Common problems are common in Dermatology

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How common is skin disease?

- Everyone will have skin disease at some point in life
- 10% UK population consult their GP each year
- Occupies 10% of GP’s time (inner cities can rise to 22%)
- 10% UK workforce self-report occupation skin disease, mostly contact dermatitis
How common is skin disease?

**Melanoma** – 3.9% cancer cases, 1.4% cancer deaths

Since 70s incidence rates have increased more rapidly than any of the current 10 most common cancers.

1 in 50 chance of getting melanoma

**Non melanoma skin cancer** – >100,000 new cases per yr

Increase by 1/3 last 10 yrs

Commonest cancer in UK
How common is skin disease in hospital?

- 31,615 in-patient episodes 2009-2010
- Figure static for ~ 10 yrs
- 40% reduction dermatology beds
- Dermatology on-call under threat

= more dermatology patients medical beds
= Physicians need to know more dermatology
Aims

• Improve your diagnostic skills = picture

• Spot important rashes – not always the common ones

• Initial basic management
Top 5 - Medicine

Drug rashes

Infections

Urticaria

Angioedema

Vasculitis

Erythrodermic patients
Infections
Always start acyclovir
Eczema herpeticum

- Disseminated HSV
- Urgent dermatology review
- If child will usually need admission
- If adult, limited, systemically well, treat as out patient
- Acyclovir +/- flucloxacillin
- Stop topical steroids
‘Bilateral cellulitis’

- normal WCC, CRP, temp
- Not responding to antibiotics
- Bilateral cellulitis - very rare

- Usually
  - stasis dermatitis
  - early lipodermatosclerosis
  - inflammatory oedema
Inflammatory Oedema

- Bland emollient (anti-septic)
- Topical steroid – moderately potent
- Vascular assessment – ABPIs
- Compression stocking
- Treat underlying medical issues
Cellulitis

• Always treat underlying skin problems:
  tinea pedis (athletes foot)
  stasis dermatitis
  psoriasis
  oedema/lymphoedema

• Erythema and pigment changes remain after
  infection settled

• Treat residual swelling with compression
  stockings
Vasculitis: systemic?

- **General symptoms** – myalgia, fever, fatigue
- **GIT** – abdo pain, nausea, bleeding, constipation
- **Renal** – proteinuria, haematuria
- **Joints** – non erosive polyarthritis
- **Cardiac** – effusions, pain
- **Respiratory** – pleurisy, effusions
Causes of cutaneous vasculitis

- Medication
- Infection
- Underlying disease e.g. CTD, IBD, CAH
- 50% idiopathic
Treatment for cutaneous vasculitis

• Manage cause e.g. medication, infection

• If not blistering or necrotic give a potent topical steroid e.g. betnovate

• If blistering start oral prednisolone e.g. 30-40mg od

• Steroid sparing agent - dapsone
Urticaria & angioedema
Weals last < 24 hrs

20% population
Classification

- **Acute** – hrs, days, few weeks

- **Episodic** – intermittent attacks, few days to weeks

- **Chronic** – persist for months to years
Acute urticaria

• Sometimes allergic:
  Drugs - most often antibiotics (0.2% in-patient)
  Food - fish, eggs, nuts, fruits
  Stings - Bee or wasp
  contact with skin - rubber latex

• Anaphylaxis:
  antibiotics, bee stings, peanuts
Non-allergic acute urticaria

• Infections
  helicobacter, dental abscess, viral hepatitis, mycoplasma, EBV
• Serum sickness
  blood transfusions, viral infection, drugs
• Medication & contrast agents
• Non-allergic food reactions
  salicylates, azo dye, benzoates
Angioedema without urticaria

- **C1 esterase inhibitor deficiency**, usually FH, test complement

- **ACE inhibitors**, most within 6 wks, 1% within first week, 20% after 6 wks

- Most idiopathic
Urticaria & angioedema

- Chlorphenamine – quick but short acting
- **Always give non sedating long acting anti-histamine not just oral steroids**
- Cetirizine quickest acting
- Desloratidine longest lasting
- Guidelines – 4 x standard dose
- Patch testing useless
- Prick testing or RAST testing
Erythroderma

- 90% skin red, often scaly
- Common pre-existing rashes – eczema, psoriasis, pityriasis rubra pilaris, blistering rashes, cutaneous T lymphoma
- Systemic disease – cancer of rectum, lung, colon, fallopian tubes; lymphoma & leukaemia; graft vs host, medication, HIV.
Initial treatment

- Supportive medical care
- Emollients
- Antihistamine – itch
- Antibiotic – infection
- Topical steroid – moderately potent
- Dermatology review
Drug rashes

- Common
- Rashes account 24% adverse drug reactions
- Many drugs cause same eruption
- Difficult to identify offending drug
- In-patients – \( \frac{1}{3} \) exanthematous, \( \frac{1}{3} \) fixed drug rashes, \( \frac{1}{5} \) urticaria
DRESS

- Drug reaction with eosinophilia and systemic symptoms
- Drug hypersensitivity syndrome
- Onset 2 – 8 wks
- Fever first then rash, 80% morbilliform
- Facial swelling (30%)
- Mucosal involvement (25%)
- Rash severity does not correlate with extent of internal organ involvement
DRESS

- Lymphadenopathy – 75%
- Haematological disorders, eosinophilia
- Hepatitis, abn LFTs 80%
- Myocarditis, pericarditis
- Pneumonitis, pleuritis, ARDS
- Meningitis, encephalitis
- Gastroenteritis, colitis, pancreatitis
- Thyroiditis, diabetes (long term sequelae)
DRESS

- Delayed T cell-mediated reaction
- Co-infection with HHV 6
- Genetic predisposition
- First degree relatives should be alerted to the risks of the suspect drug and avoid.
- Cross-reaction with phenytoin, lamotrigine, carbamazepine, phenobarbitone
Drugs

- Allopurinol
- Anti-epileptics
- Sulphonamides
- Vancomycin
- Atenolol
- Captopril
- Diltiazem
- Isoniazid
- Azathioprine
- Gold salts
- Minocycline
- Oxicam
- Abacavir
- Clomipramine
- Dapsone
Treatment

• Stop drug(s)
• Supportive medical care.
• Emollients & topical steroids
• Oral prednisolone – 40-60 mg
• Slow reduction of steroids

• Mortality – 8%
Toxic epidermal necrolysis (the scalded skin syndrome): A reappraisal

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My part in this affair was simply to recognize a clinical picture and give it the respectability of a name; and later to interest my microbiologist colleague, John Arbuthnott, in the staphylococci that were concerned in some patients. As I had anticipated it was not a new 'disease'. Immediately before me were Lang & Walker (1936), and we had many predecessors (see Solermaan, 1969; Lany, 1969; Hutje et al., 1972), including Professor Gottfried Ritter von Rittershain. My original paper (Lyell, 1955) described four cases of an eruption resembling scalding. This sign remains the unifying clinical...
SJS/TEN

- Severe drug rash
- Incidence 2 cases per million
- More common elderly

Mortality:

\[
\begin{align*}
\text{SJS} & \quad \text{overlap} & \quad \text{TEN} \\
<10\% & \quad & >30\%
\end{align*}
\]

Mortality: 10\% \quad 30\%
SJS/TEN

- Within 2 months starting drug
- Abrupt on set fever, systemic toxicity, rash
- Morbilliform rash – targetoid lesions – blisters
- Nikolsky’s sign present – shearing of skin on pressure
- Mucosal involvement – eyes, mouth, genitals
<table>
<thead>
<tr>
<th>Frequent</th>
<th>Less frequent</th>
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<tbody>
<tr>
<td>Allopurinol</td>
<td>Cephalosporin</td>
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<tr>
<td>Amoxicillin</td>
<td>NSAIDs</td>
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<tr>
<td>Septrin</td>
<td>Ethambutol</td>
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<td>Lamotrigine</td>
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<td>Carbamazepine</td>
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<td>Ciprofloxacin</td>
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<td>Piroxicam</td>
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<td>Tetracyclines</td>
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<tr>
<td>Sulfasalazine</td>
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<td>Trimethoprim</td>
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SJS/TEN- treatment

- Prompt diagnosis
- Early withdrawal of drug
- Good supportive care
- Specialised nursing care
- Dermatology and ophthalmology ASAP
- At present no specific treatment
- Lifelong avoidance of drug
EM is not SJS
EM does not progress to TEN
Summary

• lots of picture – recognise a few more conditions

• Won’t miss less common but important rashes – **DRESS, TEN/SJS**

• Emollient and potent topical steroid – cant go wrong

• Supportive medical care very important
The New Southern General Hospital

Aerial View from North