Dell Children's Dermatology Clinic

Pediatric dermatology referral guidelines

dell children's
Ascension

Contents

Clinic information

For the most up-to-date clinic information, please view the Dermatology locations directly on our Dell Children's Dermatology webpage.

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Fax referrals and patient information to 512-628-1921.

Contacting the provider on call

During office hours, physicians can reach a dermatologist by calling **512-628-1920** and choosing option 2.

After hours, reach the on-call dermatologist by calling **512-628-1920** and choosing option 2.

Physicians and APPs

For the most up-to-date list of providers, please select “Find a Pediatric Dermatologist” on our Dell Children’s Dermatology webpage.

Common indications for referral: ICD10 codes*

Diagnosis	Relevant ICD-10 codes
Acne	• L70.0 acne vulgaris • L70.1 acne conglobata • L70.4 infantile acne • L70.5 acne excoriae • L70.8 other acne • L70.9 acne unspecified
Alopecia areata	• L63 alopecia • L63.0 alopecia (capitis) totalis • L63.1 alopecia universalis • L63.8 other alopecia areata • L63.9 alopecia areata unspecified
Atopic dermatitis (Eczema)	• L20.82 flexural • L20.83 infantile • L20.89 other atopic dermatitis • L20.9 atopic dermatitis unspecified
Hemangioma of infancy	• D18 hemangioma and lymphangioma any site • D18.0 hemangioma • D18.00 hemangioma unspecified site • D18.01 hemangioma of skin and subcutaneous tissue • D18.02 hemangioma of intracranial structures • D18.03 hemangioma of intra-abdominal structures • D18.09 hemangioma of other sites
Hidradenitis suppurativa	• L73.2 hidradenitis suppurativa
Hyperhidrosis	• R61 generalized hyperhidrosis • L74.5 focal hyperhidrosis • L74.51 primary focal hyperhidrosis (rest depends on site) • L74.52 secondary focal hyperhidrosis
Keratosis pilaris	• L85.8 other specified epidermal thickening
Molluscum contagiosum	• B08.1 Molluscum contagiosum
Nevi (moles)	• Start with D22 and the rest depends on site
Onychomycosis (nail fungus)	• B35.1 Onychomycosis
Psoriasis	• L40.0 psoriasis vulgaris (plaque psoriasis) • L40.1 generalized pustular psoriasis • L40.3 palmoplantar pustulosis • L40.4 guttate psoriasis • L40.54 psoriatic juvenile arthropathy • L40.8 other psoriasis • L40.9 psoriasis unspecified

*This is not an all-inclusive list.

Common indications for referral: ICD10 codes*

Diagnosis	Relevant ICD-10 codes
Scabies	• B86 scabies
Seborrheic dermatitis	• L21.0 seborrhea capitis • L21.1 seborrheic infantile dermatitis • L21.8 other seborrheic dermatitis • L21.9 seborrheic dermatitis unspecified
Tinea capitis	• B35.0 tinea capitis
Tinea versicolor	• B36.0 tinea versicolor
Vitiligo	• L80 vitiligo
Warts	• B07.0 verruca plantaris • B07.8 verruca vulgaris (common warts) • B07.9 viral wart unspecified • A63.0 anogenital warts

*This is not an all-inclusive list.

Common indications for referral

Acne	
L70.0 acne vulgaris **L70.1 acne conglobata** **L70.4 infantile acne** **L70.5 acne excoriae** **L70.8 other acne** **L70.9 acne unspecified**	
Findings	• Closed comedones: "whiteheads;" noninflammatory; dome-shaped; can be skin-colored, whitish, or grayish papules • Open comedones: "blackheads;" noninflammatory; central dilated orifice with gray / brown / black material • Inflammatory papules or pustules: inflamed, superficial, <0.5 cm • Inflammatory nodules: inflamed, deep-seated, often tender, >0.5 cm • Distribution in areas with hormonally responsive sebaceous glands (typically the face, neck, chest, upper back, and upper arms)
Evaluation	Consider laboratory testing if there is concern for hyperandrogenism (eg, PCOS).
Treatment	• EDUCATION: Medications often take a few months to work and the patient's skin may get "worse" (dry, red, slight acne flare) before it gets better. Patients should use oil-free, non-comedogenic hair and skin care products. • COMPLIANCE: Make sure patients are using the medications as prescribed before switching to another regimen, and if side effects occur, it is important to verify they are not using other products that may be irritating (serums, toners, spinning cleanser brush). • Basic skin care: – Wash skin gently 1-2 times per day. – Apply oil-free moisturizer to skin as needed for dryness. – Apply oil-free sunscreen every morning. – When using moisturizer and/or sunscreen, medications should be applied first followed by the moisturizer and/or sunscreen. • How to apply topical medications: – Skin should be clean and dry. – A pea-sized amount of medication should be used to cover the entire face. – Consider gels for oily skin and creams for dry/sensitive skin, but when initiating a topical medication, cream may be less likely to cause irritation than gels. – Gentle cleansers and moisturizers are recommended to avoid excessive irritation from topical acne treatments. • Mild comedonal acne (mainly blackheads and whiteheads) – Mild topical retinoid at night AND an over-the-counter benzoyl peroxide wash in the morning such as PanOxyl Creamy Wash with 4% benzoyl peroxide – Adapalene 0.1% gel, now available over the counter and generally well-tolerated – Tretinoin 0.025% cream or gel

Treatment *(continued)*	• Mild mixed acne (scattered comedones and a few red inflammatory lesions) – Mild topical retinoid at night (adapalene 0.1% gel or tretinoin 0.025% cream or gel) - AND - – Clindamycin-benzoyl peroxide 1%-5% gel in the morning OR clindamycin gel/solution/ cream in morning in addition to using an OTC benzoyl peroxide wash in the morning • Moderate to early severe mixed acne (many comedones and inflammatory lesions) – Stronger topical retinoid at night (tretinoin 0.05% or 0.1% cream/gel) - AND - – Clindamycin-benzoyl peroxide 1%-5% in the morning or clindamycin gel/solution/cream in the morning in addition to using an OTC benzoyl peroxide wash in the morning - OR - – Oral antibiotic (if more severe): doxycycline 50-100 mg po daily or BID • Severe acne (cysts, nodules, evidence of scarring) – Isotretinoin (widely known as Accutane) is likely needed. Referral to dermatology is appropriate.
RED FLAGS	Acne in children ages 1 year-7 years (concern for androgen excess)
Referral details	• When to initiate referral: • Comedonal or inflammatory acne resistant to treatment after 3 months • Scarring • Nodulocystic acne with or without scarring • Acne associated with signs of androgen excess or part of a systemic disease • Acne that begins before approximately 7 or 8 years should prompt a thorough review of symptoms and likely lab workup and/or endocrinology referral due to the potential association with an endocrinopathy.

Product recommendations for acne-prone skin

Gentle skin cleansers	• Purpose Gentle Cleansing Bar • Purpose Gentle Cleansing Wash • Neutrogena Fresh Foaming Cleanser • Olay Foaming Face Wash • Olay Gentle Foaming Face Wash • Cetaphil Antibacterial Soap • Cerave Hydrating Facial Cleanser
Facial moisturizers	• Cetaphil UVA/UVB Defense Facial Moisturizer (SPF 50) • Neutrogena Healthy Defense (SPF 30 or 45) • Neutrogena Oil-Free Moisture (SPF 15) • Olay Complete (SPF 20) • Olay Complete Defense (SPF 30) • CeraVe AM Facial Moisturizing Lotion (SPF 30) • CeraVe PM Facial Moisturizing Lotion
OTC acne treatments (washes and topical medications)	• Clean and Clear Invisible Blemish Treatment, Maximum Strength (2% salicylic acid) • Clearasil Daily Acne Control Cream (10% benzoyl peroxide) • Clearasil Maximum Strength Acne Treatment (10% benzoyl peroxide) • Clearasil Ultra Rapid Action Treatment Cream (10% benzoyl peroxide) • Neutrogena Clear Pore Wash (3.5% benzoyl peroxide) • Neutrogena Oil Free Acne Wash (2% salicylic acid) • PanOxyl Acne Cleansing Bar (5% or 10% benzoyl peroxide) • PanOxyl Wash (4 or 10% benzoyl peroxide) • Panoxyl Creamy Wash (4% benzoyl peroxide) • Cerave Acne Foaming Cream Cleanser or Wash (4% or 10% benzoyl peroxide)

Common indications for referral

Alopecia areata	
L63 alopecia **L63.0 alopecia (capitis) totalis** **L63.1 alopecia universalis** **L63.8 other alopecia areata** **L63.9 alopecia areata unspecified**	
Findings	• Isolated patches of alopecia on the scalp • If there is no scale, redness, atrophy, pustules, or other skin change, and these have never occurred, the likelihood of this being a fungal infection is very low. (Antifungal medications will not help in this case.)
Evaluation	• Usually none needed • Rarely, alopecia may be associated with thyroid disease or anemia. Typically, this is a more widespread hair loss and other symptoms are present. In otherwise healthy children not exhibiting signs or symptoms of thyroid disease or anemia, in whom there is not a strong family history of either, thyroid and anemia studies do not need to be routinely checked. Use your clinical judgment as to whether this is necessary. • Unless symptoms suggestive of other autoimmune diseases occur, isolated alopecia does not warrant a full autoimmune disease workup; however, a child with alopecia may be at greater risk of other autoimmune conditions in the future.
Treatment	• Typically, treatment consists of application of a Class I or Class II (potent or super potent) topical steroid, such as clobetasol ointment, applied once daily to affected areas of scalp Monday – Friday (with a break on the weekends to minimize the risk of steroid atrophy). Follow-up within 6-8 weeks is important to assess treatment response and any potential side effects. • In the dermatology clinic, treatment options range from topical, intralesional or systemic (oral or intramuscular) corticosteroids to topical immunotherapies, stronger systemic medications such as immunosuppressants and JAK inhibitors, and more. • EDUCATION! Families should know that alopecia areata happens in approximately 1% of the general population. It is not caused by something they did or did not do. While stress may exacerbate the condition, it is not the primary cause. • Alopecia tends to be something that "turns on" and "turns off," meaning that even after hair has regrown, it may fall out again in the future. There is not a medication that can prevent this from occurring. • The more widespread and long-standing the hair loss, the more difficult it may be to treat. • No treatment is guaranteed to work for alopecia areata, though there are many options they may try.

Referral details	Most children with alopecia areata should be referred to dermatology as management may be complex, and there may be significant emotional stress associated with the disease. Other indications for referral: • Widespread hair loss • When the diagnosis is in question • Any scarring hair loss; this is not typical for alopecia areata • When there are associated skin changes or other potentially related changes • When there is significant emotional stress related to the diagnosis We are thrilled to be able to offer in-office pediatric psychology in most cases when needed and family is interested. Depending on the comfort level of the child's primary care provider, it may also be appropriate to initiate therapy while referral is pending.

Common indications for referral

Atopic dermatitis (AD, eczema)	
L20.82 flexural **L20.83 infantile** **L20.89 other atopic dermatitis** **L20.9 atopic dermatitis unspecified**	
Basics	N/A
Evaluation	None
Treatment	• EDUCATION: Families should know that AD is a chronic and relapsing disease. Gentle skin care and medication instructions should be reviewed in detail. • COMPLIANCE: Make sure patients are using the medications as prescribed before switching to another regimen. • The skin should be moisturized immediately after bathing and frequently throughout the day to "lock in" moisture. • AD severity and locations determine medications used in addition to the frequency and duration of treatments. • Topical steroids are typically used to treat a flare twice daily until clear, usually for 1 to 2 weeks, no longer than 15 days per month to minimize risk of steroid side effects (striae, telangiectasias, hypopigmentation). After initial treatment of flare, often will need to use steroids 2 to 3 days per week to maintain. • You should dispense enough medication when prescribing topicals. • Ointments are often preferable to creams due to increased efficacy and reduced irritation. However, use creams if this will increase compliance. This is often a preference in adolescent patients. • **Mild AD on the face or body:** – Hydrocortisone 2.5% ointment or triamcinolone 0.025% ointment – For AD involving the eyelids, neck, axillae, or inguinal folds, consider steroid-sparing agents – Tacrolimus 0.03% or 0.1% ointment, pimecrolimus 1% cream, or Eucrisa (2% crisaborole) ointment once or twice daily as needed for flares – You can also consider using these medications on steroid-free days for patients that flare during steroid breaks. • **Moderate to severe AD on the body:** – Triamcinolone 0.1% ointment or similar class III-IV topical corticosteroid – Wet wraps for flares or persistent areas – Apply topical steroids to affected areas, cover entire body with bland moisturizer of choice, apply cotton long johns or pajamas soaked with warm water and wrung out for 15 to 20 minutes 1 to 2 times per day for flares. If localized, may use gauze, cotton towels, or cotton socks as an alternative. – Nummular eczema (thicker, isolated, annular plaques) and lichenified plaques (particularly on hands/feet) sometimes require higher potency topical corticosteroid such as mometasone ointment with/without wet wraps to clear. – For associated pruritus, particularly at bedtime, initiate systemic antihistamines as appropriate for weight/age if no contraindications: diphenhydramine or hydroxyzine

Referral details	When to initiate referral: – Moderate AD not responding to treatment after 2 months – Severe or poorly controlled AD despite family consistently following management recommendations (topical steroids, wet wrap therapy, and oral antihistamines) – Recurrent skin infections – Significant negative impact on quality of life

Dry and sensitive skin care recommendations

Soap	• Dove for Sensitive Skin (bar preferred) • CeraVe Cleanser • Cetaphil Gentle Skin Cleanser or Bar (not face wash) • Olay for Sensitive Skin (bar or liquid) • Vanicream Cleansing Bar • Aveeno Advanced Care Wash
Detergent	• Tide Free • Cheer Free • All Free and Clear Note: Dreft is not free of fragrance
Fabric softener	• Bounce Free • Downy Free and Clear
Moisturizer	• Aquaphor Ointment • Vaseline Ointment (fragrance-free) • Vanicream Ointment • Cetaphil, Cetaphil Ointment or Cetaphil Restoraderm Cream • CeraVe Cream • Vanicream Cream • Aveeno Advanced Care Cream • Aveeno Eczema Cream • Eucerin Cream
Sunblock	• Vanicream Sensitive Skin SPF = 30 or 60 • Neutrogena Sensitive Skin SPF = 60+ • Neutrogena Pure & Free Baby SPF = 60+ • Elta MD products (sold in some medical offices and online from the manufacturer)
Diaper Cream	• Triple Paste • Aquaphor Ointment • Vaseline Ointment • Desitin Maximum Strength

Common indications for referral

Hemangioma	
D18 hemangioma and lymphangioma any site **D18.0 hemangioma** **D18.00 hemangioma unspecified site** **D18.01 hemangioma of skin and subcutaneous tissue** **D18.02 hemangioma of intracranial structures** **D18.03 hemangioma of intra-abdominal structures** **D18.09 hemangioma of other sites**	
Basics	• Some hemangiomas may be fully present at birth and rapidly involute (regress, shrink). Others may be fully present at birth and never involute. However, the typical growth cycle of a hemangioma is that it is barely noticeable or not at all present at birth, begins to grow in the first few weeks of life, and continues until roughly 6–9 months of age when it will commonly stabilize. Approximately 80% of the growth of typical hemangiomas will occur by three months of age. • After it stops growing, the body will slowly start to reabsorb part or all of the hemangioma. This is called involution. The color will fade and it will typically get softer and smaller. This may take several years. • Sometimes, after the hemangioma reaches the point of maximal involution, there is residual discoloration or fibrofatty tissue. The skin cannot always return completely to normal, particularly if there has been significant vertical growth. • Hemangiomas in the diaper area, axilla, or other areas prone to friction are at an increased risk of ulceration and must be monitored closely. Ulcerated hemangiomas can be painful and lead to scar or infection. These generally require medical management. • Certain hemangiomas are at an increased risk of causing functional or residual cosmetic defects. These include hemangiomas on or near the eyelid/eye, nose, forehead, glabella, nose, lip, ear, areola, and genitalia; and those that grow large quickly.
Evaluation	Usually none. See RED FLAGS section below
Treatment	• EDUCATION: Families should be counseled that these are benign collections of blood vessels and endothelial cells. They occur in approximately 5% to 7% of all babies. We do know they are not caused by anything the mother did or did not do during pregnancy. There are some known risk factors, such as prematurity, maternal high blood pressure, multiple gestation (twin, etc.), low birth weight; but it is still not clear what causes them. • While hemangiomas are benign, some may lead to complications. After the majority of hemangioma growth and/or an ulceration has occurred, medical treatment may only be partially effective. Ideally, treatment would be initiated early in life to prevent these complications. • While many treatments for hemangiomas exist, the treatment of choice for those that require intervention is propranolol/Hemangeol. Hemangeol may require more steps for insurance coverage but tends to be better tolerated by patients than propranolol. Treatment is usually required until approximately 9–12 months of life. Occasionally, very superficial hemangiomas may respond to timolol gel forming ophthalmic solution applied sparingly to the hemangioma BID. • If an older child with an involuted hemangioma has significant fibrofatty or other residual growth defects distressing to patient/family, it is most likely more appropriate to refer to pediatric plastic surgery over pediatric dermatology. If the main residual concern is redness, pulsed dye laser may help improve the appearance, and this would be addressed by our dermatology physicians.

RED FLAGS	• Large, segmental, plaque-like hemangiomas of the face (and rarely other areas) may be associated with PHACE(S) Syndrome and require prompt imaging studies and initiation of treatment. • Segmental, plaque-like hemangiomas of the sacral spine, buttocks, and/or genitalia may signal an underlying abnormality such as LUMBAR syndrome. • Segmental, plaque-like hemangiomas in the beard distribution of the face signal an increased risk of an airway hemangioma and patients must be monitored for any signs of respiratory compromise. These patients should see ENT as well. • If a child has 5 or more hemangiomas, this is called multiple cutaneous infantile hemangiomas and may be a sign that there are internal hemangiomas, particularly if they are small. The child should be assessed clinically (including palpation for hepatomegaly) and have an abdominal ultrasound to look for hemangiomas in the liver. If these are present, they should also have blood work to rule out effects on liver or thyroid function. They must be followed closely. Most infants with liver hemangiomas will not experience serious complications, but most will be treated with propranolol/hemangeol and followed closely. A smaller proportion of infants with liver hemangioma(s) may experience associated liver failure, high output cardiac failure, or thyroid dysfunction.
Referral details	• Most small, uncomplicated hemangiomas do not require a dermatology appointment. • If in doubt, call our office to discuss whether a patient should be worked in sooner than the next available appointment. • Hemangiomas on or near eyelid/eye, nose, forehead, glabella, nose, lip, ear, areola, and genitalia • Hemangiomas that grow large quickly and/or ulcerate • Large, segmental, plaque-like hemangiomas of the face, sacral spine, buttocks, genitalia, beard distribution, or other areas • 5 or more hemangiomas on one child • Residual color that is distressing to the patient or family. This may respond to pulsed dye laser.

Common indications for referral

Hidradenitis suppurativa (HS)	
L73.2 Hidradenitis suppurativa	
Basics	• Hidradenitis suppurativa is a chronic skin condition that causes painful skin abscesses and scarring, often in linear tracts. The most common areas affected are the underarms, between/under the breasts, groin, buttocks, and inguinal folds. • The cause is unknown but HS is more common in teens who are overweight and/or have a family history of the condition. Achieving a healthier weight may help with HS symptoms but patients should understand there are multiple factors that contribute to developing this condition and it is not their fault, nor is it a guarantee that HS will resolve at a particular body weight. • Often, more localized HS will be mistaken for a simple abscess and I&D might be performed or antibiotics prescribed, only for the area to never resolve or for the drainage or inflammation to recur. • HS can have significant negative impacts on self-esteem and quality of life • Antibiotics and antimicrobial agents are a common first-line therapy for HS, but they are often used more for their anti-inflammatory than antibacterial properties • Once seen in dermatology, additional treatments may include additional oral medications such as combined clindamycin-rifampin or isotretinoin, subcutaneous or intravenous immunomodulators, and/or local excision if feasible.
Evaluation	None
Treatment	Mild (Hurley Stage I – single or few inflammatory nodules without sinus tracts and scarring): • 4%-10% benzoyl peroxide wash once daily on affected areas • Clindamycin gel applied once or twice daily • Consider dermatology referral Moderate (Hurley Stage II – recurrent nodules and abscesses with sinus tracts and scarring): • Doxycyline 100 mg po once or twice daily • 4%-10% benzoyl peroxide wash once daily on affected areas • Dermatology referral Severe (Hurley Stage III – many abscesses, nodules, sinus tracts, and scars across a broader area, often interconnected): • Doxycyline 100 mg po once or twice daily • 4%-10% benzoyl peroxide wash once daily on affected areas • Dermatology referral
Referral details	When to initiate referral: • Most patients with HS warrant a dermatology referral

Common indications for referral

Hyperhidrosis	
R61 generalized hyperhidrosis **L74.5 focal hyperhidrosis** **L74.51 primary focal hyperhidrosis (rest depends on site)** **L74.510 axilla** **L74.511 face** **L74.512 palms** **L74.513 soles** **L74.519 unspecified** **L74.52 secondary focal hyperhidrosis**	
Basics	• Hyperhidrosis (excessive sweating) is caused by either sweat glands that respond excessively to normal signals, or by the body sending excessive signals to sweat to the sweat glands. It is common, occurring in at least 1% of the population. • Idiopathic hyperhidrosis is called primary focal hyperhidrosis and most commonly affects the axillae, palms, soles, face, and/or scalp. Sweating generally stops during sleep and should be bilateral in nature. • Hyperhidrosis may have a significant impact on a patient's self-esteem and quality of life. It often interferes with friendships, schoolwork, jobs, relationships, and other areas.
Evaluation	None
Treatment	• Treatment for hyperhidrosis often begins with aluminum chloride topical products. If these are not effective, the next line is often topical anticholinergics, glycopyrrolate or oxybutynin, iontophoresis, and/or botulinum toxin injections provided there are no contraindications. • Hyperhidrosis of axillae, hands, and/or feet: – Initiate therapy with a topical product such as Dry-sol or Certain Dry (over the counter). – Topical products must be applied to dry skin. You can achieve this by using the cool air feature on a blow-dryer if needed. Aluminum chloride mixed with sweat may lead to irritation. – If topical therapy does not provide adequate relief, consider treatment with glycopyrrolate or oxybutynin by mouth, provided there are no contraindications. Potential side effects include dry mouth, headaches, dizziness, blurry vision, heart palpitations, constipation. Care must be used to ensure the patient does not overheat when taking these medications. Medication breaks during periods of significant heat and/or exercise, adequate hydration, and education re: signs of hyperthermia must be provided.
RED FLAGS	• Excessive sweating that occurs during sleep • Generalized hyperhidrosis
Referral Details	When to initiate a referral: • Sweating that is unilateral • Sweating that occurs on the face with certain foods/triggers • Sweating that significantly interferes with patients' quality of life, self-esteem etc. • Sweating that does not respond to therapy

Common indications for referral

Molluscum contagiosum	
B08.1 molluscum contagiosum	
Basics	• Viral infection causing firm, shiny, dome-shaped papules with central umbilication that spares palms and soles • Can be associated with pruritus • Some lesions can become inflamed (generally, this indicates impending clinical improvement)
Evaluation	None
Treatment	• EDUCATION: This is a common, harmless virus that may last many months to several years. These children should not be excluded from group childcare settings or other activities. • No treatment is 100% effective. • No treatment prevents the spread of new molluscum. • New cases of molluscum can be observed clinically without treatment. If treatment is desired, options vary based upon location and number of lesions. • If families are referred to our office, they should receive counseling to set the expectation that we will also not have guaranteed treatments and rarely are able to "remove" them, though this is a common request we receive. This helps to prevent families feeling overly discouraged when they come to our clinic and are presented with similar treatment options and success rates. • Molluscum on the face, neck, axillae, inguinal folds, or genitalia: – Tretinoin 0.025% or 0.05% cream/gel to the lesions, 3 to 5 nights per week as tolerated. Note: topical retinoids may be irritating and should be avoided in patients with eczema. They should not be applied close to the eyes. • Molluscum on the trunk or extremities: – In-office treatments (cantharidin, curettage, or liquid nitrogen) every 4 to 6 weeks if available and pediatrician has experience with treatments. – YCANTH, the first FDA-approved treatment for molluscum, is now available. This is currently difficult to get approved by insurance and, if prescribed and obtained, is applied in the clinic setting. If families are hoping to have this treatment in our clinic (or in the primary care setting) they should be counseled that it is not always easily obtained and still not guaranteed to clear molluscum.
Referral details	When to initiate referral: • Most cases of molluscum contagiosum do not require dermatology referral • Symptomatic, rapidly progressing, or numerous molluscum lesions • Molluscum in immunosuppressed patients • Molluscum near the eyelid margin can, on occasion, cause chronic conjunctivitis. If your patient is experiencing conjunctivitis in the setting of molluscum near the eye, close monitoring and a referral to ophthalmology is warranted.

Common indications for referral

Nevi (moles)	
Start with D22 and the rest depends on site	
Basics	• It is normal to develop new moles in childhood and early adolescence. Moles may enlarge around puberty. • It is normal to see uniform growth or thickening of moles with overall growth of a child. • Congenital moles (moles presenting at birth or during infancy) are typically larger than acquired moles and may thicken and/or develop hair over time. • Educate families regarding the importance of regular applications of sunscreen, hats, sun-protective clothing, etc.
Evaluation	None
Treatment	None
RED FLAGS	Symptoms that require URGENT/EMERGENT consultation (when to call on-call provider, refer to ER, or refer for direct admission)
Referral details	When to initiate referral: • If a patient has been diagnosed with a dysplastic nevus, has a history of melanoma, or if there is a positive family history of either in 1st degree relative • Newborn with multiple congenital nevi • Sudden or worrisome mole changes (size, shape, or color) • Development of persistent symptoms (itching, pain, or bleeding) • If a lesion has been biopsied or removed and needs further evaluation (please include a copy of the pathology report with referral)

Common indications for referral

Onychomycosis (nail fungus)	
Specific ICD10 codes	
Basics	• Findings: nails that are thickened, brittle, discolored, separating from the nail bed, and/or have subungual debris • Adjacent skin involvement may be suspicious for fungal infection (red, scaly, or pruritic). • Recurrence is common and treatment does not always guarantee a permanent cure. • There is often exposure via one or multiple affected family members and they should also be treated by their primary care provider(s) when appropriate to minimize risk of recontamination.
Evaluation	Confirm presence of a fungal infection: • Send an adequate nail clipping for fungal culture. • The specimen is sent to microbiology in a fungal swab tube or sterile urine cup (results can take up to 4 weeks). Sometimes the results will also guide therapy based on the organism.
Treatment	Mild onychomycosis (mild nail discoloration of only a few nails): • Ciclopirox 8% nail lacquer solution nightly to the nails until clear Moderate to severe onychomycosis (brittle nails, subungual debris, etc) and fungal culture is positive for dermatophyte: • Terbinafine (comes in a 250 mg tablet and is given po q day) is preferred if there are no contraindications (eg, history of significant liver disease or potential drug interaction). • Can dose as follows: – <20 kg = 62.5 mg/day – 20-40 kg = 125 mg/day – >40 kg = 250 mg/day • Fingernails: 6-week course; toenails: 12-week course • Most healthy pediatric patients do not require blood work prior to starting an oral antifungal. If in doubt, hepatic function can be checked prior to initiating therapy. • Griseofulvin is rarely effective for onychomycosis.
Referral details	When to initiate referral: • Failure to respond to therapies above • Symptomatic or extensive nail involvement • Onychomycosis in immunosuppressed patients

Common indications for referral

Psoriasis	
L40.0 plaque **L40.1 generalized pustular psoriasis** **L40.3 palmoplantar pustulosis** **L40.4 guttate** **L40.54 psoriatic juvenile arthropathy** **L40.8 other psoriasis** **L40.9 psoriasis unspecified**	
Basics	• Findings: symmetrically distributed erythematous plaques, usually with thick, silvery scale • Common sites: scalp, diaper area, face, extensor elbows, knees, and gluteal cleft • Pruritus, Koebner phenomenon, and Auspitz sign may or may not be present
Evaluation	None
Treatment	• EDUCATION: Families should know that psoriasis is a chronic and relapsing disease • COMPLIANCE: Make sure patients are using the medications as prescribed before switching to another regimen. • Psoriasis severity and locations determine medications used in addition to the frequency and duration of treatments. • Topical steroids are typically used to treat a flare once to twice daily until as needed for flares, usually for 1 to 2 weeks, no longer than 15 days per month on average in order to minimize risk of steroid side effects (striae, telangiectasias, hypopigmentation). • You should dispense enough medication when prescribing topical medications. • For new onset guttate psoriasis (tiny papules and plaques that are often widespread), you might consider a throat or perianal swab culture if clinically relevant to check for a possible strep infection that can be associated with a flare. • Patients should moisturize several times per day with a bland, hypoallergenic cream or ointment. • You should ask about associated joint pain, redness, or swelling. • Psoriasis on the trunk or extremities: – Mild-to-moderate – triamcinolone 0.1% ointment twice daily as needed for flares • Psoriasis on the face, ears, eyelids, axillae, inguinal folds, or genitalia: – Tacrolimus 0.03% or 0.1% ointment or pimecrolimus 1% cream once or twice daily as needed for flares (medications are approved for children 2 years or older) – May also require hydrocortisone 2.5% ointment or triamcinolone 0.025% ointment 2-3x/week • Scalp psoriasis: – OTC salicylic acid, tar-containing shampoo, or prescription ketoconazole 2% shampoo daily or at least 2 to 3 times per week – AND – – DermaSmoothe FS Oil (fluocinolone in hypoallergenic peanut oil) or fluocinolone 0.01% solution once or twice daily as needed for flares in mild scalp psoriasis – OR – – Fluocinonide 0.05% solution or clobetasol 0.05% solution/gel/foam once or twice daily as needed for flares in moderate to severe scalp psoriasis

Referral details	When to initiate referral: • Mild or moderate psoriasis not responding to treatment after 2 months • Severe psoriasis with or without systemic symptoms • Suspicion for psoriatic arthritis warrants dermatology and rheumatology appointment • Significantly impacting self-esteem and quality of life

Common indications for referral

Scabies	
B86 scabies	
Basics	• Scabies is an infestation of the skin by the mite Sarcoptes scabei • Usually transmitted by close person-to-person contact, such as sibling to sibling or parents to children (especially mother to infant) • Severely itchy, especially at night • Usually distributed on the sides and webs of fingers, flexor wrists, extensor elbows, folds, peri-umbilicus, axillae, and genitalia • Infants often have palm/soles involved • Skin lesions in children are typically more inflammatory, and are often vesicular or bullous
Evaluation	Scabies is generally a clinical diagnosis in the primary care setting. Skin scrapings or microscopic evaluation in the clinic can be used for confirmation but are not always required.
Treatment	Treatment: • Permethrin 5% cream: apply to all areas of the body from the neck down to the toes and wash off after 8-14 hours. Repeat after 1 week. • Permethrin is typically used for children 2 months and older. In infants, permethrin should also be applied to scalp and face, avoiding the eyes and mouth. • Itching and lesions often persist for several weeks after successful treatment. Oral antihistamines and/or low to medium potency topical steroids are appropriate for relief. Control of transmission: • Recently used (within several days before treatment) clothing, linens, stuffed animals, etc. may be bagged for several days, machine washed on hot, and then ironed, dried in a hot dryer, or dry cleaned. • All household members and close contacts should be treated simultaneously if no contraindications, even if they do not have skin lesions/rash. The most common reasons we see treatment failure are when the entire household was not treated and/or the treatment was not repeated after 7 days. • Close contacts without skin lesions/rash may not need a second, repeat treatment.
Referral details	When to initiate referral: • Treatment failure despite proper treatment of patient and all household members • Persistent scabies infections, especially in immunosuppressed patients

Common indications for referral

Seborrheic dermatitis	
L21.0 capitis **L21.1 infantile** **L21.8 other seborrheic dermatitis** **L21.9 seborrheic dermatitis unspecified**	
Basics	• A common, benign skin condition in infants and young children that can be chronic • Often occurs in adolescents, when sebaceous activity tends to increase • The expected course is gradual resolution over a period of months to years • It is not necessary to treat all cases of seborrhea • Treatment should be initiated for moderate to severe cases and/or symptoms of pruritus/pain • A topical antifungal and topical steroid can be mixed together and used for flares on the face or body
Evaluation	None
Treatment	Scalp seborrhea: • Ketoconazole 2% shampoo, OTC selenium sulfide shampoo, or OTC Baker's P&S shampoo/solution 2 to 3 times a week (shampoo should be allowed to sit for ~5 minutes before rinsing) AND/OR • DermaSmoothe FS Oil (fluocinolone in hypoallergenic peanut oil) or fluocinolone 0.01% solution or mometasone 0.05% solution once or twice daily as needed for flares Face and body seborrhea: • Hydrocortisone 2.5% cream or triamcinolone 0.025% cream (or ointment if preferred) once to twice daily as needed for flares – AND/OR – • Ketoconazole 2% cream or otc clotrimazole cream once to twice daily as needed for flares
Referral details	When to initiate referral: • Moderate seborrheic dermatitis not responding to therapy after 2 months • Severe or widespread eruption • If the diagnosis is in doubt

Common indications for referral

Tinea capitis	
B35.0 Tinea capitis	
Basics	Findings may include: • Scaly plaques with alopecia • Patches of alopecia with black dots • Widespread scaling with subtle hair loss • Kerion
Evaluation	• A fungal swab culture should be taken prior to starting treatment – This may be obtained by moistening a fungal culture swab with the media bottom of the culture tube followed by vigorously rubbing of the affected area (results can take up to 4 weeks). • If high clinical suspicion, it is generally appropriate to start treatment while waiting for culture results. • Testing of liver function with griseofulvin or terbinafine is unnecessary in otherwise healthy children and is usually only necessary if treating for 8 weeks or longer • If signs of bacterial infection (pustules, oozing, etc), please obtain a bacterial swab culture and treat appropriately
Treatment	• Ketoconazole 2% shampoo or OTC selenium sulfide shampoo 2 to 3 times weekly – AND – • Griseofulvin Microsize 20-25 mg/kg/day po once daily or divided twice daily for 8 weeks – OR – • Terbinafine (comes in a 250 mg tablet and is given po q day) for 8 weeks – <20 kg = 62.5 mg/day – 20-40 kg = 125 mg/day – >40 kg = 250 mg/day • Fomites (objects which may retain and spread infection such as combs, hats, etc) should also be disinfected. • Incomplete treatment is common. Assess the consistency it is given in cases of poor treatment response.
Referral details	When to initiate referral: • Recalcitrant and/or severe cases, such as those with kerion, scarring, or severe alopecia

Common indications for referral

Tinea versicolor	
B36.0 tinea versicolor	
Basics	• Caused by the lipophilic Malassezia yeast species (part of the normal microflora of the skin) • Tends to occur more frequently in tropical climates • Associated with sebaceous gland activity (so more frequently seen in pubertal adolescents and adults) • Recurrences are common • Skin dyspigmentation can last months after condition treated
Evaluation	None
Treatment	• Ketoconazole 2% shampoo or OTC selenium sulfide shampoo applied to affected areas daily until clear (left on for 5 minutes prior to rinsing) • Topical antifungal creams such as ketoconazole 2% cream or otc clotrimazole cream once to twice daily until clear
Referral details	When to initiate referral: • Lack of response to therapy after 2 months • Severe or widespread eruption

Common indications for referral

Vitiligo	
L80 vitiligo	
Basics	Acquired, discrete, well-demarcated, uniformly white macules surrounded by normal skin in the absence of inflammation or textural changes
Evaluation	• None • Rarely, vitiligo in children is associated with thyroid dysfunction. Research does not support routinely checking thyroid function in all children with vitiligo, but is indicated in cases of rapid disease progression, thyroid disease signs/symptoms, and/or strong family history of thyroid disease.
Treatment	Vitiligo on the face, axillae, inguinal folds, or genitalia: • Tacrolimus 0.03% or 0.1% ointment or pimecrolimus 1% cream once to twice daily until clear (medications are approved for children 2 years or older, however, are considered off-label for vitiligo which may make it difficult to obtain insurance coverage.) • Opzelura (ruxolitinib topical) cream is approved for children 12+ years of age and is safe for use on all external areas, including thin-skinned areas such as face, eyelids, and axillae. Vitiligo on the trunk or extremities: • Triamcinolone 0.1% ointment once or twice daily on the weekdays and tacrolimus ointment or pimecrolimus cream once or twice daily on the weekends • Opzelura (ruxolitinib topical) cream is approved for children 12+ years of age and is safe for use on all (external) areas, including thin-skinned areas such as face, eyelids, and axillae
Referral details	When to initiate referral: • Poor response to the above treatments after 3 months • Extensive or distressing vitiligo • Rapidly progressing vitiligo

Common indications for referral

Warts	
B07.0 verruca plantaris **B07.8 verruca vulgaris (common warts)** **B07.9 viral wart unspecified** **A63.0 anogenital warts**	
Basics	• New cases of warts can be observed clinically without treatment. If treatment is desired, options vary based upon location and number of lesions. • No treatment is 100% effective, and some OTC therapies such as salicylic acid may achieve very similar and sometimes superior results to in office therapies. Most warts will not resolve after only one treatment, and consistency in treating is key for resolution. • It cannot be overemphasized to families that warts can last many years, are very often slow to resolve, treatment response varies widely, and they are rarely able to be "removed" despite this being frequently requested by families.
Evaluation	None
Treatment	Warts on the face, neck, axillae, inguinal folds, or genitalia: • Adapalene 0.1% gel OTC or Tretinoin 0.025% cream Rx once daily to the lesions, start 2-3x/week and can advance to nightly as tolerated. Note: Topical retinoids may be irritating and should be used with caution in patients with eczema. They should not be applied close to the eyes. Warts on the trunk or extremities: • OTC salicylic acid 17% solution or salicylic acid 40% (Wart Stick or Compound W bandages) every 1-2 nights. • Warm soak followed by gentle abrasion with pumice stone or nail file once weekly, not to be used on other areas, stop at first sign of very mild bleeding and wait to reapply topical medications until well-healed. • In-office treatments (cantharidin, candida antigen, curettage, or liquid nitrogen) every 4 to 6 weeks if available and pediatrician has experience with treatments.
Referral details	When to initiate referral: • Most warts do not require referral to dermatology • Symptomatic, rapidly progressing warts • Warts in immunosuppressed patient • Significant bullying or self-esteem issues related to the warts

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