

Dermatology through the Circle of Life

21st National Family Practitioners Congress 2018

SOUTH AFRICAN ACADEMY OF
FAMILY PHYSICIANS

The River Club, Cape Town | 24 - 26 August 2018



Nappy rash

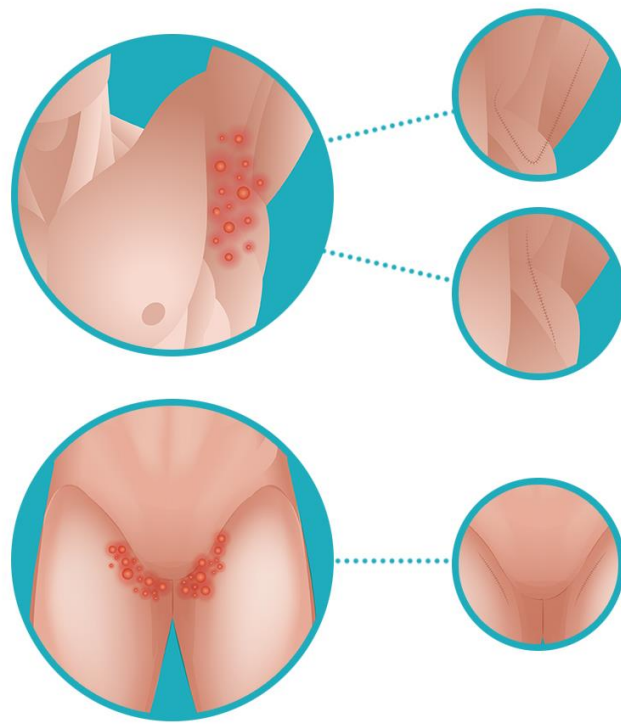
Common childhood infections

Atopic dermatitis

Acne vulgaris

Hidradenitis suppurativa

Skin cancer



Hidradenitis suppurativa

terminology

Hidradenitis suppurativa (HS)

=

Acne inversa

Prevalence

- 1%

diagnosis

- **Clinical diagnosis** (without the use of laboratory tests)

1. Typical patient

2. Typical risk factors

3. Typical skin lesions at typical sites

Typical patient

- Post pubertal (20-30)
- Female (3:1)



Typical risk factors

- Obesity
- Smoking



Typical skin lesions at typical sites

- Deep seated inflammatory, painful nodules
- Abscesses
- Ulceration
- Sinus tracts
- Discharge (pus and smelly)
- Scarring



Double comedones

Deep painful nodules



abscesses



Sinus tracts with discharge



scarring



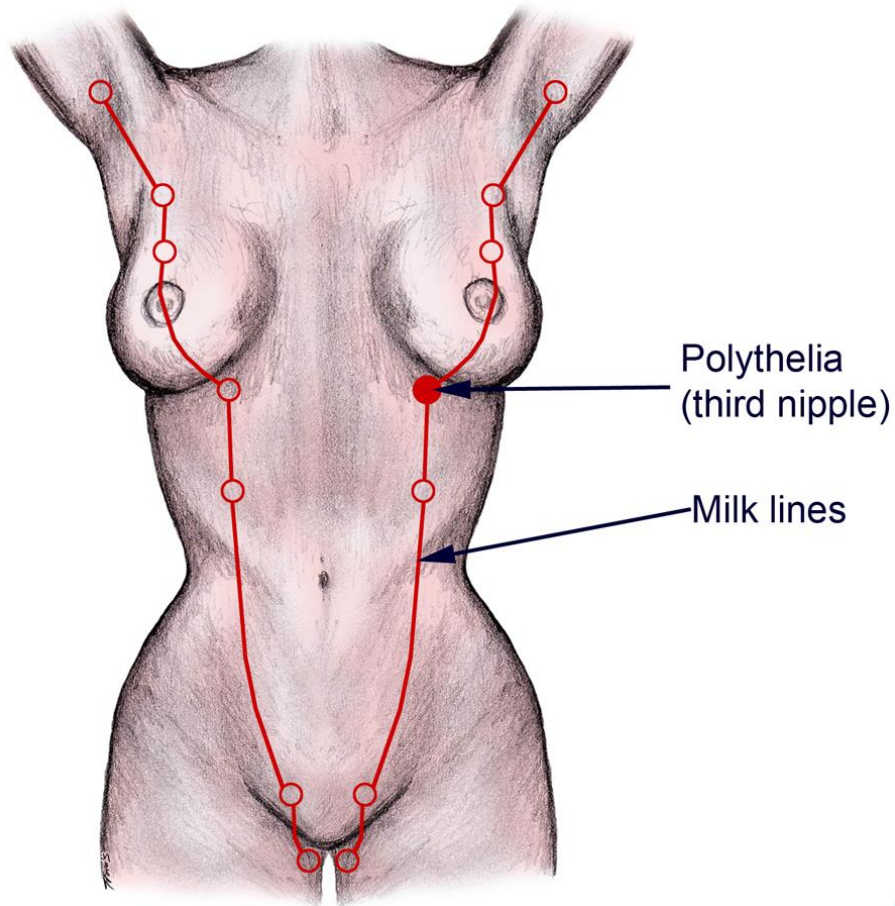
chronic



Double comedones



Typical Body sites

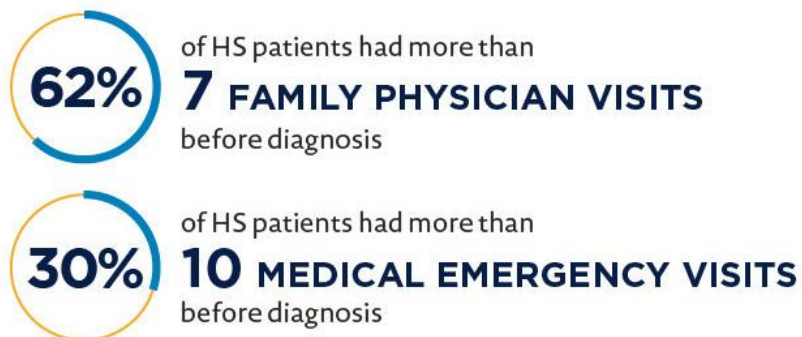


Diagnosis: Summary

1. More than one inflamed lesion
2. Chronic and recurrent
3. Bilateral
4. In milk lines



THE LONG HS JOURNEY:²



Average time for diagnosis is



Average age of diagnosis is



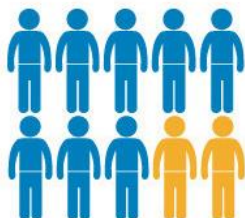
Average referral wait time for dermatologist is



MISDIAGNOSIS IS COMMON:²

8 OUT OF 10 INDIVIDUALS

has at least one misdiagnosis for HS



MAIN HS CARE PROVIDERS:²



IMPACT ON QUALITY OF LIFE:²



Low disease awareness

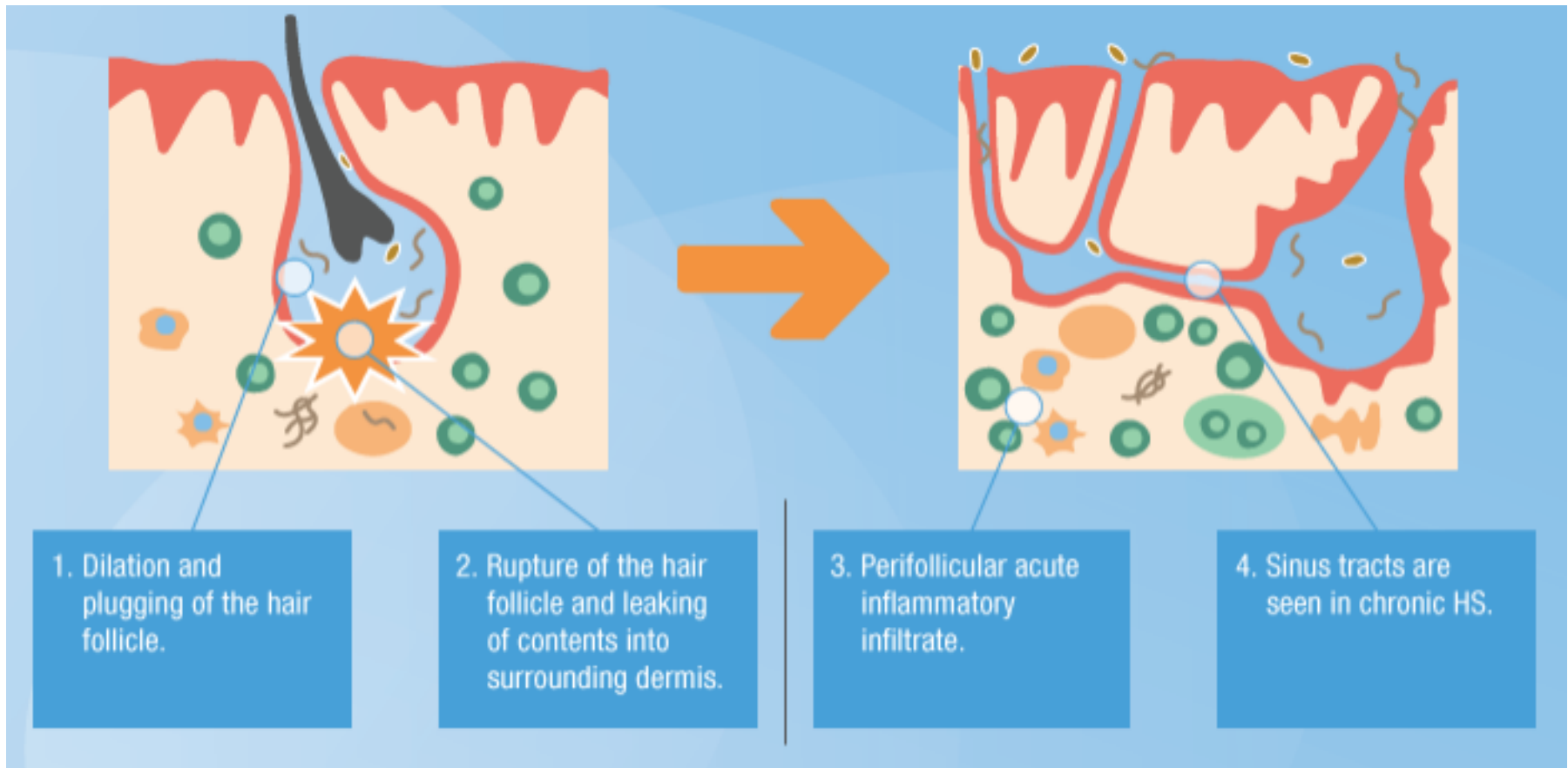


Depression



Hiding symptoms

HS Pathogeneses



Hurley staging system

Stage I.

One or more abscesses with no sinus tract or cicatrization



Stage II.

One or more widely separated recurrent abscesses with a tract and cicatrization

Stage III.

Multiple interconnected tracts and abscesses throughout the entire affected area



PSYCHOLOGICAL impact

- ❖ DLQI much worse than that of many other dermatologic diseases (chronic urticaria, psoriasis, atopic dermatitis, and even neurofibromatosis)
- ❖ **Symptoms:** soreness, stinging, itching, malodorous discharge
- ❖ **Stigma:** because of the location, of lesions in intimate sites
- ❖ **Lack of medical care:** incorrect diagnosis or the hesitancy of patients to disclose the symptoms or signs of HS
- ❖ **Economic** disabilities

Quality of Life and Hidradenitis

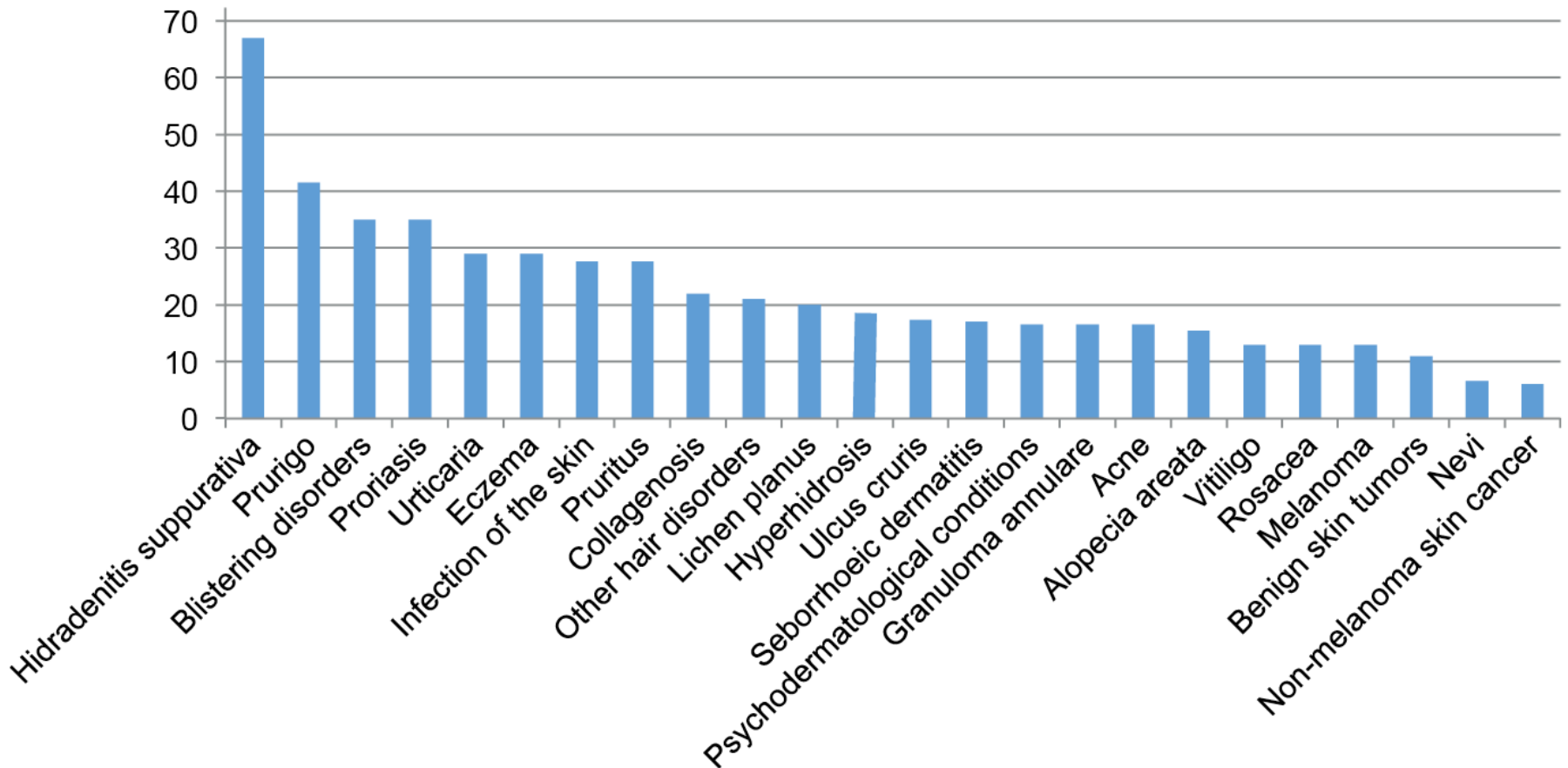
Table 3. Mean Dermatology Life Quality Index (DLQI) scores reported in different conditions (adapted from Finlay³)

Condition	DLQI score
Hidradenitis suppurativa	8·9
Alopecia ¹⁵	8·3
Acne ¹⁶	7·5
Psoriasis ¹⁷ (mild to moderate)	7·0
Hailey–Hailey disease ¹⁸	6·1
Darier's disease ¹⁸	5·9
Vascular anomalies of face ¹⁹	5·6
Atopic dermatitis ²⁰	5·5
DLQI maximum score	30

J.M. Von Der Werth, G.B.E. Jemec (2001)
Morbidity in patients with hidradenitis suppurativa
British Journal of Dermatology 144 (4), 809–813.



Impairment of Sexual Life



General
considerations

The diagram consists of three main elements. At the top, there are two adjacent chevron-shaped boxes pointing to the right. The left box is blue-grey and contains the text 'General considerations'. The right box is green and contains the text 'Medication'. Below these two boxes is a long, horizontal blue double-headed arrow. The word 'Surgery' is written in white text across the center of this arrow.

Medication

Surgery

General measures

Table VI. General treatment suggestions for all hidradenitis suppurativa patients regardless of Hurley stage

Avoidance of tight-fitting clothing
Nonnarcotic analgesics
Reassurance
Smoking cessation
Stress management
Support group referral
Weight loss



01

Antibiotics

02

Biologics
(Adalimumab)

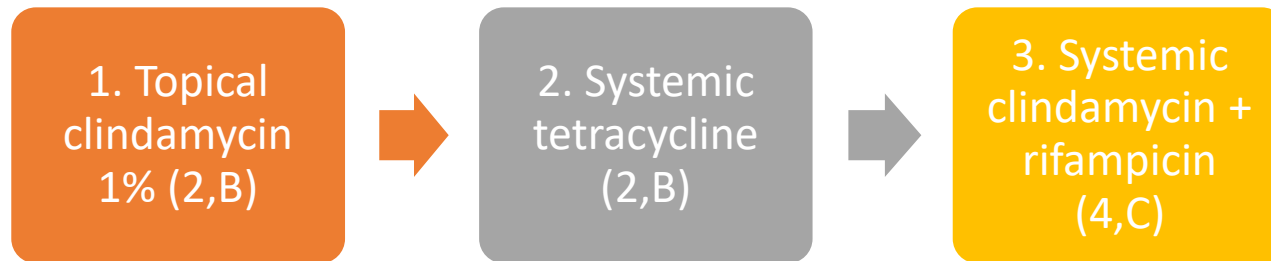
03

Other

Medications

Antibiotics

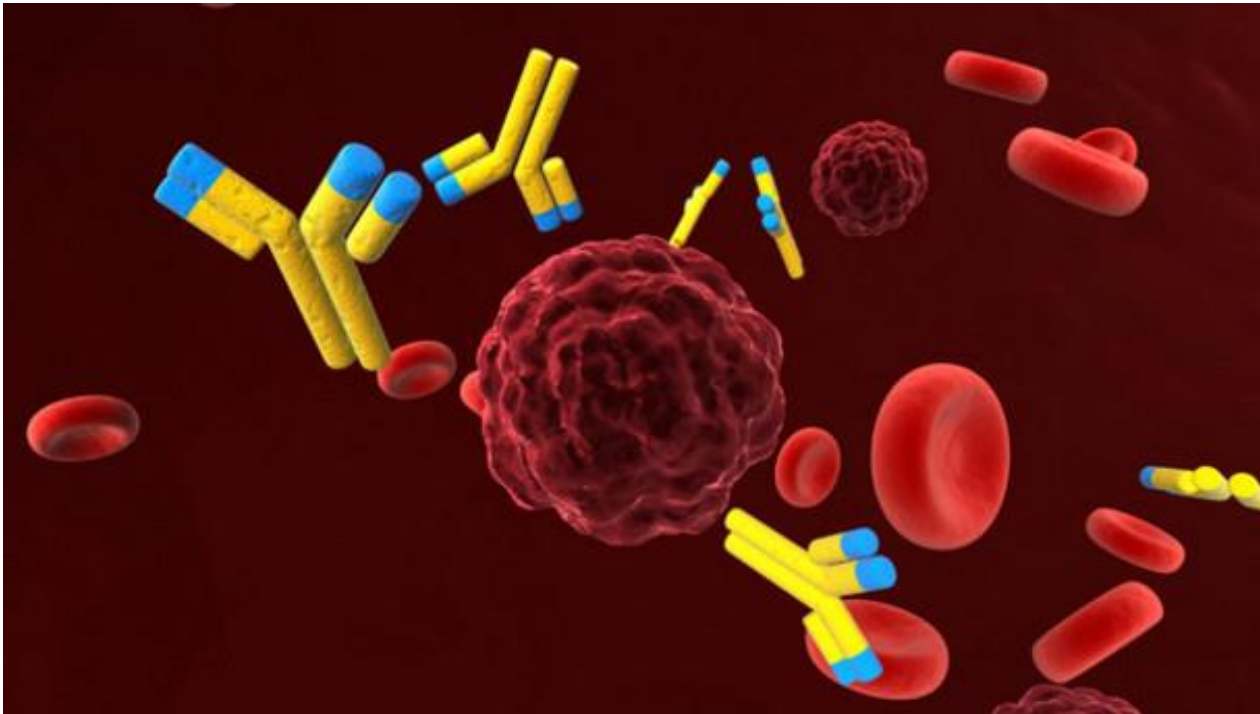
Skin microbiological cultures are not useful



Use for **3** months - reintroduce with recurrence (if they were effective at the last time of use)

No evidence for the use of other antibiotics

biologics



1

2

3

4

Adalimumab should be considered as the first choice biologic agent in moderate/severe HS after failure of conventional treatments. (2,B)

Infliximab should be considered as the second-line biologic for moderate/ severe HS (2,B)

Anakinra (2,B) has been shown to be effective and should be considered as a third-line biologic for moderate/severe HS.

Ustekinumab (4,C) is potentially effective in moderate/severe HS

Etanercept is not effective in HS (2,B)

Biologics

JAMA Dermatology Clinical Evidence Synopsis

Interventions for Hidradenitis Suppurativa

Updated Summary of an Original Cochrane Review

John R. Ingram, DM, MRCP

BOTTOM LINE There is high-quality evidence of benefit from adalimumab given weekly, while every other week dosing is ineffective, with reductions in Dermatology Life Quality Index (DLQI) scores compared with placebo of 2.8 points (95% CI, -3.7 to -2.0 points) and 1.6 points (95% CI, -3.9 to 0.6 points), respectively. Moderate-quality evidence suggests that infliximab is beneficial; RCT evidence for other interventions was lower in quality or absent, limiting further conclusions.

Comorbidities/risk factors

- Smoking
- Obesity
- Hypertriglyceridemia
- Diabetes
- Hypertension
- Metabolic syndrome
- Cardiovascular disease
- Depression
- Crohn's disease
- Spondyloarthritis

Careful assessment and referral / pre-screening if indicated

Surgery

- ❖ In **acute** situations (tense and painful abscesses)/fluctuating lesions =
Incision and draining (4,C)
- **NB: NOT sole treatment – recurrence inevitable!**
- ❖ **Limited** areas = limited excision and deroofing (4,C)
- ❖ **Widespread** = wide excision (4,C)
- ❖ **Chronic HS** without inflammation = excision to prevent recurrence (5,D)
- ❖ **CO2 laser** can be used as alternative (4,C)

presurgery

final result



Practical Treatment algorithm for
everyday practise

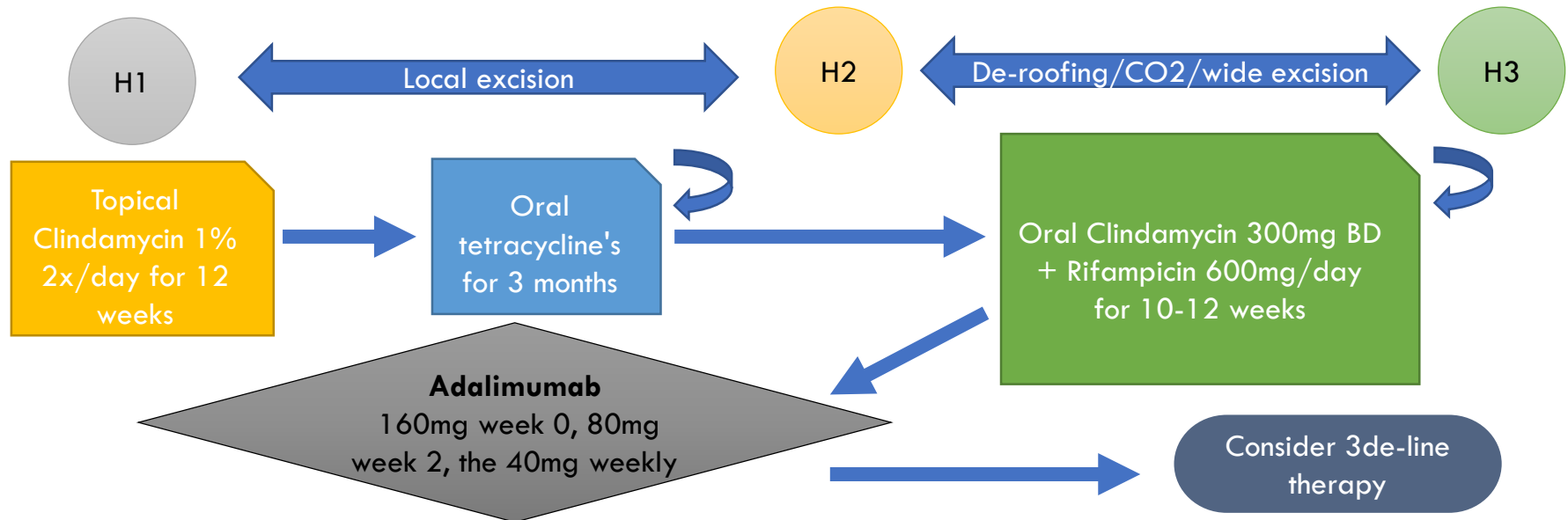
Diagnosis

General measures

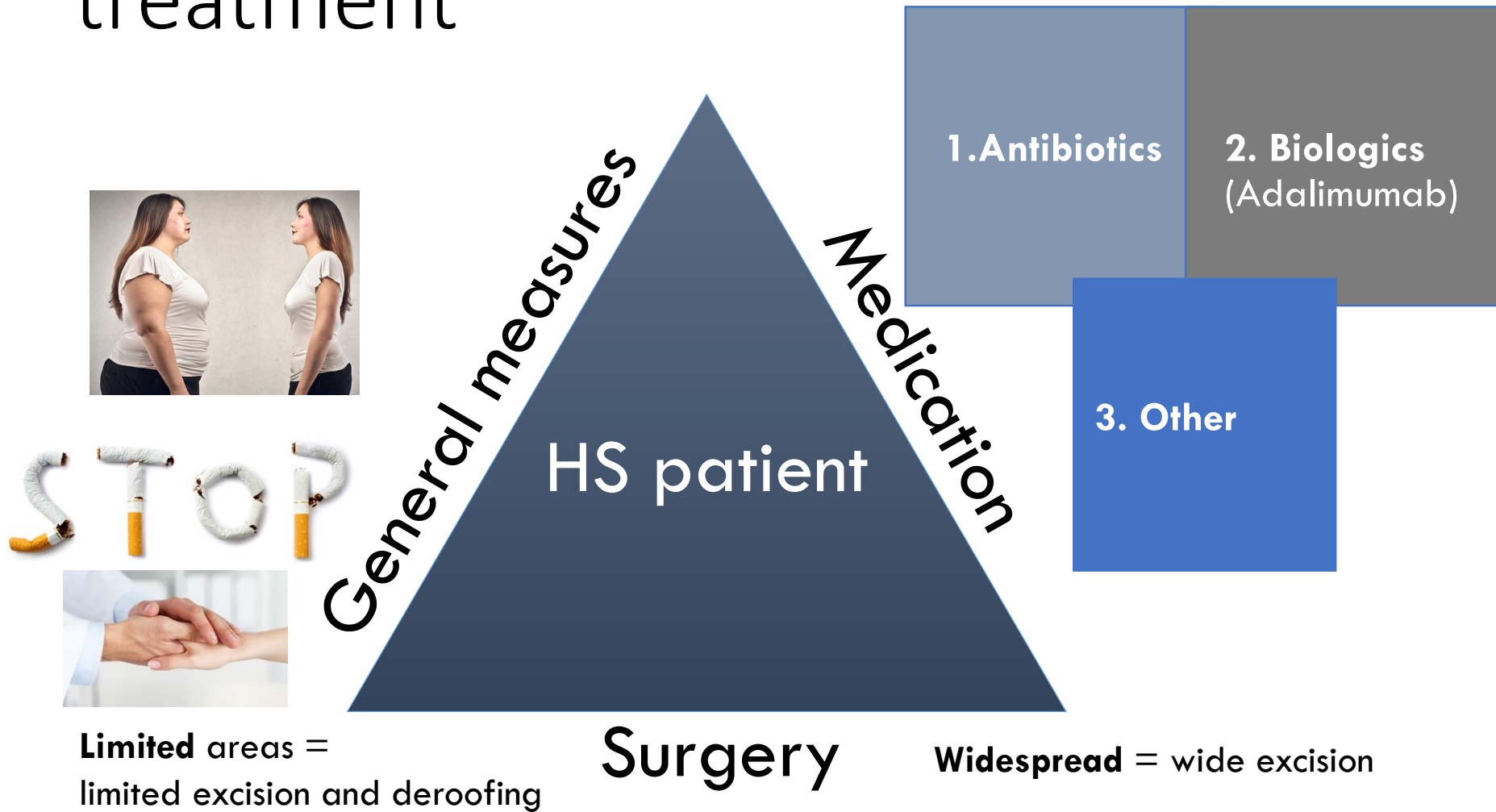
Weight loss, smoking, dressings, pain relief, superinfection

Grading

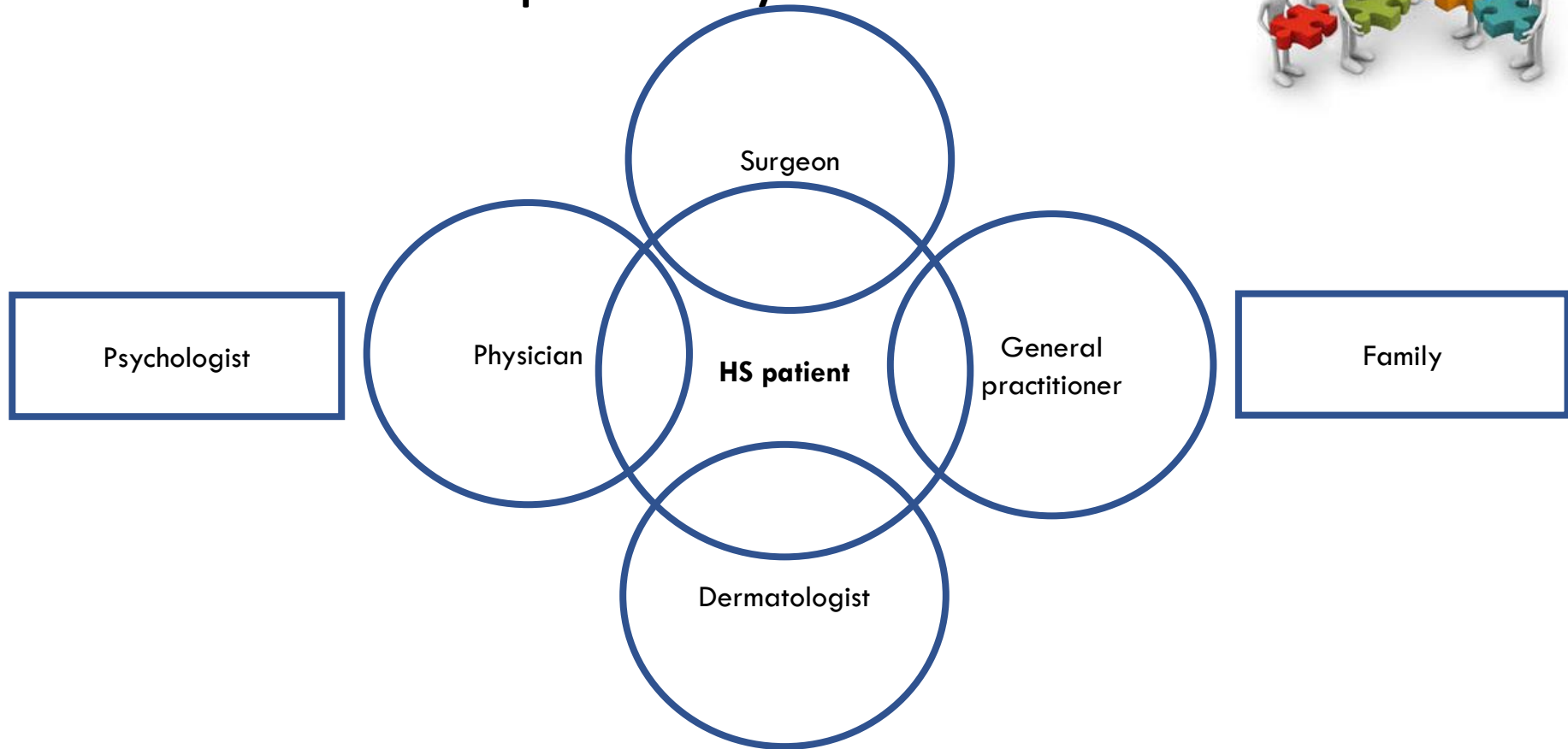
Hurley AND patients reported outcomes

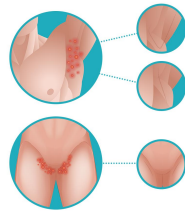


treatment



Multidisciplinary treatment





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Nappy rash

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Atopic dermatitis

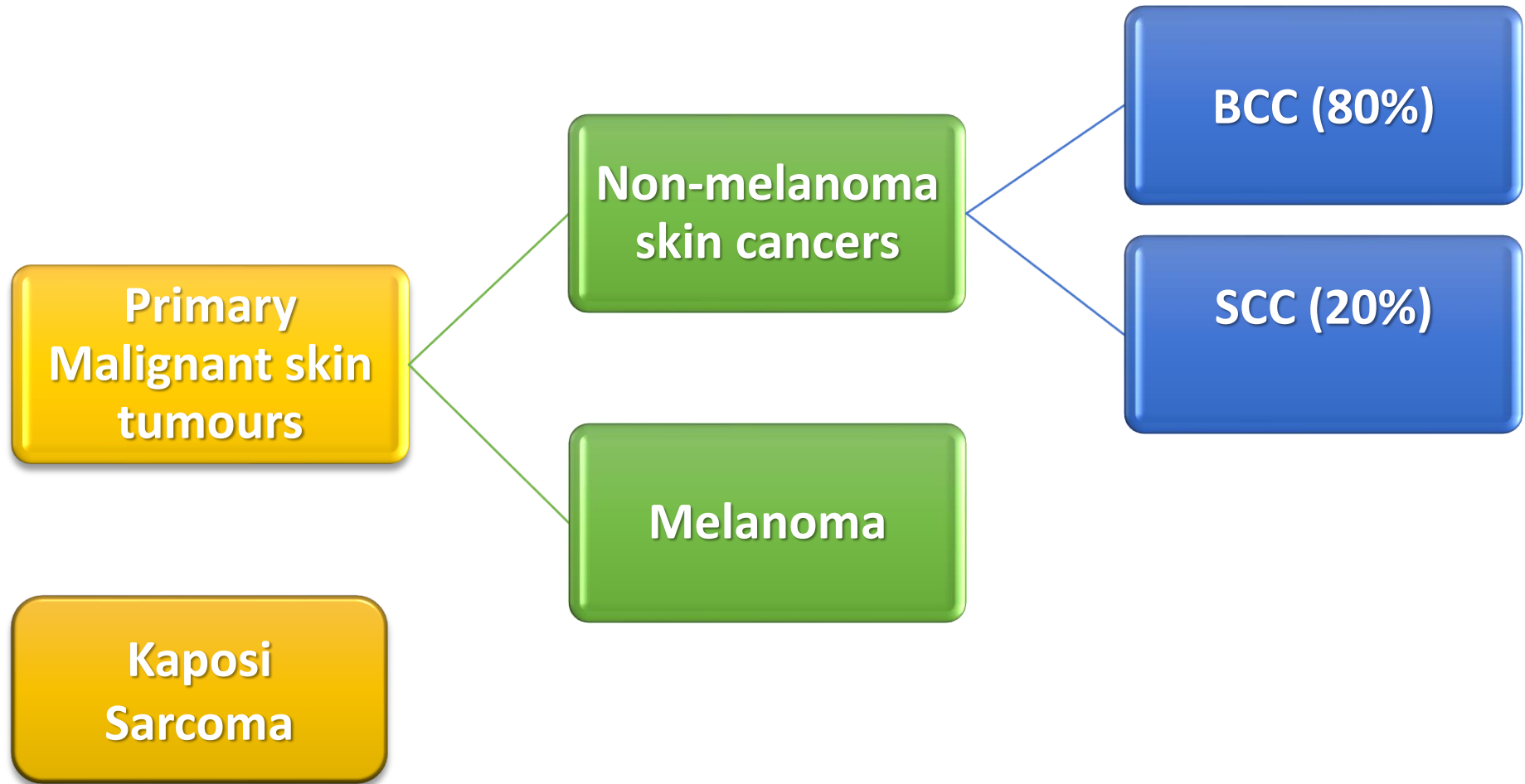
Acne vulgaris

Hidradenitis suppurativa

Skin cancer



Classification



BCC/SCC incidence

- Underestimated!!!
- BCC most common cancer in the United States
- SCC second most common skin cancer
- 3.5 million new cases (BCC/SCC) diagnosed in 2006 in the USA
- 40% of men and 30% of women will develop BCC

Melanoma incidence

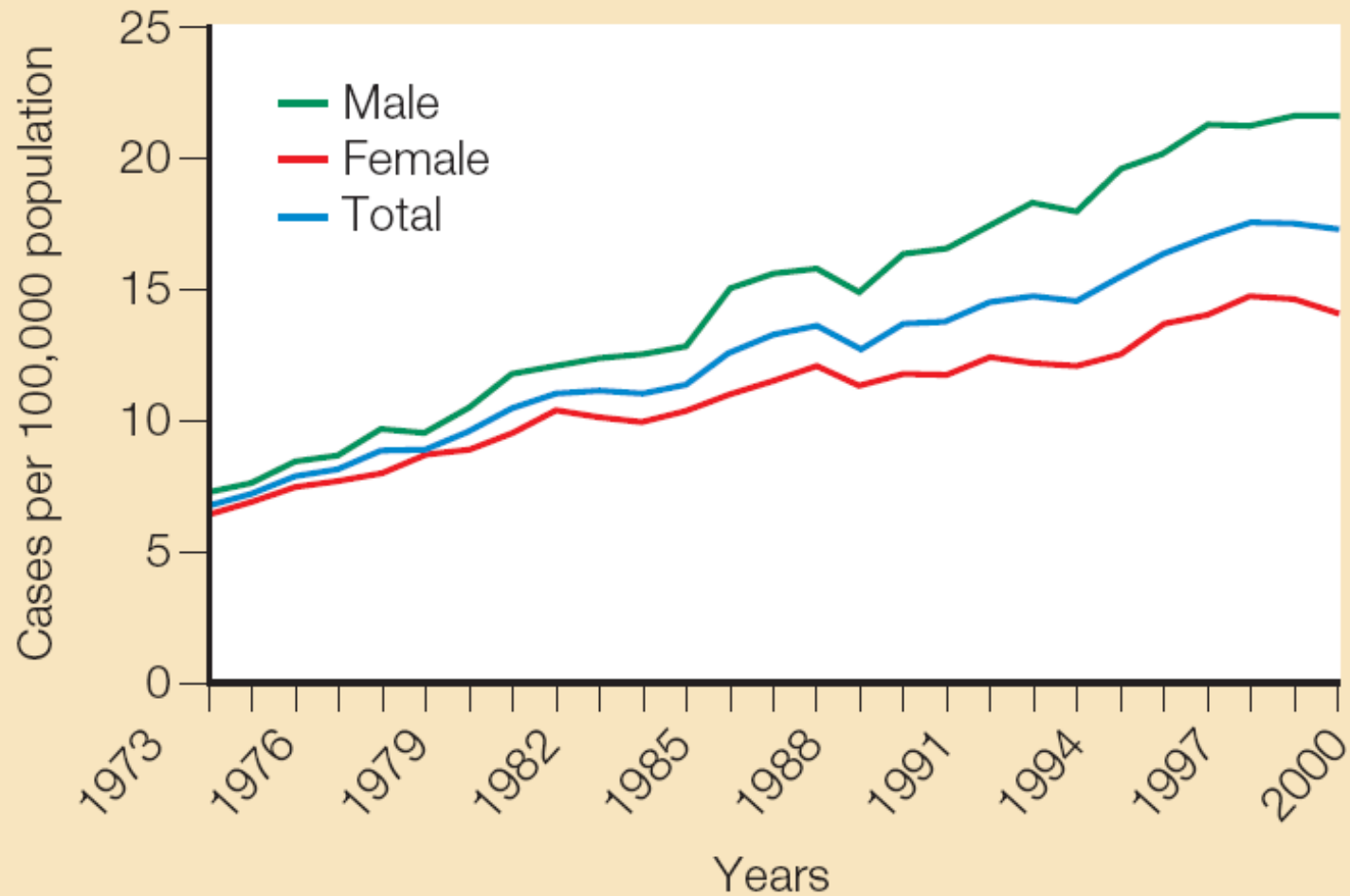
Table 4.1 Age-standardized incidence of melanoma in selected countries of the world

Country	Incidence rate ^a per 100,000	
	Male	Female
Columbia, Cali	2.5	2.7
Canada	8.5	7.5
United States, SEER White	15.4	11.6
United States, SEER Black	1.0	0.5
India, Mumbai (Bombay)	0.3	0.2
Israel, Jews	11.7	11.3
Israel, Non-Jews	1.0	0.9
Japan, Hiroshima	0.4	0.5
China, Beijing	0.3	0.2
Czech Republic	8.1	7.9
Denmark	10.5	13.4
Finland	8.0	6.7
Germany, Saarland	6.3	6.1
The Netherlands	8.0	10.9
Poland, Warsaw City	4.1	4.1
Spain, Murcia	4.1	5.4
Sweden	11.8	11.9
UK, England	5.8	7.4
UK, Scotland	7.1	9.9
Australia, New South Wales	36.9	25.9
Australia, Queensland	51.1	38.1
New Zealand	32.8	30.6

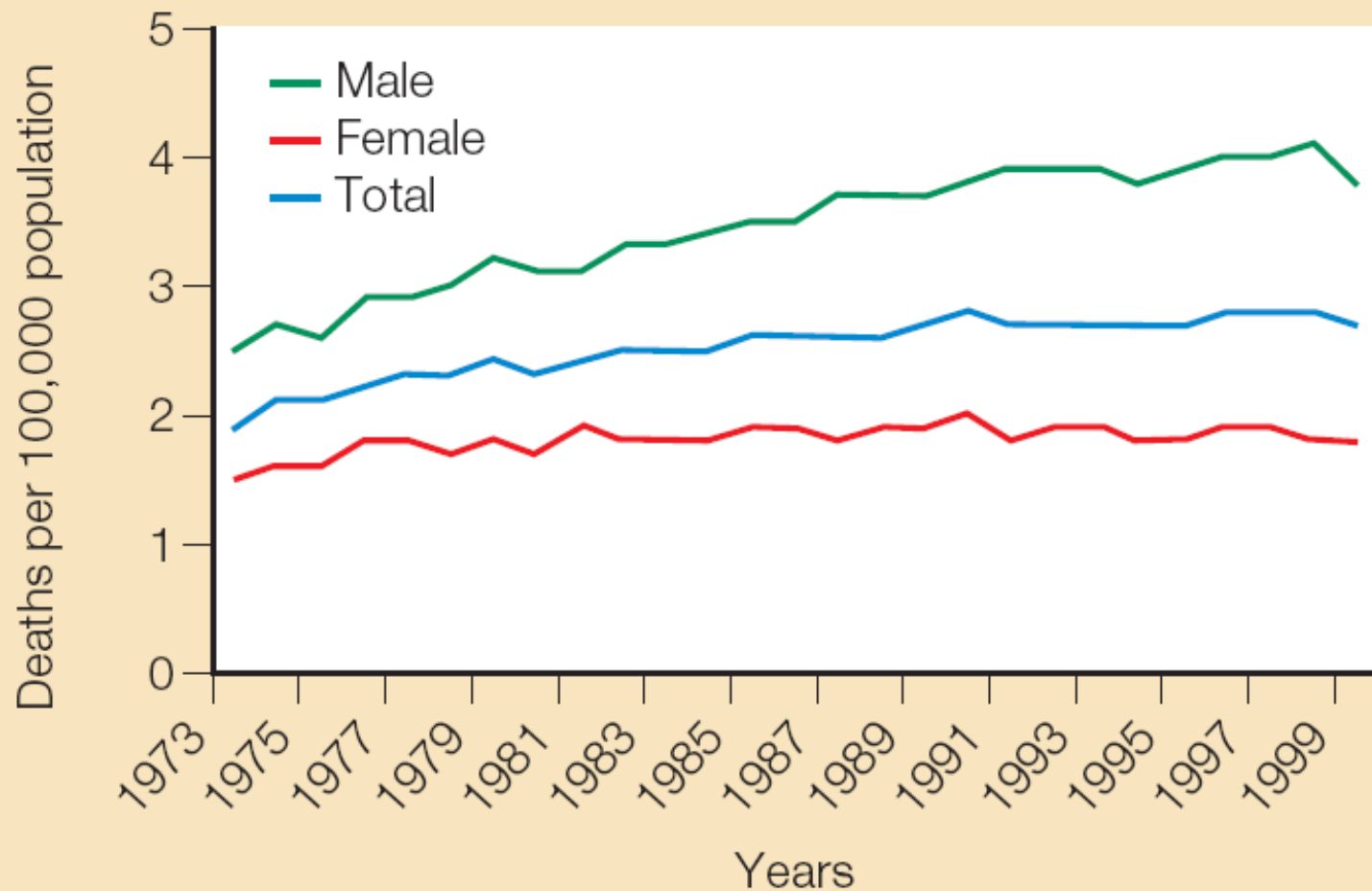
^aAge standardized at world population.

Source: Cancer Incidence in Five Continents, Vol. III. Lyon: IARC Scientific Publications; No 155, 2002

Melanoma epidemic



Melanoma deaths



South Africa Incidence

Mean age-standardised annual incidence of reported squamous cell carcinoma of the skin (SCC), basal cell carcinoma (BCC) and cutaneous melanoma (CM) per 100,000 persons in White populations of South Africa, 2000-2004.

BCC

198.3 (male)

112.8 (female)

SCC

69.5 (male)

31.8 (female)

CM

20.5 (male)

16.5 (female)

Skin malignancies are extremely common in South Africa

Dermatologists see:

BCC - every day

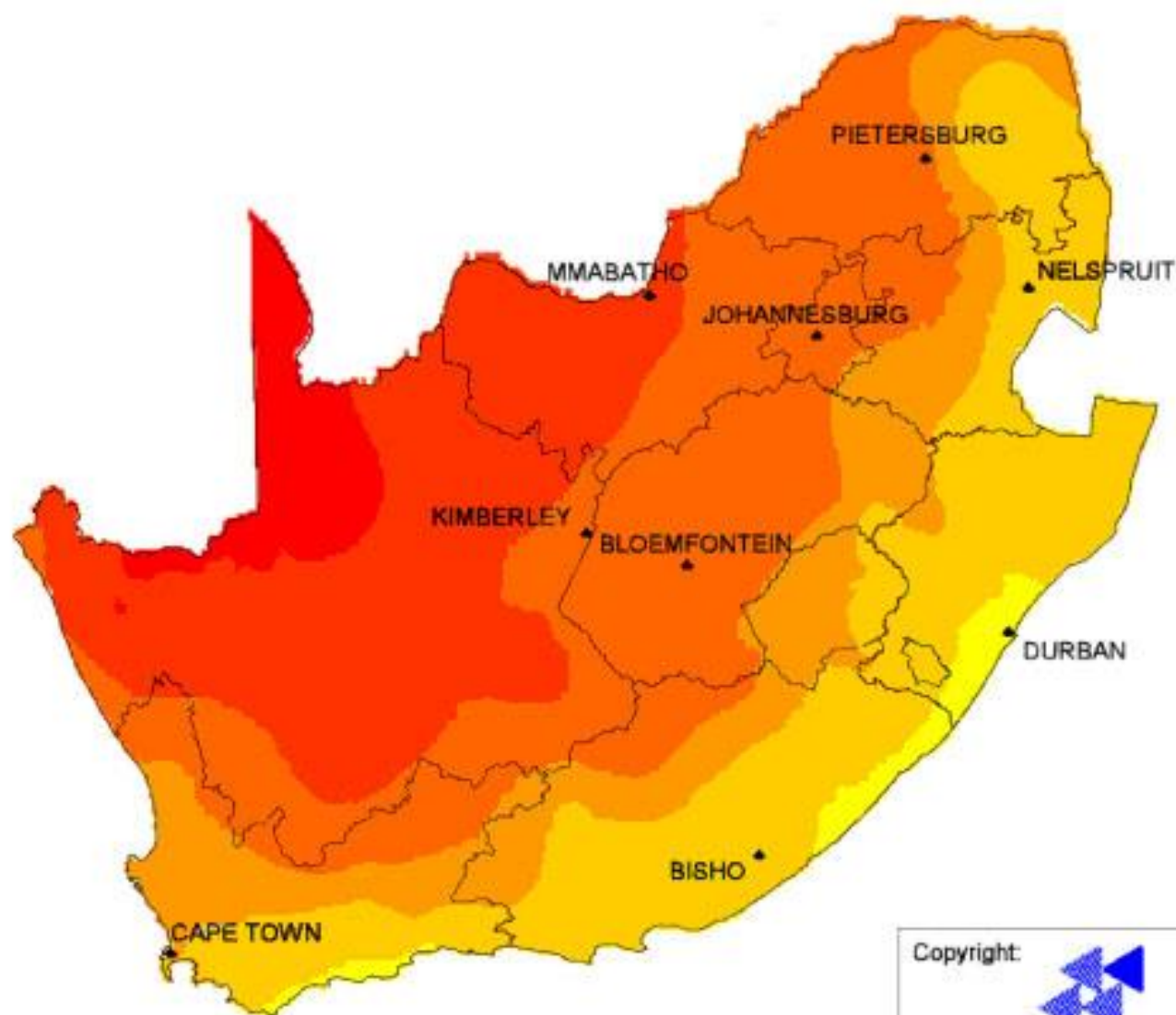
SCC - every week

MM - every month

Why the high incidence
in South Africa?



South African Renewable Energy Resource Database - Annual Solar Radiation



Annual global (direct plus diffuse) solar radiation received on a level surface.

Legend:

- Provincial boundaries
- Towns

Annual solar radiation

6000 - 6500 MJ/m ²
6501 - 7000 MJ/m ²
7001 - 7500 MJ/m ²
7501 - 8000 MJ/m ²
8001 - 8500 MJ/m ²
8501 - 9000 MJ/m ²
9001 - 9500 MJ/m ²



100 0 100 200 300 Kilometers

Copyright:



CSIR



ESKOM CORPORATE
TECHNOLOGY



MINERALS AND
ENERGY









Basal Cell Carcinoma

- nodule with ulceration
- pearly with telangiectatic vessels
- contact bleeding
- metastases : extremely rare
- locally destructive
- perineural spread → into skull









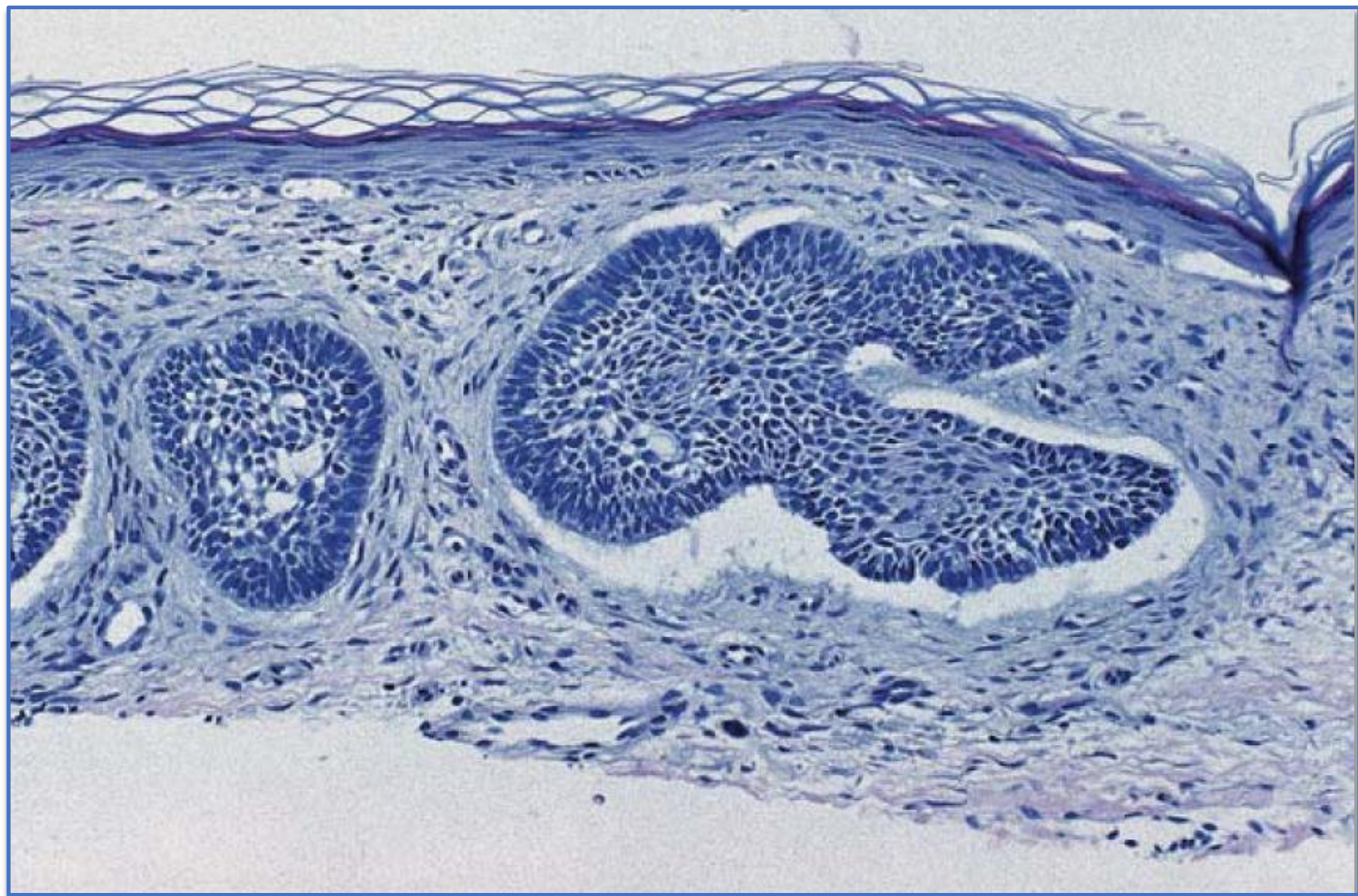




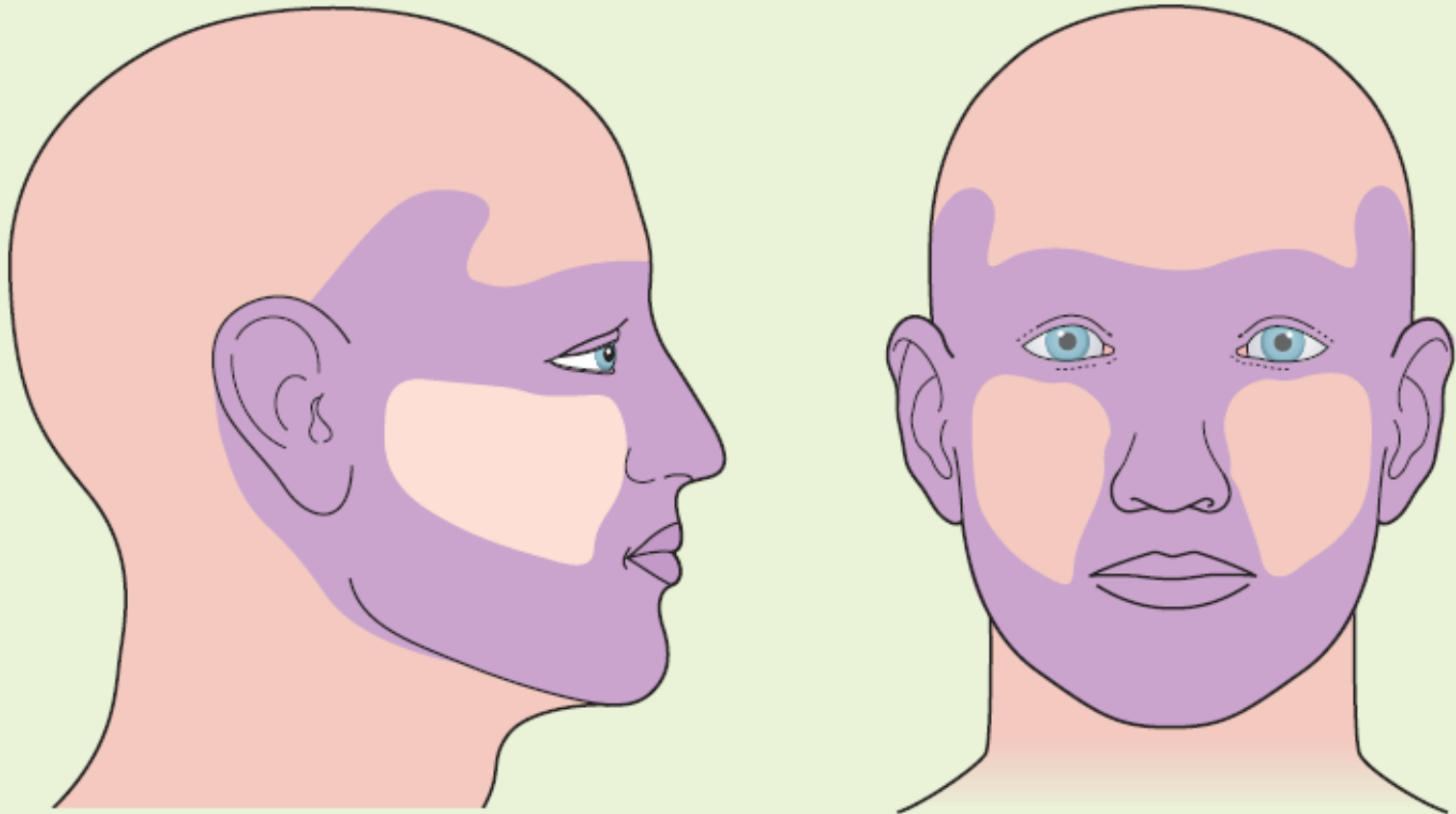








HIGH-RISK MASK AREA OF THE FACE



Treatment

- excision (Mohs' surgery)
- cryotherapy
- RT
- C&C
- intralesional interferon
- PDT
- imiquimod
- 5 FU

Learning points

- Catch lesions early
- Do not sit and watch doubtful lesions near the eye
- Non healing ulcers



Squamous cell carcinoma (SCC)

- Invasion
- Metastases : regional lymph nodes, beyond (mucosal)
- UV-light, smoking & HPV
- Keratotic lump
- Non-healing ulcer
- Rolled edge
- UV-areas

















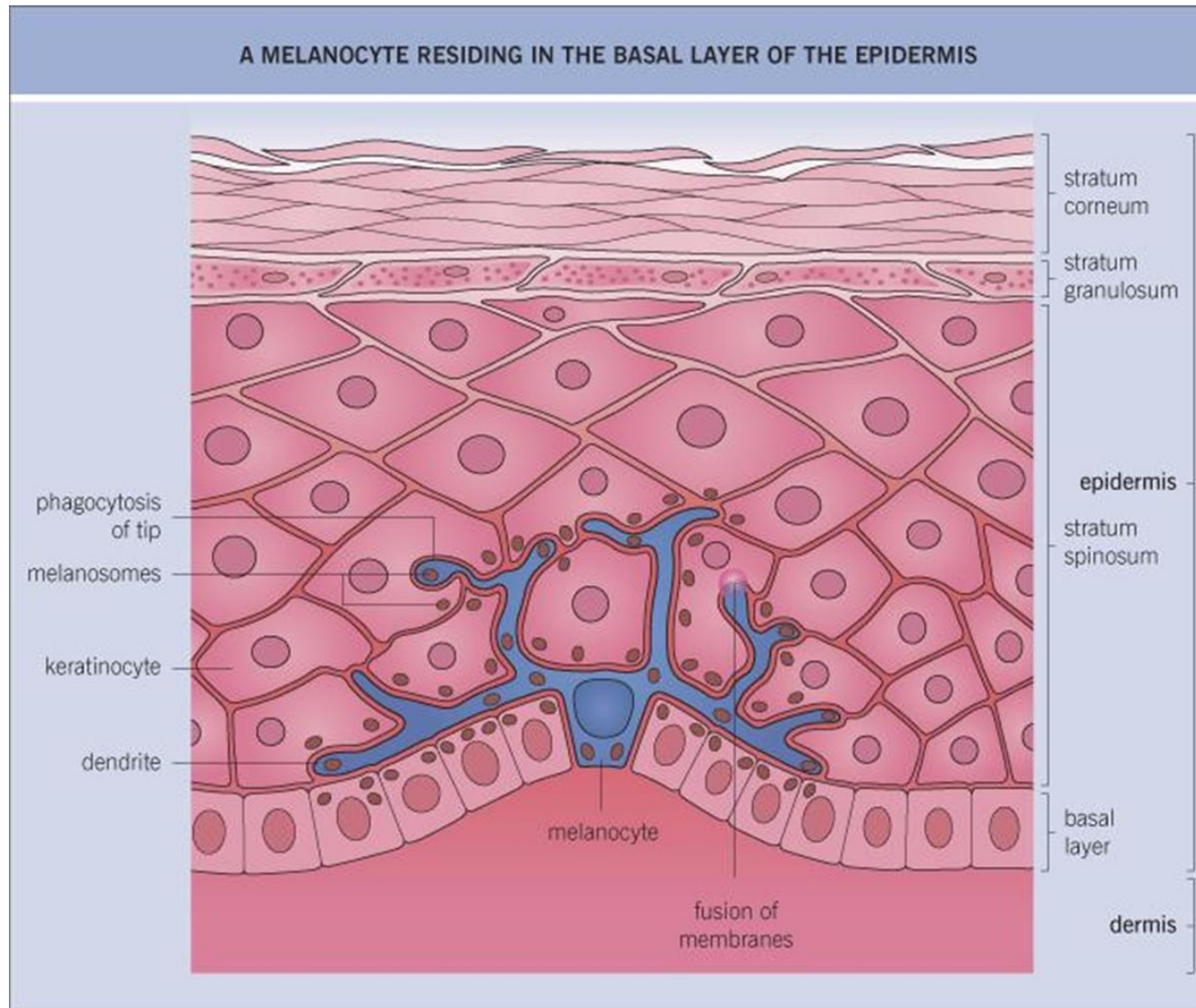
Treatment

- *excision (mainstay)*
- radiation therapy
 - surgery contraindicated
 - aggressive
 - metastatic disease

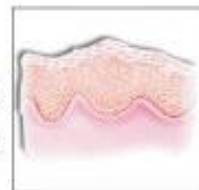
Learning points

- **Biopsy**
 - Non healing ulcers
 - Enlarging crusted lesions
 - Persistent keratotic lesion
 - Recurrent scab formation
- Fully examine sun damaged skin
- Remember the lips

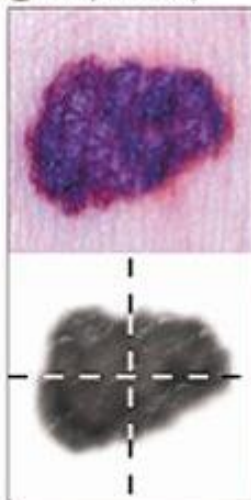
Melanoma



Melanoma, identification and diagnosis

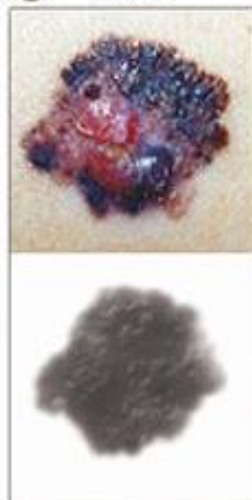


(A) Asymmetry



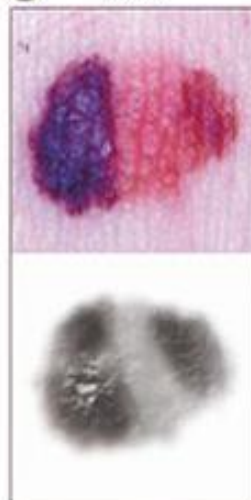
- Melanoma:
asymmetric

(B) Border



- Melanoma:
irregular borders

(C) Color



- Melanoma:
color not
homogeneous
(two or more tones:
brown, reddish, dark)

(D) Diameter



- Melanoma:
diameter >6 mm

ABCD E F

- A *a*symmetry
- B irregular *b*order
- C more than 2 – 3 *c*olours / change
- D *d*iameter > 6mm (20% < 6mm)
- E irregular *e*levation, *e*volution, *e*xamine
- F funny looking

F funny looking



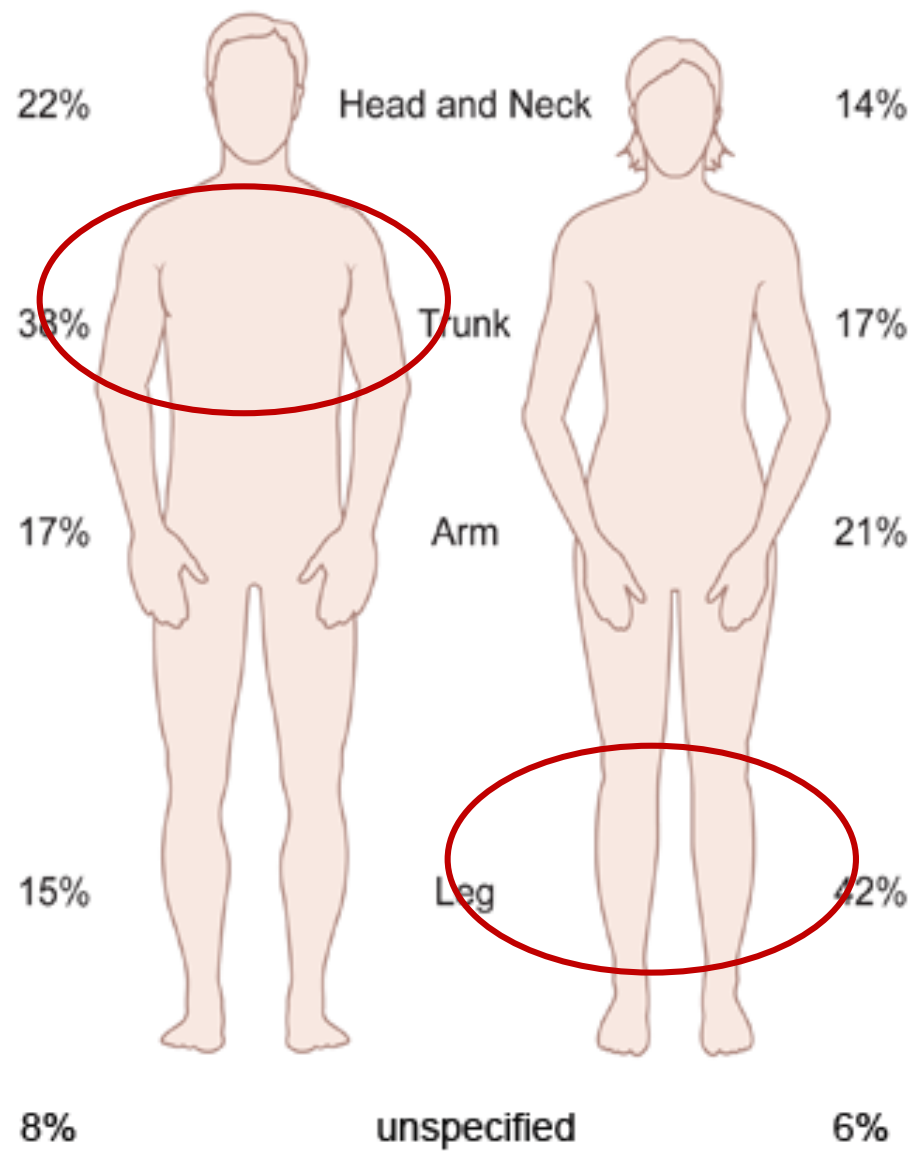


Diagram showing where melanoma is most likely to develop on the body
Copyright © CancerHelp UK

Important

- ◎ **Good lighting and magnification**
- ◎ **Train your eye**
- ◎ **Take a good history**
- ◎ **Identify high risk patients – refer, self examination**
- ◎ **Take note of any change**

Who is at higher risk?

- Personal history of melanoma
- Positive family history of melanoma
- Numerous nevi
- Dysplastic nevi
- Fair skin
- Red hair, blue eyes
- Nonmelanoma skin cancer
- Excessive UV exposure
- Indoor tanning
- Age
- Sex

What should we tell our patients?

◎ **Recognizing melanoma – ABCDE**

◎ **New and changing nevi**

◎ **Role of self-skin examination**

Ugly duckling sign



Ugly duckling sign

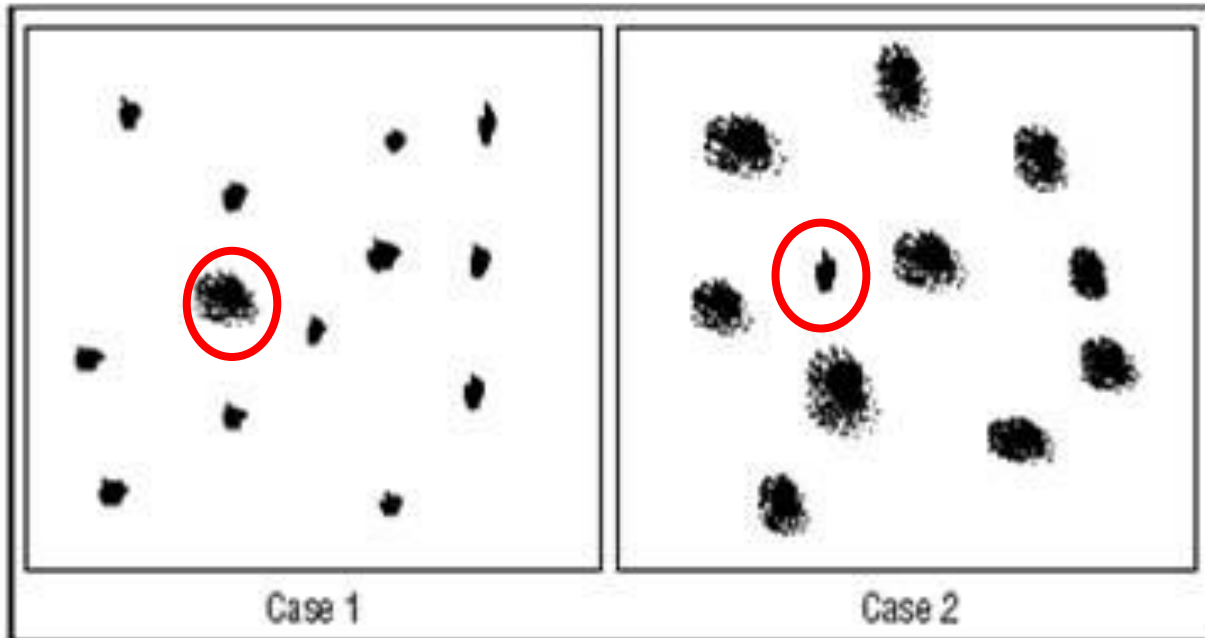


Figure 1. The “ugly duckling” nevus in case 1 deserves special attention, whereas a similar nevus would be considered normal in case 2, since most nevi share the same features. Conversely, the ugly duckling nevus in case 2 would be considered normal in case 1.

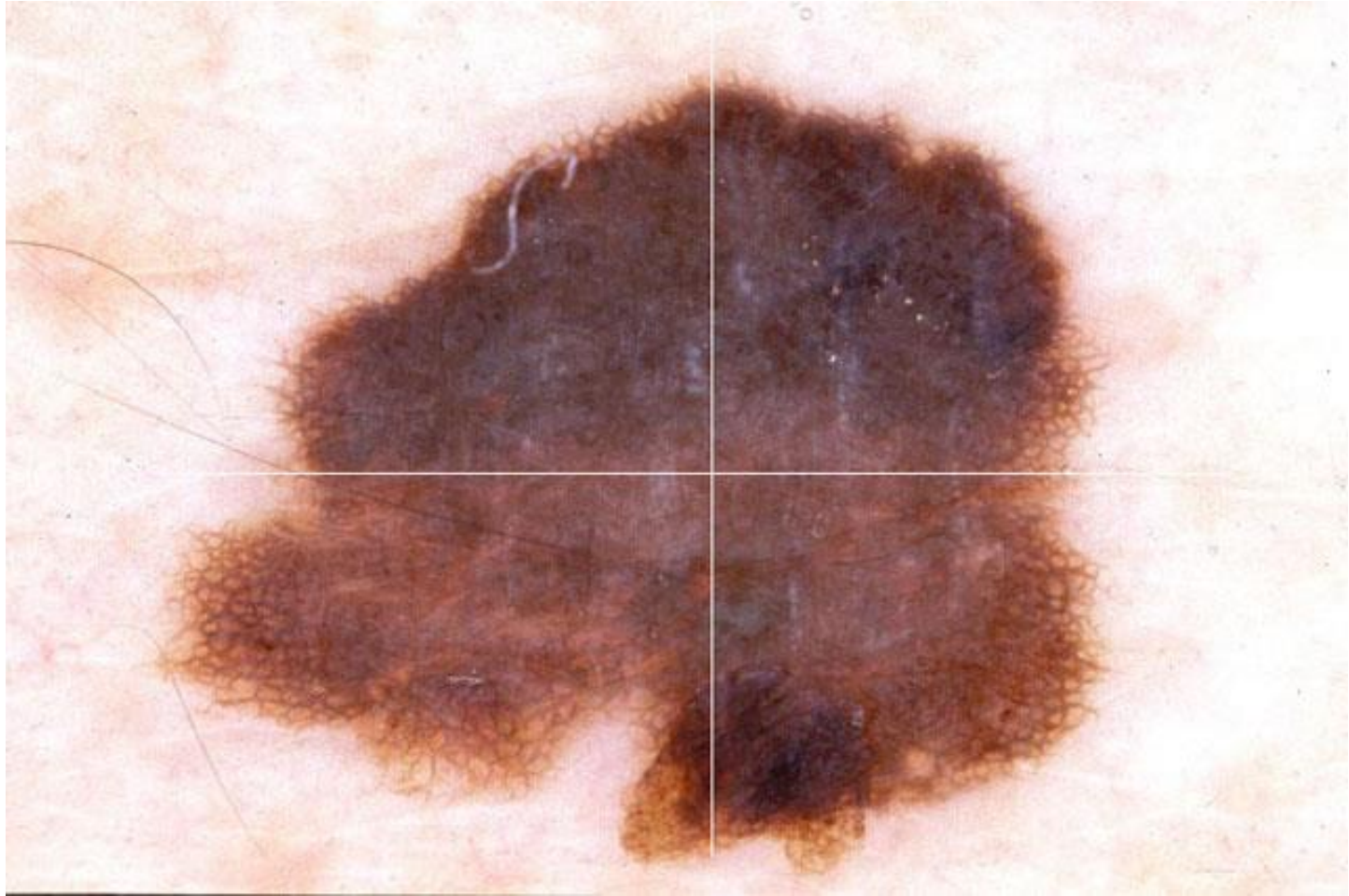
Ugly duckling sign



Dermatoscopy







Mole mapping



Image 1

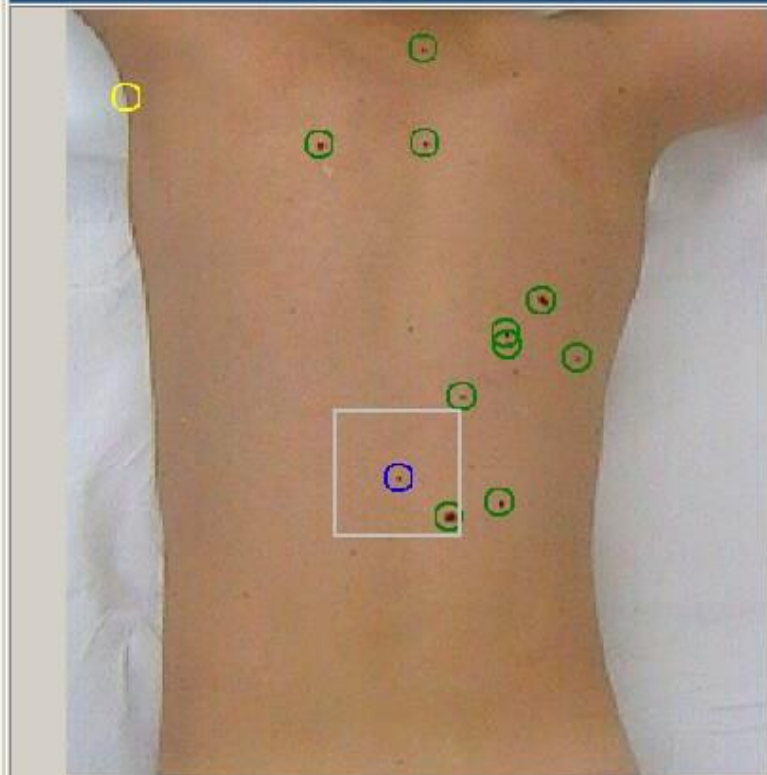
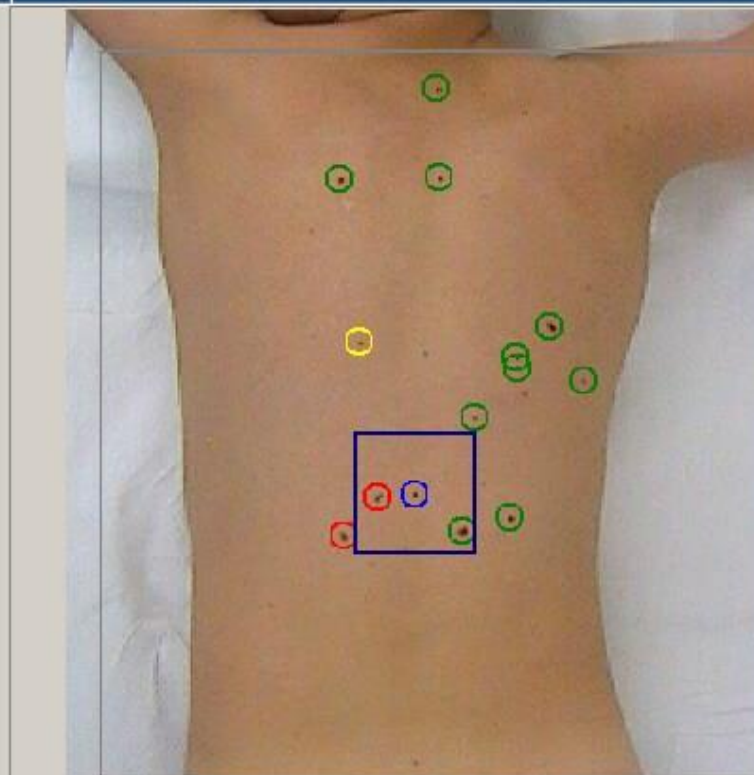
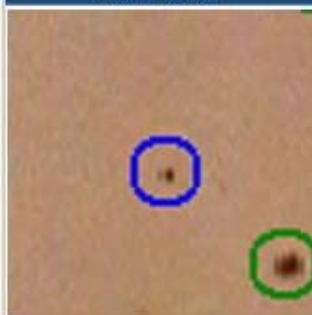


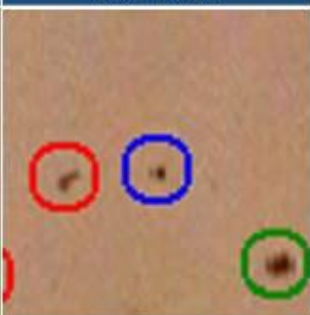
Image 2



Zoom Image 1



Zoom Image 2



Nevus Image 1



Nevus Image 2



Results

Area (px)	8.0	8.0
Form	1.17	1.17
Diff. Brightness	68.5	69.6
Inconspicuous Nevi	<input checked="" type="radio"/>	
New Nevi	<input type="radio"/>	
Conspicuous Nevi	<input type="radio"/>	

Process

Print

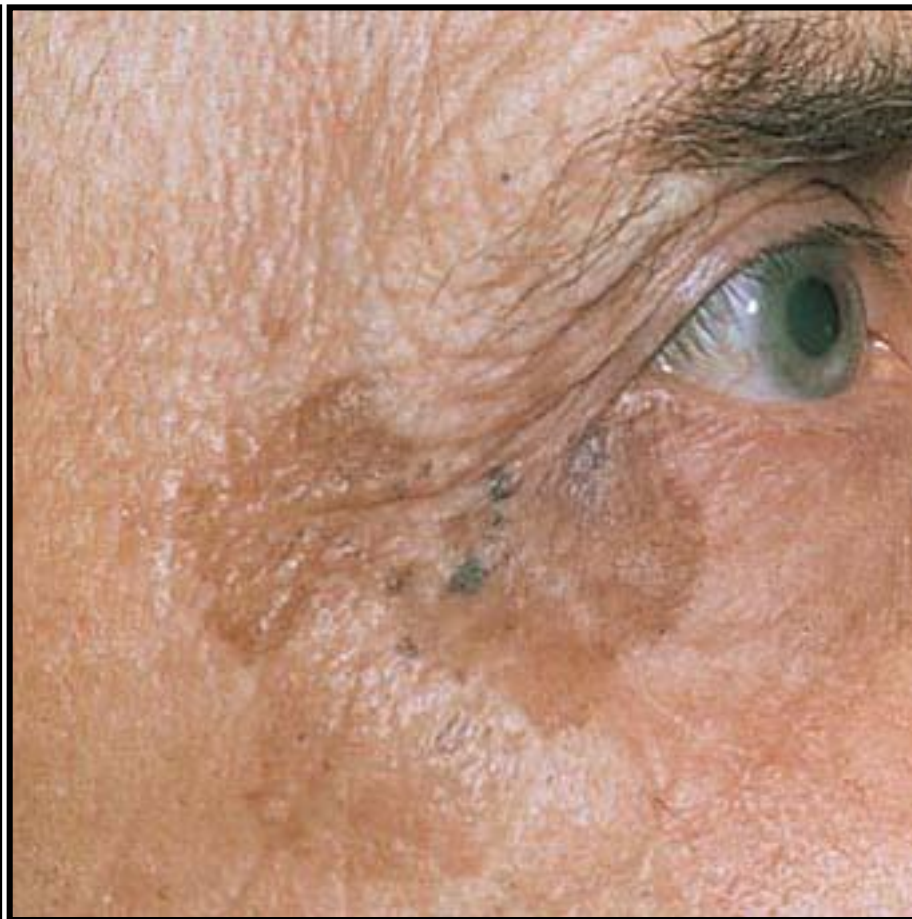
Close

10.09.2003

10.09.2003

Malignant Melamona In Situ





Superficial spreading melanoma





Nodular melanoma





Amelanotic melanoma





Acral melanomas



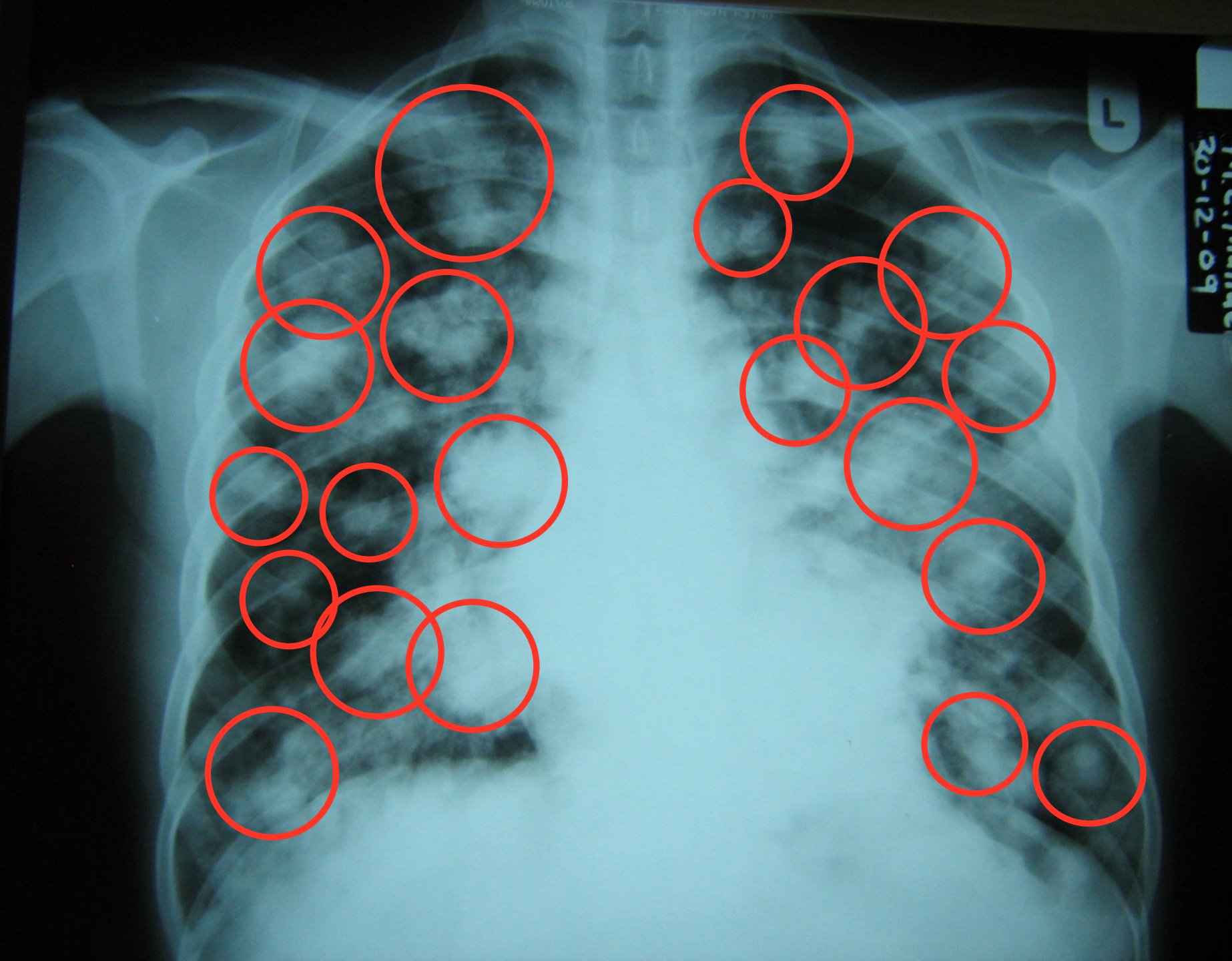






Metastatic melanoma





TREATMENT

- two stage procedure
- conservative excision / biopsy to establish diagnosis & Breslow
- therapeutic excision
- margin \equiv depth 1 – 3 cm
- elective LN excision : NO
- therapeutic LN excision : probably YES
- sentinel LN dissection : probably YES

Prevention of Skin Cancer

- ◎ avoid sunburn
- ◎ avoid UV-light between 11h00 - 15h00
- ◎ protective clothing
- ◎ sunscreen : SPF 30
- ◎ early diagnosis \equiv patient / physician knowledge

What must you now be able to do?

- ◎ Identify high risk patients
- ◎ Examine patient
- ◎ ABCDE - 'ugly duckling'
- ◎ If any doubt ---- REFER early
- ◎ Educate people – self examination, sunprotection



SunAWARE

Simple steps to prevent and detect skin cancers

- A** Avoid *unprotected* UV exposure, seek shade
- W** Wear sun protective clothing, a hat and sunglasses
- A** Apply sunscreen generously and often
- R** Routinely check skin and report changes
- E** Educate yourself and others



Thank you!



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