



Dermatology for the Emergency Department

Red Flags in a Rash

Skin pain (not just itch), Fever + widespread erythema, Purple/dusky skin, Blistering or epidermal detachment, Mucosal involvement, Recent new drugs (e.g. 8 weeks), Rapid progression, Systemic upset.

Clinical Pearl: If the skin hurts, take it seriously. Itch is common. Pain is different.

Quick ED Approach

History (onset, speed, systemically unwell, new drugs, previous skin disease). Examination (morphology, distribution, check mucosa/scalp/nails, skin pain, epidermal detachment).

Clinical Pearl: Always ask about drugs.

SJS/TEN

Think of it when: painful rash + mucosal involvement, dusky erythema, blistering, recent high-risk drug (allopurinol, lamotrigine, carbamazepine, sulphonamides, antibiotics, NSAIDs). Immediate priorities: stop culprit drug, IV fluids, pain relief, urgent Dermatology + ICU/HDU discussion, non-adherent dressings.

Warning: Avoid adhesives (plasters, tape, ECG stickers).

Clinical Pearl: Check Nikolsky sign. Positive Nikolsky = escalate. Most things can wait — TEN cannot and deteriorates in hours.

Erythroderma

>90% BSA red/inflamed. Risks: fluid loss, temperature dysregulation, CV strain. Causes: eczema, psoriasis, drugs, lymphoma.

Clinical Pearl: Erythroderma is a state, not a diagnosis. Can be chronic. Give emollients and refer.

Eczema Herpeticum

Atopic eczema suddenly worse, painful + fever, monomorphic punched-out lesions. Do NOT delay aciclovir.

Clinical Pearl: Eczema + suddenly worse + unwell = think herpes.

Meningococcal Purpura

Rare but lethal. Treat first. Don't wait to call derm.

Clinical Pearl: If in doubt, treat as meningitis.

Nec Fasc vs Pyoderma Gangrenosum

Both look frightening, management is opposite. Nec fasc = surgical emergency. PG = do NOT debride (pathergy). Usually PG accompanies inflammatory states e.g. IBD, malignancy.

Clinical Pearl: If it is PG, surgery makes it worse.

Chronic Skin Disease Flares

Often non-adherence, ran out of treatment, secondary infection. Check previous Derm letters, moisturise, restart usual topicals.

Clinical Pearl: Most flares are management failures. The patient often has a management plan they haven't been following.

Oral Steroids — Be Cautious

Can destabilise psoriasis, cause rebound flares, complicate diagnosis.

Clinical Pearl: Oral steroids can create tomorrow's emergency.

Pemphigus/Pemphigoid

Widespread blistering, erosions, mucosal involvement, elderly patients. May mimic TEN.

Clinical Pearl: Blistering + mucosal disease + unwell = do not underestimate.

Generalised Pustular Psoriasis

Widespread pustules + systemically unwell. Needs urgent specialist input. Giving oral steroids can be fatal.

Clinical Pearl: Do NOT give systemic steroids in chronic disease - you may trigger a pustular flare and make it much worse.

Chronic Urticaria

Chronic is classed as >6 weeks. This is not type 1 allergy. Give high-dose antihistamines e.g. fexofenadine 360mg twice daily and chlorphenamine.

Clinical Pearl: Chronic urticaria is usually not an allergy hunt.

Filler Vascular Occlusion

Pain after filler, blanching, livedo. Hyaluronidase urgently (often 1500 IU in 1ml saline/water), oxygen, aspirin 300mg. Risk: blindness, significant scarring.

Clinical Pearl: Pain + blanching after filler = vascular occlusion until proven otherwise.

Take-Home Messages

- If the skin hurts take it seriously
- Always ask about new drugs
- Check Nikolsky and if positive speak to intensive care
- Do NOT debride pyoderma gangrenosum
- Avoid routine oral steroids for chronic rashes
- Most dermatology can wait: TEN cannot.

DISCLAIMER: This document is intended as a brief educational aide-memoire only and does not constitute medical advice. Clinical decisions must be based on individual patient assessment, local guidelines, and senior clinical judgment. The author(s) accept no liability for clinical outcomes. Always follow your institution's protocols.

Dr Amy Perkins | April 2026

www.amyperkinsdermatology.com