PENYAKIT KULIT

1 ECZEMA / ATOPIC DERMATITIS

2. PSORIASIS

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JOHOR DARUL TAKZIM

- Job Experiences

- 2001 – 2003 : Hospital Sultanah Aminah Johor Bahru. JOHOR
- 2003 – 2007 : Medical & Health Officer KKBM, Kota Tinggi, JOHOR
- 2013 – 2014 : Fam Med Specialist, KK Kapit, SARAWAK
- 2014 – 2015 : Fam Med Specialist , KK Segamat, JOHOR
- 2015-2016 : Fam Med Specialist , KK Kempas, JOHOR
- 2016 Until Now : Fam Med Specialist,KK Bandar Mas, Kota Tinggi, JOHOR

22 years of experience in healthcare services

Always enthusiastic to learn and teach new things to all

Do good to all

DERMATITIS or ECZEMA ?

DERMATITIS

- Inflammation of Skin

ECZEMA

- Inflamed skin with other symptoms like itching, flaky or scaly rash, dry skin

ECZEMA / ESIM

- kronik
- Kondisi kulit radang : ruam kemerahan dan gatal pada kulit, kulit kasar

DERMATITIS or ECZEMA ?

Contact Dermatitis Contact Eczema

Atopic Dermatitis Atopic Eczema

Seborrheic Eczema Seborrhoeic Dermatitis

Discoid Dermatitis Discoid Eczema

DIAGNOSIS

- **The U.K. Working Party's Diagnostic Criteria for Atopic Dermatitis:**[8, level III]

  Patient must have an itchy skin condition (or parental report of scratching or rubbing in a child) plus three or more of the following:
  - history of involvement of the skin creases such as folds of elbows, behind the knees, fronts of ankles or around the neck (including cheeks in children under 10 years old)
  - a personal history of asthma or hay fever (or history of atopic disease in a first-degree relative in children under four years old)
  - a history of a general dry skin in the last year
  - visible flexural eczema (or eczema involving the cheeks/forehead and outer limbs in children under four years old)

SENSITIVITY 100%, SPECIFICITY 99%

William Kriteria

- Lebih cepat , praktis dan spesifik

1) Terdapat kulit yang gatal (atau tanda garukan pada anak-anak)

DAN lebih dari 3 tanda berikut

- Riwayat perubahan kulitatau kondisi kulit kering di fosa kubiti, fosa popliteal, bahagian anterior dorsum pedis, atau seputar leher (termasuk kedua pipi pada anak < 10 tahun)
- Riwayat asma atau hay fever pada anak (Riwayat atopi pada anak < 4 tahun pada generasi kesatu dalam keluarga
- Riwayat kulit kering sepanjang akhir tahun, dermatitis fleksural (pipi, dahi, dan paha bagian lateral pada anak < 4 tahun), awitan di bawah < 2 tahun

Jurnal Medika Hutama : Vol 3 No 2 Jan 2022 TATALAKSANA DERMATITIS ATOPIK PADA ANAK

DIAGNOSIS CRITERIA

GUIDELINES FOR THE DIAGNOSIS OF ATOPIC DERMATITIS (HANIFIN AND RAJKA CRITERIA)

Must have 3 or more basic features:

1. Pruritus
2. Typical morphology and distribution:
   - Flexural lichenification or linearity in adults
   - Facial and extensor involvement in infants and children
3. Chronic or chronically-relapsing dermatitis
4. Personal or family history of atopy (asthma, allergic rhinitis, atopic dermatitis)

Plus 3 or more minor features:

1. Xerosis
2. Ichthyosis/palmar hyperlinearity/keratosis pilaris
3. Immediate (type 1) skin test reactivity
4. Elevated serum IgE
5. Early age of onset
6. Tendency toward cutaneous infections (especially *Staphylococcus aureus and Herpes simplex*)/impaired cell-mediated immunity
7. Tendency toward non-specific hand or foot dermatitis
8. Nipple eczema
9. Cheilitis
10. Recurrent conjunctivitis
11. Dennie-Morgan infraorbital fold
12. Keratoconus
13. Anterior subcapsular cataracts
14. Orbital darkening
15. Facial pallor/facial erythema
16. Pityriasis alba
17. Anterior neck folds
18. Itch when sweating
19. Intolerance to wool and lipid solvents
20. Perifollicular accentuation
21. Food intolerance

actors

SENSITIVITY 96%, SPECIFICITY 93.8%

Diagnosis of Atopic Dermatitis Indonesia

Tabel 1. Kriteria Hanifin-Rajka untuk diagnosis DA pada anak-anak(9)

Kriteria Mayor	Kriteria Minor
- Pruritus - Bintik merah pada wajah dan/atau permukaan kulit ekstensor pada bayi dan anak-anak - Likenifikasi pada permukaan kulit fleksural - Cenderung bersifat kronik dan terjadi rekurensi - Riwayat penyakit dahulu dan penyakit keluarga seperti asma, rhinitis alergi, dan dermatitis atopik	- *Dryness* - Lipatan *Dennie-Morgan* (garis yang meningkat dibawah margin dari kelopak mata bawah) - *Alergic shiners* (kulit menjadi kehitaman di daerah bawah mata) - *Pallor* pada wajah - Ptiriasis alba - Keratosis pilaris - Iktiosis vulgaris - Hiperlinear pada telapak tangan dan kaki - Garis berwarna putih pada kulit saat terkena alat tumpul - Konjungtivitis - Keratokonus - Katarak subkapsular anterior - Serum IgE yang meningkat - Uji kulit yang reaktif

3 Kriteria Mayor

Lebih dari 3 Kriteria Minor

KONSEP PENGENDALIAN AD/DA

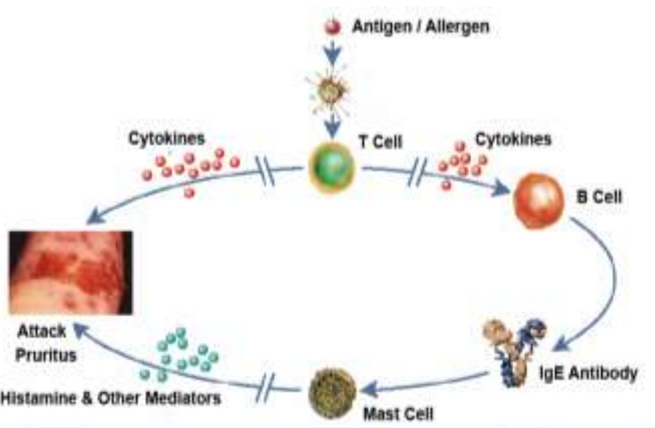
EDUKASI

PASIEN
ORANG TUA
CAREGIVER

MENGENDALI SIKLUS / GATAL

TATALAKSANA AD/ DA

HINDARI ALLERGEN



MENGURANGI INFLAMASI

FUNGSI SAWAR KULIT

Gambar 2. Faktor pencetus DA(2)

Clothing: avoid skin contact with irritating fibers (wool, large-fiber textiles); do not use tight and too warm clothing to avoid excessive sweating. New nonirritating clothing designed for AD children is being evaluated
Tobacco: avoid exposure
Cool temperature in bedroom and avoid too many bed covers
Increase emollient use with cold weather
Avoid exposure to herpes sores; urgent visit if flare of unusual aspect
Vaccines: normal schedule in noninvolved skin, including egg-allergic patients (see text)
Sun exposure: no specific restriction. Usually helpful because of improvement of epidermal barrier. Encourage summer holidays in altitude or at beach resorts
Physical exercise, sports: no restriction. If sweating induces flares of AD, progressive adaptation to exercise. Shower and emollients after swimming pool
Food allergens
- Maintain breast feeding until 4 mo if possible
- Otherwise normal diet, unless an allergy work-up has proven the need to exclude a specific food

Indoor aeroallergens
- House dust mites
- Use adequate ventilation of housing; keep the rooms well aerated even in winter
- Avoid wall-to-wall carpeting
- Remove dust with a wet sponge
- Vacuum floors and upholstery with an adequately filtered cleaner once a week
- Avoid soft toys in bed (cradle), except washable ones
- Wash bed sheets at a temperature higher than 55° every 10 days
- Use bed and pillow encasings made of Gore-Tex or similar material

Furred pets: advise to avoid. If allergy is demonstrated, be firm on avoidance measures, such as pet removal
Pollen: close windows during peak pollen season on warm and dry weather and restrict, if possible, stays outdoors. Windows may be open at night and early in the morning or during rainy weather. Avoid exposure to risk situations (lawn mowing). Use pollen filters in car. Clothes and pets can vectorize aeroallergens, including pollen

Severity Assessment

- There are numerous scoring tools used to assess AE.

- A systematic review of 382 RCTs showed the commonly used tools in descending order were:[10]
  - SCORing Atopic Dermatitis (SCORAD)
  - Eczema Area and Severity Index (EASI)
  - Investigators’ Global Assessment (IGA)
  - Six Area, Six Signs Atopic Dermatitis (SASSAD)
  - Others [e.g. Patient-Orientated Eczema Measure (POEM)]

10. Rehal B, et al. PLoS One. 2011;6(4):e17520

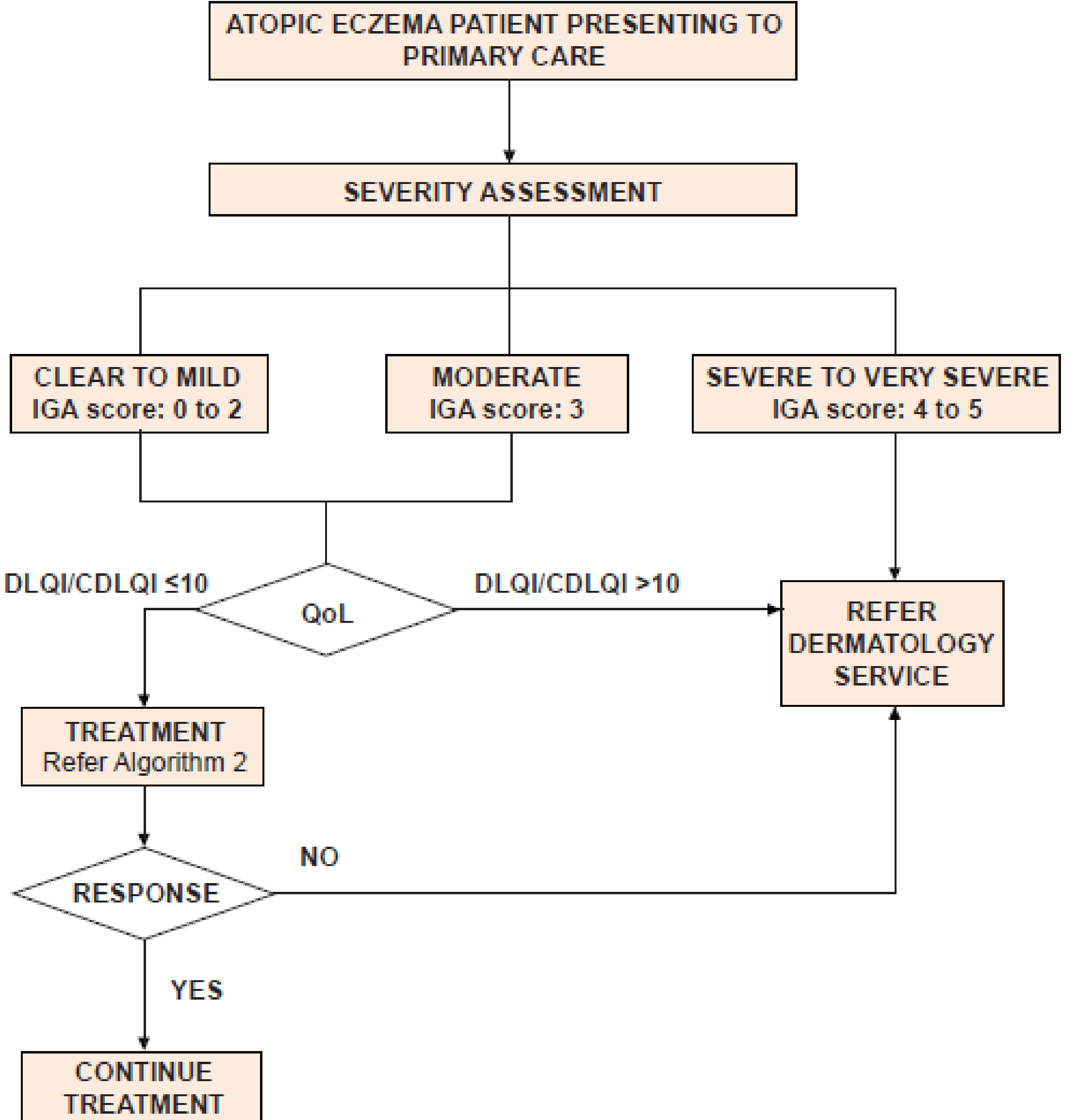
Investigator's Global Assessment (IGA)

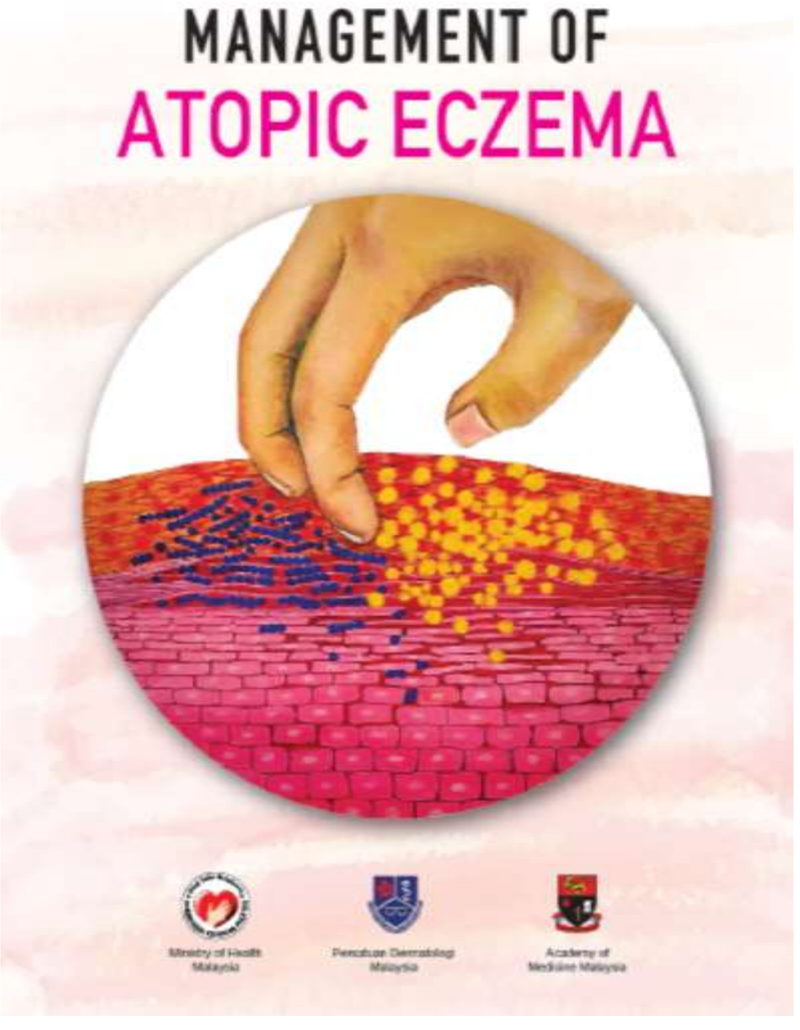
Score	Description
0 = Clear	No inflammatory signs of atopic eczema
1 = Almost clear	Just perceptible erythema, and just perceptible papulation/infiltration
2 = Mild disease	Mild erythema, and mild papulation/infiltration
3 = Moderate disease	Moderate erythema, and moderate papulation/infiltration
4 = Severe disease	Severe erythema, and severe papulation/infiltration
5 = Very severe disease	Severe erythema, and severe papulation/infiltration with oozing/crusting

Quality Of Life Severity Assessment

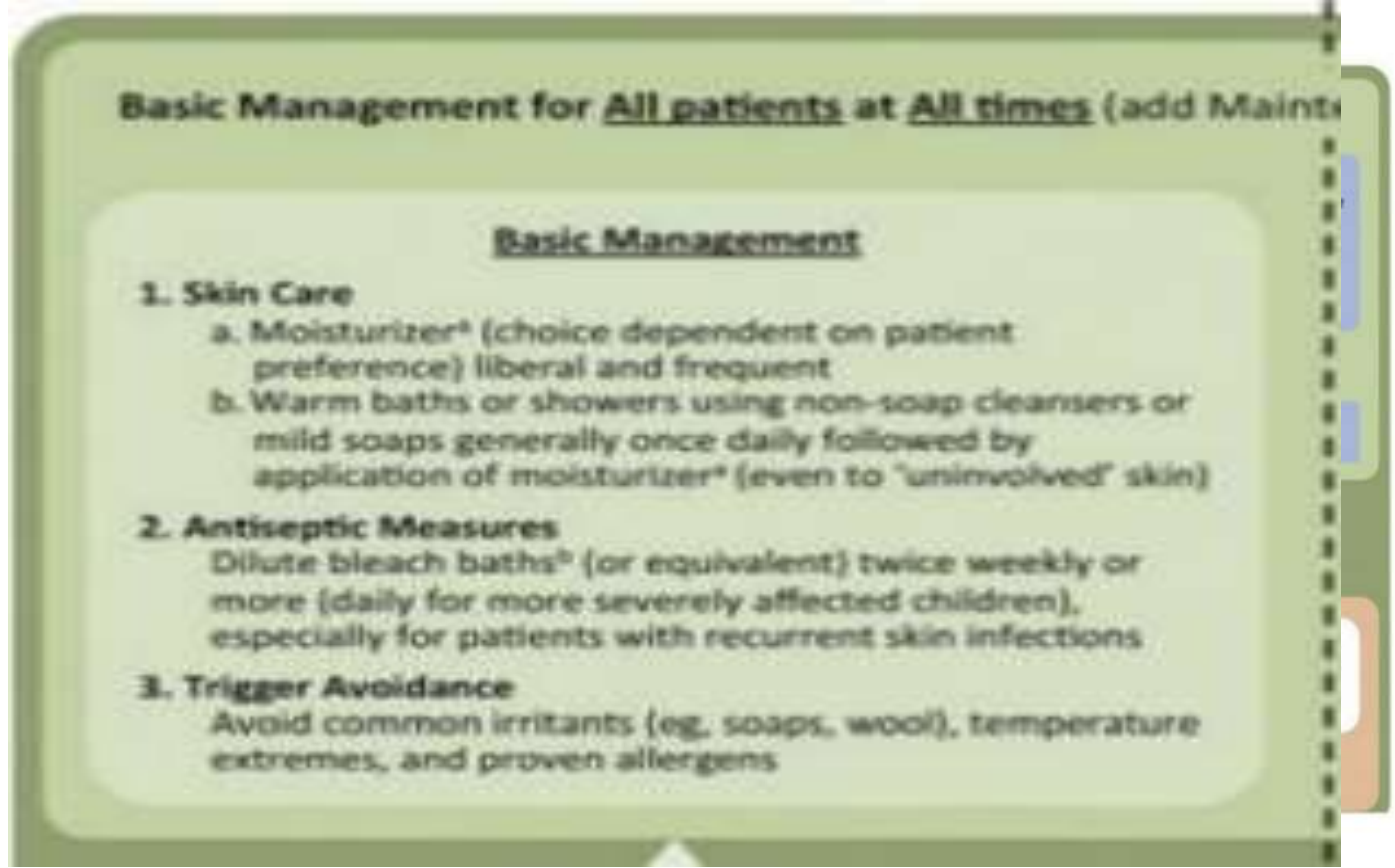
- Quality of Life (QoL) assessment is important in the management of AE.
- The most commonly validated tools used are:
    - Dermatology Life Quality Index (DLQI)
    - Children’s Dermatology Life Quality Index (CDLQI)
    - Infant’s Dermatology Quality of Life Index (IDQOL)
    - Dermatitis Family Impact (DFI)

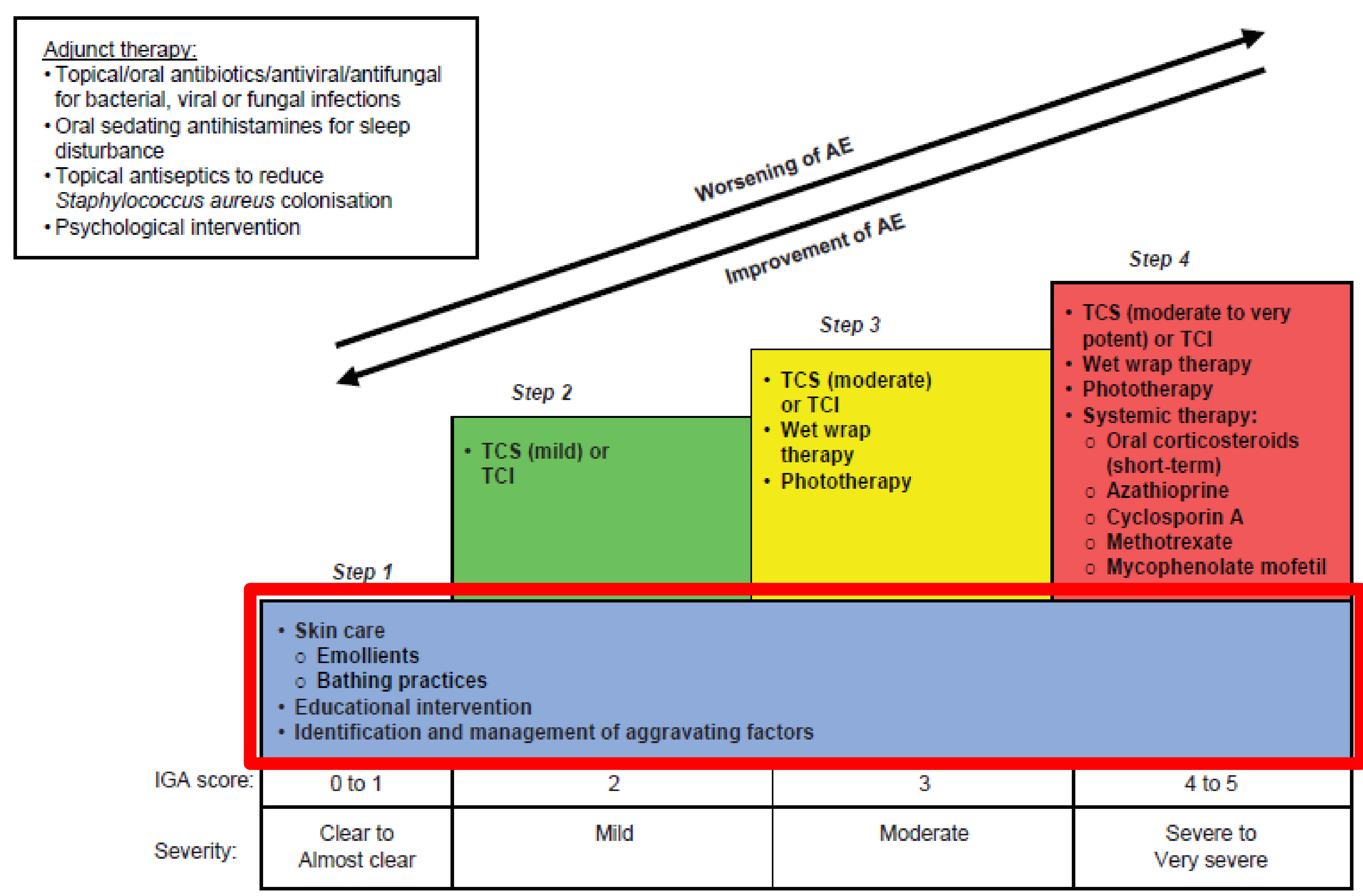
ALGORITHM 1. MANAGEMENT OF ATOPIC ECZEMA IN PRIMARY CARE





Gambar 1. Algoritma tatalaksana DA berdasarkan derajat keparahan(12)




ALGORITHM 2. TREATMENT OF ATOPIC ECZEMA
Adjunct therapy:
• Topical/oral antibiotics/antiviral/antifungal for bacterial, viral or fungal infections
• Oral sedating antihistamines for sleep disturbance
• Topical antiseptics to reduce Staphylococcus aureus colonisation
• Psychological intervention
Worsening of AE
Improvement of AE
Step 1
Step 2
• TCS (mild) or TCI
Step 3
• TCS (moderate) or TCI
• Wet wrap therapy
• Phototherapy
Step 4
• TCS (moderate to very potent) or TCI
• Wet wrap therapy
• Phototherapy
• Systemic therapy:
o Oral corticosteroids (short-term)
o Azathioprine
o Cyclosporin A
o Methotrexate
o Mycophenolate mofetil
• Skin care
o Emollients
o Bathing practices
• Educational intervention
• Identification and management of aggravating factors
IGA score:
0 to 1
2
3
4 to 5
Severity:
Clear to Almost clear
Mild
Moderate
Severe to Very severe
IGA: Investigators' Global Assessment; TCS: Topical corticosteroids; TCI: Topical calcineurin inhibitors

EMOLLIENT / MOISTURIZER

- Emollient therapy is the mainstay of management in AE.

- Emollients/moisturisers improve the epidermal barrier function and dryness leading to reduction in pruritus.

- Emollients application decreases the usage of topical corticosteroids.

EMOLLIENTS

- A Cochrane systematic review on 77 RCTs of moderate quality showed that emollients were better than no emollient:[36]
  - improved SCORAD (MD= -2.42, 95% CI -4.55 to -0.28)
  - reduced risk of flare (RR=0.40, 95% CI 0.23 to 0.70)
  - reduced rate of flare (HR=3.74, 95% CI 1.86 to 7.50)
  - reduced amount of corticosteroids used at 6 - 8 weeks (MD=-9.30, 95% CI -15.33 to -3.27)
- There was no reliable evidence to show that one emollient is more effective than another.

36. van Zuuren EJ, et al. Emollients and moisturizers for eczema. Cochrane Database Syst Rev. 2017; 2:CD012119

BATHING PRACTICES

- Longer duration of bathing (>10 minutes) may be associated with risk of greater AE severity ($p=0.0562$).[72]

- However, frequency of bathing is not associated with the severity.[73]

72. Koutroulis I, et al. Clin Pediatr (Phila). 2016; 55(2):176-181
73. Koutroulis I, et al. Clin Pediatr (Phila). 2014; 53(7):677-681

BATHING PRACTICES

- There is no evidence on clinical benefit of emollient bath additives in AE.

- There is no retrievable evidence with regards to appropriate water temperature. However, the CPG development group advices against the use of extreme temperatures (too hot or too cold) during bathing to avoid worsening of AE.

PATIENT EDUCATION

Is an important part of management

Must be patient-centered

To empower patients

Patient Empowerment

NAME:	GREEN = GO : Use preventive measures YELLOW = CAUTION: Use lower strength medications RED = FLARE : Use higher strength medications and consult your doctor
	ECZEMA UNDER CONTROL
GREEN	**REGULAR DAILY SKIN CARE** 1. Bath twice a day with gentle cleanser less than 10 minutes. 2. Apply moisturiser to all body parts immediately after bath. 3. Apply moisturiser to all body parts minimum thrice a day. 4. Bath and moisturise your skin before bed. 5. Wear suitable cloth/pyjamas, preferably cotton, to bed.
	ECZEMA WORSENING
YELLOW	**SKIN CARE DURING WORSENING** 1. Continue regular skin care from GREEN phase. 2. Apply anti-inflammatory creams till eczema clears. 2a. Face: Apply hydrocortisone 1% twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 2b. Body: Apply betamethasone (1:4) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 3. Take antihistamine (anti-itch), prescribed by doctor, half an hour before bed. 4. If eczema gets better, revert back to GREEN phase. 5. If eczema not responding within 3 days or eczema and itch worsens, move to RED phase.
	UNCONTROLLED ECZEMA
RED	**SKIN CARE DURING UNCONTROLLED ECZEMA** 1. Continue regular skin care form GREEN phase. 2. Bath daily with antiseptic wash for 5 - 7 days. 3. Apply anti-inflammatory creams till eczema clears. 3a. Face: Apply betamethasone (1:8) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 3b. Body: Apply betamethasone (1:2) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 4. Take antihistamine (anti-itch), prescribed by doctor, half an hour before bed. 5. If eczema gets better revert back to YELLOW phase, then subsequently to GREEN phase. 6. If eczema not responding within 3 days or eczema and itch worsens, consult your doctor.

Source: Paediatric Dermatology Unit, Paediatric Department, Hospital Kuala Lumpur. Written Eczema Plan. HKL. (unpublished document)

Written Eczema Action Plan (WAP)

- Daily skin care

ECZEMA UNDER CONTROL

REGULAR DAILY SKIN CARE

1. Bath twice a day with gentle cleanser less than 10 minutes.
2. Apply moisturiser to all body parts immediately after bath.
3. Apply moisturiser to all body parts minimum thrice a day.
4. Bath and moisturise your skin before bed.
5. Wear suitable cloth/pyjamas, preferably cotton, to bed.

Written Eczema Action Plan (WAP)-2

- Eczema worsening

	ECZEMA WORSENING
YELLOW	**SKIN CARE DURING WORSENING** 1. Continue regular skin care from GREEN phase. 2. Apply anti-inflammatory creams till eczema clears. 2a. Face: Apply hydrocortisone 1% twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 2b. Body: Apply betamethasone (1:4) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 3. Take antihistamine (anti-itch), prescribed by doctor, half an hour before bed. 4. If eczema gets better, revert back to GREEN phase. 5. If eczema not responding within 3 days or eczema and itch worsens, move to RED phase.

Written Eczema Action Plan (WAP)-2

- Eczema uncontrolled

RED	UNCONTROLLED ECZEMA
	SKIN CARE DURING UNCONTROLLED ECZEMA 1. Continue regular skin care form GREEN phase. 2. Bath daily with antiseptic wash for 5 - 7 days. 3. Apply anti-inflammatory creams till eczema clears. 3a. Face: Apply betamethasone (1:8) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 3b. Body: Apply betamethasone (1:2) twice a day for 5 - 7 days, then once a day for 5 - 7 days till eczema clears. 4. Take antihistamine (anti-itch), prescribed by doctor, half an hour before bed. 5. If eczema gets better revert back to YELLOW phase, then subsequently to GREEN phase. 6. If eczema not responding within 3 days or eczema and itch worsens, consult your doctor.

CRITERIA FOR REFERRAL

1) Urgent referral (within 24 hours)

- AE/AD/ DA with clinical suspicion of eczema herpeticum (eczema with widespread herpes simplex infection)
- AE with severe skin bacterial infection that requires intravenous antibiotics
- AE with acute erythroderma where the eczema is affecting more than 80% body surface area

CRITERIA FOR REFERRAL

2) Non-urgent referral

- Diagnostic uncertainty
- Severe or uncontrolled eczema:
  - requirement of potent and very potent TCS
  - frequent infections
  - poor sleep or excessive scratching
  - treatment failure with appropriate topical therapy regimen
- Parental concern
- Need for treatment demonstration/education
- Involvement of sites that are difficult to treat
- Psychological disturbance on the patient or family

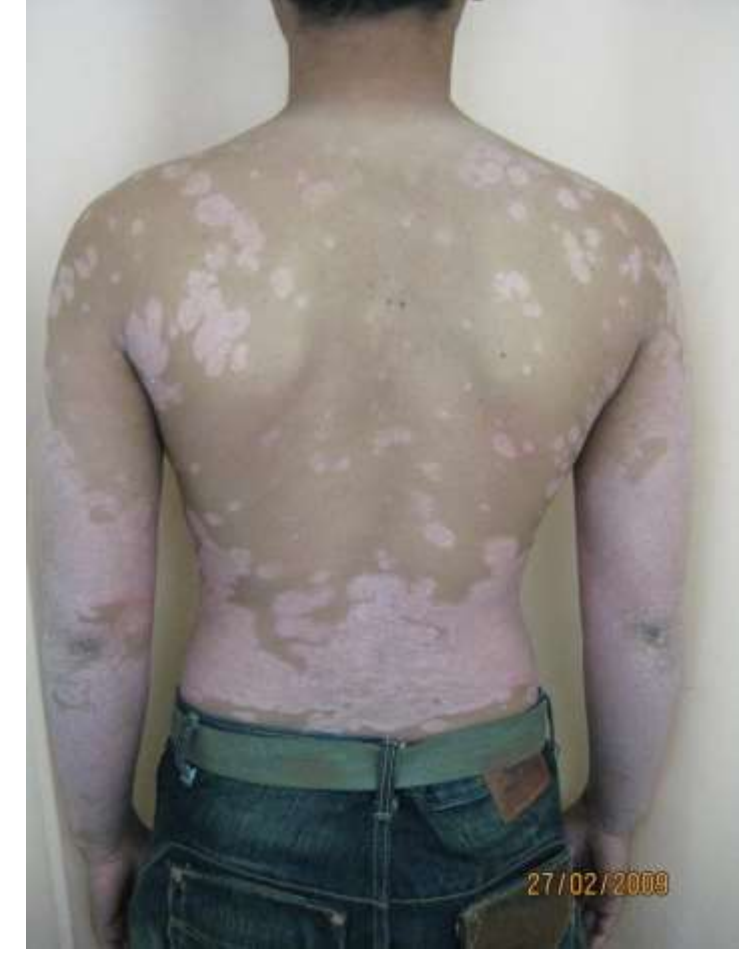
PSORIASIS

BAHASA YUNANI ; “psora” berarti gatal

penyakit sistemik berdasarkan patogenesis autoimunologik dan genetik yang bermanifestasi di kulit, sendi, serta terkait sindrom metabolik

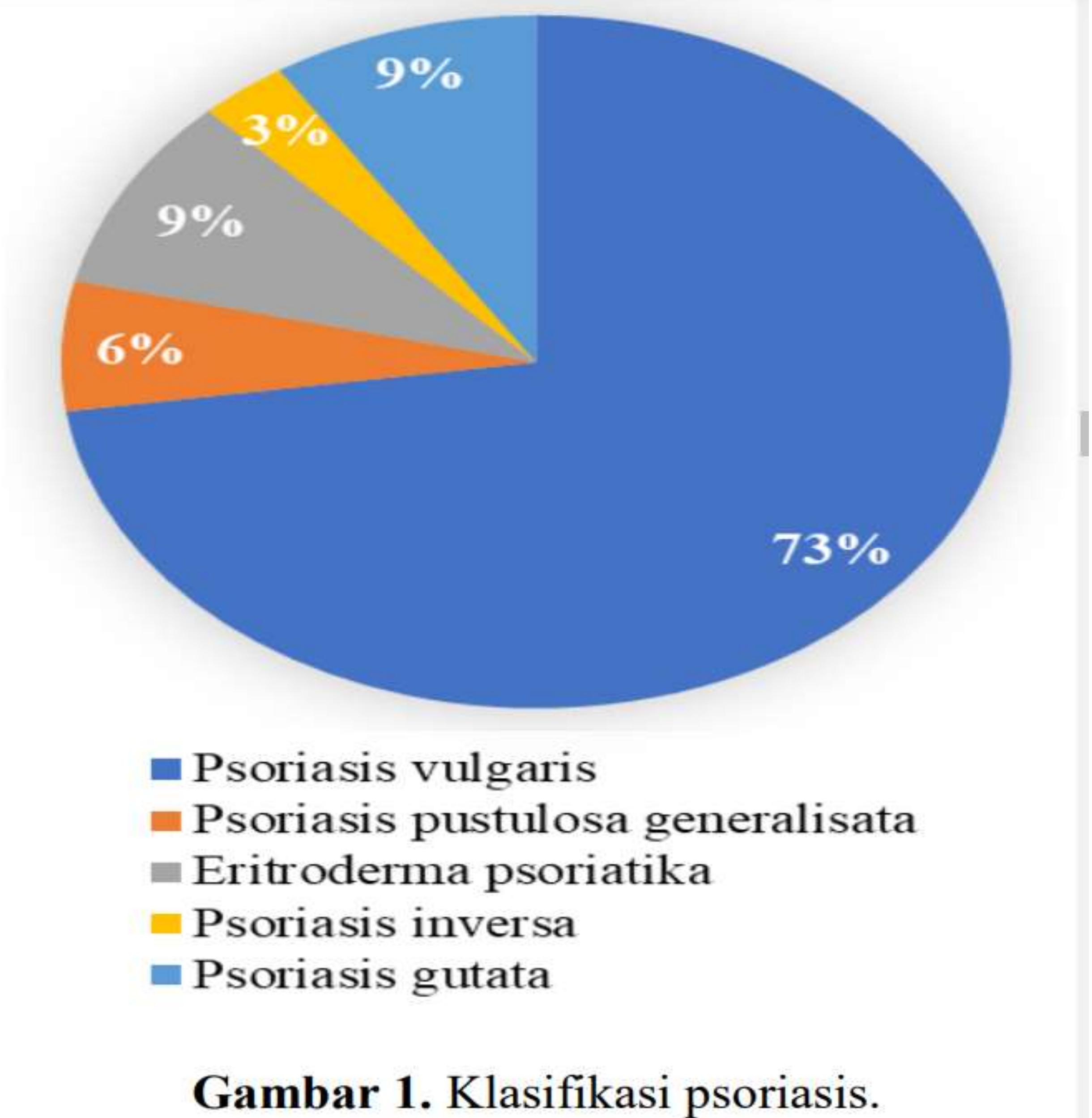
Epidemiology Of Psoriasis

- Psoriasis occurs worldwide
  - 1 - 3% of world population
- Its prevalence varies greatly among different countries and ranges from 0.2% in China to 4.8% in Norway
- There is no population-based prevalence study on psoriasis in Malaysia
  - accounts for 2-6% of yearly dermatology new clinic attendees in Malaysia



- Gudjonsson JE et.al, Clin Dermatol.2007;25:535-546.
- Tsai TF et.al J Dermatol Sci.2011 63(1):40-46.
- Choon SE et.al International J Dermatol.2013
- Siow KY et al. MJM.2004 59(3):330 - 334.

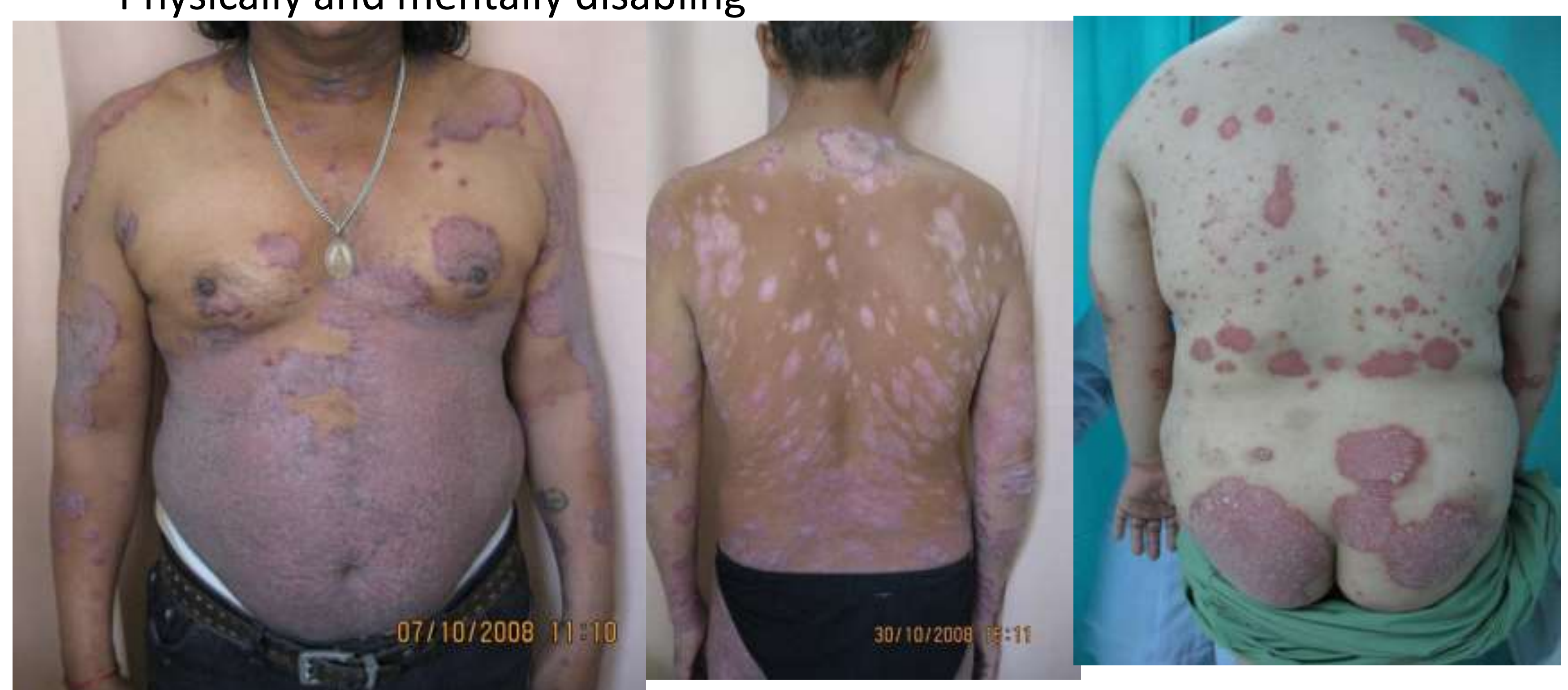
KLASIFIKASI



Gambar 1. Klasifikasi psoriasis.

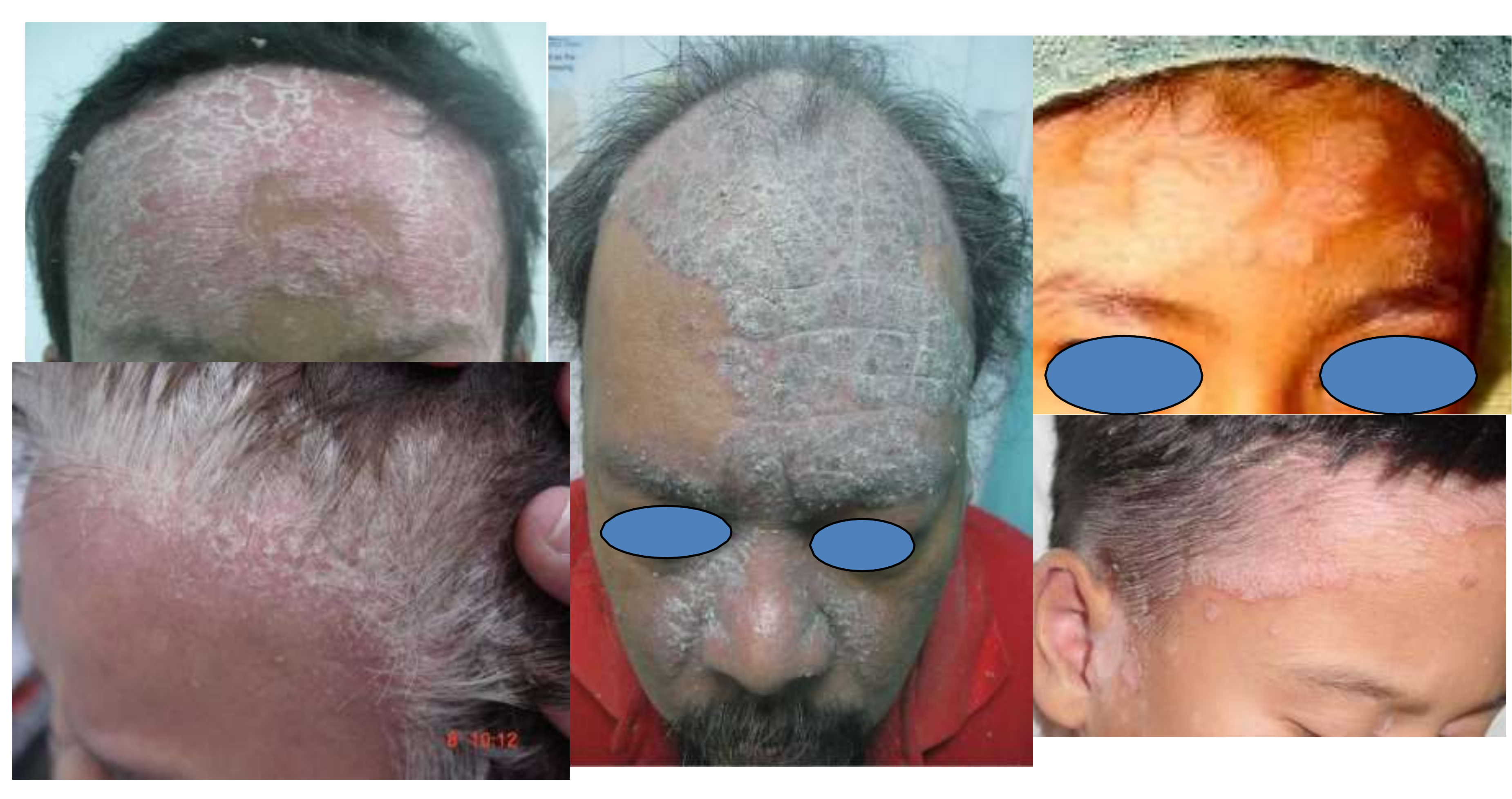
PSORIASIS VULGARIS

- In Malaysia, 8664 patients in our National psoriasis registry till June 2013
  - 85% with psoriasis vulgaris
- Physically and mentally disabling

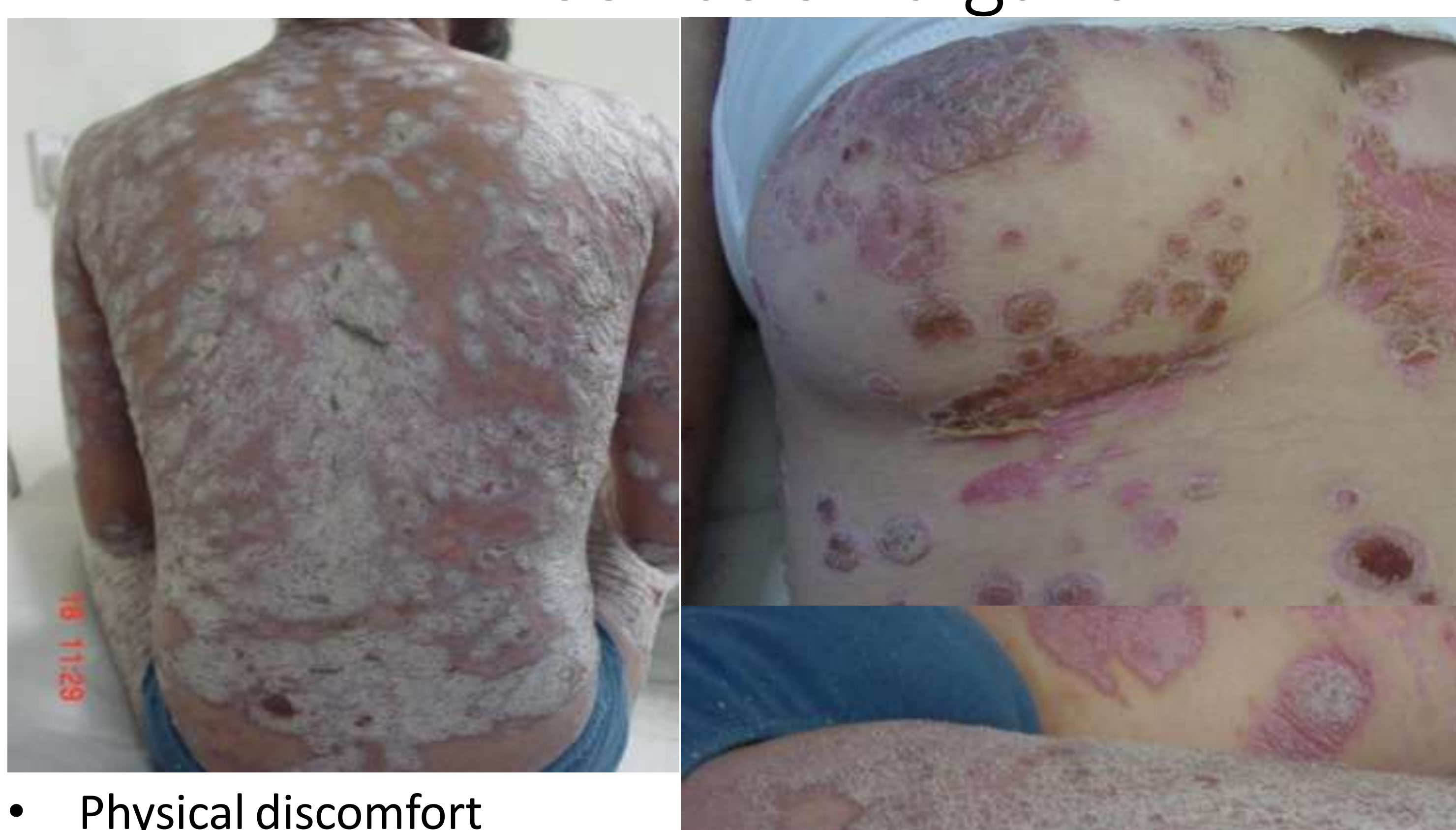


Psoriasis vulgaris

A highly visible disease

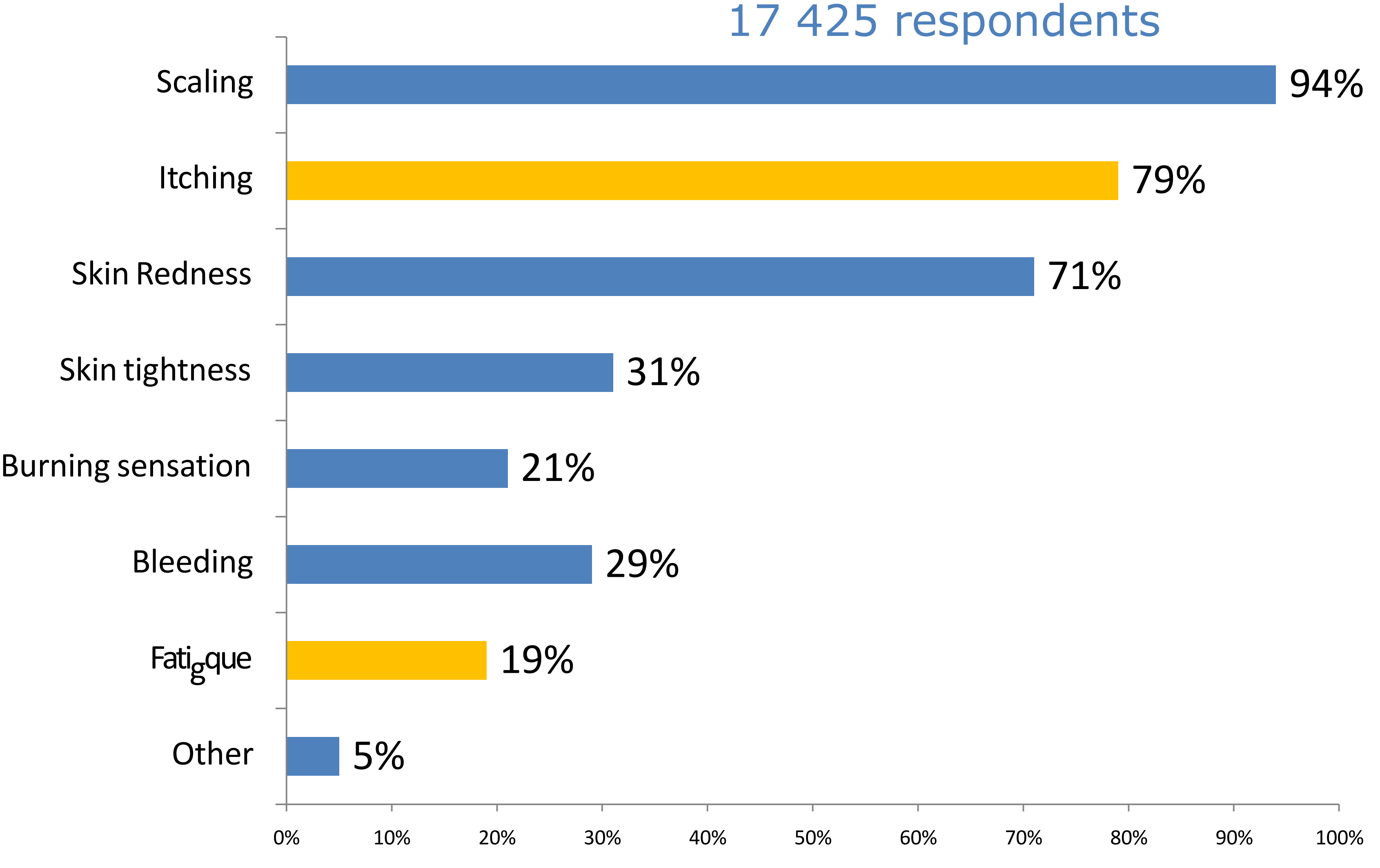


Psoriasis Vulgaris



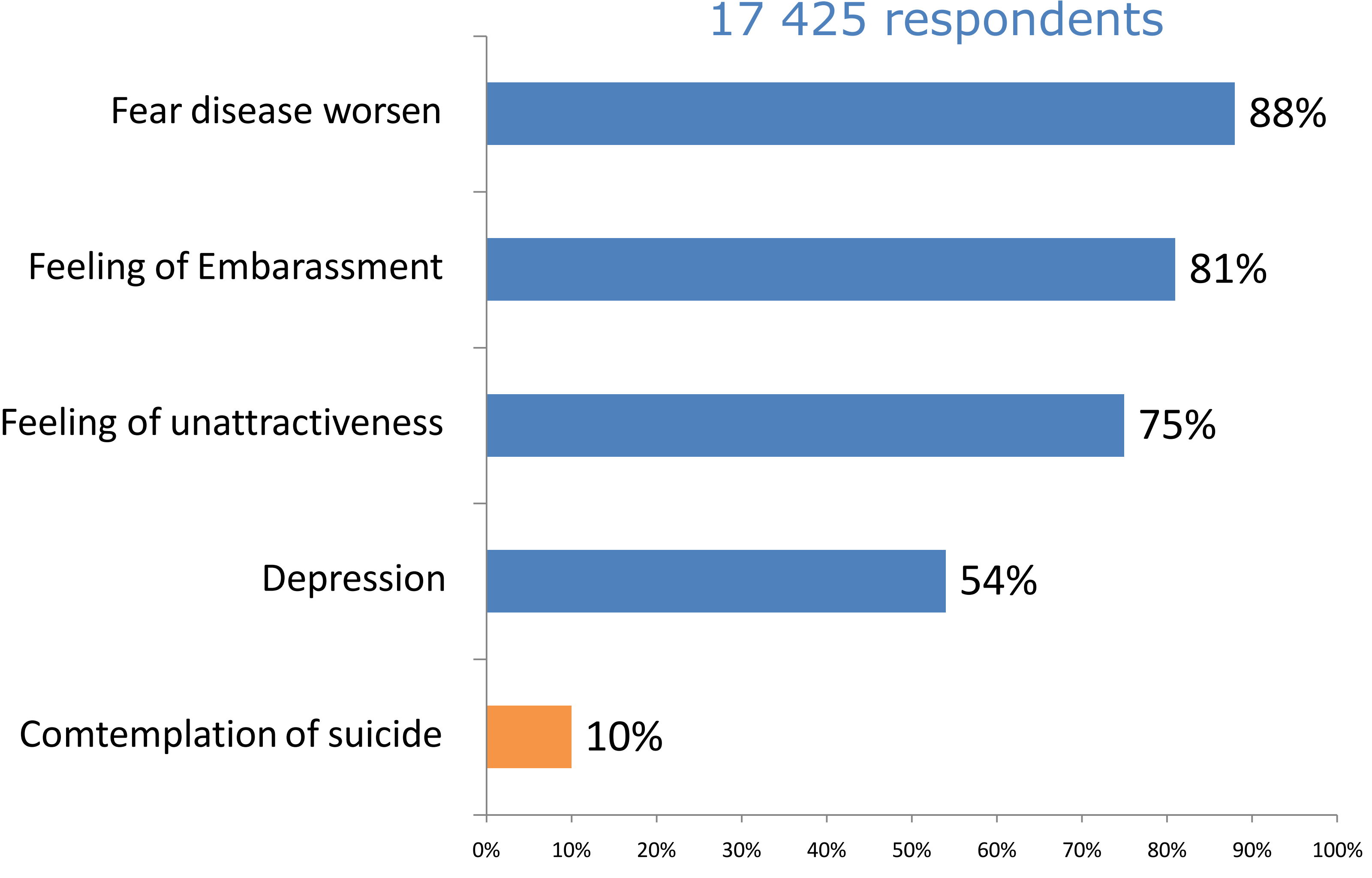
- Physical discomfort
  - Pruritus
  - Scaling
  - Tightness
  - Pain
  - Bleeding

Psoriasis symptoms

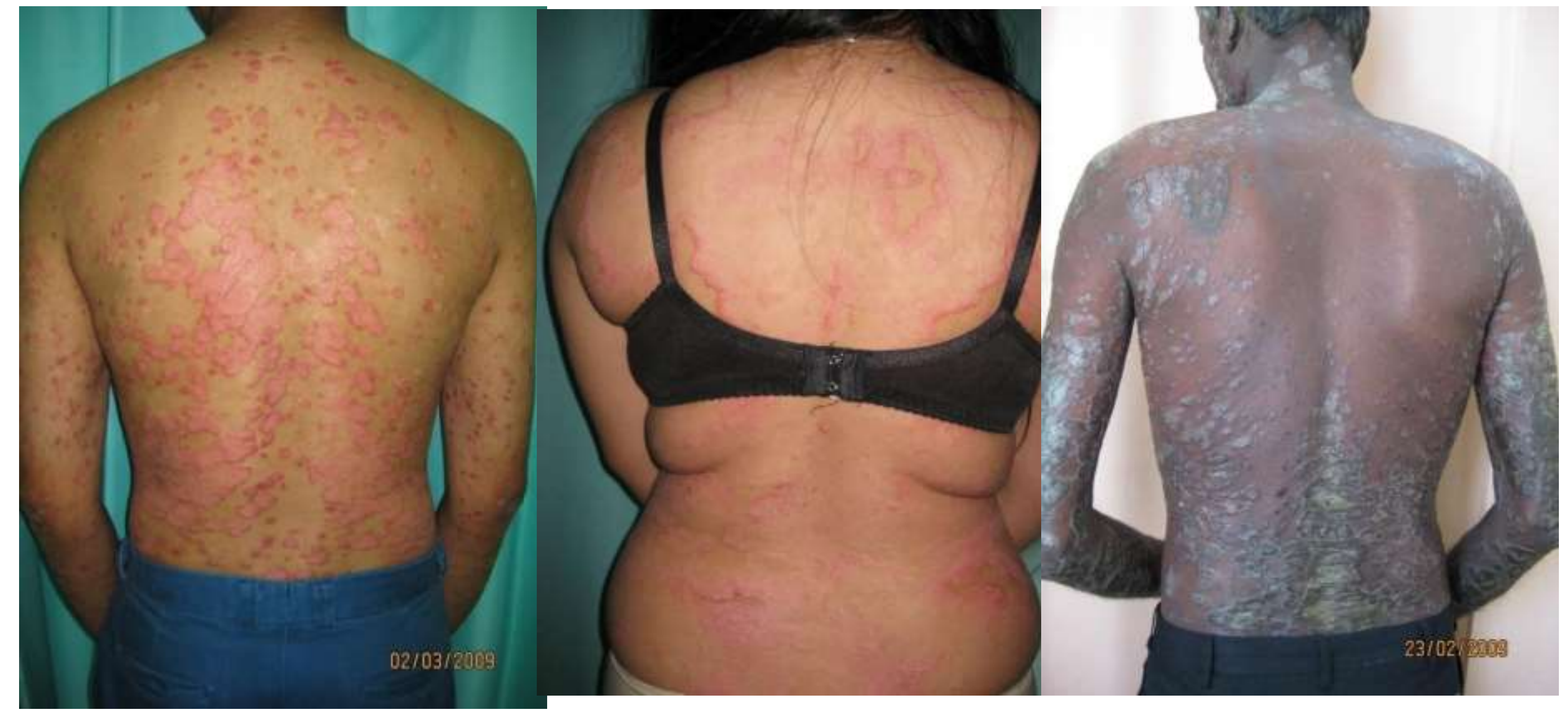


Kruger G et al. Arch dermatol 2001;137:280-4

Emotional impact of Psoriasis



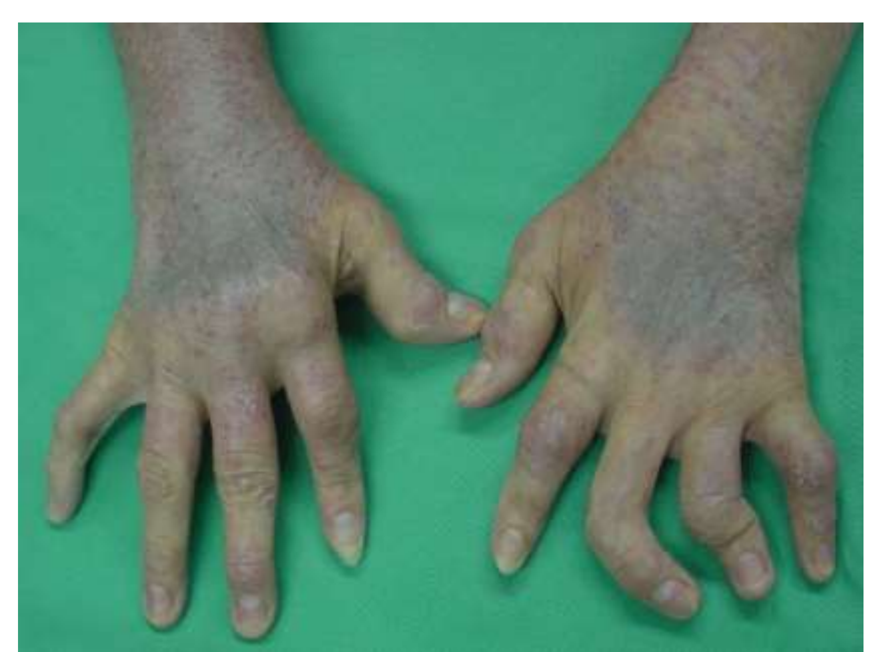
Kruger G et al. Arch dermatol 2001;137:280-4

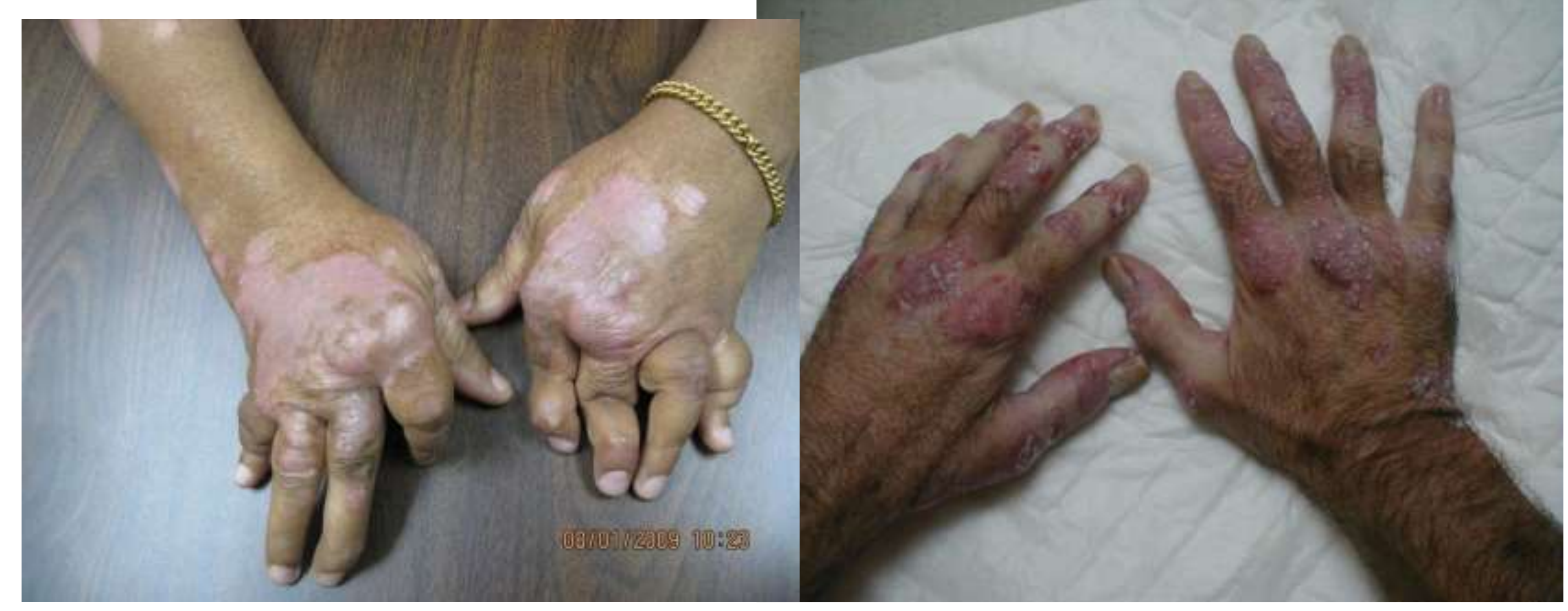


- Psoriasis causes as much disability as other major medical diseases such as cancer, heart disease, diabetes, hypertension, arthritis and depression. Weiss Sc, et al. 2002, level III; Rapp SR, et al. 1999, level III

Psoriatic Arthritis

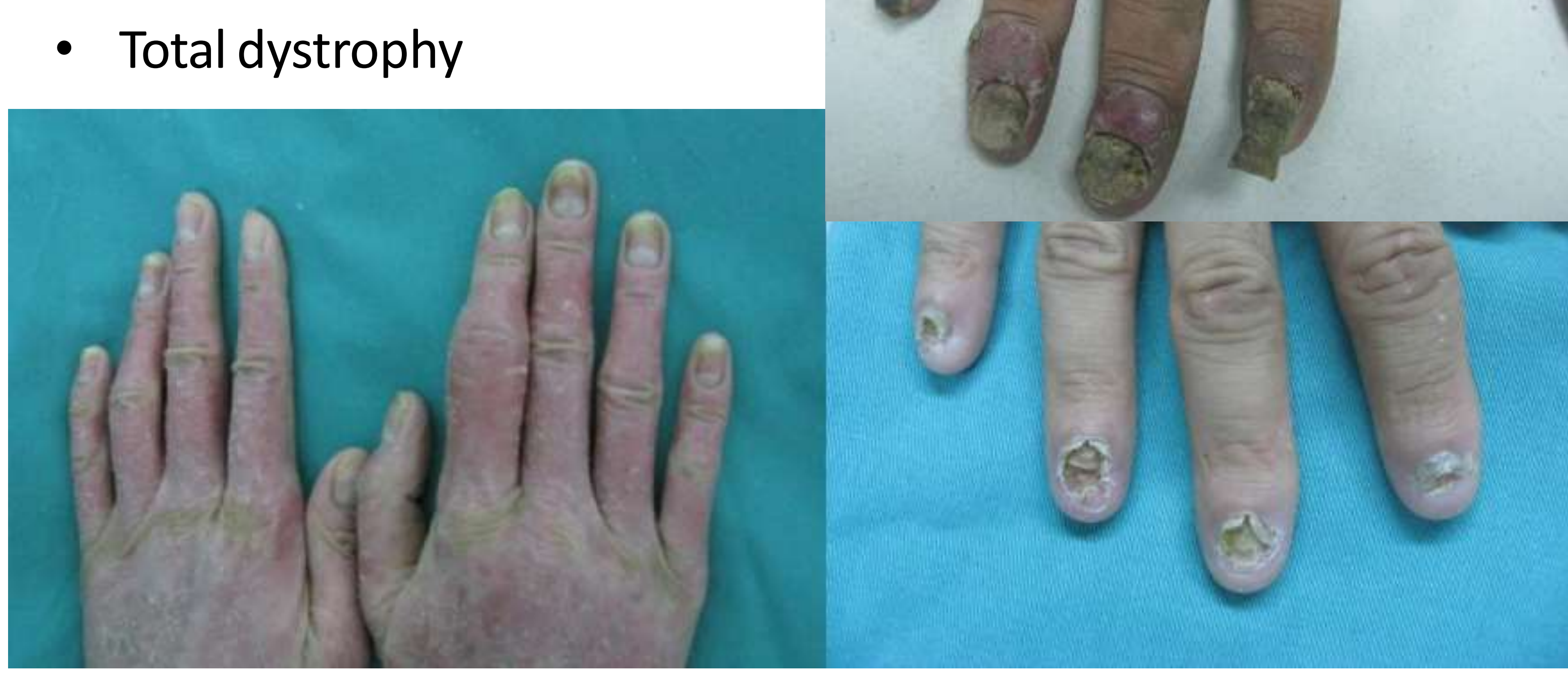
- Affects 6% - 42%
- Skin disease precedes arthritis by about 10 years in up to 85%
- 50% deformed within 2 years
- Early recognition and prompt treatment of arthritis prevent deformity





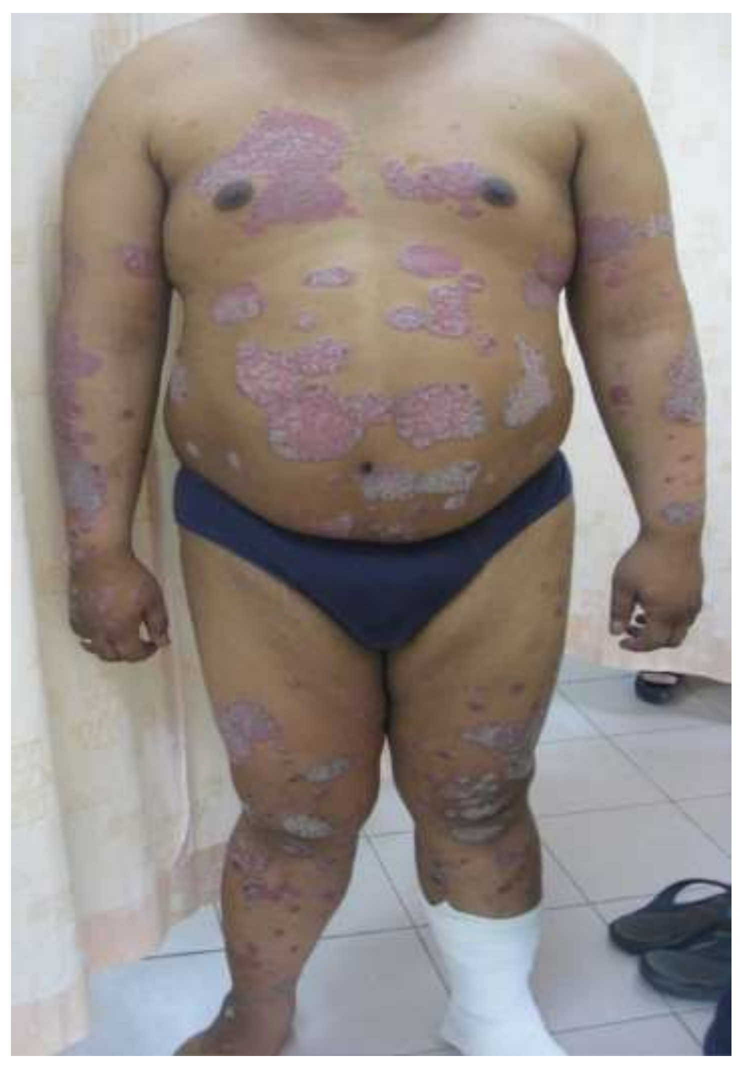
Nail Changes in Psoriasis

- 25% to 50%
- Pitting
- Onycholysis
- Subungual hyperkeratosis
- Discolouration
- Total dystrophy



Psoriasis : chronic systemic inflammatory disease

- Increased risk of cardiovascular morbidity and mortality
- Metabolic syndrome
  - Obesity, diabetes, dyslipidemia, hypertension
- Cardiovascular diseases
  - Myocardial infarct
  - Stroke
- Lymphoma
  - Hodgkin's lymphoma and CTCL
- Non-melanoma skin cancer
- Psychiatric/psychologic disorders
- Increased all-cause mortality

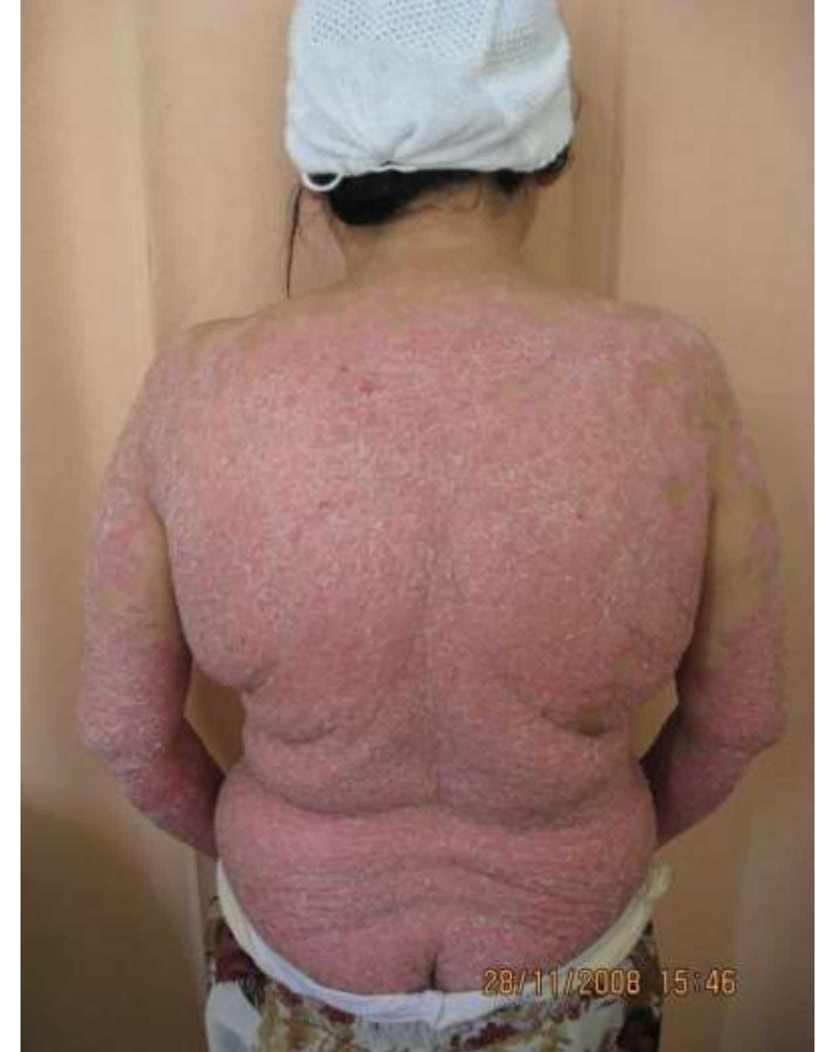


1. Herron MD, et al. Arch Dermatol. 2005; 141:1527-34. 2. Henseler T, et al. J Am Acad Dermatol. 1995;32:982-6. 3. Gelfand JM, et al. JAMA. 2006; 296:1735-41. 4. Mallbris L, et al. Eur J Epidemiol. 2004;19:225-30. 5. Gupta MA, Gupta AK. Br J Dermatol. 1998;139:846-50. 6. Gelfand JM, et al. Arch Dermatol. 2007; 143:1493-9.

Psoriasis and Life Expectancy

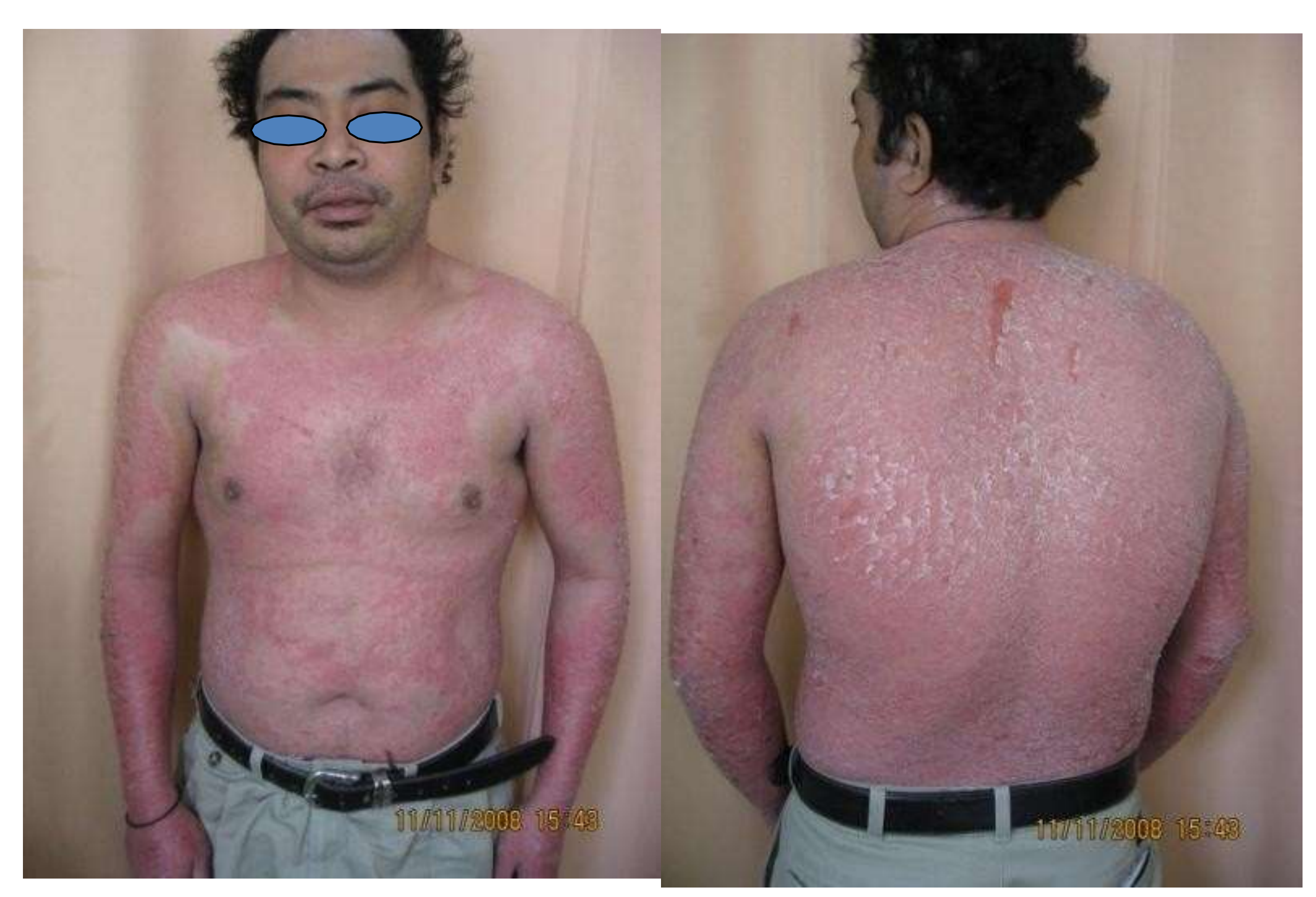
- Patients with **severe** psoriasis
  - 3 fold increased risk of developing MI
  - 3-4 year decrease in life expectancy, similar to severe hypertension
    - **Men 3.5 yrs**
    - **Women 4.4 yrs**

Mehta NN, et al. 2011, level II-2; Mehta NN, et al. 2010; level II 2; Gelfand JM, et al. 2006, level II-2



Shorter lifespan in severe psoriasis

- Risk of myocardial infarct and associated mortality highest in young patients with severe psoriasis



- Tujuan terapi psoriasis adalah tidak ada lesi, sehingga pemberian terapi dapat dimodifikasi secara perorangan.
- Selain identifikasi tipe, derajat keparahan psoriasis perlu ditentukan guna memilih tata laksana yang sesuai.
- Derajat keparahan psoriasis ditentukan dengan skor body surface area (BSA) atau psoriasis area and severity index (PASI).

- Berdasarkan Panduan Praktik Klinis (PPK) RSCM dan Perhimpunan Dokter Spesialis Kulit dan Kelamin Indonesia (PERDOSKI),
- Klasifikasi psoriasis berdasarkan skor BSA/PASI adalah sebagai berikut;

< 3% psoriasis ringan,

3-10% psoriasis sedang,

>10% psoriasis berat.

- Klasifikasi ini sedikit berbeda dengan klasifikasi Fitzpatrick yaitu;

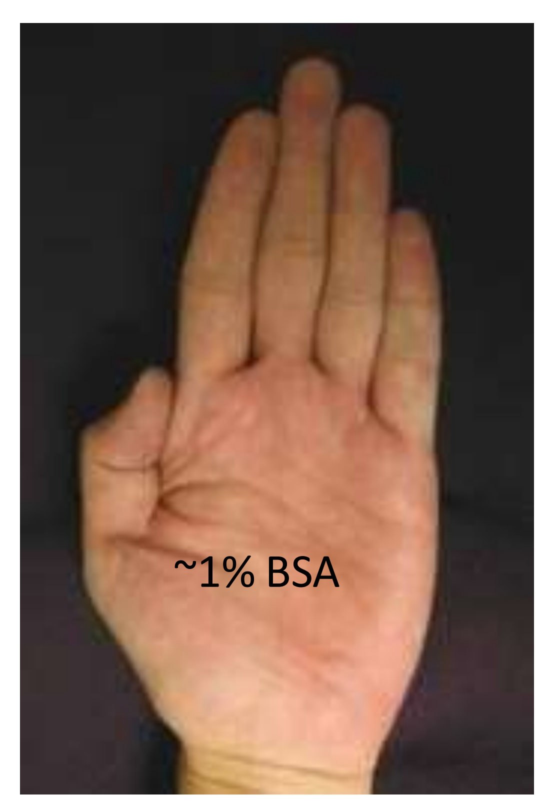
<10 % psoriasis ringan

10-30% psoriasis sedang

30% psoriasis berat.

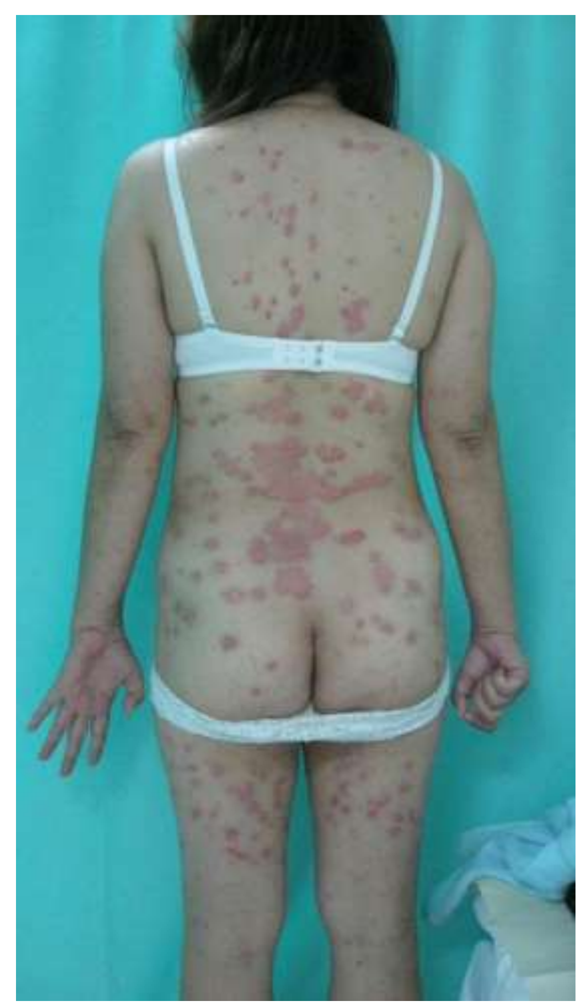
% Body surface area involvement (BSA)

- Measures extent of skin lesions
  - % body surface involvement
    - “rule of 9” or
    - taking patient’s one palm size (flat hand with thumb and fingers) as 1%
- Familiar to dermatologists
- Easily taught, easily learnt
- Simple to use



Psoriasis Area and Severity Index (PASI)

- First published in 1978 for quantifying skin disease in psoriasis
- Four regions
  - head and neck (10%)
  - upper limbs (20%)
  - trunk (include axillae and groins) (30%)
  - lower limbs (include buttocks) (40%)
- Severity of skin lesions (erythema, scaling and induration) and extent of involvement within each region
- Score range from 0 - 72
- PASI 75 = 75% reduction in PASI score
  - Used to measure efficacy in clinical trials



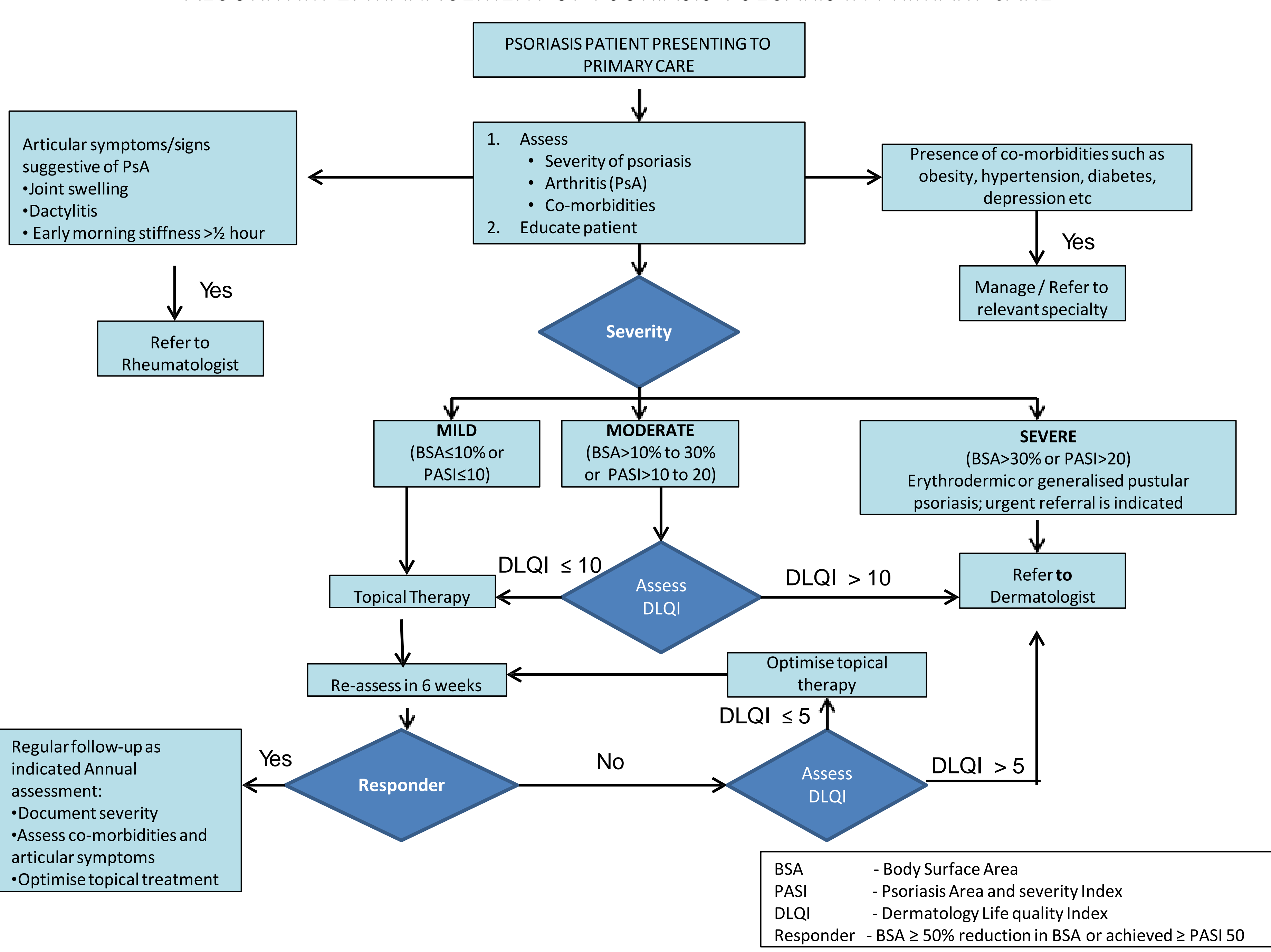
Pemilihan terapi lini pertama untuk psoriasis ringan adalah pengobatan topikal misalnya emolien, kortikosteroid, keratolitik, retinoid, analog vitamin D, atau tar.

Bila tidak memberikan respons yang baik, dapat dilakukan fototerapi.

Untuk psoriasis sedang, terapi lini pertama yang disarankan adalah fototerapi dengan ultraviolet B (UVB) broadband (BB) atau Ultraviolet B (UVB) narrowband (NB).

Sebagai lini kedua, dapat diberikan kombinasi psoralen dan ultraviolet A (PUVA). Apabila tidak memberikan respons, dapat diberikan terapi sistemik.

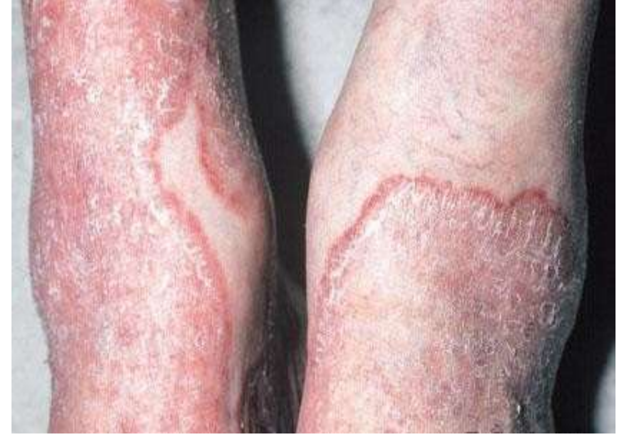
Pada psoriasis derajat berat, diberikan terapi sistemik, yaitu metotreksat, siklosporin, asitretin, serta dapat dipikirkan pemberian obat biologik. Pada kondisi



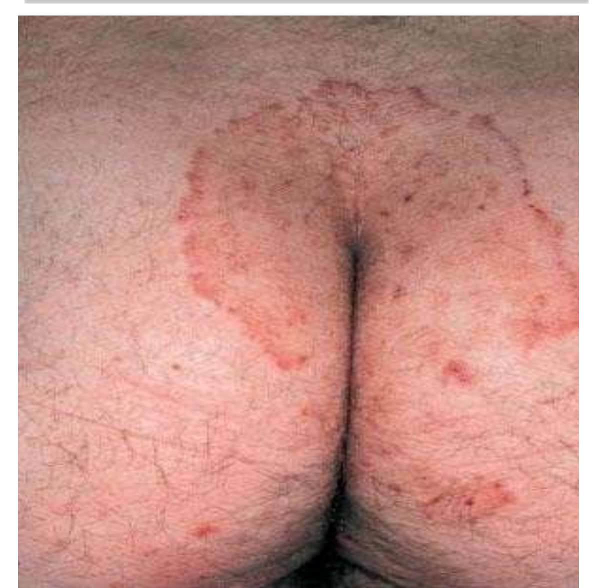
ALGORITHM 1: MANAGEMENT OF PSORIASIS VULGARIS IN PRIMARY CARE
PSORIASIS PATIENT PRESENTING TO PRIMARY CARE
1. Assess
• Severity of psoriasis
• Arthritis (PsA)
• Co-morbidities
2. Educate patient
Articular symptoms/signs suggestive of PsA
•Joint swelling
•Dactylitis
• Early morning stiffness >½ hour
Yes
Refer to Rheumatologist
Presence of co-morbidities such as obesity, hypertension, diabetes, depression etc
Yes
Manage / Refer to relevant specialty
Severity
MILD (BSA≤10% or PASI≤10)
MODERATE (BSA>10% to 30% or PASI>10 to 20)
SEVERE (BSA>30% or PASI>20) Erythrodermic or generalised pustular psoriasis; urgent referral is indicated
DLQI ≤ 10
Assess DLQI
DLQI > 10
Topical Therapy
Refer to Dermatologist
Re-assess in 6 weeks
Optimise topical therapy
DLQI ≤ 5
Regular follow-up as indicated Annual assessment:
•Document severity
•Assess co-morbidities and articular symptoms
•Optimise topical treatment
Yes
Responder
No
Assess DLQI
DLQI > 5
BSA - Body Surface Area
PASI - Psoriasis Area and severity Index
DLQI - Dermatology Life quality Index
Responder - BSA ≥ 50% reduction in BSA or achieved ≥ PASI 50

Psoriasis?

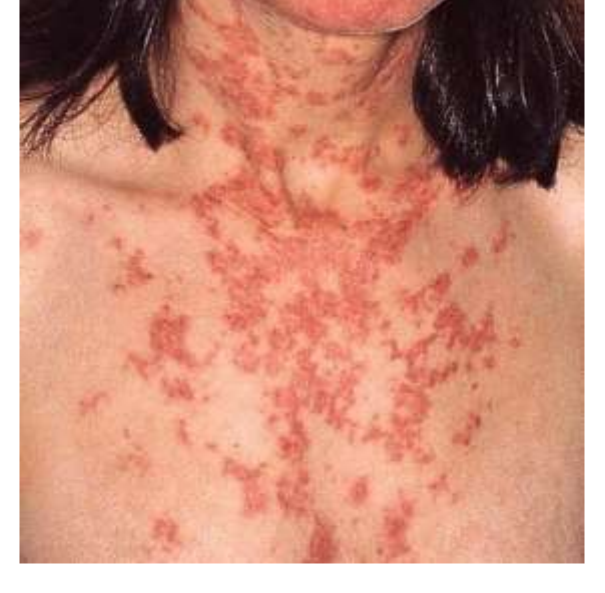
1



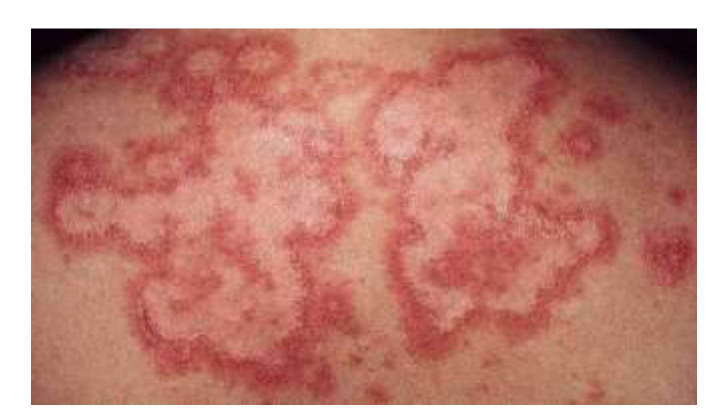
Tinea corporis



2

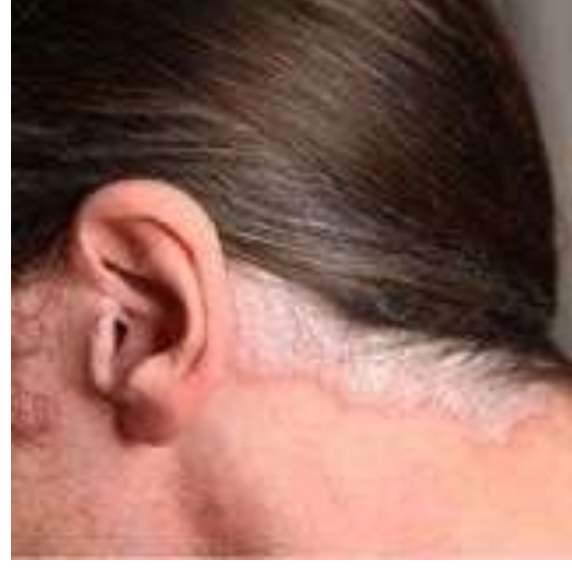


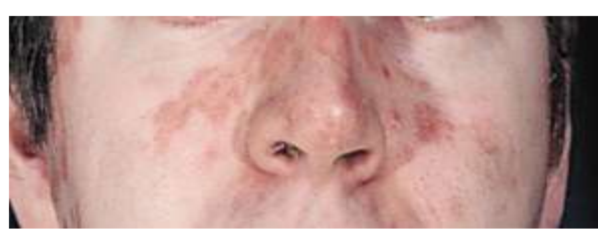
Subacute
cutaneous lupus erythematosus



Psoriasis?

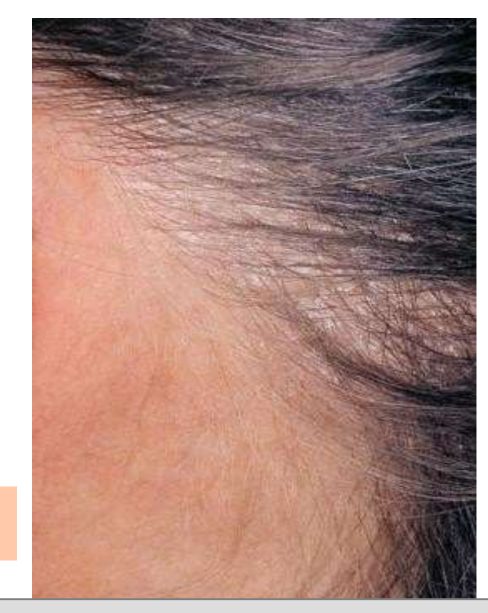
3



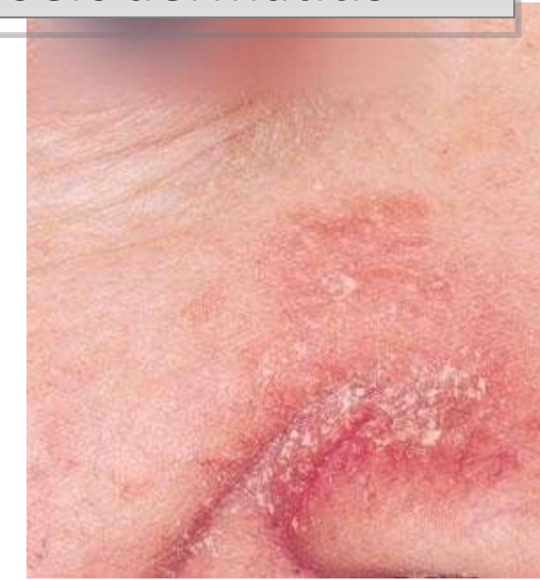


Psoriasis

4



Seborrhoeic dermatitis



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SEKIAN TERIMA KASIH