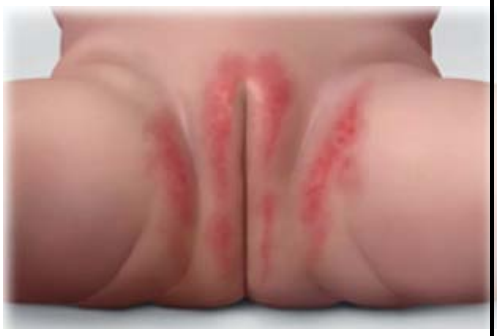
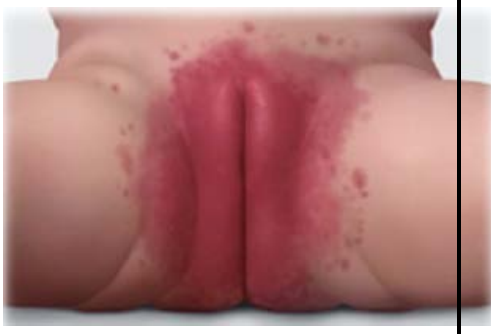
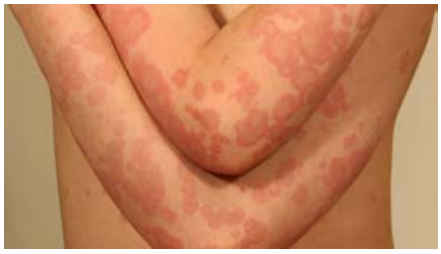
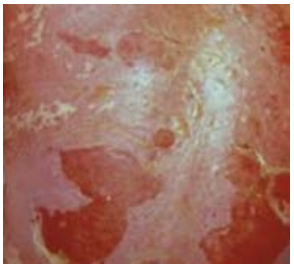
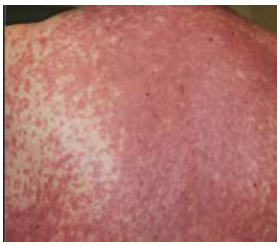
Diaper Dermatitis		
Diagnosis	**Contact Dermatitis**	***Candida* dermatitis**
Epi	Most common cause	Second most common cause
Exam	Spares creases/skin folds 	"Beefy" red rash involving skin folds w/ satellite lesions 
Treatment	Topical barrier ointment/paste (petrolatum, zinc oxide)	Topical antifungal (nystatin)

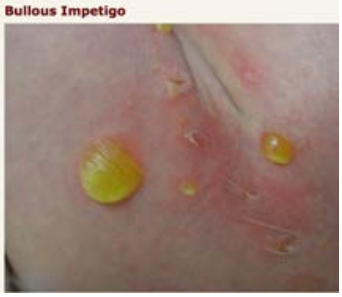
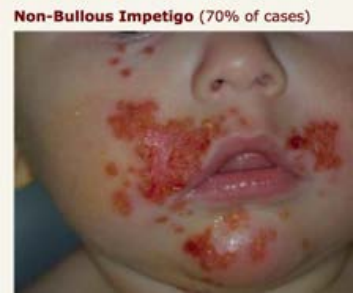
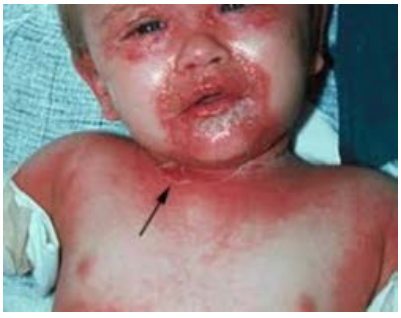
Dermatologic Conditions	
Acne	
Presentation	**Pathophys**: obstruction of pilosebaceous unit by abn keratinization and sebum w/ bacterial proliferation (P. acnes) and inflammation
Treatment	**Comedonal**: (1) topical retinoids (2) benzoyl peroxide and topical abx **Papulopustular**: (1) maximize topical tx (2) oral antibiotics (3) hormonal therapy **Nodulocystic**: isotretinoin ***Abx**: Tetracycline, Doxycycline, Minocycline, Erythromycin **Tips**: • Use topical abx in conjunction w/ benzoyl peroxide (to avoid P. acnes resistance) • Benzoyl peroxide inactivates tretinoin à apply benzoyl peroxide in AM and tretinoin in PM • OCPs and spironolactone can be considered in female pts • May take 6-8 weeks to see improvement • Rx: 30-60 gm w/ refills
Atopic Dermatitis	
Presentation	• **Def**: chronic inflammatory condition leading to pruritic, erythematous, and scaly lesions • **Presentation**: usually before 2 y/o, infants (scalp, face, extensor surfaces), children (flexural surfaces); allergic triad (asthma + allergic rhinitis) • **Complications**: superinfection w/ staph and strep (weeping, crusting, pustules) or herpes simplex (vesicles) • Associated w/ keratosis pilaris (Hyperkeratotic follicular papules, usually on back of arms but also frequently on lateral cheeks of infants and younger children) and pityriasis alba (Hypopigmented, flat, indistinct border, usually face)

Dermatologic Conditions continued on next page →

Dermatologic Conditions	
Atopic Dermatitis	
Treatment	• **Lifestyle**: eliminate allergens, short baths w/ warm water and mild soap • **Bleach baths** (decrease bacteria): ▪ For a full bathtub of water, add 1/2 cup of bleach ▪ For a half-full tub of water, add 1/4 cup of bleach ▪ For a baby tub, add 1 teaspoon of bleach per gallon of water • **Emollients**: Hydrolated Petrolatum, Vaseline™, Eucerin™, Cetaphil™ • **Topical Steroids**: (see chart) • **Topical immunomodulators**: Calcineurin inhibitors (Tacrolimus ointment (Protopic) 0.03%, 0.1%; Pimecrolimus (Elidel) 1%): used on facial lesions, less risk of tissue injury; approved for >2 years of age • **Anti-Staph antibiotics** (if bacterial infection): Cephalexin, Trimethoprim-sulfamethoxazole, Mupirocin • **Antipruritic medication**: Diphenhydramine or Hydroxyzine
Erythema Multiforme	
Presentation	• Usually skin only (minimal mucosa) • <10% BSA • **Etiology**: infection (HSV, mycoplasma PNA), medications (Penicillins, sulfonamides, NSAIDs, barbiturates) • **Presentation**: erythematous papules expanding to target-like plaques w/ dusky violaceous centers, found symmetrically on distal extremities and progress proximally 
Treatment	• Treat/discontinue underlying cause • Supportive care
Stevens Johnson Syndrome	
Presentation	• Skin + 2 or more mucosa • 10-30% BSA • **Etiology**: infection & meds (above) • **Presentation**: mucosal involvement, prodromal fever, sore throat, HA, malaise, erythematous target like lesions forming blisters that rupture
Treatment	• **DERM EMERGENCY** • Treat/discontinue underlying cause • Magic mouthwash for stomatitis, artificial tears for ocular involvement • Care to avoid scarring and adhesions • Hospitalize, treat like burn patient (fluids, electrolytes, pain, prevent infection)

Dermatologic Conditions	
Toxic Epidermal Necrolysis	
Presentation	• Skin + 2 or more mucosa • >30% BSA • **Etiology**: as above • **Presentation**: extensive skin and mucosal involvement (conjunctival, oral, genital, pulmonary), large bullae that rupture and leave large erosions (Nikosky +) 
Treatment	• DERM EMERGENCY • (see SJS) • Consider IVIG
Drug Reaction w/ Eosinophilia and Systemic Symptoms (DRESS)	
Presentation	• **Def**: potentially life-threatening adverse drug-induced reaction characterized by skin rash, hypereosinophila, liver involvement, fever, and lymphadenopathy • **Etiology**: carbamazepine, allopurinol, sulfasalazine, phenobarbital, lamotrigine, nevirapine, and more • Can also be assoc w/ HHV 6, eBV and CMV reactivation • **Presentation**: usually 2-6 weeks after initiation of drug tx, rash is often morbilliform or exfoliative and may be assoc w/ facial edema • Classify w/ RegiSCAR scoring 
Treatment	• Discontinue medication • Coticosteroids and IVIG may improve sx but evidence is not definitive • Recovery is prolonged (6 or more weeks) and may have intermittent flare-ups, 10% mortality rate

Dermatologic Conditions continued on next page →

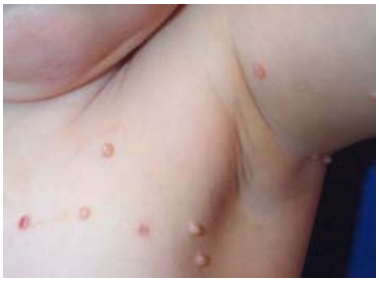
Dermatologic Conditions	
Impetigo	
Presentation	• **Def**: contagious superficial skin infection, can be primary (direct infection of previously normal skin) or secondary (infection of skin that has already been disrupted) • Classified as bullous or non-bullous (70%) ▪ **Non-Bullous**: usually occurs on traumatized skin, Staph aureus coag pos and strep pyogenes (GABHS), spread by contact, non-pruritic, no constitutional sx ▪ **Bullous Impetigo**: more common in infants and young children, caused by staph aurus coag positive (same types as toxic shock and scalded skin), bulla develop on intact skin  
Treatment	• Mupirocin (Bactroban): applied tid for 7-10 days • May need oral abx for widespread disease • If MRSA consideration, Clindamycin should be used
Staph Scalded Skin	
Presentation	• **Def**: exfoliative toxin-producing S. aureus • **Presentation**: fever, irritability, skin tenderness → diffuse erythema and flaccid blisters → scaling and desquamation 
Treatment	Case dependent: Oxacillin, Nafcillin, or Vancomycin

Dermatologic Conditions

Molluscum Contagiosum

Presentation

- **Def**: wart-like lesion caused by DNA poxvirus
- **Presentation**: small flesh-colored, dome shaped, umbilicated papules most common in school aged children, immunocompromised patient may have extensive disease; transmitted by fomites/close contact; if molluscum in genital area of child must consider possible sexual abuse



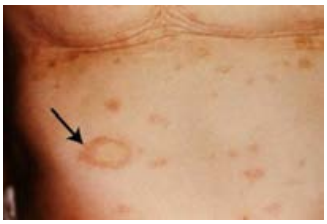
Treatment

Self-limited

Pityriasis Rosea

Presentation

- **Def**: self-limited skin condition presenting w/ a single erythematous herald patch followed w/ collection of smaller patches usually lasting between 2-12 weeks
- **Presentation**: usually presents in pts ages 10-35



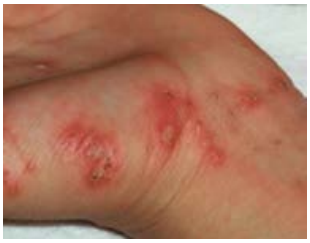
Treatment

- Self-limited
- Inform patient and family of long duration

Scabies

Presentation

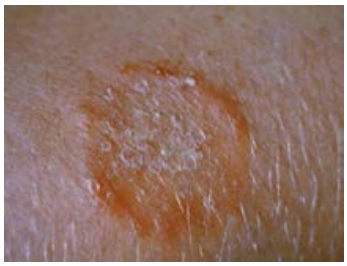
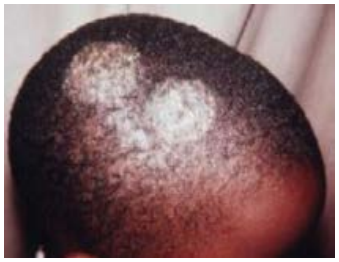
- **Def**: mite infection transmitted by contact
- **Presentation**: rash and severe itching (delayed type IV hypersensitivity) w/ papules, nodules, scaling, and sometimes linear distribution



Treatment

- Permethrin (single application has 90-95% cure rate, do not use <2 months old, can reapply in 7 days)

Dermatologic Conditions continued on next page →

Dermatologic Conditions	
Lice	
Presentation	Diagnosis usually made by nits (eggs) on hair shafts, adult lice may be difficult to see
Treatment	• 1% Permethrin rinse (Nix) and Pyrtherin (Rid) • Do not use shampoo/conditioner prior to tx • Requires retreatment 7-10 days later (not ovicidal) • Additional methods: wet combing; butter, olive oil, mayo, petroleum jelly to suffocate lice • Tx of family not usually indicated
Tinea Corporis	
Presentation	• **Def**: superficial dermatophytosis • **Presentation**: scaly erythematous pruritic patch w/ centrifugal spread and subsequent central clearing w/ raised annular border 
Treatment	• **1st line/localized**: topical antifungal (may take several weeks to clear) • **2nd line/extensive**: oral antifungals (terbinafine, griseofulvin)
Tinea Capitis	
Presentation	• **Def**: superficial dermatophytosis • **Presentation**: scaly erythematous patch that can progress to alopecia w/ inflammation 
Treatment	Oral griseofulvin or terbinafine