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Facial Pruritus in a Golden Retriever

A 13-year-old spayed female golden retriever is presented for evaluation of facial pruritus in October.

History. The dog is the only pet in the household and has a history of seasonal pruritus (June through early September). The facial pruritus has been present since September, but recently intensified. In the 2 weeks prior to presentation, a facial sore developed. The owner reported that in previous years, the pruritus had never continued beyond the end of September.

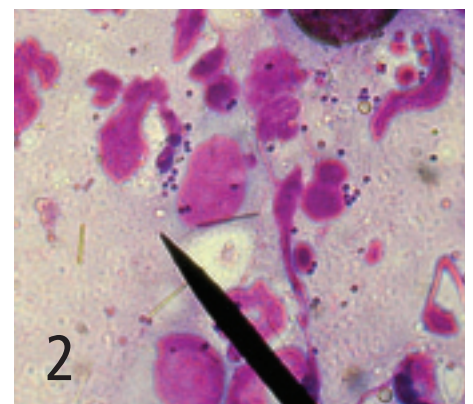
The dog is fed a commercial lamb and rice dog food and is current on vaccinations. She receives monthly heartworm preventative, a monthly topical ectoparasiticide, and is currently receiving 2 capsules of diphenhydramine (25 mg) Q 12 H to control seasonal pruritus.

Examination. Physical examination reveals a body condition score of 6/9. There is moderate dental disease, bilateral nuclear sclerosis, and crepitation present on palpation of the coxofemoral joint bilaterally. The rest of the physical exam is normal.



Dermatologic examination reveals alopecia with a tightly adherent crust mixed with moist exudate (**Figure 1**); there is matted hair on the right cheek. The rest of the examination, including a complete otoscopic examination, is normal.

Laboratory Results. Deep and superficial skin scrapings are negative for *Demodex*. Impression cytology reveals numerous degenerative neutrophils with both intracellular and extracellular cocci (**Figure 2**).



continues

ASK YOURSELF...

- What is your working diagnosis and how would you treat this dog?
- What are the 2 general goals in managing this syndrome?

Diagnosis: Pyotraumatic Dermatitis with Bacterial Folliculitis/ Furunculosis

In the author's experience, pyotraumatic lesions on the cheeks of golden retrievers and Saint Bernard dogs are a form of bacterial folliculitis/furunculosis instead of the more typical surface lesion characteristic of pyotraumatic dermatitis. In addition, the history of seasonal pruritus is consistent with a diagnosis of atopy.

Further History. Other information that should be obtained includes:

- *How does the intensity and distribution of the pruritus compare to other years?* In this case, the owner reported that, in the past, the dog had facial and pedal pruritus but never developed sores on her face. The pruritus is significantly more intense this year than in the past; this is due to the secondary bacterial infection.
- *How was the dog treated in the past and what was the response?* Some pruritic dogs may respond to antihistamines or topical products while others only respond to steroids. If steroids are needed for most of the warm weather season, other treatment options, such as allergen-specific immunotherapy (ASIT) and oral modified cyclosporine, should be pursued.
- *Did the medications cause any side effects?* The answer to this question can help determine what treatment to use and, just as important, what treatment to avoid (eg, severe polyuria/polydipsia as a result of glucocorticoids). In this case, diphenhy-

TAKE-HOME MESSAGE

Because pyotraumatic lesions on the cheek often have a deep bacterial component (rather than the surface component found with other pyotraumatic lesions), treatment is different.

DID YOU ANSWER...

- Pyotraumatic dermatitis with bacterial folliculitis/furunculosis; antibiotics, antimicrobial shampoo, and analgesics
- Treat the current clinical signs and identify and treat the underlying cause

dramine adequately controlled the dog's clinical signs.

Diagnostics. Both superficial and deep skin scrapings should be performed to evaluate for *Demodex cornei*, *Demodex canis*, and *Demodex injai*. Be aware that dogs, like cats, can have both surface and follicular *Demodex* mites. Surface impression cytology should also be performed to identify the presence of white blood cells, bacteria, and *Malassezia*.

It should be noted that intracellular bacteria are consistent with infection and therefore require systemic antibiotics. Extracellular bacteria only indicate surface colonization of the skin and require, at most, an antimicrobial shampoo.

Treatment. When treating pyotraumatic dermatitis you should have 2 goals: (1) treat the current clinical signs, and (2) identify and treat the underlying cause. Failure to accomplish both goals will increase the likelihood of recurrence.

The typical treatment for uncomplicated pyotraumatic dermatitis lesions ("hot spots") is topical therapy (steroid/antibiotic lotion) and oral steroids. However, when pyotraumatic dermatitis is associated with bacterial folliculitis/furunculosis, systemic antibiotics should be used instead. In my opinion, steroids should NOT be administered due to the deep bacterial component.

As with any type of pyotraumatic lesion the dog should be sedated before the hair on and around the lesion is clipped; this allows aggressive clipping without causing distress or pain. I also use a local anesthetic mixture of lidocaine and bupivacaine, which significantly decreases the discomfort associated with clipping.

After clipping, an e-collar should be applied. Analgesics (for 3 to 5 days) and systemic antibiotics—typically cephalexin, 10 to 15 mg Q 8 to 12 H for 30 days or longer (treat 14–21 days past clinical resolution)—should be dispensed. The lesion should be washed daily with an antimicrobial shampoo containing chlorhexidine, benzoyl peroxide, or boric acid/acetic acid. Ten minutes of contact should be allowed before rinsing. Cool compresses may be used to help break the itch–scratch–itch–scratch cycle.

Due to her age and the benign therapy needed in previous years, intradermal testing and ASIT were recommended only if intense seasonal clinical signs (requiring glucocorticoids) returned or the lesion recurred. ASIT requires 6 to 12 months before the full effect is seen. ■



at a Glance

- Systemic antibiotics (typically cephalexin, 10–15 mg Q 8 to 12 H) for at least 30 days, or 14 to 21 days past clinical resolution
- Analgesics for 3 to 5 days
- Daily washing with antimicrobial shampoo containing chlorhexidine, benzoyl peroxide, or boric acid/acetic acid
- Cool compresses to break the itch–scratch–itch–scratch cycle

See Aids & Resources, back page, for references, contacts, and appendices. Article archived on cliniciansbrief.com

ASIT = allergen-specific immunotherapy