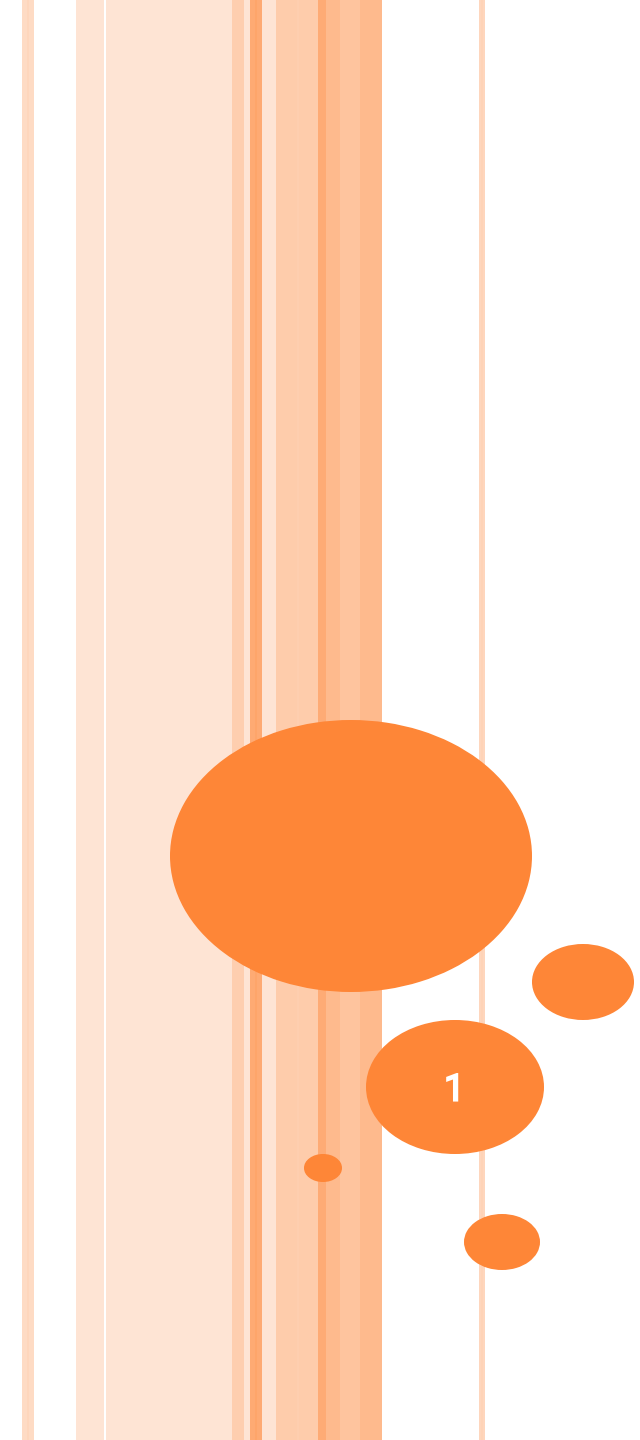




Skin problems

by:

Dr. Maha El Amami

Outlines:

1. introduction
2. Principles of Diagnosis
3. primary (basic) lesions
4. Secondary (Sequential) Lesions
5. Common Skin problems

Introduction:

Dermatologic complaints are a common reason for presentation to a general practitioner.

In such cases, one needs to determine if the complaint may be a manifestation of a more serious underlying systemic disease.

Although most skin lesions occur due to diseases primarily affecting the skin, some reflect important systemic diseases.

Such lesions may relate directly to the systemic disease, or may occur due to secondary skin diseases that develop because of immunosuppression.

Early recognition of skin changes as a marker of systemic disease will maximise patient outcomes

Principles of Diagnosis:

Dermatologic diagnosis often begins with pattern recognition.

Experts can look at most lesions and make an immediate and accurate diagnosis through pattern recognition.

The physician then combines observation of the lesions (including type and distribution) with a careful history to create an informed differential diagnosis. If the diagnosis is still not known, the physician can consult a dermatology atlas (online or print), textbook, or expert to complete the diagnosis. In some cases, further testing (scraping, culture, biopsy) may be needed

Initial Evaluation:

Although medical school teaches students to perform the history before doing the physical examination, this is not the most efficient way to approach the diagnosis of a skin condition.

When the patient has a skin complaint, immediately look at the skin while asking your questions..

History

should include:

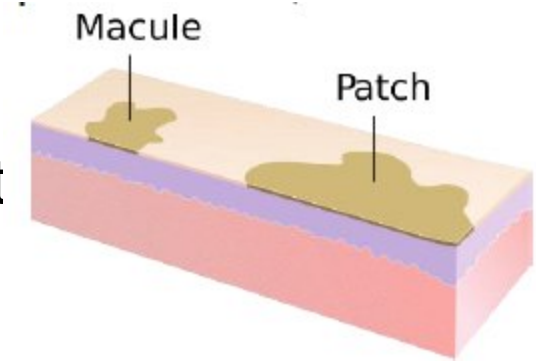
1. When? Onset – course – duration
2. Where? Start – spread – distribution
3. Local symptoms: pain, itching, bleeding, discharge, burning, ...
4. Systemic symptoms: fever, fatigue, weight loss, sore throat, ...
5. **Trigger factors: food, heat, drug, contact, ...**
6. **Treatment used, effectiveness**
7. Social history: occupation, living condition, recent travel, insect bite, extramarital relationships, effect of condition on quality of life
8. Past history: skin problems, allergies, atopic diseases, CT disorders, diabetes, IBD, thyroid disorders, drug use, smoking/alcohol
9. Family H: atopy, psoriasis, skin cancer, IBD, thyroid disorder, DM, ...

Examination: When describing a skin lesion **seven** points to be covered:

1. **Type** of lesion:

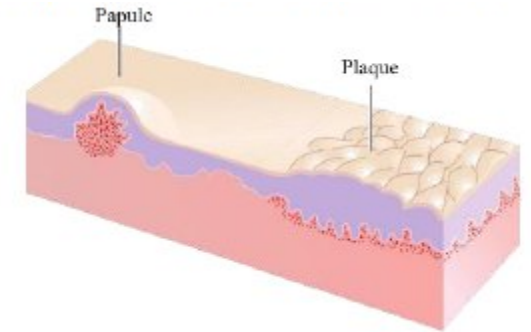
Macule: flat, non-palpable lesion, < 0.5 cm in diameter

Patch: flat, non-palpable lesion, > 0.5 cm in diameter



Papule: elevated palpable lesion, less than 0.5 cm in diameter

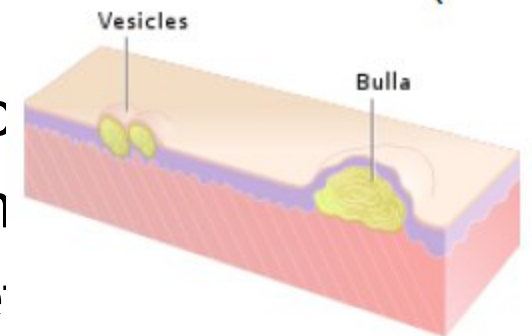
Plaque: elevated palpable lesion, more than 0.5 cm in diameter



Nodule: elevated lesion with deeper component on palpation

Vesicle: fluid-filled, elevated skin lesion (< 0.5 cm in diameter)

Bulla: fluid-filled, elevated skin lesion (> 0.5 cm in diameter)



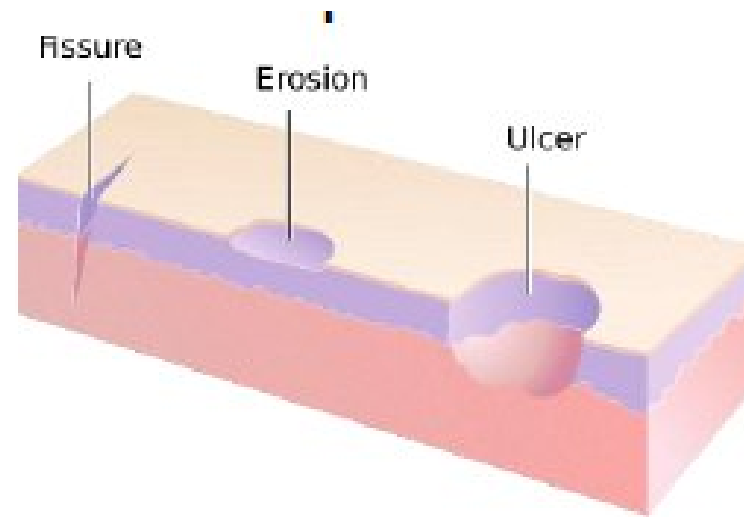
Cyst: fluid-filled, elevated skin lesion with deeper component

Pustule: Pus-containing vesicle

Erosion: loss of epidermis

Ulcer: A loss of epidermis and dermis (and sometimes deeper).

Fissure: linear tear with abrupt walls.



2. **Number:** Solitary or multiple, pattern if multiple
3. **Color** of lesion: erythematous, hyperpigmented, depigmented, skin-colored, honey-colored, silver, violet....
4. **Shape** of lesion: annular, polygonal, linear, polymorphic, ...
5. **Surface** features: rough – scaly (shedding of stratum corneum) – crusted (dried serum, blood or purulent exudate) – excoriated (scratch marks) - Lichenification (chronic thickening of epidermis with exaggeration of its normal markings) – telangiectasia (dilated superficial vessels) - ...
6. **Area involved** [remember to examine hidden areas as inframammary]
7. **Palpation:** tenderness, consistency, depth, temperature, mobility, ...

Examination by Wood's light also helps in diagnosing many conditions

Classification : Skin lesions can be classified according to:

- A. **Cause**: infection (bacterial – fungal – viral – parasitic) – inflammatory – manifestation of systemic disease – side effect of drug – tumors
- B. **Type** of lesion: maculopapular – vesicular – polymorphic - ...
- C. **Shape** of lesion: ring-like – discoid – ...
- D. **Color** of lesion: erythematous, hyperpigmented, depigmented, ...
- E. **Area** affected: scalp lesions – nail lesions – skin folds - ...
- F. **Associated symptoms**: itchy lesions – febrile rash - ...
- G. Dermatological **emergencies**

Look **carefully** at the lesions and **determine**:

1. the lesion morphology.

(use magnifying glass and good lighting)

Primary (Basic) Lesions

Secondary (Sequential) Lesions

Primary Skin Lesions



nodule



cyst



bullae



macule



plaque



wheal



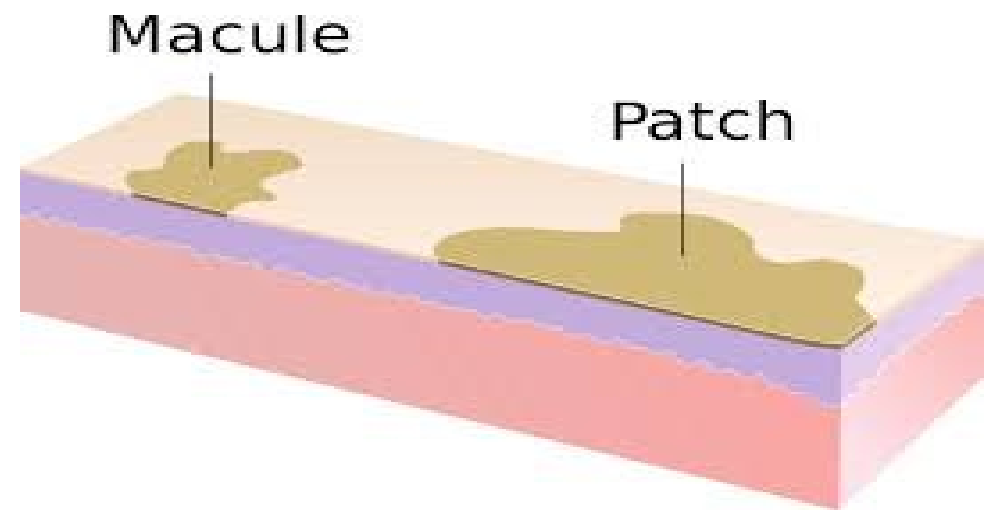
vesicle



pustule

Primary (basic) lesions:
Macule/Patch

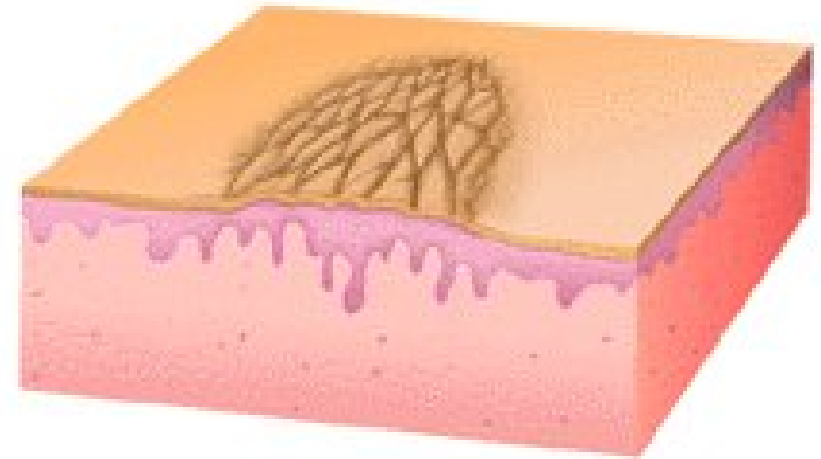
- Circumscribed color change
- No elevation or depression
- Macule: diameter ≤ 1 cm
- Patch: diameter > 1 cm





Plaque

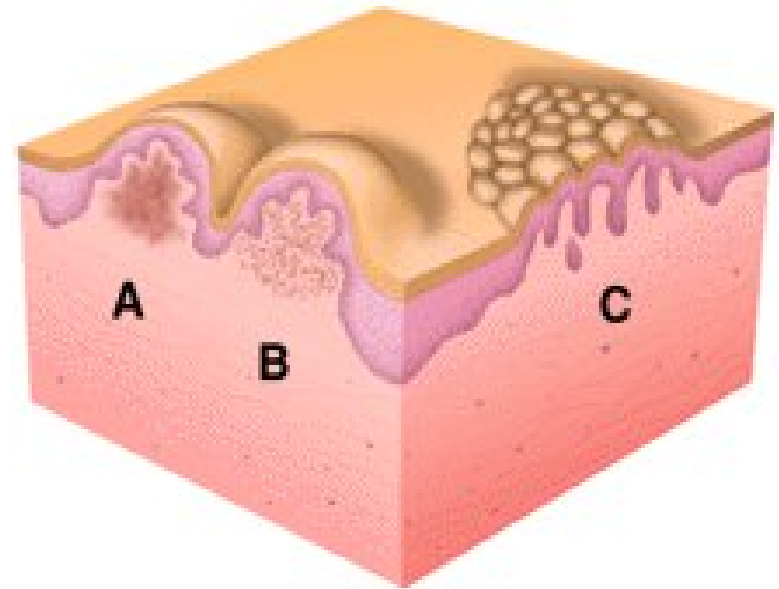
- Circumscribed, solid elevation
- Usually flat-topped
- Surface area > height
- Greater than 1 cm diameter





Papule

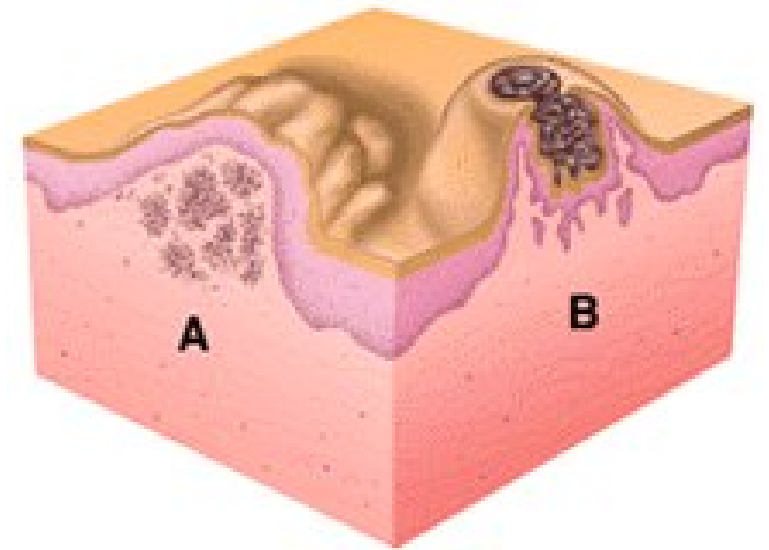
- A solid, elevated lesion
- Flat, pointed or rounded
- 1 cm or less
- Coalesce into plaques





Nodule

- Palpable, variably shaped lesion
- Epidermal, dermal, subcutaneous
- Usually elevated, any size
- Tumor is a term for any mass





Vesicle/Bulla

- Circumscribed, fluid-filled lesion
- Subcorneal, intraepidermal, subepidermal
- Vesicle: diameter 0.5 cm or less
- Bulla: diameter $>$ 0.5 cm



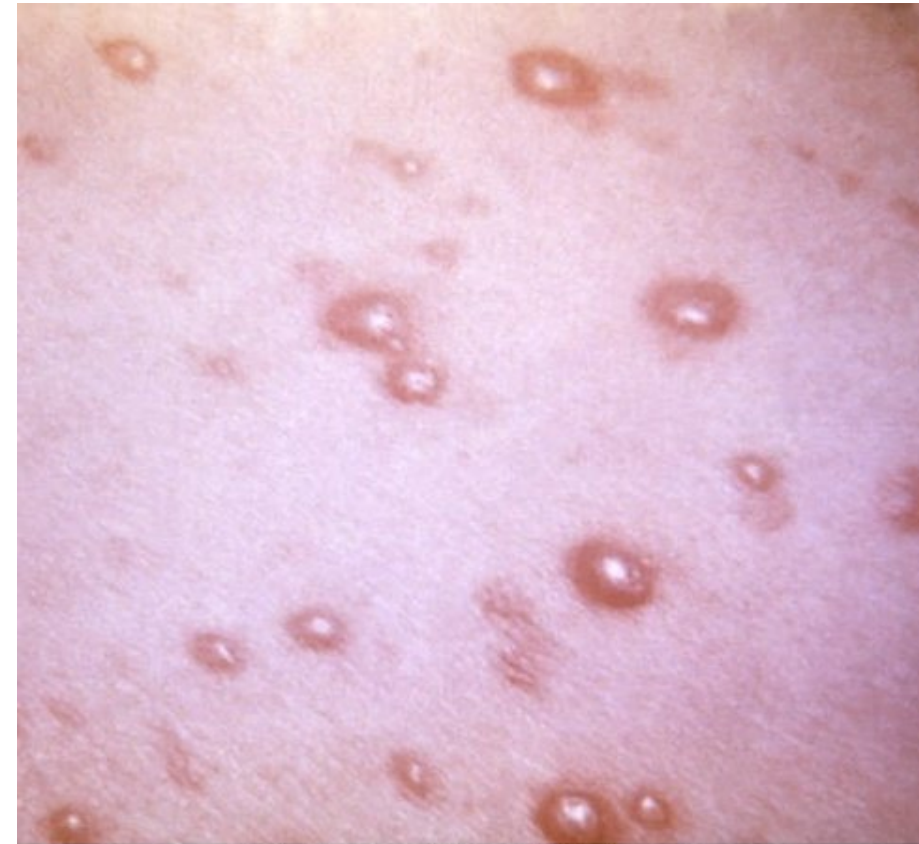
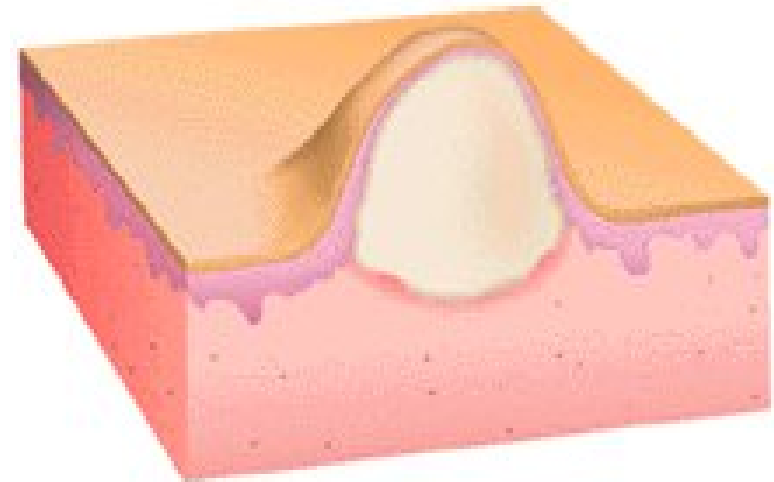


Photo Courtesy of CDC - Dr. K.L. Hermann

Pustule:

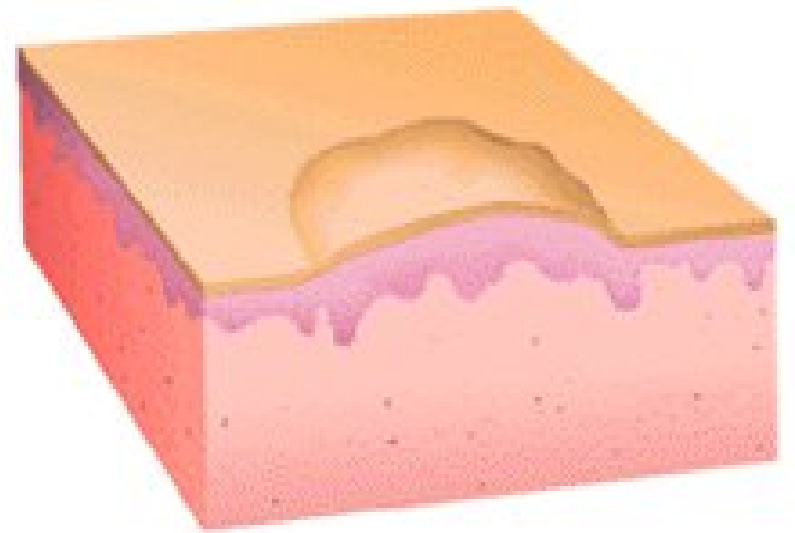
- A vesicle or bulla with purulent exudate
- May or may not be sterile
- Vary in size and shape





WHEEL:

- Firm edematous plaque
- Infiltrating fluid may cause blanching
- Usually transient





Secondary (Sequential) Lesions:

Scale:

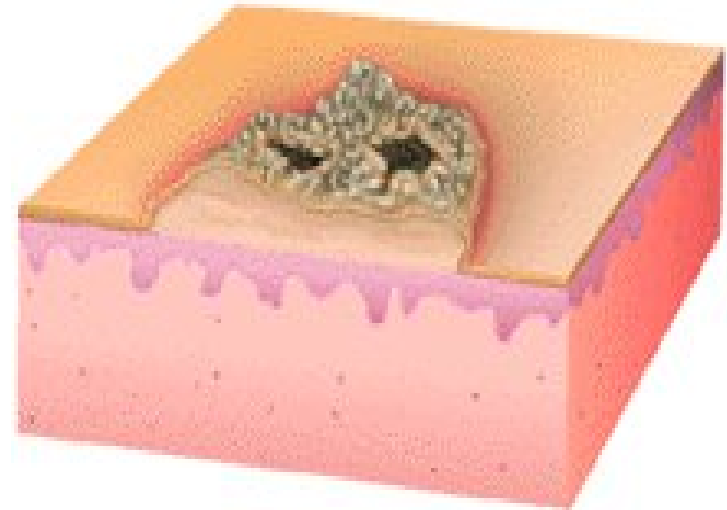
- Stratum corneum becomes perceptible
- Produced by abnormal keratinization or shedding
- Can overly macules, papules, & plaques





Crust:

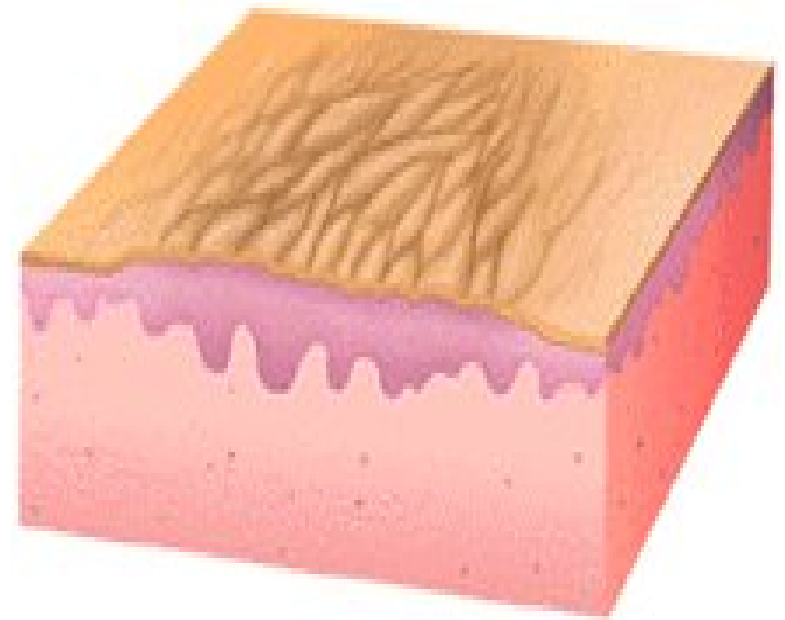
- Collection of debris on skin surface
- Dried exudate of serum, blood or pus
- A scab





Lichenification:

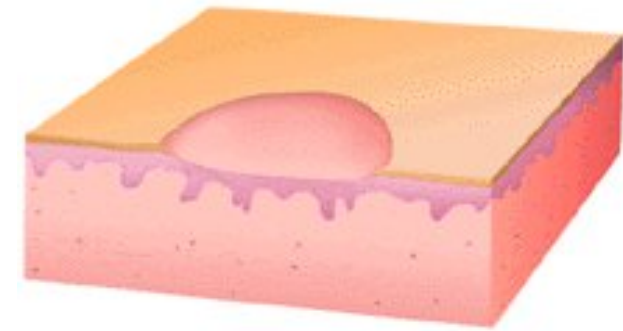
- Leathery thickening of all skin layers
- Exaggerated skin markings
- Caused by chronic scratching/rubbing





Erosion

- Focal loss of epidermis
- Loss does not penetrate into dermis
- Heals without scarring





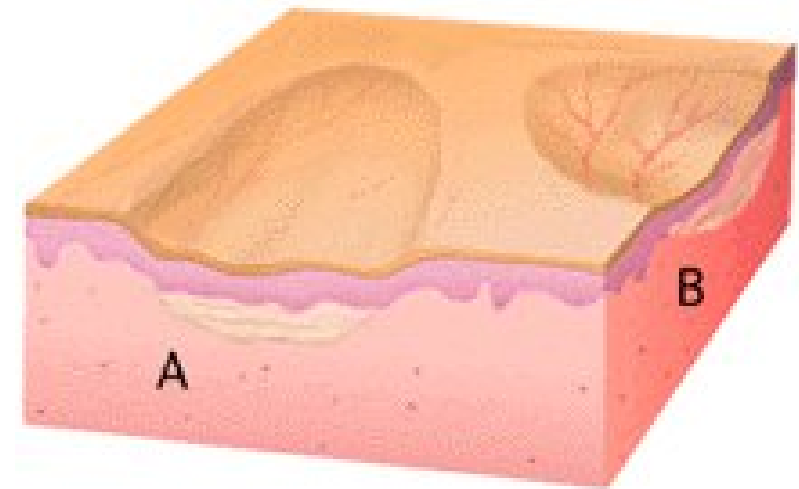
Ulcer

- Focal loss of epidermis and dermis
- Loss does penetrate into dermis
- Heals with scarring



Atrophy:

- Focal depression of the skin
- Results from thinning of the epidermis and/or dermis
- Potent topical steroids can cause





Excoriation

- Caused by scratching
- Linear loss of epidermis
- May penetrate into dermis
- May heal with scarring

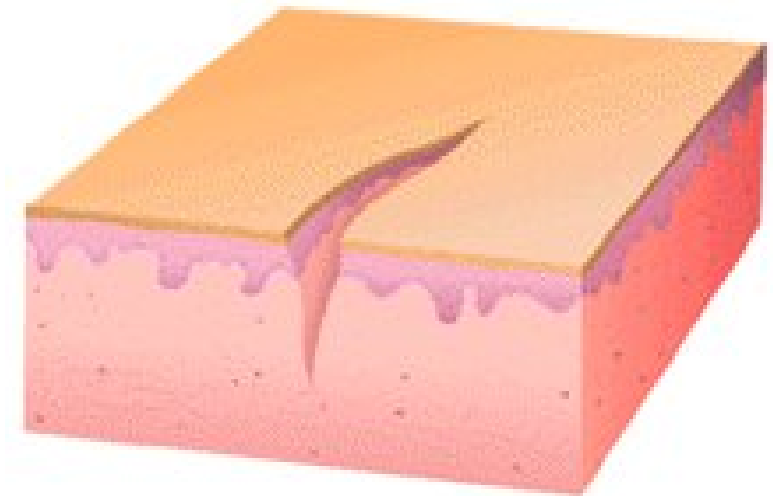




GlobalSkinAtlas.com

Fissure

- Caused by drying
- Deep linear split in the skin
- Penetrates into dermis





2. Palpation:

touch the lesions, with gloves when appropriate.

light feeling: for actinic keratosis with scaling/
sandpaper rash of scarlet fever.

deep palpation: For deeper lesions, such as nodules
and cysts

Observe the distribution of the lesions: arranged in groups, rings, lines, or merely scattered over the skin.

Determine which parts of the skin are affected and which are spared.

Be sure to look at the remainder of the skin, nails, hair, and mucous membranes.

Once the physician starts to look at the skin, the patient history will be more focused, directed toward finding the correct diagnosis

Table 2. Differential Diagnosis of Common Presenting Problems

Lesion	Infectious	Inflammatory	Drug/Toxin	Miscellaneous
Brown Macule		Post-inflammatory hyper-pigmentation	UV radiation, actinic/solar lentigo, freckle (ephelide)	Congenital: café-au-lait spots, congenital nevus, epidermal/junctional nevus Neoplasia: lentigo maligna, MM, pigmented BCC Other: melasma/chloasma ("mask of pregnancy")
Discrete Red Papule	Folliculitis Furuncle Scabies	Acne vulgaris Rosacea Psoriasis Urticaria	Bites/stings	Autoimmune: lichen planus; <i>see Papulosquamous Diseases, D16</i> Vascular: hemangioma, pyogenic granuloma Other: dermatofibroma, miliaria rubra
Red Scales	Pityriasis rosea Secondary syphilis Tinea	Dermatitis (atopic, contact, nummular, seborrheic) Discoid lupus Psoriasis	Gold	Autoimmune: lichen planus; <i>see Papulosquamous Diseases, D16</i> Neoplastic: mycosis fungoides
Vesicle	Cat scratch disease Impetigo Viral: HSV, HZV, VZV, Molluscum, Coxsackie Scabies	Acute contact dermatitis Dyshidrotic eczema		Other: dermatitis herpetiformis, porphyria cutanea tarda
Bulla	Bullous impetigo	Acute dermatitis EM, SJS, TEN, SLE	Fixed drug eruption	Autoimmune: bullous pemphigoid, pemphigus vulgaris Other: dermatitis herpetiformis, porphyria cutanea tarda
Pustule	Candida Dermatophyte Impetigo Sepsis Varicella	Acne vulgaris Rosacea Dyshidrotic dermatitis Pustular folliculitis Pustular psoriasis Hidradenitis suppurativa	Acute generalized exanthematous pustulosis (usually secondary to drug reaction)	
Oral Ulcer	Aspergillosis CMV Coxsackie Cryptococcosis HSV/HZV HIV, TB, Syphilis	Allergic stomatitis EM/SJS/TEN Lichen planus Seronegative arthropathies, SLE Recurrent aphthous stomatitis Behçet's disease	Chemotherapy Radiation therapy	Autoimmune: pemphigus vulgaris Congenital: XXY Hematologic: sickle cell disease Neoplasia: BCC, SCC
Skin Ulcer	Plague Syphilis TB Tularemia	RA, SLE, vasculitis UC (pyoderma gangrenosum)		Autoimmune: necrobiosis lipoidica diabetorum (e.g. DM) Congenital: XXY Hematologic: sickle cell disease Neoplasia: SCC Vascular: arterial, neurotrophic, pressure, venous, aphthous, leukoplakia, traumatic

cysts

	Clinical Presentation	Pathophysiology	Epidemiology	Clinical Course	Management
Epidermal Cyst	Round, yellow/flesh-coloured, slow growing, mobile, firm, fluctuant, nodule or tumour	Epithelial cells displaced into dermis, epidermal lining becomes filled with keratin and lipid-rich debris May be post-traumatic, rarely syndromic	Most common cutaneous cyst in youth – middle age	Central punctum may rupture (foul, cheesy odour, creamy colour) and produce inflammatory reaction Increase in size and number over time, especially in pregnancy	Excise completely before it becomes infected
Pilar Cyst (Trichilemmal)	Multiple, hard, variable sized nodules under the scalp, lacks central punctum	Thick-walled cyst lined with stratified squamous epithelium and filled with dense keratin Idiopathic Post-trauma, often familial	2nd most common cutaneous cyst F > M	Rupture causes pain and inflammation	Excision
Dermoid Cyst	Firm nodule most commonly found at lateral third of eyebrow or midline under nose	Rare, congenital hamartomas, which arise from inclusion of epidermis along embryonal cleft closure lines, creating a thick-walled cyst filled with dense keratin	Rare	If nasal midline, risk of extension into CNS	Excision
Ganglion Cyst	Usually solitary, rubbery, translucent; a clear gelatinous viscous fluid may be extruded	Cystic lesion that originates from joint or tendon sheath, called a digital mucous cyst when found on fingertip Associated with osteoarthritis	Older age	Stable	Incision and expression of contents Laser ablation and electrodesiccation
Milium	1-2 mm superficial, white to yellow subepidermal papules occurring on eyelids, cheeks, and forehead	Small epidermoid cyst, primarily arising from pluripotential cells in epidermal or adnexal epithelium Can be secondary to blistering, ulceration, trauma, topical corticosteroid atrophy, or cosmetic procedures	Any age 40-50% of infants	In newborns, spontaneously resolves in first 4 wk of life	Incision and expression of contents Laser ablation and electrodesiccation Multiple facial milia respond to topical retinoid therapy

Skin in Diabetes Mellitus:

Acanthosis Nigricans.

Diabetic Dermopathy.

Bullosis Diabeticorum.

Necrobiosis Lipoidica.

Diabetic Eruptive Xanthomas.

Stiff thick skin (diabetic sclerodactyly or cheiroarthropathy).

Acanthosis Nigricans:

Hyperpigmented velvety plaques of the flexures

African Americans and Hispanics > Caucasians

Benign and malignant forms

Associated with obesity, insulin resistance,
hypothyroidism, cushing

Genetic sensitivity of the skin to hyperinsulinemia

Malignant form a/w gastric ACA





Diabetic Dermopathy

Most common cutaneous manifestation of diabetes

Male more than female

“shin spots”

Benign asymptomatic red brown macules , papules on shins

Neuropathy or vascular

No treatment needed



Bullosis Diabeticorum:

Rarest cutaneous manifestation of diabetes .

Male more than female

Rapid onset painless, tense blisters on hands and feet

Trauma and microvascular disease may play a role

Spontaneous healing in 2-5 weeks

Recurrence



Necrobiosis Lipoidica:

20-35% of patients with NLD have diabetes, only about 1-3% of diabetics have NLD

Start as red-brown papules and progress to well defined yellow-brown atrophic plaques with irregular violaceous borders and telangiectasias.

Ulceration in 35%.

Shins most common

Glucose control will not clear NLD



Quiz

Erythema Nodosum



Pyoderma Gangrenosum





malar rash.



Heliotrope rash of dermatomyositis



Mucosal Lichen Planus



Thyroid Dermopathy



Vitiligo



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Xanthelasma



Neurotrophic ulcer



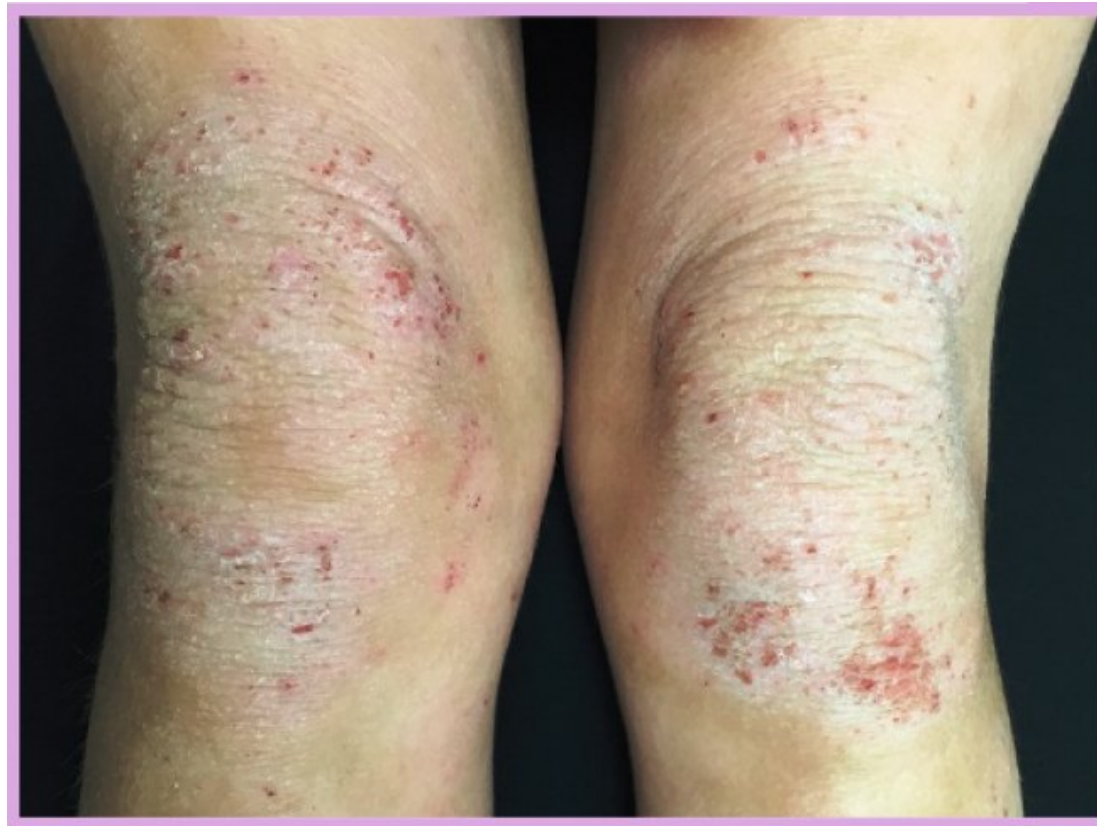
henoch schonlein purpura



Case study

Case1

An 11-year-old girl presents to the pediatric dermatology clinic as a referral for a persistently itchy rash that involves the face, neck, trunk and extremities. She has been treated by her pediatrician for atopic dermatitis (AD). The pediatrician has been treating the areas with topical hydrocortisone 2.5% cream, which has not helped control the symptoms. Her mother states that despite using generous emollients and hydrocortisone, the girl scratches rigorously at night and is unable to concentrate during school due to pruritus. She has a past medical history of moderate intermittent asthma and allergic rhinitis, and her mother reports a strong history of asthma on her side of the family without any dermatologic issues. On physical examination, there is extensive generalized xerosis of the skin with areas of eczematous lichenified plaques, many with secondary excoriations and hypopigmentation.



1. What is the pathogenesis of atopic dermatitis?
2. What are the 'atopic stigmata'?
3. What treatments are on the therapeutic ladder for atopic dermatitis?

Answers:

1. Chronic inflammatory disorder of the skin, prevalence up to 30% in children and 10% in adults.
Caused by genetic & environmental factor.
2. Xerosis, Palmar hyperlinery, white dermatographism, periorbital darkening, pityriasis alba.
3. Triamcinolone 1%

CASE 2

A 79-year-old woman presents to a dermatology clinic with a painful, itchy rash on her hand and wrist. The patient is visiting her daughter from South America and reports that while cooking, she sustained burns to the hand and wrist when she came into contact with a hot surface. She attempted to treat the areas with multiple over-the-counter topical medications. She cannot recall what she used but reports using various old antiseptics and ointments she brought from South America. However, her burn wounds have worsened and she has developed increased pain, swelling, erythema and intense pruritus at the sites of the wound. On examination there are well-demarcated scaly orange-red plaques on the medial hand and wrist with superficial fissures.



1. What is the diagnosis and the most likely causative material?
2. What is the name of the syndrome that can result from ingestion of this material?

Answers:

1. Contact dermatitis

Fragrance in soap, moisturizers, topical antiseptic.

2. Baboon syndrome

CASE 3

A 32-year-old woman presented to the emergency department (ED) with acute onset hives. While in the ED she was treated with intramuscular methylprednisolone and intravenous diphenhydramine with complete resolution of her symptoms. Eight weeks after her ED visit, she continued to have intermittent hives more than 5 days a week. The hives were unresponsive to loratadine 10 mg daily so she decided to visit a dermatologist. On examination, there are numerous annular and geographic edematous plaques on the inner thighs and upper back. Upon further questioning, she denies worsening with pressure, cold, heat, water or exercise.



1. What is the most accurate diagnosis?
2. What is the most likely cause?
3. What type of exogenous physical stimuli can cause this condition?
4. What are the potential pharmacologic treatments available and what medications should be avoided in these patients?

Answers:

1. Chronic urticaria.
2. Patient has
ordinary or spontaneous chronic urticaria which makes up to 60% of all cases of chronic urticaria.
Other causes:
Idiopathic.
Autoimmune
Infection related.
Pseudo allergic causes.
3. Physical or inducible:
Mechanical stimulus.
Temp. changes.
Sweating or stress.
4. Antihistamine on daily basis
Prednisone, montelukast, sulfasalazine

CASE 4

A 20-year-old man presents to the dermatology office for evaluation of worsening acne. He has struggled with acne since adolescence and has tried numerous topical over-the-counter products containing salicylic acid and benzoyl peroxide and prescription medications including topical clindamycin 1% gel, dapsone gel, topical azelaic acid and a topical retinoid, with only moderate improvement of his acne. He is concerned about the worsening of acne on other parts of his body, including the chest and the back. On examination, there are a few scattered erythematous papules and pustules on the forehead, cheeks and the chin (a). On the back, there are erythematous papules, pustules, and hyperpigmented papules and scars from prior acne lesions (b).



1. **What is the pathogenesis of acne?**
2. **What additional treatments should be considered in this patient?**
3. **What drugs or exposures can exacerbate acne or lead to acneiform eruptions?**

Answers:

1. Disorder of pilosebaceous unit with various clinical presentations, other pathogenesis multiple factors:
Genetic predispositions, sebum production, hormonal influence, inflammatory response, presence of propionibacterium acne on skin.
3. Lithium, carbamazepine, phenytoin, Azathioprine.

CASE 5

A 51-year-old woman presents to the Veterans Affairs (VA) dermatology clinic for the evaluation of central facial redness and flushing. She states that this began in her mid-30s and has progressively worsened over time. She notices it more during the summer after sun exposure.

She relates associated symptoms of itching, dry skin, occasional burning and warmth with flushing. On examination, there is redness with telangiectasias on the dorsal nose, cheeks and chin



1. What are the four main subtypes of this condition?
2. What are the main components of the pathogenesis of this condition?
3. What are the microorganisms associated with this condition?
4. What are the available treatment options?

Answers:

1. 1

Erythromatoteleangiectatic.

Papulo- pustular.

Phymatous.

Ocular rosacea

2. Genetic component, dysregulation of innate immune system presence of certain M.O., U.V. radiation

3. Patient with rosacea high prevalence of skin colonization with bacteria that are not topically present on skin include helicobacter pylori, bacillus oleronius.

Healthy individuals with rosacea have higher density of demodex folliculorum, and staph epidermidis

4. -Mild to moderate topical sulfacetamide, metronedazone, benzoyl peroxide, permethrin, macrolides

- Moderate to severe: Tetracycline

CASE 6

A 36-year-old woman presents to the dermatology clinic for evaluation of dark patches on her face. She states that she has noticed darkening of the skin on the sides of her cheeks after giving birth to her last child approximately 1 year ago. The area is asymptomatic but distressing to her as it is not going away. She recently started taking an oral contraceptive pill but otherwise notes no new medications. Her family history is notable for multiple autoimmune conditions including Grave's disease and systemic lupus erythematosus. She does not wear sunscreen routinely. On examination, there are hyperpigmented patches on the lateral cheeks with areas of hypopigmentation and a reticular pattern on the periphery.



1. What is the diagnosis? What are factors associated with this condition?
2. What further testing, if any, is indicated?
3. What treatment options are available?

Answers:

1. Melasma, genitic, darker skin, exposure to U.V light, pregnancy, exogenous hormone.
2. Thyroid disorder (TSH).
3. Broad spectrum sun screen, Hydro quinone, mild topical corticosteroid, chemical peels with alpha hydroxy peeling as glycolic acid.

CASE 7

A 51-year-old man presents to the dermatology clinic for an annual skin examination. He has no personal history of skin cancer but reports a history of multiple 'abnormal moles' that required removal throughout his adolescence and into early adulthood. He has a history of significant sun exposure over his lifetime and does not wear sunscreen. His family history is notable for skin cancer in his paternal grandmother. On examination, there is a red-brown slightly raised melanocytic papule with asymmetry and irregular pigmentation at the border.



1. What is the diagnosis, and what are the risk factors for developing this skin lesion?
2. What are the four major variants of this condition?
3. What are the histologic characteristics of this lesion, and what stains can help confirm the diagnosis?
4. What are the molecular targeted therapies available for advanced disease?

Answers:

1. Malignant melanoma

Genetic, highly pigmented skin, chronic sun exposure, psoralen, U.V radiation, congenital melanocytic nevi >20 cm.

2. -Superficial spreading melanoma (most common)

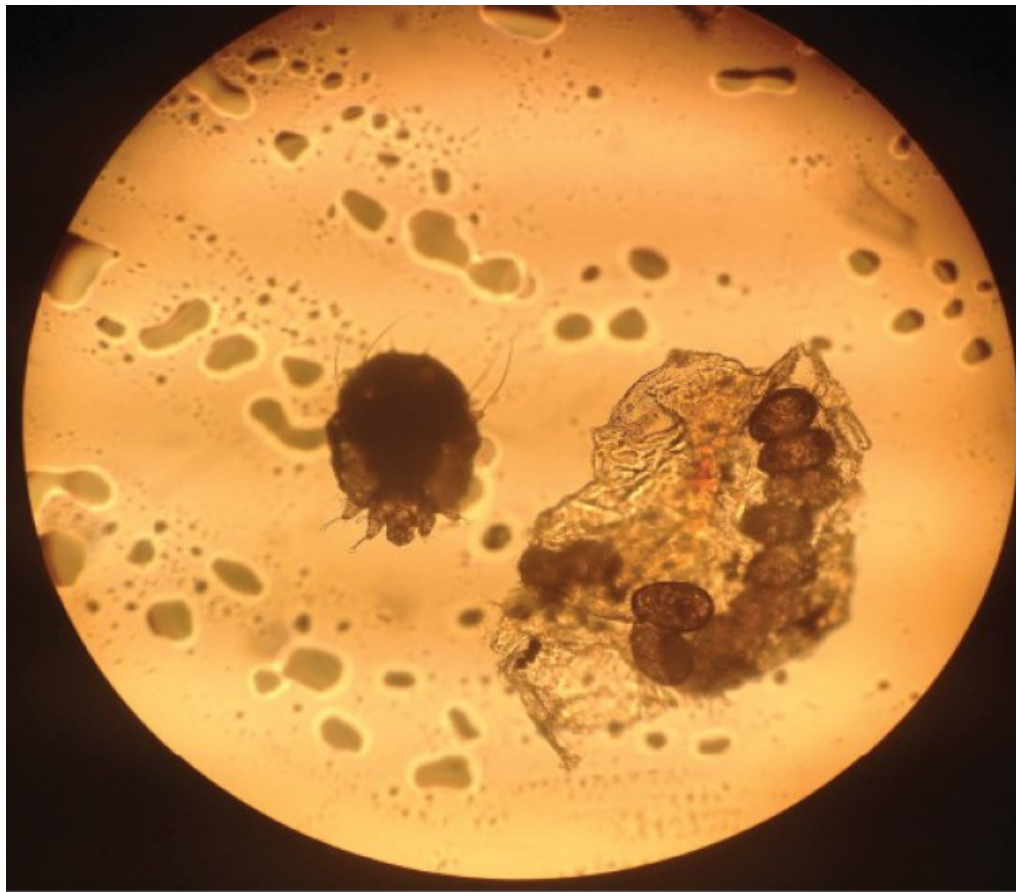
Nodular melanoma.

Lentigo maligna.

Acral lentiginous melanoma.

CASE 8

A 41-year-old man with a remote history of Hodgkin's lymphoma presents with an intensely pruritic rash that is scattered over his arms and legs and in his groin region. He states that the eruption began on his wrists and hands and has progressively spread. He denies any history of atopic dermatitis or recent travel. A skin scraping was performed with a scalpel blade and was observed under the light microscope using mineral oil



1. What does Figure show?
2. What is the most appropriate treatment for this patient and his family?
3. What is a more severe variant of this disease and in which two special populations is it more likely to be found?

Answers:

1. Scabies mite: known as *sarcoptes scabies* var. *hominus* with several eggs.
2. Permethrin 5% cream, lindane 1% lotion or cream.
3. Crusted scabies.

CASE 9

A 75-year-old man with a history of chronic obstructive pulmonary disease (COPD) and colon cancer presents with a 3-day history of an intensely pruritic and painful rash on his left mid-back. He states that it began as a tingling area before he began to develop multiple blisters. He does not have any other sites of involvement. On examination, there is a unilateral erythematous rash consisting of papules and vesicles in a dermatomal distribution on the back.



1. Which human herpesvirus is responsible for this eruption?
2. What is the clinical sign suggestive of ocular involvement?
3. What is the syndrome that can lead to facial nerve paralysis?
4. What underlying disease should be considered in multidermatomal, verrucous or disseminated presentations?
5. What is the treatment of choice, and what are the common sequelae of this disease?

Answers:

1. Varicella zoster virus
2. Hutchinson's sign
3. Ramsay hunt syndrome.
4. HIV
5. Acyclovir, famciclovir, valacyclovir
Postherpetic neuralgia.

CASE 10

A 71-year-old woman presents to the emergency room with fever, malaise and a peeling rash. She has a history notable for poorly controlled diabetes mellitus and had started a course of sulfamethoxazole– trimethoprim and ciprofloxacin for cellulitis of the right foot 8 days ago. On examination, there are large confluent areas of dusky erythema, flaccid bullae and denudation. There are also oral mucosal erosions around and inside the mouth and bilateral conjunctival injection. She is admitted to the hospital and continues to develop large confluent areas of dusky erythema on the trunk and extremities with a cigarette paper-like texture (a) with new blister formation and progression of denudation (b, c) involving 70% of the total body surface area.



- 1) What is the diagnosis?
- 2) What are the most common causes of this disorder, and what populations, if any, may be at risk?
- 3) What are the complications and sequelae of this disease?
- 4) What criteria can be used to predict mortality and what treatments are available?

Answers:

1. Steven Johnson syndrome.

The patient presents with toxic epidermal necrolysis (TEN), a severe mucocutaneous disease in the same spectrum as Stevens–Johnson syndrome (SJS). TEN has an average mortality between 25% and 35%. SJS/TEN is almost always due to drug exposures and is caused by massive keratinocyte death, which leads to separation of the skin at the dermal–epidermal junction.

2. Medications that are most often associated with SJS/TEN include antimicrobials (aminopenicillins and trimethoprim–sulfamethoxazole), antiretroviral medications (particularly non-nucleoside reverse transcriptase inhibitors), allopurinol and anti-epileptic drugs (carbamazepine, phenytoin, lamotrigine and barbiturates)
3. Areas of detached epidermis typically heal with re-epithelialization occurring within 3 weeks without any need for skin grafting. However, it is important to consult ophthalmology, gynecology and/or urology for the evaluation of mucosal involvement, as the manifestations on the mucosal surfaces can lead to sequelae such as symblepharon, conjunctival synechiae, entropion or blindness in the eyes and phimosis or vaginal synechiae in the genital mucosae.
4. The SCORTEN scale is a severity-of-illness score that can be used in patients with TEN to predict mortality. It is based on seven independent risk factors for high mortality and is assessed at the time of presentation. One point is calculated for the presence of each of the seven parameters of the SCORTEN scale, which include age (>40 years), the presence of an associated malignancy, heart rate (>120 beats/min), total body surface area of epidermal detachment (>10% on day 1), serum urea level (>27 mg/dL), serum bicarbonate (<20 mEq/L) and serum glucose (>250 mg/dL).

CASE 11

A 46-year-old Hispanic man presents to the clinic for the evaluation of a large scar on his chest. He does not remember any preceding injury or trauma to this area, and the area of scar involvement has increased over a course of months. He has associated itching, tenderness and sensitivity in the area. On examination, there is a large pink firm plaque on the central chest.



1. What is the diagnosis?
2. What systemic diseases can this diagnosis be associated with?
3. What is the prognosis?

Answers:

1. Keloid
2. Scleroderma, morphea, type IV Ehler syndrome
3. Poor.

