A Review of Common Rashes

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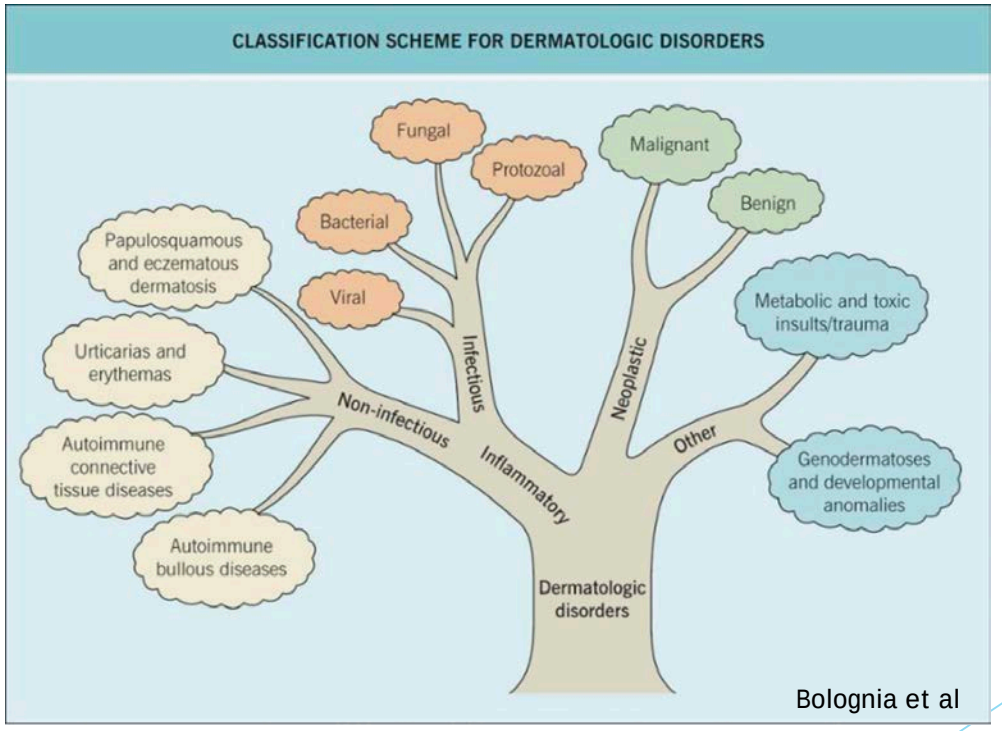
Universal Dermatology & Vein Care

- No financial disclosures

The Rash complaint

- Dermatologist's perspective
  - Rash= dermatitis= inflammatory skin disease

- Patient's perspective
  - Dermatitis
  - Acne, benign/malignant neoplasms, itch

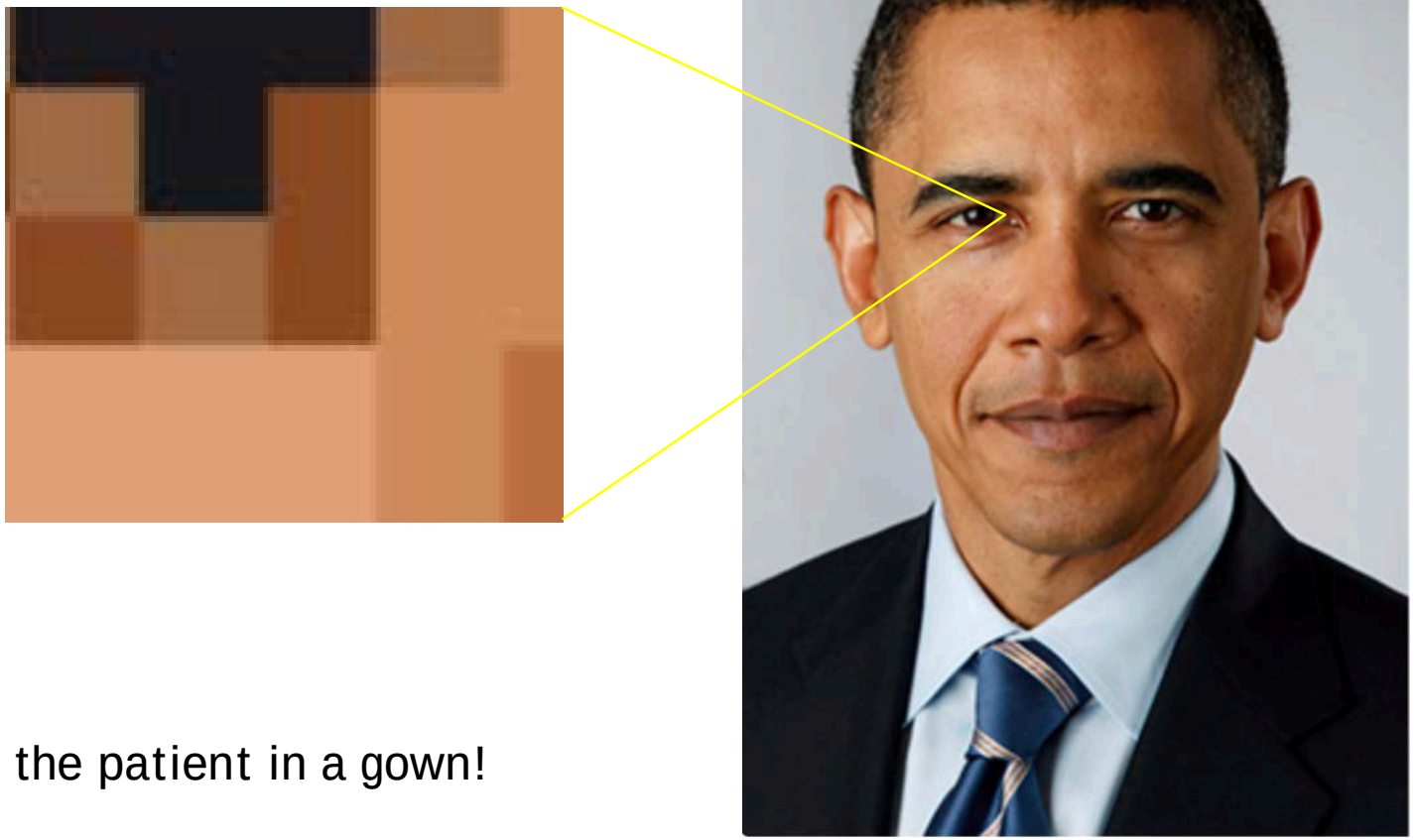


Bolognia et al

Chief complaint: “I have a rash!”

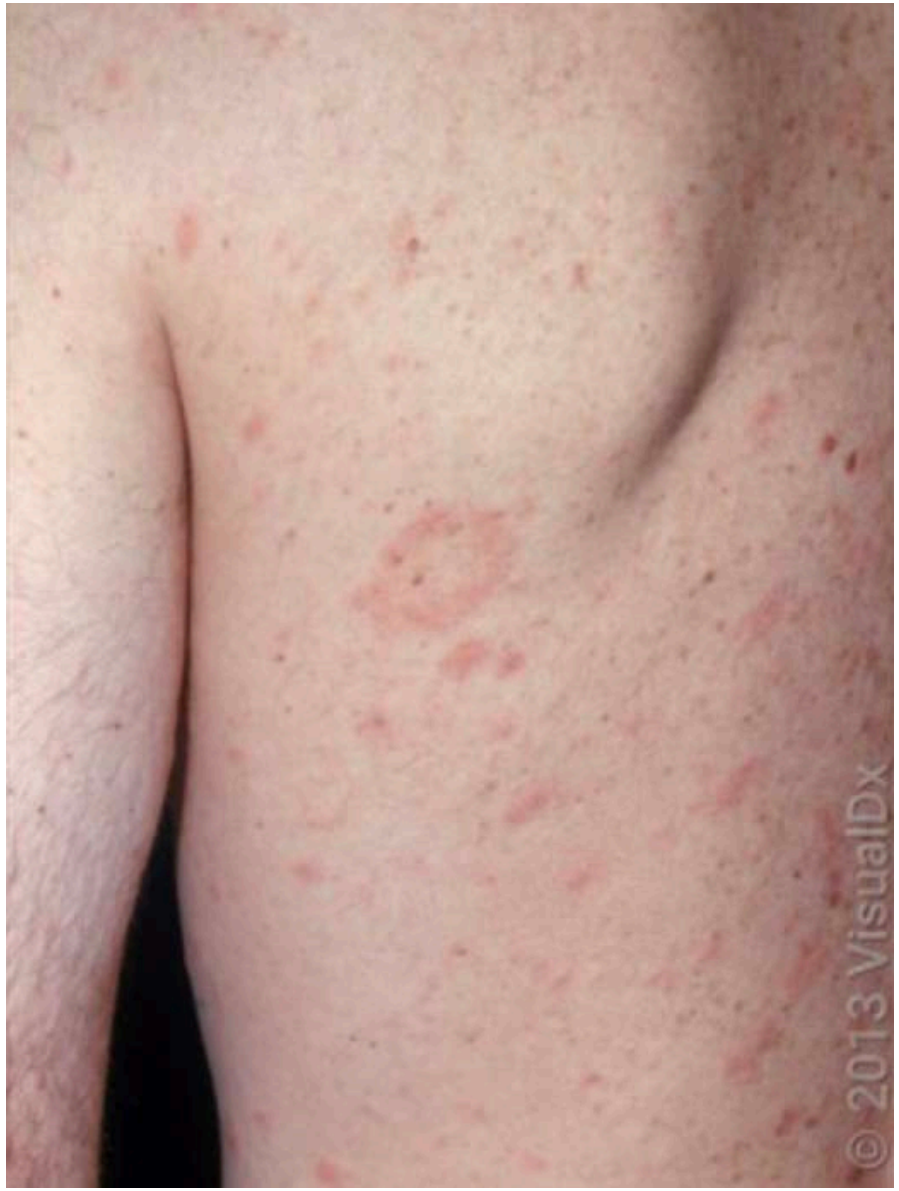
- History taking
  - Timing: days, months, years
  - Distribution: scalp, intertriginous, acral, generalized, laterality
  - Quality: Itching, burning, pain, asymptomatic
  - Modifying: Exacerbating factors, inciting event
  - What have you tried?

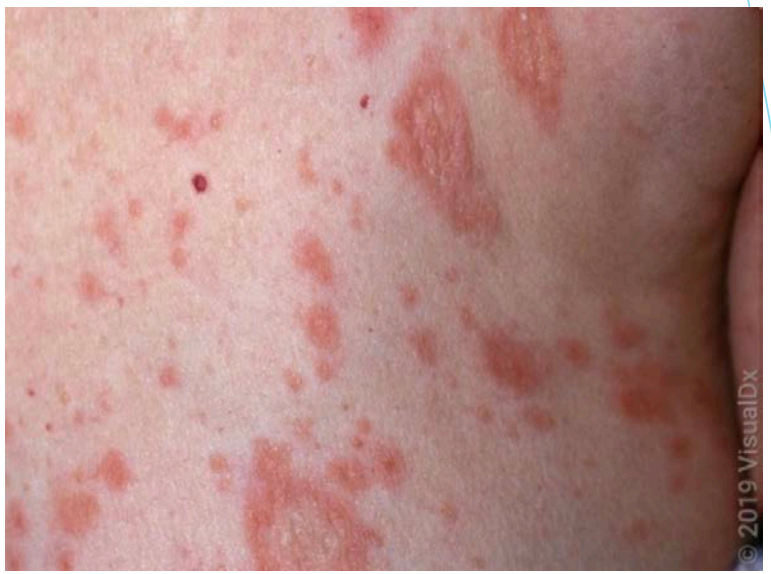
- Physical exam
  - Full skin examination
  - Good lighting



Get the patient in a gown!

Case 1

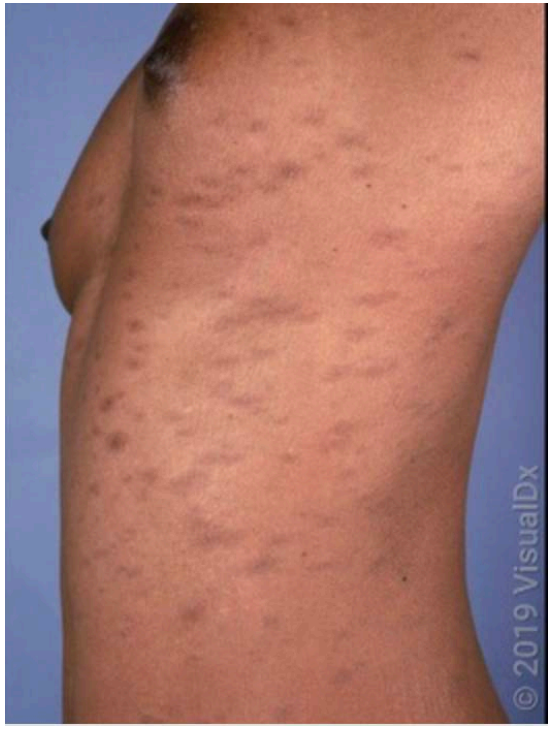




Pityriasis Rosea

- Acute self-limited papulosquamous eruption
- Adolescents and young adults
- Typically persists for 6-8 weeks with spontaneous resolution
- HHV-6 & 7 proposed etiologies

- Classically begins with solitary “herald patch” → generalized symmetric distribution over trunk and proximal extremities
  - Can involve neck, inguinal folds, rarely peripheral face
- Oval patches and plaques with central fine scale
  - Long axis along cleavage clines (”Christmas tree” pattern)
- Typically asymptomatic, or mild itch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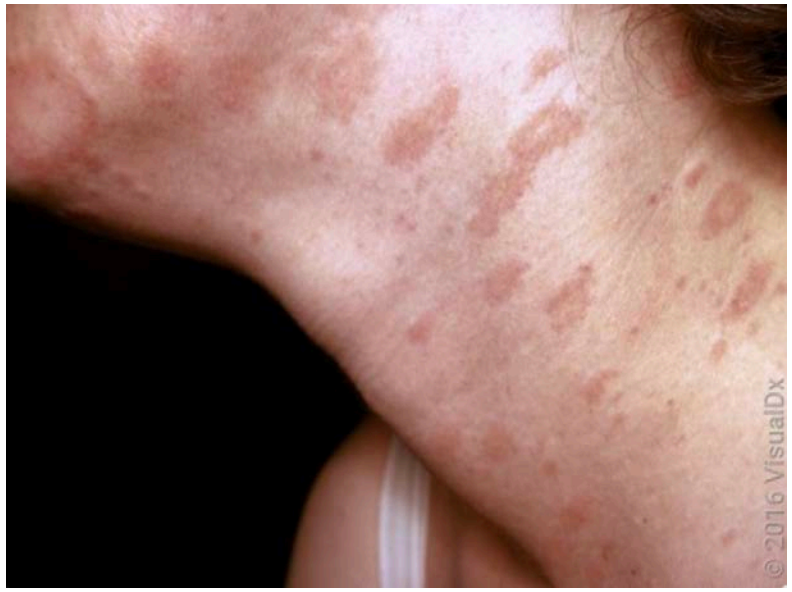
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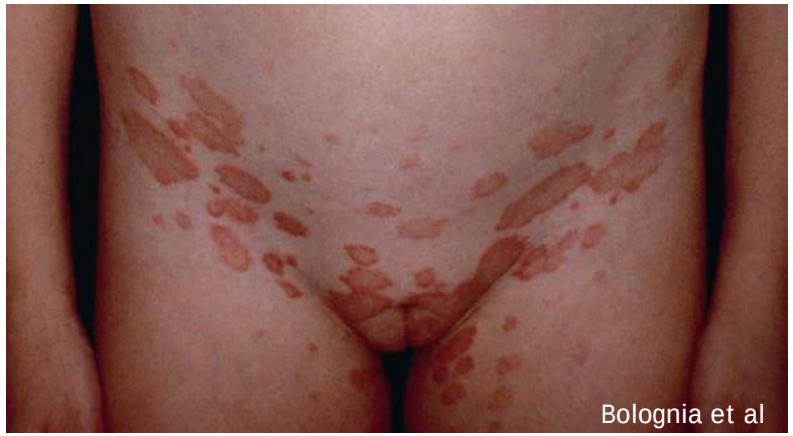
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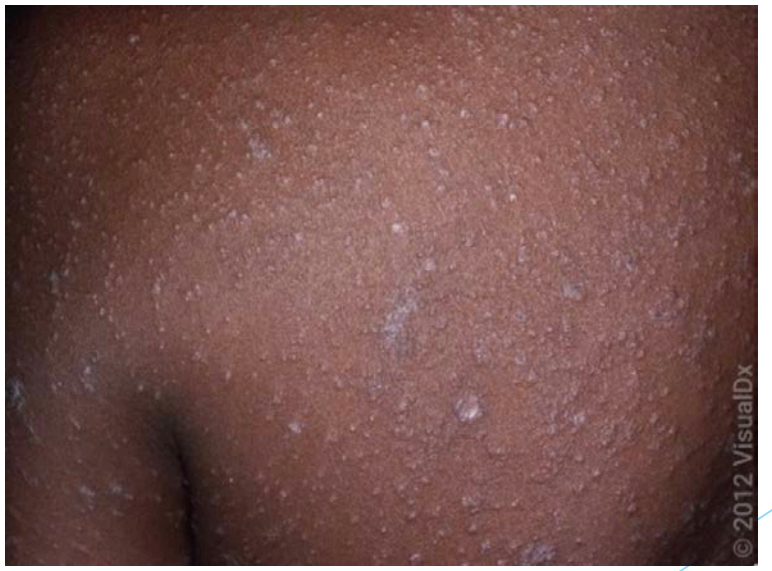
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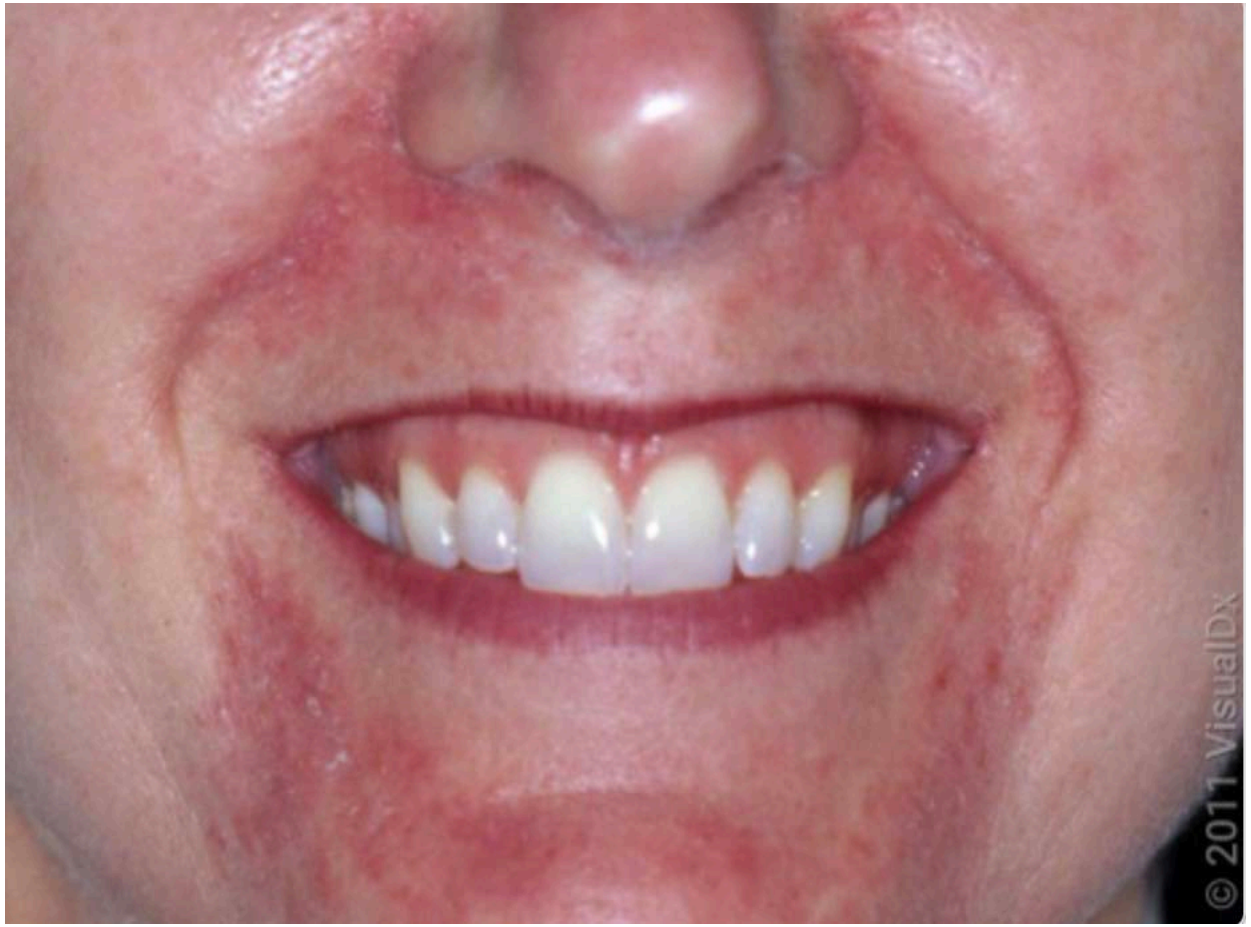
Pityriasis Rosea (PR)

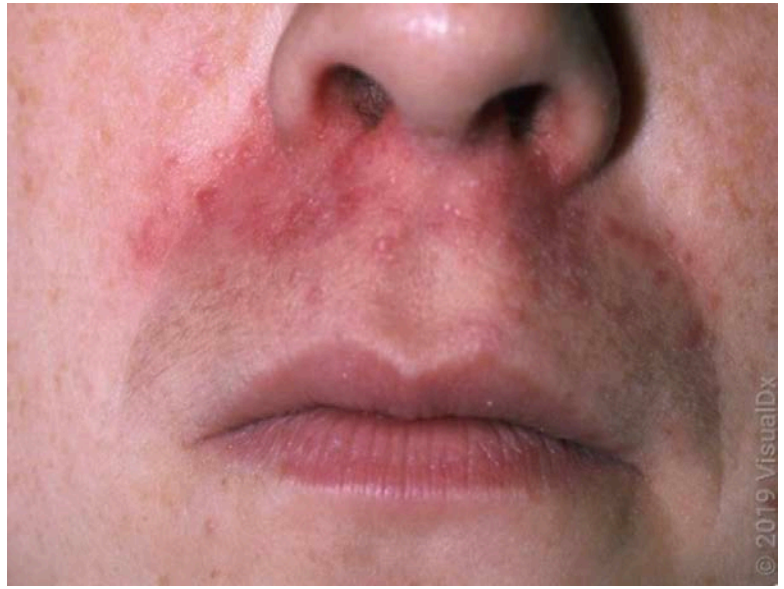
- Clinical pearls
  - If persists longer than 6-8 weeks, consider biopsy or referral
  - DDx includes secondary syphilis
    - Checks palms, soles, oral commissures
    - Consider RPR
  - PR presenting in early pregnancy (first 15 weeks of gestation)
    - Associated with birth complications
    - Consult Ob/Gyn to consider checking HHV-6 viral load and close monitoring

Case 2



Perioral dermatitis

- Commonly presents in middle aged women and children
- Grouped erythematous papulopustular eruption
- Localized perioral, perinasal and/or periocular location
- Relative sparing of immediate circumoral area
- Burning!, itch
- History of inhaled or topical corticosteroids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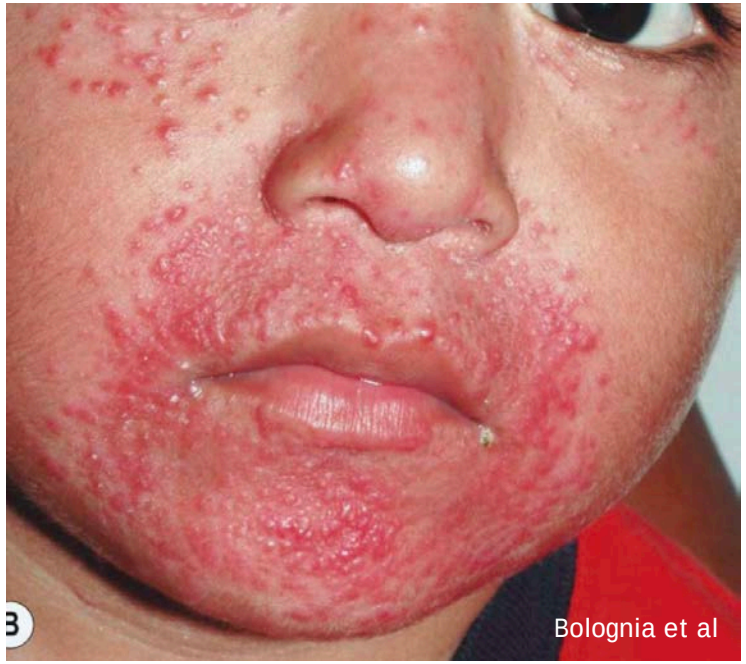
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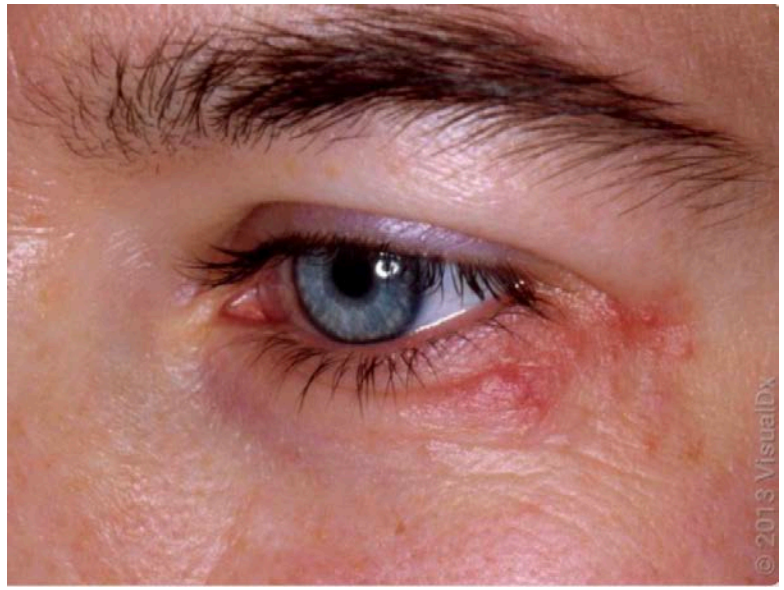
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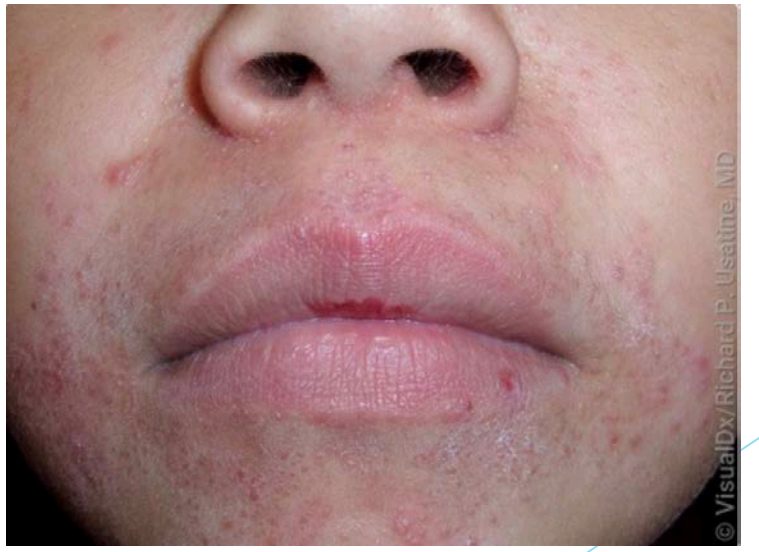
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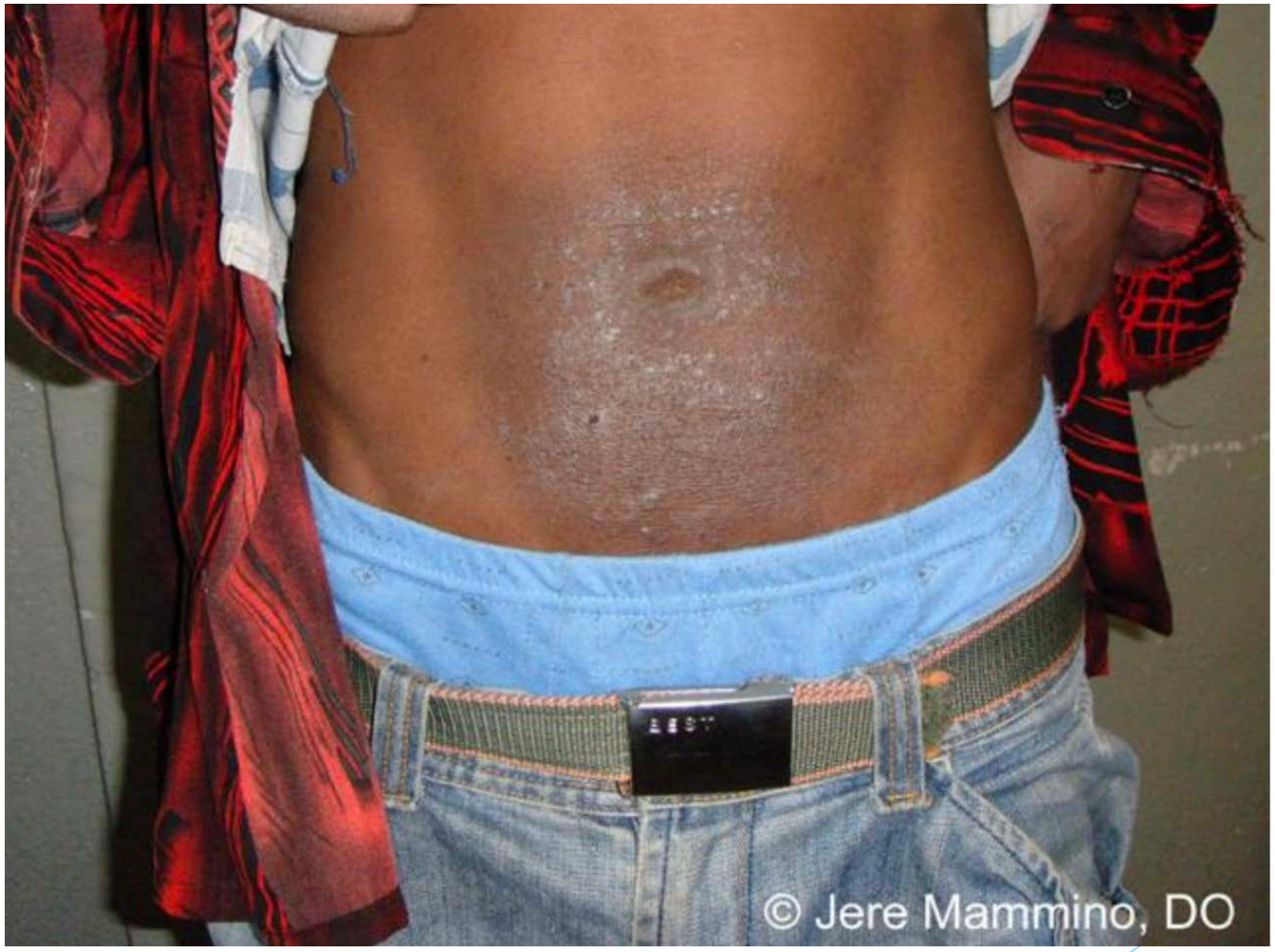
Perioral dermatitis

- Clinical pearls
  - Think **periorificial** dermatitis
  - Discontinue topical steroids
    - May need to be weaned off to avoid flare
  - Avoid fluorinated toothpaste, mint/cinnamon flavored candy, gum and toothpaste
  - Gently cleanse face after inhaled corticosteroid use
  - No comedones

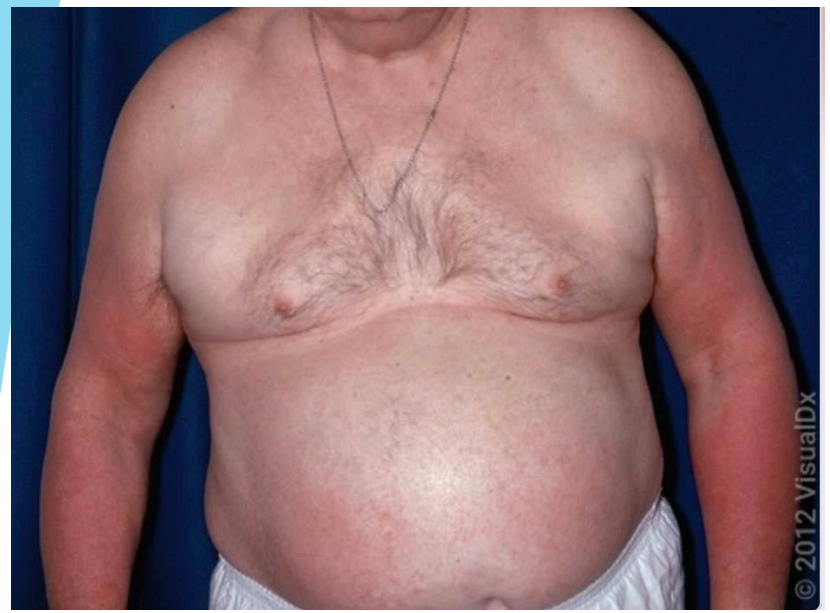
- Treatment
  - Topical clindamycin, metronidazole
  - Topical calcineurin inhibitors
  - +/- oral antibiotics

Case 3



Allergic contact dermatitis

- Delayed type IV hypersensitivity skin reaction to external stimuli
- 20% of all contact dermatitis
- Most common
  - Nickel, Balsam of Peru, Fragrance
- American Contact Dermatitis Society allergen of the year 2022
  - Aluminum
- Clinical presentations
  - Eyelid
  - Hands
  - Scalp/neck
  - Trunk/axilla
  - Dorsal feet
  - Waistband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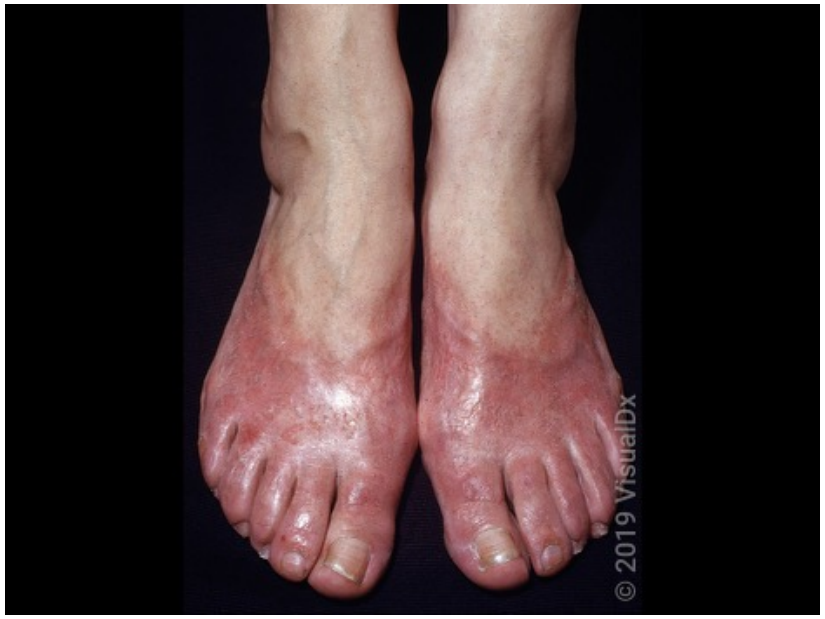
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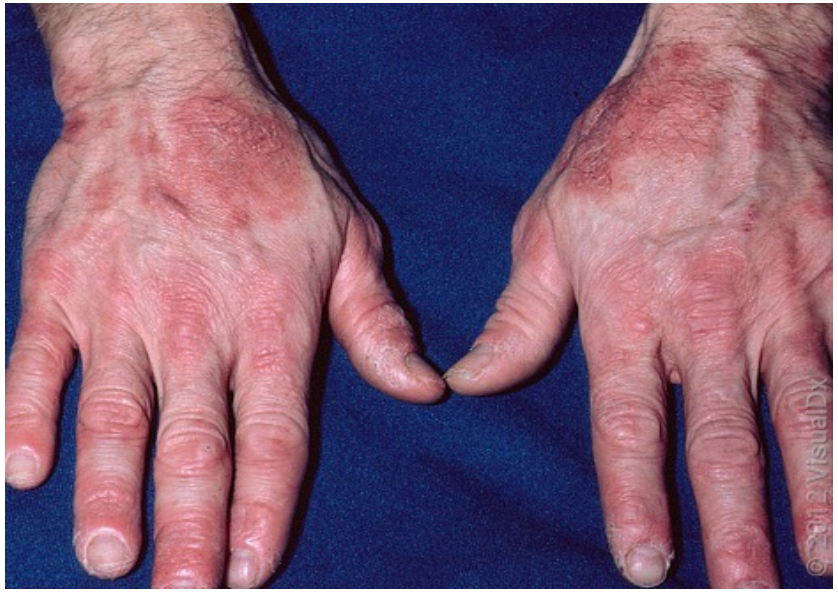
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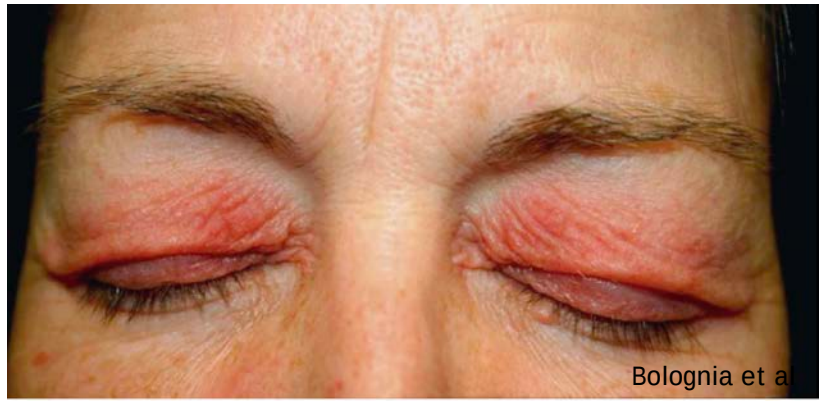
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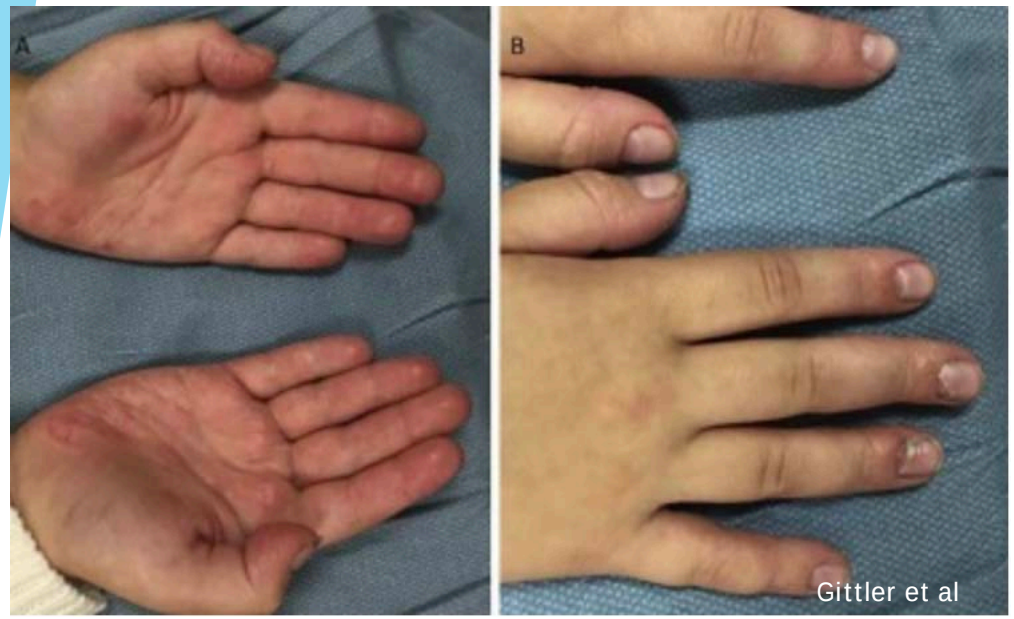
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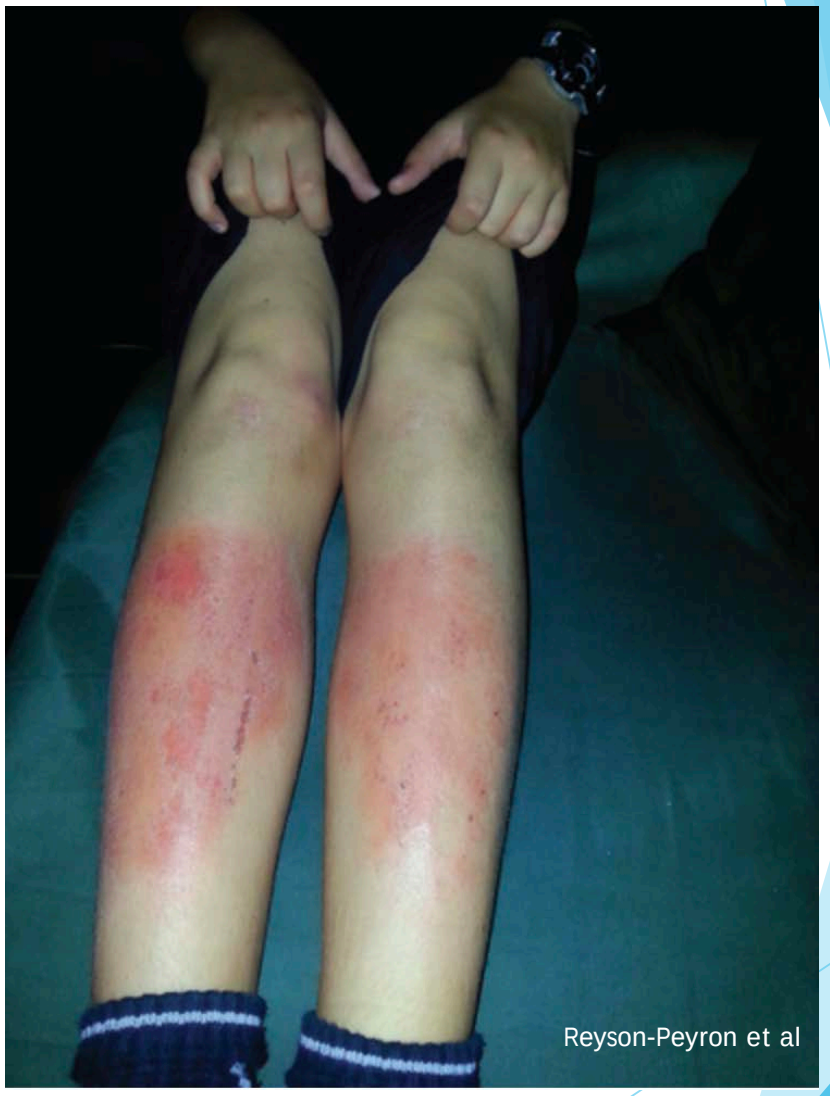
Gittler et al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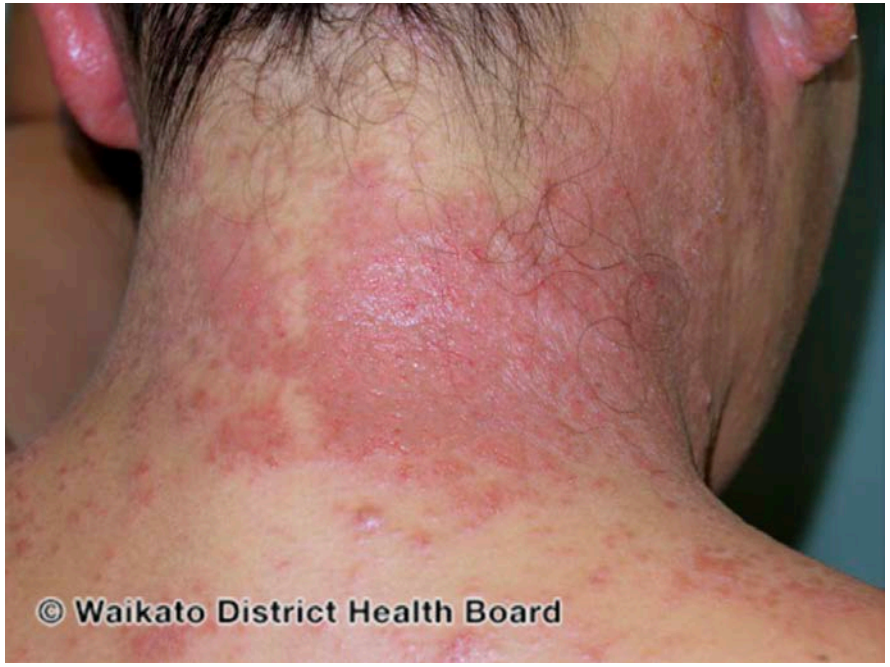
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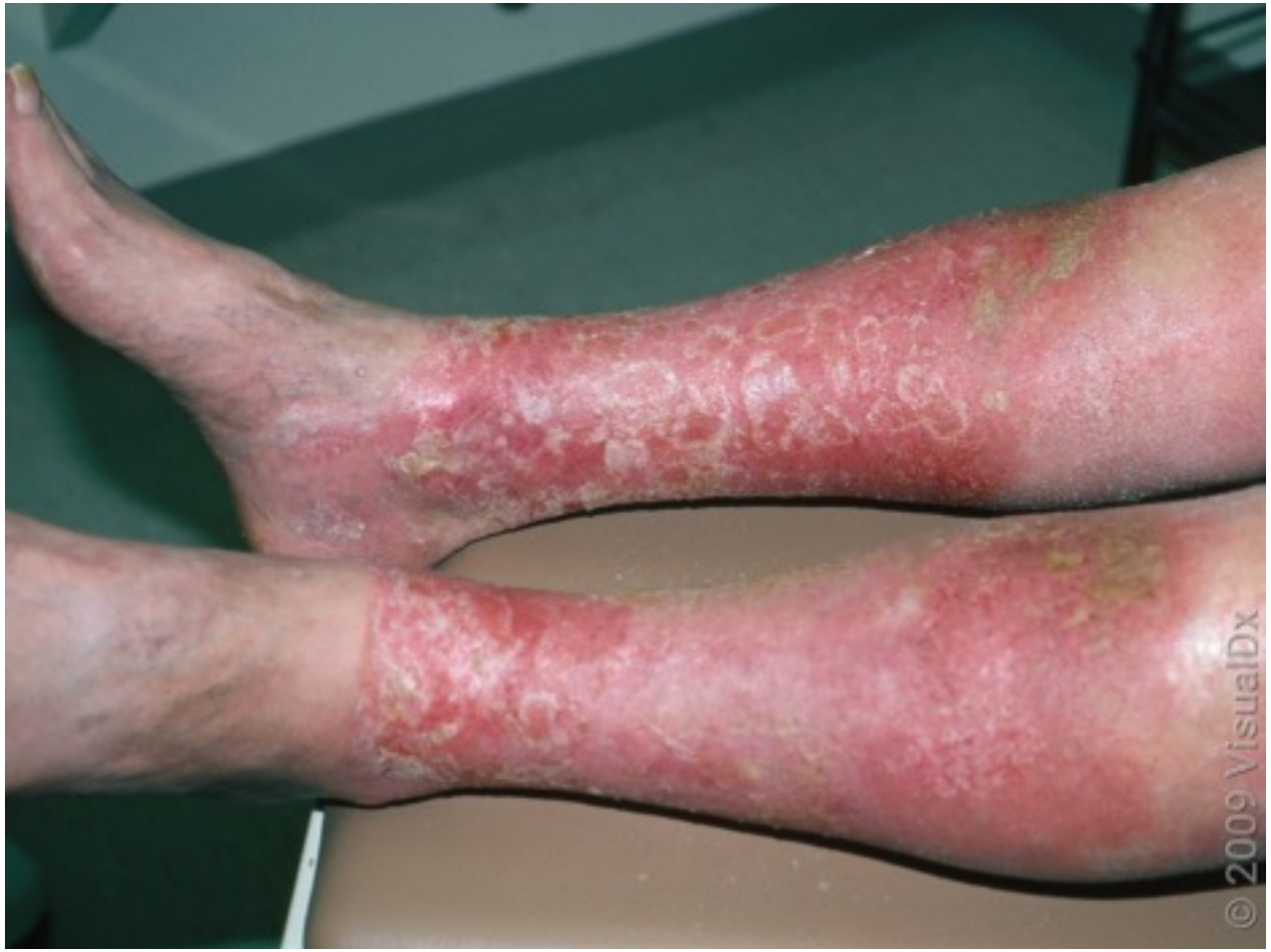
Allergic contact dermatitis

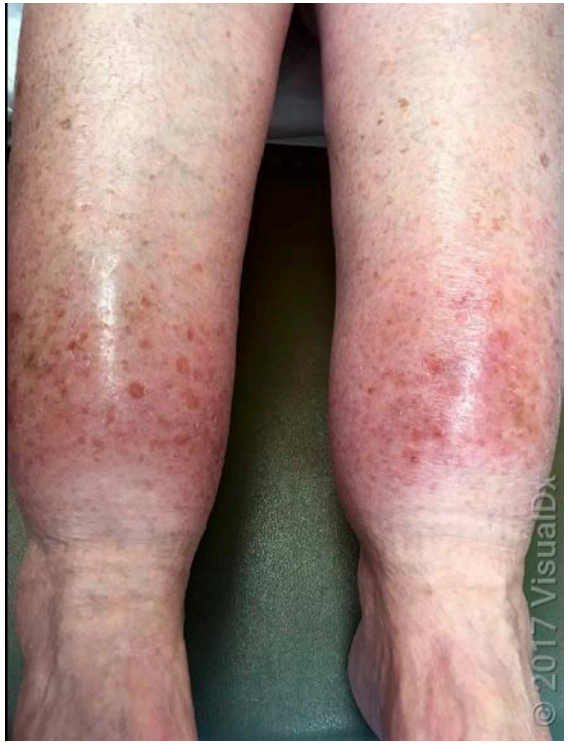
- Clinical pearls
  - Detailed history is key
    - Occupation, hobbies, timeliness, home environment, sports, personal care habits
  - Physical exam
  - Try “skin diet”
  - Refer for patch testing: TRUE test vs NACDG series

Case 4



Stasis Dermatitis

- Common component of the clinical spectrum of chronic venous insufficiency
  - Valve incompetence→ edema→ pro-inflammatory mediators, focal thrombosis, tissue hypoxia→ fibrosis
- Eczematous, weeping ill-defined plaques with brawny hyperpigmentation +/- edema
  - Itchy>>pain
- Exacerbated by allergic or irritant contact dermatitis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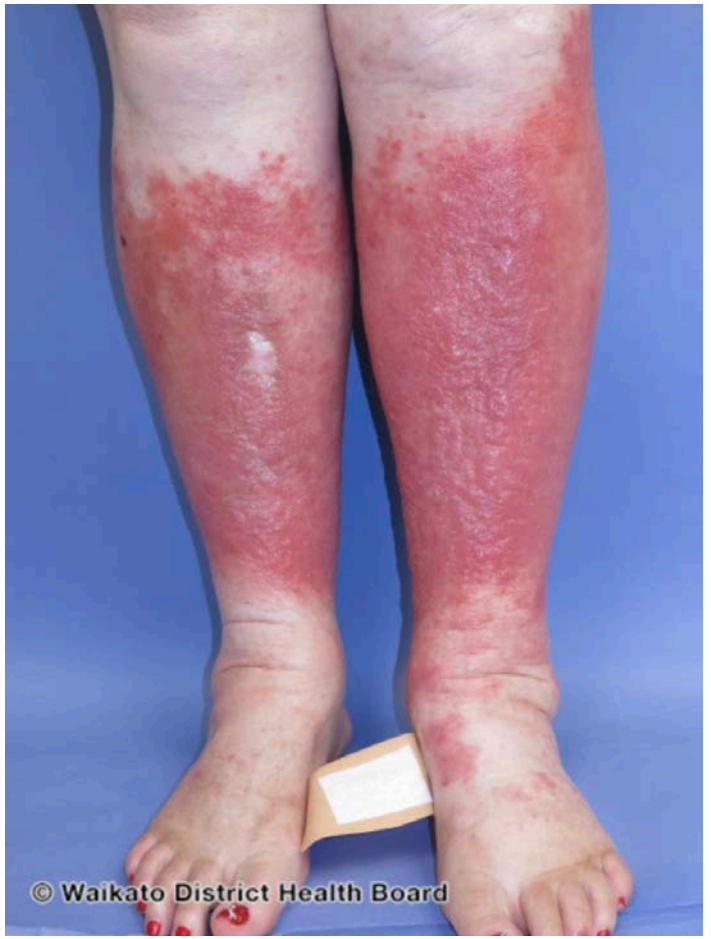
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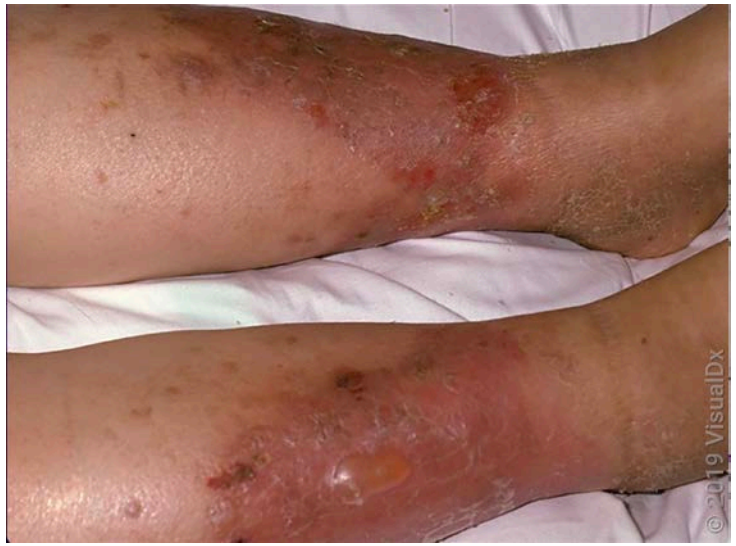
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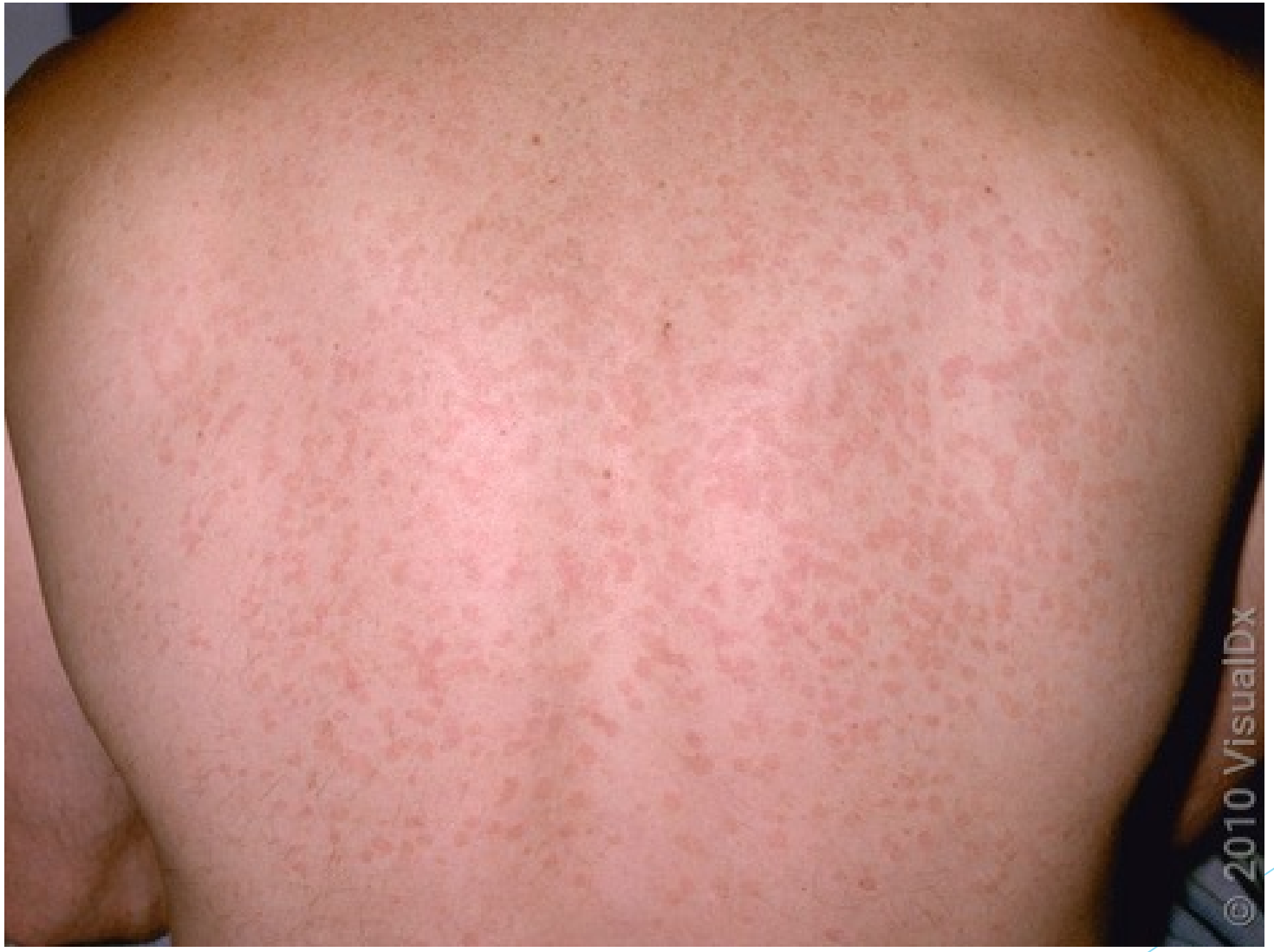
Stasis Dermatitis

- Clinical pearls
  - Bilateral cellulitis exceedingly rare
    - Cross sectional study of pts admitted from the ED over 2 years
      - 259 patients, 79 (30.5%) were misdiagnosed with cellulitis, and 52 of these were admitted primarily for the treatment of cellulitis
        - 84.6% did not require hospitalization based on ultimate diagnosis, and 92.3% received unnecessary antibiotics
    - Consider acute lipodermatosclerosis
  - DDx includes tinea corporis/pedis
    - Check toenails

  - Gentle skin care regimen
  - Topical steroids
  - Compression stockings

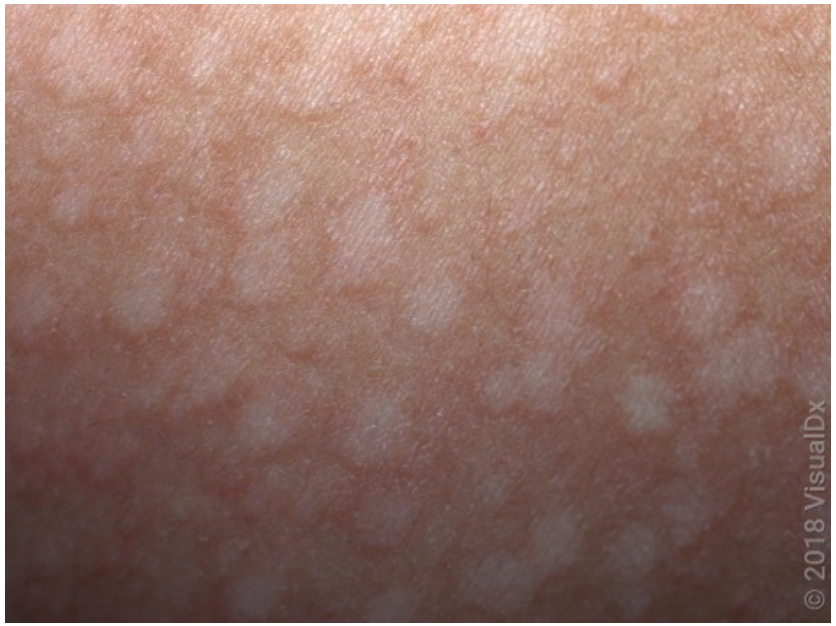
Case 5



Tinea Versicolor

- Presents commonly in young adults
- Climates with high humidity and temperatures
- Superficial fungal infection due to *Malassezia* yeast

- Hypo- or hyperpigmented macules coalescing into patches with fine scale involving seborrheic distribution
- Rarely pruritic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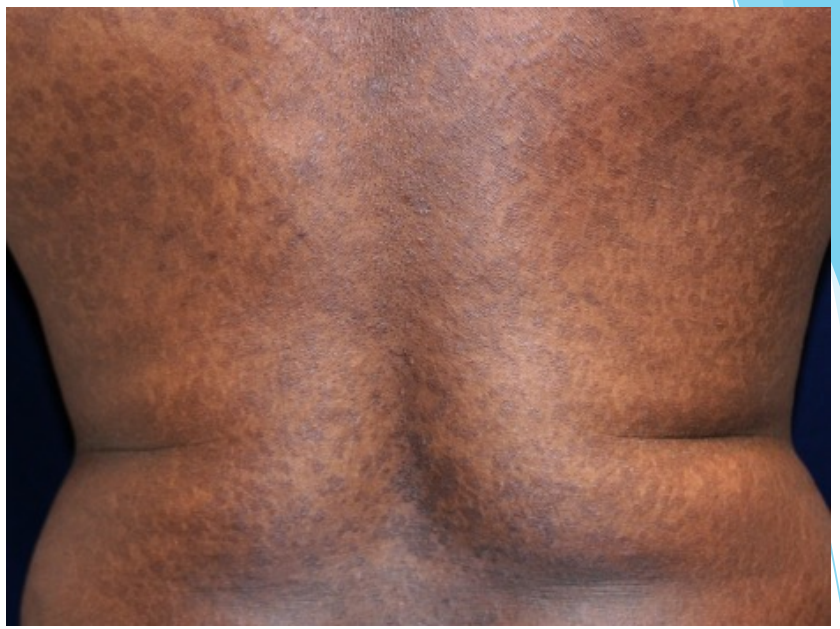

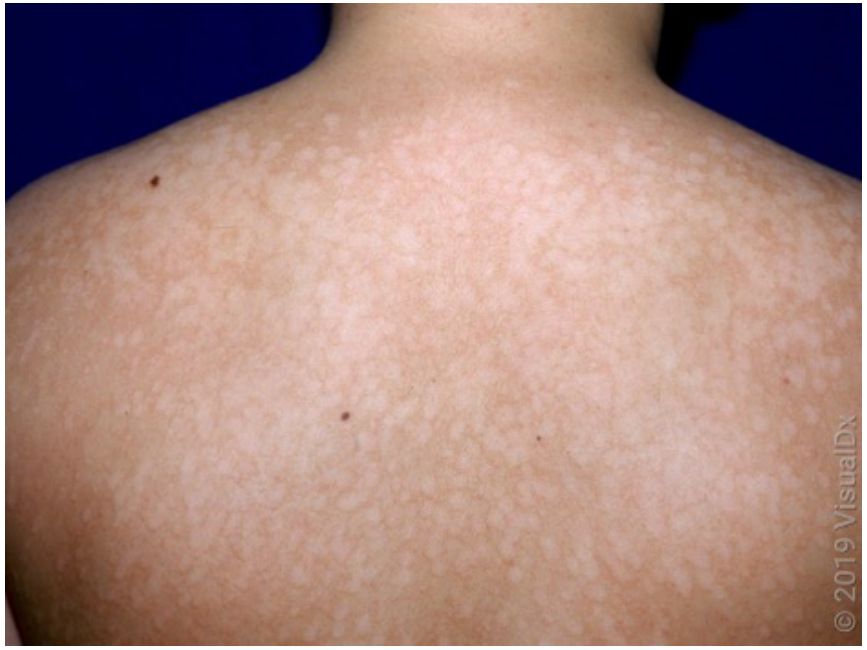
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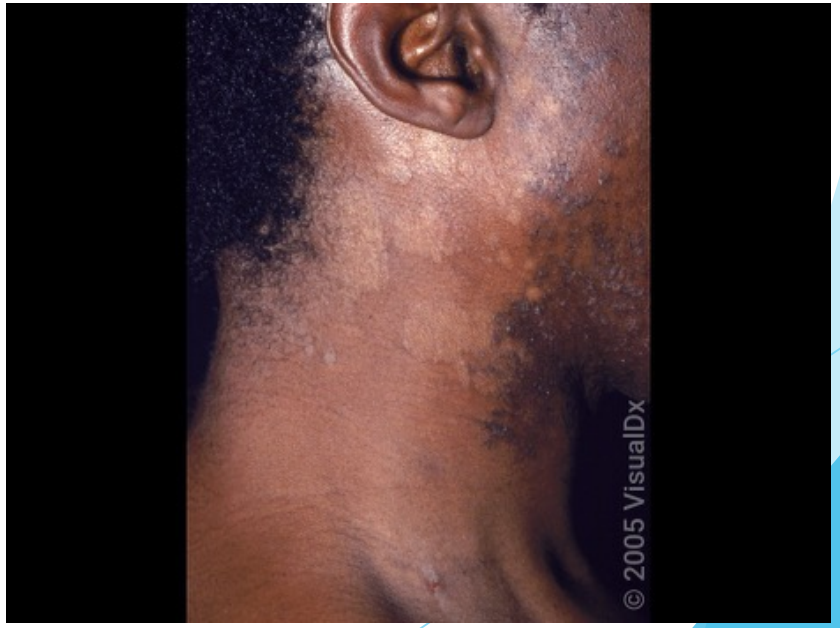
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Tinea Versicolor

- Clinical pearls
  - Check for seborrheic dermatitis of scalp/face
  - Post inflammatory changes may last weeks-months
    - Maintenance therapy may be needed to prevent flares
  - Atrophic variant

- Topical antifungals
- Pulse oral antifungals
  - Oral ketoconazole now carries black box warning

Summary

- History and physical exam are key
- Common things are common
  - Reassess, biopsy or refer if not classically responding

References

- BOLOGNIA, J., JORIZZO, J. L., & SCHAFFER, J. V. (2012). Dermatology.[Philadelphia], Elsevier Saunders.
- Gittler JK, Garzon MC, Lauren CT. "Slime" May Not be so Benign: A Cause of Hand Dermatitis. J Pediatr. 2018 Sep;200:288.
- Raison-Peyron N, Bergendorff O, Bourrain JL, Bruze M. Acetophenone azine: a new allergen responsible for severe contact dermatitis from shin pads. Contact Dermatitis. 2016 Aug;75(2):106-10.
- Weng QY, Raff AB, Cohen JM, et al. Costs and Consequences Associated With Misdiagnosed Lower Extremity Cellulitis. *JAMA Dermatol.* 2017;153(2):141–146.

Thank you!

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