Dr Shan Edwards

Dermatologist

Dermatology Clinic, Christchurch

FULLY BOOKED

Saturday, August 13, 2016

(Room 4)

11:00 - 11:55 WS #86: Differential Diagnosis Based on Classic Location - Where Does Psoriasis Fit In?

12:05 - 13:00 WS #97: Differential Diagnosis Based on Classic Location - Where Does Psoriasis Fit In? (Repeated)

DermNet NZ
All about the skin

Differential diagnosis based on classic location

Where does psoriasis fit in?

Dr Shan Edwards , dermatologist
Christchurch 2016

Conflict statement

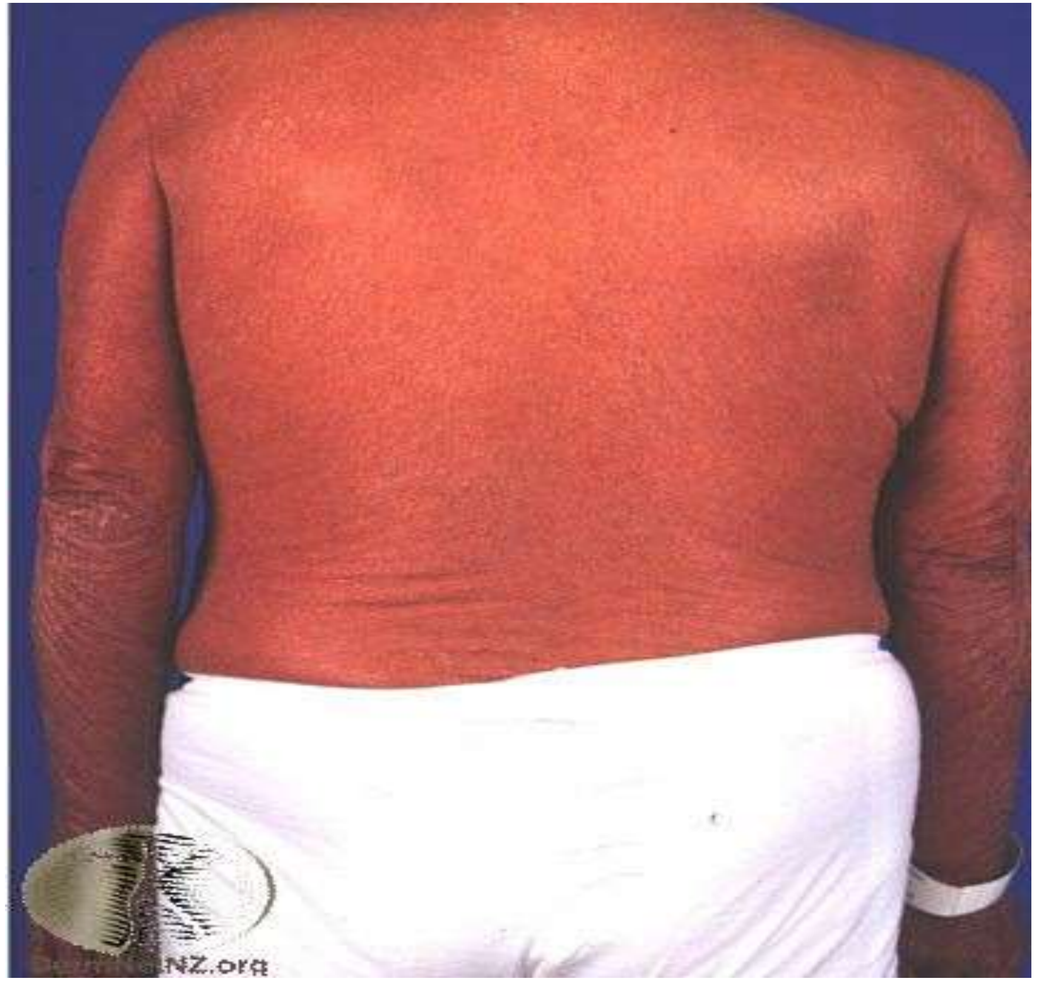
- This talk sponsored by LEO Pharma Pty Ltd
- I have no other association financial or otherwise with LEO Pharma Pty Ltd

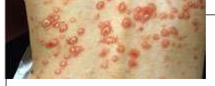
Acknowedgement

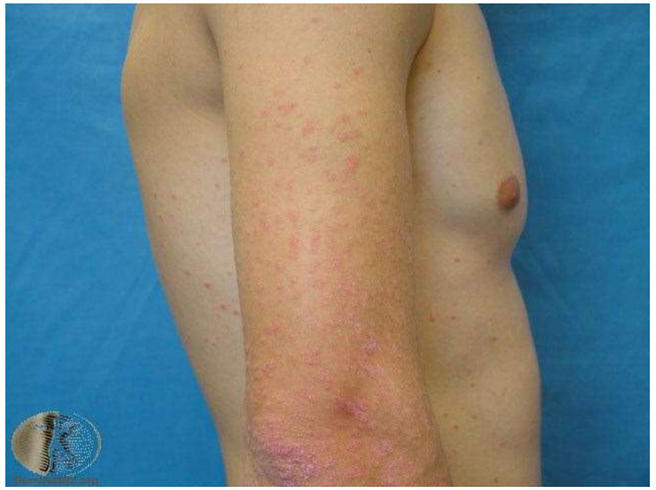
I wish to thank and acknowledge and thank A/Prof Amanda Oakley for providing a lot of the material and allowing me to use it in this talk

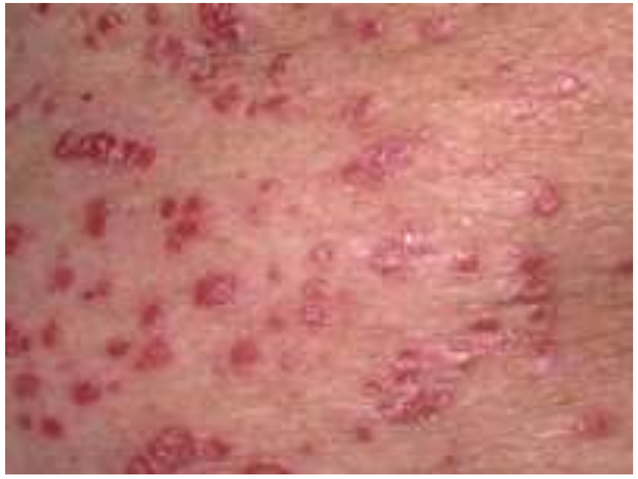
I would also like to acknowledge Dermnet NZ as a source for most of my clinical slides

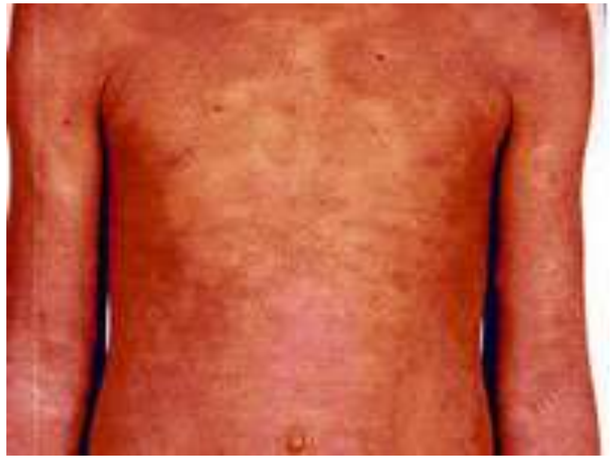
How do you diagnose red scaly skin ?

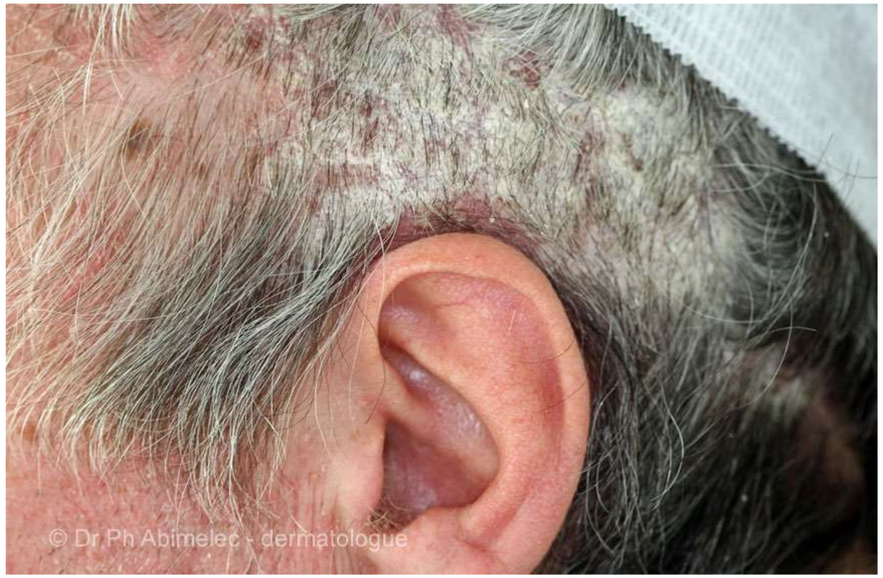











© Dr Ph Abimelec - dermatologue

Take a history (90% diagnosis made on history)

- When did scaly rash first appear?
- What do you think caused it?
- What treatments used and their effects?
- Personal history of skin problems ?
- Family history of similar disorders?
- Occupation, hobbies, other life events?
- Symptoms: itch? Other eg fever, weightloss unwell Other medical problems?(co-morbidities)
- Current medicines : how long, any new ?

When did scaly rash first appear?

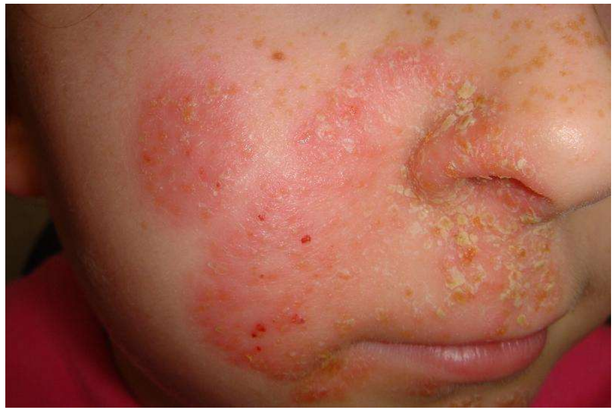
- Infancy: seborrhoeic dermatitis/eczema
- Toddler: atopic dermatitis/eczema
- Pre-schooler/primary school: tinea capitis/corporis
- Primary school: head lice
- Teenage/adult: seborrhoeic dermatitis/eczema, psoriasis
- Adult/elderly: drug rash, lymphoma, other less common skin conditions(PRP,Lupus)
- All age groups:scabies

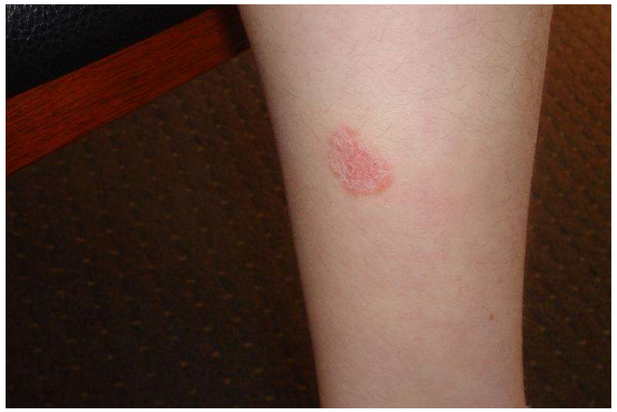
Dear Shan

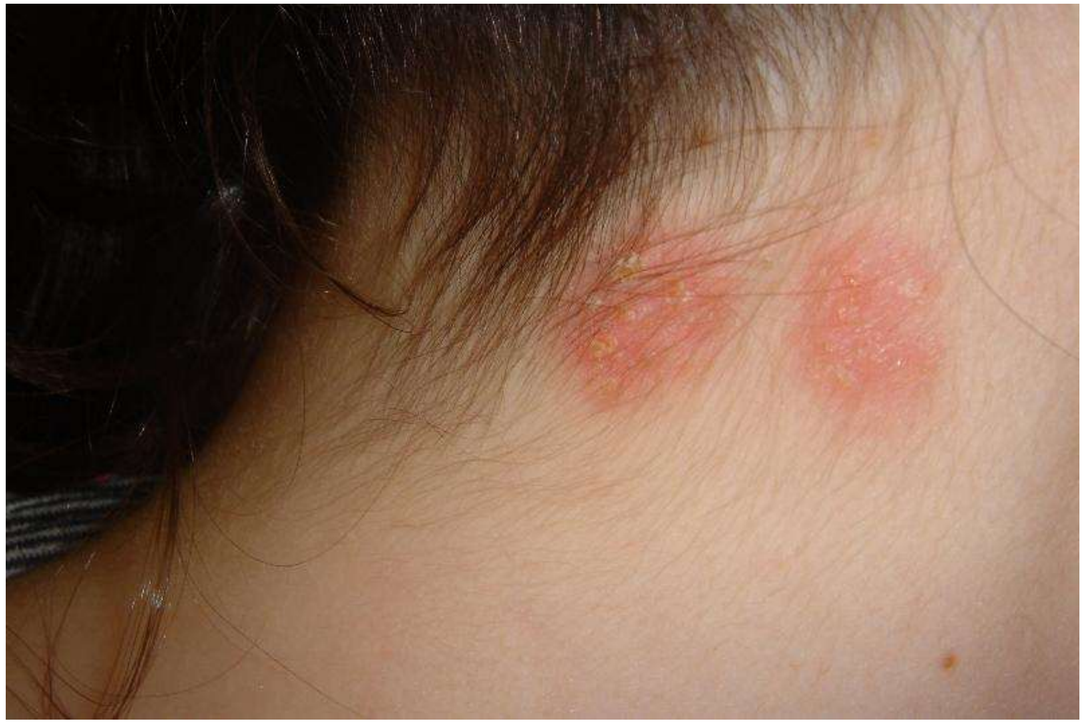
Re: Miss EM age 7yrs

I am completely puzzled by EM's rash and
particularly so since there now
appear to be other areas of her body being affected
by it. She first
presented to a recent locum with a small rash
around the right side of her
nose and the diagnosis appeared to be impetigo.

. Treatment was initially with topical Pimafucort Cream but the rash did not improve. She returned to see me on 8 July and at that stage I elected to treat her with an oral antibiotic. Swabs were taken including scrapings.







- WHAT IS THE DIAGNOSIS?

When did scaly rash first appear?

- Infancy: seborrhoeic dermatitis/eczema
- Toddler: atopic dermatitis/eczema
- Pre-schooler/primary school: tinea capitis/corporis
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- Teenage/adult: seborrhoeic dermatitis/eczema, psoriasis
- Adult/elderly: drug rash, lymphoma, other less common skin conditions(PRP,Lupus)
- All age groups:scabies

There was no bacterial
growth but a small number of fungal elements were
seen. I added a topical
antifungal cream but the rash has progressed and she
now has "satellite"
spots on her trunk and limbs.
Could this possibly be psoriasis? Some other
diagnosis?

Take a history (90% diagnosis made on history)

- When did scaly rash first appear?
- What do you think caused it?
- What treatments used and their effects?
- Personal history of skin problems ?
- Family history of similar disorders?
- Occupation, hobbies, other life events?
- Symptoms: itch? Other eg fever, weightloss unwell Other medical problems?(co-morbidities)
- Current medicines : how long, any new ?

What do you think caused it ?

- Usual answer: I don't know
- Take patient's ideas seriously:eg
  - Hair care products, new OTC product
  - Food (commonly incriminated)
  - Washing powder
  - Bugs
  - Cat/dog
  - Sun

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- Current medicines : how long, any new ?

Effects of treatment

- Topical Rx used if corticosteroid systemic or topical, cream or ointment ?
- Potency (superpotent or weak?)
- Duration and amount used ?
- Responsive or not ?
- Emollients used ? How are they being used?
- Other treatment eg tar, vitamin D cream/oint
- Effect of antihistamines

Take a history (90% diagnosis made on history)

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- Current medicines : how long, any new ?

Personal or family history?

- Infection or infestation
- Atopic dermatitis/eczema
  - Asthma, hay fever, allergic rhinitis
- Psoriasis

Take a history (90% diagnosis made on history)

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- Occupation, hobbies, other life events?
- Symptoms: itch? Other eg fever, weightloss unwell Other medical problems?(co-morbidities)
- Current medicines : how long, any new ?

Occupation, hobbies, life events ?

- Eg Hair dresser, waitress, farmer
- Recent life trauma, illness, surgery

Take a history (90% diagnosis made on history)

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- Current medicines : how long, any new ?

Symptoms: itch ? Other eg fever weightloss unwell

- Raises possibility of generalised medical condition , may be eg cut T cell lymphoma, drug rash, paraneoplastic condition.
- Preceding illness eg strep throat , flu

Take a history (90% diagnosis made on history)

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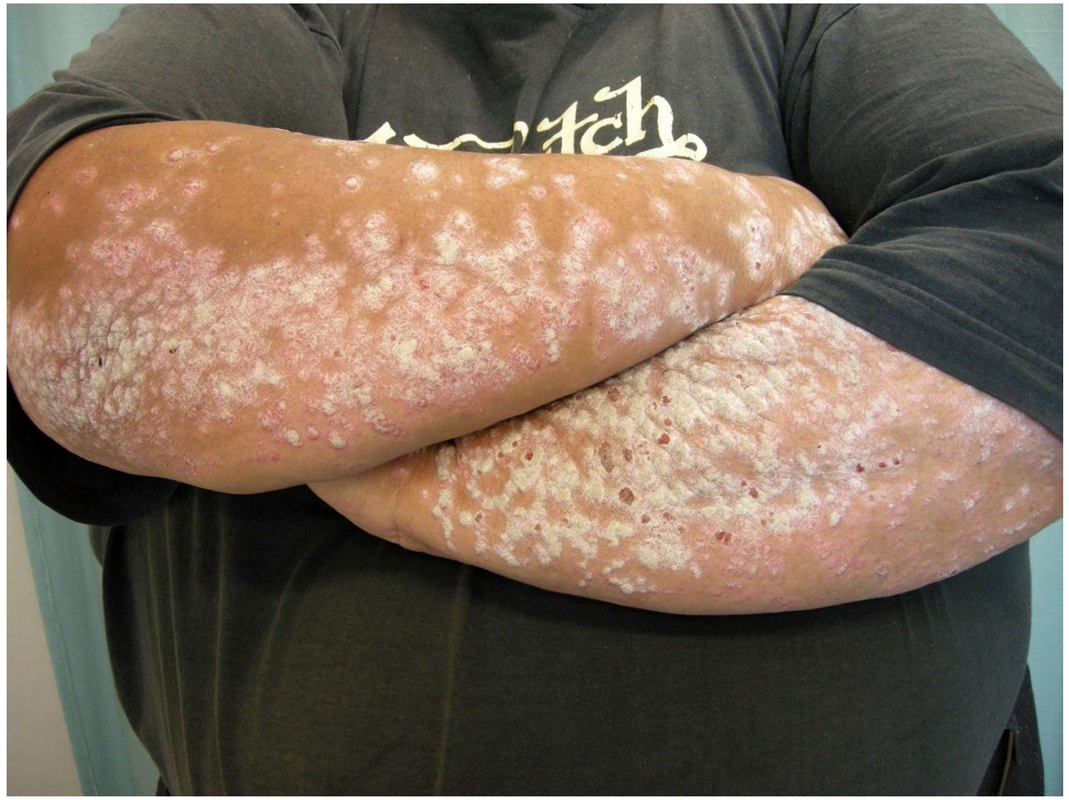
- Current medicines : how long, any new ?

Co-morbidities

Psoriasis is associated with and is an independent risk factor increased risk for CV disease and psychological disease.

Early and effective treatment of severe disease reduces these risks.



PSORIAIS IN CHILDREN: co-morbidities

- Obesity
- Hypertension
- Hyperlipidaemia
- Diabetes
- Rheumatoid arthritis
- Crohns disease and UC
- Psychiatric disorders
- (early diagnosis and management in children essential)

Take a history (90% diagnosis made on history)

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DRUG INDUCED PSORIASIFORM RASH

- Exacerbate pre-existing psoriasis
- Or
- Precipitate disease in predisposed
- Or
- Precipitate disease in non-predisposed

Drugs and psoriasis/psoriasiform rash

- Lithium
- Beta blockers
- Anti malarials
- NSAIDs
- Tetracycline
- Anti TNF (rx IBD, precipitated palmoplantar pustulosis in pts Rx for Chronic plaque type psoriasis)
- Steroid withdrawal

Drugs reported to cause psoriasis-isolated reports

- ACE
- Statin
- Terbinafine

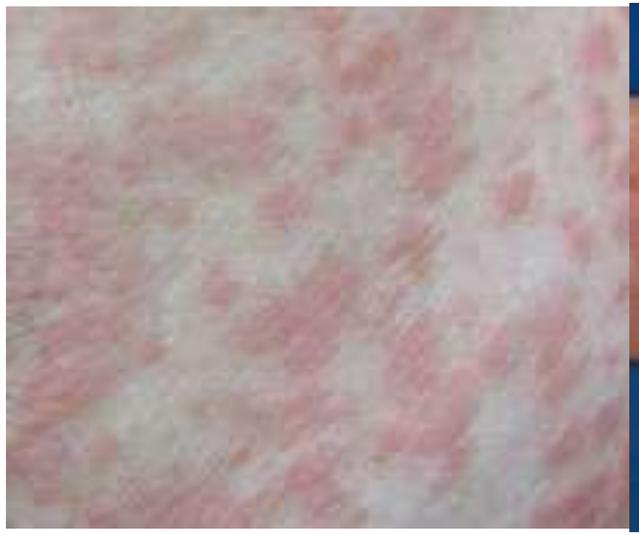
  Leuprolide (GNRH analogue)
- Imiquimod

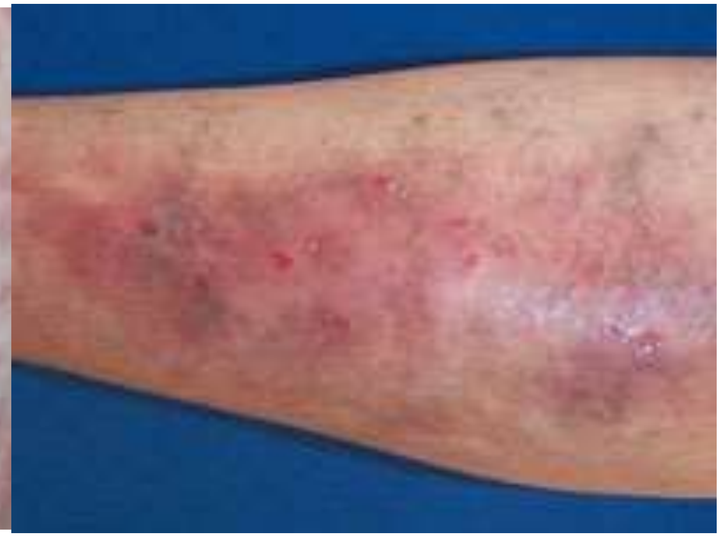
  Levetiracetam
- Mitomycin

87 yo man severe and generalized itch several months

- Partial response to clobetasol used for a week only
- Recent cellulitis , no improvement with antibiotics
- History lifelong eczema
- Varicose veins
- Meds (many years):aspirin,zopiclone, felodipine, quinapril, dipyridamole, loratidine, simvastatin, promethazine, omeprazole

- Examination
- Eczematous rash legs
- Erythematous papular rash trunk (morbilliform)





What is the diagnosis ?

What is the management ?

- ADVERSE DRUG REACTION
- 5year retrospective study hospitalised pts

- 3 commonest groups of drugs:
- Antimicrobials
- NSAIDS
- Anticonvulsants

EXAMINATION

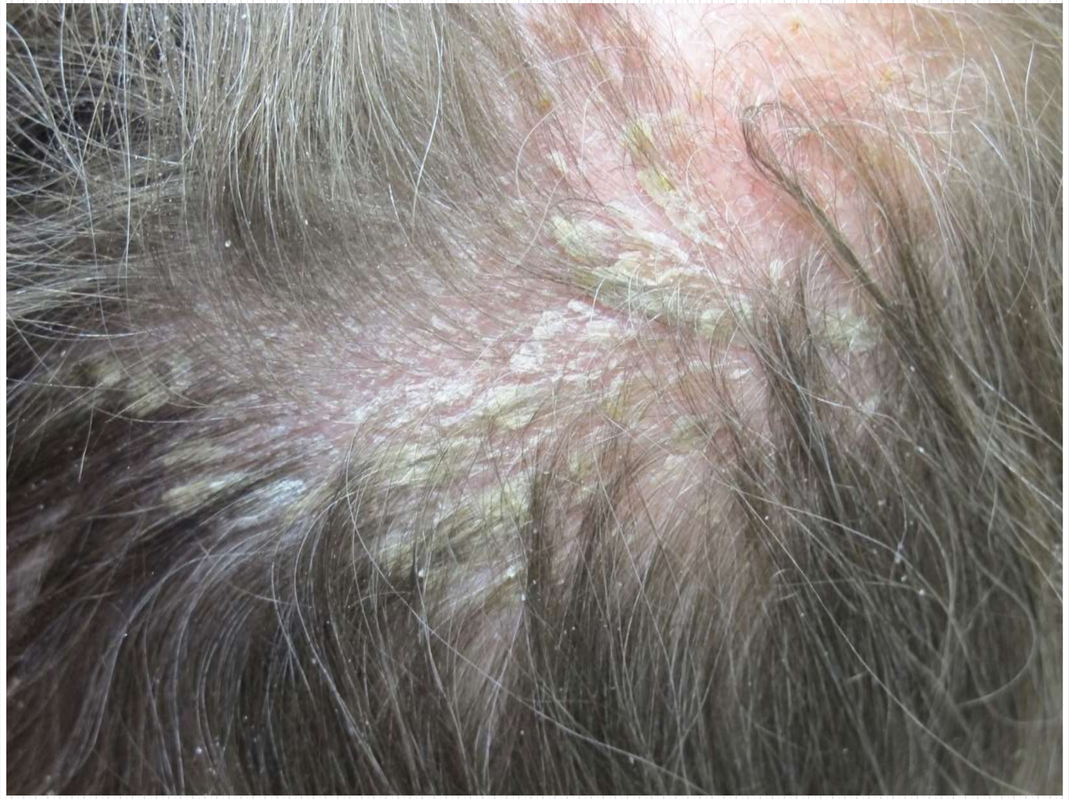
What sites are affected?

- Scalp
- Ears, behind ears
- Face: where, exactly?
- Inside mouth
- SYMMETRY VS ASYMMETRY
- Flexures vs Extensors ,
- genitals
- Trunk, limbs
- Hands, feet
- Nails

DIAGNOSIS OF SCALY SCALP

Scalp

Is it psoriasis?



Q1. 72 year-old male; scaly scalp 3 mth.
Which statement is true?

A. A scaly bald patch is diagnostic of tinea capitis
B. He's too old for new-onset psoriasis
C. Parkinson disease increases seborrhoeic dermatitis
D. Reactions to hair dye mainly affect vertex of scalp

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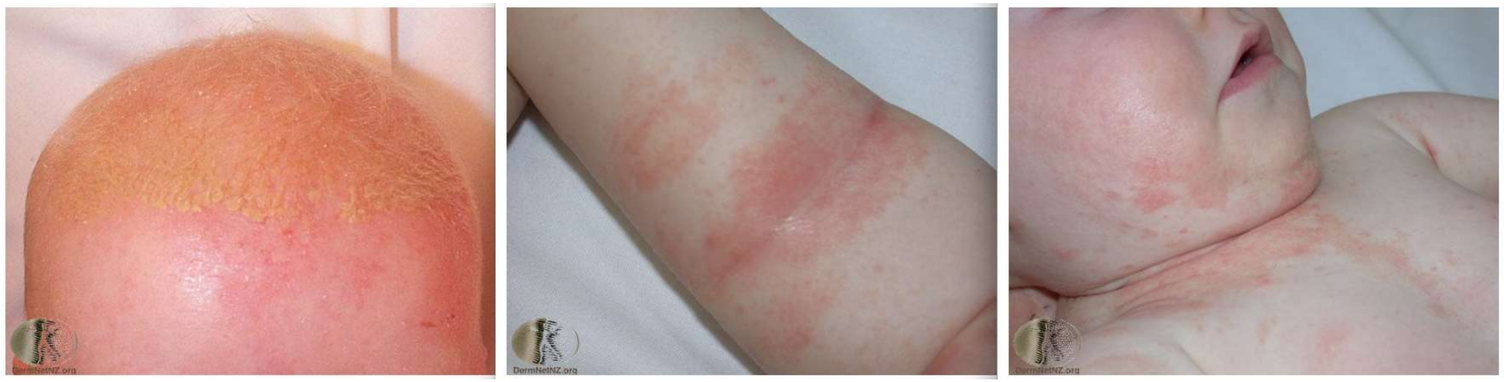
Scaly scalp

- Seborrhoeic dermatitis
- Pityriasis amiantacea
- Atopic dermatitis
- Contact dermatitis
- Discoid lupus erythematosus
- Lichen plano-pilaris
- Frontal fibrosing alopecia
- Tinea capitis
- Head lice
- Crusted scabies
- Actinic keratoses
- Seborrhoeic keratoses …

Or, is it psoriasis?

Infantile seborrhoeic dermatitis

- Onset before 3 mths
- Cradle cap
  - Dry or crusted
- Salmon-pink patches
  - Flexures / napkin
- Not especially itchy
- Resolves
  - atopic eczema may occur concurrently



Infantile seborrhoeic dermatitis: tx

- Minimise treatment
- Ketoconazole shampoo x 4 weeks
- Olive oil massages (wash off)
- Emollients might make it worse
- Unless early-onset atopic eczema, when they help

CLINICAL BOTTOM LINE

- Ketoconazole is at least as effective at treating seborrhoeic dermatitis as steroid creams and may be better at preventing recurrences, providing a good alternative to using steroid creams in infants.

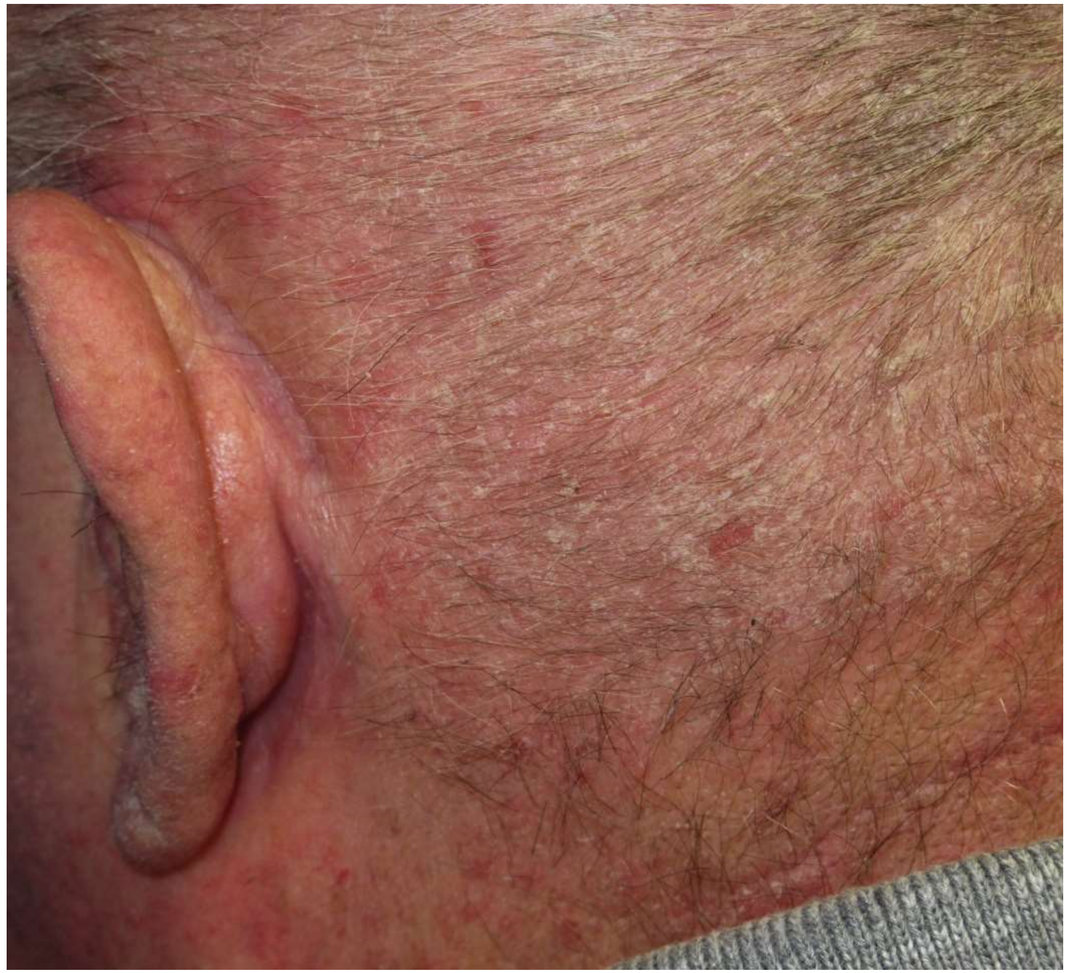
Should we treat **infantile seborrhoeic dermatitis** with topical antifungals or topical steroids?
Cohen S.
Arch Dis Child. 2004 Mar;89(3):288-9. **Review**. No abstract available.

Seborrhoeic eczema/dermatitis

- Diffuse or patchy, yellowish scale
- Mild, salmon-pink erythema, if any
- Minimal itch
- May affect flexures

Tx:

1. Ketoconazole shampoo
2. Mild topical corticosteroid lotion

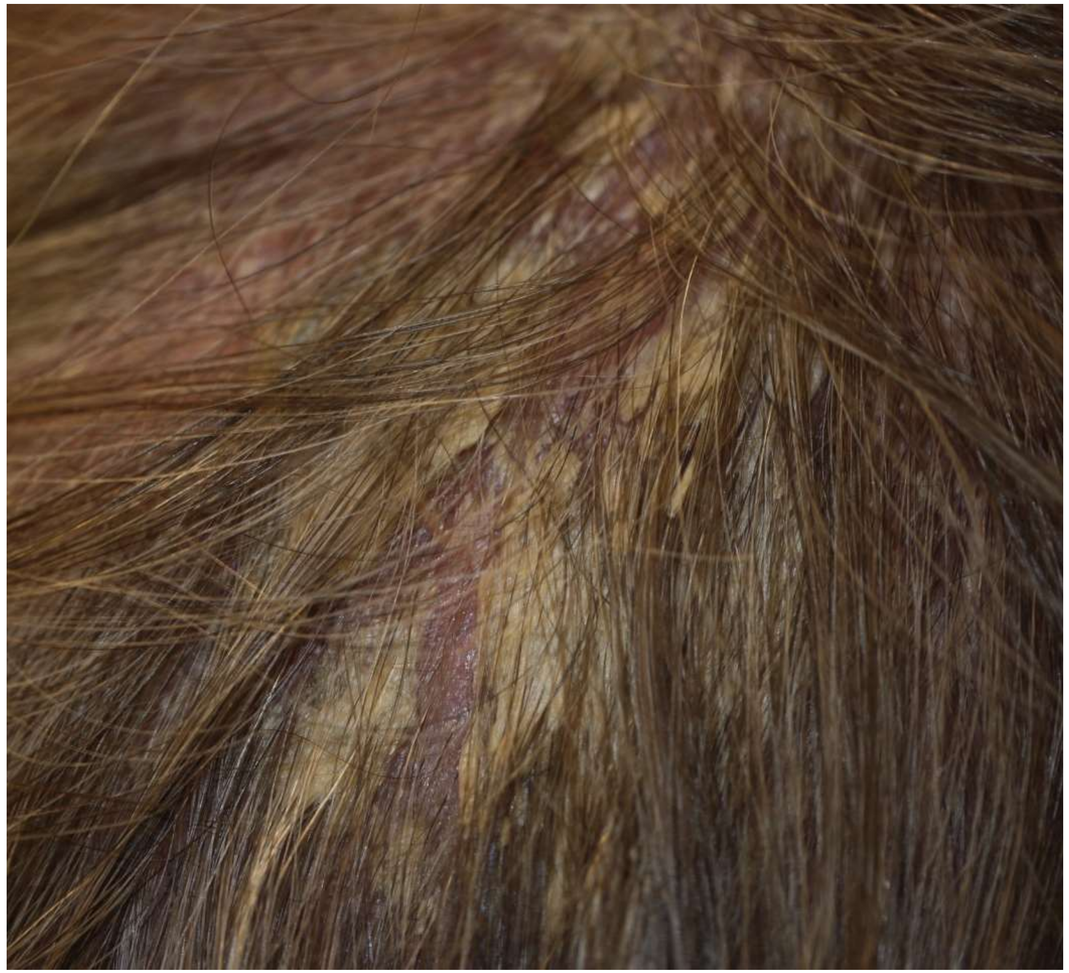


Pityriasis amiantacea

- White or yellow, adherent scale, `masses of sticky scale overlapping like tiles on a roof`
  - Often, oozy scalp surface
- Hair pulls out
  - Temporary bald spot
- May or may not have underlying seborrhoeic dermatitis or psoriasis

Tx:

1. Ketoconazole shampoo
2. Keratolytic, massaged in
   eg 6% salicylic acid in olive oil

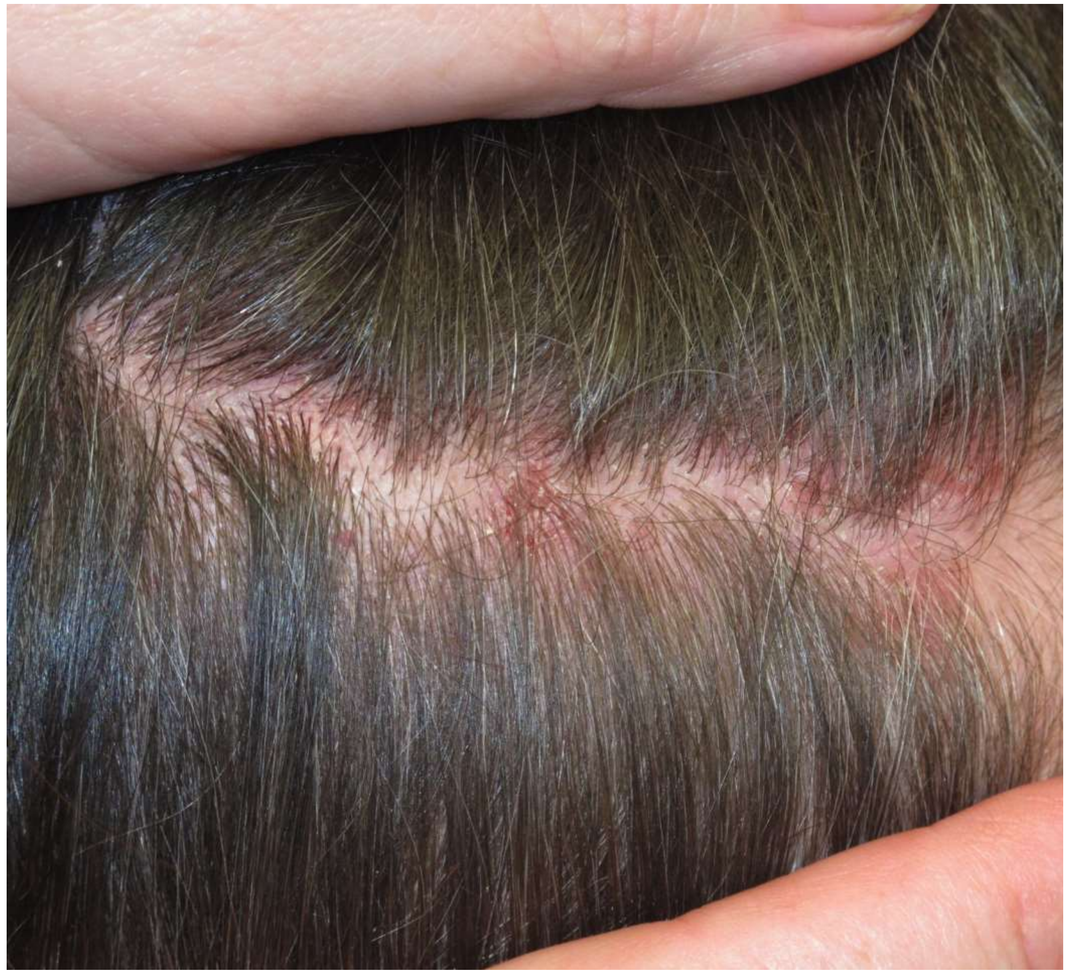


Atopic eczema/dermatitis

- Scalp rarely only site
- Scale is minimal
- Excoriations
- Often, impetiginised
- Sometimes, due to contact dermatitis

Tx:

1. Bland shampoo
2. Topical steroid lotion or cream

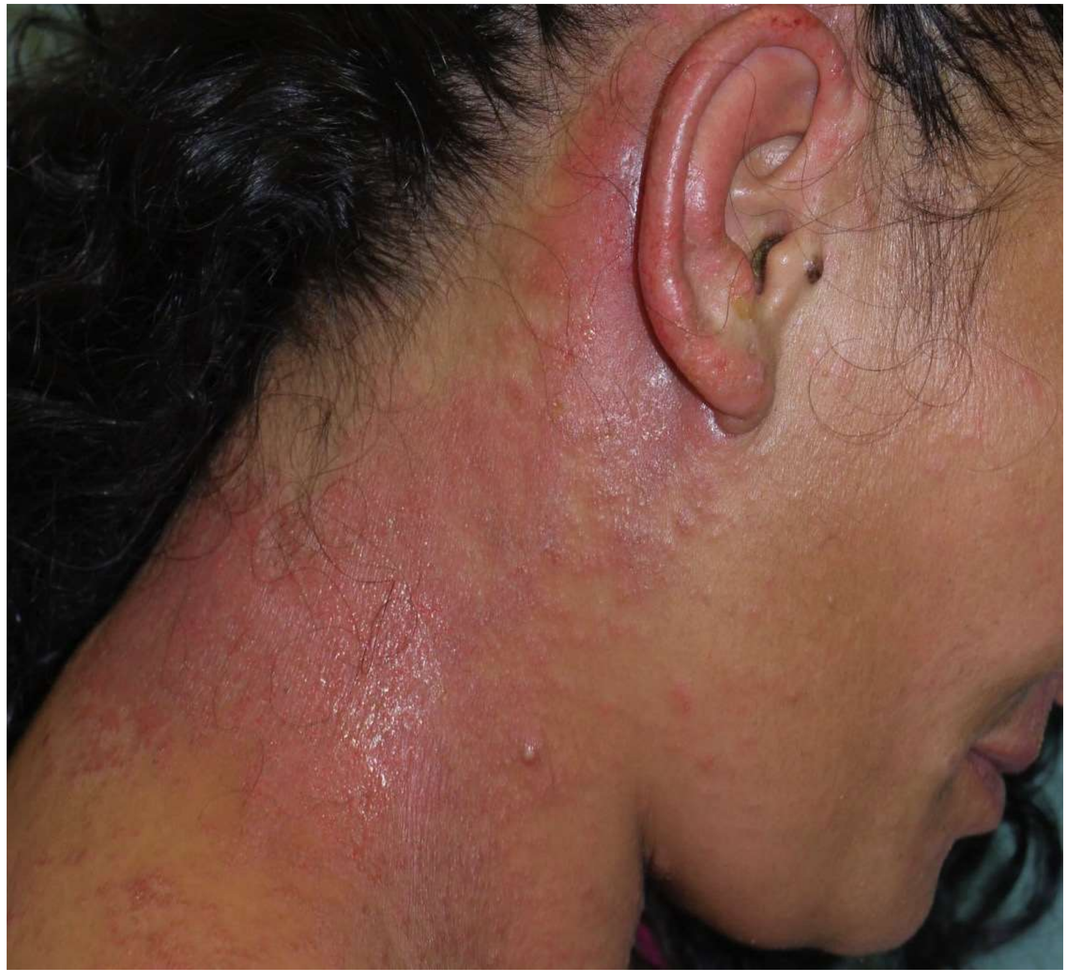


Contact eczema/dermatitis

- Often, single episode
- Sometimes, recurrent episodes
  Rarely, chronic
- Asymmetrical acute eczema
- Erythema, oedema, vesicles, itch
- Often, scalp skin is spared

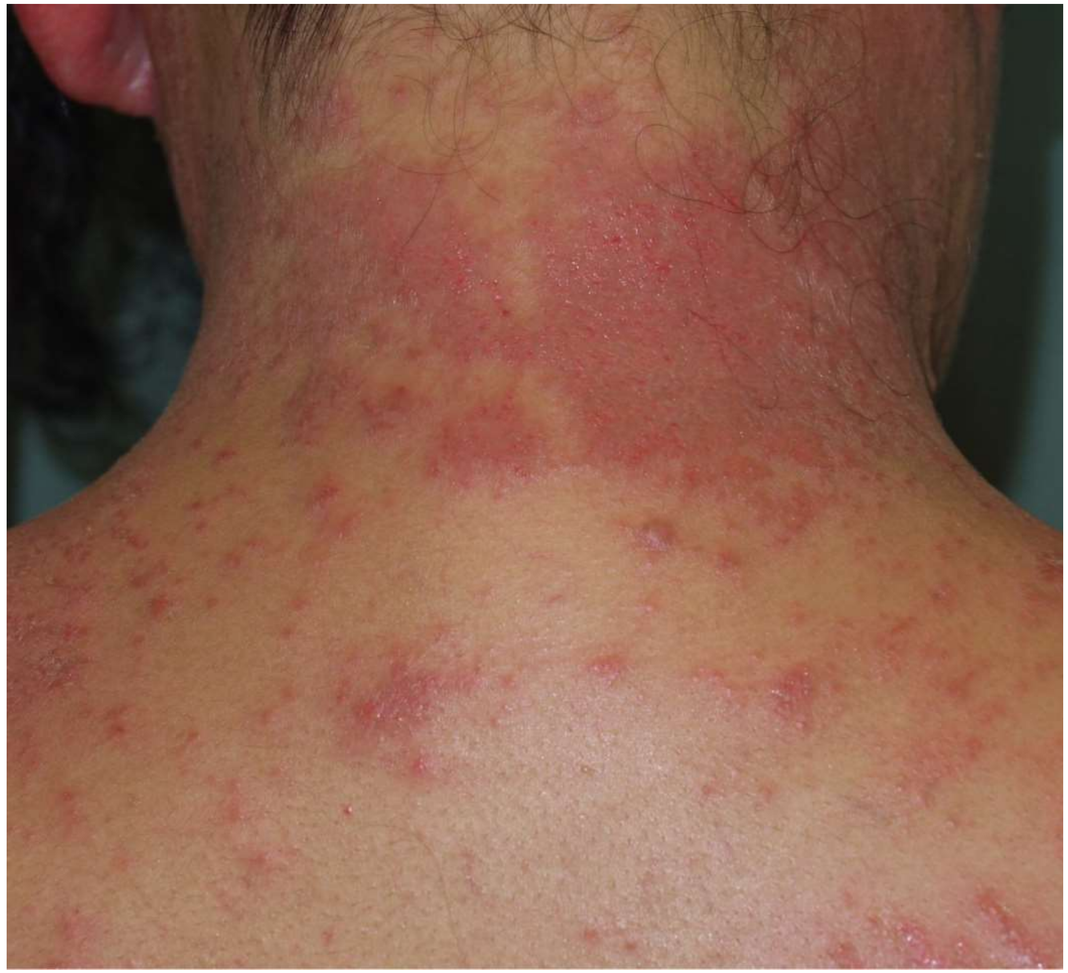
Tx:

1. Potent topical steroid cream
2. Sometimes, prednisone 40 mg x 2 wks or so



Contact eczema/dermatitis

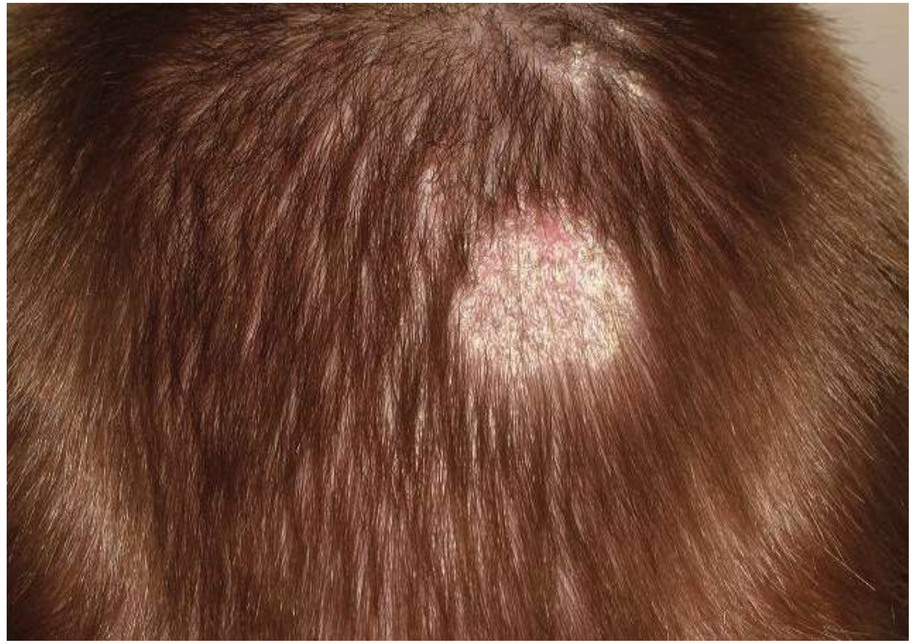
- Irritant vs allergic
  - Irritants:
    soap, detergent, alcohol
  - Allergens:
    fragrances, dyes, preservatives, perming solution etc
  - Confirmed by patch tests

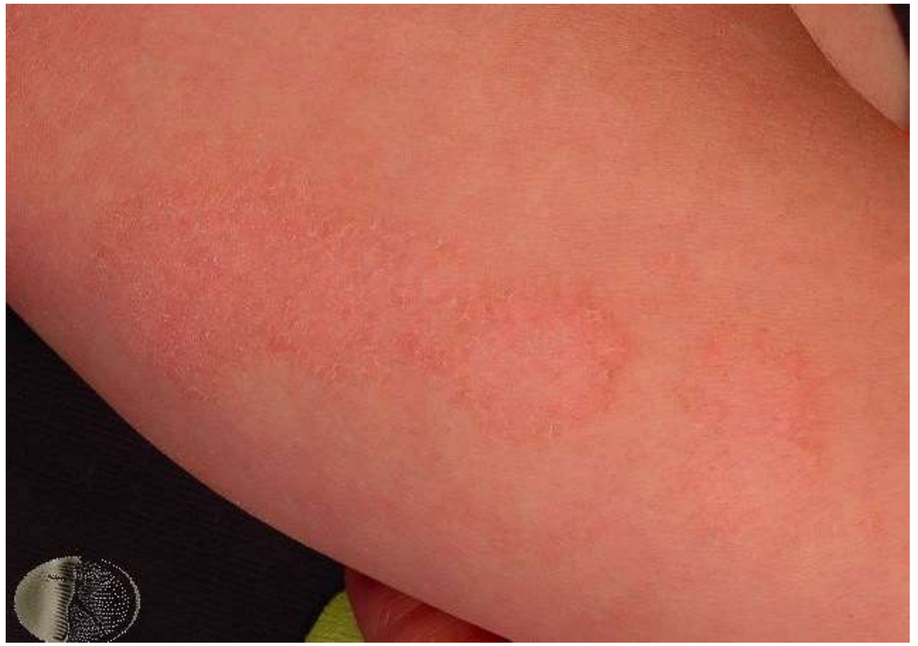


Tinea capitis

- Child
- Sibling/s may be affected
- Localised, bald scaly plaque
- Hair pulls out easily
- May have rash elsewhere
- Mycology: Microsporum canis

Tx: oral terbinafine or itraconazole



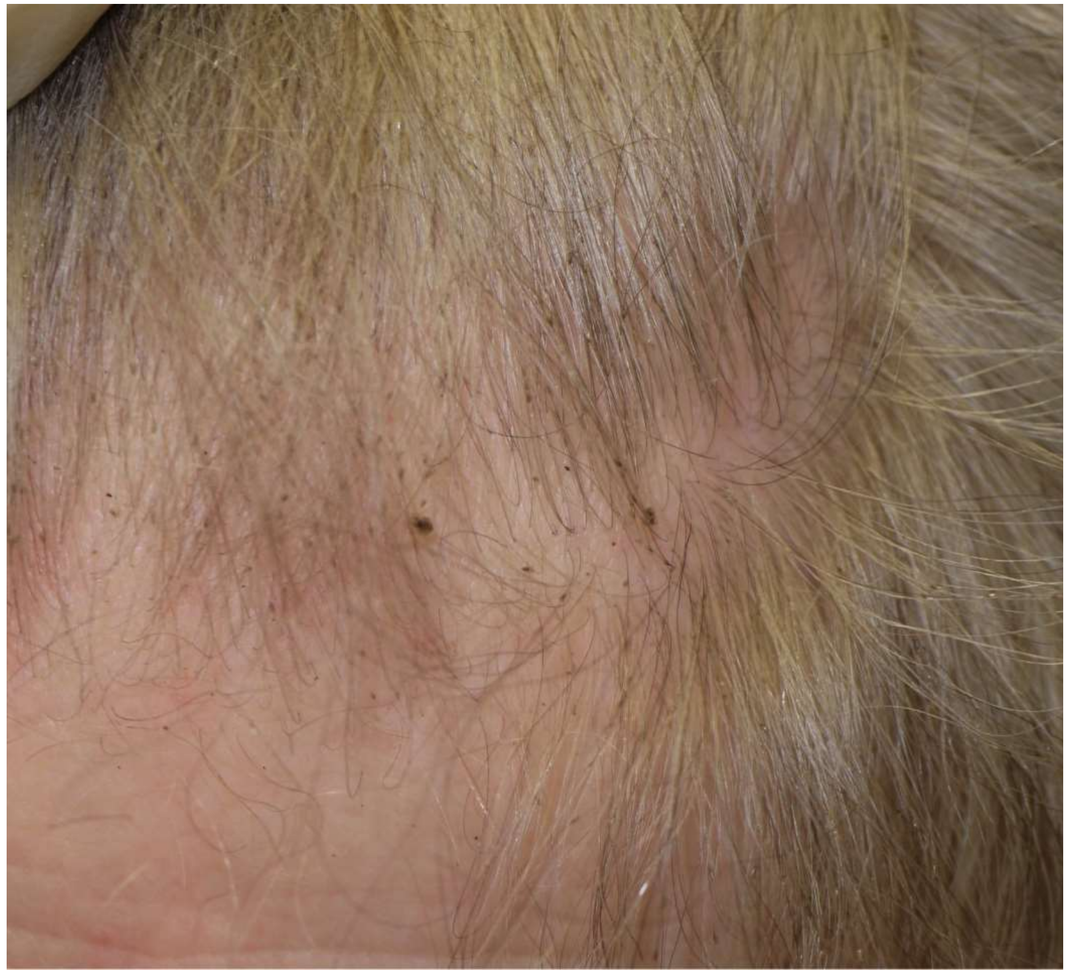


Head lice

- Usually young child
- Check nape of neck, behind ears
- Nits: adherent white grains on hair shafts, close to scalp
- Red-brown spots behind ears due to excreted digested blood
- Any hair loss is due to hair-pulling

Tx:

1. Insecticide
2. Combing

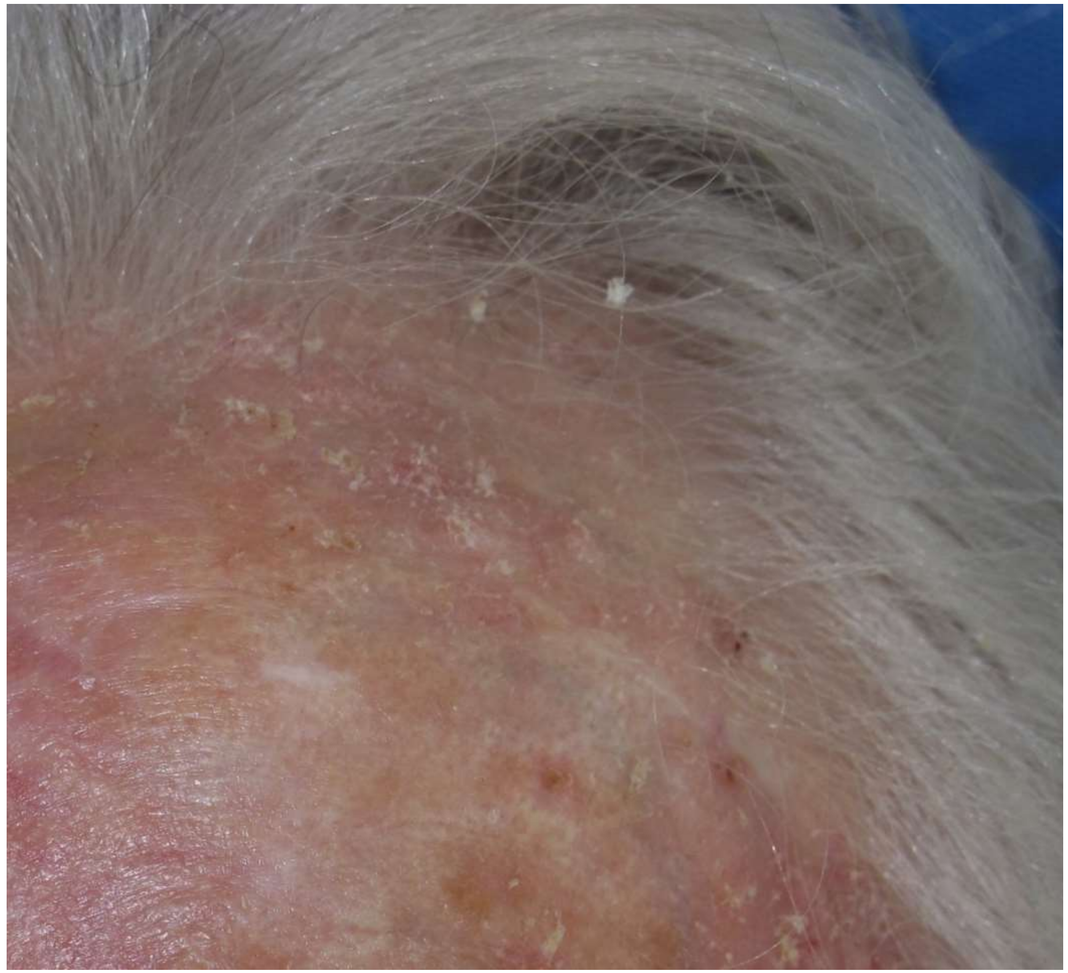


Crusted scabies

- Scalp scale can be florid
- Excoriations: few to many
- Common in dementia units
- Very contagious

Tx

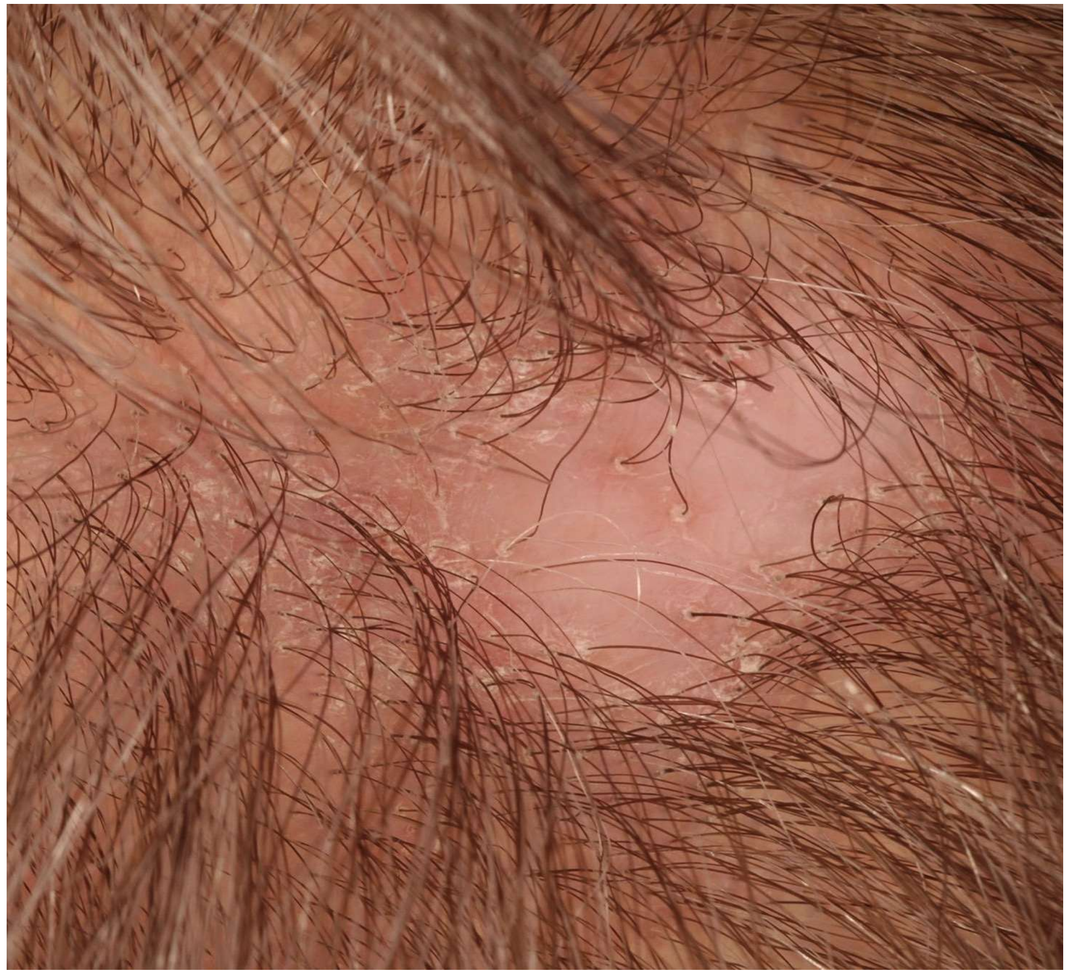
1. Identify/treat contacts
2. Permethrin lotion to scalp
3. Permethrin cream to whole body
4. Oral invermectin



Lichen plano-pilaris

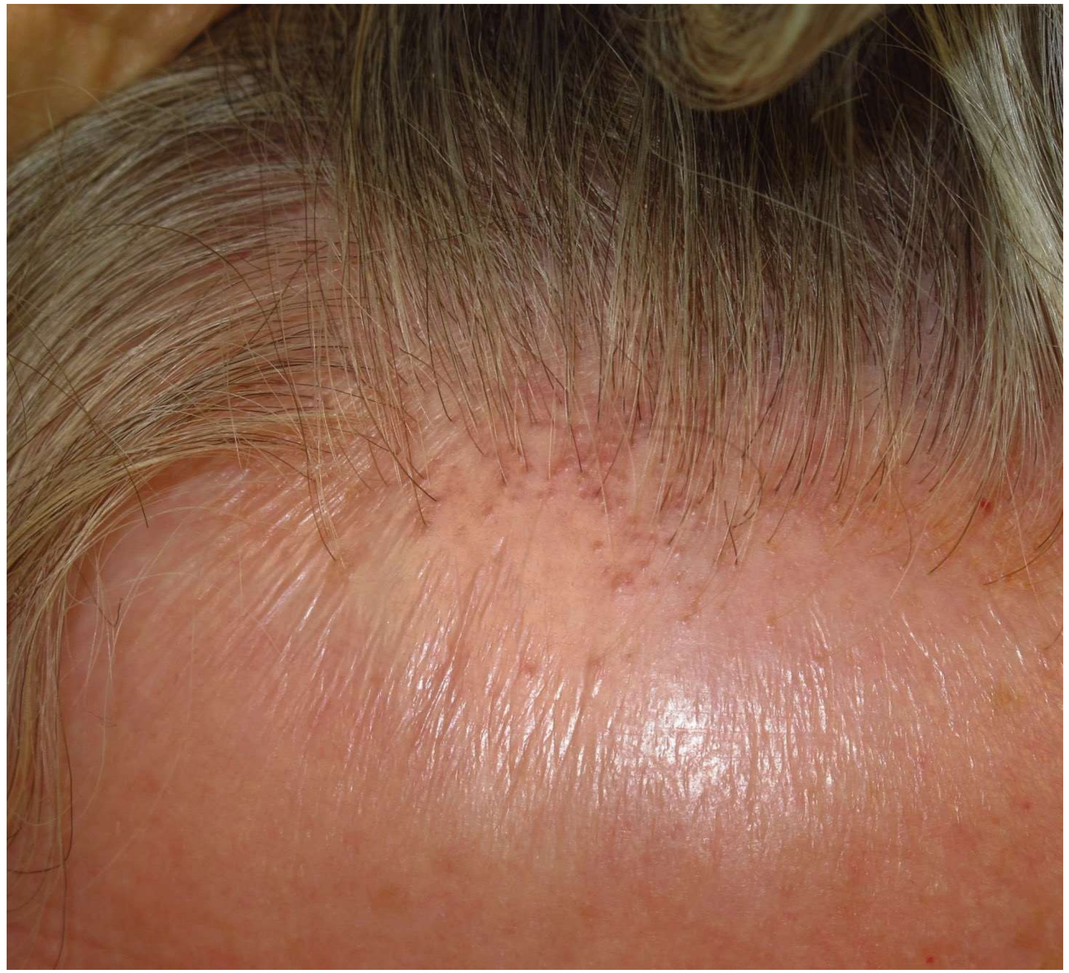
- Localised, erythematous bald plaques
- Perifollicular scale
- Lonely hairs within a scar (no follicles)

Tx: difficult



Frontal fibrosing alopecia

- Post-menopausal females
- Localised lichen plano-pilaris
- Shiny, hairless, frontal hairline

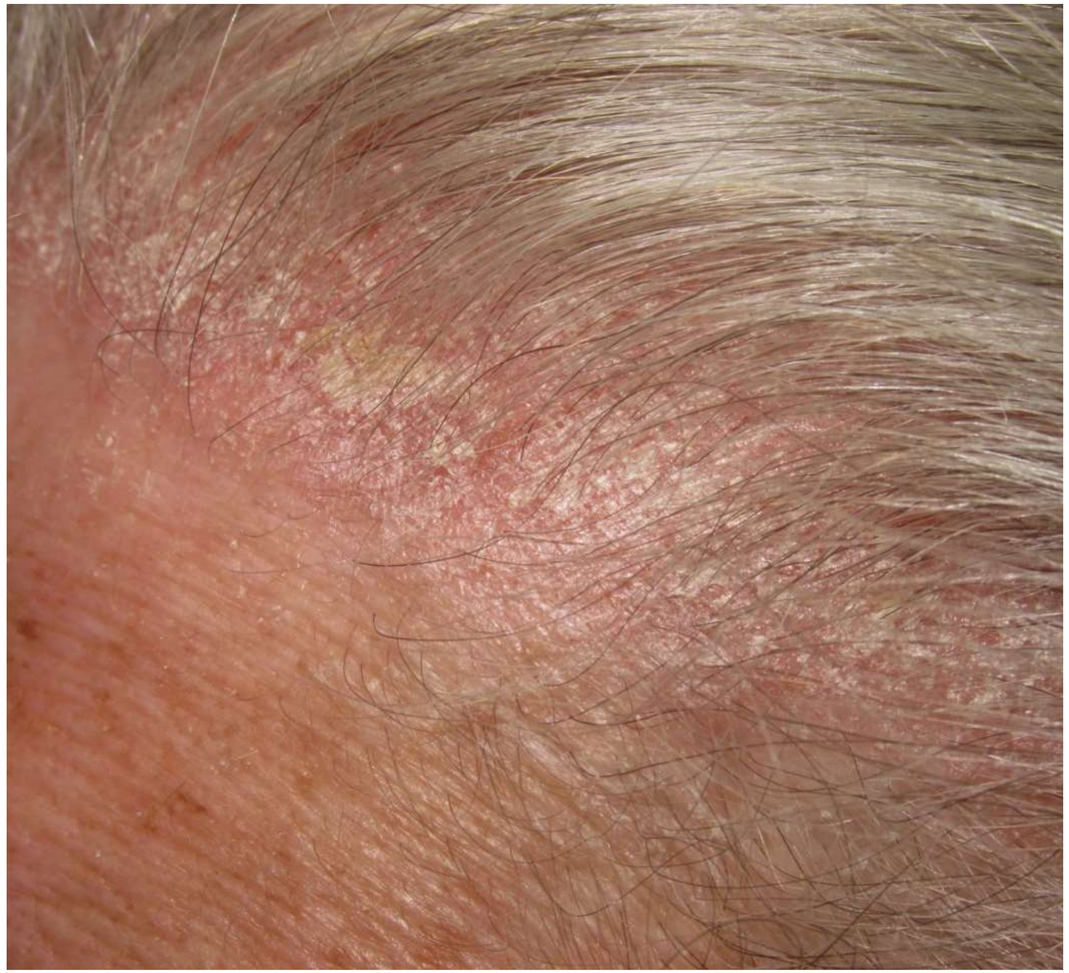


Or is it psoriasis?

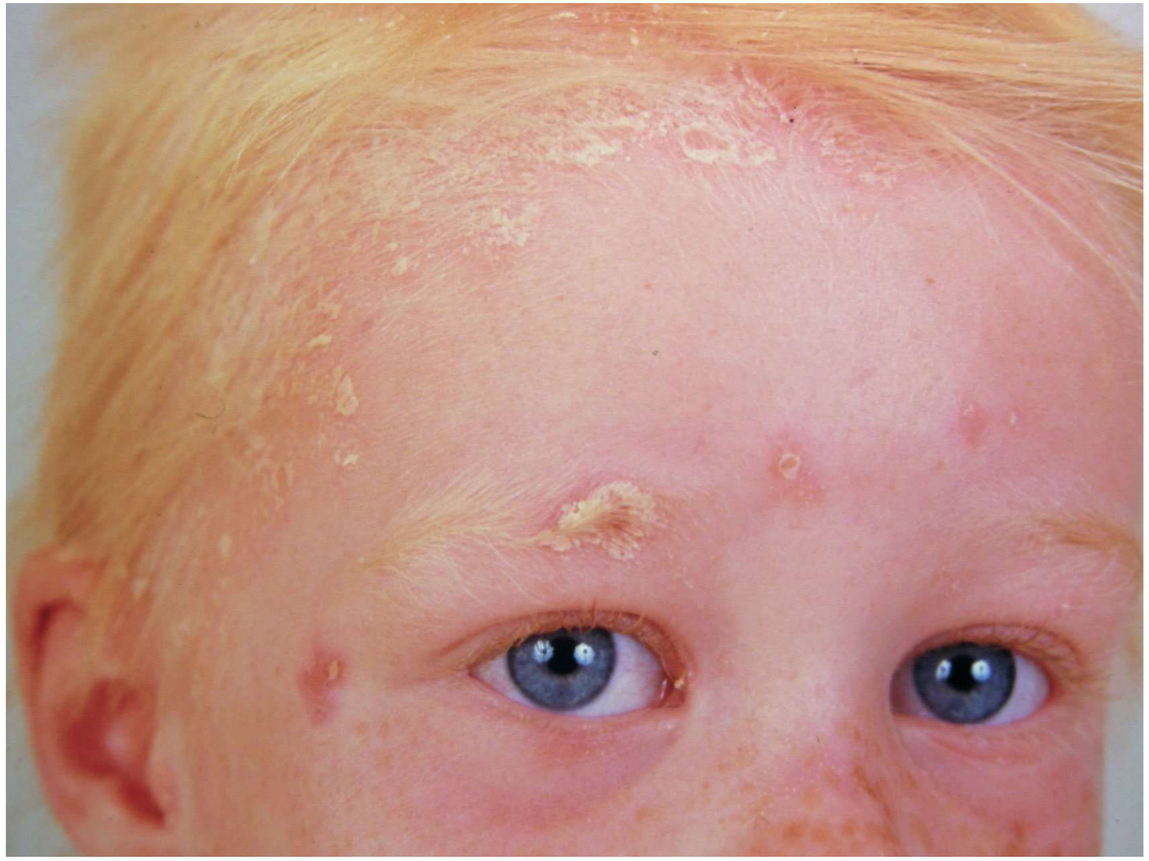
- Well-demarcated erythematous, scaly plaques; or diffuse erythema and scale
  - Silvery-white flakes
- Moderate itch
- Isolated to scalp or involves other body sites

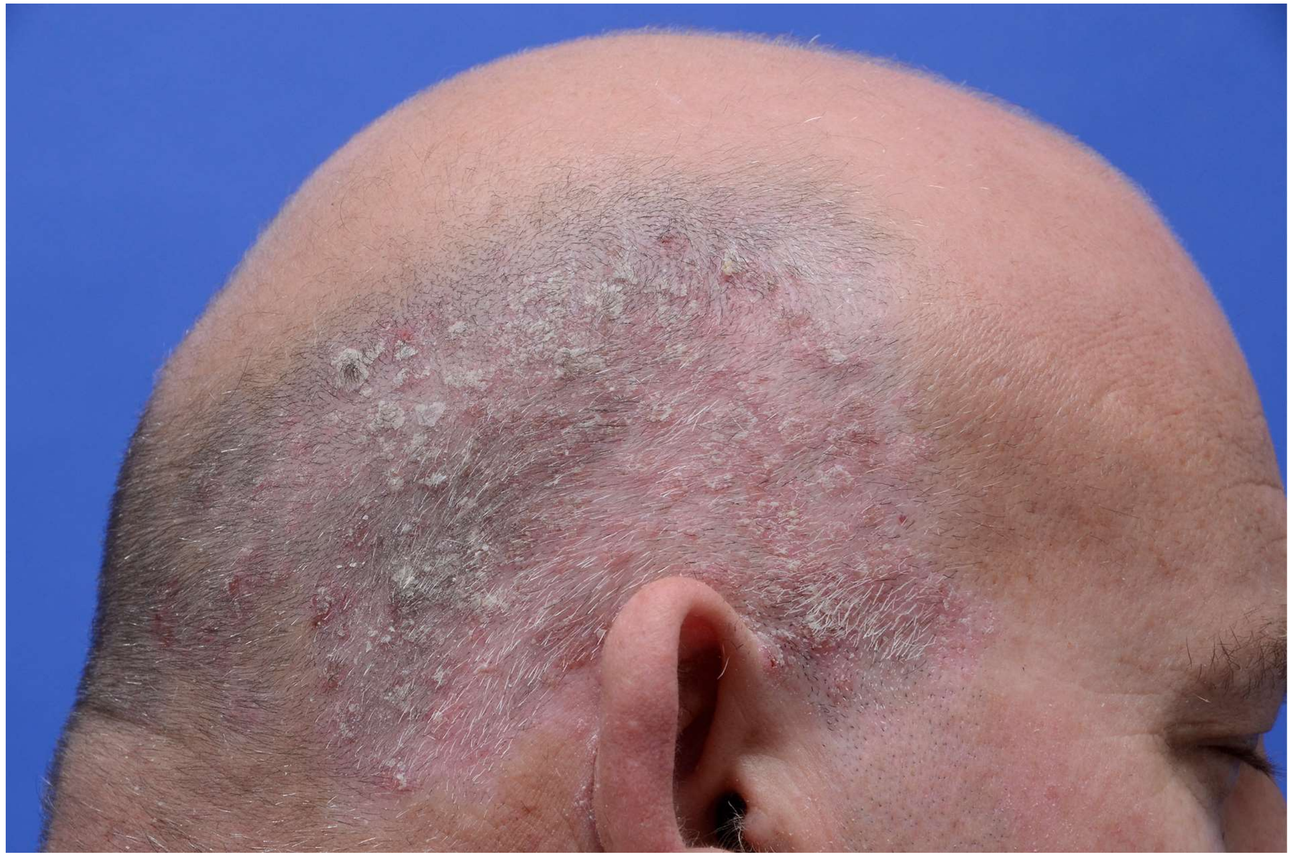
Poor response to topical therapy

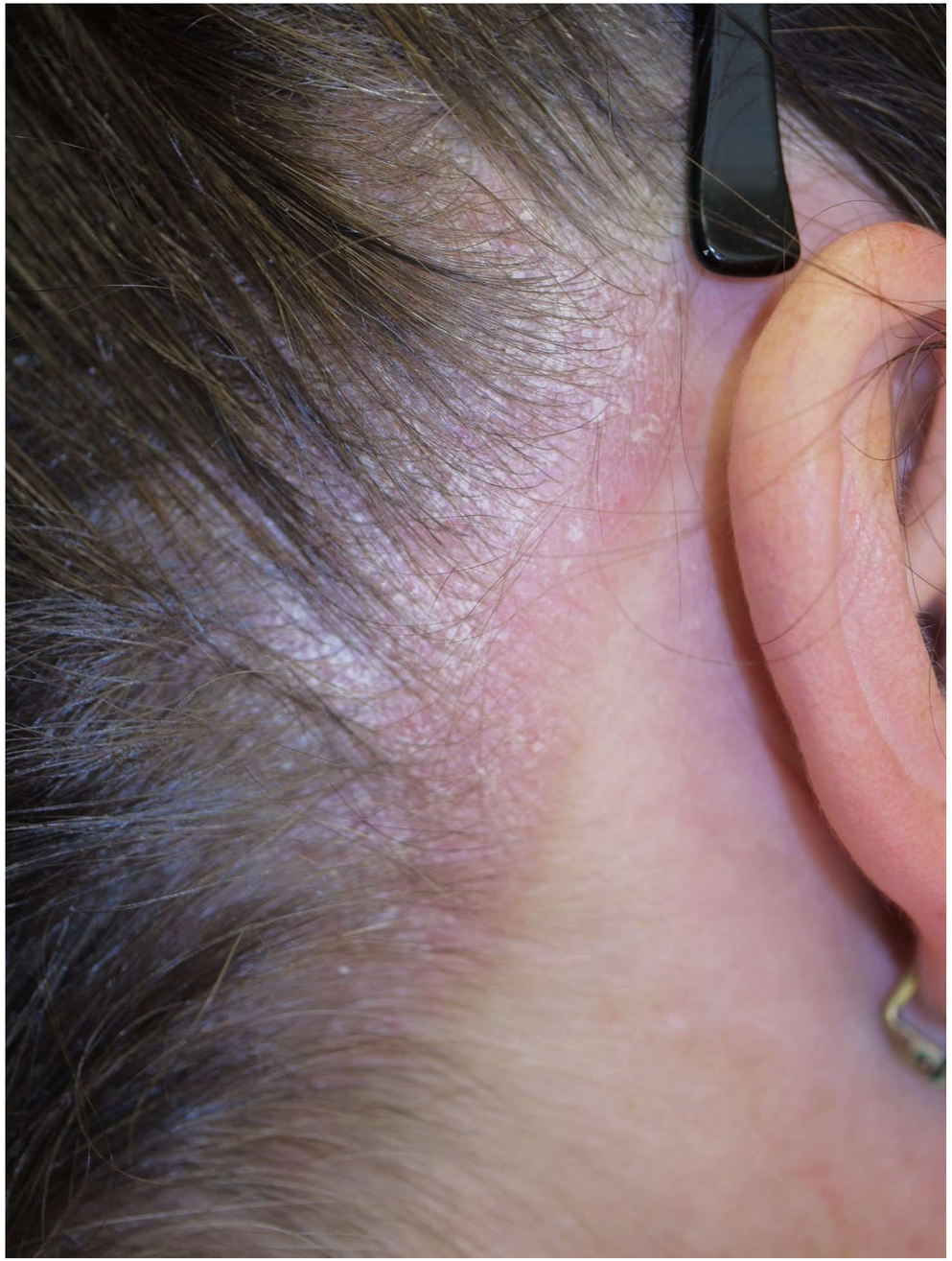
- Try twice-weekly combination:
  1. Coconut compound cream, 1 hr prior to
  2. Tar shampoo; then
  3. Calcipotriol/betamethasone diproprionate gel

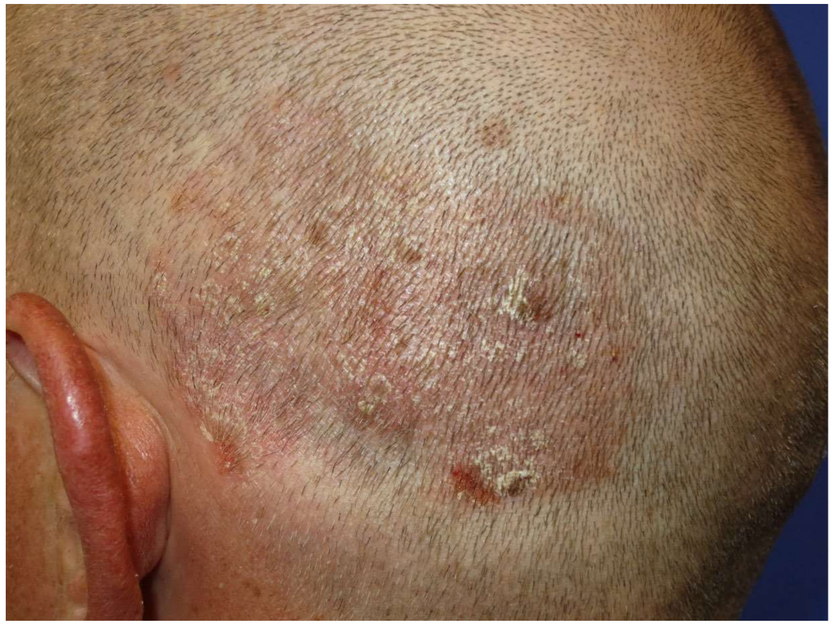


Psoriasis: small plaques

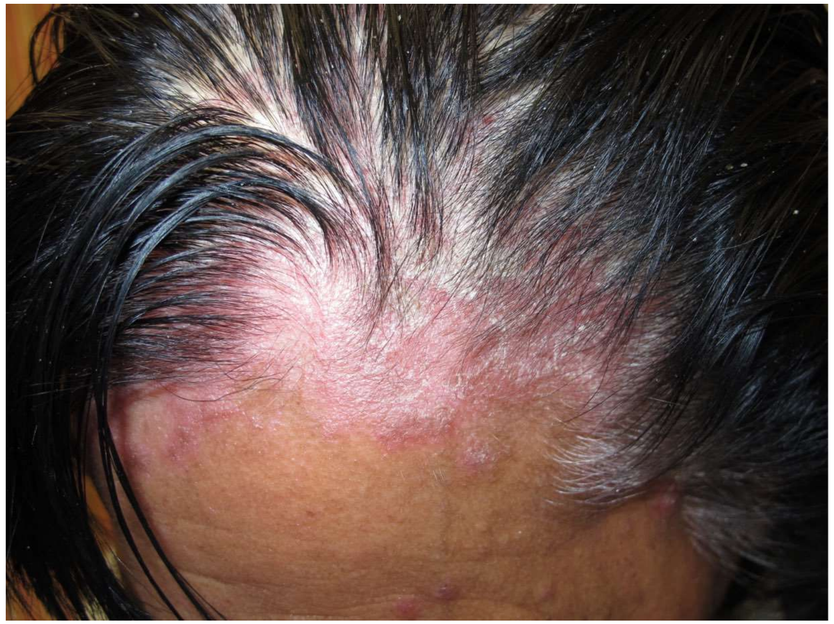






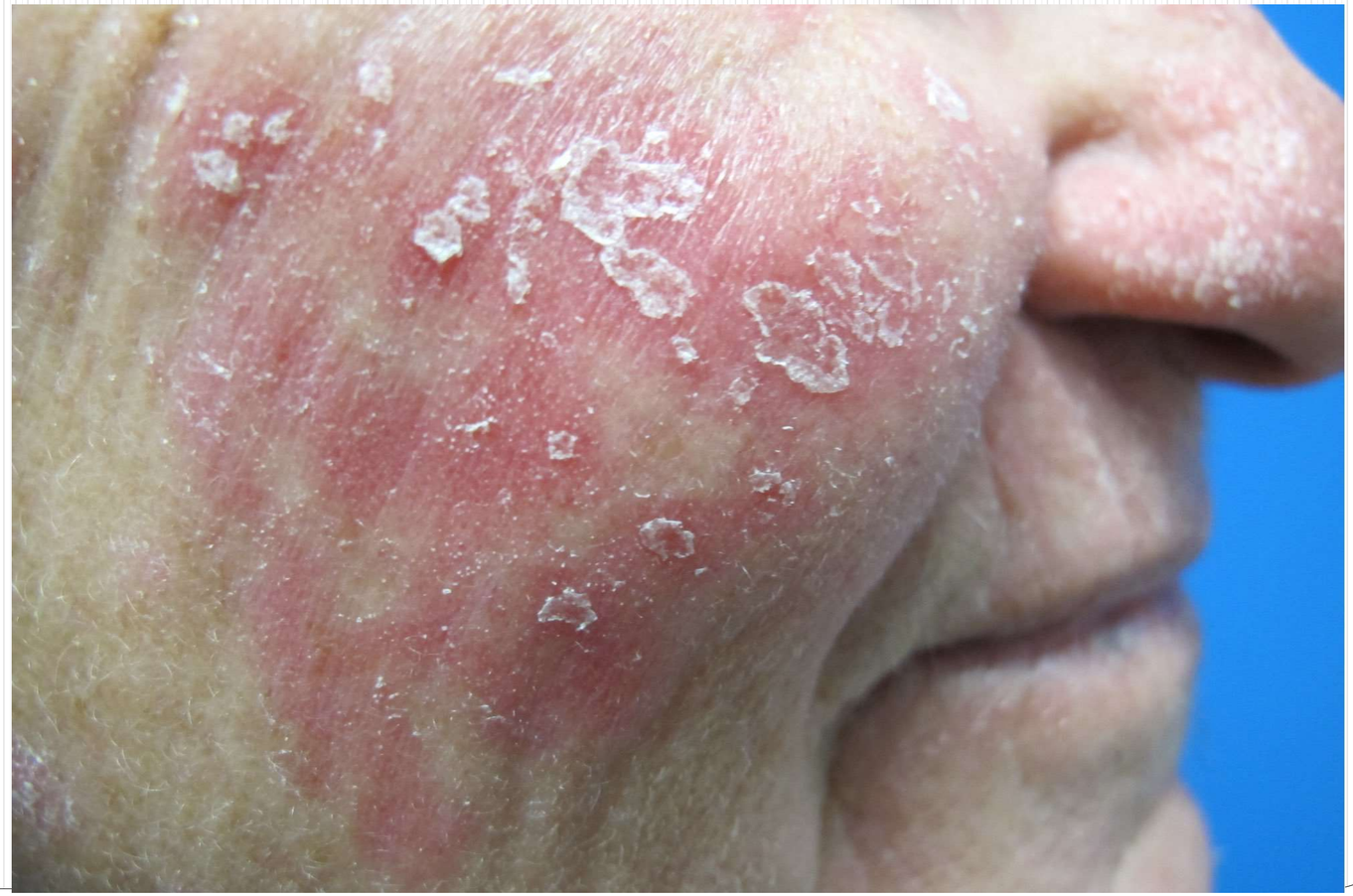


Large plaques



Face

Is it psoriasis?



Q2. 45 year-old female; scaly face
Which statement is true?

A. Tinea / dermatophytes rarely affect face

B. Photosensitivity rashes involve the nasolabial fold

C. ANA is often negative in discoid lupus erythematosus

D. Imiquimod can be used effectively to treat seborrhoeic keratoses

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Scaly face

- Seborrhoeic eczema/dermatitis
- Atopic eczema/dermatitis
- Contact eczema/dermatitis
- Photosensitive eczema
- Discoid lupus erythematosus
- Actinic keratoses
- Tinea faciei

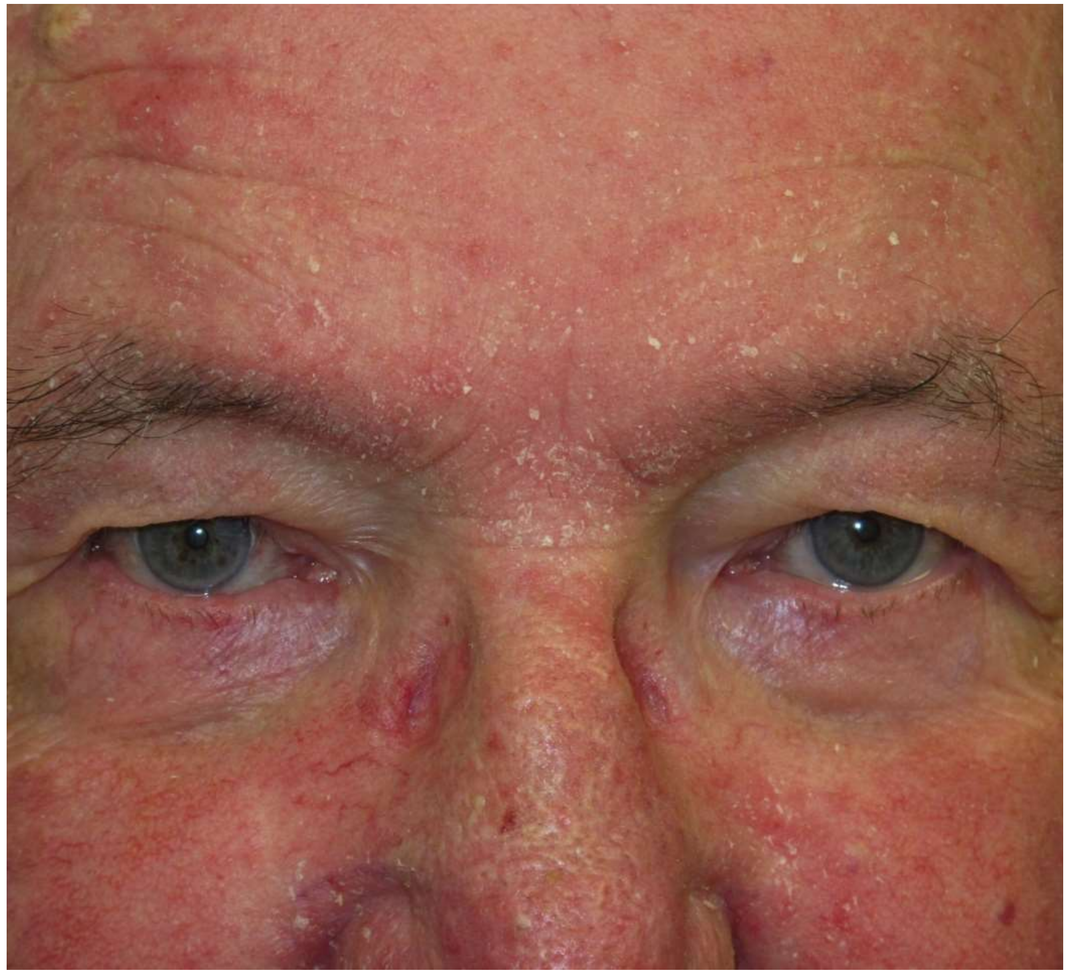
Or, is it psoriasis?

Seborrhoeic eczema

- Hairline, eyebrows, eyelids, medial cheeks, nasolabial folds, chin creases
- Poorly defined, variable, white/yellowish flaking
- Erythematous patches or thin plaques

Tx:

1. Ketoconazole cream
2. Intermittent low potency steroid cream

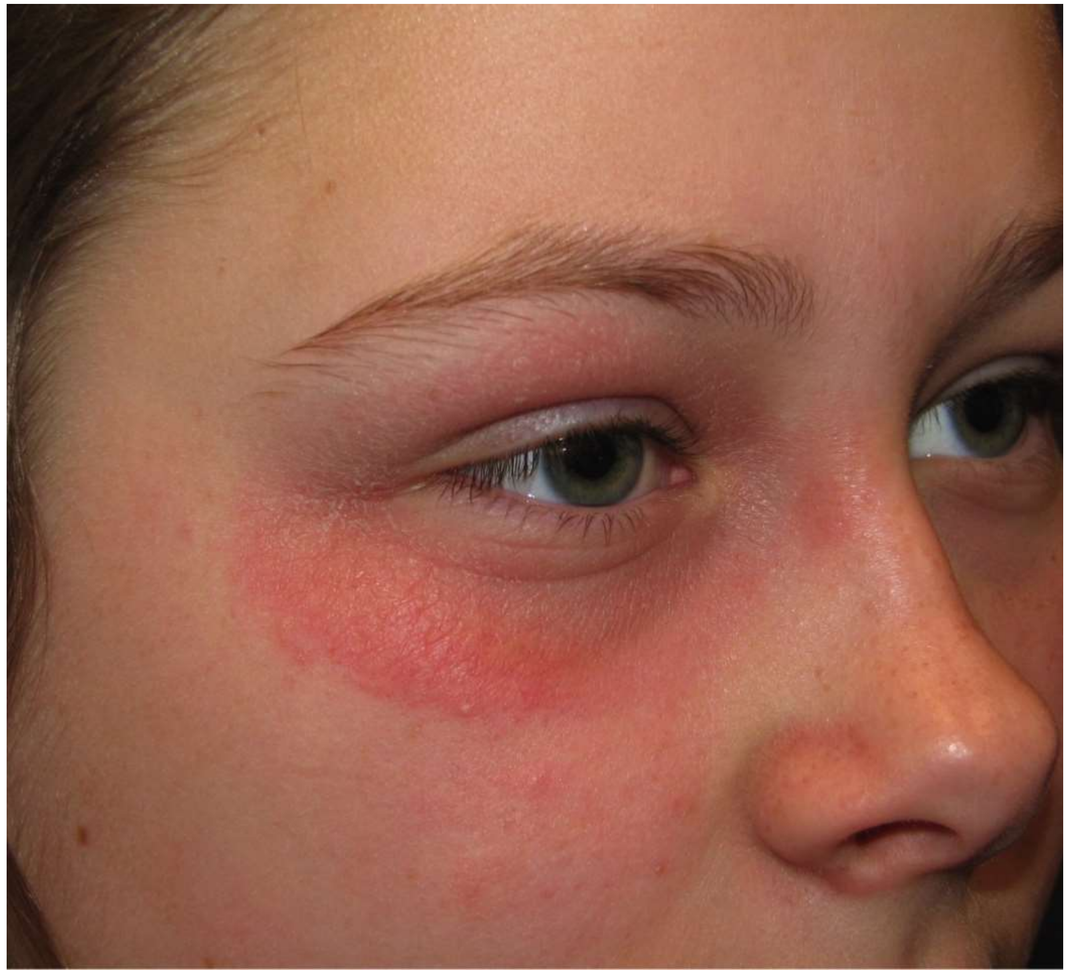


Contact eczema

- Acute, relapsing/intermittent or chronic
- Irregular, unilateral or asymmetrical
- Sharp border if contact irritant dermatitis
- Neomycin (contained in many topical creams, ointments and ear drops) is a common well recognised contact allergen
- Allergic contact dermatitis to topical corticosteroids is well recognised

Tx:

1. Avoid irritants
2. Low-potency topical steroid

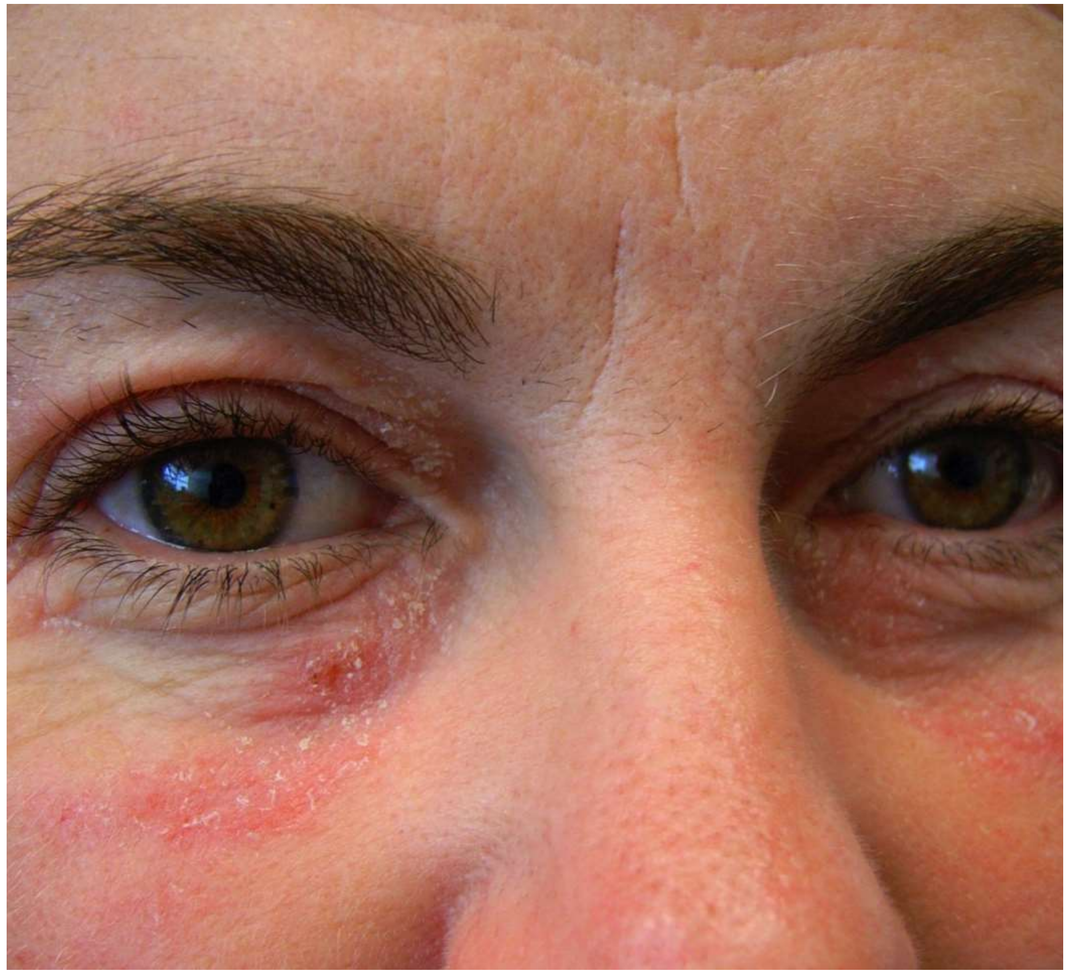


Contact eczema

- Acute, relapsing/intermittent or chronic
- Irregular, unilateral or asymmetrical
- Patch tests positive if contact allergy

Tx:

1. Avoid allergen
2. Variable-potency topical steroid
3. Sometimes, prednisone

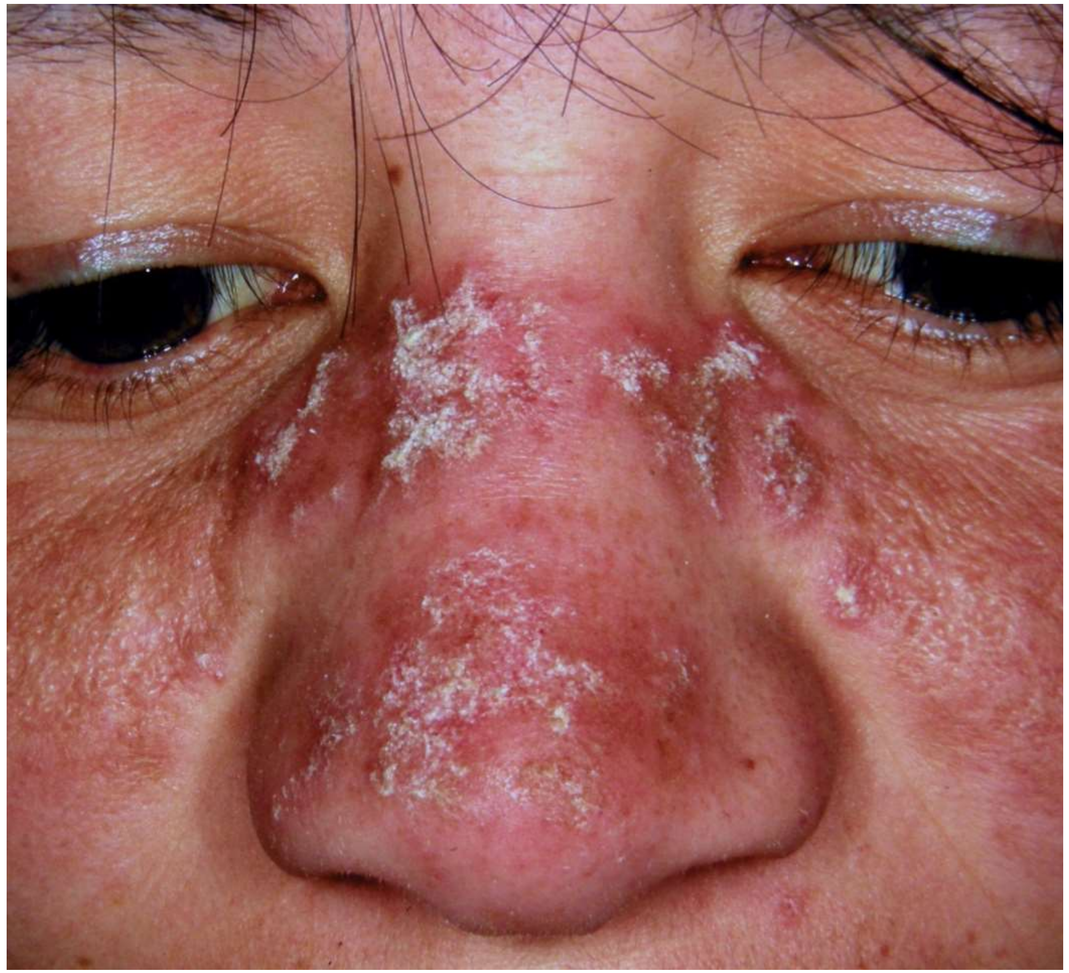


Discoid lupus erythematosus

- Nose, cheeks, ears, lips, scalp
- Circumscribed scaly plaques
- Pigmentation, scarring
- CBC, ANA, ENA often normal

Tx:

1. Sun protection
2. High potency topical steroid
3. Hydroxychloroquine
4. Immunosuppressives

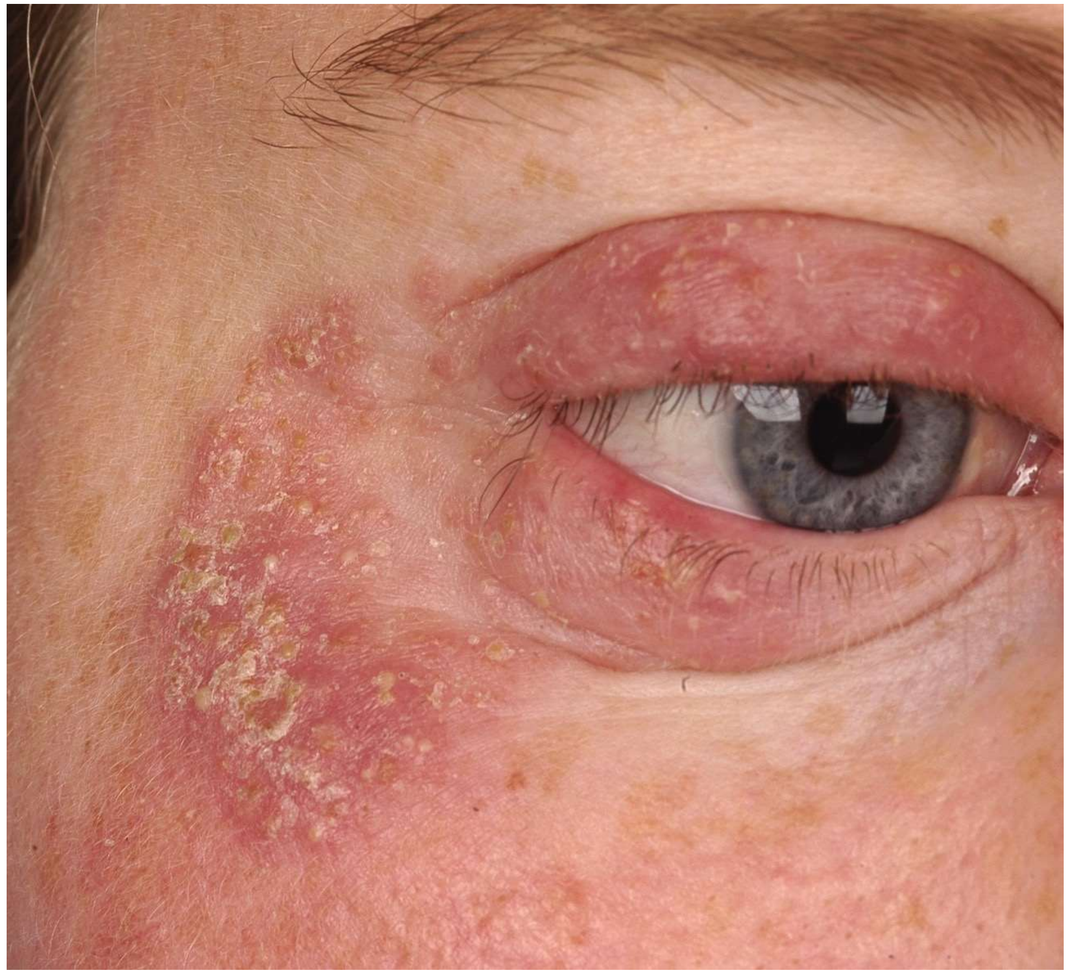


Tinea faciei

- Asymmetrical eruption
- Annular configuration is common
- Scaly edge
- Mycology positive

Tx:

1. Topical azole / terbinafine
2. Oral terbinafine or itraconazole

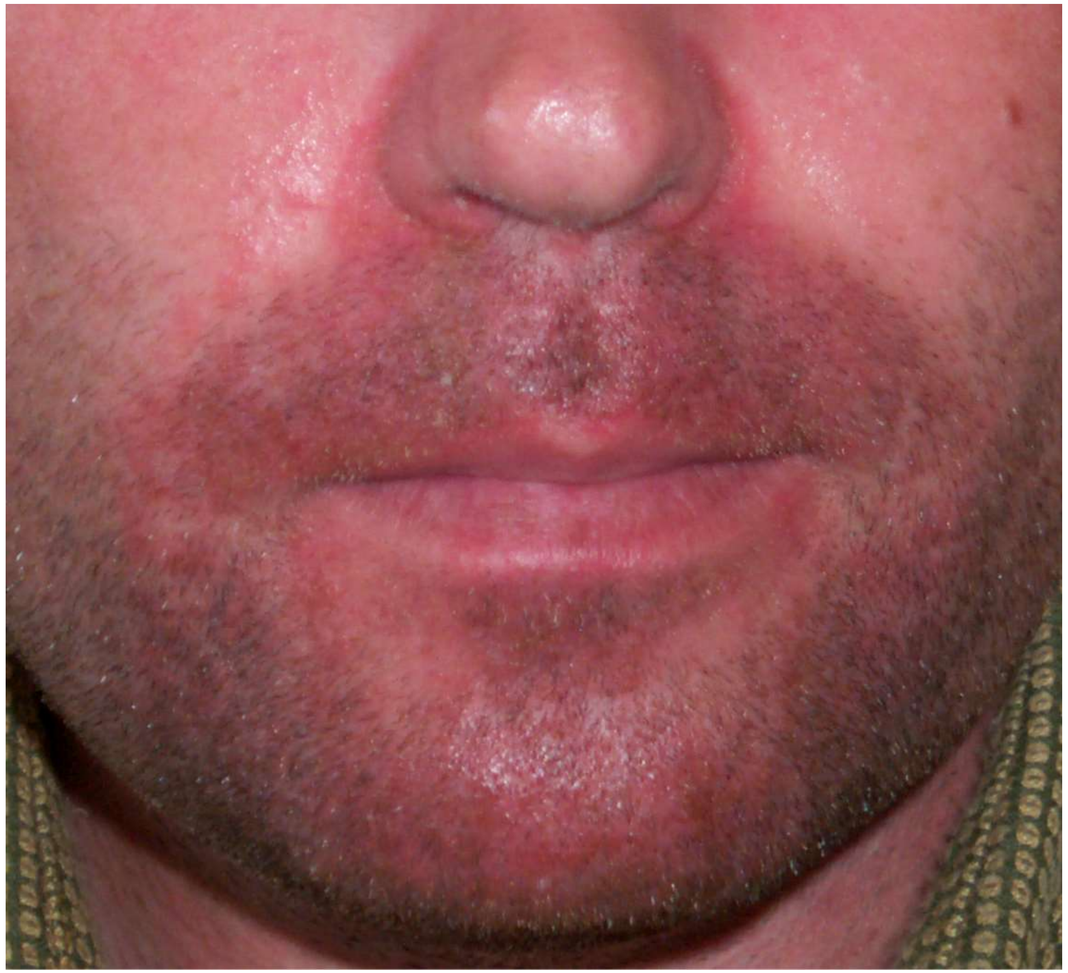


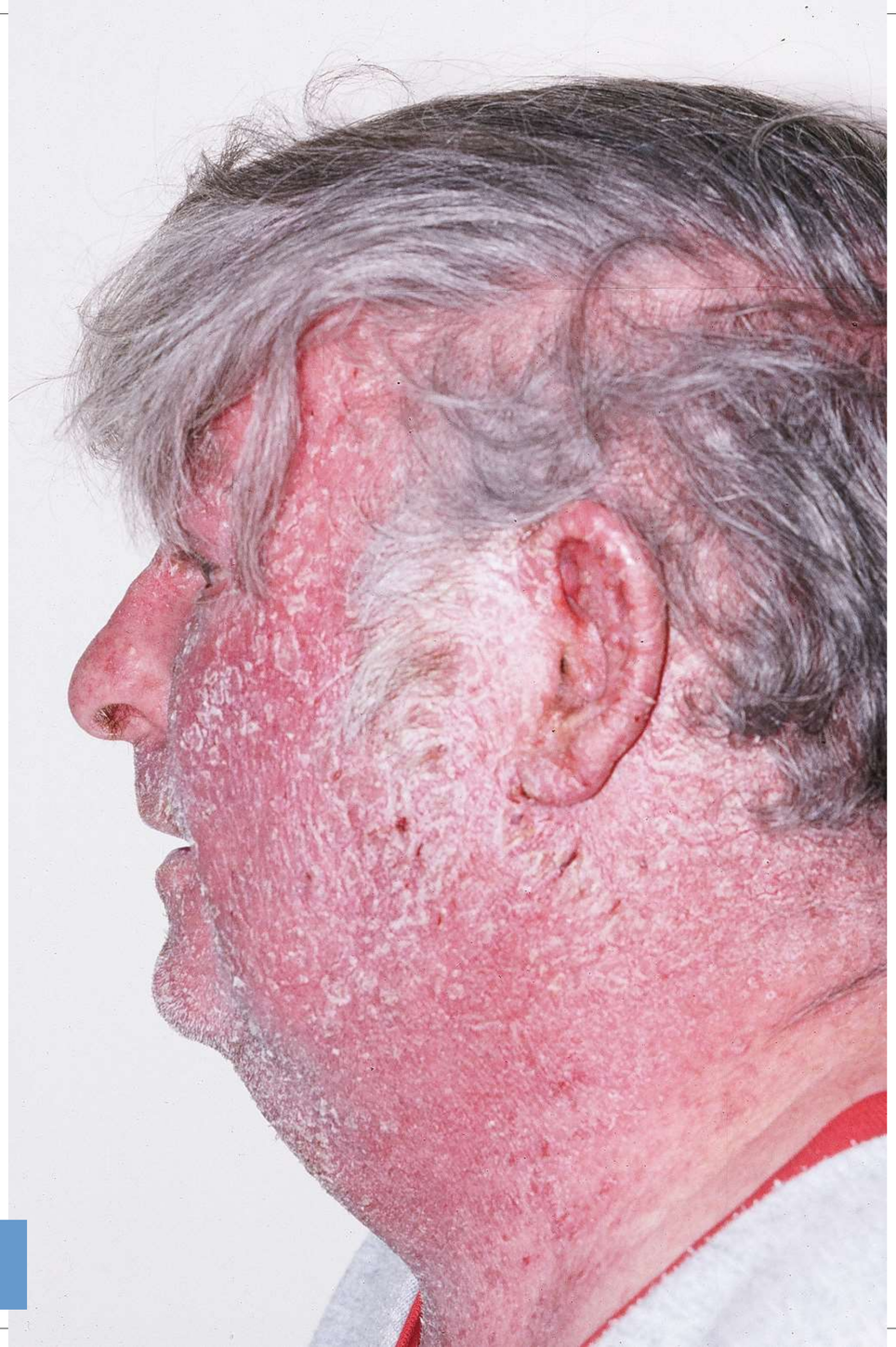
Or is it psoriasis?

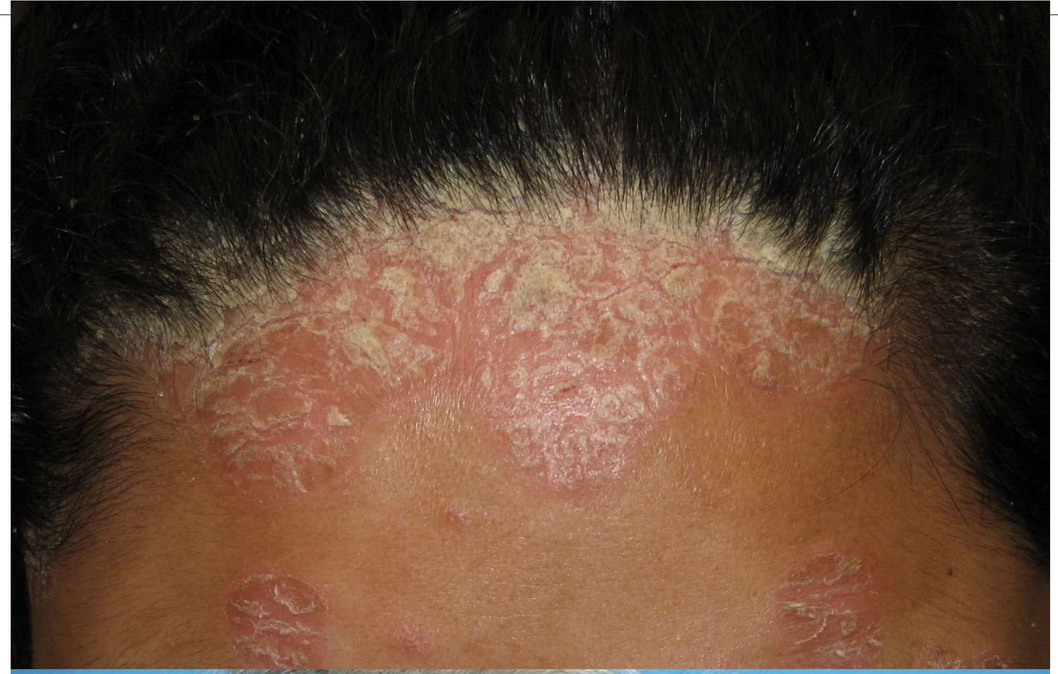
- Eyelids, temples, creases
- Well-demarcated erythematous plaques
  - Variable white scale
- Symmetrical
- More persistent than seborrhoeic dermatitis

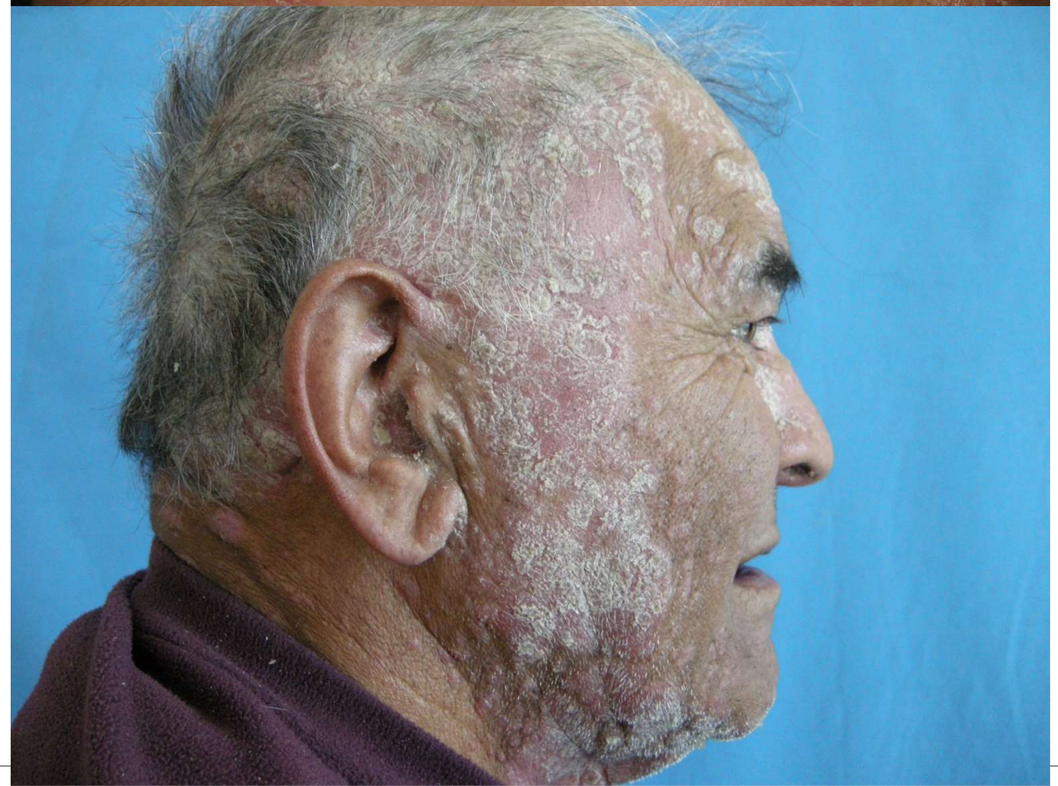
Tx:

1. Intermittent topical steroid
2. Pimecrolimus cream
3. Systemic tx







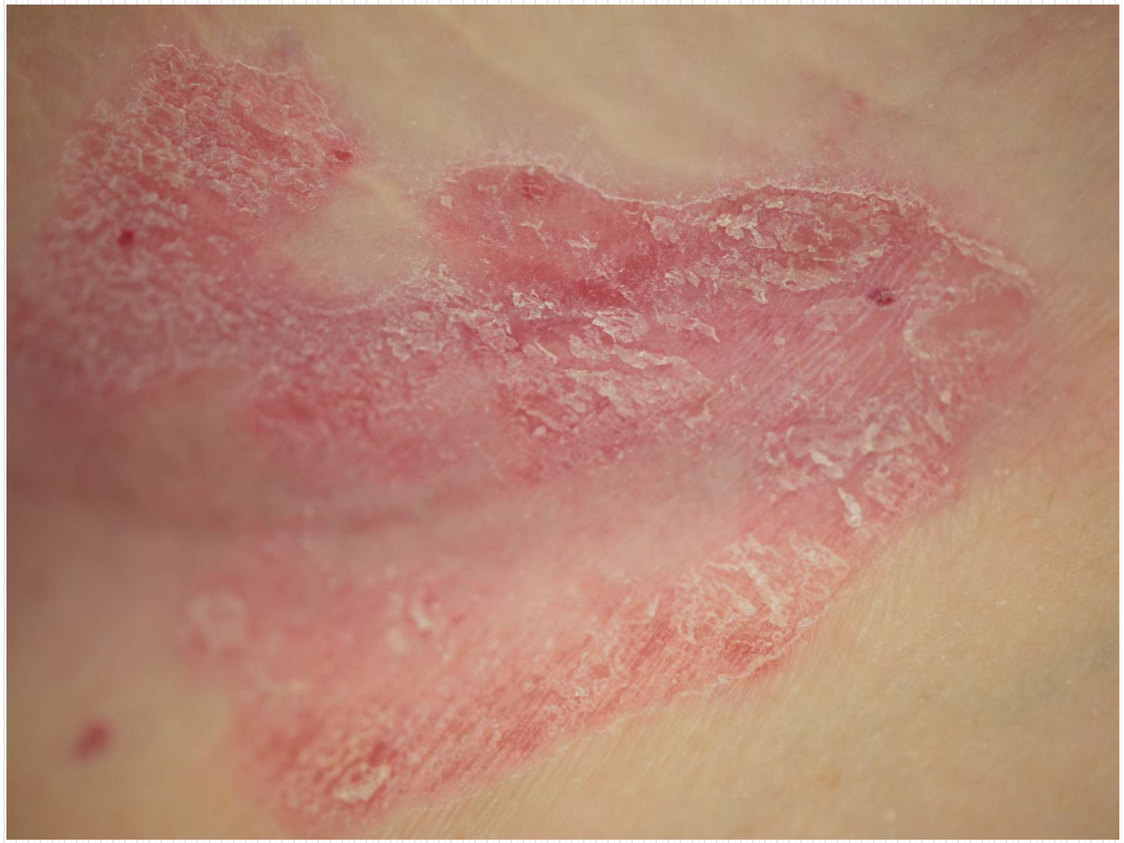


SUMMARY

- Take a detailed history
- Take a detailed DRUG history
- Ask the patients opinion
- Always do a skin scraping

Flexures

Is it psoriasis?



Q3. 61 year-old female; intertrigo
Which statement is true?

A. Yeast cells on microscopy exclude psoriasis

B. Might be allergic to nickel in brassiere underwire

C. Tinea cruris usually due to *Microsporum canis*

D. Coral-red fluorescence on Wood light = tinea

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C. Tinea cruris usually due to *Microsporum canis*

D. Coral-red fluorescence on Wood light = tinea

Intertrigo

- Infection:
  - Candida
  - Erythrasma
  - Tinea/dermatophyte
- Eczema/dermatitis
  - Atopic
  - Seborrhoeic
  - Contact

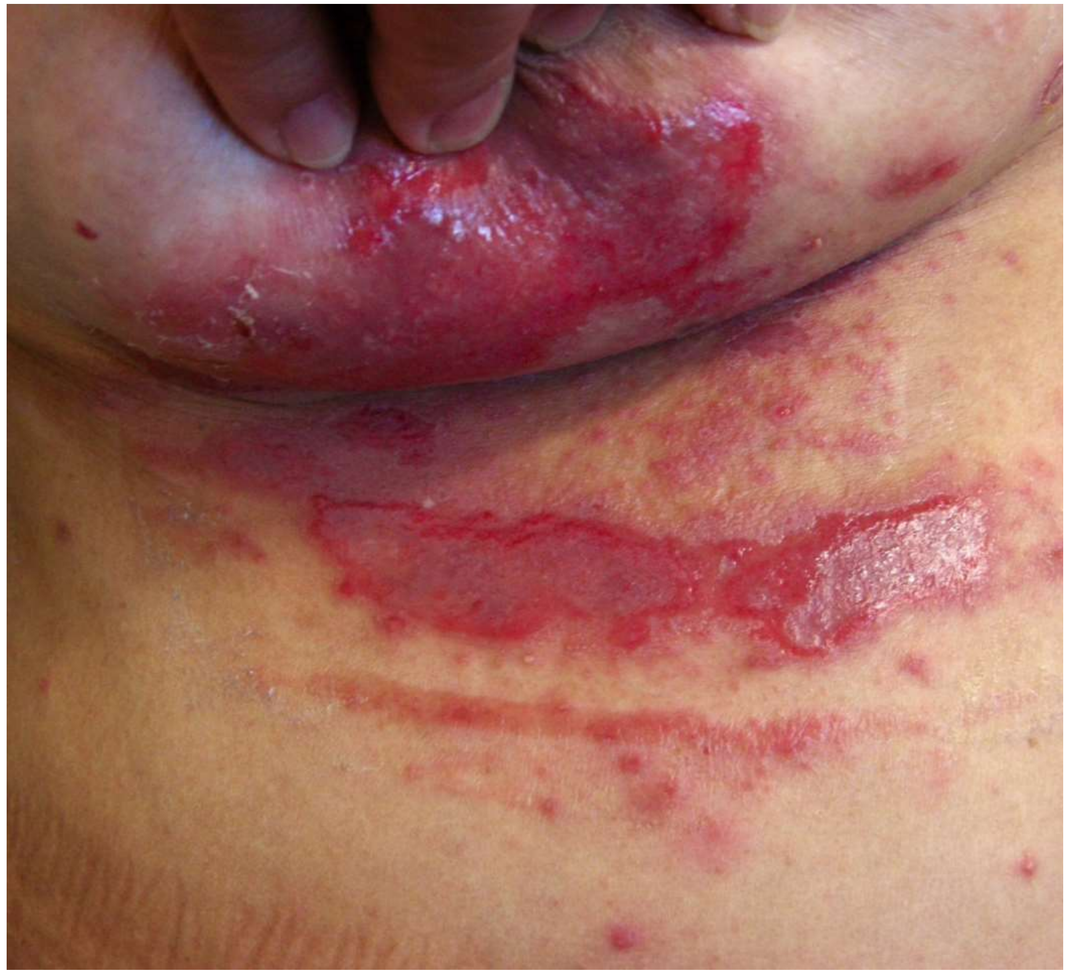
Or, is it psoriasis?

Candida albicans

- Rapid onset
- Itchy, moist, peeling, red and white skin
- Small, superficial papules and pustules

Tx:

1. Topical azole
2. Oral azole

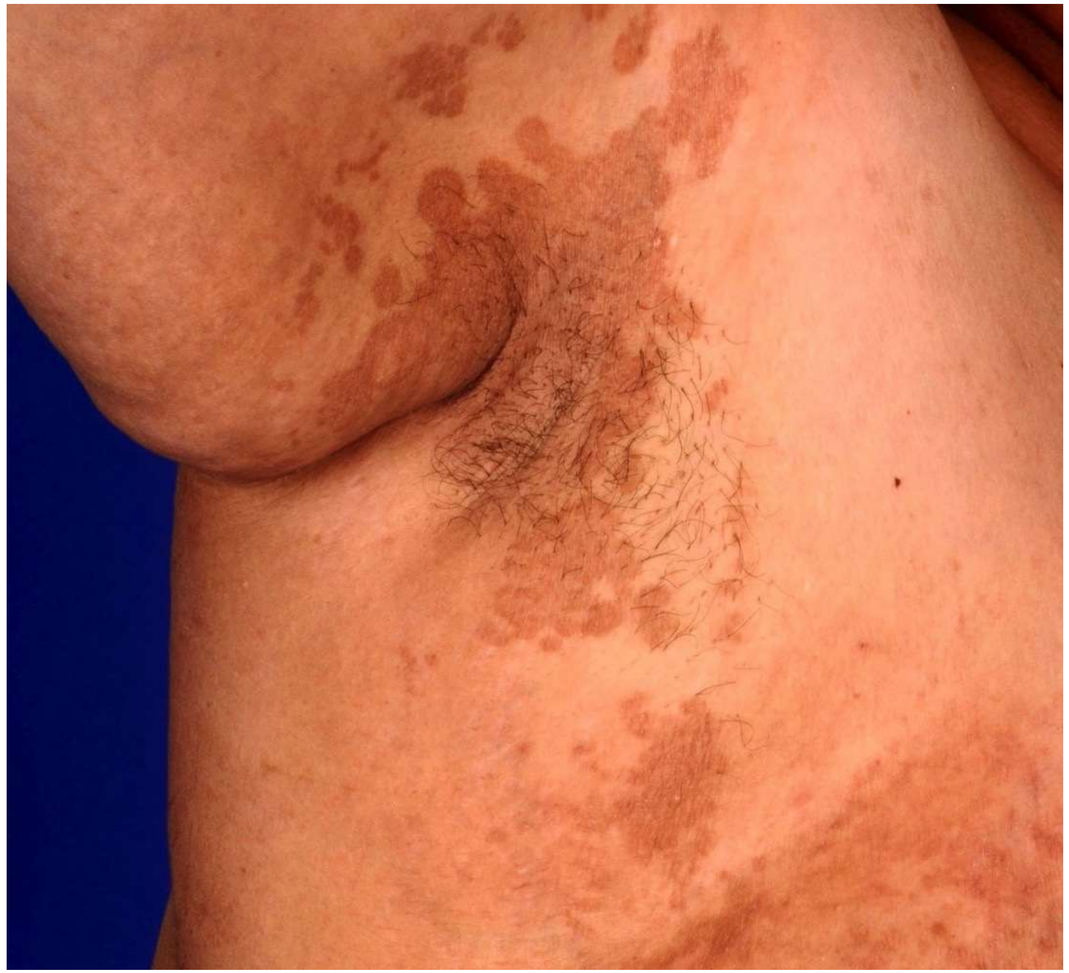


Erythrasma

- Persistent brown patches
- Minimal scale
- Asymptomatic

Tx:

1. Topical fusidic acid
2. Oral erythromycin

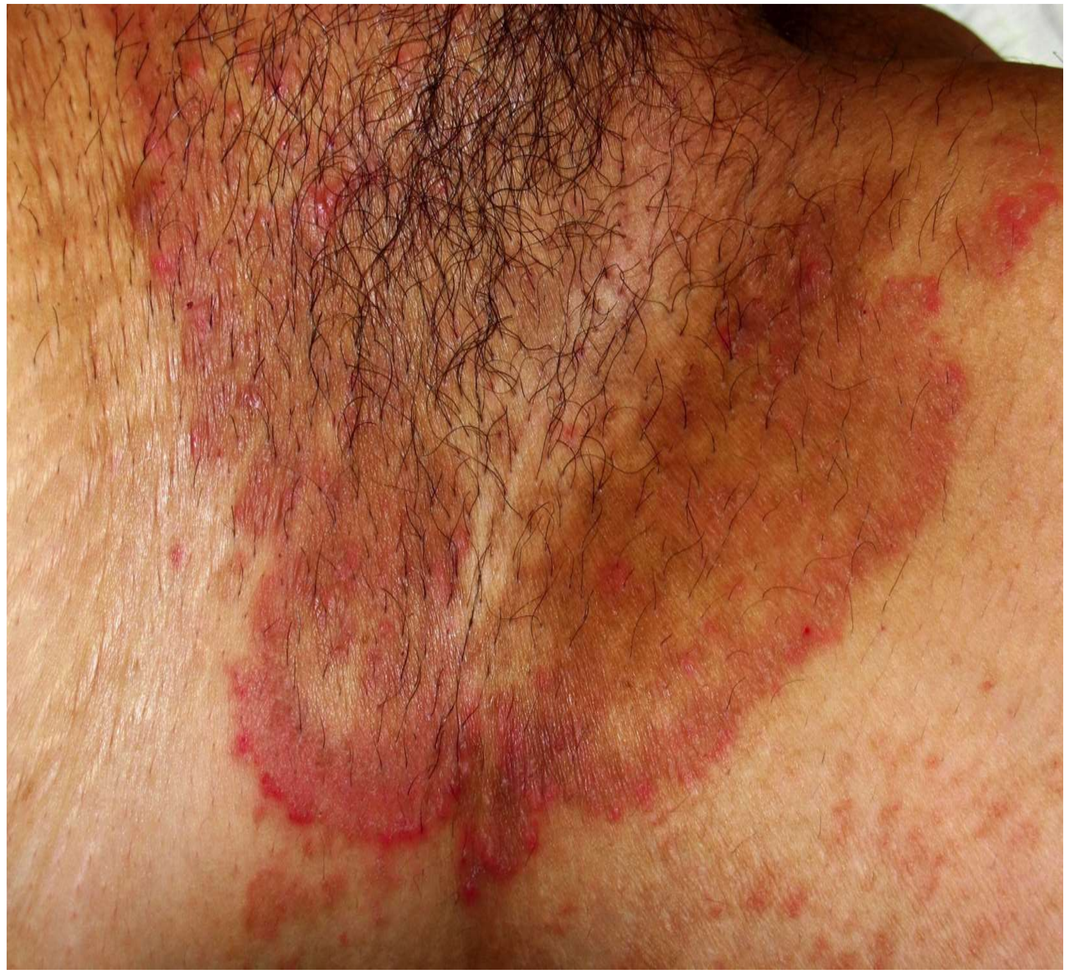


Tinea cruris

- Slowly spreads over weeks to months
- Irregular annular plaques
- Peeling, scaling

Tx:

1. Topical azole / terbinafine
2. Oral terbinafine, itraconazole

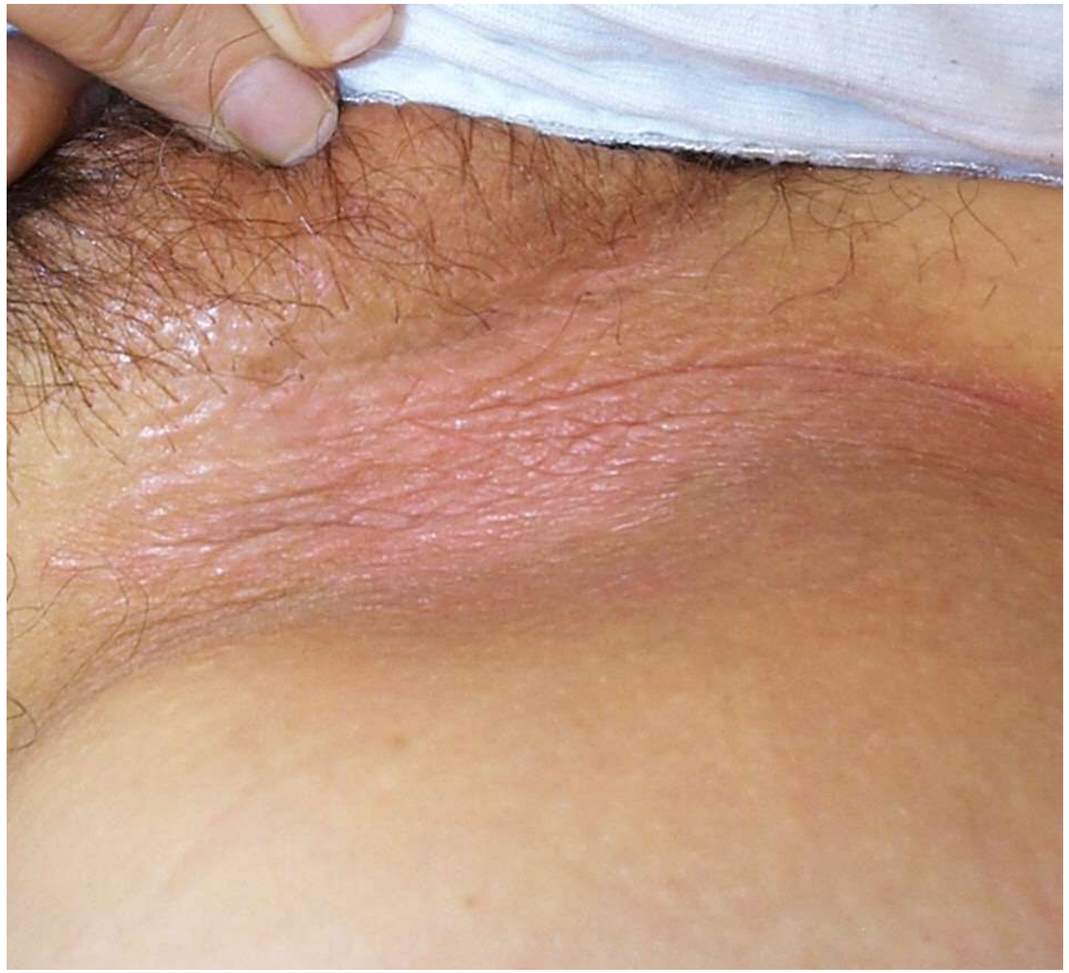


Seborrhoeic eczema

- Ill-defined, salmon-pink, thin patches
  - May be asymmetrical
- Common in axilla and groin creases
- Fluctuates in severity
- Often unnoticed

Tx:

1. Ketoconazole shampoo
2. Low-potency topical steroid

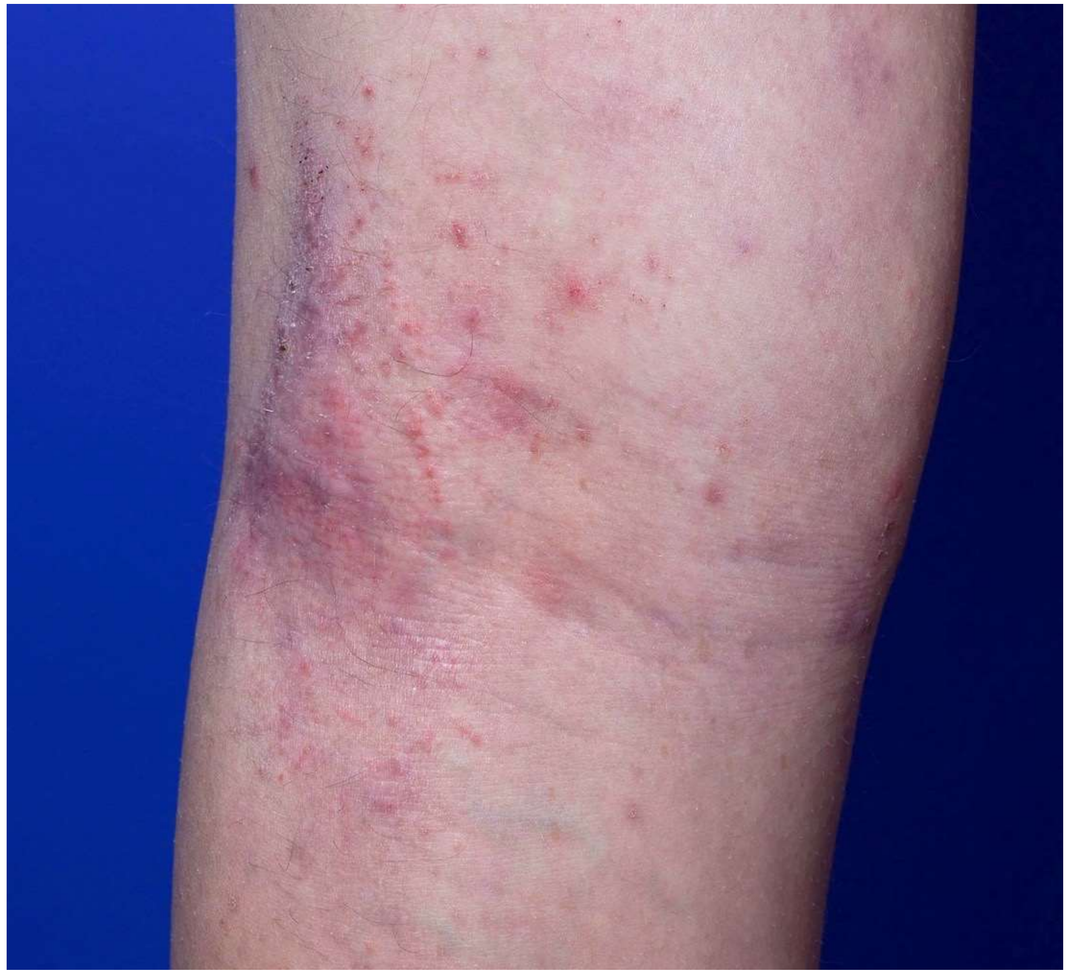


Atopic eczema

- First occurs in infancy
- Common in elbow and knee creases
- Very itchy
- Characterised by flares
  - Acute eczema is red, blistered, swollen
  - Chronic eczema is dry, thickened (lichenified)

Tx:

1. Emollients
2. Moderate-potency topical steroid

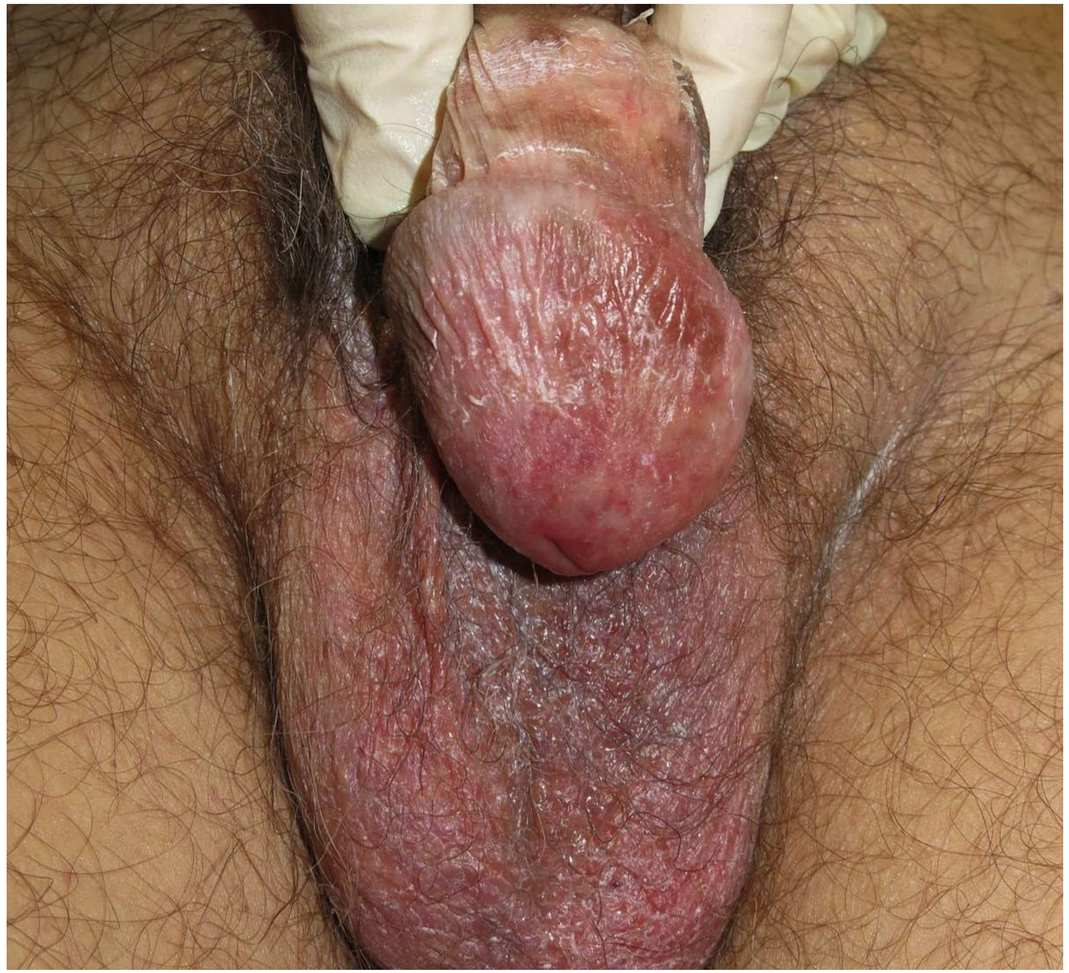


Contact irritant dermatitis

- Acute, relapsing or chronic
- Irritants include:
  - Body fluids
  - Friction
  - Soap
  - Excessive washing
  - Antiperspirant

Tx:

1. Avoid irritant
2. Low-potency topical steroid

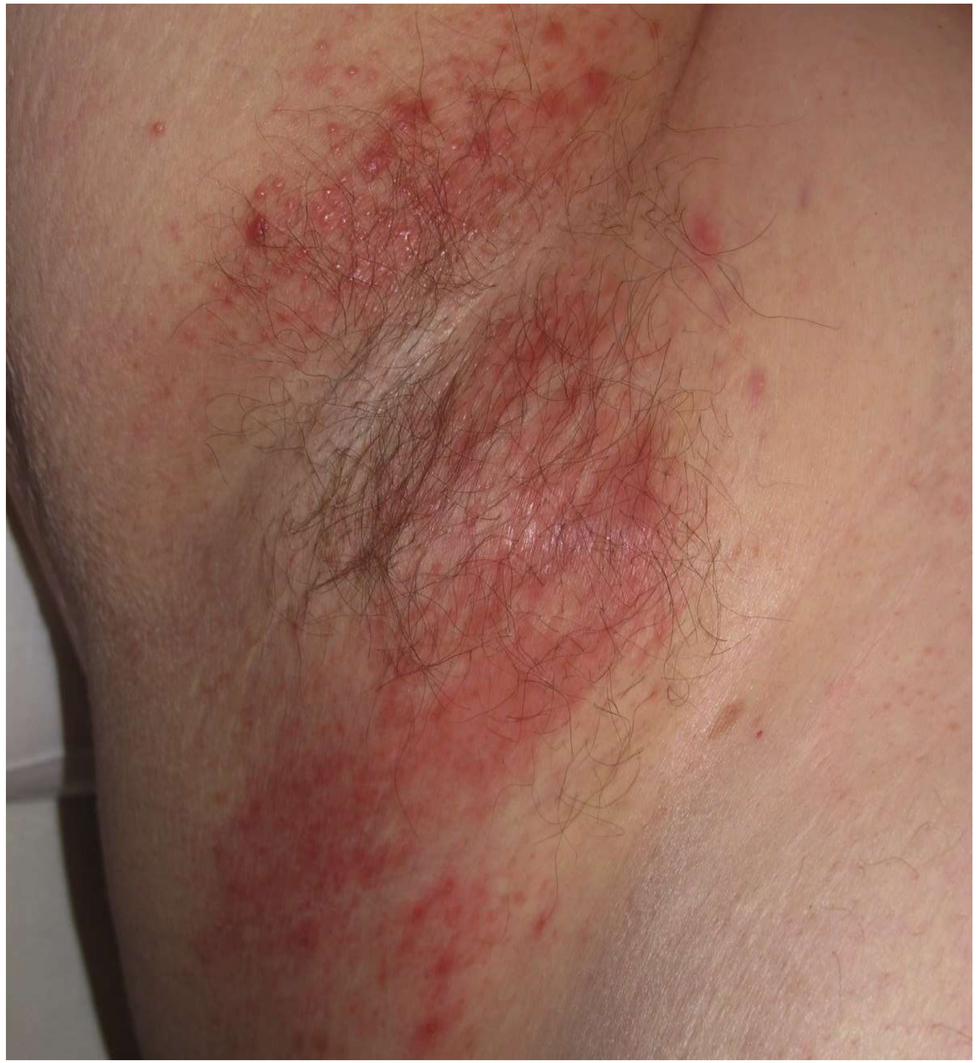


Contact allergic dermatitis

- Acute or relapsing
- Allergen may be:
  - Fragrance, preservative or medicament in deodorant, wet-wipe etc
  - Component of underwear (rubber in elastic, nickel in bra wire)

Tx:

1. Avoid allergen
2. Low-potency topical steroid

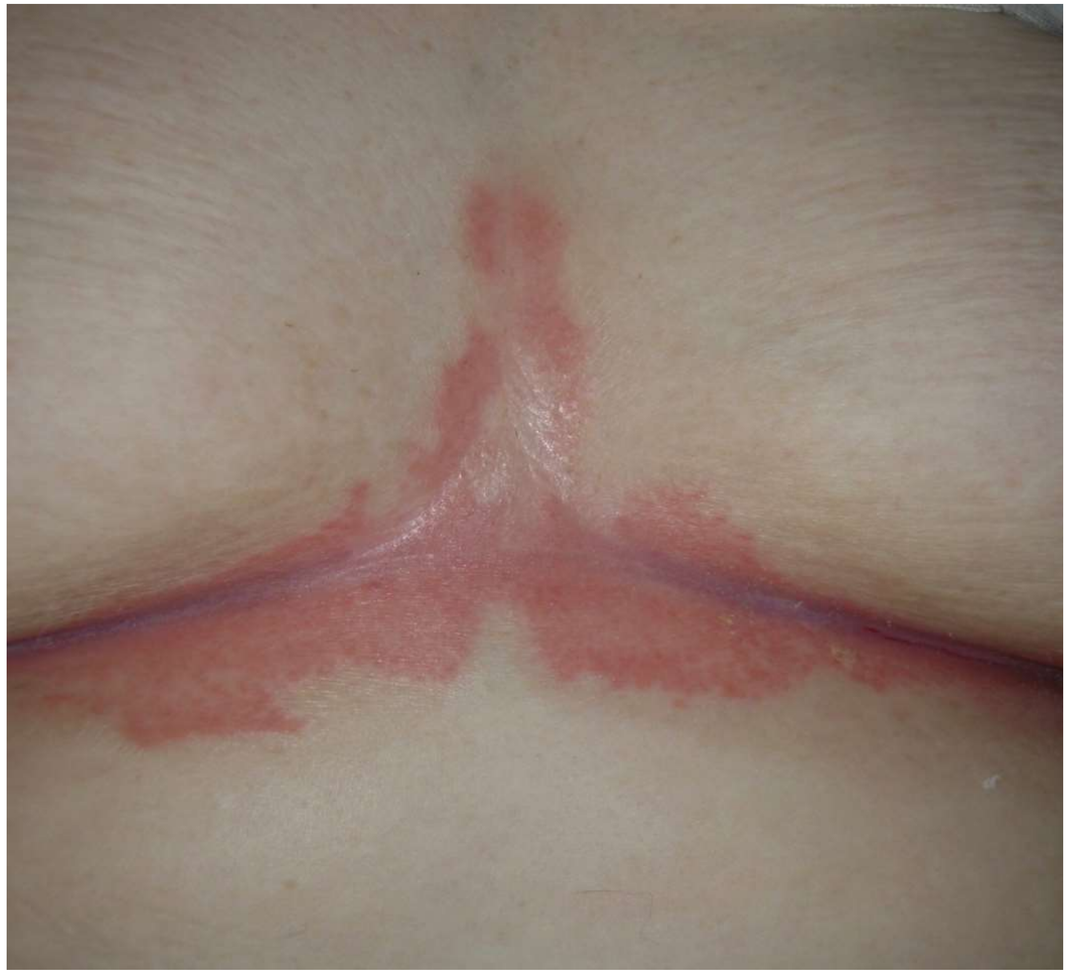


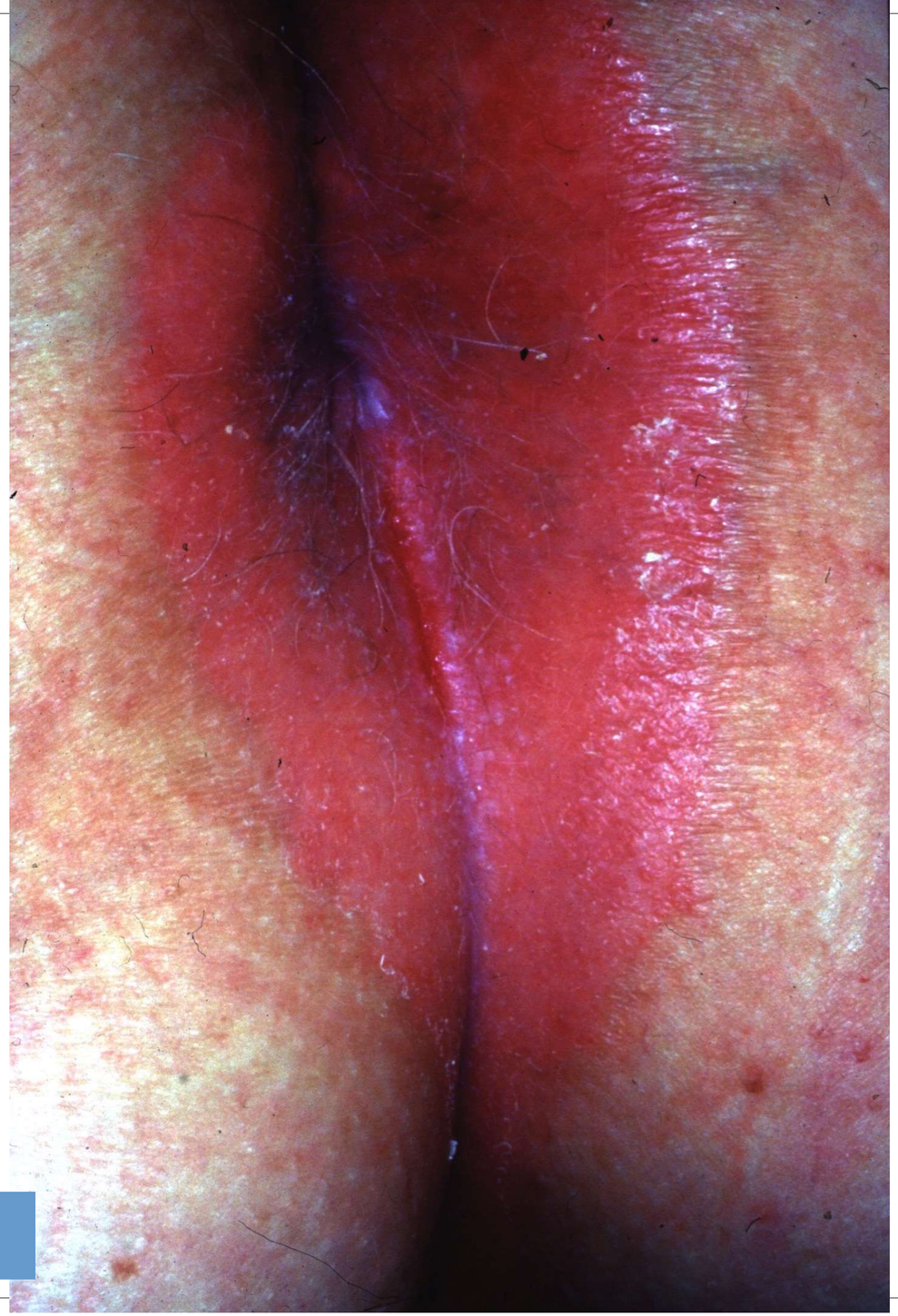
Or is it psoriasis?

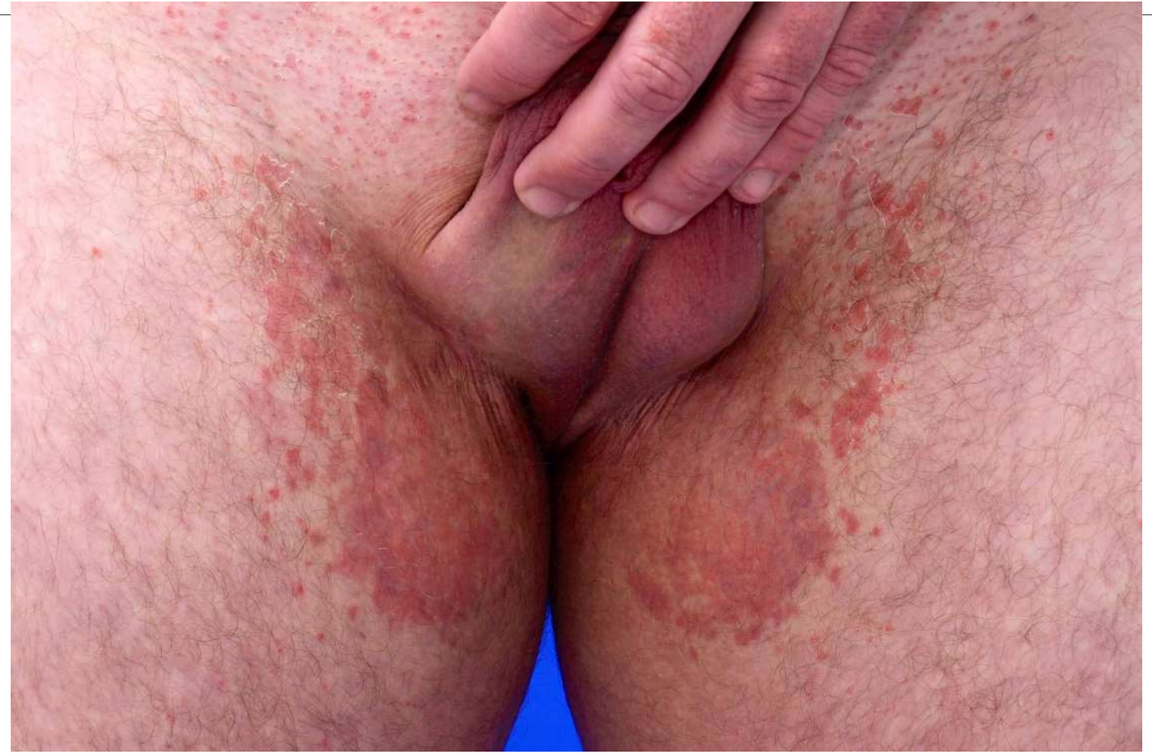
- Well-defined, smooth/shiny, red patches
  - Symmetrical
  - Fissures in creases
- Submammary, pannus, groin creases
  - Very persistent
- Red patches on other sites are scaly

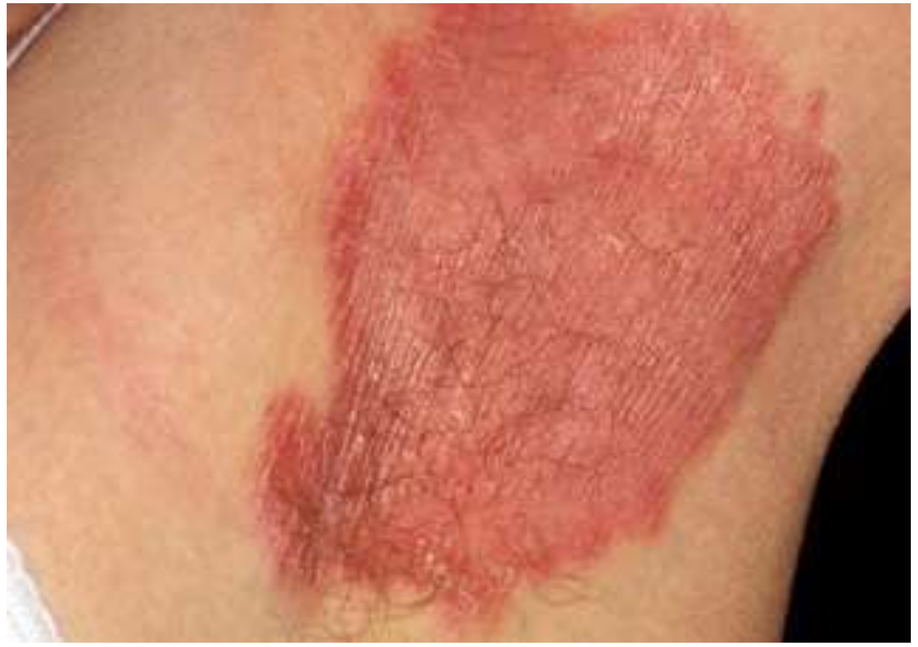
Tx:

1. Low-potency topical steroid
2. Pimecrolimus cream
3. Miconazole, if candida



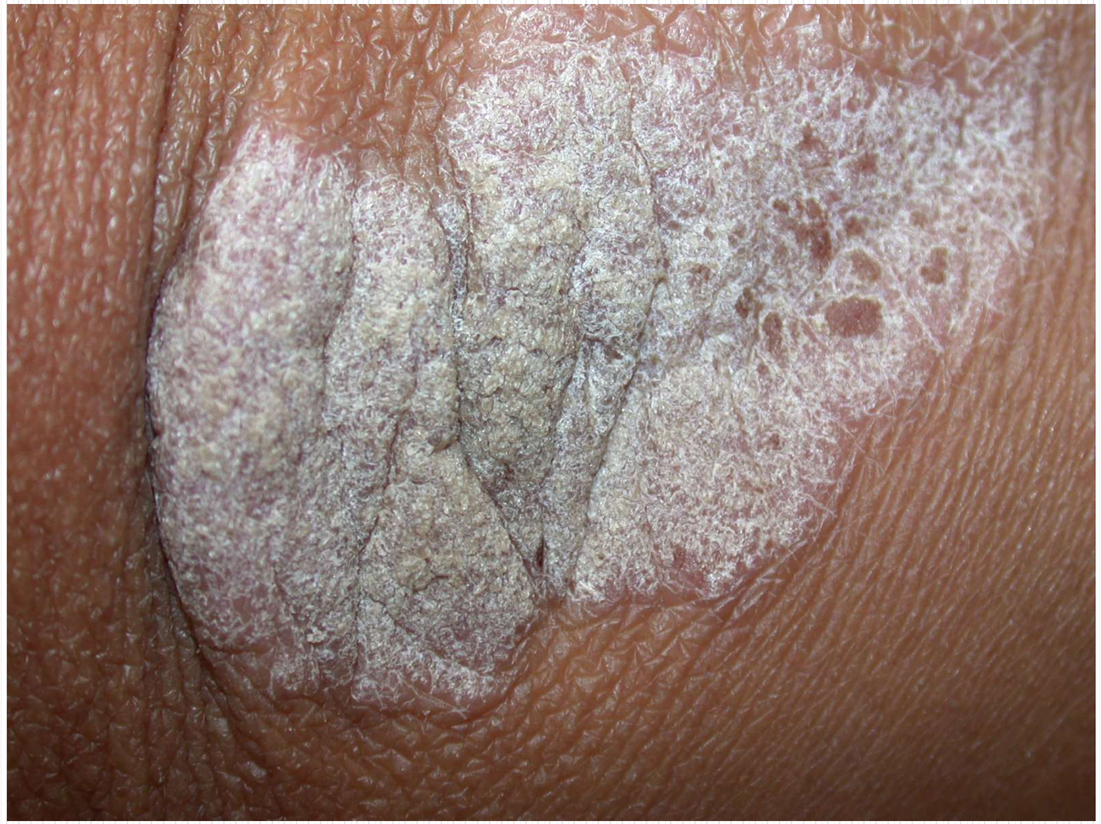






Trunk / limbs

Is it psoriasis?



Q4. 45 year-old female; scaly rash trunk / limbs
Which statement is true?

A. Pityriasis rosea starts with herald patch

B. Pityriasis versicolor is treated with oral terbinafine

C. Psoriasis is described as “polygonal violaceous plaques"

D. Anti-Ro+ associated with discoid lupus erythematosus

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B. Pityriasis versicolor is treated with oral terbinafine
C. Psoriasis is described as “polygonal violaceous plaques"
D. Anti-Ro+ associated with discoid lupus erythematosus

Scaly rash on trunk and limbs

- Seborrhoeic eczema/dermatitis
- Atopic eczema/dermatitis
- Contact eczema/dermatitis
- Lichen planus
- Secondary syphilis
- Pityriasis rosea
- Pityriasis versicolor
- Tinea corporis
- Subacute lupus erythematosus
- Annular erythema
- Drug eruption

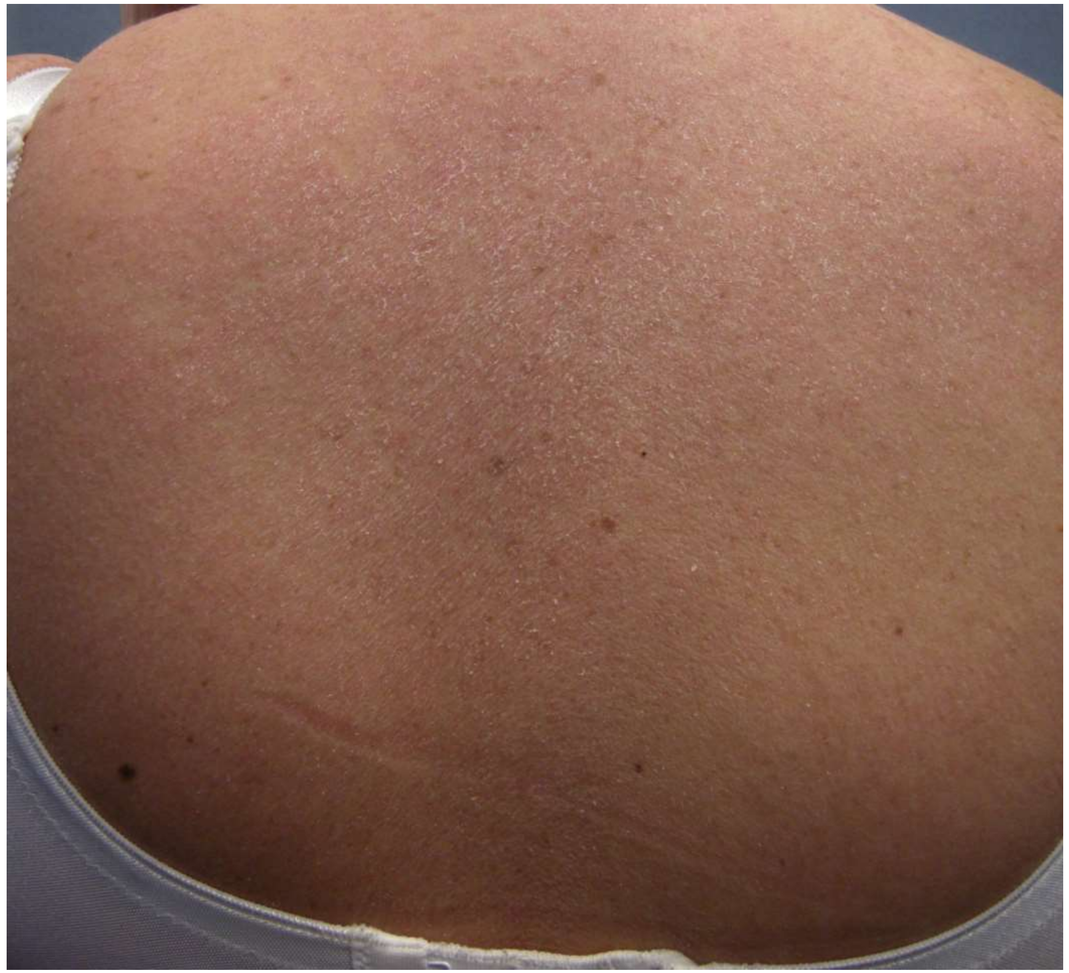
Or, is it psoriasis?

Seborrhoeic eczema

- Upper back / ant chest
- Flaking + superficial pustules
- +/- Erythema

Tx:

1. Ketoconazole shampoo
2. Low-potency topical steroid

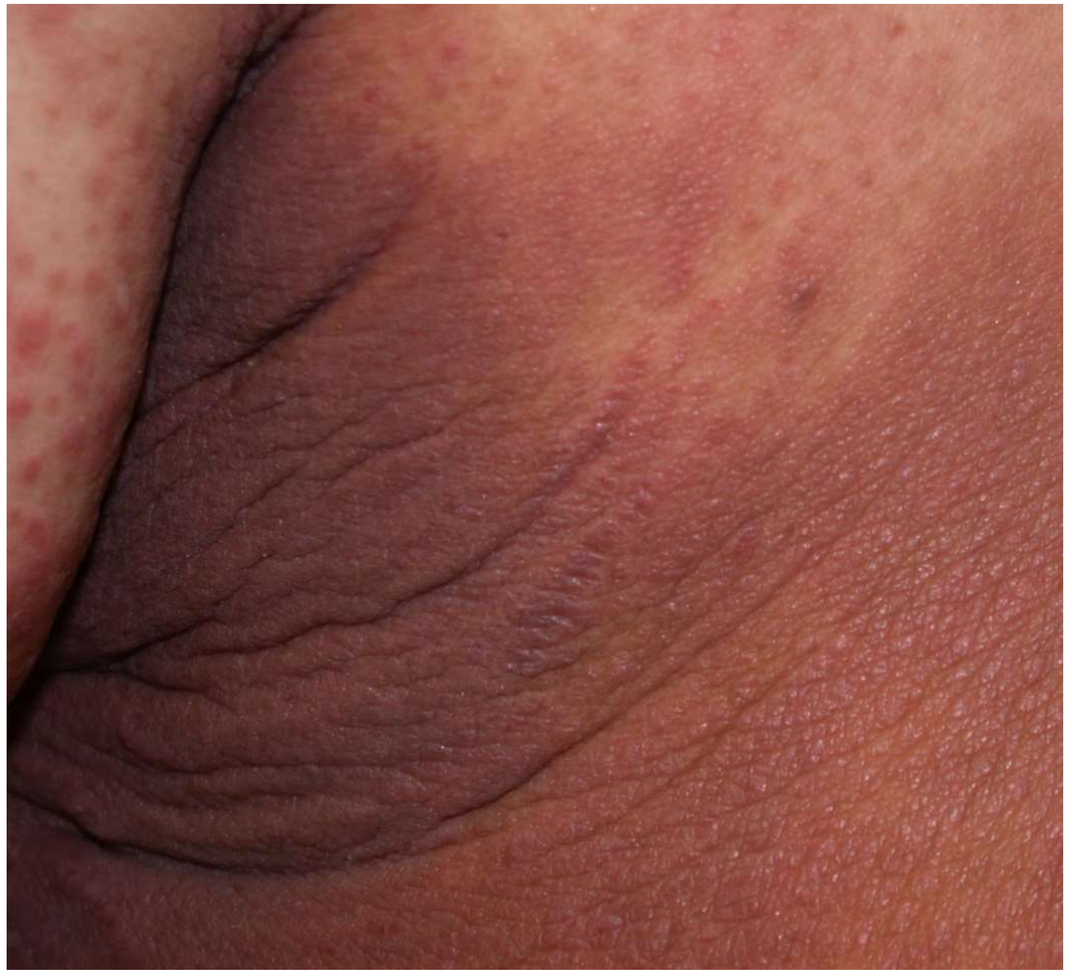


Atopic eczema

- More dry than scaly
- Intensely itchy
- Acute, subacute, chronic forms

Tx:

1. Emollients
2. Moderate/high-potency topical steroid
3. Immunosuppressive

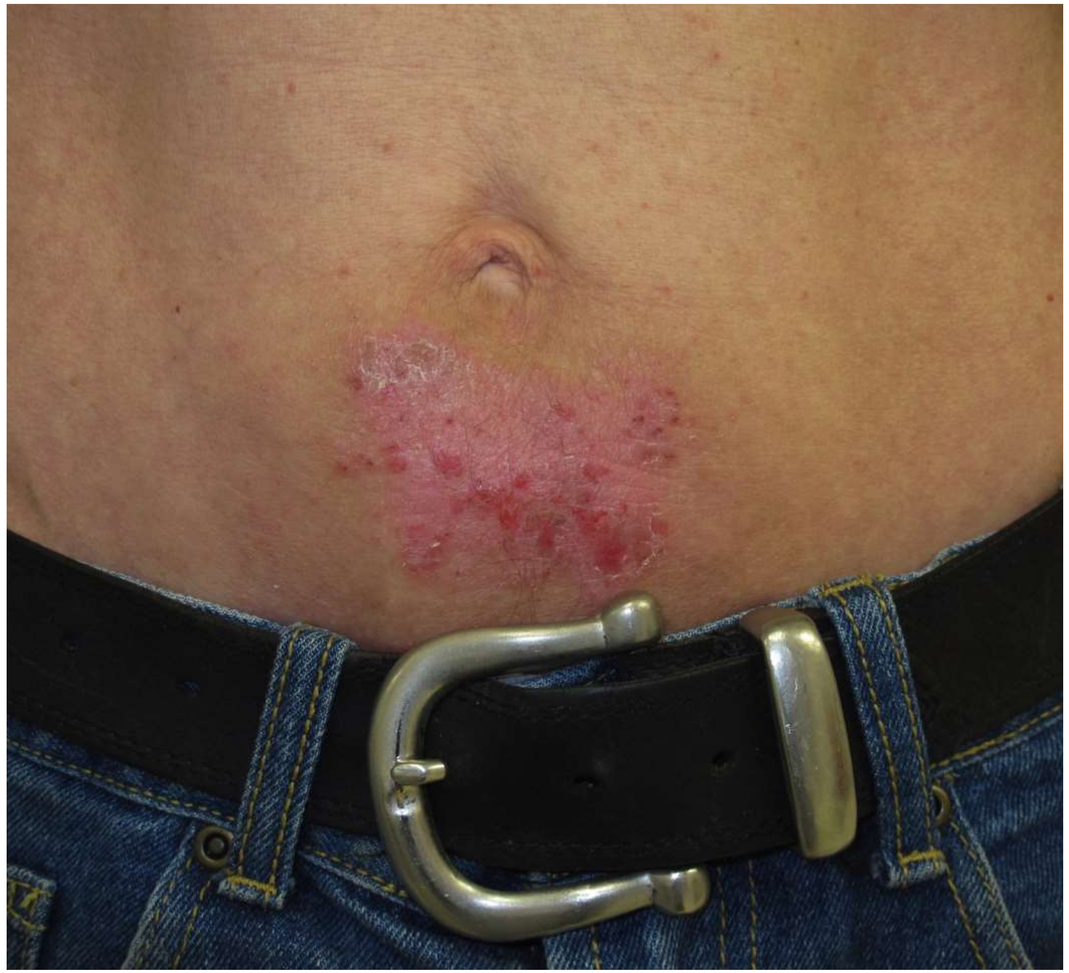


Contact eczema

- Odd, asymmetrical
- Erratic history
- May have straight edge(s)

Tx:

1. Identify irritant, allergen
2. Avoid irritant, allergen
3. Variable-potency topical steroid

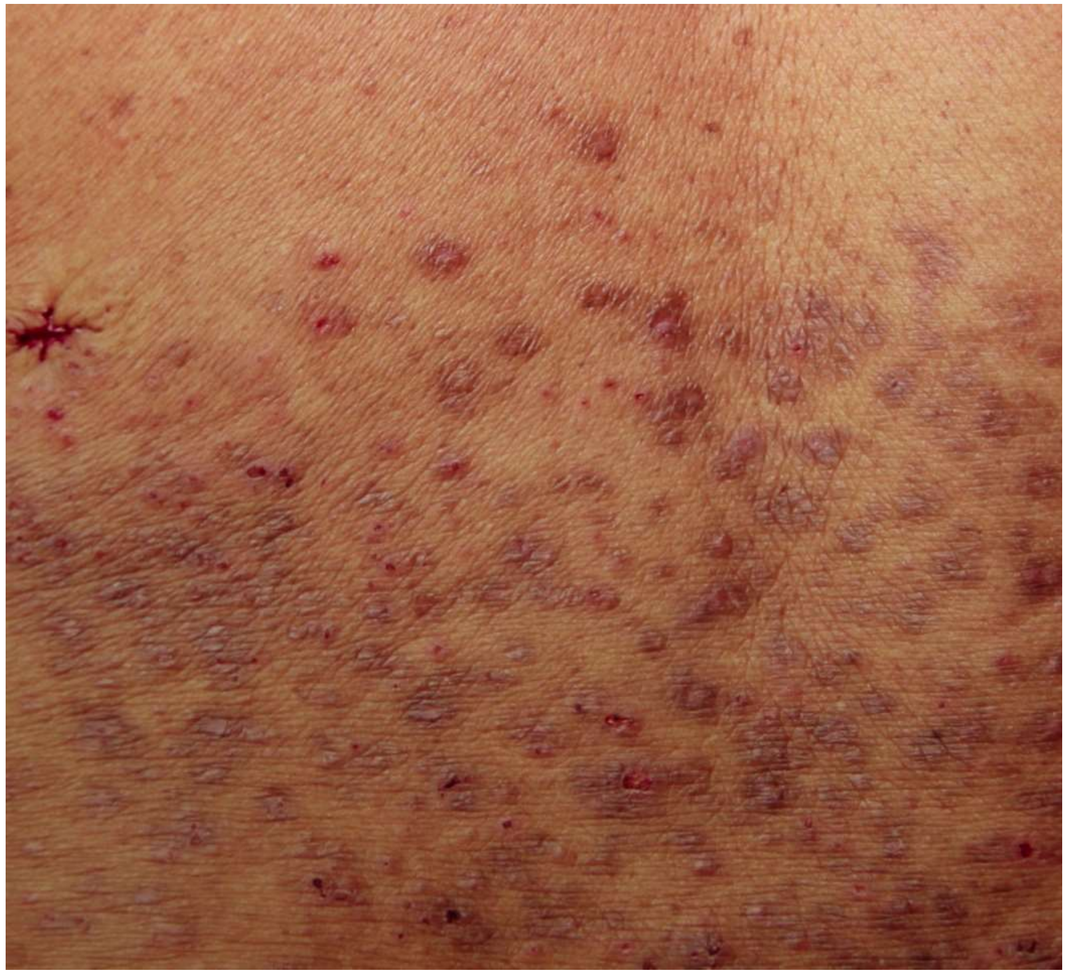


Lichen planus

- Firm papules, plaques
- Polygonal shape
- Variable itch and scale
- Violaceous hyperpigmentation

Tx:

1. High-potency topical steroid
2. Oral steroid
3. Immunosuppressive

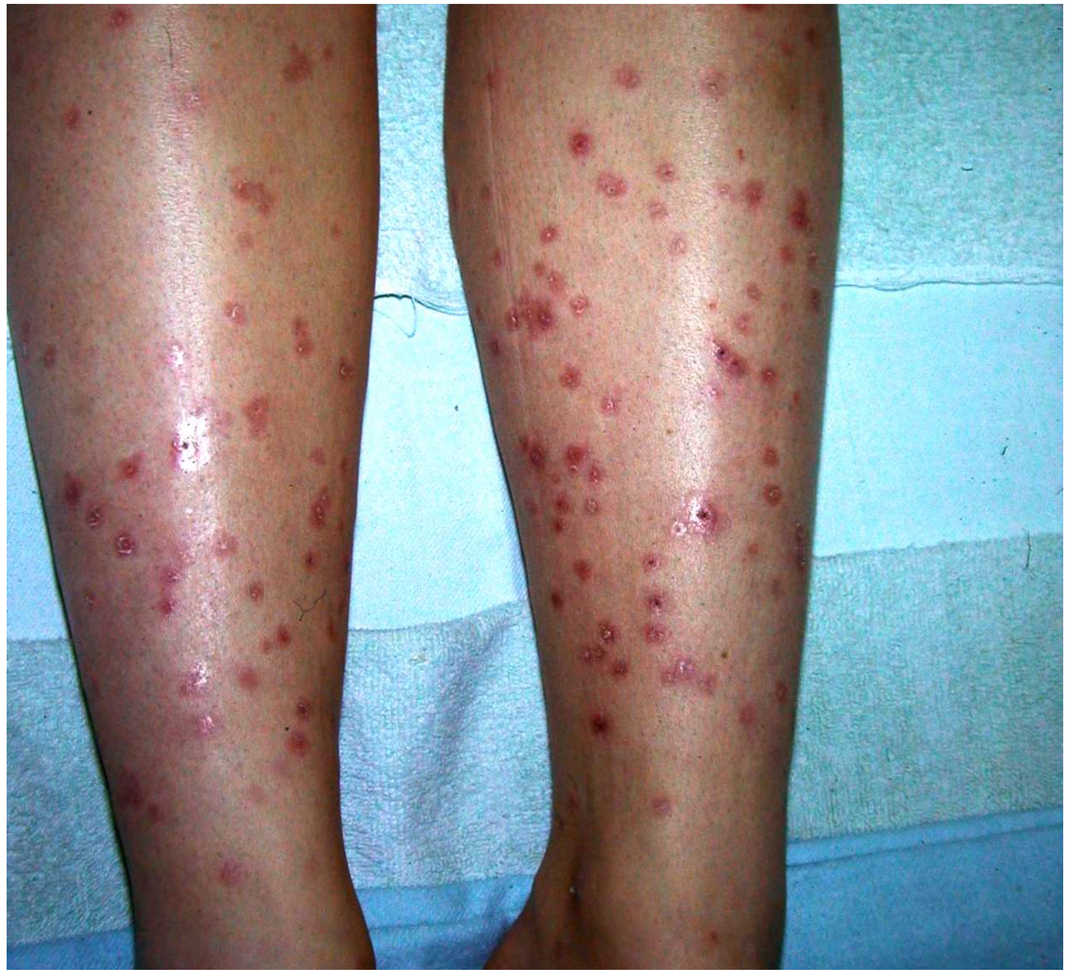


Secondary syphilis

- Rash involves palms, soles
- Positive syphilis serology

Tx:

- Penicillin

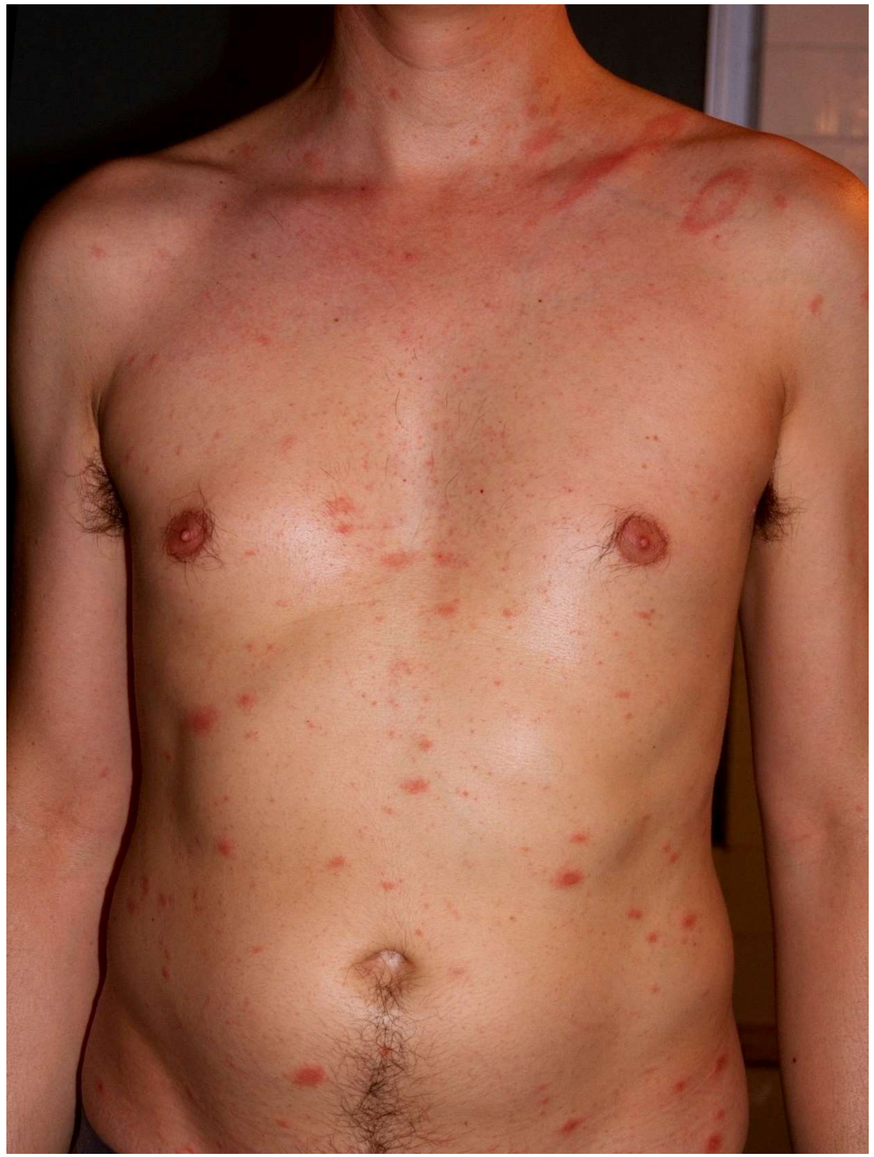


Pityriasis rosea

- Herald patch
- Oval 2–4 cm pink plaques on trunk
- Peripheral, trailing scale

Tx:

1. Expectant
2. Low-potency topical steroid
3. UVR

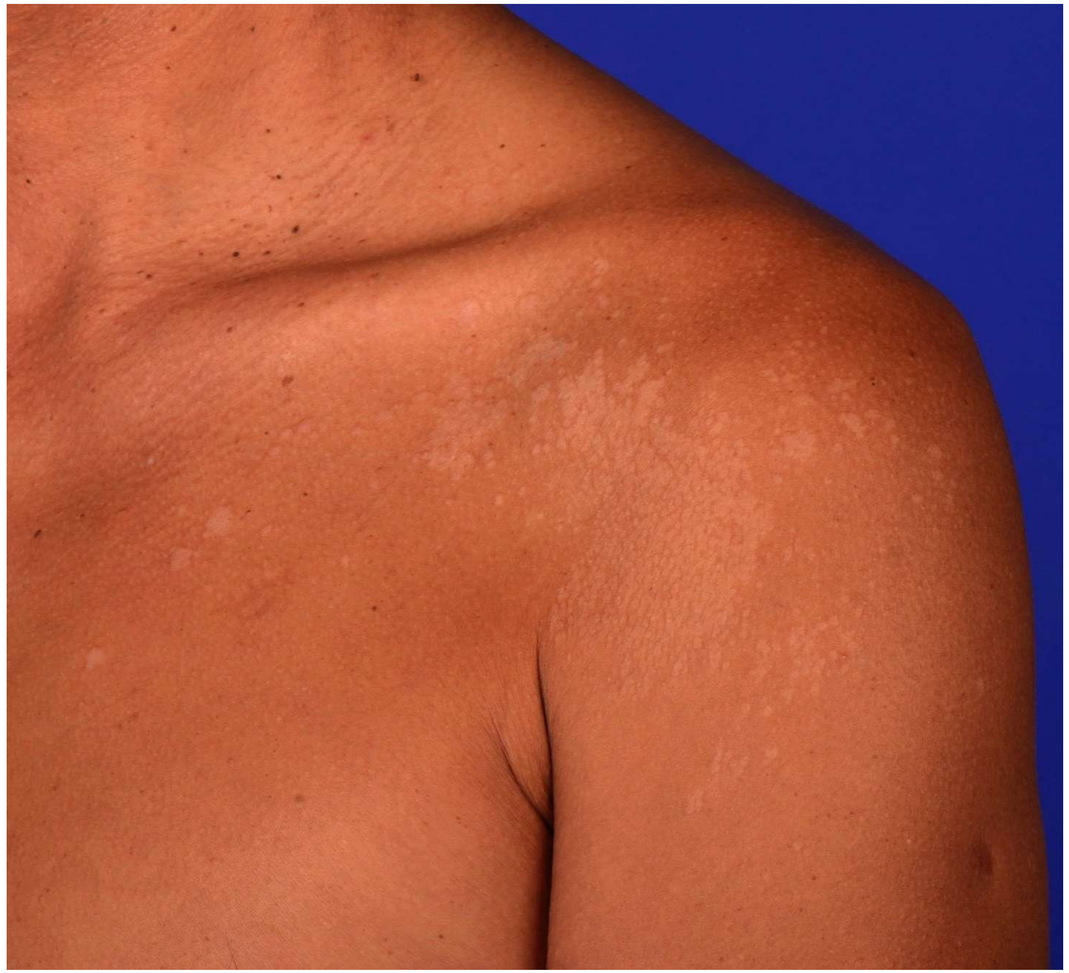


Pityriasis versicolor

- Flaky rash on trunk
- White, red, brown variants
- Microscopy: mycelia/arthrospores

Tx:

1. Ketoconazole shampoo
2. Azole cream
3. Oral itraconazole

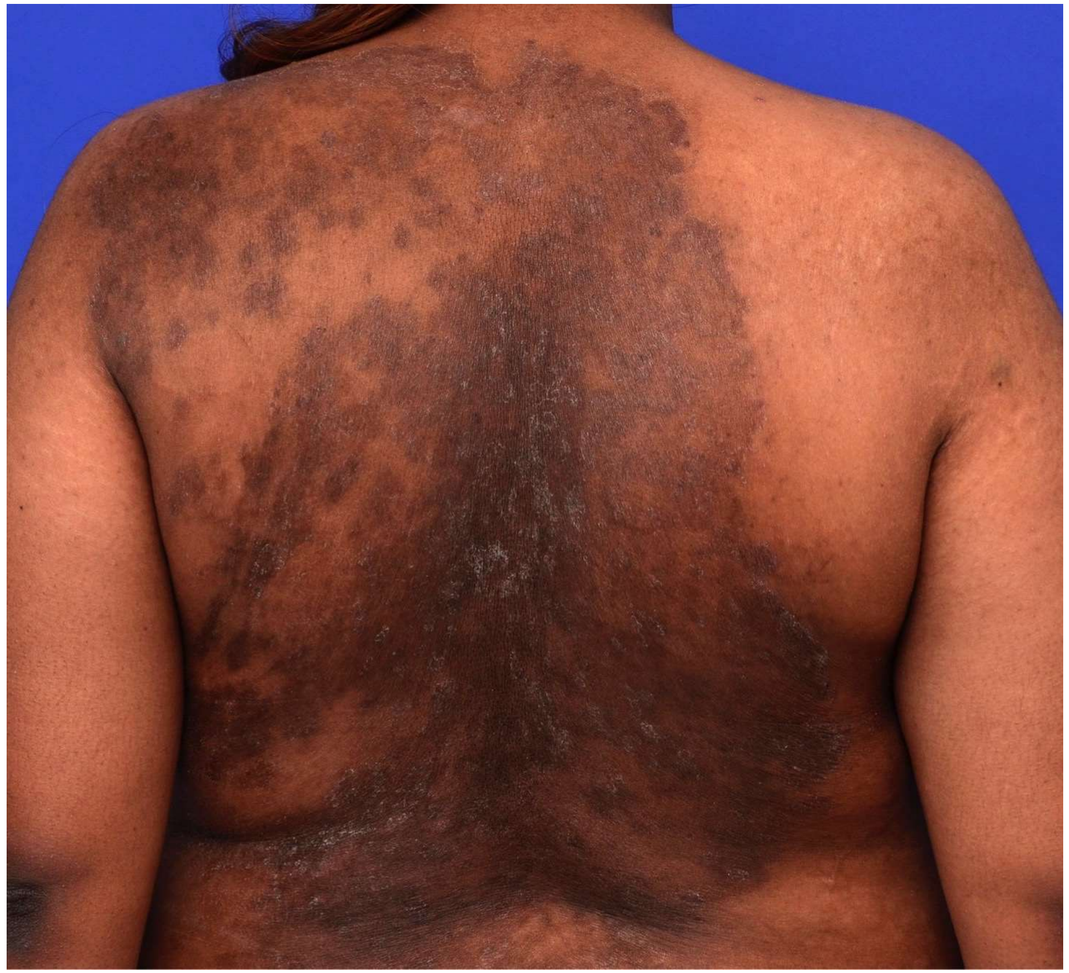


Tinea corporis

- Irregular annular plaques
- Peripheral scale

Tx:

1. Ketoconazole shampoo
2. Azole / terbinafine cream
3. Oral terbinafine, itraconazole

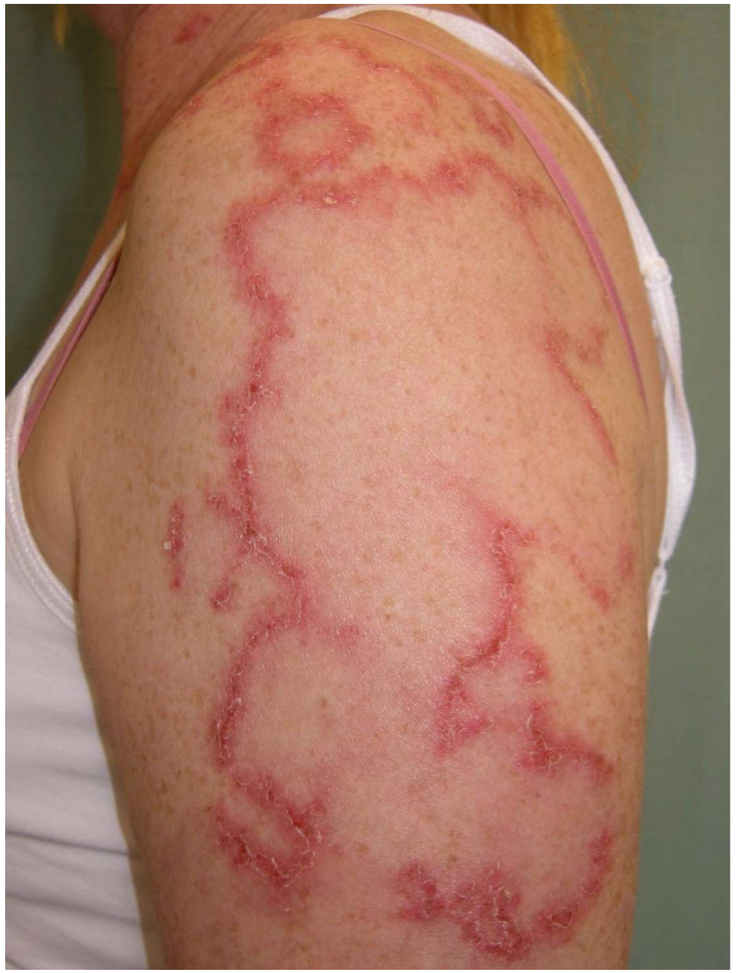


Subacute lupus erythematosus

- Upper trunk, arms
- Photosensitive
- Annular, scaly plaques
- Leaves hypopigmented macules

Tx:

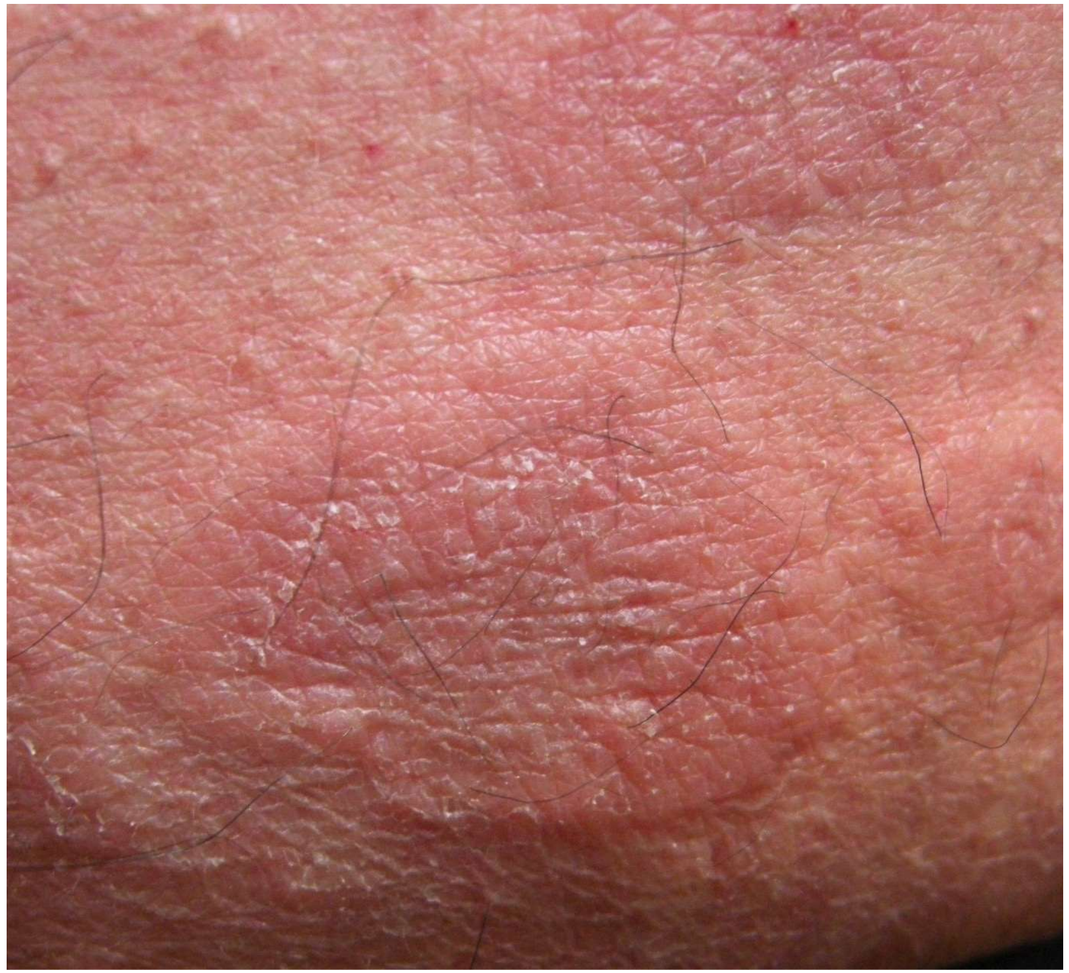
1. High-potency topical steroid
2. Hydroxychloroquine
3. Immunosuppressive



Annular erythema

- Crops of slowly enlarging erythematous annular plaques on trunk
- Trailing scale

Tx: difficult

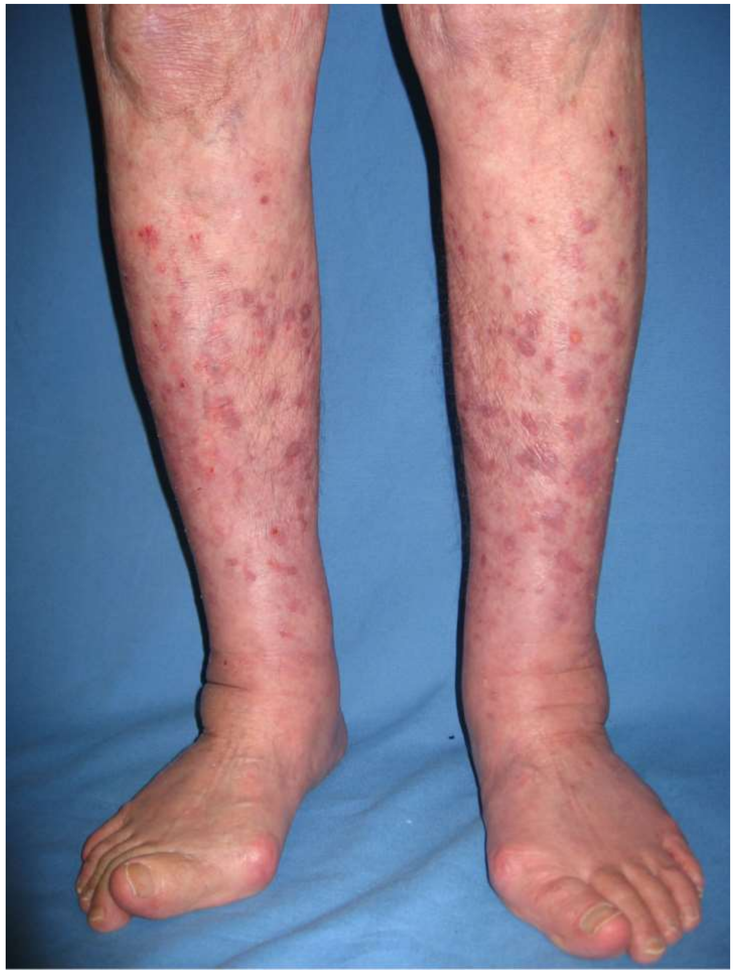


Drug eruption

- Pityriasiform or lichenoid types
- New drug eg gold, hydroxychloroquine

Tx:

1. Identify and stop drug
2. Low-potency topical steroid

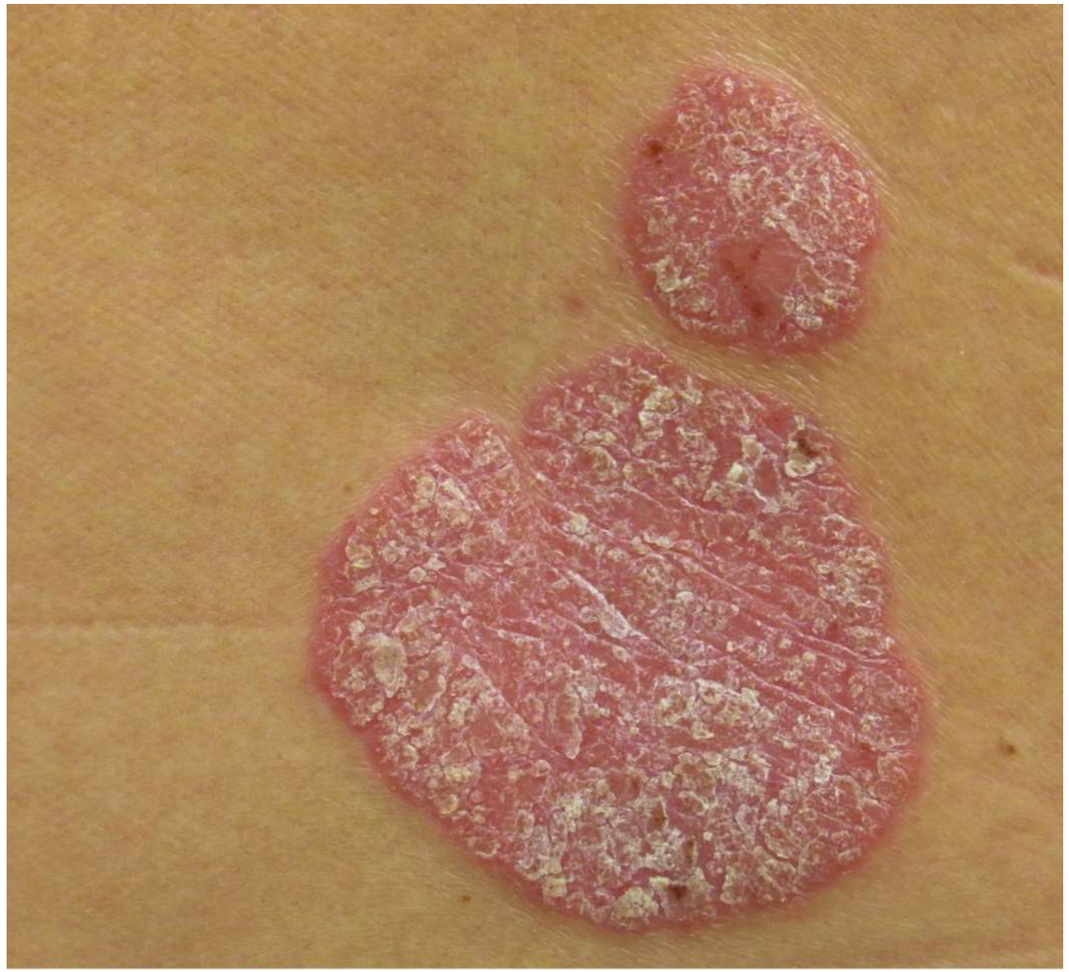


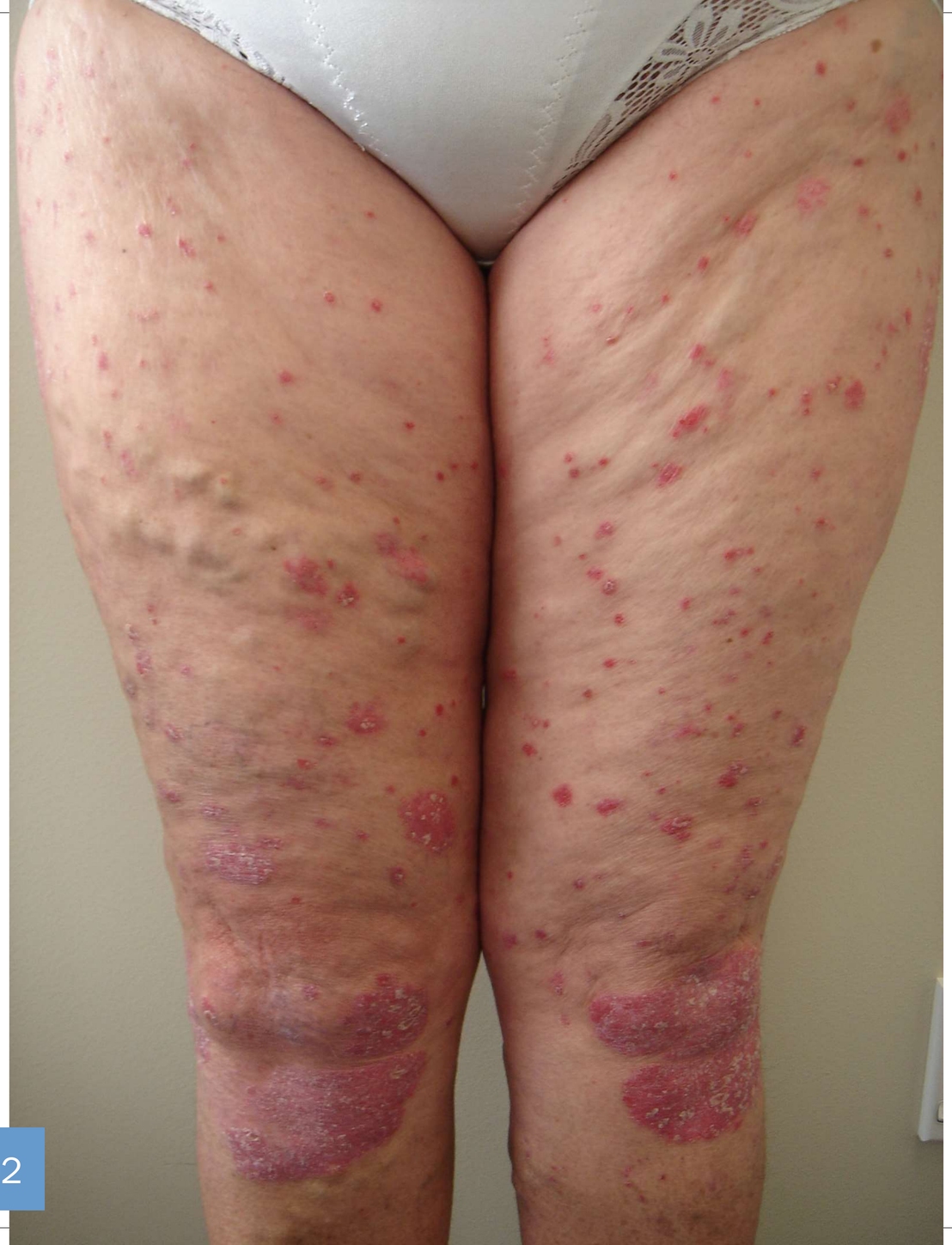
Or is it psoriasis?

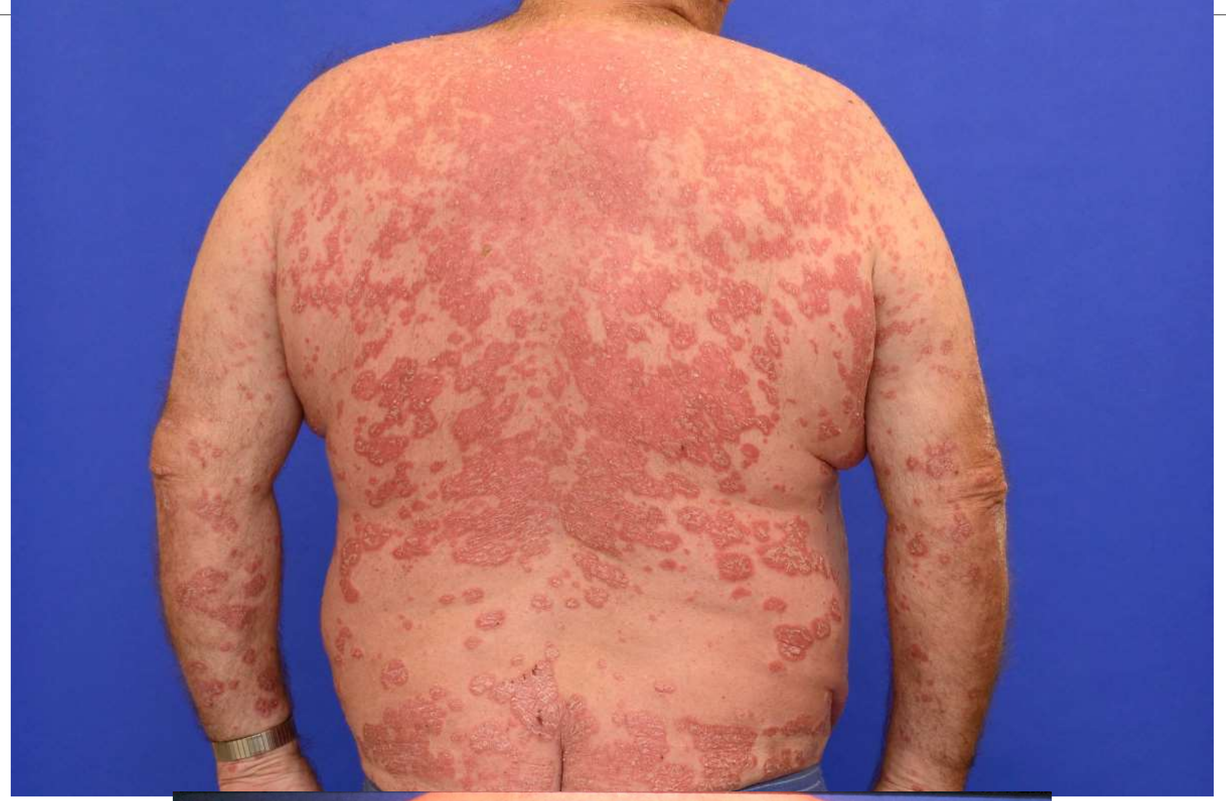
- Symmetrical
- Generalised large/small red plaques
  - > 3 cm or < 3 cm
- Well-circumscribed, silvery scale

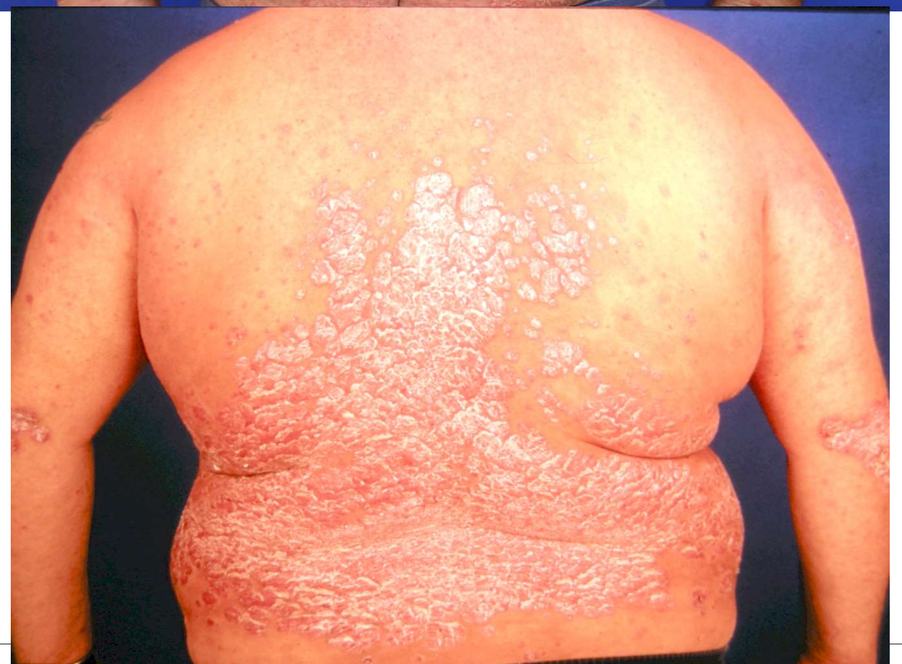
Tx:

1. Calcipotriol / betamethasone diproprionate ointment/gel, twice weekly
2. Calcipotriol ointment bd
3. UVR
4. Systemic tx







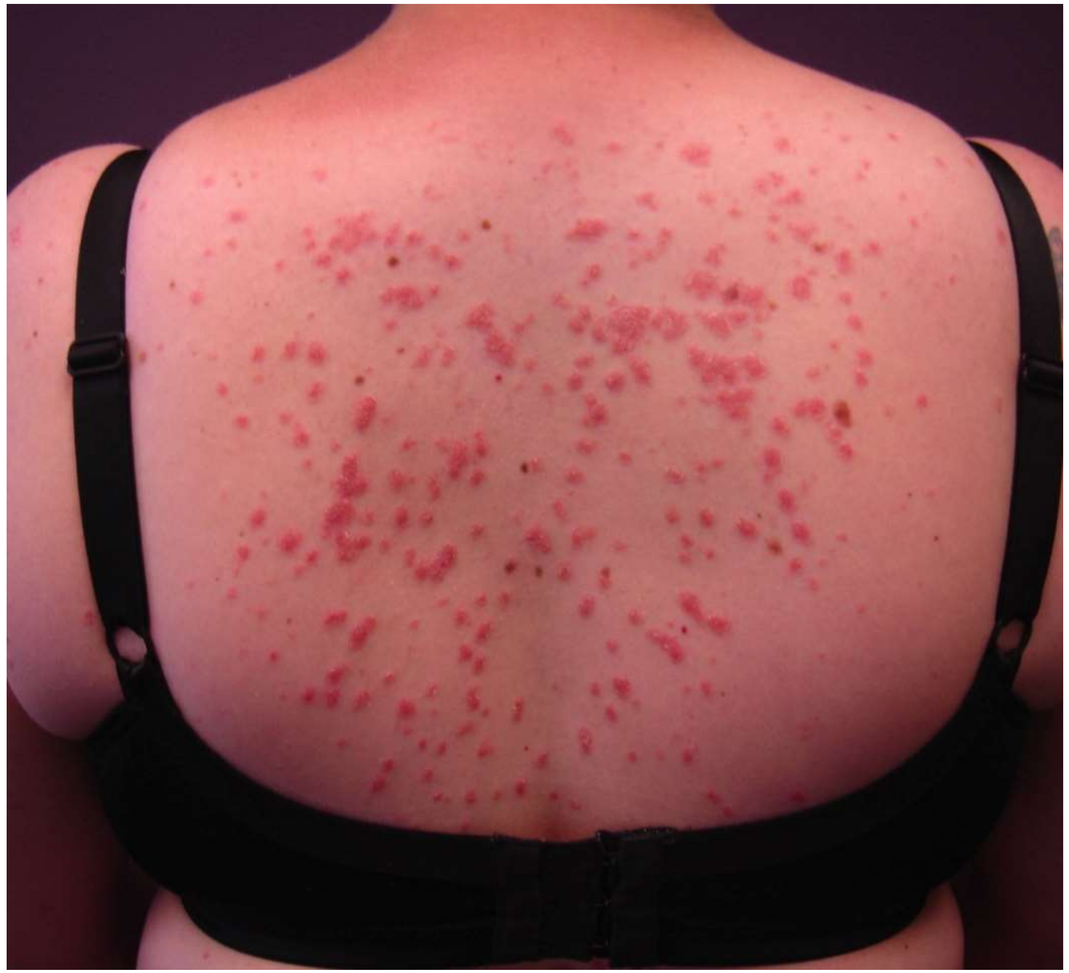


Acute guttate psoriasis

- Provoked by St. pyogenes infection
- Round, 0.5–3 cm red, scaly plaques
- Trunk > limbs
- May involve all body sites

Tx:

1. Treat throat infection
2. Emollients
3. Low-potency steroid lotion
4. UVR



SUMMARY

- Take a detailed history
- Take a detailed DRUG history
- Ask the patients opinion
- Always do a skin scraping

Psoriasis

Another great mimicker