

NPAIHB Indian Country Adolescent Health ECHO

Adolescent Dermatology – Clinical Overview Handout

Skin conditions are among the most common reasons adolescents seek health care. This clinical quick reference guide compiles high-yield dermatology guidance for primary care clinicians working with Indigenous adolescents and youth in Tribal, IHS, and Urban Indian health settings.

Dermatology Quick Treatment Guide

<i>Condition</i>	Key Features	First-Line Treatment	When to Escalate / Refer
<i>Acne Vulgaris</i>	Comedones, papules, pustules on face/chest/back	Topical retinoid + benzoyl peroxide; oral antibiotics for moderate disease	Nodulocystic acne, scarring, treatment failure → dermatology
<i>Atopic Dermatitis</i>	Pruritic chronic rash; flexural distribution common	Daily emollients; topical corticosteroids for flares	Severe disease or frequent infection
<i>Impetigo</i>	Honey-colored crusted lesions	Topical mupirocin; oral cephalexin if extensive	Rapid progression or systemic illness
<i>MRSA Abscess</i>	Painful erythematous lesion with fluctuance	Incision and drainage; TMP-SMX, doxycycline, or clindamycin if cellulitis	Recurrent infection or severe cellulitis
<i>Tinea Infection</i>	Annular rash with central clearing	Topical antifungal (clotrimazole or terbinafine)	Tinea capitis or extensive disease → oral therapy

Top Dermatology Diagnoses in Adolescent Primary Care

<i>Diagnosis</i>	Typical Presentation	First-Line Management	When to Refer
<i>Acne Vulgaris</i>	Comedones/papules on face/back	Topical retinoid + benzoyl peroxide	Scarring or nodulocystic acne
<i>Atopic Dermatitis</i>	Chronic itchy rash	Emollients + topical steroids	Severe or uncontrolled disease
<i>Impetigo</i>	Honey-colored crusts	Topical mupirocin	Systemic illness
<i>MRSA Abscess</i>	Painful fluctuant lesion	Incision & drainage	Recurrent infections

<i>Tinea Corporis</i>	Annular rash	Topical antifungal	Diagnostic uncertainty
<i>Tinea Capitis</i>	Scalp scaling + hair loss	Oral antifungal	Treatment failure
<i>Contact Dermatitis</i>	Localized itchy rash	Avoid trigger + topical steroid	Persistent or severe
<i>Viral Warts</i>	Hyperkeratotic papules	Salicylic acid or cryotherapy	Extensive lesions
<i>Molluscum Contagiosum</i>	Umbilicated papules	Usually self-limited	Widespread disease
<i>Hidradenitis Suppurativa</i>	Painful nodules in axilla/groin	Topical clindamycin	Moderate–severe disease

Red Flags in Adolescent Dermatology

<i>Finding</i>	Possible Concern	Recommended Action
<i>Rapidly spreading rash with fever</i>	Serious infection or drug reaction	Urgent evaluation
<i>Painful purpura or necrotic lesions</i>	Vasculitis or invasive infection	Emergency evaluation
<i>Severe mucosal involvement</i>	Stevens–Johnson syndrome	Immediate referral
<i>Extensive blistering rash</i>	Autoimmune blistering disorder	Urgent dermatology referral
<i>Recurrent abscesses</i>	Chronic MRSA or immune disorder	Culture lesions and consider referral
<i>Ulcers with systemic symptoms</i>	Autoimmune disease	Further diagnostic evaluation

Indigenous Adolescent Dermatology Considerations

- Skin disease may present differently across diverse skin tones.
- Limited access to dermatology specialists in Tribal and rural communities.
- Cultural practices such as traditional medicines, body art, or environmental exposure may influence skin conditions.

Clinical Pearls

- Visible skin disease can significantly affect adolescent self-esteem.
- Assess for psychosocial impact when evaluating acne or chronic skin disease.
- Refer to dermatology for severe acne, diagnostic uncertainty, or refractory disease.

References: see attached PDF references