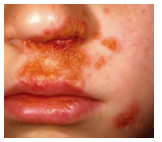
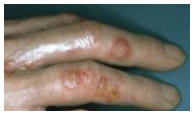
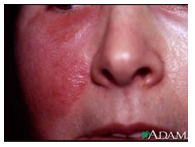
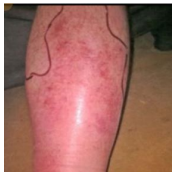
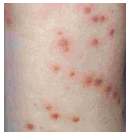
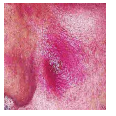
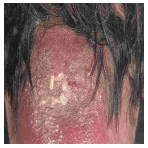
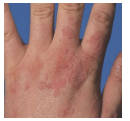
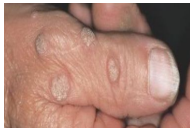
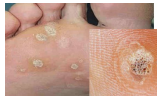
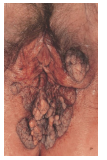
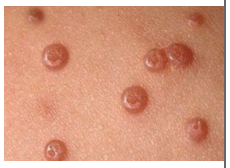
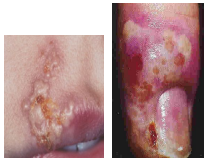
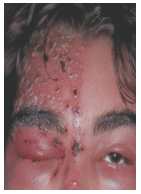
Derma Summary

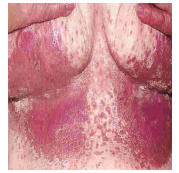
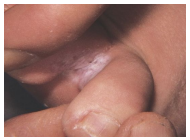
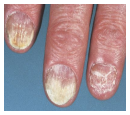
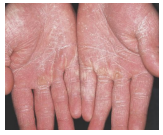
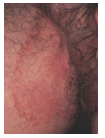
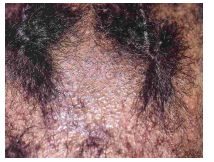
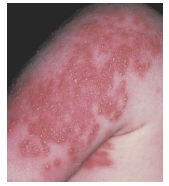
Good luck..

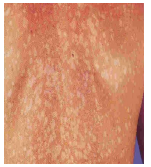
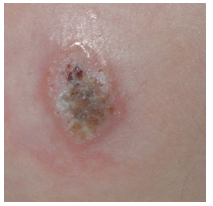
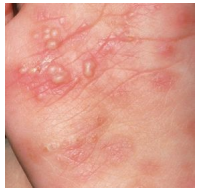
Reema Alnasser & Maha Alrabiah

Skin Infections

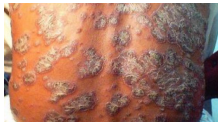
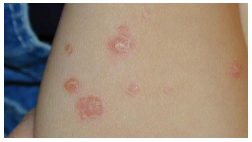
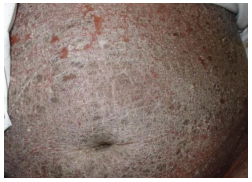
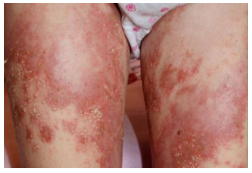
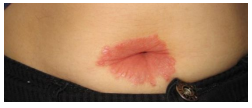
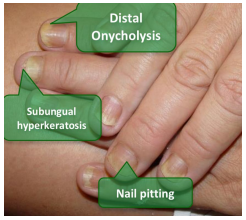
Disease		Description	Organism	+ info	Management	Picture
Bacterial						
Impetigo	Non-bullous	- Most common. - Clusters of vesicles or pustules with rim of erythema that rupture and develop **golden-yellow (Honey) crust**	- S. Aureus - Group A beta-hemolytic streptococcus	- Warm humid climate - Very contagious Complications: - Guttate psoriasis - post-streptococcal glomerulonephritis.	- Swab - Remove crust - Localised topical abx (bactroban, bacitracin) - recurrent → Mupirocin - Severe → systemic Abx (cephalosporins)	
	bullous	- Affect newborn and older children. - Flaccid bullae on grossly normal skin - Face, hands , diaper area	- S. Aureus			
Erysipelas		- Superficial infection with lymphatics involvement. - Well-defined, unilateral, red edematous. (face & leg)	- Group A beta-hemolytic streptococcus.	- Leukocytosis - Fever - Chills - Bacteremia	- Smear + culture - Cold compressor. - Oral Abx (penicillin) or I.V. for severe infection	
Cellulitis		- Deeper involvement of the dermis and subcutaneous tissue. - Acute, ill-defined, raised, hot, tender, erythematous (leg).	- Strep. Pyogenes, - S. Aureus.	- Palpable tender LN - Leukocytosis - Fever RF: DM, HTN, obesity Complication → lymphedema	- Swab + blood culture - Acetaminophen - IV penicillinase-resistant penicillin or Erythromycin if allergic.	
Folliculitis		- **Superficial** hair follicle infection - Multiple small papules / pustule on an erythematous base. - Heals without scarring	- S. Aureus	- Complications: abscess formation and cavernous sinus thrombosis.	- Topical and systemic Abx	
Furuncle (boil)		- Inflammation of **deep** portions of hair follicle		-	- Swab: Culture and GS - Antibacterial soap - Antibiotics.	
Carbuncle		- Infection of **multiple** hair follicles - Larger **more deep** seated - Drainage through multiple points in the skin.		-	- Swab : Culture and GS - Screen for carrier state - Antibiotics (IV)	

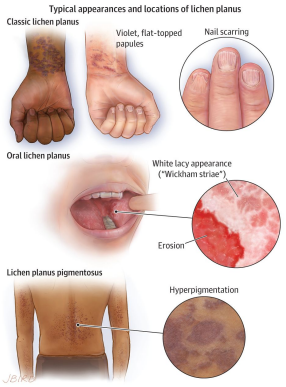
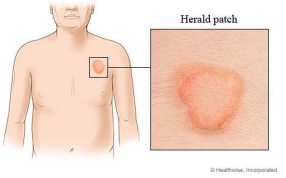
Disease		Description	Organism	+ info	Management	Picture
Viral						
Warts	**Plane** (Verruca planae)	- Affects Face, back of hands . - Flat skin colored papules, no hyperkeratosis. Not painful.	- HPV type 3,10	-	- Topical retinoids. - Cryotherapy - Laser	
	Common (verruca vulgaris)	- Affects the hands. - Common in Children - Skin color **hyperkeratotic** papules. - Koebner phenomenon.	- HPV type 1,2,4	-	- Topical keratolytics	
	Plantar (verruca plantares)	- Affects the soles. - Often painful. - Black dots, thrombosed BV.	- HPV type 1,2,4	-	- Topical retinoids. - Cryotherapy - Laser	
	Genital wart	- Most common STD - Condylomata accuminata - Penile, vulvar skin, perianal area - Cauliflower like	- HPV **6, 11** - Oncogenic: HPV **16, 18**	- Treat the partner	- Podophyllotoxin: cytotoxic - Imiquimod: immunmod. - Physical: cryotherapy, laser	
Molluscum contagiosum الملیساء المعدي		- Affects the face, neck - Skin colored papules with **central punctum** (umbilication) - Koebner phenomenon.	- Pox-virus	- Hunderson-patterson bodies. - In children by contact. - Adults: STD, immunosuppression.	- Involute spontaneously. - Curettage, cryotherapy.	
Herpes simplex		- Group of small blister. - Mucocutaneous - Painful - Recurrent	- HSV-1(H. labialis) - HSV-2 (genital herpes)	- Herpetic whitlow (fingertips) - Eczema herpeticum.	- Tzanck Smear. - Serology (IgG, IgM). - Direct fluorescent ab. - Viral culture. - Acyclovir.	
Herpes zoster		- Grouped blisters and vesicles on background of erythema. - Prodromal pain—dermatomal post-herpetic neuralgia.	- Chickenpox virus.	- Complications: **conjunctivitis** & **keratitis**. - Facial nerve affected → Ramsay Hunt Syndrome.	- Tzanck Smear. - Direct fluorescent ab - Analgesia, drying agent - Acyclovir.	

Disease		Description	Organism	+ info	Management	Picture
Fungal						
Candidiasis		- Satellite lesions → Napkin candidosis & Intertrigo (skin folds). - Paronychia, oral thrush - Very bright, ill-defined, oozing.	- Candida albican.	-	- Swab and KOH - Dry. - Nystatin cream. - Imidazole - Antifungal (itraconazole).	
Dermatophyte Infections	T. pedis	- Sole of foot (athlete's), webs. - Erosive interdigitalis. - Well defined scaly erythematous plaque, Itchy.	- Hyperkeratotic → T. rubrum - Inflammatory → T. mentagrophyte	- Itchy, chronic.	-	
	T. Ungum	- Affects the nails - Onycholysis. - Subungual hyperkeratosis.	- T. rubrum - T. mentagrophyte	-	- KOH and culture.	
	T. manun	- Diffuse dry scaling over the palm. - Hyperkeratosis with vesicle and pustules.	-	-	-	
	T. Cruris	- Infection of genital skin - Active border.	-	-	-	
	T. capitis	- Well circumscribed pruritic scaling area of hair loss (grey patch)	- Black dot → **T. tonsurans** - Ectothrix → **M. canis, M. Audouinii**	- Itchy, chronic.	- KOH and culture - Wood's light greenish-yellowish. - Topical (terbinafine, daktarin)	
	Tinea corporis	- Well-demarcated annular red hyperkeratotic plaque with central clearing (Ring worm)	- Hyperkeratotic → T. rubrum - Inflammatory → T. mentagrophyte	-	-	

Disease	Description	Organism	+ info	Management	Picture
Pityriasis versicolor **النخالة المبرقشة**	- Yellowish brown → (in white skin) - Hypopigmented → (in dark skin) - Trunk - Asymptomatic.	- **Malassezia furfur** (hyphae). - Pityrosporum orbiculare (yeast).	-	- Wood's lamp → **coppery-orange** fluorescence. - Topical imidazole (nizoral).	
Protozoal					
Leishmaniasis	- Slowly growing painful papule into ulcerated nodule or plaque - Exposed sites. - Transmitted with sandfly.	- Sand fly L.tropica , L. major - Sand fly (promastigote).	Clinical patterns: - Cutaneous: (localised or diffuse). - Mucocutaneous. - Visceral (post kala-azar): liver & spleen	- Skin biopsy (amastigotes) - Tissue impression smears (touch preparations) - smears of dermal scrapings (edge of ulcer) - Giemsa stain. - **PCR-based method.** - Rx: Parenteral pentavalent antimonials (**Sodium stibogluconate**)	
Infestation					
Scabies **الجرب**	- Severe itching worse after bathing and at night. - **Sites →** finger webs, flexor of the wrist, axillae, areolae, umbilicus, lower abdomen and scrotum. - Linear burrows (tunnel of mite) - Small erythematous papules+ variable degree of excoriation vesicles, indurated nodules or crustacean.	- **Sarcoptes scabiei var. Hominis** - 60-90 eggs in her 30-day lifespan.	- Might be complicated by secondary bacterial infection. - Other member of the family also having severe pruritus.	- India ink or gentian violet. - Tx of family members. - Washing clothing & linen - **Permethrin** cream - Lindane lotion or cream (not safe in children d.t neurotoxicity or pregnancy). - Crotamiton cream.	
Pediculosis capitis **القمل**	- Common in school children. - Severe itching of the scalp (occipital) - Posterior cervical LN.	- **pediculus humanus var capitis** → 3-6 eggs (nits) per day	- Secondary bacterial impetigo.	- Identification of nit/adult - Examination of other family members - Wash all fomites - Combing: metal nit comb - Pyrethrin. - **Permethrin** lotion	

Papulosquamous

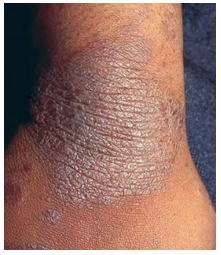
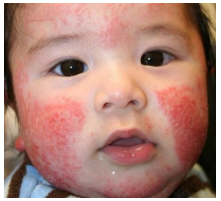
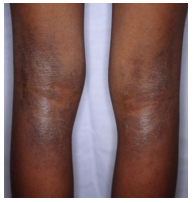
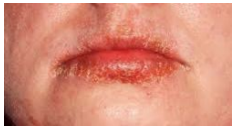
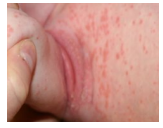
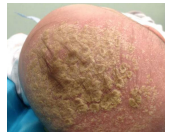
Disease	Types	Pic	Features	Notes
Psoriasis Inflammatory skin condition with reactive abnormal epidermal differentiation & hyper proliferation (within 10 days).	Plaque psoriasis (Psoriasis Vulgaris)		- Most common - Silvery scaly round-to-oval red **plaques** distributed over extensor body surfaces and the scalp	**Risk factors:** - Drugs (lithium, anti-malarial drugs, NSAIDs and beta-blockers) - Koebner phenomenon **Histology:** - Parakeratosis - Auspits sign: due to thick dermis & thin epidermis - Epidermal polymorphonuclear leucocyte infiltrates (**Epidermo-Tropism**) = (Munro abscesses) **Causes of Pustular Psoriasis:** - Idiopathic - Withdrawal of systemic steroids - Drugs; including: Salicylates, Lithium, Phenylbutazone, Hydroxychloroquine, Interferon - Strong, irritating topicals: Tar, Anthralin, Steroids under Occlusion, and Zinc Pyrithione in shampoo - Infections - Sunlight (or Phototherapy) - Cholestatic Jaundice - Hypocalcemia.
	Guttate		- Small, droplike, 1-10 mm in diameter, salmon-pink papules, usually with a fine scale - Younger than 30 years - Trigger: streptococcal infection	
	Erythro-dermic		- Scaly erythematous lesions over large areas with few typical psoriatic plaques - Hair shed; nails become ridged & thickened - Unwell, fever, leukocytosis - Increase cutaneous blood flow > Excessive body heat and hypothermia > Increase percutaneous permeability > Increase percutaneous loss of water, protein & iron	
	Pustular		- Sterile small pustules on erythematous background **1- Generalized type (von Zumbusch variant):** - Generalized erythema studded with interfolecular pustules. - Fever, tachypnea and tachycardia. - Absolute lymphopenia with polymorphnuclear leukocytosis up to 40,000/µL. **2- Localized form (in palms and soles)**	
	Psoriasis inversus (Sebopsoriasis)		- Occurs in armpits, groin and skin folds - The erythema and scales are very similar to that seen in Seborrhoeic dermatitis (it has no or very thin scales)	
	Psoriatic Arthritis		- Most commonly a seronegative oligoarthritis. - Asymmetric oligoarthritis occurs in as many as 70% of patients with psoriatic arthritis - DIP joint involvement occurs in approximately 5-10 - Arthritis mutilans: 5% of patients	

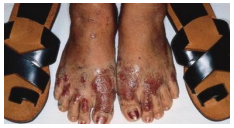
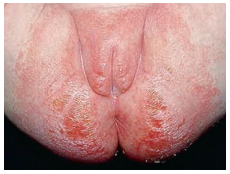
Disease	Types	Pic	Features	Notes
Lichen Planus	Hypertrophic		These extremely **pruritic** lesions are most often found on the extensor surfaces of the lower extremities, especially around the ankles.	-Associated with: Ulcerative colitis, alopecia areata, vitiligo, dermatomyositis, **HCV** infection, chronic active hepatitis, and primary biliary cirrhosis -Drug induced: Thiazide, Antimalarials, Propranolol. **Clinical features:** - Initial lesion on the flexors > generalized eruption develops with within 2-16 weeks - Papules are violaceous, shiny, & polygonal; varying in size from 1mm to greater than 1 cm in diameter - Fine, white lines, called **Wickham Stria**, are often found on the papules - Nail plate thinning causes longitudinal grooving and ridging - Subungual hyperkeratosis and Onycholysis. - **Pterygium unguis (Dorsal pterygium)** forms as a result of scarring between the proximal nailfold and matrix.
	Atrophic		- Characterized by a few lesions, which are often the resolution of annular or hypertrophic lesions	
	Erosive		- Risk of squamous cell carcinoma	
	Follicular		- Keratotic papules that may coalesce into plaques - A scarring alopecia may result	
	Annular		- Annular lesions with an atrophic center can be found on the buccal mucosa and the male genitalia	
	Vesicular and bullous		- Develop on the lower limbs or in the mouth from preexisting LP lesions	
	Actinic		- Mildly pruritic eruption - Nummular patches with a **hypo-pigmented zone surrounding a hyperpigmented center**	
	Pigmentosus		- Common in persons with **darker-pigmented skin** - Usually appears on face and neck.	
	Plano-pillaris	-	- Patchy progressive permanent hair loss mainly on the scalp	-
Pityriasis Rosea نخالة وردية	-		- Increased incidence in Spring and Autumn - Begins with **herald spot/patch** - Salmon-colored macule over trunk and proximal limbs, looks like secondary syphilis but it spares hands & soles - Pruritus is common, usually of mild-to-moderate severity	- Human herpesvirus (**HHV**)–**7** & HHV-**6** - Drug induced: - Captopril, metronidazole, isotretinoin, penicillamine, bismuth, gold, barbiturates, & omeprazole

Papulosquamous diseases management		
Psoriasis	**Lichen Planus**	**Pityriasis Rosea**

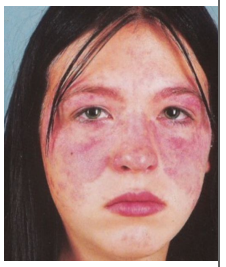
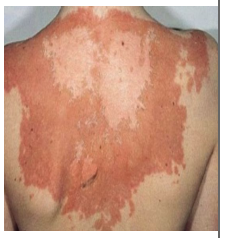
1st line Topical agent for mild to moderate psoriasis:
- Emollients
- Keratolytics (salicylic acid) > for scales
- **Coal tar & Anthralin** > for increased mitosis
- Vitamin D
- Corticosteroids
- Retinoids
 	
2nd line If no response to topical therapy or >20% BDA involved:
- Phototherapy
  - Natural sunlight
  - UVB
  - UVA & **Psoralen**
 	
3rd line If no response or + psoriatic arthritis
- Methotrexate > check for LFT
 	
Others:
- Acitretin (oral retinoid)
- **Cyclosporine**
- Biological therapy (Infliximab) > check for TB
	- Self-limited disease that usually resolves within 8-12 months.
	- Treat to prevent hyperpigmentation.
	- Antihistamine (for pruritus).
	- Topical steroids, particularly class I or II ointments
	- Systemic steroids for symptom control and possibly more rapid resolution
	- Oral Acitretin (Retinoid).
	- Photo-therapy
		- Tends to resolve over the next 6 weeks without scarring
		- Reassurance that the rash will resolve
		- Relief of pruritus
		- Topical menthol-phenol lotion
		- Oral antihistamines
		- Topical steroids
		- Systemic steroids
		- Ultraviolet B (UVB) light therapy
		- **Antiviral**

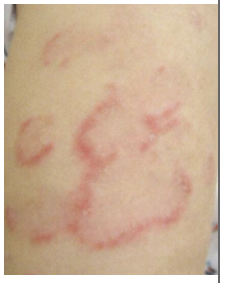
General principles of eczema /dermatitis

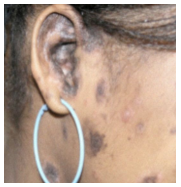
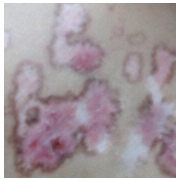
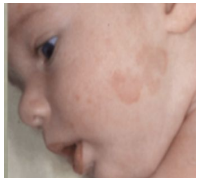
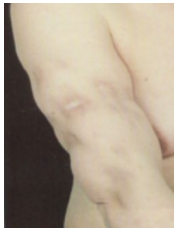
Disease	Description	Clinical features	Management	notes	Picture
Eczema (Dermatitis)	- Skin inflammation characterized by → itchy, scaly, patches of erythema.	- Subacute Dermatitis: misdiagnosed as tinea - Chronic Dermatitis: misdiagnosed as psoriasis	-	**Eczema classified:** - Acute: erosion, oozing and vesicles - Subacute: Redness + swelling, crust ± scale + infection - Chronic: lichenification, dark pigmentation and thick papules and plaques.	
Atopic Dermatitis	- Chronic relapsing itchy skin disease in genetically predisposed patients - Defective epidermal differentiation **(filaggrin mutations)** → impaired barrier function of the skin	- Colonized by S aureus. - **Infantile** → acute itchy vesicular eczema on extensor/facial involvement (Diaper area is spared) - **Childhood** → subacute and chronic at antecubital and popliteal fossae, neck, wrists and ankles, lichenification, post-inflammatory hyperpigmentation. - **Adult** → chronic inflammation on flexors and hand dermatitis.	- 70% remission before adolescence **Diagnostic Features:** - Major → pruritus, chronicity, Personal or family . - Minor → Xerosis (dry), early onset, cheilitis, nipple eczema, Dennie morgan fold, Pityriasis alba ,keratoconus. **Treatment:** - Education, Emollient. - Topical steroid - Topical immunomodulators. - Oral antihistamine - Oral Antibiotic.	- Associated with personal or family history of other atopic conditions as asthma, allergic rhinitis, conjunctivitis or atopic eczema - 85% begin before 5 yrs - AD associated with local infiltration of Th 2 that secrete IL-4, IL-5, IL-13, IL-31 - Complication: Eczema Herpeticum, Impetiginized dermatitis, Mollusca Contagiosa. المليساء المعدي	  
Seborrheic dermatitis	- In regions with high sebum production & the body folds - Erythematous red-yellow patches & thin plaques with bran-like to flaky (greasy) scales.	- Commensal yeast Malassezia furfur (**pityrosporum ovale**)	- Medicated shampoo - Topical antifungal - potency topical steroid. - Topical immunomodulators (tacrolimus & pimecrolimus) - Salicylic acid	- **Cradle cap:** scaly & crusty mass covering most of the scalp & can be seen in infantile seborrheic dermatitis.	 

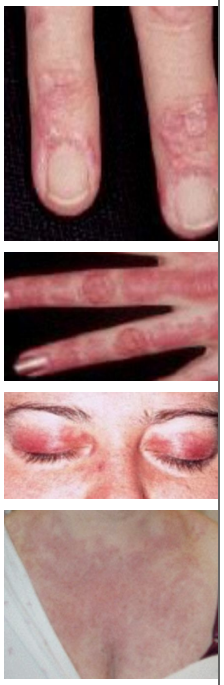
Disease		Description	Clinical features	Management	notes	Picture
Contact Dermatitis	Allergic	- Dermatitis resulting from type 4 reaction.	- Acute form present with crusted erythematous papules, vesicles & bullae that is well demarcated & *localized to the site of contact*.	**Dx:** - Hx and Examination. - PATCH testing (ACD). **Treatment:** - Topical steroid. - systemic steroid. - Oral antihistamine.	- Nickel. - Fragrances. - Preservatives. - Hair dyes. - Rubber latex.	
	Irritant	- Non immunologically mediated inflammatory reaction → direct cytotoxic effect.	- Similar to ACD but ICD **never extend beyond the area of contact**. - Painful rather than pruritic. - Occur from the 1st exposure to the irritant unlike ACD which only occur in previously sensitized individual.		- Water - Abrasives - Chemicals, e.g. - Solvents and detergents. - Napkin dermatitis - Lip licking	

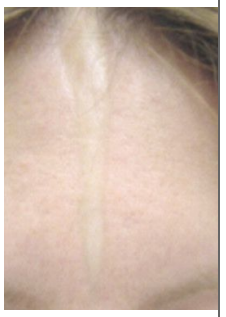
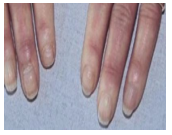
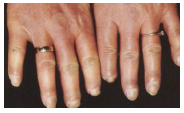
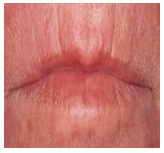
Cutaneous manifestations of SLE and other CTD (dermatomyositis , scleroderma)

Disease	Description	Diagnosis	Management	Notes	Picture
Acute Cutaneous Lupus Erythematosus	- Acute malar "butterfly rash" or more generalized photo-distributed eruption. - Non scarring.	- Hx & examination. - Skin Biopsy. - Lupus Band Test → non-lesional non-exposed skin. - CBC, ESR → high. - Urine analysis. - ↓ C3, C4 → active disease + renal involvement. **Serology**: - ANA: +ve in 95%. - **Anti-dsDNA → Specific. (indicates renal disease)**. - Anti-smith → specific. - Anti-histone Ab → drug induced lupus. - Rheumatoid factor	- Sun protection. - Potent topical steroids - Antimalarial drugs. - Oral steroids. - Methotrexate.	- ALL patients with ACLE will have SLE. - ACLE is transient, improves with improvement of the SLE. - Minocycline can cause all the type SLE symptoms except **renal involvement or CNS** involvement.	 

Subacute Cutaneous Lupus Erythematosus	- Scaly, superficial, inflammatory macules, patches, papules and plaques that are **photo-distributed,**
	
	Morphologic subtypes:
	- Annular/polycyclic lesions.
	- Papulosquamous lesions.
	  - Psoriasiform
	  - Pitryasiform
		- Clinical diagnosis
		- Skin biopsy.
		- Lupus band test.
		- **Anti-Ro/SS-A.**
		- Anti-La/SS-B.
			- Sun-protection
			- Topical steroids
			- Antimalarial drugs
				- About 1/2 patients with have SLE.
				- Skin disease, photosensitivity, MSK complaints.
				- SCLE could occur in patients with Sjögren syndrome, deficiency of the C2d, or it may be drug induced (thiazide diuretics).
					

Disease	Description	Diagnosis	Management	Notes	Picture
Chronic Cutaneous Lupus Erythematosus	- Localized or generalized. - Chronic, fixed, indurated, erythematous papules and plaques often distributed over the head & neck. - **Scarring**. - hypo/hyperpigmentation) - Epidermal changes: scales, **keratotic plugging of hair** follicles, crusting. - External ears.	- Serologic abnormalities are uncommon.	- Sun-protection - Potent topical steroids. - Intralesional steroids on the active borders. - Antimalarial drugs.	- Most common type → **Discoid lupus erythematosus** "DLE". - Risk of developing SLE is 5% - **Chilblain lupus:** Painful bluish-red papular or nodular lesions of the skin in acral locations (including the dorsal aspects of fingers and toes, heels, nose, cheeks, ears)	 
Subacute Neonatal Lupus Erythematosus	- The skin lesions occur on the face and head, morphologically resemble SCLE lesions, they are	- **Anti-Ro**/SS-A. - anti-La/SS-B antibodies.	- Transient, resolving within a few months.	- Infants develop skin disease, heart disease. - Disease usually manifests as **isolated complete heart block** → pacemaker - Thrombocytopenia / liver.	
Lupus Panniculitis	- Inflammation involving the **subcutaneous tissue**, resulting in inflamed nodules that often resolve with **depressed scars.**	- Excisional biopsy.	- Antimalarial drugs.	- They could have overlying DLE lesions "**Lupus Profundus**" - About 1/2 patients with have SLE.	
Drug-Induced Lupus Erythematosus	- **Nephritis and central nervous** system features are not commonly present.	- No antibodies to native DNA or hypocomplementemia are present.	- Drug discontinuation.	Drugs induces LE: - Chlorpromazine - Hydralazine, Minocycline - Methyldopa, Anti-TNF - Penicillamin, Isonizide - Procinamide - Quinidine. - IFN-alpha, IFN-beta.	

Disease	Description	Diagnosis	Management	Notes	Picture
Dermatomyositis	- Idiopathic chronic inflammatory disease involving the skin and skeletal muscles. **Pathognomonic findings:** - Gottron's papules → erythematous to purplish flat papules on the extensor surfaces of the interphalangeal joints. - Gottron's sign → symmetric violaceous erythema ± edema, over the dorsal knuckles of the hands, elbows, knees, and medial ankles. **Other findings:** - Heliotrope rash → periorbital edema - Shawl sign → ILD - Calcinosis.	- History & examination. - Progressive proximal symmetrical weakness. - Elevated muscle enzyme levels (creatine phosphokinase). - Electromyogram. - MRI. - Muscle biopsy. **Serology:** - ANA. - Anti-Jo-1 (anti-histidyl-t-RNA synthase). - Anti-Mi-2 -> good prognosis..	- Oral steroids. - Methotrexate. - Topical steroids. - Antimalarial. - Physiotherapy. - Surgical excision or Co2 laser.	- Diseases associated with dermatomyositis: - Lupus, rheumatoid arthritis. - Scleroderma. - Sjogren's syndrome. - Malignancies (ovaries cancer).	

Disease		Description	Diagnosis	Management	Notes	Picture
Scleroderma Chronic disease that involves the microvasculature and connective tissue → fibrosis. ↑ dermal collagen & ↓ elastic tissues → typical thickening & immobility.	Morphea	- Localized, Sclerotic, indurated plaques that may be solitary, multiple, linear. - The surface is usually smooth, with the center of the lesion a whitish or ivory color, whereas the border of active lesions is usually **violaceous**.	- History & examination - characteristic skin changes. Serology: - ANA (often +ve) - Anti-centromere antibodies (CREST) - Anti-Scl-70 "anti-topoisomerase I" - Skin biopsy.	- Treatment is symptomatic. **Raynaud's phenomenon:** - Stop smoking - Keep hands warm. - Ca channel blockers (**nifedipine**) - Aspirin. - Vasodilating drugs (**iloprost**) **Calcinosis cutis:** - Nifedipine. - Surgical - Laser excision. **Skin sclerosis:** - Physiotherapy. - Phototherapy. **GI:** - PPI. - Surgery for strictures. **Kidney:** ACE inhibitors. **In severe cases:** - Immunosuppressant. - D-Penicillamine.	- They don't develop SLE.	
	CREST Syndrome	- C = Calcinosis cutis - R = Raynaud's phenomenon - E = Esophageal dysfunction - S = Sclerodactyly. - T = Telangiectasia			-	
	Progressive Systemic Sclerosis	- Swelling of the hands and feet a ± Raynaud's phenomenon. - Telangiectasia. - Proximal nail fold changes. - Thickening and sclerotic changes involving the face & extremities→ Sclerodactyly, madonna fingers, Loss of normal facial lines Thinning of lips, (microstomia).			- Raynaud's Phenomenon - Digital ischemia due to exposure to cold and/ or emotional stress. - Causes - Rheumatic disorders. - Diseases with abnormal blood proteins - Drugs (β blockers, nicotine, cyclosporine) - Arterial disease.	  

Hair Disorders

Disease	Description	Tests	Management	+ info	Picture
Non scarring (reversible) alopecia					
Alopecia areata	- Immune mediated (T-cell) - Targeting anagen follicle. - Incidence 15-29, familial 50%. **Patterns:** - Round or oval patches - Loss of all scalp hair (alopecia totalis) - Loss of all body hair (alopecia universalis) -check eyebrow- - Ophiasis: loss of occipital hair - Sisaipho: Sparing temporal & occipital - Diffuse pattern: after stress or illness. **Nail abnormality** (Nail pitting, Koilonychia, Longitudinal ridging).	- Pull test (+) - Trichoscopy: Exclamation marks, tapered hair.	- Spontaneous resolution. - Topical sensitizers like **diphencyprone**. Weekly application to induce mild eczematous reaction & retroauricular lymphadenopathy. - **Steroids**: Topical, intralesional, oral ± methotrexate. - **Minoxidil** 2-5%. - **Anthralin.** - **NBUVB:** Risk of melanoma.	**Associated diseases:** - Atopy (allergic rhinitis, asthma, atopic dermatitis). - Autoimmune disease: Thyroiditis & Vitiligo. - Down syndrome. - Psychiatric diseases. **Bad prognostic factors:** - Earlier age of onset. - Positive FHx of alopecia. - Extensive involvement. - Prolong duration >5 y - Ophiasis.	-
Androgenetic alopecia (female pattern hair loss)	- Decline in hair production - Reduction of the anagen duration - 5 alpha reductase (5AR) causing miniaturization **Male pattern:** - Has 2 components: Frontotemporal recession (M shaped), Hair loss over vertex. - Hairs become short. - Total loss of hair except occipital region. **Female patterned hair loss:** - Sometimes there is history of increased hair shedding. Widening of the parting width. - Reduction of hair density over frontal scalp and crown. - Frontal hairline is preserved.	- Pull test: Miniaturized short **telogen**. - Part width test: Wide over crown - Trichogram: **Telogen** is more on the crown than occiput.	**Male:** - Minoxidil 2% or 5% → #Scalp irritation, hypertrichosis. - Finasteride: Reduce incidence of prostate cancer, In females a risk of abnormal genitalia in male fetus. - Surgery (hair transplant). **Women:** - Minoxidil 2% and 5%. - Anti-androgens: Cyproterone acetate, combined with OCPs → # ↑Weight, Fatigue, Mastodynia & ↓ libido. - Spironolactone → #Breast soreness, menstrual irregularity, safest. - Flutamide: ineffective in post menopause, Hepatotoxic.	- Female patterned alopecia might be associated with PCOS, acne, hirsutism.	-

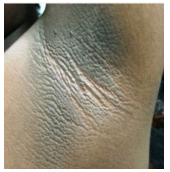
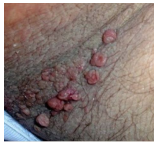
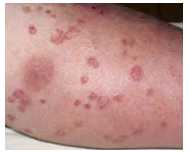
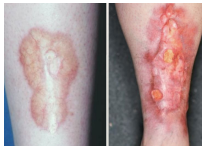
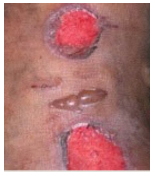
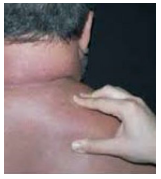
Disease	Description	Tests	Management	+ info	Picture
Telogen effluvum	- Premature conversion of Anagen to Telogen. - **Types:** - Acute (< 6 months). - Chronic (> 6 months). - Chronic repetitive. - Hair shedding starts 2 weeks after the trigger and peaks between 6-8w, and tapers in about 6-8 w. - Follicular regeneration is common within 4-6 months.	- Trichogram: anagen: telogen ratio is 70:30, Telogen is equal on different parts of the scalp - Empty hair follicles, minimal Miniaturized hairs. - Pull test is positive IF patient uses no shampoo/comb.	- Identify the triggering factor and treat it. - Minoxidil topically 2%. - Biotin 3-5mg daily. - L- cysteine supplement. - Iron & vitamin D supplement.	Triggers: - Stress. - Nutritional deficiencies - Endocrine disorders (thyroid disease). - Crash diet. - Surgery. - Drugs (Heparin, Retinoid, Propranolol, Captopril). - Fever. - Childbirth.	-
Anagen effluvum	- Severe insult to the dermal papilla producing 80% hair loss.	- Pull test: Anagen predominant	- No treatment	- Cytotoxic drugs: Doxorubicin (Adriamycin), Cyclophosphamide Paclitaxel (Taxol) Etoposide.	-
Trichotillo-mania	- Excessive pulling of one's own hair. - Affects children more. (4/17 years) - The scalp is the most common area of hair pulling, followed by the eyebrows, eyelashes. - Associated with nail biting and skin picking. - **Friar Tuck sign**: areas of hair loss with broken hairs of varying lengths arranged in a circular pattern, with unaffected hairs surrounding the area of hair loss.	- Trichoscopy: **Bleeding, different hair length, black dots.**	- Behavioral treatment. - A psychiatrist should be consulted. - SSRI (fluoxetine).	- Trichobezoars (ingestion of hair) result in intestinal obstruction, MRI and US required for diagnosis. - In children prognosis is good - In adult patients, the prognosis is poor.	-
Traction Alopecia	- Traction-inducing hairstyles. - Scarring in late stages. - Frontotemporal margins of scalp - **Fringe sign**: short terminal hairs bordering areas of marginal hair loss	- Dermoscopy:peri pilar whitish hair casts.	- Changing hair style - 2% minoxidil.	-	-

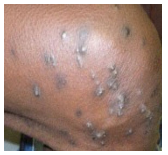
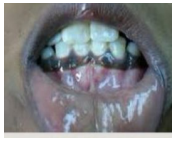
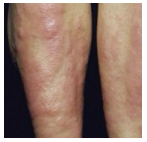
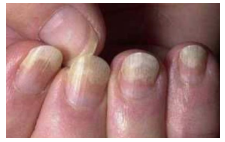
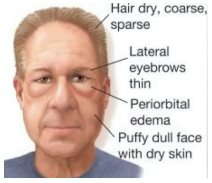
Disease	Description	Tests	Management	+ info	Picture
Scarring (irreversible) alopecia					
Chronic Discoid Lupus	- Onset: 20 and 40 years. - Inflammation is in the center - Presents with scaly erythematous plaques, follicular plugs, pigmentation and scarring alopecia	- Trichoscopy: erythema, scales, pigmentary changes and follicular plugs.	- Corticosteroids topically - intralesional injection. - Antimalarials.	- Hair follicles are destroyed & replaced by scar tissue & permanent hair loss. - The diagnostic hallmark of all scarring alopecia is visible loss of follicular ostia. - Compound follicles are also seen. Sebaceous gland may be central to the pathogenesis of scaring alopecia. - Sebaceous gland involvement is noted in lichen planopilaris and dissecting cellulitis in follicular occlusion triad.	-
Lichen Planopilaris	- Middle aged women. - Itching , pain and burning.	- Trichoscopy: perifollicular erythema & perifollicular scales at the margin of the lesion.	- Antimalarials - Dapsone - Retinoids.		-
Dissecting Cellulitis of the Scalp	- Occurs predominantly in black males, in their second to fourth decade of life. - Perifollicular pustules, nodules, and abscesses, with interconnecting sinus tracts that drain pus or blood. - Thought to result from occlusion of the pilosebaceous unit. - Acne conglobata, hidradenitis suppurativa, and pilonidal cysts are frequent concomitant diseases.	-	- Oral isotretinoin is the treatment of choice. - Intralesional corticosteroids (eg, triamcinolone acetonide). - Antibiotics such as doxycycline, ciprofloxacin, rifampicin, and dapsone. - Biologic agents such as adalimumab and infliximab		-

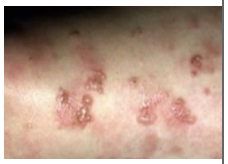
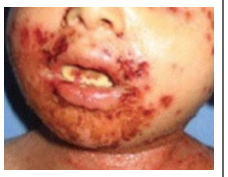
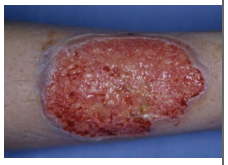
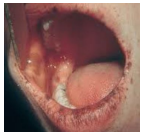
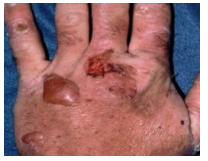
Pigmentary diseases

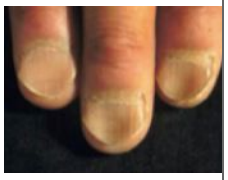
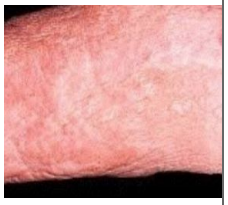
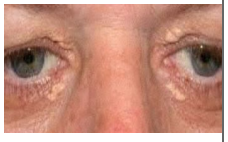
Disease	Description	Diagnosis	Management	Notes
Vitiligo	- Circumscribed depigmented macules and patches secondary to absence of functional melanocytes in vitiligo skin - Onset: 10-30 years. - Koebner phenomenon. - Sites → bony prominences, extensor forearm, ventral wrists, dorsal hands. - Leukotrichia → body hair depigmentation. (poor prognosis) - **Extracutaneous Manifestation:** Choroidal abnormalities, Iritis, Uveitis. - **Vogt-Koyanagi-Harada syndrome** → Vitiligo, Uveitis, Aseptic meningitis, Dysacusis, Tinnitus, Poliosis, Alopecia.	- Woods light shows milky white depigmentation. - TSH, ANA, CBC . - Serum antithyroglobulin and antithyroid peroxidase antibodies. - HbA1c.	Narrow-band UV-B phototherapy (**311nm**) - Safe in children, pregnant women, and lactating women. - #pruritus and xerosis. Psoralen photochemotherapy: - Widespread vitiligo. . Excimer laser (308nm): - < 30% of the body surface. . Biologic therapy (JAK inhibitors): - Tofacitinib + light. - Topical therapy: Steroid, Tacrolimus (head and neck involvement). - Vitamin D analogs. Depigmentation: - > 40% of surface area. - monobenzylether of hydroquinone cream is applied twice daily. Surgery: - Unilateral vitiligo(stable form).	**Theories**: - Autoimmune mechanisms → Thyroid disorders (Hashimoto and Graves), Addison disease, DM, Alopecia Areata. - Cytotoxic mechanisms. - Intrinsic defect of melanocytes (Abnormal rough endoplasmic reticulum). - Oxidant-antioxidant mechanisms (Accumulation of free radicals). - Neural mechanisms (nerve injuries). **Classification:** - Localized → Focal (one area), Segmental (dermatomal pattern, poliosis), Mucosal. - Generalized → Acrofacial, Vulgaris, Mixed: - Universal → Associated with multiple endocrinopathy syndrome. **DDX**: - Pityriasis Alba, Post Inflammatory depigmentation, Chemical leukoderma, Vogt-Koyanagi-Harada Syndrome.
Melasma	- Sun-exposed areas. - Symmetrical tan to brown hyperpigmented macules. - Blue or black → dermal melasma. **Patterns:** - Centrofacial → forehead, cheeks, nose, upper lip, and chin. - Malar → nose and the cheeks. - Mandibular → ramus of the mandible.	- Woods light: accentuation of the pigmentation implying epidermal rather than dermal type of pigmentation.	- High-SPF sunscreens (50+) - Topical depigmenting agents: **Hydroxyquinone** (HQ) (Side effects → Phototoxic reactions, Irreversible exogenous **ochronosis**) - Combination treatment HQ + retinoic acid +steroid + Vit.C. - Azelaic acid. - Oral proanthocyanidin. - Tranexamic acid (antifibrinolytic)	- Risk factors: melanocytic nevi thyroid disease, female, pregnancy, OCP.
Freckles	- Multiple tanned macules1-5 mm with uniform pigmentation. - Sun-exposed areas. - The macules may be discrete or confluent.	-	- Sunscreens. - Chemical peels, cryotherapy, and laser.	- Associated with fair skin and red or blonde hair. - Association with systemic disease → : Xeroderma pigmentosum, Neurofibromatosis (found in the folded regions)

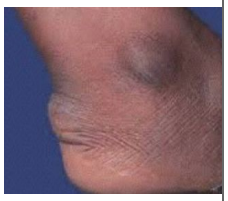
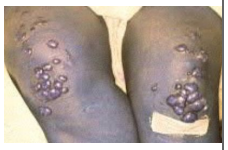
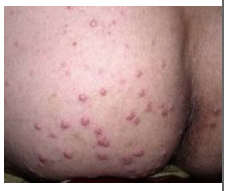
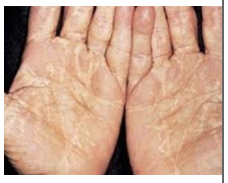
Cutaneous Manifestations Of Systemic Diseases

Disease		Features	Sites	Treatment	+ info	Picture
Endocrine						
DIABETES	**Acanthosis Nigricans**	- Hyperpigmented velvety plaques.	- Body folds and creases.	- Weight reduction. - Reducing insulin resistance.	- Indicator of insulin resistance. - ↑ conc. of insulin → ↑ affinity binding to IGF-1 → stimulation of keratinocytes and dermal fibroblasts.	
	Acrochordons [Skin Tags]	- Small, skin colored, pedunculated papules.	- Neck, axilla, eyelids.	-	- Associated with obesity and insulin resistance, acanthosis nigricans. - Related to IGF activity.	
	Diabetic Dermopathy	- Red papules → atrophic, hyperpigmented papules and plaques.	- Shins.	- Blood glucose control.	- Related to diabetic neuropathic and vascular complications. - Most Common cutaneous sign of diabetes.	
	Necrobiosis Lipodica Diabeticorum	- Erythematous papules → evolve into yellowish brown plaques with dilated blood vessels and central epidermal atrophy. - Sometimes they ulcerate.	- Pretibial area	- Topical and intralesional steroids. - Tacrolimus. - Phototherapy, cyclosporine.	- Very rare and very characteristic. - Histopathology: granulomatous reaction.	
	Bullae Diabeticorum	- Spontaneous blister- like lesions.	- Hands and feet.	- Heals without scarring.	- Rare but distinct marker of diabetes.	
	Scleredema Diabeticorum	- Woody induration and thickening of the skin.	- Mid upper back, neck, and shoulders.	-	- Common in males [obese with longstanding uncontrolled DM with complications. - Controlling DM DOESN'T affect the course of scleredema.	

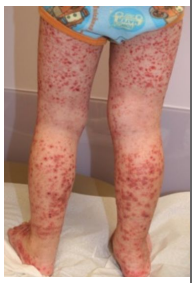
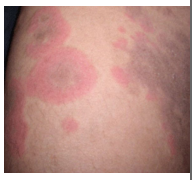
Disease		Features	Sites	Treatment	+ info	Picture
DIABETES	**Acquired Perforating Dermatosis**	- Transepidermal elimination of collagen and elastic fibers - 2-10mm, firm, umbilicated, hyperkeratotic, papules.	- Trunk. - Extremities.	- Topical keratolytics (Urea). - Topical/systemic retinoids. - Steroids, Phototherapy - Antihistamines, cryotherapy.	- Associated with chronic renal failure, diabetes mellitus.	
	Bacterial Infections	- Staphylococcus aureus and beta-hemolytic strept.	-	-	- Corynebacterium minutissimum: → Erythrasma. - Pseudomonas aeruginosa → malignant otitis externa.	
	Fungal Infections	- Candida. - Tinea pedis, tinea cruris, tinea corporis, onychomycosis.	- Warm, moist folds of the skin.	- Rhinocerebral mucormycosis → Depriment + IV Amphotericin	**Rhinocerebral mucormycosis:** - Extensive, life threatening. - Begins in the nasal passages and spreads into the orbit and cerebrum.	
Cushing's Syndrome		- Weight gain, Bruises easily. - Purple stretch marks. - Acne, Glucose intolerance.	-	-	- Pituitary gland → ↑ ACTH → adrenals ↑ cortisol. - Large doses of steroids.	
Addison's Disease		- Hyperpigmentation - Oral mucous membrane hyperpigmentation is PATHOGNOMONIC.	- Skin. - Mucous membranes.	-	- Adrenocortical insufficiency. - ACTH binding with MELANOCORTIN 1 → Hyperpigmentation.	
Thyroid	**Hyperthyroidism**	- Palmoplantar hyperhidrosis. - Pruritus. - Non-scarring alopecia. - Plummer nails. - Pretibial myxedema.	-	-	 	
	Hypothyroidism	- Coarse, rough, dry skin. - Pallor, Pruritus. - **Carotenemia.** - Diffuse hair loss. - Loss of 1/3 of the eyebrow. - Myxedematous facies.	-	-	-	

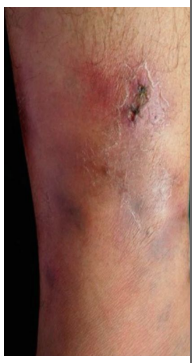
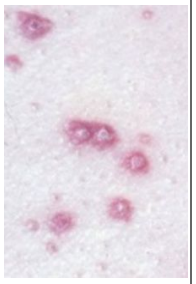
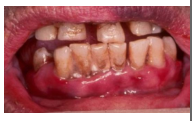
Disease	Features	Sites	Treatment	+ info	Picture
Gastrointestinal					
Dermatitis Herpetiformis	- Small, **severely pruritic**, clustered vesicular papules or plaques. - Tense subdermal blisters. - Lesions are cutaneous manifestation of **Celiac disease**.	- Symmetrically distributed over the **extensor** surfaces (elbows, knees, buttocks and shoulders).	-Gluten free diet. - **Dapsone** – 1st line. -Sulfapyridine- 2nd line. -Tetracycline (localized). -Nicotinamide (localized).	- Autoimmune blistering disorder. - Associated with a **Gluten Sensitive Enteropathy**. - Tissue Transglutaminase Antibodies (tTG). - Direct immunofluorescence → granular **IgA** in dermal papillae.	
Acrodermatitis Enteropathica	- Scaly erythematous patches and plaques → progress to vesicles, erosions, pustules. - Blisters with crustation are periorofacial. - When the infant is **weaned from breast milk.**	- Acral. - Perioral. - Perianal.	- Life long dietary **Zinc supplementation**	- Triad of → Periorificial, acral dermatitis, alopecia, and **diarrhea**. - Autosomal recessive → zinc absorption impairment in the jejunum and ileum. - Acquired in alcoholics.	
Pyoderma Gangrenosum	- Painful ulcerative with well-defined **undermined violaceous border**. - Starts as a small red papule or pustule that subsequently burst and expand to form a large non-infectious ulcer.	-	-	- **+ve pathergy test** (Behcet's disease) - Associated with ulcerative colitis, crohn's disease, RA, and leukemia. - Surgery is contraindicated.	
Peutz-Jeghers Syndrome	- Hyperpigmentation (Brown macules). - Intestinal hamartomatous polyp	- Mucous mem. - Lips and buccal mucosa - Jejunum.	-	- Autosomal dominant. - ↑ risk of malignancy in younger individuals. - Follow up for colon cancer	
Porphyria Cutanea Tarda	- Photosensitivity. - Skin fragility after trauma → erosions and bullae. - Facial hypertrichosis. - Healing leaves **milia**, hyperpigmentation and atrophic scars.	- Sun exposed areas (hands).	- Frequently associated with hepatitis C infection.	- Inherited metabolic disorder where **uroporphyrinogen decarboxylase** (UROD) is deficient.	

Disease	Features	Sites	Treatment	+ info	Picture
Hemochromatosis	- Cutaneous pigmentation → brownish bronze or slate gray. - Ichthyosis, koilonychia, hair loss (pubic area) .	- Sun exposed areas (face).	- Phlebotomy. - Chelation Therapy. - Surgery Indications → End-stage liver disease/Hepatocellular carcinoma, Severe arthropathy.	- Abnormal accumulation of iron in several organs leading to organ toxicity.	
Renal					
Uremia	- **Xerosis** → acquired ichthyosis.• - **Pruritus** → Excoriations, prurigo nodularis, lichen simplex chronicus (scratching). - Half-and-half nails → dark reddish brown distal band and a white proximal band.		- **Xerosis** → routine use of emollients. - **Pruritus** → Sedating antihistamines, emollients, phototherapy, thalidomide, gabapentin.	- Most common **<u>metabolic</u>** cause of pruritus	
Nephrogenic Systemic Fibrosis	- Large areas of thick, indurated skin with fibrotic nodules and plaques on the	- Extremities. - Trunk.	- Extracorporeal photopheresis - - Immunosuppressive.. - Phototherapy. - IVIG. - Topical steroids.	- Fibrosis of the skin and internal organs (similar to scleroderma). - Caused by **Gadolinium** exposure → imaging patients who have renal insufficiency.	
Hyperlipidemia					
Xanthelasma Palpebrarum	- Asymptomatic, and usually bilateral	- Inner canthus. - Upper eyelid.	- Surgical excision. - CO2 laser ablation. - Chemical cauterization (trichloroacetic acid). - Electrodesiccation. - Cryotherapy.	- Associated with any type of 1^{ry} hyperlipoproteinemia.	

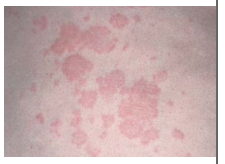
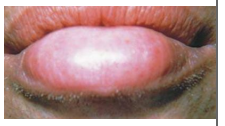
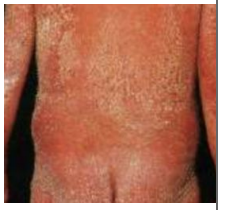
Disease	Features	Sites	Treatment	+ info	Picture
Tendinous Xanthomas	-	- Achilles tendon,. - hands, feet, elbows, and knees.	- Least responsive to treatment.	- In patients with familial hypercholesterolemia	
Tuberous Xanthomas	- Firm non-tender, cutaneous and subcutaneous yellowish nodules.	- Extensor surfaces.	- Lipid lowering agents.	- Associated with familial dyslipoproteinemia.	
Eruptive Xanthomas	- Painless, yellowish papules on an erythematous base.	- Grouped lesions → trunk, elbows, and buttocks.	- Resolves in few weeks after therapy.	- Associated with hypertriglyceridemia. - Could be seen in poorly controlled DM and acute pancreatitis.	
Plantar Xanthomas	- Elevated cutaneous yellowish-orange deposits.	- Plantar creases	-	- Associated with dysbetalipoproteinemia.	

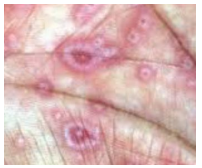
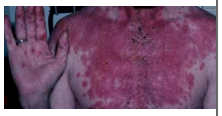
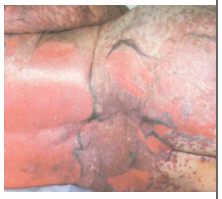
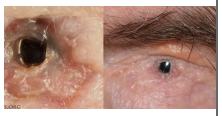
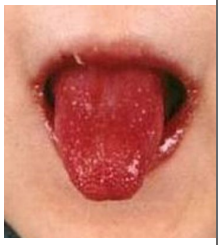
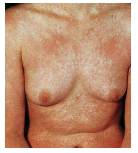
Purapura & vasculitis

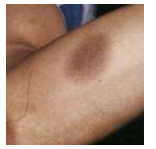
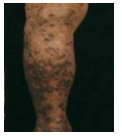
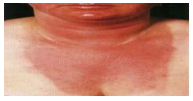
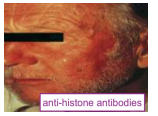
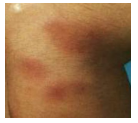
Class	Disease	Clinical features	Histology	Management	notes	Picture
Cutaneous small vessel (leuko-cytoclastic vasculitis) - Palpable purpura is the hallmark - Do Not blanch under pressure (diascopy)	Henoch-Schonlein	- Characterized by: purpura, arthralgias (can progress to arthritis with swelling around knees and ankles), abdominal pain (GI bleeding acute surgical abdomen, paralytic ileus) & renal disease (GN & renal failure). - Pulmonary hemorrhage can be fatal - Multiple palpable purpura on the extensor aspects of the extremities: lower legs, forearms & buttocks.	- Perivascular infiltrate of neutrophils (nuclear dust) - Blood vessel wall thickening - Erythrocyte extravasation - Fibrin deposits within the blood vessel wall - Endothelial necrosis (more serious illness) - immunoglobulin & complement deposits	- Supportive: D/C drug, bed rest, treat infection & pain killers - Abdominal pain: H2 blockers, corticosteroids - NSAIDs are best avoided (renal & GI complications)	- Triggers: viral infection, streptococcal pharyngitis, bacterial infections, foods, drugs (aspirin, penicillin), lymphoma - Affects children - IgA-mediated	
	Urticarial lesions "urticarial vasculitis"	- Urticarial vasculitis VS. urticaria: 1. Painful, rather than pruritic 2. Last > 24h & fixed 3. postinflammatory hyperpigmentation **Normal complement levels:** - idiopathic - limited to skin - Self-resolving **Low complement levels:** - leukocytoclastic vasculitis + diffuse interstitial neutrophils - Not limited to the skin: arthritis, arthralgia, angioedema eye symptoms, asthma, GI symptoms		- Ix: CH50, C3, C4, C1q, ANA, dsDNA, Anti-SSA & Anti-SSB, hepatitis, B&C, lupus band test **Cutaneous involvement:** - NSAIDs & antihistamines, if these fail > Colchicine, hydroxychloroquine, dapsone **Systemic disease:** - corticosteroids + steroid sparing agent (azathioprine, mycophenolate mofetil, rituximab)	- Complement levels (CH50, C3, C4, and anti-C1q) - Diseases associated with urticarial vasculitis: gammopathies (IgG & IgM), SLE, Sjögren syndrome, serum sickness, viral infections (HCV)	
	Other	- Idiopathic - Infection- streptococcal, bacterial endocarditis, parvovirus B19, HIV, hepatitis, TB - Drugs- NSAID,sulfonamides, penicillins, barbiturates, propylthiouracil - Malignancy- leukemias, lymphoma, multiple myeloma, renal, lung, prostate, breast				

Class	Disease	Clinical features	Histology	Management	notes	Picture
Small-medium vessels	Churg Strauss syndrome Microscopic polyangiitis Granulomatosis with polyangiitis (GAD) Cryoglobulinemic vasculitis		-	-	-	-
Medium vessel	Polyarteritis Nodosa	- Necrotizing vasculitis - **Cutaneous findings:** subcutaneous nodules associated with livedo reticularis that may ulcerate on the legs & feet - **Peripheral neuropathy:** tingling, numbness, sensory disturbances, weakness and absent reflexes	- Nodular arteritis - Polymorphonuclear infiltration involving medium sized arteries of the deep reticular dermis & subcutaneous tissue + extensive fibrinoid necrosis	- Most patients respond well to: aspirin, NSAIDs, prednisone, sulfapyridine, or methotrexate	- Has been associated with HBV & HCV infection, Crohn's disease, streptococcal infections, TB, and medications (minocycline) - The only laboratory abnormality is ESR	
Large vessel	Giant cell arteritis Takayasu arteritis	-	-	-	-	-
-	Vitamin C deficiency (scurvy)	- Perifollicular petechiae - Keratotic plugging of hair follicles - Hemorrhagic gingivitis	-	-	-	 

Dermatological Emergencies

Disease	Description/ Features	Management	+ info	Picture
Urticaria	- Wheals or hives. - Evanescent. - Disappear within 24 hours. - Blanch with pressure, - Intense pruritus.	- Antihistamin. - Systemic steroids (Severe).	- Release of mediators from mast cells → ↑ in vascular permeability. - Immunologic Type I (IgE mediated) or Type III. - Major mediator → IgE, major effector → Mast Cell. - Life threatening especially when associated with angioedema of the larynx. - Serum sickness → type III immune complex mediated reaction (Fever, Urticaria, Angioedema, Joint pain and swelling, lymphadenopathy).	
Angioedema	- Edema Involving the deep dermis or subcutaneous and submucosal areas.	- Non Sedating H1 antagonists. (loratadine , claritin). - Sedating H1 antagonists (itching). - Corticosteroids. - Epinephrine (lifesaving). - Hereditary Angioedema (doesn't respond to steroids) → antiandrogens (danazol), oral tranexamic acid	- Airway involvement → EMERGENCY. - Causes → Antibiotics, **ACEI**, Foods… - Hereditary Angioedema → autosomal dominant caused by **C1 esterase inhibitor** deficiency (C1 usually presents in the form of angioedema and gastric involvement without urticaria)	
Anaphylaxis	- Laryngeal edema, bronchospasm. - Erythema, pruritus, urticaria or angioedema. - Vomiting, cramps, diarrhea. - Hypotension, cardiac arrhythmia or shocks.	- ABCs. - Epinephrine. - Antihistamine.	- Within minutes to hours, severe may be fatal. - **IgE mediated** . - Causative agents: Drugs, Foods, Vaccines and Antisera.	
Erythroderma & Exfoliative Dermatitis	- Erythema with or without scales - Affecting >90% of the body. - It's common in extreme of ages	-	- Complication → Hypothermia , fluid and electrolyte loss, infection. - Drug Etiology: Sulphonamides, antimalarials, penicillin, phenytoin. - Other causes → psoriasis, cutaneous T-cell lymphoma.	

Disease	Description/ Features	Management	+ info	Picture
Erythema multiforme	- Target lesions، - little or no mucosal involvement (EM minor), - Fever , arthralgia ,sore throat.	- Acyclovir.	- Follow an infection by HSV.	
Steven Johnson Syndrome	- Mucous membrane erosions. - **< 10% BSA of epidermal detachment.** - Subcorneal blister	- Corticosteroids (early in the disease for a short period of 3-5 days).	- Severe form of EM (5% mortality). - Causes: Mycoplasma pneumonia infection, drugs (50%). - Histopath → splitting at the level of the subcorneal epidermal layer.	
Toxic Epidermal Necrolysis	- Severe mucosal involvement in conjunctiva and the eye - **< 30% BSA of epidermal detachment.**	- Withdrawal of suspected drug. - Patient cared in a burn unit or I.C.U. - Replacement of I.V. fluids and electrolytes.	- Severe form of SJS (30% mortality), major cause of death: Septicemia, electrolyte imbalance. - Causes: Drugs (95%) → anticonvulsants, sulphonamides, allopurinol, NSAID, carbamazepine. - Risk factors: Slow acetylators, Immunosuppression (HIV, Lymphoma) → acquired **glutathione deficiency**, HLAB1502. - Histopath → all the epidermis is removed - DDX: Pemphigus vulgaris.	 
Kawasaki Syndrome	- Fever > 5 days, - Conjunctivitis. - Red fissured lips, strawberry tongue. - Rash - erythema exanthem - Edema of palms and soles. - Cervical lymphadenopathy. - Coronary artery aneurysms.	**- IV aspirin.** **- Immunoglobulin,**	- Affects children. - Complications → CAD and heart problem.	
Drug Eruptions (most sensitizing root is topical)				
Maculopapular	- Exanthematous. - Morbilliform - No pustule, vesicle , blister.	-	- Seen in children on antibiotic(cefaclor).	

Disease	Description/ Features	Management	+ info	Picture
Hypersensitivity Syndrome Reaction	- Triad of fever, skin eruption and internal organ involvement.	-	- Life threatening syndrome. - **Anticonvulsants**, sulfonamide, dapsone, allopurinol, Azathioprine, Minocycline.	
Latex Allergy	- Contact Urticaria, Fatal Anaphylaxis	-	- Type 1 reaction to natural rubber latex. - Foods that cross react with latex proteins → Banana, Kiwi, Avocado, Chestnuts.	
Fixed Drug Eruptions	- Dark brown , grayish , round well demarcated. - Pigmented or inflammatory in the form of blistering.	-	- Drug reaction that happens immediately. - In males in the form of a blister in the glans penis. - Young males on minocycline for acne.	
Lichenoid Eruptions	- Resembles lichen planus. - Violaceous , scaly , papules , diffuse , mucosal.	-	- Psoriasiform → with lithium , BB, anti- malarial	
Photosensitivity	-	-	- Photoxic → non-immune mediated more of an irritation e.g. psoralen , doxycycline for acne. - Photoallergic.	
Drug induced Pemphigus	- The more superficial the more crustaceans.	-	- Superficial pemphigus (foliaceus). - Classical drug causing it is penicillamine and ACEI. - Separation (intraepidermal) above the basement membrane . - In bullous pemphigoid → Tense blister because the split under the epidermis (subepidermal.)	
Lupus Erythematosus-like syndrome	-	-	- Causes → Hydralazine, procainamide, sulfonamide, Minocycline, INH. - Antihistone Antibodies.	
Erythema Nodosum	-	-	- Due to inflammation of subcutaneous fat (panniculitis). - Causes: **TB**, penicillin, tetracycline, OCP.	

Disease	Description/ Features	Management	+ info	Picture
Blistering Diseases				
Pemphigus	- Flaccid blisters intraepidermal. - Weeping painful erosions. - Sloughing of the intact skin next to the blister. - Positive Nikolosky's sign. - Positive asboe – Hansen sign or (bulla spread sign). - Acantholysis. - Intra-epidermal cleft.	- Systemic corticosteroids.. - Immunosuppressive therapy (Azathioprine, Mycophenolate, Mofetil). - IVIG → resistant cases.	- **Vulgaris**: IgG autoantibodies attack desmosomplyin → detachment of keratinocytes → floating of cells. - **IgG and C3** in the intercellular space of epidermis. - Age – sixth decade of life. **Classification:** - Vulgaris → skin and mucous membrane involvement. - Vegetans, Foliaceus. - Fogoselvagem → black fly insect pits. - Paraneoplastic → chronic lymphocytic leukaemia.	
Pemphigoid	**Bullous Pemphigoid:** - Large bullae on erythematous plaques or normal appearing skin. - No or only mild involvement of mucous membrane. - Sub-epidermal tense blister. So it's tense (lower abdomen , groin, flexors of Arms & legs). - Negative Nikolsky's sign	- Systemic: Steroid. - Antibiotics: Tetracycline, Minocin. - Dapsone. - Immunosuppressive therapy (Azathioprine, Mycophenolate, Mofetil).	- Autoimmune subepidermal blistering disorders with circulating **IgG** and basement membrane zone (BMZ)-bound IgG antibodies (ABS) and **C3**. - Diagnosis: CBC: Eosinophilia, IgE:, HIST, **DIF**	
Pemphigoid gestationis:	- Erythematous urticarial Plaques, alone or with papules, vesicles, blisters, erosions (abdomen, proximal extremities). - Intense pruritus. - **Subepidermal** blister	- Potent steroids (avoid the systemic in the 1st tri). - Topical drugs, drying agents and antiseptic	- Resemble herpes because its vesicular. - C3, IgG at BMZ, H.G. Factor in Patient's Sera. - Starts at the 2nd, 3rd trimester. - Flares at postpartum, OCP . - Purely anti-HLA antibodies from the paternal placenta.	