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**SUMMIT**

# Dermatology in DPC



*High-Yield Diagnosis, Cost-Effective Management, and Referral Pearls*

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1



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2

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3

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4

## Learning Objectives

1. Recognize hallmark clinical features of common dermatologic conditions—including eczema, psoriasis, acne, alopecia, suspicious skin lesions, and skin infections—with attention to variations across skin tones.
2. Apply evidence-based, cost-effective treatment strategies suited to the DPC model, prioritizing accessible therapies and practical follow-up tools.
3. Identify referral and escalation thresholds, integrating collaborative dermatology approaches (e-consults, telederm, or local partnerships) that enhance continuity of care within the DPC framework.



5

## Areas of Focus

### Recognize

- Hallmark features of common skin conditions encountered in DPC practices.
- Different morphology and distribution patterns
- How erythema and inflammation may look different across skin tones



### Treat

- Evidence-based first-line regimens that are accessible and cost-aware
- Simple follow-up timelines that prevent premature treatment failure
- When to use low-, medium-, and high-potency topical therapies, systemic treatments



### Refer / Collaborate

- Red flags where delay changes outcomes
- When telederm or e-consult is appropriate vs in-person dermatology referral
- How to take quality photos and focused clinical questions for e-referrals



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6

## Before the Cases: Skin Tone and Surrounding Skin Changes the Visual Signal

### Erythema may look like...

- Pink or red
- Violaceous or plum-colored
- Hyperpigmented brown
- Gray-brown or ashy
- Warmth, edema, scale, and symptoms may be more reliable than redness when identifying inflammation



### Common reasons diagnoses are missed

- Under-calling inflammation in darker skin
- Mislabeling pigment as “just discoloration”
- Missing follicular patterns
- Forgetting palms, soles, scalp, and nails during skin exams



### What to document

- **Morphology:** papules, plaques, scale, crust, pustules
- **Distribution:** flexural, extensor, dermatomal, acral, follicular
- **Symptoms:** itch, pain, burning, tenderness
- **Photos:** overview + close-up + scale marker



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7

## A Fast Dermatology Framework for DPC Visits

### 1. One-line morphology

- Annular scaly plaque
- “Lichenified flexural plaques”
- “Follicular papules/pustules”
- “Smooth patch of coin-shaped hair loss”
- “Non-healing pearly papule”



### 2. Distribution

- Flexural → eczema
- Extensor/nails → psoriasis
- Annular/asymmetric → tinea
- Sun-exposed or non-healing → skin cancer
- Scalp crown + symptoms → scarring alopecia



### 3. Time course + trigger

- **Hours–days:** urticaria, drug eruption, infection
- **Weeks:** eczema, tinea, psoriasis, acne flare
- **Months:** TE, chronic dermatitis, evolving lesion
- **Trigger:** illness, medication, new product, hair practice

### 4. Risk filter

- Pain out of proportion
- Fever/systemic symptoms
- Mucosal involvement
- Rapid progression
- Scarring, ulceration, bleeding, evolution



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8

## Low-Cost Tools That Upgrade Dermatology Care in DPC

### In-office tools

- Dermatoscope or smartphone derm lens



- Measuring tape/ruler for lesions

- Photo consent workflow

- Simple rash/hair loss intake template

### Follow-up tools

- **2-week** check for infections or uncertain rash
- **4-week** check for eczema/psoriasis flare control
- **8-12 week** check for acne/hair loss response
- **Photo comparisons** under similar lighting
- Clear “call sooner if...” instructions

### DPC advantage

- Longer visits can catch exposures and adherence barriers
- Direct communication can prevent steroid misuse or other medication confusion
- Membership model supports serial photos and check-ins
- Derm partnerships can be built into care pathways



Let's Dive into Some Cases...

## Case 1

### Clinical story

- A 32-year-old Black woman presents with a 5-month history of “dark, dry patches” that flare every Winter.
- Symptoms: severe itch at night; scratches until skin feels thick and sore.
- Distribution: antecubital fossae, popliteal fossae, sides of the neck; no clear annular edge.
- History: childhood asthma, seasonal allergies; uses fragranced body wash and lotion.
- Exam: lichenified hyperpigmented plaques with fine scale; mild fissuring; no honey crust or pustules.



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11

### Live Content Slide

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**Poll: Which initial DPC plan best fits the pattern while minimizing harm and cost?**

12

## Case 1: Answer & Differential Reasoning

B. Treat as atopic dermatitis plan with site-appropriate topical therapy and barrier repair



### Why the tempting alternatives are wrong

**A. Terbinafine** Tinea stays on the differential, but the story lacks a classic annular advancing border/central clearing. If uncertain or steroid worsens it, perform KOH.

**C. Clobetasol everywhere** Too potent for face, neck/folds, groin and too long for routine flares; raises risk of atrophy, dyspigmentation, striae, and steroid acne.

**D. Oral prednisone** May rebound and does not build a sustainable eczema plan; reserve systemic therapy for select severe cases, ideally with dermatology input.

**Clinical pearl:** In skin of color, "dark and itchy" may be active inflammation, not just pigment.

## Case 1: Treatment & Escalation for Atopic Dermatitis

### First-line foundation

- Lukewarm short showers (max 10-15 min)
- Fragrance-free cleanser
- Thick cream/ointment within 3 minutes of bathing
- Petrolatum as 2<sup>nd</sup> layer when needed

**Recommended brands:** Dove, Vanicream, Cetaphil, Cerave, La Roche Posay, Aquaphor

### Flares: body

- **Triamcinolone 0.1%** ointment BID x up to 2 weeks (moderate) or **Clobetasol 0.05% /Halobetasol 0.05%**(severe)
- Advise patient to take 1 week break and repeat if needed
- Avoid long continuous courses without reassessment

### Face/folds/neck

- **Hydrocortisone 2.5% or Desonide 0.05%** short course
- **Tacrolimus 0.1%/pimecrolimus 1%** if recurrent or steroid-sensitive site
- Avoid high-potency steroids in folds

*\*Can consider non-sedating anti-histamine (cetirizine or fexofenadine) to assist with pruritus*

### When to suspect infection

- Honey crusting
- Pustules
- Pain/tenderness > itch
- Fever or rapidly worsening flare
- Culture if recurrent or not responding



### Follow-up

- Itch should improve in days; pigment takes months.
- Recheck in 2-4 weeks for technique/adherence

### Refer / escalate

- Severe or widespread disease
- Recurrent flares or infections
- Sleep disruption despite appropriate topicals and oral anti-histamines
- Possible need for biologic, or JAK discussion

**Helpful Tip:** write two plans—daily maintenance and flare rescue—so patients do not use steroids indefinitely.

## Case 2

### Clinical story

- A 46-year-old man with obesity presents for “dry elbows” that have not improved with OTC hydrocortisone.
- He mentions 45 minutes of morning stiffness in hands and heel pain that improves as the day goes on.
- Exam: sharply demarcated plaques with thick white scale on elbows, knees, and post-auricular scalp.
- Nails: pitting and distal onycholysis.
- He asks if you can just prescribe a stronger cream because dermatology wait times are long.



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15

### Live Content Slide

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**Poll: Which next step is most important before simply escalating the topical steroid?**

16

## Case 2: Answer & Differential Reasoning

A. Screen for psoriatic arthritis + start topical therapy + refer appropriately



### Why the tempting alternatives are wrong

#### B. Increase topical steroid therapy

While a stronger topical steroid will help psoriatic plaques, it fails to address possible joint involvement/psoriatic arthritis

#### C. Terbinafine

Onychomycosis can mimic nail psoriasis, but nail pitting plus psoriasis plaques and inflammatory joint symptoms is not a "fungus only" story.

#### D. Biologic only

Many patients with limited psoriasis respond to topical regimens. Biologics are not automatic, but joint disease changes urgency.

**Clinical pearl:** Ask every psoriasis patient: "Any morning stiffness, swollen joints, heel pain, or dactylitis?"



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17

## Case 2: Treatment & Escalation

### Limited plaque psoriasis

- High-potency topical steroid ointment (**Clobetasol 0.05% or Betamethasone 0.05%**) to plaques BID x 2–4 weeks
- Weekend or intermittent maintenance for recurrent plaques
- Add **Calcipotriene 0.005% cream** if affordable/available

### Scalp

- **Clobetasol or fluocinonide 0.05%** solution, foam, ointment
- **Ketoconazole 2% or Salicylic Acid** shampoo
- Oil vehicles may be preferred for textured hair

### Avoid pitfalls

- Avoid chronic daily topical steroid without long term plan
- Avoid high potency on face/genitals/folds
- Do not miss nail disease or joint symptoms, which require early/systemic intervention

### Ask + document

- BSA estimate
- Nail involvement
- Genital/inverse disease
- Morning stiffness/swollen joints
- Impact on work/sleep/mental health

### Refer to dermatology

- >10% BSA or rapidly spreading
- Face/genital/palm/sole disease
- Failed appropriate topicals
- Systemic therapy consideration

### Refer to rheumatology

- Inflammatory joint pain
- Dactylitis
- Enthesitis/heel pain
- Persistent morning stiffness
- Positive screening tool such as PEST (Psoriasis Epidemiology Screening Tool)

**Pearl:** topical therapy can start today, but inflammatory joint symptoms should not wait for the rash to be "bad enough."



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18

### Case 3:

#### Clinical story

- A 24-year-old woman presents with 2 years of inflammatory acne and “dark spots that never go away.”
- Distribution: cheeks, jawline, chin; flares the week before menses.
- Exam: comedones, inflammatory papules, a few tender nodules, and brown macules consistent with PIH.
- She previously stopped tretinoin after 2 weeks because she noticed more bumps and felt that the cream made her peel and “look darker.”
- She requests oral antibiotics because she wants improvement before her wedding in 6 weeks.



#### Live Content Slide

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**Poll: Which regimen and counseling best addresses the acne, PIH, and antibiotic stewardship?**

### Case 3: Answer & Differential Reasoning

- D. Combination acne + PIH plan with slow-start retinoid and benzoyl peroxide/salicylic acid cleanser



#### Why the tempting alternatives are wrong

**A. Doxycycline alone** Antibiotic monotherapy is poor stewardship and relapse is common if no maintenance topical plan exists.

**B. Hydroquinone only** Treating pigment while active acne continues will show limited/no improvement as underlying acne isn't being treated

**C. Strong tretinoin** Irritation can worsen PIH and adherence. Start low/slow and pair with moisturizer and sunscreen.

**Clinical pearl:** In skin of color, the "scar" complaint is often PIH—treat acne and pigment together.



21

### Case 3: DPC Treatment & Escalation

#### OTC starter plan

- Benzoyl peroxide 2.5–5% wash 2-3 times/week
- Salicylic acid 2% cleanser every other day (morning) -> leave on 1-2 minutes
- Gentle cleanser (alternate mornings and every evening)
- Adapalene 0.1% pea-sized amount 2–3 nights/week -> nightly as tolerated
- Noncomedogenic moisturizer

#### Hormonal pattern

- Ask menstrual flare, jawline, hirsutism, irregular periods
- Spironolactone if appropriate candidate
- Consider PCOS evaluation when clinically indicated



#### Prescription add-ons

- Tretinoin 0.025%+ cream if tolerated (comedonal and hormonal acne)
- Azelaic acid 15% for acne + PIH
- Topical Clindamycin 1% (lotion or wipes). For inflammatory/hormonal acne. Best when paired with occasional benzoyl peroxide use

#### PIH counseling

- Daily tinted broad-spectrum sunscreen
- Pigment fades over months, not days
- Avoid picking and harsh scrubs
- Minimize irritation combining multiple products together

#### Moderate inflammatory acne

- Doxycycline—short course-(GI upset and photosensitivity)
- Limit duration; plan exit strategy
- Continue BPO/Sal acid + clindamycin + retinoid maintenance

#### Refer / escalate

- Nodulocystic acne
- Scarring or rapid worsening
- Isotretinoin candidate
- Failure after 3 months of good adherence
- Severe distress



**DPC pearl:** Give a "retinoid ramp" handout—most failures are heavy handedness+ irritation + impatience, not medication inefficacy ("sandwich technique").



22

## Case 4

### Clinical story

- A 36-year-old woman reports dramatic hair shedding for 8 weeks: handfuls in the shower and hair on her pillow.
- Triggers: hospitalized with influenza-like illness. Also started tirzepatide 2 months ago and has had 15-lb weight loss so far.
- Exam: diffuse decreased density but no discrete patches of hair loss
- Hair pull test: several telogen hairs from multiple scalp areas.
- No itching, burning, pustules, scale, or loss of follicular openings.



### Live Content Slide

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**Poll: Which DPC approach best reassures appropriately while not missing dangerous hair loss?**

## Case 4: Answer & Differential Reasoning

- B. Likely telogen effluvium with targeted workup, counseling, and red-flag screen

- Abrupt diffuse shedding 2–4 months after physiologic stress is classic for telogen effluvium. (illness, surgery, accidents, GLP-1 weight loss, etc)
- Normal scalp exam, positive hair pull test and lack of focal patches support a nonscarring shedding process.
- The DPC role is to identify triggers, correct deficiencies, set expectations, and monitor for persistence or red flags such as inflammation or scarring, non improvement to standard treatments.

### Why the tempting alternatives are wrong

- A. Alopecia areata** AA usually presents with smooth, well-circumscribed patches, ophiasis, or diffuse AA with other clues; ILK is not for classic TE.
- C. Tinea capitis** Consider in children, scale, lymphadenopathy, broken hairs, pustules/kerion. Adult diffuse shedding with normal scalp is less typical.
- D. Urgent biopsy** Biopsy is useful for scarring, unclear, or persistent alopecia. Classic acute TE with normal scalp can be managed initially.

**Clinical pearl:** Ask: shedding vs thinning, diffuse vs patchy, and scarring vs nonscarring.

25

## Case 4: Treatment & Escalation

### TE workup

- Ferritin/iron studies when indicated
- TSH, Free T3, T4, Anti-TPO and Anti-Thyroglobulin, ANA (if indicated)
- Vitamin D, B12, Folate
- Medication and supplement review
- Nutrition/protein intake

### TE counseling

- Trigger often 2–4 months prior
- Shedding often improves over 3–6 months
- Visible density recovery can take 6–12 months
- Avoid crash dieting and tight styles during recovery period
- **OTC Supplements:** *Xtress, Nutrafol, Ashwaghandha*

### Optional treatments

- Correct deficiencies (if present)
- Topical minoxidil if prolonged shedding or overlap with androgenic alopecia
  - \*Can also consider oral form
  - \*Do NOT stop at once (taper)
- Treat seborrheic dermatitis if present
- Avoid unnecessary supplements if labs normal (optimal)

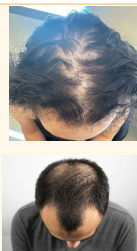
### Alopecia areata

- Smooth patches
- Exclamation point hairs
- Nail pitting may occur
- Derm referral if extensive, rapidly progressive, pediatric, or distressing



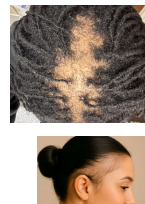
### Female/Male pattern loss

- Gradual thinning
- Widened part
- Miniaturization
- Often overlaps with TE
- Minoxidil is first-line +/- spironolactone, finasteride



### Scarring alopecia red flags

- Pain, burning, tenderness
- Pustules or scale with hair loss
- Loss of follicular openings
- Crown-centered CCCA
- Traction with recession/fringe sign



**Helpful Tip:** Scarring alopecia is time-sensitive—early referral can preserve follicles.

26

**Case 5:****Clinical story**

- A 29-year-old wrestler has a 10-week “eczema patch” on the face
- Initial treatment elsewhere: triamcinolone 0.1% cream BID for 6 weeks.
- Now the lesion is larger with a less obvious border, peripheral papules, and intermittent itch.
- He has a dog with patchy hair loss and shares towels at the gym.
- Exam: isolated asymmetric plaque with minimal scale at the edge on the right cheek; no fever or tenderness.

**Live Content Slide**

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**Poll: What is the highest-value next step in a DPC office?**

## Case 5: Answer & Differential Reasoning

• C. If LFTs wnl within the past 3 months, start oral terbinafine 250mg/day + topical ketoconazole 2% cream

- Worsening/enlargement with topical steroid is a major clue for dermatophyte infection.
- Steroids can suppress scale and inflammation, making tinea less classic and more diffuse.
- Exposure history—wrestling, shared towels, animal contact—raises pretest probability.
- Topical ketoconazole 2% cream or terbinafine 1% cream BID x 4-6 weeks preferred for localized infection

### Why the tempting alternatives are wrong

**A. Clobetasol** Escalating steroid can further mask and spread fungal infection.

**B. Terbinafine** C. If normal liver function, start oral terbinafine 250mg/day due to follicular involvement

**D. Observe** Tinea can spread to contacts and other body sites; treatment is low-cost and effective.

**Clinical pearl:** When a rash worsens with steroid, fungus moves up the differential.

## Case 5: DPC Treatment & Escalation

### Classic clues

- Annular plaque
- Active scaly border
- Central clearing
- Asymmetric distribution
- Exposure: pets, gyms, wrestling, household contacts

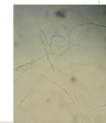
### When steroids confuse it

- Less scale than expected
- Spreading plaque despite treatment
- Pustules or follicular edge
- Temporary itch relief then worsening
- Recurrent "eczema" in the same exact location



### KOH tips

- Scrape active border
- Use enough scale
- False negatives happen if sample poor
- Culture if recurrent, widespread, or uncertain



### Treatment

- Topical terbinafine 1% or ketoconazole 2% cream BID x 4-6 weeks
- Avoid steroid-antifungal combo creams
- Treat feet/groin if reservoir



### Escalate

- Hair-bearing scalp involvement
- Extensive/refractory disease
- Immunosuppression
- Concern for Majocchi granuloma
- Failed appropriate topical therapy
- *Terbinafine 250mg/day x 4-6 weeks*

### DPC counseling

- Do not share towels
- Wash athletic gear
- Spray shoes, flip flops with Lysol
- Check pets/household contacts
- Return if worsening after 2 weeks



**DPC pearl:** avoid clotrimazole-betamethasone as a reflex—it can create the next case of tinea incognito.

## Case 6

### Clinical story

- A 32-year-old African American woman presents with an intensely itchy rash that began on the dorsal arms and hands several hours after returning from a beach vacation and has progressed
- First major sunny exposure/vacation of the year.
- Similar eruption occurs nearly every Spring.
- No new medications, products, illness, oral ulcers, fevers, or arthralgias.
- Exam: grouped skin colored papules on the chest, neck, and forearms; face largely spared.



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31

### Live Content Slide

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**Poll: Which management approach is most appropriate?**

32

## Case 6: The Vacation Rash

- B. Topical corticosteroids + photoprotection counseling

### Polymorphous Light Eruption (PMLE)

- **Sun-triggered skin reaction** (often spring/summer or vacation-related)
- **Delayed immune response to UV light** (not a true sunburn)
- **Itchy bumps, papules, or plaques** on sun-exposed areas
- **Improves with sun avoidance, protective clothing, sunscreen, and gradual UV exposure**

### Why the tempting alternatives are wrong

**A. Lupus workup** No oral ulcers, scarring, arthralgias, or constitutional symptoms.

**C. Solar Urticaria** No hive-like lesions, doesn't resolve within 24 hours

**D. Folliculitis** No pustules or follicular pattern.

Clinical pearl: 'Every sunny vacation I break out' should raise suspicion for PMLE.

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33

## Case 6: Treatment & Escalation

### First-line management

- SPF 30–50 broad-spectrum sunscreen (RE-APPLY)
- UV-protective clothing
- Wide-brimmed hats
- Avoid outdoors during peak UV hours (10am–3pm)
- Oral antihistamines 1–2 hours before sun exposure
- *Heliocare* or *Sol Defense* supplements

### Follow-up

- 2–4 weeks during active flare if persistent
- Before major travel for possible pre-emptive treatment if recurrent with each trip

### Moderate disease

- Triamcinolone 0.1% cream/ointment BID x 7 days
- Clobetasol 0.05% or Halobetasol 0.05% cream BID x 7 days
- Oral antihistamines for itch

### Refer / escalate

- Diagnostic uncertainty
- Severe recurrent disease
- Failure of therapy

### Severe disease

- Short prednisone taper (Medrol dose pak)
- Dermatology referral
- Consider photo-hardening



DPC pearl: The best treatment for PMLE is prevention through sun avoidance and skin protection.

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34

## Case 7

### Clinical story

- A 62-year-old patient presents for hypertension follow-up and casually mentions a “mole” on the upper back.
- History: spouse noticed it 6 months ago; patient thinks it is darker and larger.
- Exam: 1.5cm asymmetric pigmented plaque on the R upper back with irregular border and two shades of brown/black.
- No pain or itch. Patient asks if you can “just freeze it off.”
- You do not have dermoscopy training but can take high-quality photos today.



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35

### Live Content Slide

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**Poll: What is the safest DPC triage decision?**

36

## Case 7: Answer & Differential Reasoning

- A. Biopsy or expedited dermatology referral; do not freeze or empirically treat

- ABCDE's of melanoma
- A destructive procedure can delay diagnosis and remove histologic architecture.
- Consider scoop shave or punch biopsy of lesion if small lesion
- Opt for several scouting shave biopsies vs excisional biopsy (no margins) if larger lesion

### Why the tempting alternatives are wrong

**B. Cryotherapy** Acceptable for classic benign lesions (seborrheic keratosis), not for evolving irregular pigmented lesions unless diagnosis is certain.

**C. Reassure** Melanoma often does not hurt. Lack of pain is not reassuring.

**D. Steroid + check-in 4-6 weeks** Inflammatory treatment does not address malignancy risk; delay is unsafe.

*Clinical pearl: If you are worried enough to photograph it repeatedly, biopsy or refer.*

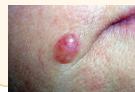
## Case 7: Treatment & Escalation

### ABCDE + ugly duckling

- Asymmetry
- Border irregularity
- Color variation
- Diameter can be <6 mm
- Evolution or looks different from patient's other lesions

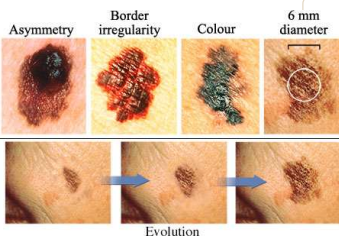
### Non-melanoma clues

- Non-healing sore
- Bleeding/crusting lesion
- Pearly papule with telangiectasias
- Hyperkeratotic tender papule
- Scar-like shiny plaque



### Do not destroy when...

- Pigmented + changing
- Diagnosis uncertain
- Lesion recurs after treatment
- Bleeds without trauma
- Acral/nail lesion concerning



### Refer urgently

- Changing pigmented lesion
- Rapidly growing nodule
- Non-healing ulcer
- Pigmented nail streak with red flags
- Immunosuppressed patient with suspicious lesion

### Taking Photos

- Overview showing body location
- Close-up in focus
- Ruler/coin for scale
- Dermoscopy if available
- Include duration/evolution/symptoms



DPC pearl: "E" for evolution beats reassurance—document a plan that closes the loop.

## Treat, Watch, or Refer? A Decision Matrix

### Treat in DPC

- Mild atopic dermatitis
- Limited plaque psoriasis without joint symptoms
- Mild/moderate acne without scarring
- Tinea corporis with classic features
- Impetigo
- Hair shedding with clear trigger or hormonal hair loss

### Treat + Watch Closely/Possible TeleDerm Consult

- Uncertain rash after first-line therapy failure
- Scarring alopecia symptoms/signs
- Moderate acne requiring systemic medications
- Cellulitis/abscess not responding to standard of care
- Uncertain skin lesion with questionable need for biopsy

### Refer to In Person Dermatology

- Suspected melanoma or evolving nail/acral pigment
- Psoriasis with inflammatory joint symptoms
- Severe drug eruption/blistering/mucosal involvement
- Infection with, rapid spread, or pain out of proportion



39

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40

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## **Social Q&A for Dermatology in DPC: Confidently Managing Common Skin Conditions in Direct Primary Care**



41

# QUESTIONS?

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42



43