Society of Rural Physicians of Canada
26TH ANNUAL RURAL AND REMOTE MEDICINE COURSE
ST. JOHN'S NEWFOUNDLAND AND LABRADOR
APRIL 12 - 14, 2018

• 267

Dr. Rochelle Dworkin • HANOVER • ON

DERMATOLOGIC PROBLEMS IN PREGNANCY

It's not all PUPP! Come and learn in an interactive fashion about the skin in pregnancy, especially rare conditions that you don't want to miss. The talk will be applicable to all doctors who provide antenatal care at any stage during a pregnancy.

1. Be able to diagnose and treat the most common skin problems in pregnancy. 2. Explore which conditions can lead to future adverse pregnancies 3.Determine why some skin conditions worsen in pregnancy, and why some get better.

PREGNANCY AND THE SKIN

SRPC Annual Meeting 2018
St. John's NFLD
Dr. Rochelle Dworkin

Objectives

- To understand the normal physiologic changes of pregnancy as it relates to skin and hair.
- To be able to differentiate the various rashes specifically associated with pregnancy and know which ones to worry about.
- To understand why some general skin conditions improve in pregnancy, why some get worse and what you can do for the suffering pregnant woman.

Disclaimer

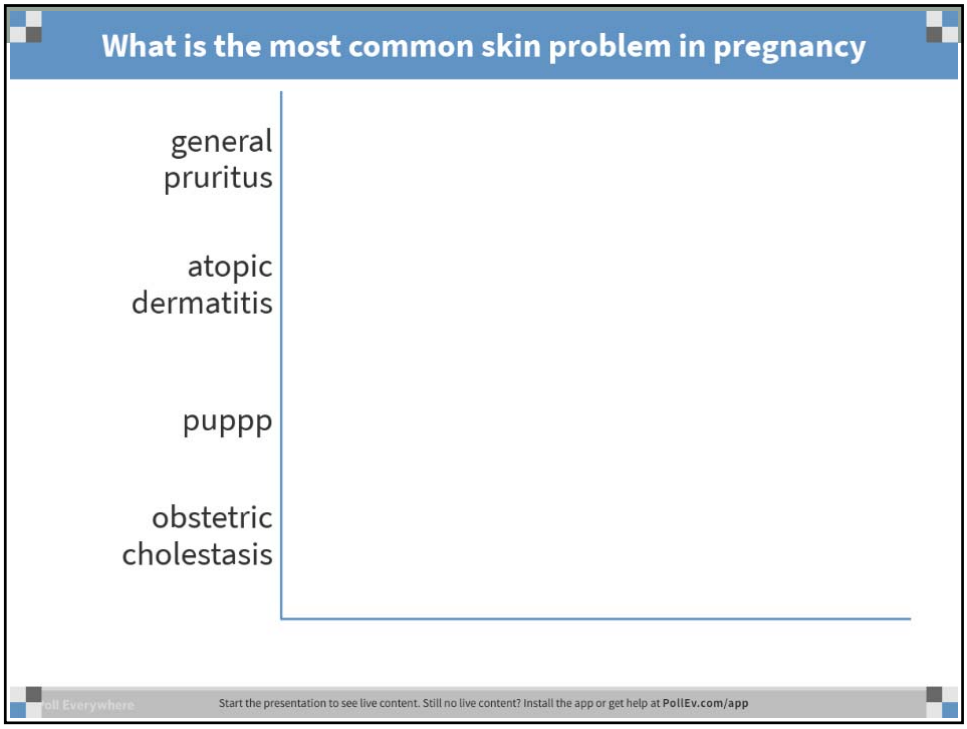
- I do not have any association with any pharmaceutical company and most likely never will.

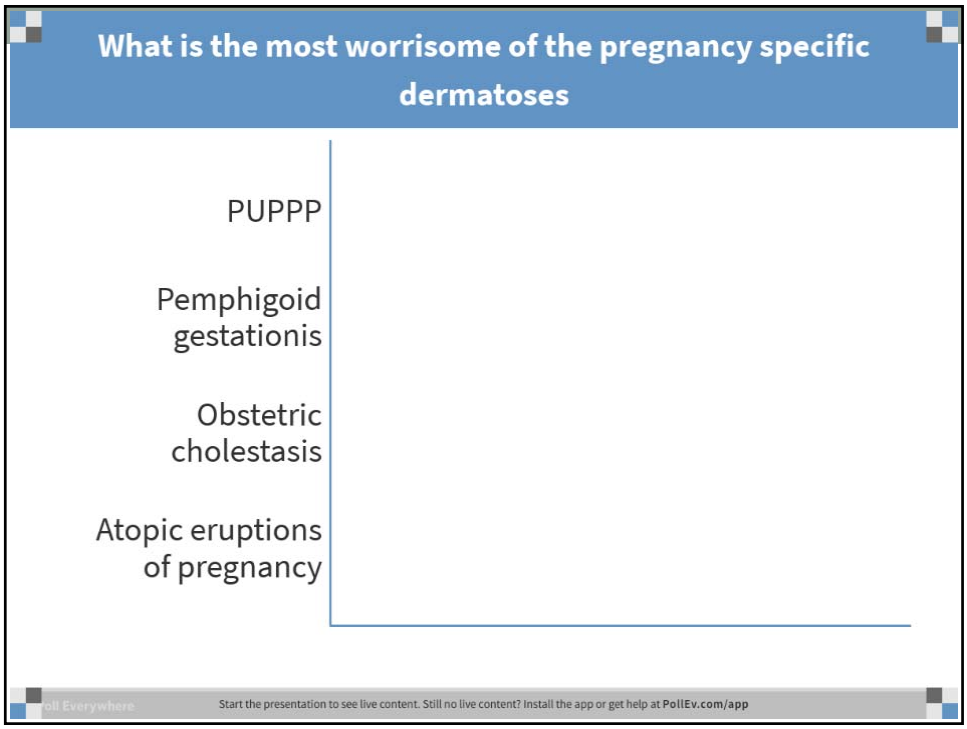
Activate your phones

- To join polleverywhere:

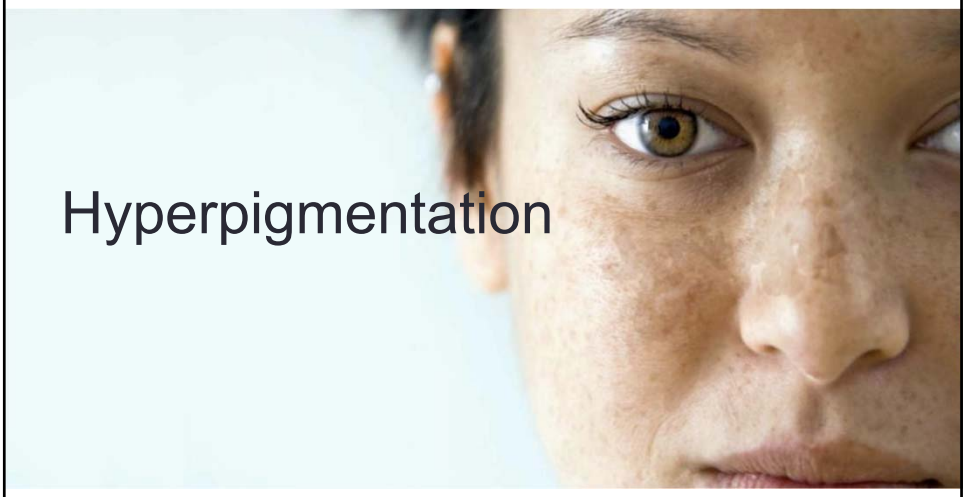
Text Rochelledwor643 to

37607


What is the most common skin problem in pregnancy
general pruritus
atopic dermatitis
puppp
obstetric cholestasis
Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

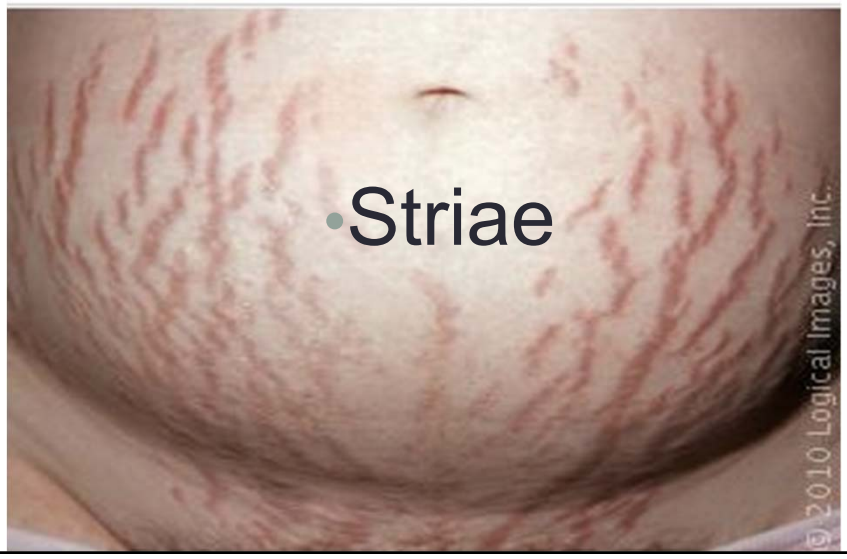

What is the most worrisome of the pregnancy specific dermatoses
PUPPP
Pemphigoid gestationis
Obstetric cholestasis
Atopic eruptions of pregnancy
Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

Physiologic changes



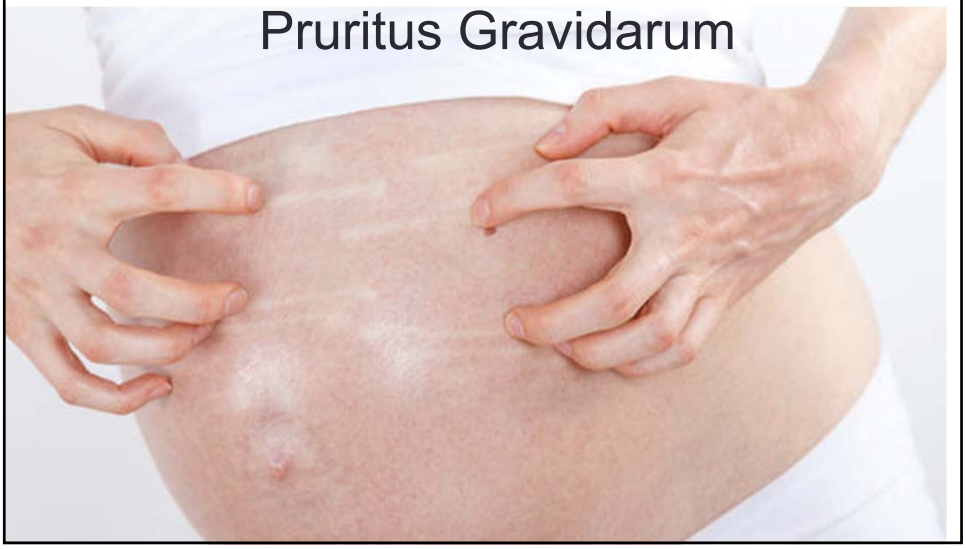
Hyperpigmentation

Physiologic changes



- Striae

Physiologic changes



Physiologic changes

- Hair changes:
  - Mild hirsutism, mild thickening of scalp hair
  - Possibility of telogen effluvium post partum.

- Nail changes:

-transverse and longitudinal grooving
-brittle
-distal onycholysis

- Resolves post partum

Physiologic changes

- Vascular changes

Leads to:
-spider nevi
-palmar erythema
-pyogenic granulomas
-facial flushing
-varicosities
-non-pitting edema

Physiologic changes

Changes in glandular activity

-Increased sebaceous and eccrine gland activity

-Decreased apocrine gland activity

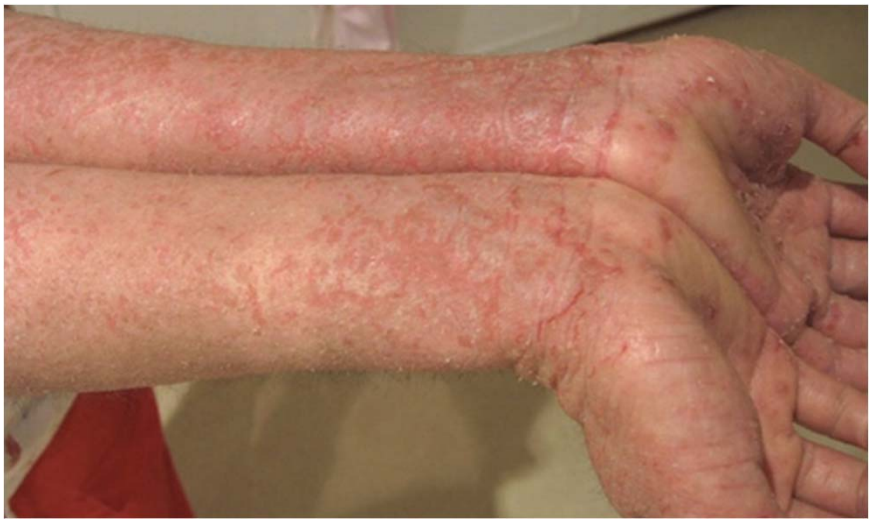
Specific Dermatoses of Pregnancy

- Atopic eruption of pregnancy
- PEP/PUPPP
- Obstetric Cholestasis
- Pemphigoid Gestationis

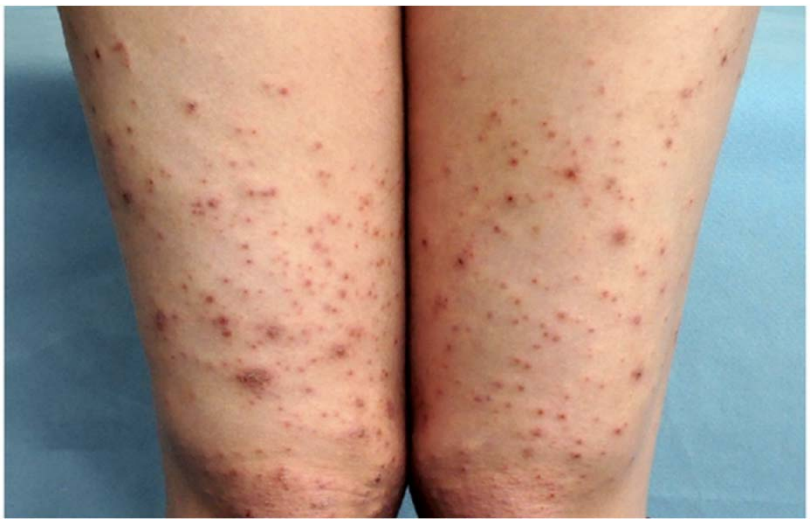
Atopic Eruption of Pregnancy

- Most common of the pruritic pregnancy specific dermatoses
- Onset usually before the third trimester
- Benign, self limited pruritic rash of pregnancy in patients with a personal or family history of atopic dermatitis
- 2 types – E(exzematous) type:2/3
- P(prurigo) type: 1/3

Atopic Eruption of Pregnancy



Atopic eruption of pregnancy



Atopic Eruption of Pregnancy

- (+)ve family history
- Pruritus + prurigo(papules) or dermatitis
- Follicular variant also recognized
- Secondary findings of excoriations and secondary infection
- 20% of cases with pre-existing AD
- 80% of cases present for first time in pregnancy
- Location=Generally - face, neck ,between breasts, flexural limb surfaces

Atopic Eruption of Pregnancy

Diagnosis

- History and Physical
- Blood tests may show elevated IgE
- Non-specific histopathology
- Negative DIF.

Atopic Eruption of Pregnancy

Differential Diagnosis

- Other specific pregnancy dermatoses - PG, PUPP, ICP
- Dermatoses coinciding with pregnancy – scabies, pityriasis rosea, allergic rashes, drug eruption

Atopic Eruption of Pregnancy

Treatment

- Mild cases – mild/moderate TCS
- Severe cases – potent TCS/short course of steroids/UVB
- Pruritis will not be relieved by antihistamines but can use for sleep
- General measures
- Treat bacterial secondary infections

Atopic Eruption of Pregnancy

Outcome?

PEP/PUPPP

Polymorphic **E**ruption of **P**regnancy

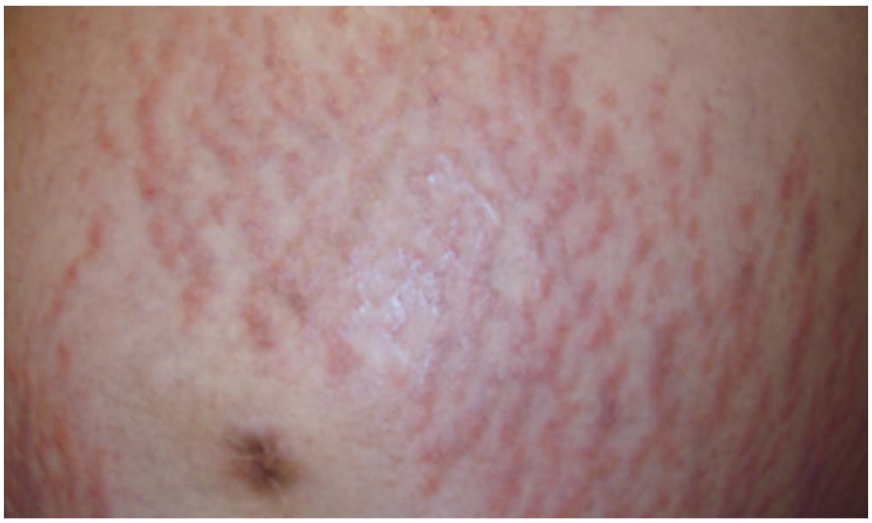
or

Pruritic and **U**rticarial **P**laques and **P**apules of **P**regnancy

PEP

- common 1:160
- Primips
- Increased incidence in multiple gestation, xs weight gain in pregnancy
- 3rd TM or can be immediate post-partum

PEP



PEP

- Etiology:

PEP

Diagnosis

- History and physical
- Histopathology: Typical path report “dermal edema, scant eosinophils, perivascular lymphatic infiltrate”…...
- DIF negative

PEP

Differential Diagnosis

- Other specific dermatoses of pregnancy
- Coinciding disorders – scabies, eczema, drug eruptions, erythema multiforme, urticaria.

PEP

Treatment

- Mild -sedating antihistamines (first generation)
- -emollients
- -mild TCS
- Moderate – moderate potency TCS
- Severe – potent-ultrapotent TCS
  -short course of oral prednisone
- -Consider IOL if resistant to Rx
- General measures for all

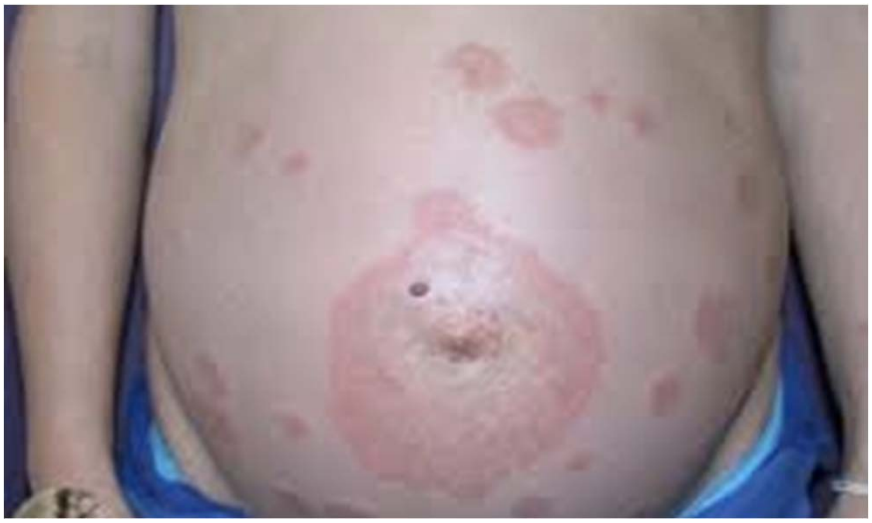
PEP

Outcome?

Pemphigoid Gestationis

- AKA – Herpes gestationis
- Rare but important to know about as implicated in adverse pregnancy outcomes and .
- 1:60,000
- Usually 3rd TM, immediate post partum

Pemphigoid Gestationis



Pemphigoid Gestationis

Diagnosis

- History and physical
- Biopsy will confirm:

Pathology – subepidermal blisters containing eosinophils

DIF - (+)Ve – "linear C3 basement membrane zone deposition"

Pemphigoid Gestationis

Treatment

- Mild: moderate->potent TCS, emollients, 1st generation antihistamines
- Severe –oral prednisone (50mg-100mg/day) cyclosporin, azathioprine, plasmapharesis, IVIG
- IOL
- General measures

Pemphigoid Gestationis

Outcome?

- Can improve in final weeks of pregnancy
- Can flare subsequently post partum and with menstruation and in OC users
- Worsens with each subsequent pregnancy – will start early – but can skip pregnancies
- OB risk of prematurity and IUGR; monitor closely as per IUGR risks and counsel re: subsequent pregnancies.

ICP/ OC

Intrahepatic Cholestasis of Pregnancy

AKA

Obstetric Cholestasis

OC

OC

- Reversible form of cholestasis
- Onset usually TM3 pregnancy, can recur in subsequent pregnancies
- Severe pruritus with NO rash, skin lesions are secondary to scratching, classically eves/overnight and involving soles and palms
- Hormonal, genetic and environmental factors

OC

Diagnosis

- History and physical
- Elevated Bile acids (>11 Umol/l for (+)ve dx)
- Elevated LFTs (ALT)
- Histopathology non-specific, Neg DIF.

OC

- Differential Diagnosis
  - Other specific dermatoses of pregnancy
  - Other hepatic and pruritic disorders – acute fatty liver of pregnancy, HELLP syndrome, hepatitis, gallstones, hyperemesis gravidarum, Fe deficiency, Thyroid disease and lymphoma

OC

- Treatment
  - Urso 15mg/kg/day
  - Sedating antihistamines for night
  - UVB light
  - General anti-pruritus measures

OC

Outcome

- Good maternal prognosis and symptoms will resolve within 1-2 days after delivery.
- MOST serious of the pregnancy specific dermatoses wrt fetal risks – intrapartum fetal distress(22-33%)
  --premature births (19-60%)
  --stillbirth (1-2%)
- Careful monitoring of fetal well being starting at 34 weeks or when diagnosis is made – lab work
- Current and subsequent pregnancies – induce at 37 weeks
- -

General skin diseases in Pregnancy

Due to immunologic changes in pregnancy

Can get Worse:

- AD
- Acne
- Rosacea
- Lupus skin manifestations
- Benign skin tumors –and possibly melanoma
- Viral/fungal infections (warts, candida)
- Scabies

General skin diseases in pregnancy

Can get better:

- Psoriasis
- Acne (can get better or worse)

A good resource

Murase JE, Heller MM, Butler DC

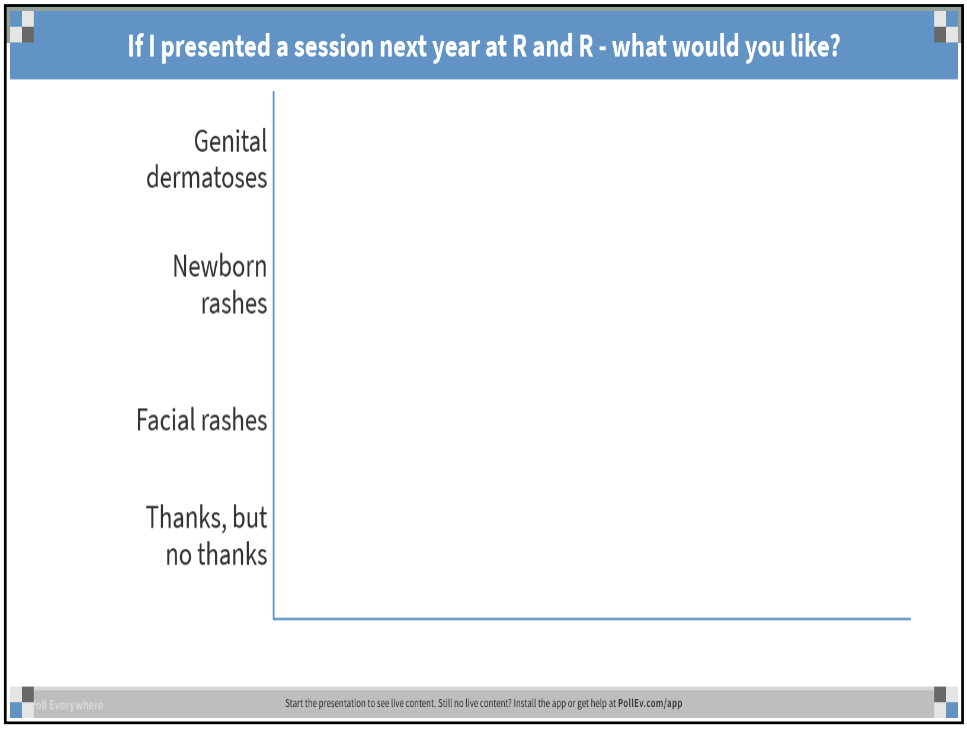
Safety of dermatologic medications in pregnancy and lactation

Part 1 – pregnancy

Part 2 - lactation

J AM Acad Dermatol

March 2014


If I presented a session next year at R and R - what would you like?
Genital dermatoses
Newborn rashes
Facial rashes
Thanks, but no thanks
Poll Everywhere
Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app