Dermatology Week

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Clinical Mythbusters in Seborrheic Dermatology 2025: Better Diagnosis, Treatment, and Long-Term Care

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Disclosures

- **Tina Bhutani, MD:** Advisory Board – AbbVie, Arcutis, Aslan, Boehringer Ingelheim, Bristol Myers Squibb, Dermavant, Galderma, Incyte, Janssen, LEO, Lilly, Novartis, Pfizer, Sanofi, Sun, Takeda, UCB; Grant/Research Support – Amgen, Castle, CorEvitas, Novartis, Pfizer, Regeneron; Speaker's Bureau – AbbVie, Amgen, Arcutis, BMS, Dermavant, Galderma, Janssen, LEO, Lilly, Ortho, Sanofi, UCB

- **Oyetewa Asempa, MD, FAAD:** Advisor – Arcutis, Regeneron, Sanofi, Veradermics; Speaker – Arcutis

Learning Objectives

- Describe common myths surrounding the pathophysiology and treatment of SD, and apply updated evidence to clinical decision-making

- Evaluate therapeutic strategies beyond antifungals and corticosteroids, incorporating newer anti-inflammatory and barrier-supportive agents into patient-centered care

- Implement long-term management plans that address adherence, relapse prevention, and psychosocial burden through shared decision-making and patient education

SD = seborrheic dermatitis.

Myth #1:
“Seborrheic Dermatitis Is Caused by Malassezia; Antifungals Are Therefore the Best Treatment”

Polling: What Is the Primary Cause of SD?

- Which of the following options best reflects the primary driver of SD pathogenesis?

A. A dysregulated cutaneous immune response with skin-barrier dysfunction interacting with commensal Malassezia and sebum (multifactorial pathogenesis)

B. Autoimmune attack on melanocytes with secondary scaling

C. Overgrowth of Malassezia alone is the root cause, so antifungals are universally first-line

D. Primary bacterial infection (*Staphylococcus aureus*) in sebaceous areas

Seborrheic Dermatitis

- Erythematous patches with yellow, greasy scales and superficial flaking, in sebaceous gland-rich areas
  - Scalp, face (especially nasolabial folds, eyebrows, and glabella), chest
- Often appears hypopigmented in darker skin tones

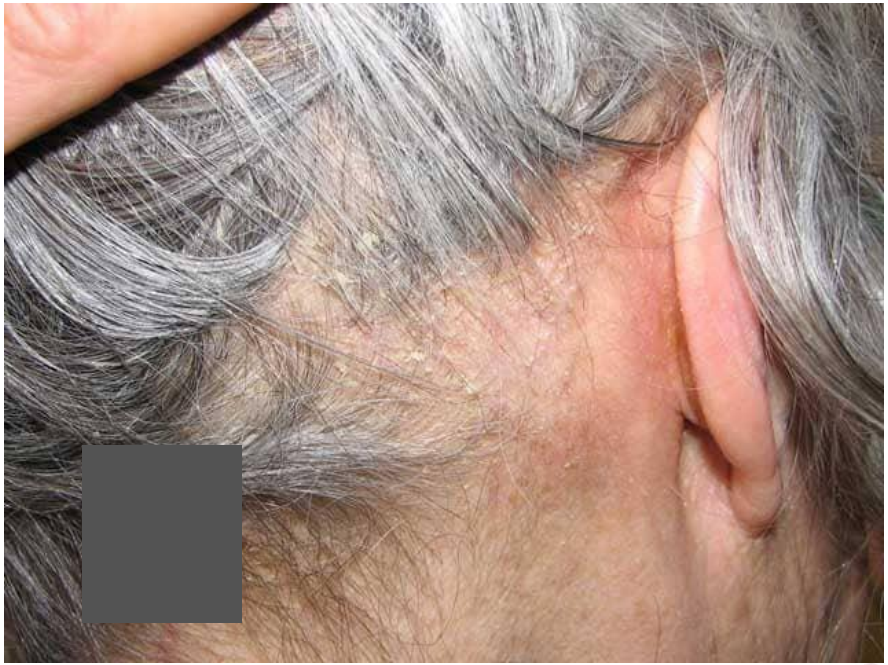
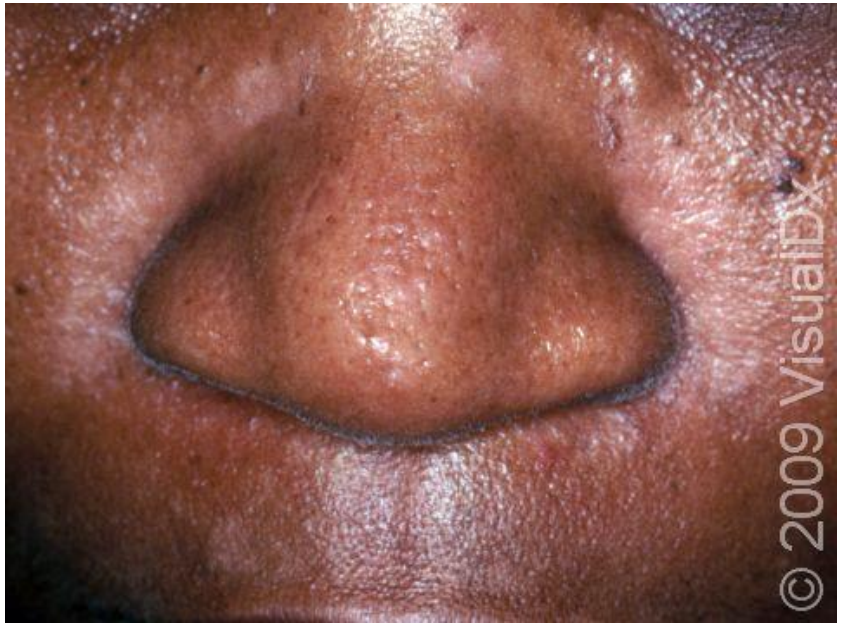


Image source: DermNet.

Pathogenesis

- Multifactorial pathogenesis
  - Barrier dysfunction
    - Altered ceramide composition and increased TEWL in lesion skin → microbial colonization
  - Immune dysregulation
    - Th17/Th22, Th1 activation → upregulation of inflammatory cytokines
  - Microbiome alteration
    - Malassezia load, increased Staphylococcus, and decreased Cutibacterium



TEWL = transepidermal water loss.

Rosel J, et al. *Exp Dermatol*. 2024;33(1):e14952. Ungar B, et al. *J Am Acad Dermatol*. 2025;92(6):1277-1287.

Why the Myth Persists

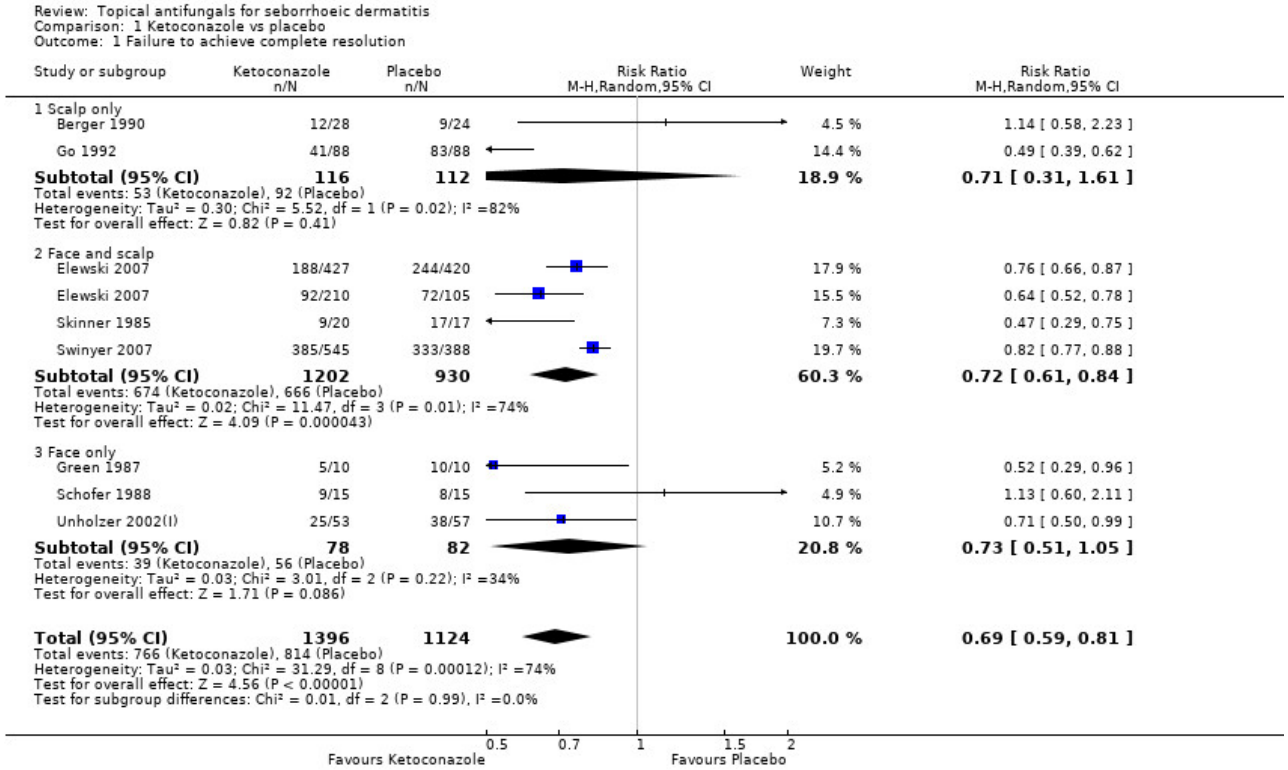
Historical observations of Malassezia yeast on affected skin

Early efficacy of antifungal treatments

Strong association between the disease and fungal etiology in both clinical practice and research

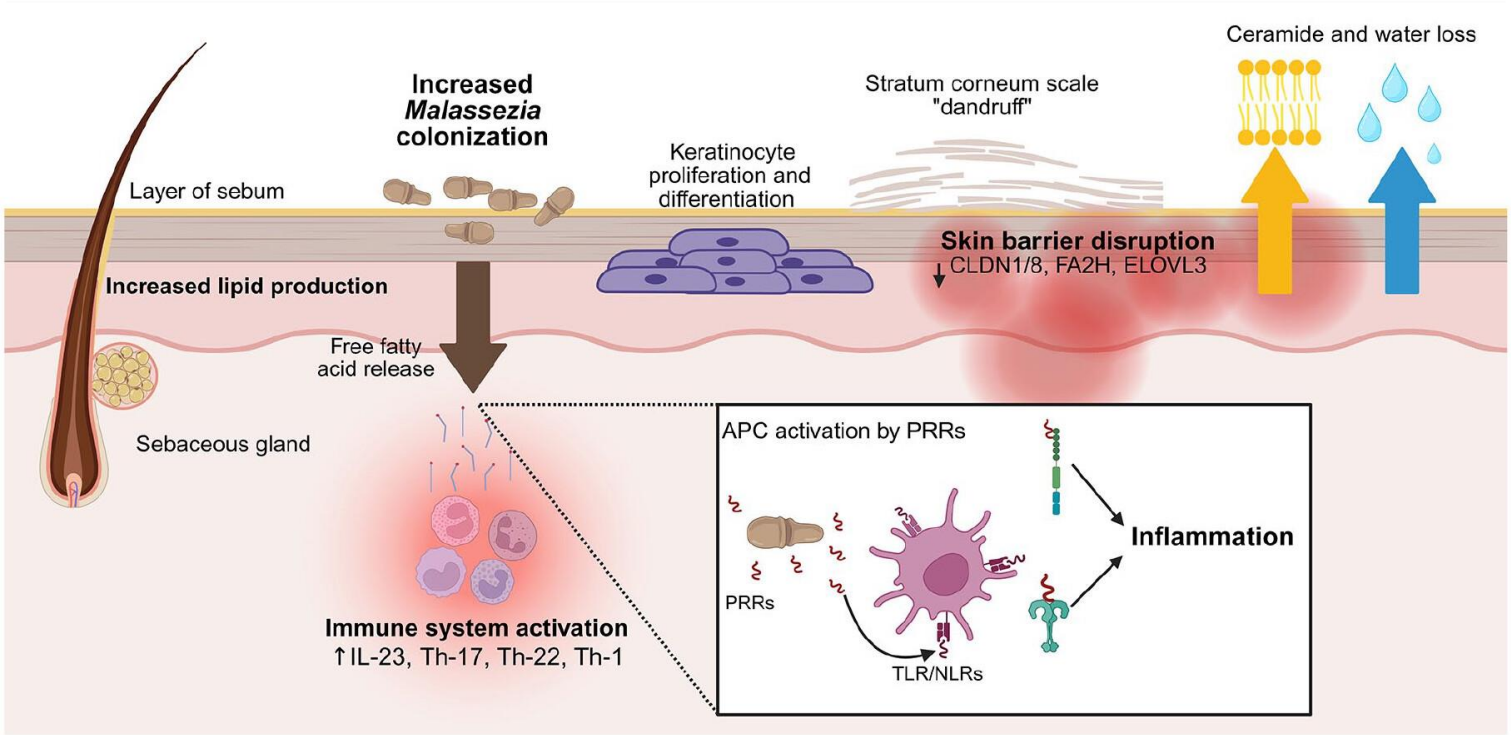
Chang CH, Chovatiya R. *Arch Dermatol Res*. 2024;316(4):100.

Antifungals Show Short-Term Efficacy

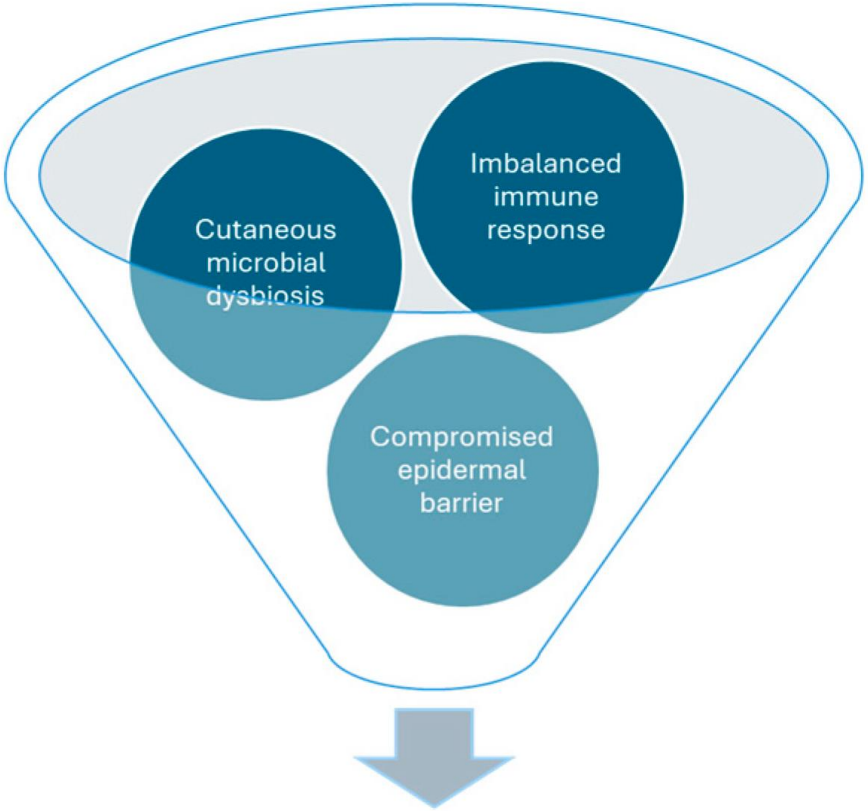


Okokon EO, et al. *Cochrane Database Syst Rev*. 2015;(5):CD008138.

Complex Pathogenesis of Seborrheic Dermatitis



Turchin I, et al. *J Cutan Med Surg*. 2025 [Epub ahead of print].



Need a Multimodal Approach to Treatment

Galizia G, et al. *Cosmetics*. 2024;11(6):208.

Re-Polling: Assess Updated Perceptions

1. Which of the following options best reflects the primary driver of SD pathogenesis?

   A. A dysregulated cutaneous immune response with skin-barrier dysfunction interacting with commensal Malassezia and sebum (multifactorial pathogenesis)

   B. Autoimmune attack on melanocytes with secondary scaling

   C. Overgrowth of Malassezia alone is the root cause, so antifungals are universally first-line

   D. Primary bacterial infection (*Staphylococcus aureus*) in sebaceous areas

Key Learning Point

- Shift from “fungal-only” model of managing seborrheic dermatitis to a multimodal, immune-focused model of management

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Myth #2:
“Topical Corticosteroids Are the Safest and Most Effective Approach for Long-Term Management”

Polling: What Is Your Go-To for Long-Term SD Management?

2. Which of the following would be considered the optimal go-to strategy for the long-term (maintenance) management of SD?

   A. Antifungal monotherapy (eg. ketoconazole shampoo/day cream) exclusively

   B. Continuous use of mid-potency or higher topical corticosteroids indefinitely

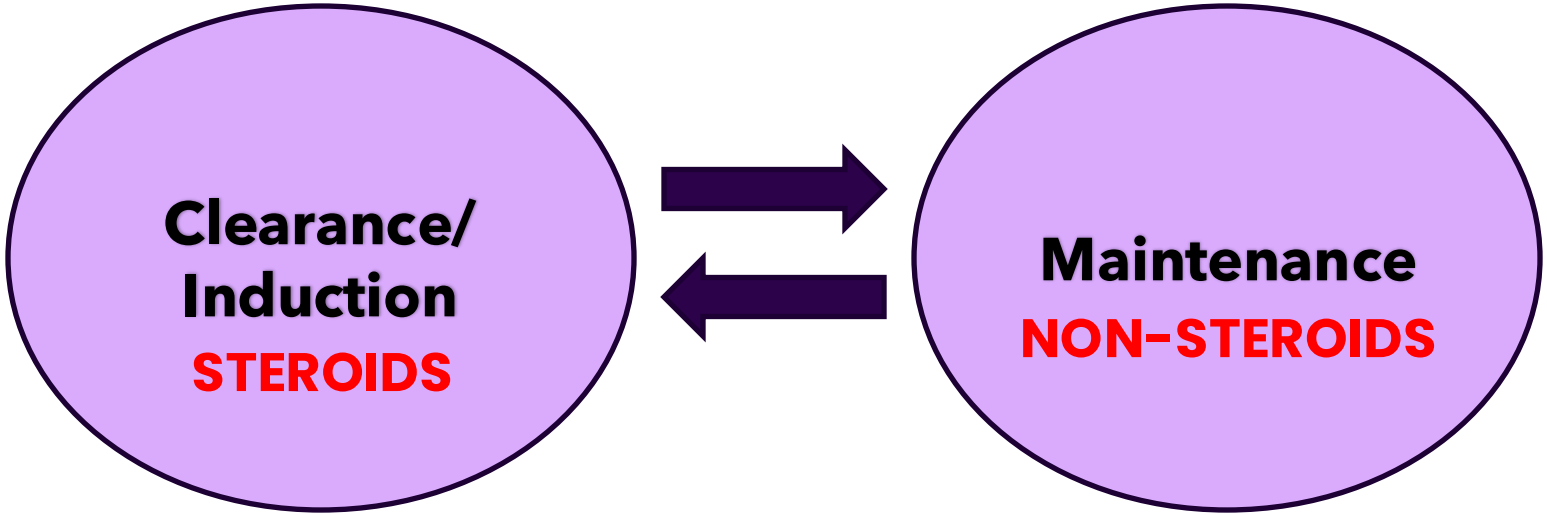
   C. Intermittent/rotational use of nonsteroidal anti-inflammatory topicals (eg. roflumilast 0.3% foam, ketoconazole 2% cream) together with antifungals and barrier support

   D. Systemic immunosuppressants (eg. low-dose oral steroids or systemic immunomodulators) as maintenance

Why the Myth Persists?

- Rapid symptom relief
- Low cost
- Familiarity/historical reliance
- Limited earlier alternatives

Concept for Treating Chronic Skin Disease



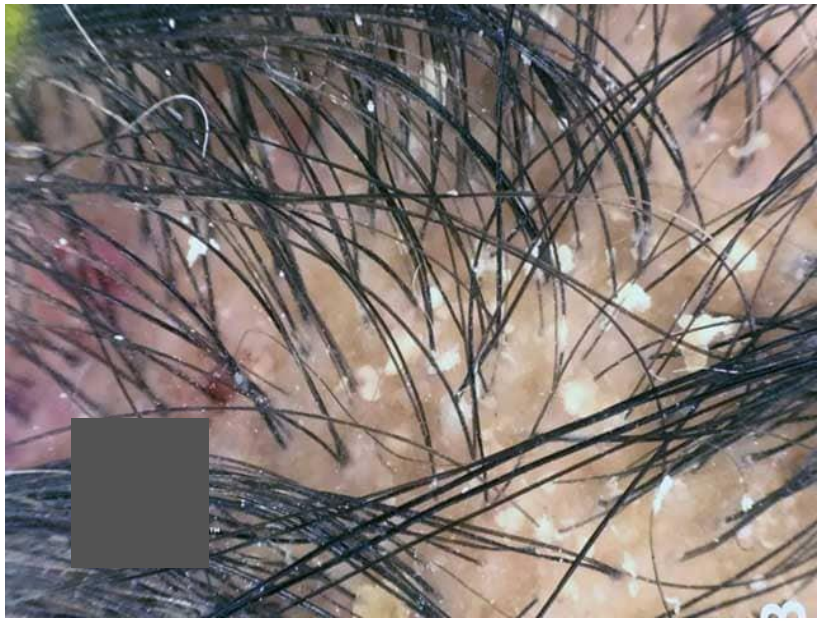
Classic SD Treatment Options

- **Topical corticosteroids**
  - **Highly effective** in reducing inflammation
  - Drawbacks: **Atrophy**, hypopigmentation, tachyphylaxis, rebound flares
- **Topical calcineurin inhibitors**
  - Tacrolimus, pimecrolimus (has been shown to be **particularly effective with re-pigmentation** in darker skin tones)
  - Steroid-sparing options, **favorable safety**
  - Drawbacks: Often burn on initial application
- Others: Topical antifungals, sulfur, tar, pyrithione zinc

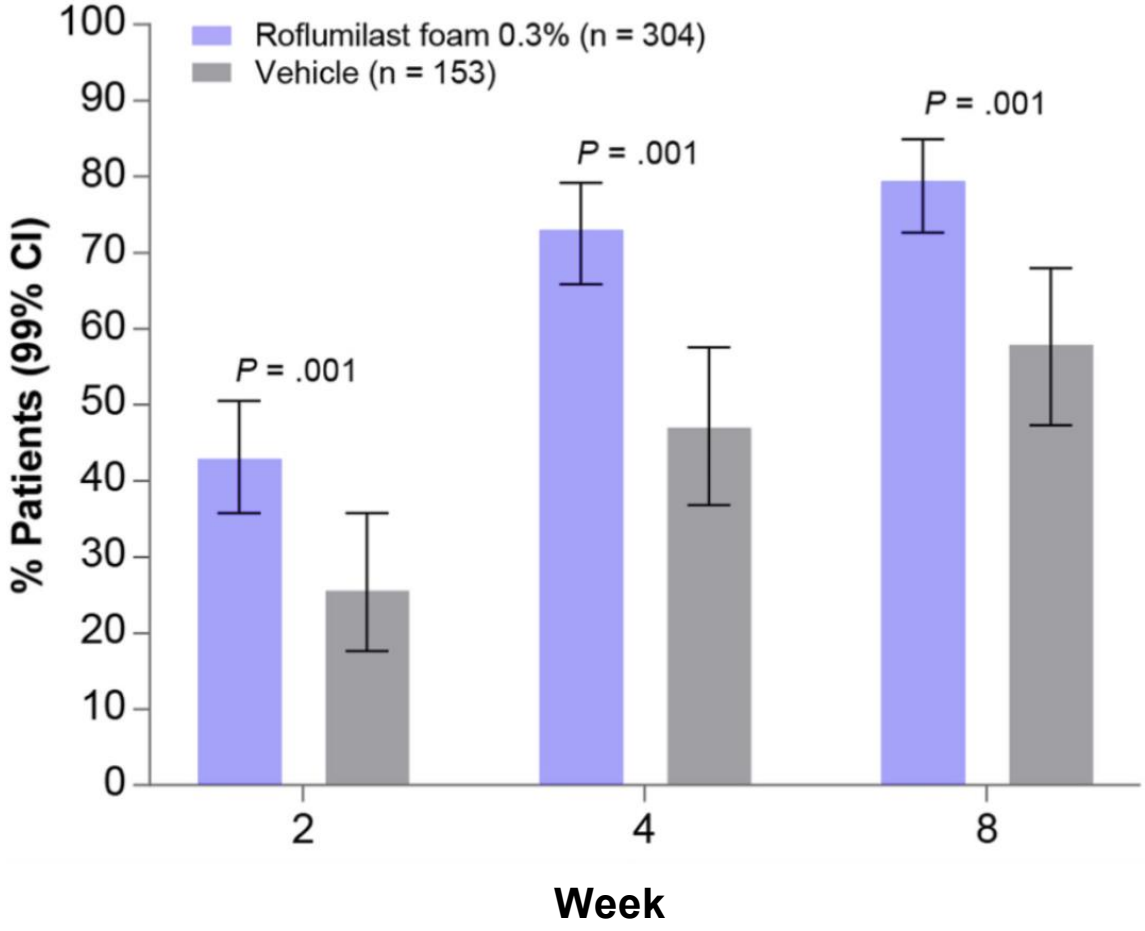
High WA, et al. *J Am Acad Dermatol*. 2006;54(6):1083-1088. Kastarinen H, et al. *Cochrane Database Syst Rev*. 2014;2014(5):CD009446.

Newer Therapies

- **Roflumilast foam 0.3%** (FDA approved)
  - **PDE-4 inhibitor**
  - Phase 3 trial data: 80% IGA success at 8 weeks; rapid itch relief within 48 hours
  - No duration of use or body location limitations
- **Emerging agents**
  - Crisaborole (PDE-4 inhibitor)
  - Apremilast (PDE-4 inhibitor) microemulsion gel
  - Tapinarof (PAhR agonist)

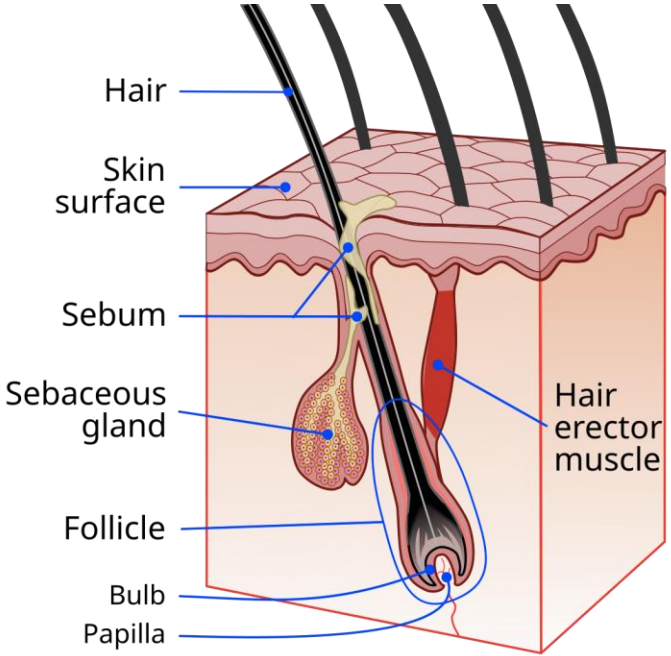


IGA = investigator global assessment.
Image source: DermNet. Blauvelt A, et al. *J Am Acad Dermatol*. 2024;90(5):986-993. Zirwas MJ, et al. *JAMA Dermatol*. 2023;159(6):613-620.



Blauvelt A, et al. *J Am Acad Dermatol*. 2024;90(5):986-993.

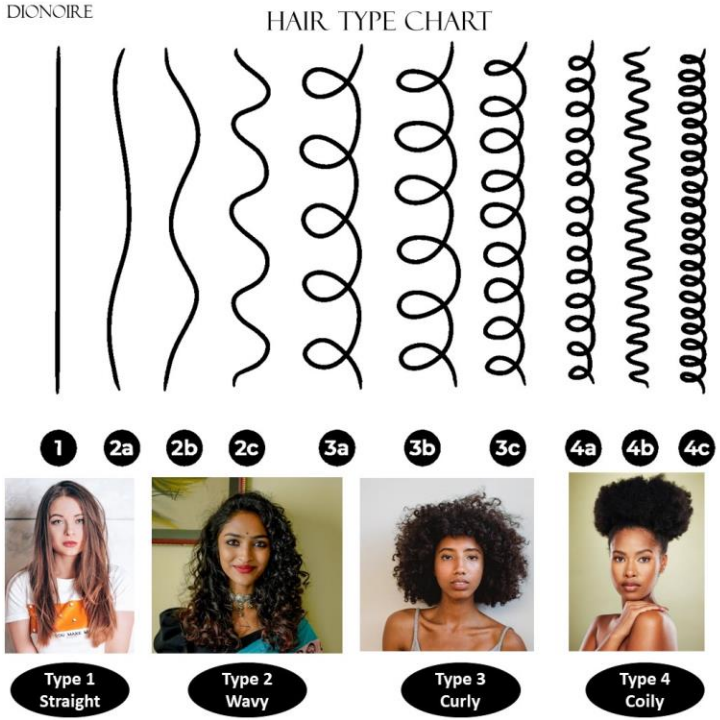
Impact of Hair Texture on Management



- Sebum down the hair shaft to maintain hydration/moisture, has harder time traveling down the shaft the more curly the hair is
- **Curly hair more naturally prone to dryness, more likely to break**
- Thus, variability in hair texture leads to variability in recommended hair washing frequency
- Leave-on products may be more effective than shampoos in curlier hair types

Kim S, et al. *J Cosmet Dermatol Sci Appl.* 2021;11(3):204-216. Khumalo NP, et al. *J Am Acad Dermatol.* 2000;43(5 Pt 1):814-820.

Patient Centered Approach to Treatment Selection



- Ask for vehicle preferences
- Think about
  - Hair type
  - Hair care practices
  - Current or future planned hairstyle
  - Ease of use
  - Personal preference

Re-Polling: Reassess Treatment Strategy Preferences

2. Which of the following would be considered the optimal go-to strategy for the long-term (maintenance) management of SD?

   A. Antifungal monotherapy (eg. ketoconazole shampoo/day cream) exclusively

   B. Continuous use of mid-potency or higher topical corticosteroids indefinitely

   C. Intermittent/rotational use of nonsteroidal anti-inflammatory topicals (eg. roflumilast 0.3% foam, ketoconazole 2% cream) together with antifungals and barrier support

   D. Systemic immunosuppressants (eg. low-dose oral steroids or systemic immunomodulators) as maintenance

Key Learning Point

- Steroid-free regimens can now be prioritized for sustained safety and efficacy

Myth #3:
“Seborrheic Dermatitis Is a Trivial Nuisance with Minimal Impact on Quality of Life”

Polling: How Significant Is SD's QoL Burden?

3. How significant do you consider the impact of SD to be on a patient's quality of life (QoL)?

   A. Minimal—it's mostly cosmetic and doesn't affect daily function or mental health

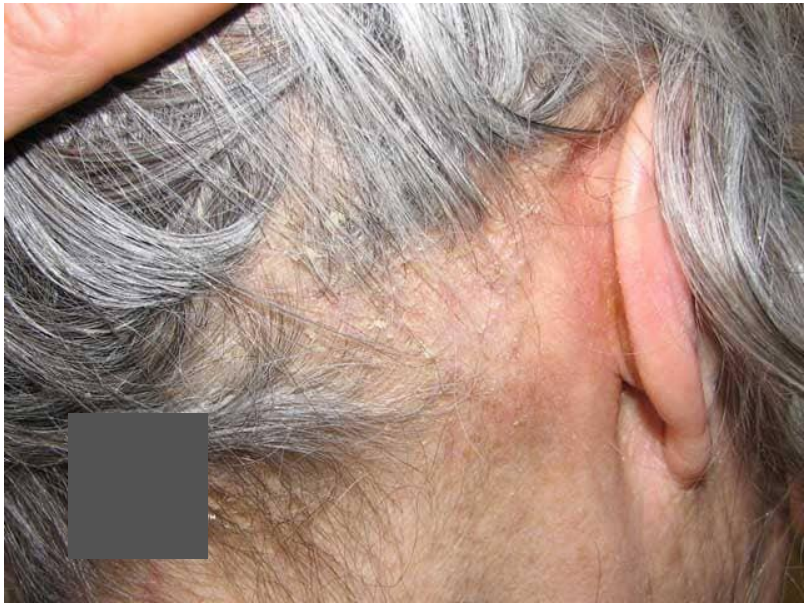
   B. Mild—occasionally itchy or flaky, but rarely distressing

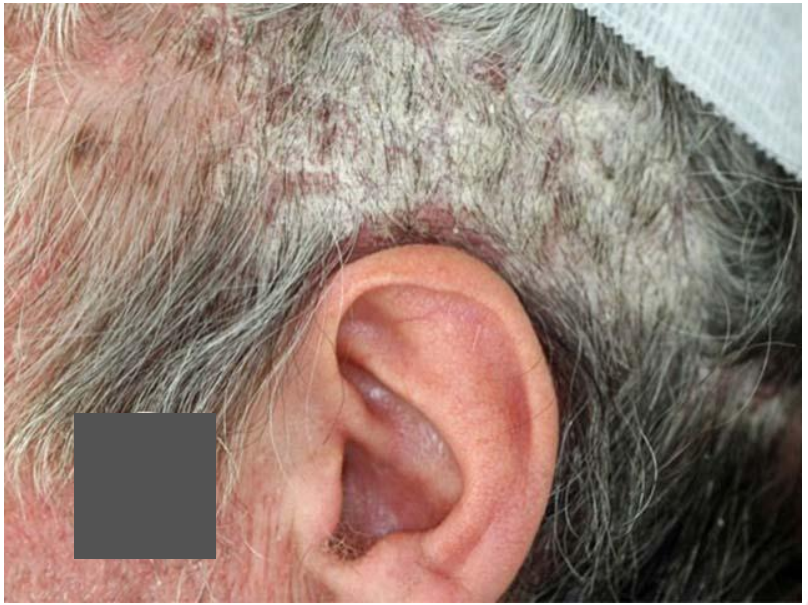
   C. Moderate to severe—symptoms, visibility, and chronicity can cause notable psychosocial and emotional distress comparable to psoriasis or acne

   D. Variable—only in severe scalp cases, otherwise negligible

Why the Myth Persists

- Symptoms appear mild compared with AD or psoriasis

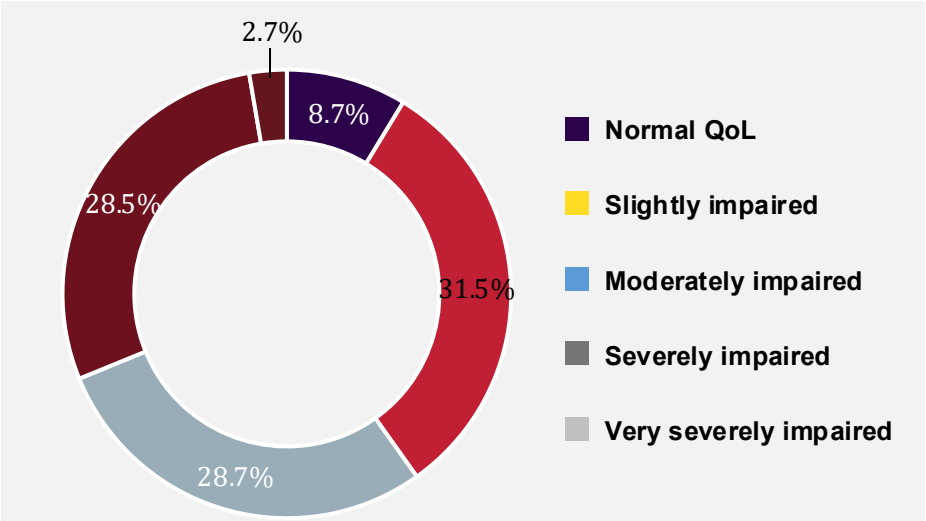




AD = atopic dermatitis.
Images source: DermNet.

Seborrheic Dermatitis and Quality of Life

- Female patients with seborrheic dermatitis and dandruff experienced greater reductions in QoL than male patients, including embarrassment and restrictions in clothing choice
- Patients with scalp lesions experience bothersome flaking that may lead to a loss of self-esteem
- Seborrheic dermatitis is associated with anxiety and depression, as well as increased rates of emotional somatization, loss of self-esteem, and negative social image



QoL impairment, measured by DLQI score, in a study of 899 patients with seborrheic dermatitis in Poland

DLQI = Dermatology Life Quality Index.

Araya M, et al. *Indian J Dermatol*. 2015;60(5):519. Szepietowski JC, et al. *Mycoses*. 2009;52(4):357-363. Karimkhani C, et al. *JAMA Dermatol*. 2017;153(5):406-412. Gül AI, et al. *Arch Clin Psychiatry*. 2017;44(1):6-9.

Polling: Assess Changes in Appreciation of QoL Impact

3. How significant do you consider the impact of SD to be on a patient's quality of life (QoL)?

   A. Minimal—it's mostly cosmetic and doesn't affect daily function or mental health

   B. Mild—occasionally itchy or flaky, but rarely distressing

   C. Moderate to severe—symptoms, visibility, and chronicity can cause notable psychosocial and emotional distress comparable to psoriasis or acne

   D. Variable—only in severe scalp cases, otherwise negligible

Key Learning Point

- Patient-centered strategies are essential for durable outcomes

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Thank You