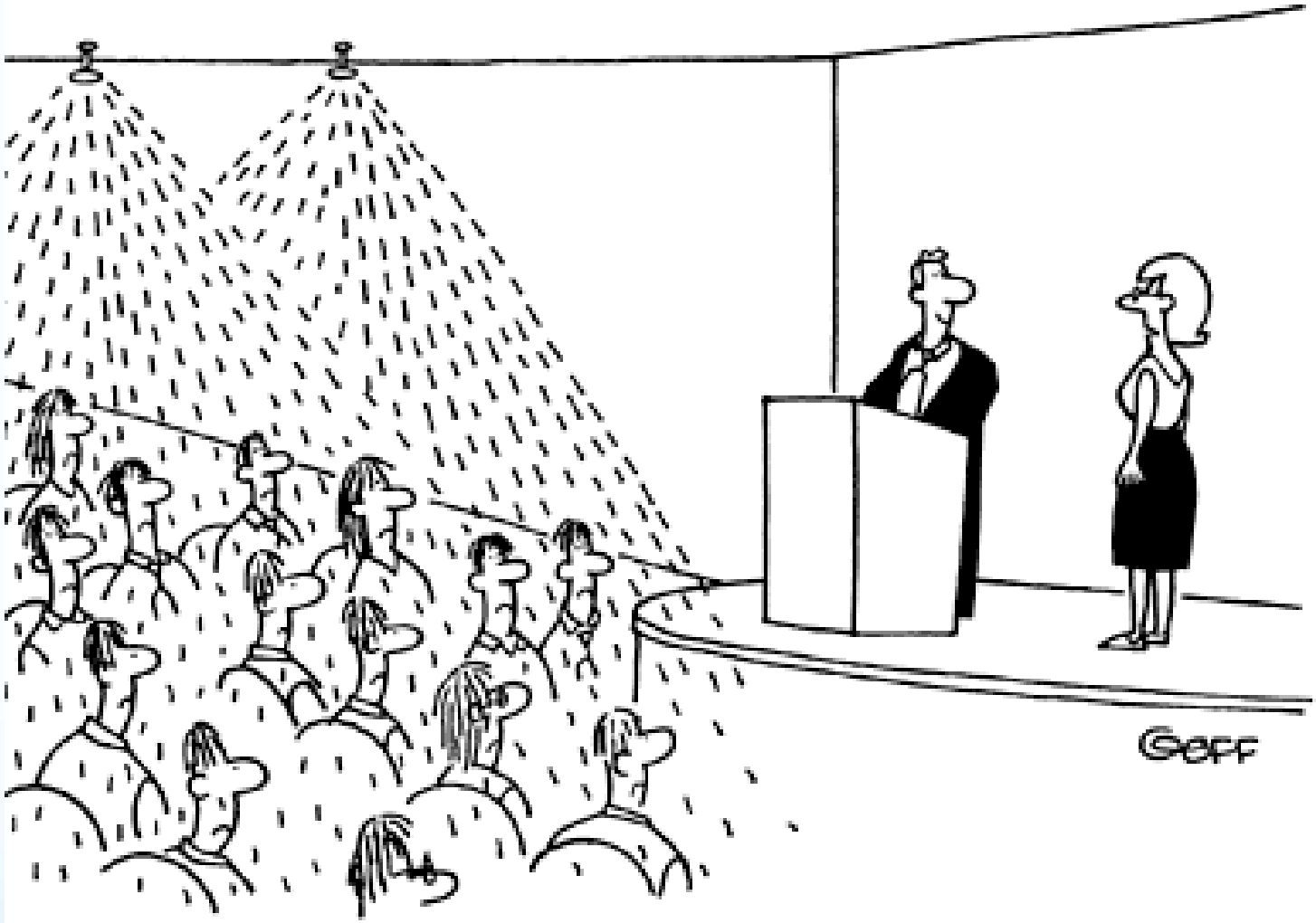
Name That Rash!

Shane Silver MD, FRCPC



"You're not allowed to use the sprinkler system to keep your audience awake."

Faculty/Presenter Disclosure

- **Faculty:** shane silver

- **Relationships with commercial interests:**
  - **Not applicable for this talk**
  - **Have been on Advisory boards for Elie Lillie, Jansen, Amgen, Abbvie**

Disclosure of Commercial Support

- **No commercial support**
- **<u>Potential for conflict(s) of interest</u>:**

  Not applicable to this talk

Mitigating Potential Bias

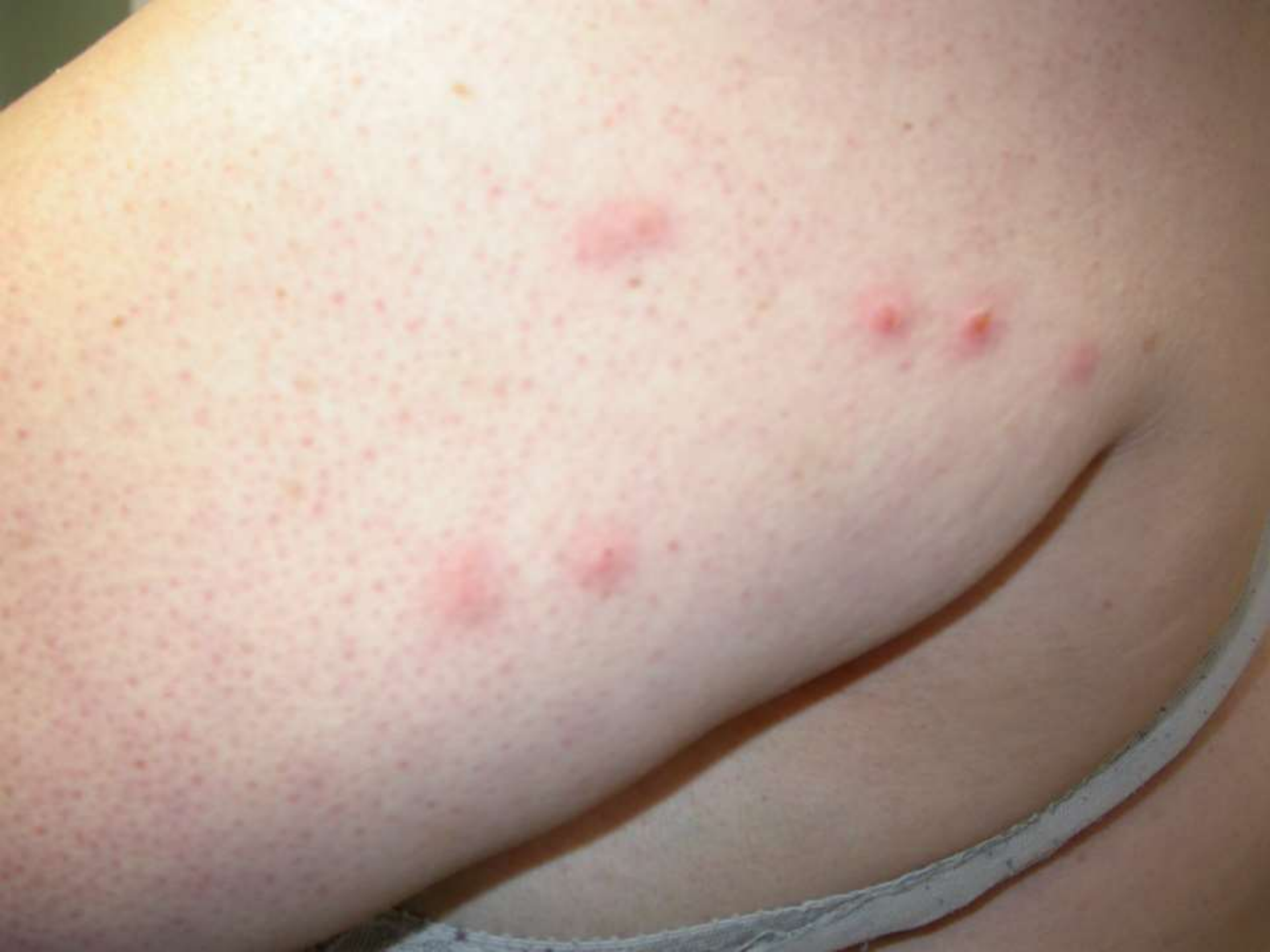
Not applicable to this talk

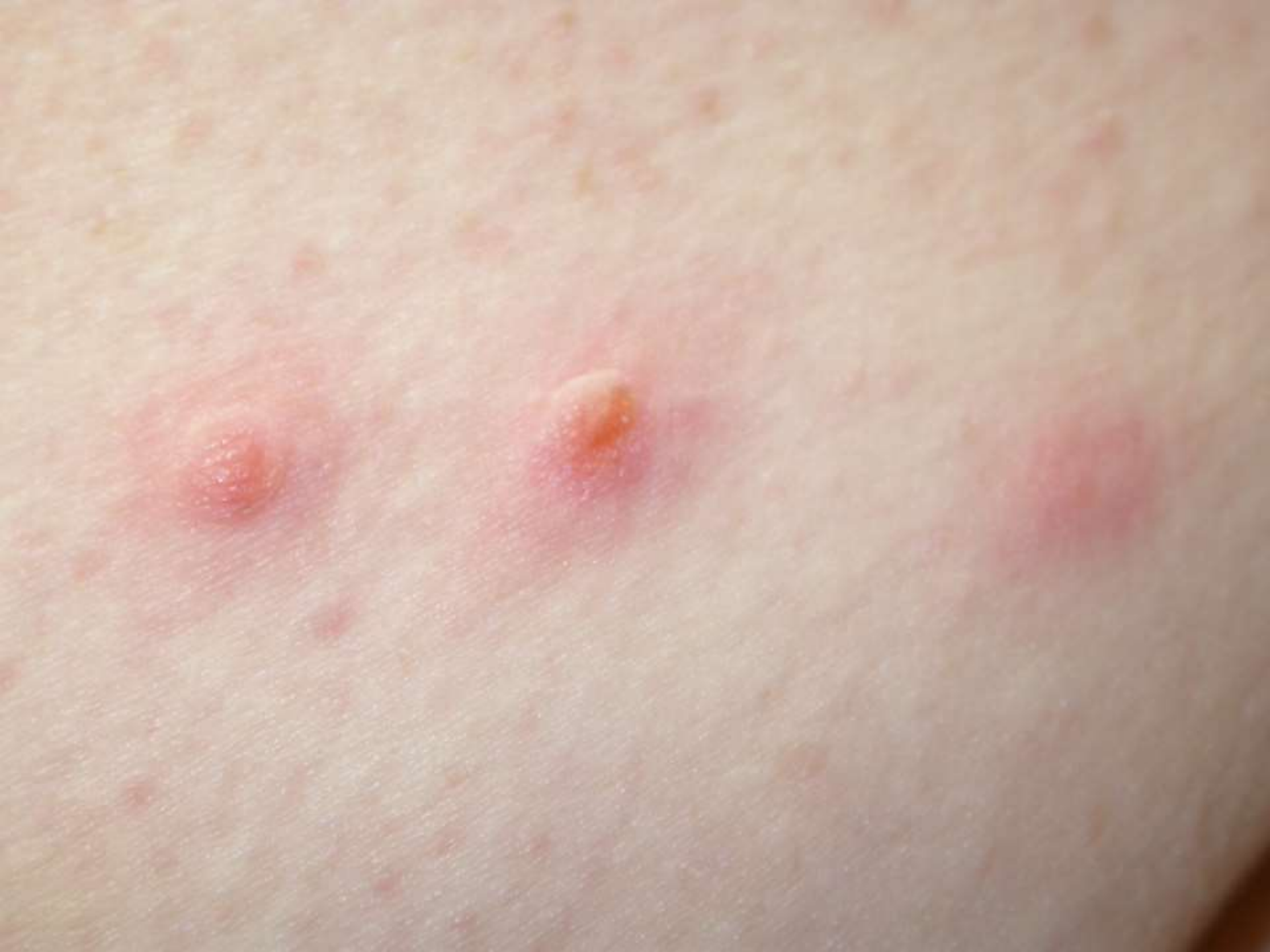
Outline

- 1. Multiple cases requiring your impute
- 2. Important to recognize these entities.
- 3. Some may be more common presentations in your office others rare but still important to diagnose.
- 4. Stay awake!!

Case

- 43 year old female with multiple papules on exposed body surface areas





Differential Diagnosis

- 1. Urticaria
- 2. Bed Bugs
- 3. Hot tub folliculitis
- 4. Impetigo

Bedbugs

- Cimex lectularius
- Live 6-12 months, 200-500 eggs/lifetime
- In crevices of home
- Can live 7-45 degrees C
- Exposed areas
- Treat symptomatically
- Cannot travel up low friction (vaseline bed posts)

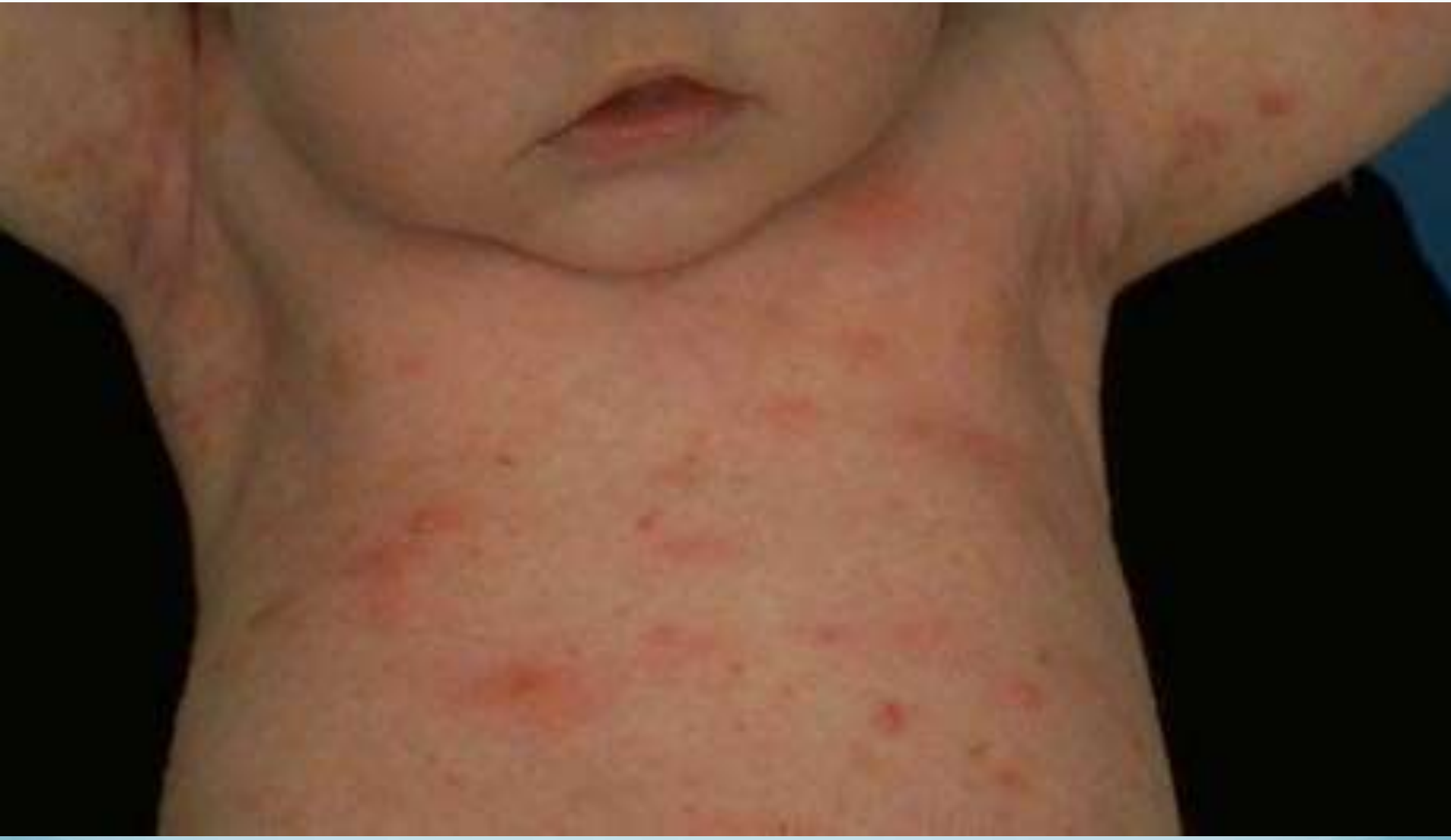
Bed Bugs

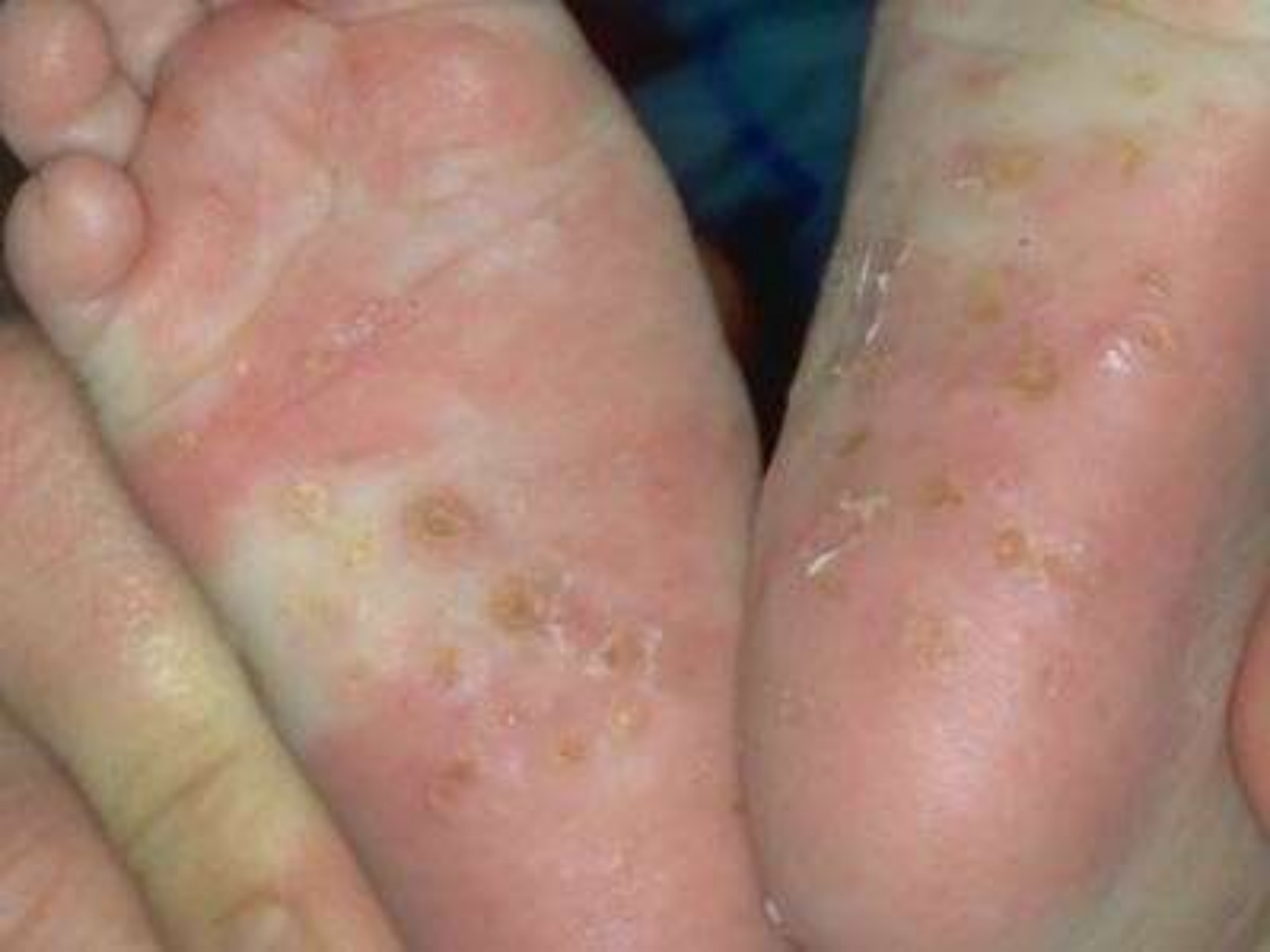
- Plastic mattress cover
- Wash linens in high heat
- Professionally steam mattress
- Professional exterminator
- **NOT EVERYONE REACTS TO BEDBUGS**


KEEP
RIGHT

Case

- 9 month old infant with a rash for 5 days
- Restless, irritable, afebrile
- Mother noticed lesions diffusely





Diagnoses

1. Scabies
2. Atopic dermatitis
3. Viral exanthem
4. varicella

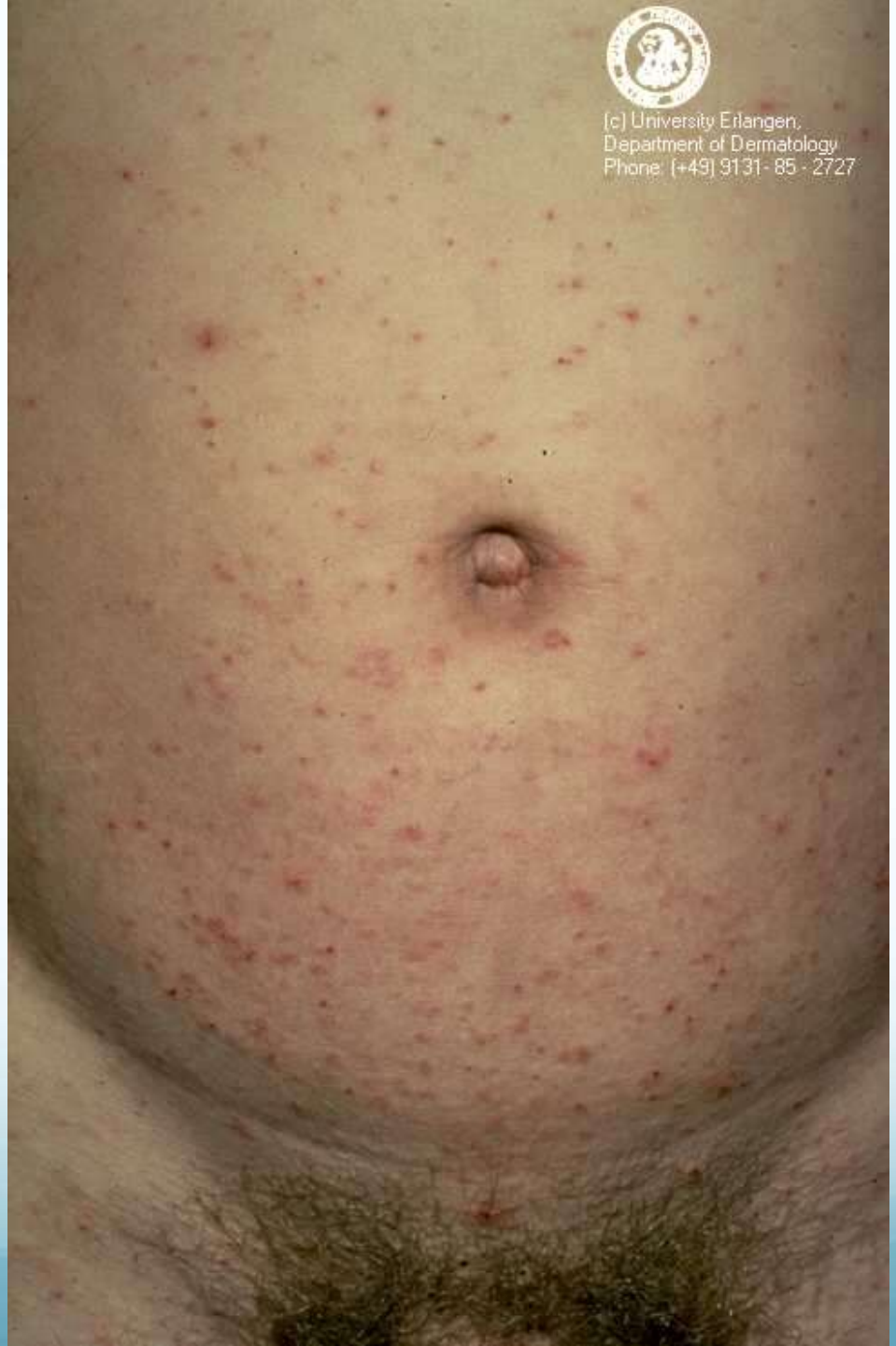
Scabies

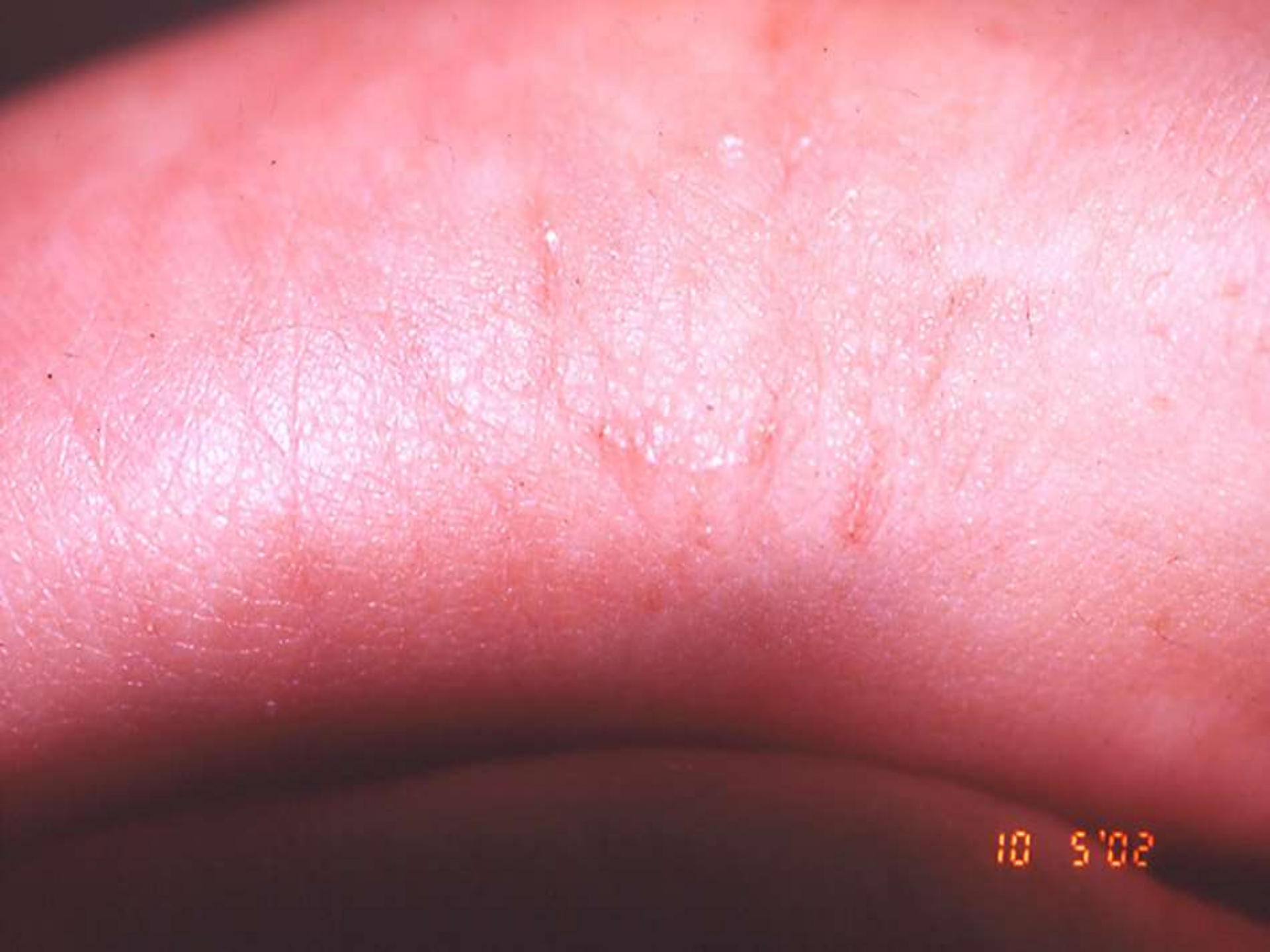
Scabies

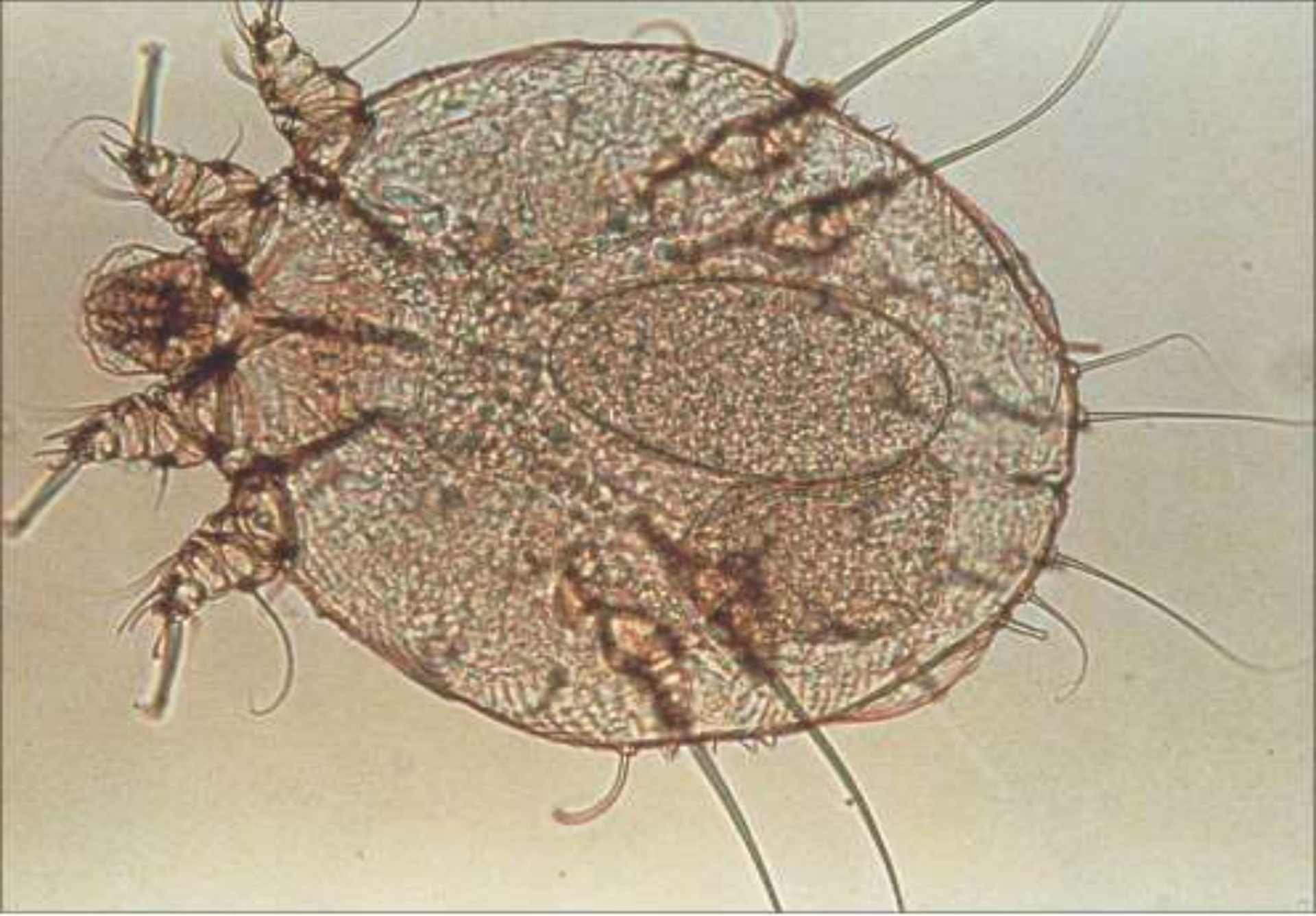
- Human infestation – Sarcoptes scabiei var humanus
- World wide – no socioeconomic predilection
- Delayed hypersensitivity reaction Intractable pruritus – worse in evening
- 11-12 mites with classic case

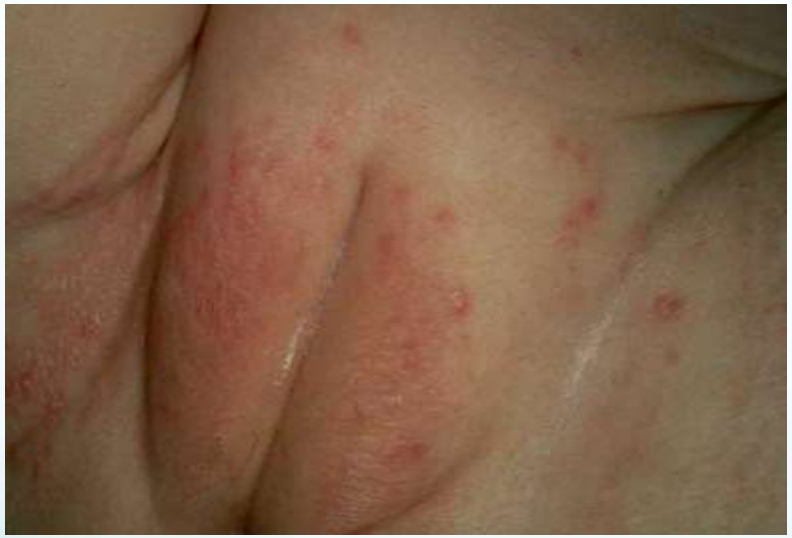
Scabies

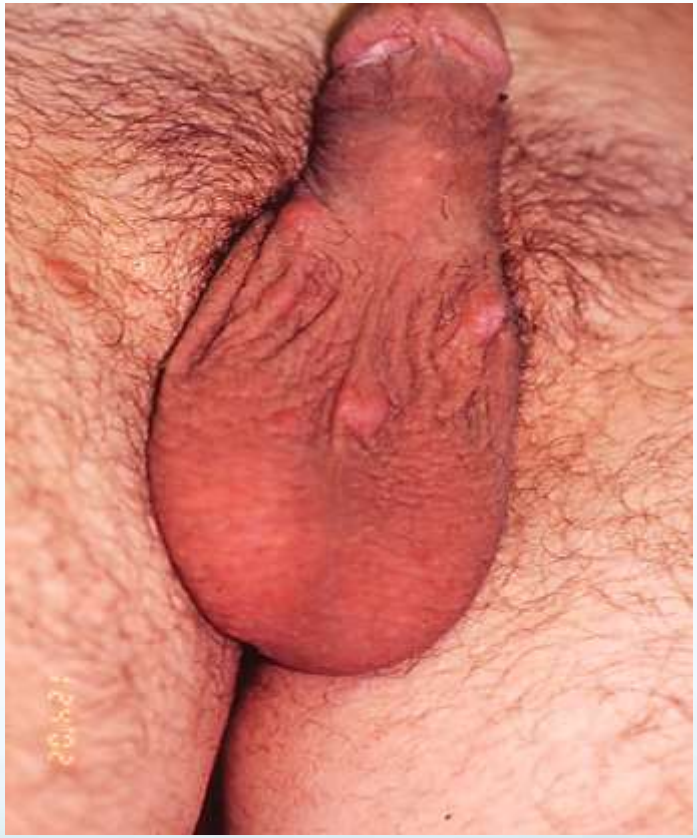
- Classic physical locations
- Check scrotum in males and genitals in females
- **NEW SCROTAL NODULES IN PRURITIC MALE IS SCABIES**
- **BURROW**
- Diagnosis – burrows, oil immersion


(c) University Erlangen,
Department of Dermatology
Phone: (+49) 9131 - 85 - 2727


10 5'02







Scabies

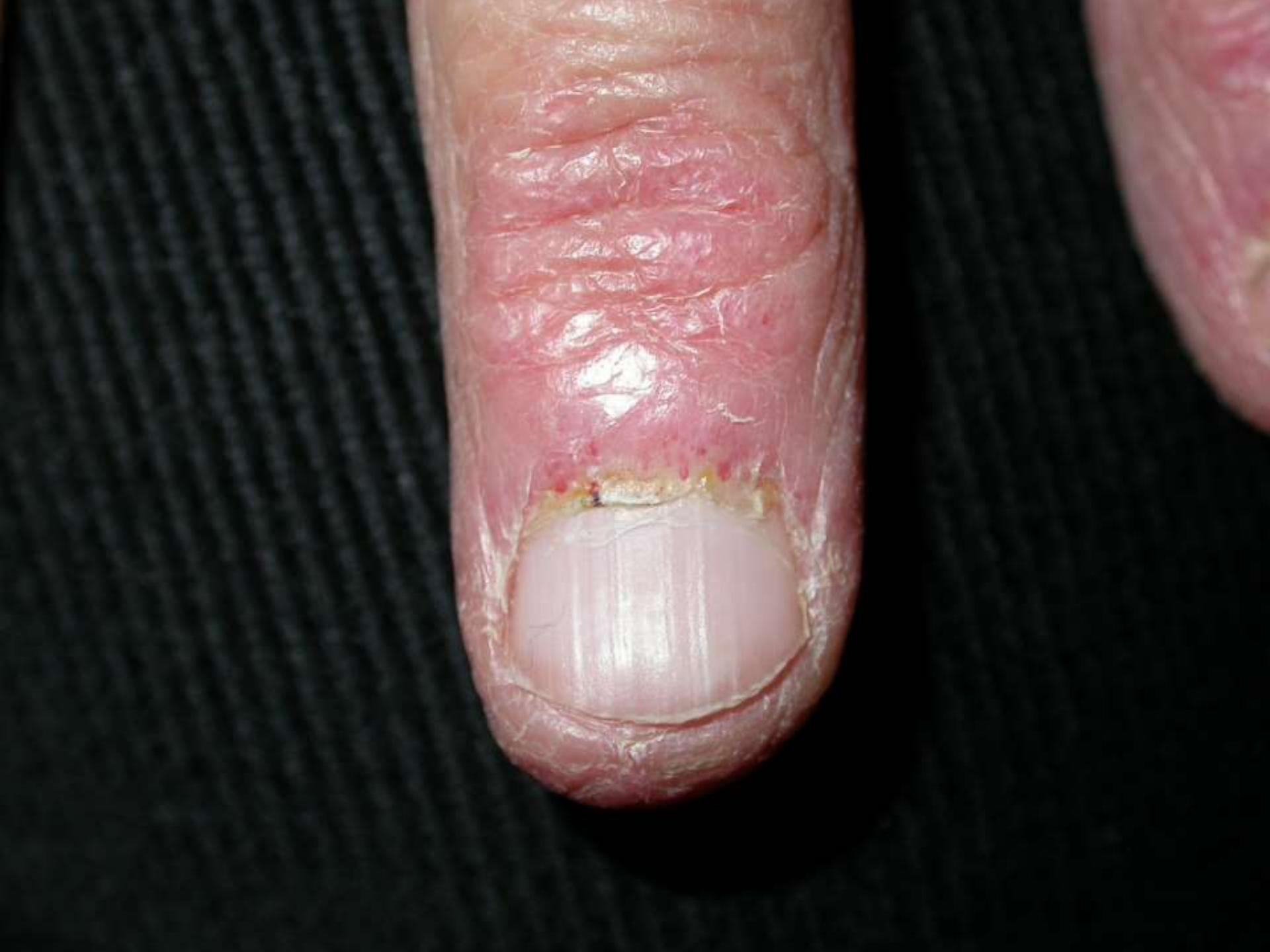
- Treatment
  - All members of household
  - Neck, post-auricular to toes
  - Infants and toddlers face
  - Permethrin 5% cream (nix, kwellada P), repeat
  - Lindane 1%
  - Sulfur
  - Crotamitron
  - ivermectin

Scabies

- Treatment
  - All clothes
  - Antipruritic medications
  - Pruritus may last weeks

Case

- 48 year old female with nail fold changes for 3 months

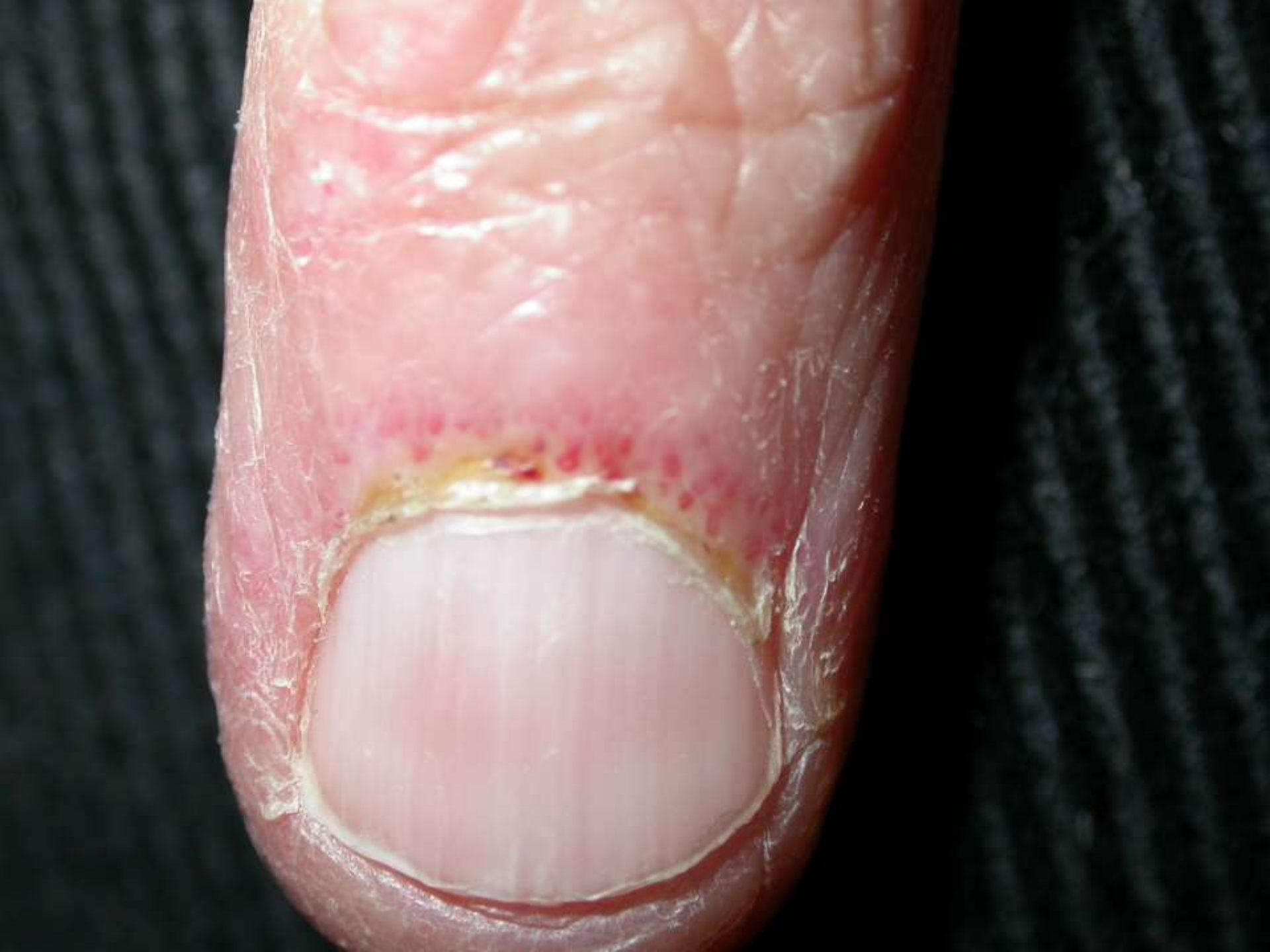


Differential Diagnosis

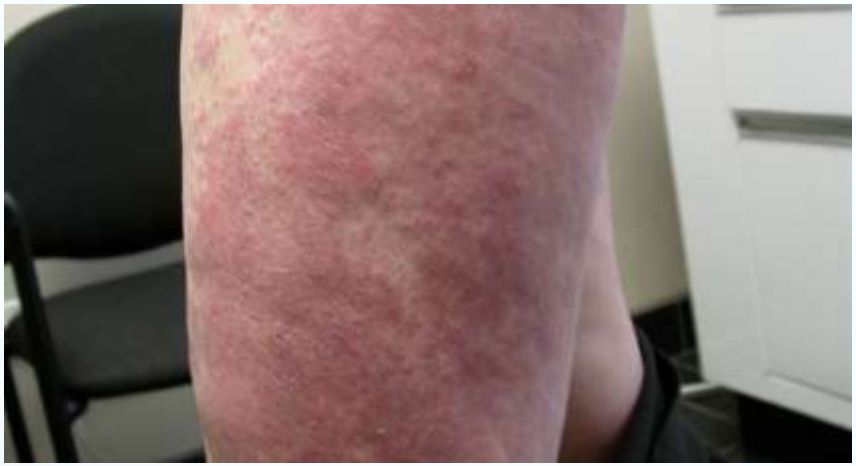
- 1. Lupus
- 2. Scleroderma
- 3. Dermatomyositis
- 4. Hand dermatitis
- 5. 1,2, and 3

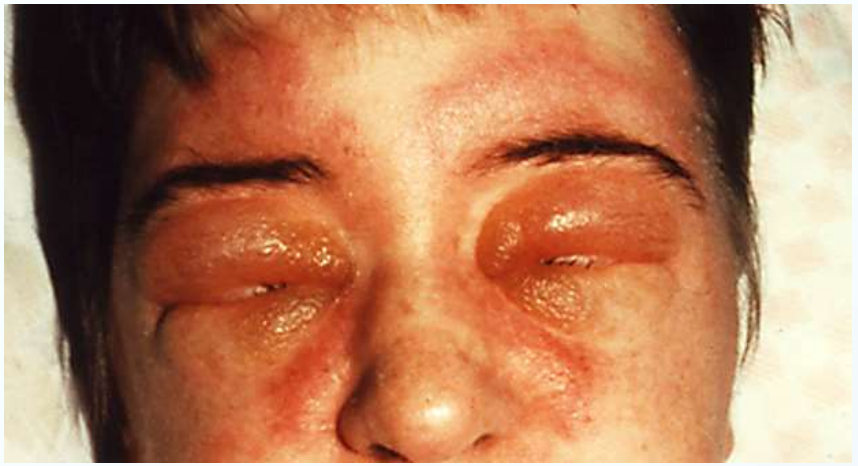
Diagnosis

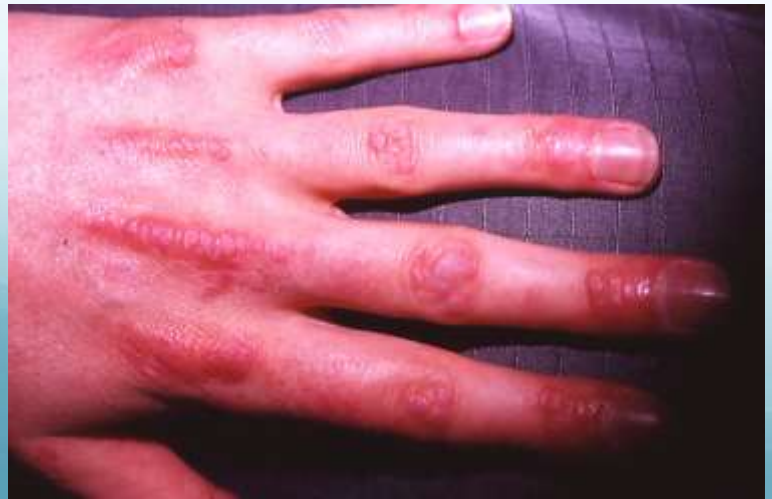
- Dermatomyositis, Lupus or Scleroderma
- **NAIL FOLD DITATATION IS ONE OF ABOVE**

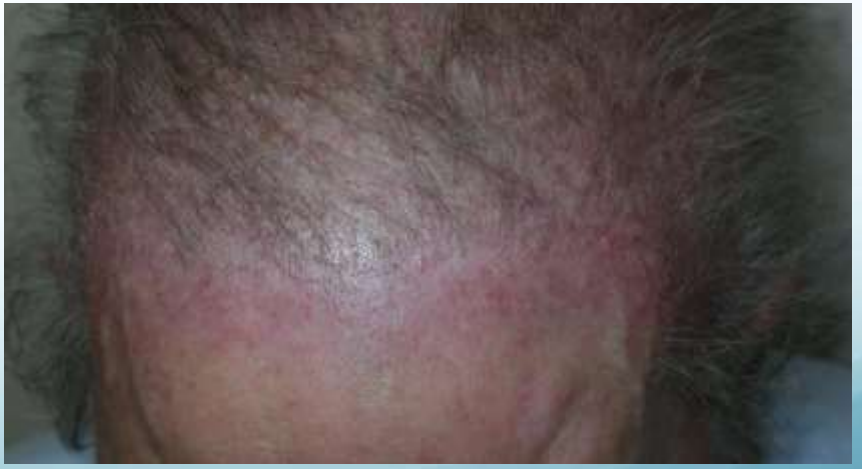


Dermatomyositis

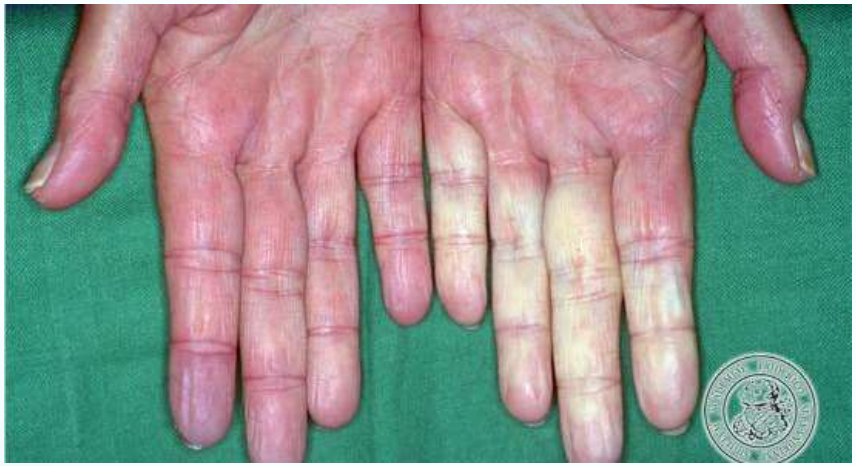


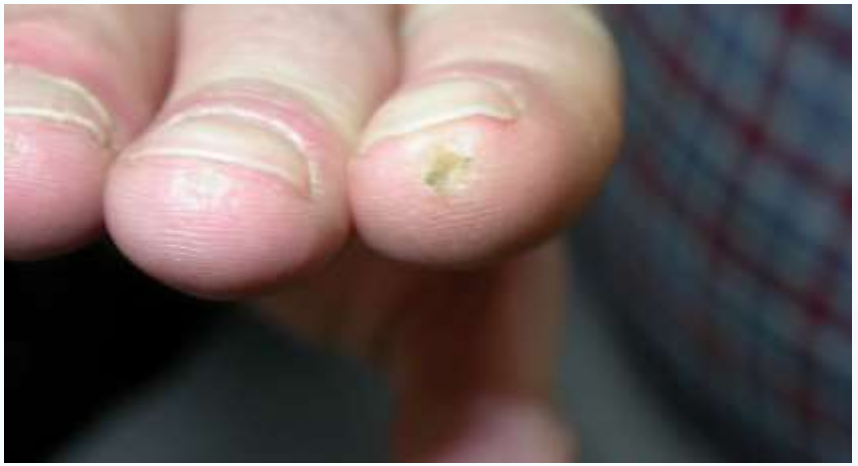


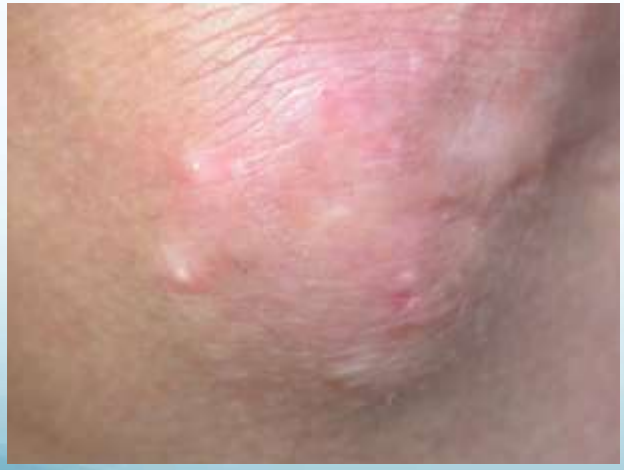


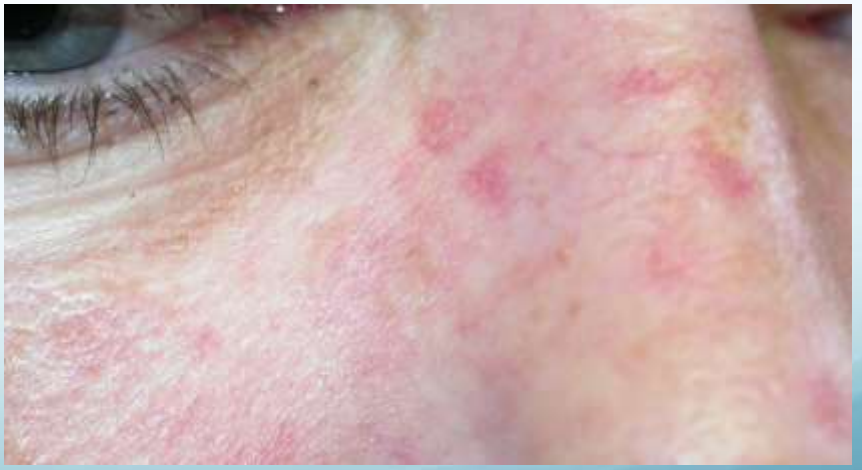


Scleroderma

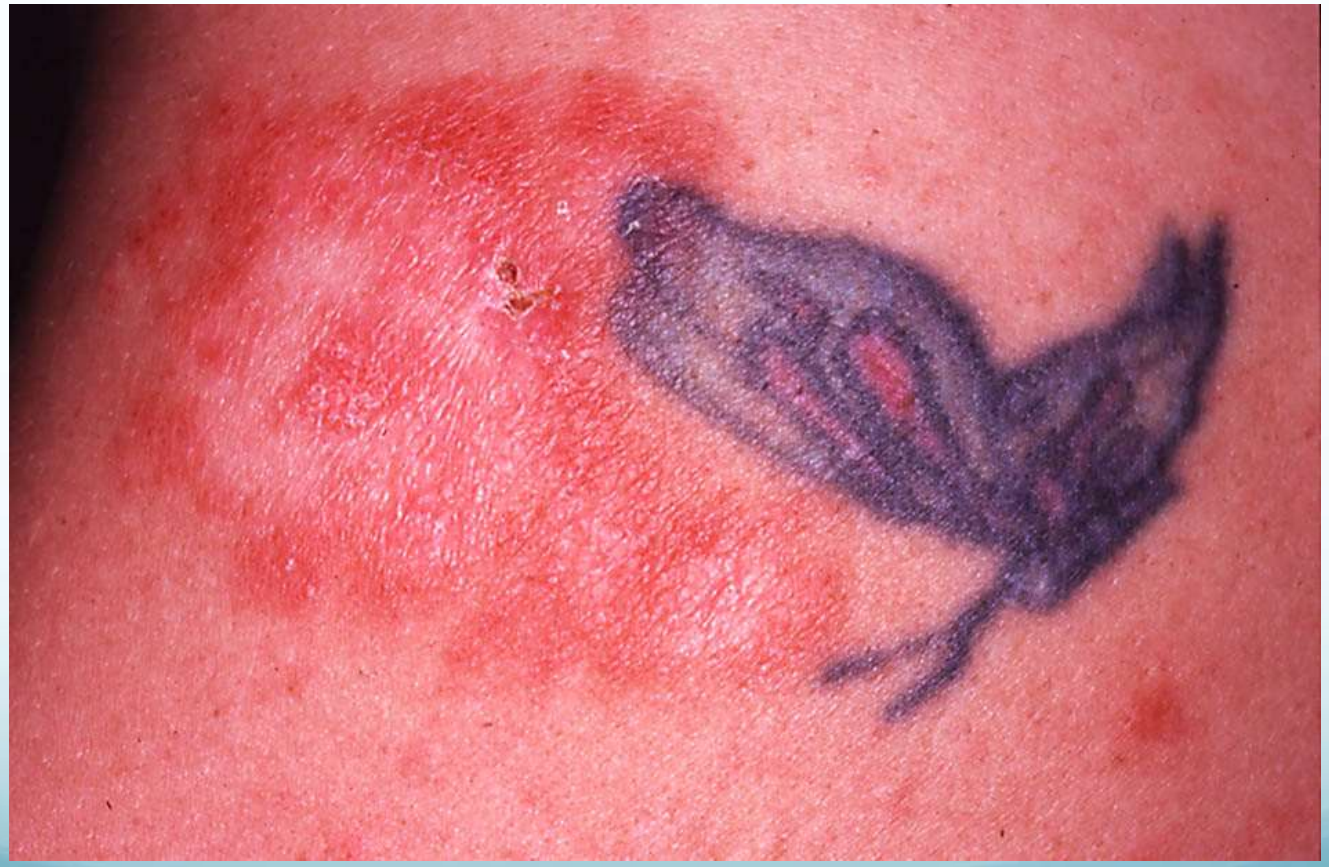


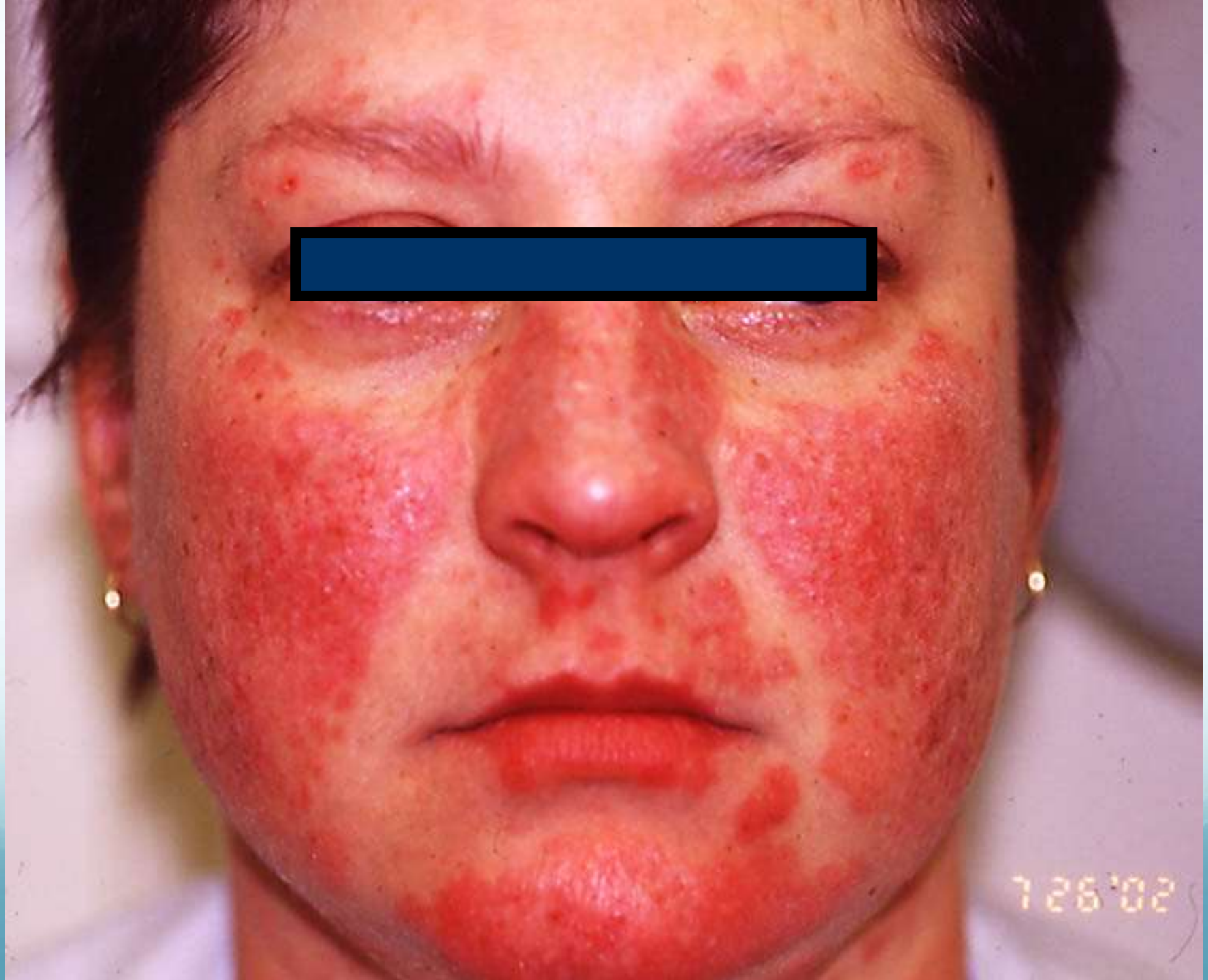






Lupus the Butterfly Rash

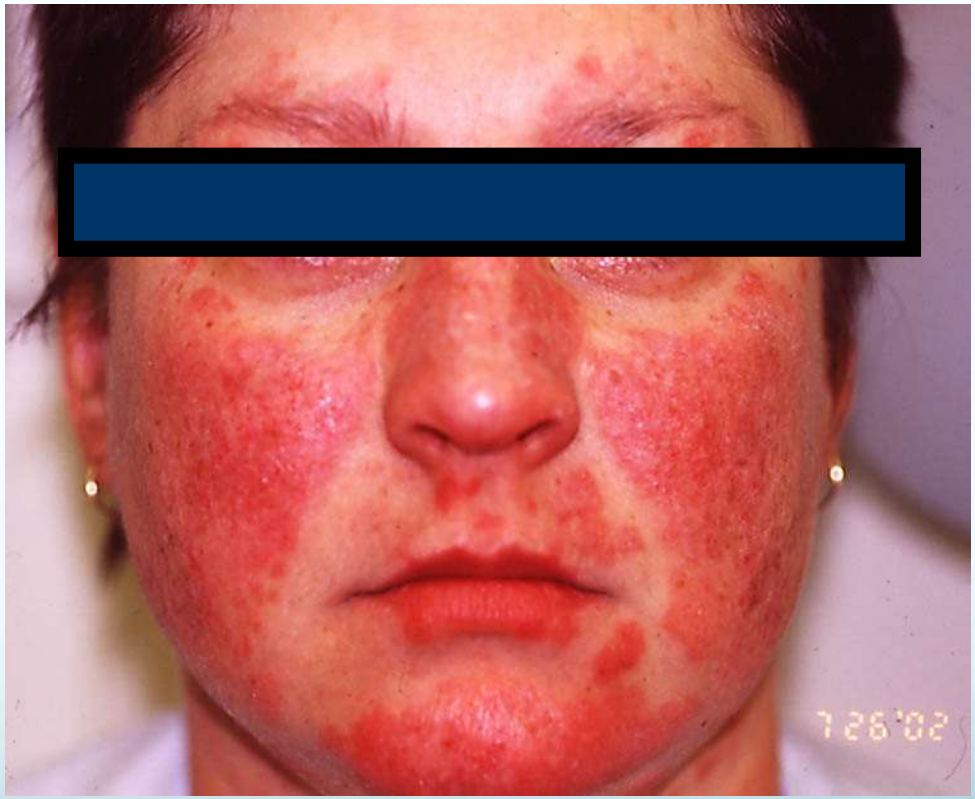



7 26 '02

Lupus- acute

Butterfly rash- transient follows sun exposure and resolves without scarring

Associated with systemic disease

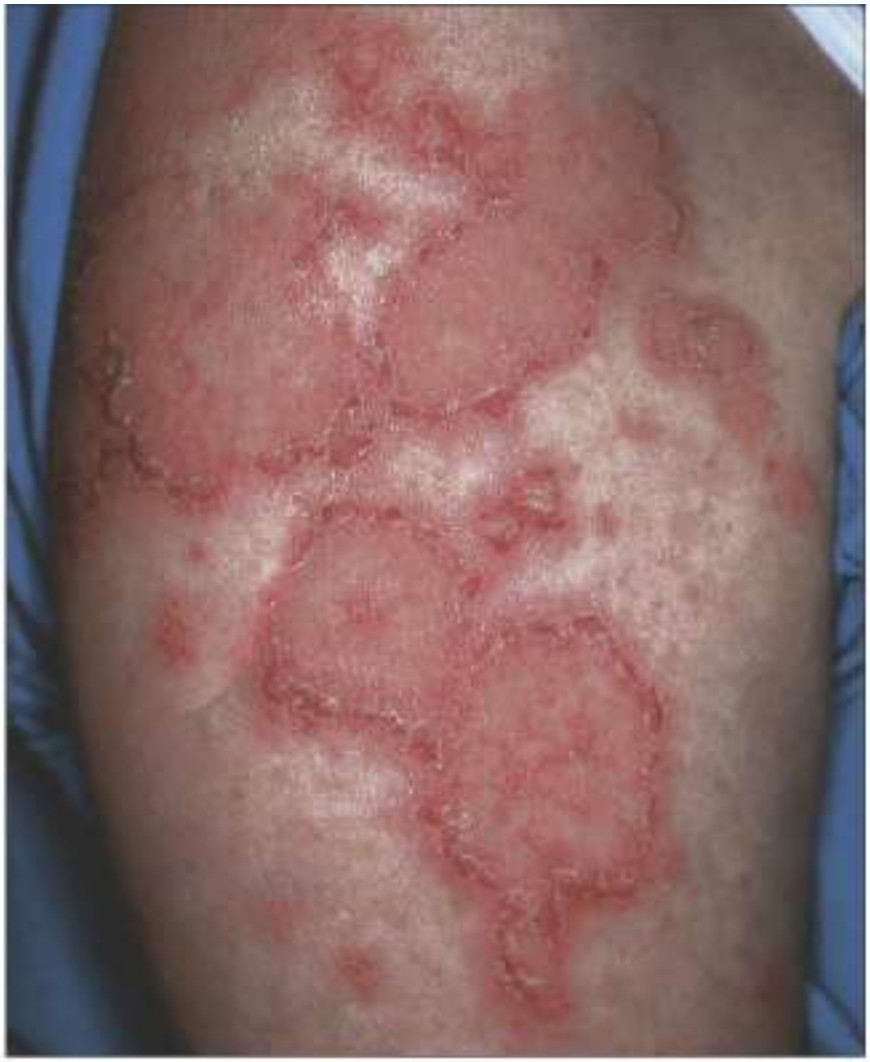


Lupus - Subacute

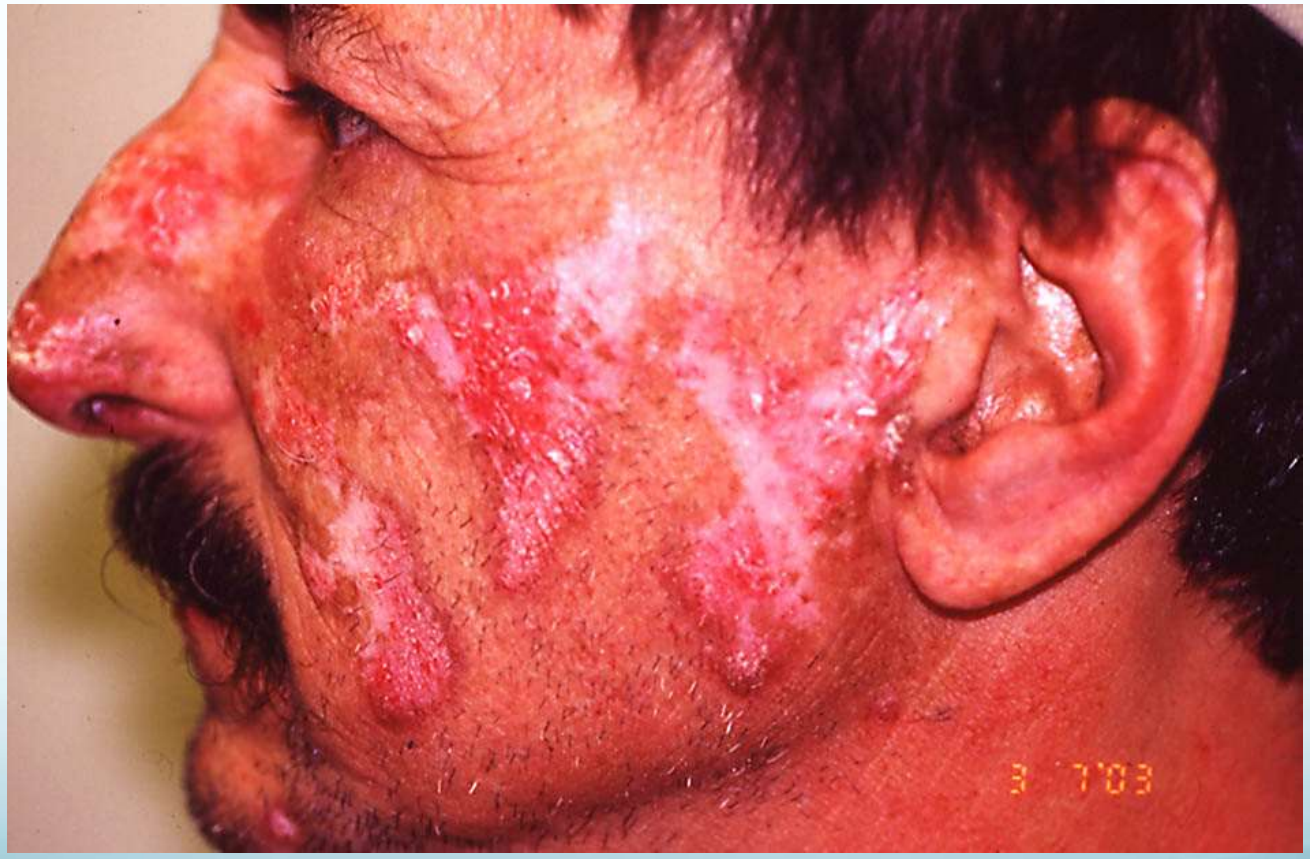
Two types – annular and psoriasiform

50% associated with systemic disease

Secondary to medication – HCTZ, Lamisil, Diltiazem, Nsaids



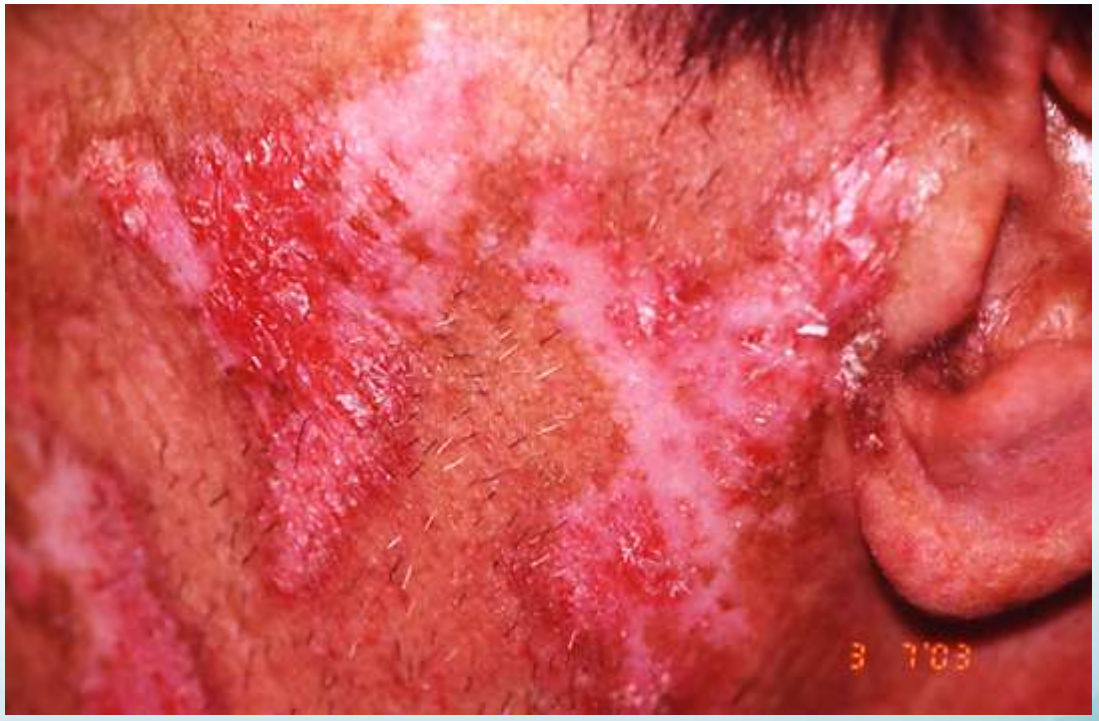
Lupus – Chronic (Discoid)

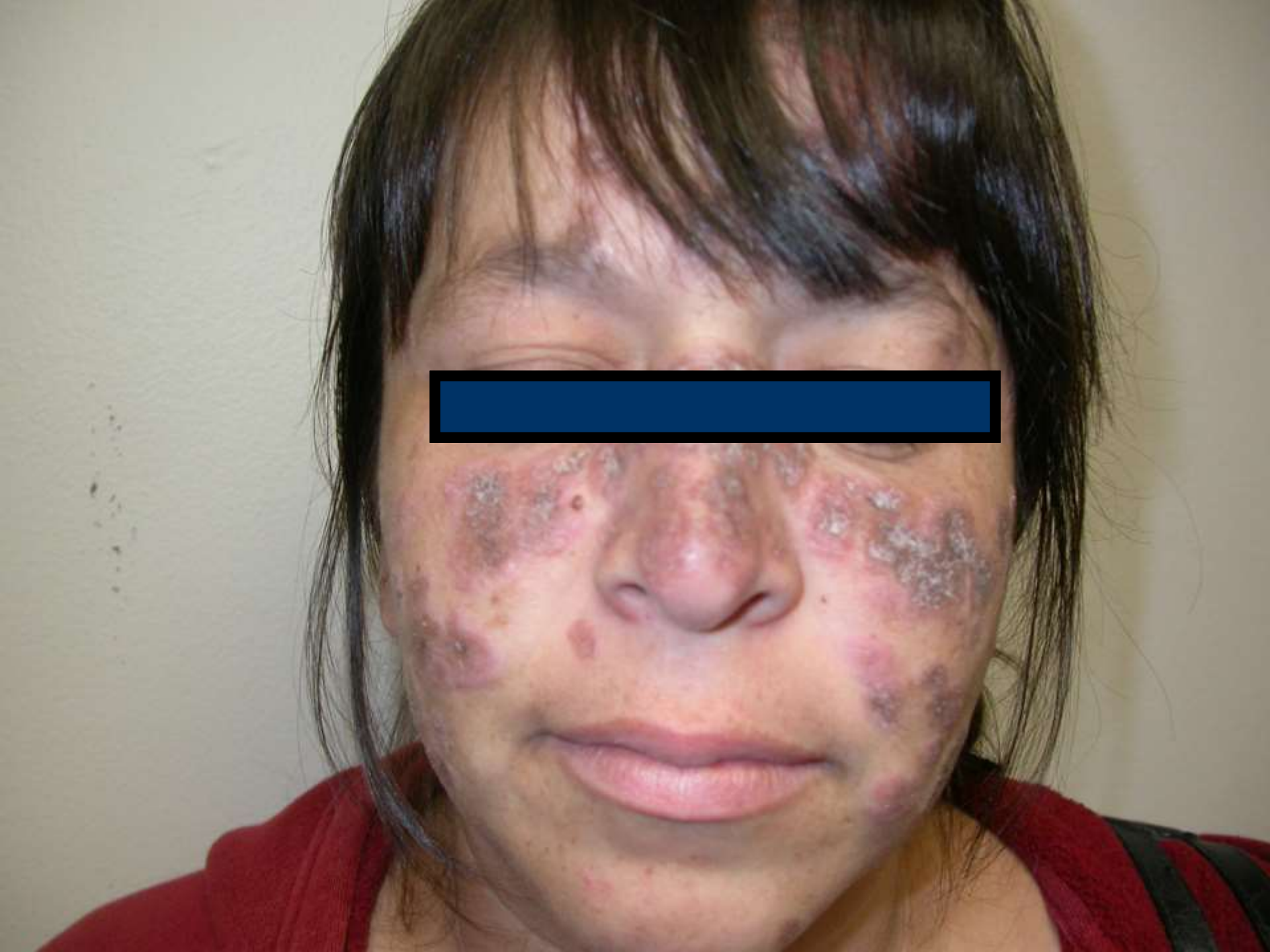


Lupus – Chronic (discoid)

Hyperpigmentation, hypopigmentation, atrophy, follicular plugging, and scarring

5% associated with systemic disease



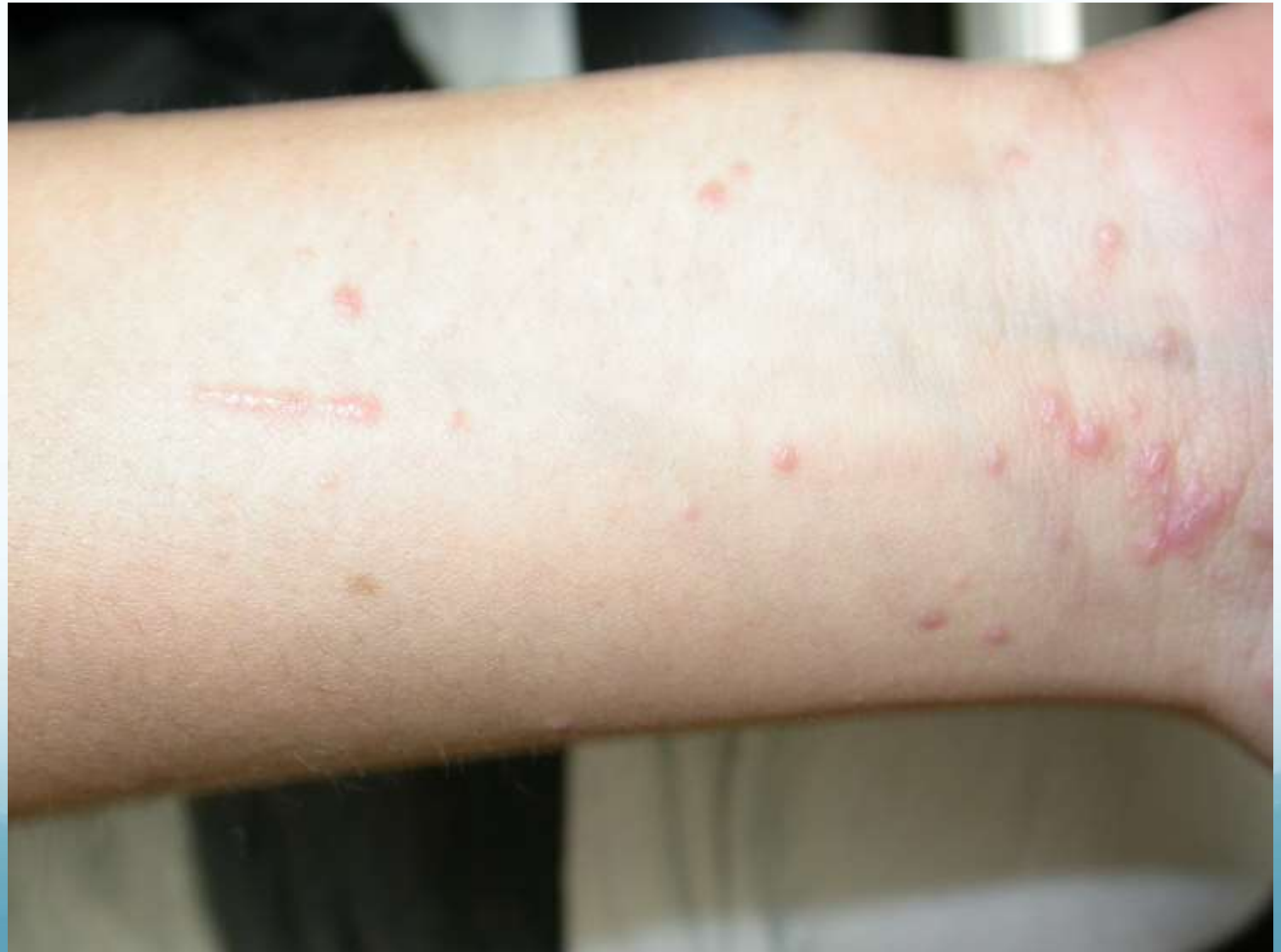



off the mark
by Mark Parisi
www.offthemark.com
... AND THEN I HEARD A LOUD BANG AND WHEN I TURNED BACK HE WAS GONE!
www.offthemark.com

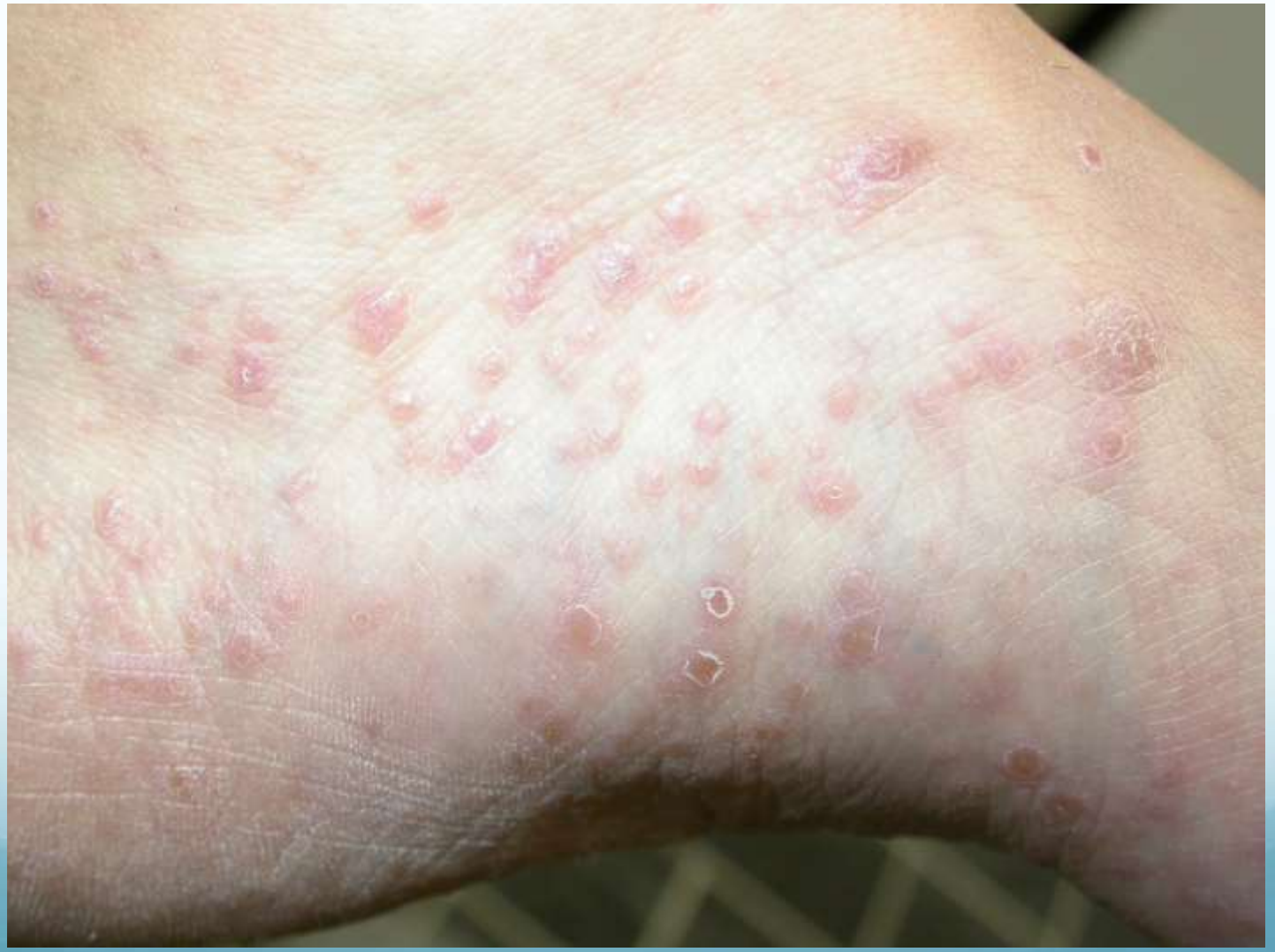
Case

- 34 year old female with 3 month hx of extreme pruritus
- Diffuse
- Spares face
- No one else at home involved
- Pmed not relevant

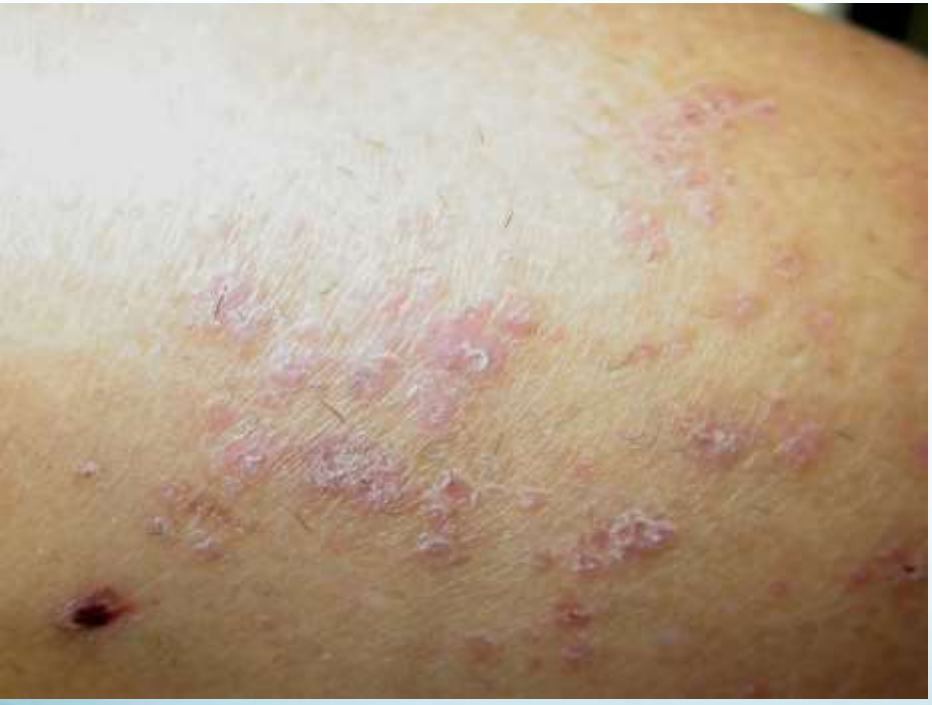
Case

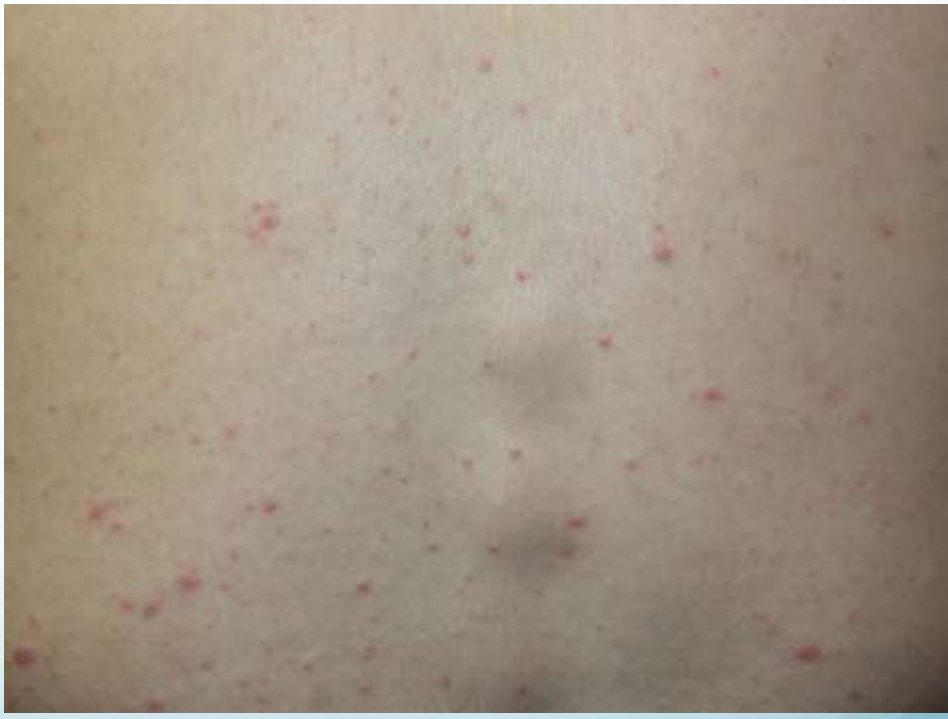


Case

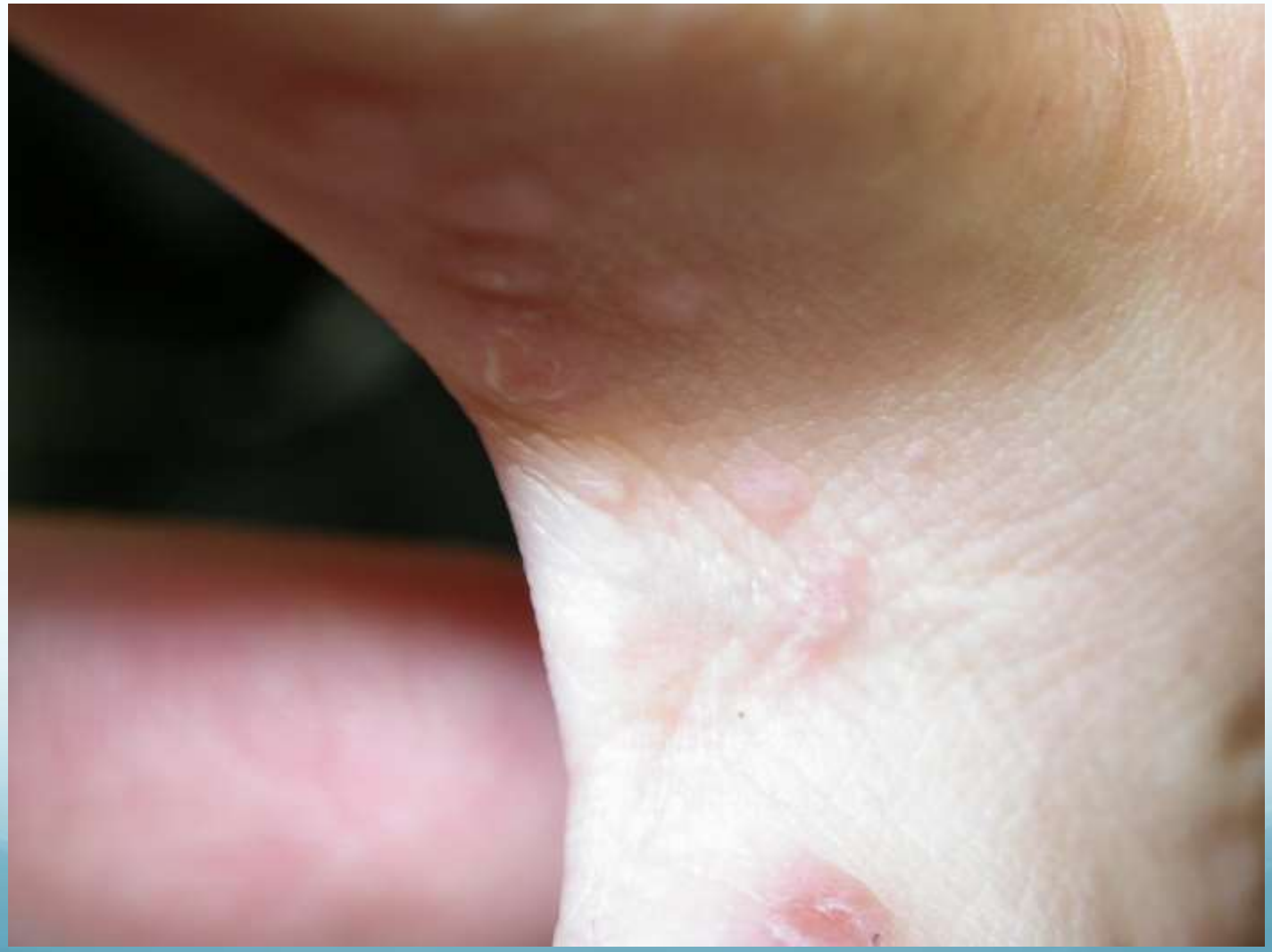


Case





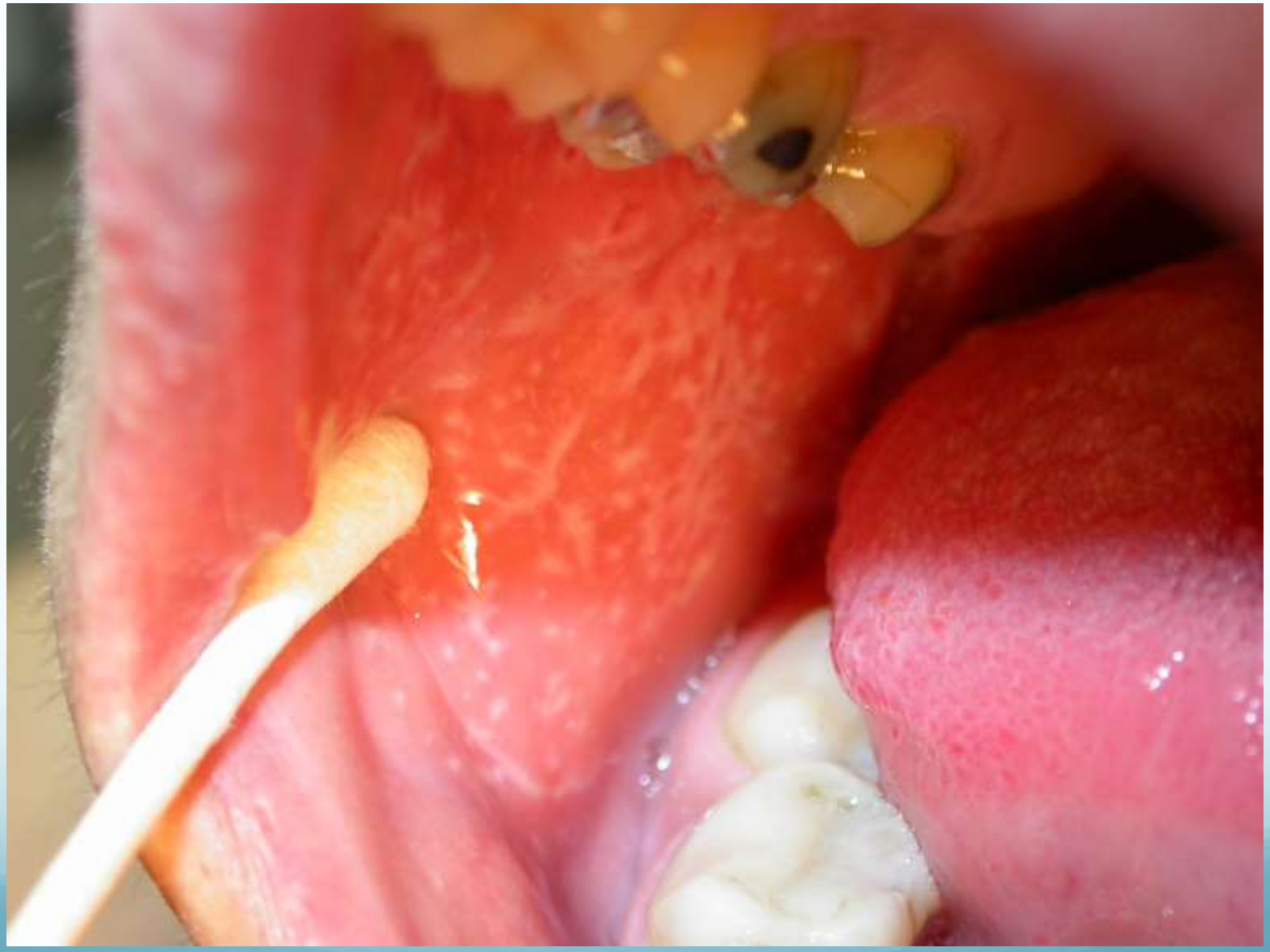
Case



Case

- What is your diagnosis?

1. Viracella
2. Lichen Planus
3. Scabies
4. Atopic dermatitis



Case

- What is your diagnosis?

1. Viracella
2. Lichen Planus
3. Scabies
4. Atopic dermatitis

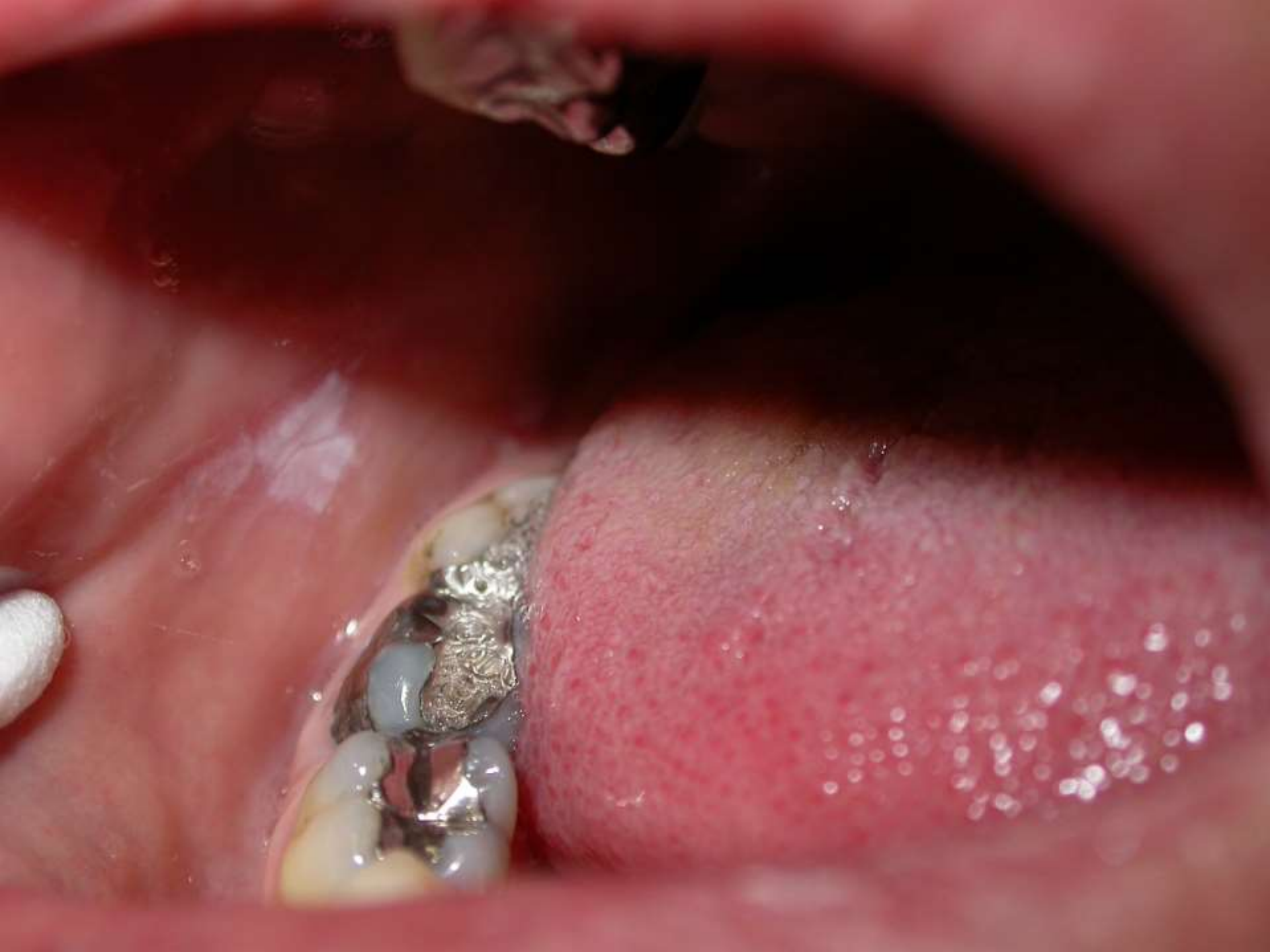
Lichen Planus

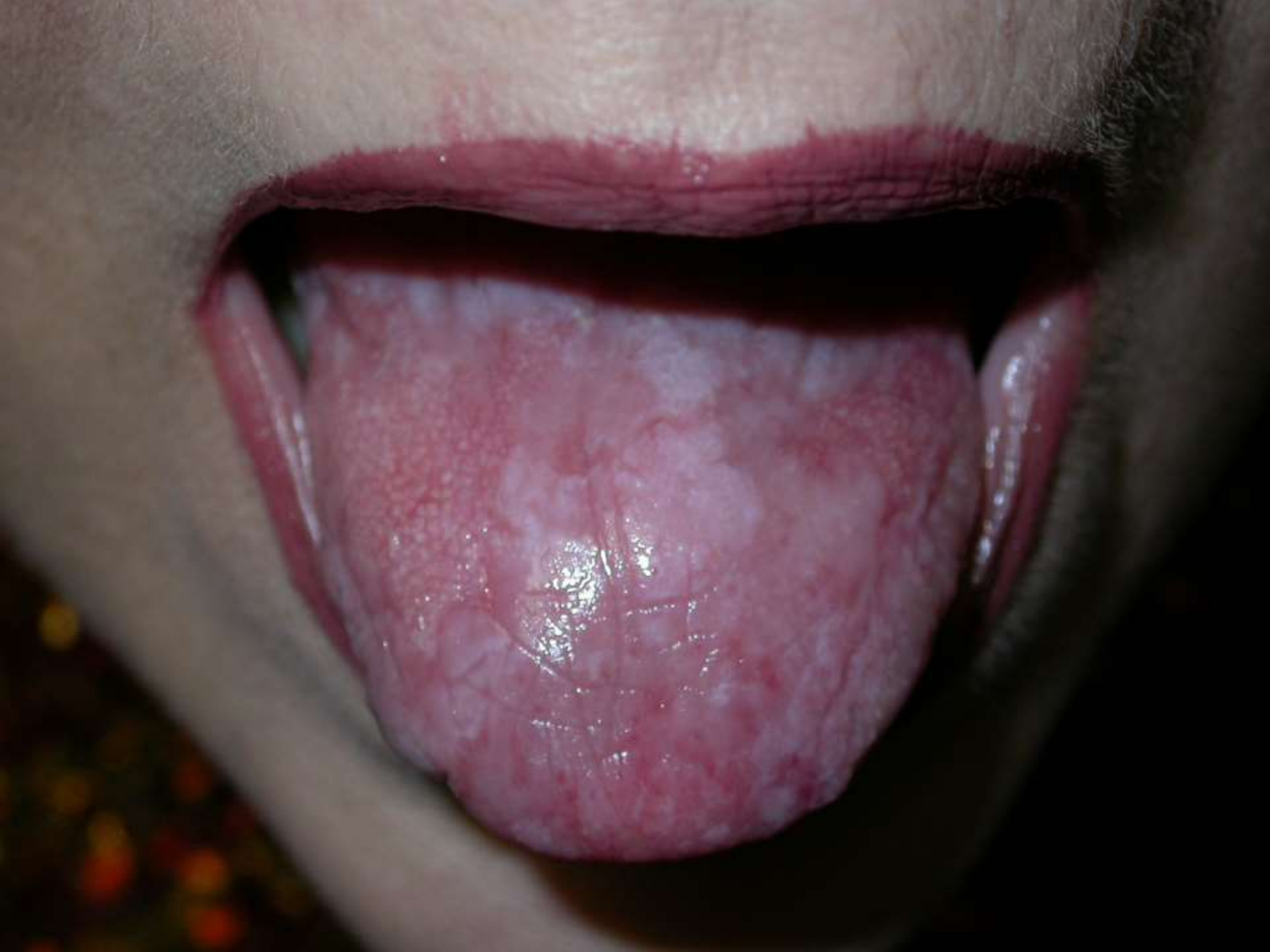
Lichen Planus

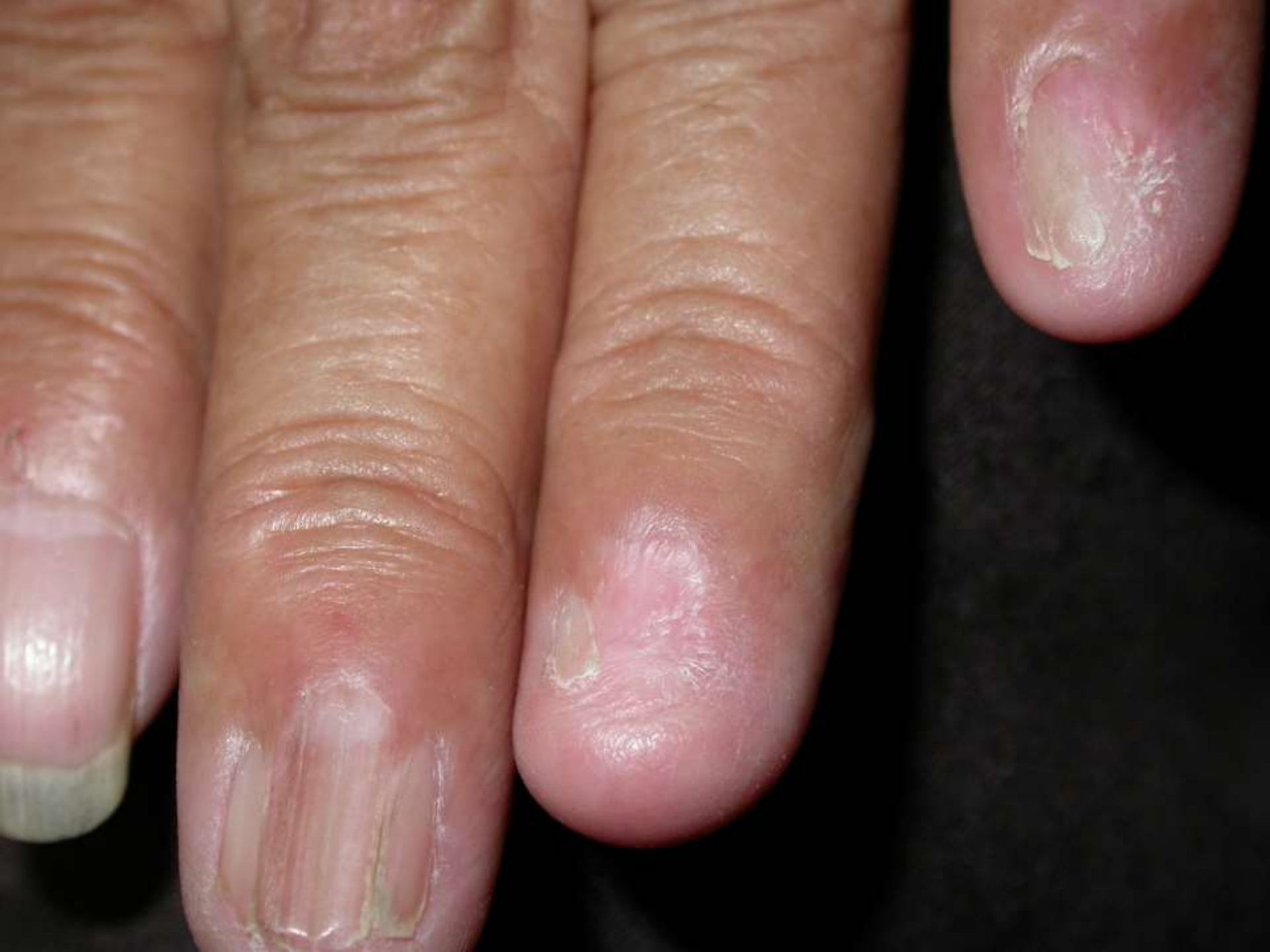
- Unknown etiology
- Skin and mucous membranes
- 30-60 years of age
- Purple, polygonal, pruritic, planar, papule
- Flexor surfaces of wrists, and ankles
- Wickham’s striae, koebnerization

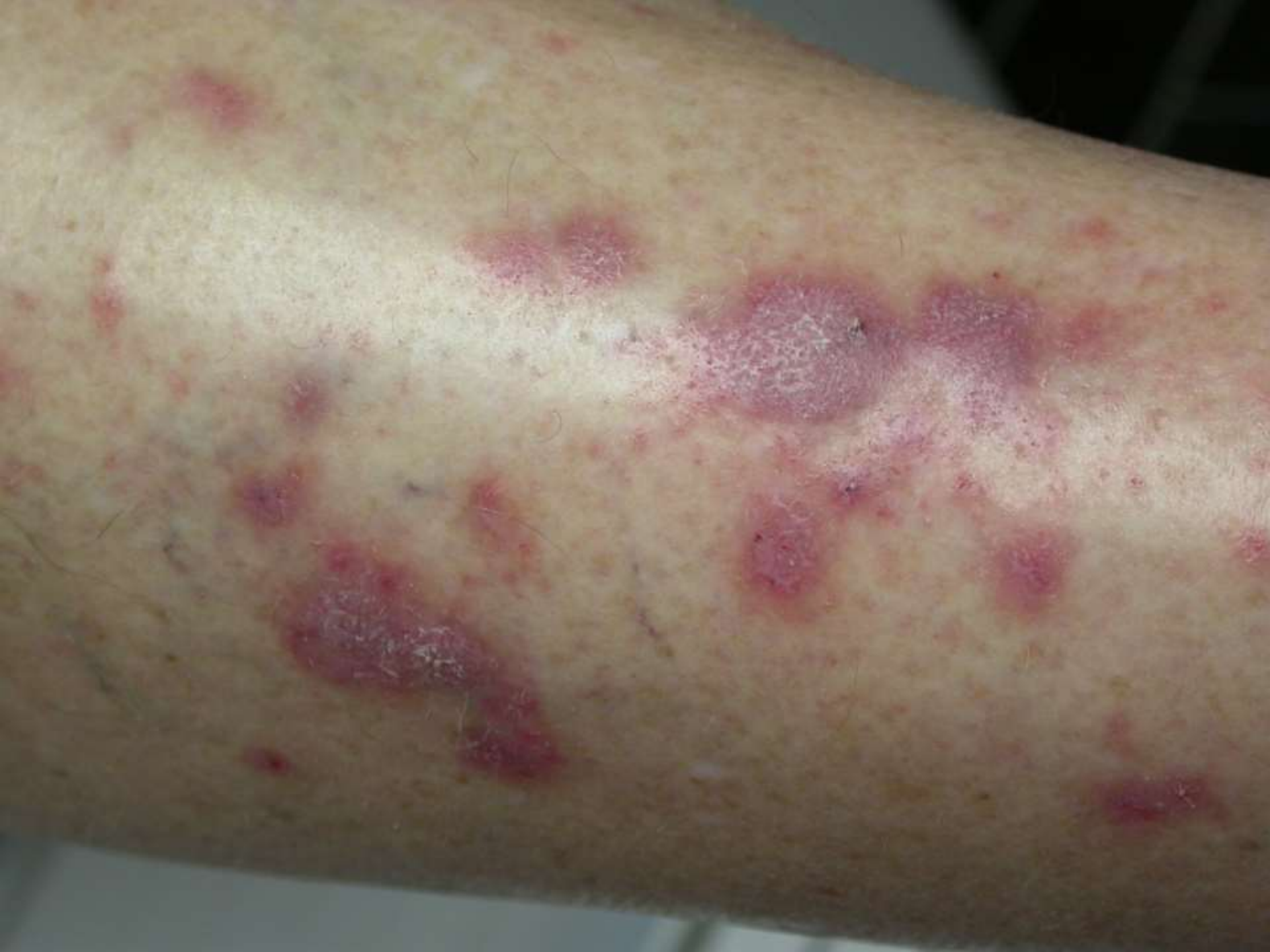
Lichen Planus

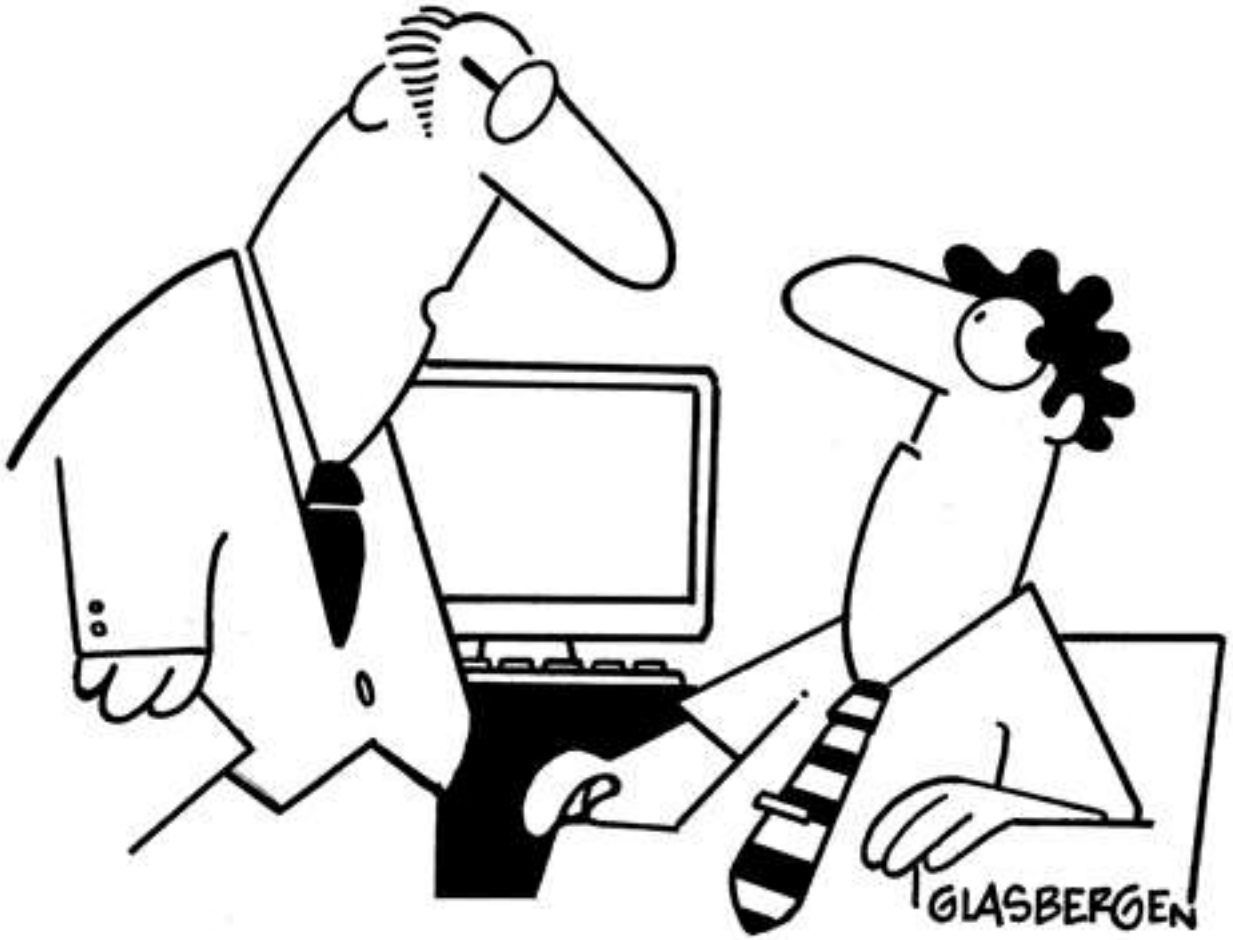
- Many clinical subtypes
- 50% will have oral lesions
- Hepatitis C???
- Medications – HCTZ, antimalarials, gold, furosemide, propanalol, captopril, tetracycline
- 50% of patients will clear within 9 months
- Topical steroids, systemic steroids, retinoids, UV therapy, metronidazole, immunosuppressants







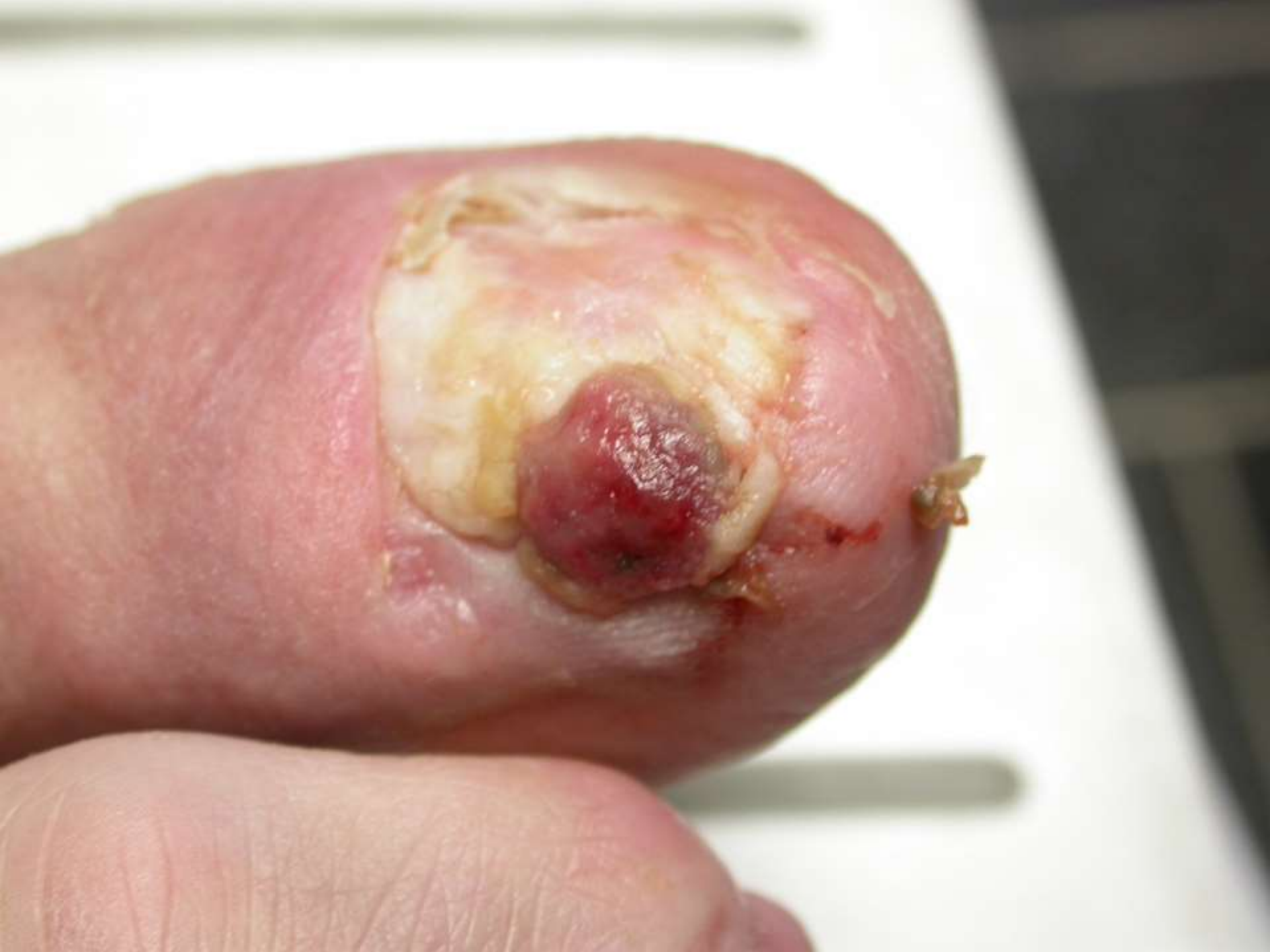




"I'd like you to do a presentation on business ethics. If you don't have time to prepare something, just steal it off the Internet."

Case

- 57 year old male with eroded friable papule on great toe for 1 month

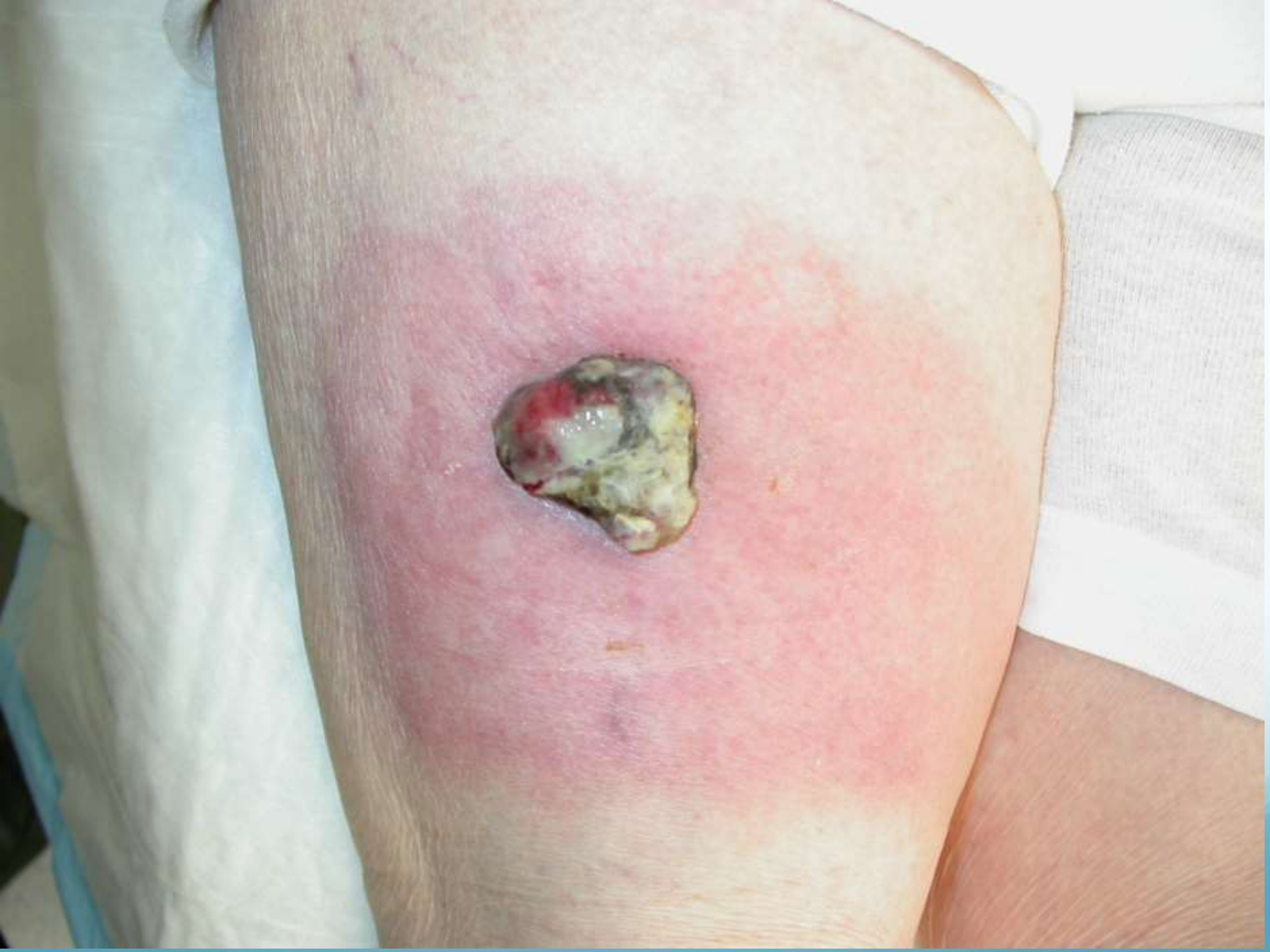


Differential Diagnosis

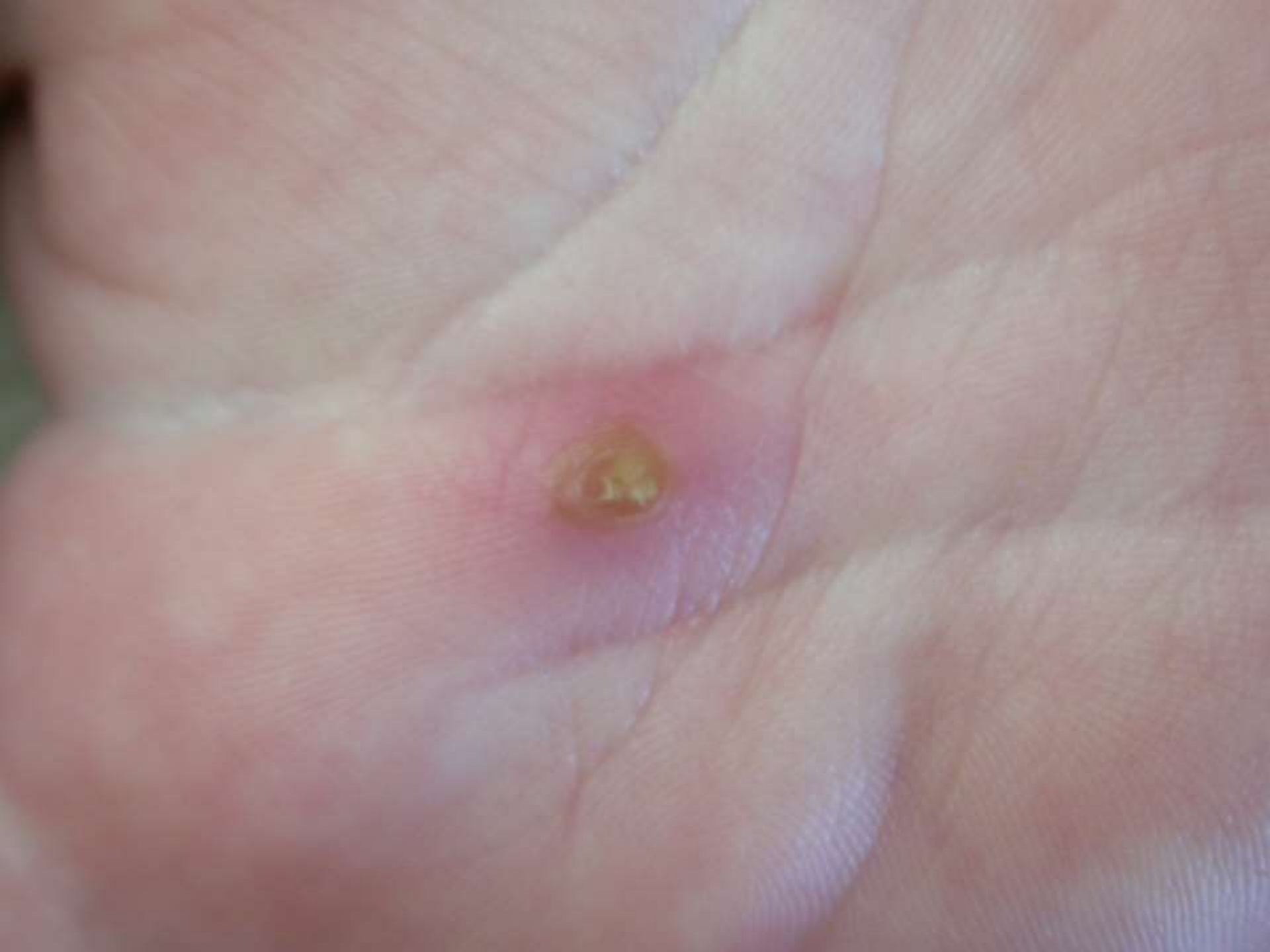
- Melanoma
- Squamous cell carcinoma
- Pyogenic granuloma
- Basal cell carcinoma

Pyogenic Granuloma

- Friable papule of granulation tissue
- Secondary to trauma
- **CAN MIMIC MALIGNANCY SO BIOPSY**

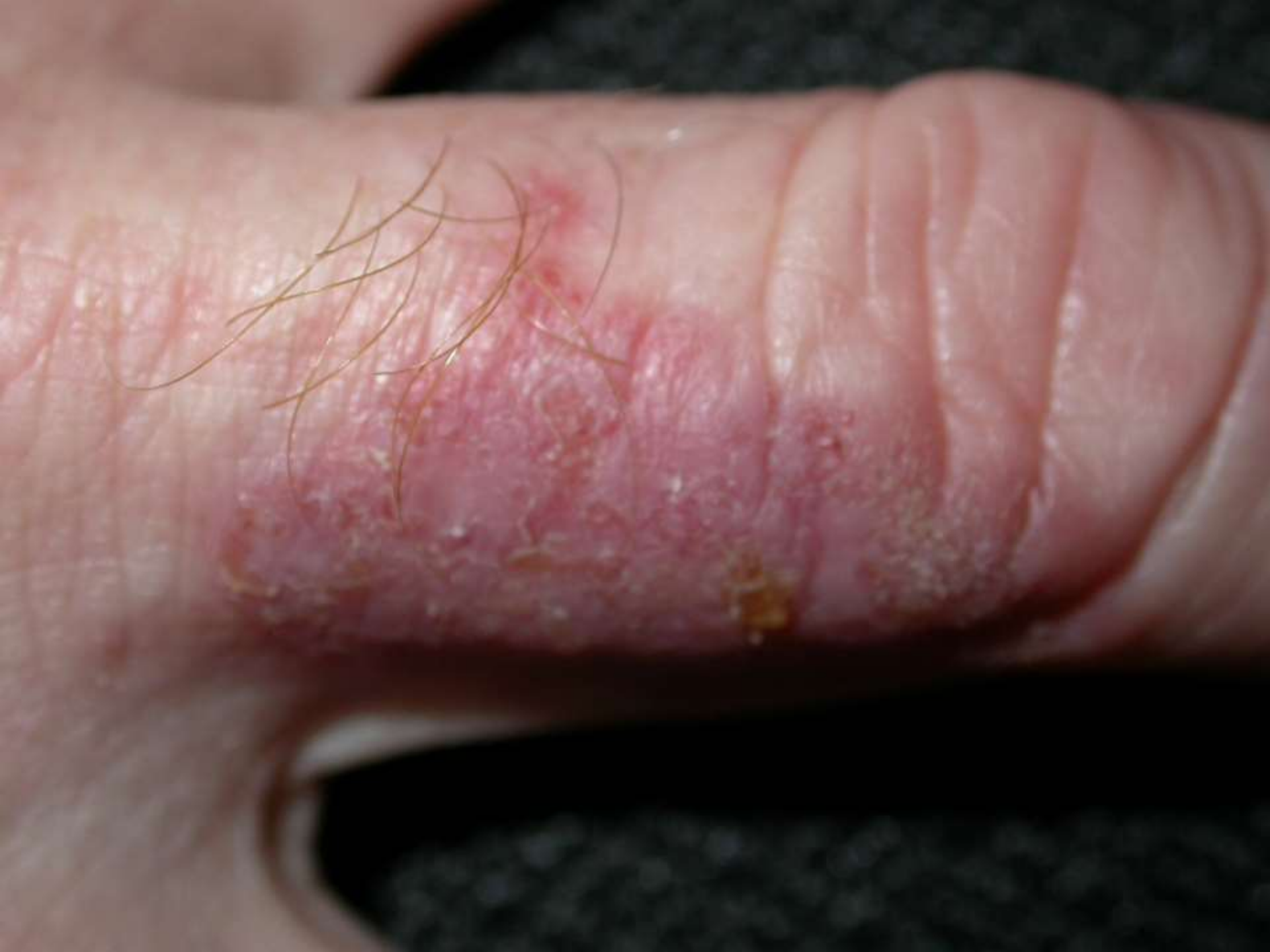


METRIC 1
2 3 4 5 6 7 8 9 10 11 12 13 14
2mm 3mm 4mm 6mm 8m
Alo
(IMIQ



CASE

- Chronic rash on finger in 54 year old male
- Asymptomatic
- No response to multiple topical steroids



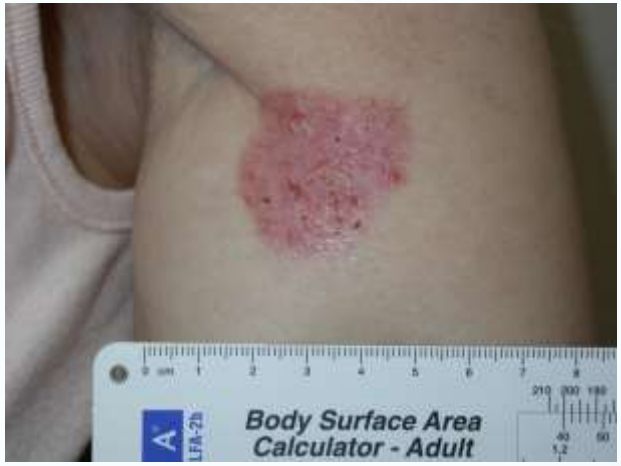
Differential Diagnosis

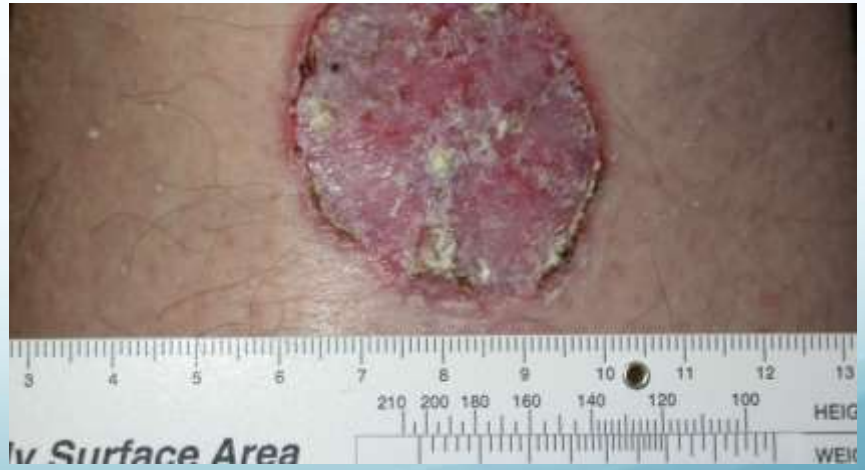
- 1. Psoriasis
- 2. Bowens disease (SCC in Situ)
- 3. Eczema
- 4. Tinea

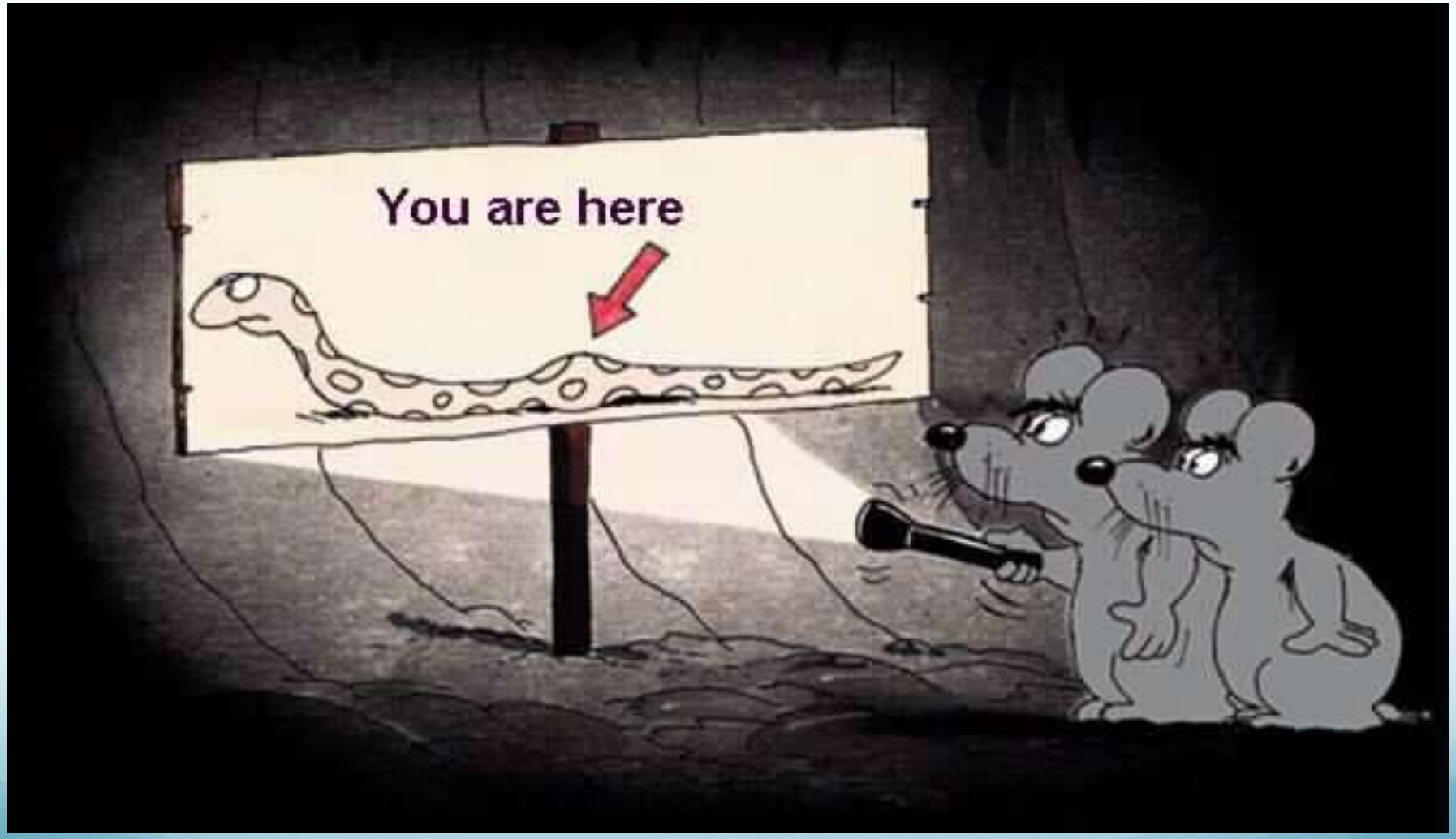
Bowens Disease (scc in situ)

SCC in situ

- **IF A LESION DOES NOT RESPOND TO THERAPY CONSIDER BIOPSY OR REFERRAL**

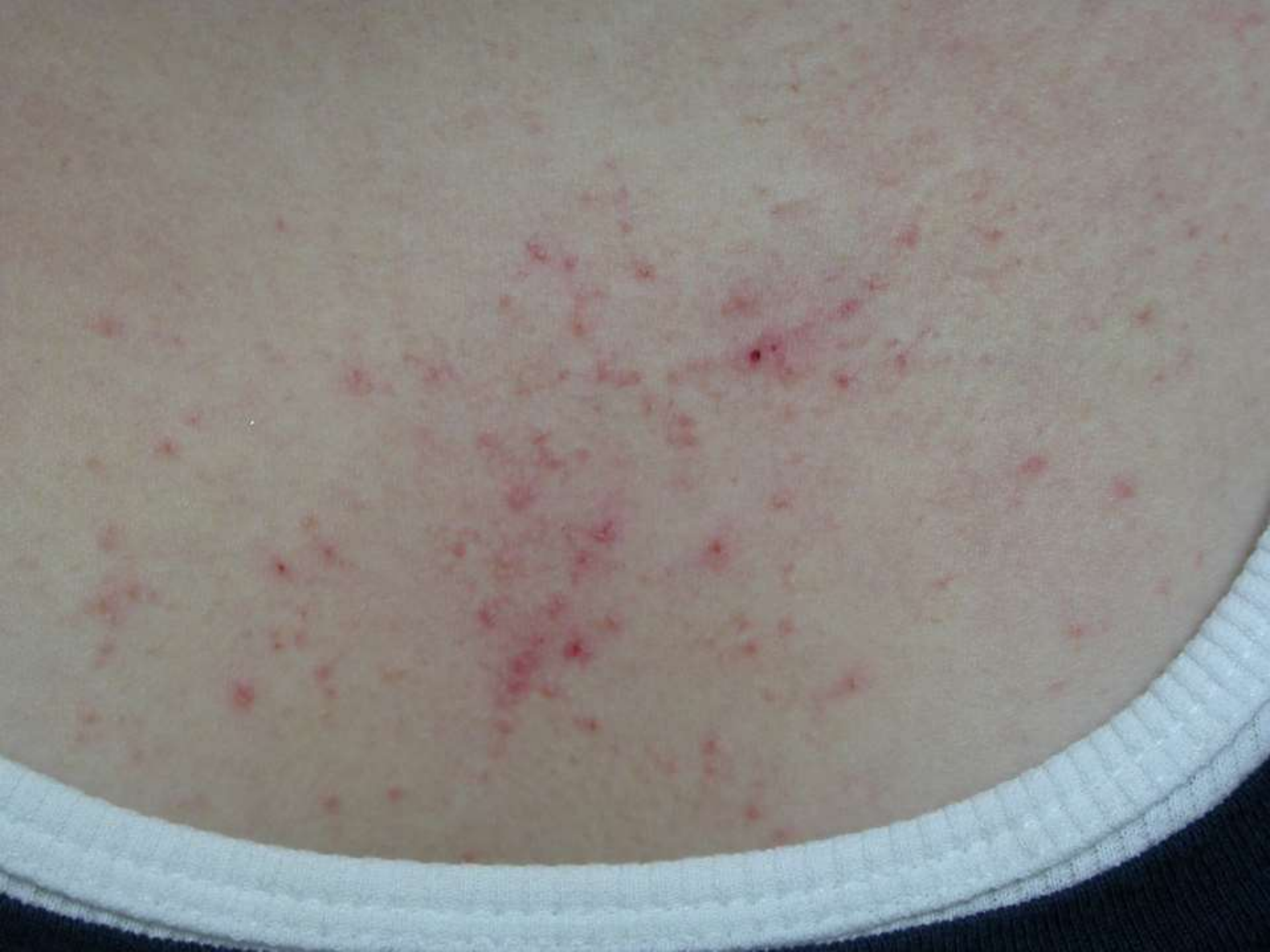


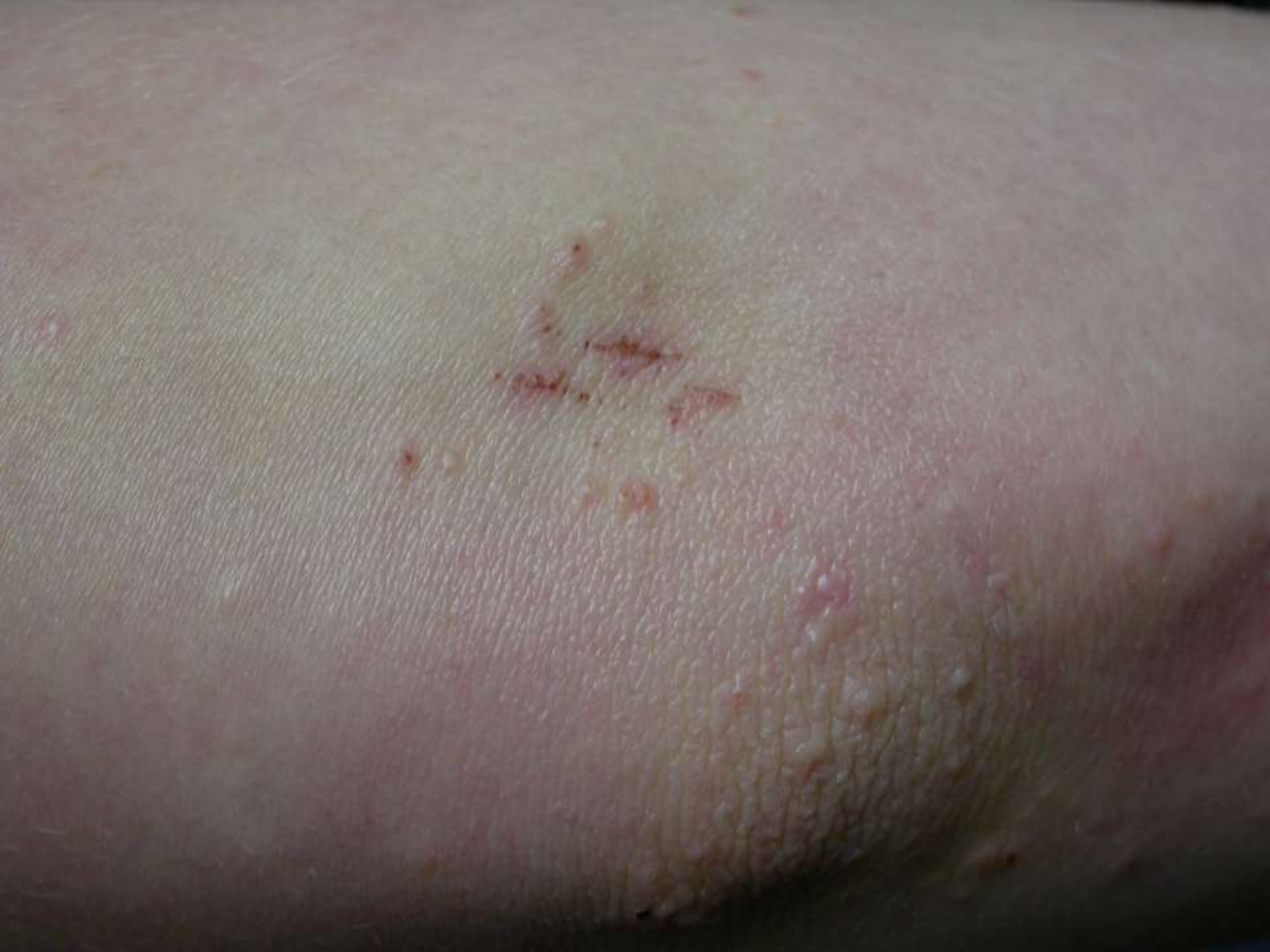



You are here

CASE

- 17 year old female with a pruritic rash diffusely on the body



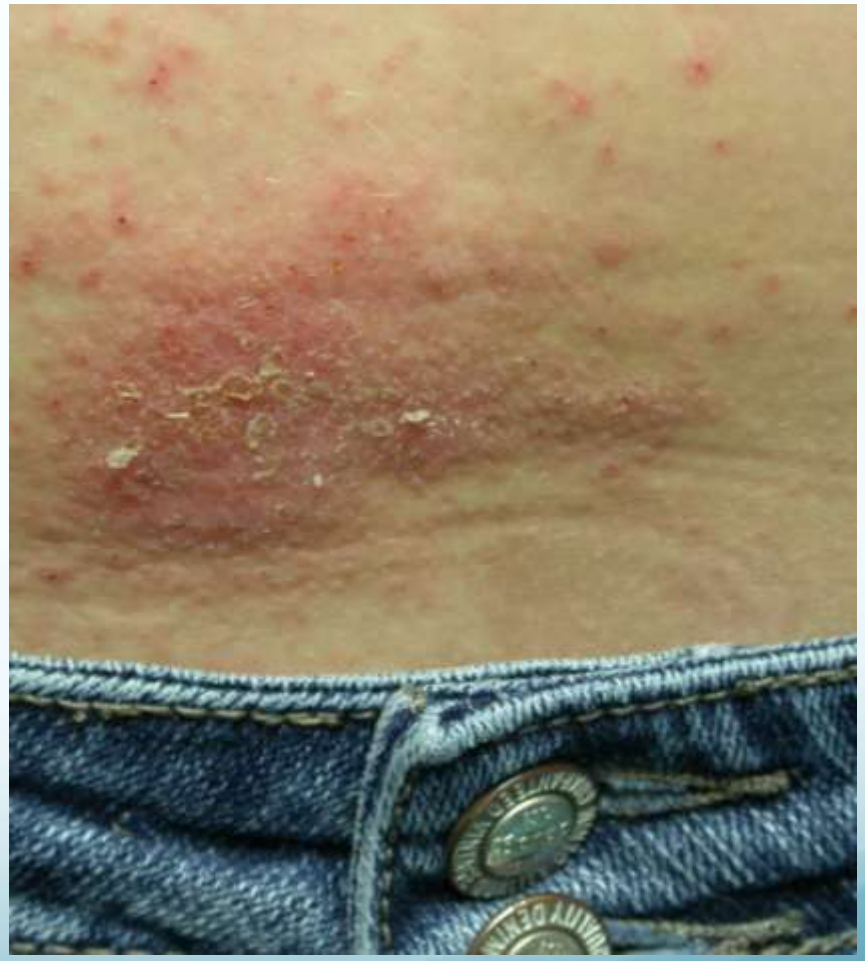


Differential Diagnosis

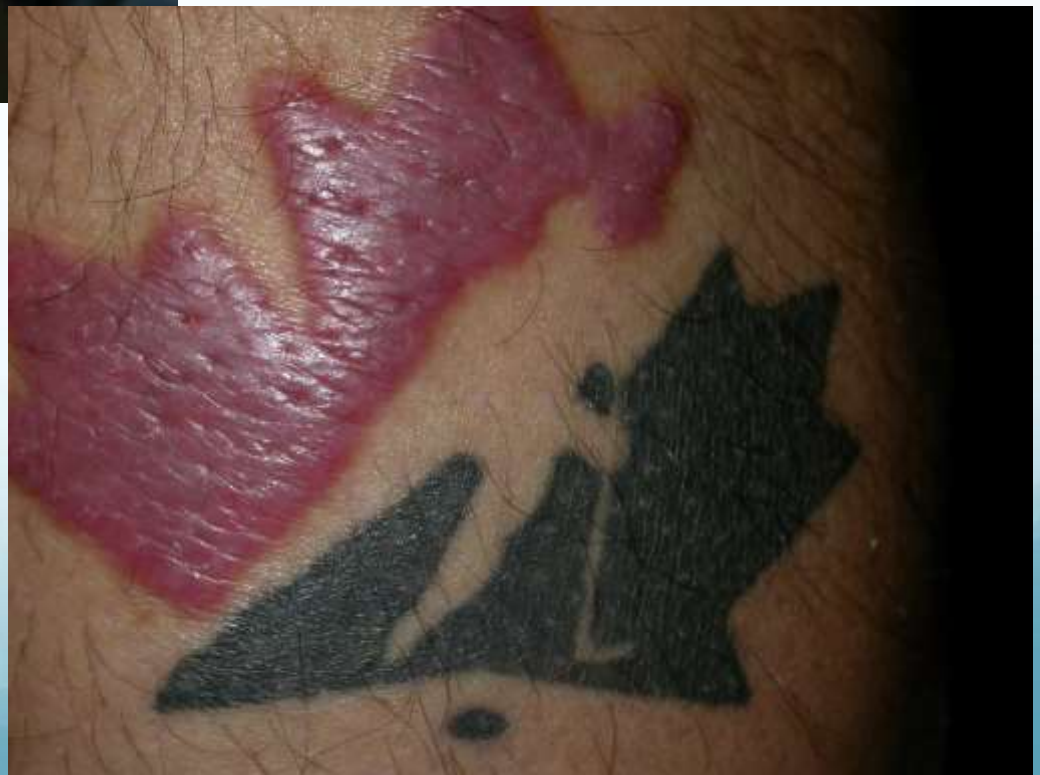
- Atopic dermatitis
- Scabies
- Lichen planus
- Nickel dermatitis

Nickel Dermatitis

- **DIFFUSE PRURITIC PAPULES CAN BE AUTOECZEMATIZED CONTACT DERMATITIS USUALLY FROM NICKLE**

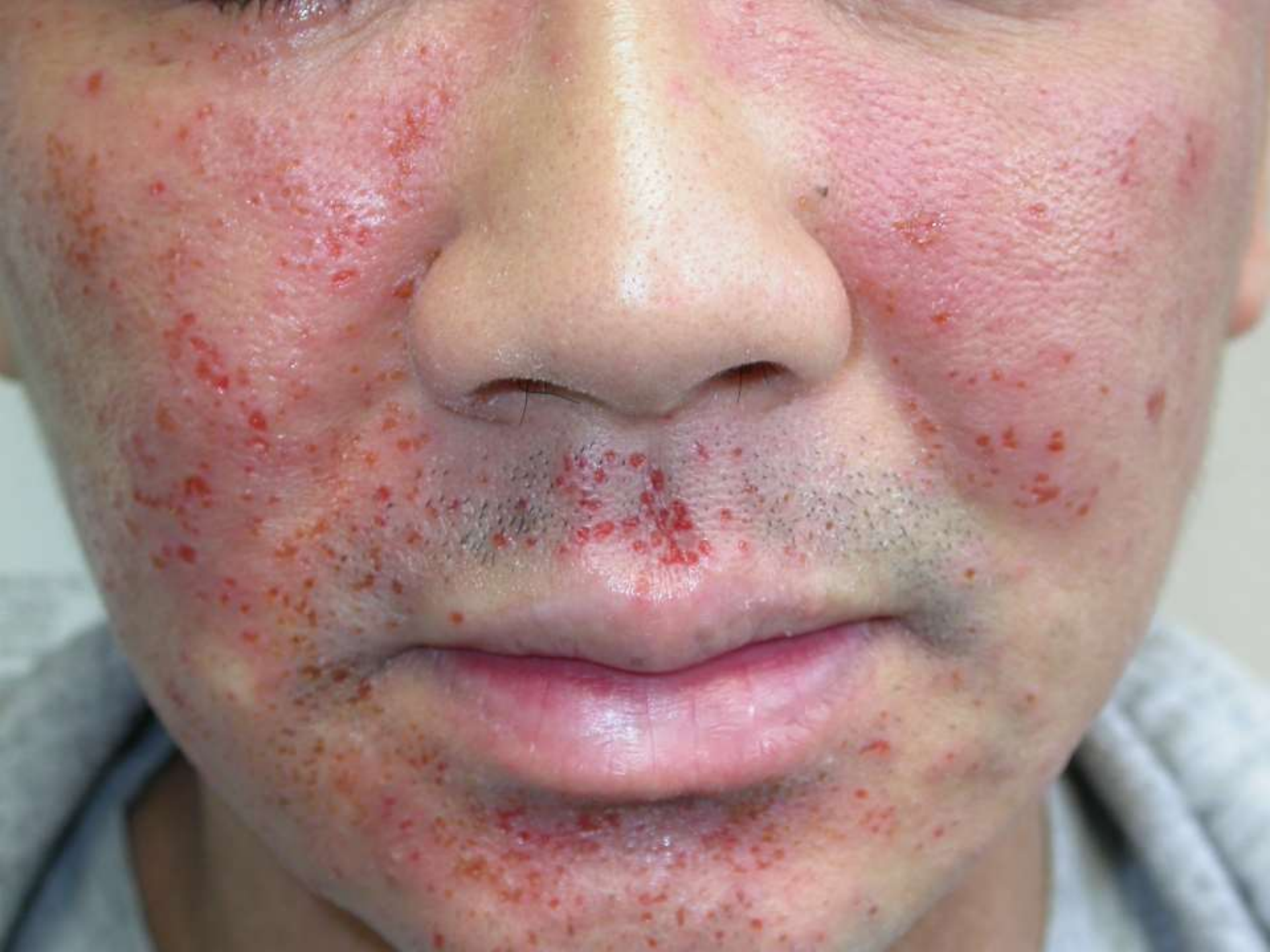


Photoinduce red-dye tatoo rxn



Case

- 23 year old male with a history of atopic dermatitis
- Febrile x 2 days, lymphadenopathy
- Rash which described as “weeping and spreading on the face”

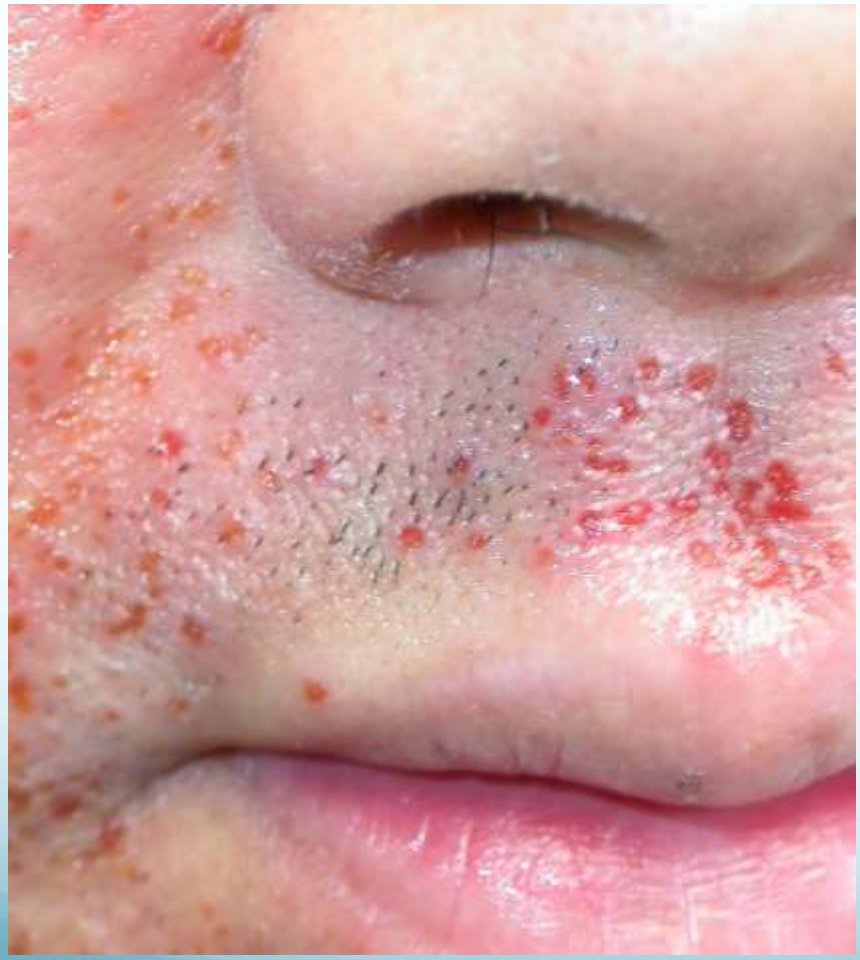


Differential Diagnosis

- Impetigo
- Eczema herpeticum
- Atopic dermatitis
- Allergic contact dermatitis

Eczema Herpeticum

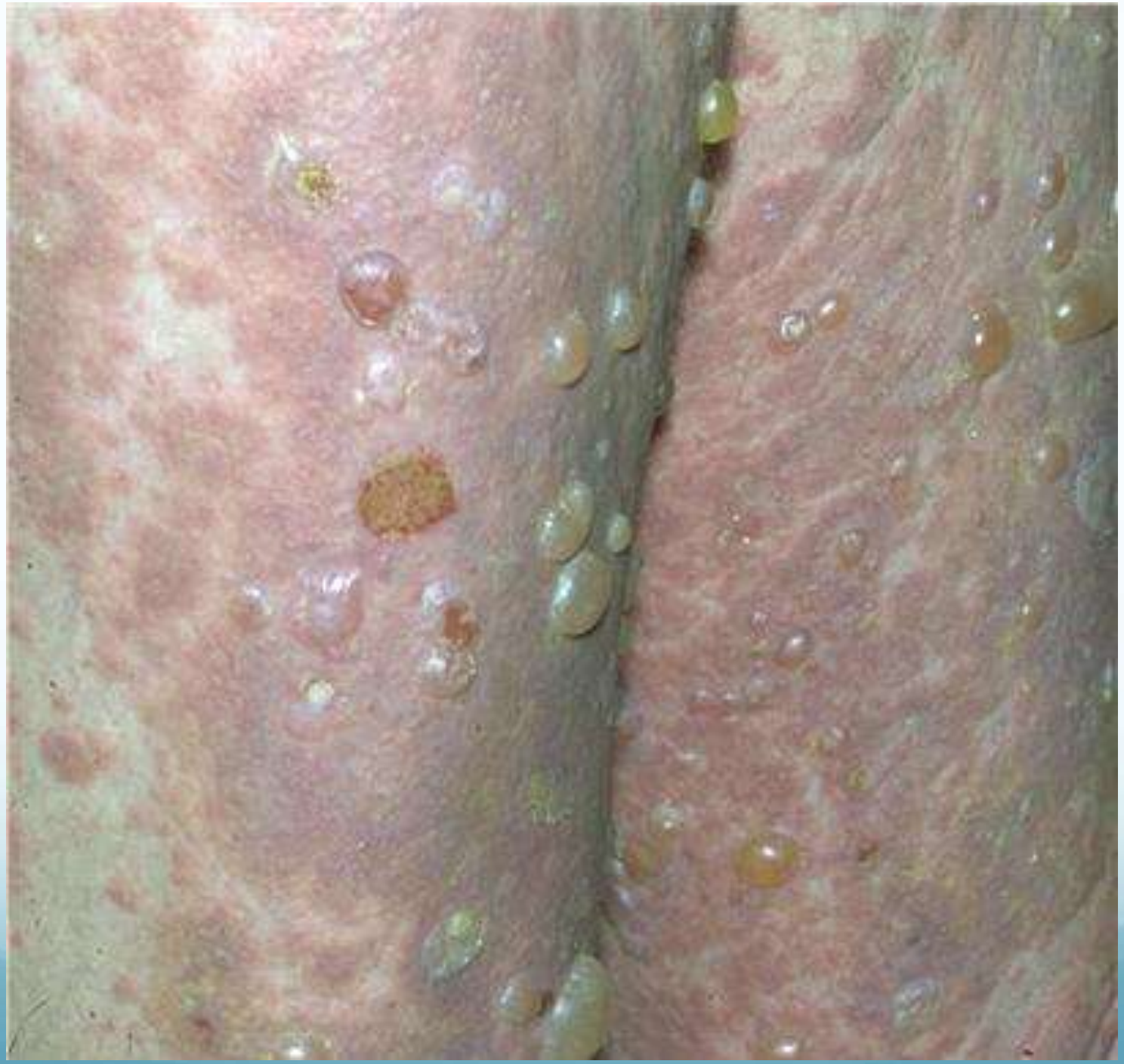
Eczema Herpeticum



- Complication of atopic dermatitis Superinfection with HSV-1
- Rapidly evolving morphologies
- Patients can look toxic (mortality possible)
- Secondary complications
- Acyclovir
- **PUNCHED OUT EROSIONS=HSV**

Case

- 55 year old male with 3 week history of pruritic eruption
- Bullae developing
- No previous skin disorders
- Phx: Hypertention



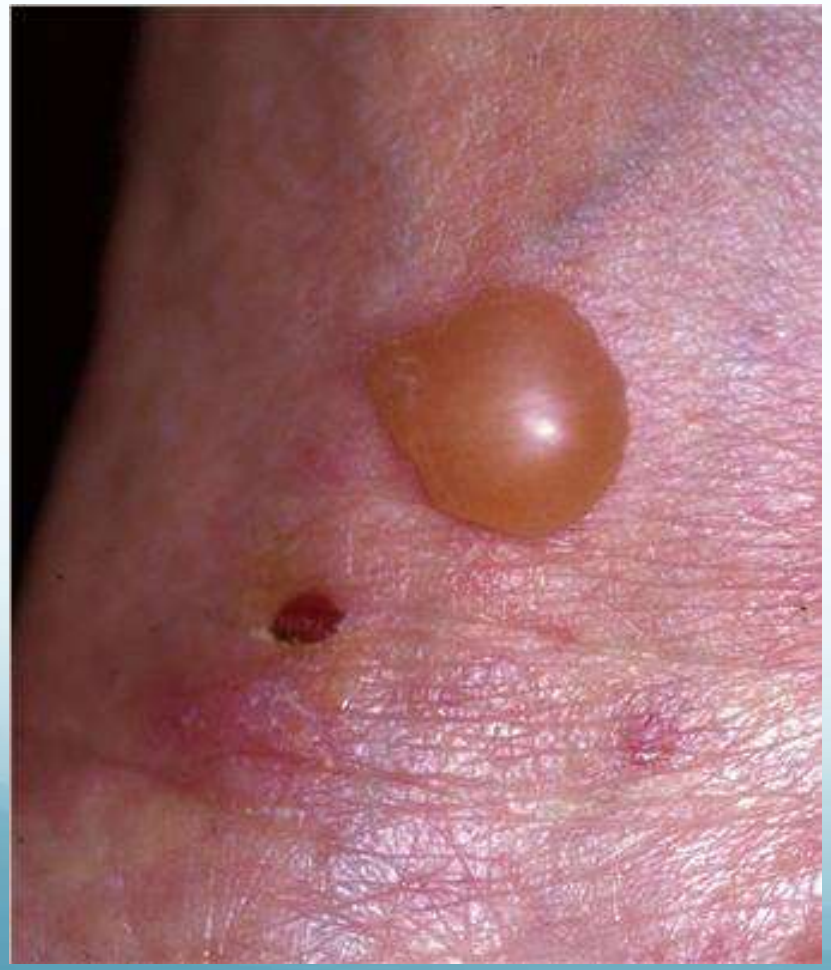
Case

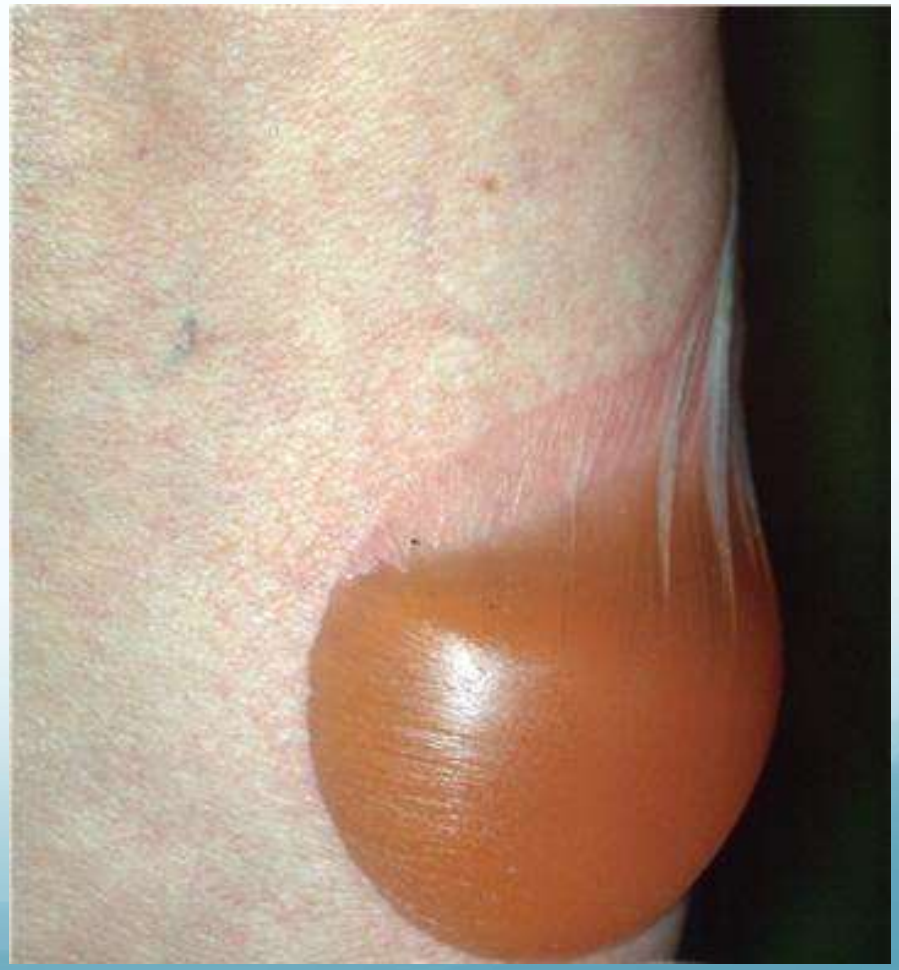
- What is your diagnosis?

1. Bullous impetigo
2. Bullous pemphigoid
3. Pemphigus
4. Allergic contact dermatitis

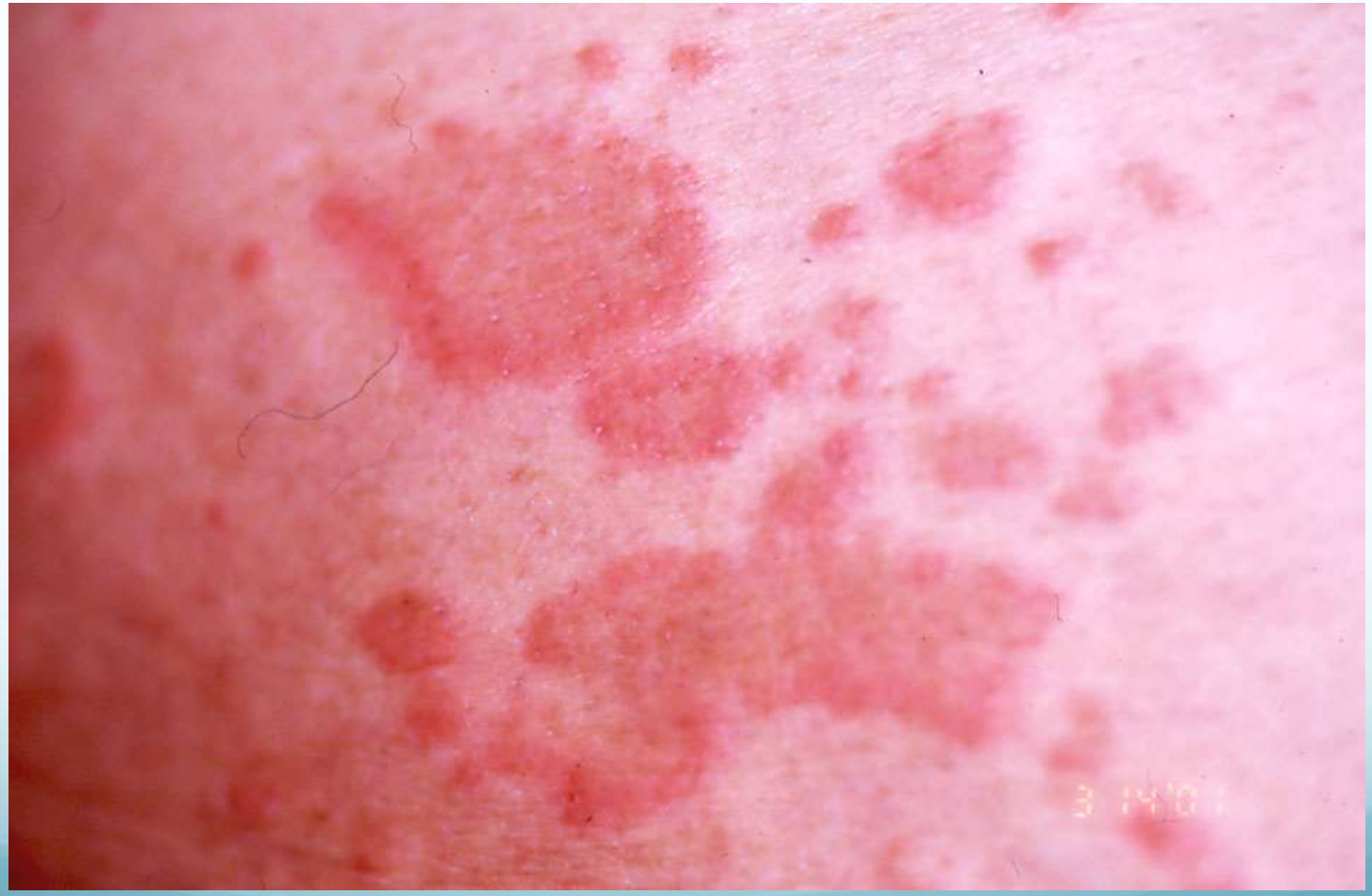
Bullous Pemphigoid

Bullous Pemphigoid





Bullous Pemphigoid-urticarial



Bullous Pemphigoid

- Most common blistering disease
- Subepidermal blisters
- > 60 yrs
- >90 yrs- ↑risk 300X
- 7 per million/yr

Bullous Pemphigoid

- Large tense bullae- normal or red skin
- Urticarial lesions
- Intense pruritus
- Localized or generalized
- Non-scarring
- Mucous membranes- 10-35% (oral)

Drug-induced Bullous Pemphigoid

- Lasix
- ACE inhibitors
- Amoxicillin
- Ciprofloxacin
- Penicillamine
- Gold
- Neuroleptics

Bullous Pemphigoid Prognosis

- Self-limited - months to yrs
- Remission – 50% within 2.5-6 yrs
- Mortality not frequent

Bullous Pemphigoid Therapy

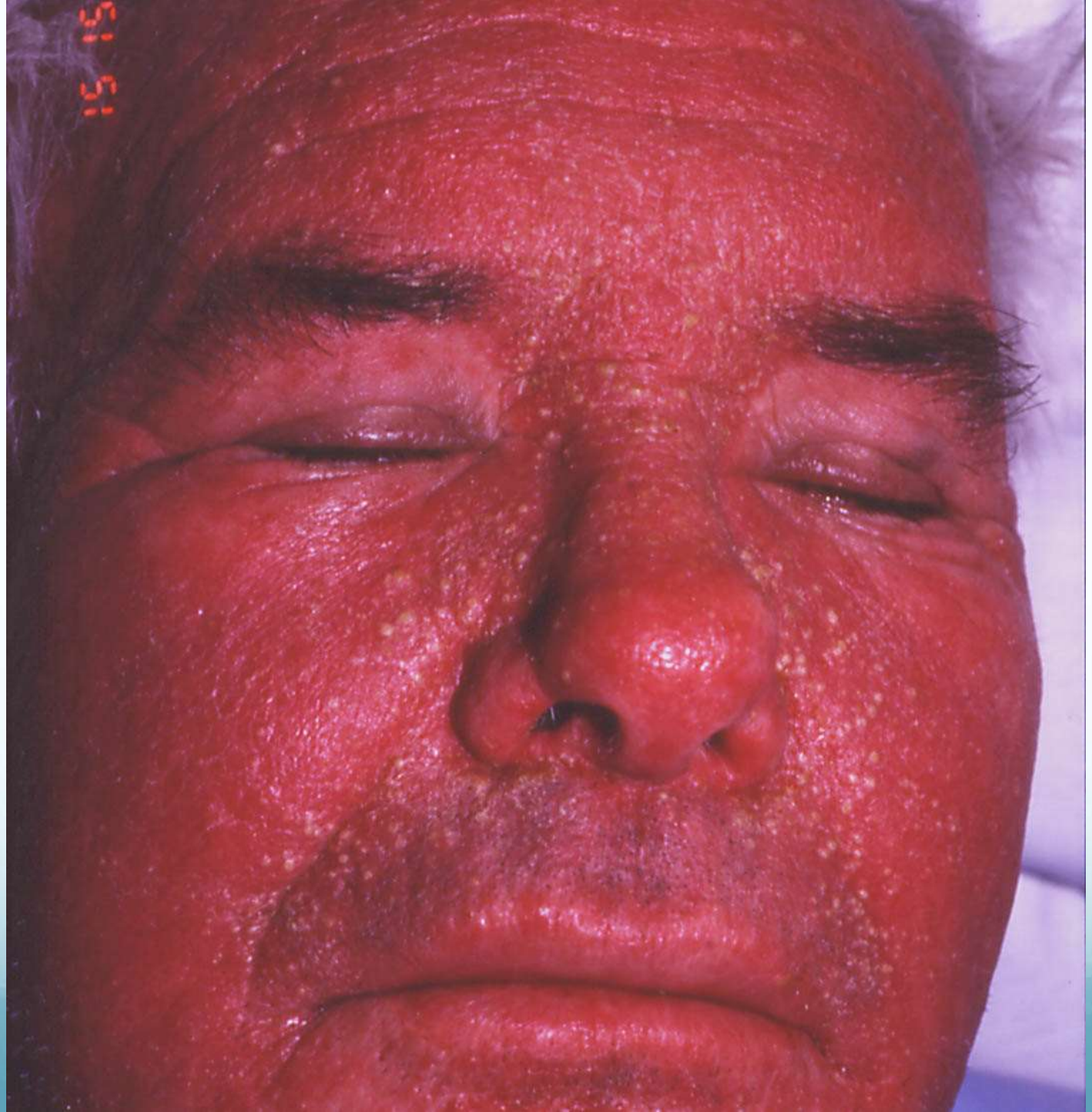
- Localized Disease- topical corticosteroids
- Extensive Disease
  - Prednisone
  - Immunosuppressants
    - Azathioprine, mycophelolate mofetil, methotrexate
  - Tetracycline and nicotinamide
  - Dapsone, sulfapyridine
  - IVIG

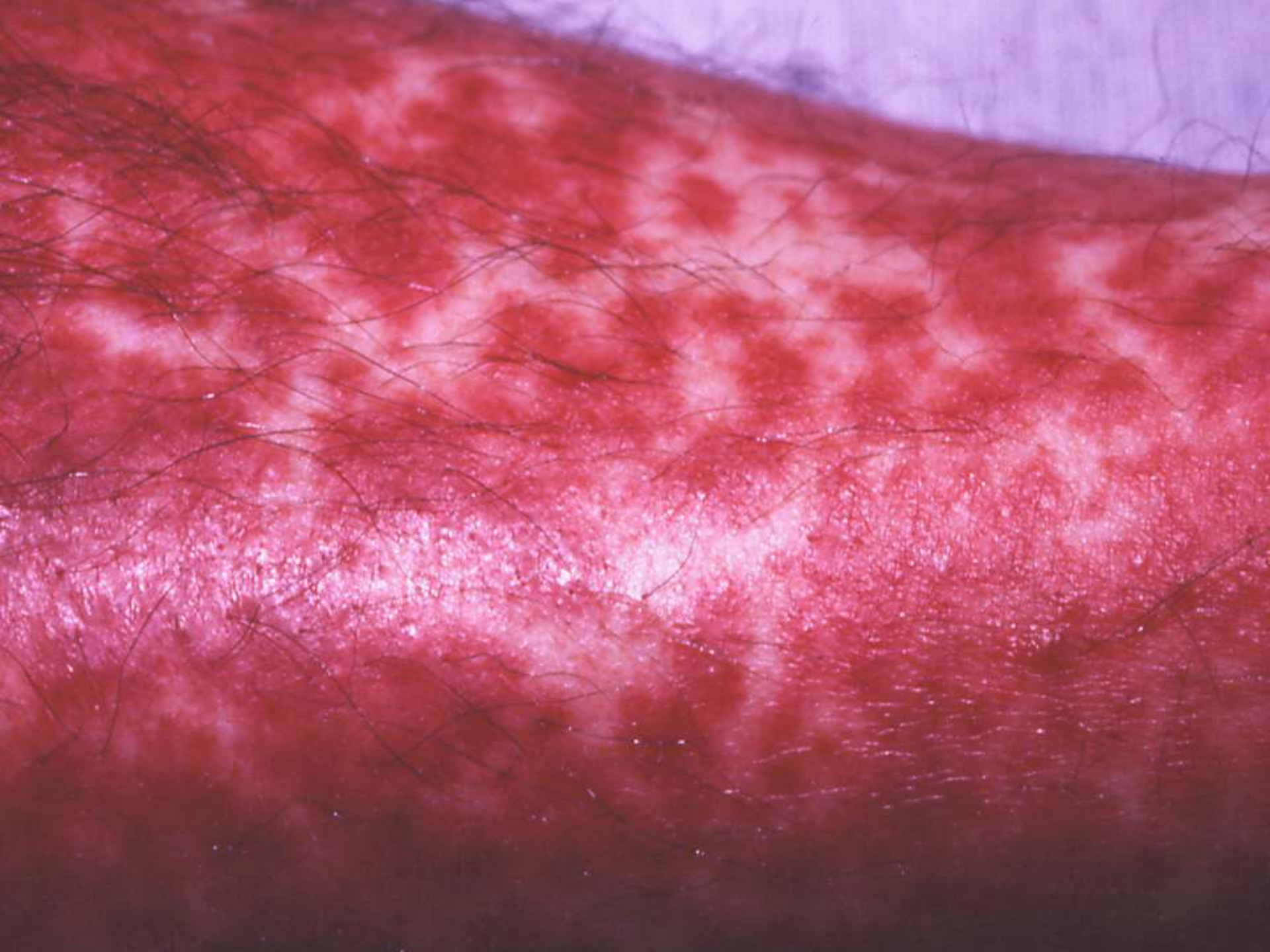
Bullous Pemphigoid

- **ANY ELDERLY INDIVIDUAL WITH CHRONIC FIXED PRURITIC URTICARIAL PLAQUES – R/O BULLOUS PEMPHIGOID**

Case

- 46 year old male with 2 seizures in the last 2 months
- Started on carbamezapine 3 weeks ago
- Noticed rash began on his face spread to his trunk > legs
- Fever, Chills, SOB, normal urine output, oral MM pain
- Lymphadenopathy, diffuse erythroderma with MM involvement, liver edge was palpable
- Labs: eosinophilia, Inc LFTS,
- C-xray – “pneumonia”





Case – Differential Diagnosis

1. Viral exanthem – EBV
2. Toxic epidermal necrolysis
3. Anticonvulsant hypersensitivity syndrome/ DRESS
4. Vasculitis

Anticonvulsant Hypersensitivity Syndrome/ DRESS Syndrome

DRESS

- Dilantin, carbamazepine, phenobarbital, Lamotrigine
- Cross reaction in 70%
- Arene metobolites – toxic
- Deficient in epoxide hydroxylase
- Incidence is 1 in 1000 – 1 in 10000
- 2 – 6 weeks (occ longer)

DRESS

- Skin
  - Morbilliform, erythroderma, targets, skin desquamation, purpura
  - All mm may be involved
- Lymphadenopathy, hepatomegally (57%), fever, eosinophilia (30%), Inc LFT's(51%), atypical lymphocytes, nephritis (11%), ARDS

DRESS

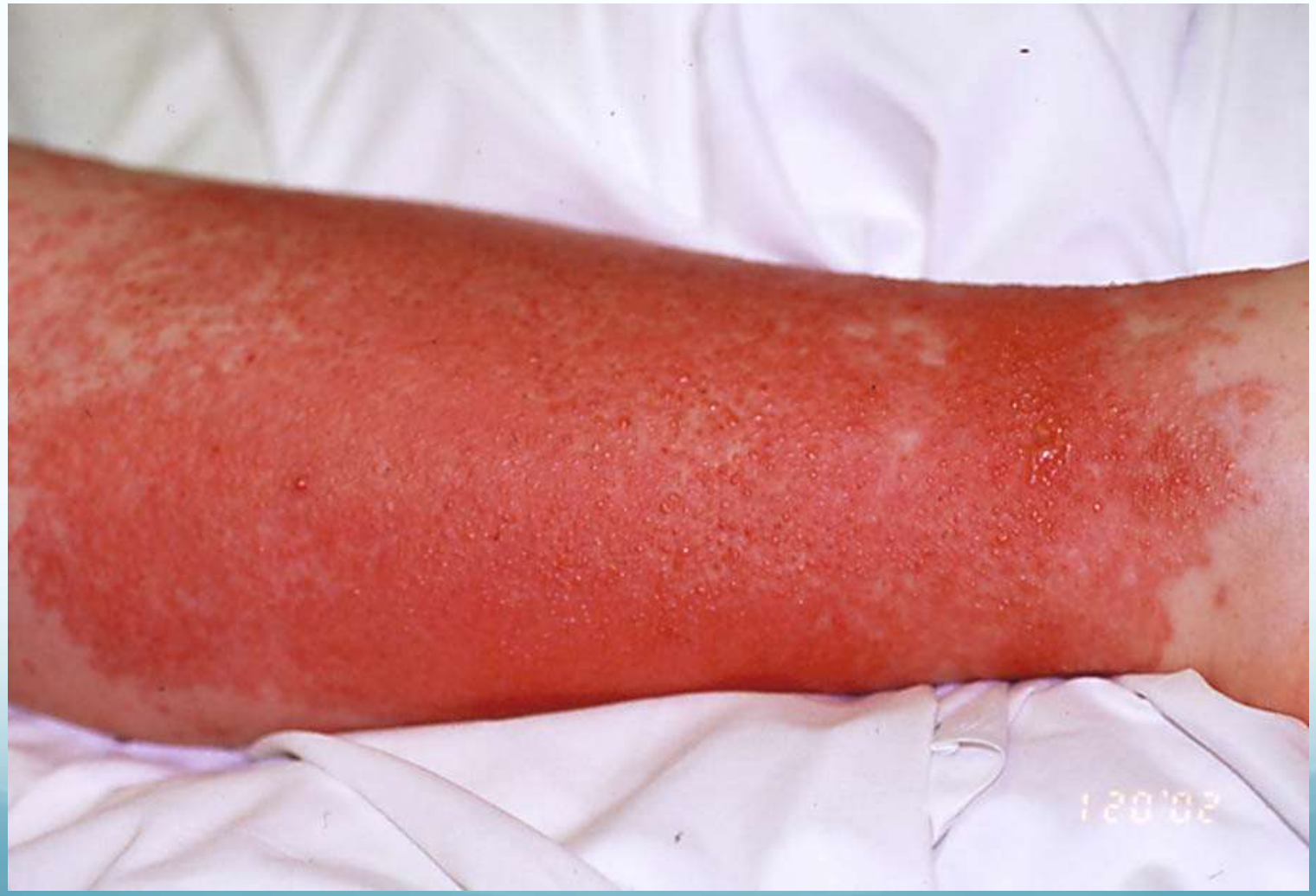
- Management
  - Discontinue the anticonvulsant
  - Supportive
  - Systemic steroids – hepatitis, nephritis, ARDS
  - Choose carefully another anticonvulsant class
  - 1-3 months post monitor for hypothyroidism


You must
clearly explain
your problem

Case

- 17 year old female with acute painful and pruritic erythema on the left lower extremity
- Increased warmth
- Otherwise well
- Chills , no fever on admission
- CBC – WBC high normal

Case



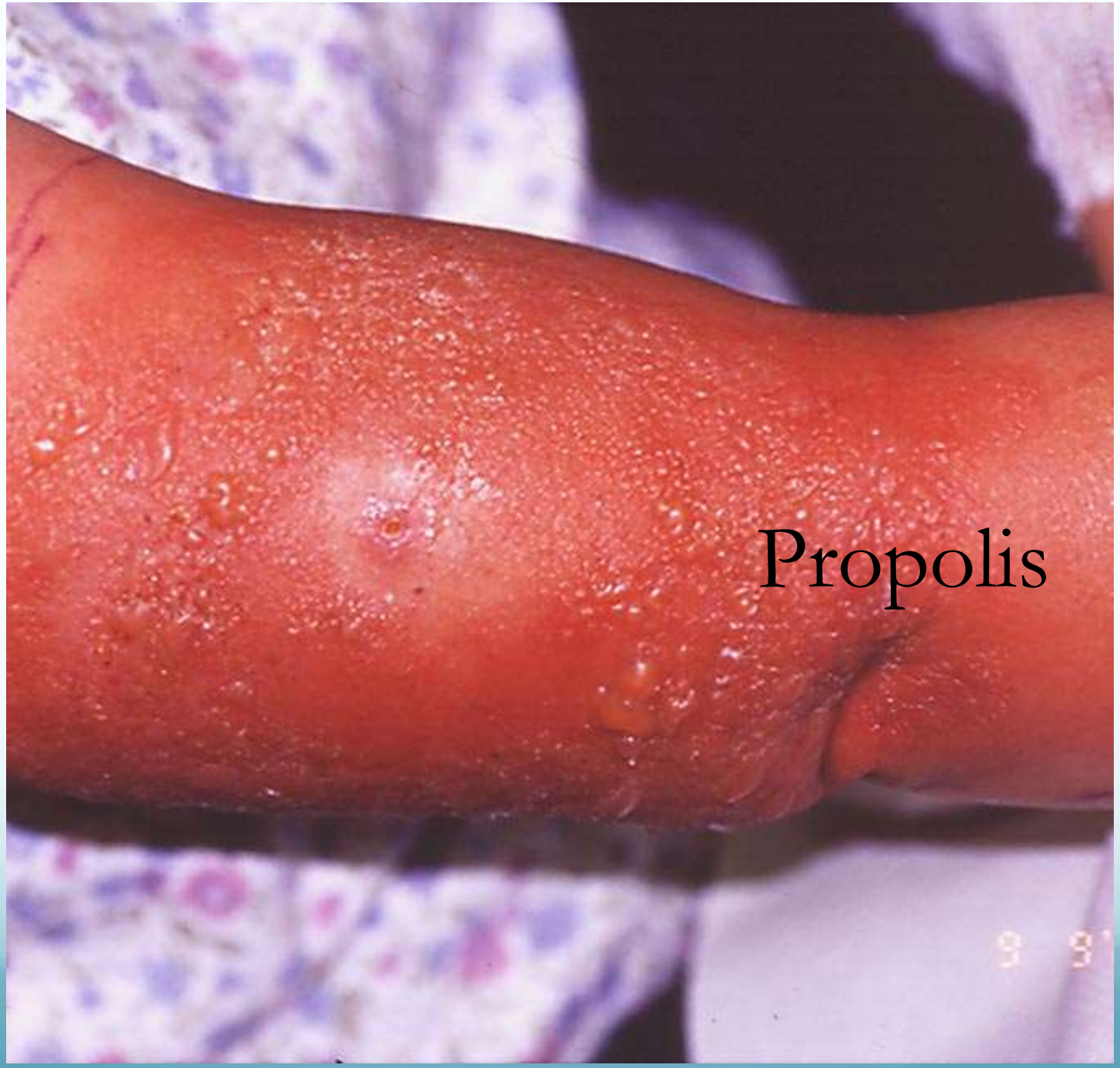
Case Differential Diagnosis

1. Cellulitis
2. Allergic contact dermatitis
3. Venous stasis
4. vasculitis

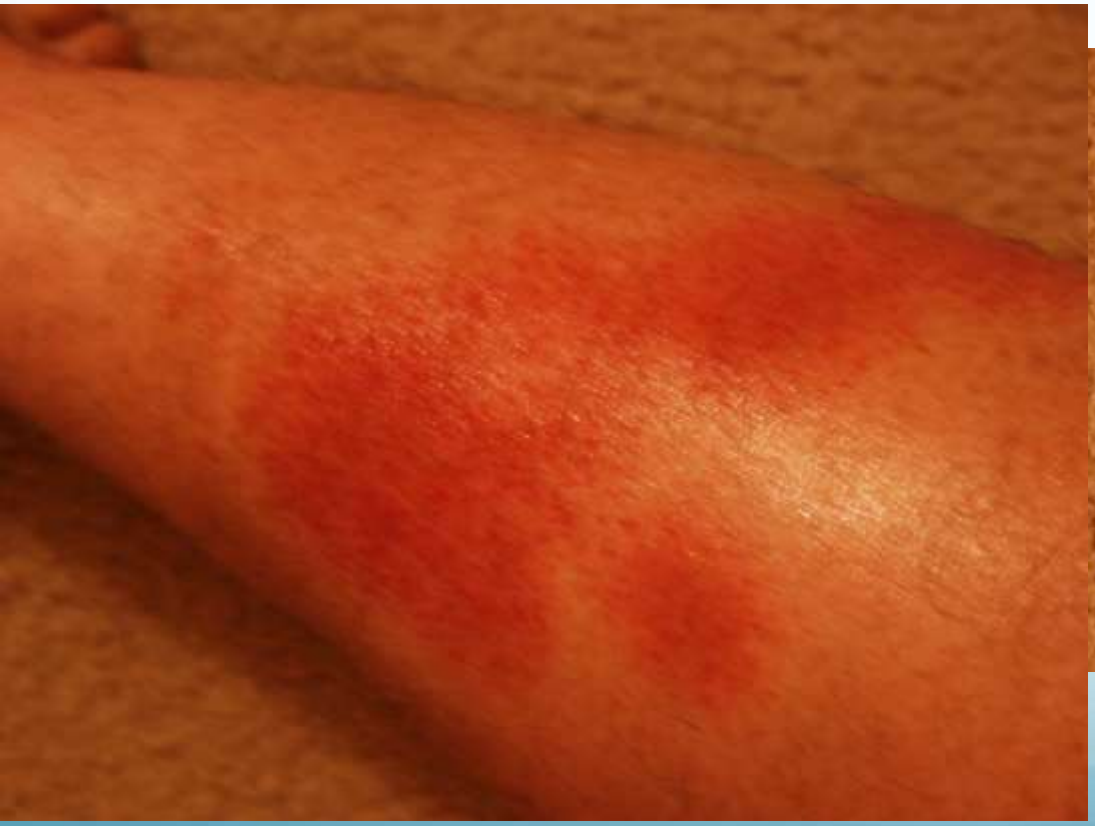
Allergic Contact Dermatitis

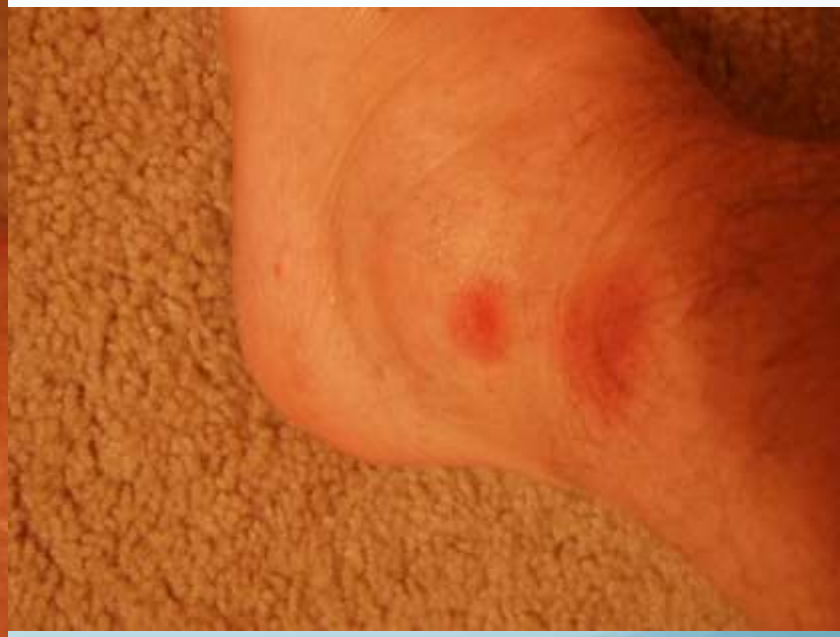
Case

- 2 days earlier used NEET for hair removal
- Prednisone over a long taper
- Clobetasol ointment BID
- cleared

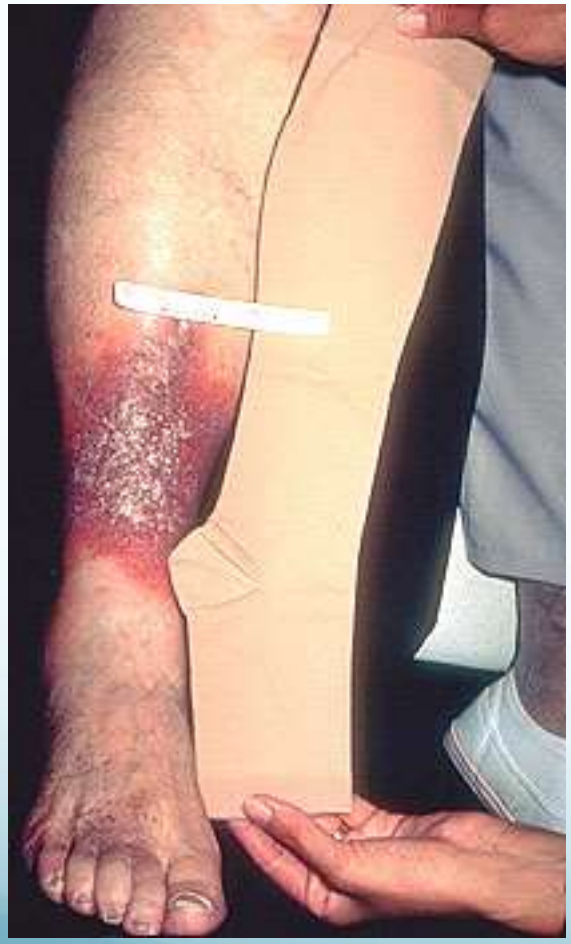

Propolis

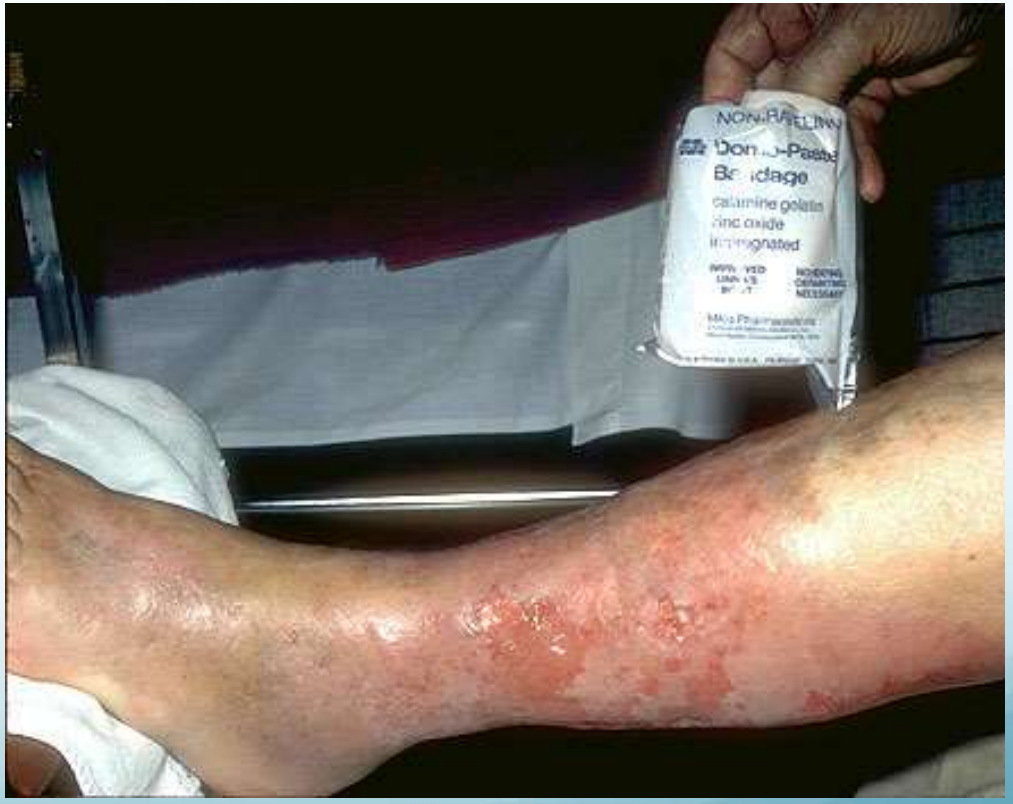
Fixed Drug Eruption



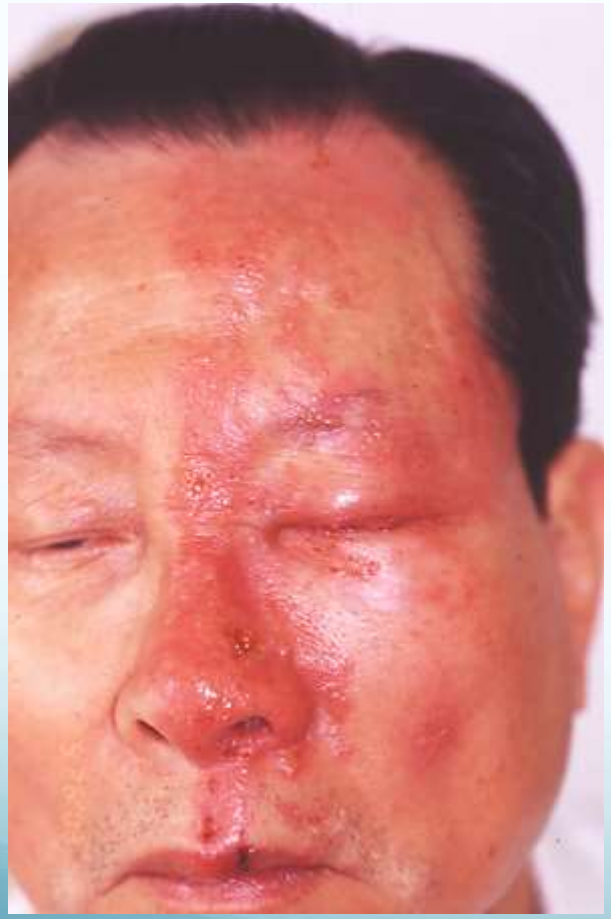


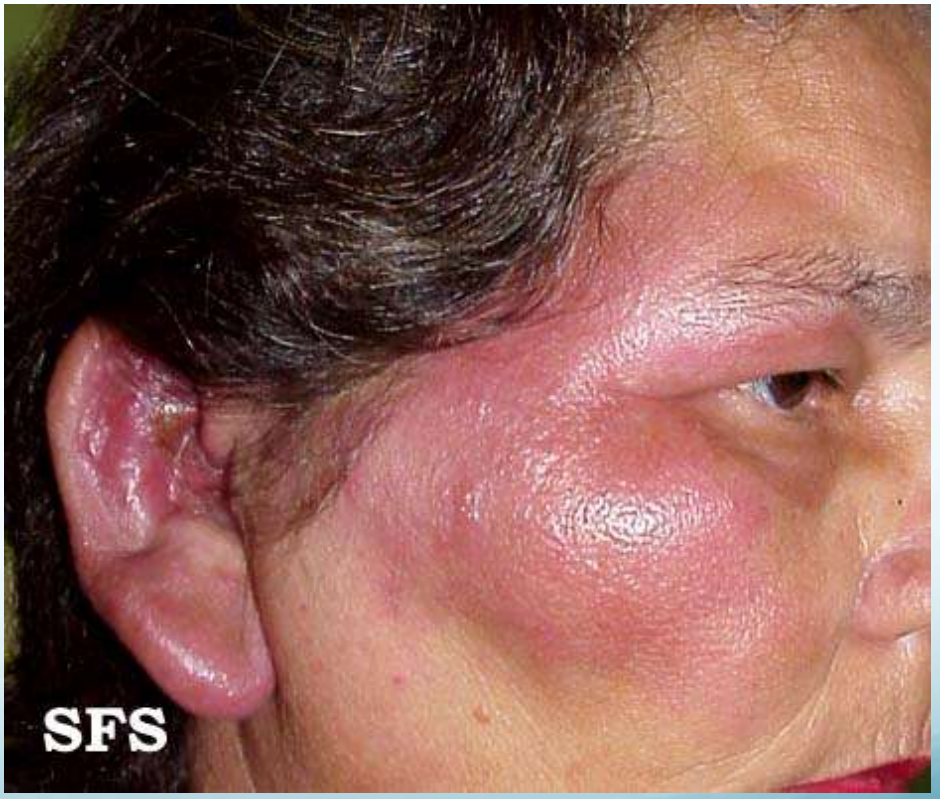
Venous Stasis





Infectious





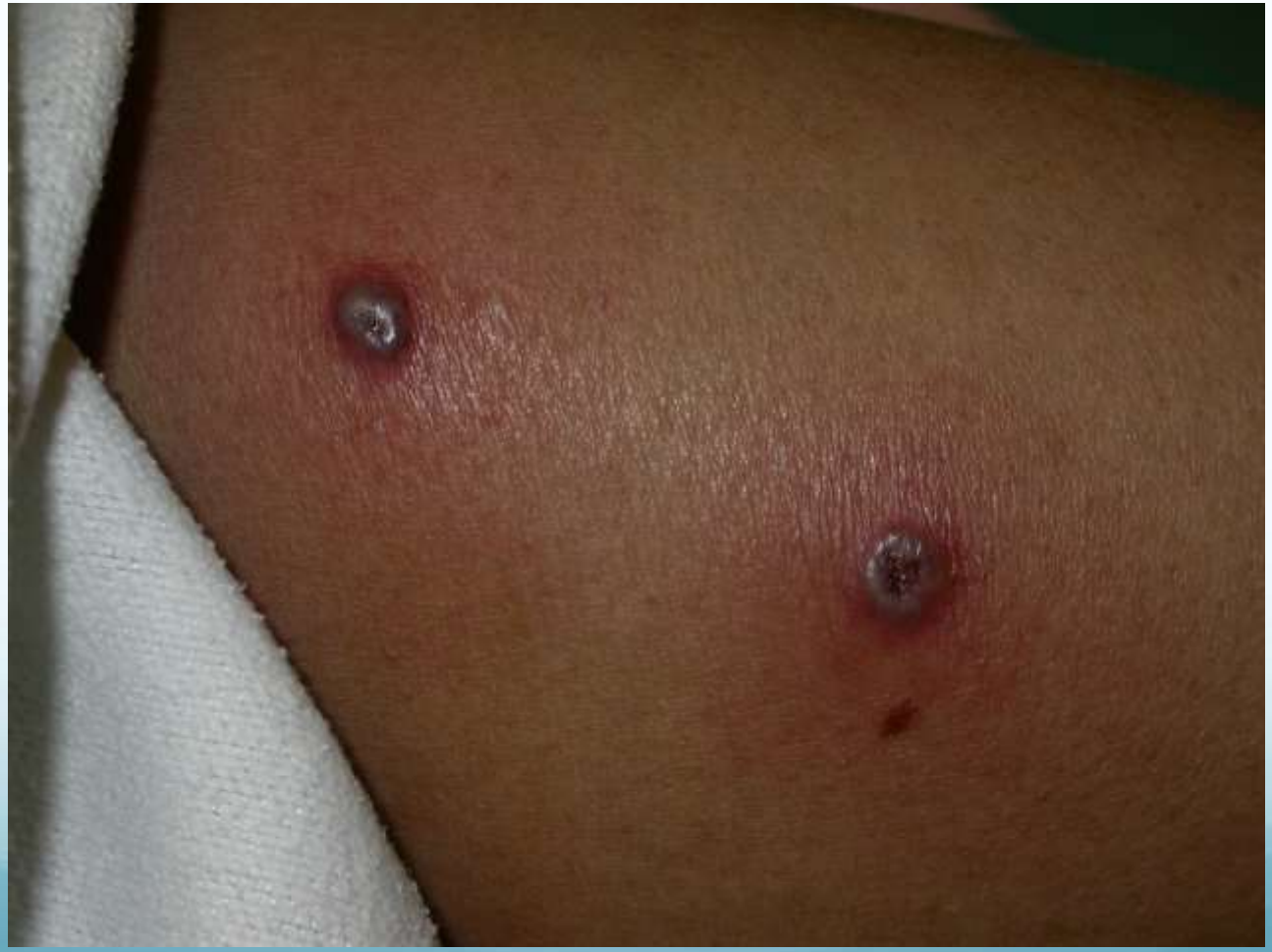
Allergic Contact

- Differential Diagnosis
  - Venous stasis
  - Cellulitis
  - Eosinophilic cellulitis
  - Fixed drug eruption
  - Second degree Burn

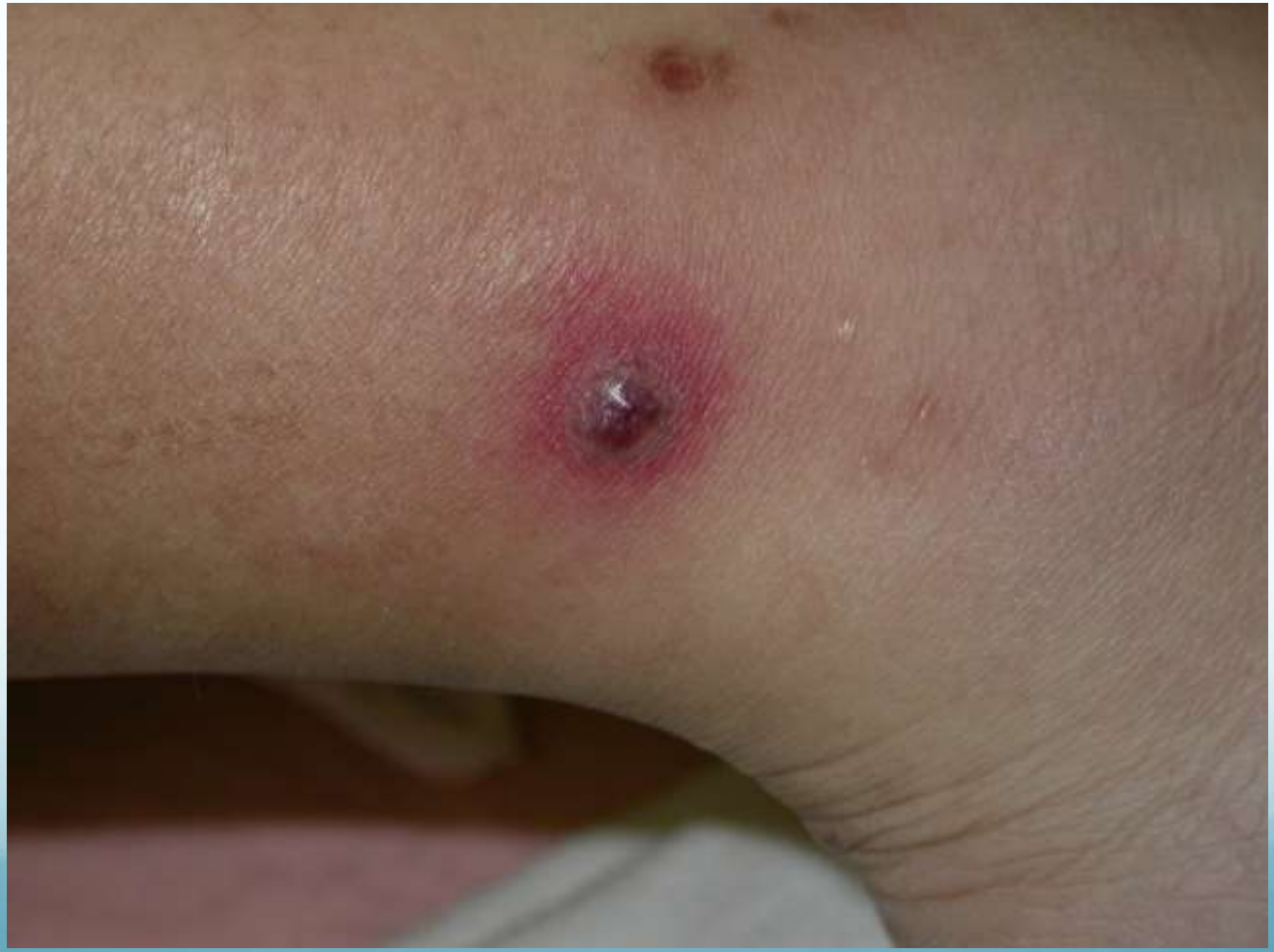
Case

- 39 yr old native female with 10 day history of violaceous papules scattered diffusely on the body
- Extremely painful
- Sexual contacts – 2 in last month
- No fever, no chills
- Labs normal

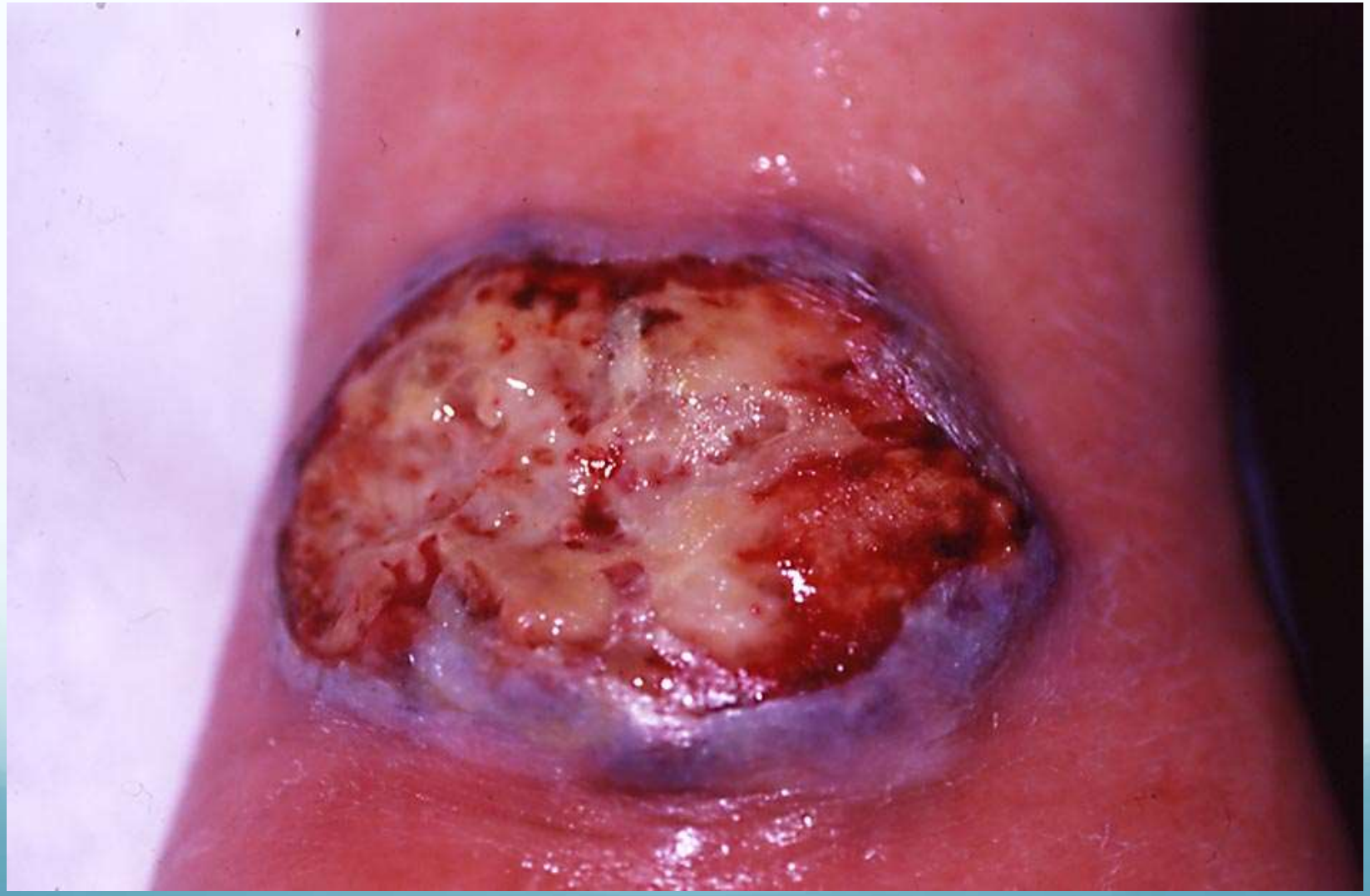
Case



Case



Case



Case 3 - Diagnosis

1. Gonnorhea
2. Vasculitis
3. Furunculosis
4. Pyoderma gangrenosum

Pyoderma Gangrenosum

Pyoderma Gangrenosum

- A destructive inflammatory skin reaction in which a painful nodule or pustule breaks down to produce an enlarging ulcer
- Uncommon
- Any age
- Female predominance

Pyoderma Gangrenosum

- Exaggerated destructive inflammatory response
- Blocked by immunosuppression
- Predominant inflammatory cell is the neutrophil
- Pathergy

Pyoderma Gangrenosum

- No definitive test
- A diagnosis of exclusion – biopsy is NB!
- Histology - massive infiltration with polymorphs and abscess formation compatible with PG
- Negative culture and absence of organisms critical to rule out other diagnosis

Pyoderma Gangrenosum

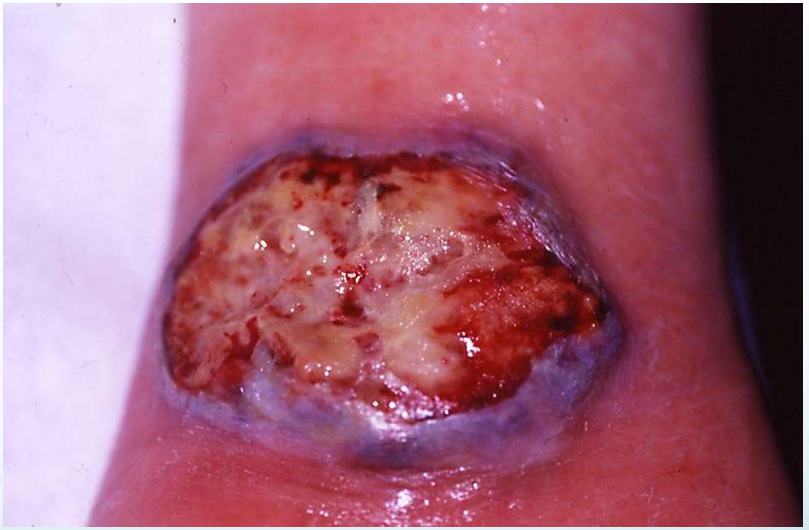
- 10% of cases misdiagnosed as PG
  - Vasculitis
  - Arterial or venous disease
  - Malignancy
  - Infection
  - Drug
  - Exogenous

Weenig R. et al

N.E.J.M. 18: 347:1412 2002

Pyoderma Gangrenosum

- Begins as nodule or pustule with an expanding erythematous halo
- Ulcer, raised violaceous overhanging border, boggy necrotic base
- Confined to the dermis or extend down to fascia
- Explosive or gradual expansion



Pyoderma Gangrenosum

- 50 % to 70 % for classical P.G.
- Ulcerative Colitis 0.6 % to 5%
- Crohns Disease 1.2%
- Arthritis
- Paraproteinemia
- Myeloproliferative Disease
- Sarcoidosis, Takayasu, Connective tissue disease

Pyoderma Gangrenosum

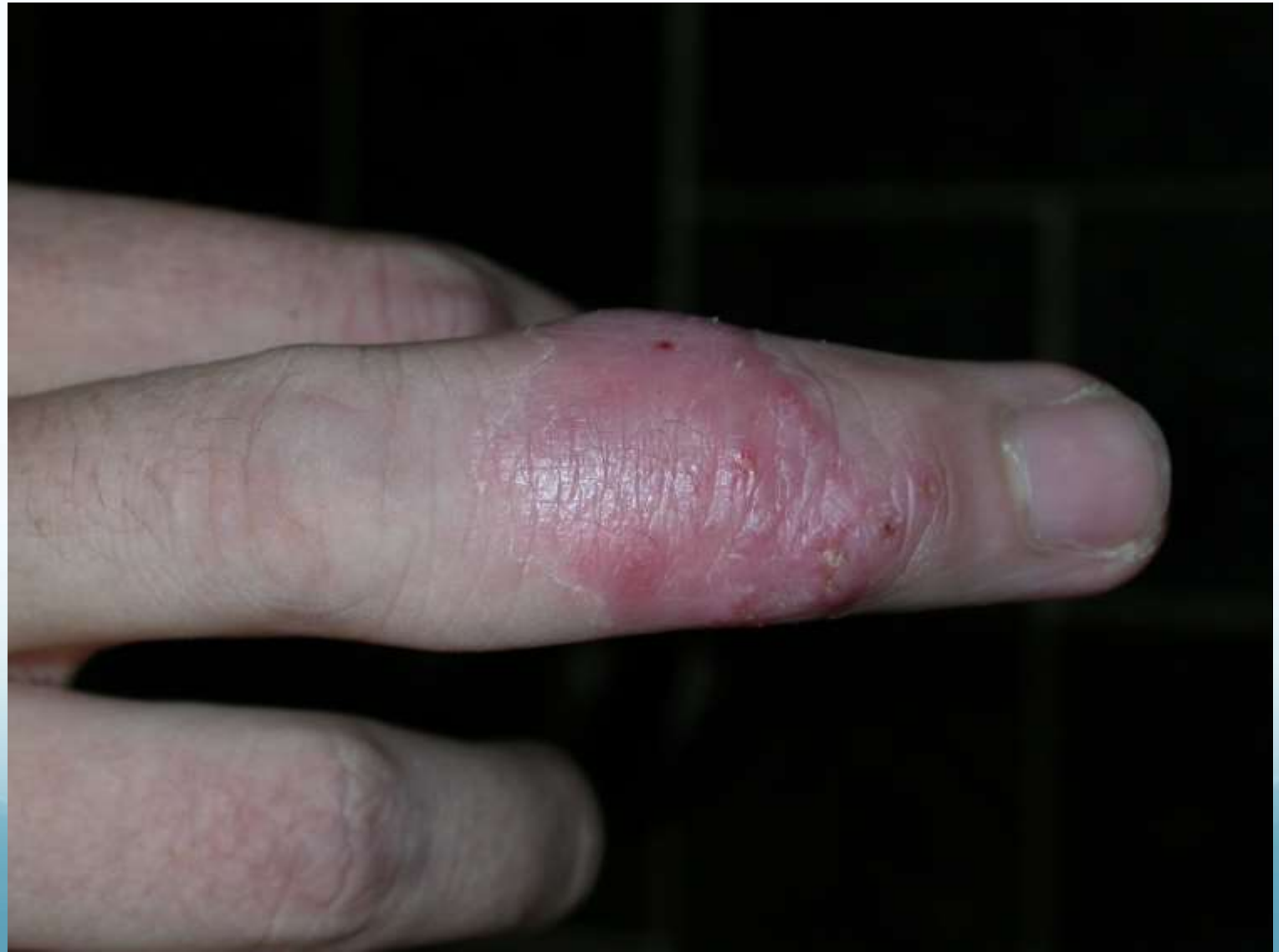
- Topical – steroids, tacrolimus
- Systemic Steroids
  - High dose or pulse therapy
- Cyclosporin, MMF, Imuran, IVIG
- Anti-TNF biologics
  - Infliximab
  - Etanercept
- Other - Dapsone, Clofazimine, Thalidomide, Methotrexate

Case

- 24 year old male with 1 month history of ascending nodules on L arm
- Painful
- Mild arthralgia
- Did garden and remove rose bushes from his back yard
- No constitutional symptoms

Case

Case



Case - Diagnosis

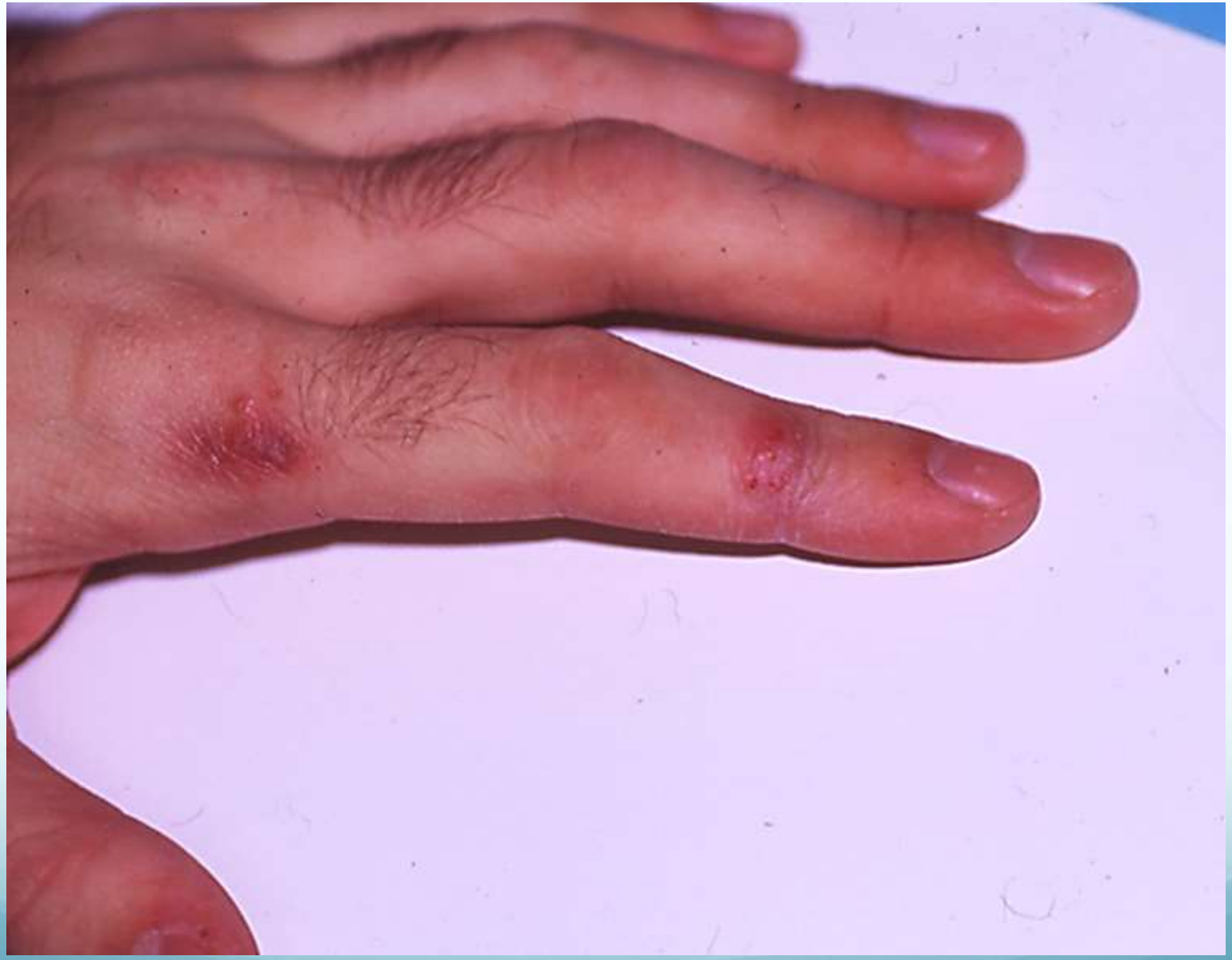
1. Mycobacterium Marinum (fish tank granuloma)
2. Sporotrichosis
3. Furunculosis
4. Sarcoma

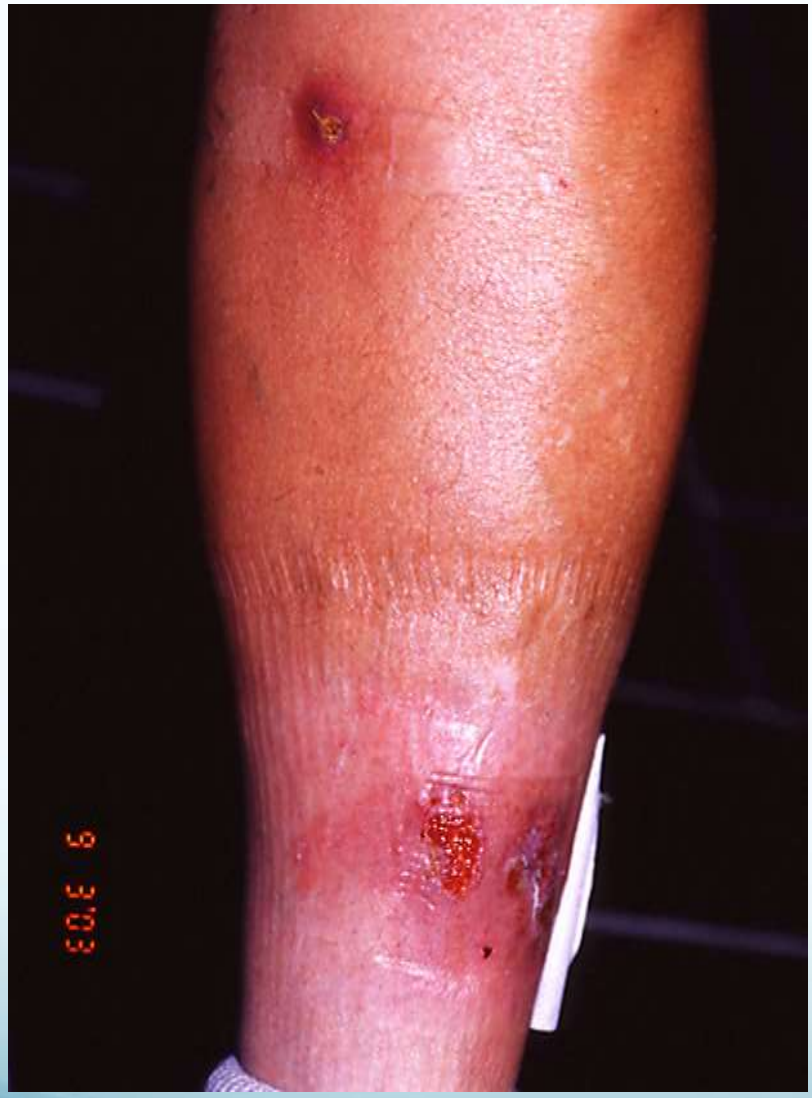
Mycobacterium Marinum

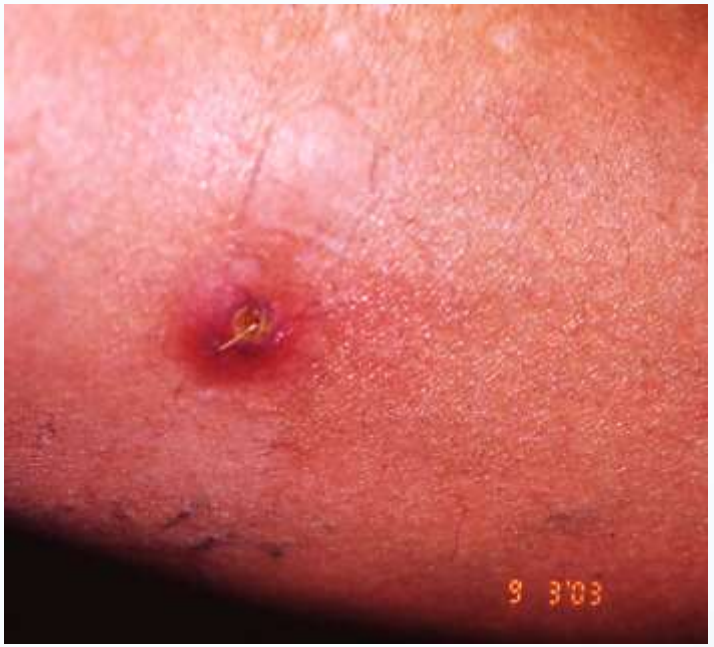
Mycobacterium Marinum

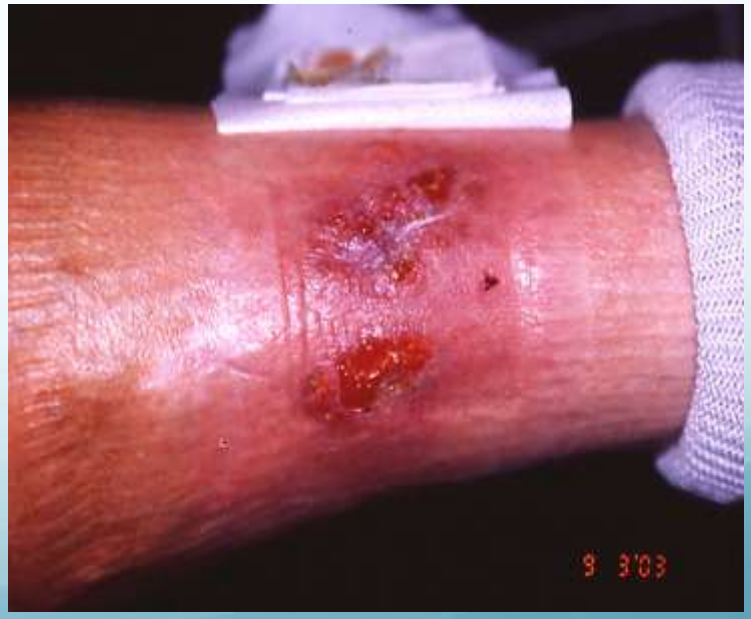
- Trauma and water and fish related hobbies
- 2-3 week incubation
- Rarely ulcerate
- Heal spontaneously in 1-2 years
- Bursitis
- NO LYMPHADENOPATHY
- Minocycline, rifampin, levofloxacin, septra, azithromycin

Mycobacteria Marinum




9 3'03


9 3'03


9 3'03

Sporotrichoid spread

- Sporotrichosis
- M. Marinum
- M. Kansasii
- Cat scratch – B. henselae
- Tularemia
- Nocardia
- Leshmaniasis
- Metastases


EAT
MOR
CHIKIN