Common Rashes in the Primary Care Setting

Leah Belazarian, MD

April 9, 2013
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 2\textsuperscript{nd} 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 dermatology 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 distribution 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