Body System: Integumentary

Session Topic: Dermatologic Conditions

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Physicians have knowledge gaps with regard to diagnosing and evaluating common skin diseases (e.g. acne, dermatitis, rosacea). • Primary care physicians often receive inadequate dermatology training in medical school and residency. • Patients with skin disease often have misconceptions about appropriate skin care. • Physicians have knowledge gaps with regard to appropriate coding/billing for skin procedures. • Physicians have knowledge gaps with regard to selecting appropriate treatment therapies for skin diseases.	1. Evaluate the presented skin condition and determine differential diagnosis and the need for further testing or referral. 2. Counsel patients on lifestyle modifications and proper skin care to control flare-ups and avoid outbreaks. 3. Create a disease management strategy for patients with a diagnosed dermatologic condition based on the type and severity of the condition. 4. Devise an evidence-based treatment plan, considering referral to a dermatologist when treatment goals are not met or when there is significant scarring.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will

encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient eduction and resources
- Provide updates on new treatment therapies, changes to therapies, or warnings associated with existing therapies. Provide recommendations regarding new FDA approved medications; including safety, efficacy, tolerance, and cost considerations relative to currently available options. **Include relevant FDA REMS education for any applicable medications.**
- Provide recommendations to advise patients who present with acne on proper skin care to control and avoid outbreaks.
- Provide recommendations for selecting and implementing a classification/grading system to determine acne severity and guide treatment decisions.
- Provide recommendations for drug therapy options for the treatment of acne and creating a combination therapy plan when needed.
- Provide recommendations for evaluating prescribing considerations for isotretinoin.
- Provide recommendations for recognizing symptomatology of the different types of eczema and dermatitis.
- Provide strategies and resources to counsel patients on lifestyle modifications to control flare-ups and triggers for atopic dermatitis and contact dermatitis.
- Provide strategies for recognizing when patients require patch testing to confirm or rule out allergic contact dermatitis.
- Provide recommendations for creating a disease management strategy for patients with eczema and dermatitis based on the type and severity of the condition.
- Provide specific examples illustrating the use of skin procedure encounter forms to assist in proper coding and documentation
- Provide specific strategies and resources to assist physician-learners in developing collaborative care plans, including coordination of referral and follow-up as necessary

Needs Assessment:

For the purposes of this AAFP FMX topic, the focus will be on skin conditions that are most commonly addressed by family physicians, particularly those that are identified as areas of need within the AAFP membership. Skin procedures (including nail disorders), skin cancer (including

evaluating skin lesions), and wound care (including ulcers) are addressed in other FMX topics. In an analysis of data from the National Ambulatory Medical Care Survey (NAMCS), the most common skin disorders diagnosed by family physicians were acne, dermatitis, pyoderma, tinea, benign neoplasms, and candida; and the three most prescribed medication classes for skin problems were antihistamines, topical anti-infectives, and adrenal corticosteroids.[1,2] Data from the 2015 National Ambulatory Medical Care Survey indicates that family physicians made the diagnosis of contact dermatitis/eczema, during more than 823,019 office visits.[3]

Skin problems and diseases have become a growing reason for which patients seek treatment; in 2010, diagnostic screening of the skin occurred, or were ordered, in over 167 million office visits; and among those, benign neoplasm was the primary diagnosis is over 11 million of those office visits.[4] Acne is the most common skin disorder in the U.S., affecting 40 to 50 million Americans; nearly 85% of people have acne at some point in their lifetime. While it typically starts around puberty, it can affect adults well into their lifetime.[5] Teenagers (age range, 12-17 years) comprised only 36.5% of patients with acne, while patients 18 years or older comprised 61.9%. Depression was reported in 10.6% of females with acne.[6] The total direct cost associated with the treatment of acne exceeded $2.2 billion in 2004, including costs for prescription and over-the counter medication. Additionally, the overall prevalence of atopic dermatitis (eczema) in the United States is approximately 11%, with only 10% of cases diagnosed after five years of age.[7]

Data from recent American Academy of Family Physicians (AAFP) CME Needs Assessment and Common Medical Procedure surveys indicate that family physicians have gaps in medical knowledge and skill with regard to nail disorders, viral skin disorders, skin cancer , ulcers, hypo/hyper-pigmentation, aesthetic procedures, wound care, acne treatment.[8,9] CME outcomes data from 2012, 2013, and 2015 AAFP FMX (formerly Assembly) *integumentary* and *dermatologic conditions* session suggest that physicians have knowledge and practice gaps with regard to acne and dermatitis, specifically with regard to acne treatment, differential diagnosis of different eczemas; effective use of allergy patch testing in dermatitis diagnosis; effective pharmacologic and non-pharmacologic dermatitis treatment options; providing effective patient education; and developing collaborative action plans to manage eczema.[10-12]

A review of the literature suggests that while dermatologic conditions can be effectively managed in the primary care setting, more than 68% of initial evaluations are referred to a dermatologist, thereby increasing the cost of care with no improvement to overall quality.[13,14] Primary care physicians frequently lack the confidence to effectively diagnose and treat common skin conditions. In part, this is due to inadequate training in medical school and residency, as many have no or limited requirements for a formal clinical rotation on their dermatology service.[15] Physicians often have difficulty diagnosing a generalized rash because many different conditions produce similar rashes, and a single condition can result in different rashes with varied appearances.[16] For example, mycosis fungoides (cutaneous T-cell lymphoma) mimics eczema in its early stages and is rarely diagnosed correctly at initial presentation. Reevaluation and possible referral are imperative in chronic eczematous conditions that do not respond to therapy.[16,17]

Additionally, coding for common skin procedures is frequently a challenge for family physicians, and requires continuing education on appropriate skin procedure coding practices, including tools and resources to avoid mistakes.[18,19] In addition to physician or practice gaps in providing optimal dermatologic care in the primary care setting, patients have their own misconceptions about managing common skin conditions such as acne, rosacea and eczema. Patients with acne and rosacea are frequently confused about selecting appropriate skin care products, cosmeceutical and cosmetics; therefore, physicians should be prepared to counsel patients and offer recommendations.[20-22]

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[23,24]

Additionally, physicians can improve their care of patients with common skin conditions (e.g. acne, rosacea, eczema) by engaging in continuing medical education that provides practical integration of evidence-based recommendations from the following evidence-based recommendations and guidelines:

American Academy of Family Physicians (AAFP) Recommended Curriculum Guidelines for Family Medicine Residents state that family physicians should possess the following competencies, attitudes, knowledge, and skills to provide optimal care of skin conditions commonly seen in practice:[25]

- Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of comprehensive preventive care.
- Diagnose and treat common skin diseases proficiently and adeptly perform common dermatologic procedures (Medical Knowledge)
- Utilize diagnostic and evidence-based treatment guidelines, as well as maintain up-to-date knowledge and usage of evolving dermatologic treatment technology (Practice-based Learning and Improvement)
- Communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a nonjudgmental, caring manner (Interpersonal and Communication Skills, Professionalism)
- Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and how to coordinate needed referrals to specialty providers (Systems-based Practice)
- Confidence in managing the majority of skin conditions
- A positive approach to psychosocial needs of patients who have skin disorders
- Willingness to counsel patients with skin conditions
- A desire to learn and perform common dermatologic procedures
- A constructive relationship with dermatologists, when appropriate
- Classification and terminology of skin disorders
- Diagnosis of common dermatologic disorders based on history, topography, and morphology
- Management of common skin disorders

- Prevention of skin diseases
- Skin manifestations of systemic diseases
- Prevention, recognition, and management of common skin cancers (including basal cell carcinoma, squamous cell carcinoma, Kaposi sarcoma, and melanoma)
- Pharmacology of skin medications

Physicians may improve their care of patients with dermatologic conditions by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:

Pityriasis Rosea: Diagnosis and Treatment[26]

- Symptoms of pityriasis rosea can be managed with oral or topical corticosteroids or oral antihistamines.
- Macrolide antibiotics have no benefit in the management of pityriasis rosea.
- Acyclovir is effective in the treatment of pityriasis rosea and may be considered in severe cases.

Pigmentation Disorders: Diagnosis and Management[27]

- Triple combination therapy (fluocinolone 0.01%/hydroquinone 4%/tretinoin 0.05% [Tri-luma]) is the most effective agent for treatment of moderate to severe epidermal melasma.
- Triple combination therapy (fluocinolone 0.01%/hydroquinone 4%/tretinoin 0.05%) can enhance resolution of solar lentigines treated with cryotherapy.
- Class III corticosteroids and narrowband ultraviolet B are the most effective and safest treatments for localized and generalized vitiligo, respectively.
- Topical tacrolimus (Protopic) 0.1% ointment is a safe and effective alternative to topical corticosteroids for treatment of pityriasis alba.
- Topical antifungal agents and topical adapalene (Differin) gel are effective treatments for tinea versicolor.

Acne Vulgaris Treatment[28,29]

- First-line treatment for mild acne vulgaris includes benzoyl peroxide or a topical retinoid, or a combination of topical medications including topical antibiotics.
- Tetracyclines are the preferred oral antibiotic, and doxycycline and minocycline have been shown to be more effective than tetracycline.
- Topical or oral antibiotics should not be used as monotherapy because of the risk of developing resistance.
- Topical retinoids are effective in the treatment of noninflammatory and inflammatory acne.
- Oral antibiotics are effective for the treatment of moderate to severe acne.
- Benzoyl peroxide should be used in conjunction with topical and oral antibiotics to reduce the risk of bacterial resistance.
- After treatment goals are reached, oral antibiotics should be replaced with topical retinoids for maintenance therapy.
- Topical antibiotics are more effective when used in conjunction with topical retinoids.

- Combined oral contraceptives can be used to treat inflammatory and noninflammatory acne in female patients
- Androgen blocking agents, e.g., spironolactone, are effective in the treatment of acne in female patients. (Use in males limited by gynecomastia.)
- Isotretinoin is effective for more severe cases. It requires extra effort to prescribe, but can be a helpful addition for a Family Physician's patients.

Rosacea: Diagnosis and Treatment[30]

- Mild cleansers and moisturizers, broad-spectrum sunscreens (sun protection factor [SPF] 30 or greater), and sun avoidance measures should be used to manage all cutaneous rosacea subtypes.
- First-line therapy for mild to moderate inflammatory rosacea includes topical metronidazole (Metrolotion, Metrocream, Metrogel) or azelaic acid (Finacea).
- Brimonidine (Mirvaso) can be used to treat persistent facial erythema associated with rosacea.
- Topical ivermectin (Soolantra) may be used for the treatment of papulopustular rosacea.
- Subantimicrobial-dose doxycycline (Oracea) can be used to treat inflammatory lesions of papulopustular rosacea.
- Subantimicrobial-dose doxycycline in combination with topical azelaic acid or metronidazole can be used to treat moderate to severe inflammatory lesions or mild inflammatory lesions that have not responded to initial therapy.
- Mild ocular rosacea should be treated with eyelid hygiene and topical antibiotic agents, such as metronidazole and erythromycin.
- Topical ophthalmic cyclosporine drops (Restasis) are more effective than artificial tears in the management of mild ocular rosacea.
- Oxymetazoline cream has been shown to be safe and effective at reducing erythema in a small portion of treated patients, but research showing its effectiveness relative to other options is lacking. It is more expensive than alternative treatment options and should be considered in patients for whom other treatments have not decreased erythema sufficiently. It has not been studied in patients with cardiovascular conditions[31]

Atopic Dermatitis[7]

- Emollients are a mainstay of therapy for atopic dermatitis.
- Topical corticosteroids are first-line treatment for atopic dermatitis flare-ups.
- Topical calcineurin inhibitors are second-line treatment for moderate to severe atopic dermatitis.
- Antibiotics are not useful in reducing flare-ups of atopic dermatitis unless there is clear evidence of a secondary infection.
- Ultraviolet phototherapy is effective for treating severe or refractory atopic dermatitis.
- The immunomodulatory agents cyclosporine (Sandimmune) and interferon gamma-1b are effective for treating severe or refractory atopic dermatitis.
- New agents dupilumab (Dupixent) and crisaborole (Eucrisa) offer new approaches for atopic dermatitis

Diagnosis and Treatment of Seborrheic Dermatitis[32]

- Topical antifungal agents are the first-line therapy for acute and long-term treatment of seborrheic dermatitis of the face and body.

- Topical corticosteroids are effective in treating seborrheic dermatitis and should be used sparingly to avoid adverse effects.
- Topical calcineurin inhibitors are effective, well-tolerated second-line treatments for seborrheic dermatitis, but they are not approved by the U.S. Food and Drug Administration for this use.

Diagnosis and Management of Contact Dermatitis[33]

- In patients with contact dermatitis, the priority is to identify and avoid the causative substance.
- Localized acute allergic contact dermatitis lesions are successfully treated with mid- or high-potency topical steroids, such as triamcinolone 0.1% (Kenalog, Aristocort) or clobetasol 0.05% (Temovate).
- On areas with thinner skin (e.g., flexural surfaces, eyelids, face, anogenital region), lower-potency steroids, such as desonide ointment (Desowen), can be helpful and minimize the risk of skin atrophy.
- If allergic contact dermatitis involves extensive areas of the skin (greater than 20 percent), systemic steroid therapy is often required and offers relief within 12 to 24 hours.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Atopic dermatitis: an overview[7]
- Diagnosis and treatment of acne[29]
- Pityriasis Rosea: Diagnosis and Treatment[26]
- Diagnosis and management of contact dermatitis[33]
- Pigmentation Disorders: Diagnosis and Management[27]
- Acne Vulgaris Treatment[28,29]
- Rosacea: Diagnosis and Treatment[30]
- Diagnosis and Treatment of Seborrheic Dermatitis[32]
- Common benign skin tumors[34]
- Newborn skin: Part II. Birthmarks[35]
- Common skin conditions during pregnancy[36]
- Dermatologic Conditions in Skin of Color: Part I[37]
- Dermatologic Conditions in Skin of Color: Part II[38]
- 12 errors to avoid in coding skin procedures[18]
- Don't get burned coding common skin procedures[19]
- How to reduce your malpractice risk[39]

- Thinking on paper: documenting decision making[40]
- Simple tools to increase patient satisfaction with the referral[23]
- Exam documentation: charting within the guidelines[41]
- Health Coaching: Teaching Patients to Fish[42]
- Are you ready to discuss complementary and alternative medicine?[22]
- Engaging Patients in Collaborative Care Plans[43]
- FamilyDoctor.org. Skin Rashes and Other Changes - Symptom Chart (patient education)[44]
- FamilyDoctor.org. Eczema and Atopic Dermatitis | Overview (patient education)[45]
- FamilyDoctor.org. Acne | Overview (patient education)[46]
- FamilyDoctor.org. Rosacea | Overview (patient education)[47]

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