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Psoriasis, Eczema & Scaly Rashes

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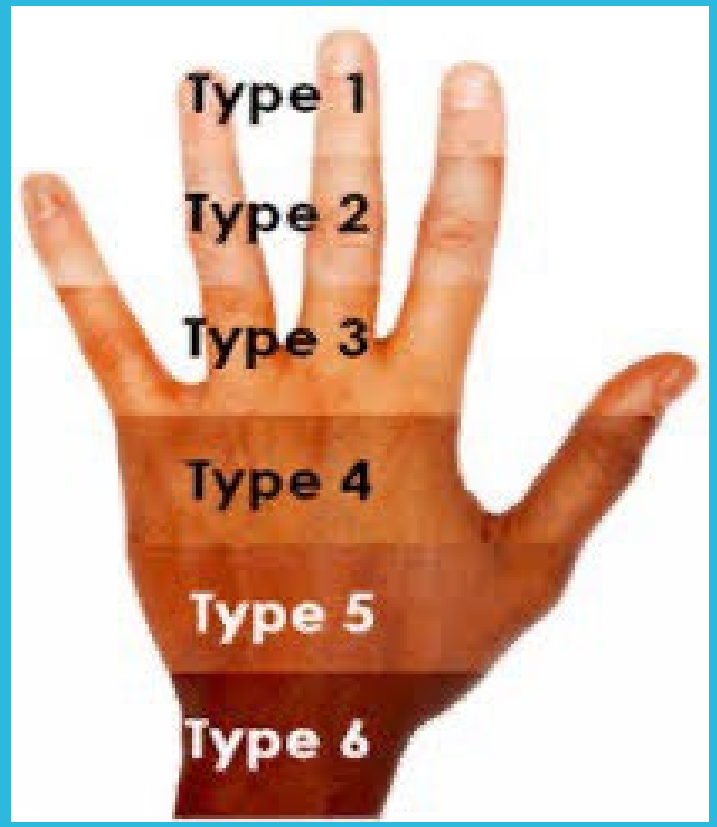
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Learning Objectives

1. Recognize clinical findings in patients with psoriasis and eczema
2. Become familiar with psoriatic comorbidities
3. Review management strategies for psoriasis and eczema

Fitzpatrick Skin Type (Phototype)

Determined by the amount of melanin in the skin & skin reaction to sunlight





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Skin Color Affects Appearance of Rashes

Darker Skin Tones

Erythema less obvious
Misinterpret as post-inflammatory pigment change
Underestimate severity
More violet/gray

Pigmentary changes
Hyperpigmentation
Hypopigmentation













55-year-old man, phototype I skin, 30-year history of a widespread rash







He also has arthritis and nail changes



16-year-old, phototype III skin, recently moved to the US from Thailand and developed widespread rash





Middle-aged man, phototype VI skin, rash for many years





Differential Diagnosis

- **Psoriasis**
- Atopic Dermatitis
- Contact Dermatitis
- Tinea Corporis
- Cutaneous Lupus
- Pityriasis Rosea
- Secondary Syphilis
- Mycosis Fungoides



Psoriasis: thick, confluent scale



Atopic dermatitis: thinner scale, lichenification



Tinea: central clearing, advancing edge of scale

Psoriasis

- Prevalence = 3% of US adults
- 30% cases present < age 20
- Family history 30-40%
- Well-demarcated scaly plaques
- Silvery scale ("micaceous")
- Favors extensor surfaces, classic = elbows & knees
- Scalp, ears, umbilicus, genitals, nails, gluteal cleft







https://www.dinosaursrocksuperstore.com/products/mica-rock-samples

Psoriasis Types

- Plaque 60-75%
- Guttate
- Inverse = body folds
- Palmoplantar
- Pustular
- Erythrodermic

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Psoriasis: Plaque

- Well demarcated scaly plaques
- Extensor surfaces
- Trunk
- Scalp
- Symmetric









Psoriasis: Scalp/Ear







Psoriasis: Palmoplantar



Scaly, red





Thickened skin +/- fissures



Scale, pustules

Psoriasis: Guttate





- "Drops," younger patients, scale may be minimal
- May follow *Streptococcus* infection (throat, perianal): antibiotic Rx can help







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Psoriasis: Inverse/Genital













Intertriginous Rashes DDx

- **Candidal intertrigo:** moisture/friction, red, satellite papules/pustules





- **Tinea cruris:** central clearing, advancing edge, annular/arcuate



Intertriginous Rashes DDx

- **Erythrasma:** well-demarcated thin pink/brown finely scaly plaques (bacterial)





- **Seborrheic dermatitis:** salmon color on light skin, flakier scale, less confluent





Back to the first case:
Psoriasis can cause nail changes and arthritis



Psoriasis: Nail Changes



Pitting, onycholysis, oil spot



Subungual hyperkeratosis



Crumbling

Psoriatic Arthritis

- 20-30% of psoriasis patients (but only 1-2% of children with PsO)
- Psoriasis precedes arthritis 85% (8-10 years)
- Inflammatory arthritis (small & large joints, spine/pelvis)
- Soft tissue inflammation (tendon/ligament insertion, tendons)
- Increased risk: Nail dystrophy, scalp psoriasis, intergluteal/perianal





Psoriasis Comorbidities: Multisystem Inflammatory Disease

- Cardiovascular: myocardial infarction, stroke
- Metabolic Syndrome: insulin resistance, Type 2 DM, obesity, dyslipidemia, hypertension
- Inflammatory Bowel Disease
- Non-Alcoholic Fatty Liver Disease (associated with metabolic syndrome)
- Depression/Anxiety

- PRIMARY CARE = Major role in screening PsO patients

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Psoriasis Comorbidities: What About Pediatric Patients?

- Less data for kids
- If we screen kids with PsO, can we intervene earlier?
- Obesity: routine screening, if + evaluate for insulin resistance/DM
- Blood pressure: yearly
- Lipids: between ages 9-11, again between ages 17-21
- Ask about: Arthritis symptoms, mental health



Menter A et al. 2020. Joint American Academy of Dermatology- National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis in pediatric patients. JAAD 82(1): 161-201.

Psoriasis: Topical Steroids

Low potency: face, neck, genitals, intertriginous

- Hydrocortisone 2.5% (or 1% OTC)

Medium potency: trunk, extremities

- Triamcinolone 0.1% (comes in larger tube 80g and 454g jar)

High potency: thicker plaques, extensors, hands/feet

- Clobetasol 0.05%, betamethasone dipropionate 0.05%

For scalp: solution, foam or oil

- Clobetasol 0.05% solution or foam, fluocinolone 0.01% oil

Combination therapy: Taclonex (betamethasone dipropionate & calcipotriene) ages 12+

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Non-Steroidal Topicals for Psoriasis

VTAMA (tapinarof) cream (age 18+)

- Aryl hydrocarbon receptor agonist



Zoryve (roflumilast) 0.3% cream (2+), 0.3% foam (12+)

- PDE4 inhibitor



Calcipotriene 0.005% ointment/cream (18+), foam (4+)

- Vitamin D analog (can be irritating)



Tazarotene cream/gel 0.05% & 0.1% (18+)

- Retinoid (can be irritating)



Topical calcineurin inhibitors (off label)

- Tacrolimus, pimecrolimus

Topical Maintenance Therapy Strategies

Cycle on/off PRN

Intermittent TCS Dosing: 2-3 days/week

Transition to nonsteroidal topicals

Rotate TCS & nonsteroidal

- M-F nonsteroidal, Sat-Sun topical steroid
- Rotate weeks

Psoriasis: Systemic Treatment

Biologics (injectable): moderate/severe PsO, most indicated for PsA

- *TNF-alpha inhibitors*: Humira (adalimumab), Enbrel (etanercept)
- *IL-17 inhibitors*: Taltz (ixekizumab), Cosentyx (secukinumab), Bimzelx (bimekizumab)
- *IL12/23 inhibitor*: Stelara (ustekinumab)
- *IL-23 inhibitors*: Tremfya (guselkumab), Skyrizi (rizankizumab)

Oral Biologic: moderate/severe PsO

- *IL-23 inhibitor*: Icotyde (icotrokinra) (new 2026)

Oral Small Molecules

- *PDE4 Inhibitor*: Otezla (apremilast), mild/mod/severe PsO, PsA
- *TYK2 Inhibitor*: Sotyktu (deucravacitinib), mod/severe PsO



Psoriasis: Traditional/Systemic Treatment

Phototherapy (nbUVB)

Immunosuppressants

- Methotrexate (PsO, PsA)
- Cyclosporine (PsO)

Oral Retinoid

- Acitretin (PsO)

Psoriasis: Pediatric Systemic Treatment

Biologics (injectable):

- Enbrel (etanercept): mod/severe PsO age 4+, juvenile PsA age 2+
- Taltz (ixekizumab): mod/severe PsO age 6+
- Cosentyx (secukinumab): mod/severe PsO age 6+, juvenile PsA age 2+
- Stelara (ustekinumab): mod/severe PsO, PsA age 6+

Biologic (oral)

- Icotyde (icotrokinra): mod/severe age 12+ (new 2026)

Oral Small Molecules

- Otezla (apremilast), mod/severe PsO, PsA, ages 6+

Sun HY et al. 2022. Biologics for pediatric psoriasis: A systematic review and meta-analysis. Pediatr Dermatol 39(1): 42-48.

Psoriasis: How to Choose a Systemic Tx?

Plaque Psoriasis

Highest Efficacy/Fastest/Fewest Injections: IL-17 & IL-23 inhibitors

Easiest to start: Otezla (oral, no labs)

Prefer Oral/Needle-Phobic: Otezla, Sotyktu, Icotyde

Mild, but need systemic: Otezla

Psoriatic Arthritis

Best: TNF-alpha inhibitors, IL-17 inhibitors (also IL-12/23, IL-23)

Inflammatory Bowel Disease: avoid IL-17 inhibitors

Best: TNF-alpha inhibitors, IL12/23 inhibitor (also IL-23)

Congestive Heart Failure: avoid TNF-alpha inhibitors

- Best: Anything else

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Psoriasis: Pregnancy & Lactation

Topicals:

Pregnancy: Low/mid-potency topical steroids, topical calcineurin inhibitors, salicylic acid

Lactation: Topical steroids, topical calcineurin inhibitors, calcipotriene, VTAMA likely safe (avoid nipple area for all)

Biologics:

Pregnancy: TNF-alpha preferred: Cimzia (certolizumab) > Enbrel (etanercept)

Lactation: Biologics considered safe

McMullan P et al. 2024. Safety of dermatologic medications in pregnancy and lactation: An update - Part I: Pregnancy. JAAD 91(4): 619-648.
Yaghi M et al. 2024. Safety of dermatologic medications in pregnancy and lactation: An update - Part II: Lactation. JAAD 91(4): 651-668.

Benefits of Biologics Beyond Skin/Joints:

Can we prevent/reverse effects of inflammation?

Reduction in markers of systemic inflammation: CRP/ESR

Cardiovascular Disease

Several studies: reduced risk of MI, major CV events, vascular inflammation (most data with TNF-alpha agents)

Depression

Reduced depressive symptoms (vs conventional tx)

On the Horizon: Effects of GLP-1 agonists on psoriasis under study now

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Psoriasis Tx Considerations

Body surface area (BSA)
- Mild: <3%
- Moderate: 4-9%
- Severe: 10+%

Other severity factors
- Sensitive/special areas (hand/foot, genital, scalp, face)
- Symptoms, QOL, activity

Evidence of psoriatic arthritis

Previous/Failed Treatments

Tx comorbidities: Obesity, HTN, DM, lipids, mental health, insulin resistance

Other medical Hx: IBD, CHF etc









Assessment & Tx

Body surface area (BSA)
- Moderate: 4-9%
- Severe: 10+%

+Psoriatic arthritis

Previous/Failed Treatments
- Topical steroids (at least)

Topical Steroids (Rx enough!)
- Body: Triamcinolone 0.1% 160/454 g
- Thick areas: Clobetasol 0.05%

Plan for Systemic Treatment: Biologics
- Adult PsO/PsA: TNF-alpha or IL-17 best
- Adult PsO: Any biologic/oral
- Teen PsO: IL-17









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31-year-old man, phototype III skin, with an itchy rash







- **Hx of childhood eczema**, resolved by high school. Moved to US from Japan and developed widespread pruritic eruption.
- Affects whole body including face. Arms are currently the worst.
- PMH: Seasonal pollen allergies. Denies history of asthma.
- Current Meds: hydrocortisone 1% cream, triamcinolone 0.1% cream





Differential Diagnosis

- **Atopic Dermatitis**
- Contact Dermatitis
- Psoriasis
- Tinea Corporis
- Scabies
- Seborrheic Dermatitis
- Pityriasis Rosea
- Eczematous Drug Rxn
- Mycosis Fungoides



Psoriasis: thick, confluent scale



Atopic dermatitis: thinner scale, lichenification



Tinea: central clearing, advancing edge of scale

Dermatitis/Eczema = Umbrella Term

- Inflammation of the skin causing dry, red, scaly itchy plaques
- Several Subtypes:

  Atopic Dermatitis (what is commonly meant by “eczema”)

  Nummular Eczema

  Contact Dermatitis

  Seborrheic Dermatitis

  Asteatotic Dermatitis

Atopic Dermatitis

Prevalence in US = Adults 8%, Children 13% (Black children 22%)

Presentation: 60% by age 1, 85% < age 5 (often improves with age)

- Adult onset in 25% affected adults

Family history of atopy 70% (AD, allergies, asthma, food allergy)

Key features: Chronic/relapsing, itchy, dry skin, flexural involvement (current/past)

Different patterns based on age

Skin Barrier Dysfunction = drier, itchier, less resistant irritants/allergens

Atopic Dermatitis





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Atopic Dermatitis in Skin of Color

AD more prevalent, severe

Increased pruritus

Erythema may be violet

Increased:

- Lichenification
- Hypo/hyperpigmentation
- Follicular prominence
- Prurigo nodularis
- Extensor involvement









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Atopic Dermatitis: Babies/Little Kids

Favors face, head, extensor surfaces, may ooze









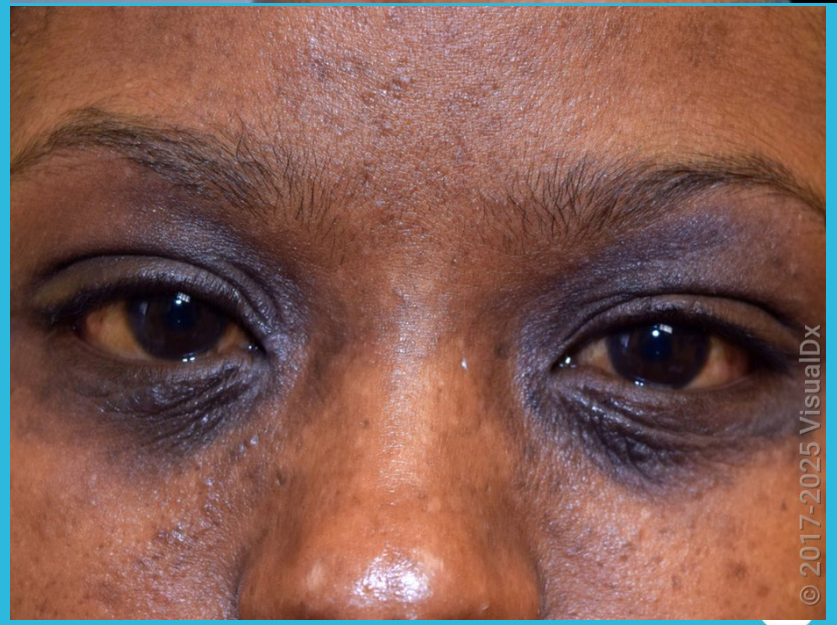
AD: Older Kids/Adults

Flexural, neck, eyelids









Atopic Dermatitis: Other Spots







Atopic Dermatitis: Associated Conditions



Hyperlinear Palms



Pityriasis Alba



Keratosis pilaris

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Atopic Dermatitis Can Also Affect the Nails



Horizontal ridging
Inflamed nailfold



Longitudinal ridging
Pitting
Inflamed nailfold



Pitting

Haenssle HA et al. 2014. When all you have is a dermatoscope-start looking at the nails. Dermatol Prac Concept 4(4): 11-20. www.ConferMED.com

Atopic Dermatitis: Emollients









Helps skin barrier

Immediately after bath or handwashing

2x/day

Thick (cream, ointment)

Fragrance free

Atopic Dermatitis: Topical Steroids

Low potency: face, neck, genitals, intertriginous

- Hydrocortisone 2.5% (or 1% OTC)

Medium potency: trunk, extremities

- Triamcinolone 0.1% (comes in larger tube 80g and 454g jar)

High potency: thicker plaques, extensors, hands/feet

- Clobetasol 0.05%, betamethasone dipropionate 0.05%

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Non-Steroidal Topicals for AD

Good for sensitive areas, most approved for kids

Calcineurin inhibitors

- Tacrolimus oint 0.03% age 2+, 0.1% age 16+
- Pimecrolimus cream 1% age 2+





PDE4 Inhibitors

- Eucrisa (crisaborole) oint 0.03% age 3 mos
- Zoryve (roflumilast) cream 0.05% age 2-5, 0.15% age 6+
- Adquey (difamilast) 1% oint: age 2+ (new 2026)







Non-Steroidal Topicals for AD

Good for sensitive areas, most approved for kids

JAK Inhibitors

- Opzelura (ruxolitinib) cream 1.5% age 2+
- Anzupgo (delgocitinib) cream 2% age 18+ (CHE)

Aryl Hydrocarbon Receptor Agonist

- VTAMA (tapinarof) 1% cream, ages 2+







AD Systemic Treatment

Biologics (injectable):

- Dupixent (dupilumab) IL-4/13, ages 6 mos+ (also: asthma, prurigo nodularis, and others)
- Adbry (tralokinumab) IL-13, ages 12+
- Ebglyss (lebrikizumab) IL-13, ages 12+
- Nemluvio (nemolizumab) IL-31, ages 12+

Oral JAK Inhibitors

- Cibinqo (abrocitinib), ages 12+
- Rinvoq (upadacitinib), ages 12+

AD Traditional Treatment

Phototherapy

- Narrow-Band UVB

Oral Steroids

- Avoid if possible, risk of rebound/side effects
- Best as a rescue & bridge to safer systemic therapy
- Longer tapers 10-12 days (avoid the short tapers)

Immunosuppressants (not FDA approved for AD)

- Cyclosporine, methotrexate, mycophenolate mofetil, azathioprine

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AD: Pregnancy & Lactation

*weigh risk of tx vs risk of worsening/flare/secondary infection

Topicals:

Pregnancy: Low/mid-potency topical steroids, topical calcineurin inhibitors

Lactation: Topical steroids, topical calcineurin inhibitors, VTAMA (tapinarof) is likely safe (avoid nipple area for all)

Biologics:

Pregnancy: Dupixent (dupilumab) probably safe (limited data so far is reassuring)

Lactation: Biologics considered safe

McMullan P et al. 2024. Safety of dermatologic medications in pregnancy and lactation: An update - Part I: Pregnancy. JAAD 91(4): 619-648.
Yaghi M et al. 2024. Safety of dermatologic medications in pregnancy and lactation: An update - Part II: Lactation. JAAD 91(4): 651-668.
Sánchez-García V et al 2025. Safety of Dupilumab Therapy for Atopic Dermatitis during Pregnancy: A Systematic Review and Meta-analysis. Acta Derm Venereol. Feb.

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Atopic Derm Tx Considerations

Body surface area (BSA)
- Mild: <3%
- Moderate: 4-9%
- Severe: 10+%

Other severity factors
- Sensitive areas (hand/foot, face, genital)
- Symptoms, QOL, activity
- Severity of itch
- Secondary infections (*Staph*, HSV)

Previous/Failed Treatments

Comorbidities: Asthma, allergies, prurigo nodularis, etc





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Assessment of This Case

Body surface area (BSA)
- Severe: 10+%

Other severity factors
- Sensitive areas: Face
- Severity of itch
- Secondary infections (*Staph*): see punctate erosions, crusting

- *Most AD patients *Staph* carriers, *Staph* toxins can drive immune dysfunction

Previous/Failed Treatments
- Topical steroids low/mid potency





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Treatment Recommendations

Skin Care
- Emollients
- Fragrance-free skin/laundry care

Topicals
- Face: hydrocortisone or nonsteroidal
- Body: triamcinolone 0.1% 454 g jar
- Thick areas: clobetasol 0.05%

Antihistamines
- May help with itch/allergies if active
- Allegra/Zyrtec

Make Plans for Systemic Tx
- Dupixent (dupliumab), Adbry (tralokinumab), Ebglyss (lebrikizumab)

Treat Bacterial Component
- Bacterial culture (lesion, nares)
- Oral antibiotic (cephalexin), mupirocin





Cases



25 yo woman with hx eczema, itchy rash on knees for a long time

Scratches until skin bleeds.

Tried different topicals in the past, but they were too messy and left “grease stains” on her clothes

Skin Findings?

Tx Considerations/Duration?



Findings
Lichenification
Hyperpigmentation
Erythema
Crusting/erosions

Considerations for Treatment
Extensor area
Thick Skin
Possible secondary infection?
Dislikes ointments (use a cream)

Treatment Options
High-potency topical steroid (clobetasol cream)
*Likely need 4-6+ weeks
Mupirocin
Later, consider maintenance strategy
(intermittent dosing, rotation with non-steroidal



- **31 yo woman hx psoriasis**
- Worsened during pregnancy, spread from elbows to face/scalp/ears
- Previous good response to Taclonex (betamethasone dipropionate & calcipotriene) cream
- Now breastfeeding





- **Treatment options now/later?**
- **Special Considerations?**







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Assessment & Tx Options





Severity
BSA: Mild to moderate (depending on how much scalp is involved)
Sensitive/Special Areas Involved
Face, scalp (can be really miserable)
Breastfeeding
Limits tx options somewhat

Topicals Now
Face/Ears: Hydrocortisone, tacrolimus/pimecrolimus, VTAMA
Elbows: Clobetasol, could rotate with calcipotriene later (or Taclonex)
Scalp: Clobetasol solution or foam, Salicylic Acid shampoo

Systemics While Breastfeeding (if needed)
Biologics: IL-17, IL-23 highest efficacy

Systemics After Breastfeeding
Biologics or orals (if preferred)

Thank You!

Questions?