



SPA PCP Treatment & Referral Guideline
Dermatology

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I. Seborrheic Dermatitis (690.10)

- A) Scalp/face/chest: Nizoril or Tar or DHS Zinc or Selenium Sulfide shampoos 2-3 x's/week (all over-the-counter). Sal Acid containing shampoos may aid in reducing scale (ex: T-Sal shampoo by Neutrogena or DHS).
 - a) Add synalar or lidex solution to affected regions of scalp b.i.d. for pruritus.
- B) Face/Trunk: Topical immunomodulatory or steroid cream to affected regions b.i.d., p.r.n. only. Addition of topical or oral antibiotics is appropriate for secondary folliculitis or impetiginization. Expect improvement in 1-2 weeks. If unresponsive → refer to Dermatology.

II. Atopic Dermatitis/Eczema (691.8)

- A) Remove environmental irritants. Use gentle cleansers (Cetaphil, Dove, Aveeno, Aquanil). Aveeno oatmeal products in bath water may provide added relief.
- B) Daily bathing is acceptable. Limit duration to 3-5 min in tepid water → pat skin dry → immediately proceed with medication and emolliation as described below within 3 minutes to prevent evaporation of moisture in skin.
- C) Prescription therapy: Topical immunomodulatory or steroid cream/ointment (specific for body region). Medication should be applied b.i.d. to affected areas only. Emollients: For successful skin hydration, Ointments > Creams > Lotions. Apply liberally and repeat several times a day if needed.
- D) Antihistamines: children with active atopic dermatitis may actually benefit from being somewhat sedated. Benadryl and Atarax can be used simultaneously (they have somewhat different mechanisms of activity) and may be more effective if used that way. Claritin may be tried for the older child. Antihistamines should be included on a regular basis. Addition of oral antibiotics is appropriate for secondary impetiginization (dicloxacillin, cephalexin, erythromycin). Expect improvement in 1-2 weeks. If persistent or progressive → refer to Dermatology.
- E) Systemic steroids can effectively resolve severe flares of eczema (>50% TBSA; 3-week slow prednisone taper); however, consider systemic risks of repeated treatments. Patients with severe disease may benefit from systemic immunosuppressive therapy (cyclosporin, cellcept, imuran). Refer to Dermatology for evaluation and treatment.

III. Contact or Nummular Dermatitis

- A) Remove offending agent if known.
- B) Topical immunomodulatory or steroid cream/ointment to affected areas b.i.d.
 - a) Promote regular skin care and protection (cotton gloves; emolliation to entire skin b.i.d.)
 - b) Avoid irritants or common cutaneous allergens (avoid Vitamin E oil, fragrances).

- c) Addition of oral antibiotics is appropriate for secondary impetiginization or infection.
- d) Expect improvement in 1-2 weeks. If persistent or progressive → refer to Dermatology.

IV. Asteototic Dermatitis (706.8)

- A) TAC 0.1% or Lidex ointment bid p.r.n. inflammation (redness, pruritus)
 - a) Scale will result from preceding inflammation. This can be helped with simple emolliation (keratolytic agents).
 - b) Antihistamine therapy for pruritus. Addition of oral antibiotics is appropriate for secondary impetiginization.
 - c) Avoidance of chemicals, detergents, excess use of soaps, fragrances, or other aggravating agents.
 - d) Use of rubber gloves with cotton liners with prolonged exposure to water, cleansers.
 - e) Emolliation on a frequent basis (ideally after water exposure)
 - f) Expect improvement in 1-2 weeks. If no improvement of with frequent recurrences → refer to Dermatology

V. Stasis Dermatitis (secondary to venous insufficiency) (459.81)

- A) TAC 0.1% or Lidex ointment b.i.d. for inflammation
 - a) Emolliation b.i.d.-t.i.d. to entire legs. Leg elevation while at rest; walking exercise as tolerated.
 - b) Educate patient to that discoloration will likely remain.
 - c) 15-20 mmHg support hose during waking hours on regular basis.
 - d) Expect improvement in 1-2 weeks. If no improvement of with frequent recurrences → refer to Dermatology

VI. Alopecia Areata (704.01)

- A) Apply a topical immunomodulatory or steroid cream/ointment q.d. -b.i.d. for 3-6 months → monitor for hair regrowth. Hair may be de-pigmented in early regrowth phase.
 - a) If resistant to therapy or extensive → refer to Dermatology.
 - b) Assess for associated conditions: thyroid disease, rheumatoid arthritis, pernicious anemia, vitiligo.
- B) Second treatment option: Intralesional kenalog (5 to 10 mg/ml concentration). Inject to subcutaneous level around periphery of patch. Repeat q. month times 3 months. If no evidence of hair re-growth by month 4, discontinue and refer patient to Dermatology.

VII. Vitiligo (709.01)

- A) Apply a topical immunomodulatory or steroid cream/ointment for 3-6 months → monitor for re-pigmentation (follicular or rim pattern).
- B) Avoid skin injury (koebnerization).
- C) Suggest controlled sun exposure (20 min sun exposure avoiding 10-4 pm hours).
 - a) Remind patients that the normal surrounding skin will tan more rapidly, producing an increase in the cosmetic contrast of skin coloration.

- D) Topical camouflage creams may be useful. Artificial skin tanners (vegetable dyes) can also minimize appearance of de-pigmentation (not considered sun protective however).
- E) Narrow-band UVB (ultraviolet B) or PUVA (ultraviolet A light therapy) may be indicated for extensive involvement.
 - a) Consider referral for treatment (risk: possible increase in future skin cancer development).
- F) Skin grafts and permanent (normal) skin bleaching treatments are usually not cosmetically optimal and require extensive discussion regarding expectations and risks.
 - a) For progressive disease → refer to Dermatology.
- G) Assess for associated conditions: thyroid disease, rheumatoid arthritis, pernicious anemia, alopecia areata.

VIII. Warts (078.10) / Molluscum Contagiosum (078.0)

- A) Liquid Nitrogen (cryotherapy) 15-20 second rapid freeze → let thaw, repeat.
 - a) Expect potential blistering or transudate
 - b) Reassess in 3 to 4 weeks for retreatment
 - c) Average # treatments: **5 to 9 treatments** every 3 weeks for average wart removal.
- B) Patient can use OTC Sal acid plasters (ex: mediplast) after inflammation subsides from cryotherapy (approx 1 week).
 - a) Avoid picking and trauma (koebnerization).
 - b) If NO signs of improvement after 3 visits, proceed below.
- C) Podophyllin (25%) or Cantharidine – Apply to individual lesions and allow to dry (while in office).
 - a) Avoid treating lesions on face and those close to mucosal surfaces. Have parent ‘wash off’ the medicine after 2 hours from application (have them record the exact duration of therapy).
 - b) Reassess at follow-up visit. If the patient experienced no irritation, then extend duration of medication contact slowly as tolerated to achieve mild irritation (recommend increase in 2 hour increments up to 8 hours).
 - c) Repeat treatments once a month.
 - d) If no improvement after 3 visits once irritation is achieved → refer to Dermatology.

IX. Non-symptomatic onychomycosis (110.1) (Unknown whether this qualifies for insurance coverage)

- A) OTC Lotrimin solution or Fungoid Tincture b.i.d. OR prescription Naftin gel b.i.d.
- B) Trim and file plates short and thin; keep cool and dry.
- C) If symptomatic → refer to Dermatology. Have patient discontinue all topical medications for 1-month prior to visit.

X. Scabies (Non-Norwegian) (133.0)

- A) Permethrin 5% (Elimite) cream to entire body neck down at night (include nails, genitalia, skin folds) → shower in a.m. Repeat in 1 week (one 60 gram tube adequate for both applications) Launder linens & clothes OR dry clean OR seal in a bag for 2 weeks. Treat family members and close contacts. Addition of antihistamine for pruritus.

XI. Lice (Head and Pubic) (132.9)

- A) Permethrin 1% (NIX) or Pyrethrin 1% (RID) – OTC: Apply to towel-dried hair x's 10 min; may repeat in 1 week.
- B) Comb nits off hair shaft in direction toward the scalp.
Alternative: Vaseline occlusion to all nits and base of scalp overnight → shampoo in a.m.

XII. Herpes Simplex (054.9) and Varicella Zoster (053.9)

- A) Recommend confirmation of condition with a viral culture.
- B) See Common Therapeutic Product Guideline for specific treatments and dosages.
- C) Consider IV Acyclovir therapy for diffuse eruptions (ex: eczema herpeticum) or eruptions in immunocompromised hosts.

XIII. Acne Vulgaris (705.1)

- A) Gentle cleansing only; avoid OTC scrubs, astringents, toners, and other acne products while introducing prescription medications.
- B) Avoid physical manipulation (i.e.: picking), which can promote scar formation.
- C) Consider birth control pills for mild acne if appropriate (Orthotricyclen is the only FDA approved formulation for mild to moderate acne vulgaris; other low-dose estrogen agents should help as well).
- D) Educate patients that therapy requires 6-8 weeks to initiate effect.
- E) Comedones only
- a) Choice 1: Begin a topical retinoid agent each evening.
- 1) Retin-A (tretinoin): 0.01% gel, 0.025% cream or gel, 0.05% cream, 0.1% cream.
- 2) Differin (adapalene): 0.1% cream or gel
- 3) Tazorac (tazarotene): 0.05% cream or gel, 0.1% cream or gel
- F) Non-retinoid comedolytic agent: Azelex (azelaic acid): cream
- a) Start with application 2 nights per week, and then gradually increase an additional evening application every two weeks as tolerated.
- b) If stinging occurs, wait 20 minutes after washing face.
- c) Avoid application close to eyelid margins, creases of nose, and around mouth.

- d) Initiate non-acne promoting facial sunscreen in a.m.
- e) Encourage patients to continue this regimen for a minimum of 4 to 6 months, as optimal results will require regular and continued usage for this period.
- f) Choice 2: Benzoyl peroxide 5% gel q. a.m. Warn patients that this can bleach clothing, towels.
 - 1) Reassess in 2 to 3 months. Can add the choice not selected above if little or no benefit is achieved

G) Comedones, limited red papules, few pustules:

- a) Begin a topical retinoid agent each evening (see above).
- b) Add a topical antibiotic agent in the morning (benzamycin gel, benzaclin lotion, cleocin T lotion, or 10% sulfacetamide lotion).
- c) Reassess in 2 to 3 months. If little or no benefit is achieved, proceed to C below

H) Comedones, many red papules, many pustules:

- a) Begin a topical retinoid agent each evening (see above).
- b) Add oral antibiotic treatment:
 - 1) Tetracycline (500 mg) b.i.d. (taken on empty stomach)
 - 2) Doxycycline (100 mg) b.i.d. (photosensitizing)
 - 3) Minocycline (50 to 100 mg) b.i.d. (risk of headache, dizziness)
 - 4) Erythromycin can be considered for patients intolerant to above (500 mg) b.i.d.
- c) Reassess in 2 to 3 months. Expect > 50% improvement. If this is observed, continue therapy until patient achieves complete clearance (of new lesions) for 4 to 6 weeks, then taper to one pill a day → remain clear for additional month, then stop.
- d) If < 50% improvement, proceed to next oral medication choice above.

I) Nodulocystic acne:

- a) Isotretinoin. Physicians must participate in iPledge program (www.ipledgeprogram.com) and be fully aware of pre-prescription and drug monitoring requirements.
- b) Can refer to dermatology

XIV. Acne Rosacea (695.3)

- A) Telangiectatic: If possible, avoid conditions that produce vasodilatation or increase in redness (alcohol, spicy foods, sun exposure, and caffeine). Patient may opt to pursue cosmetic intervention with laser/light treatments.
- B) Mild papular acne: Topical metrogel (oily skin), metrolotion (nl skin), metrocreme (dry skin) b.i.d.
- C) Significant papules: Initiate oral antibiotic therapy as outlined for Acne Vulgaris Consider the addition of a topical retinoid at night. Proceed with caution, as this may aggravate condition (consider Differin cream or Azelex).
- D) Cystic Acne: Initiate oral antibiotics as above for Acne Vulgaris

E) Assess for ocular symptoms (blepharitis, keratitis, conjunctivitis). Effective therapy is with oral antibiotics.

F) Try to avoid use of topical steroids, as this can eventually worsen Rosacea.

G) If resistant to therapy → refer to Dermatology

XV. Melanocytic Nevi (216.)

A) Normal # moles: 25 to 30 per individual

B) 'New' moles may appear through 4th decade of life

C) If a mole appears 'unique' (black sheep), changes (outline, color, texture, rapid growth), develops symptoms (bleeding, unprovoked itch) → Proceed with punch biopsy procedure or Refer to Dermatology. Try to avoid shave procedures that will increase risk of deep tumor transection.

XVI. Actinic Keratoses (702.0)/ Actinic Cheilitis (702.0)

A) Appear as scaly, telangiectatic, possibly pigmented or hyperkeratotic lesions on sun-exposed areas.

B) Precursors to squamous cell carcinoma.

C) Treatment: Cryotherapy 10 seconds → thaw → repeat.

D) Expect significant reduction or resolution in 4 to 6 weeks. May require repeat treatment.

E) Consider topical fluorouracil treatment (0.5% Carac, 1% fluoroplex, 5% effudex): apply q.d. to b.i.d. for 2-3 weeks to affected area. Warn patients regarding sun sensitivity and temporary inflammation and irritation. Treat small areas at a time.

F) If persistent despite initial intervention, numerous, friable, enlarging → refer to Dermatology.

XVII. Suspected non-melanoma Cutaneous Neoplasm (238.2)

A) Consider 'neoplasm' in lesions that enlarge, bleed, and persist despite primary intervention.

B) Proceed with biopsy evaluation (punch or shave procedure) or directly refer Dermatology.

C) Consider the post-procedural scar that will remain following your chosen biopsy method.

- D) COSMETIC CONDITIONS - (e.g.: not a medical condition unless complicated = continued growth, bleeding/irritation, inflammation, color or texture alteration, problematic with hygiene/clothing).
- a) Some forms of non-scarring alopecias (hair loss)
 - b) Benign epidermal and dermal lesions:
 - 1) Seborrheic Keratoses-removal of multiple is self-pay
 - 2) Acrochordons (skin tags)-removal of multiple is self-pay
 - 3) Benign nevi (moles)
 - 4) Dermatofibroma
 - 5) Xanthelasma
 - 6) Callus
 - 7) Lipomas
 - 8) Sebaceous Hyperplasias, Syringomas
 - c) Non-symptomatic scars: Some keloids, hypertrophic (thick), or atrophic (thin) scars/striae
 - d) Pigmented Lesions:
 - 1) Freckles, Lentigines
 - 2) Melasma
 - 3) Café au Lait
 - 4) Post-inflammatory
 - e) Vascular Lesions:
 - 1) Angiomas (cherry)
 - 2) Telangiectasias (spider telangiectasias)
 - 3) Varicosities

APPROVAL:



SMF/SPA Medical Director

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