Lessons Learned from 10 Challenging Cases

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Disclosures

- Speaker
  - Valeant
  - Bayer
- Advisory Board Representative
  - Ranbaxy/Sun
  - Allergan
“Dermatology? Jeez, the whole profession is ah, just put some aloe on it.”

-Seinfeld
Case #1:
“A bruise is a lesson...and each lesson makes us better”

-George R.R. Martin, A Game of Thrones
5 month old female presents with new rash on left lateral chest wall and left upper inner arm

Appears asymptomatic

Rash consists of teeny monomorphic pink papules on left upper inner arm and left lateral chest wall

Initial diagnosis: Unilateral laterothoracic exanthem

Recommendations: Observation and f/u in 3 wks
Case #1

- Pt follows up 3 wks later and rash has become more widespread - torso, proximal extremities
- Still appears asymptomatic
- Nothing on palms and soles
- Rash consists of teeny pink papules and some larger pink papules with a superficial pustule on top
- Revised diagnosis: Viral exanthem vs Eosinophilic Pustular Folliculitis (EPF)
- Recommendations: Clobetasol bid as spot treatment and f/u in 3 wks
Pt follows up 3 wks later and rash has continued to get worse - now extensive on torso, arms and legs

- Still seems asymptomatic
- Still consists of pink papules with some larger pink papules with a superficial pustule
- Still nothing on palms and soles
- Diagnosis: EPF
- Recommendations: Biopsy to confirm diagnosis given lack of response to Clobetasol
Biopsy shows changes consistent with eosinophilic pustular folliculitis

Changes were so classic that dermatopathologist requested permission to use the slides for his teaching deck

Diagnosis: EPF

Recommendations: Trial of several different topical steroids

- Clobetasol
- Betamethasone Dipropionate
- Dermasmoothe
Case #1

- Pt follows up and rash is unchanged
- Now patient seems itchy and she is failing to gain weight
- Diagnosis: EPF
- Recommendations: Consider trying prednisolone
Case #1

- While we were considering oral pred, the pt’s family sought out a 2nd opinion
- Upon exam, it was obvious to the other provider that the patient had scabies
- Rash resolved completely with permethrin
Case #1- Lessons Learned

- Don’t let a biopsy result “blind you” and prevent you from considering other diagnoses and properly reevaluating the patient.
- If a patient isn’t responding as expected (clobetasol typically works quite well for EPF), the first step is to reconsider the diagnosis. Try to look at it with fresh eyes.
- Learn from the experience. Let it haunt you for a little while. But be better the next time a similar situation presents itself.
Case #2:
“When you hear hoofbeats, think of horses, not zebras”

- Medical Proverb, 1950s
Case #2

- 17 month old healthy boy with h/o eczema presented with 1 wk history of rash on his torso
- Asymptomatic, child was feeling well
- Mom describes the rash as looking “like a cheetah”
- Pt’s rash had a mixture of morphologies. He had some 3-4 mm blue grey macules mixed with 3-5 mm somewhat indented skin colored areas
- Some of the indented skin colored areas had a pinpoint pink papule within them
- Mom said that 2 wks prior, pt had a rash on his torso that was typical of his “dairy rash” that he gets whenever he accidentally has dairy. It only lasted a day.
- DDx included weird viral exanthem, weird PIH/anetoderma reaction to “dairy rash”, atypical lichen planus, PLEVA
Case #2

- Labs done by PCP were normal including:
  - CBC
  - CMP
  - Uric acid
  - LDH
  - CRP
  - PT/PTT
  - ESR
Case #2

- Pt followed up 1 week later and rash was unchanged
- Skin biopsy was performed
Clinical Photographs
Clinical Photographs
Case #2- Histopathology results

- Pathology was read out as “distorted follicle with neutrophilic and lymphocytic inflammation and associated dermal whirled morpheaform collagen thickening”
Case #2

- Given the follicular involvement, I opted to treat it as a weird folliculitis
- Started patient on keflex
- Within 3 days, the rash was clear!
Case #2- Lessons Learned

• Common things are common and can present atypically
• Don’t “psych out” your dermatopathologist
Case #3:
“Sometimes the best diagnostic test is the followup visit.”

-Ron Hansen, MD
Case #3

- 12 yr old girl presented with 1 yr history of rash on her lower legs
- The spots appear, turn bruiselike, then resolve
- Asymptomatic
- Really worsened after climbing the “Incline” at Pike’s Peak
- On exam, the patient had nontender reticular erythematous-violaceous patches on lower legs and thighs with some violaceous areas that were slightly palpable
Pt complained of mild joint pains in shoulders and knees but no h/o inflammatory changes
- Was having a lot more fatigue which was unusual for her
- Complained of “tingling” sensations in legs but no numbness or nerve issues with arms
- No GI issues
Case #3- Photos
Case #3- Histopathology

- Had been seen by different dermatologists and had 2 previous biopsies
- Both showed vague changes- superficial and mid dermal perivascular dermatitis without features of panniculitis or vasculitis
- I did an additional biopsy (making sure to sample one of the palpable lesions) which showed the same
Case #3 - Labs

- CBC and CMP normal
- CRP and sed rate normal
- ANA, RF, cANCA, pANCA, antiphospholipid antibody, and cryoglobulins negative
- U/A normal
- PT/PTT/INR normal
- ASO normal
Case #3

- Her rash seemed so characteristic of PAN, but nothing else was supporting that in terms of labs and pathology
- Patient had a thorough eval by peds rheum and peds hematology and everything was normal
- We opted to take a “wait and see” approach
Case #3

- 1.5 yrs after I met the patient (and 2.5 yrs into the rash), the patient came to followup with new whitish skin changes around her left ankle
- The changes were clearly consistent with atrophie blanche and allowed us to diagnose this as livedoid vasculopathy
- Patient was started on baby aspirin daily and compression stockings and all of her lesions have cleared
- She has had recurrence when she stops the baby aspirin so she has had to continue it
Case #3 - Lessons Learned

- If you do an appropriate workup that turns up nothing, it is ok to watch and wait
- Often conditions will declare themselves over time or simply resolve
Case #4

“Never say never.”

-Charles Dickens, Pickwick Papers 1837
-And also Justin Bieber, 2011
32 yr old female presented with 2 month history of rash on forehead and scalp

Previously treated with elidel and fluocinonide by another provider but only worsened

On exam, the pt had erythematous scaly annular patches on bilateral forehead and extending into left temporal scalp

Exam was consistent with tinea facei/tinea capitis
Case #4

- Given that the tinea was involving the face and scalp, the area had been previously treated with fluocinonide, and the patient was an inpatient peds oncology nurse (dealing with immunosuppressed patients), I prescribed Griseofulvin 500 mg bid
- Went over griseofulvin counseling
Case #4

- Patient returns for followup 4 wks later
- Rash is improved by about 75%
- Patient reports nausea, epigastric pain, and poor appetite for the past 5 days
- Given symptoms, I ordered labs
# Case #4- Labs

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**NOTES:** (c)  
***MDRD TRACEABLE GLOMERULAR FILTRATION RATE ESTIMATION***  
GFR UNITS= mL/min/1.73 Square Meters  
The Glomerular Filtration Rate (GFR) is an estimate of renal function calculated from the patient's serum creatinine, age, and race and normalized to an average adult body.
Case #4

- Patient was admitted and monitored by GI/Hepatology service
- Eventually the LFTs started to trend down
- T Bili was slower to trend down
- Nausea persisted for several weeks
- Predicted that it will take 8 wks for her LFTs to normalize
- Ultrasound and hepatitis serologies were done
- Conclusion was that this was Griseofulvin induced liver toxicity
- 1 in a million
Case #4

The treatment of dermatophytosis: Safety considerations

Edgar B. Smith, MD Albuquerque, New Mexico

The past 4 decades have witnessed major advances in the pharmacologic treatment of dermatophyte infections. We have gone from irritant and marginally effective topical preparations to highly effective topical agents and systemic drugs that are useful in even the most recalcitrant forms of these common infections. With new agents have come new safety considerations. The purpose of this review is to consider the potential implications of the drugs currently available to dermatologists.

TOPICAL ANTIFUNGAL AGENTS

Topical antifungal medications are most useful in superficial infections of the glabrous skin. They are helpful in infections of the scalp and nails, in tinea and extensive infections of the trunk, and in infections of the thick stratum corneum of the palms and soles. Moreover, topical antifungal agents used the treatment of dermatophyte infections are sometimes less effective in individuals who are immunosuppressed. However, there is no doubt that topical antifungal agents are far less likely than systemic agents contain alcohols or other irritants, which are the most likely causes of tinea medicamentosa reactions. Of these reactions are so mild that they do not preclude continued use of the medication.

True allergic contact dermatitis, characterized by a delayed onset of redness, itching, and scaliness but without the isolated reports with all products. The offending allergen in such cases has been the active antifungal agent or the component of the drug’s base. Table I summarizes the preservatives and other ingredients used in topical preparations currently available in the United States.

SYSTEMIC AGENTS

The development of systemic agents for the treatment of dermatophyte infections began with the availability of griseofulvin in the 1950s. More recent...
International Summit on Cutaneous Antifungal Therapy, Focus on Tinea Capitis, Boston, Massachusetts, November 11–13, 1994

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Abstract: This article reports the highlights of presentations made at an international symposium held on November 11–13, 1994, in Boston, Massachusetts, on the subject of cutaneous antifungal therapy. Some of the key points pertaining to the epidemiology, etiology, pathogenesis, presentation, and management of tinea capitis are reviewed. Special emphasis is placed on the current state of antifungal therapy for this condition, as well as novel treatments under investigation.

At the time of World War II, the pharmacologic agents available for the treatment of fungal infections included weak acids, phenolic dyes, and undecynic acid, which was regarded as the major breakthrough in antifungal therapy during the 1940s. Not until the early 1960s was an orally effective antibiotic, griseofulvin, introduced for the management of dermatophytosis. The synthetic antifungal compound tolnaftate and the polyene antibiotics, used primarily for the treatment of Candida infection, were the major antifungal agents available until the late 1970s, when the first azole antifungals were introduced. These compounds, including clotrimazole, econazol, bifonazole, ketoconazole, and terbinafine, were effective against a wide spectrum of fungal organisms. Terbinafine has the added advantage of both topical and oral activity. (J AM ACAD DERMATOL 1990; 23:776-8.)

IMIDAZOLES

Other broad-spectrum agents subsequently developed, the iodinated trichlorophenols owe antifungal activity to the disruption of the fungal cell membrane. The only drug of this class, haloprogin, was somewhat superior to tol naftate.
The Optimal Therapy for Tinea Capitis

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In 1958 Gentles (1) experimentally induced ringworm in guinea pigs and discovered that he could cure their infection with griseofulvin, a new antibiotic derived from a Penicillium mold. Subsequent widespread use of this drug ushered in a period of “detente” between man and dermatophyte for more than two decades, as griseofulvin proved both a safe and effective therapy for tinea capitis as well as a number of other superficial dermatophyte infections.

Unfortunately, this period of relatively peaceful coexistence between man and dermatophyte may be coming to an end. The last two decades have witnessed an increasing incidence of tinea capitis in urban populations (2), as well as new, more subtle clinical patterns of disease. Of most concern is the emergence of griseofulvin-resistant isolates of Microsporum audouinii and Trichophyton tonsurans. Although therapeutic options for the treatment of these infections are currently available, experts are cautious about supporting the use of any new agent until enough experience has been gained to ensure its safety and efficacy.

Although it is reasonable to continue the use of griseofulvin as first-line therapy, at the present time, it is unwise to ignore clear problems that exist with this agent. Increasingly higher doses of this drug have become the standard of care, as have prolonged courses of treatment. These therapeutic decisions have not come from scientific laboratory evidence that the drug is less effective, but rather from clinical experience that the previously recommended dosing and shorter duration of therapy are now insufficient to eradicate infection. Scientific data regarding griseofulvin resistance in these two fungi have recently been presented, and further data are eagerly awaited.

Tinea Capitis: An Overview with Emphasis on Management

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Abstract: Tinea capitis is perhaps the most common mycotic infection in children. In North America the epidemiology of tinea capitis has changed so that Trichophyton tonsurans now predominates over Microsporum audouinii. With this transition the utility of the Wood’s light for diagnosis has been reduced since T. tonsurans infection is Wood’s light negative. Griseofulvin has been the mainstay of therapy for the last 40 years. The newer antifungal agents—itraconazole, terbinafine, and fluconazole—appear to be effective and safe for the treatment of tinea capitis.
Meta-analysis of randomized, controlled trials comparing griseofulvin and terbinafine in the treatment of tinea capitis

Hong Liang Tey, MRCP (UK), Andy Soon Leong Tan, MPH, and Yin Chew Chan, MRCP (UK)
Singapore, and Philadelphia, Pennsylvania

Background: Griseofulvin has been the standard treatment for tinea capitis but newer, particularly terbinafine, are increasingly being used because of their shorter duration of treatment and consistent absorption rates.

Objective: We sought to compare the efficacy of oral griseofulvin and oral terbinafine in the treatment of tinea capitis.

Methods: A search of MEDLINE, EMBASE, Cochrane Central Register of Clinical Trials, and Skin Group Ongoing Skin Trials Register was performed up to January 2010 for randomized trials comparing griseofulvin and terbinafine in the treatment of tinea capitis in immunocompetent patients. The primary outcome measure was the complete cure rate. The mycological and clinical cure rates were secondary outcome measures. Pooled treatment effect was calculated using a random-effects model and the I² test was used to check for heterogeneity among the studies.

Results: Seven studies involving 2163 subjects were included. There was no significant difference in efficacy between griseofulvin (mean duration of treatment 8 weeks, range 6-12 weeks; mean duration of treatment 4 weeks, range 2-6 weeks; odds ratio = 1.12 favoring griseofulvin, 95% confidence interval [CI] = 0.785-1.919; P = .37) and terbinafine (mean duration of treatment 6 weeks; odds ratio = 0.99, 95% CI = 0.73-1.42; P = .91). In the pooled analysis of 5 studies in which Micronema species were the predominant (>65%) pathogenic dermatophyte, terbinafine showed higher efficacy (odds ratio = 1.49, 95% CI = 0.975-2.277; P = .065). Subgroup analysis of terbinafine was more efficacious than griseofulvin in treating Trichophyton species (1.61, 2.051; P < .001) and terbinafine was more efficacious than terbinafine in treating Microsporum species (0.408; 95% CI = 0.254-0.656; P < .001). Both griseofulvin and terbinafine demonstrated good tolerability in the studies.

Commentaries

Are laboratory studies necessary for griseofulvin therapy?

Elizabeth F. Sherertz, MD Winston-Salem, North Carolina

Sometimes we find ourselves doing things in the clinic because we were taught to do them. I recently questioned my own routine of obtaining laboratory studies for patients receiving griseofulvin therapy for more than 6 weeks. A review of six major general textbooks of dermatology revealed that none suggested the requirement of laboratory monitoring of griseofulvin therapy. Roberts and Mackenzie in the textbook of dermatology by Rook et al. state that measurement of hemoglobin and WBCs is not indicated but mention that proteinuria can occur. Bickers et al. recommend that blood studies be performed two times in the first month and every 3 to 4 months thereafter, noting that the hematologic effects can be transient. Saned and Mandell, in a widely used pharmacology textbook, recommend that blood studies be done during griseofulvin therapy at least once weekly during the first month of treatment.

The recommendations for obtaining laboratory studies go back to early studies with griseofulvin. Livingood et al. reported in 1960 their results of liver, hematologic, and renal studies of 66 patients receiving prolonged griseofulvin therapy. The absence of adverse effects on liver function and serum tests of liver enzymes is the main result. Our recommendation is to monitor patients receiving griseofulvin's effect on patients. He further said that "routine blood cell counts of patients receiving griseofulvin were useless."

With the cost of laboratory tests and the reported toxicity from griseofulvin, physicians should update and modify our individual guidelines for when and which laboratory tests are necessary. My literature review suggests that a urinalysis is most likely to change during therapy, but all other tests are not. This is not known. Clinicians remain important for contraindications, such as concomitant corticosteroid therapy. A review of extensive expert panel and laboratory results of many patients who receive griseofulvin on a long-term basis may offer some guidance about the safety of this valuable drug and clarify the need for laboratory monitoring.

REFERENCES

Griseofulvin

Griseofulvin was first introduced in 1958 for the treatment of dermatophyte infections (52–57). Since then it has been widely used for treating tinea capitis and is currently considered the “gold standard” against which other therapies are judged.

SPECIFIC ORAL ANTIFUNGAL AGENTS
Griseofulvin

Griseofulvin is a widely used drug, but data regarding hepatic reactions are difficult to find. Two well-documented, published cases of intrahepatic cholestasis with griseofulvin exist. However, it is estimated that more than 20 million patients have received griseofulvin, which makes the reported incidence of hepatic reactions comparatively rare.

Cases of leukopenia with this agent have also been reported. However, it is difficult to confirm whether these cases were drug related. There is some evi-
Case #4

- The remaining dilemma is how to treat the patient.
- Her tinea is improved, but not clear.
- We can’t use griseofulvin and we can’t use any oral -azoles or terbinafine with her current liver status.
- Typically topicals do not work for tinea facei/tinea capitis, but I opted to try Extina (ketoconazole) foam hoping that it will be effective.
Case #4 - Lessons Learned

- Never say never
- Rare reactions happen
- Evaluate what happened and the decisions you made
- Would you do the same thing again?
- You can’t not use valuable medicines just because these rare things happen
Case #5

“Don’t spend time beating on a wall, hoping to transform it into a door.”

-Coco Chanel
16 yr old male presented for evaluation of acne on face, chest and back
Also has eczema on his scalp
Pt has h/o autism spectrum disorder and won’t use anything on his skin because he doesn’t like the way it feels
Won’t even moisturize or wash his face
Case #5

- The number of children “on the spectrum” is growing every day
- A lot of these children have tactile sensitivity that can make it difficult to manage their skin conditions
- These patients simply will not use some conventional “go to” therapies because of their sensitivities
- Through trial and error, I have figured out several products that pts with tactile sensitivity like
Case #5

- HPR Plus Foam
- Desonate gel
- Olux E foam
- Enstilar foam
- Kenalog “no touch” spray
- Finacea foam
- And sometimes it’s easier to opt for oral medications
Understand a patient’s sensitivities and try to come up with a treatment plan that they are going to use and be ok with

If they don’t like the feel of the medicine, they are just not going to use it
Case #6

“It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

-Franklin D Roosevelt
• 8 yr old male presented for 2 yr history of skin tightening
• Pt has h/o ADHD, mild autism, fetal alcohol syndrome
• Comes in with his adoptive parents
• Originally started on right inguinal crease and right thigh. Now spreading to right buttock, left post upper arm.
• Sometimes painful
• On exam, pt had several patches of skin that were as firm as granite. No overlying hyperpigmentation
Case #6

- Family had recently moved from Texas
- Thorough workup including skin biopsy had been done in Texas
- Conclusion was stiff skin syndrome
- Pt had no features of scleroderma, no history suggestive of nephrogenic fibrosing dermopathy, and pathology differentiated it from morphea profunda
- Pt was on MTX at the time of our 1st visit. Family had not found it helpful
- Was trying to do physical therapy
Stiff skin syndrome is quite rare—around 44 reported cases since 1970.

No good treatment besides physical therapy to promote mobility and range of motion.

SPD Meeting 2013 I asked for advice from anyone and everyone that talked to me and I got a few suggestions:

- UVA1
- Gleevec
- Xeljanz
After discussion and working with a peds hem/onc colleague, we started gleevec
Pt was on it for about 1.5 yrs. Seemed to slow down the progression, but hard to tell
Developed peripheral neuropathy due to the gleevec so we stopped it
Patient relatively rapidly developed new areas of involvement over 3 mos
Started him on dasatinib July 2015- similar to gleevec but no risk of peri neuropathy
At last visit, he had noticeable improvement in previously affected areas
Case #6- Lessons Learned

• When a condition has no known treatment, just try something that makes sense
• Discuss the pros and cons with family, but usually families are willing to think “outside the box” with these rare conditions
Case #7

“Everyone gets so much information all day long that they lose their common sense.”

-Gertrude Stein
Case #7

- 4 yr old boy with lamellar ichthyosis presented for evaluation of a facial rash
- He had been managing his lamellar ichthyosis with another peds derm provider, but when the facial rash didn’t improve they wanted another opinion
- Rash had been going on for a few months
- Consisted of eczematous patches and pustules
- A previous culture had been positive for staph
- Pt had been treated with keflex x 7 days, azithro x 7 days, nystatin/triam mix, metronidazole cream without success
Case #7

- Even with the changes of the lamellar ichthyosis, it was clear that the facial rash involved the areas around the eyes, nose and mouth.
- It was consistent with periorificial dermatitis.
- It has responded to oral antibiotics, but recurrence has been a struggle.
Case #7- Lessons Learned

- Just because someone has a rare genetic skin disease, doesn’t mean that they can’t have a very common skin disease superimposed
- If you take the lamellar ichthyosis changes out of it, the diagnosis was relatively simple
Case #8
“Crying helps me slow down and obsess over the weight of life’s problems”.

- Sadness from Pixar’s Inside Out
14 yr old male with severe acne that has failed oral antibiotics and several topical meds

- Starts isotretinoin

- At 2 month followup, pt complained of some “short fuse” like symptoms, but denied symptoms of depression and said that overall he was feeling good on the medicine
Case #8

- 2 wks later the patient’s mom calls in a panic
- The pt has become increasingly more distant and depressed
- He has become more angry
- Mom found on his phone that he texted a friend that he wanted to kill himself
Case #8- Accutane and depression

• The association between isotretinoin and depression became a big deal when a senator’s son committed suicide while on accutane in 2000

• Since then the association between the two has been somewhat unknown and ambiguous
From 2005-2015, I had not seen true depression on accutane.

I have seen patients with “short fuse syndrome”.

I had gotten to the point where I was mentioning the possible association with mood issues, but I was downplaying it.
During 2015 and 2016, I have had 3 male patients become severely depressed on accutane. None of them had h/o mood issues prior.

Appears to happen acutely

All 3 admitted that they felt the symptoms early on, but had lied to me about it because they saw the improvement the accutane was having with their skin

2 of them were cutting themselves unbeknownst to their friends and family

All 3 of them expressed suicidal ideation

1 of them was admitted to the hospital on a psych hold

All 3 of them stopped the accutane and their mood returned to normal
There IS an association between accutane and depression, albeit rare (3 cases in 10 yrs)
I now always examine the chest and arms in patients on accutane to evaluate for cutting
Seems there is a bit more risk with males
Case #9

“Don’t waste your energy trying to change opinions... Do your thing, and don’t care if they like it.”

-Tina Fey, Bossypants
Case #9

- 4 y/o female with history of skin lesions that started 2 yrs ago
- Initially presented as 1 patch on the left upper arm
- Saw a dermatologist in CO Springs several times and 2 biopsies were done which showed granulomatous inflammation suggestive of infection, but no stains were positive for infection
- Pt was referred to peds ID for further eval and screening bloodwork which showed abnormalities with several immunoglobulins
- Immunology workup at Natl Jewish revealed positive genetic testing for Ataxia Telangiectasia and the patient was diagnosed with AT
Case #9

• Since the diagnosis of AT, the patient’s skin lesions have progressed
• The initial patch on left upper arm has gotten bigger and she has developed a large patch on right leg and smaller patches on chest and left dorsal foot
• Newest patch is on the left lateral canthus and mom is quite concerned that this is appearing on her face
The pt was evaluated at Children’s Derm and an additional biopsy was done which also showed granulomatous inflammation with negative infectious stains

Pt was empirically treated with oral azithromycin for 3 mos and topical ketoconazole without any improvement

When I saw patient in April, I opted to try treatment with clobetasol on body and elidel to lesion on face
Case #9

- On exam, pt does not have prominent telangiectasia on the conjunctiva, cheeks or lips (she is only 4 so presumably they will develop in the future)
- She has 2 round pink-purple somewhat firm, somewhat scaly well demarcated plaques on left upper arm and right leg
- 2 pink papules on left dorsal foot and chest
- 5 mm circular pink scaly patch on left lateral canthus
Case #9- Clinical photographs
Case #9 - Clinical Photographs
Case #9 - Clinical Photographs
2 CO Springs biopsies showed granulomatous inflammation concerning for infection

- PAS negative
- AFB was read as positive based on a clump of 30 organisms, however it was suspicious for false positive or contaminant given the “clump” and the fact that there was a similar clump on the edge of the tissue outside of the cells
- IHC was done with lymphoma workup panel including CD1a, 20, 30, 4 and 8. CD1a was slightly low, probably due to underlying immunodeficiency and suspicion for lymphoma based on stain results was low

Biopsy from Children’s Derm showed perivascular and interstitial granulomatous dermatitis. No microorganisms seen.
The pt was referred to me because the immunology team wanted more biopsies done for special infectious disease tests

I felt that enough biopsies had been done on this 4 yr old

I felt this was simply cutaneous granulomas that can occur in patients with Ataxia-Telangiectasia

I did not want to do more biopsies on the patient

It can be difficult to go against the “orders” from a referring provider or team, but you have to do what you feel is right

I did end up having the patient attend a dermatology grand rounds and the entire room agreed with me
Even though other doctors treat kids with skin disease, we are the skin specialists for a reason.

No one knows dermatology as well as dermatologists.

Stand up for your knowledge and your experience (even if you are a young physician).

Practice medicine the way YOU feel comfortable.
Case #10
“A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.”

-Winston Churchill
Case #10

- Currently 10 yr old girl with history of psoriasis
- Has had psoriasis since age 5
- Started on scalp
- Now involves scalp, arms, legs, private area
- Has only worsened over time
- Has been treated with topical steroids, elidel, and light therapy
- At several points, I mentioned systemic therapy
Case #10

• The treatment of pediatric psoriasis is 10 yrs behind the treatment of adult psoriasis

• Discussed systemic options with pt and parents
  • Methotrexate
  • Enbrel
  • Humira
  • Stelara
Case #10

- When I mentioned stelara, the pt herself said loudly “That’s what I want”
- Parents took some convincing but agreed
- Insurance covered it (!)
- The patient is a small 10 yr old so she is receiving 22.5 mg stelara every 3 mos
- She is 100% clear and she and her family are so happy
- She went to camp for the first time
- She can go to sleep overs
- Friends don’t ask her about all the scaling
Case #10- Lessons Learned

- See the opportunity in a difficult situation to change a person’s life for the better
- Listen to your patients, even the kids!
- Be willing to take a (responsible) leap of faith!
When it comes down to it, we are all just trying to do our best every day.

We all make mistakes, as much as we hate to admit it.

The important thing is that we try hard, we do what we think is right, and we learn from our mistakes and missteps.

Always try to put yourself in the patient’s shoes.
“Keep your feet on the ground, and keep reaching for the stars.”

-Casey Kasem, American Top 40
Quotes that I Loved but Couldn’t Fit

• “I like you...you have the boldness of a much younger woman” – Jack Donaghy, 30 Rock
• “Saving lives? She’s one step above working at the Clinique counter” – Seinfeld
• “Some people are worth melting over” – Olaf, Frozen
• “These people are members of a community that care about where they live. So what I hear when I’m being yelled at is people caring loudly at me” – Leslie Knope, Parks and Rec