



Common Skin Complaints and Updates

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Disclosures

- No financial disclosures
- I will be discussing the off-label use of spironolactone in the treatment of acne

Agenda

- Sunscreen
- Acne vulgaris
- Rosacea
- Seborrheic dermatitis
- Tinea
- Intertrigo
- Scabies
- Herpes

Sunscreen

- **Broad-spectrum** (protects against UVA and UVB rays)
- **SPF 30 or greater**
- **Water-resistant**
- Chemical vs physical sunscreens
 - **Physical: zinc oxide or titanium dioxide**
 - **Tinted sunscreens** protect against **visible light (indoors)** which can worsen dark spots and melasma



Sunscreen

- **FDA issued a proposed rule in 2019, later a proposed order in 2021**
 - Generally recognized as safe and effective (GRASE)
 - **Zinc oxide**
 - **Titanium dioxide**
 - **Not GRASE (these aren't present in legal US sunscreens)**
 - PABA
 - Trolamine salicylate
 - **Requesting more information**
 - Commonly used in US: ensulizole, octisalate, homosalate, octocrylene, octinoxate, oxybenzone, avobenzone
 - Not commonly used in US: cinoxate, dioxybenzone, meradimate, padimate O, sulisobenzone

Take home sunscreen points

- The FDA has not deemed these ingredients unsafe and has not asked the public to stop using sunscreens that contain them
- If the proposed rule makes you or your patients uneasy, look for sunscreens whose **active ingredients** are the physical blockers **zinc oxide or titanium dioxide**

Acne vulgaris

- Assess severity
 - Mild
 - Nodules, scarring
 - Moderate
 - Severe
- Target treatments based on severity
 - **Mild** may respond to **topicals alone**
 - **Moderate to severe** typically necessitates **oral therapy** (antibiotics, isotretinoin)
- Key point: **oral antibiotics should be prescribed WITH topicals** as the latter will hopefully serve as the long-term maintenance regimen

Acne vulgaris: moderate



Source: DermNet - <https://dermnetnz.org/topics/acne-face-images>

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Acne vulgaris: severe



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<https://dermnetnz.org/topics/acne-face-images>

Acne vulgaris

- Prescription topicals
 - **Topical antibiotics (clindamycin, erythromycin):** should **be given with anti-bacterial like benzoyl peroxide (BPO)** to prevent formation of antibiotic-resistant bacteria
 - BPO 5%/Clindamycin 1%(Benzaclin) and BPO 5%/Erythromycin 3% (Benzamycin) are popular
 - BPO comes in wash, solution, and gel forms
 - Wash is great for back/chest acne
 - Some patients may only tolerate BPO as a spot treatment because of side effects (dryness)

Acne vulgaris

- Prescription topicals
 - Topical antibiotics
 - **Dapsone 7.5% gel**: can consider if above topical antibiotics not effective or patient not tolerating combo with BPO, typically **more expensive/harder to get** (even though now generic), **cannot use with BPO due to temporary yellow/orange discoloration** of skin and hair

Acne vulgaris

- **Topical retinoids (adapalene, tretinoin)**: mainstay of acne treatment, works on skin turnover, particularly effective for comedones, can improve dyspigmentation, a bit of wrinkle reduction
 - Apply to full face (avoid periocular skin)
 - **Tretinoin**: I typically start at 0.05% (mid-strength) and escalate to 0.1% (highest strength) if tolerated
 - **Adapalene**: low strength (0.1%) now available OTC

Acne vulgaris

- Counseling
 - Acne **worsens before it improves**
 - Can take **3-4 months to see full effects** of meds
 - Dryness/flaking/redness/peeling! Most will **build tolerance with consistent use**, but minority of patients cannot tolerate these
 - Use **non-comedogenic moisturizer** to counteract side effects
 - Start topical retinoids every other night and **increase to nightly as tolerated**
- **Gentle face washes** are best, do not need to scrub harshly

Acne vulgaris

- Oral antibiotics
 - Guidelines advise **only 3-4 month courses!**
 - If patient does not respond after 3-4 months OR does not maintain adequate response on topicals alone after finishing antibiotics, should be referred to derm for consideration of isotretinoin
 - Because of side effect profile (short and long term), **doxycycline is typically preferred over minocycline or bactrim**
 - Typical regimen: **doxycycline 100 mg BID x 3-4 months**
 - **WITH topicals!**
- Isotretinoin (only dermatologist can prescribe)

Special considerations

- **Spironolactone** in females
 - **Off-label, but extensively used**
 - Unlike oral antibiotics, **can be long-term option**
 - 50 mg daily can suffice, but can increase to 100-200 mg daily
 - Counseling: should not get pregnant while on drug, debate over lab monitoring, I don't typically check potassium unless taking greater than 100 mg daily, can cause **menstrual irregularities** like spotting

Special considerations

- Newer topicals: studies almost always compare to vehicle alone (not existing acne topicals), usually more expensive/harder to get
- **Clascoterone 1% cream** (Winlevi, 2020): topical androgen receptor inhibitor, approved for males and females age 12 and older, applied BID
 - Consider adrenal suppression when using large amounts
 - I consider in patients whom I suspect hormonal component to acne, females who don't want spironolactone, can use with topical retinoid if tolerated
- **Clindamycin 1.2%/adapalene 0.15%/BPO 3.1% gel** (Cabtreo, 2023)

Benzenes in BPO products

- **Benzene** is a **carcinogen** and can form when BPO degrades, low levels of benzenes are acceptable but high levels are concerning
- **Independent testing lab** (Valisure) studied levels of benzene in BPO-containing cleansers and lotions, found **elevated levels** of benzene when products incubated at **room temp, 98.6 F (body temp), 122 F (accepted pharmaceutical stability testing temp), and 155 F (hot car temp)**
- Valisure used FDA's methods for measuring benzenes which are more accurate than USP's methods
- My take: do not dismiss findings, more data needed, telling pts to refrigerate BPO products, discard after 3-6 months, avoid heated storage

<https://www.dermatologytimes.com/view/updates-on-benzene-in-benzoyl-peroxide-products-at-aad>

Rosacea



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<https://dermnetnz.org/images/rosacea-images>

Rosacea

- **Pink bumps and pustules** respond to **topicals and oral antibiotics**, but redness does not typically respond much
 - **Metronidazole gel or cream** daily (1% - once daily, 0.75% BID)
 - **Azelaic acid 15% gel** once daily: some activity against redness, more irritating than others
 - **Ivermectin 1% cream** once daily
 - Sodium and sulfur combo: **sulfacetamide sodium-sulfur 10%-5% topical lotion** once daily (great for combo rosacea/sebderm)
 - Some compounding pharmacies combine several of above into one topical
 - **Doxycycline**: flare dosing is similar to acne (100 mg BID x 3-4 months), if pts recurs off flare dosing can consider **40-50 mg once daily long term**

Rosacea

- Redness/flushing
 - **Avoid triggers**
 - **Sun protection**
 - **Gentle skin care**
 - **Topical vasoconstrictors** (brimonidine 0.33% gel, oxymetazone 1% cream): typically used QAM
 - More data on oxymetazone re: rebound redness
 - **Most responsive to laser** (PDL, KTP), usually requires cash payment, multiple treatments

Phymatous rosacea



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Seborrheic dermatitis



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<https://dermnetnz.org/topics/seborrhoeic-dermatitis>

Seborrheic dermatitis

- **Ketoconazole 2% shampoo** is mainstay, works better than OTC shampoos, use **2-3 times weekly**, leave on for 2 min or so before rinsing off, can also use as face wash
 - **Ciclopirox 1% shampoo** is alternative for those who don't like how keto makes their hair feel
 - Can also use **ketoconazole 2% cream** BID x 2-3 week to active rash on face
 - Alterating shampoos, including OTCs, helpful for some
- **Topical steroids** in solution or oil form can help with itch
 - I typically give clobetasol 0.05% solution – can use BID prn to itchy spots on scalp
 - Alternatives: lidex (fluocinonide 0.05% solution), dermasmooth (fluocinolone 0.01% oil)

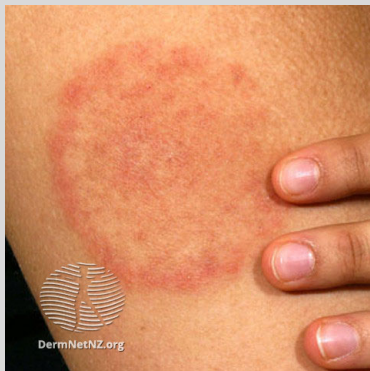
Seborrheic dermatitis

- Differential diagnosis: psoriasis

Tinea

- **Tinea capitis** is **rare in adults** (more likely in children), flaky scalp should be treated as seborrheic dermatitis, if not responsive should be referred to derm
- Tinea corporis
- Tinea pedis
- Tinea unguum/onychomycosis

Tinea corporis



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<https://dermnetnz.org/topics/tinea-corporis-images>

Tinea corporis

- If focal, treat with **ketoconazole 2% cream BID x 2-3 weeks**, refer to dermatologist if does not clear
- If more extensive, can treat with oral antifungals, I typically use **terbinafine 250 mg daily x 2 weeks** if no contraindications, refer to dermatologist if does not clear
- Differential diagnoses: nummular dermatitis (variant of eczema), granuloma annulare, cutaneous T-cell lymphoma

Tinea pedis



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<https://dermnetnz.org/topics/tinea-pedis-images>

Tinea pedis



Source:DermNet - CC BY-NC-ND 3.0 NZ

<https://dermnetnz.org/topics/tinea-pedis-images>



Author: [Dr Hari K Kasi](#) - CC BY-NC-ND 3.0 NZ

Tinea pedis

- Tinea pedis (and lower legs): can be itchy, can also service as nidus for infection (cellulitis) so I'm more inclined to treat
 - I first try **ketoconazole 2% cream BID x 2-3 weeks** when rash active, if responds but recurs have pt use BIW even when clear

Tinea unguum/onychomycosis

- Unsightly for pts, but not dangerous, **treatments are not reliably effective**, topicals have about 5-8% success, oral antifungals have about 50% success rate
 - **Oral terbinafine** 250 mg x 3 months, debate about lab monitoring, some do LFTs prior to starting and after 6 weeks in older pts or those with co-morbidities
 - **Pulse itraconazole**, beware of drug-drug interactions

Intertrigo



Brodell RB, et al. Intertrigo. In: UpToDate, Connor RF (Ed), Wolters Kluwer. (Accessed May 7, 2024.)

Intertrigo

- Presents in **skin folds**, most commonly inguinal folds and under breasts, sometimes in axillae
- Secondary to a combination of **heat, moisture, bacteria, fungus/yeast**
- Mild cases respond to topical anti-fungals/yeast, more severe cases require topical anti-inflammatory and barrier cream (diaper paste) as well and/or oral antifungal

Intertrigo

- I generally start with **ketoconazole 2% cream** BID x 2-3 weeks to active rash, if resolves but recurs try use BIW even when clear
 - If interested in clearing faster/providing more immediate relief, you can also have pt use **hydrocortisone 2.5% cream or ointment 1-2 times daily for 1 week BUT must be careful about overuse** bc of side effects and that overuse of topical steroids may exacerbate some of the drivers of intertrigo long-term

Intertrigo

- If recalcitrant, I have patients start using **zinc oxide barrier/diaper paste** (I like Triple Paste or Extra Strength Desitin) daily, always applying over any prescription topicals
- Sometimes short courses of **oral fluconazole** are necessary for quicker relief, but topicals will still be maintenance regimen
 - If **satellite papules**, likely strong **yeast** component and would go for fluconazole earlier

Candida intertrigo



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<https://dermnetnz.org/topics/skin-problems-associated-with-diabetes-mellitus>

Inverse psoriasis



Brodell RB, et al. Intertrigo. In: UpToDate, Connor RF (Ed), Wolters Kluwer. (Accessed May 7, 2024.)

Tinea cruris



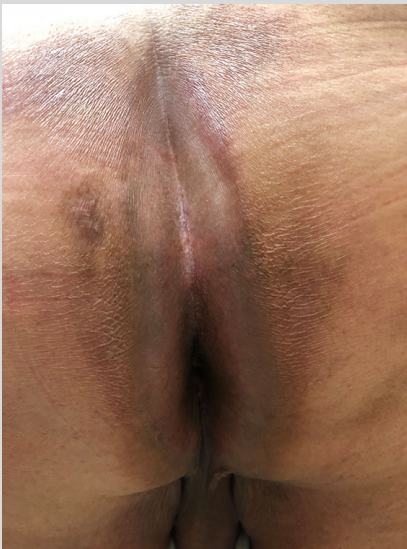
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Inverse psoriasis



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Intertrigo



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Lichen sclerosus



Lichen sclerosus

- **Females: labial, perineum, perianal** skin
- Clinical clues: **tearing** during intercourse, **fissures** (sometimes very shallow), **itching and/or pain** (but not always), **loss of architecture** later in disease course
- Also consider in pre-menopausal adult women
- **Males: typically involves tip/head of penis**
- **Requires high potency topical steroids** (usually **clobetasol 0.05% ointment**) usually daily during flares and twice weekly as ongoing maintenance
- Recommend **specialist referral** to confirm diagnosis (often with biopsy) and for ongoing monitoring given increased risk for dysplasia

Perianal extramammary Paget disease



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<https://dermnetnz.org/topics/extramammary-paget-disease>

Combination topicals

- **Clotriamzole/betamethasone**: dermatologists mostly steer clear of combination topical anti-fungal/yeast and steroids bc of the risk for **tinea incognita**
 - Topical steroid helps with visible inflammation in the short term, but actually promotes the growth of fungus/yeast (if they're present) such that the rash continues to recur and the fungus/yeast are actually driven deeper in the skin and are harder to treat, eventually requiring oral meds

Topical anti-inflammatories

- Topical steroids
 - **Face, groin, folds of skin: low strength**
 - Hydrocortisone 2.5% cream/ointment
 - Desonide 0.05% cream/ointment
 - **Torso and extremities: medium strength**
 - Triamcinolone 0.1% cream/ointment
 - **Hands, feet, scalp: high strength**
 - Clobetasol 0.05% cream/ointment/solution (scalp)

Topical anti-inflammatories

- General rules for topical steroids
 - **Ointments stronger than creams** but also **more greasy**
 - **Creams can be more irritating than ointments** bc they contain alcohol
 - Can use BID prn, if using BID daily need to start thinking about taking breaks, I advise BID Mon-Fri and breaks on weekends OR BID x 2 weeks and then 1 week break before restarting

Topical anti-inflammatories

- Topical non-steroidal anti-inflammatories
 - Can be nice because you don't have to worry about topical steroid side effects of thinning/atrophy with consistent use
 - Burning sensation may limit use in some
 - Generally not used diffusely, often considered for face, folds, neck
 - **Tacrolimus 0.1% ointment:** BID prn to affected skin
 - Can be used on face, groin, and folds, but may be more likely to burn in these locations
 - 0.03% ointment is strength approved for kids, may be helpful for pts who cannot tolerate 0.1% secondary to burning
 - **Pimecrolimus 0.1% cream:** BID prn to affected skin

Topicals for itchy, dry skin

- **Thick, bland** emollient **without scent** in **tub or jar**
- Vaseline/petroleum jelly
- Cetaphil
- CeraVe
- Vanicream
- Sarna anti-itch cream/lotion (camphor-menthol 0.5%/0.5%)
- Aquaphor: contains lanolin which is an allergen for some

Scabies



Source:DermNet - CC BY-NC-ND 3.0 NZ

<https://dermnetnz.org/topics/tinea-pedis-images>

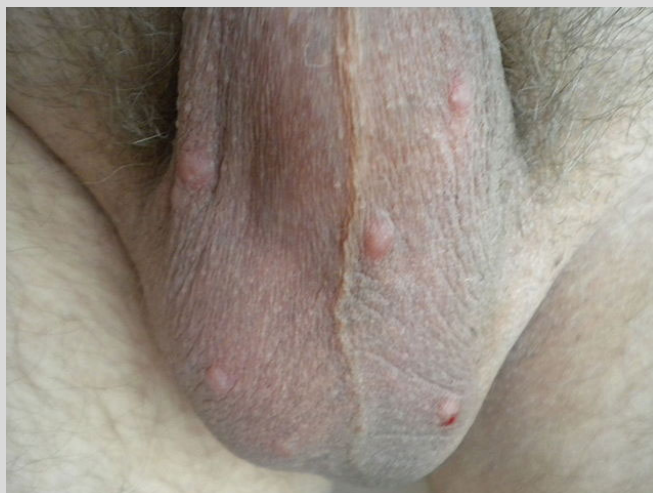


Author: [Gzzz](#) - CC BY-SA 4.0



Author: [Fhgd](#) - CC BY-SA 3.0

Scabies



Author: [Dogad75](#)

Scabies



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<https://dermnetnz.org/topics/tinea-pedis-images>

Scabies

- **Permethrin 5% cream:** apply from neck down once, rinse off 6-8 hours later, repeat this 7 days later
- **Alternative: oral ivermectin 200 mcg/kg** as single dose followed by a repeat dose in 1-2 weeks
 - 0.2 x weight in kg
 - Only comes in 3 mg pills
- Wash sheets in hot water
- Close contacts should be treated as well

Herpes simplex virus (HSV)

- Classic presentations: orofacial or genital

https://commons.wikimedia.org/wiki/File:Herpes_labialis_-_opryszczka_wargowa.jpg



https://commons.wikimedia.org/wiki/File:Genital_herpes_female.jpg



Author: - CC
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Varicella zoster virus (VZV)

- Classic presentations: varicella (chicken pox) or zoster (shingles)



Source: DermNet - CC BY-NC-ND 3.0 NZ

<https://dermnetnz.org/topics/tinea-pedis-images>

HSV and VZV: 'dew drops on a rose petal'



Author: [Arenavittorio](#) - CC BY-SA 4.0

HSV and VZV: scalloped borders



Source: DermNet - CC BY-NC-ND 3.0 NZ

<https://dermnetnz.org/topics/tinea-pedis-images>

HSV and VZV

- Diagnosis
 - PCR swab the base of lesion (de-roof if base is not exposed)
 - Send for HSV 1/2 PCR and VZV PCR (2 separate orders)

HSV and VZV

- Treatment
 - **Best if initiated within 72 hours of onset**, but likely still some benefit thereafter (definitely if still getting new lesions)
 - Recommend looking up because regimen depends on HSV or VZV, local or generalized, primary or recurrent, and whether patient is immunocompromised
 - I prefer valacyclovir over acyclovir because less frequent dosing and better absorbed