Common Rashes in the Primary Care Setting

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Disclosures

- No conflicts of interest
- Will be discussing off label uses of medications

Goals

- Self assessment questions
- Survey of common rashes in primary care
- Focus on how to recognize and treat
- Questions

Urticaria- basic features

- Edematous pink papules and plaques
- Sometimes normal exam
- Often strange shapes
- Evanescent
- Itchy but not scratched
- May be associated with angioedema- deeper swelling that lasts 72 h

Acute vs. Chronic
6 weeks*

- Upper respiratory tract infns- 40%
- Drugs- 9%
- Food- 1%
- Idiopathic- 50%

- Idiopathic
- Autoimmune
- Infection-related

Management

- Trial of antihistamines
  - Understand the limitations
  - Not PRN
  - Cetirizine 10mg, Loratadine 10mg, fexofenadine 180mg
- Non-drug therapy
  - Cooling lotions (menthol creams)
  - Avoid aggravating factors- ASA, NSAIDS, opiates

Further management

- Increase dose of 2nd generation antihistamine
- Add sedating antihistamine at night
  - Hydroxyzine 10-75 mg, shorter acting
  - Diphenhydramine 10-25mg
- Add H2 blocker
  - Ranitidine 150mg BID
  - Should not be used alone
- Prednisone- crisis or angioedema

Stasis dermatitis

- Caused by venous hypertension d/t incompetency of valves
  - Distension of capillaries
  - Leakage of fluid into tissues
  - Extravasation of RBCs
  - Leads to a microangiopathy & chronic inflammation

Other contributing factors

- Dry skin
- Contact sensitization
  - Topical abx, lanolin, preservatives, fragrances
- Irritant dermatitis
  - Exudates macerate surrounding skin
- Bacterial colonization

Clinical features

- Pruritic
- Erythema
- Scaling
- Scratch marks/excoriations
- Oozing/crusting
- Lichenification

Clinical features

- Edema
- Hemosiderin deposition
- Acute lipodermatosclerosis- subfascial edema and inflammation, mimics cellulitis
- Chronic lipodermatosclerosis- woody induration, “inverted wine bottle”
- Venous ulcers

Treatment

- Management of venous hypertension
  - Compression
  - Lifestyle changes
  - Exercise of calf muscles
- Topical corticosteroids
- Emollients

Allergic contact dermatitis

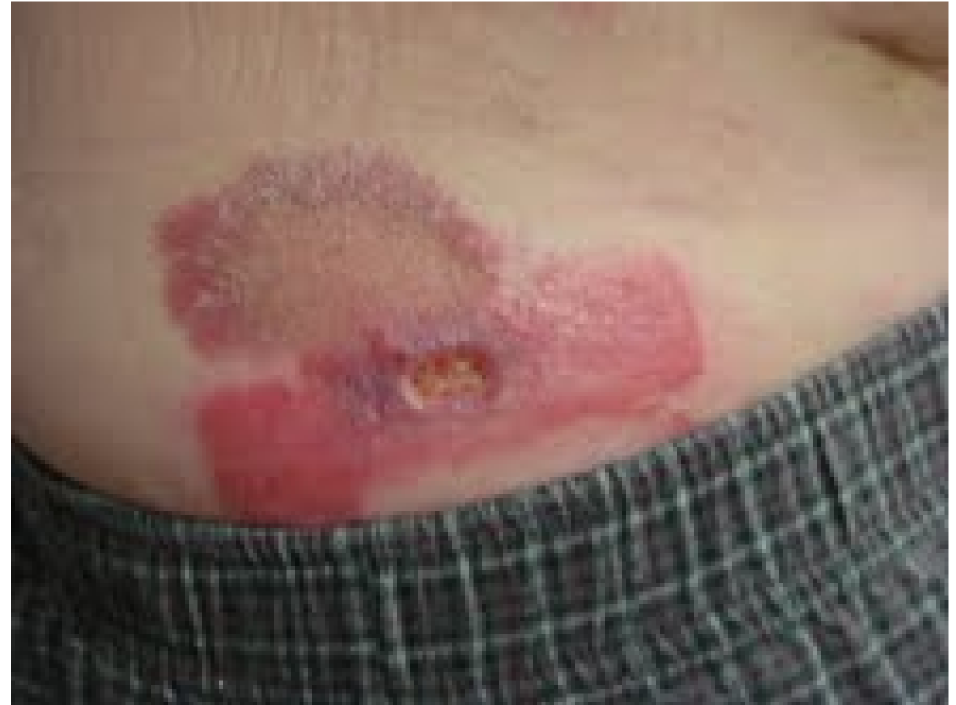
- Delayed type hypersensitivity from contact with a chemical
- Previous sensitization
- Acute and chronic
- Gold standard is patch testing

Clinical features

- Well demarcated erythematous, scaly plaques or blisters
- Linearity is very suggestive of plant contact
- Anatomy gives rise to clues

Examples of ACD

- Poison ivy, sumac, oak
- Nickel
- Bacitracin, neomycin
- Fragrance
- Preservatives
- Topical steroids



ACD Myths

- I have been using this for 20 years
- My rash is spreading
- I stopped using it and the rash didn't go away
- That is not where I am exposed to that allergen

Treatment

- Acute
  - Mid to high potency topical steroids
  - Burow's solution OTC
  - Prednisone if significant facial involvement or widespread very symptomatic disease
- Chronic
  - More tailored topical steroid choices
  - Eliminate obvious allergens
  - Consider derm referral for evaluation and patch testing

Psoriasis

- Can start at any age
- Itchy at times
- Worsens with infection, stress, alcohol, smoking, certain meds, season

Clinical features

- Morphology
  - Well demarcated
  - Varying redness
  - Varying scale
- Location
  - Common- elbows, knees, lumbosacral back, umbilicus, scalp, nails, ears
  - Sometimes- hands, feet, flexural, genitals
  - Rarely- face

Management

- Topical steroids
- Phototherapy- NBUVB
- Retinoids- acitretin, watch lipids
- Methotrexate- watch cum dose/liver
- Biologics- etanercept (Enbrel), adalimumab (Humira), ustekinumab (Stelara)
- Assess for joint disease
- Assess cardiac risk factors

Myocardial infarction

- Increase risk with moderate/severe psoriasis independent of other cardiac risk factors
- JAMA 2006
- Counsel regarding the other cardiac risk factors

Leukocytoclastic vasculitis

- AKA small vessel vasculitis
- Inflammation and necrosis of blood vessels usually due to circulating immune complexes
- Classic presentation is palpable purpura
  - Raised lesions that do not blanch
  - Favor lower extremities
  - Assoc itching or burning
- Multiple etiologies

Etiology

- Meds
- Malignancy
- Connective tissue diseases
- Infection- Staph, Strep, HCV
- Cryoglobulinemia
- Henoch Schonlein purpura
- Idiopathic

Evaluation & Management

- Thorough H&P, ROS
- At very least- guaiac, BUN, Cr, UA
- Treat underlying cause
- Topical steroids
- Oral steroids when needed for systemic disease or progressive, ulcerative disease
- Tends to be self limited

Drug exanthem

- Prototypical drug allergy
- Type IV hypersensitivity reaction
- 7-14 d after med is started, develops sooner with rechallenge
- "Maculopapular"
- Morbilliform- symmetric distibution of erythematous macules and papules, typically becoming confluent centrally
- Resolves over 1-2 weeks

Something else?

- Asymmetric? Geometric? → consider ACD
- Facial edema? → consider DRESS
- Blisters? → consider SJS/TEN
- Systemic involvement? → consider DRESS
- Viral sx → viral exanthem

Management

- Supportive
- Topical corticosteroids helps with pruritus
- Discontinue offending agent

Take homes

- Urticaria- treat with antihistamines
  - Most of the time, don’t need steroids
  - May be hard to find the cause of chronic urticaria
- Stasis dermatitis
  - Bilateral cellulitis is uncommon
  - Multifactorial approach is necessary
- Allergic contact dermatitis
  - Look for linear, geometric, & asymmetric distributions
  - Refer for patch testing

Take homes

- Psoriasis
  - Look for the clues
  - Remember to look for associated diseases (cardiac RFs, arthritis)
- Leukocytoclastic vasculitis
  - Palpable purpura
  - Kidneys and abdomen
  - Drugs and idiopathic
- Drug exanthem
  - Recognize morbilliform
  - Look for worrisome features