6-Seborrheic Dermatitis

Epidemiology:

- All ages, typically **post-puberty ages 30-50 y/o**
- On average, 1 in 20 of people affected.

Background:

- Lipophilic commensal yeast**, malassezia furfur** (Pityrosporum ovale)
- Those affected have **higher** levels of **triglycerides** and **cholesterol** and **low** levels of **squalene and FAs** in their sebum
    - Lower levels of P.acnes (converts triglycerides to Free FAs which are antimicrobial to malassezia species)
- Triggers: **Stress, Immunosuppression, Sun Exposure, Heat, Fever**

PEARL: If you see severe seborrheic dermatitis in a pt what are some associated disorders? **Neurologic dz** (e.g. Parkinson's or Epilepsy) & **HIV/AIDs**

Clinical Presentation:

- **Symmetric erythematous patches** with overlying **greasy-yellow scale** affecting the **seborrheic areas (scalp, face, chest, & intertriginous)**. Itching and burning may be present.
    - Adults: M>F, onset in 30s-50s
    - Infants (**"cradle cap"**): one week after birth. Classic erythematous, **itchy patches** with **greasy yellow scale** that **resolve** by **4 months involving face**, **post-auricular, sternum, & intertriginous areas**
- Spectrum of dz
    - **Mild**: dandruff on the scalp w/out erythema
    - **Moderate**: typical clinical picture above with thickening plaques (sebopsoriasis)
    - **Severe**: erythroderma covering 90% of BSA

Differential

- **Scalp (Adult)**
    - **Psoriasis**: more circumscribed thick silvery plaques that are less itchy. Additional lesions elsewhere on body! LOOK for NAIL changes! + FH of Pso, + Pso triggers (SICK LAB)
    - **Tinea Capitis**: younger population (3-7 y/o). broken hairs to go along with erythema as well as posterior lymphadenopathy
    - **Chronic Contact Dermatitis**: >itchy. New hygiene products? Shampoo.
- **Face (Adult)**
    - **Rosacea**
    - **Actinic Keratosis**: scale are less yellow/greasy
    - **Lupus**: malar rash spares nasolabial folds vs seb derm involving this location
    - **Dermatomyositis**: heliotrope rash is more violaceous
    - **Tinea faciei**: more annular asymmetrically distributed on check
- **Face (Infant)**
    - **Atopic Dermatitis**: onset later at 1-16 weeks vs seb derm at 1 week. Location on face & flexor surfaces. Look for family hx of atopic triad (atopic derm, allergic rhinitis, asthma). More pruritic and inflammatory
    - **Psoriasis**: uncommon and more adherent scales
    - **Tinea capitis**: look for broken hairs and posterior lymphadenopathy

Diagnosis:

- **KOH Prep** ("**spaghetti & meatballs**"; hyphae & spores)
- **Biopsy –** if diagnosis unclear
- HIV testing – if severe/refractory to treatment

Histology:

- **Regular acanthosis** (regular rete ridge depth + thickened epidermis), **spongiosis, shoulder parakeratosis**

Treatment:

- Scalp: Topical anti-inflammatory + Topical antifungals
    - **Selenium Sulfide (Selsun Blue), Ketoconazole shampoo,** ciclopirox, salicylic acid, or tar shampoo
        - 2-3 x weekly- 5 to 30 minutes
- Face: Topical Antifungals
    - **Ketoconazole vs ciclopirox + 2.5 % hydrocortisone**
- Infants: **Conservative approach w/ no tear shampoo → Selenium Sulfide**
- Patient Education:
    - Chronic nature of seb derm: **control** not necessarily cure
    - Maintenance therapy once flare controlled
        - Selenium sulfide vs ketoconazole on weekend
        - Calcineurin inhibitor (tacrolimus & pimecrolimus)