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PRACTICAL PRESCRIBER

Aspi F Golwalla
Sharukh A Golwalla

20th Edition

JAYPEE

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2 CHAPTER Skin and Sexually Transmitted Diseases

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PRINCIPLES OF PRESCRIBING IN DERMATOLOGY (DO'S AND DONT'S)

1. Detailed history of allergy due to drugs taken in the past should be taken before prescribing any drug. Also history of ingestion of other drugs must be obtained to avoid drug interactions, e.g., with antihypertensive or antidiabetic drugs, phenobarbitone with ketoconazole.
2. Nature of treatment depends on the stage of the disease. More acute the condition less strong the local applications, e.g., lotions for acute conditions, creams for subacute conditions, creams or ointments for chronic conditions.
3. Vehicle in which the medication is incorporated requires careful consideration as does the manner of application. Use of incorrect form of medicament will aggravate rather than improve the condition by causing sensitization.
4. Areas near the eyes and genitals should be treated with mild remedies because of increased percutaneous absorption (especially corticosteroids) leading to thinning atrophy.
5. Adhesive plaster should be used with caution and not close to an acute skin lesion.
6. Patent or proprietary preparations should be used only after studying their composition, side effects and contraindications.
7. Ultraviolet therapy should be used with discretion in local treatment as wrong use of it may aggravate the condition. It should be

avoided in cases with a history of photosensitivity and in lupus erythematosus or antifungal treatment. H/o G6PD should be obtained to prevent hemolysis.

8. H/o previous application of corticosteroids can change the clinical picture of the disease (e.g., Ringworm—Tinea incognito).
9. X–ray therapy in skin diseases should be left to the expert.
10. If malignancy is suspected, biopsy should be done before starting any treatment.
11. Associated diseases, such as diabetes, hypertension, peptic ulcer or pulmonary tuberculosis should be excluded before prescribing certain drugs such as corticosteroids.
12. Avoid all drugs in the first trimester of pregnancy. Use minimum unavoidable drugs in later pregnancy. Strong steroid ointments should be avoided since if applied for a long time, they are absorbed into the blood. Ask for epilepsy/fits as drugs given for the same may interact with some antifungal drugs.
13. Additional drugs may have to be incorporated in the prescription to counteract the side–effects of the main drug prescribed, e.g., antacids when corticosteroids are used.
14. Patient who has been fully treated should be re–examined at frequent intervals to observe remote untoward effects of drugs prescribed and to check a relapse.
15. In contagious skin disease, not only the patient but all the family members and contacts should be examined and if found infective, should be treated simultaneously, e.g., for scabies, ringworm (Tinea).
16. Treatment should be divided into two parts:
    a. Local.
    b. Systemic.

    Topical therapy is the mainstay in dermatological practice. Understanding the principles of the therapy is important.
17. Many topical agents penetrate the skin barrier (with increasing concentration) and enter the blood circulation. Absorption is

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more in infants and children and this must be kept in mind with corticosteroids applied on larger areas.

18. Hydration of skin before topical application enhances absorption. If local application is not applied in correct strength, it may give rise to side effects like irritation, burning, besides altering efficacy.

DISEASES DUE TO ARTHROPOD PARASITES

Scabies

Lesions not complicated by secondary infection:

℞ Gamma benzene hexachloride lotion 1% or cream

or ℞ Permite (Permethrin) cream, treatment of choice.

or ℞ Ascabiol lotion or benzyl benzoate lotion 25% (12½% in children).

To be used externally thus:

Lotion or cream should be applied from neck down to toes, left overnight and application repeated for two consecutive nights or left on skin for 48 hours and repeated weekly for 2–3 weeks.

Note: Gamma benzene hexachloride should be avoided in pregnancy, infants, young children or with history of seizure disorders.

Patient should have a bath with soap and hot water with rubbing and scrubbing to open all burrows, and dry the skin before applying the medicine.

Bedding and clothing need not be laundered or disinfected.

or ℞ Ivermectin in a concentration of 0.8% can be applied overnight. Second application after 5 days.

℞ Tab. Ivermectin is the first effective systemic therapy. Dose 12 mg on empty stomach and can be repeated at interval of 2 weeks.

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Note: Ivermectin should be avoided in children weighing <15 kg, old age, during pregnancy and lactation.

Unless treatment is aimed at all infected persons in the family, reinfection will almost always occur.

All the family members and contacts should be treated simultaneously to prevent re-infection.

Lesions complicated by secondary pyoderma:

℞ Sepmax or Bactrim DS 1–×–1 × 5 days.
or ℞ Ampicillin 500 mg tds 5–7 days/or Azithromycin
or ℞ Tab. Amoxicillin + Cloxacillin 500 mg tds
℞ Neosporin cream/Soframycin
To be applied for 8 days followed by above treatment.
℞ Mupirocin cream
or ℞ Fusidic acid cream

If severe secondary infection:

℞ Tab. Cephalexin 250 mg tds × 3–5 days
In children—30–50 mg/kg in 4 divided doses
In neonates—125 mg bd × 3–5 days

Cases resistant to treatment:

Combination of treatment (a) and (b) or (b) and (c).
℞ Tab. Ivermectin 12 mg Hs

For pruritus:

℞ Tab. Fexofenadine 120–180 mg od × 10 days
or ℞ Tab. Cetrizine 10 mg od
℞ Tab. Bepotastine 10 mg bd
or ℞ Tab. Loratidine 10 mg od, or Bilastine 20 mg bd
℞ Betnovate–N cream mixed with Crotorax cream
or ℞ Zovate–GN cream + Crotorax cream
℞ For 8–10 days, then stop the steroid cream.

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For severe pruritus:

℞ Instrel gel (pranoxin HCl)

Pediculosis (capitis, corporis and pubis).

Treatment same as for scabies.

(Take care to see that the application does not come in contact with the eyes).

℞ Permethrin 1% rinse

or ℞ Cyban (malathion 0.5% lotion – Lederle).

or ℞ Mediker (synthetic pyrethroid).

or ℞ Gamma benzene hexachloride for 3–4 weeks

Repeat application after one week.

Since body lice live in clothing especially in seams, laundering of clothes and underclothes and bedding at high temperature.

Pediculosis scalp (pediculosis capitis): Shampoo the hair and scalp using a regular shampoo. After drying the hair apply the lotion for 10 minutes and wash and dry the hair. Use a fine toothed comb to remove any remaining nits.

Pediculosis pubis (crab lice)—same as scabies

Permethrin 1% or ivermectin 06% wt. to volume overnight.

Systemic: Ivermectin 12 mg single dose.

DISEASES DUE TO FUNGI

Ringworm of Skin

(T. corporis, T. cruris, T. pedis, T. capitis)

- *Griseofulvin* was commonly used for fungal infections of the skin, Terbinafine and ketoconazole are now used. Indications for (or oral antifungals) dermatophyte infections.
- Fluconazole 150 mg OD for 6–12 weeks

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- Itraconazole 100 mg bd is more effective since ringworm resistance has developed to many anti antifungals.
  1. Tinea capitis.
  2. Tinea pedis and tinea manuum (optional).
  3. Tinea corporis either widespread or with underlying predisposing factor like diabetes, immunosuppressive therapy, or HIV infection, or not responding to topical antifungals.
  4. Tinea unguium: Oral antifungals like terbinafine and itraconazole are preferred because of higher efficacy in nail infections.

     Dosage: 250 mg bd or 500 mg od.

Duration of Griseofulvin therapy

Body skin: 4 weeks

Skin and hair: 4–6 weeks

Palms and soles: 6–8 weeks

Finger nails: 6–12 months

Toe nails: 12–18 months

Note: Griseofulvin can cause alcohol intolerance and reduces efficacy of oral contraceptive pills.

Fluconazole (Zocon) 2–6 mg/kg for 4–6 weeks.

Itraconazole (Candistat) 100 mg bd for 6–12 weeks bd.

For nails: Finger nails. Pulse therapy: 200 mg bd for 7 consecutive days per month for 2 months. Toe nails; 3 months. Tinea versicolor 1000 mg stat.

Bedding, clothing, towels should be compulsorily be laundered and disinfected to prevent re-infection.

Terbinafine. Dermatophytosis:

Tinea crusis/corporis : 250 mg bd × 6–12 weeks

Tinea pedis : 250 mg bd × 6–12 weeks

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Tinea capitis : 250 mg bd × 6–12 weeks
Finger nail : 200 mg bd × 6–12 weeks } Antifungal
Toe nail : 200 mg bd × 6–12 weeks } lacquers for nail

Note: Antifungal drugs are contraindicated in patients on some psychiatric drugs and anticonvulsants, cardiac and hepatic disease.

Local treatment: Butenafine or tolnaftate lotion/cream or luliconazole eberconazole or topical liposomal amphotericin.

Topical:

℞ Abzorb powder or
℞ Candid powder or Daktarin powder, luliconazole, eberconazole powder.
During daytime for folds, i.e., groins, axillae, between toes.
or ℞ Canesten cream
or ℞ Daktarin gel
or ℞ Batrafen cream
or ℞ Terbinafine (Terbiderm, Sebifin) cream HS × 2 weeks

At night –

℞ Canesten cream (Clotrimazole 1%)
or ℞ Imidil cream (Lyka), Luliconazole more effective.
or ℞ Daktarin gel
or ℞ Zole ointment. Along with –
℞ Whitfield's ointment:
Acid salicylic 3 G
Acid benzoic 6 G
Emulsifying ointment 100 G
for soles and nails.
℞ Tab. Sporanox 100 mg bd × 5–6 days
℞ Zinc Pyrithione lotion bd × 1 week

Topical treatment should be applied affected and surrounding because lesions may be widespread and clinically inapparent.

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℞ Nizral 2% shampoo applied to the skin and allowed to dry and left overnight for 3 consecutive days.

℞ Ketoconazole 400 mg single dose repeated after a week.

or ℞ Ketoconazole (Nizral) cream.

Continue application for one month.

It no response to above treatment – Surgical removal of nails followed by above treatment.

Tinea Versicolor (Pityriasis Versicolor)

℞ Sodium thiosulphate (Hypo) 40 G
Water to 100 mL.
To be applied twice a day during daytime for 3–4 weeks.

or ℞ Canesten cream

or ℞ Daktarin gel

or ℞ Nizoral (Ketoconazole) cream HS × 1–2 months

or ℞ Selsun shampoo to be applied on the lesions half hour before bath for 3–5 weeks.

or ℞ Terbiderm (Terbinafine) cream bd × 10 days

℞ Tab. Fluconazole 400 mg stat. Repeat after 2 weeks if required.

Note: Griseofulvin tabs. have no effect on tinea versicolor.

For superficial mycoses of skin, oral mucosa or vagina.

℞ Nystatin cream

Moniliasis (Candidiasis) of Skin, Mucous Membrane and Nail

Rule out diabetes and HIV infection –Patients taking antibiotics, corticosteroids and other immunosuppressive drugs, or contraceptive pills, pregnancy and those in a debilitated state.

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℞ Nizral or Zimig cream
or ℞ Zole ointment
or ℞ Imidil cream (Lyka)
or ℞ Daktarin gel (Ethnor)
or ℞ Candid cream
or ℞ Terbiderm cream
Apply twice a day for 10 days.
Abzorb powder or Candid powder additionally for dressing
℞ Castellani's paint
or ℞ Amphotericin B lotion or ointment.
℞ Candid mouth paint for oral candidiasis

If severe:

℞ Ketoconazole tablet (Nizral or Phytoral or Ketozole) 200 mg 1 od for 10 days.
or ℞ Itraconazole 200 mg/day for 2–3 weeks.
Note: Give only if liver function is normal and no H/o jaundice for 1 year prior.
or ℞ Tab. Fluconazole 150 mg once a week for 3–4 weeks.

If candidal paronychia: Doxycycline 100 mg OD.

Prevention: Avoid putting hand in water and washing or cleaning with detergent soap. Rubber gloves can be worn or ointments which prevent contact with skin can be used, e.g., Siloderm, Protectoderm, Contaderm.

Wash with mild KM_NO_4 or betadine solution to remove the crust and then apply locally ointments, e.g., neosporin, fusidic acid, supirocin, candil lotion.

BACTERIAL INFECTIONS

Impetigo

℞ Tab. Erythromycin 250 mg—one four times daily for 7 days
or ℞ Tab. Sepmax (or Bactrim DS) 1 bd × 7 days

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or ℞ Tab. Amoxy + Cloxa. tds × 5 days
or ℞ Tab. Cefadroxil 250–500 mg bd × 5–7 days
or ℞ Tab. Cefuroxime 250 mg bd × 5–7 days
Children 125 mg bd × 5–7 days
℞ Tab. Cephalexin 500 mg 1–1–1 × 7 days
℞ Clarithromycin 250–500 mg bd
℞ Bactroban or T–bact cream or Fucidin or Neosporin ointment. Apply twice daily for 10 days
℞ Clindamycin (Clindac A) solution applied on alternate days
℞ Ampicillin + Clavulinic acid 625 mg bd
℞ Piperacillin 150 mg/kg/d in 3 divided doses
℞ Retapamulin (Retarel) ointment

Boils (Furuncles)

℞ Same as for Impetigo

Sycosis Barbae

℞ Same as for Impetigo.

Carbuncles

℞ Same as Impetigo
Treatment of diabetes is very important, hospitalization to control and monitor diabetes and infection
Surgery if needed.

Folliculitis

℞ Same as Impetigo but continue local antibiotics for 1 month.
Clindamycin (Clindac A) solution Rub into scalp at night.

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Cellulitis

℞ Antibiotics as in Impetigo, hospitalization with IV antibiotics.

Tuberculosis of Skin

Treatment of all types of tuberculosis of the skin:
℞ Isoniazid 300 mg daily for 6 months plus ethambutol
℞ Rifampicin (450 mg for those weighing 60 kg or less and 600 mg daily for those more than 60 kg) for 6 months, plus
If Rifampicin not tolerated –
Second line AKT –
Clarithromycin. Refer to newer TB drugs.
Levofloxacin
Rifabutin
Quinolones

Anthrax

℞ Injection Penicillin G 2 million units 6 hourly for 2–4 weeks
or ℞ Erythromycin 500 mg 1–1–1 × 7 days.
or ℞ Tetracycline
Avoid incision.

Leprosy

Paucibacillary leprosy

(Indeterminate tuberculoid or borderline tuberculoid):
℞ Dapsone 100 mg/day (1–2 mg/kg) plus
℞ Rifampicin 600 mg (450 mg if weight <35 kg) once monthly on empty stomach for 6 months.
Multibacillary leprosy (Lepromatous, borderline lepromatous, or borderline).
℞ Rifampicin 600 mg once a month, plus
℞ Dapsone 100 mg/day at night after food, plus

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℞ Clofazimine 50 mg/day and one 300 mg dose once monthly for 2 years –
Note: Clofazimine causes increased pigmentation of skin. Dapsone should not be given if pt. is G6PD positive. Anemia should be corrected.
℞ Ethionamide 250–375 mg/day.

or ℞ Rifampicin 600 mg
Ofloxacin 400 mg — Once a month pulse
Minocyclin 100 mg — therapy for 12 months

Lepra reaction:

Type I

Mild reaction:

℞ Chloroquine + Aspirin

Severe reaction:

Steroids + Aspirin with or without large doses of Clofazimine + splinting of affected nerves.

Type II lepra reaction (Fever with few skin lesions only).

Mild/moderate reaction:

Rest + Aspirin + Chloroquine/antimonials when associated with bone/joint problems.

Severe reaction:

Rest + Analgesics + Steroids. Thalidomide–Clofazimine in large doses 300 mg/d in divided doses esp. in chronic recurrent ENL steroid dependent.

Immunoglobulin IV in refractory cases.

℞ Rifampicin 450 mg in the morning for one month.
℞ Tab. Prednisolone 5 mg
1st week – One four time daily
2nd week – One thrice daily

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The Medical Practitioner's Handy Consultant has emerged as an indispensable resource for medical professionals. Its concise and comprehensive text, covering a wide range of ailments—including medical emergencies—has been widely accepted and appreciated.

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