

Dermatitis Referral Guideline

Indications for Specialty Care Referral

- Continued treatment for 2-3 months as outlined has failed to improve the condition or in spite of treatment the condition continues to spread and worsen.
- The diagnosis is uncertain and it is felt the patient may have some other refractory condition such as psoriasis or lichen planus.
- Consider referral to Allergy Clinic for children with moderate to severe atopic dermatitis when there is suspicion for possible food allergy as a trigger or if the child has other atopic disease (allergic rhinitis, asthma) that is also not well controlled. A referral does not need to be sent to dermatology if it is already being sent to allergy.
- Patient with > 20 % total skin involvement not responsive to treatment
- Patients with >10 % skin involvement of sensitive areas such as eyelids, hands or other intertriginous areas not responsive to treatment
- Patients requiring high frequency use of high-potency steroids
- Patients with erythroderma or extensive exfoliation
- Patients with coexisting asthma and/or rhinitis should be referred to Allergy
- Patients with significant impairment of life activities, such as sleep disturbances or loss of work days

Criteria for Return to Primary Care

- Improvement after resolution of an acute flare-up of the dermatitis.
- Dermatologic evaluation confirms the diagnosis of dermatitis and improvement is expected.

Diagnosis/Definition

- Varies from patches of moist, red, oozing, crusted skin to patches of dry, thickened, hyperpigmented skin. Thickened, firm, excoriated nodules (Picker's nodules) which are extremely pruritic, easy to reach and have been frequently scratched may occasionally be seen.

Initial Diagnosis and Management

- See Care of Dermatitis Handout
- History and physical exam to include bathing habits and frequency, temperature of bath/shower water, type of soap, examination of not only the lesions in question but also of the entire skin for evidence of dry skin.
- KOH preparation to rule out tinea if the dermatitis is limited or annular and the diagnosis is in doubt.
- Skin biopsy is not indicated at the PCM level for this condition.
- Bathing/showering should be limited to every other day or less and only body temperature water (NOT HOT!) should be used and duration of showers should be minimized to less than 5 minutes. Dove soap may be used but only in the axillary and groin areas (unless the patient is unusually dirty/sweaty); the remainder of the body just rinsed off quickly with plain body temperature water.

- After bathing, liberal amounts of moisturizer (Eucerin, Vaseline, etc.) should be applied to the total skin surface. This should be applied as a “chaser” to any topical steroid used.
- Soft clothing should be worn next to the skin, avoiding contact with irritating materials such as wool.
- Appropriate use (bid application to improve, then tapered) of topical steroid creams will be helpful:
 - Hydrocortisone cream 1% to the patches of dermatitis on the face, axillary, and groin areas.
 - Triamcinolone ointment 0.1% applied to the trunk and extremity lesions.
- Oral antihistamine (Benadryl 25mg or Atarax 10mg) given several times during the day and especially at night is helpful for the itching. Document education of caution regarding side effect of drowsiness. If sedation is a problem, consider a low or non-sedating antihistamine such as Zyrtec (10 mg daily) or Allegra (180 mg daily).
- In children with moderate to severe atopic dermatitis, up to 1/3 may have a food allergy as a trigger for their eczema. Consider testing for food allergy via routine Allergy clinic consultation when their eczema does not improve despite good topical therapies.

Ongoing Management and Objectives

- With continued treatment and modification of bathing habits, gradual resolution of the dermatitis is normal. Dermatitis may be a chronic, recurring condition and periodic flares are common. The periodic flares may be reduced in frequency by ongoing emollient use, but require reinstatement of topical steroids to achieve clearance. There may be occasional patches that are resistant to mid-potency steroids such as Triamcinolone 0.1% (Class IV) and these may require treatment with short courses of stronger steroid creams such as betamethasone valerate 0.1% (Valisone) cream (Class III). Non-steroidal immunomodulators that may be used as steroid-sparing agents tacrolimus (30gm tube of 0.03% and 60gm tube of 0.1% ointment [Protopic]) and a 30gm tube of 1% pimecrolimus cream [Elidel]. These are not considered first-line agents, should be used on a case-by-case basis, and should be refilled if they provide successful maintenance or remission.