When a patient presents to the dermatology office complaining of scalp itch, he or she may report frustration with the recurrent symptom, a history of failed at-home therapies, and concern about the appearance of associated lesions on the scalp. The clinician recognizes that several dermatoses may be associated with scalp itch in children and adults (Tables 1, 2). Successful management depends on accurate diagnosis and initiation of an effective, patient-friendly treatment regimen.

**Step 1. Visual Examination**
Evaluation of primary lesions will provide clues to the proper diagnosis. While thickened, silver, scaling plaques obviously indicate psoriasis, a diffuse, fine, white scale—with or without erythema—is a sign of seborrheic dermatitis. Scaling in tinea capitis tends to be well-demarcated and erythematous, with central clearing and fine peripheral scale, with or without associated hair loss. In African-American patients tinea capitis can resemble non-inflammatory...

**Salary and Benefits: Negotiate from Strength**

Anyone seeking employment knows that the ideal position may be elusive. Sometimes a candidate must set aside certain less important preferences in order to find a job that meets critical criteria. But a fair salary is not a priority to set aside. According to Society of Dermatology Physician Assistants’ (SDPA) President Joe Monroe, PA-C in a statement on the association website, some newly employed dermatology PAs are earning less than $30,000 annually in “apprentice positions.” This is far below the American Academy of Physician Assistants’ (AAPA) recently reported average national salary for full-time clinically practicing PAs of $84,396 (aapa.org). Although this figure is a national average across a range of specialties, it is illustrative.

Physician assistants should earn a salary that reflects their level of training and experience. Most dermatology PAs earn a base salary with bonuses based on production (usually a per-...
For children and adults, Cloderm® is the mid-potency topical steroid with proven safety in extensive clinical trials.

- Uniquely formulated to be selectively absorbed where it’s needed\(^1\)
- Designed to minimize the likelihood of local and systemic side effects
- Proven efficacy as early as Day 4\(^1\)
- The most common adverse events with Cloderm include dryness, irritation, folliculitis, acneiform eruptions, and burning. Cloderm is contraindicated in patients who are hypersensitive to any of the ingredients of this product. As with all topical corticosteroids, systemic absorption can produce reversible HPA-axis suppression.

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Avondale
corticosteroids. Corticosteroids are bound to the liver and are then excreted by the kidneys. Long-term use, and the addition of occlusive dressings, may be more susceptible to systemic toxicity. (See PRECAUTIONS: Pediatric Use.) If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted.

In the presence of dermatological infections, the concomitant use of an appropriate antifungal or antibacterial agent should be considered. If a favorable response does not occur promptly, the corticosteroid should be discontinued and the infection handled appropriately.

Information for the Patient:
Patients using topical corticosteroids should be advised not to use more than the amount recommended for the area to be treated because excessive absorption of the topical corticosteroid may cause systemic adverse effects. (See PRECAUTIONS: Information for the Patient.) If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted.

Precautions:
1. This medication is to be used as directed. Do not use in the eyes, ears, or nose. Do not use on cuts, abrasions, or skin eruptions. Do not bandage or cover the treated area with an occlusive dressing. These reactions are listed in an adverse reaction section.
2. This medication is to be used at the recommended dosage levels. The more potent corticosteroids achieve local therapeutic effect in man. Nevertheless, caution should be exercised in the use of corticosteroids for simple dermatoses.
3. The treated skin area should not be exposed to excessive heat, trauma, or extended sunlight.
4. Patients should report any signs of local adverse reactions especially under occlusive dressing.
5. Parents of pediatric patients should be advised not to use this product in the diaper area, as it will be removed by clothing.

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Five Resolutions for Dermatology PAs

The year is still new. Here are five ways to improve your professional and personal life and the care you provide patients.

“Making resolutions is a cleansing ritual of self-assessment and repentance that demands personal honesty and, ultimately, reinforces humility. Breaking them is part of the cycle.”
—Eric Zorn

You just have to love the New Year! Three hundred sixty-five fresh untouched days to right old wrongs, relinquish bad habits, improve thyself, and start anew. I feel more positive and energetic just thinking about the opportunities ahead! A short way into the new year, the gym is still packed with newly resolved exercisers and all that holiday cheer is becoming a memory. In the spirit of self-assessment and improvement, I’ll propose a list of resolutions for the dermatology PA in 2007.

Resolution #1
Resolve to be the kind of person that other people want to work for.

We all have numerous different roles and responsibilities in life, and we want to excel at all of them. We want to be good spouses, parents, children, and grandparents; at work we want to be excellent clinicians and solid employees. But, perhaps one of our greatest roles and responsibilities is that of office leader. It doesn’t matter if you have one medical assistant or a team of assistants and ancillary staff, you are a leadership presence within your practice. Given the volume of patients that we see and the number of procedures we perform, dermatology is probably one of the few medical specialties in which PAs have so much direct leadership responsibility. It’s a great opportunity, but it’s an even greater responsibility.

To really be an effective office leader, you have to know the people you’re working with. What are their strengths, their weaknesses, their likes and dislikes? How do they like to be rewarded and praised? What motivates and inspires them to perform at a higher level? These are things that can’t be inherently known, nor are they the same for each person. It takes time, open dialogue, and a genuine interest in others before you can really affect significant positive change in your coworkers’ performance and attitude.

When I think back on the really great people I’ve worked with, I come away with a short list of attributes and characteristics.

They were all great communicators who took the time to make sure they were understood. They all had a genuine interest in me as a person and in my immediate family. They were all consistent in their praise and consistent in their discipline. They valued their honesty, integrity and character more than their bank accounts. It’s the rare person that can be a great leader, but it’s something that we should all aspire to be.

So, this year, be quicker to praise and slower to discipline. I’ll try to mimic the behaviors that I’m expecting from others and lead by example. I’ll spend more time getting to know my co-workers, and more importantly, letting them know the real me. This year I’m going to be the person I always wanted to work with.

Resolution #2
Resolve to appreciate and enjoy every day.

I still can’t believe how incredibly lucky I was to find medicine, and specifically dermatology. Some people were just born to be caregivers, and the rest of us just somehow stumble into it later in life. We have so many opportunities to meet interesting people, make diagnoses that change lives, and prescribe treatments that improve ailments. But it can sure be a grind sometimes! Too many patients, not enough time, too little sleep, too many commitments—after a while it adds up to a lot of stress. It seems the harder you work, the deeper the hole gets. It all seems pretty hopeless and helpless sometimes. While it sounds like depression, it’s probably something closer to that bane of the working person—burnout!

So, this year I’m going to try to enjoy something about every day. If it means cutting back on my schedule a little so I can go to more swimming practices, I’ll do it. If it means picking up my dusty tennis racquet on Saturday morning, I’m going to do it. If it means just sitting back and reflecting on the past and anticipating the future, then I’ll do that too. I’m going to go on to be disciplined with my sleep and exercise as I am with my office schedule. But above all else, at least once every day, I’m going to lean back, smile, and realize I’ve succeeded in life. Despite all the adversity, failures, and disappointments, I’m supremely satisfied and lucky to be in this position. I’m sure most of you feel the same way…or you will if you make time to reflect.

Resolution #3
Resolve to get organized this year.

I just can’t believe how much paper there is in life! Medical journals, bills, general correspondence, solicitations, advertisements, etc. The pile on my desk is high enough to make Sir Edmund Hillary get a nosebleed! Then there’s the computer disorganization, with all the e-mails, downloaded files, spreadsheets, half-written articles—it’s no wonder my desktop is just slightly faster than the Commodore 64 model I had in high school!

While most people think that disorganization is just one symptom of procrastination, I don’t see it that way. My wife would tell you...
that I have my paper very nicely organized into more than 40 stacks on the office floor. I’m slowly getting around to each of them and just yesterday I finished up my 2001 income taxes! Kidding aside, something really must be done. Disorganization saps our energy, motivation, and efficiency. No wonder we would rather spend time in the exam rooms than our offices. There’s much more work to be done on our desks than on the exam table, and little of it is mentally stimulating!

So, get out the label maker, buy a box of manila folders, and put the Sharpie to work. Keep what’s important, and toss the rest. Make a conscious effort to set aside time each day to manage some of the paperwork and get more organized. Start to meet obligations and deadlines ahead of schedule, because you plan work as vigorously as you plan fun. This is going to be a great year, with a lot less clutter. Really, I mean it this time!

**Resolution #4**

**Resolve to learn a lot more than you already know about dermatology.**

I’ve said it before and I’ll say it again, dermatology is the most fascinating, diverse, and occasionally frustrating specialty in the medical universe. We have an amazing array of diagnoses and disease processes with complex names, synonyms, laymen’s terms, and descriptions. It’s really quite maddening to think of everything there is to know in this specialty. I think most of us spend a lot of time focusing on the common diseases, the differential diagnoses for common problems, and have a working knowledge of the “zebras.” We know the common things and their variants when we see them, often before we even here the medical history and without biopsy, or labs. We also know when things fall outside of the “norm” or just don’t look right.

Then, just when you start to feel comfortable, efficient, and effective you get slapped back to reality. Someone comes in with a rash that doesn’t fit any diagnosis. Is it a drug eruption? A viral exanthem? An atypical variant of something common? You search your memory, have you seen it or something similar before? Have you read anything about this sort of condition? It doesn’t seem to matter if you’ve been in dermatology for one year or 10, we all have these challenging moments. But, you’ll have a lot fewer if you continuously build on your knowledge base and go back to review the common things on a regular basis.

In 2007, I think the Comprehensive Review Notes in Dermatology for the Physician Assistant is a great place to start. This 12 chapter, nearly 500 page binder has been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams. It’s been used by dermatology residents for years to prepare for their board exams.

**Resolution #5**

**Resolve to get more involved in my local, state, and national PA organizations.**

Despite more than 40 years of history, the PA profession is still in its toddler phase. We have finally established our place in the contemporary healthcare landscape due to the tireless efforts of the PAs who have gone before us. PAs now work in virtually every medical specialty and our numbers are growing steadily. This is especially true in dermatology. Just five short years ago when I joined the Society of Dermatology PAs, my assigned member number was 283. Now the newest Society members are get numbers in the 1400s. Estimates vary, but there are probably another 200-300 PAs that work in dermatology but are not yet members of the Society. The SDPA is the only professional organization that represents the professional interests of physician assistants in dermatology. Its leadership consists of unpaid volunteers that work countless hours at night and on weekends to meet the goals of the organization. This situation is not unique to dermatology or the SDPA. I’ve seen it with virtually every PA organization that I’ve been a part of in the last 10 years, including other specialty organizations, State PA Chapters, and even the AAPA.

A common excuse I’ve heard for not getting involved is, “I just want to practice medicine, I don’t want to get caught up in the politics.” I think you would be surprised to learn how little politics really exists in PA organizations. Most PA leaders realize how much work there is to be done and are extremely grateful for any assistance they can get. The PA leaders I’ve known have been very open individuals, generous with their time and knowledge. You don’t have to run for office, chair a committee, or speak in public to get involved. Find an area that interests you, let somebody know, and jump right in.

**The Resolution Solution**

It’s easy to make resolutions and easier to break them. Don’t measure success by how quickly or how well you progress. Instead, congratulate yourself for making the effort. Set aside time to achieve your goals, enhance your working environment, sharpen your clinical skills, advance your specialty and improve your day to day experiences. Look for sources and resources, such as the SDPA and local PA society, that can help you and that you can help, as well.
Scalp Itch
Continued from p. 1

ry seborrheic dermatitis, presenting as fine scale without erythema.

Discoid lupus erythematosus presents with asymmetric, well-defined, elevated, red to violaceous flat-topped plaques with firmly adherent scale. Follicular plugging is prominent.

With time, irritation, and manipulation (patient scratching and picking), the thick, lichenified plaques of lichen simplex chronicus can progress to prurigo nodularis. In prurigo nodularis, papules or plaques are elevated on an erythematous base; lesions are often excoriated. Note that patients may be reluctant to admit history of pruritus. Asking if they itch or whether they scratch the area may cause a patient to become defensive. Instead, ask the patient how these lesions bother him or her and rely on your clinical observation to assess a possible neurocutaneous element to the presentation.

Actinic keratoses are rough and scaly papules or red or yellowish crusty papules, often on an erythematous base. Seborrheic keratoses are waxy, tan-brown or black macules and papules known for their characteristic “stuck-on” appearance. Tinea annulacea presents as large, oval, yellow-white plates of scale that may have a warty or papillated surface firmly adhered to the scalp and hair.

Allergic contact dermatitis may be characterized by bright red patches that are well-demarcated with or without scale, often associated with pruritus. Patients will often have a history of newly applied topical and sometimes oral products or agents.

When assessing children, rule out infestation. In addition to active lice, check for nits, which are extremely pruritic and adhere to the base of the hair shaft near the scalp.

Finally, some patients will present with what is commonly called “seasonal scalp itch,” a generalized scalp pruritus of unclear etiology often with associated erythema or minor skin trauma (resulting from patient scratching) but usually with no clearly identifiable lesions. Seasonal scalp itch is common and may have many causes. Humidity, “dry scalp,” or stress may be implicated, as well as oral medications, hair products, hygiene, or metabolic disorders.

Occupational exposure associated with wearing headgear, hairnets, or sports equipment may also play a role. Ultimately, the reasons people itch are as varied as the mechanisms that may precipitate the phenomenon.

Although these general descriptions of clinical features share some common characteristics, certain elements of the presentation direct the differential diagnosis. A thorough patient history can further assist diagnosis in many cases, providing details about the onset and duration of scalp itch and associated lesions.

Step 2. Additional Testing

Clinical evaluation and assessment of the primary lesions’ size, shape, color, and distribution along with consideration of the patient history is the first “test” and in some cases sufficient for the clinician to confidently state a diagnosis. Response to standard therapy may be viewed as confirmation of the diagnosis. For example, when it is difficult to differentiate a steroid responsive dermatitis from a fungal etiology, sustained response to a topical corticosteroid will confirm the prior diagnosis; although corticosteroid therapy may initially calm the rash, it does not eliminate the fungus, leading to flare with continued use.

Additional tests may be necessary to reach a firm diagnosis. Tests to consider include:

- KOH preparation to rule out fungal etiology.
- Skin biopsy when clear distinction between various dermatoses is not clinically evident or disease is non-responsive to traditional therapeutic interventions. In the case of scarring alopecia of unknown origin, a biopsy may be used to identify discoid lupus erythematosus.
- Patch testing if an allergen is suspected.
- When the review of systems reveals that the patient has more generalized itch (scalp pruritus might be most troubling, thus prompting the initial appointment) or when reasonable treatment attempts have failed, consider routine laboratory testing to uncover possible systemic causes of generalized pruritus. Order tests based upon severity and symptoms. For example, a patient who admits feeling sluggish or hyper may be experiencing hyper- or hypo-thyroidism. Testing may include a comprehensive metabolic panel, CBC with differential, TSH with T3 and T4. ANA levels generally are not positive in discoid lupus erythematosus but will be for systemic lupus erythematosus. Though SLE typically presents with generalized itch, localized itch may be reported.

Of course in addition to these tests, a comprehensive occupational and social history may reveal important clues. If the social history reveals recent stress, suspicion of a neurodermatitis may increase. A patient history of occupational sun exposure increases the possibility of AKs and cutaneous cancers.

Step 3. Identify Treatment Challenges

Clinicians are familiar with standard therapeutic interventions for the various scalp dermatoses discussed above. Options include antifungal shampoos, oils, topical steroids, and antihistamines. Rather than review all of these options in depth, we believe it is helpful to review important considerations that help guide treatment selection and support successful pharmacologic management.

Compliance with the therapeutic regimen is critical. With scalp dermatoses, two primary issues may influence compliance: 1) Ease of application to hair-bearing scalp and 2.) visibility of scalp dermatoses and the role of hairstyle in a person’s appearance. It is important to choose products the patient can apply easily to the scalp and that will not interfere with the patient’s appearance once applied. If “messier” products or occlusion are necessary, recommend use at bedtime or when convenient to the patient’s schedule. Generally for treatment of the scalp, topical foam formulations offer greatest ease of use because they can be easily applied and spread over large areas with no mess. Solutions are also easy to apply but may drip and are sometimes “oily” feeling. Gels are an option for use on the hair-bearing scalp but are best reserved for localized application. Shampoo formulations provide effective short-contact drug delivery to the entire scalp.

Question patients about insurance coverage, which may influence access to a particular vehicle formulation.

Use of multiple products, either in combination or via two or more applications per day, may be necessary. However, it is important to simplify regimens as much as possible. To further support compliance, clearly write out instructions for the patient. Provide a timeline of anticipated response and schedule follow-ups in a period of two to three weeks rather than a month or more. Faster follow-up allows assessment of response to therapy, thus confirming the diagnosis or permitting re-evaluation.

Be particularly sensitive to the needs of elderly patients. Older patients may find medications expensive or directions for use confusing. Keep in mind that patients living in a skilled nursing facility may not have treatments administered as often as directed, so you may need to alter the regimen for optimal results. When using topical corticosteroids, be aggressive. Use the highest appropriate potency for a shorter period of time to provide better results than longer-term use of a lower-potency agent. A high-potency agent

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Table 1. Dermatoses Associated with Scalp Itch in Children

<table>
<thead>
<tr>
<th>Seborrheic Dermatitis</th>
<th>Tinea Capitis</th>
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<tr>
<td>Atopic Dermatitis</td>
<td>Tinea Amiantacea</td>
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Table 2. Dermatoses Associated with Scalp Itch in Adults

<table>
<thead>
<tr>
<th>Neurodermatitis</th>
<th>Seborrheic dermatitis</th>
<th>Psoriasis</th>
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</thead>
<tbody>
<tr>
<td>Tinea capitis</td>
<td>Seborrheic keratoses</td>
<td>Lichen simplex chronicus</td>
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<tr>
<td>Prurigo nodularis</td>
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“Seasonal scalp itch”
If you currently work with local schools to provide sun safety education or are considering getting involved, consider the SunSafe model that incorporates parents, coaches, and teachers. According to a study in Pediatrics, a collaborative approach to sun safety education involving teen peer leaders, health professionals, and other adults produced better sun protection behaviors on average among participating teens compared with teens not involved in similar programs.

For your older patients at risk for skin cancer, consider couples training for skin exams. An Archives of Dermatology study found that those who cohabitate are more likely to perform skin exams for melanoma; couples may encourage each other to do skin exams and help each other to perform them. Individuals trained to perform self-exams seek treatment at an earlier stage of melanoma and are less likely to die from it.

Finally, as you emphasize physical sun protection in your message to patients, be sure they understand the true role of clothing in blocking UVB. Standard fabrics seem to provide relatively little protection, especially when wet. Therefore, emphasize to patients the need for specially-treated sun protective clothing and hats. Recommend at-home UV-blocking laundry additives. These have been shown to effectively reduce UV transmission through multiple subsequent soap and water washings.

**Mistakes and Misconceptions**

Some common mistakes hinder successful management of scalp dermatoses. A common problem is under-treating pediatric patients. Concerned about risks associated with corticosteroid use, clinicians may either use a product whose potency is too low or cut short the treatment period. In reality, using higher-potency topical corticosteroids to help reduce scale and thereby enhance penetration of other topical therapies is more effective than using lower-potency agents. Be willing to reassess the diagnosis if standard interventions are not yielding the expected response. While poor compliance may account for some treatment failures, incomplete response or lack of response to treatment generally suggests that the initial diagnosis was incorrect. Re-evaluation of lesions, a comprehensive patient history, and additional tests may identify the appropriate diagnosis.

Though we’d like to think it never happens, due to scheduling pressures some clinicians may initiate treatment without first obtaining a biopsy, even when a biopsy is clearly indicated. It is always better to err on the side of caution: if there is any doubt, obtain a biopsy.

As noted above, patients must receive ample education about the nature of their condition and its treatment. Provide educational brochures and handouts. And give each patient a written, individualized instruction sheet. Patients who experience a relapse may feel that therapy “did not work.” To avoid this, be sure that patients understand the recurrent nature of their condition and the need for faithful adherence to the treatment regimen. Advise patients what to do should they experience a flare (whether to reintroduce the intervention medication, schedule an appointment, etc.). Finally, do not assume that lack of response signifies non-compliance. Limited or no response may signify an inaccurate diagnosis. Perhaps the diagnosis is accurate but the prescribed drug dosage or potency is too low. Perhaps the patient needs a therapeutic boost (such as occlusion of a topical corticosteroid). Maybe the pharmacy provided the patient the wrong medication. Assess all factors to identify and correct the problem.

**Start from Scratch**

Approach each case with a fresh perspective. Careful visual exam coupled with patient questioning may lead to an accurate diagnosis and direct a course of treatment. In certain cases, additional questioning and testing will be necessary to identify the underlying etiology.

When treating scalp dermatoses, prescribe patient-friendly regimens that promote compliance. Provide clear instructions and offer education about the nature of the dermatitis and potential recurrence. Emphasize maintenance interventions to promote scalp health and minimize the risk of recurrence.

In the event of non-response, clinicians willing to re-assess the diagnosis and the prescribed regimen have the most satisfied patients.
As a dermatologist, you face a new challenge with each patient.

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