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**Dokter Umum Berkualitas
Menuju Layanan Primer yang Unggul
dan Efisien**

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Dermato-venerology in Primary Healthcare Service According to SKDI 2012

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Introduction

Competency of general practitioner in Indonesia is regulated in *Standar Kompetensi Dokter Indonesia (SKDI)* made by *Konsil Kedokteran Indonesia*. It is divided into several levels:

- Level 1: To know and explain
- Level 2: To diagnose and refer
- Level 3: To diagnose, give initial treatment, and refer
 - o 3A. Not emergency
 - o 3B. Emergency
- Level 4: To diagnose and give complete treatment independently.
 - o 4A. Competency is gained when doctor is graduated
 - o 4B. Proficiency is gained after internship or Continuous Medical Education

There are 79 diseases explained in SKDI related to integument system where most of them is included in level 4A which means general practitioner should be able to diagnose and treat independently in primary healthcare service.

Virus Infection

Verruca vulgaris is a disease characterized by painless lumps but it can also be painful if appears on hand or sole of the feet. The most common site of this disease is back, hand, and fingers. In children it often appears on neck and face. Physical examination shows grey or brown or skin-like color papule or nodule with sharp margin, squamous, verrucous or irregular, solitary or grouped, with few millimeters to 1 centimeter size. Histopathology evaluation shows papillomatosis, acanthosis, hyperkeratosis, and rete ridge toward medial side. Non medicamentosa therapy can be done by avoiding direct contact and maintaining good hygiene. Medicamentosa therapy can be done by electric surgery, laser surgery, keratolytic,

caustic agent (25%-50% salicylic acid, 25% trichloroacetate), and intralesion therapy (bleomisin and interferon).

Varicella is very common in primary healthcare setting. It starts with prodromal symptoms such as fever, malaise, headache and then develops into skin eruption with erythematous papule which turns into pustule and burst becoming crust. While this process happens, another vesicle develops creating polymorphic description for this disease. Main therapy of varicella is symptomatic therapy, but antiviral agent such as acyclovir can be given in certain indications.

Herpes simplex can happen in both man and woman. Type 1 herpes simplex virus usually attacks children while type 2 herpes simplex virus usually happens in second or third decade of life associated with increased sexual activity. It is characterized by painful vesicle, erupted 7 or more days after exposure, and sometimes also cause leukorrhea in woman. Tzanck test with Giemsa coloring shows multinuclear giant cell with intranuclear inclusion body.

The course of morbilli or measles is divided into 3 stages, prodromal stage for 4-5 days, eruption stage, and convalescence stage. Eruption stage is characterized by the appearance koplik spot and rash starts from the back of the ear and spreads into face, trunk, arm, and leg. Symptomatic therapy and vitamin A is the main therapy of morbilli. Antibiotic can be given if secondary infection is present.

Bacterial infection

Furuncle is inflammation in hair follicle and surrounding tissue usually caused by *Staphylococcus aureus* infection. The term furunculosis is used when there are more than one furuncle and carbuncle is used in grouped furuncle. Predilection of furuncle is the ones that are moist and experience much friction such as axilla, buttock, back, neck, and face. Physical examination shows cone-shaped erythematous nodule with pustule and the center. Nodule will soften and forms pus-filled abscess. This abscess then burst and forms fistule. Topical antibiotic can be used for small lesion while systemic antibiotic is more effective for extended lesion.

Erythrasma is usually found in axilla and groin. It can be asymptomatic, itchy, or even accompanied with burning sensation. Physical examination shows erythroscaly lesion with red or brown fine scales depends on the skin color of the patient. Tetracycline, clindamycin, or 2% sodium fusidate can be used as topical treatment, while drug of choice for systemic treatment is erythromycin 4 x 250 mg for 14 days.

Erysipelas is caused by Group A *Streptococcus* which infiltrates to skin layers through microlesion. Predilection of erysipelas is face and feet, but can be found in

stomach, hand, and neck. Physical examination shows bright erythematous lesion with sharp and elevated margin. It is painful and warm in palpation. Bulla with seropurulent liquid can be found and in severe condition skin erosion can be seen.

Leprosy or morbus hansen is a chronic infection caused by *Mycobacterium leprae*. Diagnosis of leprosy can be made if one of three cardinal sign is present: (i) hypopigmentation or erythematous macule of plaque with loss of sensation, (ii) Peripheral nerve enlargement with or without nerve impairment (sensory/motoric/autonom), (iii) Fast acid bacteria is found in slit skin smear. Leprosy usually doesn't appear on warmer parts of the body such as axilla, groin, and head.

Fungal infection

Typhiasis versicolor is common in daily practice. It is characterized by itchy hypopigmentation macule. Tinea can occur in head (tinea capitis), beard (tinea barbae), face (tinea facialis), trunk (tinea corporis), hand (tinea manus), nail (tinea unguium), groin (tinea cruris), and feet (tinea pedis). Generally, symptom of tinea is itch in the lesion area and can be identified by the appearance of central healing. Additional workout for tinea includes 20% KOH staining, culture, or wood lamp. Therapy for tinea is itraconazole, griseofulvin, or terbinafine.

Mucocutan candidiosis is usually found in skinfolds area and perianal. It is erythematous macule with sharp margin, scaly, and wet. It is usually surrounded by satellite lesion appears as vesicles or small pustules or bulla. Satellite lesion can burst leaving an erosive area and can develop like the primary lesion. Nystatin, amphotericine B, and azole group can be given as therapy.

Parasite infestation and insect bite

Itch caused by pediculosis capitis is a delayed hypersensitivity reaction and usually appears 2-6 weeks after first exposure. An intense itch can cause scratch followed by excoriation and secondary infection. Definite diagnosis is made when at least one living louse is found at visual inspection. Visualisation can be done with bright light, magnifying glass, and "lice brush". Lice are usually found in the back of the ear and in the back of the neck. Those who are proven to have lice should be treated immediately. Those who live close to that person also should be examined.

Insect bites cause itch, pain, redness, or swelling. Pathognomotic sign of insect bite is urtica and papule appear simultaneously surrounded by erythematous zone where punctum is found in the center of the lesion. Punctum can appear as hemorrhagic or black crust. The principle of insect bite management is to reduce systemic or local inflammation. Local inflammation can be reduced by washing the bite area with water and soap. Acute angioedema should be treated soon as it can

cause airway obstruction. If airway obstruction present, epinephrine can be given subcutan continued with 60-80 mg/day prednisone for 3 days, dose can be lowered by 5-10 mg/day. If the patient is stable, systemic antihistamine can be given orally for 7 days. Moderate to strong potency of topical corticosteroid such as 0,1% mometasone furoate or 0,5% betamethasone valerate can be given twice a day for 7 days.

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Update on Diabetes Mellitus Management: Focus on Glimepiride to Insulin Basal

Tjokorda Gde Dalem Pemayun

I. Pendahuluan

Dalam menghadapi meningkatnya prevalensi global diabetes mellitus tipe 2 (DMT-2), yang diperkirakan prevalensinya 9% tahun 2014, para dokter di pusat pelayanan primer semakin bertanggung jawab atas keputusan melakukan inisiasi terapi insulin pada pasien, yang sudah maksimal mendapatkan obat hipoglikemik oral (OHO). Kenyataan saat ini menunjukkan bahwa kegagalan memulai terapi insulin intensif menimbulkan inersia klinis (*clinical inertia*) di seluruh dunia. Pada DMT-2, terapi insulin dapat digunakan untuk menambah terapi OHO atau sebagai terapi pengganti OHO. Data dari *National Health and Nutrition Examination Survey* menunjukkan bahwa persentase pasien DMT-2 khususnya di AS, dengan A1C $\geq 9\%$ mulai membak/menurun, (13% menjadi 12,6%). Hampir sekitar 57% penderita DMT-2, hanya menggunakan terapi OHO saja, sehingga penggunaan insulin kombinasi dengan OHO perlu dipertimbangkan dengan menyesuaikan kondisi klinik, sehingga tercapai glukosa darah optimal. (1)

II. Pedoman terapi OHO dan insulin di poliklinik rawat jalan

Semua pasien DMT-2, berisiko tinggi mengalami komplikasi kronik makroangiopati. Upaya pencegahannya adalah meningkatkan kepatuhan program terapi, yang mengikuti pedoman ADA (*American Diabetic Association*) atau PERKENI (Perkumpulan Endokrinologi Indonesia). (2) Banyak pedoman praktik klinis di seluruh dunia untuk mengelola DMT-2, baik di tingkat lokal, regional dan internasional. Salah satu diantaranya adalah ADA karena dapat diterima secara luas dan dapat dimodifikasi sesuai dengan daerah dan sarana yang tersedia. (3)

Pedoman yang diikuti sekarang, secara garis besar menyarankan penggunaan insulin *long-acting* (basal) untuk menambah terapi dengan satu atau dua OHO atau satu OHO ditambah GLP-1 agonis bila kadar A1C $> 9\%$ dengan gejala dan tanda klinik hiperglikemia atau kondisi katabolisme. Penyesuaian dosis insulin harus disesuaikan setiap tiga atau empat hari sampai target kadar glukosa darah tercapai. Target pengendalian adalah glukosa darah puasa dan *premeal* 80-130 mg/dL dan 2 jam *postprandial* < 180 mg/dL. (4)