Update in Internal Medicine 2026

Saturday, May 2 • 8 a.m. – 4 p.m.

UT Southwestern Medical Center, T. Boone Pickens Medical Education & Conference Center

Outpatient Dermatology for the Internist

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UT Southwestern Medical Center

Case 1

A 26 YO man with history of depression presents to your practice with a 3-month history of eyelid rash. He notes no new personal care products, no change in his occupation. However, he did recently start lifting weights.

What is the correct diagnosis and trigger:

A) Angioedema – Acquired

B) Allergic Contact Dermatitis – Nickel

C) Dermatomyositis – Occult Malignancy

D) Seborrheic Dermatitis – undiagnosed HIV

E) Rosacea – Environmental Triggers

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Eyelid Dermatitis – Source and Risk Factors

Common Allergic Triggers:

Personal care products: cosmetics, shampoos, and cleansers

Allergens or irritant transmitted via the hands (nickel and nail polish)

Site-specific factors:

Thinnest skin on the Human Body

High Vascularity

Eyelid Dermatitis – clinical presentation

Erythema, scale, lichenification, and edema (which can be striking)

Can be asymmetric (especially if allergen is transmitted by hands due to Right vs Left Handedness)

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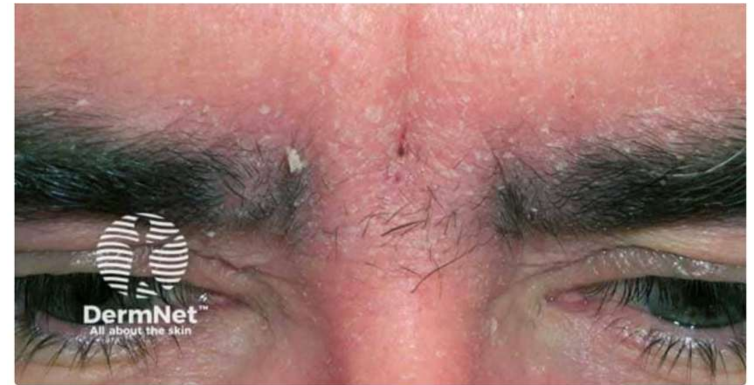
Eyelid Dermatitis- Mimics and Differential Diagnosis

Angioedema



Seb Derm

Dermatomyositis
(Heliotrope)

Ocular
Rosacea

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Eyelid Dermatitis – Treatment Pearls

Tacrolimus 0.1% ointment (my preferred agent) - BID use, can be used indefinitely. 19% of patients have immediate irritancy, place in the fridge and apply when cool. Patients can develop tolerance after a few applications.

Other agents / Strategies:

Ruxolitinib (Opzelura)

Desonide 0.05% cream or Hydrocortisone 2% (just 1 refill, then refer)

Referral for Patch Testing

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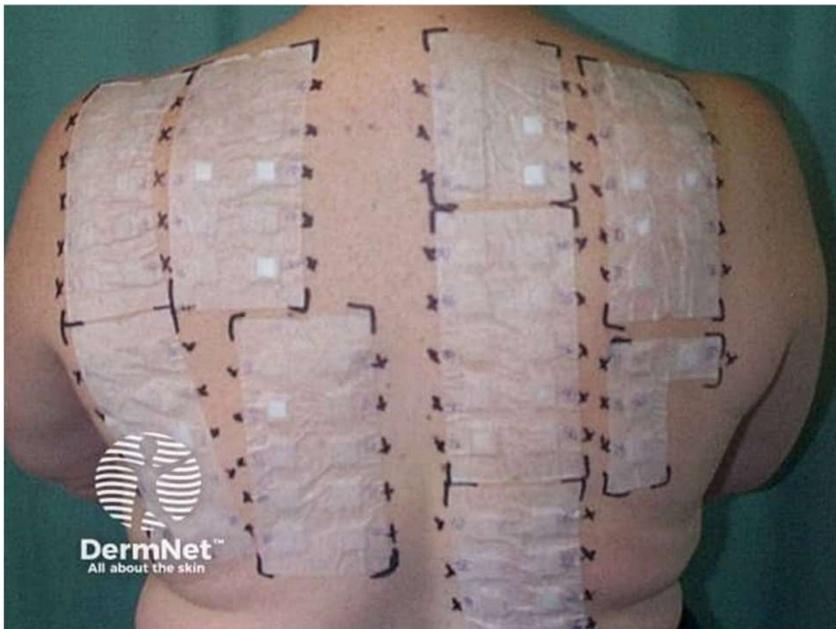
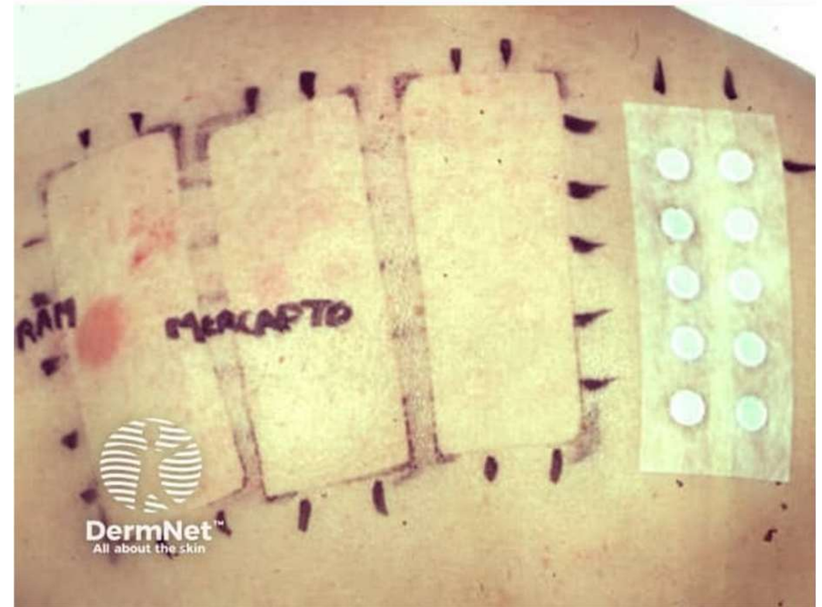
Contact Dermatitis Patch Testing





Challenging process, patches placed and read at 48h and 96h. Quite Costly.

Contact Dermatitis Open Application Testing

- Patient can apply personal care product to flexor forearm daily for 21 days.

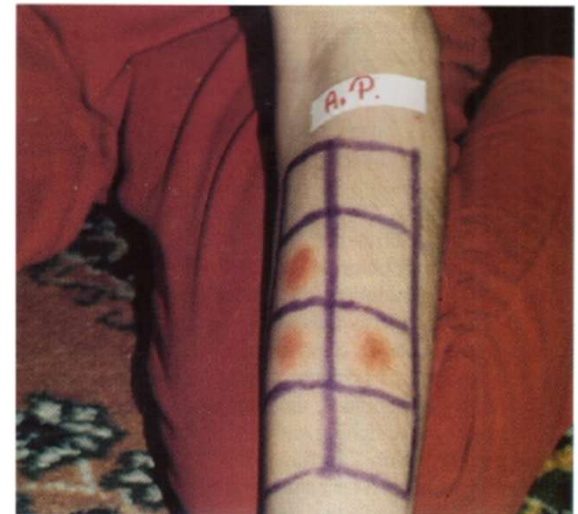
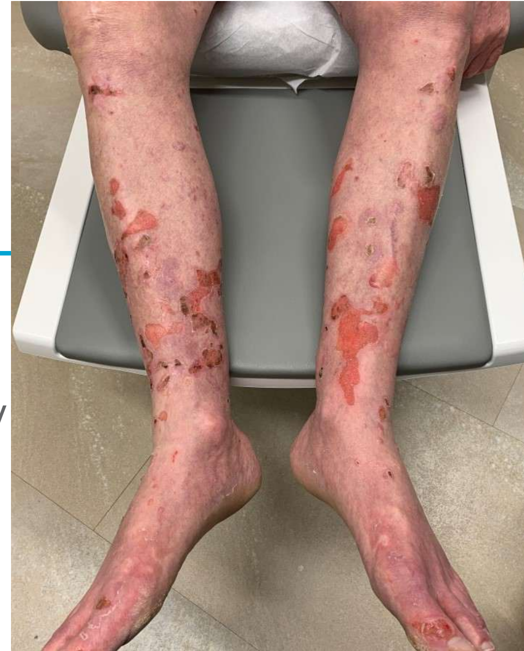
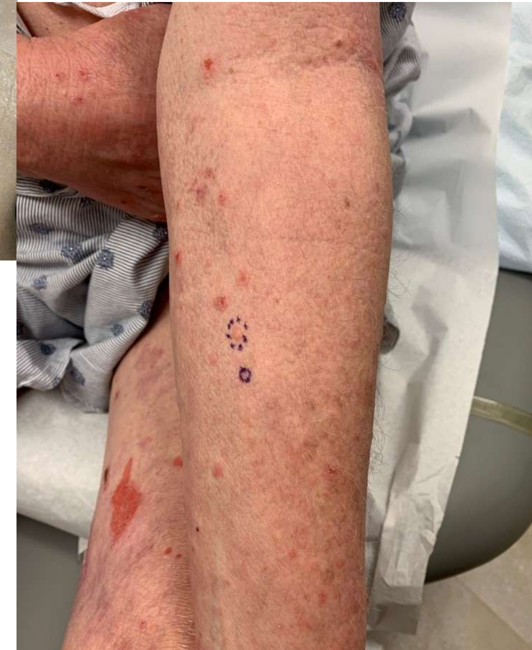


Photo credit: TY - JOUR AU - Spiewak, Radoslaw AU - Maslowski, T AU - Bozek, Andrzej AU - Brewczynski, Piotr PY - 1995/01/01 SP - T1 - A double case report: clinically different occupational dermatoses resulting from identical exposure to work environment at a photographic laboratory VL - 2 JO - Annals of Agricultural and Environmental Medicine

Case 2

A 67 year-old man with PMH of hypertension under treatment with Nivolumab for Metastatic Melanoma presents to your office with 3 weeks of this intensely pruritic eruption.





What is the diagnosis and what treatment has been demonstrated to negatively effect survival?

A- Bullous Pemphigoid – Dupilumab

B- Bullous Pemphigoid – Clobetasol Ointment

C- Bullous Pemphigoid – Prednisone

D- Erythema Mutiforme – Colchicene

E- Varicella Zoster – Valacyclovir

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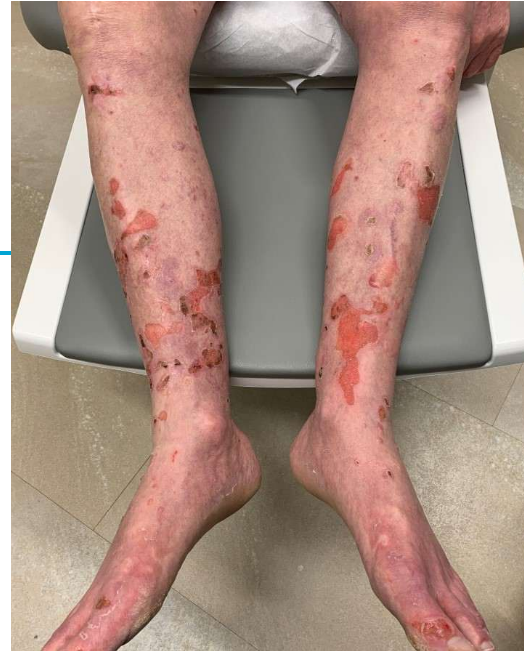

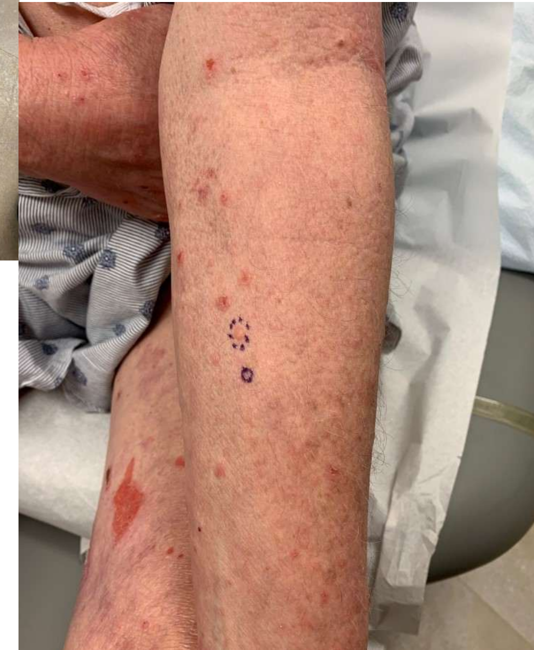

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Checkpoint inhibitor Related Bullous Pemphigoid

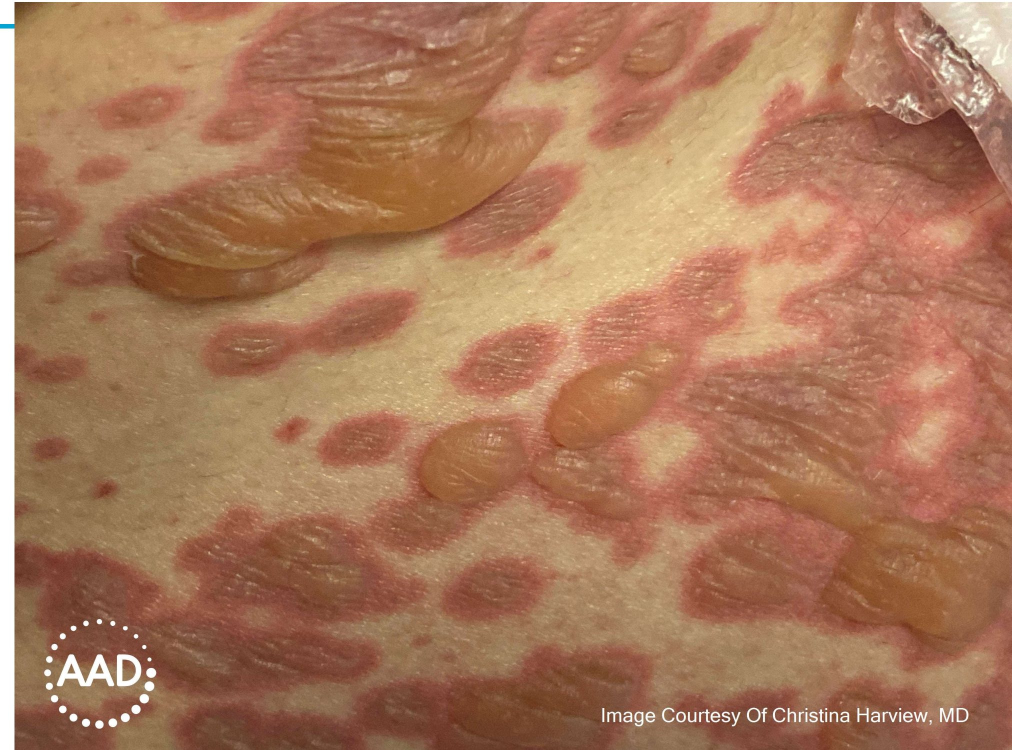
Associated with PD-1 and PD-L1 inhibitors

Late toxicity (mean onset 14 weeks)

May persist for months after discontinuation

Oral steroids reduce patient survival

Dermatology intervention can prolong patient survival



CPI-Related Bullous Pemphigoid - Treatment

Ultrapotent Steroids (Clobetasol 0.05% ointment)

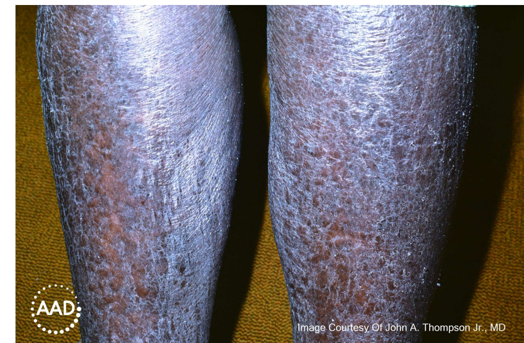
Dupilumab (Dupixent)

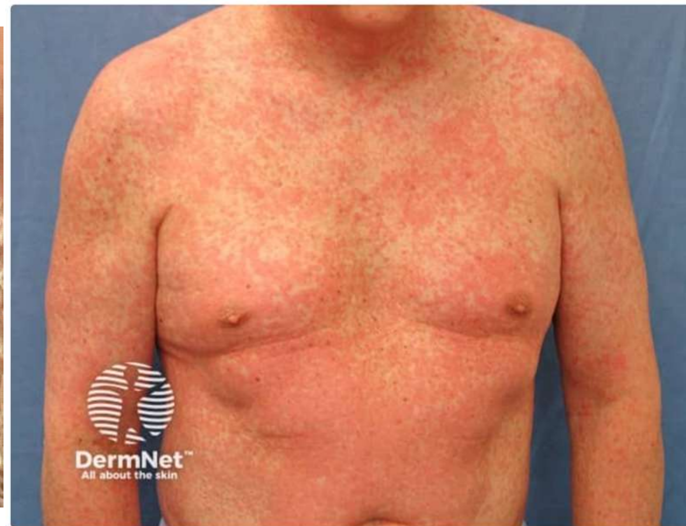
Doxycycline

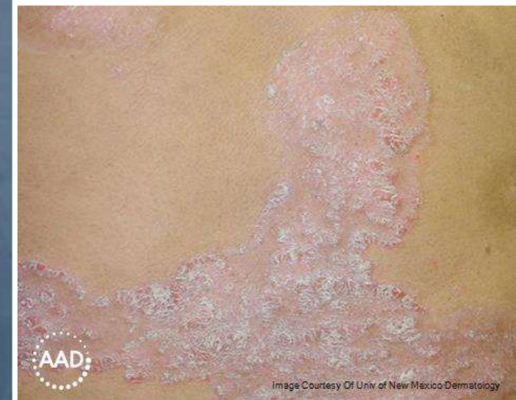
Nicotinomide

"Checkpoint inhibitor cause induce dermatology"

Atopic Dermatitis, Alopecia, Bullous Pemphigoid, **Lichen Planus**, **Maculopapular Rash (MPR)**, **Psoriasis**, **Pruritus**, Stevens-Johnson / Toxic Epidermal Necrolysis, Vitiligo







CPI – Maculopapular Rash and Pruritus

Maculopapular Rash is most common reaction seen

20% of PD-1 Patients

Up to 60% of CTLA patients

Pruritus is the second most common adverse event.

Emollients: Colloidal Oatmeal Containing

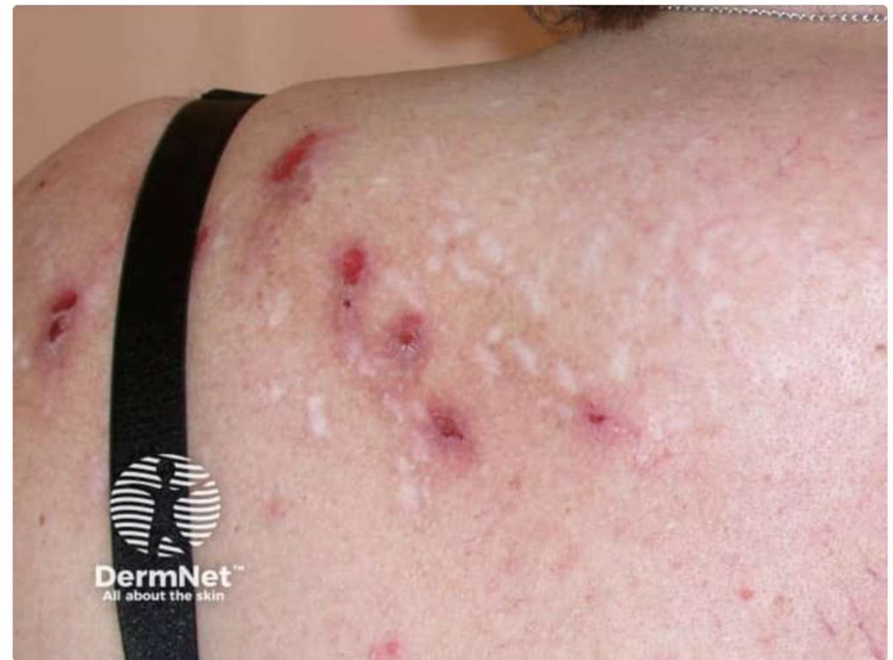
Pramoxime containing

Triamcinolone 0.1% cream

Antihistamines and Gabapentin

Dupilumab

Phototherapy



Question 3

A 35 YO female with PMH of treated hyopthyroidism presents with 8 weeks of the following recurrent rash. She states that lesions come and go over the course of hours, lasting no more than 5-6 hours and resolve without scarring.

What lab abnormality could positively predict her response to treatment?

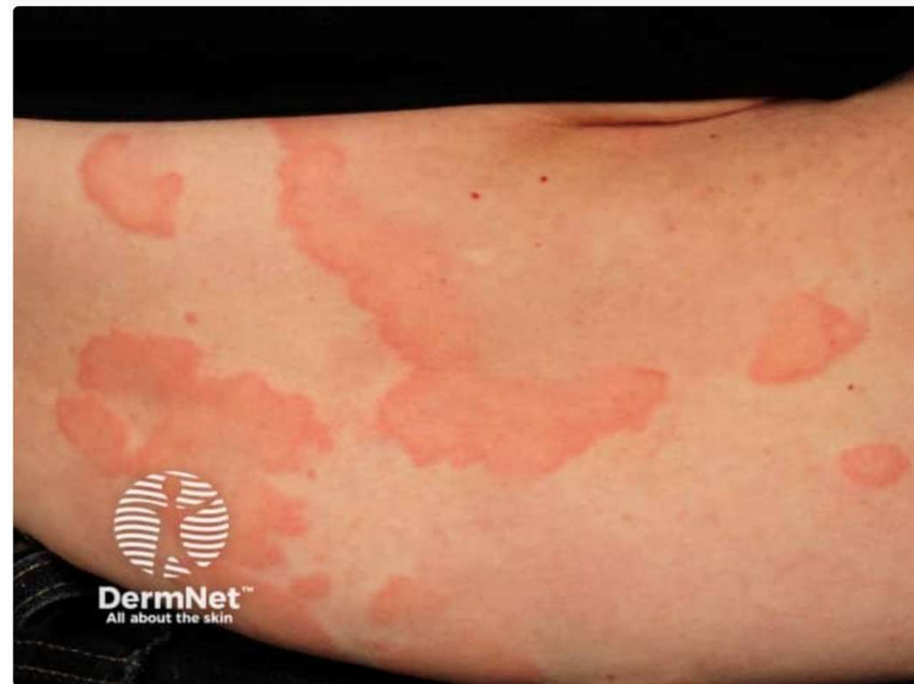
A- Low Immunoglobulin A

B- Elevated Immunoglobulin E

C- Low Complement 3 (C3)

D- Thrombocytosis

E- Abnormal Serum Protein Electrophoresis



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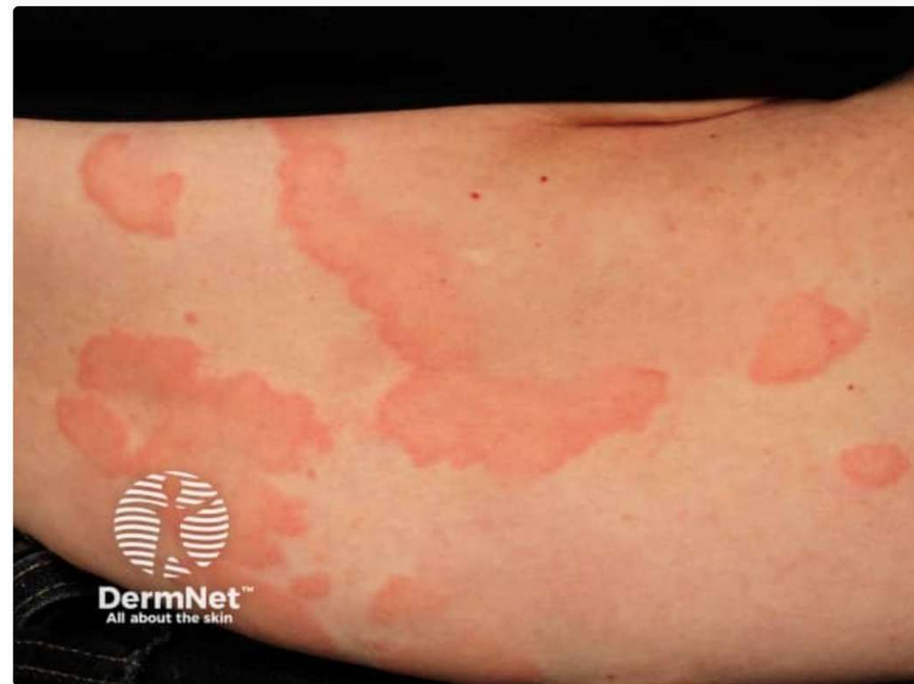

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Chronic Urticaria – clinical features

Chronic Urticaria episodes lasting greater than 6 weeks.

Divided between Chronic Spontaneous and Chronic Inducible.

Inducible urticarias include: (dermatographism, cold, hot, cholinergic, etc.)

Co-exist in 35% of patients.

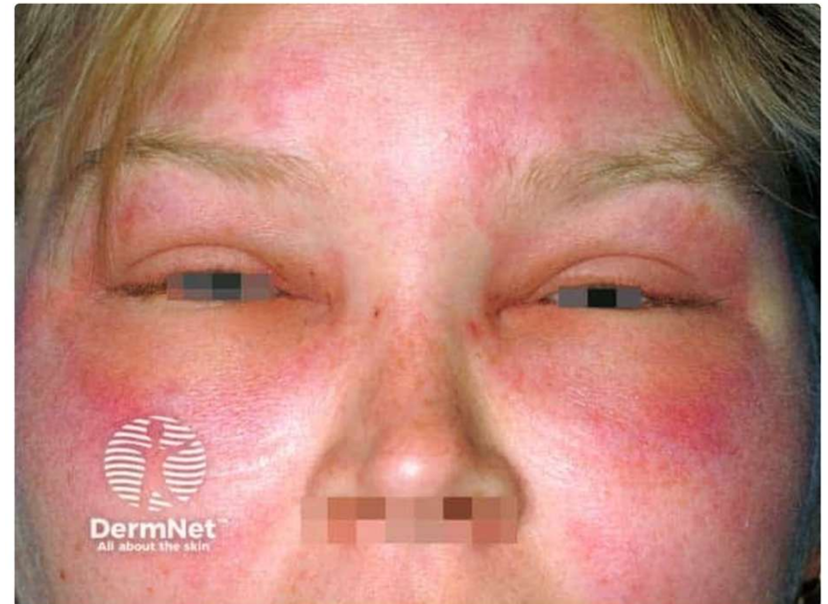
Pruritic, evanescent wheals, may have angioedema

Lesions last <24 hours

No Blistering

No Scarring

Large Burden on Patient Quality of Life



Chronic Urticaria - Pearls

Patients rarely have lesions in clinic.

Photographs are helpful.

Many patients report non-response to antihistamines:

However, 40% of patients referred to tertiary care centers clear on licensed doses.

Must be taken daily.

Can take up to 4x dose of second generation.

Chronic Urticaria – Omalizumab & Dupilumab

Omalizumab

humanized anti-IgE monoclonal antibody

High baseline IgE levels marker for response

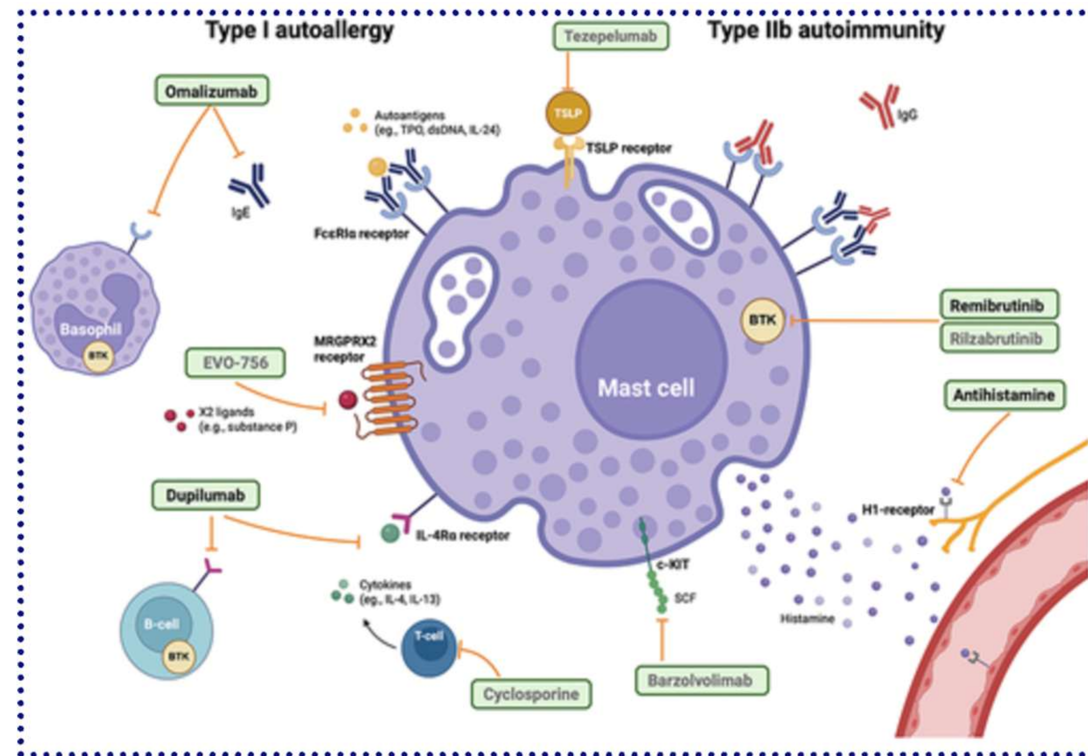
SQ Injection – initiated at infusion center, then home

Dupilumab

Monoclonal Antibody against IL-4 and IL-13

SQ injection Q2 weeks at home.

Eye irritation can be a side effect of treatment



Chronic Urticaria - Remibrutinib

Highly Selective Bruton Tyrosine Kinase Inhibitor

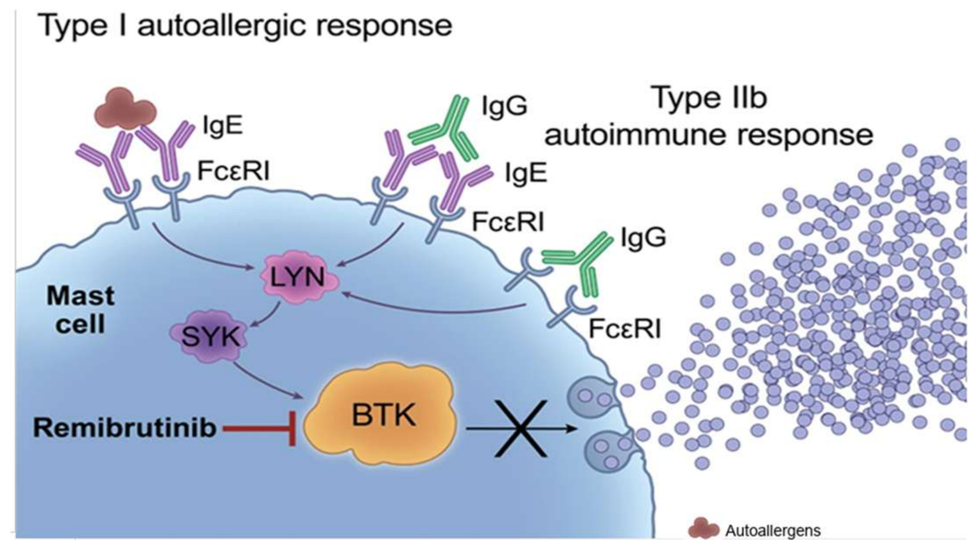
Blocks mast cell release of histamine

Safer than other BTK inhibitors

Mucocutaneous Bleeding 9%

Suspend treatment 3-7 days prior to surgery

Caution when used with other agents that induce bleeding



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Case 4

A 68 YO female with PMH of Ulcerative Colitis treated with Infliximab presents with this rapidly growing lesion.

What is the most likely diagnosis:

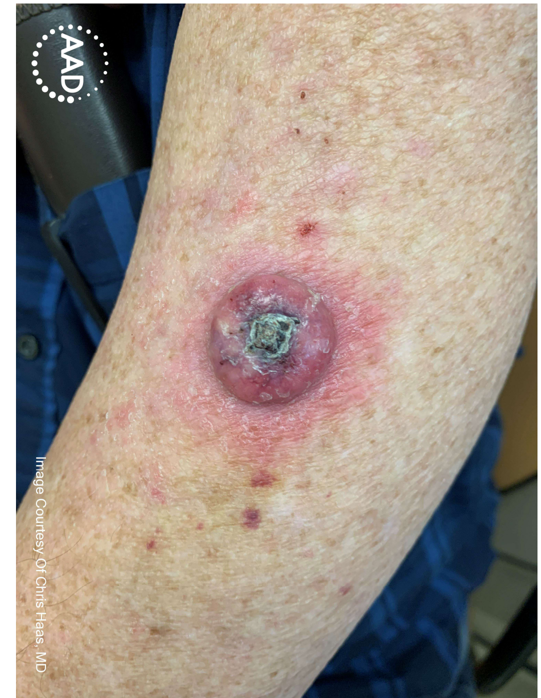
A) Actinic Keratoses

B) Basal Cell Carcinoma

C) Melanoma (Invasive)

D) Merkel Cell Carcinoma

D) Squamous Cell Carcinoma



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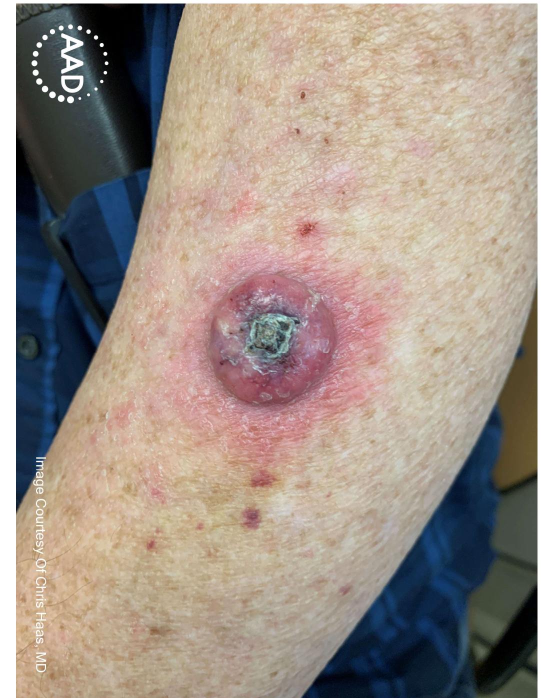
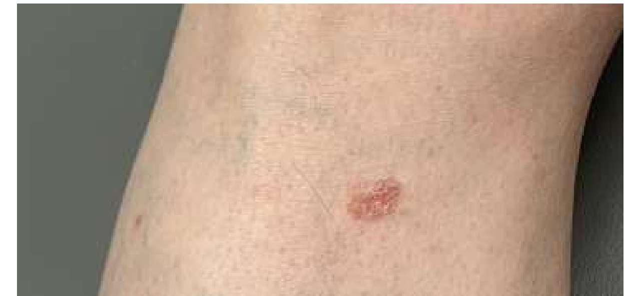
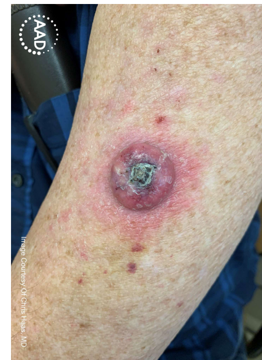
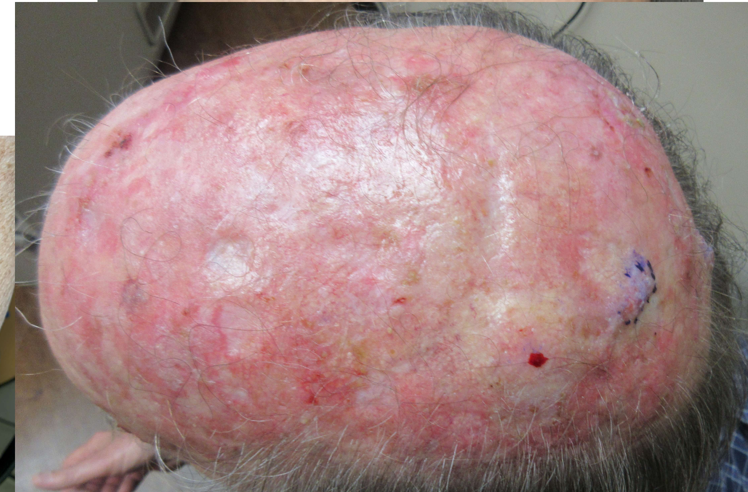


Non-Melanoma Skin Cancer: SCC - Clinical Features

- Arises on chronically sun-damaged skin
  - bald scalp, face, neck, extensor forearms, dorsal hands, and shins
- Immunosuppression (transplant patients, treatments for rheumatologic conditions or IBD, HIV)
- Skin Colored or Red
- Papulonodular or Plaque
- Scale, crusting, erosions

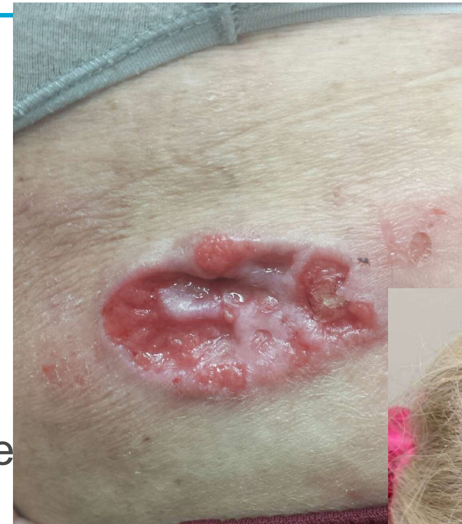


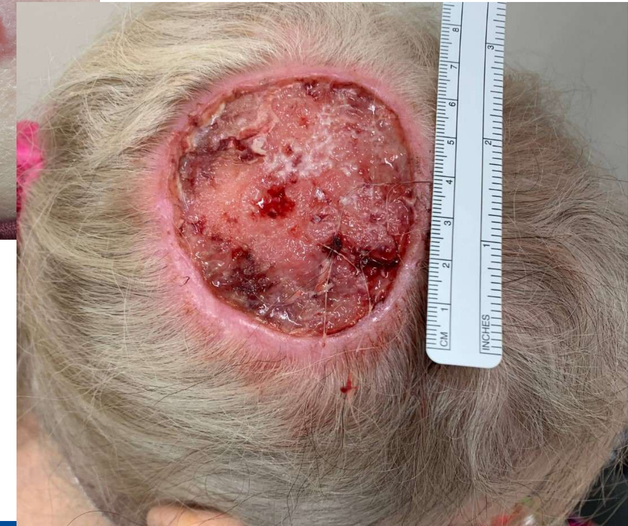




Non-Melanoma Skin Cancer: BCC - Clinical Features

- Arises on sun-damaged skin
- But, may arise in sun protected sites
  - Nodular BCC: Skin Colored or Pearly with Telangiectasia. May ulcerate
  - Superficial BCC: pink, minimally elevated papule or thin plaques
  - Pigmented BCC: lesions can have dark black pigment simulating Malignant Melanoma





Non-melanoma skin cancer lesion treatment

- Several medical and surgical treatment options
- Suspicion for SCC / BCC should prompt referral to dermatologist for evaluation and discussion of specific treatment approaches

Non-melanoma skin cancer lesion treatment

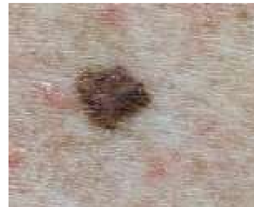
- Surgical Treatments:
  - Destructive treatments
  - Excision with appropriate margins
  - Mohs micrographic surgery if indicated
- Non-surgical treatment options:
  - Radiation therapy for poor surgical candidates
  - Other options for poor surgical candidates: photodynamic therapy, topical fluorouracil, or topical imiquimod.

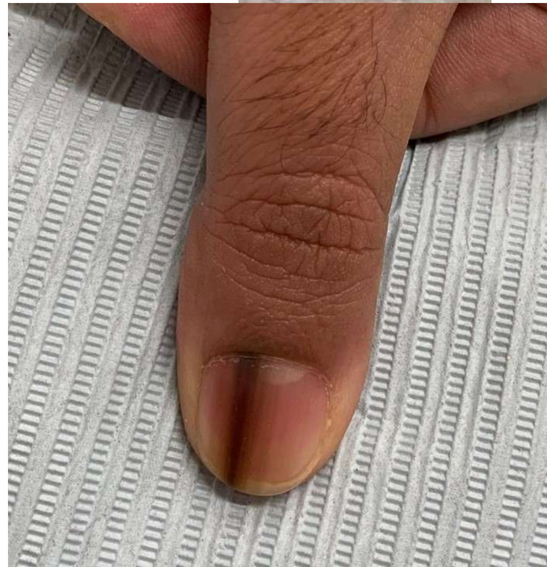
Non-Melanoma Skin Cancer: Follow-up after diagnosis / treatment

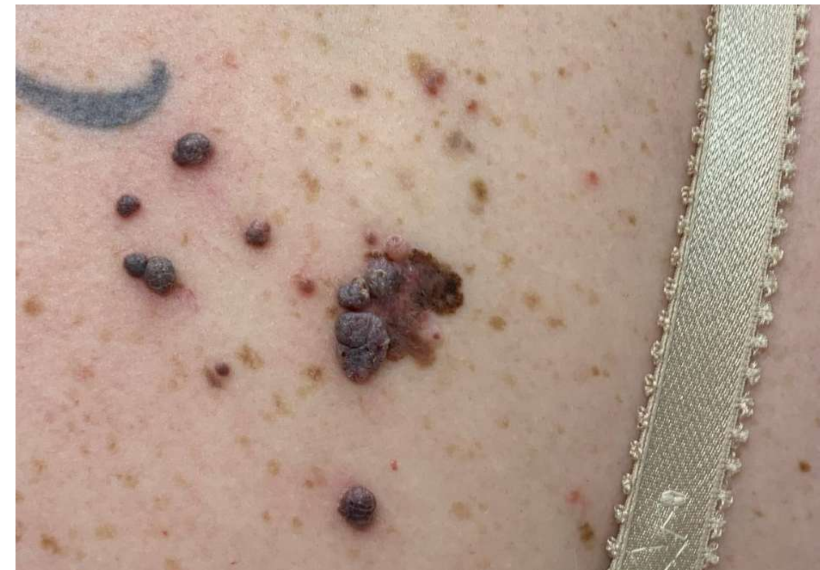
- American Academy of Dermatology Recommends in-office screening at least 1 time per year
- Counseling on sun avoidance, sun protection, and use of sunscreen SPF 30+

Skin Cancer: Melanoma Clinical Features

- Malignant Melanoma is responsible for the majority of deaths from skin cancer.
- Incidence increasing.
- Mortality rates stabilized in 1990s and now decreasing.







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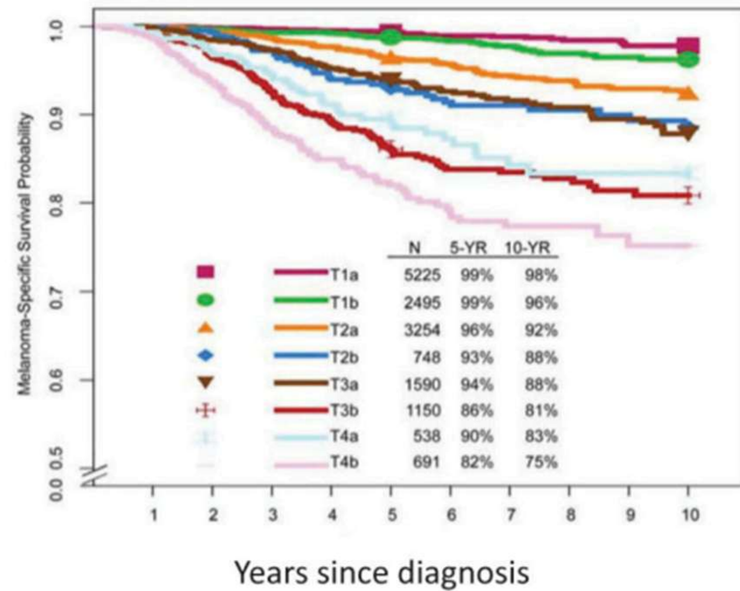
Melanoma Survival Improvement AJCC 8th vs 7th

8th edition



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Published in final edited form as:
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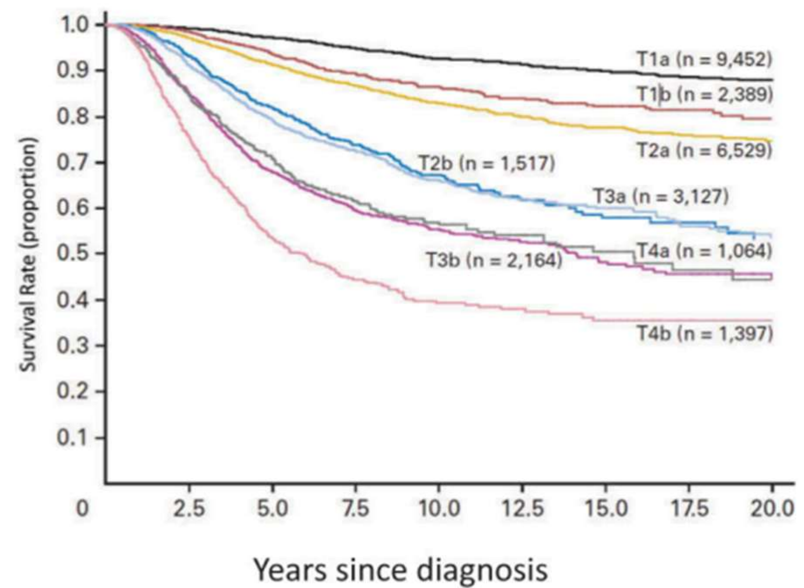
7th edition



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References

DeKoven JG, Warshaw EM, Reeder MJ, et al. North American Contact Dermatitis Group patch test results: 2019-2020. Dermatitis. 2023;34(2):90-104.

Hine AM, Waldman RA, Grzybowski A, Grant-Kels JM. Allergic disorders of the eyelid. Clin Dermatol. 2023;41(4):476-480.

Huang CX, Yiannias JA, Killian JM, Shen JF. Seven common allergen groups causing eyelid dermatitis: education and avoidance strategies. Clin Ophthalmol. 2021;15:1477-1490.

Geisler AN, Phillips GS, Barrios DM, Wu J, Leung DYM, Moy AP, Kern JA, Lacouture ME. Immune checkpoint inhibitor-related dermatologic adverse events. J Am Acad Dermatol. 2020 Nov;83(5):1255-1268. doi: 10.1016/j.jaad.2020.03.132. Epub 2020 May 23. PMID: 32454097; PMCID: PMC7572894.

Warp PV, Giménez-Arnau AM, Kim BS, Netchiporouk E, Metz M, Yosipovitch G, Elman SA. Chronic Urticaria Part I: Clinical overview and molecular basis. J Am Acad Dermatol. 2026 Jan 9:S0190-9622(25)03505-4. doi: 10.1016/j.jaad.2025.12.106. Epub ahead of print. PMID: 41520887.

Warp PV, Giménez-Arnau AM, Kim BS, Netchiporouk E, Metz M, Yosipovitch G, Elman SA. Chronic Urticaria Part II: Clinical management and therapeutics. J Am Acad Dermatol. 2026 Jan 4:S0190-9622(25)03506-6. doi: 10.1016/j.jaad.2025.11.104. Epub ahead of print. PMID: 41494572.

Klein JC, Shahwan KT, Petric UB, Mallela T, Voller L, Ruiz E, Ran N, Granger EE, Koyfman S, Vidimos A, Wysong A, Hirotsu K, Carucci JA, Carter JB, Cañueto J, Girardi FM, Mangold AR, Brodland DG, Zitelli JA, Willenbrink TJ, Lotter W, Jeanselme V, Nikahd M, Nijhawan RI, Srivastava D, Carr DR. Impact of immunosuppression on cutaneous squamous cell carcinoma outcomes. J Am Acad Dermatol. 2026 Jan;94(1):151-160. doi: 10.1016/j.jaad.2025.09.042. Epub 2025 Sep 18. PMID: 40975132.

Rojas KD, Perez ME, Marchetti MA, Nichols AJ, Penedo FJ, Jaimes N. Skin cancer: Primary, secondary, and tertiary prevention. Part II. J Am Acad Dermatol. 2022 Aug;87(2):271-288. doi: 10.1016/j.jaad.2022.01.053. Epub 2022 Feb 14. PMID: 35176398.

Keung EZ, Gershenwald JE. The eighth edition American Joint Committee on Cancer (AJCC) melanoma staging system: implications for melanoma treatment and care. Expert Rev Anticancer Ther. 2018 Aug;18(8):775-784. doi: 10.1080/14737140.2018.1489246. PMID: 29923435; PMCID: PMC7652033.

Thank You