Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Dermatology pre-referral guidelines – seborrhoeic dermatitis (dandruff)

Fiona Stanley Hospital Dermatology

Disclaimer

These guidelines have been produced to guide clinical decision making for general practitioners (GPs). They are not strict protocols. Clinical common-sense should be applied at all times. These clinical guidelines should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. Clinicians should also consider the local skill level available and their local area policies before following any guideline.

Introduction

Seborrhoeic dermatitis (known colloquially in the scalp as dandruff) is caused by an overgrowth of pityrosporum yeast (also known as *malassezia furfur*) and then an immune reaction to this overgrowth. It is often scaly and variably itchy and is found in areas where the lipophilic yeast is found in high numbers (often the same areas people suffer from acne, where there is increased sebaceous glands - eg scalp, face, chest, armpits, groin and genitals). It is more common in older children (pubertal) and adults, but infantile seborrheic dermatitis (<6 months of age where maternal hormones are still on board) is also a common presentation.

It can be difficult to clinically differentiate seborrheic dermatitis from scalp eczema, tinea capitis or mild psoriasis.

If hair loss is seen, consider tinea and do a skin scraping and hair pluck for fungal microscopy and culture.

If obvious plaques, consider psoriasis.

If a history of atopy and the skin is very dry and itchy, consider atopic dermatitis.

Pre-referral management

First line treatment

- Wash scalp more often making sure to massage the scalp with shampoo.
- Anti-dandruff (anti-yeast) shampoos containing either selenium sulphide, zinc pyrithione, ketoconazole or coal tar.
- A topical steroid lotion eg Mometasone furoate lotion in the scalp can be used and will help itch but will not deal with the fundamental issue and can cause side effects in the long term so should be paired with anti- yeast measures.
- Topical steroids on the face should be avoided if possible as steroid rosacea can be caused in the long term.
- Elidel cream for facial seborrheic dermatitis is a good alternative to topical steroids.

Other considerations

- Seborrhoeic dermatitis can be exacerbated by stress, illness, medications, occupations and other hormonal states.
- Severe and refractory seborrrhoeic dermatitis can be a presenting feature of immunodeficiency including HIV.

Other treatments may be used at the hospital

- Isotretinoin
- Oral anti-fungal agents

When to refer

- Refractory dandruff – may be a different diagnosis or need other treatments, eg systemic retinoids.
- Steroid side effects, eg scalp dysaesthesia, telangiectasia, or sebo-rosacea.

Essential information to include in your referral

- Types of treatments trialled, their effect and reason for cessation.
- Any investigations, eg fungal microscopy/culture of skin scrape/hair pluck, HIV status.

Useful patient resources

1. https://dermnetnz.org/topics/seborrhoeic-dermatitis - Dermnet NZ
2. https://www.dermcoll.edu.au/atoz/seborrhoeic-dermatitis-cradle-cap/ - Australasian College of Dermatologists
3. https://pedsderm.net/site/assets/files/1028/spd_seb_derm_color_web.pdf - Society of Pediatric Dermatology

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