



Five Things Physicians and Patients Should Question

1 Do not treat tinea capitis with topical medications only.

Tinea capitis, a dermatophyte infection of the hair shafts of the scalp, is treated with antifungal agents. Topical treatments cannot penetrate the hair shaft itself, which is where the infection lies; thus, monotherapy with topical medications is insufficient to effectively treat the infection. This insufficient treatment can lead to increased health care costs resulting from multiple visits and the prescribing of ineffective medications. For this reason, when tinea capitis is suspected or is diagnosed, systemic treatment is warranted, most commonly with off-label griseofulvin or terbinafine. Terbinafine is effective for most types of tinea capitis and is less expensive than griseofulvin with improved compliance because of a shorter required course of treatment. Topical treatments such as ketoconazole shampoo and selenium sulfide shampoo may be used adjunctively to decrease carriage of viable spores, thus possibly decreasing the time to cure and decreasing shedding of the organism, which decreases risk of transmission of infection to other individuals.

2 Do not routinely order laboratory tests for associated autoimmune diseases in patients with vitiligo in the absence of signs and/or symptoms of the diseases in question.

Vitiligo is a depigmenting disorder believed to have an autoimmune origin. It is well-established that patients with nonsegmental vitiligo have an increased risk of other autoimmune conditions, with subclinical hypothyroidism being the most common. There is also a higher risk of having antithyroid antibodies (TPOs). Other autoimmune conditions have been associated with vitiligo but less commonly.

Recognizing the risk of associated autoimmune conditions has led physicians to screen patients with vitiligo for other diseases. There is no convincing evidence that extensive workups in the absence of specific clinical suspicion improves outcomes for patients and may in fact beget additional costs and harms. Although many studies suggest ordering these tests, it is based largely on the increased cosegregation of vitiligo and thyroid disease and not on improved outcomes from having identified an abnormal laboratory test result. Therefore, thyroid function testing including screening for thyroid autoimmunity or hypothyroidism is only indicated for clinical findings such as goiter, slow growth and hypothyroid symptoms, or a strong family history of thyroid disease.

3 Do not routinely order laboratory tests for patients with alopecia areata in the absence of signs and/or symptoms of the diseases in question.

Alopecia areata is a hair loss disorder believed to have an autoimmune origin. It is well-established that patients with alopecia areata have an increased risk of other autoimmune conditions, with thyroid disease being the most common. As in the case of vitiligo, it is more common to find thyroid autoantibodies or subclinical hypothyroidism than overt thyroid disease, unless there are clinically suspicious findings. Patients identified as having subclinical hypothyroidism are not currently treated and may even have resolution of the abnormal TSH.

Recognizing the risk of associated autoimmune disease has led physicians over time to screen patients with alopecia areata for other diseases. There is no convincing evidence that extensive workups in the absence of specific clinical suspicion improves outcomes for patients and may in fact beget additional costs, including follow-up for patients screening positive, as well as harms. Although many studies suggest ordering these tests, this is based largely on the increased cosegregation of alopecia areata and thyroid disease and not on improved management strategies or outcomes from having identified an abnormal laboratory test result. Therefore, thyroid function testing, including screening for thyroid autoimmune disease or hypothyroidism, is only indicated for clinical findings such as goiter, slow growth and hypothyroid symptoms, or a strong family history of thyroid disease.

Avoid the use of combination topical steroid antifungals for tinea corporis, Candida skin infections, and diaper dermatitis.

Although combination topical antifungal/corticosteroids have been approved for the treatment of tinea corporis, candidiasis, and diaper dermatitis, we recommend against use of these agents.

Many providers are unaware that the combination products contain a relatively high-potency topical steroid. For treatment of tinea corporis, the application of a topical antifungal agent alone is recommended. If symptoms such as severe pruritus require concomitant application of a topical steroid, a separate low-potency agent can be prescribed, allowing for a tapering course that should be limited to less than 2 weeks. A separate topical antifungal cream can be continued longer until the infection is cleared. This will reduce the risk of systemic absorption of the topical steroid.

Combination products are often used for treatment of diaper dermatitis. In most patients, diaper dermatitis is an irritant contact dermatitis from stool that will usually respond to barrier diaper creams/ointments alone.

Combination products, if applied with every diaper change, can result in skin atrophy, striae, and systemic absorption of the relatively high-potency topical steroids. It is instead recommended that barrier products be applied with every diaper change in this circumstance and a second low-potency topical steroid be applied, as needed, no more than twice a day and tapered as soon as the dermatitis is under control.

Combination products are also often expensive and not covered by pharmacy plans.

Avoid the use of systemic (oral or injected) corticosteroids in most cases of atopic dermatitis.

Although systemic corticosteroids can lead to rapid clearing of disease and improvement in pruritus, many short- and long-term adverse effects limit their use, including significant growth retardation, adrenal suppression in more than 90%, and rebound flaring and/or worsening of disease at the time of corticosteroid discontinuation. Atopic dermatitis treatment guidance put forth by the American Academy of Dermatology specifically advises against the use of systemic steroids in children with atopic dermatitis, with few exceptions.

In general, atopic dermatitis can be adequately controlled with good skin care practices and topical prescription therapies. In patients who have recalcitrant disease, phototherapy and/or steroid-sparing systemic agents may be required for adequate control. Systemic corticosteroids should only be prescribed for severe flares once all other treatment options have been exhausted and should be limited to a short course for the purpose of bridging to a steroid-sparing agent.

How This List Was Created

Members of the American Academy of Pediatrics Section on Dermatology submitted the top 5 topics for *Choosing Wisely* items based on a review of the literature and expert opinion of the most common dermatologic problems seen in primary care pediatrics. The list was then peer reviewed and approved by more than a dozen relevant AAP Committees, Councils and Sections. The AAP Executive Committee and Board of Directors granted final approval of the list.

The guidance in this list does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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