PURPOSE

To assure that DOP inmates with skin lesions are receiving appropriate Primary Care for their lesions

POLICY

All DOP Primary Care Providers are expected to follow this guideline and/or will document in the medical record any deviations from this guideline and the reasoning behind the need for deviation.

PROCEDURE

MANAGEMENT OF SKIN LESIONS

1) Lesions suspected of being **malignant**:
   a) A punch biopsy should be performed at the unit level to rule in or out malignancy;
   b) Lesions involving the nose, eyelids, external ear or ear canal, lips, neck overlying the great vessels, or genitalia may be referred without prior biopsy;
   c) Lesions documented to be malignant may be referred for surgical excision;

2) Lesions with little or no malignant potential may be referred for surgical excision if one of the following is met:
   a) Moderate to severe symptoms reasonably and directly related to the lesion which cannot be controlled medically;
   b) Cysts with three or more episodes of infection not improved with appropriate treatment.

3) **Actinic Keratosis(AK)**: The treatment of AKs begins with prevention. Avoiding sun exposure prevents AK. Active treatment of AKs depends upon the size of the lesion and the number of lesions present. All lesions may not need to be treated. Treatment should be done on the ones that are enlarging and becoming a threat for the development of squamous cell carcinoma. Some AKs may spontaneously regress.

4) **Anogenital condyloma** (venereal warts)
   a) Perform anoscopic examination at the unit to rule out the presence of intraanal lesions
   b) If no intraanal lesions are present, attempt treatment at unit with two or more of the following over a period of 3 months:
      i) Podophyllin 25% solution
      ii) Trichloroacetic or bichloracetic acid
      iii) Histofreeze
      iv) Podofilox 0.5% may be requested as non-formulary agent if above treatments fail
      v) Imiquimod (Aldara) - may be requested as a non-formulary agent if treatment with two of the above is unsuccessful

c) Refer to general surgery, urology, or OB/GYN if one of the following is met:
   i) Lesions failed to respond to the above treatment
   ii) Intraanal lesions present
   iii) Large lesions causing obstructive symptoms are present

5) **Warts**
   a) In general these lesions are considered cosmetic and most will spontaneously resolve within two years. Referrals will be approved only when there is clear documentation that a lesion is causing significant symptoms or disability. Initial treatment should be attempted at the unit level with one or more of the following, unless the patient has diabetic neuropathy or advanced peripheral vascular disease:
   b) For localized warts you may consider one of the following treatments. Trim skin over and around the wart and then apply one of the agents listed below:
      i) Salicylic acid topical 17% solution (Duofilm,)
      ii) Duct Tape:
         (1) Cut a piece big enough to cover the wart
         (2) Leave it on for six days
         (3) Remove duct tape, soak wart in water, and debride the lesion
         (4) Repeat process until wart is gone
         (5) Stop if excessive irritation or no improvement in three weeks
      iii) Histofreeze:
   c) Snip excision should be used for filiform warts
   d) For patients with extensive warts one of the following treatments can be considered:
      i) Cimetidine, high dose (30-40 mg/kg/day) for up to three months (81 to 83% clearance in three months)
      ii) Zinc sulfate, 10 mg/kg/day to a maximum of 600 mg/day (complete clearance and 61% at one month and 87% at two months)

6) **Plantar warts**
   a) These are benign lesions and most will spontaneously resolve within two years. Only lesions causing symptoms require any treatment, these are usually lesions overlying pressure points.
   b) Initial treatment should be attempted at the unit level with one or more of the following, unless the patient has diabetic neuropathy or advanced peripheral vascular disease:
      i) Salicylic acid
         (1) 40% salicylic acid plaster (Mediplast)
            (a) Debride lesion with scalpel or Dremel tool
            (b) Apply plaster to cover the lesion and the surrounding 1 to 2 mm of normal tissues and tape in place
            (c) Keep dry for 48 to 72 hours
            (d) Remove patch and debride again
            (e) Repeat the process as needed with or without a 24 to 48-hour rest period
         (2) 17% salicylic acid topical solution (Duofilm)
            (a) This is best used in conjunction with Histofreeze
            (b) It may be used alone for small lesions

ii) Duct Tape: See above for technique
iii) Histofreeze
(1) Debride lesion
(2) Apply Histofreeze for 40 seconds to all parts of the lesion
(3) Apply salicylic acid 17% topical solution (Duofilm) twice daily starting one day after each freeze
(4) Repeat Histofreeze every 14 days
(5) Continue treatment until all abnormal tissue has been destroyed

c) Referrals will be considered if symptomatic lesions do not respond with least two of the above treatments, **or** the patient has diabetic neuropathy or advanced peripheral vascular disease.

7) **Keloids**
a) These are generally considered cosmetic lesions and treatment is not authorized
b) Symptomatic lesions should be treated at the unit level with one of the following:
i) High potency topical steroids;
ii) Emollients;
iii) Intralesional steroids:
(1) Use 10 mg per milliliter triamcinolone or equivalent potency parenteral corticosteroid (this concentration can be obtained by mixing one part of 40 mg per milliliter triamcinolone with three parts sterile water);
(2) Consider anesthetizing skin with ethyl chloride
(3) Using a 27 or 30G one half inch needle inject 0.1-0.2 mL at a depth of about one quarter inch into the keloid every 1 to 2 cm.
(4) Repeat the above (can gradually increase dose upto 40mg/ml triamcinolone) every one to two weeks until the lesion has significantly regressed or is no longer symptomatic.
c) If the lesion is causing significant problems, consideration may be given for dermatology referral.

6/22/07
Paula Y. Smith, MD, Director of Health Services Date

SOR**:** Deputy Medical Director

Clinical Guidelines Committee

References

Breen E, Bleday, R. Condylomata acuminata (anogenital warts). UpToDate version 14.1, January 12, 2006.

Goldstein BG, Goldstein AO. Cutaneous warts. Up-to-date grants that. UpToDate version 14.1, August 8, 2005.

Pearlman DL. Weekly pulse dosing: effective and comfortable topical 5-fluorouracil treatment of multiple facial actinic keratoses. J Am Acad Dermatol 1991; 25: 665-7.

Orlow SJ, Paller A. Cimetidine for the treatment of warts. J Am Acad Dermatol 1993; 28: 794-6.

Glass AT, Solomon BA. Cimetidine therapy for recalcitrant warts in adults. Arch Dermatol 1996; 132: 680-2.

Focht DR, et al. The efficacy of duct tape versus cryotherapy in the treatment of verruca vulgaris (the common wart). Arch Pediatr Adolesc Med 2002; 156: 971-4.

Al-Gurairi, et al. Oral zinc sulfate in the treatment of recalcitrant viral warts: Randomized placebo controlled clinical trial. Br J Dermatol 2002; 146: 423-31.

Gibbs S, et al. Local treatments for cutaneous warts: Systematic review. BMJ 2002; 325: 451-4.

Ricketti JC, Niedbala RS. Histofreezer: A study of a new method of cryosurgical treatment of Verrucae Plantaris. The Lower Extremity 1995; 2(3).