SWMOIC ‘06
Operational Dermatology
Acne & Beyond

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NMCSD-Dermatology
26 July 2006
What's your diagnosis?

MELANOMA
Objectives

• Discuss common skin conditions
• Basic management
  – You as a primary care provider
  – Highlight patient education
  – Pitfalls & Mismanagement
• Recognize skin cancers
• When to refer to dermatology
Recommended References

• Clinical Dermatology, 4\textsuperscript{th} ed
  – Thomas P. Habif
  – ISBN: 3323013198

• Color Atlas & Synopsis of Clinical Dermatology
  – ISBN: 0071360387
Acne
Acne

- Disease of the pilosebaceous units
- Hormonally influenced
- Disfiguring
Acne Classification

- Comedonal
  - Non-inflammatory
  - Whiteheads
  - Blackheads

- Inflammatory
  - Red papules
  - Pustules

- Nodulocystic
Comedonal acne
Inflammatory acne – Mild
Inflammatory acne – Moderate
Nodulocystic acne
Other involved areas
Treatment

• Good **MILD** skin care
  – mild soaps
  – gentle washing
    ▪ No facial scrubs – BAD, BAD, BAD

• Acne comes from within
  – Not from dirt
  – Not from foods
Comedonal Acne

• Start with low dose retinoid
  – Retin-A 0.05% cream
  – Switch to Retin-A micro 0.04%
    ▪ after several weeks
    ▪ or when adjusted
• Benzoyl peroxide 5% gel/wash

• +/- topical antibiotics
  – Cleocin T lotion or gel
Retinoids

• Reduces keratinocyte cohesion
  – Opens plugged pores
  – Prevents plugging
• Problems
  – Irritating
  – Photosensitizing
Retinoids

• *To avoid irritation:*
  – Go easy in the beginning
    ▪ Use lower strength to start (creams, low %)
    ▪ Use 2 nights per week
    ▪ Increase as tolerated to nightly use
  – Apply on very dry face
    ▪ Wash face, then wait 15-20 minutes
  – Avoid moist areas
    ▪ nasal folds, periorbit, oral commissures
Retinoids

• Apply only at night
  – Photosensitivity
  – Use mild non-comedogenic moisturizer in the morning with SPF 15-30
Response to Retinoids

Patient education
- Acne will get worse before it gets better
- Should continue even though face clears
Retinoids

- Retin A
  - Cream 0.025%, 0.05%, 0.1%
  - Gel 0.01%, 0.025%
  - Micro 0.04%, 0.1%
- Differin gel
- Tazorac
- This is **KEY** to long term acne tx!
Benzoyl Peroxide

- Antibacterial
- Minimizes bacterial resistance
- Mild peeling effect
- Bleaches colored cloth

- 5% wash or gel
Inflammatory acne – Mild

• Dry face with topical antibiotics first
  – Cleocin T gel/lotion x 2-3 weeks

• Introduce retinoids
  – Retin-A 0.05% cream
  – Switch to Retin-A micro 0.04%
    ▪ after several weeks
    ▪ or when adjusted

• Continue topical antibiotics

• Benzoyl peroxide 5% wash
Topical Antibiotics

• Clindamycin
  – Cleocin T gel or lotion
  – Combinations – Clinda + Benzoyl Peroxide
    ▪ BenzaClin
    ▪ Duac

• Erythromycin – high resistance
  – T-Stat, Erygel, Benzamycin
  – Discouraged
Inflammatory acne – mod to severe

• Pustules +/- some cysts, nodules

• Start with oral antibiotics
  – Doxycycline/Minocycline 100 BID
  – Maintain for about 3 months

• Benzoyl peroxide 5% wash

• When face calmed down:
  – Introduce & maintain retinoids
  – Decrease antibiotics or wean off
  – Switch to topical antibiotics

• Oral contraceptives for females
Oral Antibiotics

• Various mechanisms
  – Antibacterial action
  – Inhibit neutrophil chemotaxis
  – Reduces inflammation

• Many choices
  – Tetracyclines: TCN, Minocycline, Doxy
  – Clindamycin
  – Bactrim
Tetracycline

- Cannot take with food, dairy products, antacids, iron
- Take 2 hrs after meal or 1 hr before
- Can irritate empty stomach
- 500mg BID
- May stain gums
Minocycline

- Can be taken with food
- Still affected by dairy products
- Expensive
- 50-100mg BID
- Side-effects:
  - Nausea & vomiting, vertigo, CNS problems, hyperpigmentation, lupus-like hypersensitivity reaction, hepatitis, livedo reticularis
Doxycycline

- As effective as minocycline
- Fewer side effects
  - photosensitivity 1%
- Cheap!
- Every clinic stocks it
- Can take with food
- 100mg BID
Other Oral Antibiotics

- Clindamycin – “poor man’s Accutane”
  - 300 mg PO BID
  - Pseudomembranous colitis
- Trimethoprim/Sulfamethoxazole
- Ampicillin
- Erythromycin – resistance
  - Highly discouraged
Oral Antibiotic Goals

• Gets acne under control
  – Use for 3-4 months
  – Taper dose slowly after clearance of inflammatory lesions

• Switch to topicals alone
Hormone modulator

- Suppress ovarian hypersecretion of androgens
- Spironolactone
  - Should probably be done by Dermatology
- Ortho Tri-Cyclen/Cyclen
- Yasmin
  - Very good
  - Monitor potassium
    - Can cause hyperkalemia
    - Do not mix with Spironolactone
Nodulocystic Acne

• Oral antibiotics
• Oral contraceptives if female
• Refer to Dermatology for Accutane
• Intralesional Kenalog (a drop of 2.5mg/cc to each nodule)

• These patients should be managed by Dermatology
Accutane

- Reserved for the worst form of acne
  - Nodulocystic
  - Severe inflammatory acne unresponsive to conventional therapy
    ▪ Documented history of failed treatment

- Refer to Dermatology
  - New dispensing program: *iPledge*
    ▪ Easy to dispense to males
    ▪ More cumbersome for females
**Accutane – Prep your patients**

- Be willing to put up with follow-ups
  - Monthly visits
  - Monthly labs prior to actual visit

- Start females on birth control – 2 forms
  - Pills, IUD, Depo shot, etc…
  - Partners: condoms, vasectomy

- Be able to deal with side effects
Accutane Side Effects

- Dry skin, redness, cheilitis
- Dry eyes, epistaxis
- Hypertriglyceridemia/lipidemia
- Liver abnormalities
- Various cytopenias, elevated ESR
- Depression
- Hyperostosis
Acne Summary

• Be patient – controllable, **NOT curable**

• Stick with one regimen x 3 months at least
  – Many different combinations available
  – Make sure of compliance

• 75% clearance is a good result

• Torso much harder to clear
Contact dermatitis
Contact Dermatitis

• Mild non-blistering lesions
  – Short course of potent steroids on small areas
    ▪ Clobetasol/Lidex BID x 10-14 days
  – Identify and avoid culprit
  – Oral antihistamines if itchy
Contact Dermatitis

• Blistering and weeping lesions
  – Decompress, but DO NOT peel large vesicles
  – Domeboro soaks/Cool compresses

• Use systemic steroids if severe:
  – Oral Prednisone taper !!!!
    ▪ 60mg qAM X 5days, 40 mg qAM X 5days,
      20mg qAM X 5days
  – Short taper leads to rebound
Eczema
Eczema

• A “garbage” term, but we use it because people have heard of it

• Many different appearances, but similar pathogenesis and treatment
Atopic dermatitis
Nummular Eczema
Nummular Eczema
Hand Eczema
Lichen Simplex Chronicus
Factors That Provoke Itching

- Dryness of the skin
- Sweating, excessive heat, cool air
- Wool clothing, synthetic fibers
- Stress
- Contact allergens
- Food allergy (minority of patients)
3 Pillars of Eczema Tx

- Emollients
- Anti-histamines
- Topical Steroids
Start with Good Skin Care

• Avoiding drying soaps
  – Dove unscented bar soaps
  – No bottled soaps
  – Use soap only on areas that need true cleansing (neck, axilla, groin)

• Avoiding anything that smells too good
  – Perfumes, designer lotions/creams

• Aggressive use of emollients
Emollients

• Apply immediately after shower
  – Aquaphor/Baby Oil

• Use something at least TID-QID

• Ointments/Creams – preferred!!
  – Greasier, better hydrators

• Lotions – discouraged
  – easier to apply, but less protection
Emollients

- Ointments
  - Aquaphor, Vaseline

- Creams
  - Vanicream, Cetaphil, Moisturel

- Other
  - Vegetable shortening, mineral oil
Topical Steroids

- Don’t be steroid shy, but don’t go crazy
- Ointments are better
- Creams are more drying, irritating, sensitizing
- Forget about cosmetic elegance…
Steroid Strategy

• Severe eczematous dermatitis
  – Start with short course of strong steroids
    ▪ Lidex 0.05% ointment
    ▪ Cyclocort 0.1% ointment
    ▪ Triamcinolone 0.1% ointment
  – Use BID Monday to Friday, not weekends
  – Do not use on face, axilla, groin
Steroid Strategy

• Facial dermatitis or intertriginous skin
  – Use Class 6 or 7 ointments/creams for a good period of time
    ▪ Desonide 0.05% cream
    ▪ Hydrocortisone 1.0 or 2.5% cream/ointment
  – You should still watch for signs of steroid complications
Cutaneous Side Effects

- Atrophy, striae, wrinkling
- Erythema, burning, stinging
- Pigment alteration
- Telangiectases
- Acne, folliculitis
- Perioral dermatitis
Steroid Overuse
Perioral Dermatitis due to Steroid overuse on face
Antihistamines

• Itch - Scratch - Rash cycle
  – rash worsens with scratching

• Proper use:
  – Atarax 25-50 mg po TID if severe itching
  – Combo therapy:
    ▪ Sedating: Atarax 25-50 mg po qHS
    ▪ Non-sedating: Zyrtec, Claritin, Allegra qAM
Antibiotics

• Almost all atotics colonized with Staph

• Impetigo
  – juicy, honey-colored crusting
  – Topical abx if mild
  – Oral (Diclox, Keflex) if severe
Set Reasonable Expectations

- *Prevention, NOT cure is the goal*

- Inherited disorder, not contagious

- Personal/family history of atopy
  - eczema, hay fever, asthma

- Need to learn to adapt to changing environment
  - Patient moving to SD from humid places

- Will wax/wane, even with good care
Molluscum
Molluscum

• 1-5 mm flesh-colored, dome-shaped, umbilicated papules

• Pox virus
Clinical Findings

• Spread by physical contact
  – Common in kids
  – STD in adults

• Autoinoculation

• Face, torso

• Severe in eczema patients
Molluscum Treatment

- Cryosurgery
- Salicylic Acid
- Aldara
- Curettage
- Tretinoin
Pityriasis rosea
Pityriasis Rosea

• Salmon-colored plaques with “trailing collarette” of scale
• “Christmas tree” distribution on trunk
• Starts with **herald patch**, then smaller papules/plaques develop
• ?Viral etiology
• May be pruritic
• Important DDx: **syphilis**
  – √ RPR
PR – Treatment

• If pruritic:
  – Mild topical steroid
  – Oral antistaminines for pruritus

• Limited sun exposure helps clear lesions

• Oral erythromycin
  – Success in one study in patients with PR over 2 years of age
Psoriasis
Mild to Moderate Psoriasis
Mild to Moderate Psoriasis

• Dovonex® (Calcipotriene) 0.005% ointment
  – synthetic analog of vitamin D
  – slows skin cell growth, flattens plaques, removes scale
  – apply thin QD/BID and rub in gently
  – Max dose 100 g/week

• High potency topical steroids
  – Clobetasol 0.05% or Lidex 0.05% ointment
  – Apply BID Monday to Thursday
  – Decrease as plaques thinned

• Light therapy (UVB, UVA) – refer to derm
Severe Psoriasis

- Refer to dermatology
- Light therapy
- Systemic
  - Retinoids (Acitretin)
  - Methotrexate, Cyclosporine
- Biologics
  - Regulates immune system
  - Injectionables, need refrigeration
  - They allow sailors to deploy & remain on ships
PSORIASIS TREATED WITH REMICADE
Guttate Psoriasis

• May be related to URI (Strep infection)
  – Oral antibiotics x 2 weeks
• Responds best to NB-UVB light therapy
Patient education

• No permanent cure
• Controllable if compliant with medication
Scabies
Scabies

- Infestation *Sarcoptes scabiei*

- Spreads by intimate contact
  - close skin to skin contact
  - sexually transmission
  - fomites

- Female mites burrow in to skin & lay eggs

- Live for about 30 days

- Eggs hatch in 3-4 days
Clinical Manifestations

- Takes about 1 month to show a rash following initial infestation
- Host becomes sensitized to mites
- *Pruritus* is the chief symptom
Favored sites
If you suspect scabies, you have to look at the groin...
Diagnosis

• History

• Typical distribution of lesions

• Oil prep of skin scrappings
  – Mites
  – Eggs
  – Scybala (fecal pellets)
Scabies Prep

- Put a drop of mineral oil on slide
- Take #15 blade, dip into oil
- Scrape suspicious lesions
  - Fresh nodules, crusted papules, burrows
- Oil helps flakes stick to blade
- Wipe goo on slide, scrape again
- Put on coverslip and look under scope
Scabies Treatment

• Permethrin 5% cream (Elimite)
  – Apply from neck to soles
  – Leave on 8-12 hours
  – Repeat in one week
  – Treat close intimate contacts

• Ivermectin 200ug/kg (~15 mg po) x 1
  – Repeat in one week
Treatment

• Topical antipruritic agents
  – Calamine lotion
  – Sarna

• Oral antihistamines
  – Atarax
  – Zyrtec, Claritin, Allegra
Post-Scabietic Pruritus

- Persistence of itching despite treatment
- Due to hypersensitivity from remaining dead mites and mite products
- May last up to 4 weeks
- Be mindful of treatment failure
  - Due to improperly administered medication and inadequate education
Important part of Treatment

• Mites die if off the human body for 1 week
• Wash beddings and used clothes and do not use for at least 7-10 days
• Clean beds and floors with routine cleaning agents just before scabicide is removed.
Seborrheic dermatitis
Seborrheic Dermatitis

- Greasy flaky scales
  - Scalp
  - "T" of the face
    - Eyebrows
    - Paranasal
    - Mustache
    - Chin
  - Mid-chest
  - Mid-upper back
Seb Derm – Scalp Tx

• T-Gel, Tar, Ketoconazole shampoo
  – Apply on moist scalp x 15 min
  – Wash off with regular shampoo
  – Use daily initially
  – Then 2-3 times for prevention

• Topical steroids – if scales are thick
  – Dermasmoother FS oil apply prior to going to bed and wear shower cap
  – Kenalog spray QD-BID
  – Synalar solution
Seb Derm – Facial Tx

• Start with a low dose steroid
  – Desonide 0.05% lotion/cream AAA BID x 10-14 days max

• Maintenance treatment
  – Triple Cream AAA qd, then 2-3x/week
    ▪ Salicylic Acid 2% + Sulfur 3% + HC 0.5% Cream
  – Ketoconazole shampoo AAA 10-15 min then wash off, 2-3x/week
Tinea
Tinea

• Simple lab tests:
  – KOH prep (if you have a microscope)
    ▪ Scrape leading edge with #15 blade
    ▪ Drop of KOH with cover slip
    ▪ Wait for a few minutes or gently heat slide
    ▪ Look for branching hyphae
  – Fungal Culture
    ▪ Get a culture swab, wet with sterile water
    ▪ Rub on scaly areas vigorously
    ▪ Send to lab in a sterile cup (not in a culture medium)
Bullous Tinea
Tinea

• Topical therapy
  – Lamisil, Miconazole, etc…
    ▪ Spectazole recently removed from formulary
  – Treat about ½” beyond edge of rash
  – Treat until clear, then 1-2 more weeks
  – Antifungal powders to shoes QD forever
Mycolog...

12 years later
When to give oral antifungal...

• Hair-bearing areas
  – Tinea capitis, Majocchi’s granuloma, some palms/soles, and nail involvement

• Bullous tinea (palms/feet)
  – Lamisil 250 mg po qd x 2 weeks

• Onychomycosis (nails)
  ▪ Treat for 4-6 months
Tinea: oral medication

• All have some degree of hepatotoxicity
  – Check LFTs for prolonged use
  – Avoid other hepatotoxin
    ▪ EtOH, Tylenol, supplements, etc...

• May interfere with other meds

• Take Griseo with fat, Itraconazole with food, Terbinafine, Fluconazole with or without food
Pointers for Tinea Pedis

• Antifungal foot powder daily on feet and in shoes
• Alternate shoes/boots
  – Allows shoes to dry up
• Change socks frequently
• Make sure nails are not infected
Onychomycosis
Onychomycosis

• Prove it’s fungus
  – KOH
    ▪ Just like KOH scraping for tinea
    ▪ Takes long to dissolve nail material
  – Culture
    ▪ Cut a piece of nail and send for “fungal culture”
    ▪ Wait for 4-6 weeks to get results
  – PAS staining of nail plate
    ▪ Cut a piece of nail
    ▪ Send for “Tissue Exam” – r/o onychomycosis
Onychomycosis

• Only 50% dystrophic nails have fungus

• Do **LFT’s** before and while on oral antifungal
  – Co-existing liver pathologies?
  – Other medications that affect the liver?
    ▪ Cholesterol medication
  – Heavy drinker?
Onychomycosis

- **Terbinafine**
  - Fingernails: 1 tab PO QD X 6 wks
  - Toenails: 1 tab PO QD X 12 wks
  - Pulse Therapy: 1 tab PO BID X 1 week/mo, repeated X 3-4 mo

- **Fluconazole**
  - 1 tab PO Q week X 12 -16 weeks or longer

- **Itraconazole**
  - 2 tab PO BID X 1 week/mo, repeated X 3-4 mo
Onychomycosis

• Topicals: Very safe, but ineffective
  – Fungoid Tincture
  – PenLac

• Nails grow very slowly
  – 6-9 mos fingernails
  – 12-18 months for toenails
Tinea Versicolor
Tinea Versicolor

- Organism: *Malassezia furfur*
- Yeast cells with stubby hyphae
  - Spaghetti and meatballs
- Common in the tropics (likes sweat and oily surfaces)
- On weight benches in every gym
Tinea Versicolor

• Some people are more susceptible
• Secrete azeleic acid
  – interferes with melanin formation
  – can be hyper- or hypopigmented
  – even when treated, discoloration stays for a long time
TV Treatment

- **Topical**
  - Selenium sulfide
  - Ketoconazole shampoo
  - Antifungal creams

- **Systemic**
  - Ketoconazole 400 mg x1
    - Take with OJ/soda
    - Workout, leave sweat on skin overnight
    - Repeat one week later
    - Rare, but potential fulminant hepatotoxicity
  - Itraconazole 200mg/d for 5 days
More TV Treatment

• Apply Selsun from scalp to knees
• Let sit for 10 min, rinse
• Do everyday for 1-2 weeks
• Maintenance:
  – 2-3 times per week
  – scheduled treatments – “payday routine”
• New spots = reinfected
Urticaria
Urticaria

• Acute (<6 wks)
• Look for precipitating cause
  – Drugs
    ▪ OTC
    ▪ Vitamins
    ▪ Vaccinations
    ▪ Supplements
  – Food
  – Infection
    ▪ feet (tinea)
    ▪ vaginal candidiasis
    ▪ dental
Urticaria

- Suppress with antihistamines & hope it goes away
- Atarax
- Non-sedating (Zyrtec, Claritin, Allegra)
- Periactin
Urticaria

- Chronic: (>6 weeks)
- ↑ incidence in some ethnic groups
- Same treatments
- Look for some sign of infection, malignancy, etc… (usually find none)
- If individual lesion persists for >24 hrs, could be urticarial vasculitis → refer to dermatology
Warts
Filiform wart
Periungual wart destroying nail matrix
Flat Warts
Verruca Plana

- Flat warts
- Usually on face
- 2-5mm smooth papules
- Spread by shaving
- May be hundreds
Verruca Plantaris

- On plantar areas of feet – no skin lines
- Tend to be flattened by pressure
- Often painful
- Can cluster in a “mosaic wart”
- May need to distinguish from corns
Condyloma Acuminata

- “Genital warts”
- Often from sexual contact
- Need to consider sexual abuse if on a child; vertical transmission possible
- May be large and polypoid
- Need STD workup – transmissible even if not visually present
- Dangerous to women
  – Annual PAP’s
Treatment Considerations

- No one treatment is effective
- Recurrence is the rule
- Latency – may occur years after transmission
- Pt’s age – more common in younger
Treatment Considerations

• You **must** do combination treatment
  – Salicylic acid home therapy
  – Cryotherapy every 3-4 weeks
Home therapy – Sal Acid

- Salicylic acid is a keratolytic
  - Duofilm 17%
  - Medioplast 40%
- Soak in warm water for 10-15 minutes
- Pare with blade or pumice stone
- Apply acid
- Duct tape over night
- Pare off white, dead skin before applying another layer of salicylic acid
- Repeat process everyday until next round of cryotherapy
Cryotherapy

- Liquid nitrogen
- Cryac vs. cotton applicator
- Pain is good…
  - “if it didn’t hurt, you didn’t do it long enough”
- “10 second thaw rule”
- Need to a 2 mm rim of normal skin around wart
  - Or else, it will come back as a ring of wart
- Residual hypopigmentation (dark-skin)
Undertreated wart
Overtreated wart
Cryotherapy

• Possible blistering
• Damage to deeper structures – nerves
  – Beware of this when treated warts on fingers
• Multiple treatments Q2-3weeks
• Does not do well on plantar warts
Plantar Warts – Treatment

• If extensive and painful, refer to podiatry or dermatology

• What we can do in derm:
  – Triple acid therapy
    ▪ Phenol/TCA/Pyruvic
  – Candida albicans antigen
    ▪ Intraleisional injection
  – Laser surgery
What about Genital warts?
Genital/anal warts

- Liquid nitrogen

- Podofilox (Condylox)
  - Gel or solution for genital warts
  - Gel only for perianal warts
  - AAA BID x 3 consecutive days, off 4 days, repeat cycle x 4 weeks
Genital/anal warts

- Imiquimod (Aldara)
  - Very expensive medication
    - Pharmacy will only dispense 12 packets at a time
    - Use one packet for 3 applications
  - Apply 3 times weekly at night x 12-16 weeks
  - Mechanism:
    - Immunomodulator
    - Induces IFN, TNF, IL’s

- May want to debulk warts with liquid nitrogen or Podofilox
Recognizing Skin Cancers
Basal cell carcinoma

- Most common skin malignancy
- Occurs in areas of chronic sun exposure
- Slow growing and rarely metastasizes
- Locally destructive, disfiguring if neglected
Basal cell carcinoma

- Pearly, telangiectatic
- Various forms:
  - Nodular
  - Superficial
  - Cystic
  - Morpheaform (scar-like)
Neglected BCC
Squamous Cell Carcinoma

- Second most common skin cancer
- Arises on sun-exposed skin of middle-aged and elderly individuals
- Can metastasize
- Various morphology
Melanoma

• Malignancy of melanocytes
  – Skin, eyes, GI, brain
• 4% of all skin cancers
• Causes the greatest number of skin cancer–related deaths worldwide
  – Tends to metastasize
• Detect them while they’re thin!
  – Lower mortality
“A” melanotic melanoma

Mimics pyogenic granuloma!!
Melanoma in unusual sites
Don’t spray suspicious lesions with liquid nitrogen
Metastatic melanoma

Whole body PET image

Transaxial PET images

Liver

Kidney

Bladder
<table>
<thead>
<tr>
<th>Normal Mole</th>
<th>Melanoma</th>
<th>Sign</th>
<th>Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="normal_mole_image.png" alt="Normal Mole Image" /></td>
<td><img src="melanoma_image.png" alt="Melanoma Image" /></td>
<td>Asymmetry</td>
<td>when half of the mole does not match the other half</td>
</tr>
<tr>
<td><img src="normal_mole_image.png" alt="Normal Mole Image" /></td>
<td><img src="melanoma_image.png" alt="Melanoma Image" /></td>
<td>Border</td>
<td>when the border (edges) of the mole are ragged or irregular</td>
</tr>
<tr>
<td><img src="normal_mole_image.png" alt="Normal Mole Image" /></td>
<td><img src="melanoma_image.png" alt="Melanoma Image" /></td>
<td>Color</td>
<td>when the color of the mole varies throughout</td>
</tr>
<tr>
<td><img src="normal_mole_image.png" alt="Normal Mole Image" /></td>
<td><img src="melanoma_image.png" alt="Melanoma Image" /></td>
<td>Diameter</td>
<td>if the mole’s diameter is larger than a pencil’s eraser</td>
</tr>
</tbody>
</table>

Photographs Used By Permission: National Cancer Institute
All types of skin cancers

• Refer to Dermatology clinic
  – Persistent lesions
  – Non-healing, ulcerated, eroded
  – Bleeding
  – Changing in color
  – Patient is worried about it
  – Don’t be a cowboy!

• For melanomas
  – Call the clinic for an ASAP consultation
Final words . . .

• Train your people, especially your IDCs

• Respect and be good to your Chief and Corpsmen…and your job will become easier
Good Luck!!