INTEGUMENTARY · NGN NCLEX 2026

Seborrheic *Dermatitis*

A chronic, relapsing inflammatory skin condition affecting sebum-rich regions — scalp, face, ears, chest. Linked to *Malassezia* yeast overgrowth. Common in infants ("cradle cap"), adults 30–60, immunocompromised, and Parkinson's clients.

📍 Scalp · Face · Chest | Malassezia yeast | ♾ Chronic · Relapsing | ⚠ Not contagious

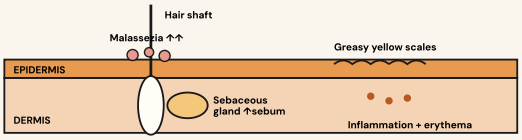
1 Definition & Overview

- Chronic inflammatory skin disorder in **sebaceous-gland-rich areas**.
- Driven by overgrowth of **Malassezia furfur** (commensal yeast) + sebum + inflammatory response.
- Infants: **cradle cap** (self-limiting). Adults: lifelong flares.
- Worse with stress, cold/dry weather, illness, HIV, Parkinson's.

🧯 WHY IT MATTERS

Severe or sudden-onset seborrheic dermatitis in an adult can be an **early presenting sign of HIV/AIDS** or neurologic disease. Always assess in context.

2 Pathophysiology



Malassezia overgrowth on lipid-rich skin → Yeast breaks down sebum → free fatty acids → Greasy yellow scales, erythema, itch ← Inflammation + ↑ keratinocyte turnover

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Signs & Symptoms

🟢 Mild / Early

- **Dandruff** — fine, dry, white flakes on scalp
- Mild pruritus (itch)
- Slight redness in nasolabial folds, eyebrows
- Infants: yellow, greasy scaly patches on scalp ("cradle cap")

🔴 Moderate / Severe

- **Greasy yellow scales** on erythematous base
- Well-demarcated red patches: eyebrows, glabella, nasolabial folds, postauricular, presternal chest
- Blepharitis (eyelid margin scaling, crusting)
- Burning, stinging — esp. after sweating
- Possible secondary bacterial infection

🚨 RED FLAGS

Sudden severe flare in adult → screen for **HIV**. Extensive scalp involvement in infant unresponsive to care → consider **Leiner's disease** (immunodeficiency) or **Langerhans cell histiocytosis**. Erythroderma (>90% body surface red) is a dermatologic emergency.

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Priority Nursing Interventions

ASSESS

- Inspect scalp, face, ears, chest, intertriginous folds
- Document distribution, scale color/character, erythema, excoriation
- Screen risk factors: HIV, Parkinson's, stress, recent illness

INTERVENE (ABCS → SAFETY → SKIN)

- **Administer** antifungal shampoo (ketoconazole 2%, selenium sulfide, zinc pyrithione) — leave on 5–10 min before rinsing
- **Apply** low-potency topical steroid to face (hydrocortisone 1%); medium-potency to scalp/body — short courses only
- **Soften** infant cradle cap with mineral oil 15 min → gentle brush → mild shampoo
- **Avoid** harsh soaps, alcohol-based products, scratching
- **Monitor** for secondary infection (warmth, pus, fever) → notify HCP

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Pharmacology

DRUG / CLASS	ACTION	NURSING PEARLS
Ketoconazole 2% **(shampoo / cream)**	Antifungal — kills Malassezia	Leave on 5 min; 2×/wk × 4 wk. Avoid eyes.
Selenium sulfide **Zinc pyrithione**	Antifungal / antiseborrheic	OTC shampoos. May discolor light hair.
Hydrocortisone 1%	Low-potency topical steroid — ↓inflammation	Face/folds only. **Short-term** — skin atrophy with overuse.
Pimecrolimus **Tacrolimus**	Calcineurin inhibitor — non-steroid anti-inflammatory	Steroid-sparing. Avoid sun. Black-box: lymphoma risk (rare).
Coal tar shampoo	Slows keratinocyte turnover	Photosensitivity. Strong odor. Stains.
Salicylic acid	Keratolytic — lifts scales	Useful for thick plaques on scalp.

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NCLEX Test Traps ⚠

✗ **Wrong:** Treat infant cradle cap by aggressively scrubbing the scalp.
✓ **Right:** Soften with mineral oil 15 min, then **gently** brush — never pick or scrub.

✗ **Wrong:** Apply potent steroid (triamcinolone, betamethasone) to the face long-term.
✓ **Right:** Face = **low-potency only** (hydrocortisone 1%) and short courses. Potent steroids cause atrophy, telangiectasia, perioral dermatitis.

✗ **Wrong:** Tell the client seborrheic dermatitis is contagious.
✓ **Right:** It is **NOT contagious**. It is a chronic inflammatory response to a normal skin commensal.

✗ **Wrong:** Confuse with **psoriasis** (silver scales, well-defined, extensor surfaces) or **tinea capitis** (broken hairs, alopecia, kerion).
✓ **Right:** Seborrheic = **greasy yellow scales**, sebum-rich zones, no hair loss.

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Patient & Family Education

- **Chronic & relapsing** — manageable, not curable. Flares are normal; resume treatment promptly.
- Use medicated shampoo **2–3×/week**; lather, leave on 5–10 min, rinse.
- Rotate shampoo types (ketoconazole / zinc / selenium / tar) to prevent resistance.
- Wash face with **gentle non-soap cleanser**; pat dry — no scrubbing.
- Avoid alcohol-based toners, harsh exfoliants, hot showers.
- Manage triggers: **stress, fatigue, cold/dry weather, sweating**.
- Apply steroid **thinly**; stop when clear; don't share tubes.
- Sun exposure (in moderation) may help — but use sunscreen.
- Infant cradle cap: usually resolves by 8–12 months; reassure parents.
- Notify HCP: yellow pus, fever, rapid spread, eye involvement.

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Memory Boosters

SEBUM

- **S**caly greasy yellow plaques
- **E**rythema in folds (nasolabial, postauricular)
- **B**aby cradle cap / **B**lepharitis
- **U**nresponsive severe → think **HIV**
- **M**alassezia is the culprit

SHAMPOO

- **S**elenium sulfide
- **H**ydrocortisone (face, low-dose)
- **A**ntifungal — ketoconazole
- **M**ineral oil for cradle cap
- **P**imecrolimus (steroid-sparing)
- **O**il-free gentle cleanser
- **O**il of tar (coal tar)

🔁 Quick Compare

FEATURE	SEBORRHEIC	PSORIASIS
Scale	Greasy **yellow**	Dry **silver**
Location	Sebum-rich (scalp, face, chest)	Extensor surfaces, scalp, nails
Itch	Mild–moderate	Variable
Cause	Malassezia + sebum	Autoimmune T-cell
Auspitz sign	Negative	**Positive**

🎯 Pattern Recognition

- "Greasy yellow flakes on scalp + nasolabial folds" → **seborrheic dermatitis**
- "Infant with thick yellow scalp scales, otherwise well" → **cradle cap**
- "Adult with sudden severe seborrheic flare + weight loss + thrush" → **screen for HIV**
- "Parkinson's pt with facial scaling + dandruff" → classic seborrheic

NCJMM CLINICAL JUDGMENT SCENARIO

Six-Step Clinical Judgment Model

Scenario: *A 42-year-old male presents to the clinic with a 3-month history of worsening flaky, itchy red patches on his scalp, eyebrows, and nasolabial folds. He reports recent unintentional 15-lb weight loss, fatigue, and oral white patches. PMH: unremarkable. He states, "My dandruff shampoo isn't working anymore." Vital signs: T 99.8°F, HR 92, BP 118/74, RR 18, SpO_2 98%.*

01

RECOGNIZE CUES

Greasy yellow scales in sebum-rich zones, **refractory** to OTC treatment, weight loss, oral thrush, low-grade fever. Pattern of **severe atypical seborrheic dermatitis + constitutional symptoms**.

02

ANALYZE CUES

Severe, refractory seborrheic dermatitis + oral candidiasis + weight loss = suspicious for **immunocompromise**. HIV is a leading consideration. Could also be Parkinson's-related, but no neuro signs.

03

PRIORITIZE HYPOTHESES

#1 HIV/immunocompromise (constellation of skin + thrush + weight loss). #2 Refractory seborrheic dermatitis alone. #3 Psoriasis (less likely — scale color, location).

04

GENERATE SOLUTIONS

Notify HCP. Anticipate **HIV testing** with informed consent, CD4 count, oral exam for thrush, basic labs. Continue ketoconazole shampoo. Consider topical antifungal for thrush.

05

TAKE ACTION

Counsel client privately on HIV testing rationale; obtain consent. Draw labs. Educate on shampoo technique. Provide emotional support. Refer to dermatology + ID. Maintain confidentiality.

06

EVALUATE OUTCOMES

Reassess in 1–2 wk: skin response to therapy, HIV result & disclosure, CD4 trend, weight, thrush resolution. Adjust plan based on HIV status; initiate ART if positive; reinforce adherence.