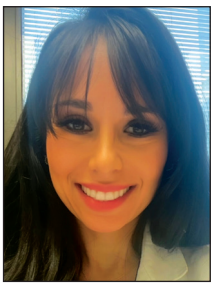

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Clinical Pearls

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Seborrheic dermatitis

By Maryam Safaee, MD, FAAD

1. Seborrheic dermatitis (SD) is a chronic condition which will wax and wane during a patient's lifetime. Although it has an ambiguous etiology, it is mostly thought to be driven by an abnormal immune response to *Malassezia* yeast, primarily affecting body areas with increased numbers of sebaceous glands and larger sebaceous glands such as the scalp, face, upper trunk, and anogenital region. Thus, when unsure if scalp findings are suggestive of SD versus other eczematous eruptions, looking at body sites such as the upper trunk and anogenital region may help narrow the diagnosis.[1]

2. Seborrheic dermatitis has an increased prevalence among individuals with HIV and in some instances can be the first presenting sign. Consider HIV testing if a patient presents with extensive SD and/or therapy-resistant SD. In some cases, it may involve atypical sites such as the extremities.[2]

3. Severe and recalcitrant SD is more prevalent among patients with neurologic conditions such as stroke and Parkinson's disease. Facial immobility in such patients may result in greater accumulation of sebum which in turn leads to growth of *Malassezia*. Interestingly, some studies have shown seborrheic dermatitis may indeed be a premotor feature and early identifier in persons later diagnosed with Parkinson's disease.[3]

4. Although the mainstay of therapy for seborrheic dermatitis includes combination of topical azoles and topical corticosteroids, severe SD can be a challenge to treat. However, recent studies have shown promise in the use of low-dose oral isotretinoin as a viable management option with improvement at doses ranging from 10-20 mg a day.[4]

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