasis

Tinea

Eczema

Tinea

Eczema
Differential diagnosis: Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema

- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
  - Crusted scabies

- Cutaneous lymphoma
  - Mycosis fungoides

Secondary syphilis    Tinea
Crusted scabies

Tinea

Differential diagnosis: Papulosquamous

- Inflammatory
  - Psoriasis
  - Eczema
- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
  - Crusted scabies
- Cutaneous lymphoma
  - Mycosis fungoides
**Take-home points**

- If it scales, scrape it!!
- Localized disease, treat with topical therapy
- Widespread disease, treat with systemic therapy
- If misdiagnosed as an inflammatory condition and treated with topical steroids, may present in atypical fashion as dermatophytic folliculitis
- Consider skin biopsy
Take home points
Differential diagnosis: Papulosquamous

- Inflamatory
  - Psoriasis
  - Eczema
- Infectious
  - Secondary syphilis
  - Pityriasis rosea
  - Erythema migrans
  - Tinea infection
  - Crusted scabies
- Cutaneous lymphoma
  - Mycosis fungoides

Case 4

- 50 year-old patient concerned about appearance of toe nails
- Read about laser treatment and some new topical treatments, and wants to know your opinion about them
Laser treatment for onychomyosis:

A. Is effective for every patient and works quickly
B. Has been shown to have a limited beneficial effect in a small number of patients
C. Is superior to terbinafine
D. Covered by most insurance carriers
Laser treatment for onychomyosis is

A. Is effective for every patient and works quickly
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Onychomycosis: Laser treatment buzz

- Noveon®
- ALA-PDT
- Cost $750-1500
- Treatment not covered by most insurance carriers
- MOA: selectively damage fungi without harming adjacent tissue

Noveon®

- FDA cleared for other indications, not onychomycosis
- n=26

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<td>Unchanged or worse</td>
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<td>Slight or moderate improvement</td>
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<td>Marked improvement or cleared</td>
<td>8%</td>
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Limitations
- Nail debridement was not controlled for


Figure 6. Representative treated case with mild disease at baseline (A) and with, at most, minimal residual disease after 180 days (B).

**ALA-PDT**

- Case reports
- Nail softened and clipped off prior to treatment

Baseline

Piraccini BM et al. JAAD 2008;59:S75.

**Efinaconazole (Jublia)**

- 10% topical solution
- Applied once daily for 48 weeks
- No debridement

**Comparison**

- Complete cure rates (in study)
  - Efinaconazole: 17.8% and 15.2% (2 trials)
  - Package insert: Complete or almost complete cure, 23-26%
  - Oral itraconazole 14%
  - Oral terbinafine 38%

Tavaborole (Kerydin)

- 5% solution applied once daily for 48 weeks.
- Complete or almost complete cure rates of 15-18%.

Onychomycosis: standard treatment

- Oral terbinafine 250 mg PO QD
  - x 6 weeks for fingernails
  - x 12 weeks for toenails
- Alternative: itraconazole (See Appendix B for dosing regimens)
- Who to treat?
  - Consider no treatment in otherwise healthy patients
  - Consider treatment for diabetic patients with recurrent cellulitis
Take home points

- Laser treatment
  - Cost is high
  - Not covered by insurance carriers
  - Studies available not particularly impressive

- New topical treatments:
  Efinaconazole/Tavaborole
  - Inferior complete cure compared to oral terbinafine

- Oral terbinafine still most effective treatment

Case 5

- 55-year old male presents with “red, itchy bumps” on his face, arms, and legs
- He and his wife returned from a weekend vacation to New York City 5 days prior to presentation
- Rash began the day he returned
- Based on news reports he was concerned about bedbugs
- Wife without symptoms
Bedbugs discovered on Lexington Ave. line after four N trains are sent for fumigation

A No. 5 train was taken out of service Friday after a rider reported seeing a bedbug fall off a homeless man, an official said. Another N train, the fourth this week, has also been taken out of service because a motorman reported bedbugs in the cab, a transit source said.

BY PETE DONAHUE / NEW YORK DAILY NEWS / Friday, August 9, 2014, 9:17 PM
Bedbugs in the news

http://www.freebedbugadvice.com/bed-bugs-have-gone-mainstream/

Bedbugs

- Ectoparasites: “blood meals”
- Primary host: humans
- Typically feed at night while host sleeps
- After blood meal, seek areas that are warm and dark
- Can travel 100 feet, but usually live within 8 feet of host
- Lifespan: 6-12 months. Can survive for months without feeding
- Transmission: direct between hosts, ventilation ducts, luggage

Clinical manifestations: cutaneous

- No reaction seen in ~ 30%
- Erythematous pruritic papules/nodules, sometimes in linear configuration
- Often on exposed body sites, including face
- Bites not felt, lesions 1-2 (up to 14) days after bite
- Blood spots or skin from molting seen on sheets

Clinical manifestations: cutaneous

Delaunay P et al. CID 2011;52:200; Uptodate.com

Clinical manifestations: cutaneous

Bernardeschi C et al. BMJ 2013;346:bmj.f138
Differential diagnosis:
Pruritic erythematous papules

- Inflammatory skin disease
  - Dermatitis herpetiformis
  - Prurigo nodularis
  - Lichen planus
- Arthropod bites
  - Fleas, mosquitoes, scabies
- Drug reaction
- Lymphomatoid papulosis

How do you make diagnosis?

1. Clinical suspicion
   - Morphology and distribution of clinical lesions
   - Blood spots, skin from molting
2. Identification of bed bugs
   - Licensed pest control operator
3. Confirm clinical resolution after eradication
4. Exclude other possibilities – skin biopsy might be needed
Bedbugs, a vector of infection?

- Bedbugs have been proven to carry 45 pathogens
  - Hepatitis B virus
- No definitive evidence of transmission to host
- However, recent study suggested might be vector of T. Cruzi in animal model

Delaunay P et al. Bedbugs and Infectious Diseases. CID 2011;52:200

Bedbugs management

- Bedbug eradication
- Symptomatic therapy
  - Bites do not require treatment
  - If patient uncomfortable:
    - Oral antihistamines
    - Topical mid-potency corticosteroids

Take home points

- Bedbugs has had a recent insurgence
- Diagnosis is based on clinical suspicion plus identification of bedbugs
- Not all people exposed to bed bugs will develop clinical disease
- Eradication necessary to eliminate infestation
- Treat if symptomatic

Take home points: Differential diagnosis: Pruritic erythematous papules

- Inflammatory skin disease
  - Dermatitis herpetiformis
  - Prurigo nodularis
  - Lichen planus
- Arthropod bites
  - Fleas, mosquitoes, scabies, bed bugs
- Drug reaction
- Lymphomatoid papulosis
Case 6

- 54 year-old woman with hypertension, status-post knee replacement surgery who developed a prosthetic knee joint infection

- Initially treated with nafcillin x 4 weeks and then transitioned to trimethoprim and sulfamethoxazole (TMP-SMX)

- 2.5 weeks after starting TMP-SMX, develops fevers to 39°C

Case 6, cont.

- Three days later, morbilliform rash

- Rash started on the face, neck and upper arms, then spread to the lower extremities

- Periorbital and mid-facial edema

- Diffuse lymphadenopathy involving cervical, axillary and inguinal nodes
Laboratory values

- CBC with differential:
  - WBC: 25
  - Eosinophil count: 3.0 (normal: 0-0.4)
- AST 125; ALT 110
- Blood cultures x 2: negative

Differential diagnosis

- Infection
- Drug reaction
The most likely diagnosis is:

A. Sepsis from prosthetic joint infection
B. Simple morbilliform drug eruption
C. Drug-induced hypersensitivity syndrome to Septra
D. Leukemia with cutaneous involvement
E. Drug-induced hypersensitivity syndrome to nafcillin
The most likely diagnosis is:

A. Sepsis from prosthetic joint infection
B. Simple morbilliform drug eruption
C. **Drug-induced hypersensitivity syndrome to Septra**
D. Leukemia with cutaneous involvement
E. Drug-induced hypersensitivity syndrome to nafcillin

**Drug-induced hypersensitivity syndrome (DIHS)**

- Potentially life-threatening adverse drug reaction
- Skin rash AND internal organ involvement
- Initially observed in patients on anticonvulsants
- Previously:
  - Phenytoin hypersensitivity syndrome
  - Anti-convulsant hypersensitivity syndrome
  - Drug reaction w/ eosinophilia and systemic symptoms (DRESS)
DIHS: Cutaneous manifestations

- Primary morphology: maculopapular, morbilliform
- Often preceded days of by fevers
- Starts on face and upper body spreads distally
- Peri-ocular and facial edema
- Skin edema → vesicles, bulla

DIHS: Internal involvement

- Hepatic (70-90%): ↑AST/ALT, AlkPhos.
- Lymphadenopathy (75%) – local or general
- Hematologic system
  - Leukocytosis, WBC up to 50, atypical lymphocytes
  - Eosinophilia >2.0 (normal 0.0-0.4)
- Renal (11%): often interstitial nephritis
- Occasional cardiac and thyroid involvement
Standard initial evaluation

- CBC with differential
- LFTs
- BUN/Creatinine
- Depending on symptoms
  - EKG, Echocardiogram (TTE)
  - TSH, T4

Standard monitoring if DIHS confirmed

- Monthly TSH, T4 x 6 months
Most common agents

- Sulfonamides (sulfamethoxazole, etc.)
- Anticonvulsants (phenytoin, carbamazepine)
- Minocycline
- Allopurinol
- Nevirapine
- Abacavir
- Dapsone

DIHS: Timing

- Usually develops within 2-6 weeks after starting on new medication
- Can start sooner on re-challenge
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**Rash**
Treatment and prognosis

- Discontinue offending medication
- Systemic steroids for internal involvement, usually with starting dose of 1 to 1.5 mg/kg/day
- 10% mortality rate, usually from fulminant hepatitis

Cutaneous drug reactions

- DIHS
- Simple drug rash
- Life-threatening drug rashes
  - Bullous drug reactions - Stevens-Johnson syndrome (SJS)/toxic epidermal necrolysis (TEN)
Cutaneous drug reactions

- DIHS
- Simple drug rash
- Life-threatening drug rashes
  - Bullous drug reactions: Stevens-Johnson syndrome (SJS)/toxic epidermal necrolysis (TEN)

Simple drug rash

- Clinical morphology can be nearly identical to DISH, although face usually not involved
- No visceral involvement
- Usually develop within first 2 weeks of new med
- Often start in the groin/axilla and then generalize within 1-2 days
- Standard evaluation: CBC with diff, LFTs, BUN/Cr
Simple morbilliform eruption
Cutaneous drug reactions

- DIHS
- Simple drug rash
- Life-threatening bullous drug rashes
  - Bullous drug reactions: Stevens-Johnson syndrome (SJS)/toxic epidermal necrolysis (TEN)

Bullous drug reactions: SJS/TEN

- Clinical morphology:
  - Start: erythematous, dusky red or purpuric macules
  - Next: Coalesce to bullae that break easily
    - Large sheets of epidermis slough from underlying dermis
    - Asboe-Hansen sign
    - Angulate regions

- Timing:
  - 7-14 days after medication, sooner if re-exposure

- Prodromal symptoms in some: 1-3 days before skin lesions: fever, eyes stinging, and dysphagia
Bullous drug reactions: SJS/TEN

- Definitions arbitrary:
  - SJS < 10 % BSA w/ ≥ 2 mucosal surfaces
  - SJS/TEN overlap 10-30% BSA
  - TEN > 30% BSA

- Histopathology helpful:
  - Lymphocytes along the dermal-epidermal junction
  - Necrotic keratinocytes and full-thickness necrosis

- Differential diagnosis
  - Staphococcus scaled scale syndrome
  - Paraneoplastic pemphigus
Case 6: Take home points

- Drug chart important
- DIHS - later onset than most other drug reactions
- DIHS involves multiple visceral organs
- Since DIHS clinical morphology can be identical to a simple drug eruption, evaluate for systemic involvement in any drug rash
- Clinical morphology can be helpful in narrowing the type of drug reaction
- Histopathology helpful in some drug reactions

Case 7

- 55 year-old woman with obesity, chronic venous insufficiency and onychomycosis presents for evaluation of erythematous plaques on the lower legs
- Recently developed ulceration over medial malleolus
- Plaques are slightly tender to palpation and warm
- Afebrile
The most likely diagnosis is

A. Bullous pemphigoid
B. Venous stasis dermatitis
C. Eczematous/nummular dermatitis
D. Erythema nodosum
E. Cellulitis
The most likely diagnosis is

A. Bullous pemphigoid
B. **Venous stasis dermatitis**
C. Eczematous/nummular dermatitis
D. Erythema nodosum
E. Cellulitis

**Venous stasis dermatitis**

- Bilateral involvement, usually
- Pitting edema
- Varicosities
- Hyperpigmentation
- Cutaneous inflammation - sharply demarcated erythematosus papules coalescing into a plaque
  - Secondary hyperkeratosis, vesicles, crusting, ulceration, usually of medial malleolus
- If red, hot or tender, only mildly
Venous stasis dermatitis

Differential diagnosis

- Cellulitis
- Eczematous dermatitis
Cellulitis

- Unilateral, usually
- Edematous – fine wrinkling of not evident as skin surface appears smooth and taught
- Painful
- Warm
- Irregular border
- Skip areas, sometimes
- Fever, frequently but not always
- Ascending lymphangitis
- Regional LAD

Predisposing factors for cellulitis

- Trauma to skin
- Tinea pedis/onychomycosis
- Underlying lymphatic or vascular compromise
- Obesity
- Edema

Inflammatory dermatoses often mis-diagnosed as cellulitis

- RTC - in office derm consult vs. no consult for PCP suspected cellulitis
  - 29 patients, 20 with derm consult/9 no consult
  - 20 with the derm consult, 2 determined to have cellulitis
  - Other diagnoses “pseudocellulitis” included
    - Eczema (n=4)
    - Stasis dermatitis (n=3)
  - Conclusion: Derm consult helpful in dx of cellulitis

Approx. 33% of cases mis-diagnosed in other studies

Arakaki RY. JAMA Dermatol 2014;150:1056
David CV Dermatol Online J 2011;17:1
## Comparison

<table>
<thead>
<tr>
<th></th>
<th>Venous stasis dermatitis</th>
<th>Cellulitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Bilateral</td>
<td>Unilateral</td>
</tr>
<tr>
<td><strong>Border</strong></td>
<td>Well-demarcated</td>
<td>Poorly demarcated</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>Mildly painful &amp; red</td>
<td>Very painful and red</td>
</tr>
<tr>
<td><strong>Skin surface</strong></td>
<td>Scaly - not shiny</td>
<td>Shiny and smooth</td>
</tr>
<tr>
<td><strong>Lymphangitis with LAD</strong></td>
<td>Not present</td>
<td>Often present</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td>• No signs of venous stasis, with exceptions • Predisposing factors</td>
</tr>
</tbody>
</table>

## Differential diagnosis

- **Cellulitis**
- **Eczematous/nummular dermatitis**
Eczematous/nummular dermatitis

Take home points

- Stasis and eczematous dermatitis often misdiagnosed as cellulitis
- Cellulitis usually unilateral, poorly demarcated, and associated with lymphangitis and LAD
- Consider dermatology consultation if unsure if cellulitis is the correct diagnosis
Case 8

- 45 year-old HIV-positive patient presents for evaluation of a lesion on the penis
- CD4 count 350 cells/μL
- Viral load undetectable
- The lesion has developed over the past 2 months
What would you do to evaluate this lesion?

A. Empiric treatment for genital warts
B. Herpes viral culture and/or direct fluorescent antigen (DFA) test
C. Empiric treatment for condyloma lata
D. Skin biopsy
E. B and/or D
Viral culture/DFA results

- HSV I

Verrucous herpes infection

- Occurs in immunosuppressed patients
- Lesions typically more in number compared with conventional herpes
- Lesions can become vegetative, hypertrophic, and condyloma-like nodules or plaques
- Lesions slower to heal and more painful 2/2 ineffective cell-mediated immunity
- Debate regarding whether related to immune restoration

Lehloenya R Dermatol Clin 2006;24:549.
Conventional herpes
Differential diagnosis: Hypertrophic genital plaques

- Infection
  - Condyloma acuminata
  - Condyloma lata
- Squamous cell carcinoma

Condyloma acuminata Verrucous herpes

https://expertconsult.inkling.com/read/dermatology-bologna-jorizzo-schaffer
Condyloma lata  Verrucous herpes

https://expertconsult.inkling.com/read/dermatology-bolognia-jorizzo-schaffer

Squamous cell carcinoma  Verrucous herpes

- Differential diagnosis broad
- Consider skin biopsy if unsure of diagnosis

Herpes in immunocompromised-
widespread distribution
Herpetic whitlow

Take home points

- In immunocompromised host, herpes can present with a more verrucous morphology and a more widespread distribution than conventional herpes
- Verrucous herpes often mis-diagnosed as condyloma or squamous cell carcinoma
- Consider skin biopsy if unsure of diagnosis
- Herpetic whitlow is herpes infection on fingers
Acknowledgments

- Timothy Berger, MD – clinical photos
- Raza Aly, MD – clinical photos
- Luis Requena, MD – clinical photos
- Lindy Fox, MD – clinical photos
- Kanade Shinkai, MD – clinical photos

Appendix A:
Treatment of tinea: Oral regimens

- **Extensive infection, immunocompromised, or failed topicals:** Systemic therapy recommended
  - Terbinafine 250 mg QD x 1-2 week
  - Fluconazole 150 mg Q week x 2-4 weeks
  - Itraconazole 200 mg QD x 1-2 weeks
  - Griseofulvin 250 mg TID x 2 weeks
Appendix B: Onychomycosis: Itraconazole regimens

- Fixed dose
  - Fingernails – 200 mg PO x 6 weeks
  - Toenails – 200 mg PO x 12 weeks

- Pulse therapy
  - Fingernails – 200 mg PO BID x 1 week/month x 2 months
  - Toenails – 200 mg PO BID x 1 week/month x 3 months