# Common Dermatoses in the Elderly

Family Medicine Review Course
31st May 2025

# The elderly and their skin

- All skin conditions that affect young adults can affect the elderly
- However, the elderly suffer from a greater proportion of certain dermatoses due to:
  1. Age – cumulative time to accrue risk factors (e.g. sunlight, occupational)
  2. Medications
  3. Poorer immune system
  4. Comorbids

# Let’s make derm simple

- Classify your dermatoses into:

1. Itchy
2. Painful
3. “Ugly”

- By the end of this session, you should now have a brief approach to all rashes

# Case #1 – crusted (Norwegian) scabies

Differentials for scaly itchy rashes should include:

1. All forms of eczema
   - In elderly, easy to just blame dry skin (asteatotic/xerotic)
   - Rule out contact dermatitis, venous stasis
2. Infections – parasitic and fungal
   - Scabies, esp with risk factors and correct clinical presentation
   - Extensive tinea corporis
3. Pruritus secondary to organ failure, medications
   - Most commonly CKD, cirrhosis, but also iron deficiency, hypothyroidism, etc
   - Pruritogenic medications like opioids

# Case #2 – exanthem from drug reaction

Differentials for non-scaly itchy rashes should include:

1. Exanthem
   - Consider drugs and infections (can be para- or post-infectious)
   - If febrile, think of more serious drug causes (SCARs), or more serious infections (dengue, toxic shock syndromes)
2. Urticaria and related conditions
   - Urticaria – rule out angiooedema/anaphylaxis. Drugs >> parainfectious
   - Urticarial dermatitis, urticarial vasculitis, bullous pemphigoid – more chronic

**Caveat: A non-scaly dermatosis on a background of asteatosis will look scaly. History is key in this case

# PAINFUL

# Case #3 – Herpes zoster

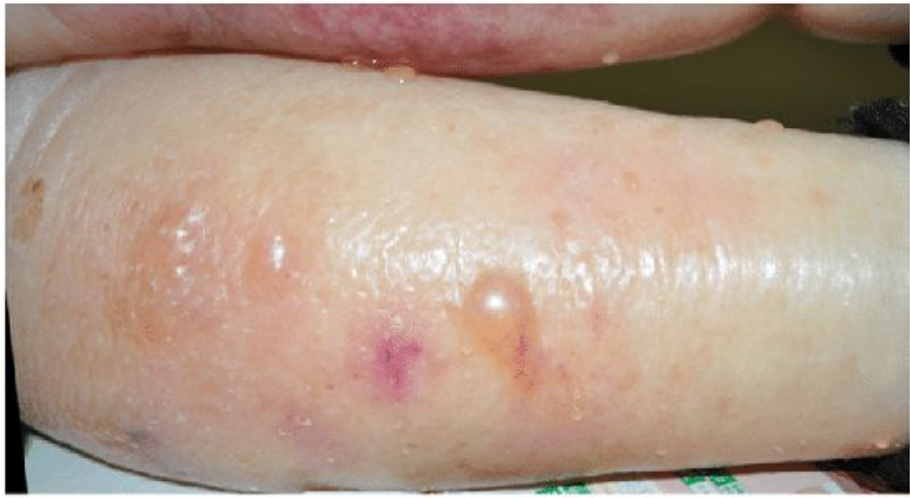
- Management – think of 3 things:
  1. Antiviral – shortens duration of rashes, and hence duration of pain
  2. Pain relief – Ample analgesia
  3. Precautions – contact, + airborne if immunocompromised or disseminated
- When derm sees a patient with zoster, main thing is to exclude:
  1. Disseminated zoster – may portend systemic involvement (encephalitis, pneumonitis, hepatitis)
  2. Herpes zoster ophthalmicus / otis
  3. Secondary infections

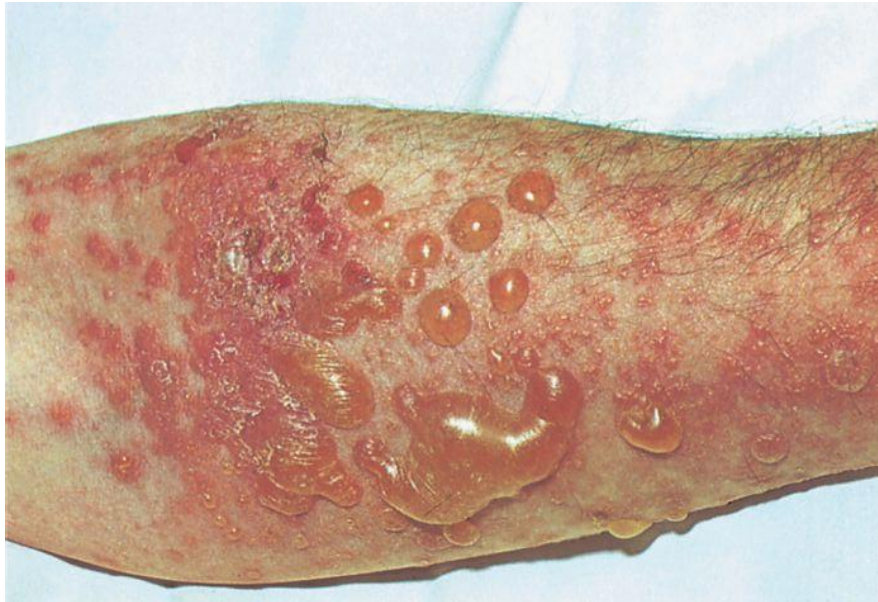
# Case #4 – Stevens-Johnson Syndrome

- Acute epidermal necrolysis – one of the only derm emergencies
  - SJS = BSA <10% detached/detachable epidermis
  - TEN = BSA >30% detached/detachable epidermis – this is very bad
  - For 10-30% BSA: SJS-TEN overlap
- **Latency: 1-4 weeks**
- Early SJS may not have dusky or eroded areas, and look like exanthems – beware the patient who feels an exanthem is painful
- Treatment: stop offending agent (most important step), KIV cyclosporin A, TNF-a inhibitors, steroids + IVIG

# Case #5 – oedema bullae

- Bulla ≠ bullous pemphigoid (BP) all the time
- BP – itchy, chronic, should have urticated plaques. **Itch** predominates symptoms
- Oedema bullae – only over oedematous sites, no itch, painful if deroofed
- Many other causes of blistering
  - Inflamed
  - Non-inflamed



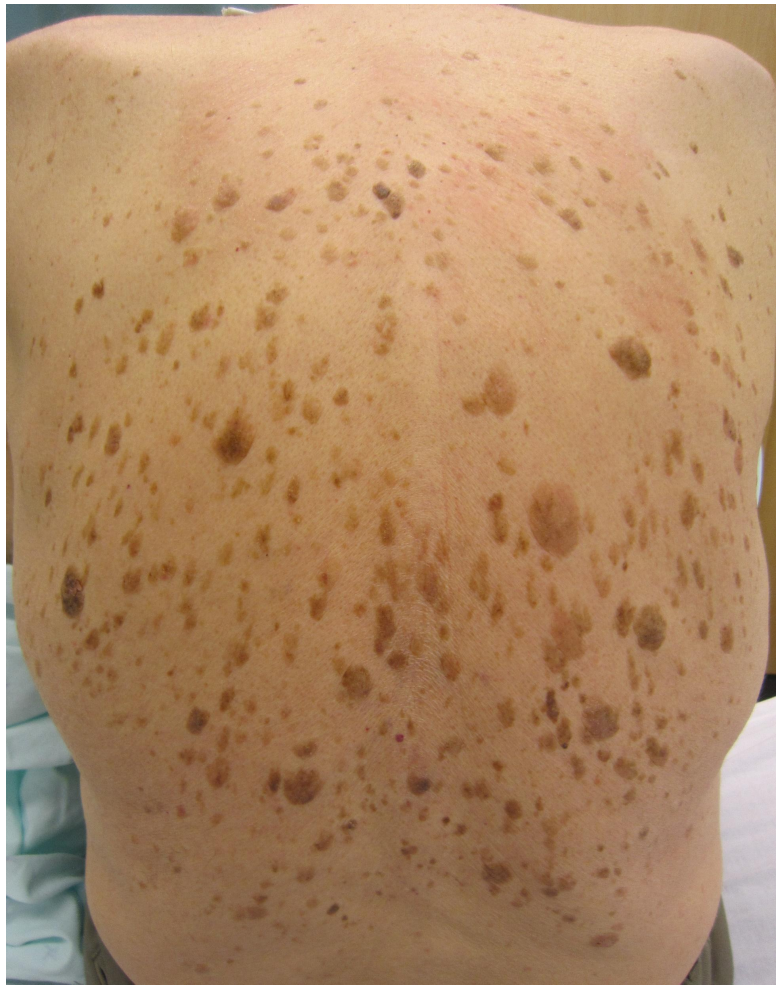


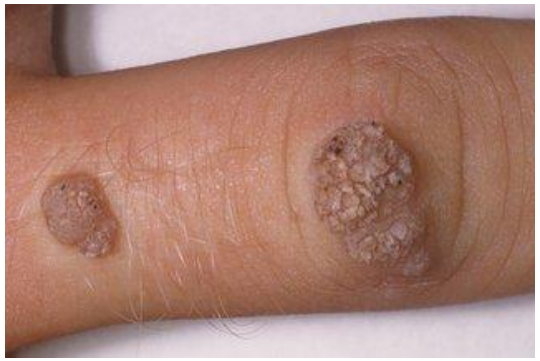
# Case #6 – Marjolin's ulcer

- SCC transformation of long-standing ulcer - rare
- This is regardless of underlying aetiology
- Pathophysiology – chronic inflammation
- Ddx (often more likely):
  1. Infected ulcer
  2. Arterial/venous ulcers (pain if not neuropathic)
- If ulcer looks like it has an unusual growth, or edges look craggy, consider SCC transformation

# Case #7 – seborrhoeic keratosis

- Pigmented verrucous stuck-on papules/plaques
- If you wonder if something is a viral wart or a melanoma, you are probably looking at a seb K
- Part of skin aging – completely benign, no risk of malignancy
- Eruptive Seb Ks – Leser-Trélat sign  Paraneoplastic sign!
- Ddx: Viral wart





# Case #8 – Basal cell carcinoma

- Most common skin cancer in the world
- In Asians, tend to be pigmented
- Slow growing – hardly metastasises nor kills. Morbidity is mostly in the form of local invasion
- BCCs in frail elderlies – option to not treat is okay, since it is unlikely to be the cause of decline/death
- Ddx: melanoma (rare in Asians), pigmented SCC, adnexal tumours

# Summary – **Itchy** dermatoses

1. Infective
   - Scabies (and other parasites e.g. lice)
   - Fungal (tinea, candida)

2. Eczematous
   - Contact dermatitis
   - Venous eczema
   - Asteatotic eczema
   - Think of ruling out T-cell lymphoma if there is some nodularity or ulceration

3. Exanthematous (what you would call “maculopapular” rash)
   - Rule out SCARs
   - Consider drugs and infection
   - Can be autoimmune in right context

4. Urticarial
   - Rule out angiooedema/impending anaphylaxis
   - Rule out bullous pemphigoid
   - Consider drugs

5. No obvious dermatoses
   - Screen secondary causes (organs, drugs)

# Summary – **Painful** dermatoses

1. Infective
   - Viral – HSV, zoster
   - Bacterial – think of all the layers of the skin
2. Blistering
   - Rule out SJS/TEN
   - All blisters will hurt when burst and deroofed – does not help with aetiology much
   - Identify underlying cause of blistering with the help of other clues
3. Ulcerative
   - Rule out superimposed infection, and rule out cancer
   - Thereafter, find the underlying cause of the ulcer and address it
4. Purpura and ecchymoses
   - Rule out underlying coagulopathy or fracture
   - Rule out vasculitis in the appropriate context

# Summary – **“Ugly”** dermatoses

1. Warty
   - Viral – HPV
   - Seb K (non-pigmented variant)
   - Always consider ddx of AK/SCC
2. Nodular
   - Rule out cancer
   - Warning symptoms: Grew rapidly, painful, contact bleeding, discharge, “never heals”
3. Dyspigmentation
   - No hard and fast rule, but be on the lookout for “ugly ducklings” or “double takes”
   - Think harder if something you saw made you uncomfortable