DERMATOLOGY ALERT

6 Referrals you can avoid

Failure to achieve successful results doesn't always mean your diagnosis was wrong. Here's how to avoid several types of unnecessary referrals dermatologists frequently encounter.

by M Caplan, MD

While most patients referred to me require a thorough dermatologic workup, some really don't belong in my office. If their own doctors had made the diagnosis, they could have managed the problem themselves.

Sometimes the misdiagnosis is simply a matter of oversight. In other instances it is "secondary": The doctor makes the correct diagnosis, but because the patient seems not to respond to treatment, he second-guesses himself and refers the patient. This confusion may result from a lack of awareness of the disease's natural history, failure to recognise side effects of therapy, or poor patient compliance.

The purpose of this article isn't to point the finger of criticism or to deliver a high-handed lecture. Rather, it's to help you avoid several types of unnecessary referrals that I see frequently.

1 Is it a therapy-related dermatitis?

Agents that are particularly likely to produce contact dermatitis include ethylenediamine, used as a preservative in many topical creams; topical antibiotics, especially neomycin and nitrofurazone **(Fig 1)**; topical antihistamines; and topical anaesthetics.

Intertriginous and stasis areas are especially prone to contact dermatitis from these agents.

The problem also may occur when gamma benzene hexachloride is prescribed for scabies. The agent is extremely effective in killing adult larvae and ova; in fact, a single application is usually sufficient.

However, itching may persist for as long as three weeks after treatment, a confusing factor in itself, for the patient or you may mistakenly believe therapy has failed.

When a dermatitis should be improving with therapy but isn't, suspect the therapeutic agent.

This may lead to reapplication of the scabicide, which can cause an irritant dermatitis that may last indefinitely. This secondary diagnostic problem often finds its way into my office.

2 Does your female patient have male-pattern baldness?

Although it's probably here to stay, the term "male pattern" is really inappropriate, since women go bald in the same way as men. As is the case with men, the tendency to bitemporal thinning and diffuse hair loss over the crown can be inherited from either side of the family, although in women such baldness starts at a later age than in men and isn't as extensive.

In the absence of other signs or symptoms, a family history of baldness may be all you need to diagnose hereditary alopecia.

If you fail to recognise the tendency, however, you may diagnose thyroid deficiency, or a reaction to a preparation such as hair dye, shampoo, or permanent-wave solution.

You may then get poor results trying to treat the presumed disorder, subject the patient to the unnecessary expense of laboratory tests, and end up referring her.

The first thing to do when a female patient complains of thinning hair is to ask about baldness on both sides of her family.

3 Are fluorinated steroids aggravating the problem?

Because fluorinated topical steroids are used so often, their side effects merit a special alert. If your patient has chronic itching in the anogenital area, for example, you may prescribe one of these medications.

However, because the skin in that region is thin, warm, and moist, the drug may be absorbed into the dermis and cause additional, excessive thinning.

When used for prolonged periods it can also cause telangiectasia, capillary hemorrhage, and frank striae. If you don't recognise these side effects, you may prescribe further application of the steroid, and the eventual result may be ulceration.

Fluorinated topical steroids used on the face can cause similar atrophy, and the telangiectasia may be disfiguring. The agents may also produce or aggravate perioral dermatitis, inflammatory papules around the mouth **(Figure 3).** If they are mistaken for acne, a topical antiacne preparation may be prescribed that is likely to be even more irritating.

4 Is vaginal discharge causing that itching?

If a "dermatitis" of the vulvar area isn't responding to topical agents, the real problem may be irritation due to chronic vaginal discharge.

The discharge need not be heavy; in some patients even a mild to moderate vaginal discharge can produce irritation and pruritus at the introitus. Do a pelvic exam for vaginitis or cervicitis before changing therapy or referring the patient.

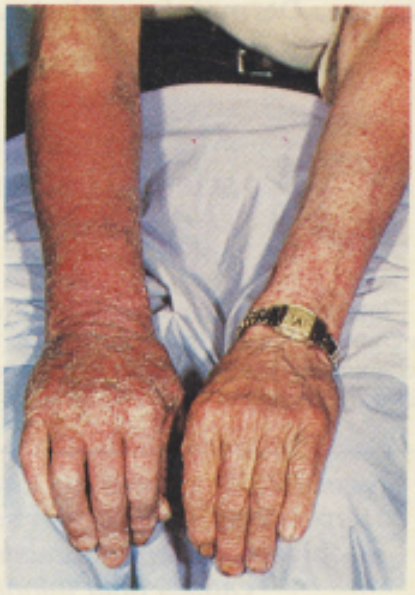

Fig 1
Dermatitis of this man's hand and arm was exacerbated by the nitrofurazone ointment prescribed to treat it.

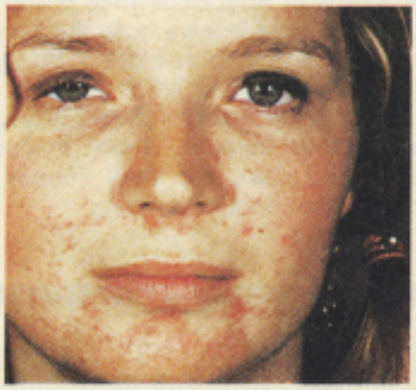

Fig 2
Perioral dermatitis may occur when fluorinated steroids are used for prolonged periods on the face.

Fig 3
Lichen sclerosus et atrophicus of the vulva may be mistaken for leukoplakia. In the top figure the lesion extends to the perineum and perianal skin in the typical figure-eight pattern.

5 Are you confusing lichen sclerosus et atrophicus with leukoplakia?

Interpreting the whiteness of vulvar lichen sclerosus et atrophicus as leukoplakia that heralds malignant change can result not only in unnecessary referrals but in unnecessary vulvectomy as well.

Leukoplakia causes hypertrophy of the epidermis, while lichen sclerosus et atrophicus, except in unusual instances, causes only thinning.

I addition, leukoplakia that gives rise to carcinoma of the vulva usually involves only the vulvar skin. It almost never occurs before menarche. In contrast, lichen sclerosus et atrophicus may occur in premenarcheal girls and may involve both the perineal and perianal skin, often in a figure-eight or hourglass configuration **(Figure 4).**

If you're uncertain of the diagnosis, do a punch biopsy, taking samples from numerous suspiciously thickened areas. The small wounds made by a 3-mm punch don't require suturing.

6 Are birth control pills making her acne worse?

Many young women with acne vulgaris find that their problem becomes exacerbated around the time of menses. Taking oral contraceptives on a cyclic basis may improve the condition.

Indeed, some doctors prescribe the Pill for this specific purpose, and not merely as a contraceptive.

In some patients, however, oral contraceptives aggravate rather than relieve acne.

Aggravation may occur if the pills have an androgenic effect or if their estrogenic effect is relatively small. The diagnosis, then, is not one of poorly manageable acne but of a special sort of drug eruption.

In such instances, you'll probably get good results by switching the patient to a more estrogenic agent.