Dermatology in the AMU........
VERSION FOR THE WEBSITE

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Case 1: The Red man
Erythroderma

- Erythroderma: any skin disease involving >80% BSA.
- Can be the 1st presentation of a skin disorder or uncontrolled activity of a pre-existing dermatosis.
Causes of Erythroderma

• Adverse Drug reaction
• Acute flare of an Inflammatory skin disorder: Psoriasis, Eczema, PRP.
• Sezary Syndrome (T Cell Lymphoma of skin)
• Para neoplastic phenomena: haematological & internal malignancies
• GvH disease
John: 50 yr old man

- Presented via A&E to clinic
- Acute onset of a rash
- No previous skin problems.
- No FHx
- PMHx: Very well
- No medications
Management of Erythroderma

• Dermatology opinion.
• Supportive therapy. Monitor vital signs, fluid balance. Most need admission.
• Relevant Investigations
• Discontinue all unnecessary medications
• Optimise skin care: emollients, topical steroids, Dressings.
• Antibiotics & Anti histamines if appropriate
• Systemic therapy: will be directed by the underlying diagnosis eg use of MTX for Psoriasis
John: Pityriasis Rubra Pilaris

- Bloods & skin biopsy
- Intensive topical therapy
- Pt refused admission
- Weekly review at Dermatology clinic
- Oral Retinoids
- Oral MTX
Case 2: Red Legs
Unilateral vs Bilateral
Cellulitis: Unilateral red leg

- Patient c/o Pain, swelling, malaise, fever.
- Examination: Erythema, oedema, warm to touch, can blister.
- Check the toes: ? tinea
- Don’t forget Necrotizing Fasciitis!!!!

- RFs: Lymphoedema, Diabetes, Immune suppression, ↑BMI
Cellulitis: Management

• Rest
• Elevate leg
• IVAB
• Treat any associated skin condition

• **Recurrent:** Prophylactic AB eg penicillin V or macrolides.

• Many also have other skin problems
Necrotizing Fasciitis
“Why is this cellulitis not improving???”

It is not cellulitis!!

VENOUS ECZEMA
Venous Eczema

- Increased venous pressure, leakage of fibrin to soft tissues, tissue damage & hypoxia
- Inflammation in soft tissues:
  - **Acute:** Erythema, oedema, **blisters**, scaling
  - **Chronic:** Induration, haemosiderin deposition, fibrosis, ulceration.

- **Aetiology:** Immobility, acute illness, Cardiac failure, ↑ age.
Management of Venous Eczema

- Antiseptic soaks: eg KMn04
- Topical steroids
- Elevation
- COMPRESSION: check ABPIs: bandage vs hosiery
- Don’t forget contact allergy & fungal infection.
Case 3: Complications of the Herpes Virus
High risk groups

• Immune compromised: HIV, Chemo, Transplant, immune suppressive therapy
• Atopic eczema
Erythema Multiforme

• Distinct reactive eruption which occurs most commonly in response to HSV infection. Mycoplasma & Strep can trigger a similar reaction
• Appears ~ 7 days after HSV 1 or 2 viral infection.
• Cutaneous involvement: Target like eruption.
• Mucosal involvement: erosive cheilitis & haemorrhagic crusting.
Erythema Multiforme

Management:
• Supportive
• Eye & Mouth care
• ? Systemic steroids
• If recurrent: Proph anti viral therapy
Case 4: An unusual Ulcer
Amanda: 23 yr old girl

- 1 month Hx of tender lesions on shins
- Then an ulcer appeared: admitted to hospital.
- PMHx: Recent intermittent PR bleeding & ↑ frequency of bowel motions.
- Bloods ESR 78 & CRP 40
- Receiving IVAB in the ward: no improvement
2° Group G Strep infection:
But ulcer not responding to AB.....
Erythema Nodosum & Pyoderma Gangrenosum

- Seen by Gastro & awaiting colonoscopy
Pyoderma Gangrenosum

Pyoderma gangrenosum presents as a rapidly enlarging, very painful ulcer. It is one of a group of auto-inflammatory disorders known as the neutrophilic dermatoses.
Pyoderma Gangrenosum

- 1908 Louis Brocq, Paris
- “Pyoderma”.....purulent
- “Gangrenosum”......necrotic & rapidly extensive
Pyoderma Gangrenosum

50% of PG cases are associated with underlying systemic disease:
- Inflammatory bowel disease
- Rheumatoid or sero -ve arthritis
- Haematological malignancy
Acute Febrile Neutrophilic Dermatosis
“Sweets Syndrome”

- Erythematous to violaceous tender papules, pustules & nodules
- High fever, neutrophilia, raised ESR
- Classically upper body
- Koebner response
- Generally heal without scarring
- Ocular manifestations common

Responds very well to oral steroids
Case 5: 
My skin is peeling .........
40 yr old Lady. Started Omeprazole for dyspepsia 3 days ago....
12 hours later.......
Toxic Epidermal Necrolysis

The most severe drug eruption:
Characterised by blistering & epidermal sloughing.
High risk groups for Drug Rashes

- ICU/HDU
- Haematology / Oncology patients
- Neurology: anti epileptics
- Renal
- Liver patients & new drug for Hep C: Boceprevir
- HIV patients
Nikolsky sign:

- Gentle pressure extends blisters
- The epidermis is easily detached from the underlying dermis by lateral pressure
- **Great care needed when handling patients**
Causes of SJS/TEN:

- Sulphonamides
- Septrin
- Trimethoprim
- NSAIDs
- Anti-convulsants
- Allopurinolol

15% cases: no drug culprit
SCORTEN

• Predicts prognosis
  – Age > 40
  – Presence of malignancy
  – Epidermal detachment > 30%
  – Heart Rate > 120
  – Bicarbonate < 20mmol/l
  – Urea > 10 mmol/l
  – Glucose > 14 mmol/L

Predicted Mortality
• 0-1 3%
• 2 12%
• 3 35%
• 4 58%
• 5 or more 90%
Management of SJS/TEN:

• Stop the implicated drug
• **SUPPORTIVE CARE**
• Admit to HDU, ICU or Burns unit
• Analgesia
• Good IV access
• Nutrition: NG. Avoid TPN
• Fluid balance: don’t overload
• Air mattress
• Do not debride skin: SWP & N/A dressings
• Prevent infection
• Ophthalmology opinion
• Mouth care
• DVT prophlaxis
• Role of Steroids: avoid
• Role of IVIG: debated
• Role of Ciclosporin: ??
Long term sequelae

- Ocular
- Psychological
- PTSD disorder
Case 6: The guilty brown spot
62 yr old man

- Previously very well
- Admitted to Stroke Unit
- Acute R sided weakness & loss of speech
- CT Brain: multiple lesions suggestive of haemorrhagic metastases.
- Further imaging: Pulmonary Metastatic disease.
- Skin Exam.......large brown lesion on the back.
Metastatic Malignant Melanoma
Dermatology Red Flag lesions

We will endeavour to see within 2 weeks of referral

Suspected MM & SCC
The Farmer’s Tan!

Questions......