Emergency Medicine for Rural and Indigenous Communities Conference

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Inclusive Dermatology: A Case Review

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SCHOOL OF MEDICINE
DEPARTMENT OF DERMATOLOGY

Presentation prepared by:

Date prepared:

Conflict of Interest Disclosure Statement

I have no conflicts of interest to declare – other than a genuine interest and dedication to improving healthcare disparities that inordinately affect Indigenous communities

PLEASE DO NOT TAKE SCREENSHOTS

Learning Objectives

- Become familiar with opportunities to increase diversity, equity and inclusivity (DEI) in Dermatology as pertains to clinical care, education, and research
- Consider how this applies in the Primary Care/Urgent Care/Emergency Services settings
- Gain practical knowledge about the diagnosis and treatment of common and/or worrisome skin findings in a range of skin types, including those most pertinent to Indigenous peoples
- Help us amplify initiatives!

DERMATOLOGY – DEI OPPORTUNITY

Approx 4K currently employed in the US

85.5% women, 14.5% men

Average age 48 o

Ethnicity of dermatologists:

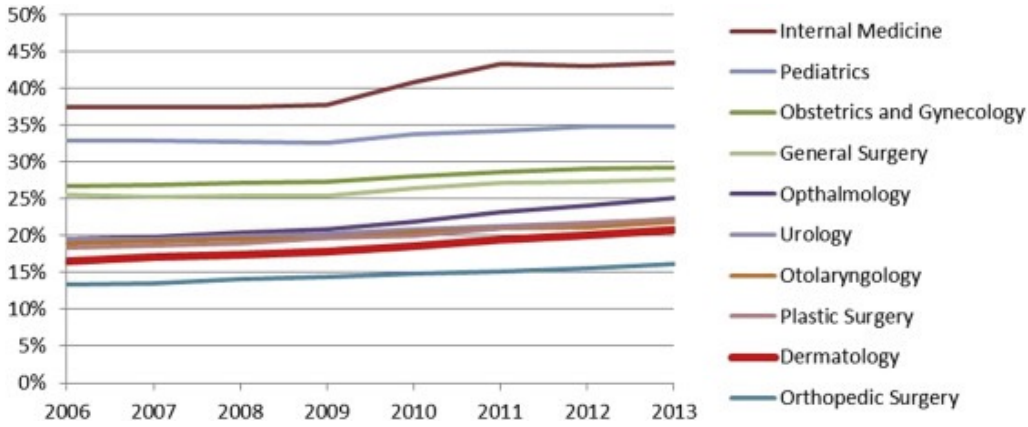
- **White (65%)**
- **Asian (18%)**
- **Hispanic or Latinx (5-9%)**
- **Black (3%)**
- **No quotable # for NA/AI**

Majority located in NY and LA

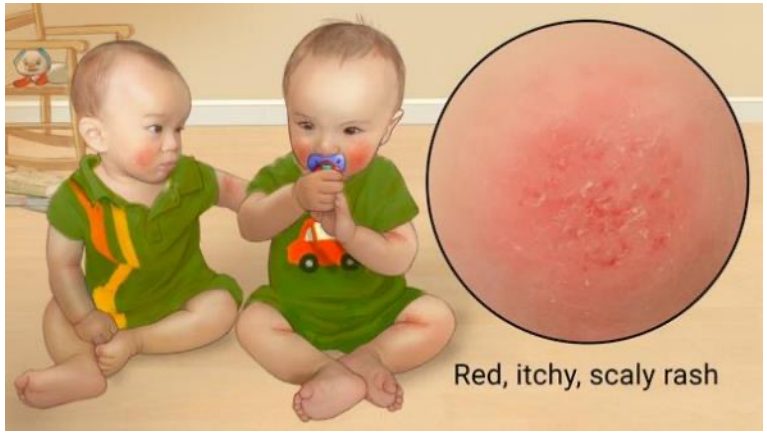
Initiatives re "Skin of Color" – more later

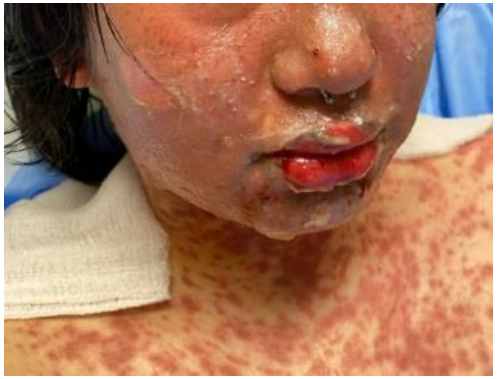
Stigmatization (eg Images of STIs disproportionately)

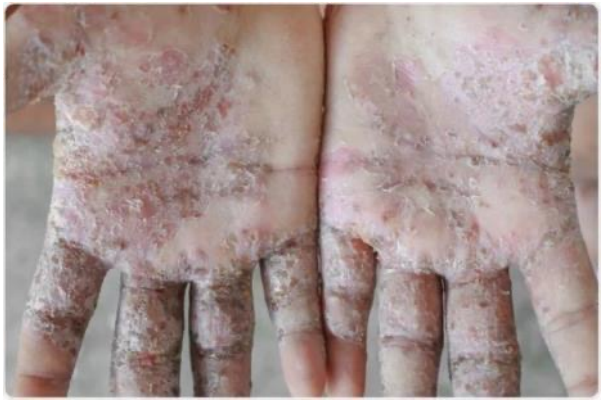
Lack of diverse representation in Derm clinical trials

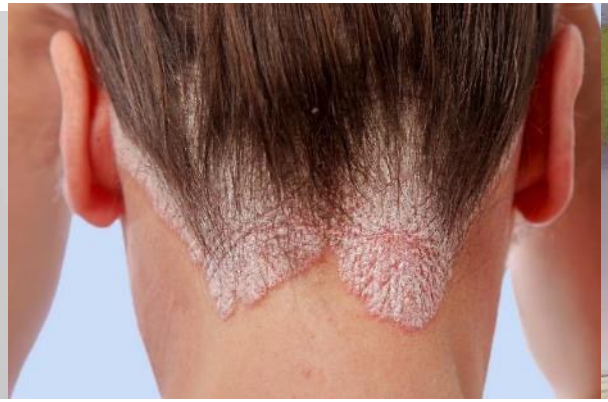


EXAMPLES FROM TEXTBOOKS/WEBSITES









DERMATOLOGY in New Mexico… (Population 2.2 million)

Approx 35 BC Dermatologists (Standard expected = 80-90)

- Most not full-time
- Difficult to access if Medicaid/Medicare/IHS and/or new
- Long wait times…
- Impact on quality of life, health care disparities, severity of disease and/or pathology
- Majority-Minority state (48% Hispanic/Latinx, 11-12% NA/AI/Indigenous)

UNM Dermatology specifically

- Small program (9 Faculty, 9 Residents) but dedicated and growing…
- Based in Albuquerque NM; UNM Hospital w longstanding charter to care for NA/AI population
- Clinics in Gallup NM (Navajo), Sandoval County (7 Pueblos within)
- (If you have any friends/colleagues interested, UNM Derm is hiring!)

Strong partnership with Primary Care/Internal Medicine/Peds etc

- Our goal for PC to have confidence managing basic skin conditions in all ages
- Know when to advocate for more urgent/emergent referrals/admissions
- Recognize Derm specialty care = very limited resource in many Western/rural areas

DERMATOLOGY and INDIAN HEALTH SERVICE (IHS)

- Mean driving distance between a rural HIS/tribal facility and nearest Derm clinic 68 miles
- Majority (62%, n = 21) of facilities without a Dermatology clinic within 35 miles
- 32% (n = 11) over 90 miles from a Dermatology clinic
- Of 25 responding Derm sites, 6 (22%) didn't accept Medicaid; 6 (22%) didnt accept IHS
- Study noted that this burden is associated with many costs/issues including:
  - Time spent driving
  - Time away from work or caregiving
  - Costs of owning a vehicle and paying for gas
  - Roads in rural areas may not always be passable
  - Public transportation is limited or unavailable in rural areas
- Is telehealth an answer…? perhaps

- Evaluation of Barriers to Telehealth Programs and Dermatological Care for American Indian Individuals in Rural Communities and editorial, "A Cultural Context for Providing Dermatologic Care to American Indian and Alaskan Native Communities Through Telehealth," published in *JAMA Dermatology (2019)*

DERMATOLOGY and IHS

- Very rare Derm services at IHS facilities
  - Examples: Phoenix IMC and Choctaw Nation
- Barriers to developing telehealth partnerships w outside entities
  - “PALS” Line in NM
  - Reliance on Grant-funded/Volunteer services (eg AAD Volunteer Teledermatology Program)
- Barriers to accessing specialty care in communities otherwise

- Derm likely has lot to learn to truly become “culturally competent/responsive”
- Examples:
  - Hair as a personal/tribal identifier, sacrosanct status
  - Role of traditional medicine/healers in the community
  - +/- distrust of Western medicine/topicals, testing/biopsies etc
  - Certain diagnoses not as commonly brought up as a complaint - ?acne

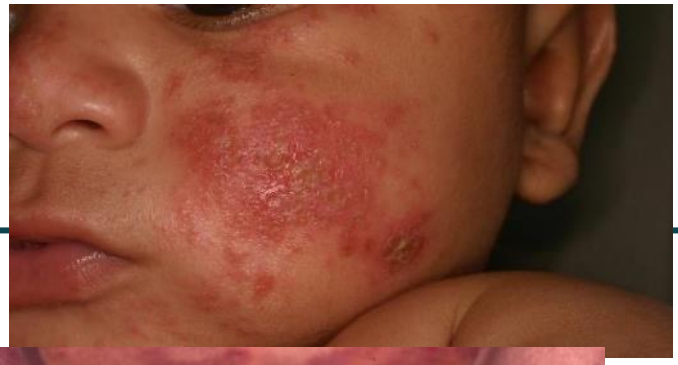
CASE REVIEW: WITH DEI LENS

FRONT LINE INDIGENOUS PARTNERSHIP

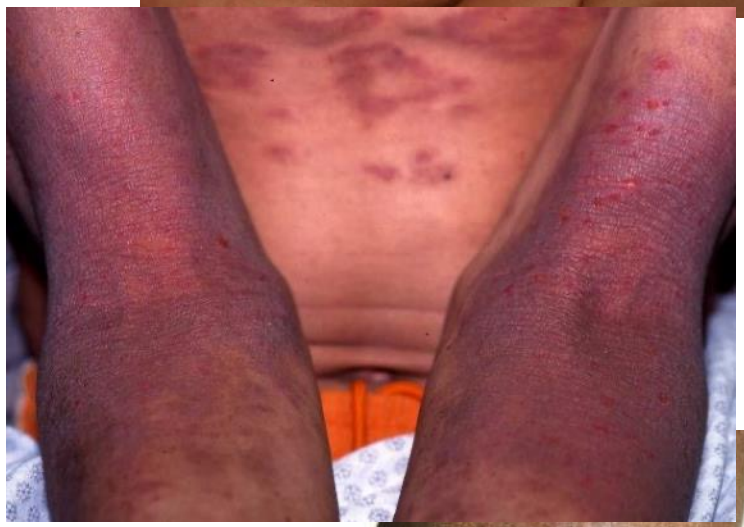
HARVARD HUMANITARIAN INITIATIVE

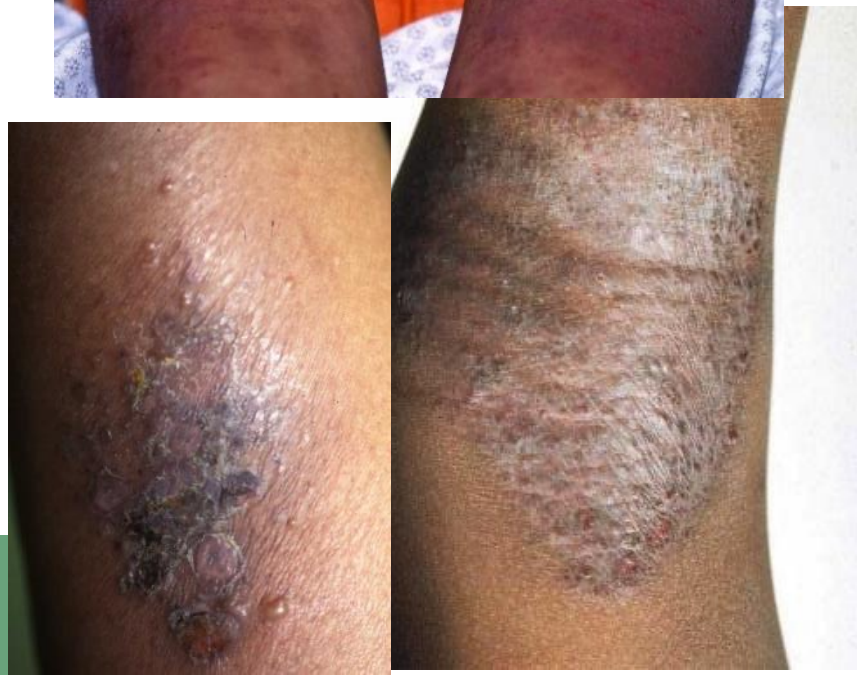
Mass General Brigham

ATOPIC DERMATITIS



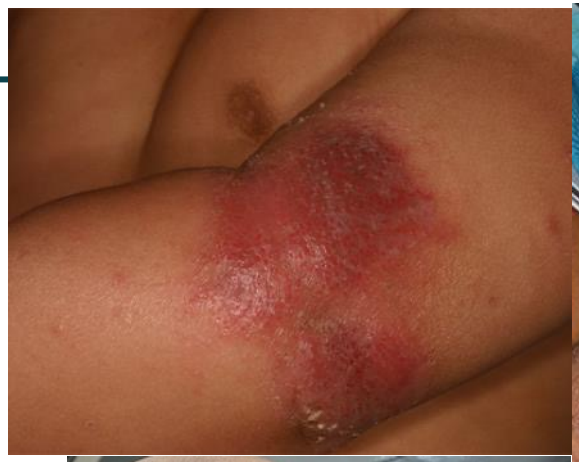
- Up to 20% pediatric population
- Atopic march – AR, Asthma, Food allergies
- Treatment approach:
  - Gentle dry skin care – hypoallergenic, fragrance free
  - Appropriate topical medications
    - Steroids – high potency for short term effect
    - Tacrolimus/pimecrolimus, others
  - Oral antihistamines (sedating for itch at night)
    - Hydroxyzine 1mg/kg/qhs prn
    - +/- nonsedating for atopiy/AR triggers
  - Trigger avoidance if applicable
  - Escalation to systemic management when needed
    - CsA 4-5 mg/kg/day, MTX, +/- Prednisone
    - Dupulimumab
    - JAK1 inhibitors?

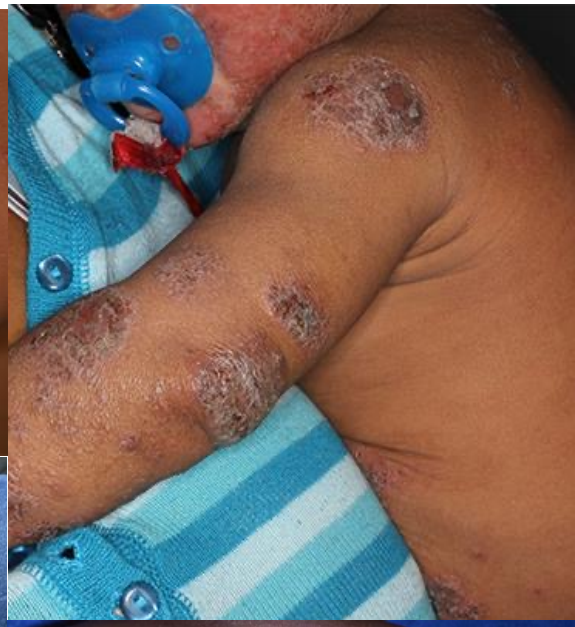


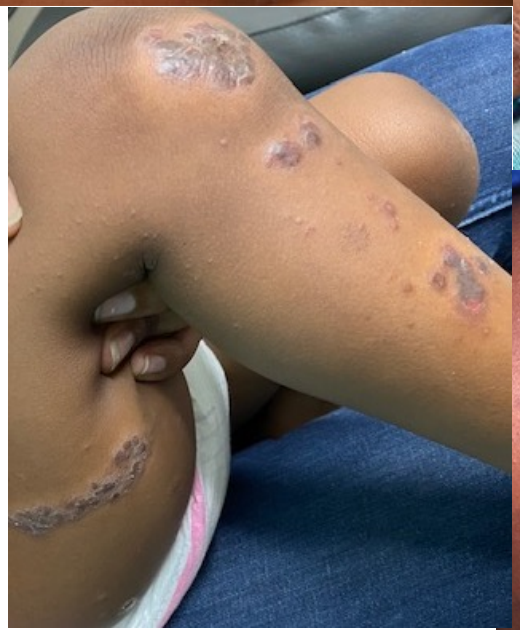


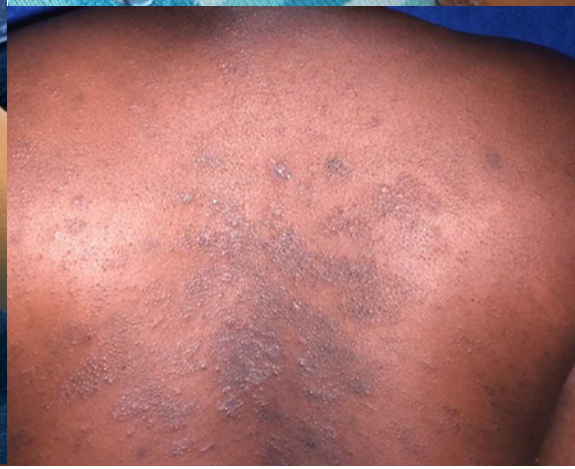
AD: Clinical Pearls

- Erythema/erythroderma may be harder to appreciate in SOC
- Many pts w severe AD “give up”
- Association w behavioral health/depression/SI
- Frequent infection/impetiginization
  - EROSION/crusting on exam
  - Usually MSSA
  - Dilute bleach baths, low threshold PO ABX
- Home resources should be understood
  - ?Running water/bathtub?
  - Budget for OTC products/adherence
  - Environmental triggers (hay, dust, woodsmoke)

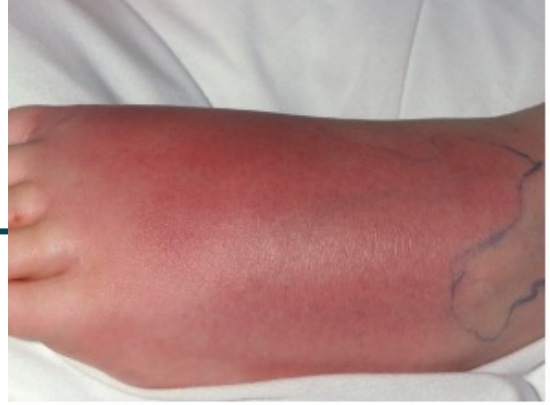




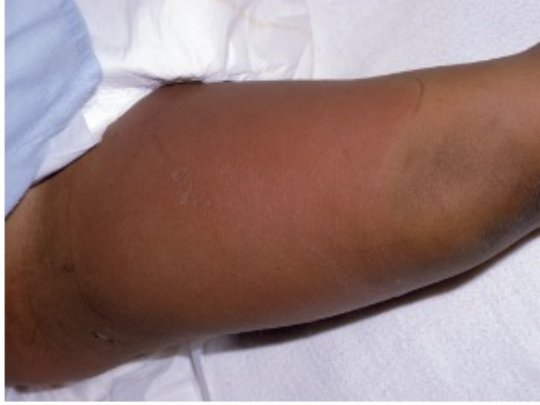




IMPETIGO/CELLULITIS

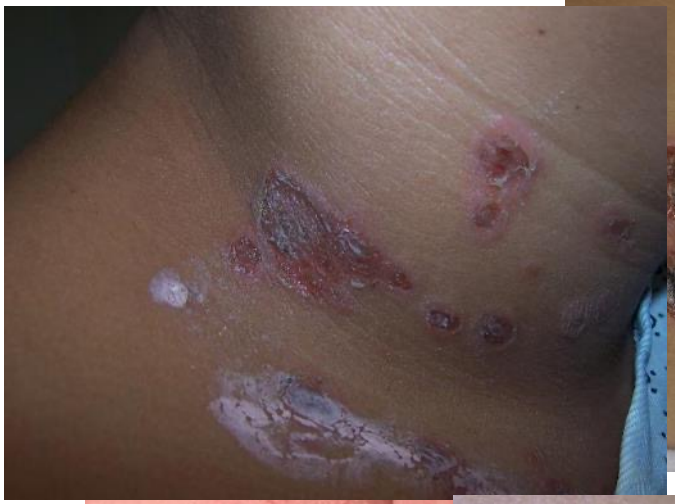


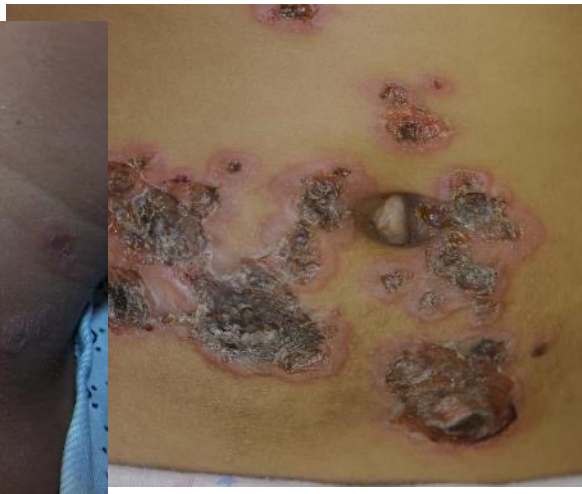
Cellulitis on a white patient … VisualDx

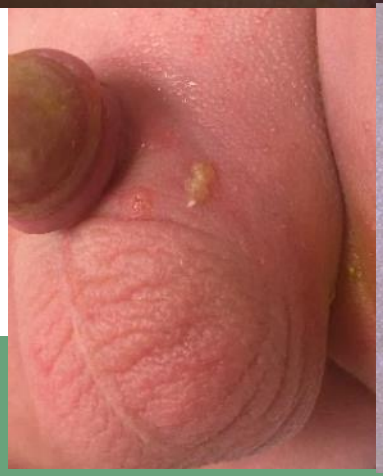


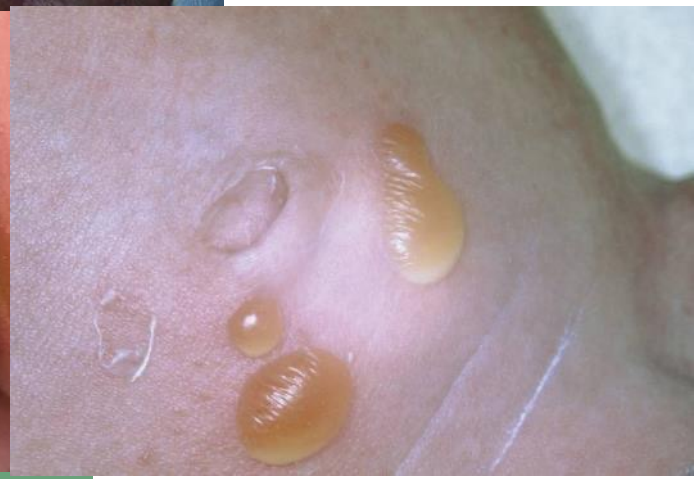
… and on dark skin. VisualDx

- Again, erythema may be underrecognized
- **Cellulitis:**
  - Warmth/heat, tenderness, edema
  - May even vesiculate
  - Should be unilateral/focal
- **Impetigo/Bullous Impetigo:**
  - Face/perinasal; Groin/thighs/abd
  - Fragile vesicles/bullae
  - May just see erosion
  - Low threshold oral ABX (Staph!)
  - ?Topical steroid - inflammation
  - If chronic:
    - Dilute bleach baths/OTC benzoyl peroxide
    - Topical clinda or mupirocin

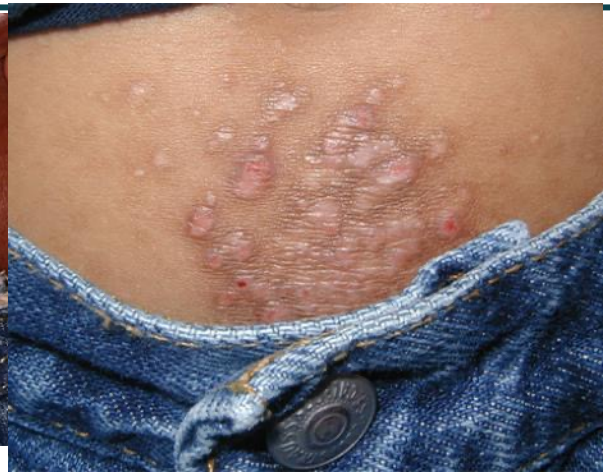


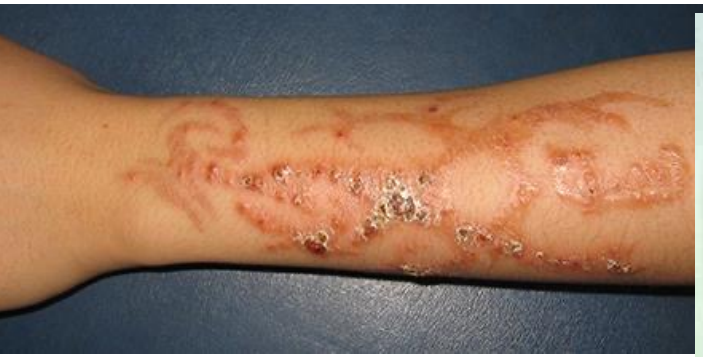


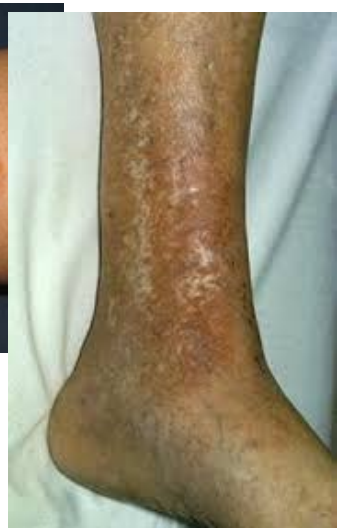


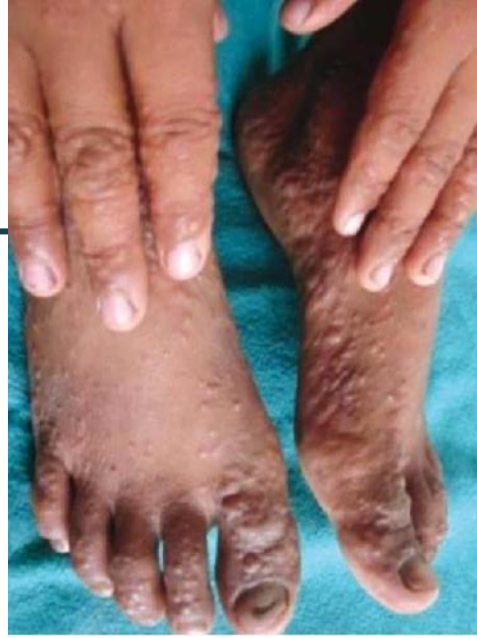


CONSIDER CONTACT DERMATITIS







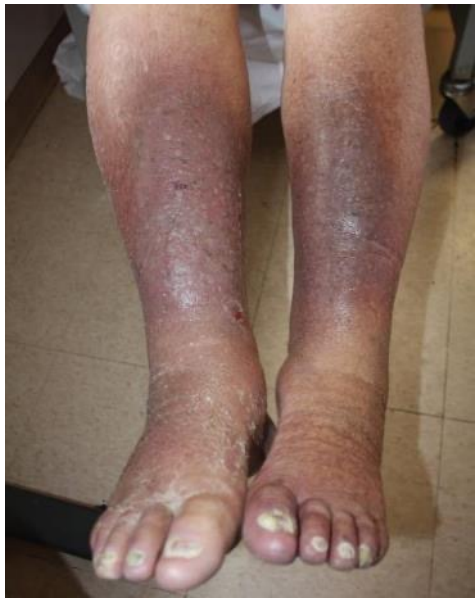


Common culprits:

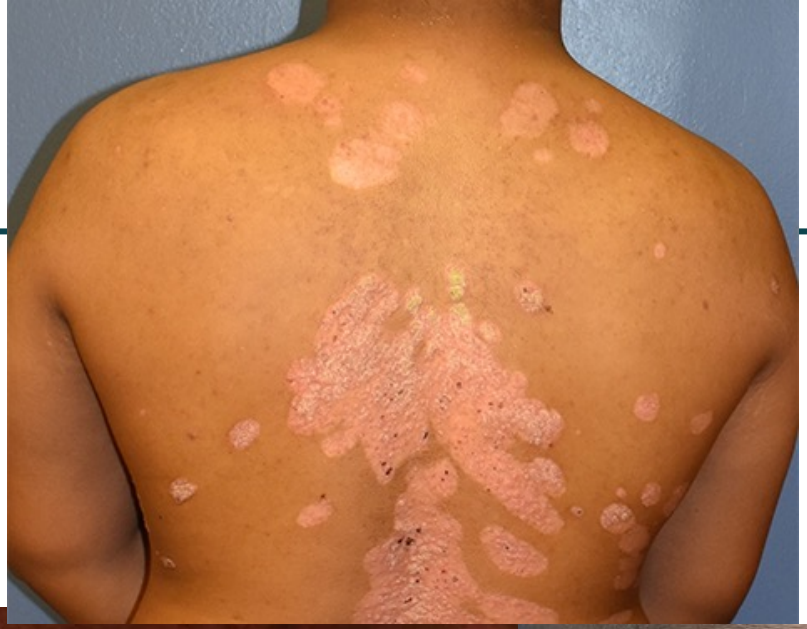
- Nickel
- Fragrance
- PPD/Henna
- Bacitracin/OTC abx

Possible sequelae:

- Id reaction
- Misdiagnosis



PSORIASIS (FLARE)



Any age, common, +/- itch

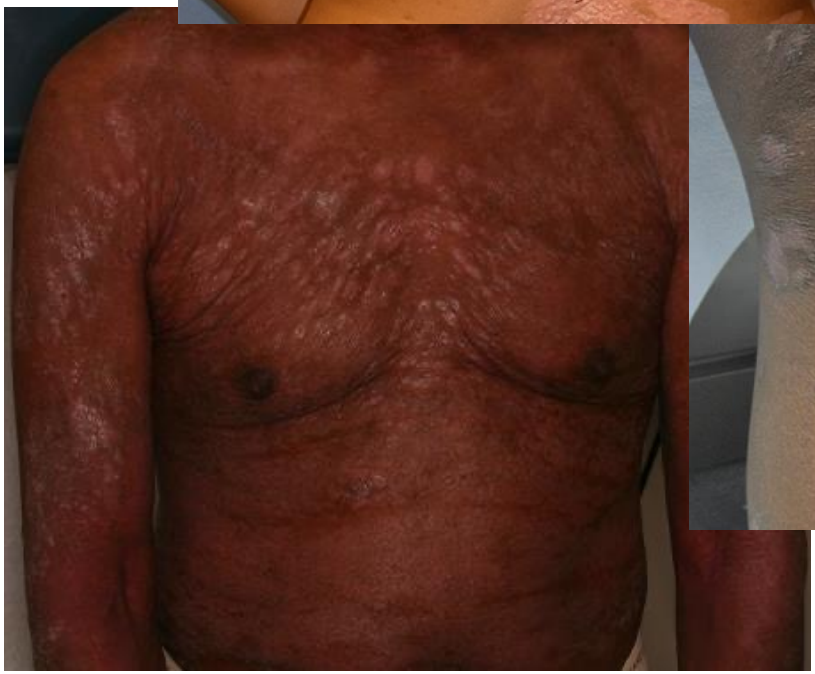
Crisp/well defined edges, DRY scale

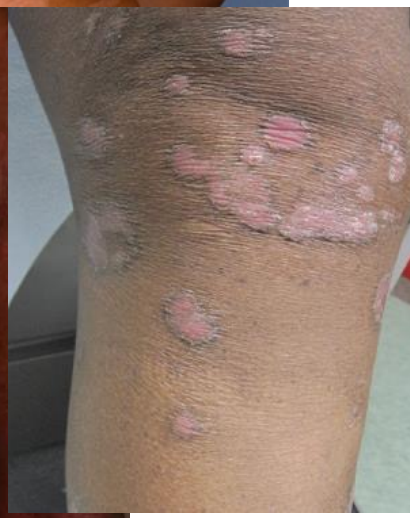
Scalp/ears/genital/folds/umbilicus

Erythema/erythroderma may be underappreciated SOC

Associated PsA, CVD, obesity, etc

- Multisystem proinflammatory d/o
- Behavioral health impact
- Substance use disorders

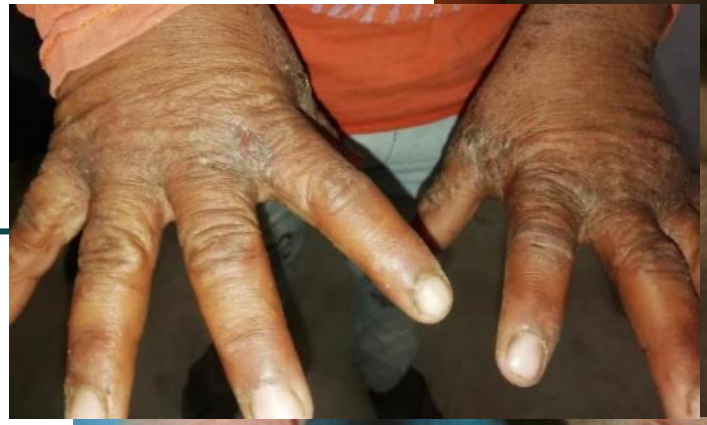


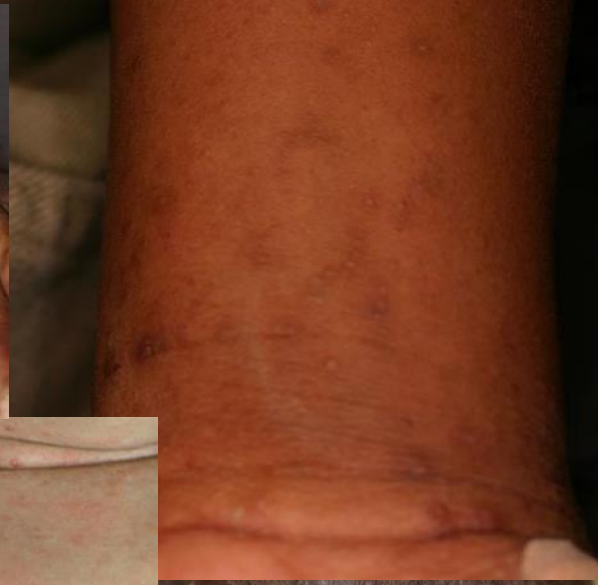


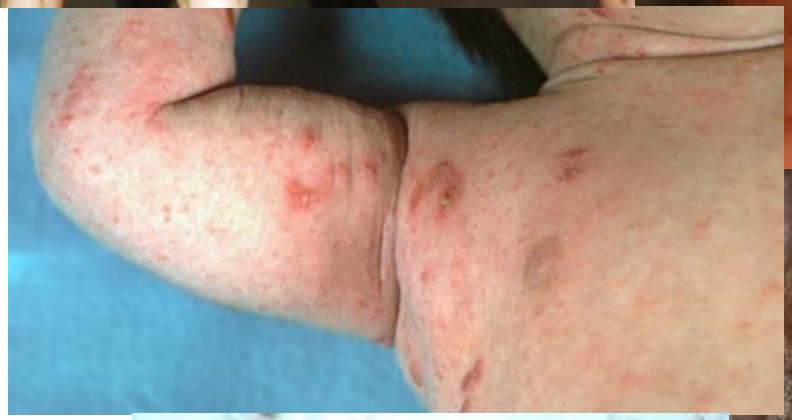
Treatment:

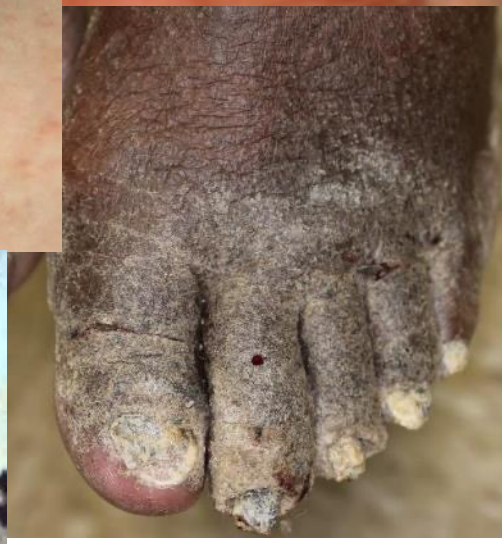
- Topical steroids (avoid high potency long term)
- Other: tar, calcipotriene, tacrolimus, tazarotene
- Phototherapy
- Systemics: Biologics (IL-17/23), CsA, MTX
- Screening for TB
- AVOID systemic steroid – rebound/flare

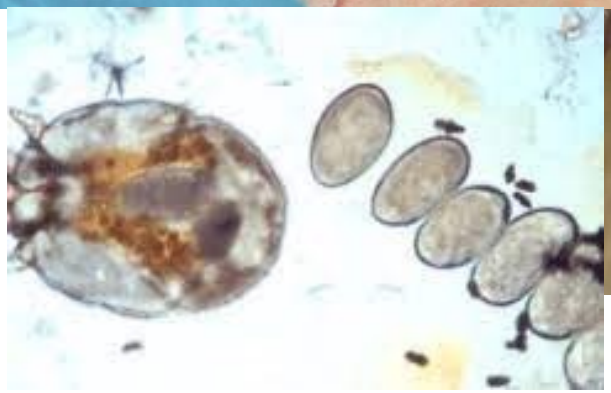
SCABIES





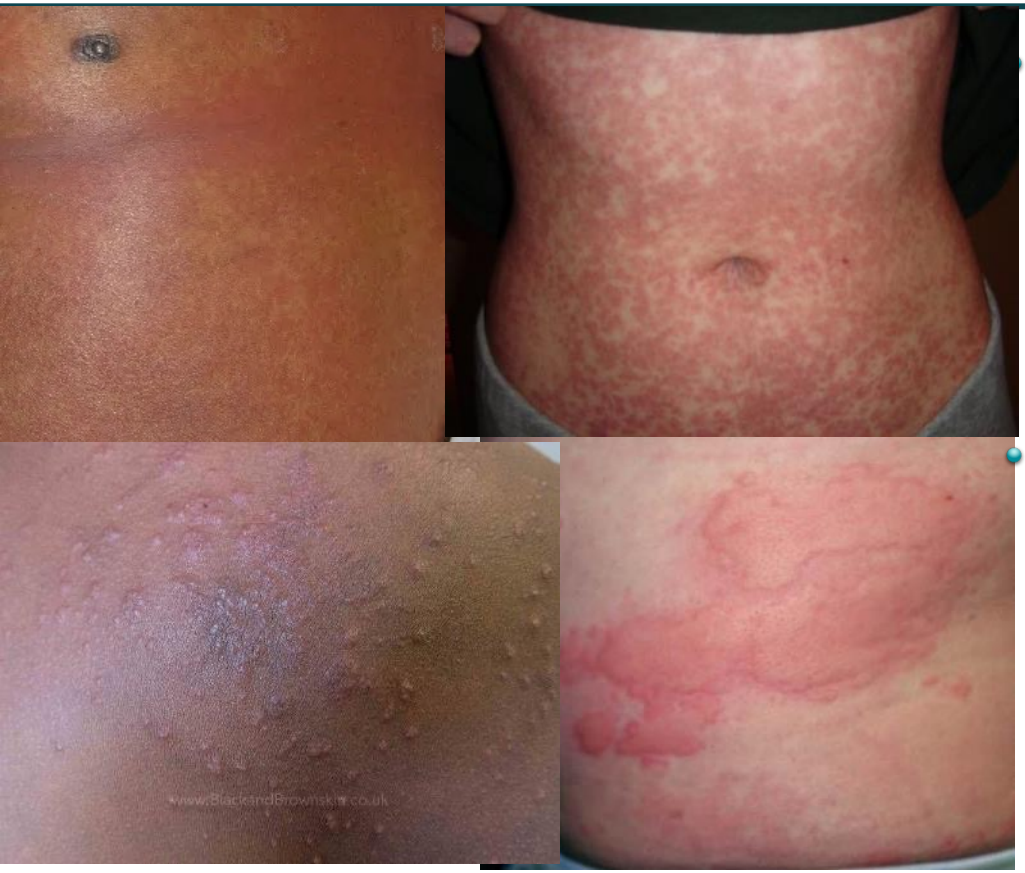






- New onset pruritic eruption
- Can mimic fungal, LCH etc
- Classic hands/feet, folds
- Infantile atypical – nodules
- Mineral oil prep easy & quick
  - Must get to pinpoint bleeding
- Treatment:
  - Standard permethrin cream
    - Apply head to toe, sleep in overnight; repeat in 1 week
    - Launder bedding w high heat
    - Treat all family members!
  - Oral ivermectin
  - Other topicals: Sulfur etc (pregnancy)

DRUG ERUPTIONS – MORBILLIFORM VS URTICARIAL



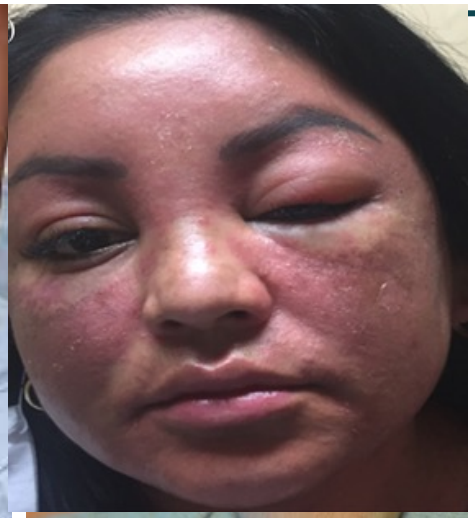
MORBILLIFORM

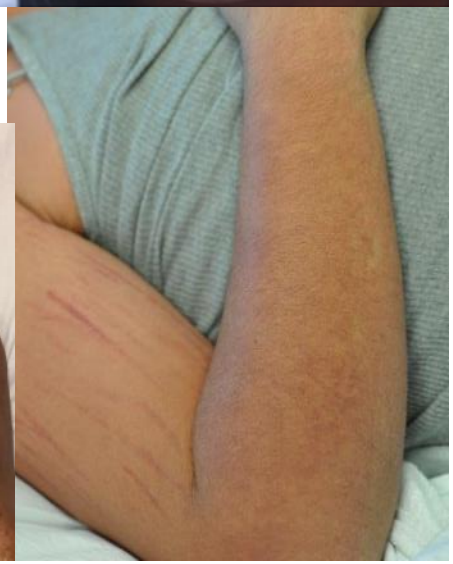
- "Measles-like", maculopapular
- +/- Itch
- Drug vs viral – indistinguishable
- Symptomatic management
- Can treat through w med if necessary

URTICARIAL

- Transient wheals/edema
- +/- Itch
- Drug, food, viral, idiopathic (acute)
- Chronic often idiopathic (vs AI, thyroid)
- D/C any offending med – anaphylaxis
- Antihistamines, +/- topical steroid

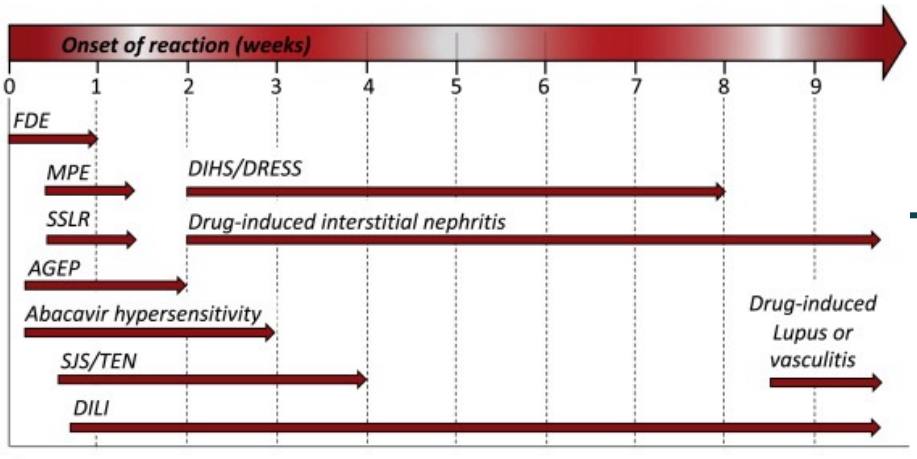
DRUG ERUPTIONS:
DRUG HYPERSENSITIVITY

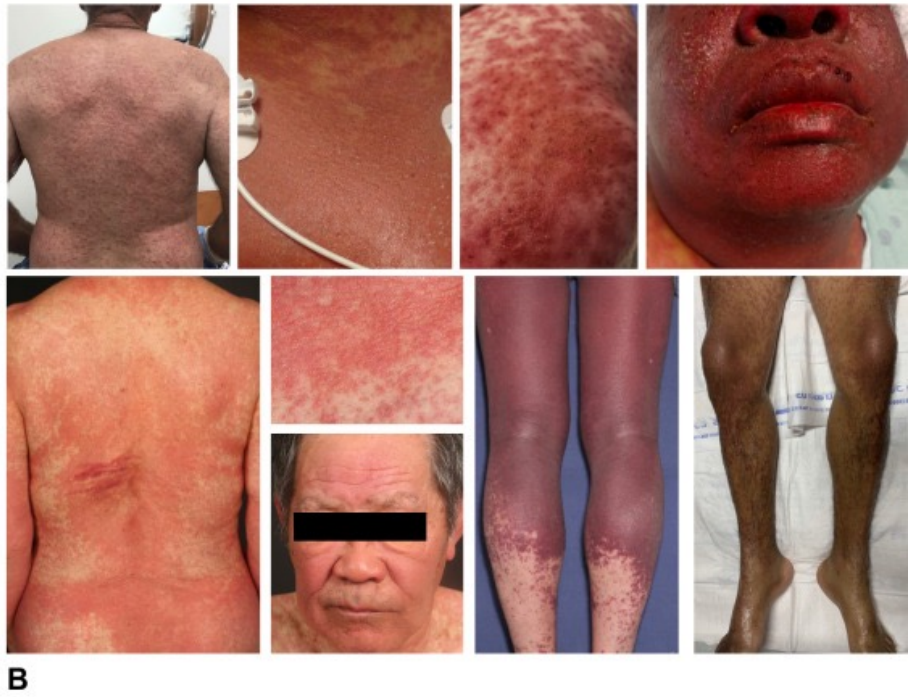




- AKA DRESS – Drug Rash w Eos and Systemic Symptoms
- Fever, malaise, +/- LAD
  - Skin, Liver, +/- Myocarditis, Pneumonitis, CNS etc
- Nonspecific eruption + EDEMA (Facial/acral)
- WEEKS after starting med
- Eosinophilia not always present
- +/- Itch; +/- Mucosal rare
- Common Triggers
  - Aromatic anti-epileptics
  - Sulfonamide abx
  - Minocycline

DRUG ERUPTIONS: DRUG HYPERSENSITIVITY





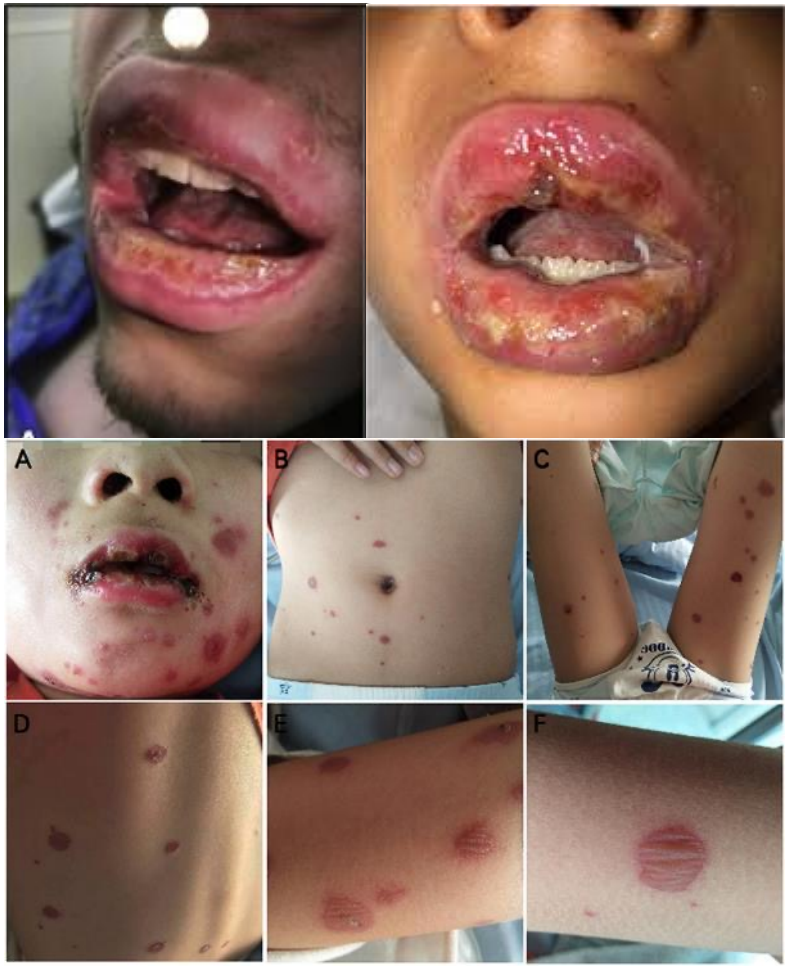
- Evaluation
  - CBC w diff, LFTs, TFTs
  - Imaging depending on symptoms (eg CXR/Echo)
  - Skin biopsy not specific but consider to r/o other entities
- Treatment
  - D/C offending med
  - Topical steroid/antihistamine
  - Consider prednisone/systemic treatment for Liver involvement/more severe
  - Usually requires LONG taper/GI involvement for hepatic management
  - ?Possible increased risk autoimmunity/thyroiditis long term

Drug-Induced Hypersensitivity Syndrome (DIHS)/Drug Reaction With Eosinophilia and Systemic Symptoms (DRESS): Clinical Features and Pathogenesis. J All and Clin Immunology 2022

ERYTHEMA MULTIFORME (EM) VS REACTIVE INFECTIOUS MUCOSAL ERUPTION (RIME)

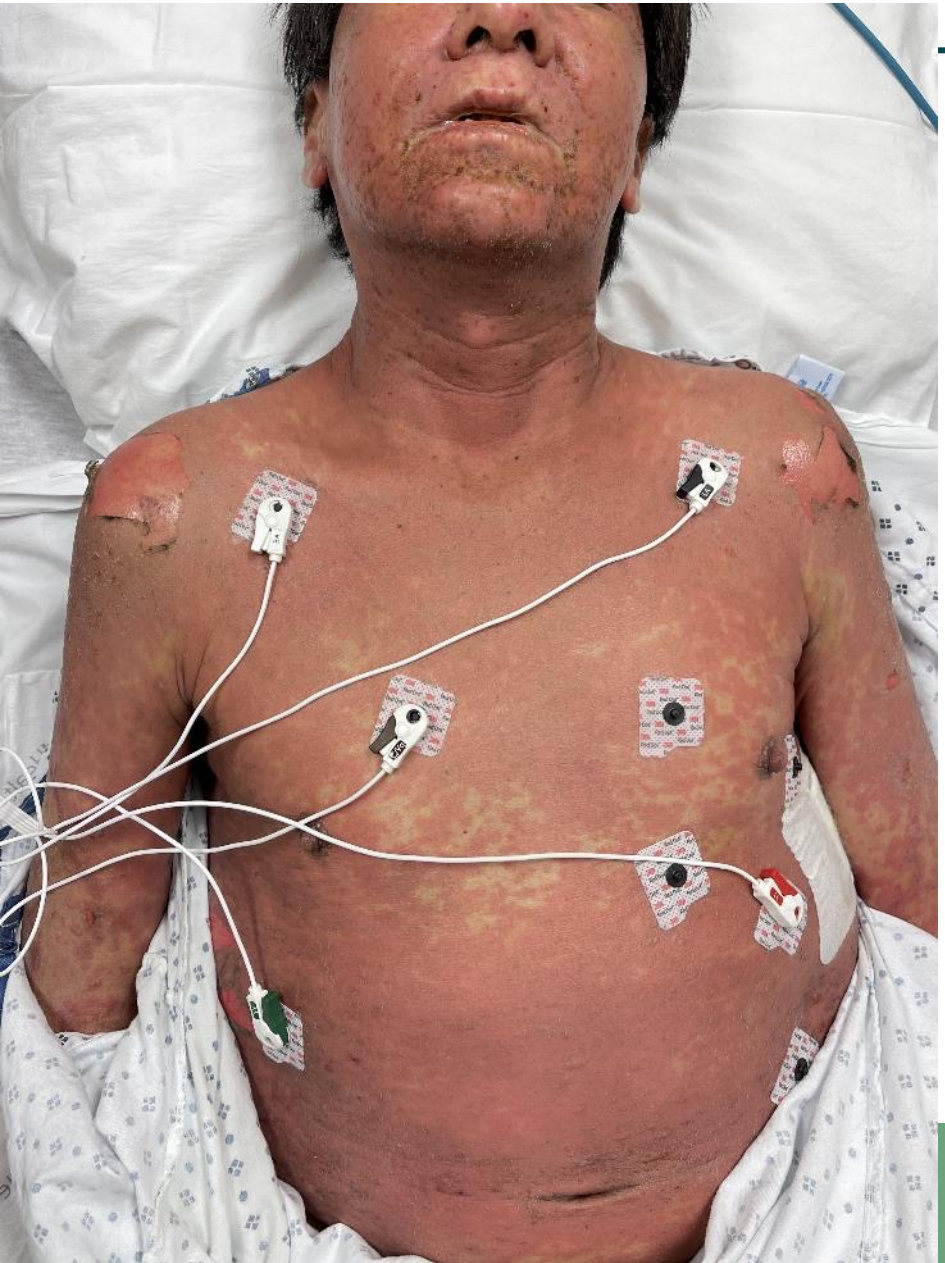
- Previously MIRM – Mycoplasma induced Reactive Mucositis
- Recognized other triggers, including COVID
- ? Prior “EM Major”?
- Often teens/young adults
- Cough followed by mucositis (2+ sites)
- +/- Skin rash

- Treatment:
  - Identify/treat infxn if possible
  - Symptomatic management
  - +/- steroids, cyclosporine



Case Report: Clinical and Immunological Features of a Chinese Cohort With Mycoplasma-Induced Rash and Mucositis

STEVENS-JOHNSON/TOXIC EPIDERMAL NECROLYSIS



Hypersensitivity disorder spectrum

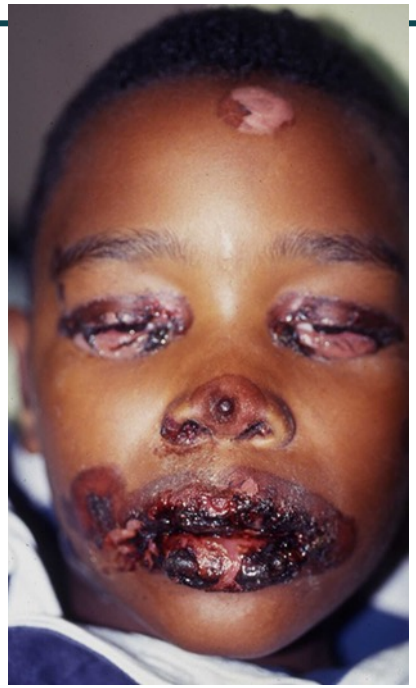
- In kids, SJS > TEN
- TEN potentially fatal

? Increased incidence/severity w liver comorbidity?

? Genetic tendency amongst Asian, NA/AI populations?

- Secondary to viral illness, medication, other
- Fever, systemic sx, mucosal erosions + epidermal detachment:
  - <10% SJS
  - 10-30% Overlap
  - >30% TEN

SJS/TEN – EVALUATION/TREATMENT



- Can evolve rapidly (hours)!
- Needs ICU monitoring/transfer
- Ophtho/GYN/Uro evaluation
- Fluid management
- Dressings/Wound care (burn unit)
- Pain control
- DC offending trigger
- Treatment:
  - Cyclosporine
  - IVIG
  - Steroids?
  - TNF-alpha inhibitors (Etanercept)?

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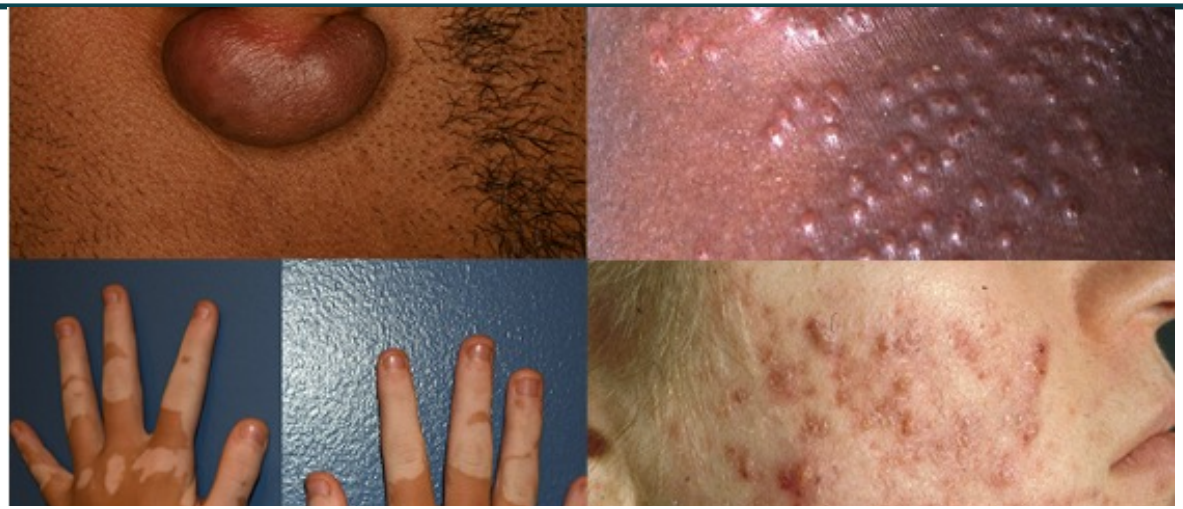
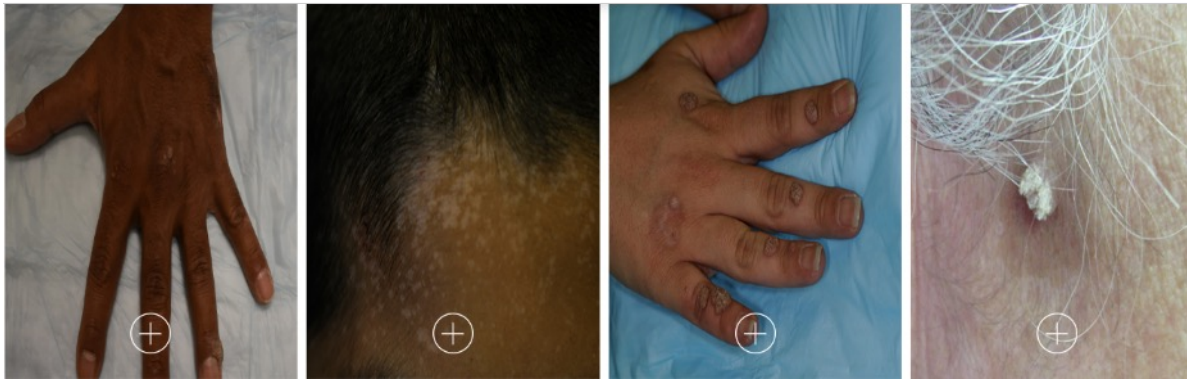
INCLUSIVITY ATLAS

https://hsc.unm.edu/medicine/departments/dermatology/inclusive-dermatology/

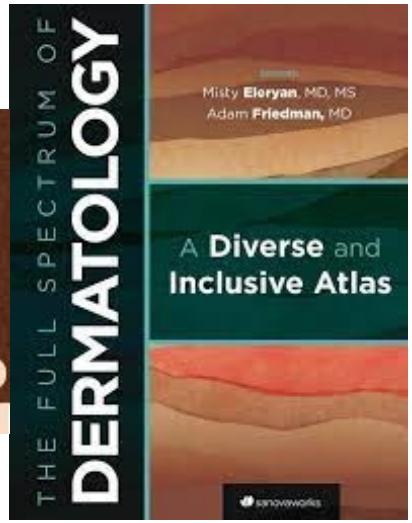
- Goal to compile/continually develop images from diverse patient population
- Open access
- Target audience = learners, primary care colleagues, patients
- “Fitzpatrick”1-5/6 skin types
- Goal for equity of representation
- To help or contribute email:
  - HSC-Derm-Atlas@salud.unm.edu

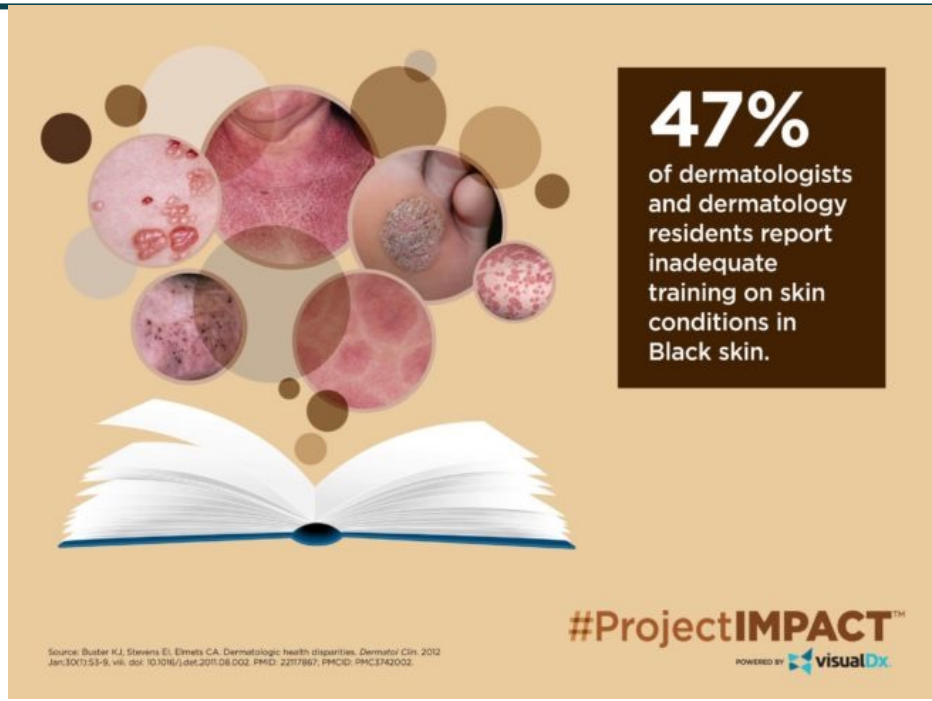




OTHER NATIONAL INITIATIVES

- VisualDX – “Skin of Color Sort”
- Project Impact (VisualDx+)
- “The Full Spectrum of Dermatology: A Diverse & Inclusive Atlas” textbook
- https://www.blackandbrownskin.co.uk/ mindthegap





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OTHER (REGIONAL) OPPORTUNITIES

UNM DERM ECHO PROGRAM

- Free registration/participation; attend when you can
- Short basic lectures by expert faculty
- Shared patient cases/images for real-life learning
- Fridays at 12 noon MST
- Lead Dr. John Durkin, MD, FAAD
- https://hsc.unm.edu/medicine/departments/dermatology/project-echo/

U COLORADO – NATIVE SKIN HEALTH INITIATIVE

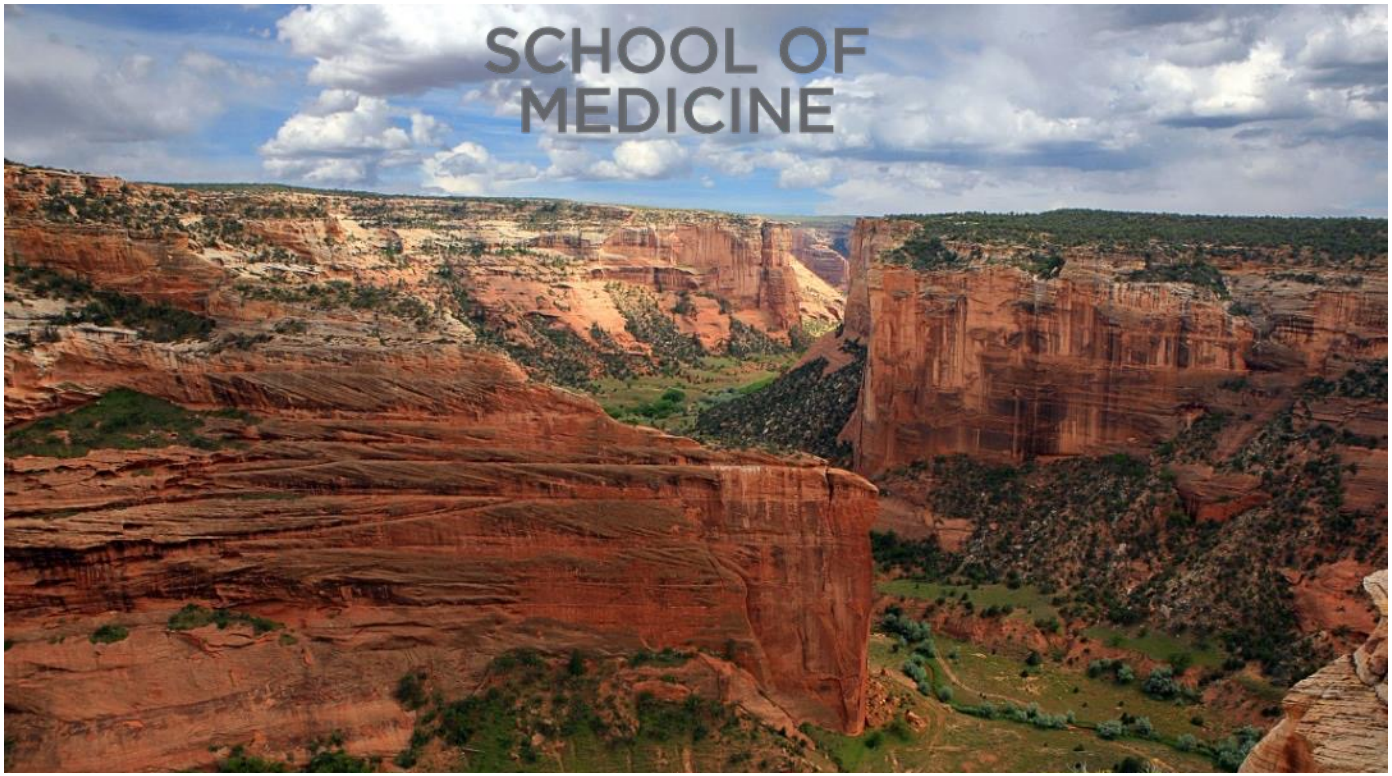
- Research on NA/AI perspective/access
- https://coloradosph.cuanschutz.edu/research-and-practice/centers-programs/caianh/projects/native-skin-health

UNM DERM CME FOR PRIMARY CARE

- Summer conference - Hybrid model
- Albuquerque NM/UNM core faculty +
- Procedural workshops, varying topics
- Consider attending! 2023 Dates TBD
- https://hsc.unm.edu/medicine/departments/dermatology/news-cme-events/dermatology-for-primary-care.html

Thank you!

asmidt@salud.unm.edu



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Emergency Medicine for Rural and Indigenous Communities Conference

September 15th - 17th, 2022

End of Presentation

Questions?

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