FIRST, A FRANK TALK ABOUT ZIKA VIRUS.

Zika is new to the spotlight, but it was first reported from Uganda in 1947. It is spread by mosquito bite. It has been isolated from semen, and it is currently unknown how long the virus stays in semen, but it is felt to persist longer in semen than blood. Men who have traveled to areas where Zika is endemic should wear condoms or abstain from sex with women who are or could become pregnant. To prevent mosquito bites, wear long sleeves and long pants. Try to stay indoors or behind window and door screens. Sleep under a mosquito net. Wear insect repellent, being careful to follow the directions! Always apply sunscreen first, then insect repellent. Speak to your pediatrician or family physician about protecting your child. Clothing and gear treated with permethrin can be quite useful.

Most people infected with Zika do not know it. The most common symptoms are fever, rash, joint pain, and conjunctivitis but muscle pain and headache are also common. The virus incubation period is not known but felt to be a week or less. Symptoms usually last a few days. Travel history is vital! Mention any recent travel history to treating physicians. If you are pregnant and develop rash or fever, or the above symptoms, consult with the physician providing obstetrical care.

The treatment is symptomatic – rest, fluids, acetaminophen. Having the infection likely results in immunity. The big consequences of this infection are the birth defects of skull size and brain of infant, so it cannot be overemphasized how important prevention is if you are pregnant or trying to conceive! Much misinformation is floating about. Check reputable resources such as your physician or www.cdc.gov/zika.

IT’S SUNSCREEN SEASON SUMMER INTO FALL.

’Tis the season! From mid-March to the end of October (here) or year round (closer to the equator or high altitudes) protect yourself! Just like there is no safe exposure to tobacco, there is no safe sun exposure. I’ve heard the arguments – get your vitamin D from a pill, minimum of 600 I.U. daily. Clothing helps with long sleeves and pants and broad brimmed hats, but nearly 90% of skin cancers occur on face, neck and hands, which is where sunscreen comes in. Sun exposure is peak 9:30am to 4:30pm, so if possible defer outdoor activity to earlier or later. Let’s face it, that’s not always practical. If you have to be outdoors protect your exposed skin. Ultraviolet A rays penetrate deeper and cause wrinkles and tanning. Ultraviolet B rays are higher energy and burn. Both can cause skin cancer.

Broad spectrum sunscreen blocks both UVA and UVB. It should be applied 20-30 minutes before sun exposure, and reapplied every couple of hours (particularly if sweating or swimming). Guidelines are one ounce (shot glass full) of sunscreen covers exposed skin. Apply evenly, directly into your skin and keep your skin safe out there!

HOW TO TREAT BITES AND STINGS.

Most insects don’t bite or sting unless provoked (the exception are mosquitoes, lice, or bed bugs which are after a blood meal). Stings can be fatal (usually anaphylaxis from venom). Susceptible individuals must carry an epinephrine auto injector. Many diseases are transmitted by bites – malaria, plague,
Lyme, West Nile and Zika are just a few examples.

Most bites and stings result in redness, swelling, itching or pain. Wasp and bee stings can be severe and life threatening. Ant bites frequently cause pustules/pimples. Spider bites are rare and may cause blisters or necrotic (black scab) ulcerations and occasionally systemic symptoms.

Seek medical help if you experience symptoms beyond the site of the injury, which could include hives. If short of breath call 9-1-1. If the area looks infected – warm, fever, red streaks, pus – seek help. If you have severe symptoms such as a history of wheezing, chest pain/tightness, shortness of breath, fainting, weakness, throat closing – call 9-1-1 or go to the nearest emergency room.

Good first aid for bites and stings includes carefully removing the stinger, by scraping along the skin, NOT grabbing and squeezing. Using ice ten minutes per hour, or a cool compress often is soothing. Topical corticosteroids twice daily for a week can reduce redness and itching. Topical anesthetics can be useful, but it is possible to develop an allergy to them. Oral antihistamines may help a person sleep, but have a limited role in the absence of hives. If tender, take acetaminophen or ibuprofen. Calamine lotion can dry up something that is weeping. Most of these will resolve in a few days.

As always, your physician is an excellent source of information. The Department of Dermatology is at your service to answer questions on these or other skin, hair, and nail questions. We want you to have a safe and enjoyable summer into the fall, so please wear sunscreen!

For more information or to schedule an appointment please call 605-665-1722.
The diagnosis of Lyme Disease may inspire indifference in some, and fearful panic in others. Since first described in 1975, it has achieved some notoriety. Since information is the best weapon to dispel unnecessary fear, read on to be armed with the facts and not be frightened by rumor or misinformation.

The vector - or biting insect - for Lyme Disease (LD) is the deer tick, “Ixodes dammini.” The disease is an infection caused by “Borrelia burgdorferi,” a type of bacterium called a spirochete (spyro-keet), which was isolated in 1982. LD in the U.S. occurs primarily in the Northeast, Midwest, and West with infections occurring almost exclusively between May and November. More than 80% of cases occur in June, July and August.

The characteristic early rash or lesion of LD is called “erythema migrans” (EM). Clinical symptoms begin with EM and an acute flu-like illness (body aches, low grade fever, malaise). The rash occurs in at least 75% of adults, but is much less common in children. Some call this skin lesion a “bulls-eye” rash because of its appearance.

Only 20 - 30% of patients will actually recall a tick bite. Many patients will notice a small red spot or bump at the site, most commonly in the thigh, groin or armpit areas. Three to 30 days later (the average is 7 days), there is a gradual expansion of redness. The advancing edge is usually blue-red, warm and has no scale (unlike tinea corporis or ringworm, a fungus). Centrally, the lesion will usually clear as it grows, leaving a ring. There may be firmness, blisters, or a scab. Half of patients with EM complain of burning; however, itching, pain or localized hair loss are rare.

One fourth of patients will have multiple lesions. Without treatment, lesions will fade in about four weeks. It is possible, however, for the spots to remain for months.

Left untreated, late complications (late-Lyme) include arthritis (10% of patients, usually knees); cardiac involvement (usually young men); or neurological problems. A late sequel on the skin is acrodermatitis chronica atrophicans (ACA), which is paper-thin skin on the backs of the hands and feet that spreads inward.

The good news is that excellent treatment is available when given
Get the facts
get rid of the fear

Within the first few weeks of infection. Early treatment with antibiotics is straightforward and almost always results in a full cure. Treatment typically lasts in the 14 to 30 day range. Oral therapy for EM is usually sufficient; however, more aggressive treatment regimens such as IV antibiotics are needed for cardiac, neurological, or arthritic involvement. Tragically, half of the patients who have suffered from late-Lyme and develop arthritis will not respond to antibiotics and may become disabled.

Blood tests to diagnose Lyme Disease are notoriously unreliable. Identifying EM early is still the most sensitive evidence of early infection.

Your best weapon is to always inspect for ticks after returning from an outdoor activity. The tick needs to be attached for 24 hours to transmit the disease to the bloodstream. Nymphs (smaller or immature ticks) may be hard to see.

If you have questions or concerns, contact your primary care physician or dermatologist, Dr. James Young. Our ConvenientCare clinic is also open for urgent care after hours.

For more information or to schedule an appointment please call 605-665-1722.
Psoriasis (from the Greek word psora-to itch) is a chronic immunologic, non-contagious skin disorder. It may be systemic (psoriatic arthritis), genetic, or inflammatory. It may be anywhere on the body but favors scalp, elbows, knees, hands, feet, nails and genitalia. The most common form of psoriasis is characterized by plaques—raised, thick, scaly, inflamed patches of skin covered with silvery scale. It may itch or burn but surprisingly, frequently has no symptoms. At least 7 million people have psoriasis, or about 1 in 40 people in the US. About 250,000 new cases are diagnosed yearly, affecting both sexes, all ages, and all races (although more Caucasians are affected than Blacks or Asians). Most commonly, it starts between ages 15 and 35.

Psoriasis treatment costs third-party insurance payers between $1.6 and $3.2 billion per year. This is more than for emphysema or epilepsy. The more severely affected person naturally has more challenges and greater expense than someone with less severe disease.

About 400 people receive disability for psoriasis each year, and an equal number die from psoriasis complications. About 10-20% of psoriasis patients will develop psoriatic arthritis. Psoriatic arthritis causes pain and swelling in and around joints and can lead to permanent joint damage. Psoriatic arthritis is more common in patients with severe psoriasis, those with nail involvement, and the elderly. In addition, severe psoriasis is now known to be associated with heart disease and lymphoma, but run-of-the-mill psoriasis is not.

Psoriasis is almost certainly triggered by multiple factors. It can be inherited. It may be started by trauma to the skin, such as sunburn, scrapes, and bruises. Infections, classically strep, are a well-recognized trigger. Many medicines are reported to cause or aggravate psoriasis. Common medications include, but are not limited to: beta-blockers, ACE inhibitors, antimalarials, lithium, NSAID, systemic corticosteroids, IL-2, and granulocyte-macrophage colony stimulating factor. For most people, stress is a factor, and psoriasis is worse in winter time nearly universally. Many, if not most, psoriasis patients can find no trigger.

Psoriasis is graded by the amount of skin involved, as well as where. For instance, someone with severe psoriasis of palms and soles may be completely disabled, even though only 4-5% of their body is involved.

Treatment goals are to control, because a cure does not exist. Patients may strive for perfectly clear skin, but in reality that rarely, if ever, happens. Psoriasis tends to eventually become resistant to anything used on it, so changing agents from time to time is normal.

Conventional therapies for less extensive psoriasis, which can also be used as adjuncts for more aggressive treatment, have classically consisted of topical applications. Tar in various forms: anthralin, vitamin D analogs, retinoids (vitamin A analogs), and corticosteroids are all useful.

Whenever psoriasis involves more than 10-15% of body surface area, application of a topical to each and every place becomes increasingly impractical. Ultraviolet light becomes an increasingly attractive modality. Yankton Medical Clinic, P.C. has a dedicated light unit with hand and foot treatment capability. In the recent past, narrow band UVB has...
taken the place of PUVA, being nearly as effective without the toxicity.

Systemic agents include methotrexate, cyclosporine, and acitretin. These agents balance advanced effectiveness with increased risk for toxicities and drug interactions. Regular monitoring is mandatory, as well as close regular follow-up.

The new thrust in treatment is biological agents. These agents target only the lymphocyte or cytokine involved in causing psoriasis. Some can activate TB infections, so a pre-treatment TB skin test is needed. They are given only by injection. Several can be self administered at home, while others require office administration. Some require monitoring blood work while others do not. They are quite expensive, but most insurance companies offer at least some payment.

For the most part, these agents represent a major advance in psoriasis therapy.

Major advances in psoriasis research and treatment make ours an exciting time! What may have just a few years ago seemed messy or hopeless is now full of new possibility. The Department of Dermatology at Yankton Medical Clinic, P.C. stands ready to counsel and guide interested patients through the various possibilities. We both want the best treatment for you and your psoriasis.

For more information or to schedule an appointment please call 605-665-1722.