

Female Dermatology Top to Bottom

DR MELISSA CARROLL
ASCOT DERMATOLOGY

TOP - SCALP

- Alopecia = hair loss
- 3 main types of alopecia
 - 1) *Alteration of hair cycle - 'non-scarring'*
 - 2) *Scarring*
 - 3) *Defect in structure of hair shaft*

Androgenetic alopecia aka Female Pattern Hair Loss



AGA/FPHL - features

- Common, non-scarring hair loss condition
- Midline part and crown affected
- Increased shedding - can cycle
- Any time from puberty
- Mainly clinical diagnosis



AGA - Management

- Support/Educate
 - Facebook – Australia & NZ Hair Loss Support Group for Women; Hair Loss Boss
- Camouflage/wigs/Topplik hair fibres
- Medications:
 - Female – Minoxidil top or oral/spironolactone/finasteride*



Telogen Effluvium



Telogen Effluvium

- Non-scarring alopecia
- Increase in hair shed
- Acute - often a trigger within past 6/12 and clears over 6/12
- Chronic – may not be a trigger and may last for years



TE - clinical

- Thinning of hair of whole scalp +/- other hair-bearing areas
- Consider blood work up for chronic TE
- Hair pull test +
- Usually no need to biopsy



TE - Management

- Reassure – complete hair regrowth possible – even for chronic TE
Shedding can continue for years...BUT DON'T GO BALD!
- Replace any losses eg iron, thyroid
- +/- Hair/skin/nail vitamin
- (Minoxidil)



Alopecia Areata



Traction alopecia



Photo of trichotillomania



FACE

- Acne
- Rosacea
- Periorificial dermatitis

Acne

- So common!
- Ugh – social media!
- Realistic expectations
- 'Chronic acne'



What type of acne is it? Affects treatment

- Comedones?
- Inflammatory – how severe?
- Combo?
- Body affected?



Acne - All About Acne website

- Main treatments available
 - Topicals:*
 - benzoyl peroxide
 - retinoids
 - combo products
 - clascoterone
 - Orals*
 - OCP
 - antibiotics
 - isotretinoin
 - spironolactone



Some tips...

- always consider a retinoid
 - counsel about skin tolerance/adjustment to topicals
 - PO antibiotics should be used in conjunction with a topical and max 4-6 months
 - if not responding/flaring on cessation - refer
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Rosacea

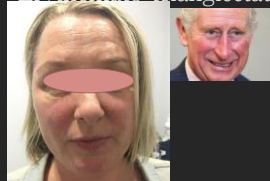
- Chronic inflammatory skin condition affecting face
- Not completely understood
- Females > Males
- 30-60yo onset
- 'Celtic curse'
- Consider triggers



Subgroups of rosacea

- Erythemato-telangiectatic
 - Papulopustular
 - Ocular
 - Phymatous
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Erythemato-telangiectatic & Papulopustular



Ocular & Phymatous



Rosacea management - erythema and teles

- Educate the patient – control vs cure
- Avoid triggers (though may still flare)
- Topicals

Gentle skin cares

Brominidine – transient vasoconstriction of superficial blood vessels

- Light/lasers

IPL/vascular laser – for background erythema and teles

- Better – not permanent – may need top-ups



Papules, pustules

- Topicals

*Azelaic acid, metronidazole, **ivermectin***

Oral

Doxycycline, erythromycin, minocycline, (tetracycline)

- Weeks-months
- Best with topical – use it to maintain response
- Often need re-treatment

Isotretinoin – low-dose longer term

- May need ophthalm referral for eyes if not responding eg good advice for eye toilet, top CsA, IPL



Periorificial Dermatitis



Periorificial dermatitis

- Barrier dysfunction
- Medications - TCS, steroid inhalers
- Social media again! Cosmetics.
- Physical factors: UV light, heat, and wind worsen perioral dermatitis.
- Comorbidities – PHx atopy, FHx atopy



POD - presentation

- An acneiform eruption
 - *Clusters of skin-coloured to red papules, vesicles, and pustules*
- Surrounding skin is often dry
- Scaly or flaky skin surface
- Burning sensation or skin tightness and sensitivity
- +/- itchy/discomfort
- Usually a clinical diagnosis



Periorificial Dermatitis Treatment

- NO TOPICAL STEROIDS!!!
- Simple skin care and AVOID triggers – common to flare
 - *zero therapy if motivated!*
- Topical – pimecrolimus/azelaic acid/topical antimicrobial – *takes time*
- Oral – responds well to PO Abs – Doxy, Erythromycin
 - *rarely might need isotretinoin*
- Treat each episode – continue to try to find a trigger



BOTTOM

- Get ready....

Lichen Planus



Extra-mammary Paget Disease



Vulval Psoriasis



Vulval Lichen Simplex



Vulval Lichen Simplex

- Itchy = lichenified skin
- Spontaneously or with underlying conditions eg dermatitis, psoriasis
- Skin is thickened, excoriated +/- scale
- Genitals // perineum // perianal
- Widespread OR localised AND/OR asymmetrical
- Often Hx of atopy +/- dermatitis elsewhere



Environmental modifications important - often several/many

- Soap/bubble bath/essential oil
- Sanitary pads and liners
- Prolonged use of antifungal creams
- Lubricants
- Wet wipes
- Douching
- Waxing/shaving and associated products
- Nylon underwear/Pantyhose/G-strings
- Tight clothes/Gym clothes

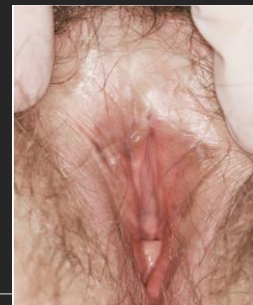


Short-term management as needed

- Topical corticosteroids
 - effective and appropriate for genital dermatitis
- ENVIRONMENTAL MODIFICATIONS
- Can use for long periods of time but MONITOR
- Ointments preferable
- Try to match potency to presentation
- (Calcineurin inhibitors)



Lichen Sclerosus



Lichen Sclerosus

- Chronic, inflammatory skin disorder
- Skin thinning/sclerosis and anatomical destruction
- Esp common in pre-pubertal girls and peri/post-menopausal women
- 10 times more common in women than in men
- Causes not fully understood - genetic, hormonal, irritant, immunological

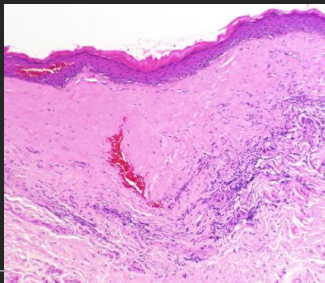


Lichen sclerosus

- Itch and pain most common - can be asymptomatic
- Pale, atrophic, sometimes wrinkled skin
- Fissuring common
- SCC risk
- Extragenital variant - more refractory to treatment



LS - biopsy



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Management

- Environmental modifications
 - Emollient
 - TCS – fine to use as long as monitored
 - try to match potency to symptoms
 - get to lowest potency and application but NO RUSH
 - Regular review
 - Long-term follow-up
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