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SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

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Dermatology Referral Guidelines

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This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.

E-CONSULT DISCLAIMER:

E-consults are based on the clinical data available to the reviewing provider, and are furnished without benefit of a comprehensive evaluation or physical examination. All advice and recommendations must be interpreted in light of any clinical issues, or changes in patient status, not available to the reviewing provider. The ongoing management of clinical problems addressed by the e-consult is the responsibility of the referring provider. If you have further questions or would like clarifications regarding e-consult advice, please contact the reviewing provider. If needed, the patient will be scheduled for an in-office consultation.

All URGENT consultations require provider-to-provider communication. If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.

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ACNE

1. **Background**
    a. Primary care physicians should initiate treatment for mild to moderate acne.

2. **Pre-referral evaluation and treatment**
    a. Depending on the type of acne treated, appropriate therapies may include:
        i. Initial trial of: topical clindamycin 1% solution BID and topical benzoyl peroxide such as 5% gel BID or OTC 2.5-10% cleanser, soap bar, cream, or gel
        ii. If 3 months of that regimen fails, then the addition of a topical retinoid such as topical tretinoin (Retin-A) 0.05% cream QHS may be appropriate if patient is not trying to get pregnant
        iii. If that fails then consideration of adding an oral antibiotic such as doxycycline, minocycline, cephalexin, or Bactrim DS may be appropriate if patient is not trying to get pregnant
        iv. In certain cases, the addition of an oral contraceptive medicine if there are no contraindications may also help acne (e.g. Ortho Tri-Cyclen)

3. **Indications for referral**
    a. Severe cystic acne/scarring or fulminant (acute robust onset)
    b. Isotretinoin (Accutane) is being considered.
    c. Acne is associated with signs of androgen excess, such as hirsutism and androgenic alopecia.
    d. Lack of satisfactory response to treatment after a reasonable amount of time (usually 10-12 weeks).
    e. Once the patient's acne is satisfactorily improved, the patient's acne care can be transitioned to the primary care physician.

BENIGN SKIN LESIONS

1. **Background**
    a. Patients commonly request removal of skin lesions that are presumed by the physician to be benign. Patients referred for removal of benign skin lesions need to understand that removal of these lesions is considered cosmetic, and therefore, **not performed** in the dermatology clinic. These patients should **NOT be referred** to the dermatology clinic. If they are referred to the dermatology clinic **the referral will be denied.** These patients can be referred/seek outside providers for these services. Additionally,

they should be advised that this IS NOT a covered insurance benefit.

b. Benign lesions:
    i. Benign melanocytic nevi,
    ii. (Non-inflamed) Cysts,
    iii. Dermatofibromas,
    iv. Hemangiomas,
    v. Lentigines,
    vi. Lipomas,
    vii. (Asymptomatic) keloids,
    viii. Melasma,
    ix. Seborrheic keratoses,
    x. <u>Skin tags/Acrochordons – see Background</u>
    xi. Telangiectasias

3. Indications for referral

a. A presumably benign lesion:
    i. grows or enlarges
    ii. exhibits spotty color changes and/or irregular margins
    iii. begins to bleed or ulcerate
    iv. becomes symptomatic, inflamed, pruritic, painful or infected; OR
    v. is irritated by clothing or activities because of its physical location.
b. Large numbers of nevi in a patient with a personal or family history of melanoma.

DERMATOSES

1. Background

a. Inflammatory dermatoses are difficult to distinguish from each other and from certain malignant skin diseases. With appropriate training, the primary care physician may be able to diagnose and treat common inflammatory dermatoses ("rashes") such as:
b. Dermatoses:
    i. Atopic dermatitis,
    ii. Contact dermatitis,
    iii. Drug and other allergic eruptions,
    iv. Dyshidrotic eczema,
    v. Pityriasis rosea,
    vi. Seborrheic dermatitis

2. Pre-referral evaluation and treatment

a. Therapy should be initiated with topical corticosteroids appropriate for the affected body site, for example:
    i. hydrocortisone 2.5% cream for face, neck, armpit, or groin
    ii. triamcinolone 0.1% ointment for body, avoiding the face, neck, armpit and groin
b. With the exception of self-limited problems (such as poison oak), systemic steroids should be avoided for most chronic dermatoses. Proper patient education (moisturizers, bathing techniques, etc.) should be discussed for chronic conditions.
c. Antihistamines may provide temporary relief from pruritus: (*these are common adult doses)
    i. cetirizine 10mg PO qam
    ii. loratadine 10mg PO qam
    iii. AND/OR hydroxyzine 25-75mg PO qhs prn itch

3. Indications for referral

a. Diagnosis is in question.
b. Lack of satisfactory response to treatment after a reasonable amount of time (usually ~3-4 weeks).

FUNGAL INFECTION

1. Background

a. Superficial cutaneous fungal disease may be difficult to diagnose and differentiate from non-infectious inflammatory dermatosis. If properly trained and C.L.I.A. certified, the primary care physician may be able to use potassium hydroxide (KOH) examinations and/or fungal cultures to diagnose dermatophyte infections. It is clinically appropriate that KOH or fungal culture be done to confirm the diagnosis before initiating treatment since these tests may yield false negative results after antifungal agents have been initiated.

2. Pre-referral evaluation and treatment

a. Appropriate therapy should be initiated with topical antifungal agents.
    i. For example topical ketoconazole 2% cream or OTC terbinafine 1% cream BID to AA of tinea
b. If extensive involvement, tinea capitis, or symptomatic onychomycosis exist
    i. Fungal culture and documentation should be done first
    ii. Systemic antifungal agents should be initiated thereafter. This is important since certain causative organisms (especially for onychomycosis) may not respond to currently available antifungal agents.

3. **Indications for referral**
    a. Lack of satisfactory response to antifungal treatment after a reasonable amount of time (usually 3-4 weeks).
    b. In cases where systemic antifungal medication is thought to be needed for a prolonged time (tinea capitis, severe tinea corporis, or onychomycosis) and when the primary care physician is unfamiliar with the use of these medications.

HAIRLOSS

1. **Background**
    a. Patients commonly present for the complaint of hair loss.
    b. The primary care physician may be able to diagnose the cause by history and inspection (such as post-partum, post-surgical, or male pattern baldness), but many other causes exist; and a thorough workup may be necessary.
    c. Telogen effluvium is self-limited and requires no treatment.

2. **Pre-referral evaluation and treatment**
    a. Androgenic alopecia treatment agents such as minoxidil (Rogaine) is over the counter and is not covered by insurance.
    b. Checking thyroid function tests and looking for anemia may be beneficial in certain cases

3. **Indications for referral**
    a. Cause is not obvious by history and inspection of the scalp. Often the dermatologist will be able to determine clinically which patients need a complex workup or skin biopsy and will simplify the process of reaching a diagnosis.
    b. Primary care physician does not have appropriate experience to manage or treat congenital or acquired hair loss or diseases such as alopecia areata or hair loss associated with infection of systemic disease.
    c. Scarring alopecia is present.
    d. Unresponsive to therapy or recommendations (usually two months).

HERPES SIMPLEX INFECTION

1. **Background**
    a. In non-HIV-positive cases the primary care physician may be able to diagnose oral, labial, cutaneous, or genital herpes simplex virus infections and begin treatment (when necessary) with oral antiviral agents.

b. Herpes simplex can be difficult to diagnose in HIV-positive patients. It can also be challenging in patients with underlying skin disease such as atopic dermatitis (eczema), a.k.a eczema herpeticum.

2. **Pre-referral evaluation and treatment**
    a. Performance of Tzanck smear, viral culture, immunofluorescence, or PCR will increase the diagnostic accuracy and is important to consider before therapy is undertaken.
    b. Topical acyclovir has not been shown to be effective in immunocompetent patients and should not be prescribed.
    c. Oral antiviral agents may be necessary

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Lack of adequate response to treatment after a reasonable amount of time (usually 5-7 days) for any episode.
    c. Ocular involvement (refer to Ophthalmology).
    d. Patient is immune compromised.

HERPES ZOSTER INFECTION

1. **Background**
    a. Usually, a clinical diagnosis of herpes zoster (shingles) is sufficient without a viral culture or immunofluorescent test.

2. **Pre-referral evaluation and treatment**
    a. Early intervention (within 72 hours of onset only) with systemic antiviral treatment and topical Domeboro compresses may shorten the duration of active lesions and acute pain.
    b. **Antivirals should not be initiated in immunocompetent patients whose symptoms began more than 72 hours prior to presentation to the physician, even if new lesions continue to develop.**

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Lack of satisfactory response to treatment after a reasonable amount of time (usually 5-7 days), or complications.
    c. Ocular involvement (refer to Ophthalmology).
    d. Post-herpetic neuralgia exists three months after acute infections.
    e. Patient is immune compromised.

IMPETIGO AND PYODERMA

1. **Background**
2. **Pre-referral evaluation and treatment**
    a. The primary care physician should diagnose and treat impetigo and other bacterial pyodermas with oral or topical antibiotics.
    b. Culture prior to oral or topical antibiotics if diagnosis is in question.

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Lack of satisfactory response to treatment after a reasonable amount of time (usually 3-5 days).

MOLLUSCUM CONTAGIOSUM

1. **Background**
    a. Molluscum contagiosum, although a benign self-limited process in some children, will commonly spread in other children and may be associated with immunosuppression in adults. Multiple lesions of molluscum contagiosum, especially on the face, may be a cutaneous marker of underlying atopic dermatitis, HIV infection or another immunodeficiency.

2. **Pre-referral evaluation and treatment**
    a. The primary care physician who is adequately trained should initiate therapy with liquid nitrogen if the risks of potential sequelae are acceptable to the patient.
    b. Another option is to have the patient apply a topical retinoid (e.g. OTC Differin gel) once or twice a day to the AA; patient should watch out for irritation and the medicine should not be applied too close to the eyes, mouth, or genital skin because of risk of irritation. Please note some irritation is normal and means the medicine is working but if significant irritation develops the med should be stopped.

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Primary care physician doesn't have office facilities or appropriate experience to treat.
    c. Lack of satisfactory response to treatment after reasonable amount of time (usually 8-12 weeks).

PEDICULOSES

1. **Background**

a. Head, body, and pubic lice represent a public health problem. The causative organisms are visible to the naked eye and can frequently be diagnosed by the primary care physician.

2. **Pre-referral evaluation and treatment**
    a. Treatment should be initiated with appropriate topical preparations (e.g. Elimite, Rid).
    b. Proper patient instructions (e.g., laundry, nit combs) should be discussed.
    c. Sources and contacts should be identified and treated if possible.

3. **Indications for referral**
    a. Diagnosis in question.
    b. Lack of satisfactory response to treatment after a reasonable amount of time (usually 2-3 weeks).

PSORIASIS

1. **Background**
2. **Pre-referral evaluation and treatment**
    a. Primary care physicians should initiate treatment in patients with plaque-type psoriasis involving up to 10% of the body surface area.
    b. Therapy should be initiated with topical corticosteroids and antihistamines as appropriate for the affected body site for example:
        i. Hydrocortisone 2.5% cream BID for face, neck, armpit, or groin
        ii. Triamcinolone 0.1% ointment BID for body avoiding the face, neck, armpit and groin
        iii. Lidex or Synalar solution BID for scalp psoriasis
        iv. Antihistamines PRN for itch
    c. Systemic steroids should NOT be used for psoriasis as this can trigger a dangerous pustular psoriasis flare.
    d. Proper patient education (moisturizers, bathing techniques, shampoos) should be discussed.

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Lack of satisfactory response to topical treatment after a reasonable amount of time (usually 3-4 weeks).
    c. Pustular lesions are present.
    d. Special treatments such as phototherapy (UVB), immunosuppressives, retinoids, intralesional corticosteroids, etc., are being considered.

SCABIES

1. **Background**
    a. Scabies represents a public health problem. Most causes of pruritus are not caused by scabies; and, therefore, the offending organism should be identified by performing a scabies preparation prior to treatment.

2. **Pre-referral evaluation and treatment**
    a. Once infestation is documented, the primary care physician should initiate therapy to the entire household with topical permethrin 5% cream. Repeat treatment 1 week after initial treatment is usually warranted.
    b. Proper patient instructions should be discussed.
    c. Post-scabetic pruritus can persist for several weeks and may be treated with topical corticosteroids and oral antihistamines.

3. **Indications for referral**
    a. Primary care physician doesn't have office facilities or appropriate training and experience to perform scabies preparations.
    b. Lack of satisfactory response to the treatment after a reasonable amount of time (usually 3-4 weeks).

SKIN CANCERS

1. **Background**
    a. The dermatologist should be the primary referral source for evaluation of patients presumed to have skin cancers regardless of the size or location of the lesion as a skin biopsy is almost always needed first to guide management.
    b. The dermatologist is able to manage most of the lesions requiring treatment and will be the best source for deciding which patients need specialty procedures such as Mohs micrographic surgery or radiation therapy.

3. **Indications for referral**
    a. Any patient with lesions suspicious for malignancy.
    b. Patient is at high risk for recurrence or new skin cancer.

VITILIGO

1. **Background**
    a. Auto-immune destruction of melanocytes leads to completely depigmented areas (stark white)
    b. A positive family history of vitiligo or other auto-immune conditions such as thyroiditis may be present

2. **Pre-referral evaluation and treatment**
    a. Ask about thyroid ROS and check TFTs if appropriate.
    b. Patient can start a regimen of a low potency topical steroid (e.g. hydrocortisone 2.5% cream BID) to AA on the face/neck/armpit/groin that the patient desires to be treated or a mid-potency steroid (e.g. triamcinolone 0.1% oint BID) to AA on the body excluding face/neck/armpit/groin. If no signs of improvement after 3 months then these medicines should be stopped.
    c. These white areas are much more likely to sunburn and accumulate chronic sun damage than normal skin. Patients should be counseled to use good sun protection when outside more than 5-10 minutes.

3. **Indications for referral**
    a. Diagnosis is in question.
    b. Primary care physician doesn't have appropriate training and experience to treat.
    c. Lack of satisfactory response to treatment after a reasonable amount of time (usually 3 months).

WARTS

1. **Background**
    a. Frequently, common warts are self-limited; and contagion is usually dependent on patient's susceptibility.
    b. Genital warts may be pre-malignant and should be treated/followed until resolution for at least six months.
        i. Sexual partners should always be checked as well.
        ii. Multiple genital warts in children should raise the question of child abuse.

2. **Pre-referral evaluation and treatment**
    a. Adequately trained primary care physicians may elect to treat with a variety of agents including:
        i. Liquid nitrogen
        ii. Trichloracetic acid
        iii. Duct tape
        iv. QHS home application of OTC salicylic acid products (40% for thick areas such as palms and soles (e.g. WartStick or

Mediplast) or 17% for more sensitive areas (e.g Duofilm))

b. Regular PAP smears and biopsies (if indicated) may help detect pre-malignant genital HPV lesions.

3. Indications for referral

a. Diagnosis is in question.
b. Primary care physician doesn't have office facilities or appropriate training and experience to treat.
c. Lack of satisfactory response to in-office and/or at-home treatment after a reasonable amount of time (usually 2-3 months).

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