PCP Treatment & Referral Guidelines

DERMATOLOGY

Developed September 1, 2001

Revised/Approved March 2020

Many patients have concerns about their skin. Some have had skin cancer (melanoma or other types) and have realistic concerns to have cancers diagnosed early. Some have skin diseases that are complex and require medical dermatology management with systemic medications. Some have conditions that have failed first line management and need referral for management. These guidelines are intended to assist with the decision of when to refer based on appropriate diagnoses, management needs, or failure of first-line management in the primary care setting. These guidelines also include some information to assist with first-line management.

I. Guidelines for Nevi, Lumps, Bumps, Cysts, Etc.

Considerations for Skin Cancer Screening:
It is very important to screen patients at risk or with concerning lesions, but also to not over-refer for benign lesions as that limits access to dermatologic care for those that need it.

Below are listed some of the appropriate skin cancer screening reasons for referral:
- Patients with a history of melanoma or a family history of first-degree relatives with melanoma need regular dermatologic screening. The frequency depends on their specific history and number of nevi.
- Patients with Non-Melanoma Skin Cancer (Basal Cell and Squamous Cell Carcinoma) need screening based on their history.
- Older age, more marked photo damage, history of multiple lesions would be appropriate for regular dermatology care.
- Transplant patients need regular dermatologic care with their higher rate of skin cancers, particularly five years after transplant.
- Patients with >50 nevi, a history of dysplastic nevi need yearly skin exams as they are higher risk for melanoma.
- Changing lesions, particularly those meeting the ABCDE's, bleeding, "ugly duckling" or "black sheep" appearance.

Melanocytic Nevi:
May be congenital or early acquired, and continue to develop through mid-adult life.
Pattern should remain consistent on an individual (i.e.: normal spots tend to join the herd) If a mole appears 'unique' (black sheep or ugly duckling), changes (outline, color, texture, rapid growth), develops symptoms (bleeding, unprovocated 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. Avoid partial biopsies or biopsy of "dark area" of a single lesion. The scarring and clinical presentation is difficult to follow both clinically and any future pathology.
Shave procedures may result in "transaction of nevus" at deep margin.

Actinic Keratosis/ Actinic Cheilitis:
Appear as scaly, telangiectatic, usually pink, possibly pigmented 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 (a lot of lesions in an area with notable photodamage): consider topical chemotherapy product or refer to Dermatology

Suspected non-melanoma Cutaneous Neoplasm (Basal Cell, Squamous Cell or other):
Consider 'neoplasm' in lesions that enlarge, bleed, and persist despite primary intervention (cryo, topical 5-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*

- Rhytids (wrinkles), Photoaging
- Seborrheic keratosis
- Benign cysts, milia
- Angiomas
- Benign Nevi
- Lentigines (sun spots)
- Melasma (pigment after pregnancy or other hormonal meds in women)
- Lipomas
- Acrochordons (skin tags)

Removal or treatment may be indicated with associated symptoms, enlargement, pain, interference with hygiene or clothing.
Please help educate patients that benign lesions as above are usually considered “not medically necessary” to be treated unless notable issues, and there may be a separate charge for treatment.

II. Primary Care Therapeutic Algorithm for Common Dermatoses

Refer to COMMON THERAPEUTIC PRODUCTS IN DERMATOLOGY for medication selections (at end of document).

Suspected Tinea Cruris/Pedis/Corporis: (superficial dermatophyte infection):
Suggest over-the-counter (terbinafine cream, butenafine cream) OR prescription antifungal creams to affected area (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- betamethasone dipronate/clotrimazole).
For complex, persistent cases, weigh the use of oral antifungal usage based on patient’s medical and rx history.

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 (terbinafine or butenafine cm) 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 2-4 times a month for maintenance
For complex, persistent cases, weigh the use of oral antifungal usage based on patient’s medical and rx history.

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)

Atopic Dermatitis/Eczema:
General Recommendations:
Daily baths are appropriate. Use gentle cleansers, avoid scrubbing. Limit duration to about 5 min in tepid-warm 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. (see algorithm)

Moisturizers: For successful skin hydration, Ointments > Creams > Lotions. Apply liberally and repear 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. Be sure patients do not use OTC antibacterial ointments (polysporin, neopsorin, bacitracin as they cause frequent contact dermatitis).

Systemic steroids can effectively resolve severe flares of eczema (>50% TBSA; 3-week slow prednisone taper – not a one week or medrol dose pack, rebound occurs); however, consider systemic risks of repeated treatments.

Persistent and widespread atopic dermatitis failing these therapies is appropriate for referral to dermatology.

Seborrheic Dermatitis:
Scalp/face/chest: Ketoconazole cream or shampoo, Zinc Pyrithione andSelenium Sulfide shampoos for first-line and part of maintenance regimen. (all OTC products)Use 2-3 x/week. Salicylic Acid containing shampoos may aid in reducing scale (ex: T-Sal shampoo by Neutrogena or DHS shampoos), but can be irritating. Tar shampoos (Neutrogena T-Gel, Cutar) are effective but can stain light colored, white-gray, or highlighted hair.

Add steroid solution to AA on scalp for pruritus prn.
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 sensitive skin moisturizer to optimize epidermal barrier.
Addition of topical (mupirocin) or oral antibiotics are appropriate for secondary folliculitis or impetiginization.

Contact Dermatitis:
Remove offending agent if known. Note that scented and many “natural” products can be very problematic. Many shampoos and hair products can cause dermatitis not only on scalp, but on back and neck. Vanicream TM product line has many of the least allergenic products. Note also that it can take two months for a contact dermatitis to calm down.
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 (mupirocin) or oral antibiotics is appropriate for secondary impetiginization or infection.

Hand Dermatitis:
Moisturize on a frequent basis (ideally after water exposure). Emollients during day that are less greasy (hand creams such as Neutrogena, Cerave, Eucerin, Cetaphil), Aquaphor or Vaseline at bedtime and as often as tolerated.
Superglue may be used to seal fissures.

Some creams with keratolytics (lactic acid or urea) may cause burning and should be avoided when disease active.

Avoidance of irritants and allergens: cleaning agents, some foods (spicy, acidic), soaps, fragrances, prolonged exposure to water. Avoidance of dish-washing is important when flaring. Use of cotton-lined rubber gloves with prolonged exposure to water, cleaning agents.

Mild to potent topical steroid ointment to AA bid for 1-2 weeks for active inflammation (redness, edema, pruritus)

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

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.

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 Æ pat skin dry Æ immediately proceed with medication and emollients/moisturizers 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 steroid sparing Dovonex (calcipotriene .005%) cream or Vectical (calicitriol) 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 flaring disease in area of trauma (koebnerization).
Suggest controlled sun exposure (20 min sun exposure avoiding 10-4 pm hours) for appropriate patients.
Scalp involvement: Appropriate shampoo use with the addition of liquid steroid solution for pruritus; possible keratolytic with steroid (DermaSmoothe FS).

Consideration for dermatology referral: failing these therapies, widespread involvement (>20%BSA) or severe focal disease (eg palmar-plantar) requiring consideration of systemic therapies (eg. methotrexate, biologics, etc) or for dermatology review in appropriate patients for consideration of phototherapy)
Addition of topical or oral antibiotics is appropriate for secondary impetiginization.

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 Æ monitor for hair regrowth. Hair may be depigmented in early regrowth phase.
If resistant to therapy or extensive loss 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. Or if appropriate, oral treatment with ivermectin (dosing based on weight).

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.
Note modified dosing with renal disease.

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 in female patients.

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.
Consider spironolactone (assess renal function status): 25-100 mg/day dosage if persistent in adult women. With no renal concerns, do not need to monitor renal function at low dose.
Consider screening for isotretinoin therapy. Referral to dermatology.

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. Rhofade and Mirvaso topical products q day
(vasoconstriction) also available, but have varied insurance coverage.

B. Mild papular acne: Topical metronidazole formulation qd-bid. Allow 2 months to assess efficacy. If fail metronidazole topically, consider Azeleic acid topically.

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

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 (Doxycycline)

Consider spironolactone (assess renal function status): 25-100 mg/day dosage if persistent in adult women. With no renal concerns, do not need to monitor renal function at low dose.

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.
Use of OTC silicone gel scar sheets can be very helpful. Apply each night.

Improvement in *symptoms* (pain, pruritus), *firmness*, and *elevation* may be obtained with intralesional 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.

III. 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 ImmunomodulatorAgents:
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 2-12yo), 0.1% ointment (>12 yo)

Topical Steroid Agents:
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 Æ can shampoo in am (60, 120 ml) (mild strength)

Can consider Fluocinonide (Lidex-mid-upper) or Clobetasol (strong) solution
Dermasmoothe FS scalp 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) or Butenafine are better antifungals - OTC
Miconazole Nitrate 2% solution (Fungoid Tincture) – OTC
Naftifine 1% liquid (also a Naftin gel) (15, 30, 60 ml)
Econazole 1% cream (Spectazole) (15, 30, 85 mg)
Ketoconazole (Nizoral) shampoo
Please NO - Lotrisone (betamethasone dipronate/clotrimazole)! (strong steroid, weak anti-fungal!)

Oral Antifungal Treatment for Tinea Versicolor:
If pt is a candidate based on health. Assess for med interactions. Avoid EtOH.
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
Note: VanicreamTM line least allergenic other than Vaseline/Aquaphor. Local drug stores carry some of the line, or on-line sources. Also, coconut oil OK.

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 or very dry skin.
Carmol 20 (urea) cream - OTC Carmol 40 cream (other brands and generics available)
Am Lactin (lactic acid) cream - OTC Lac Hydrin (lactic acid) lotion or cream
Scalp: Mineral oil under warm towel wrap

Dermasmoothe FS scalp oil to scalp overnight. Shampoo in am (contains steroid and salicylic acid)

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 in between.
Use to all hair-bearing areas that are affected (ex: chest, brows, beard) GENTLY. NO fingernails.

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. Many insurances will not cover combination, can mix rx clindamycin gel with otc BPO gel.
Aczone gel (dapsone gel, so not in pregnant/breastfeeding) 5%, 7.5%.

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.
NOTE: Differin/Adapalene 0.1 gel is OTC and first line of the retinoids.

Retin-A (tretinoin): 0.01% gel, 0.025% cream or gel, 0.05% cream, 0.1% cream
Differin (Adapalene): 0.1% cream (rx) or gel (otc), 0.3% gel RX
Epiduo (Adapalene + Benzoyl Peroxide): 1 – 2.5% gel (combo product may not be covered, can mix otc Differin/adapalene and BPO)
Tazorac (tazarotene): 0.05% cream or gel, 0.1% cream or gel (must have failed adapalene and tretinoin for coverage)

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 (not as good for treating acne, consider in patients that other antibiotics not a good option)
Doxycycline: 100 mg po bid (with non-mineral (Ca, Fe) containing foods; photosensitizing)
Minocycline: 50 to 100 mg po bid (with non-mineral (Ca, Fe) containing foods; risk of HA/dizziness). Risk of pigmentation, including Permanaent greyish discoloration of teeth.

Septra/Bactrim: One SS or DS po bid (higher risk of adverse drug reactions)
Isotretinoin (Accutane) therapy – refer to Dermatology

Herpes Simplex (054.9) and Varicella Zoster (053.9):

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. Note topical acyclovir oint/cream, abreva otc cream, are minimally effective.
Consider IV Acyclovir therapy for diffuse eruptions (ex: eczema herpeticum) or eruptions in immunocompromised hosts. Or if concern meningitis or pneumonia.

Acyclovir Valtrex Famvir	200 mg 5x/d or 400mg	1 gm bid x 10d	250 mg bid
HSV primary infection	tid		
HSV recurrent	400 mg bid or tid	2 gm bid x 1 d	125-250 mg bid
Suppression	400 mg qd	0.5 to 1 gm qd	250 mg bid
VZV (shingles)	800 mg 5x/d	1 gm tid	500 mg tid

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