Cases That Teach You Something

Matthew J Zirwas, MD
Director, Ohio Contact Dermatitis Center
Case 1

68 y/o male who has been referred to you to see if there are options for topical therapies that might augment the effectiveness of the systemic antibiotics prior to amputating additional digits to eradicate resistant infection.
What does it teach you?

Dx: Pustular Psoriasis

- Not all pus is infectious
- Other specialties know nothing about derm
- Surgeons like to cut
Case 2

A 27 y/o female is comes to see you with recurrent squamous cell carcinoma of the nose. It was initially biopsied and then excised by ENT. Excision was done in the OR with frozen section margins.

Initially healed well, then began to ulcerate again.
Case 2

Was just released from hospital after her second admission for infection. Completed two weeks of IV vancomycin with minimal improvement, at best.
What does it teach you?

- **Dx: Trigeminal Trophic Syndrome**

  - Other specialties know nothing about dermatology

  - When an ulcer doesn’t make sense and there isn’t much inflammation, think self-induced
Case 3

- A previously healthy 38 y/o female physician who has been your patient x 4 years for botox and fillers contacts the office for an urgent appointment.

- She has been experiencing recurrent flushing, along with diarrhea, palpitations, headaches, and sweats.
Case 3

- The episodes have occurred 4x over the last 10 days.

- She doesn’t have the eruption when you see her in the office that day, but she has taken a picture with her iPhone.
What does it teach you?

- Dx: Scromboid Fish Poisoning
  - History does help sometimes
  - Identifiable causes of flushing are pretty rare
Case 4

- 50ish female who is an existing patient comes to office for emergency visit

- 4 day onset of tense, non-pruritic blisters on arms
Case 4

- On extensive history, patient spent the day before onset gardening, working on her hostas, and wonders if this could be allergy to hostas?
On further questioning, the hostas were covered with small black beetles that she had never seen before.

Could these be the cause?
Case 4

Black Blister Beetle
Epicauta pennsylvanica
What does it teach you?

- **Dx: Blister beetle exposure**
  - Weird bugs live everywhere
  - People can also have weird reactions to common bugs
  - Google and Wikipedia are your friends
Asian Lady Beetle
Case 5

- 56 y/o male who has been seeing another dermatologist in town for years

- Has been getting a pretty bad rash on the trunk that has been resistant to topical steroids but responds to systemics
What does it teach you?

- Dx: Allergic contact dermatitis to propylene glycol in Vanicream, Cetaphil, and topical steroids
  - Propylene glycol allergy is not rare
  - Know at least one moisturizer and several steroids that are propylene glycol free
    - CeraVe
    - TAC and desonide ointment, Clobetasol solution
Case 6

- 24 y/o female presents for treatment of keloid
- Present x 8 months, no symptoms, doesn’t recall anything that triggered it
What does it teach you?

- Dx: DFSP
  - If something doesn’t fit, do a biopsy
Case 7

- Referring primary care office calls and asks you to see a patient urgently

- 48 y/o male with progressively worsening rash x 2 weeks, feels unwell

- Been in urgent care x 2, PCP x 3 – now considering admitting
What does it teach you?

- **Dx**: DRESS Syndrome from allopurinol started about 6 weeks before rash started
  - LFTs about 4x normal, eos about 18%
  - Treated with prednisone x about a month with good resolution
  - Most drug rashes are NOT eczematous
Case 8

- 64 y/o female with longstanding history of rheumatoid arthritis

- Presents with large, tense blisters on the toes x months

- Not painful or pruritic
What does it teach you?

- Dx: Pseudoporphyria from Leflunomide used to treat RA
  - Most drug rashes are NOT eczematous
Case 9

- 73 y/o woman presents with dermatitis of face, neck, chest, forearms x 8 months

- Using Dove Unscented Sensitive Skin Bar, CeraVe, and TAC ointment

- Not getting any relief
What does it teach you?

- Dx: ACD to lavender oil in diffuser

- Use of essential oils is REALLY common

- If you don’t ask the to think to tell
One of your patients asks you to see their 12 y/o daughter for a ‘rash’ on her legs

- Does not itch

- Been using triamcinolone cream on it daily x about a year
  - Reports being told to use it as a moisturizer
What does it teach you?

- Dx: Striae from steroid overuse
  - Kids are more susceptible to striae
  - You have to REALLY misuse steroids to get striae
  - Steroid induced striae are at least partially reversible
Case 11

- 69 y/o male sent to you by another dermatologist with severe, recalcitrant rash x 8 months

- Has inflammatory bowel disease, being treated with Cimzia
What does it teach you?

- **Dx:** Pustular psoriasis-like eruption due to TNF-alpha inhibitors
  - Most drug rashes are NOT eczematous
  - TNF-alpha inhibitors cause a pustular psoriasis like eruption fairly commonly when used for IBD but never when used for psoriasis
  - IL-12 and IL-23 inhibitors work great for both psoriasis and IBD
Amicrobial Pustulosis of the Folds due to Cimzia
Case 12

- 41 y/o female with extremely pruritic eruption of the soles x 2 years
- No rash anywhere else
- Aggressive tinea treatment was no help
What does it teach you?

Dx: ACD to unknown allergen in soles of shoes
- Worth empirically treating all severe eruptions of the soles for tinea
- If arch not involved, think allergy to insoles
- Patch testing with shave biopsies of the soles can be really helpful
Case 13

- 23 y/o male presents for evaluation of lesions on penis

- Mainly asymptomatic, but may have some stinging or burning with intercourse
What does it teach you?

**Dx: Pearly penile papules**

- Most bumps on the penis are normal findings
  - Pearly penile papules
  - Prominent sweat or sebaceous glands
- Men are very concerned about if their penis appears normal
- Aggressively reassure that the findings are not due to an infection
Case 14

- 38 y/o male presents with violaceous, flat topped, highly pruritic papules on extensor aspects of arms and legs.

- You diagnose lichen planus and initiate sulfasalazine

- He calls about 2 weeks later with complaints of new onset blisters
What does it teach you?

- **Dx: Drug induced pemphigoid from sulfasalazine**
  - Most drug eruptions are eczematous
  - It is fortunate that sulfasalazine is not used much
Case 15

- 3 y/o boy with progressively worsening atopic dermatitis is referred to you
- Was initially well controlled with topical steroids, but are no longer working
- Recent biopsy confirmed atopic dermatitis
What does it teach you?

- **Dx: ACD to frankincense being used by mom to treat atopic dermatitis**
  - Essential oils are really common and you should be asking about them specifically
  - The band-aid sign should make you highly suspicious of contact dermatitis
Case 16

- 61 y/o male presents with “rash” x 4 months
- Quite pruritic, has not responded to topicals prescribed by his primary care doctor
- Path is non-specific mix of spongiotic with some interface
What does it teach you?

Dx: Symmetrical Drug Related Intertriginous and Flexural Exanthem

- Most drug eruptions are NOT eczematous
- Path is generally not very helpful with rashes
  - Can somewhat rule things out and can occasionally give a specific diagnosis
Case 17

- 35 y/o female referred to you by rheumatology for recommendation on therapy for her lupus
- Has not had significant systemic issues – primary problem is her skin
What does it teach you?

- Dx: CREST Syndrome
  - Other specialists know almost nothing about skin
  - Sending people to rheumatology when you suspect a rash is a manifestation of a rheumatoid disease is usually not a great strategy
Case 18

- 53 y/o male presents for follow-up for psoriasis of the nails

- Topicals haven’t been helping and at last visit your colleague suggested a biologic might be the next step
What does it teach you?

- **Dx: Alopecia Areata affecting the nails**
  - Alopecia areata can affect the nails and the pitting is different than the pitting in psoriasis
  - If they have nail issues, at least take a second to look at their hair and scalp – the two are related
Case 19

- 53 y/o female presents for suspected allergy to elastic in her bras

- It is present while wearing bras during the day, but is worst at night after taking them off

- Victoria secret bras seem to be the worst
What does it teach you?

- **Dx: Dermographism**
  - If allergy to underwear, bra, socks are suspected, it is usually dermatographism.
  - Often is worst right after taking the item off.
  - The tighter it is, the worse it is.
Case 20

- 24 y/o female presents for progressive facial vitiligo
- Has been recalcitrant to topical steroids and tacrolimus
What does it teach you?

- **Dx:** Hypopigmenting seborrheic dermatitis
  - Vitiligo that has been present for a while will always be DEPIGMENTED – not hypopigmented
  - Hypopigmenting seb derm is not rare and topical steroids will not help it is not post-inflammatory hypopig, it is due to azelaic acid released from
Thank You!
Bonus Slides
Chronic Telogen Effluvium

- Oral minoxidil reduces shedding by 50% at 12 months
  - Seems to help with “trichodynia” as well
- 0.25 mg/day
  - 1 teaspoon of 2% minoxidil solution into 2 measuring cups of water
  - Take ¼ teaspoon daily
Female Pattern Alopecia

- Same minoxidil regimen as above
- Drop of about 1 point in blood pressure
- Facial hypertrichosis really uncommon
Brittle, Slow Growing Nails

- Minoxidil topically works a little bit

- I do:
  - Oral minoxidil as above
  - L histidine as described previously
    - Filaggrin increase may increase quality of nails by aggregating keratin more effectively
Frontal Fibrosing Alopecia

- Benzophenones in products for color treated hair may be a major cause
- Have patients avoid them!
Chlorine Dioxide

- Most effective anti-septic known
  - i.e. better than bleach, chlorhexidine, hydrogen peroxide, benzoyl peroxide, etc
  - Effective against biofilms, MRSA, Pseudomonas

- Zero irritation
  - Equivalent to normal saline when applied to wounded skin
Chlorine Dioxide

- **Direct, potent keratolytic** – studied in the 1950s
  - Breaks disulfide bonds holding keratin together
    - Things we call “keratolytics” have no keratolytic activity, they just support normal desquamation

- **Anti-inflammatory**
  - Denatures extracellular inflammatory cytokines
Chlorine Dioxide

- **HOW?**
  - Rapidly oxidizes specific amino acids
    - Especially rapidly reacts with cysteine and disulfide bonds
  - Unlike other disinfectants, does not oxidize other organics molecules
    - Lipids in cell membranes, carbohydrates, etc
  - Is inactivated by glutathione as soon as it enters human cells
Chlorine Dioxide for Acne

Baseline
Twice daily wash, once daily spot treatment

Three weeks

Twice daily wash, once daily spot treatment
Chlorine Dioxide for Keratosis Pilaris

Once daily wash x 2 weeks
“Rosacea”

- Some (maybe most) cases of rosacea are driven primarily by *demodex*

- **Clues:**
  - Tiny pustules
  - Itching
  - Relatively poor response to standard therapy
Demodex Therapy

- Ivermectin 1 mg / 10 lbs x 1, repeat in a week
- Metronidazole 250 mg po tid x 14 days, first dose at same time as first dose of ivermectin
- Maintenance topical therapy with metronidazole and ivermectin for
Sebacceous Hyperplasia
Sebacceous Hyperplasia

- Curable.
- Permanently.
- Isotretinoin 40 mg po qd x 2 months
- I don’t check any labs
  - Baseline triglyceride if they haven’t EVER had it checked before
Delusions of Parasitosis

- The organism, if it exists:
  - Lives under the skin, so nothing topical works
  - Doesn’t respond to ivermectin, albendazole, abx

- Most pesticides work by paralyzing the organism

- Pimozide is used to reduce movement

- Pimozide is acting as a pesticide
Self-Injurious Behavior

*N*-Acetylcysteine for Nonsuicidal Self-Injurious Behavior in Adolescents: An Open-Label Pilot Study

<table>
<thead>
<tr>
<th>NSSI type</th>
<th>Frequency (N=35)</th>
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<tbody>
<tr>
<td>Cutting</td>
<td>35 (100)</td>
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<tr>
<td>Scratching</td>
<td>18 (51)</td>
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<tr>
<td>Interfering with wound healing</td>
<td>18 (51)</td>
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<tr>
<td>Burning</td>
<td>17 (49)</td>
</tr>
<tr>
<td>Banging head or hitting self</td>
<td>17 (49)</td>
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<tr>
<td>Carving</td>
<td>13 (37)</td>
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<tr>
<td>Sticking with needles</td>
<td>13 (37)</td>
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<tr>
<td>Biting</td>
<td>11 (31)</td>
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<tr>
<td>Pinching</td>
<td>8 (23)</td>
</tr>
<tr>
<td>Hair pulling</td>
<td>6 (17)</td>
</tr>
<tr>
<td>Rubbing skin</td>
<td>6 (17)</td>
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</tbody>
</table>
Self-Injurious Behavior

- Needed 1800 mg BID
  - Also studying in skin picking d/o and trichotil
- About $15/month on amazon
Flat Warts

- RDBPC study of topical vs oral isotretinoin
  - Oral dose = 0.5 mg/kg/d
Polypodium Leucotomomas Extract

- Doesn’t work for melasma
- Works for PMLE
  - 3, 4, or 5 pills per day based on bodyweight
- Prevents sunburn
  - SPF of between 3 and 7 with dose of 1080 mg
    - 240 mg q8h x 3 on day prior, then 360 mg 1 hr before irradiation


Polypodium Leucotomomas Extract

How I use it

- I use it personally and for my family when we go to the beach in the winter
- 20 mg/kg (about 1 pill per 25 lbs) about 30 minutes before sun exposure starts
  - 8 pills for me
  - If in a rush, dump the capsules into water and drink as a tea
- Has to be quality P. Leucotomas Extract
  - Once got cheap generic polypodium leucotomas extract and we all got burned to a crisp
Polypodium Leucotomomas Extract

- Is this safe?
  - Tested up to 1200 mg/kg/day x 90 days in rats
    - 120,000 mg/kg/day in me
    - 500 pills per day
  - No toxicity at all at this dose

- Do I need to “reapply”?
  - Half-life of 4-6 hours, so no


Rutin and Vitamin C for Pigmented Purpuric Dermatosis

- 50 mg Rutin (or Rutoside) bid + 500 mg vitamin C bid

Almost unbelievable effective and fast
Rutin and Vitamin C for Pigmented Purpuric Dermatosis

Questions

– How fast does it work?
  ▪ 2 weeks to 2 months

– Do you need to continue it indefinitely?
  ▪ Reasonable to stop, but about half relapse

– How well does it work in solar purpura?
  ▪ It works, but I don’t know how reliably