

Madigan Army Medical Center

Referral Guidelines

Seborrheic Dermatitis

Diagnosis/Definition

- Chronic superficial inflammatory disease of the skin.
- Predilection for the scalp, eyebrows, nasolabial creases, ears, sternal area, groin and gluteal crease.
- Characterized by scant, loose, dry, moist or greasy scales and by crusted, pink or yellow patches of various shapes and sizes; by remissions and exacerbations; and more or less by itching.
- On patients with darker skin tone, lesions may have a gunmetal color, and may be annular or arcuate.
- On the scalp manifests as dry powdery dandruff or an oily type with erythema and thick crusts. Frequently spreads beyond the hairy scalp.
- On and in the ears, seborrheic dermatitis is frequently mistaken for otitis externa. There is scaling in the external ear canals, around the auditory meatus and in the postauricular region or under the lobe. In these areas the skin often becomes red, fissured and swollen giving the appearance of an infection.

Initial Diagnosis and Management

- Evaluation: A focused history and physical examination. Areas to be examined should include the scalp, ears and mid-face.
- Emphasize that this is a chronic disorder with no cure but with several good forms of treatment which can control symptoms. Document education and provide handout or brochure (American Academy of Dermatology website is: www.aad.org).
- The scalp should be shampooed several times per week. Selenium sulfide (Selsun or Exsel lotions), tar, zinc pyrithionate and resorcin shampoos are all excellent. Stress that shampoo should be left on the scalp for 3 to 10 minutes (to allow penetration) prior to rinsing. Other alternative shampoos are ketoconazole (Nizoral) and salicylic acid (T-sal). (Note that in the experience of one of the staff dermatologists, Nizoral products have been less than successful for most patients.)
- Corticosteroid solutions such as Synalar, Fluonid and Valisone (betamethasone 17-valerate) lotion applied BID to the scalp are effective and may be necessary to improve seborrheic dermatitis to a maintenance level. Luxiq (betamethasone valerate) and Olux (Clobetasol) foams are also useful, but some patients complain of irritation due to the foam itself. Nizoral cream may also be useful for daily facial maintenance and may be worth trying.
- Ear involvement may be treated with low potency topical steroid creams. Tridesilon Otic Lotion (0.5 percent desonide and 2 percent acetic acid) is also effective.
- On glabrous skin (such as the thin skin of the forehead) non-fluorinated topical steroid preparations are adequate (hydrocortisone 1%, Desonide, Westcort, etc.).
- Topical steroids should not be used for blepharitis, as steroid preparations used in this area may induce glaucoma and cataracts. Gently cleansing the eyelid skin with Johnson's baby shampoo or Cetaphil may be beneficial.

Ongoing Management and Objectives

Major objective is symptom relief as this is a chronic disorder with intermittent exacerbations and maintained clearance rather than "a cure" is the reasonable objective.

Indications for Specialty Care Referral

Signs and symptoms that bring into question the correct diagnosis (i.e., petechiae, severe oozing or crusting, significant alopecia, severe or resistant symptoms).

Severe Seborrheic Dermatitis not responding to treatment as outlined above after 1-2 months of care.

Criteria for Return to Primary Care

Completed Dermatology evaluation which confirms the diagnosis and appropriate management of seborrheic dermatitis or any other diagnosis which may be managed at the primary care level.

Pictures of [Seborrheic Dermatitis](#) from NZ DermNet - New Zealand Dermatological Society

Last Review for this Guideline: **January 2010**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator