SMF PCP Treatment & Referral Guideline
Dermatology
Developed February 1, 2003; Reviewed: August 20, 2008; Revised: March, 2016

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PRIMARY CARE THERAPEUTIC ALGORITHM for COMMON DERMATOSES

Refer to COMMON THERAPEUTIC PRODUCTS IN DERMATOLOGY for medication selections.

**Suspected Tinea Cruris/Pedis/Corporis:** (superficial dermatophyte infection):
- Suggest over-the-counter OR prescription antifungal creams to AA bid x 2-3 weeks
- Can add antihistamine therapy for associated pruritus and as tolerated.
- Avoid potent steroid-combinations to face/groin/breast (ex: avoid Lotrisone).

**Suspected Tinea Versicolor:**
- Topical therapy: Recommend over-the-counter (selenium sulfide or ketoconazole) shampoo to AA for 15 minutes qd x 3-5 days OR OTC antifungal cream bid x 2 weeks.
- Oral Therapy: consider for widespread eruptions
- Remind patient that hypopigmentation will resolve over several weeks despite rapid mycologic cure.
- Avoid sun exposure in order to minimize accentuation of pigment contrast.
- Consider Shampoo/cream Rx 2-4 times a month for maintenance (prophylactic) therapy.

**Suspected Eczematous Conditions:**
- Important to educate patients that there are “no cures” - Therapies are intended to relieve symptoms of itch, reduce inflammation (ie: erythema, edema, scale), and to minimize recurrences by optimizing epidermal barrier (barrier repair may take several weeks)

I. *Atopic Dermatitis/Eczema:*

- General Recommendations:
  - Daily baths are appropriate. Use gentle cleansers, avoid scrubbing. Limit duration to 3-5 min in tepid water → pat skin dry → immediately proceed with medication and moisturizing as described below within 3 minutes to prevent evaporation of moisture in skin.

- Prescription therapy: Topical immunomodulator or steroid cream/ointment (specific for body region). Medication should be applied generously, bid to AA x 1-2 weeks only.

- Moisturizers: For successful skin hydration, Ointments > Creams > Lotions. Apply liberally and repeat several times a day if needed.

- Antihistamines should be included on a regular basis to minimize reflexive scratching/excoriations.

- Consider non-sedating formulation in am with sedating formulation at HS.

- Addition of topical or oral antibiotics is appropriate for secondary impetiginization.

- Systemic steroids can effectively resolve severe flares of eczema (>50% TBSA; 3-week slow prednisone taper); however, consider systemic risks of repeated treatments.
II. Seborrheic Dermatitis:
Scalp/face/chest: Nizoral (ketoconazole), Zinc Pyrithione, Selenium Sulfide shampoos minimum 2-3 x/week (all over-the-counter), gentle fashion. Sal Acid containing shampoos may aid in reducing scale (ex: T-Sal shampoo by Neutrogena or DHS). Tar shampoos effective but can stain light colored, white-gray, or highlighted hair.

Add steroid solution to AA on scalp bid prn pruritus.

Antihistamine therapy as tolerated for pruritus.

Face/Trunk: Topical immunomodulator or steroid agent (specific to body region) to AA bid x 1-2 weeks prn.

Avoid hot water, irritants, scrubbing. Apply daily bland moisturizer to optimize epidermal barrier.

Addition of topical or oral antibiotics are appropriate for secondary folliculitis or impetiginization.

III. Contact or Nummular Dermatitis:
Remove offending agent if known.

Topical immunomodulator or steroid cream/ointment (specific to body region) to AA bid x 1-2 weeks only.

Antihistamine therapy as tolerated for pruritus.

Avoid hot water, irritants, scrubbing. Apply daily bland moisturizer to optimize epidermal barrier.

Addition of topical or oral antibiotics is appropriate for secondary impetiginization or infection.

IV. Hand Dermatitis:
Mid to potent steroid ointment bid x 1-2 weeks to areas of active inflammation (redness, edema, pruritus)

Scale will result from preceding inflammation. This can be helped with simple moisturizing (caution: some keratolytic agents can be irritating).

Antihistamine therapy for pruritus and as tolerated.

Avoidance of chemicals, detergents, excess use of soaps, fragrances, or other aggravating agents.

Use of rubber gloves with cotton liners with prolonged exposure to water, cleansers.

Moisturize on a frequent basis (ideally after water exposure). Superglue to fissures.
Addition of topical or oral antibiotics is appropriate for secondary impetiginization.

V. **Stasis Dermatitis (secondary to venous insufficiency):**
Mid to potent ointment bid x 1-2 weeks.

Moisturize bid-tid to entire legs.

Antihistamine therapy for pruritus and as tolerated.

Must minimize lymphedema: leg elevation; walking/exercise as tolerated; 15-20 mmHg compression stockings during waking hours on regular basis; wt management.

Educate patient to that discoloration may persist.

VI. **Asteototic Dermatitis:**
TAC 0.1% cream or ointment bid until inflammation resolves (usually within 1 week).

Avoid aggressive cleansing, hot water exposures or prolonged immersion in water.

Limit bathing to 3-5 min in tepid water using mild soap if needed → pat skin dry → immediately proceed with medication and emolliation as described above (see Atopic Dermatitis).

Continued and regular moisturizing bid-tid

Antihistamine therapy for pruritus and as tolerated.

Psoriasis:
Appropriate steroid agent bid until plaques thin to level of normal skin (redness may temporarily persist). Continue frequent moisturizing (bid-tid) to entire body following application of medication.

Encouraged daily use of OTC moisturizers. Steroids/Rx’s are NOT to be used as their emollient.

Antihistamine therapy for pruritus and as tolerated.

Can consider Dovonex cream or Vectical ointment bid to specific lesions bid Mon-Fri with application of a potent steroid to lesions bid on weekends. Alternative: Dovonex/Vectical qam then topical steroid qHS to focal lesions. Limit total volume of Dovonex to 120 grams per week

Limit total volume of Vectical to 200 grams per week.

Avoid skin injury (koebnerization).

Suggest controlled sun exposure (20 min sun exposure avoiding 10-4 pm hours).
Scalp involvement: Appropriate shampoo use with the addition of liquid steroid solution for pruritus; possible keratolytic with steroid (DermaSmoothe FS).

Assess for arthralgias. If suspect psoriatic arthritis, consider referral to rheumatology

**Hair Loss**

Differentiate between Scarring processes (redness, scale, itch, pain) vs Non-Scarring processes

Scarring or Inflammatory Conditions require treatment to prevent further hair loss

Non-Scarring or Non-inflammatory conditions are often difficult to reverse.

**Alopecia Areata – a Non-scarring condition:**

Apply a topical immunomodulator or steroid cream/ointment to outer rim of AA qd-bid for 3-6 months → monitor for hair regrowth. Hair may be depigmented in early regrowth phase.

If resistant to therapy or extensive → refer to Dermatology.

Assess for associated conditions based on clinical exam and ROS: thyroid disease, rheumatoid arthritis, pernicious anemia, vitiligo. Few small patches in adults are less concerning for associated internal disorders. New widespread patches in adults or Pediatric cases can have a higher rate of associations.

**Vitiligo:**

Consider topical immunomodulator or steroid cream/ointment (specific to body region) for 3-6 months → monitor for repigmentation (follicular or rim pattern)

Avoid skin injury (koebnerization).

Suggest controlled sun exposure (20 min sun exposure avoiding 10-4 pm hours). Remind patients that the normal surrounding skin will tan more rapidly, producing a increase in the cosmetic contrast of skin coloration.

All other times, continue sun-protection to AAs.

Topical camouflage creams may be useful. Artificial skin tanners (vegetable dyes) can also minimize appearance of depigmentation (not considered sun protective however).

**Warts/Molluscum Contagiosum:**

Liquid Nitrogen (cryotherapy) 15-20 second rapid freeze → let thaw, repeat.

Expect potential blistering or transudate

Reassess in 3 to 4 weeks for retreatment

Patient can use OTC Sal acid plasters (ex: Mediplast or Sal Acid liquids plus duct tape occlusion) after inflammation subsides from cryotherapy (approx 1 week)
Avoid picking and trauma (koebnerization).

If NO signs of improvement after 3 visits refer to Dermatology

**Non-symptomatic onychomycosis:** (unknown whether oral therapy qualifies for insurance coverage)
Consider OTC antifungal solution qHS OR prescription antifungal cream/agent to tip of affected nail(s) qHS for 6 months minimum.

Trim and file plates to minimize micro-lifting from shoes; keep cool and dry

**Scabies (Non-Norwegian):**
Permethrin 5% (Elimite) cream to entire body neck down at night (include nails, genitalia, skin folds) shower in am.

Repeat in 1 week

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 and as tolerated.

Warn patients of possible “post-scabetic itch” (prolong inflammation) which may last 2 months.
Rx topical steroid agent (specific for body region) bid x 2 weeks. Increase emolliation.

**Herpes Simplex and Varicella Zoster:**
Recommend confirmation of condition with a viral culture if necessary.

See Common Therapeutic Product Guideline for specific treatments and dosages.

Consider IV Acyclovir therapy for diffuse eruptions (ex: eczema herpeticum) or eruptions in immunocompromised hosts (higher risk of viremia with associated conditions, including pneumonitis, meningitis with varicella).

**Acne Vulgaris:**
Gentle cleansing only; avoid OTC scrubs, astringents, toners, and other acne products while introducing prescription medications.

Avoid physical manipulation (ie: picking) which can promote scar formation.

Consider birth control pills for mild to moderate acne if appropriate
Educate patients that therapy requires 6-8 weeks to initiate effect.
Appearance of scars (atrophy, redness, discoloration) will improve within 6-12 months after acne inflammation has subsided. Encourage patience before pursuing cosmetic intervention.

A. Comedones only:

Begin a topical retinoid or non-retinoid comedolytic agent each evening.

Warning: these products can produce irritation and sun-sensitivity!

Start with application 2 nights per week, then gradually increase an additional evening application every two weeks as tolerated.

If stinging occurs, wait 20 minutes after washing face.

Avoid application close to eyelid margins, creases of nose, and around mouth.

Initiate non-acne promoting facial sunscreen moisturizers in am-tid for comfort.

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.

Reassess in 3 to 4 months. Can add the choice not selected above if little or no benefit is achieved.

B. Comedones, limited red papules, few pustules:

Begin a topical retinoid or non-retinoid comedolytic agent each evening (see above).

Add a topical antibiotic agent in the morning.

Reassess in 3 months. If little or no benefit is achieved, proceed to C below

C. Comedones, many red papules, many pustules:

Begin a topical retinoid or non-retinoid comedolytic agent each evening (see above).

Warning: these products can produce irritation and sun-sensitivity!

Add oral antibiotic treatment.

Reassess in 3 months. Expect > 50% improvement. Continue therapy only with ongoing improvement, then initiate withdrawal (average 6 months).

If < 50% improvement, proceed to next oral medication choice above.

D. Nodulocystic acne:
Initiate oral antibiotic therapy as above.

Consider screening patient for isotretinoin therapy

**Acne Rosacea:**

A. Telangiectatic: If possible, avoid conditions that produce vasodilatation or increase in redness (alcohol, spicy foods, sun exposure, caffeine). Patient may opt to pursue cosmetic intervention with laser/light treatments. MIRVASO topical cream q day (vasoconstriction) also available.

B. Mild papular acne: Topical metronidazole formulation qd-bid. Allow 2 months to assess efficacy.

C. Significant papules/cysts: Initiate oral antibiotic therapy as outlined for Acne Vulgaris

   Consider the addition of Azeleic Acid produce at night.

   Consider isotretionoin

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

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

Perioral Acne:

Variant of Rosacea; often Steroid induced.

Topical Metronidazole (Metrogel, Metrolotion, or Metrocreme). First line, may be slow to clear.

Patience.

Consider oral Abx 2-4 weeks (EES, TCN, Doxycycline).

Consider spironolactone (assess renal function status): 25-100 mg/day dosage if persistent in adult women.

Avoid topical steroid agents; can consider topical immunomodulator cream/ointment.

**Cysts (Epidermal Inclusion, Pilar, Other benign cystic lesions):**

No intervention indicated unless progressive growth, irritation, history of inflammation or infection.

If infected → initiate appropriate antibiotic coverage.
If inflamed → consider intralesional kenalog injection (10 to 40 mg/ml concentration depending on size and location).
Can perform I&D to relieve pressure; however, cyst may reform.

Consider surgical excision for persistent, problematic cysts when quiescent.

**Hypertrophic Scar/Keloid:**
Scars are addressed by alterations of contour, texture, color, and symptoms.

Improvement in *symptoms* (pain, pruritus), *firmness*, and *elevation* may be obtained with intrallesional kenalog injections (10 to 40 mg/ml concentration range injected into the firm component of scar).

Repeat injections q month and reassess for improvement, reducing concentration as scar thins; withhold once scars reduce to level of surrounding skin.

Risk of excessive injections = atrophy or herniation of soft tissue.

Scar may ‘re-thicken’ and require repeat treatments in future.

If a clinical scar ‘grows, bleeds, appears asymmetric, or is unexplained’, consider biopsy evaluation prior to intervention.

**Melanocytic Nevi:**
May be congenital or early acquired, and continue to develop through mid adult life.

Pattern should remain consistent on an individual (ie: normal spots tend to join the herd)

If a mole appears ‘unique’ (black sheep), changes (outline, color, texture, rapid growth), develops symptoms (bleeding, unprovoked itch) → Proceed with full excision (depth to superficial subcutaneous fat with narrow margins-2 mm) to allow for thorough pathologic examination OR refer to Dermatology.

Shave procedures may result in “transaction of nevus” at deep margin.

**Actinic Keratosis/ Actinic Cheilitis:**
Appear as scaly, telangiectatic, possibly pigmented or hyperkeratotic lesions on sun-exposed areas.

Precursors to squamous cell carcinoma; however, slow to transform.

Treatment for Discrete AKs: Cryotherapy 10 seconds → thaw → repeat.

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

Field AKs: consider topical chemotherapy product or refer to Dermatology.

**Suspected non-melanoma Cutaneous Neoplasm:**
Consider ‘neoplasm’ in lesions that enlarge, bleed, persist despite primary intervention (cryo, FU)

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

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

**Diagnoses for which intervention and/or treatment may not be covered under insurance plans**

- Rhyrtids (wrinkles), Photoaging
- Seborrheic keratosis
- Benign cysts, milia
- Angiomas
- Benign Nevi
- Lentigines
- Melasma
- Lipomas
- Acrochordons (skin tags)

Removal or treatment may be indicated with associated symptoms, enlargement, interference with hygiene or clothing
COMMON THERAPEUTIC PRODUCTS in DERMATOLOGY

Quantity Guideline:

Adults: Approximately 30 gm will cover the average body x1
15 gm will cover the hands qd x 1 week
1 gm will cover the face x 1

Children: Reduction of quantity per age (body surface area)
‘small’ = 15 gm tube ‘medium’ (average) = 30 gm tube ‘large’ = >60 gm tube

Indications for therapy: “Rash” = “inflammation” (hyperemia, edema, scale, pruritus). These areas are “palpable”
(If skin appears just rough, dry, scaly, brown, thickened, or smooth red color → advise simple moisturizing and repair)

Duration of therapies: In general, clinical response should be observed in 1 to 2 weeks with appropriate volume and regularity of application (often sooner).

**Topical Immunomodulator Agents:** sig: Apply to AA bid (all body sites) x 1-2 weeks prn ‘rash’
Elidel (pimecrolimus) cream (>2 yo)
Protopic (tacrolimus) 0.03% ointment (ages 2-15 yo)
0.1% ointment (>15 yo)

**Topical Steroid Agents:**

Eyelid margins: sig: Apply to AA bid x 1 week prn ‘rash’
Prefer immunomodulator agents: Elidel, Protopic.
Steroid agents: Hydrocortisone 0.5% ointment (OTC) or ophthalmic dexamethasone drops.
Aquaphor (or Vaseline petroleum jelly = VPJ) qHS for maintenance care.

Face/Groin/Axilla: sig: Apply to AA bid x 1-2 weeks prn ‘rash’
Hydrocortisone 1% cream or ointment (OTC) or 2.5% cream or ointment
Desonide 0.05% cream or ointment (15, 30, 60 gm tubes)

Body/Extremities: sig: Apply to AA bid prn ‘rash’
TAC 0.025%, 0.05% or 0.1% cream or ointment (15, 30, 60, 240 gm) (mild-mid strength)
Fluocinonide (Lidex) cream, ointment (mid-upper strength)
Clobetasol, Betamethasone cream, ointment (strong)

Scalp: Fluocinolone 0.025% (Synalar) solution to scalp (few drops with finger tips) at night for pruritus → can shampoo in am (60, 120 ml) (mild strength)
Can consider Fluocinonide (Lidex-mid-upper) or Clobetasol (strong) solution
Dermasmoothe FS oil to scalp at night → shampoo in am.

**Topical Antifungal agents:** sig: Can apply to toenails (tips) and/or affected area bid
Clotrimazole 1% cream or solution (Lotrimin) – OTC
Terbinafine 1% cream (Lamisil) – OTC
Miconazole Nitrate 2% solution (Fungoid Tincture) – OTC
Naftifine 1% liquid (Naftin gel) (15, 30, 60 ml)
Econazole 1% cream (Spectazole) (15, 30, 85 mg)

Ketoconazole (Nizorall) shampoo
NO Lotrisone!

**Oral Antifungal Treatment for Tinea Versicolor:**  If pt is a candidate. Assess for med interactions.
- Terbinafine: 250 mg p qd x 14 days
- Fluconazole: 150-200 mg qd x 7 days OR 150-200 mg q week x 3 consecutive weeks

**Topical Moisturizers:**  Efficacy: Ointments > Creams > Lotions.
sig: Apply to entire body qd-bid.
Best agent: Affordable, easily located, preferred vehicle to the patient.
Ex: Vaseline petroleum jelly (ideal), Aquaphor, Cetaphil, Cerave, Eucerin, Lubriderm, Aveeno

**Keratolytic Emollients:**
sig: Apply to affected area qd-bid for removal of ‘scale’
Caution: do not apply to areas of active ‘inflammation’. These products may sting when applied to open fissures.
- Carmol 20 (urea) cream - OTC
- Carmol 40 cream
- Am Lactin (lactic acid) cream - OTC
- Lac Hydrin (lactic acid) lotion or cream

Scalp: Mineral oil under warm towel wrap
Dermasmoothe FS oil to scalp overnight ➔ shampoo in am (contains steroid)

**Shampoos:**  Sig: Daily use most effective. Patients may benefit from alternating brands monthly.
Therapeutic effect may be maintained by use of recommended shampoos once weekly with addition of their preferred brand inbetween.
Use to all hair-bearing areas that are affected (ex: chest, brows, beard) GENTLY. NO fingernails!

*Watch for possible discoloration from Tar-containing shampoos on Blonde hair

**Seborrheic Dermatitis:**  Selenium sulfide 1% (ex: Selsun blue)
Zinc Pyrithione 1-2% (ex: DHS Zinc, Head & Shoulders, Denorex)
Salicylic Acid 1% (ex: DHS Sal, TSal by Neutrogena)
Ketoconazole 1% (ex: Nizoral)
Tar (ex: DHS Tar, TGel by Neutrogena, Denorex)
*Baby shampoo washes to eyelashes with QTip

**Psoriasis:**  Salicylic Acid 1% (ex: DHS Sal, TSal by Neutrogena)
Tar (ex: DHS Tar, TGel by Neutrogena, Denorex)

**Oral Antipruritics:**  Sedating: Benadryl, Hydroxyzine (10, 25 mg), Doxepin (10, 25 mg)
Less or Non-sedating: Zyrtec, Claritin, Allegra

**Acne Medications:**
Topical Antibiotics:  sig: apply qd to bid
Clindamycin solution, gel, lotion
Sulfacetamide lotion (ex: Klaron, Sulfacet-R)
Metronidazole gel 1%, metronidazole 0.75% lotion, cream.
Benzamycin gel (benzoyl peroxide plus erythromycin) – must refrigerate
Benzaclin gel (benzoyl peroxide plus clindamycin), Duac

Topical Retinoids:  Comedolytic. Thought to work at ‘preventing’ start of teenage acne. May exacerbate adult acne conditions. Allow 6 months to have maximum benefit with application at least 5 nights/week.

Retin-A (tretinoin): 0.01% gel, 0.025% cream or gel, 0.05% cream, 0.1% cream
Differin (Adapalene): 0.1% cream or gel
Epiduo (Adapalene + Benzoyl Peroxide): 1 – 2.5% gel
Tazorac (tazarotene): 0.05% cream or gel, 0.1% cream or gel

Non-retinoid comedolytic agents:  Benzoyl Peroxide gel (DO NOT combine with tretinoin)
Azeleic acid (Azelex gel 20%, Finacea gel 15%)

Oral Medications:  Erythromycin: 500 mg po bid
Tetracycline: 500 mg po bid on empty stomach
Doxycycline: 100 mg po bid (with non-mineral containing foods; photosensitizing)
Minocycline: 50 to 100 mg po bid (with non-mineral containing foods; risk of HA/dizziness)
Septra: One SS or DS po bid (higher risk of adverse drug reactions)
Isotretinoin therapy

**Herpes Simplex (054.9) and Varicella Zoster (053.9):**
Recommend confirmation of condition with a viral culture.

Duration of therapy (non-suppressive): 5 to 7 days unless otherwise indicated. If immunocompromised, suggest continue therapy for 72 hours after last new lesions appears.

Consider IV Acyclovir therapy for diffuse eruptions (ex: eczema herpeticum) or eruptions in immunocompromised hosts.

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<tr>
<th></th>
<th>Acyclovir</th>
<th>Valtrex</th>
<th>Famvir</th>
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<tr>
<td>HSV primary infection</td>
<td>200 mg 5x/d</td>
<td>1 gm bid x 10d</td>
<td>250 mg bid</td>
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<tr>
<td>HSV recurrent</td>
<td>“ or 400 mg tid</td>
<td>2 gm bid x 1 d</td>
<td>125-250 mg bid</td>
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<td>Suppression</td>
<td>400 mg qd</td>
<td>0.5 to 1 gm qd</td>
<td>250 mg bid</td>
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<td>VZV</td>
<td>800 mg 5x/d</td>
<td>1 gm tid</td>
<td>500 mg tid</td>
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**Topical Chemotherapy Cream for Actinic Keratoses (702.0):**
Fluorouracil (FU = carac 0.5%, fluoroplex 1%, efudex 5%)

Apply to AA qHS (carac) or bid (1%, 5%) for 3 weeks as tolerated.  
Once redness/irritation appears, reduce frequency of application through the 3 weeks.  
Sun-sensitizing! Consider Fall or Winter Treatment periods.  
Important to limit treatment area (ex: palm-size) for improved tolerance.

Recommend Vaseline petroleum jelly 2 to 3 times/day for added comfort.  
This will not eradicate entire field. Lesions may recur. Consider repeat rx in the future if needed.