Dermatology Quizzes

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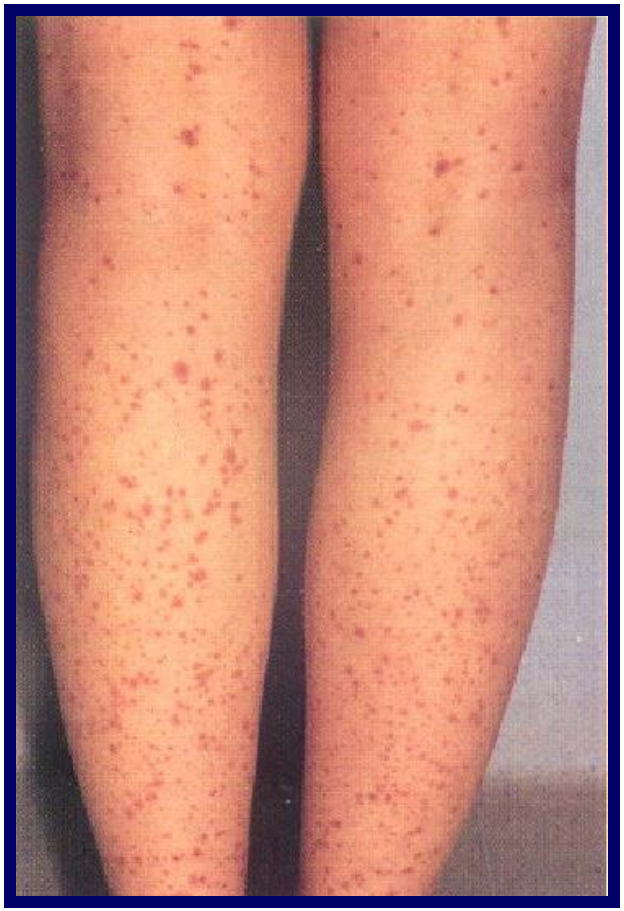


This child became unwell and developed abdominal pain, painful swelling of the joints and a purpuric eruption on the lower legs. Her platelet count was normal and she had received no drugs.

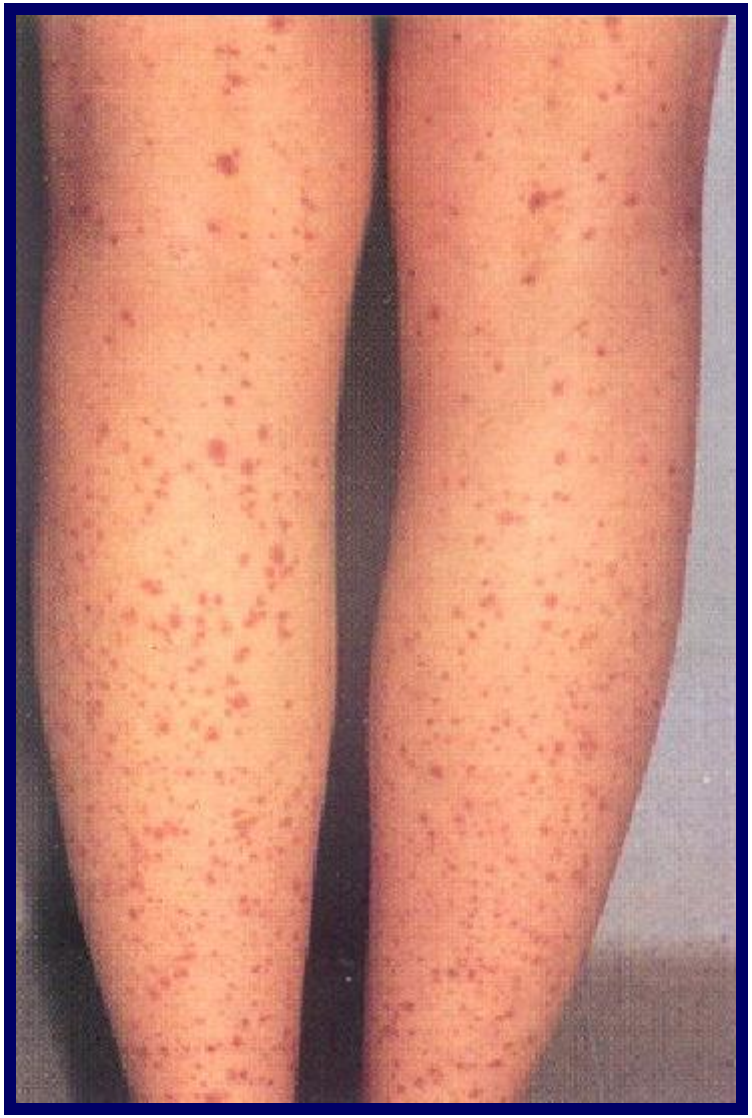
Q1. What is the condition ?

Q2. What other problems might arise ?

Q3. What is the cause ?

Q4. What is the treatment?

Henoch-Schonlien Purpura



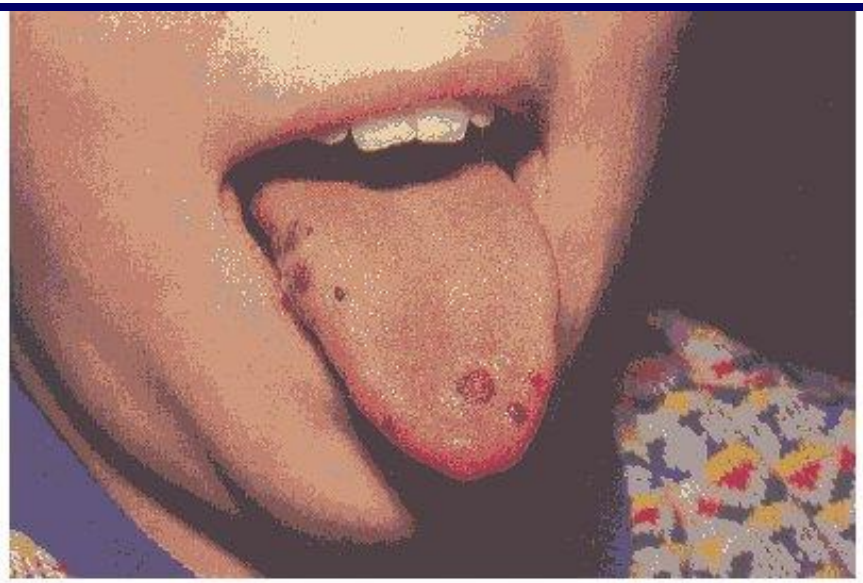
A2. Bleeding from the gut and Acute glomerulonephritis

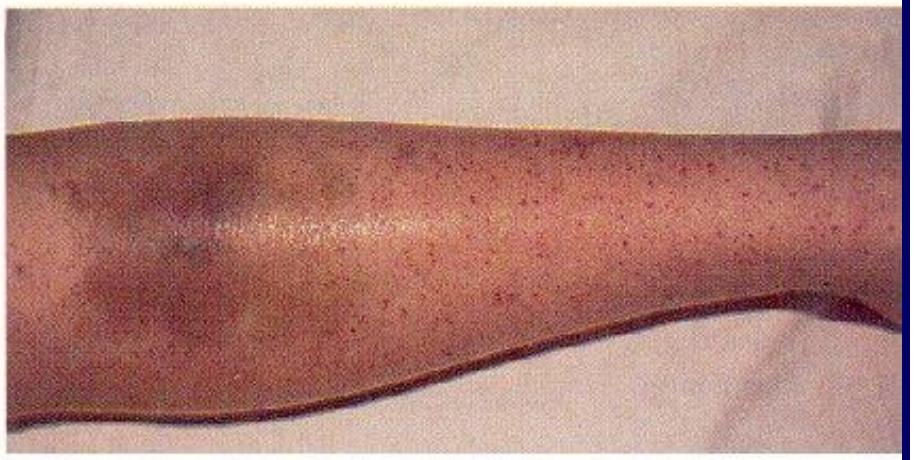
A3. Usually none is found. In former years streptococcal infection was thought to he important. It is now regarded as an immune complex disease but the antigen is usually difficult to identify.

A4. High-dose steroids

This 9-year-old girl presented with a rash some days after a coryzal illness. Examination showed multiple petechiae with ecchymosis on the shins and tongue.

Admission to hospital was arranged the same day -a full blood count showed a low platelet count of 45 x 109/1. A bone marrow aspirate, performed the next day, confirmed the diagnosis of **idiopathic thrombocytopenic purpura.** The patient is being treated with reducing doses of oral steroids and her platelet count is back to normal.





Henoch Schonlein purpura

Localized oedema

face, hands, feet, scrotum

Arthritis

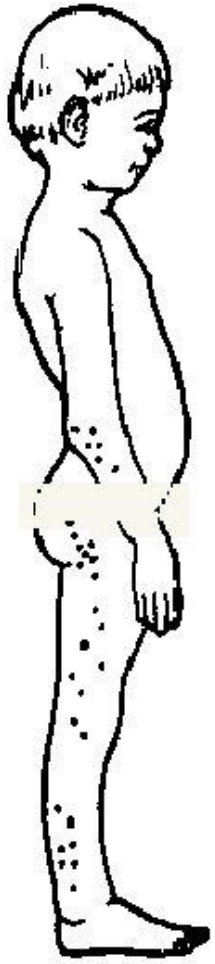
flitting, large joints

Abdominal pain

melaena

haematemesis

haemorrhage with oedema of gut wall



Nephritis

microscopic haematuria

proteinuria

mild focal glomerulonephritis

Maculopapular-purpura rash

buttocks and extensor surface of legs and arms

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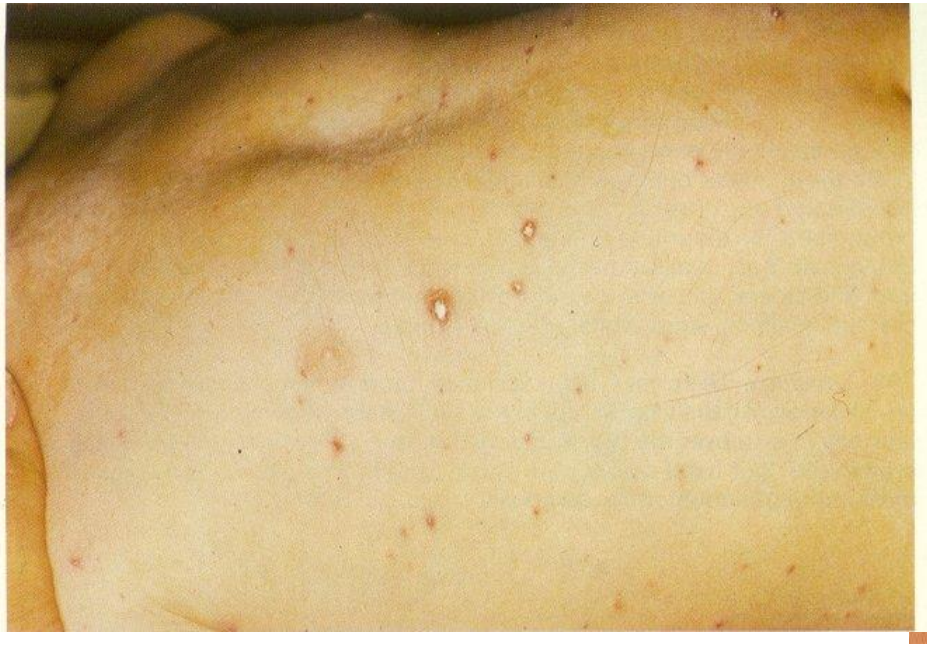
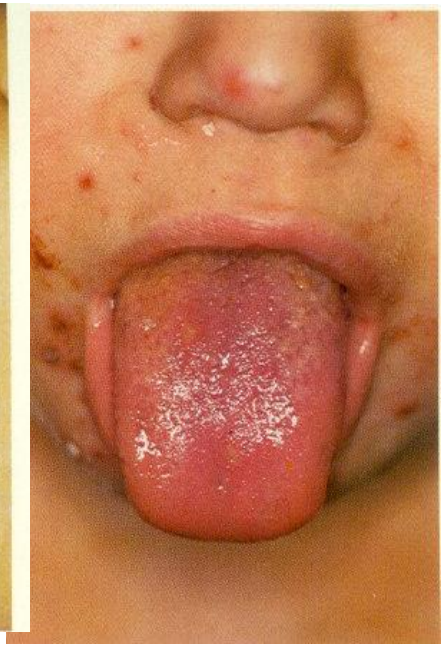


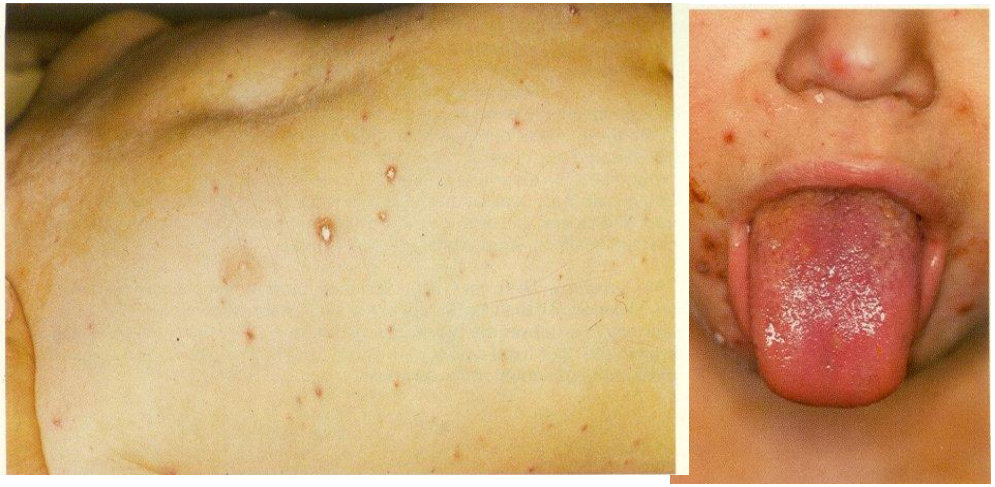


A child presented with pyrexia and eruption which consisted of papules, pustules and vesicles.

Q.1 **What is the disease ?**

Q.2 **What complication may occur ?**

Chickenpox



A2. Complications :

Secondary infection:

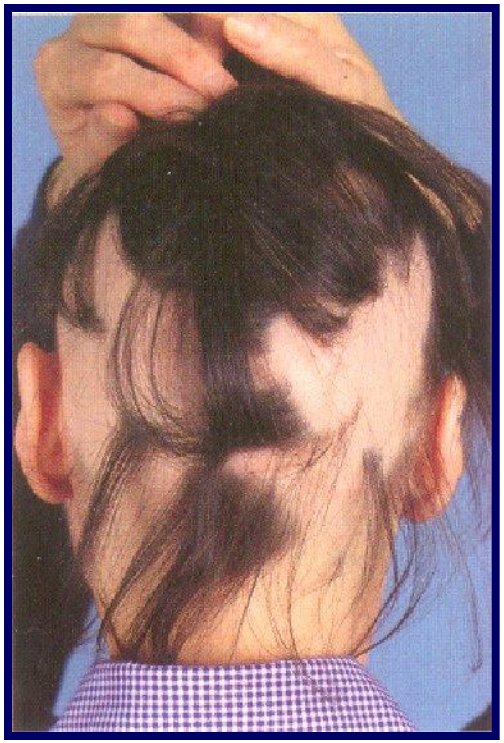
Thrombocytopenic purpura Encephalitis

Varicella pneumonia (usually in adults)

and those with impaired immune response.

3

This boy has developed a smooth round bald patch on the scalp.



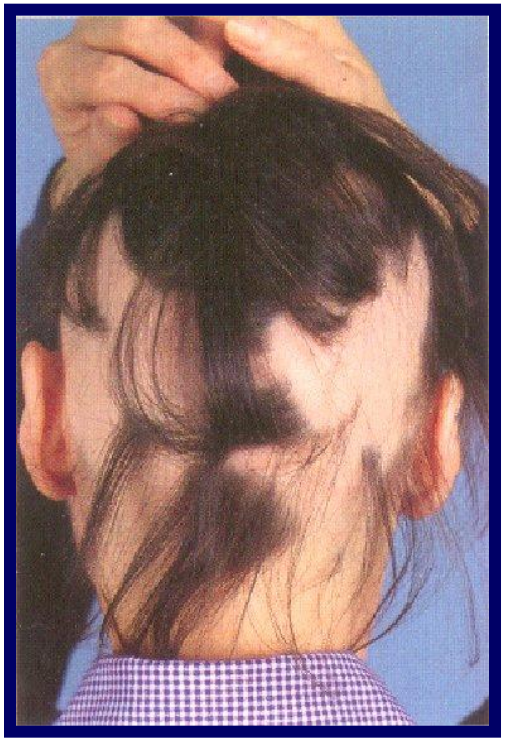
Q.1 What is this most likely to be ?

Q.2 hat is the prognosis ?

Q.3 Name some other causes of patchy hair loss in a child ?

Q.4 Name three systemic diseases in which non-scarring alopecia may occur ?

Alopecia areata



A.2 In most cases patches regrow completely in a few months some follow a relapsing pattern and 'm some cases *A* the hair is lost (Alopecia totalis).

A.3 Ringworm infection (tinea capitis), hair plucking.

A.4 SLE, Secondary syphilis, sickle cell anaemia

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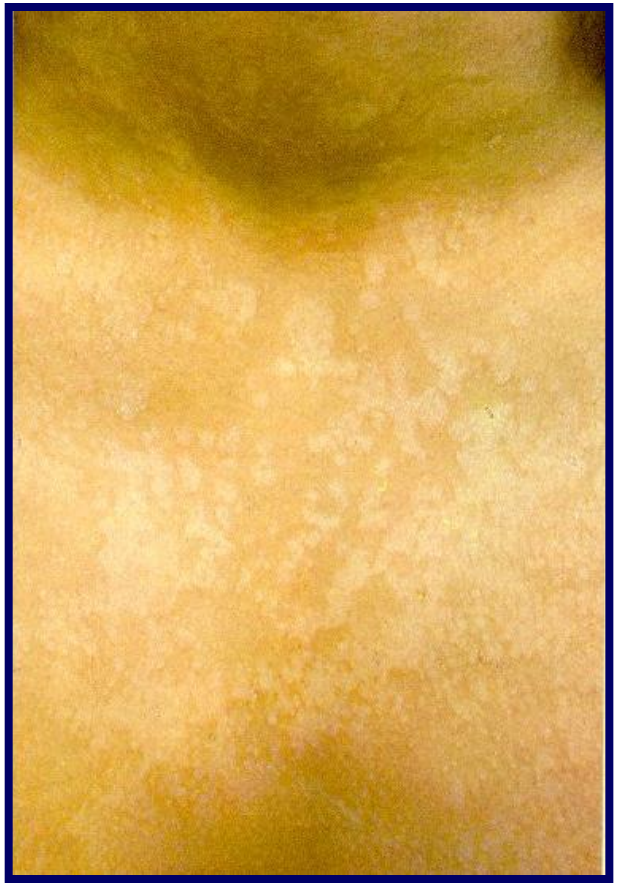


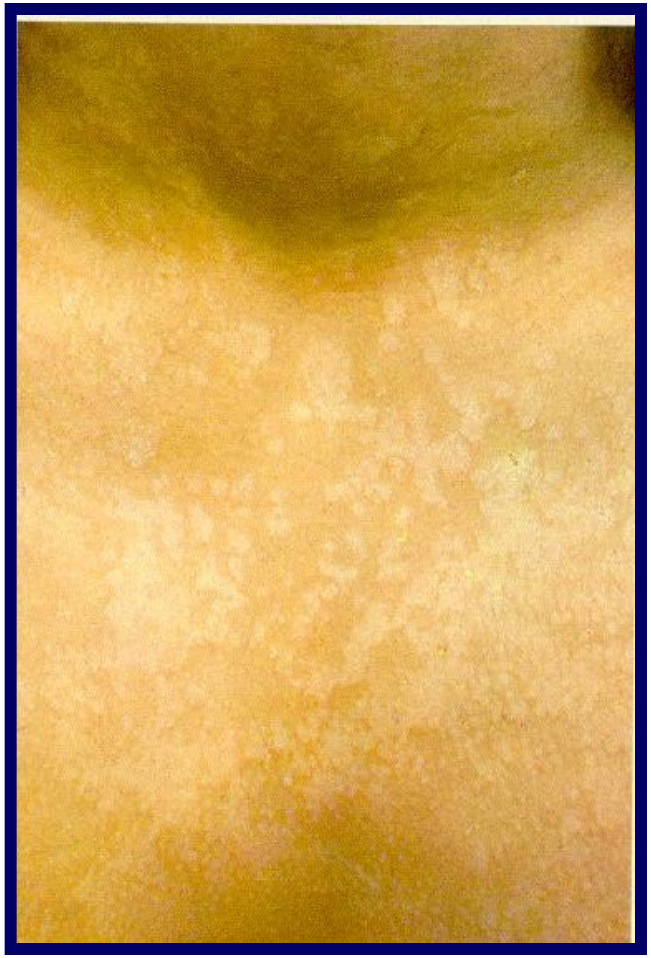
A symptomless, white slightly scaly eruption increased throughout 3 years over a man's trunk

Q1. What is it ?

Q2. What is the differential diagnosis ?

Q3. How would you treat it ?

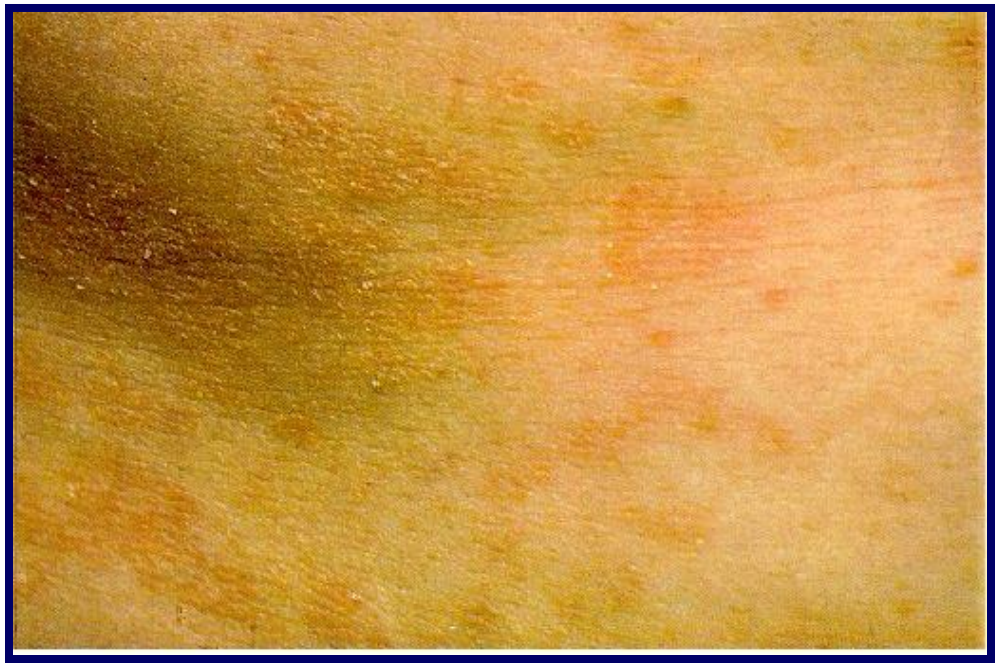
Pityriasis versicolor

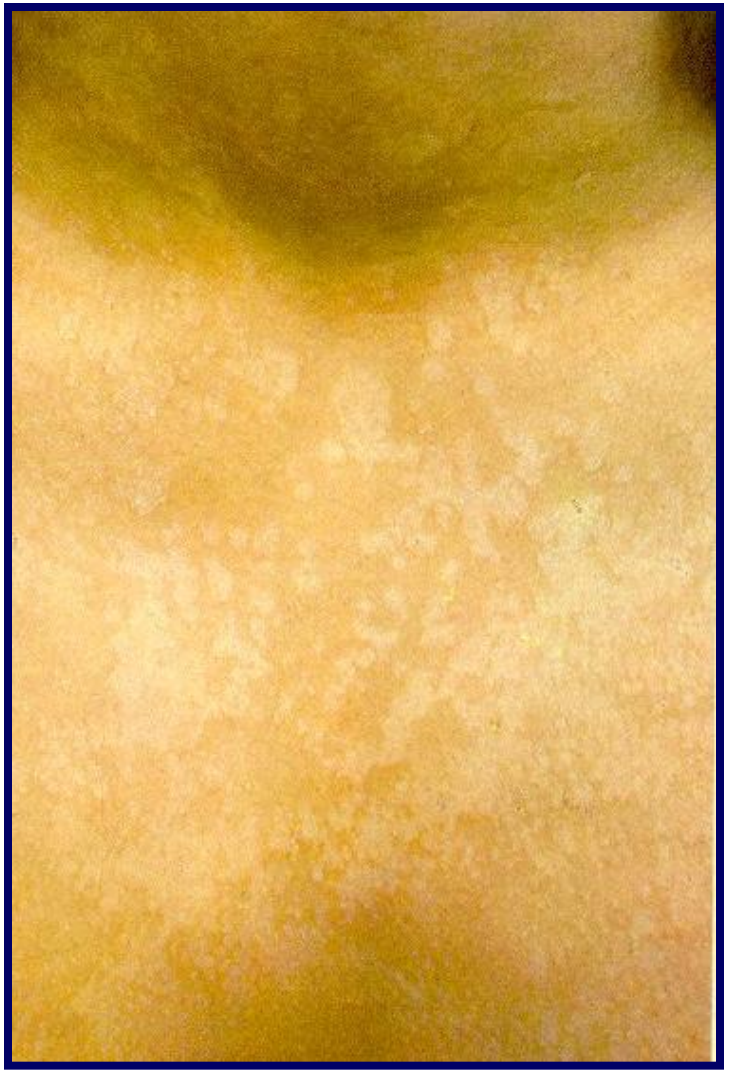


A2. It is not to he confused with vitiligo when this is usually total loss of skin melanin in affected areas.

A3. With topical agents e.g. benzoic acid compound ointment BPC(Whitfield's ointment), selenium sulphide lotion, creams or lotions of the imidazole group. None offers a permanent cure.

Pityriasis versicolor





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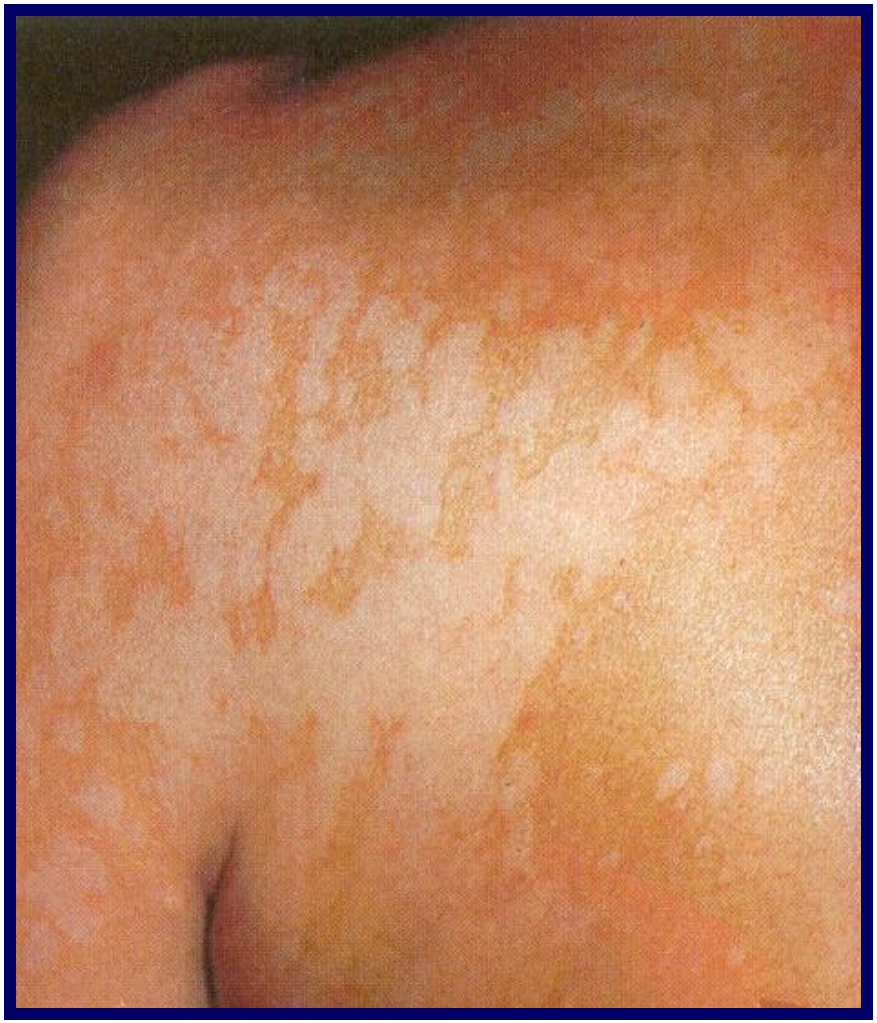


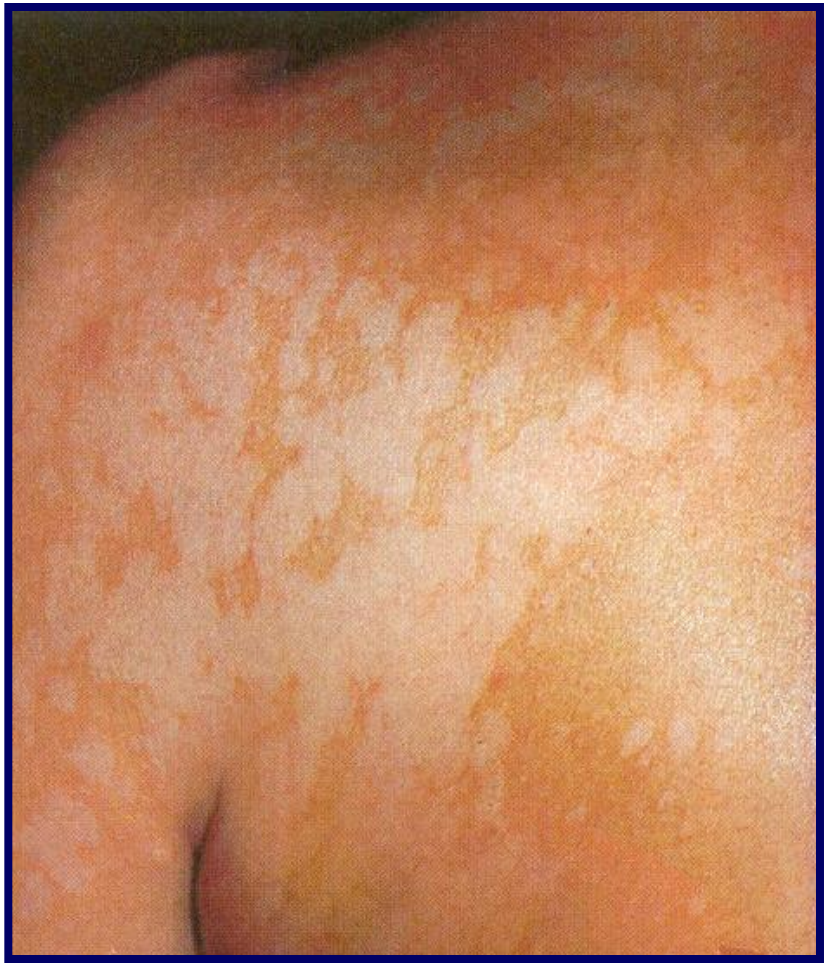
This is 22-year-old building laborer presented in September with white patches on his trunk.

Q1 What is the diagnosis?

Q2 Is the cause known?

Q3 Are any other conditions associated with this disorder?

Pityriasis versicolor



A2. Caused by pityrosporum yeast (or pityrosporm ovale-orbicalare)

A3. No other condition is associated with this disorder

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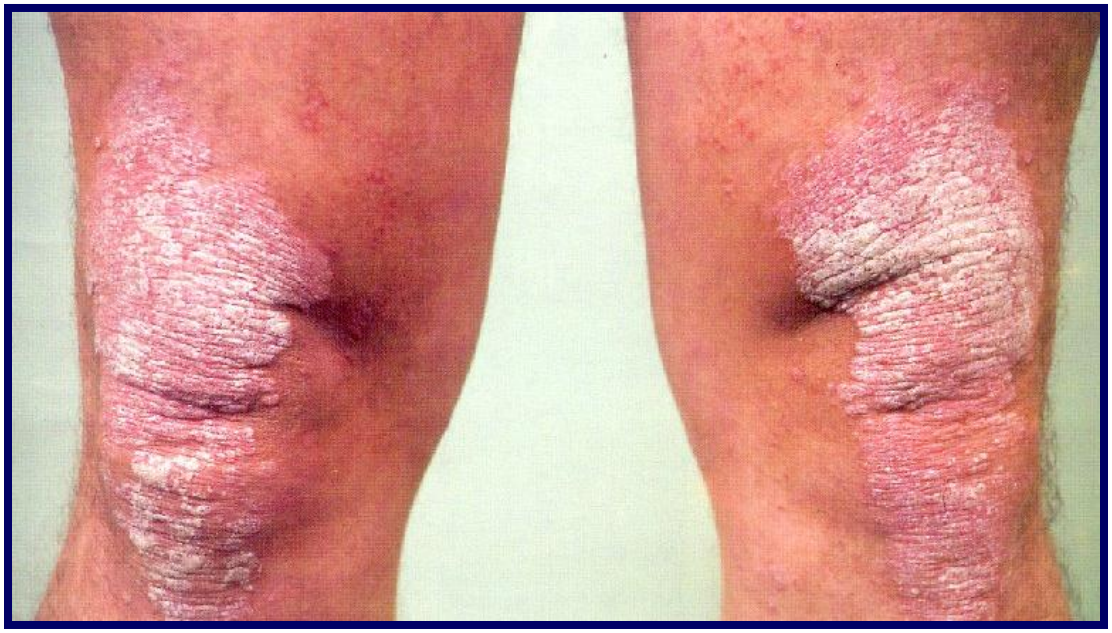


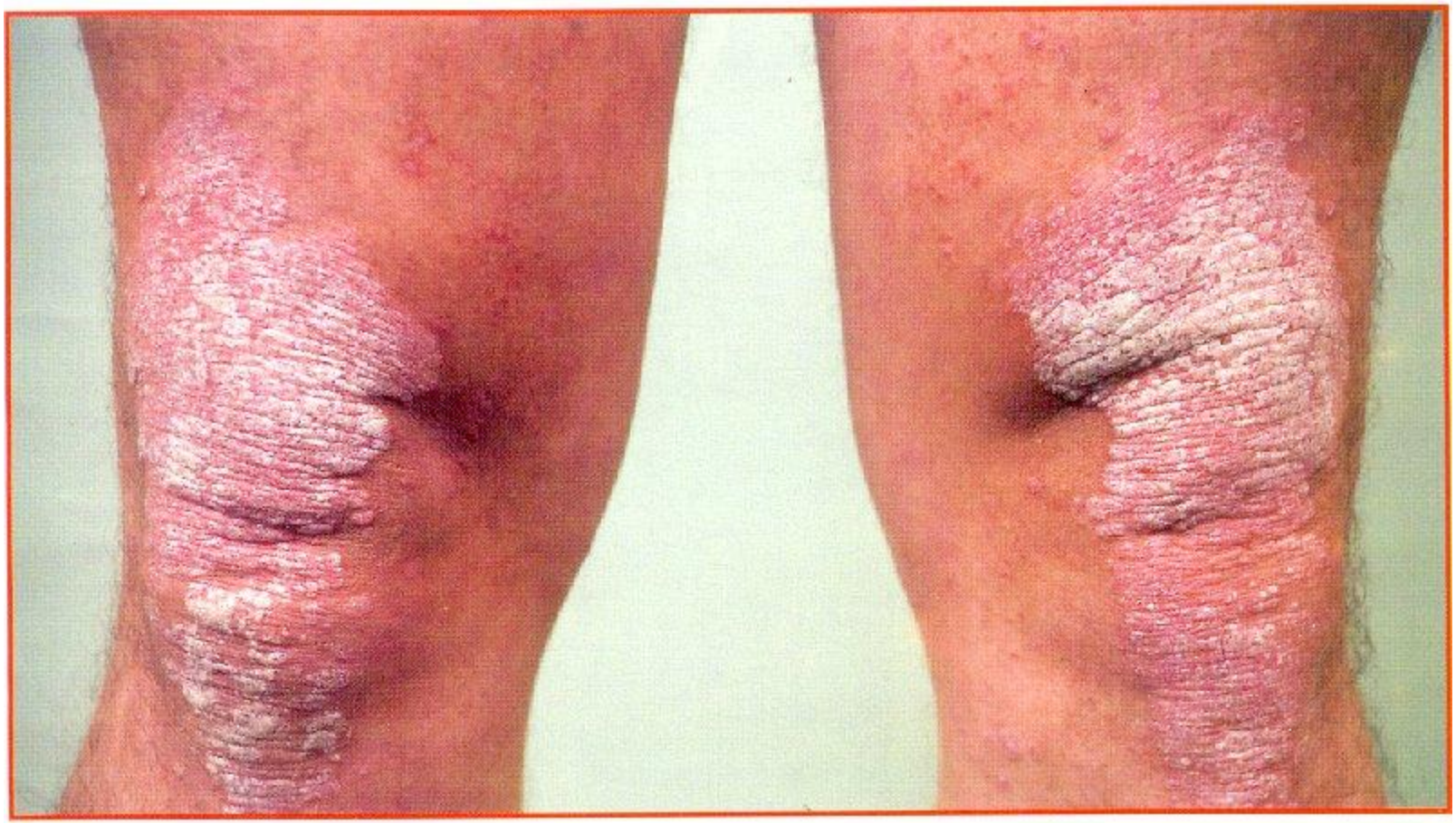
A 32-year-old woman presented with silvery plaques over the knees. The affected areas were not itchy but gentle removal of the scales caused pinpoint bleeding.

Q1. What is the diagnosis

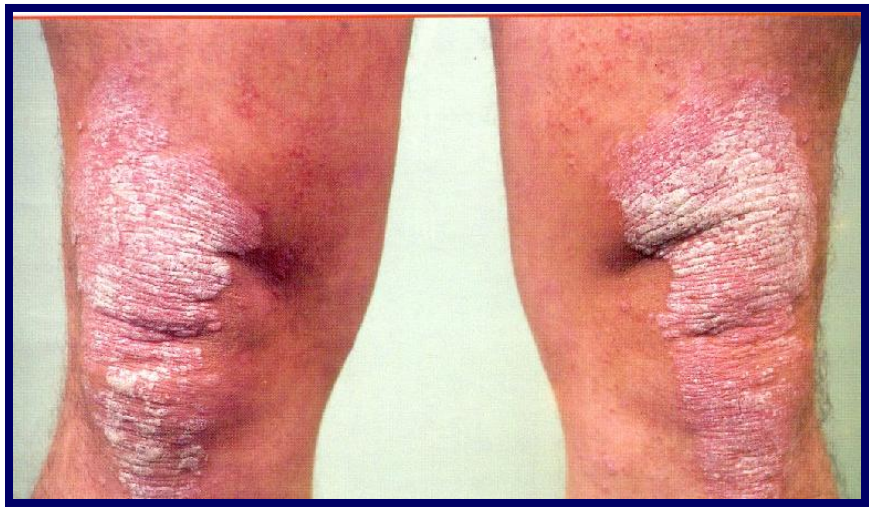
Q2. Where else should you look for lesions ?

Q3. With what may it he associated ?

Psoriasis



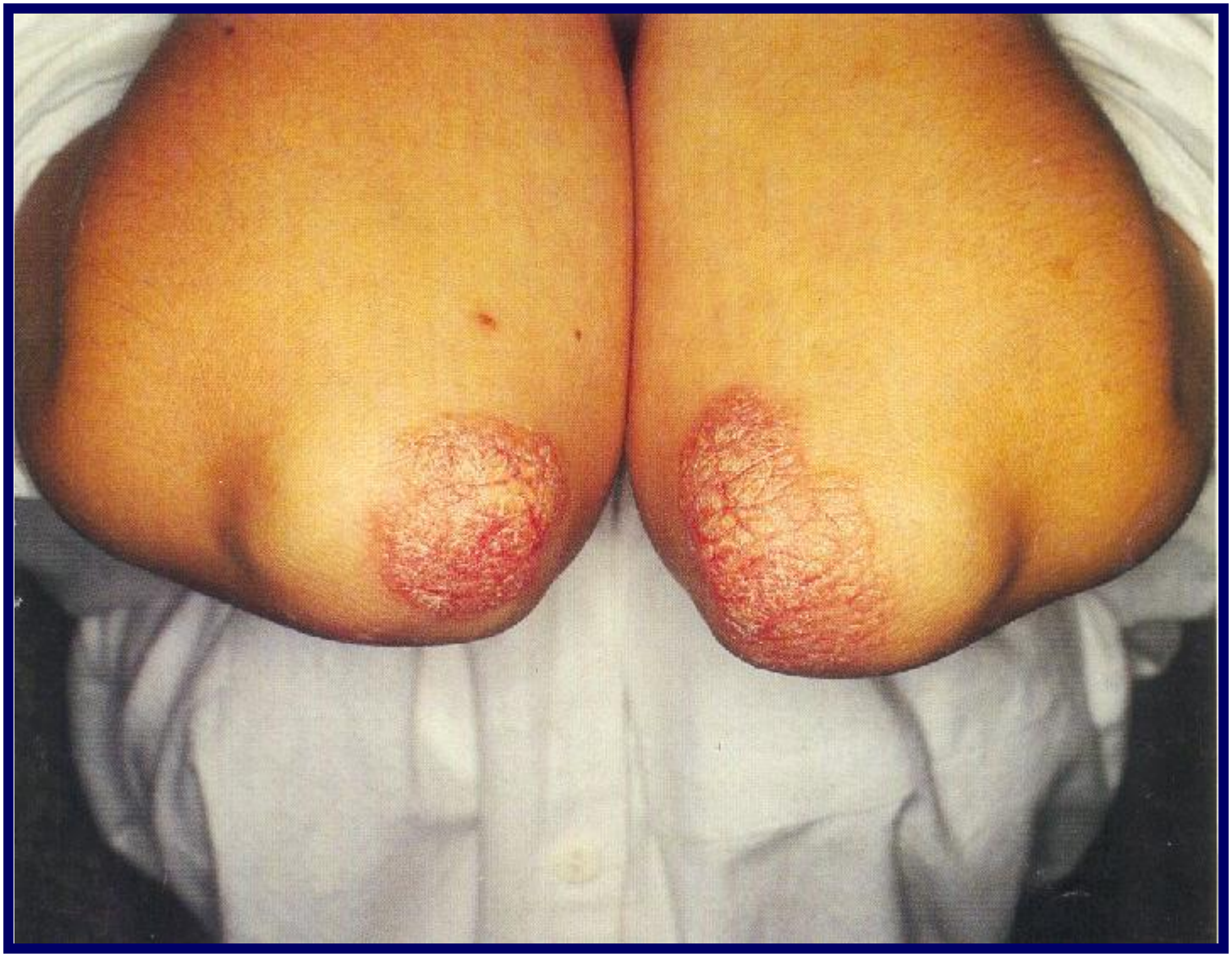
Psoriasis vulgaris



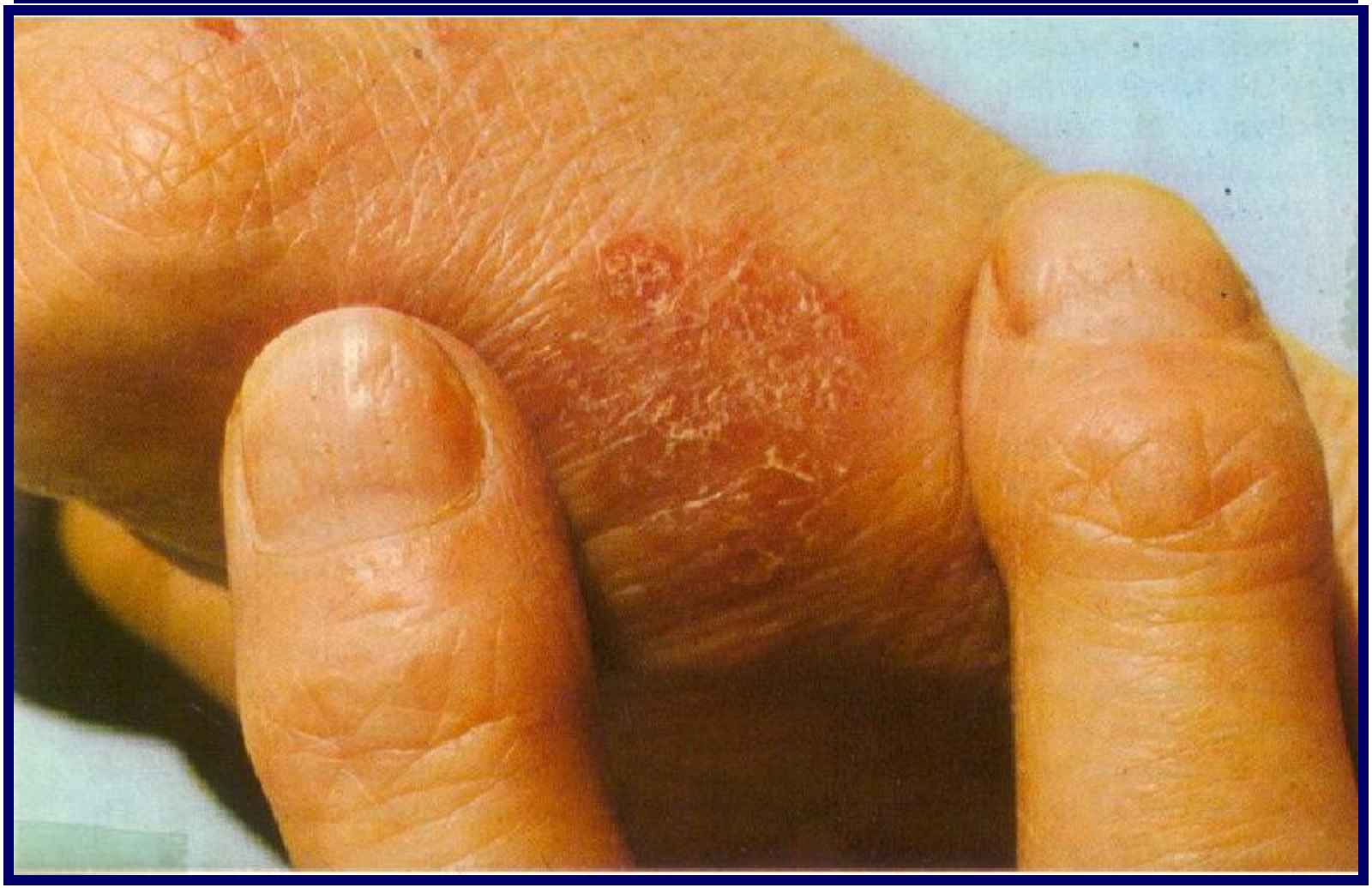
A.2 Scalp , nails , elbows , umbilicus , lower back and anogenital area.

A.3 Various form of arthropathy rheumatoid arthrtis like osteoarthritis- like affecting distal interphalangeal joints of the fingers, ankylosing spondylitis - like affecting sacro-iliac joints, arthritis mutilans.

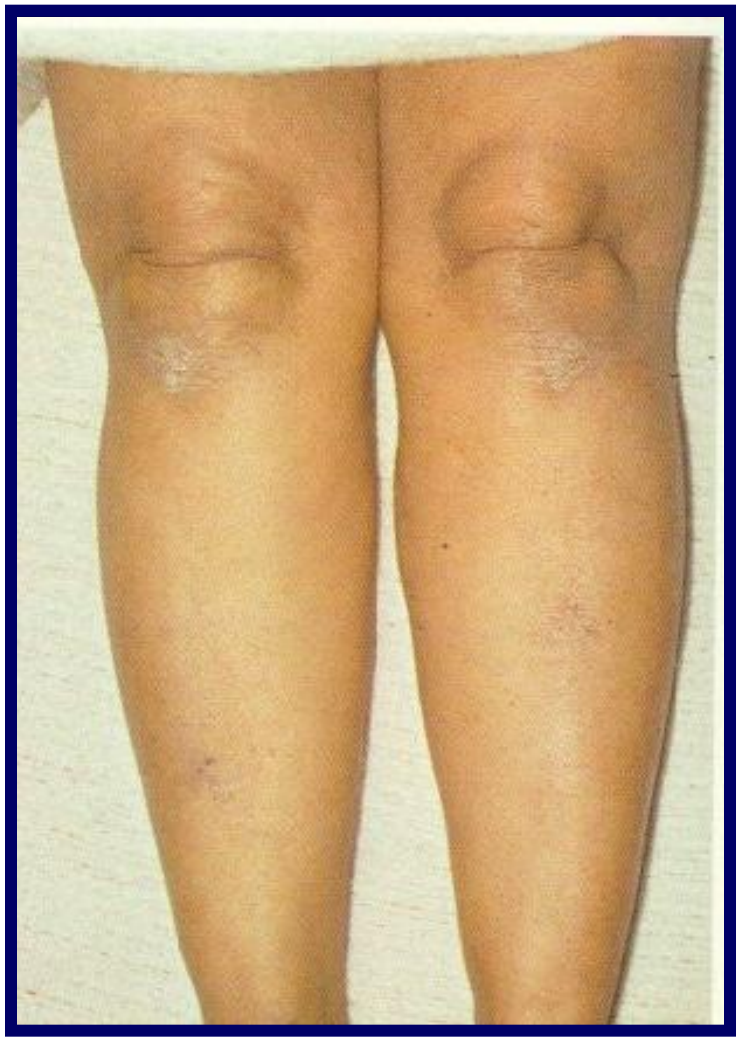
Pityriasis versicolor



Pityriasis versicolor

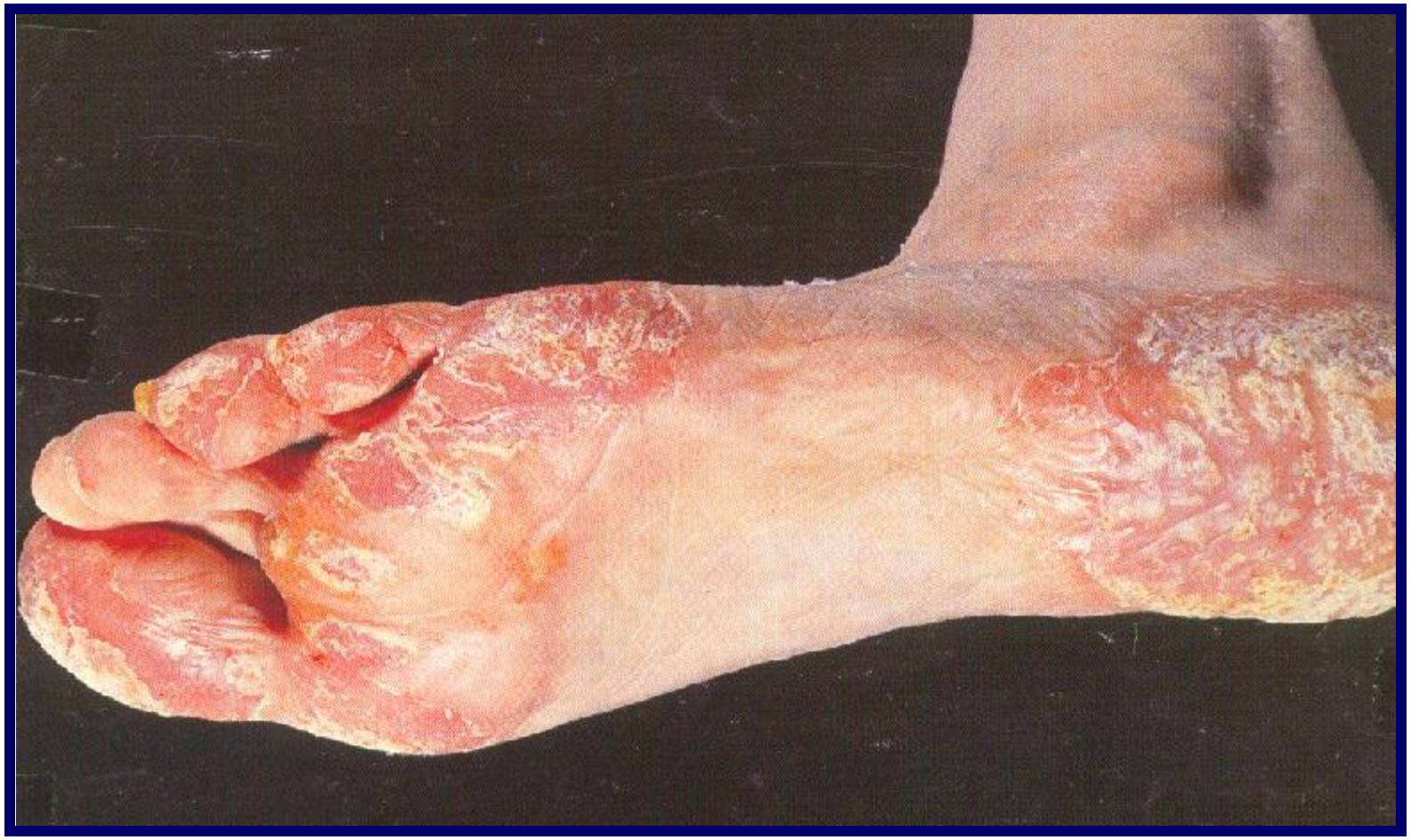


Calloused knee



The weight is carried on the tibial tuberosities when kneeling on hard stone floor. This must be differentiated from psoriasis which has a predilection for the knee

Psoriasis



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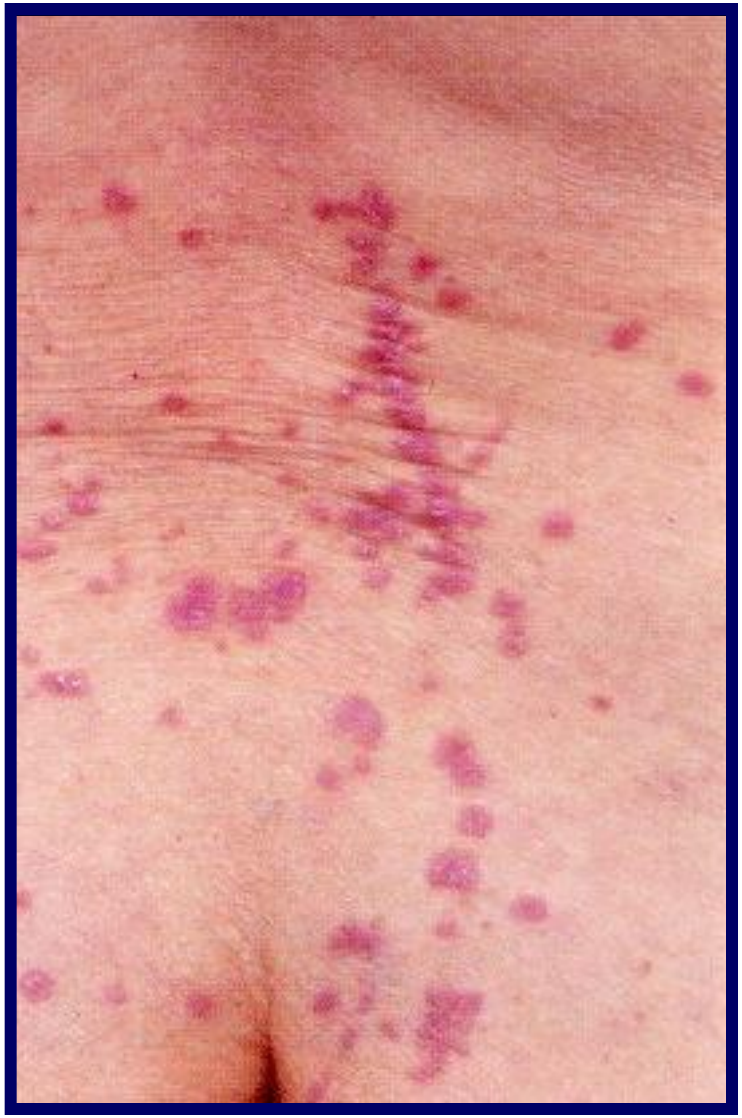
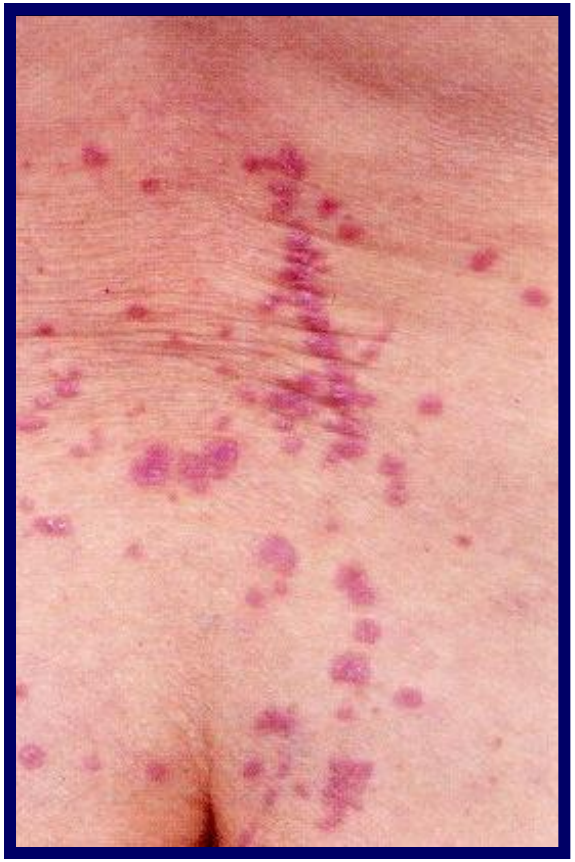
This man has lichen planus. During the course of the disease he developed a linear lesions in a scratch on his feet

Q1. What is this phenomenon called?

Q2. What other skin disorders may be have in this way

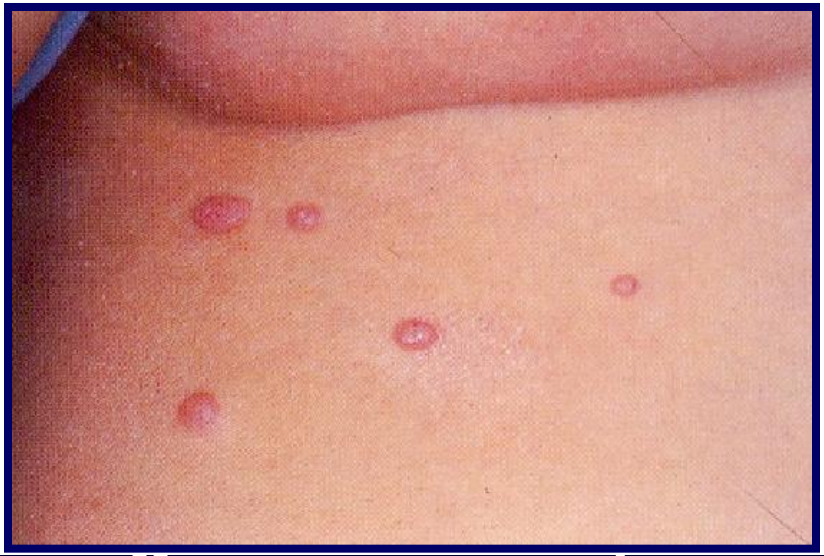


Koebner Phenomenon (or isomorphic)

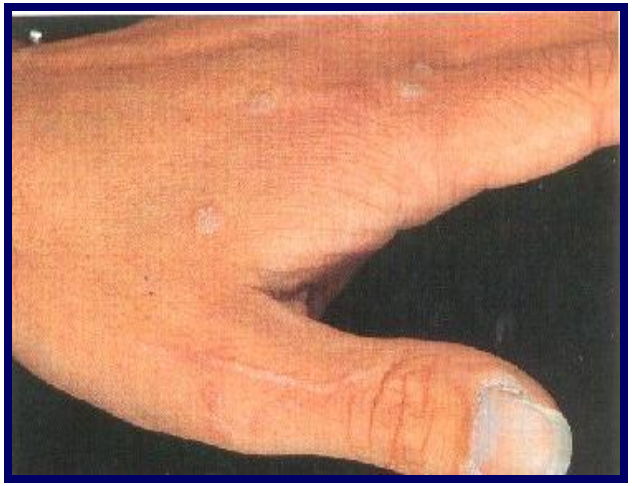


Other skin conditions:
Vitiligo, Warts & Molluscum contagiousa.

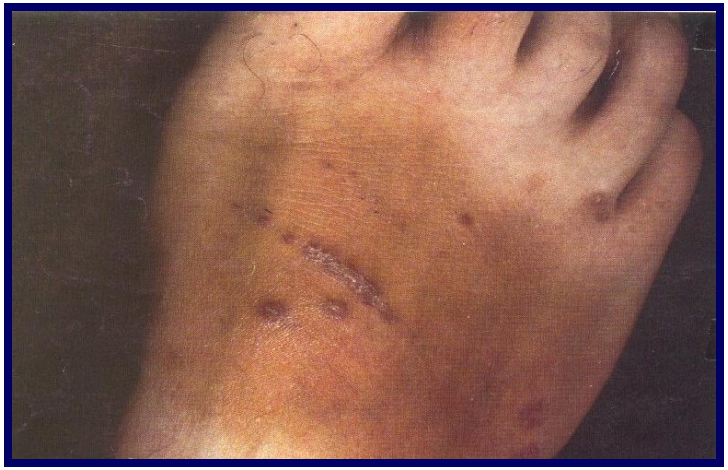
Koebner Phenomenon



Molluscum contagiosum

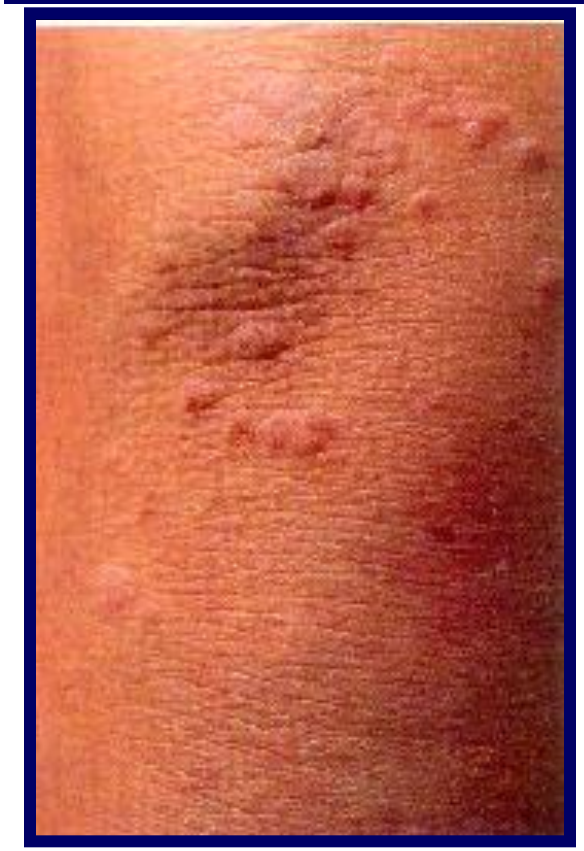


Planer warts

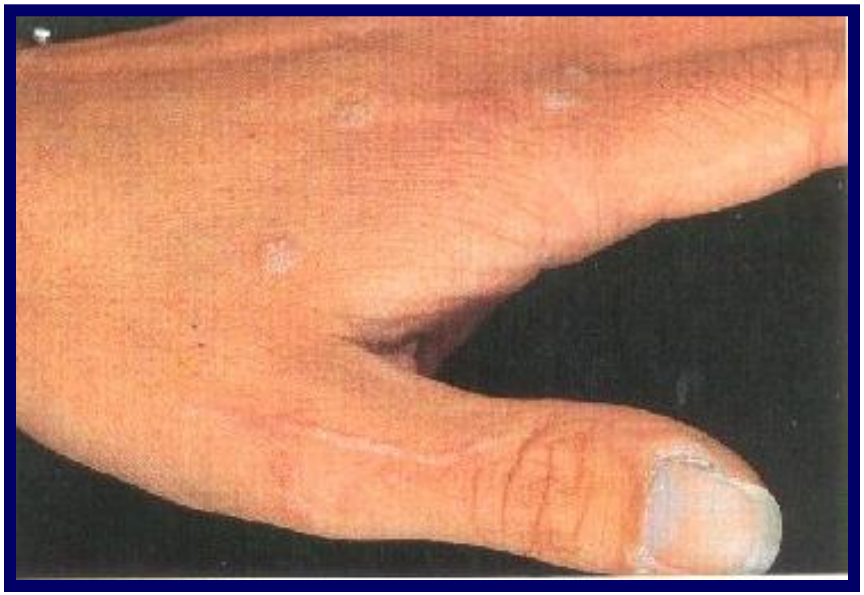


Psoriasis

Plane warts



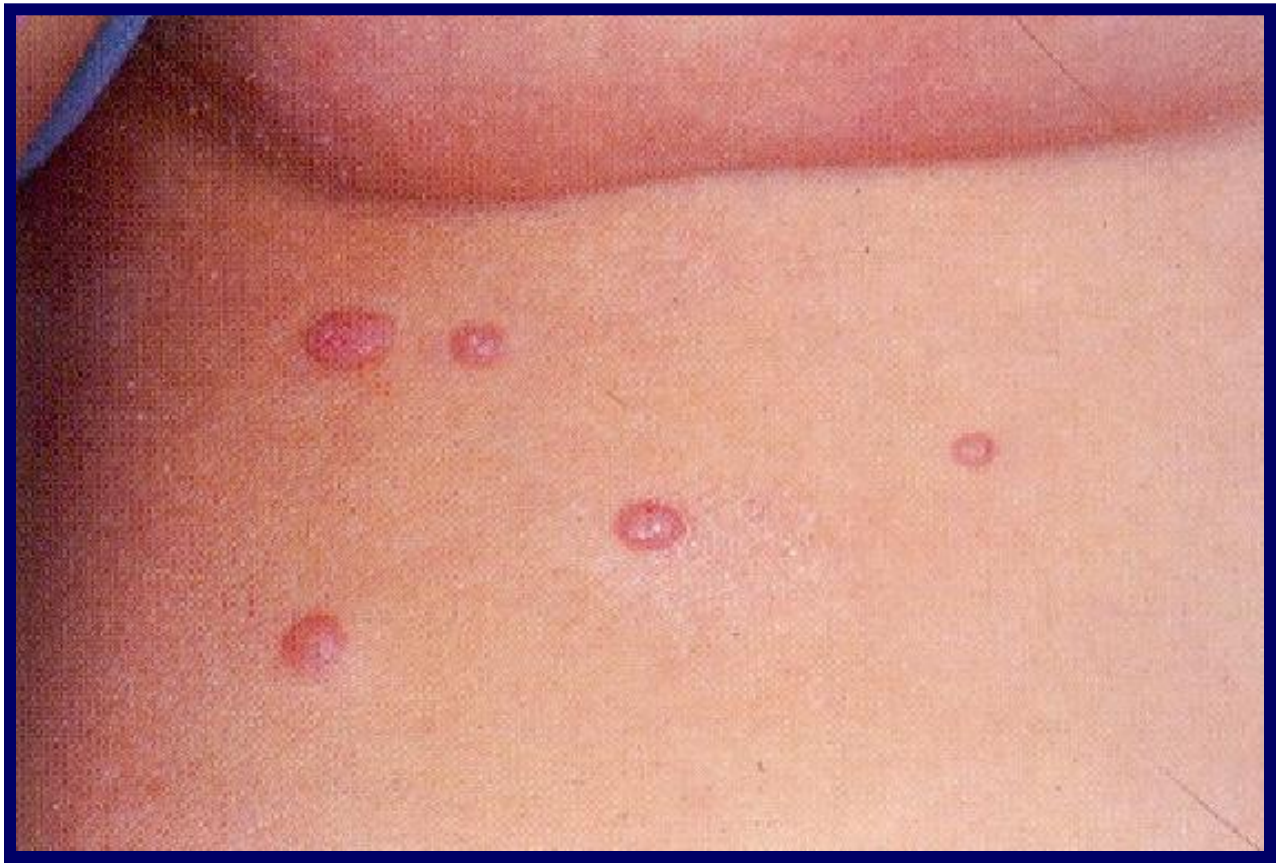
Plane warts.



Planer warts showing Koebner Phenomenon

Molluscum contagiosum

Koebner Phenomenon



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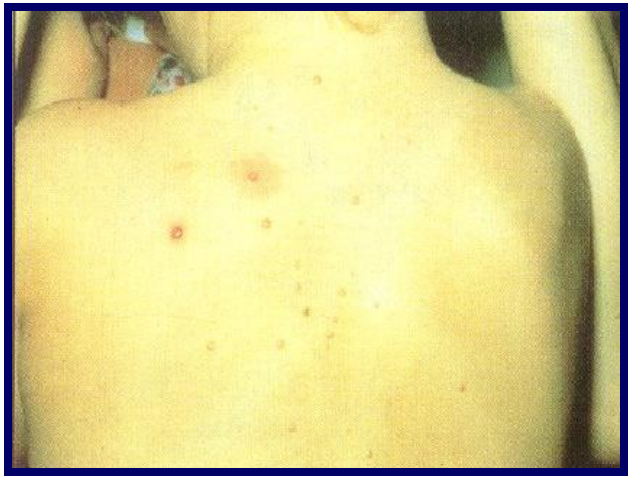
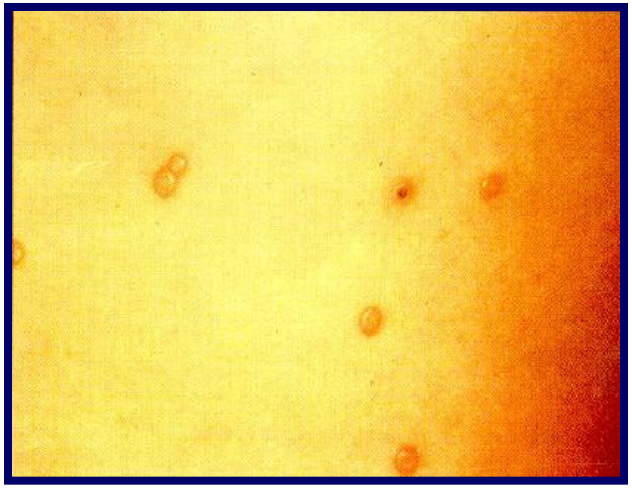




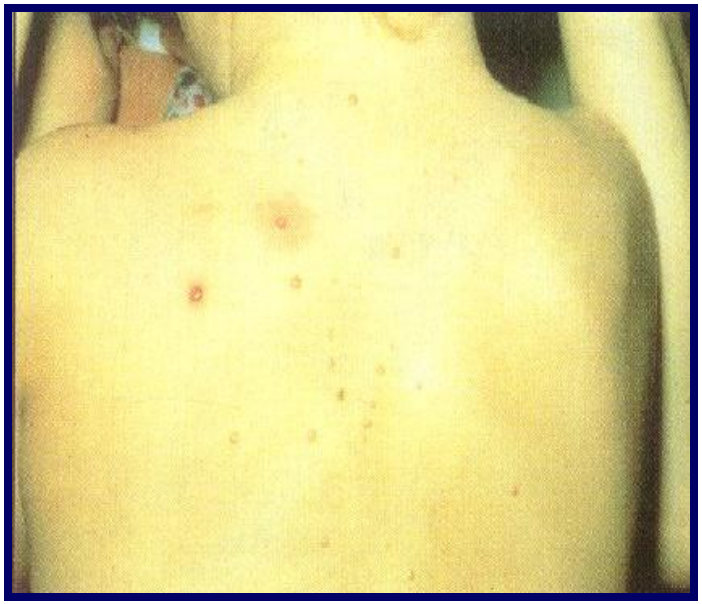
Nana 3 -year-old girl has asymptomatic papules on her trunk. The process had begun 2 months earlier as a single large lesion on her upper back. Soon thereafter, numerous clustered, flesh-colored, dome- shaped papules-some of which had a central dell-appeared over her scapula. Although each lesion appeared to be vesicular, no fluid could be aspirated. The asymmetric, clustered distribution of the lesions strongly suggested an external cause rather that a cutaneous eruption brought on by an internal derangement.

Q1. What is the diagnosis?

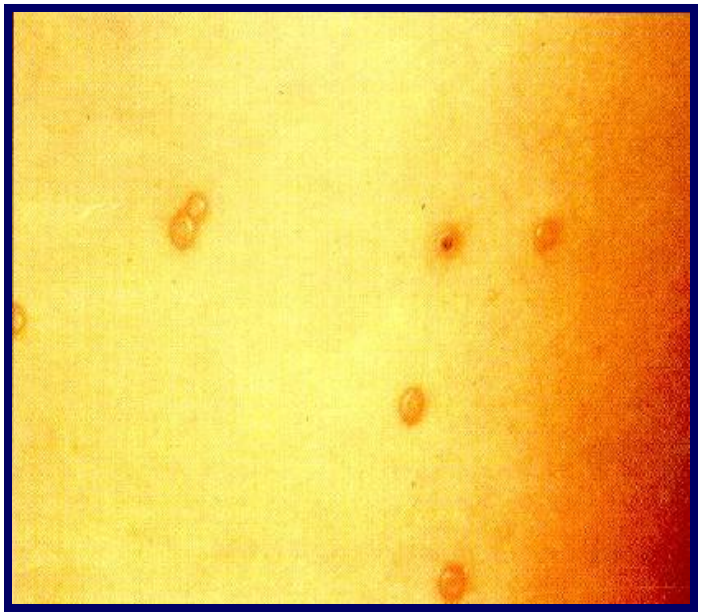
Q2. What is the differential diagnosis ?

Molluscum contagiosum

Differential possibilities include: Insect bites . Scabies . Warts .



These small papules- clustered over the scapula- began several weeks earlier as a single lesion



Flesh-colored, dome-shaped, cratered papules are a cutaneous manifestation of a DNA virus

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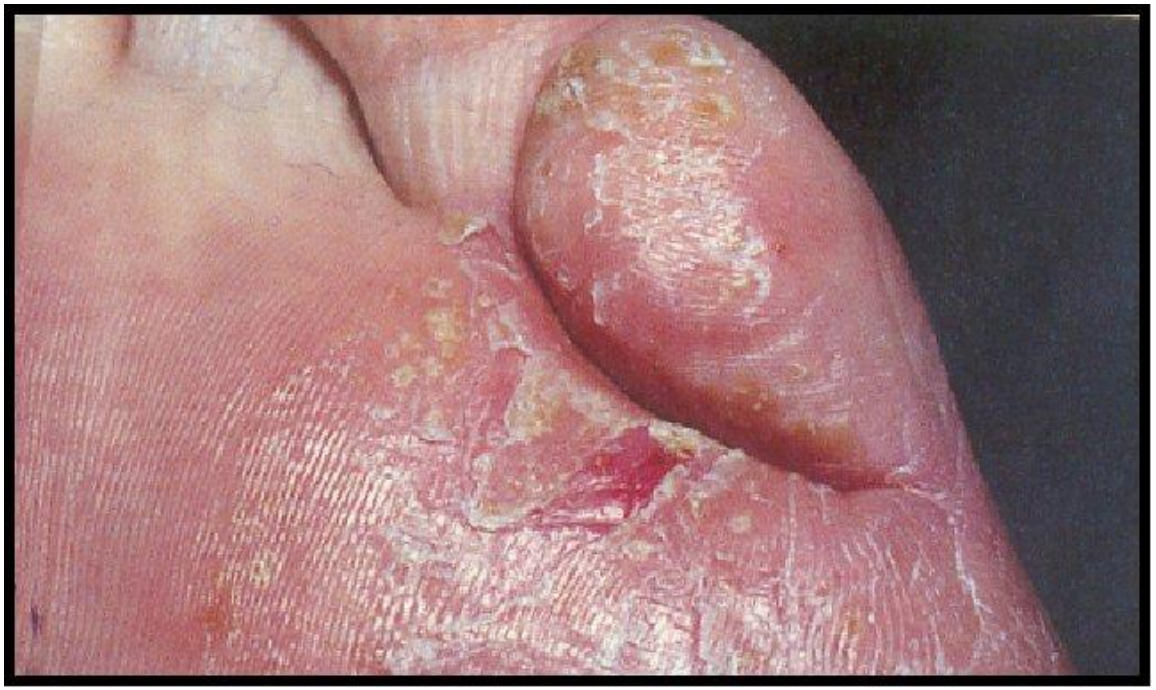


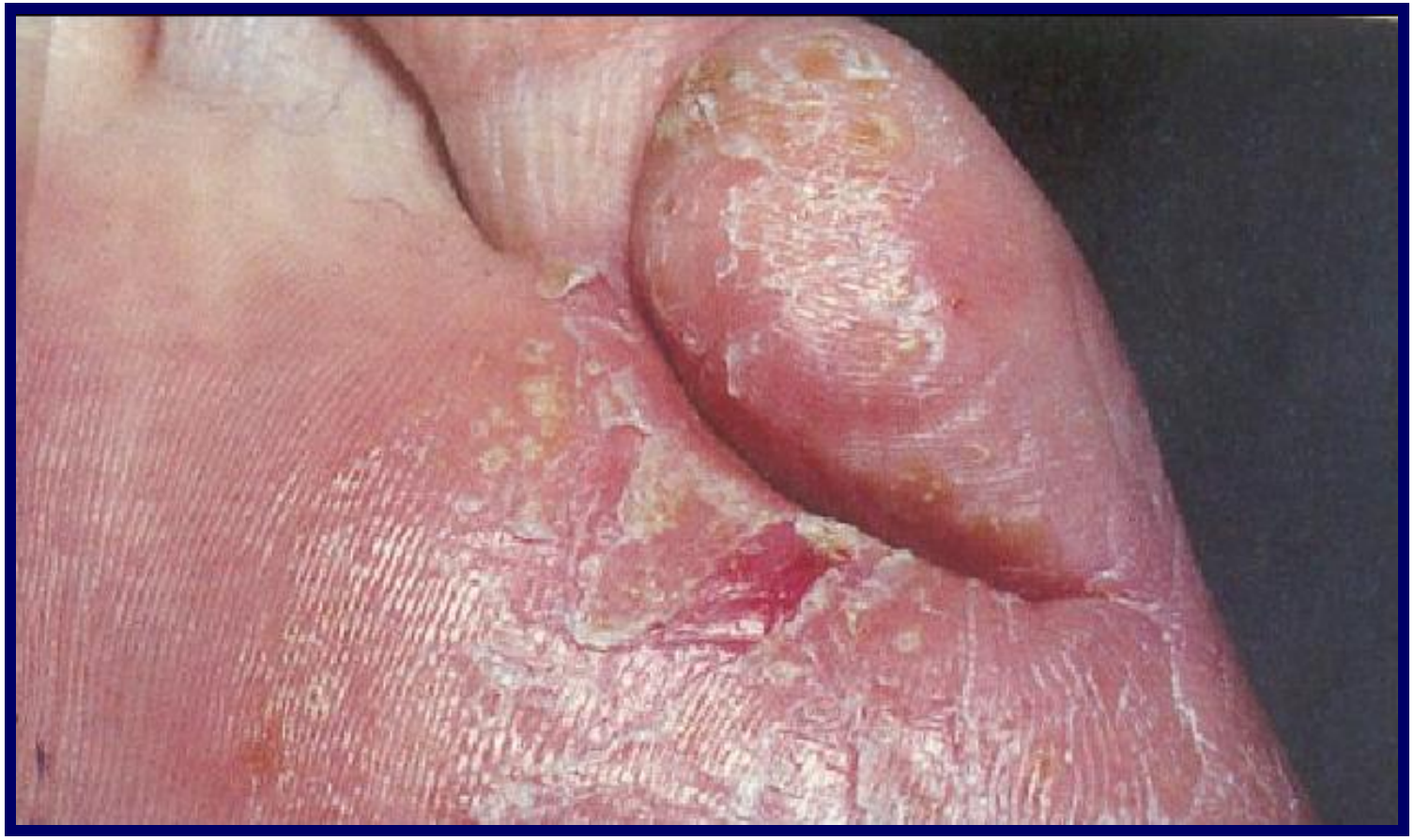
There is an itchy marginated scaly eruption on the foot.

Q.1 What is it?

Q.2 How does the infection arise, and what structures are involved ?

Q.3 What investigations are needed ?

Q.4 What is your management



Studies suggest that as many as 10 % of adults may have tinea pedis

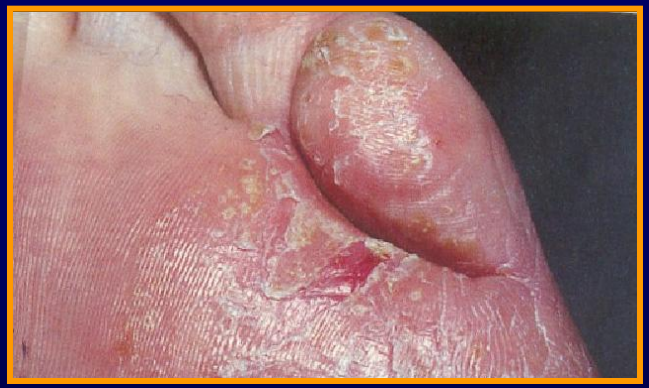
Tinea Pedis

A2. Minor trauma or occlusion of the skin is necessary for the initial invasion by the finger. Infection is confined to the stratum corneun.

A3. Microscopic examination and culture of skin scrapings to demonstrate and identify the fungus.

A4. General Measures :

- Light, loose and non-occlusive footwear.
- Drying and application of talcum powder.
- Reduce sweating.
- Drying agents
- Antimicrobial agents - Antifungal BD
- Combined antifungal with neomycin.



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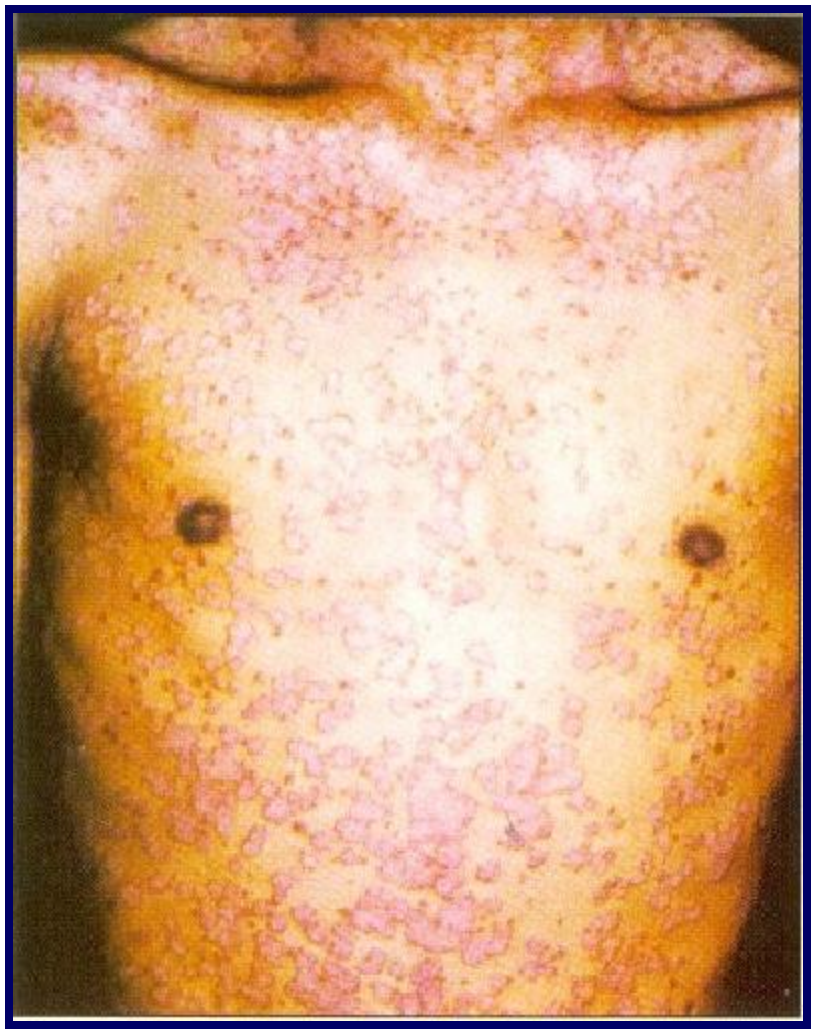


This 18-year-old man presented with erythematous, maculo-papular, dry and scaly eruptions all over his body which had been present for 5 days. The cutaneous lesions appeared about 10 days after a sore throat.

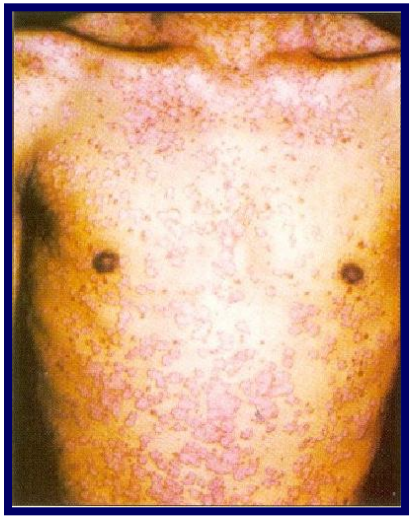
Q1. What is the diagnosis?

Q2. Is there any association between throat infection and this skin disorder?

Q3. What is the prognosis?

Q4. What is the treatment?

Acute guttate psoriasis.



A2. Yes. There is a strong association between streptococcal pharyngitis and widespread and sudden onset of guttate psoriasis.

A3. Good. Guttate psoriasis is usually self-limiting.

A4. Treatment is diverse but suppressive, since there is no cure yet available. Aggressive treatment is not indicated. Tar in low concentrations and ultraviolet B radiation are helpful. A course of oral penicillin or erythromycin can be given if there is bacteriological evidence of streptococcal throat infection.

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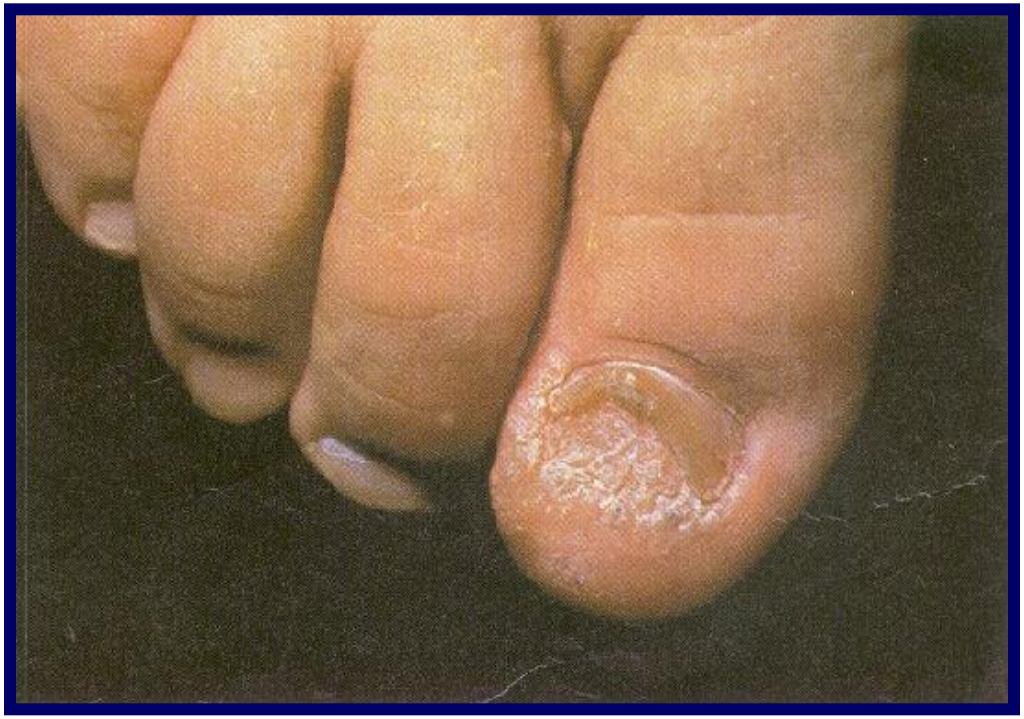
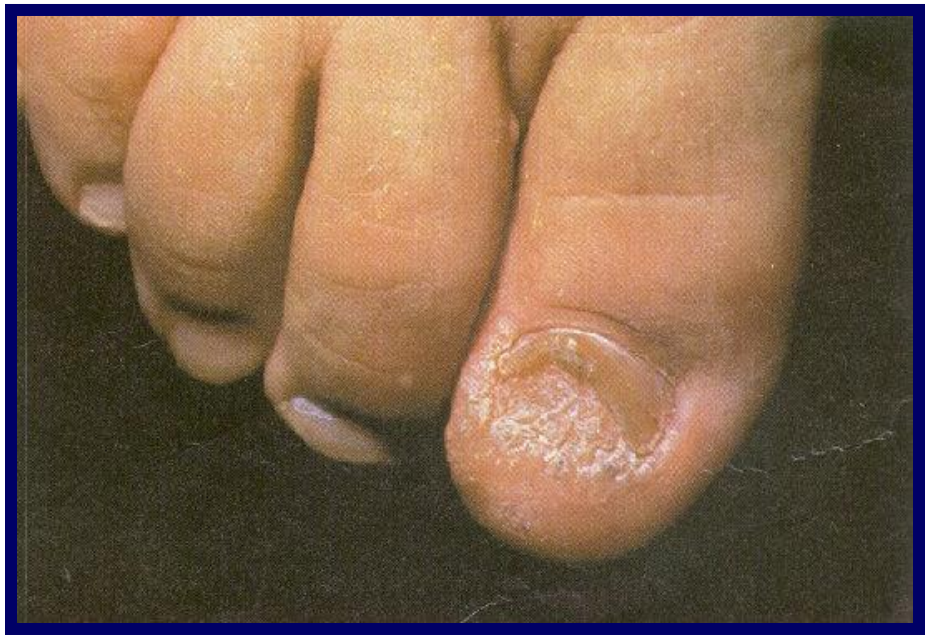


Q1. Describe the lesion

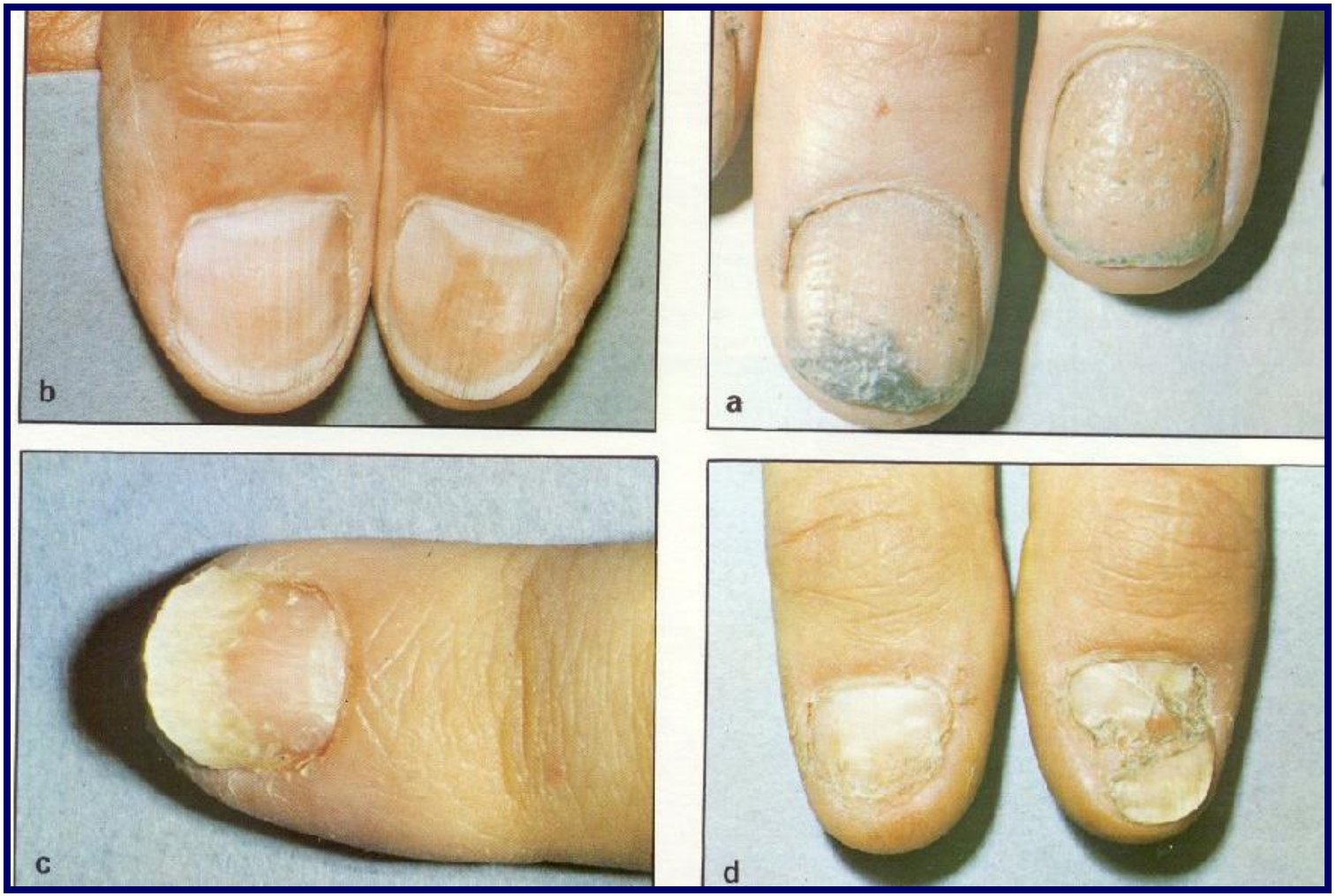
Q2. What is your deferential diagnosis?



A1. The great toenail has been gradually changing
It's markedly dystrophic, with distal splitting of the nail plate

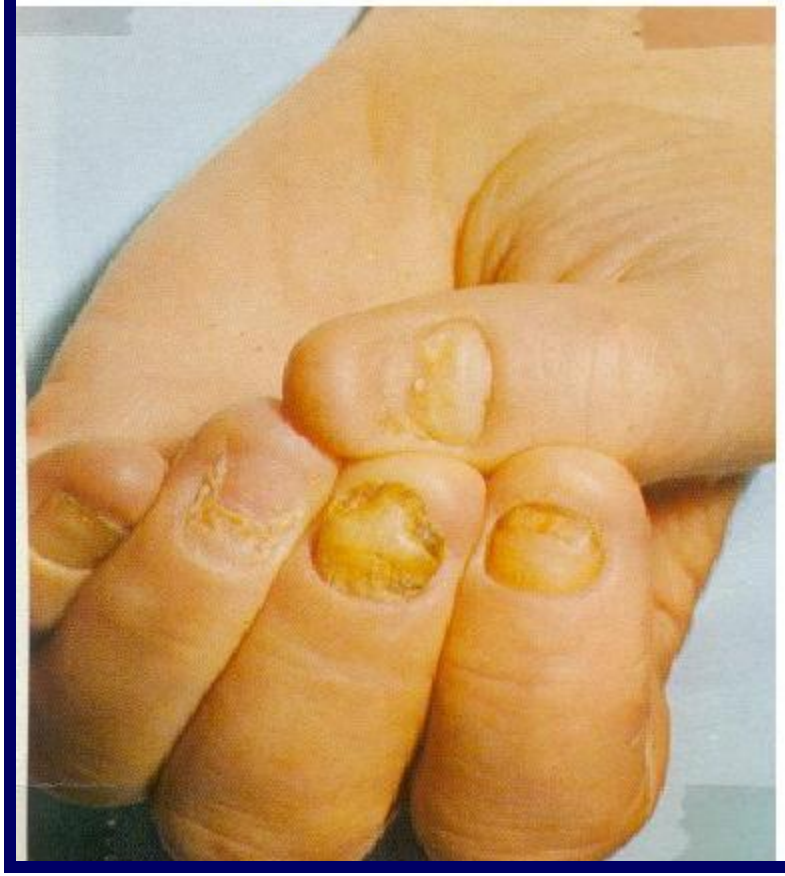
A2. Differential diagnosis:

Psoriasis
Lichen planus
Subunguanal tumors
Onychomycosis
(fungal nail infection)

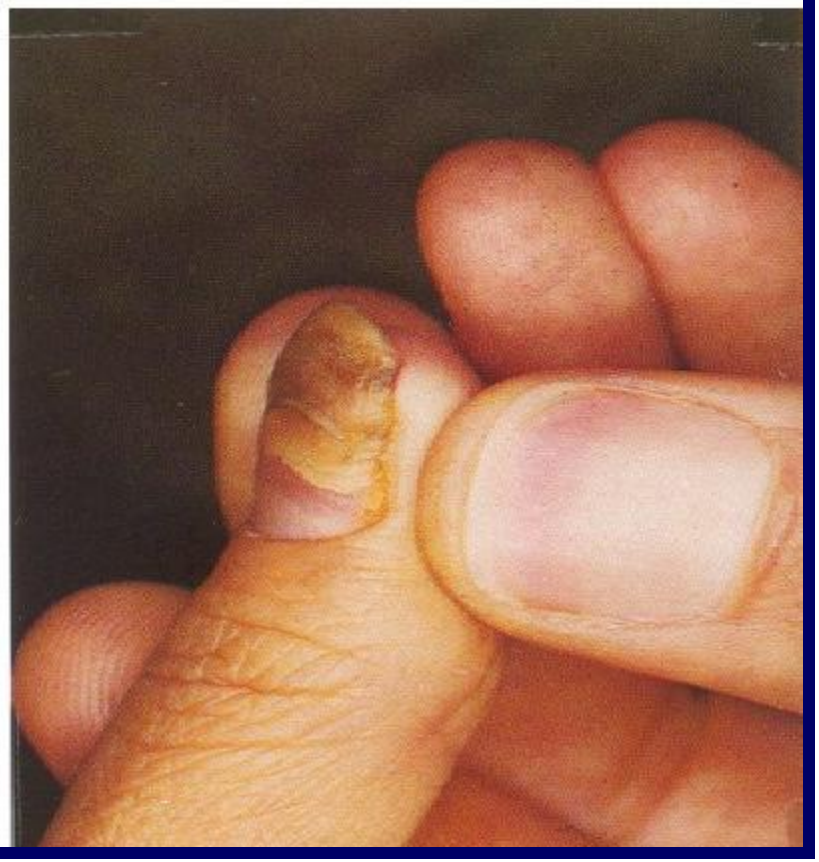


Psoriasis of nails (a) Oil-drop appearance. (b) Pitting and onycholysis. (c) Subungual keratosis. (d) Distortion of whole nail.

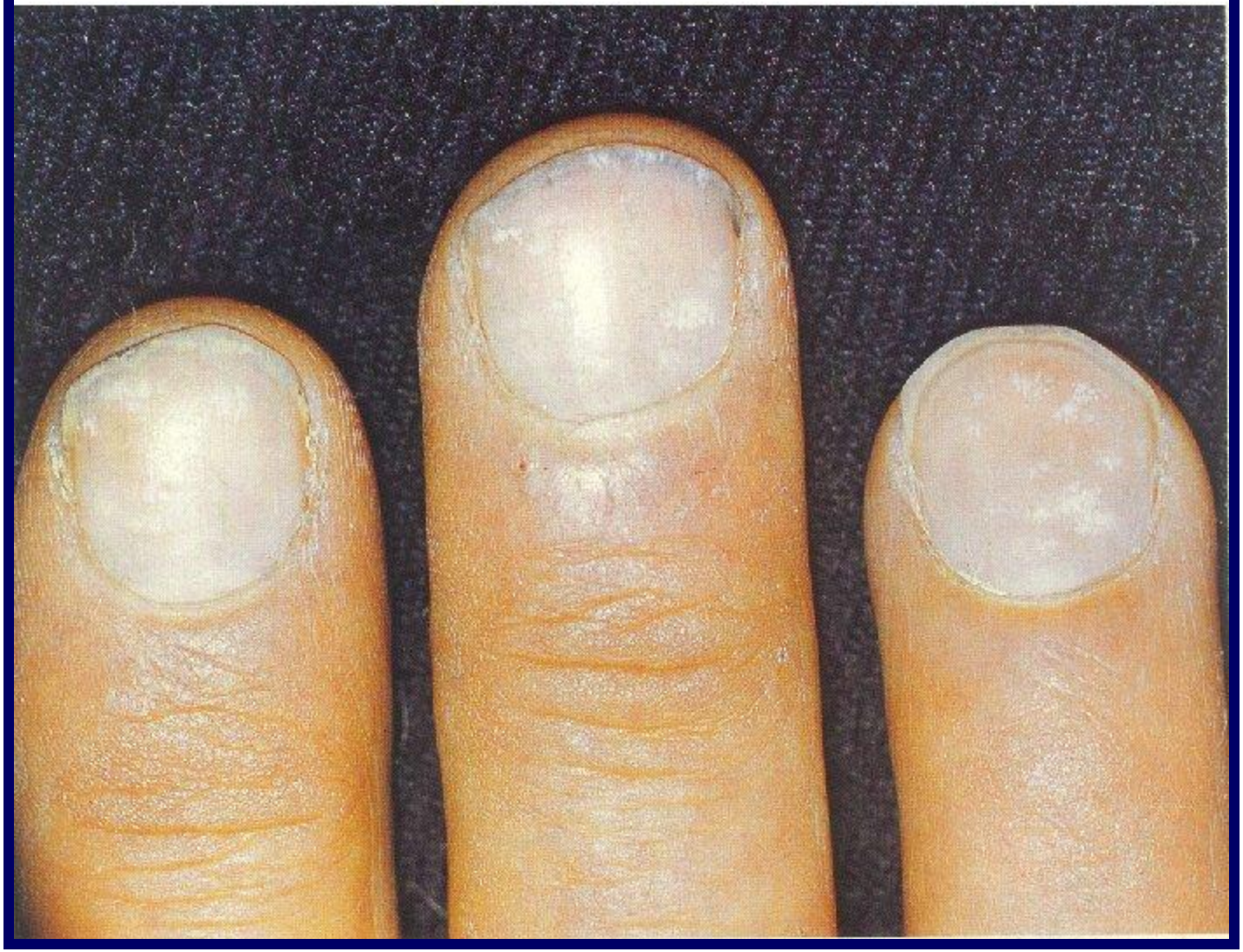
Pitting on the nail



Onycholysis



Leuconychia totalis



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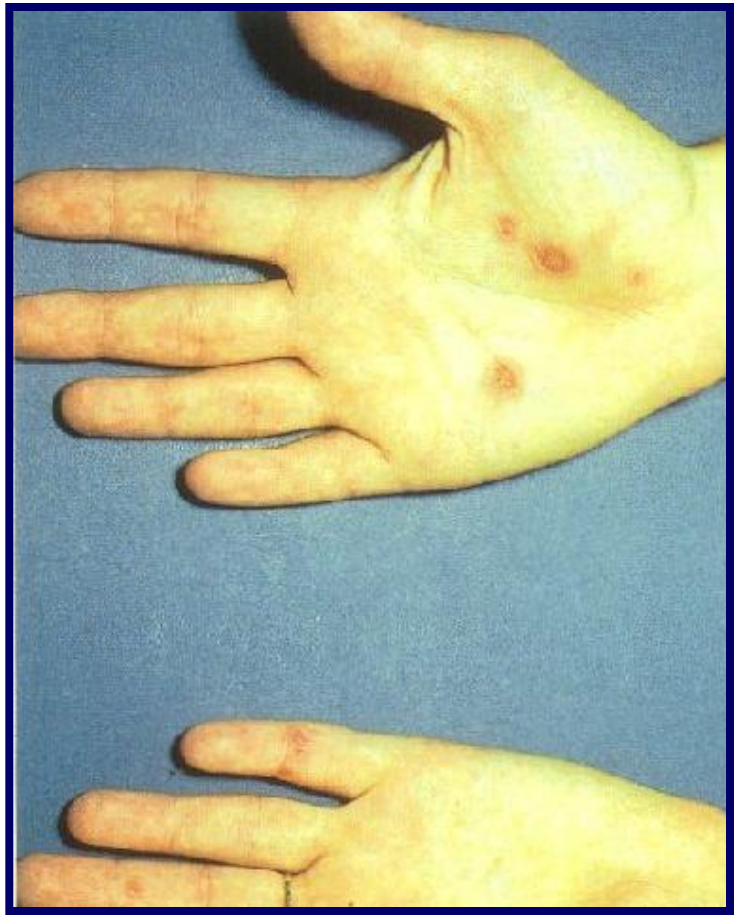
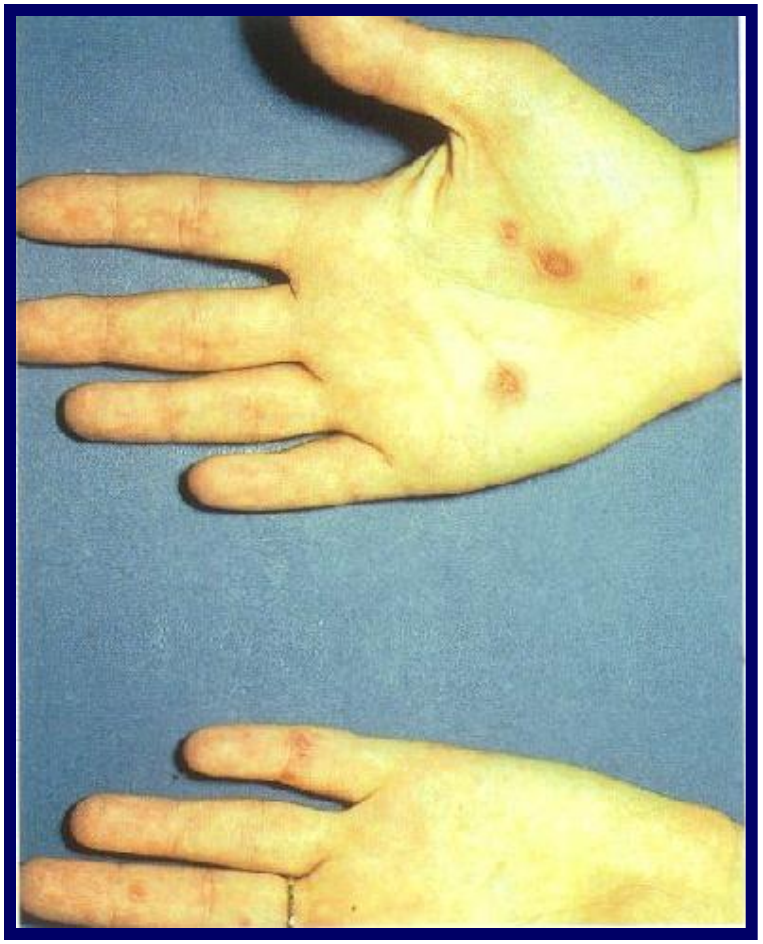


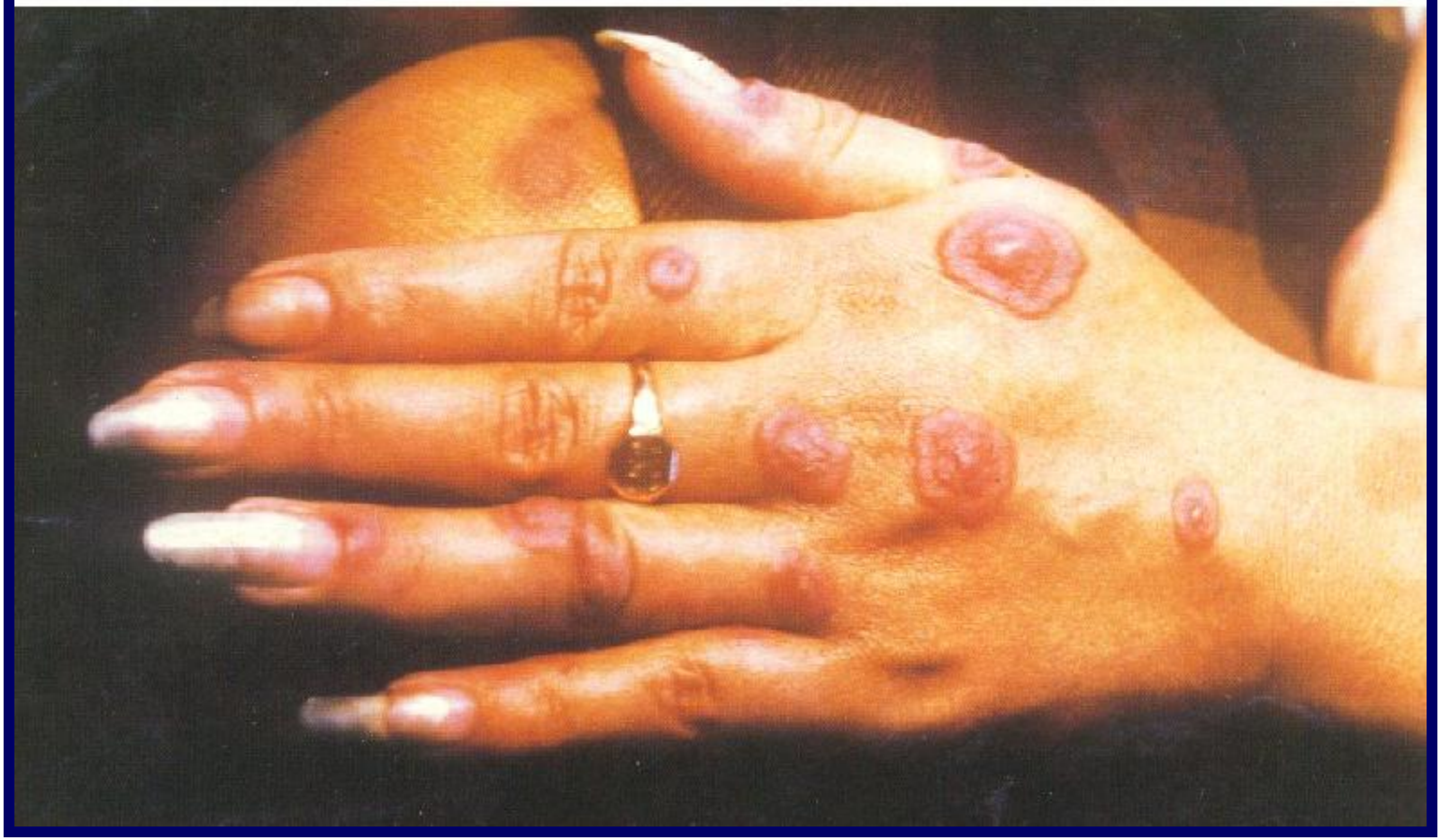
This woman aged 25 had been treated for ulcerative colitis for approximately three weeks with steroid enema and sulphalazine.

Q. What are the lesions on her hands.

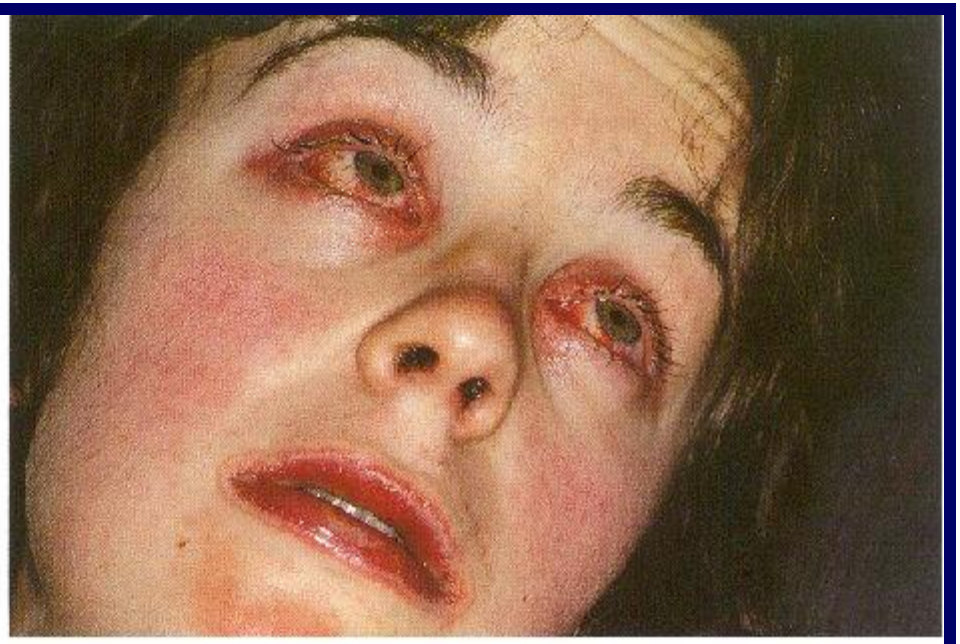
Erythema Multiforme

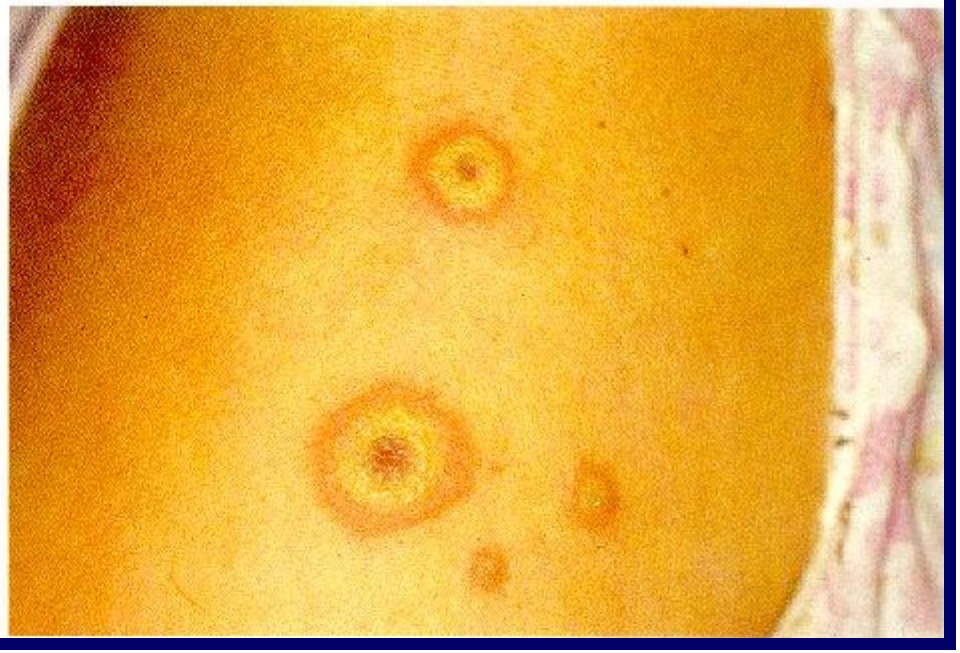


Erythema Multiforme with "bulls eye" target lesions

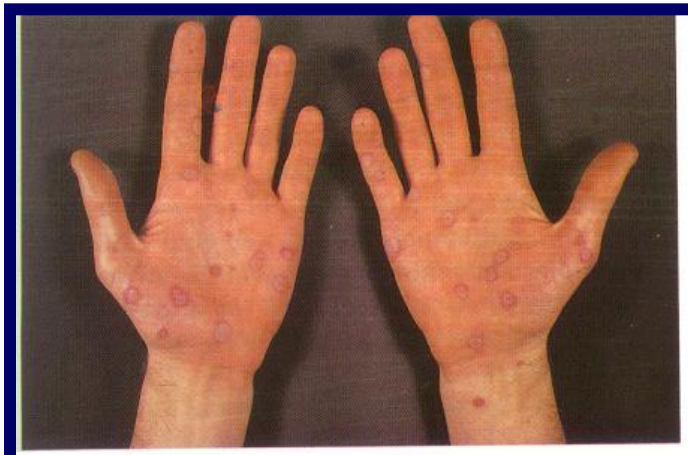


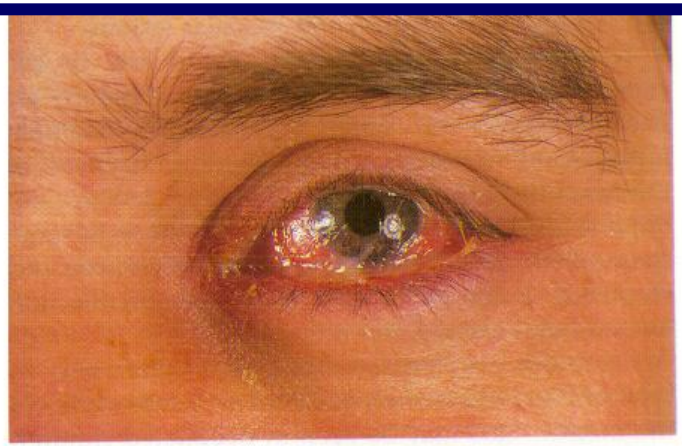
Steven-Johnson syndrome

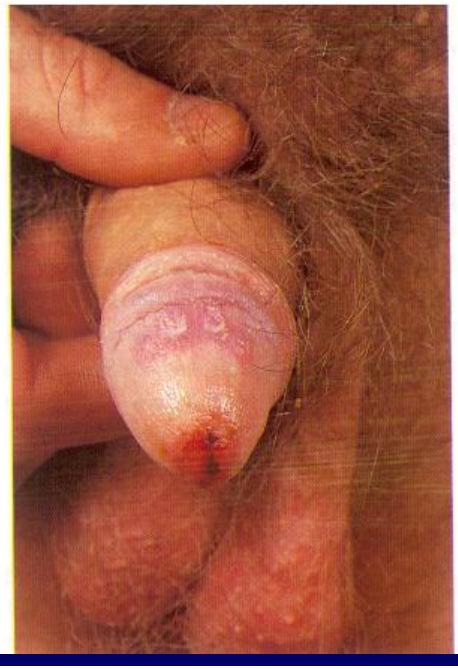


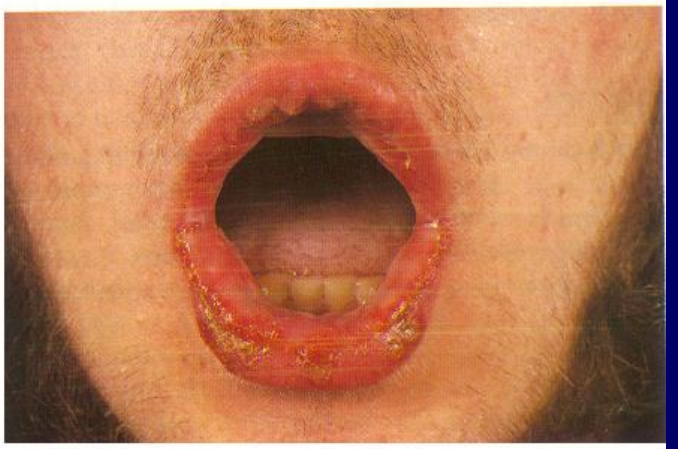


Steven-Johnson Syndrome







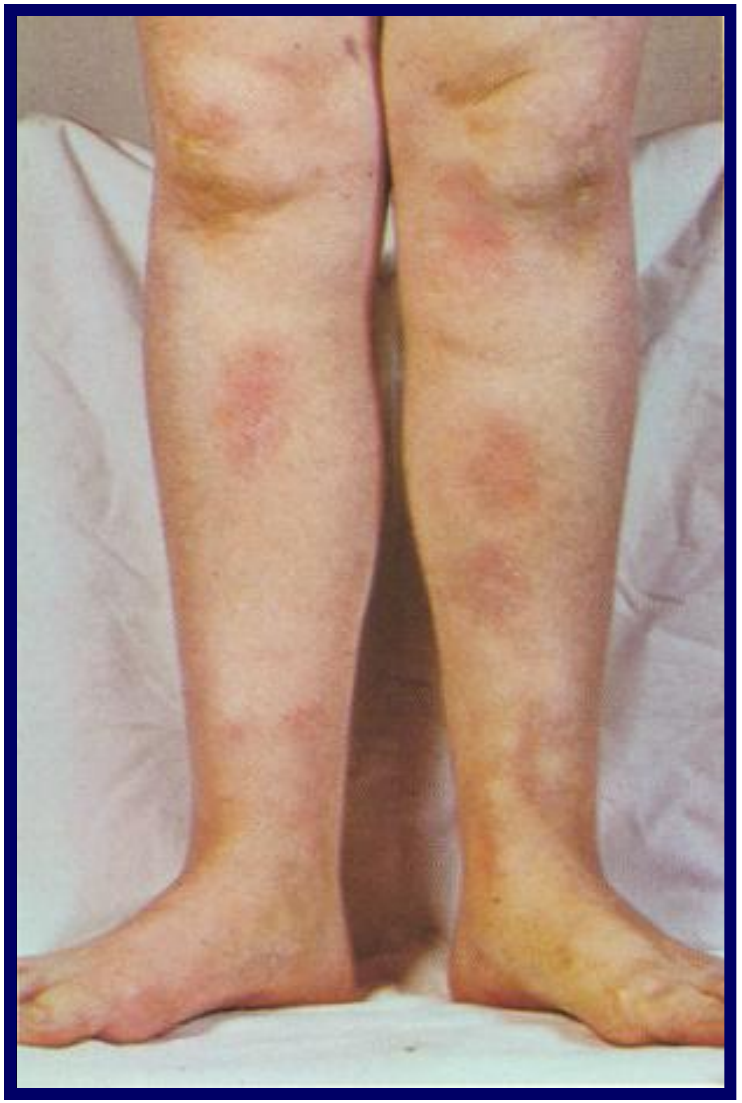


15

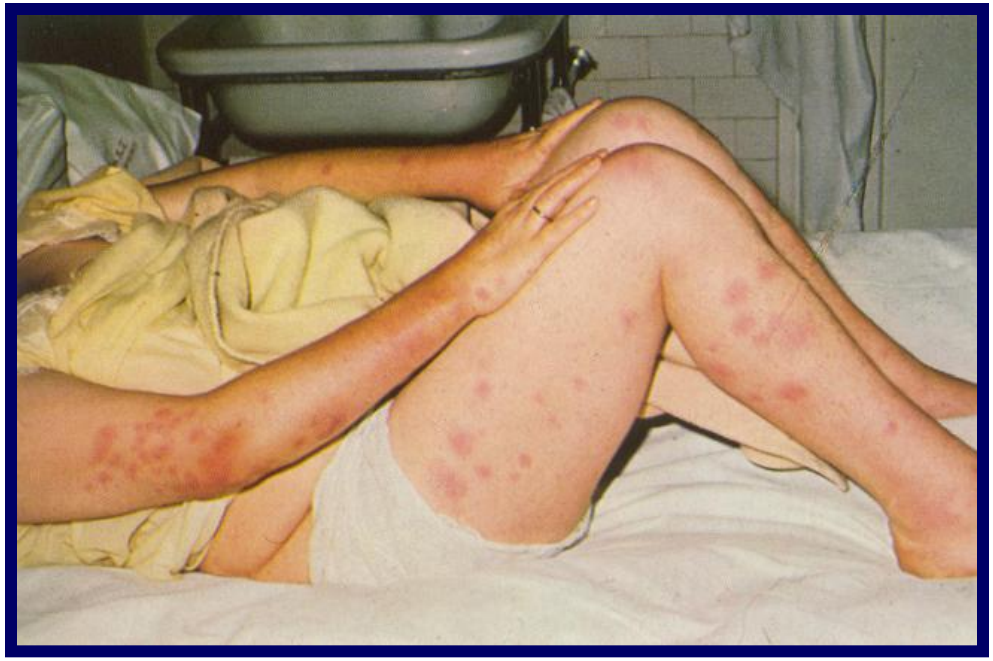
A young lady had a 10 days history of tender red lumps on the legs.

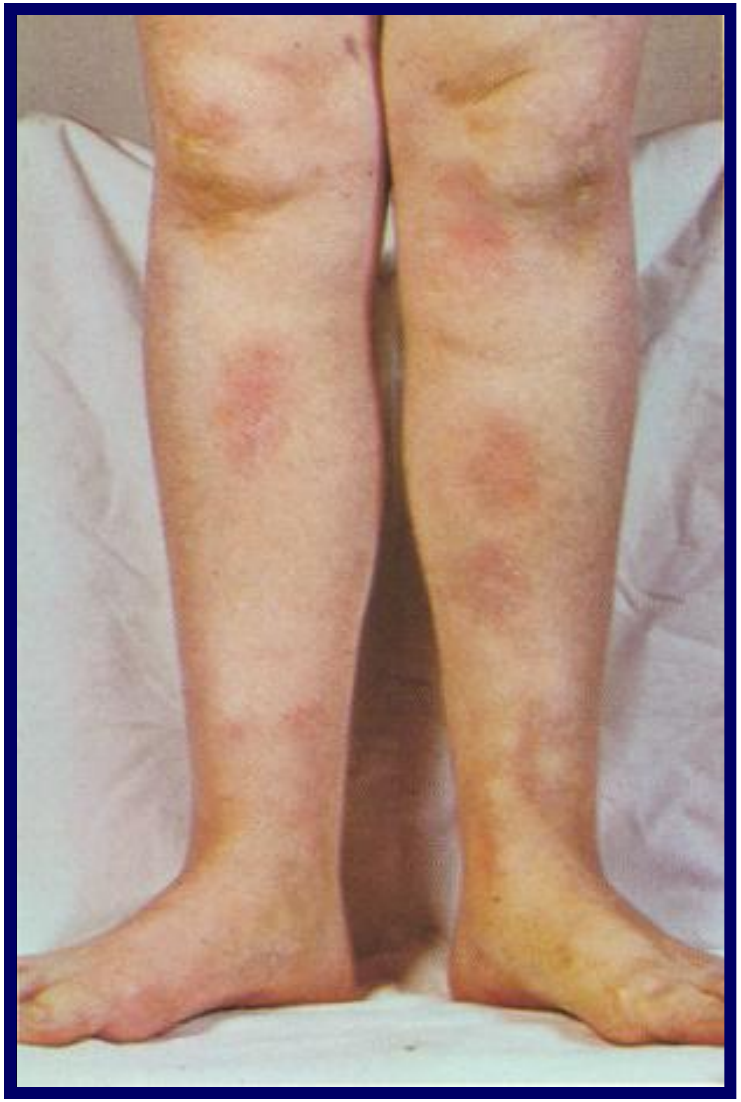
Q1. What is the diagnosis ?

Q2. How many possible causes can you suggest ?



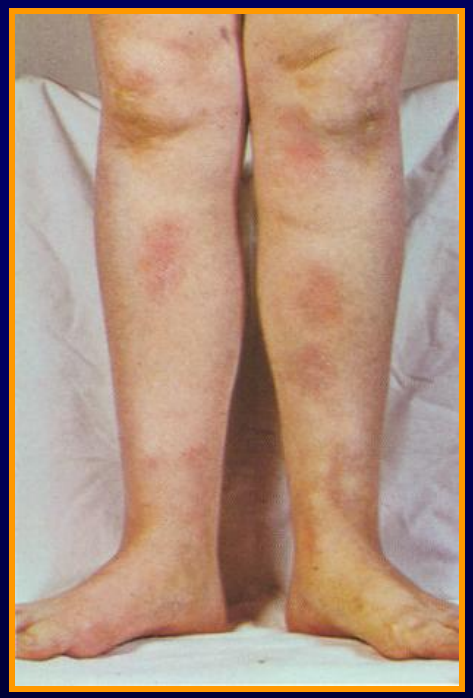
Erythema Nodosum





possible causes of erythema nodosum:

- Sarcoidosis
- Post-streptococcal infection
- Drug-associated (e.g. sulfonamides)
- Primary TB
- Behcet's disease
- Ulcerative colitis
- Lymphogranioloma venereum
- Cat-scratch disease
- Blastomyocosis
- Yersinia (pasleurella) infection
- Lymphoma
- In many cases no cause is found.



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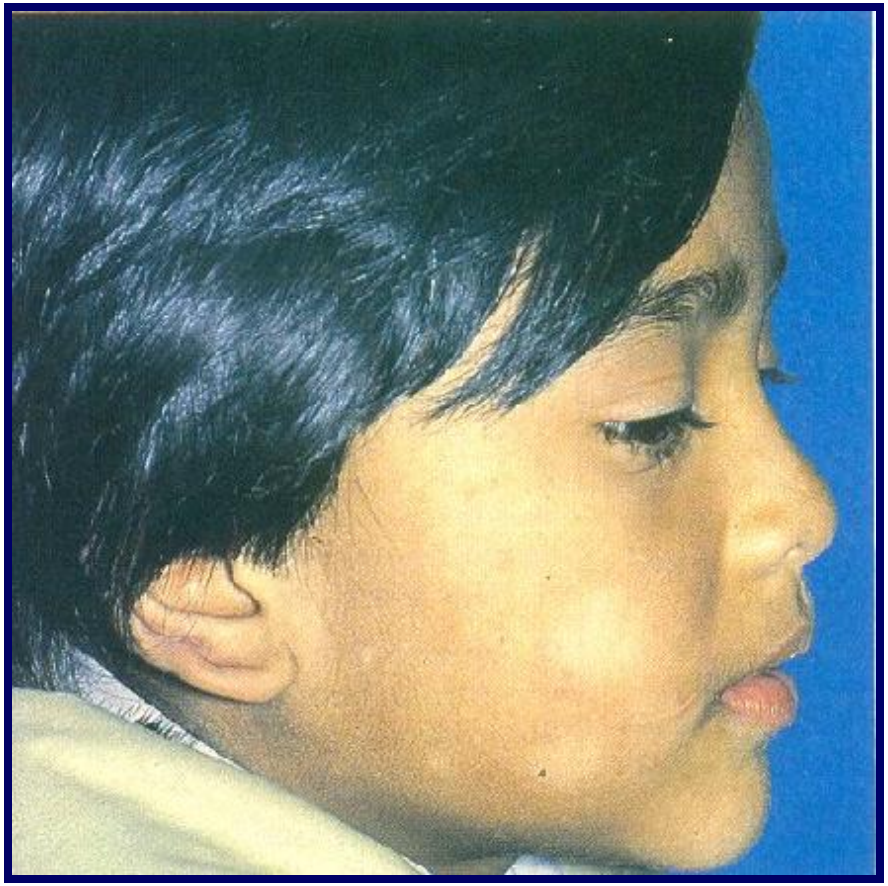
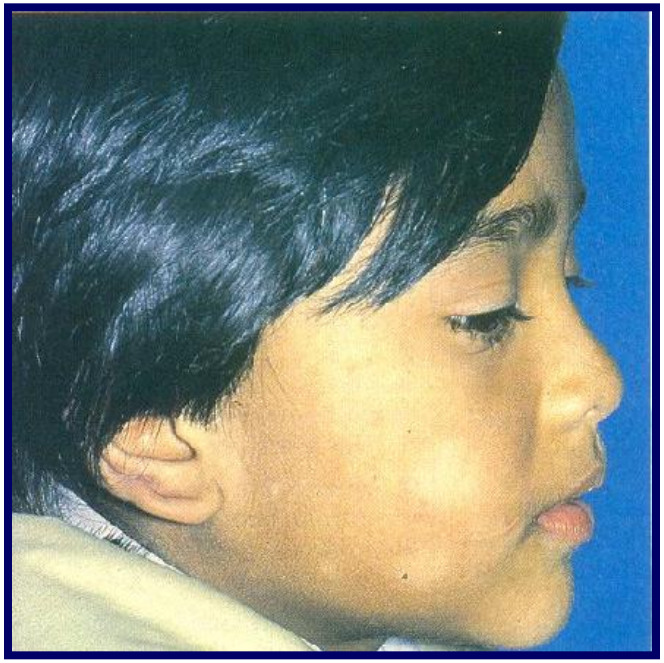


This is a young Chinese patient has pale scaly facial patches. Her mother is terrified that this is vitiligo.

QI. What is the diagnosis?

Q2. What is the natural history of the condition?

Pityriasis alba

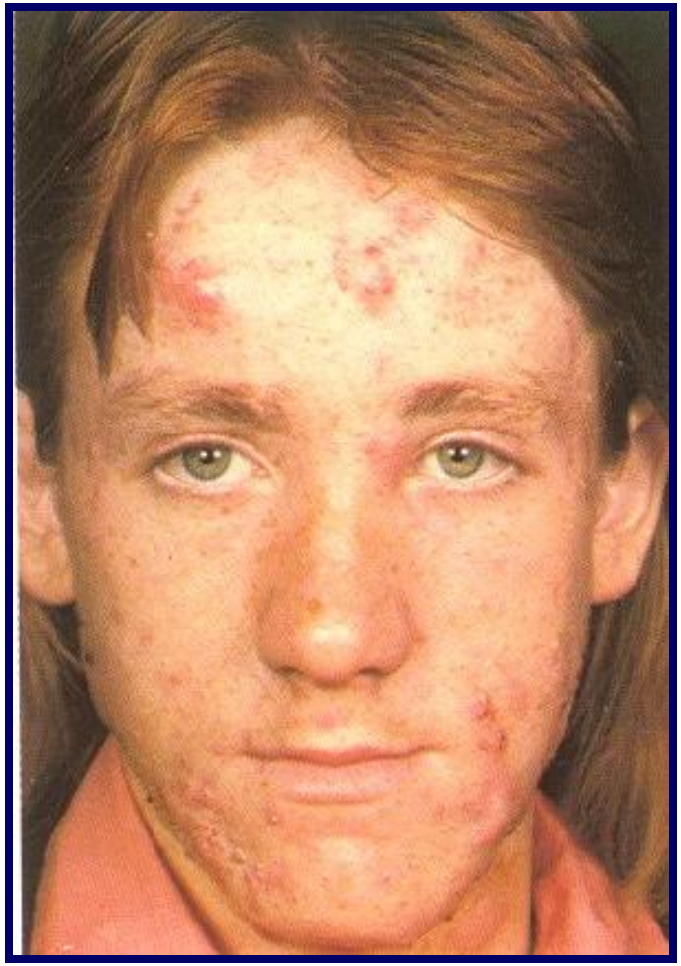


A2. The condition fades spontaneously.

Vitiligo appears milky white under Wood's light.

Pityriasis alba appears a tan color.

17



A young man presented with scarring and papule & pustules over his face. 5 years ago he had been prescribed antibiotics with good results. He had not continued with therapy as recommended.

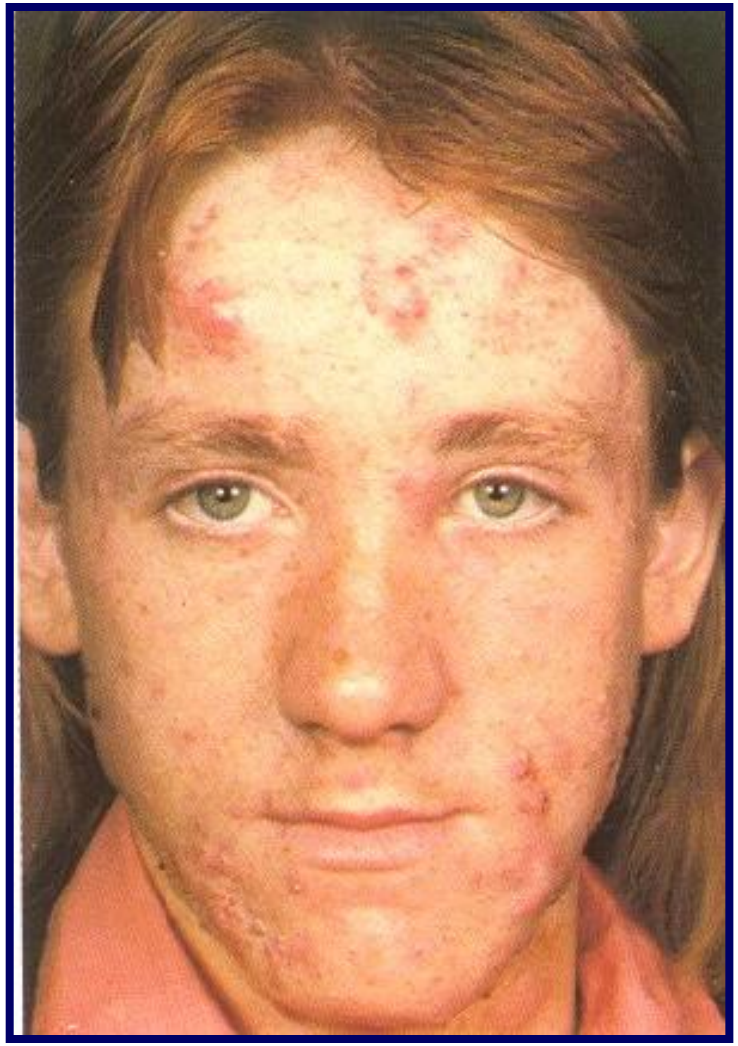
Q.1 What was his initial condition

Q.2 Where else should you look for lesions

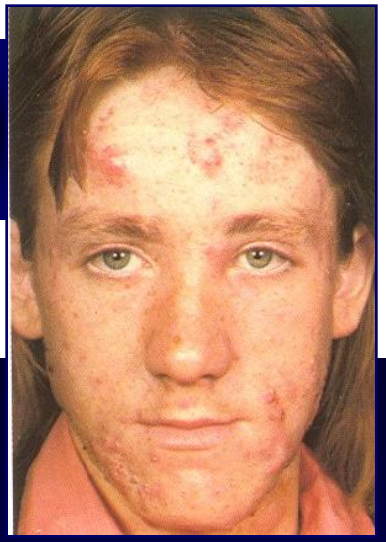
Q.3 Is there an inherited predisposition to the condition ?

Q.4 What is your management ?

Acne



Severe acne vulgaris



A2. Chest & Back

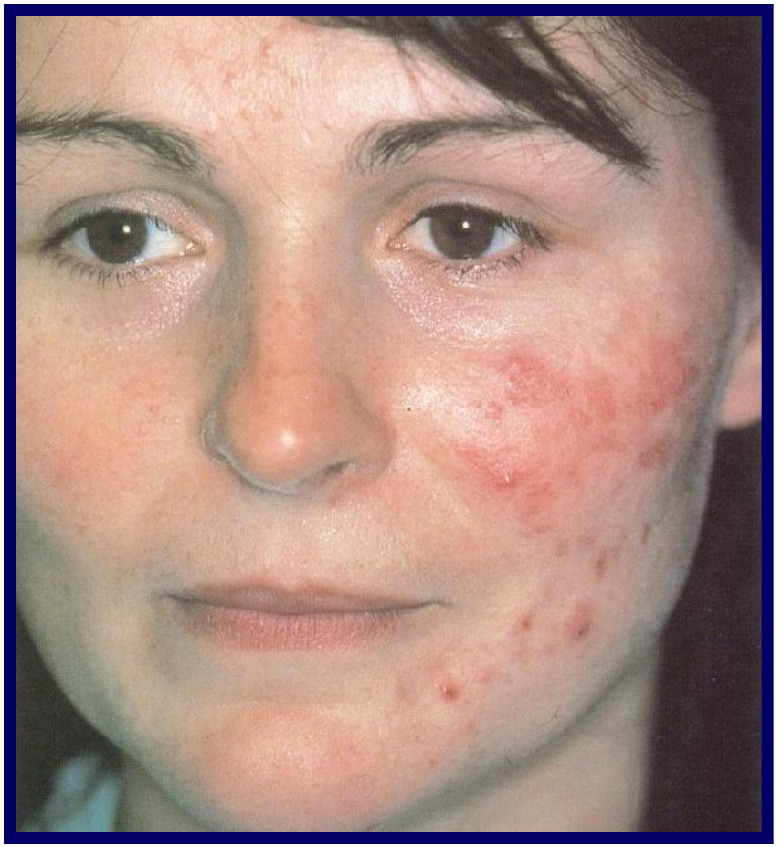
A3. Acne has familial bias. In a survey one or both parents of half of the patients had suffered from acne. Fewer than 10% of boys without acne had a parent with a history of acne. Men with XYY genotype are pre- disposed to nodulocystic acne.

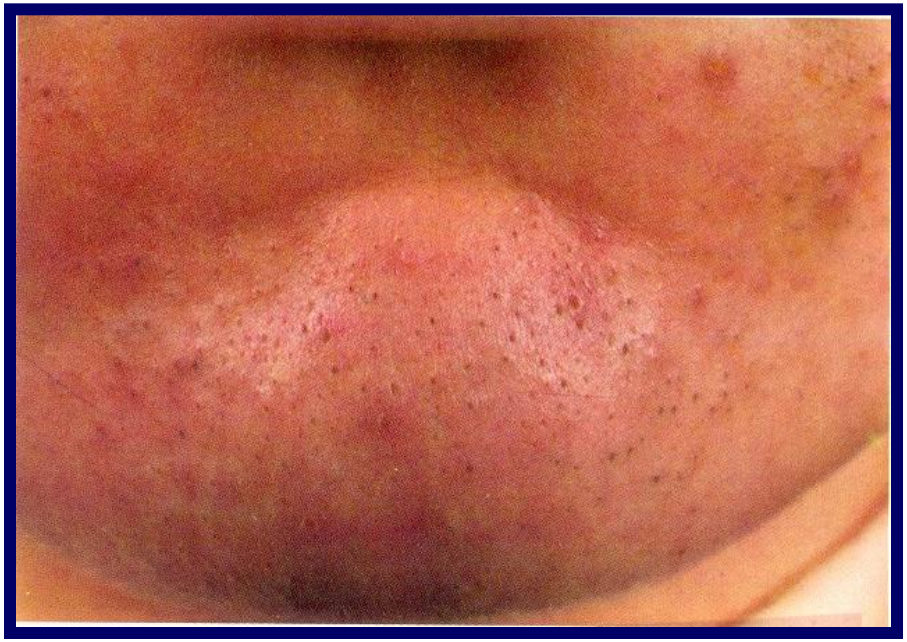
A4. Topical therapy : *Benzoyl-peroxide , Tretinoin*

Oral antibiotic e.g.. Erythromycin or Doxycyclin

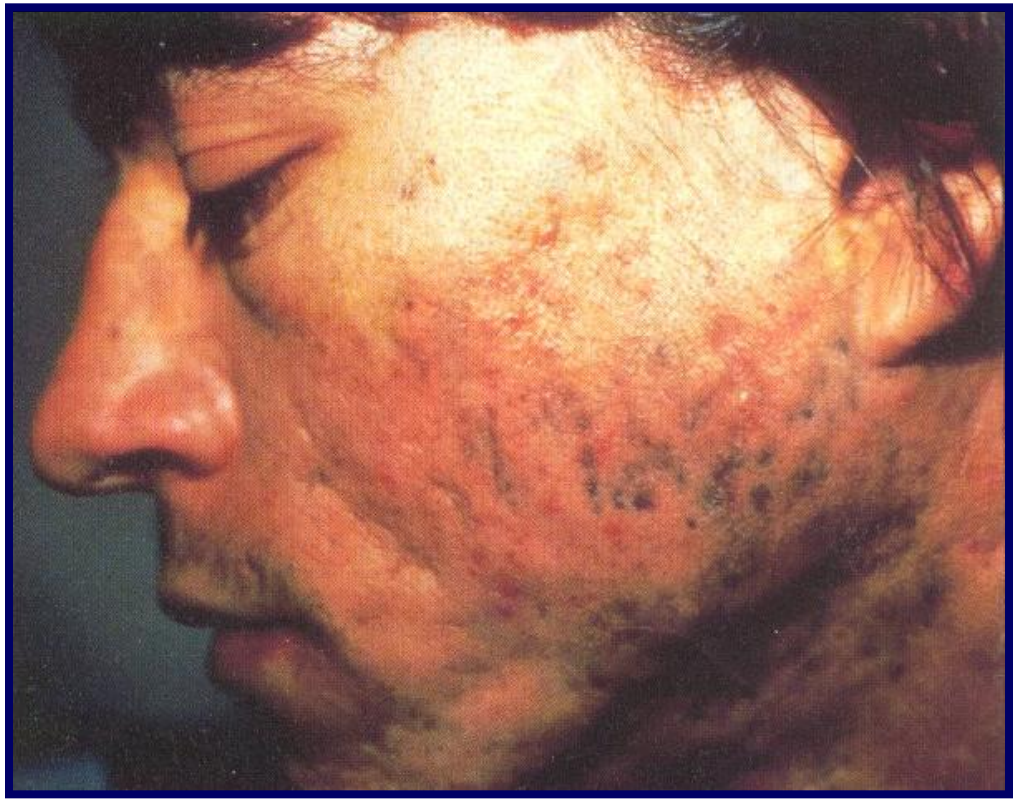
Refer for oral isotretinoin.

Acne

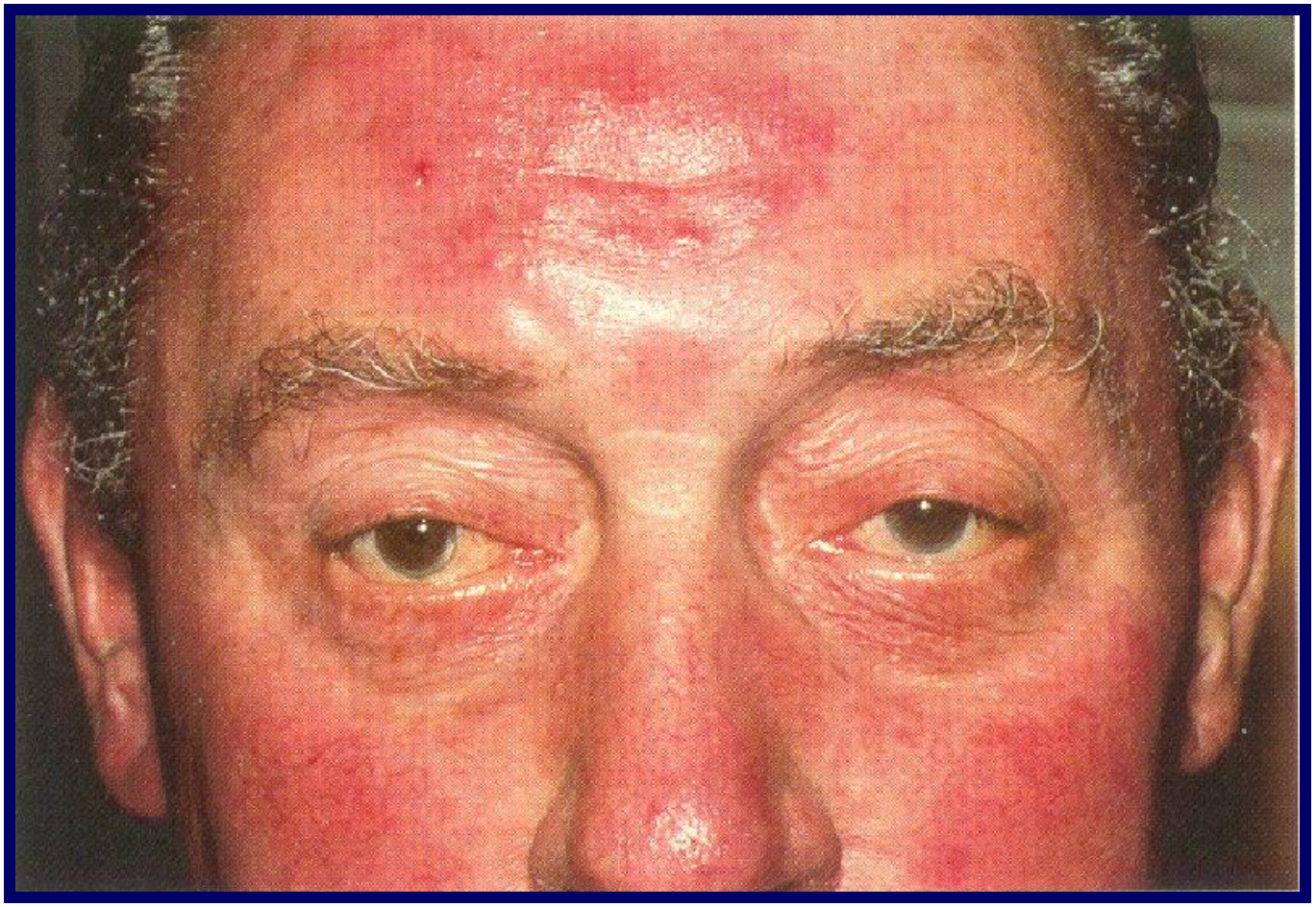




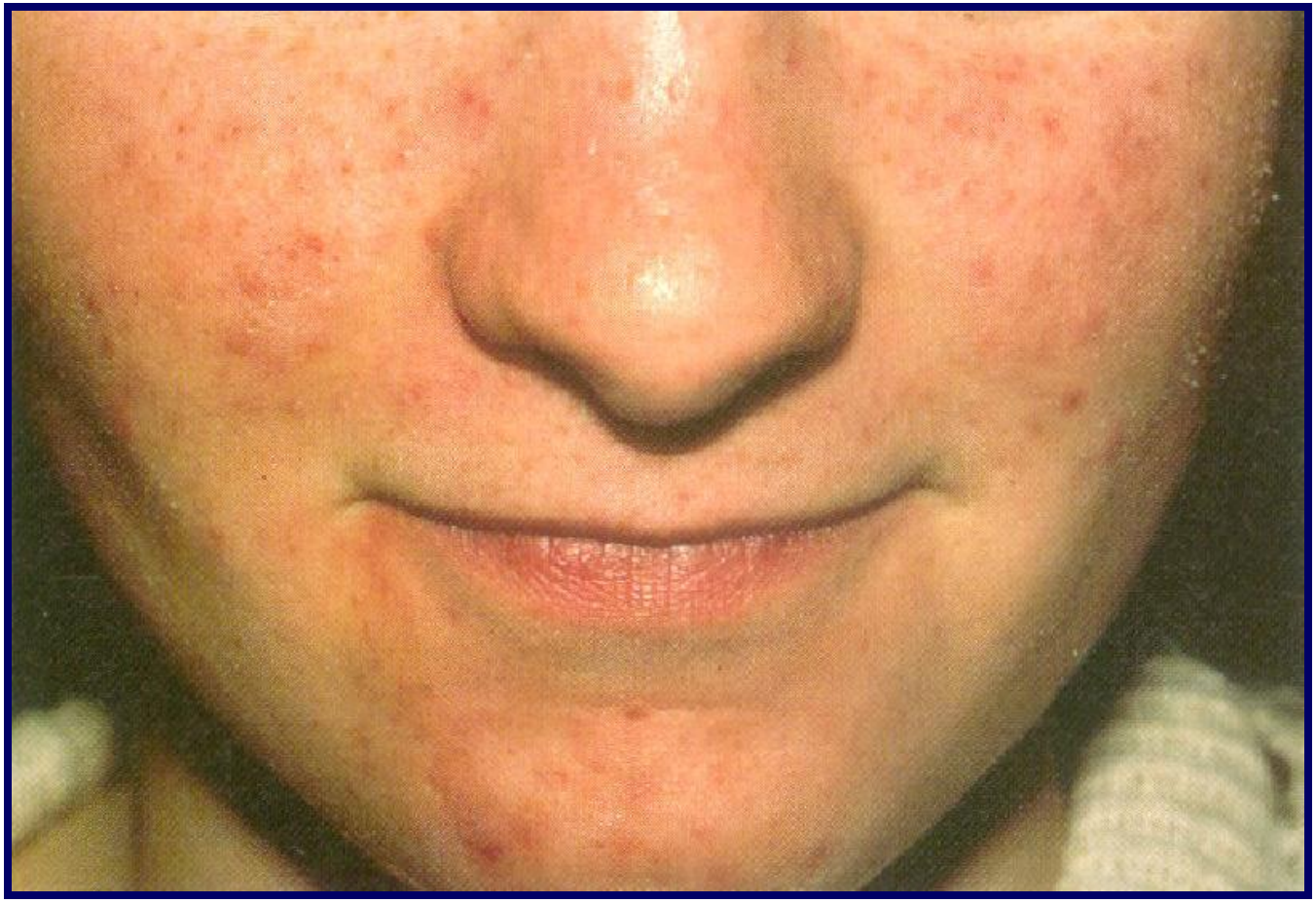
Acne



Gray discoloration in the numerous old acne scar of the face as side effect of Minocycline



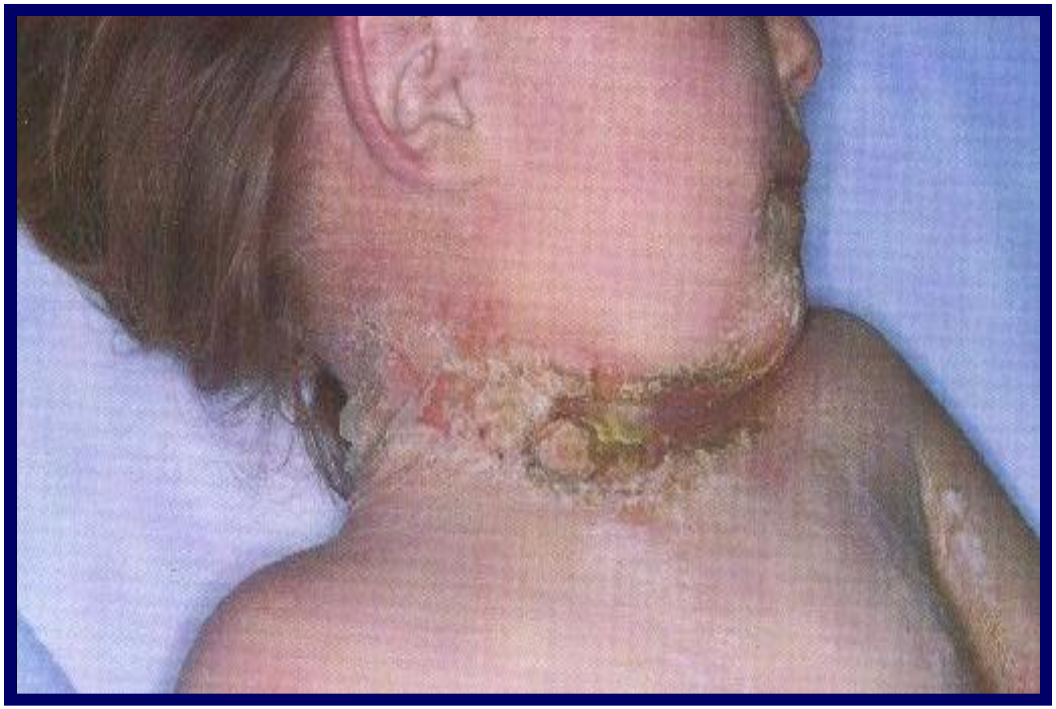
Typical case of rosacea: small papules and pustules on an erythematous, telangiectatic background. The most common sites are the central cheeks, forehead, tip of the nose and chin



Rosacea is easily confused with acne, acne vulgaris tends to occur in a younger age group and comedones are usually present. Comedones are not seen in rosacea

Skin Infections

18



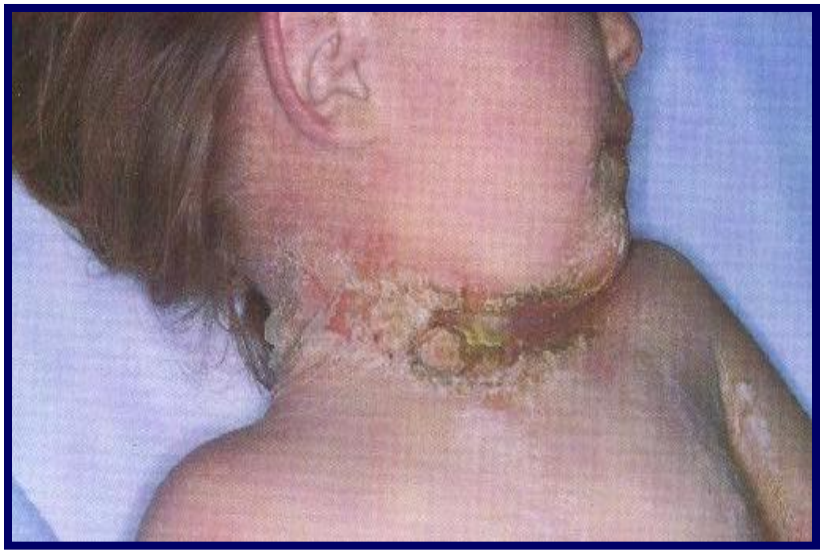
A young girl has a spreading exudative and crusted eruption on her neck for 10 days.

Q1. What is the eruption ?

Q2. What organisms are responsible ?

Q3. What internal disease is a rare complication ?

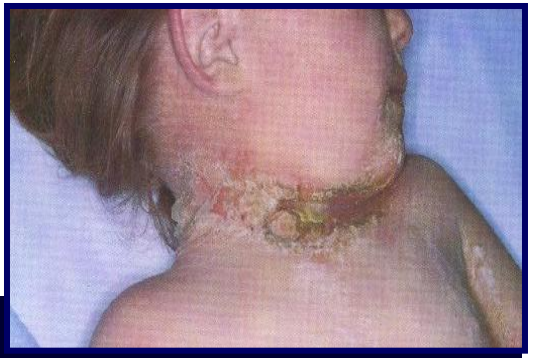
Impetigo



A2. Either Staphylococcus aureus or Streptococcus pyogenes

A3. Acute glomerulonephritis if the skin was infected by a nephotogenic streptococcus.

Impetigo



Presentation:

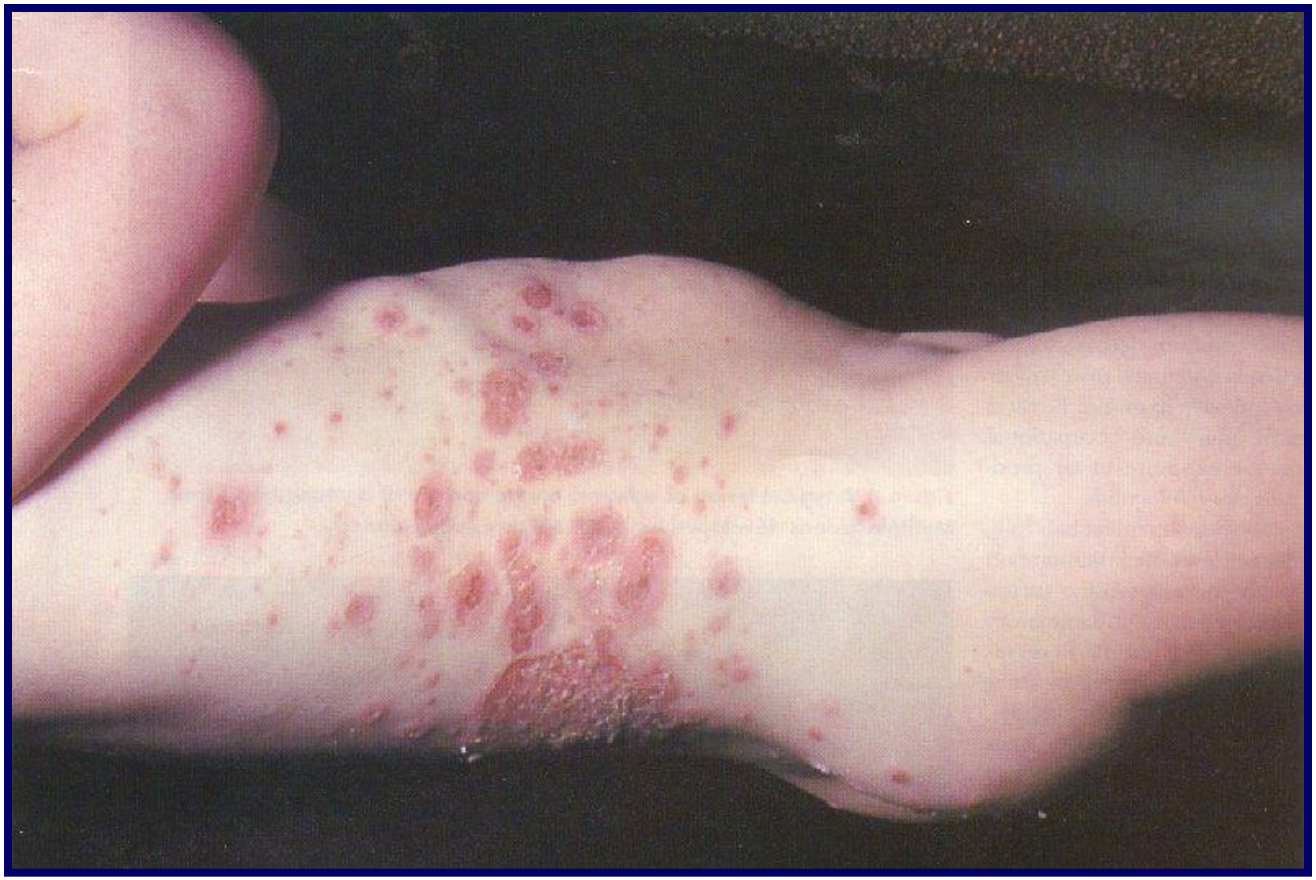
Multiple golden yellow crust on an erythematous base. Usually 1-2 cm in diameter. Alternatively, bullous lesions on the skin in an otherwise well patient.

Investigations:

Not usually necessary. Diagnosis is essentially clinical

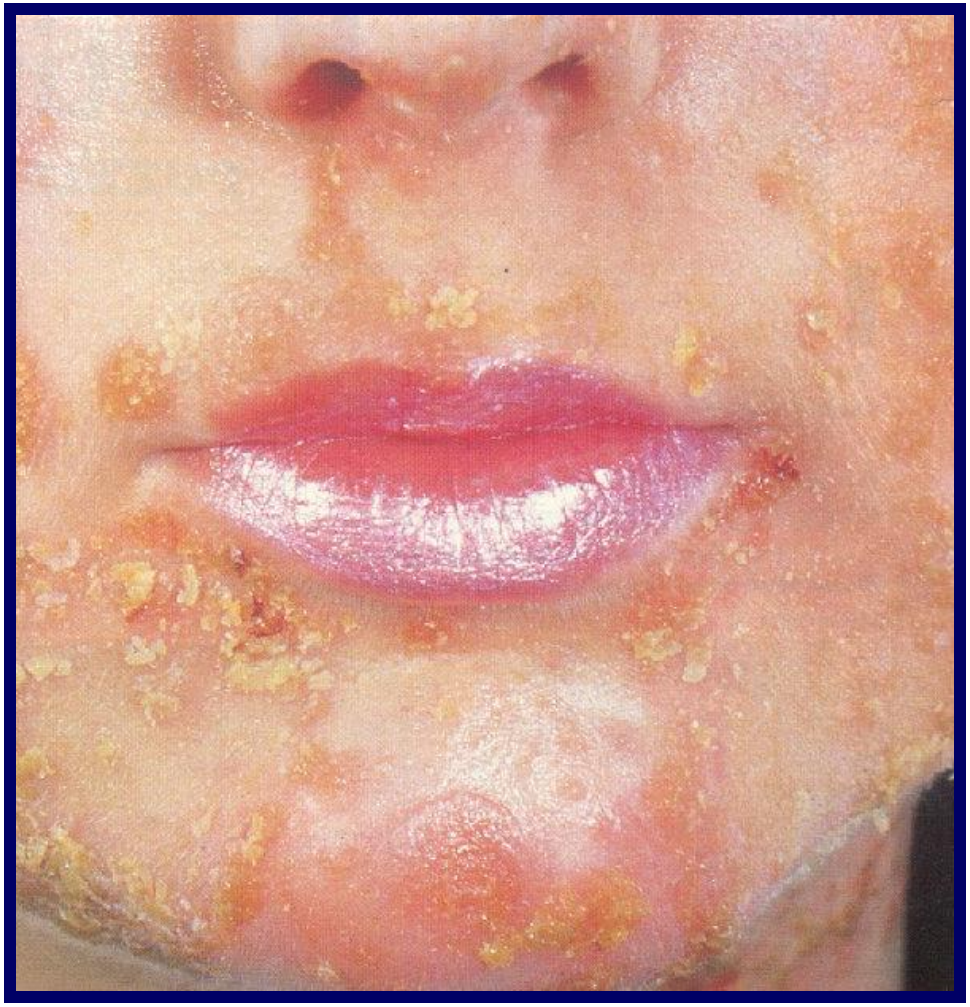
Treatment:

Small well-circumscribed lesions respond to topical antibiotics. Systematic treatment with flucloxacillin or erythromycin is not usually required, except for extensive lesions.



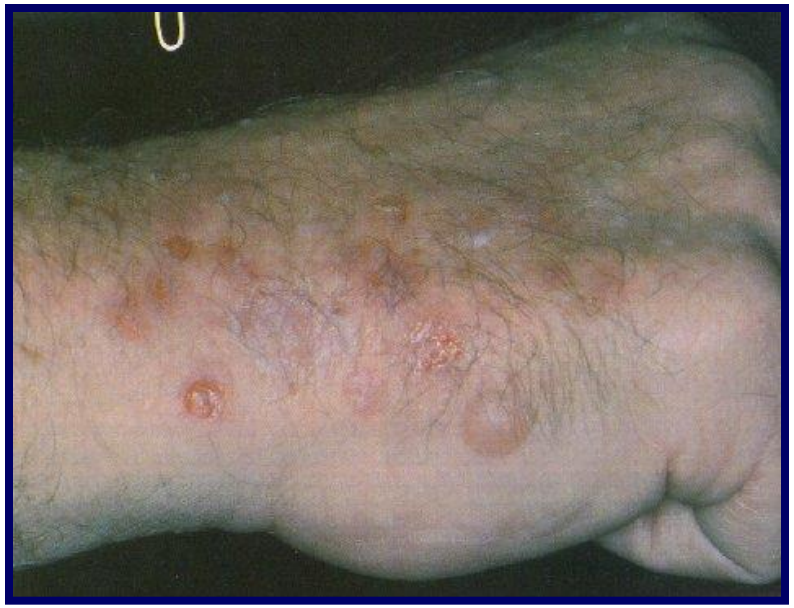
A young child with extensive lesions of bullous (staphylococcal) **impetigo** on the trunk

Impetigo



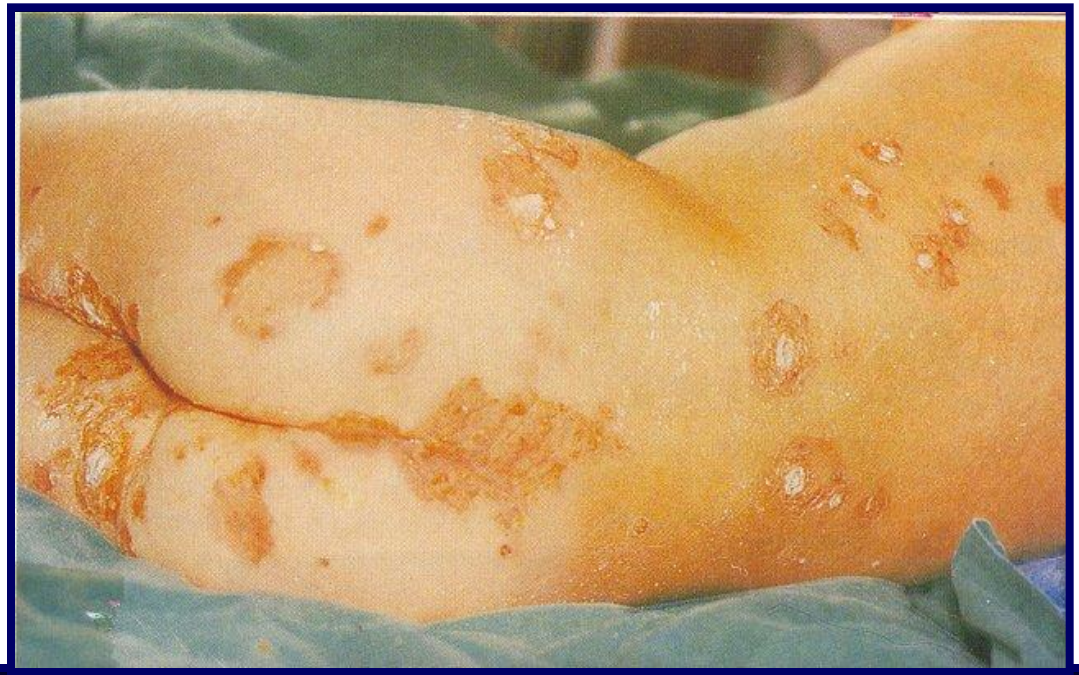
Thick, yellow crusts on the background of erythema and superficial erosion in patient with streptococcal

Bullous Impetigo



This man developed rash on his hand resembling cigarette burns the lesions were progressive and a diagnosis of impetigo was made. The infecting organism is usually staphylococcus aureus. In this case treatment with oral antibiotics (flucloxacillin 250 mg four times daily) was effective.

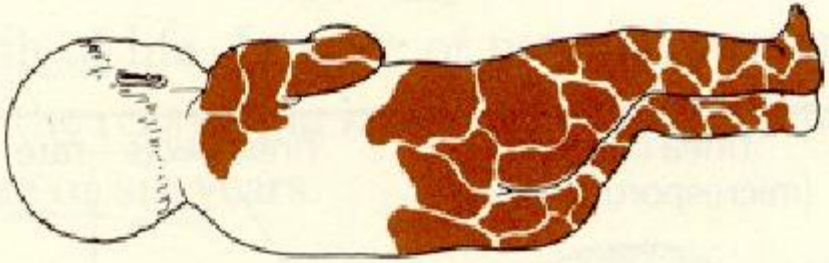
Bullous Impetigo



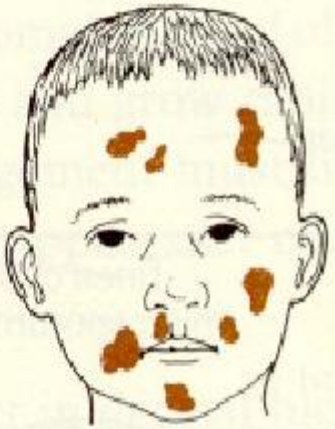
A 4-year-old boy presented with this widespread bullous rash after returning from a holiday> the diagnosis is 'scalded skin syndrome' (bullous impetigo). Epidermal change of erythema followed by flaccid bullae, which later rupture; are caused by staphylococcal endotoxin. These usually heal over 7-14 days.

Bacterial skin infections

Scalded skin syndrome



Impetigo

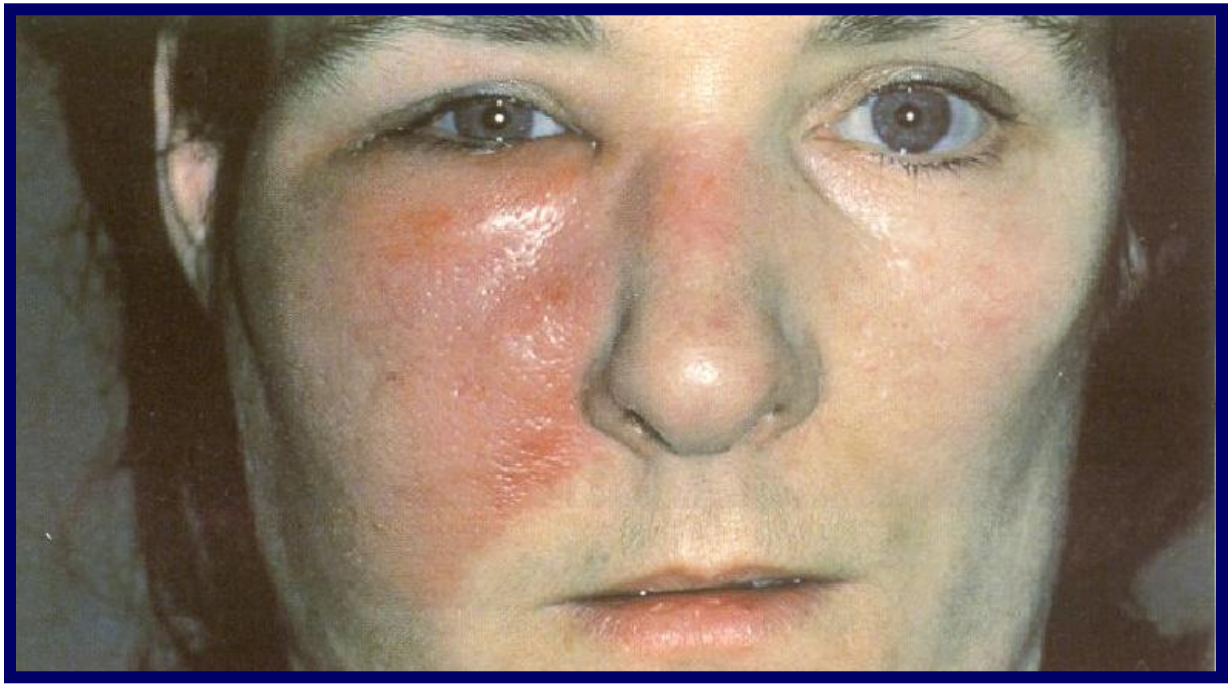


Golden crusts

Staphylococcus

Streptococcus

19

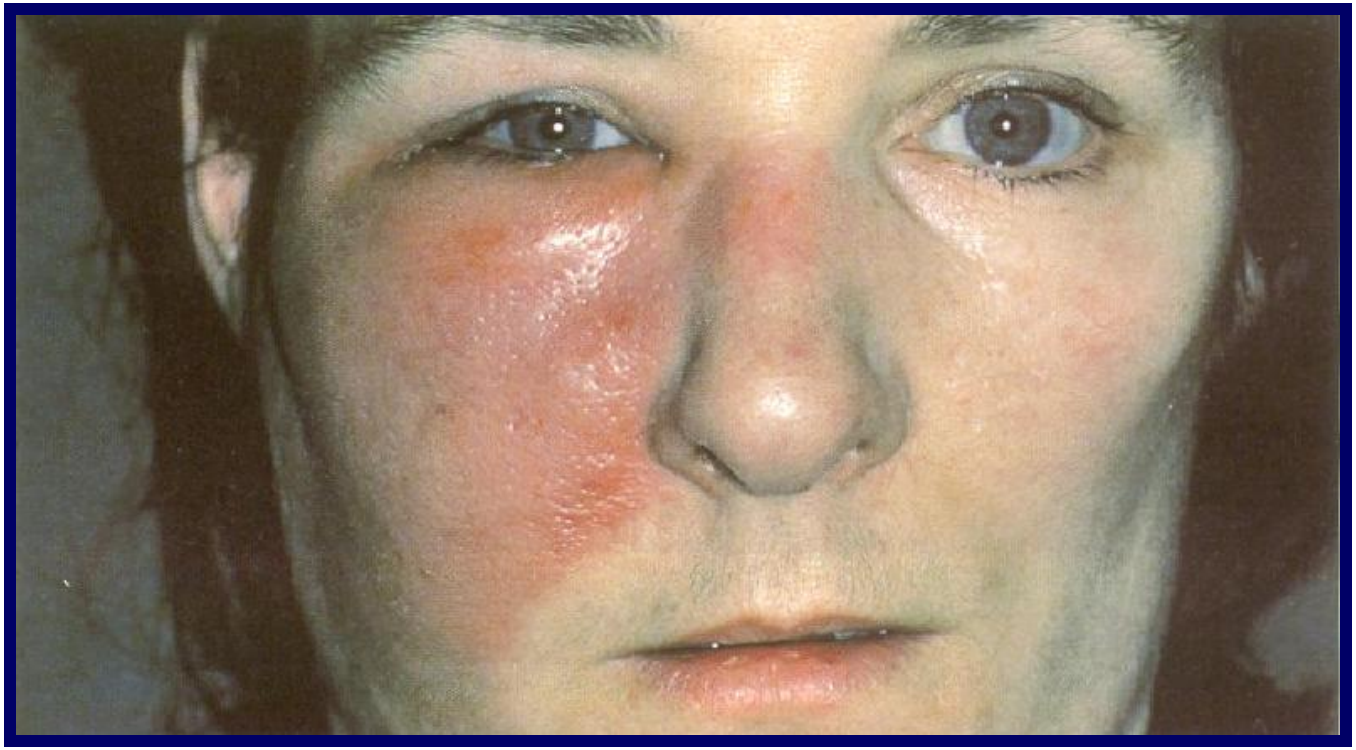


Q1. What is the eruption ?

Q2. What organisms are responsible ?

Q3. What internal disease is a rare complication ?

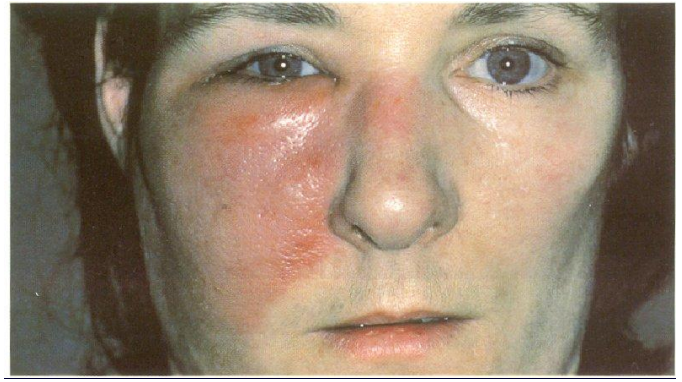
Erysipelas



Well-demarcated erythematous swelling of facial; this condition is more often bilateral

Erysipelas

It is a superficial skin infection with redness, swelling, mild pain, and heat sensation with well defined borders. There may be a breach of skin where the infection entered.



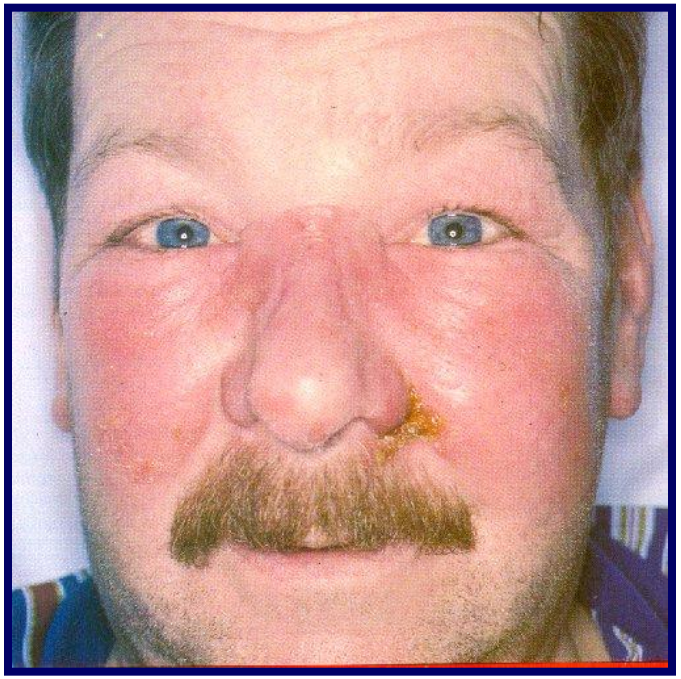
A2. The causative organism is a group A beta hemolytic streptococcus.

A3. If classical symptoms, no investigations are required.

Treatment: Penicillin or erythromycin

Erysipelas

Presentation: Superficial skin infection with redness, swelling, mild pain, and heat sensation with well defined borders. There may be a breach of skin where the infection entered.



Investigations: If classical symptoms, no investigations are required. The causative organism is a group A beta hemolytic streptococcus.

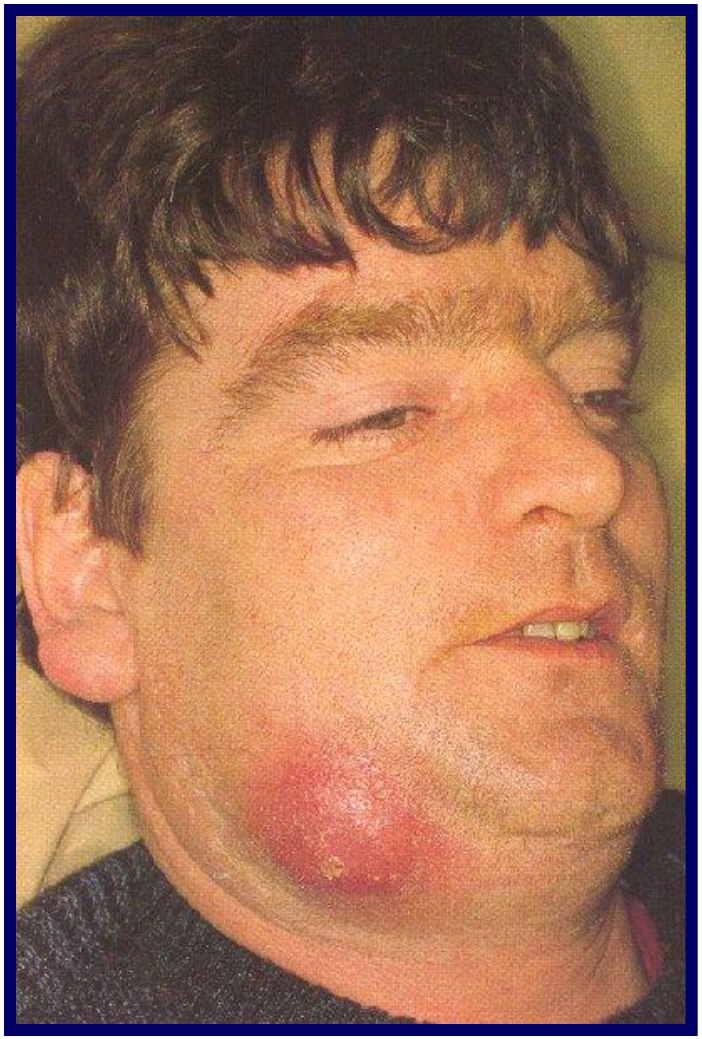
Treatment: Penicillin or erythromycin

20

Q.1 **What is the diagnosis ?**

Q.2 **What organisms are responsible ?**

Q.3 **What is your management ?**

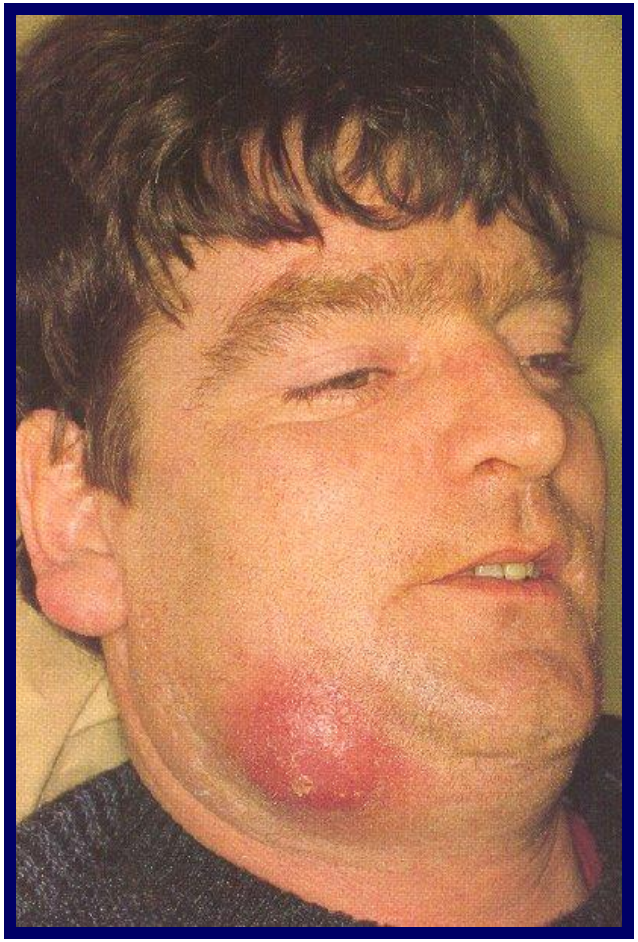


Boils

Presented as focal abscesses of staphylococcal etiology.

A2. Pus can be cultured if indicated.

A3. Simple drainage by incision. However, if lesions are multiple or infection appears to be spreading, then treat with oral flucloxacillin or erythromycin.



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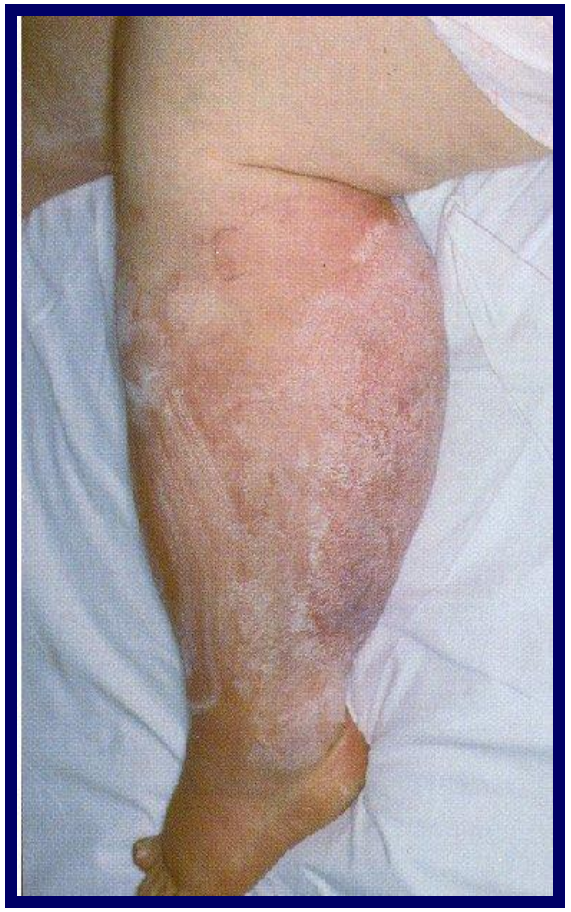


Q1. What is the diagnosis ?

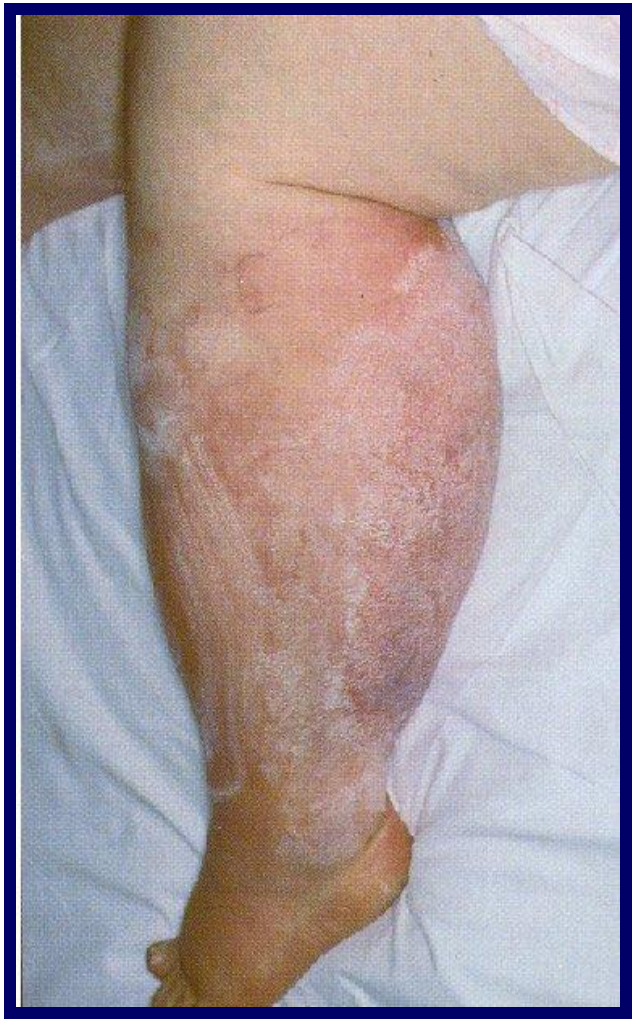
Q2. Is there any investigation?

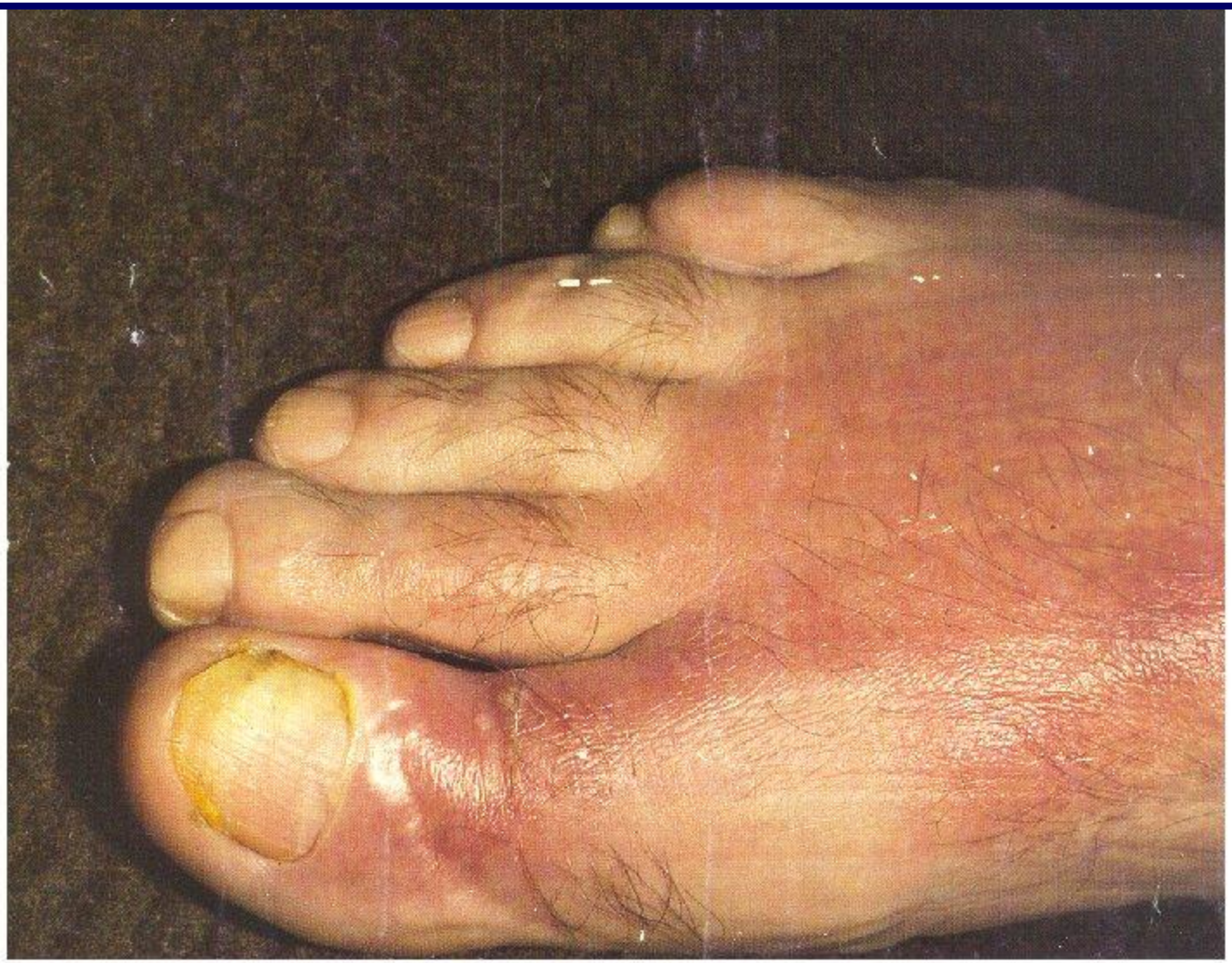
Q3. What is your management ?

Cellulitis

Presented as deeper infection than erysipelas, with less-well-defined borders. Diagnosis is usually clinical

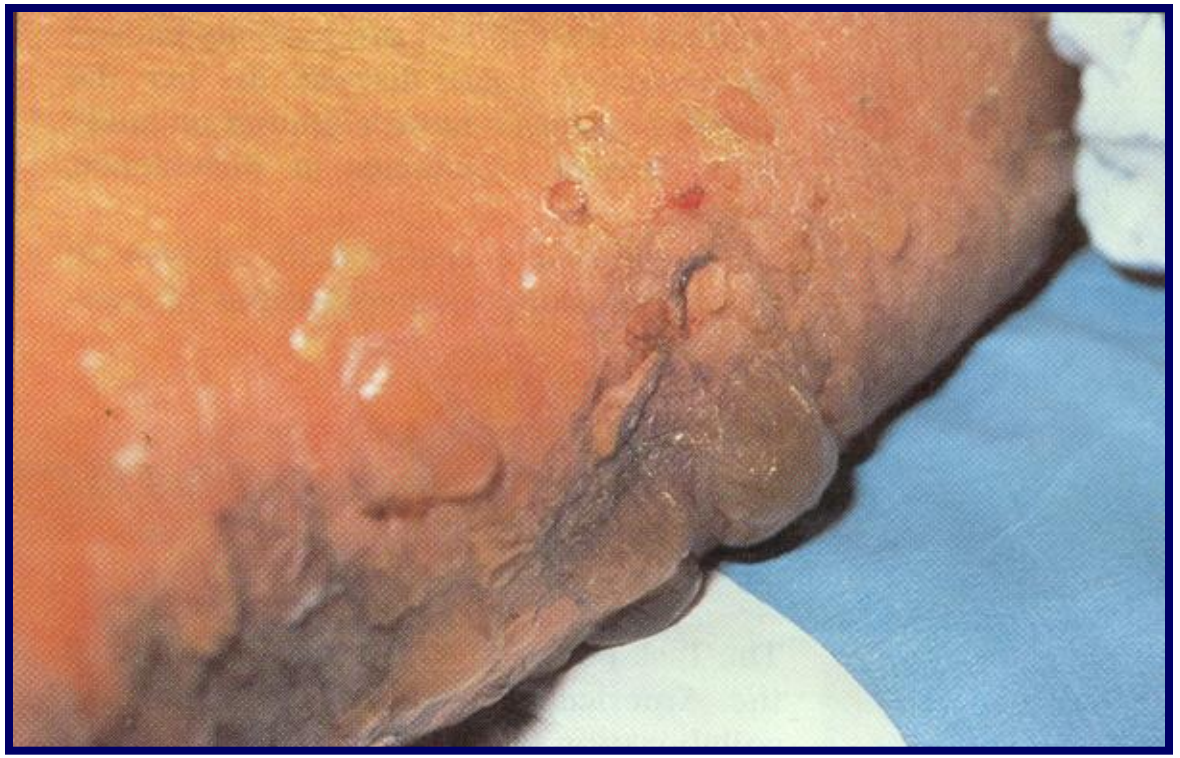
A2. Investigations is not usually necessary. If there is a site of entry of infection, a swab should be taken. **A3.** Treatment: antibiotics such as flucloxacillin or erythromycin , that eradicate staphylococcal aureus.





Cellulitis of the foot secondary to whitlow

22

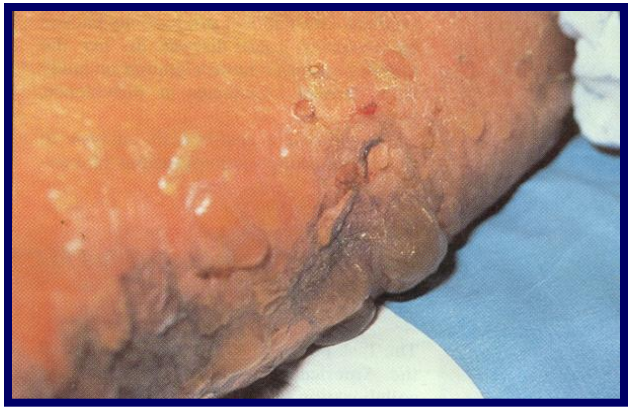


A 20-year-old woman comes to ER with 4-day history of sore throat and a skin eruption, extremely ill, has a high fever and is jaundiced and dyspneic

Q1. What is the diagnosis?

Q2. What is the differential diagnosis?

Skin-eating infection
(Necrotizing fasciitis)



It is caused by virulent streptococcal organism The characteristic signs are erythroderma with multiple bullae and necrosis which caused the discoloration.

A2. Differential diagnosis?

* Toxic shock syndrome
* Erythema multiforme
* Toxic epidermal necrosis

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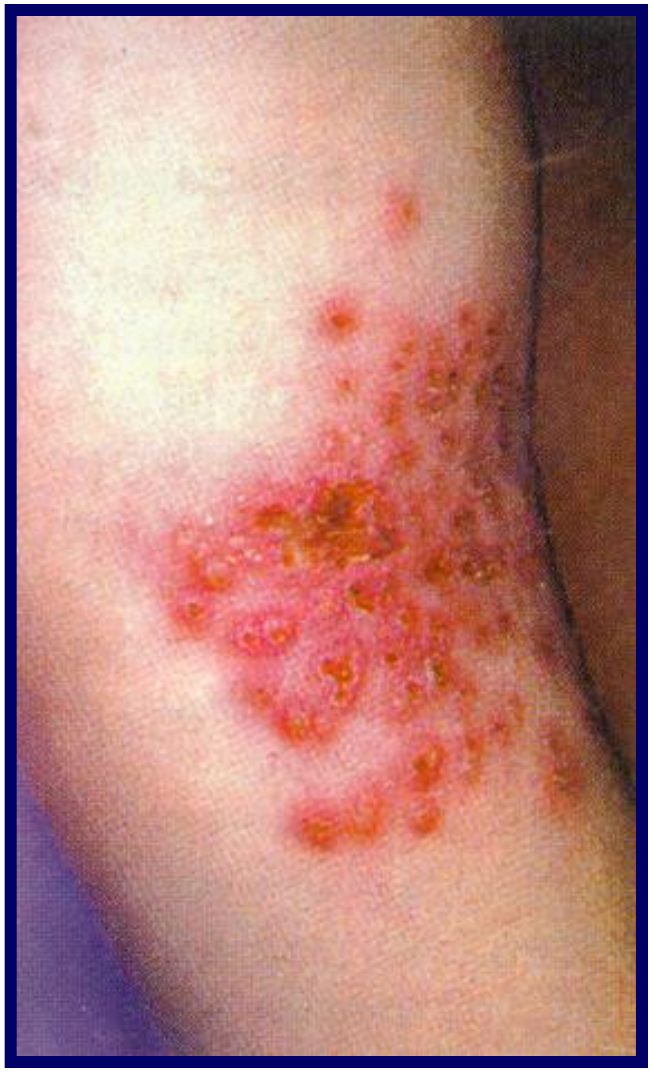
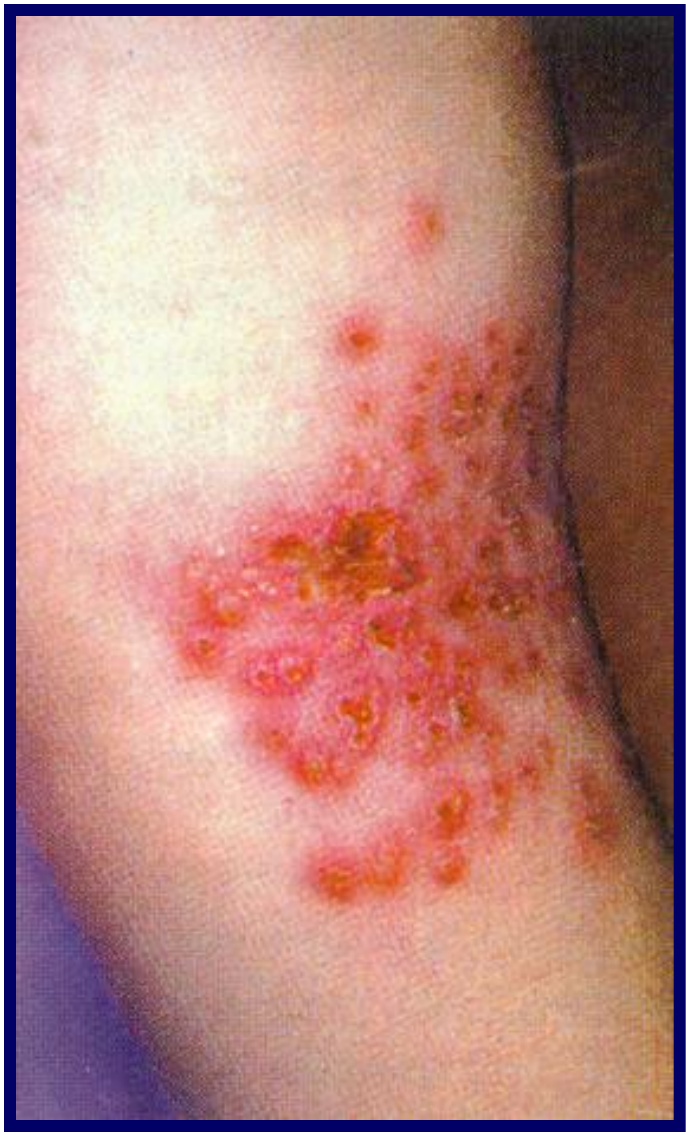


Q1. What is the diagnosis ?

Q3. What is the differential diagnosis ?

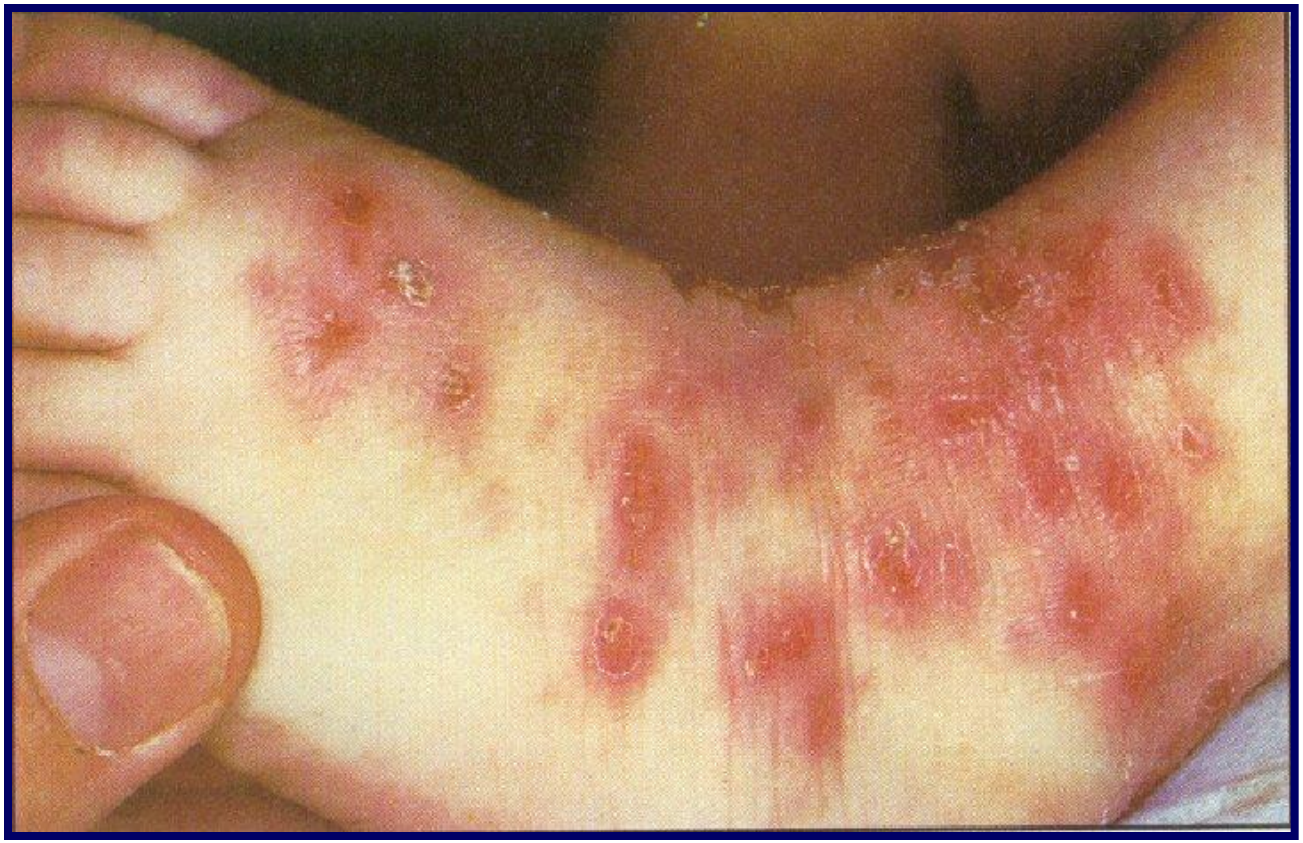
Herpes simplex



Cluster of eroded umbilicated vesicles on the antecubital area

A2. Differential diagnosis:

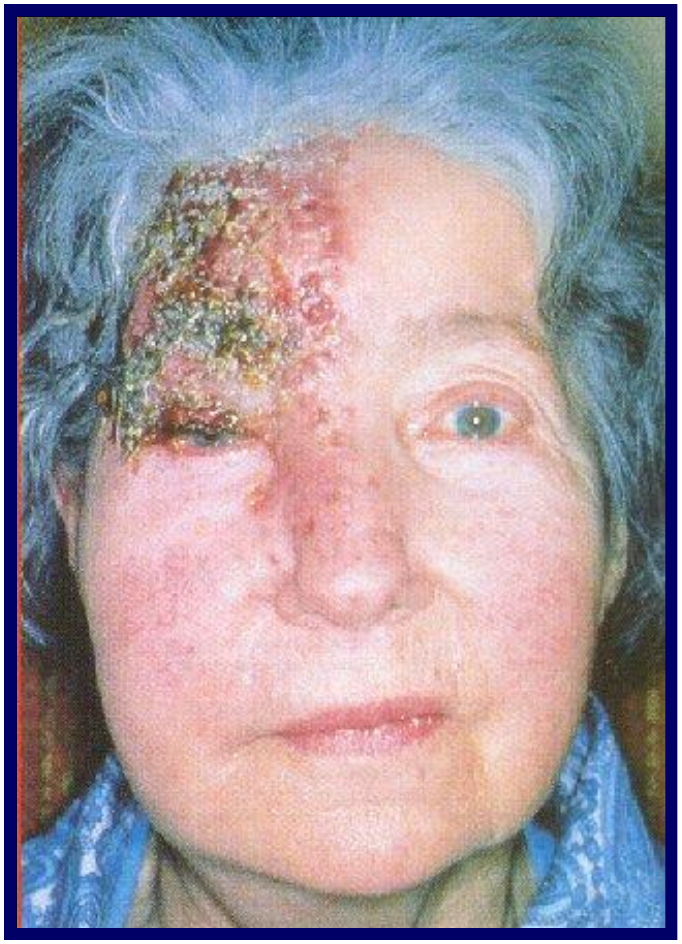
* Acute dermatitis
* Mulluscum contagiosum
* Superficial folliculitis



Herpes simplex infection associated with atopic dermatitis

It was misdiagnosed as pyoderma and treated with antibiotics for more than 2 weeks

24

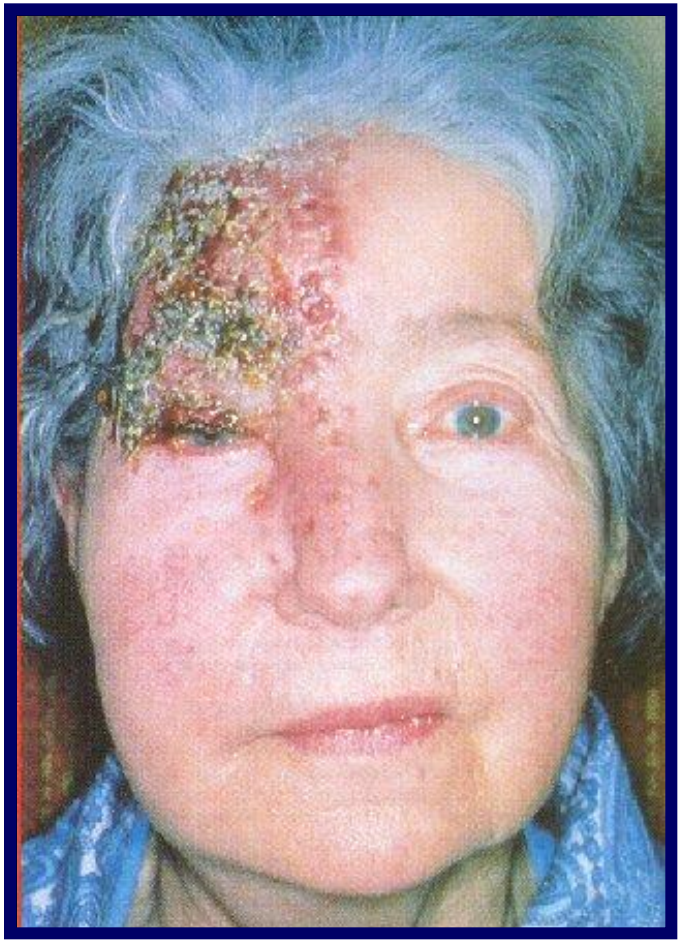


Q1. What is the diagnosis ?

Q2. Is there any investigation?

Q3. What is your management ?

Zoster ophthalmicus (Shingles)



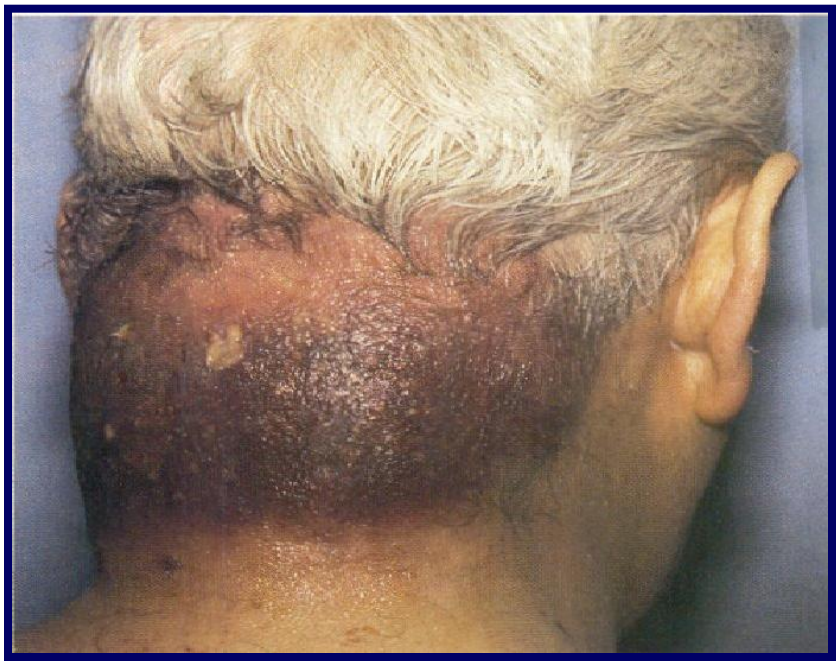
Presentation: Pain with a vesicular eruption followed by scabbing and skin scarring in the region of the cutaneous distribution of the ophthalmic maxillary divisions of the trigeminal nerve.

Complications: Iritis, keratitis and post-herpetic neuralgia.

Investigations: Diagnosis is clinical.

Treatment: Patients may benefit from systemic acyclovir (Zovirax; 800 mg given five times daily for 5 days) prescribed early during the course of the infection.

25



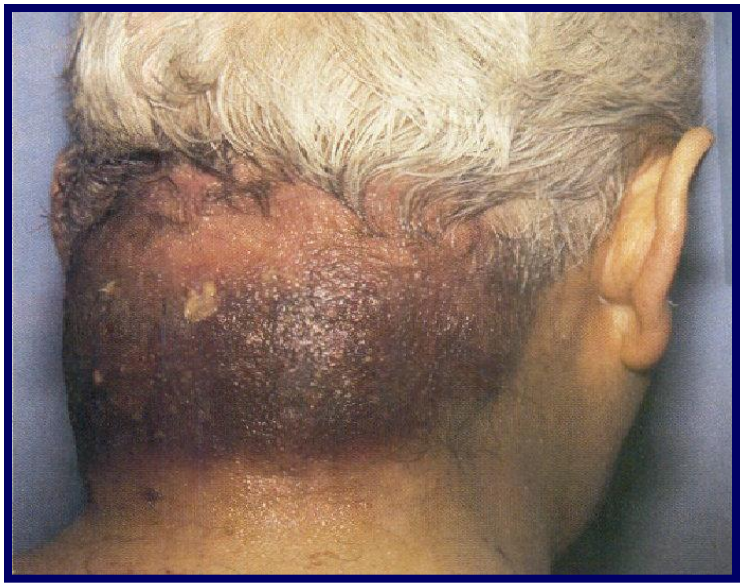
This 47-year-61d man presented with a large swelling on his neck of 4 days duration, There were no other symptoms.

Q1. What is the diagnosis?

Q2. With what other medical condition is this associated?

Q3. What is the treatment?

Carbuncle

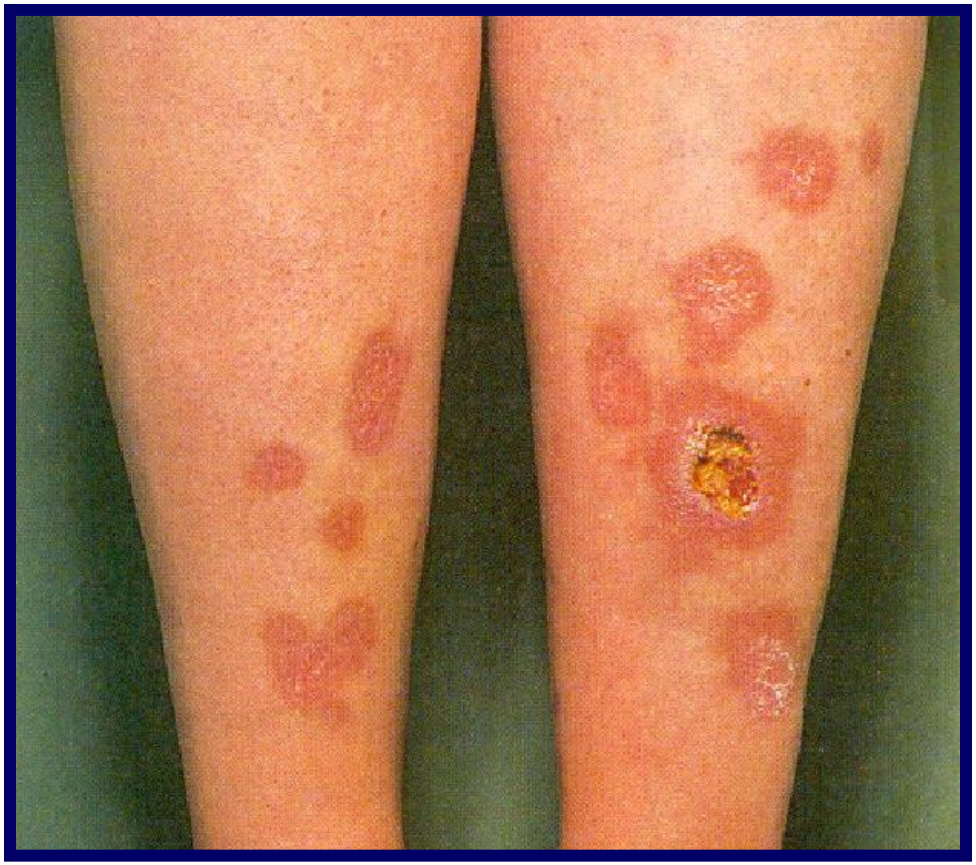


Carbuncle is an infective gangrene of the subcutaneous tissue, sometimes associated with diabetes. Males are more often affected and the nape of neck is a common site. Staphylococcus aureus is the usual offending

A2. Diabetes mellitus.

A3. Wide incision and drainage.

26

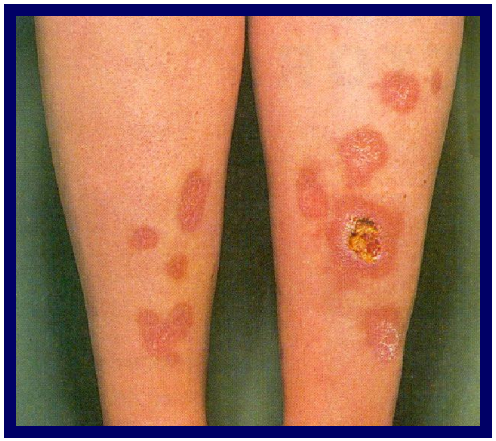


Q1. What is the diagnosis?

Q2. Is this always associated with an endocrine disorder?

Q3. Of what dermal constituent is this primarily a disorder?

Necrobiosis lipoidica

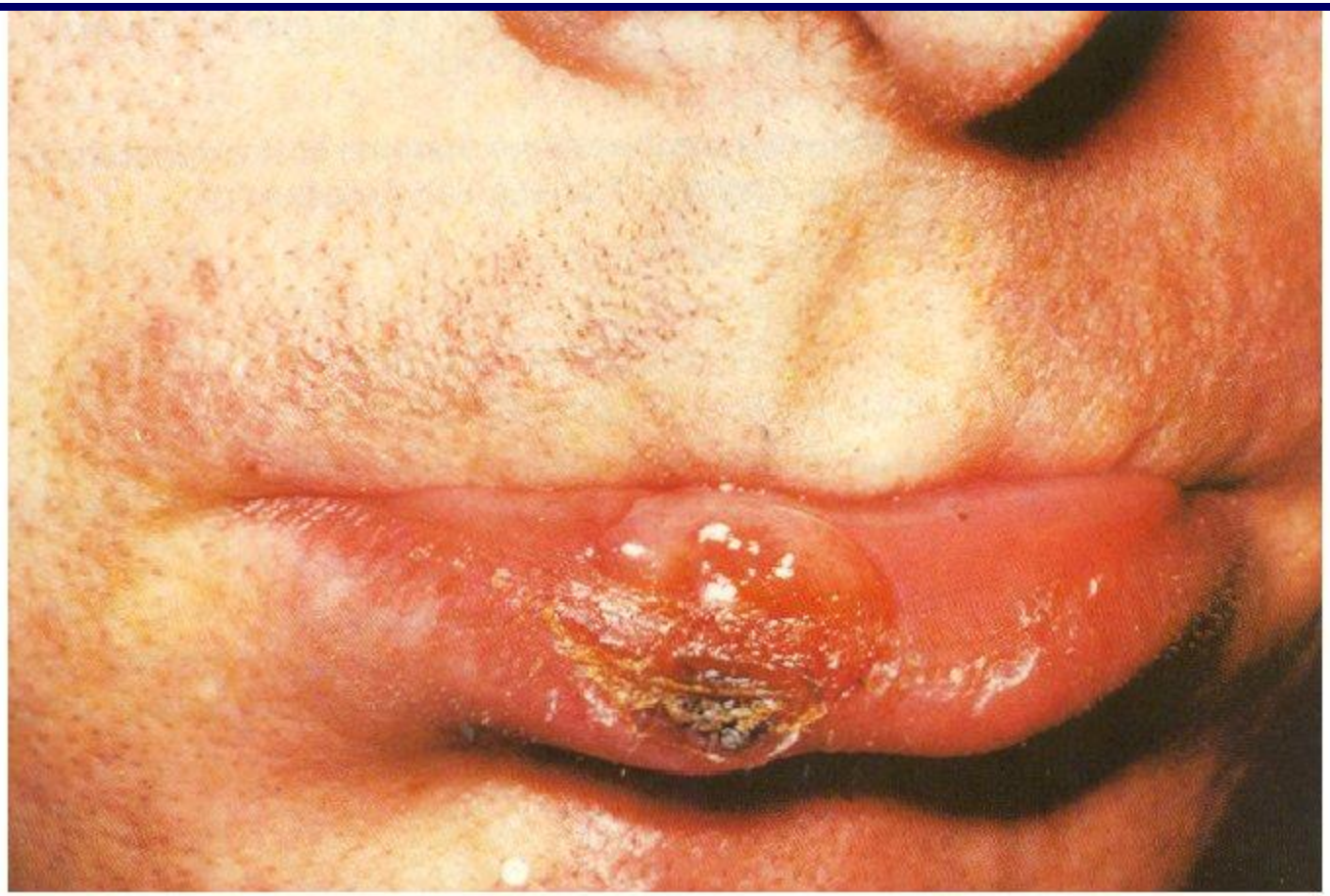


It is an uncommon granulomatous degenerative disorder of dermal collagen. Atrophy of the skin of the shin is typical, with an orange-yellow discoloration allowing clear visualization of the underlying venous plexuses. About 500/o of affected patients have diabetes mellitus, a further 20% have abnormal glucose handling during steroid administration, and 300/o are idiopathic. The condition affects about 0,3% of all diabetic patients. Ulceration is an uncommon, though distressing, complication.

A2 No.

A3 Collagen.

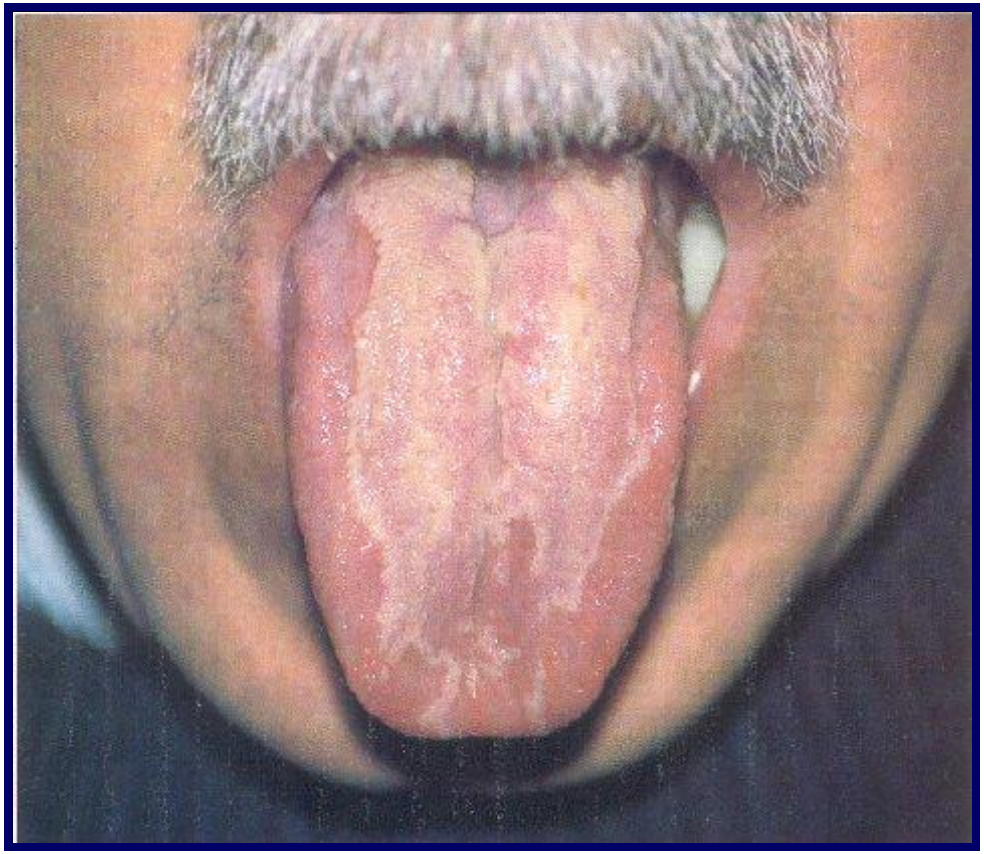
27



Primary syphilitic chancre of the lip

Ulcer in the lip may be traumatic, infected, or malignant (Basal cell carcinoma) in origin

28

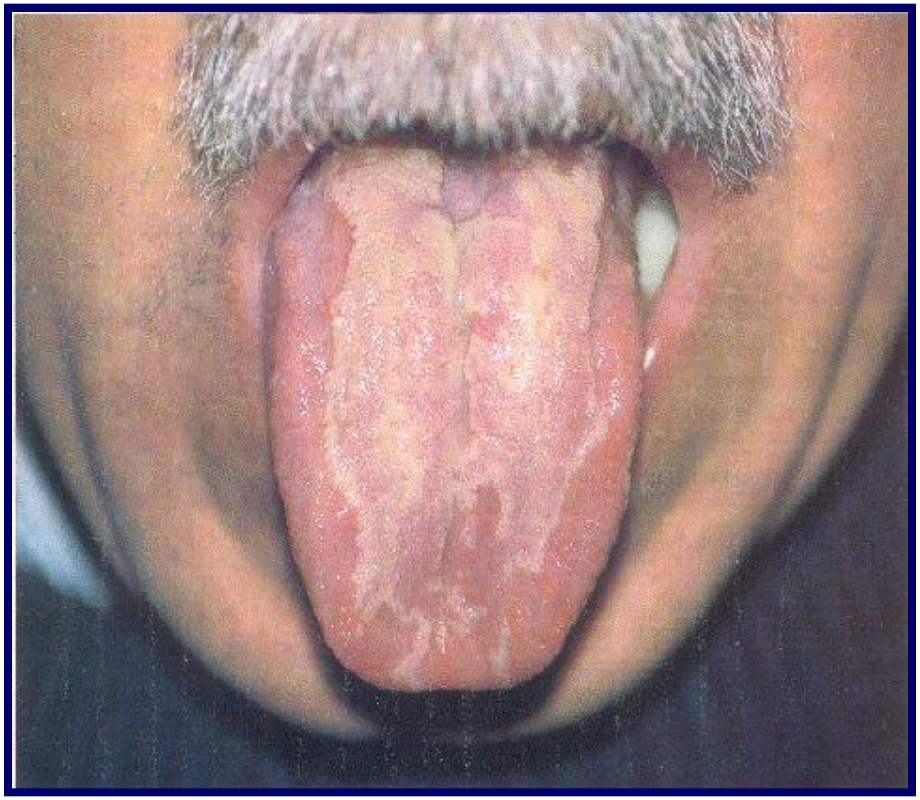


This is 58-year-old asthmatic presented with painful tongue.

Q1. What is the diagnosis?

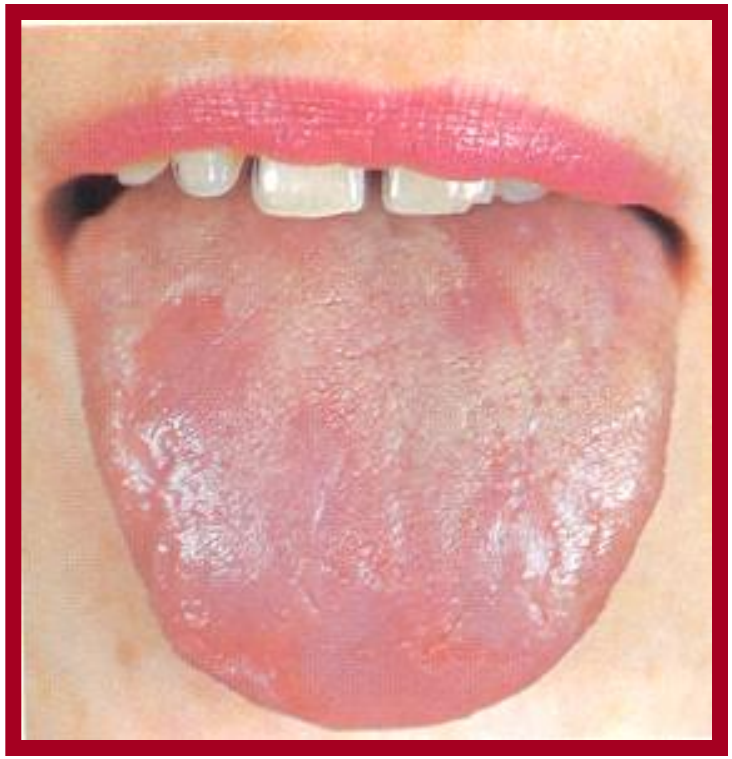
Q2. What is the management?

Geographical tongue



It is also known as erythema migrans or benign migratory glossaries. Apart from transient stinging it is usually asymptomatic and requires no treatment

29



Q1. What is this condition?

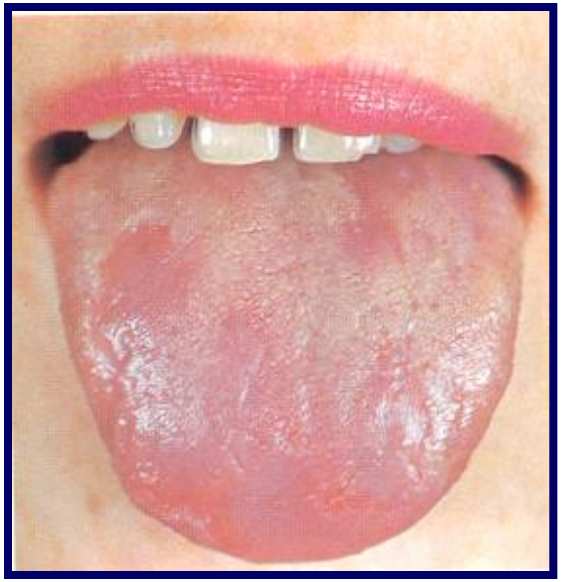
Q2. Is this a typical pattern?

Q3. What is the differential diagnosis?

Q4. How would you treat it?

Geographical tongue

(benign migratory glossitis)

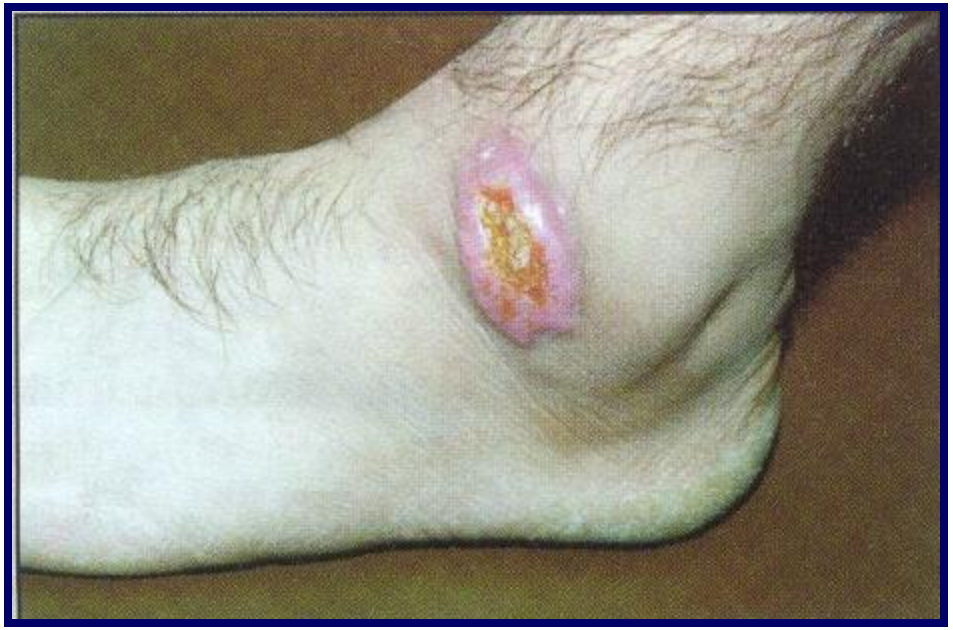


A2. **Yes. It is most common in young women.**

A3. **Leukoplakia. Candidosis, vitamin deficiency and some skin disorders.**

A4. **Reassurance, anti-inflammatory mouthwashes**

30



A 22-year-old Saudi patient noticed painless sore on his foot for about 6 weeks, it gradually increased in size. The rest of his skin was clear and there was no constitutional upset.

Q.1 What is the most probable diagnosis ?

Q.2 What is the means of transmission ?

Q.3 How is the diagnosis confirmed ?

Q.4 Is generalized infection a danger ?

Q.5 What is the prognosis if untreated ?

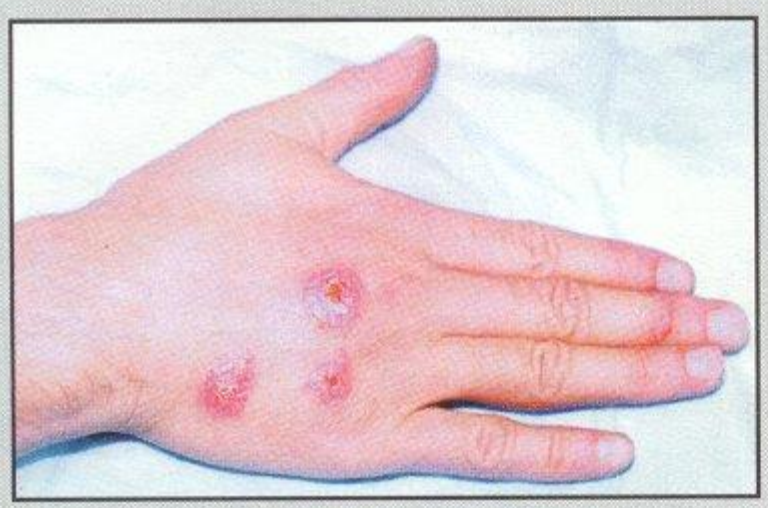


Figure 1. Cutaneous leishmaniasis due to L.major showing erythematous papules and nodules with central crusts

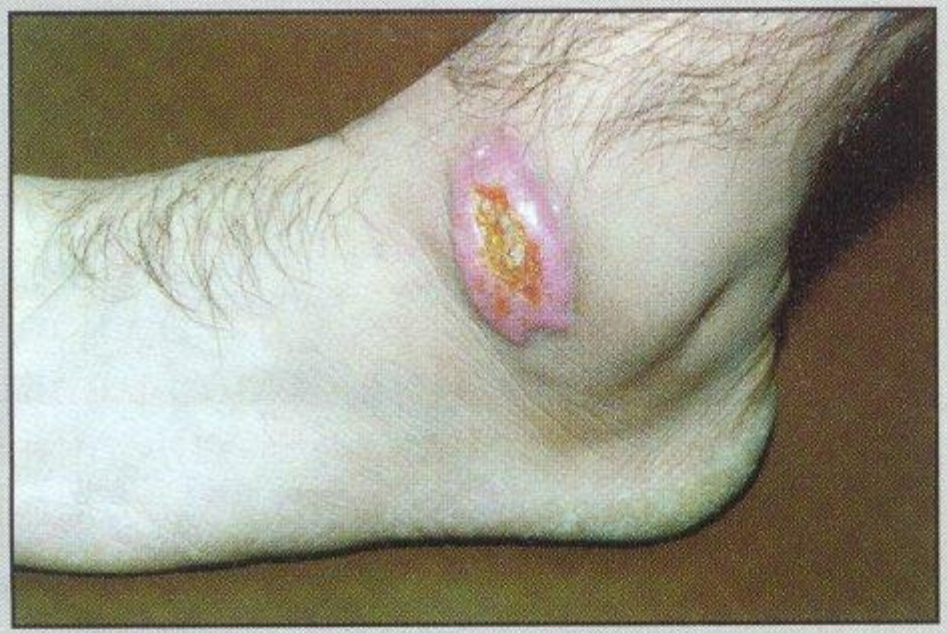
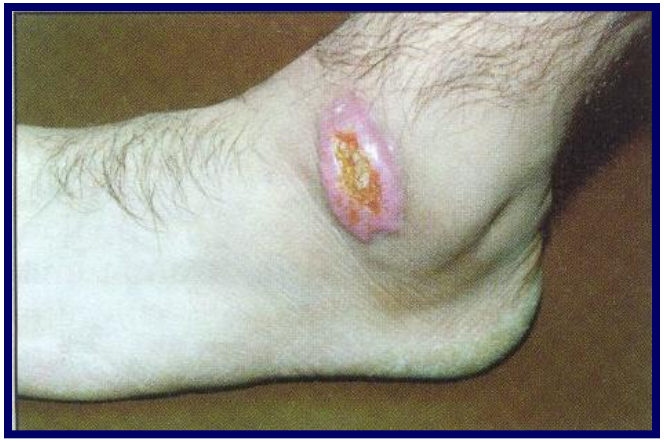


Figure 2. The typical nodulo-ulcer seen in Oriental sore

Cutaneous Leishmaniasis



A2. Transmitted from dog to man by the bite of sandfly.

A3. Diagnosis is confirmed by aspiration from the edge of the lesion to demonstrate the amastigote of leishmania.

A4. Infection remains localized to the skin.

A5. Prognosis: Over a period of months or years the lesion will heal with scaring and disfiguring partly as a result of secondary infection.

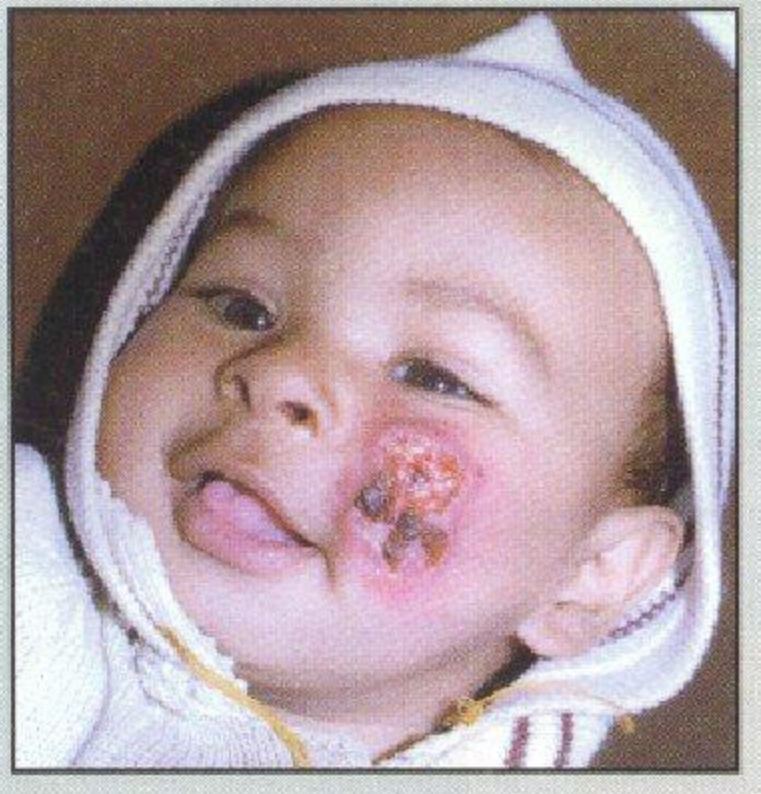


Figure 3. Ulcerative type of Oriental sore on the face of a child (before treatment)

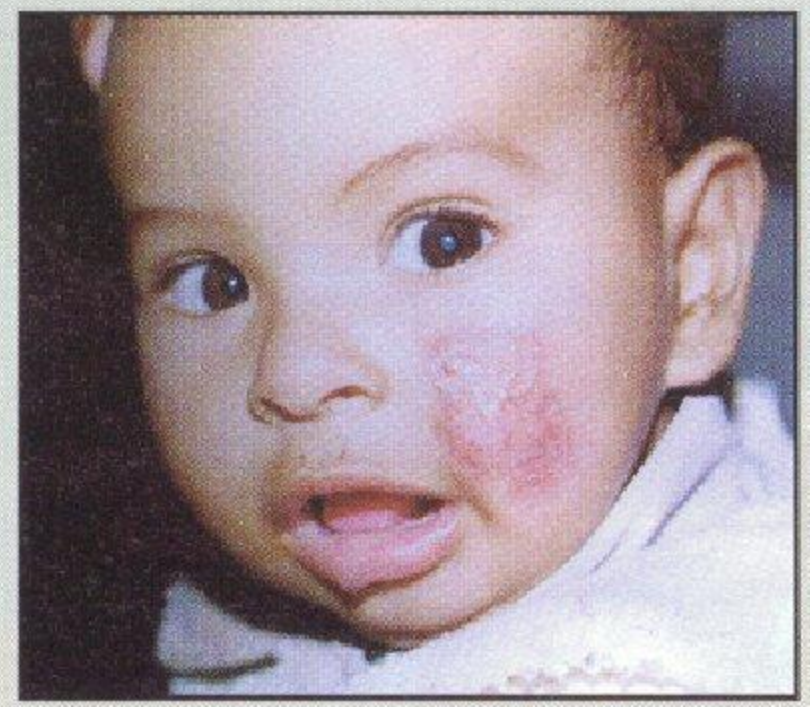


Figure 4. The same child showing healed up cutaneous leishmaniasis (after parenteral Sodium stibogluconate)

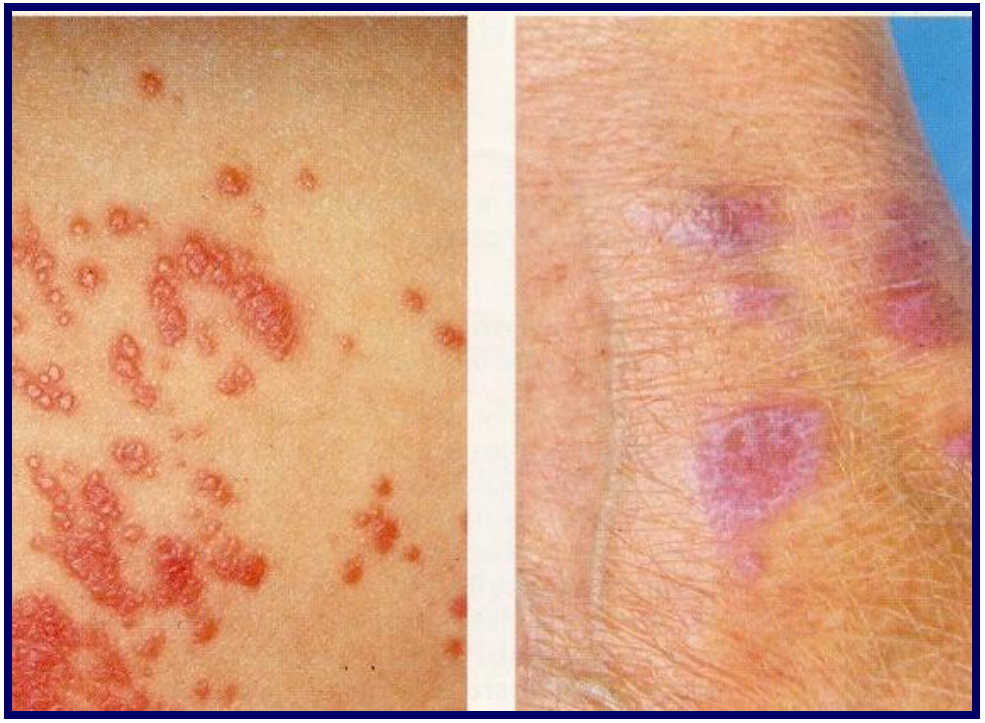
Cutaneous Leishmaniasis

Presentation: A non-itchy cutaneous lesion which tends to be circular or oval and which fails to heal despite traditional treatments. A history of travel in endemic areas is a prerequisite.

Investigations: A radial smear taken from the circumference of the lesion (which has been pinched to make it bloodless) will reveal the causative organism on microscopy.

Treatment: A spontaneous cure will occur with time (and lack of a diagnosis). Repeated applications of local heat will effect a cure, but pentavalent antimony (Stibogluconate) is often used.

31



These lesions were noted during evaluation of itchy purple lesions on the flexor aspect of the wrists.

Q1. What is the diagnosis?

Q2. What proportion of patients with skin lesions have oral lesions?

Q3. What is the significance of oral lesions on their own?

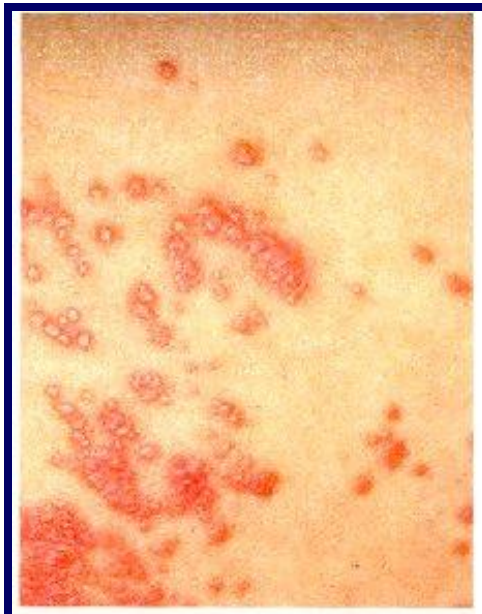


Fig. 1

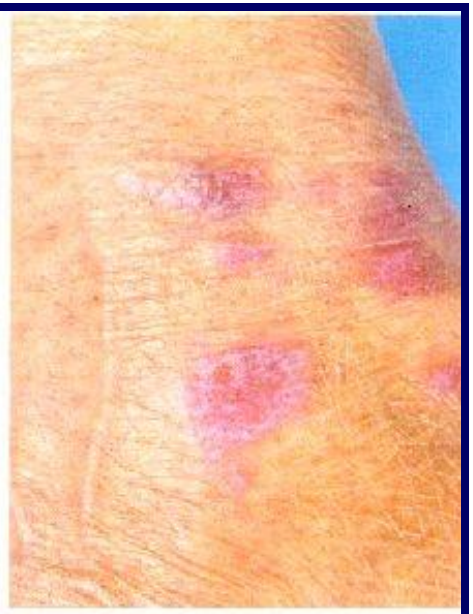


Fig. 2

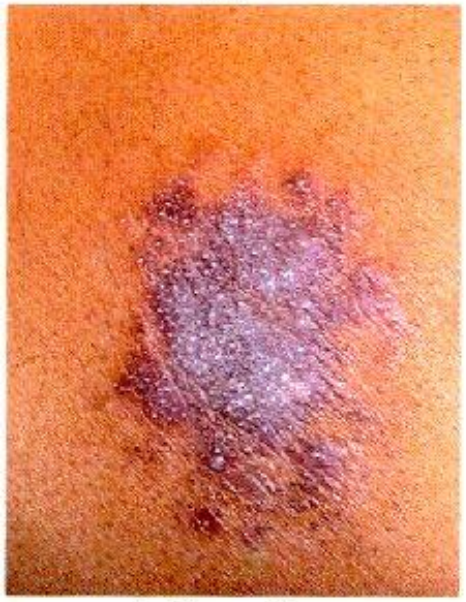


Fig. 3

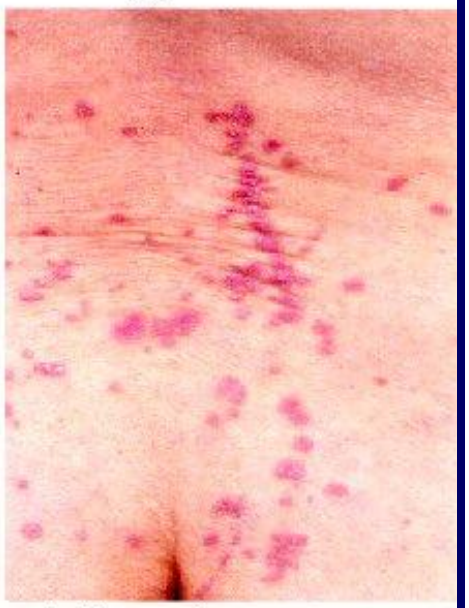


Fig. 4

Lichen Planus

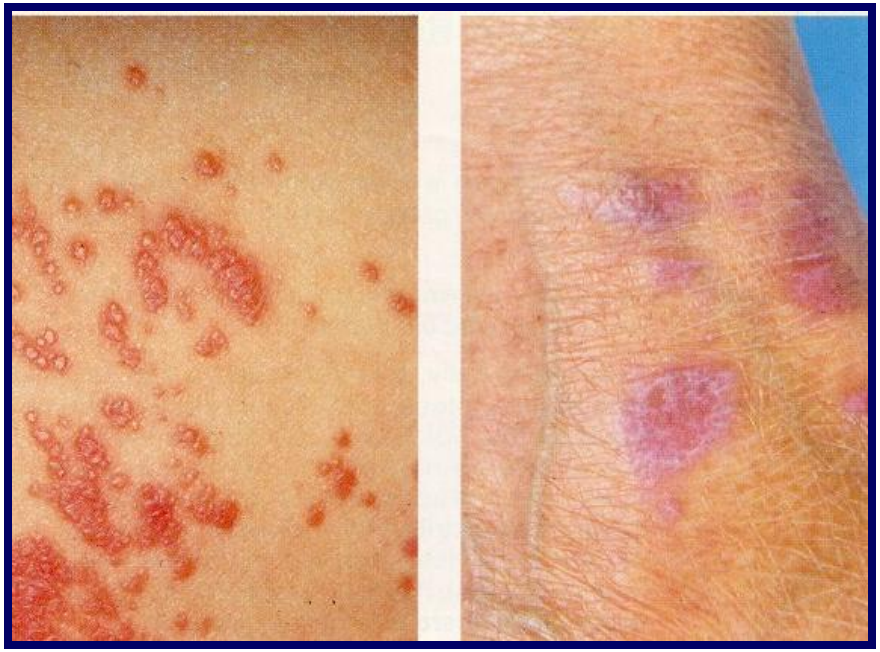
Fig. 1 Flat-topped violaceous papules

Fig. 2 Wickham's striae (lichen planus).

Fig. 3 Hypertrophic lichen planus.

Fig. 4 Lichen planus **(Koebner phenomenon).**

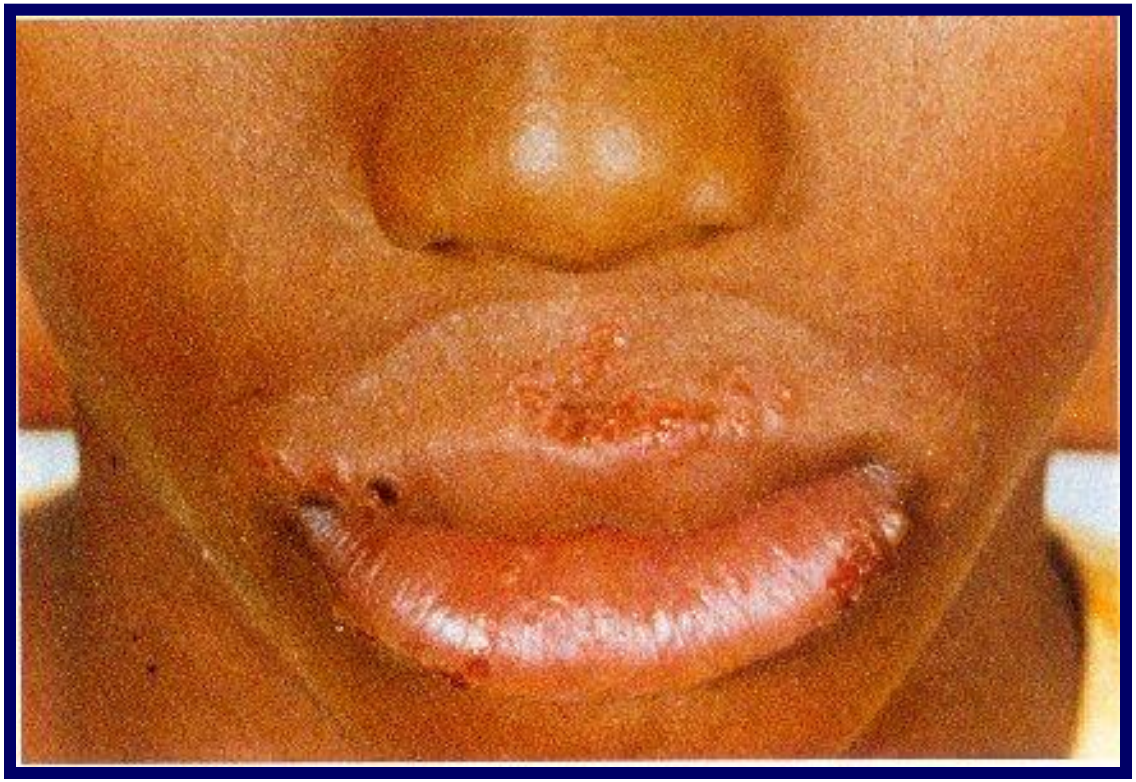
Lichen planus



A2. bout 75%, but most are asymptomatic.

A3. Oral lichenoid changes are relatively nonspecific, but may occur as a reaction to dental amalgam.

32

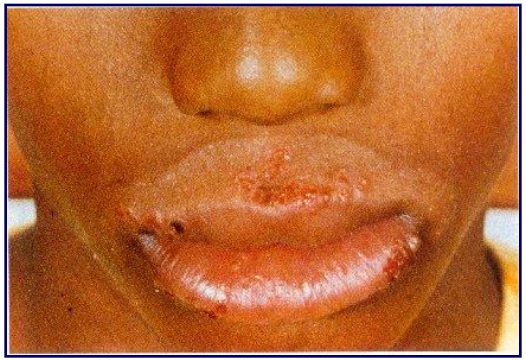


A child presented with thickening of his lips

Q1. What is the diagnosis?

Q2. What is your management?.

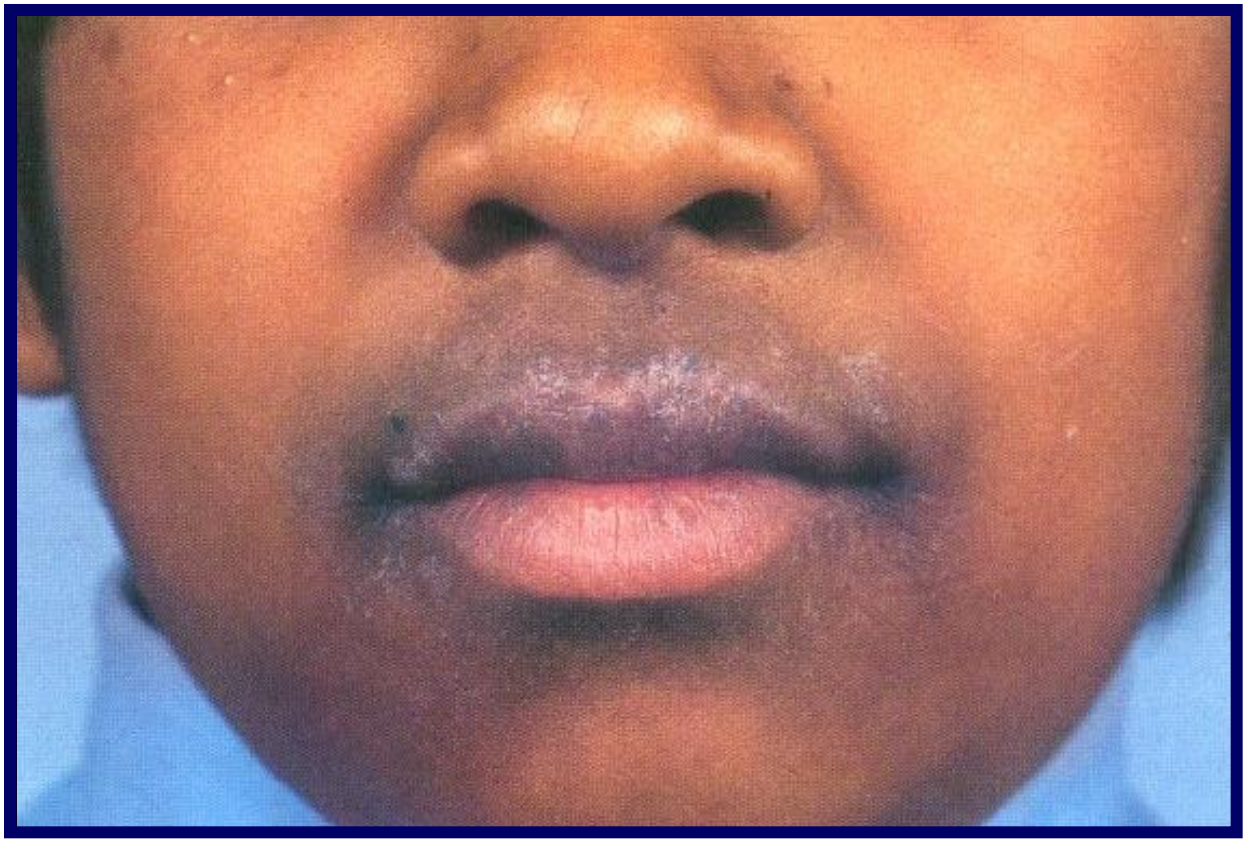
Lip Lick dermatitis



Lip lick dermatitis is a form of contact dermatitis caused by frequent lip llicking and is seen mostly in emotionally disturbed children.licking of the lips produces increased salivation and thickening of the lips. Eventually a distinctive marginated perioral zone of dry scaly inflammation originates, resembling the exaggerated mouth make- up of a clown.

A2. Treatment should ideally involve psycho- therapy, but parents will not always accept that lip licking is the cause. Local applications of a mild steroid combined with antimycotic preparation lead to rapid cure.

Lick eczema

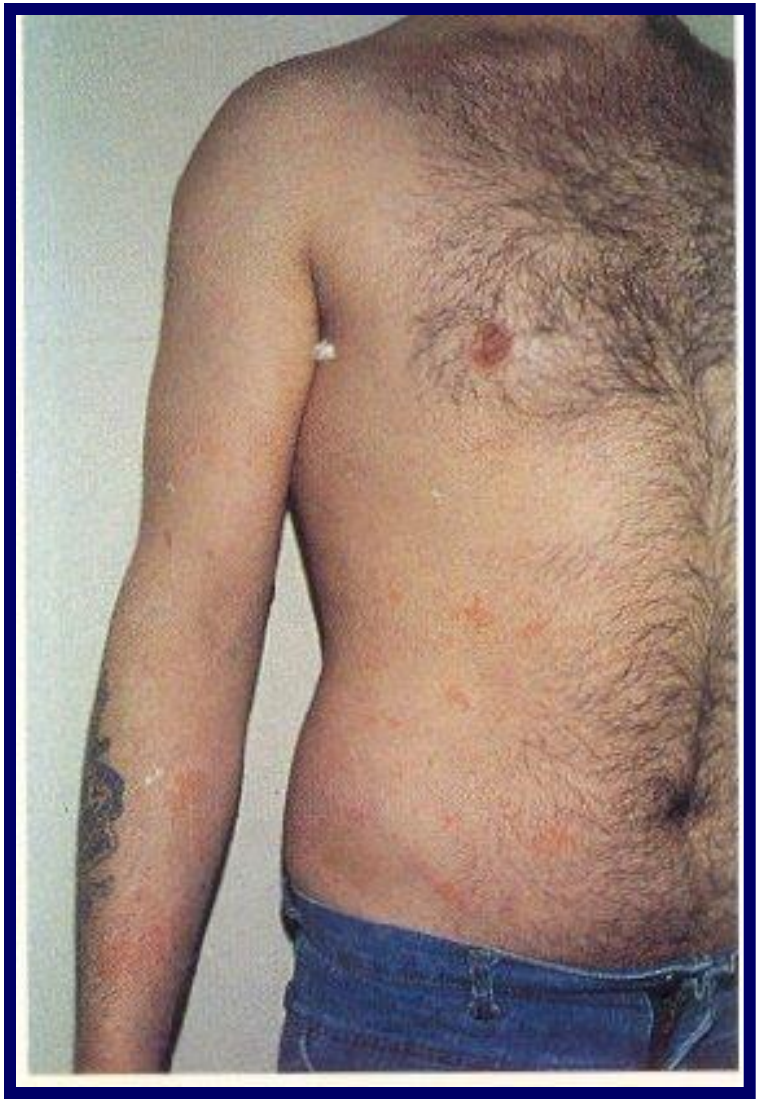


33

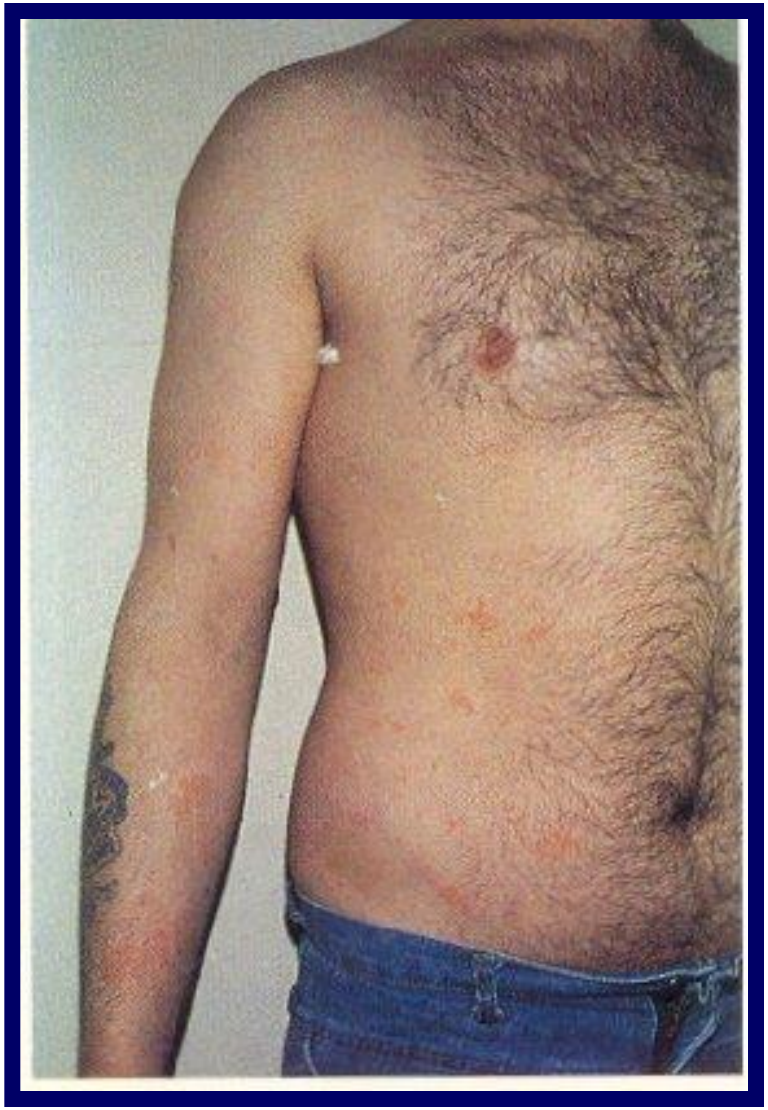
This 32-year-old ex-intravenous drug abuser complained of headaches and arthralgia.

Q1. What abnormality is shown

Q2. What is its significance?

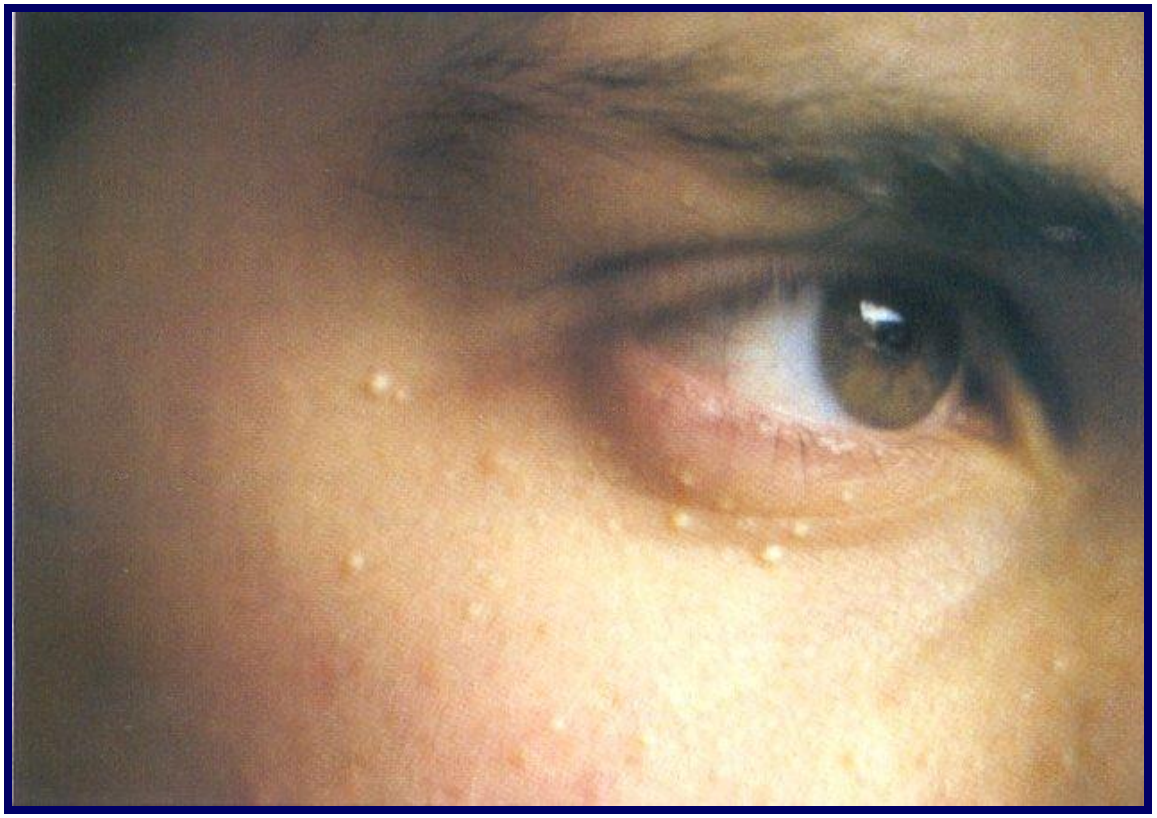


A maculo-papular rash



A2. This may occur shortly before seroconversion in HIV-infected individuals

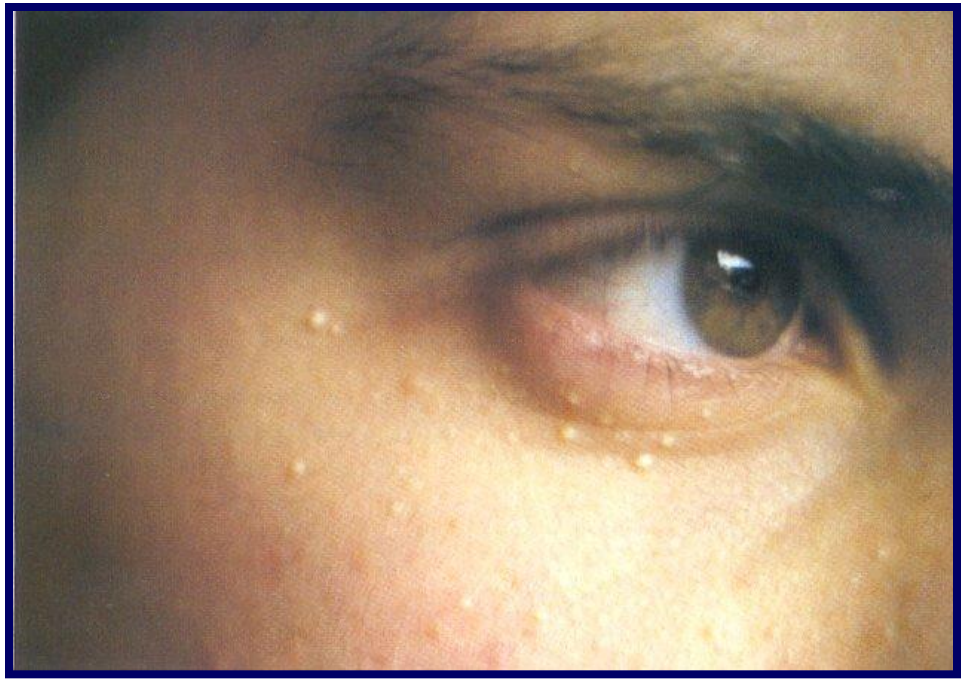
34



This 16-year-old boy was concerned about white spots under his eyes.

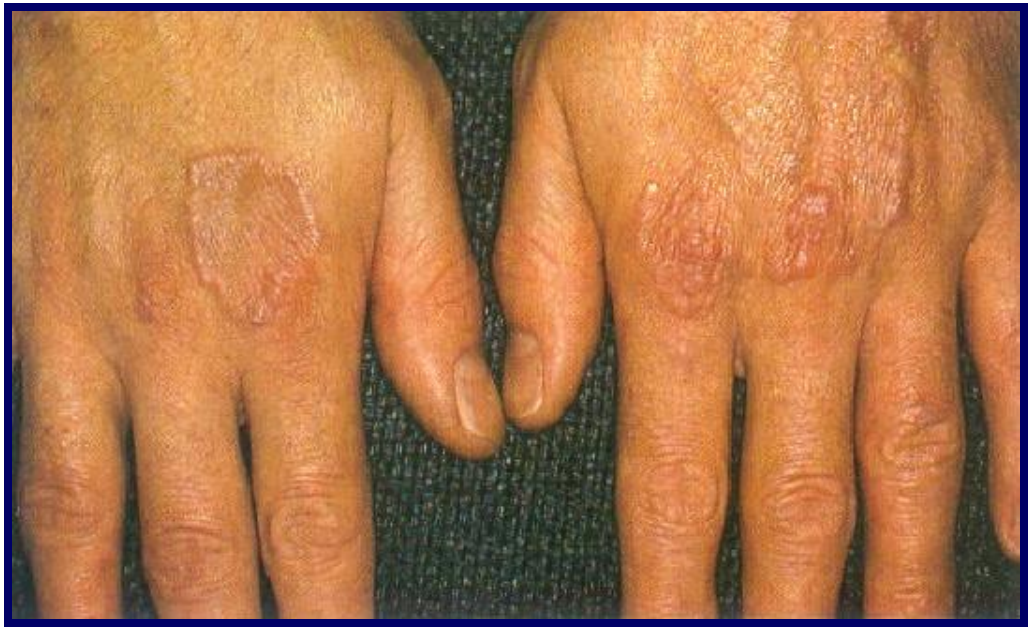
Q1. What abnormality is shown

Kerion



There are tiny keratin-filled cysts which could be drained with sterile needle with immediate effect

35



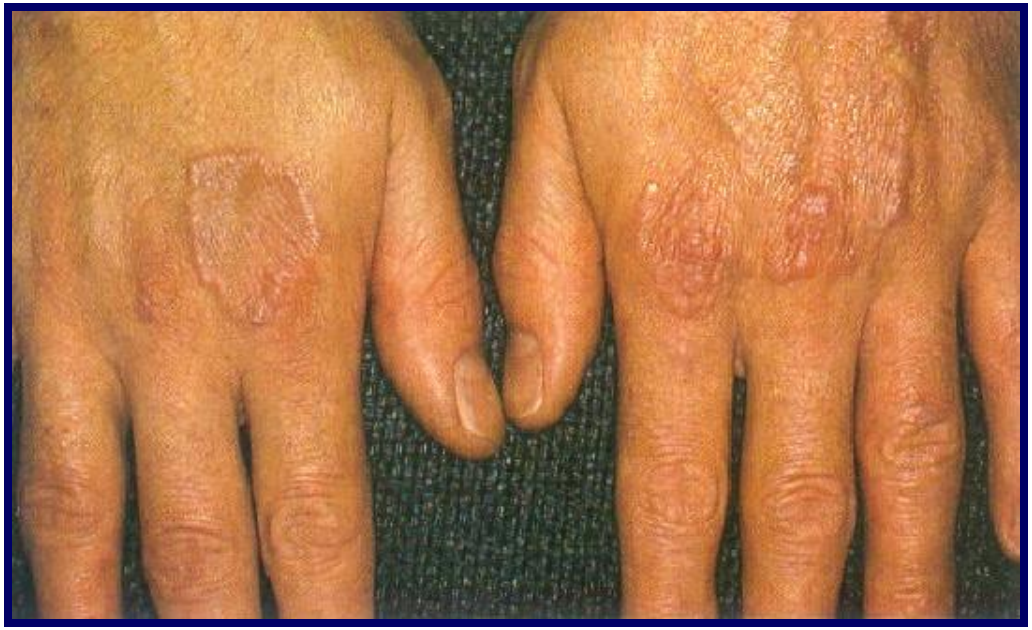
These patches appeared on the hands of a 40-year-old man. They were mistaken for tinea infection but failed to resolve with antifungal treatment.

Q1. What is the diagnosis?

Q2. With what other skin condition is it closely associated?

Q3. Is any locally applied treatment effective?

Granuloma annulare



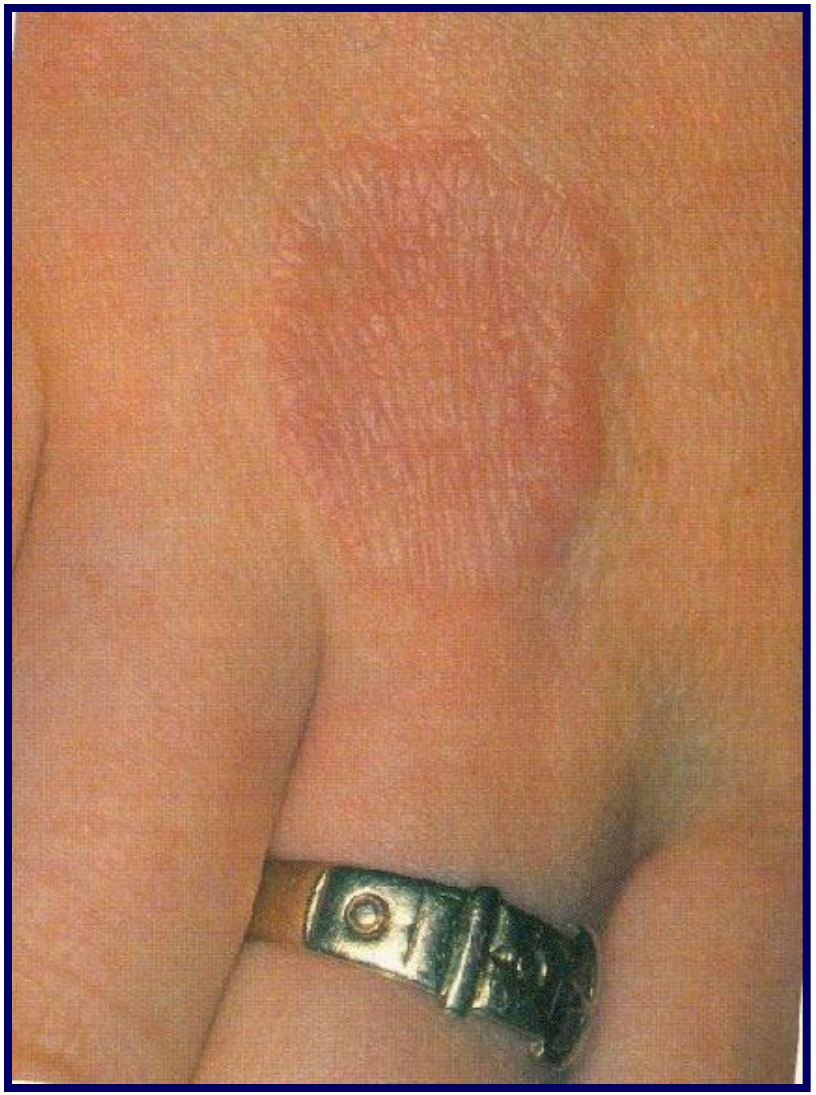
A2. Necrobiosis lipoidica.

A3. Yes. locally applied treatment is effective intralesioal corticosteroids may speed resolution.

Granuloma annulare

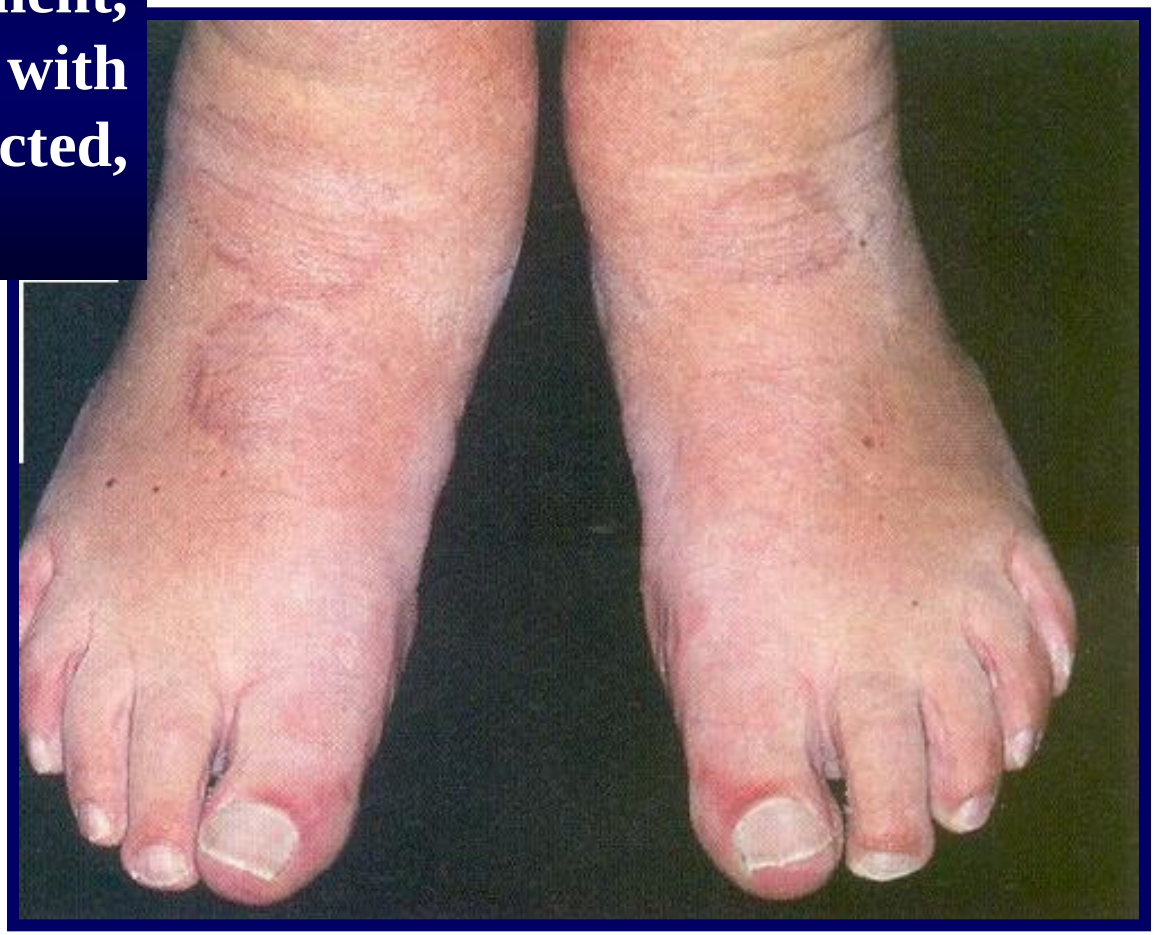
Lesions are usually found on the back of the hand and the knuckles. They comprise dermal nodules fused into a rough ring shape. Lesions are skin-colored or slightly pink. There is an association with diabetes, but only in a few adults who have extensive lesions.

No treatment is required as the lesions gradually disappear without scarring over a period of 1 or 2 years.



Granuloma annulare

In most cases the lesions resolve without treatment, but if an association with diabetes is suspected, urinalysis is indicated



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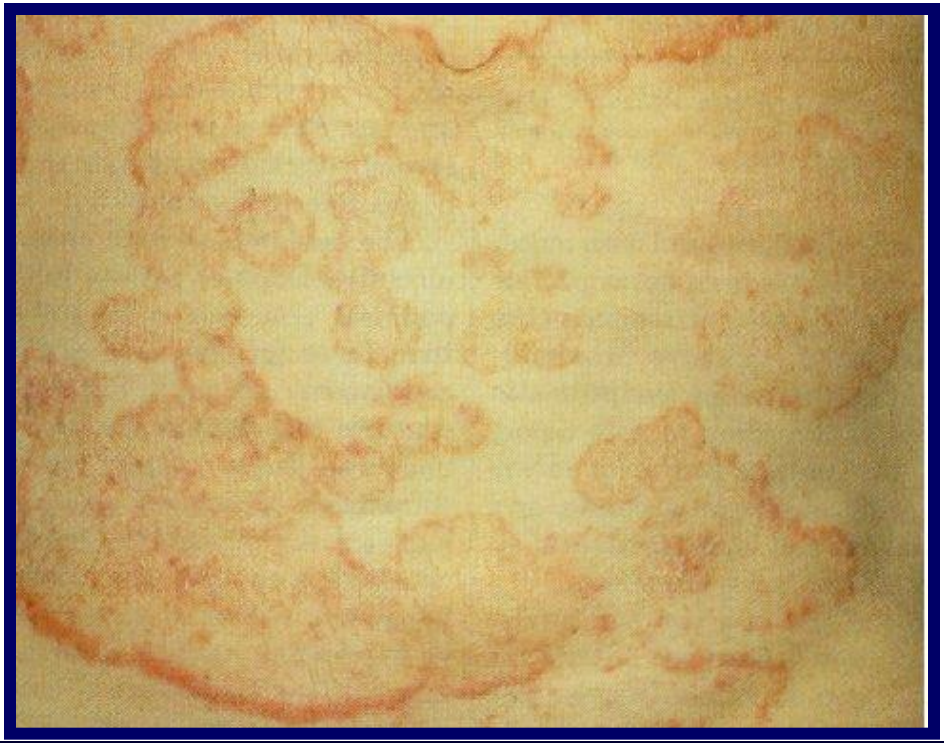
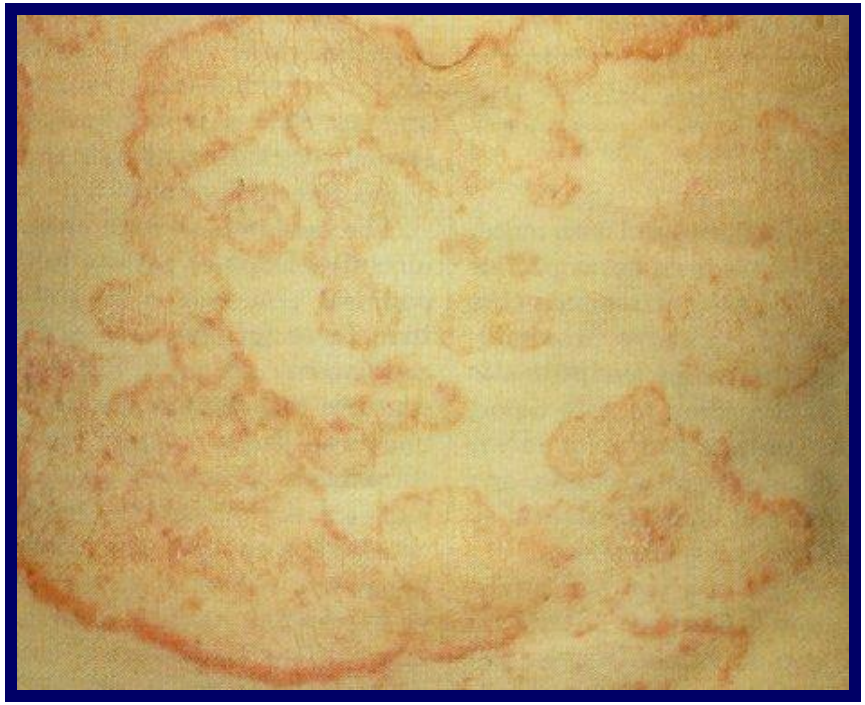


53-year-old man on chronic immunosuppressant drugs after a kidney transplant presented with a rapidly evolving eruption on the trunk. Skin examination revealed sharply marginated interconnected scaly, red plaques in an annular (advancing margins and central clearing) configuration

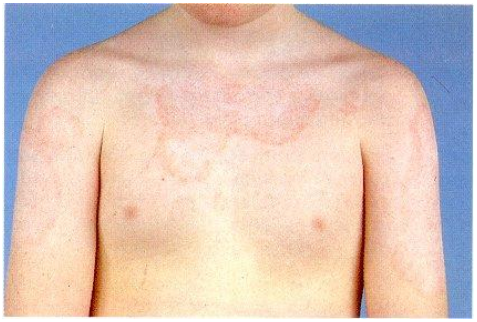
Q. What is the differential diagnosis of annular lesions?

Differential diagnosis of annular lesions

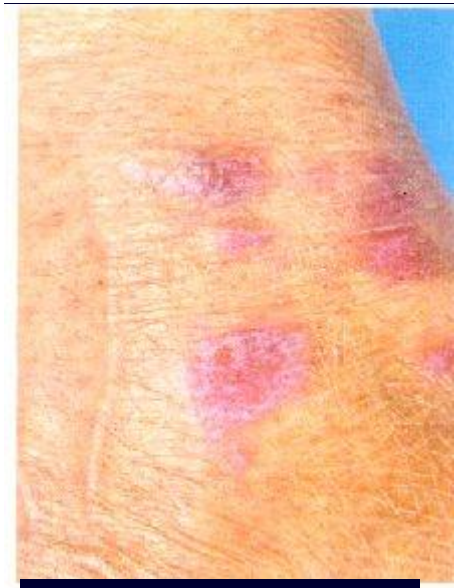


1. Fungal infection
2. Lichen planus
3. Luls (syphilis)
4. Lupus
5. Psoriasis
6. Pityriasis rosea
7. Parapsoriasis

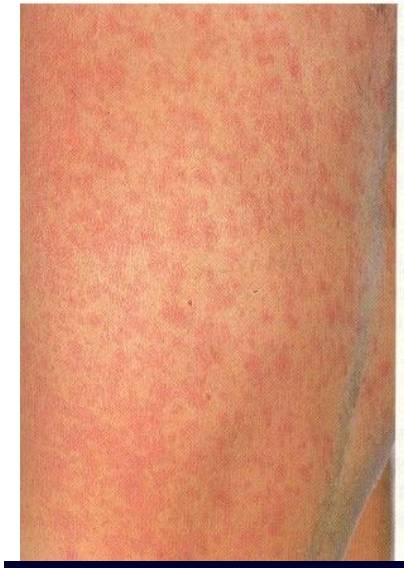
Differential diagnosis of annular lesions

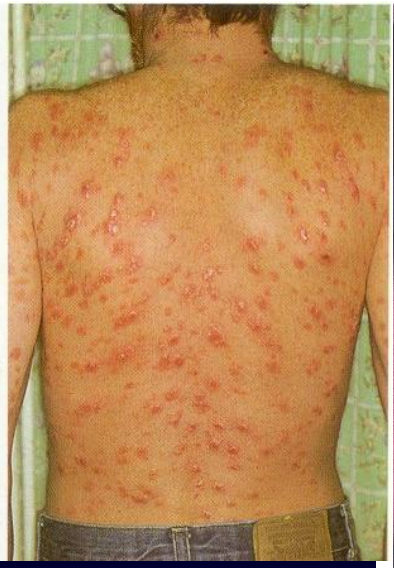


Fungal infection

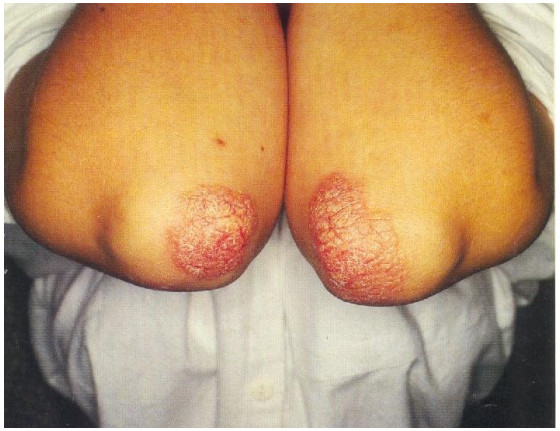


lichen planus

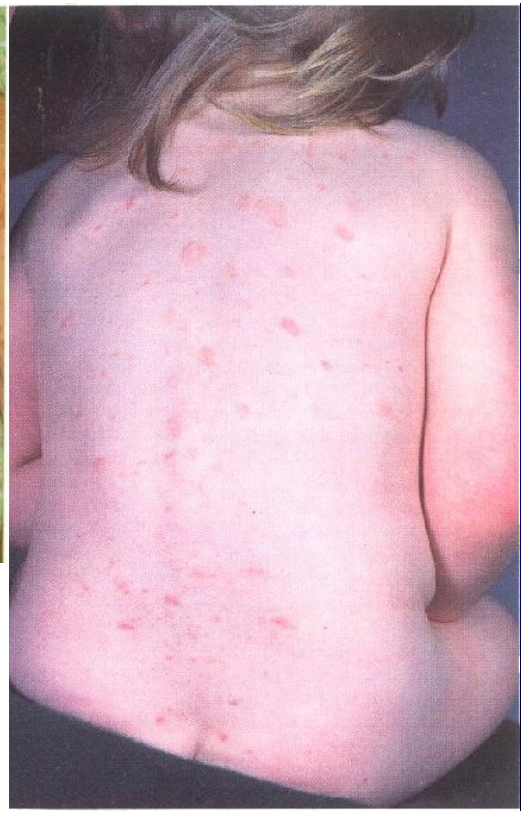




Secondary Syphilis-rash

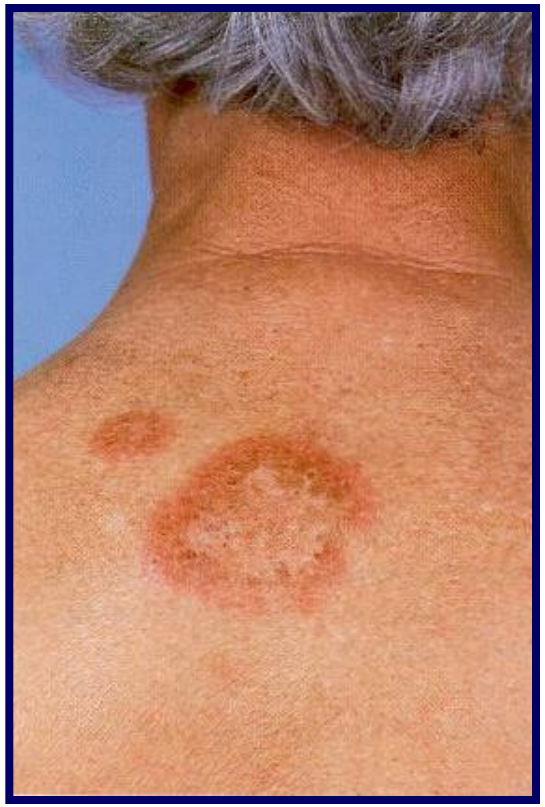


Psoriasis

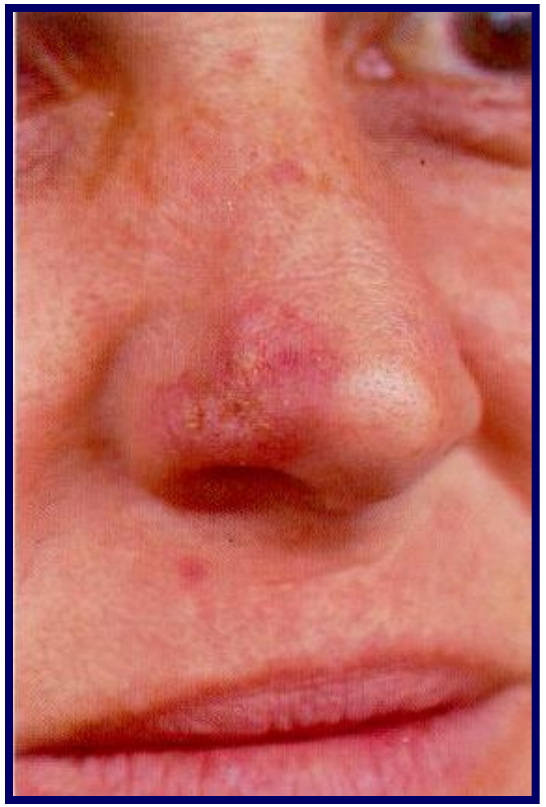


Pityriasis rosea

Discoid lupus erythematosus

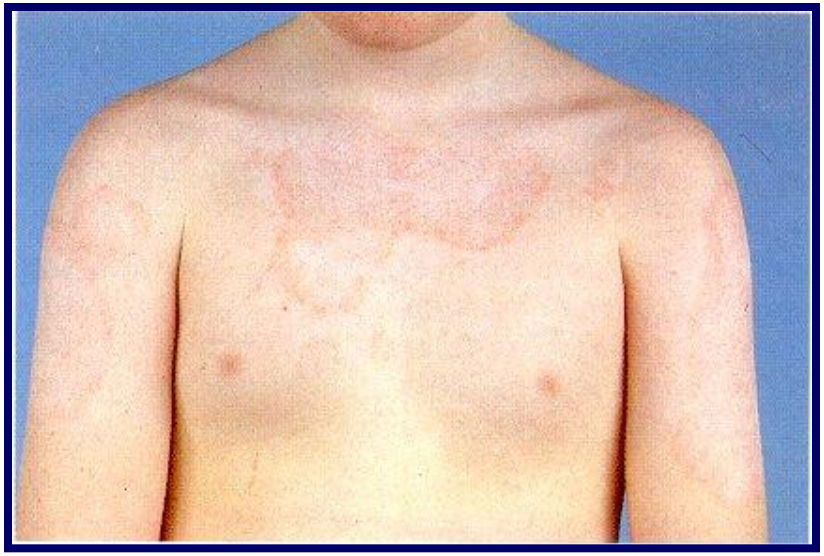


Discoid lupus erythematosis

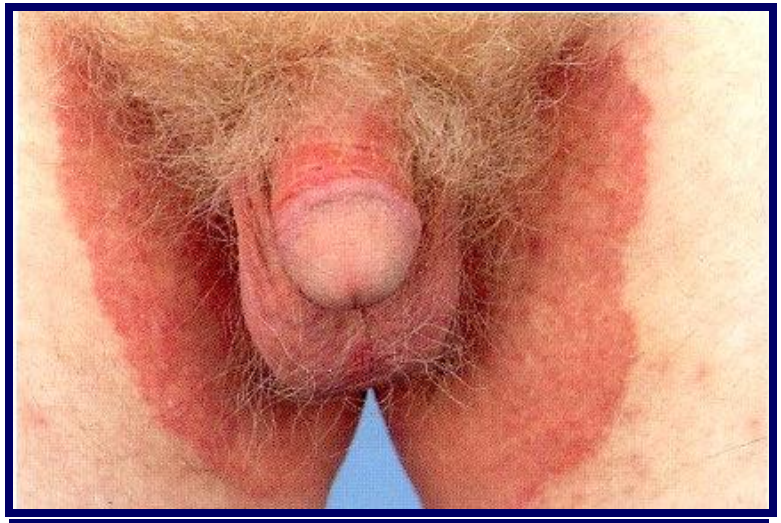


Well-defined plaque of DLE on nose with follicular plugging / scarring.

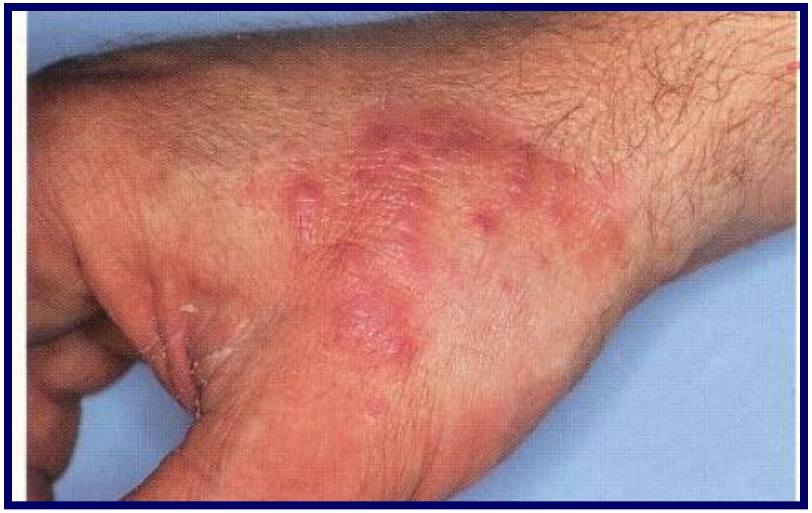
Fungal Infections



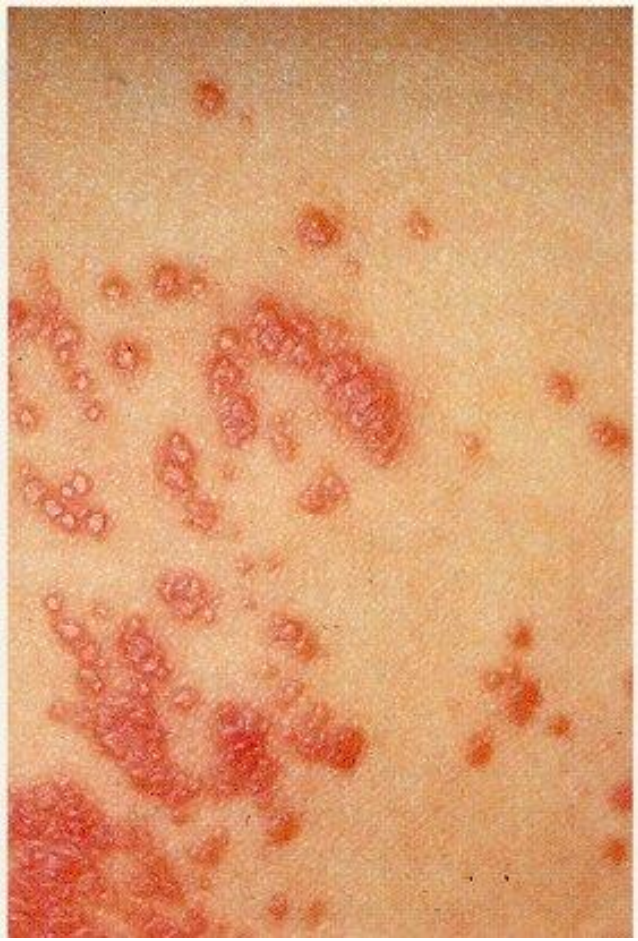
Tinea corporis.



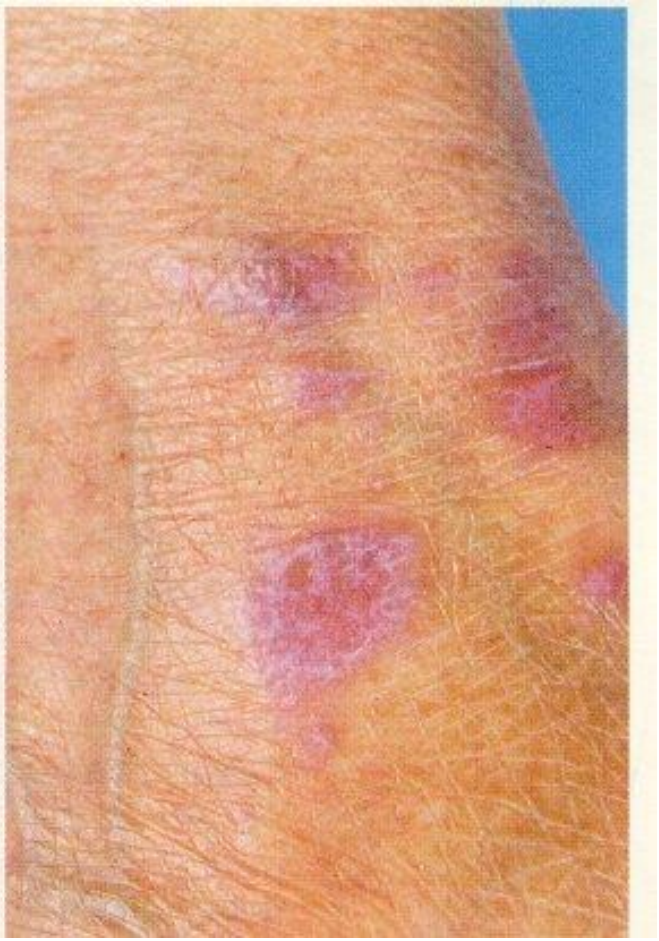
Tinea cruris



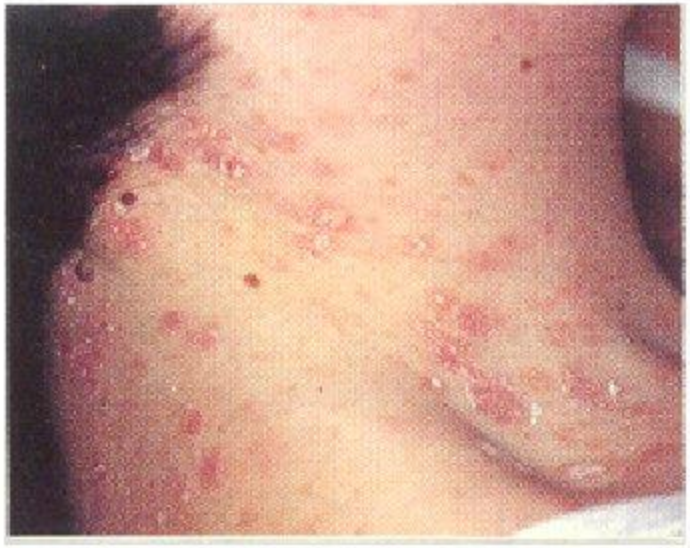
Ringworm granuloma



Flat-topped violaceous papules of lichen planus.



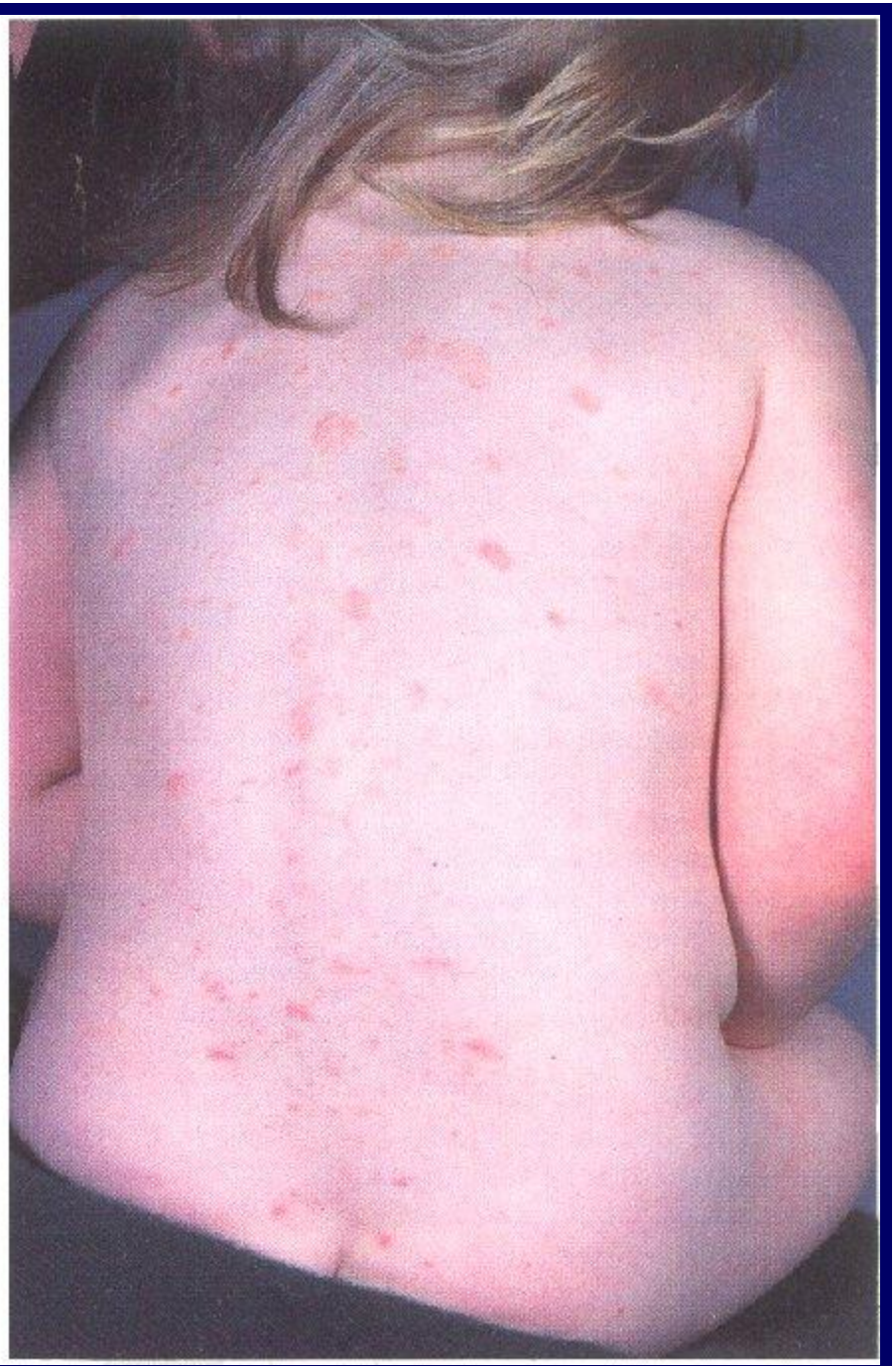
Wickham's striae (lichen planus).



Pityriasis rosea affecting base of neck – note the peripheral collarette of scale

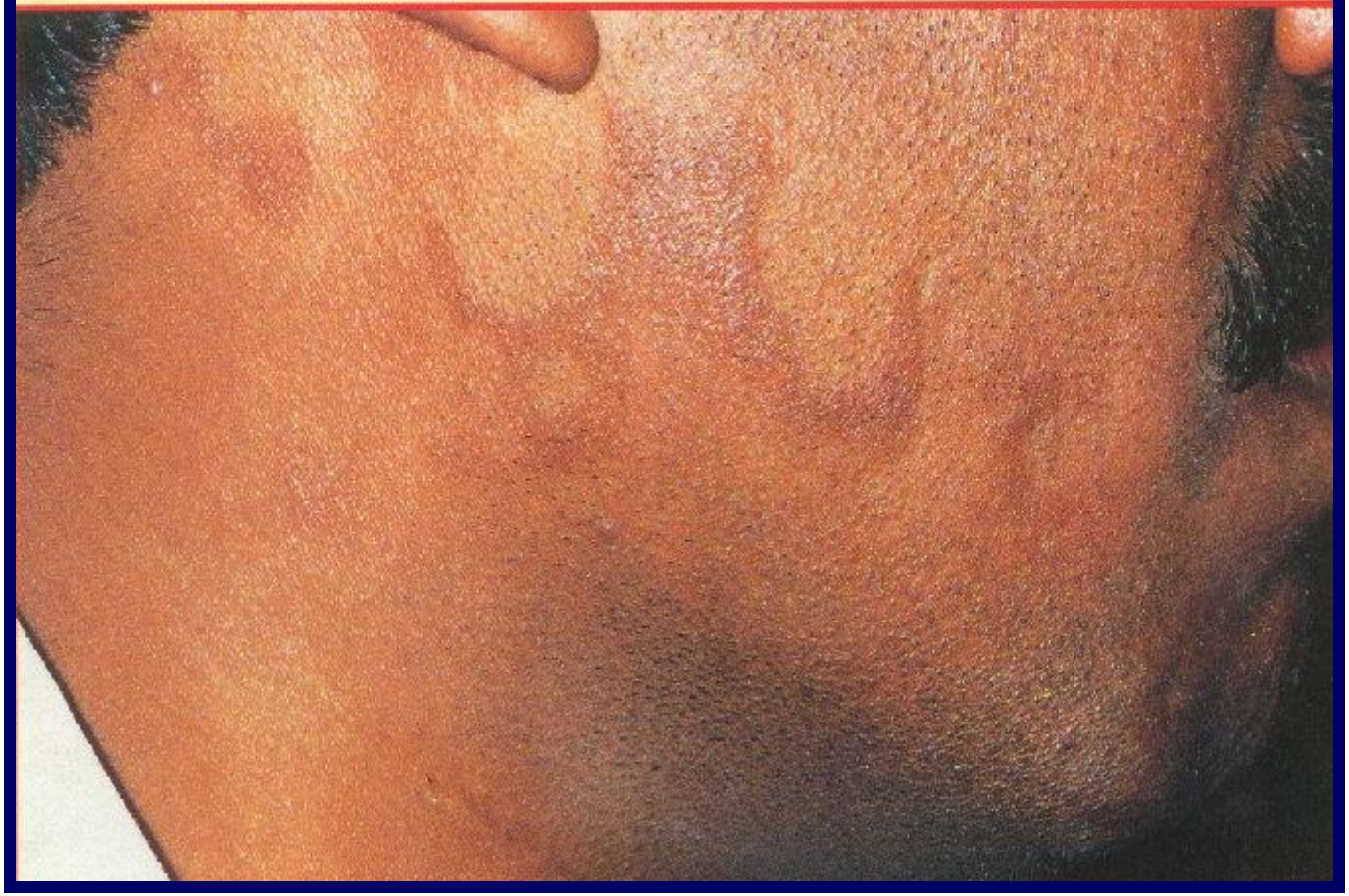
Pityriasis rosea

Differential diagnosis:
Seborrhoeic dermatitis
Secondry syphilis
Psoriasis



Annular lesions (Urticaria)

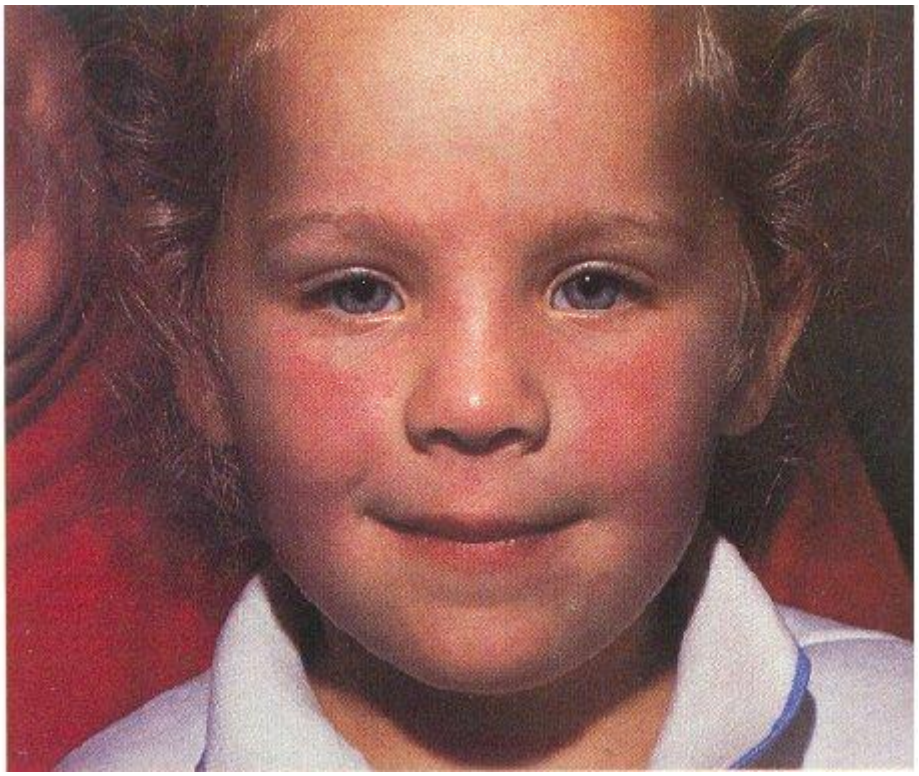
Flesh-coloned weals, usually allergic response



This 4-year-old girl presented with a faint rash all over her body and marked erythema of the cheeks. Three other children in her nursery school had the same symptoms. She and her friends were perfectly well except for the changes in the skin

Q1. What is the likely diagnosis?

Q2. What is the infecting agent?



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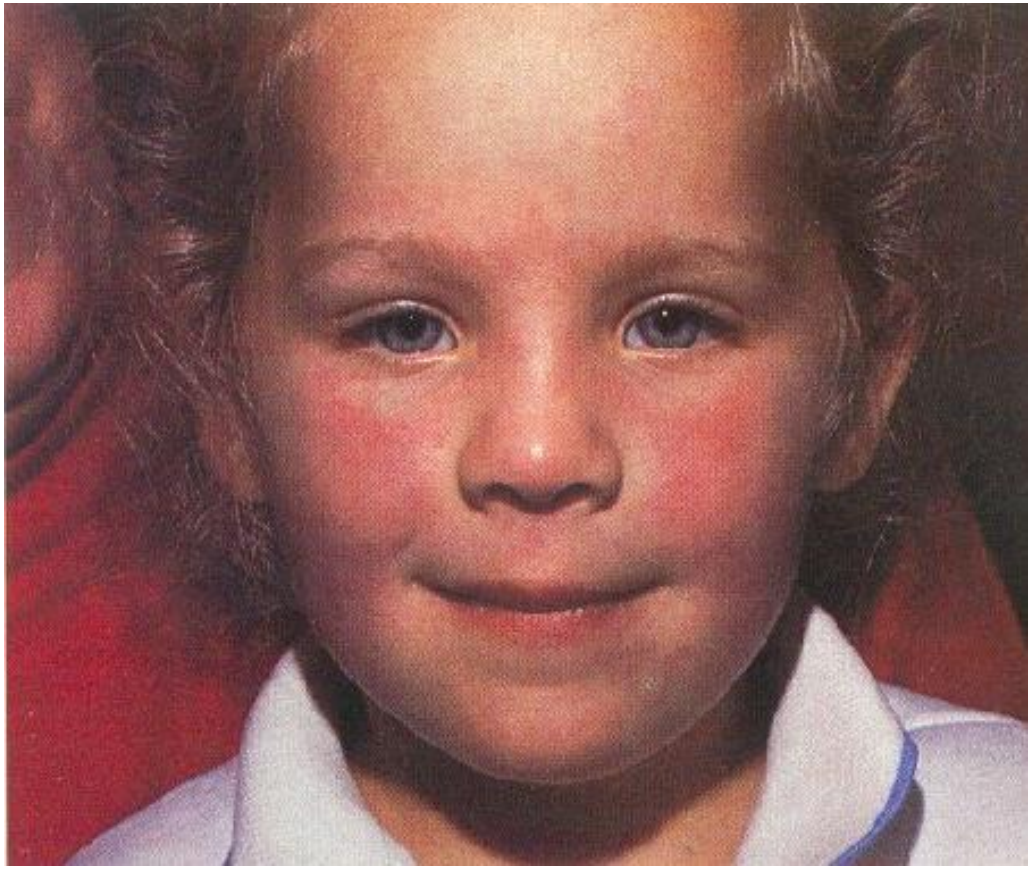
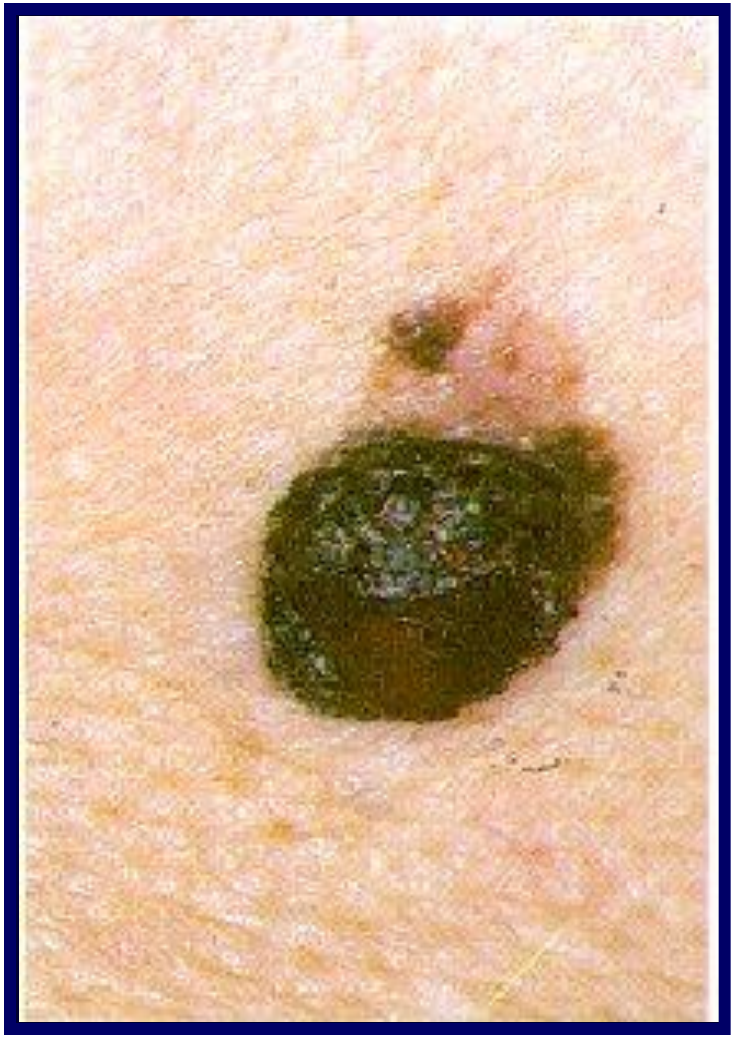
Erythema infectiosum



A1 Or Slapped cheek disease or fifth disease

A2 parvovirus

38

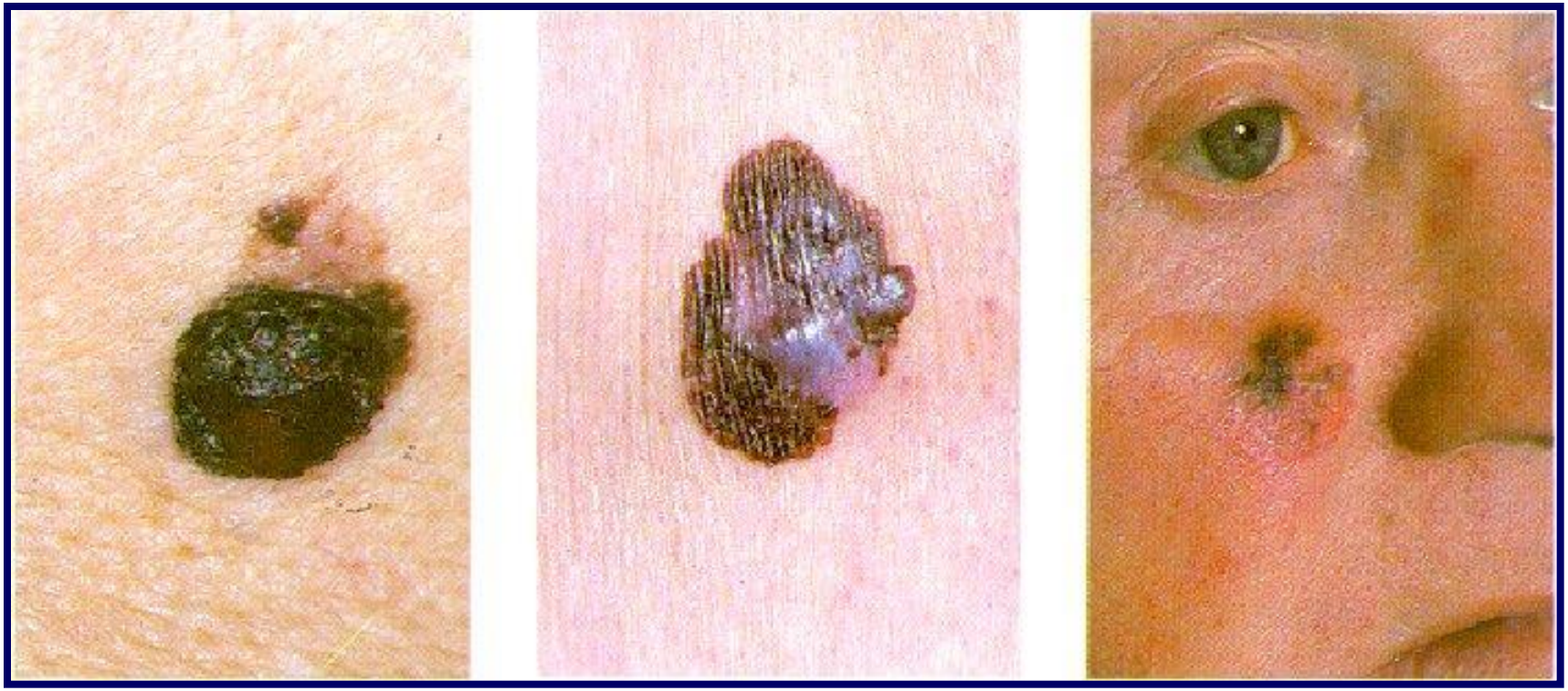


Slowly growing pigmented lesion (about 3-2 cm) on the face of a 32 years old man.

Q.1 What is it ?

Q.2 Name other three pigmented lesions which occasionally inter into differential diagnosis ?

Q.3 Mention two etiological factors ?



Nodular melanoma. **Superficial melanoma. with nodules** **Lentigo maligna.**

Malignant Melanoma

A2. Differential diagnosis:

Seborffioeic Keratosis

Compound melanocytic nevus

Blue nevus

Pigmented histocytoma

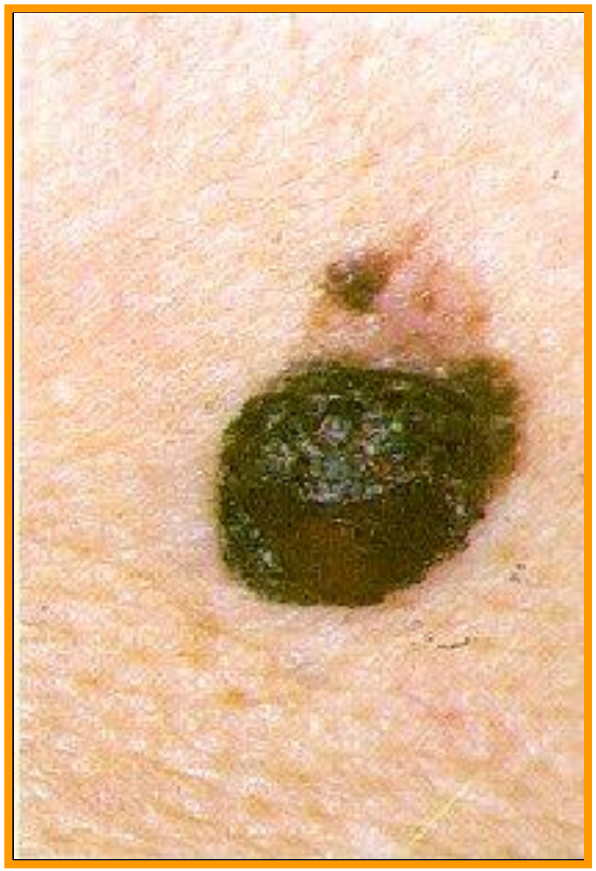
Pigmented basal cell carcinoma

A3. Etiological factors:

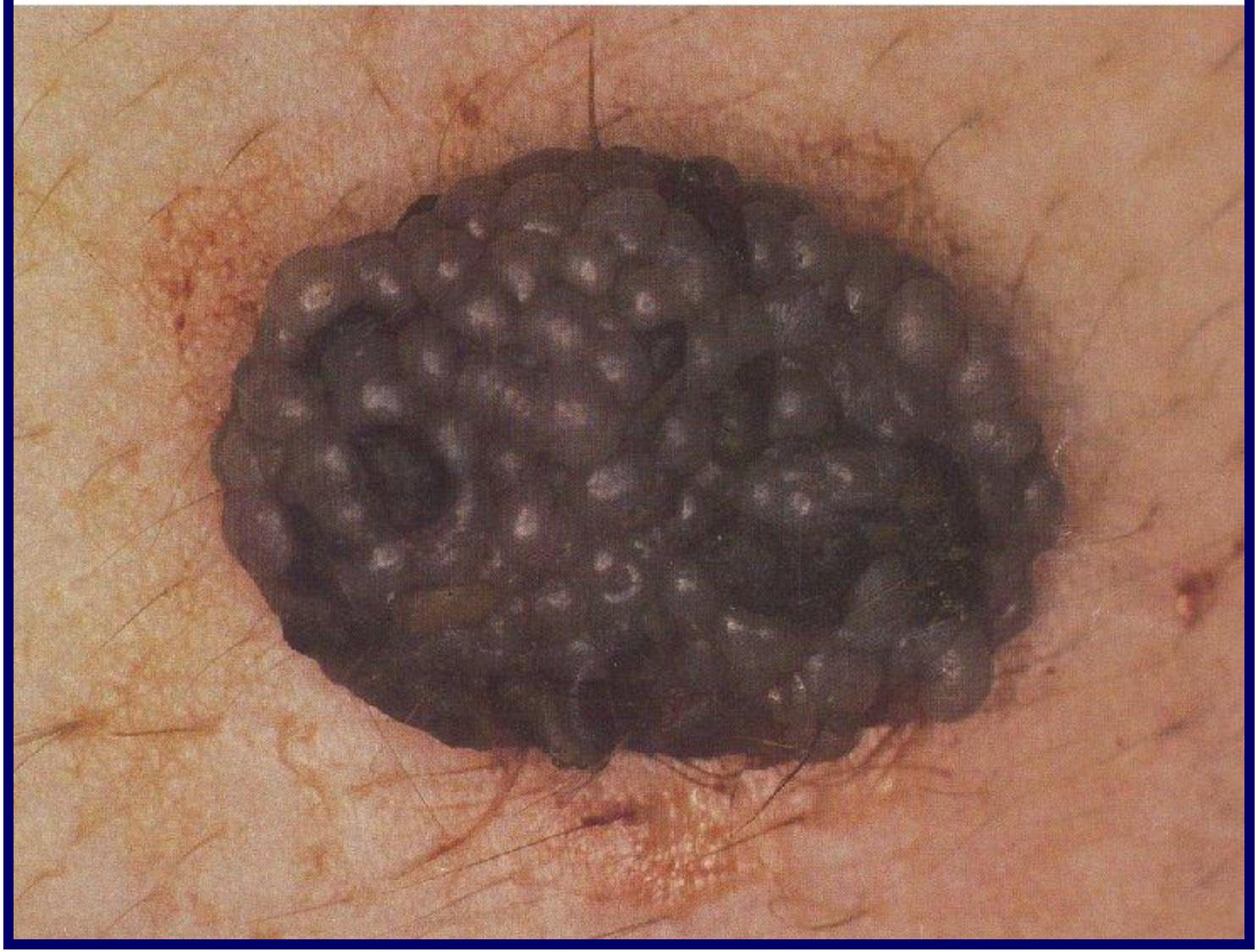
Sunlight

Racial susceptibility

Penetrating trauma occasionally has given rise to a malignant melanoma.



Multipolypoid naevus



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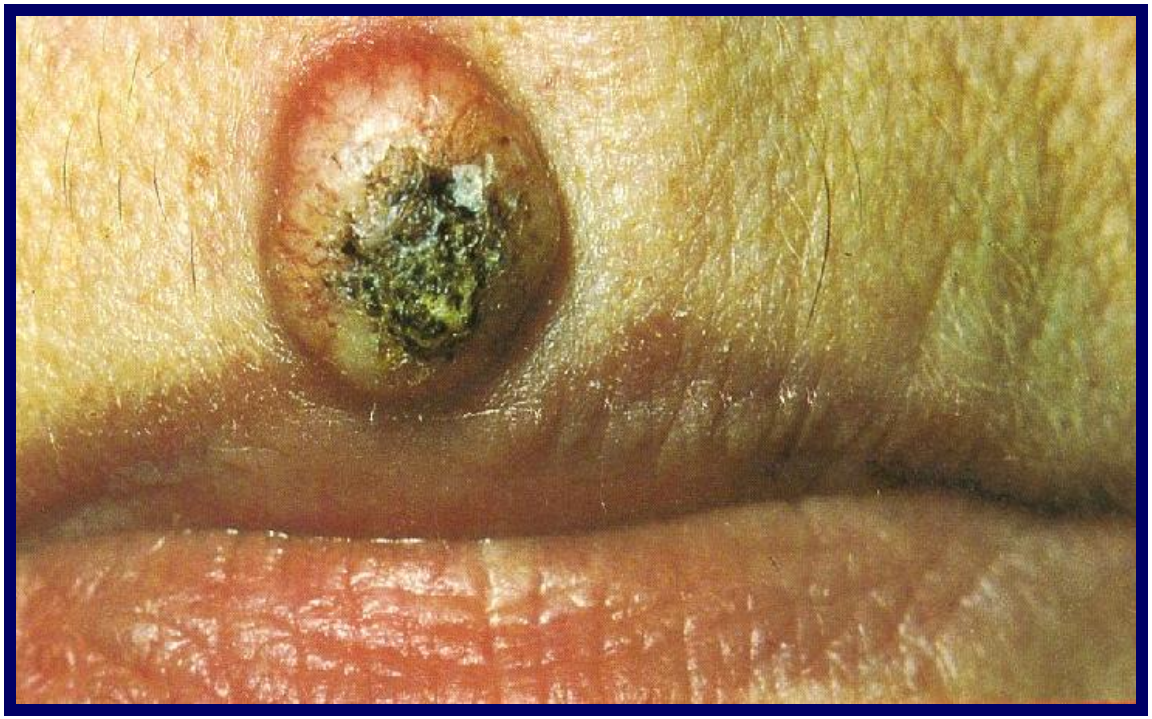
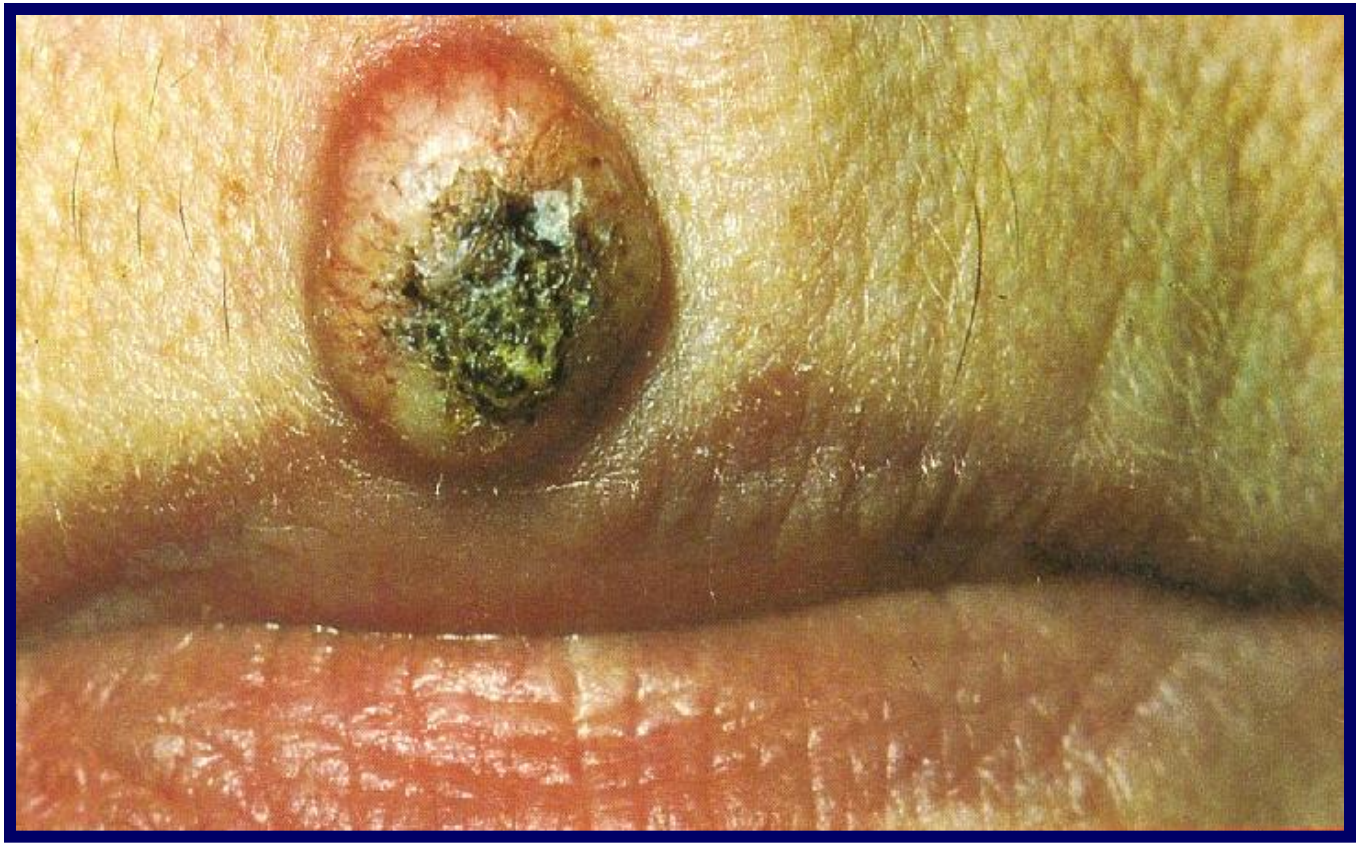


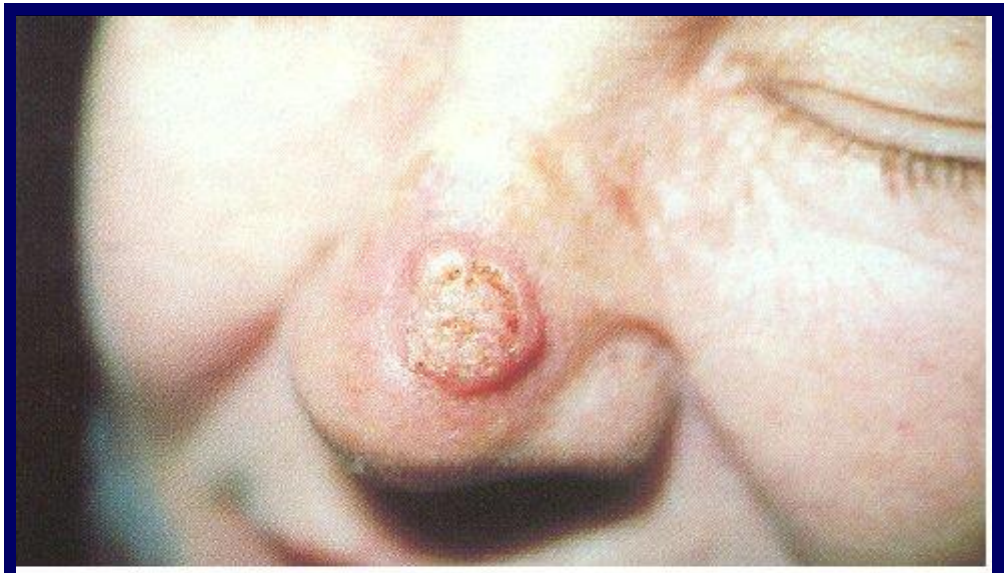
A 52-year-old school teacher developed "pimple" that rapidly growing over 6 weeks

Q1. What is the diagnosis?

Q2. What is the differential diagnosis?

Keratocanthoma



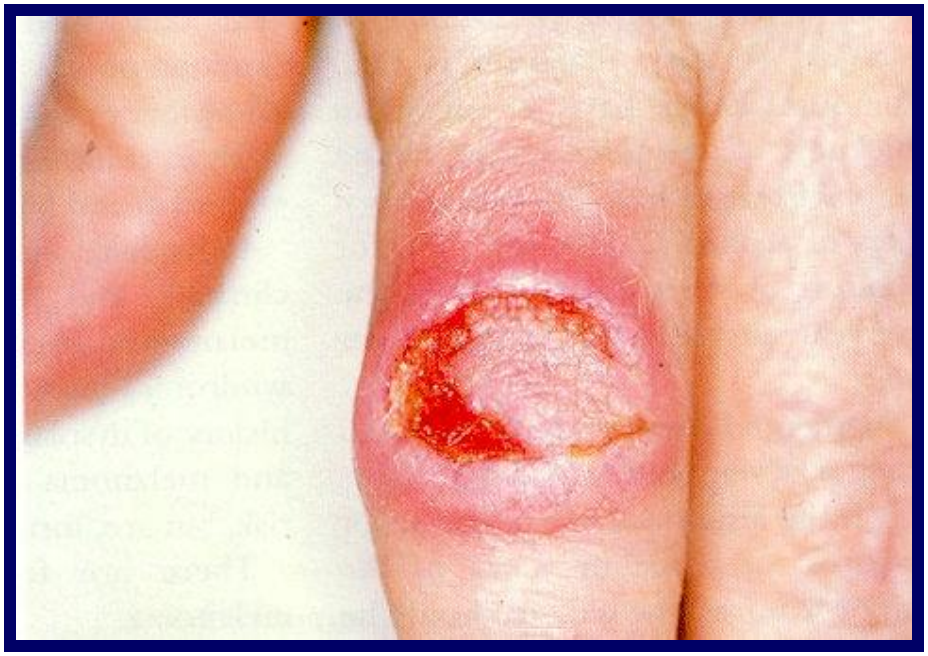


Keratocanthoma

Differential diagnosis:

* Infctious granuloma,
* Warts
* Cutaneous malignancy.

40



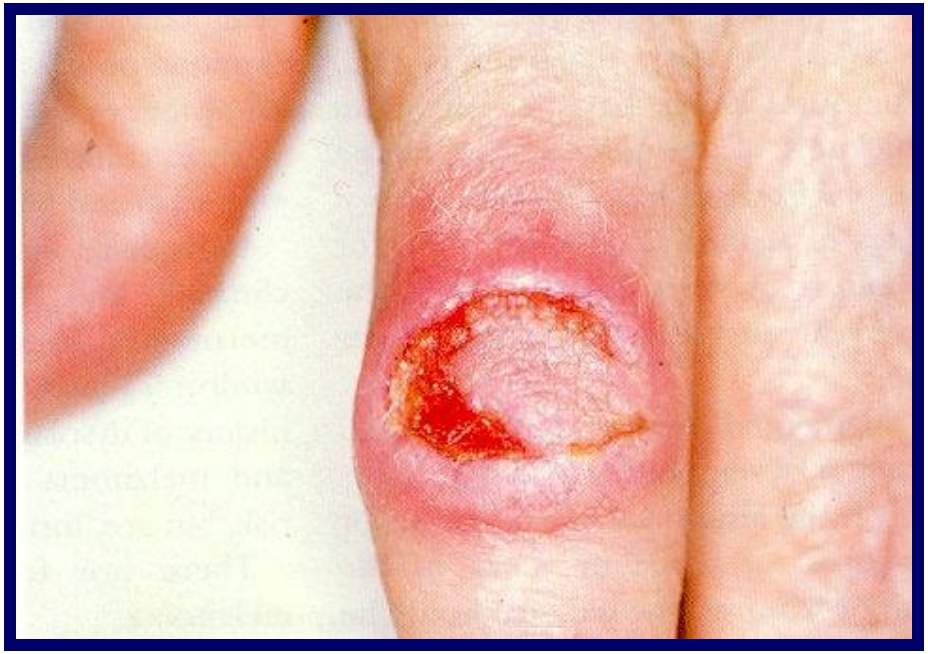
The lesion on the finger of an elderly man grew without symptoms for several months.

Q1. What is the likely diagnosis?

Q2. How would you prove it?

Q3. What is the most important factor in its production?

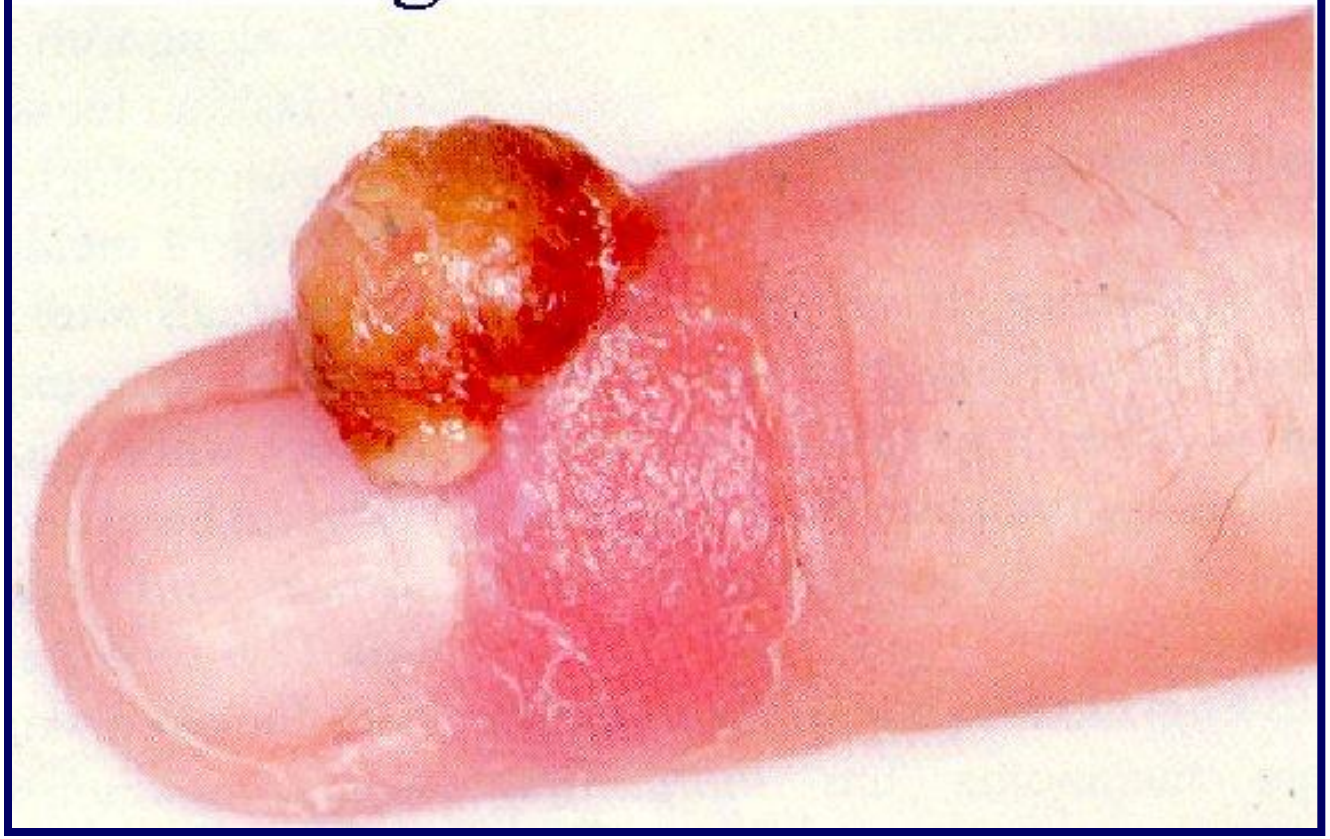
Squamous cell carcinoma.



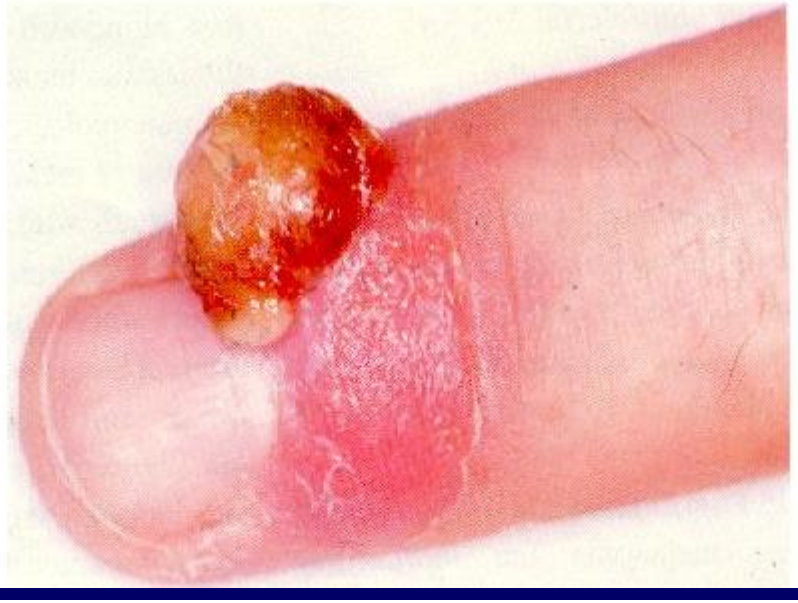
A2. Biopsy for histopathology

A3. Excessive sunlight exposure.

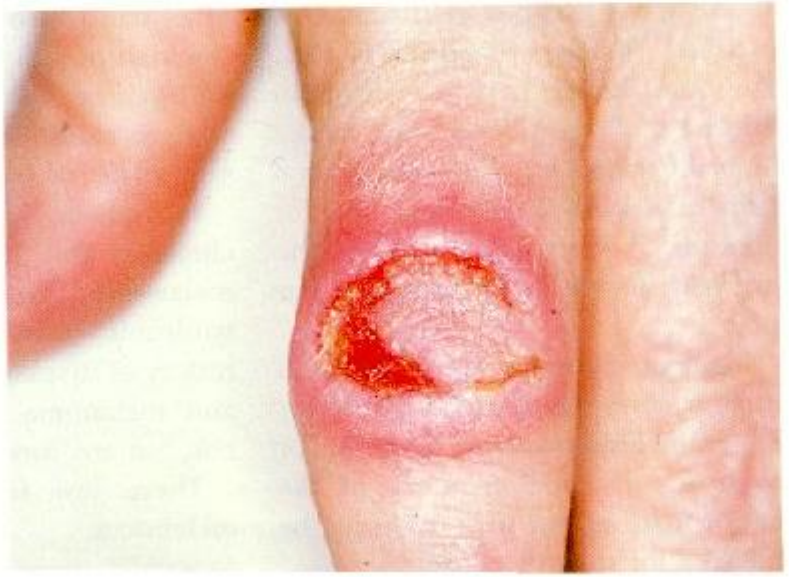
Pyogenic granuloma or eruptive angioma showing crusted surface



Pyogenic granuloma



Squamous cell carcinoma



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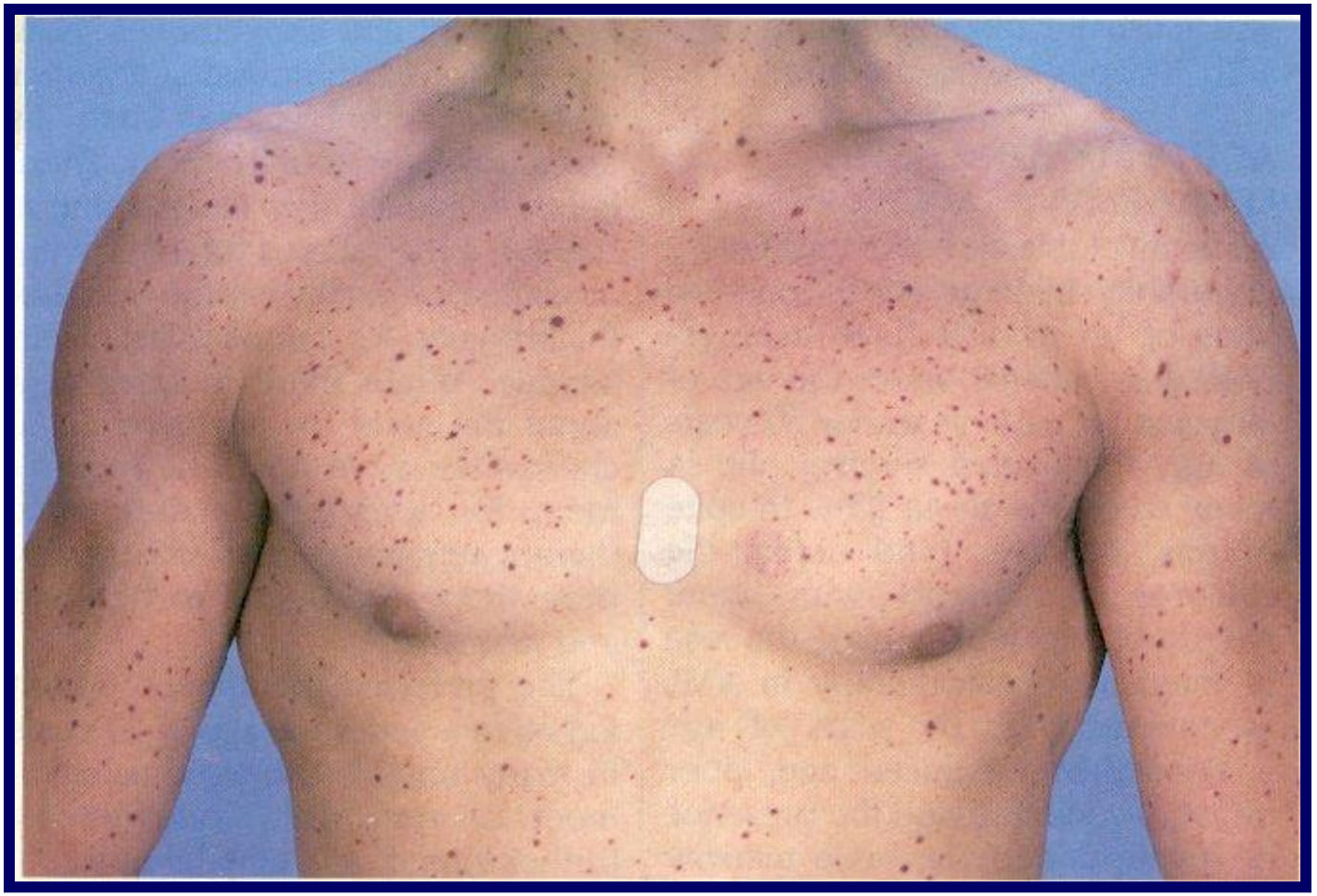


Acute leukemia: diffuse purpura on the chest of a young man who was admitted with a history of bleeding and bruising

42

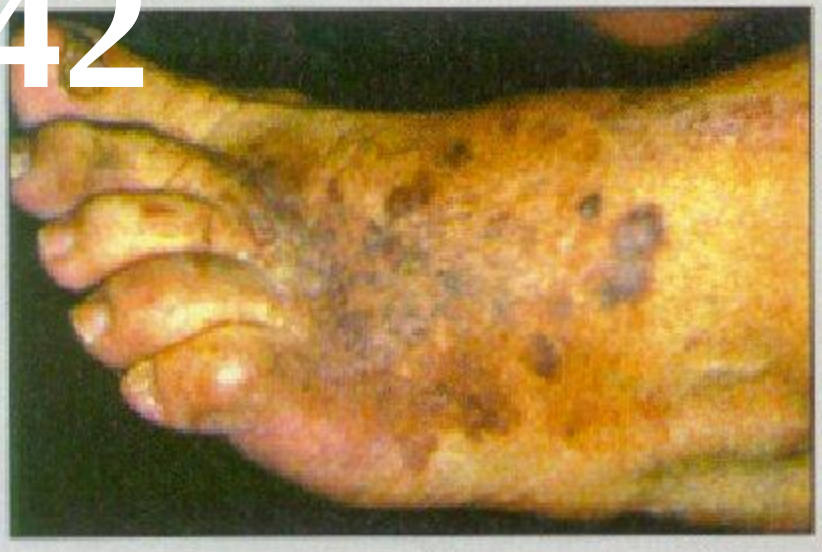
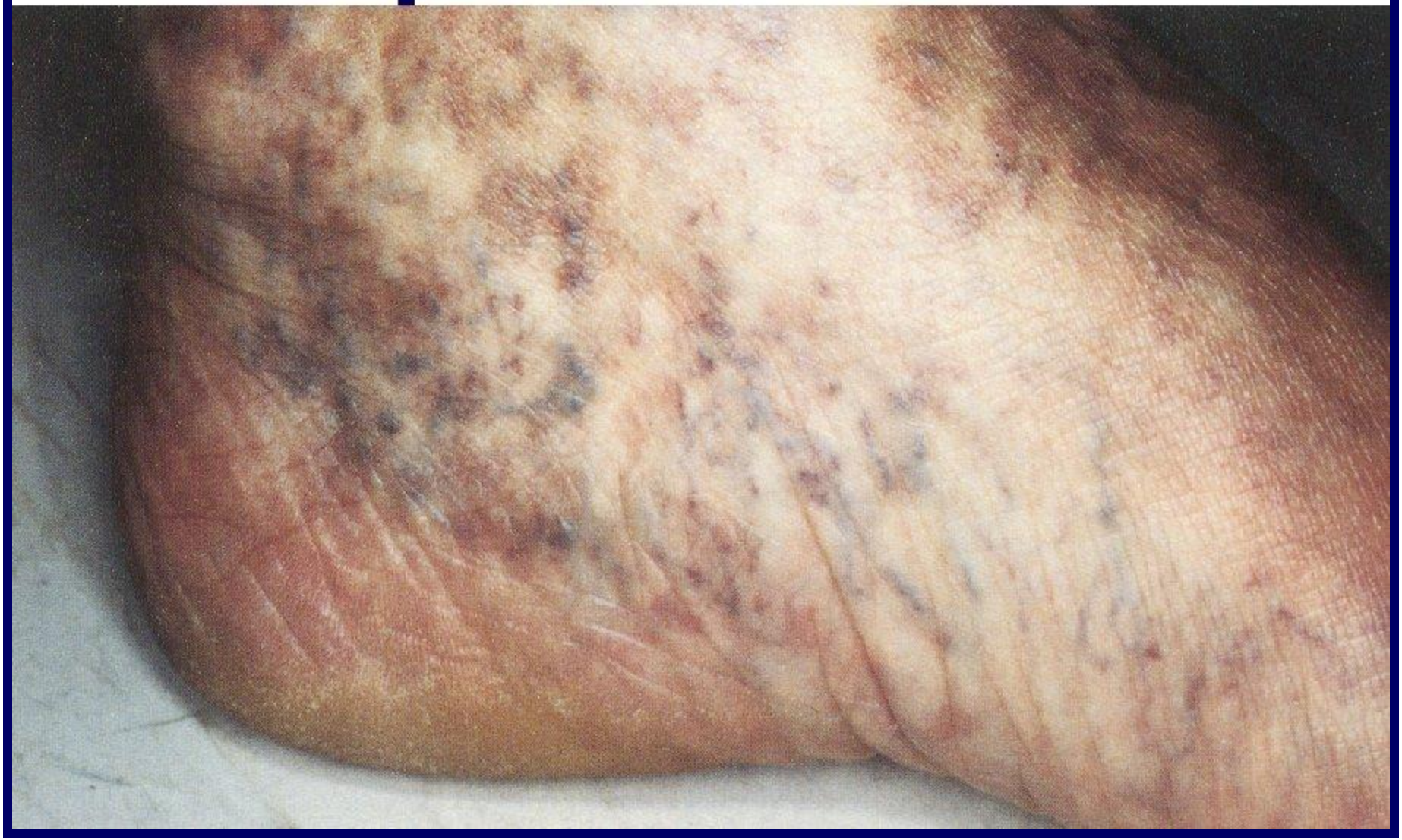


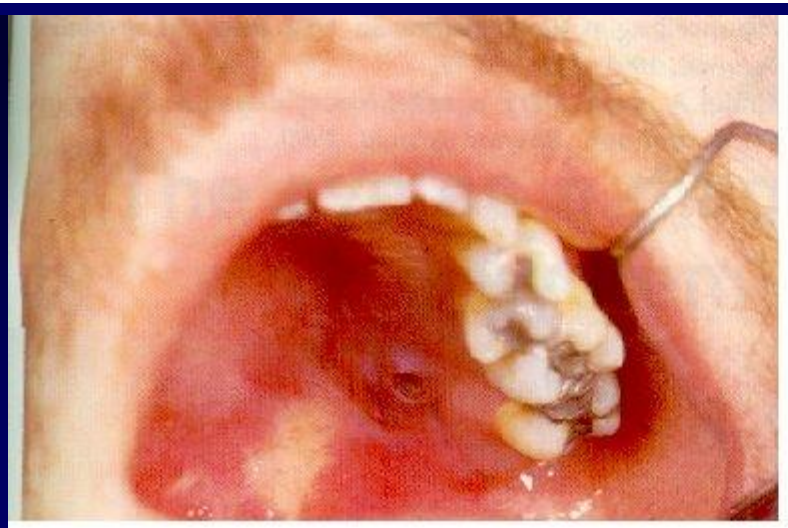
Figure 1. Violaceous and pigmented plaques on the back of the foot.

Figure 2. Ovoid violaceous lesions, resembling scars, on the side of the trunk.

Progressive discolored lesions on the lower limbs and trunk's sarcoma"

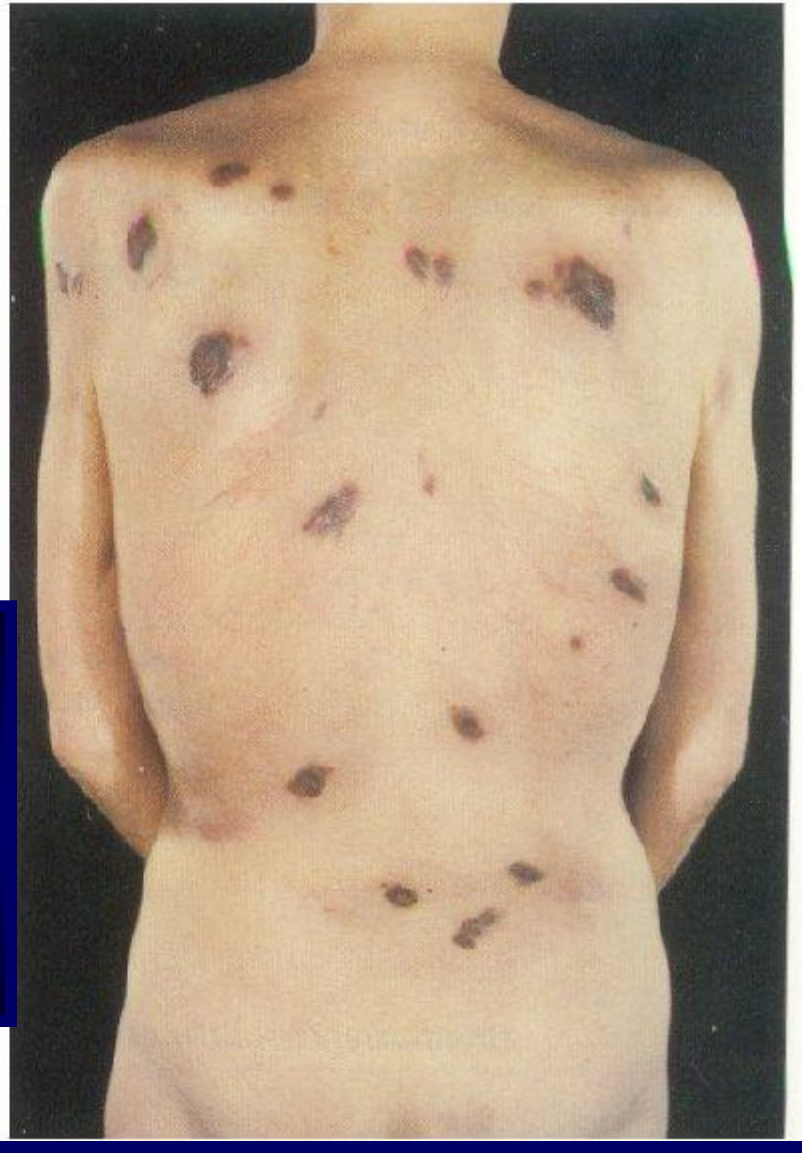
Kaposi's sarcoma





Oral Kaposi's Sarcoma

Cutaneous Kaposi's Sarcoma in a homosexual man



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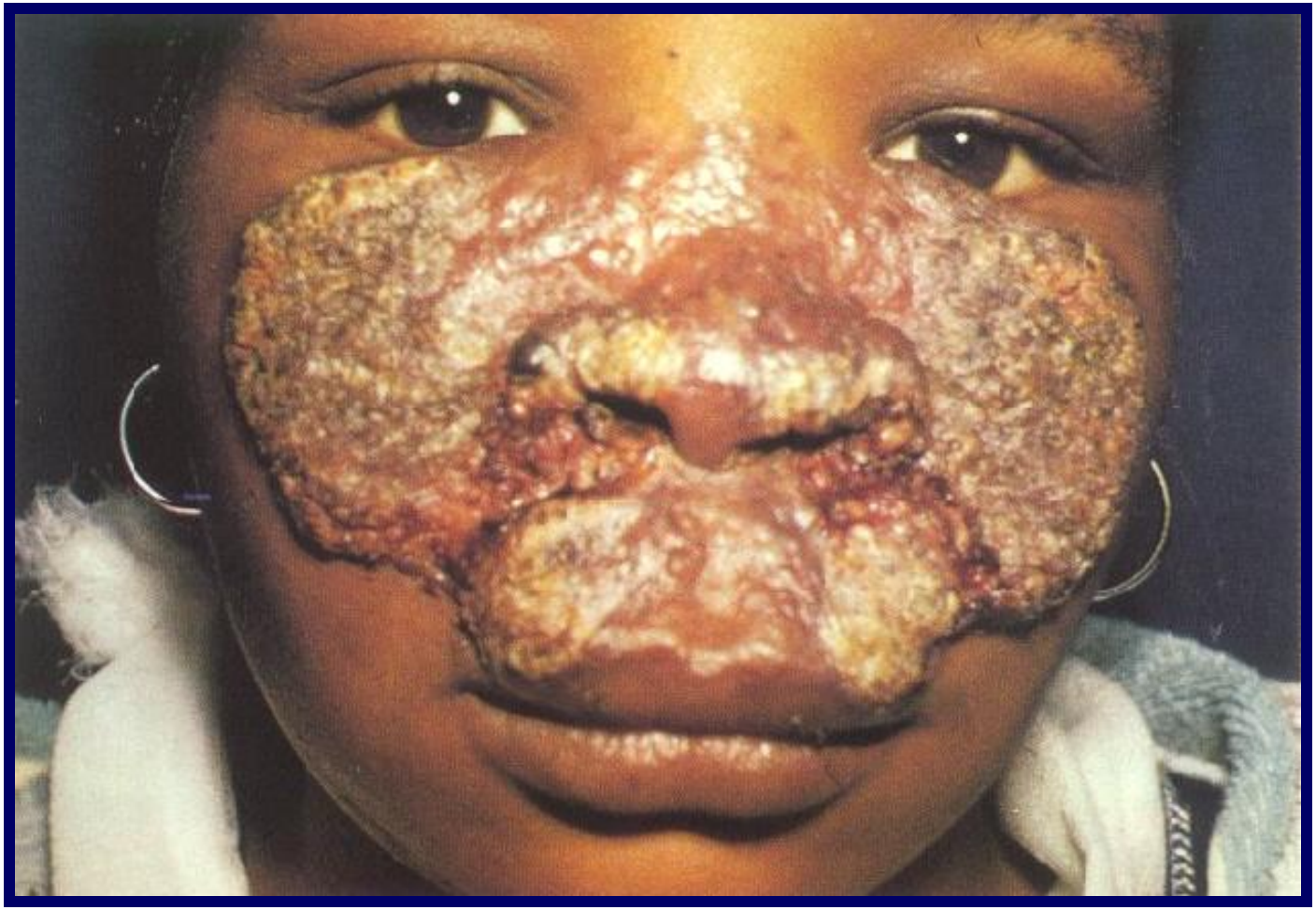
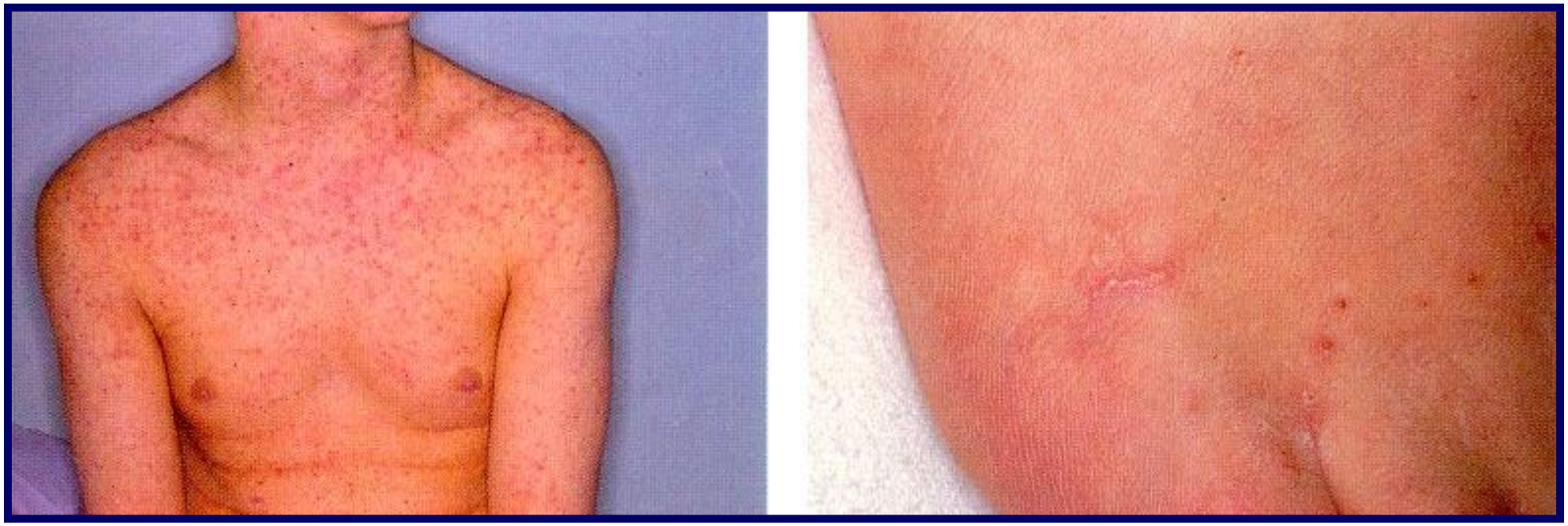


Active lupus vulgaris **(tuberculosis of the skin)** Exuberant hypertrophic ulceration spreading over the nose and malar areas.

44



A patient developed a rash consisting of small red slightly elevated papules and vesicles, unevenly distributed and intensely itchy, especially where he was warm. A close up of one of the lesion is shown.

Q.1 What is the diagnosis

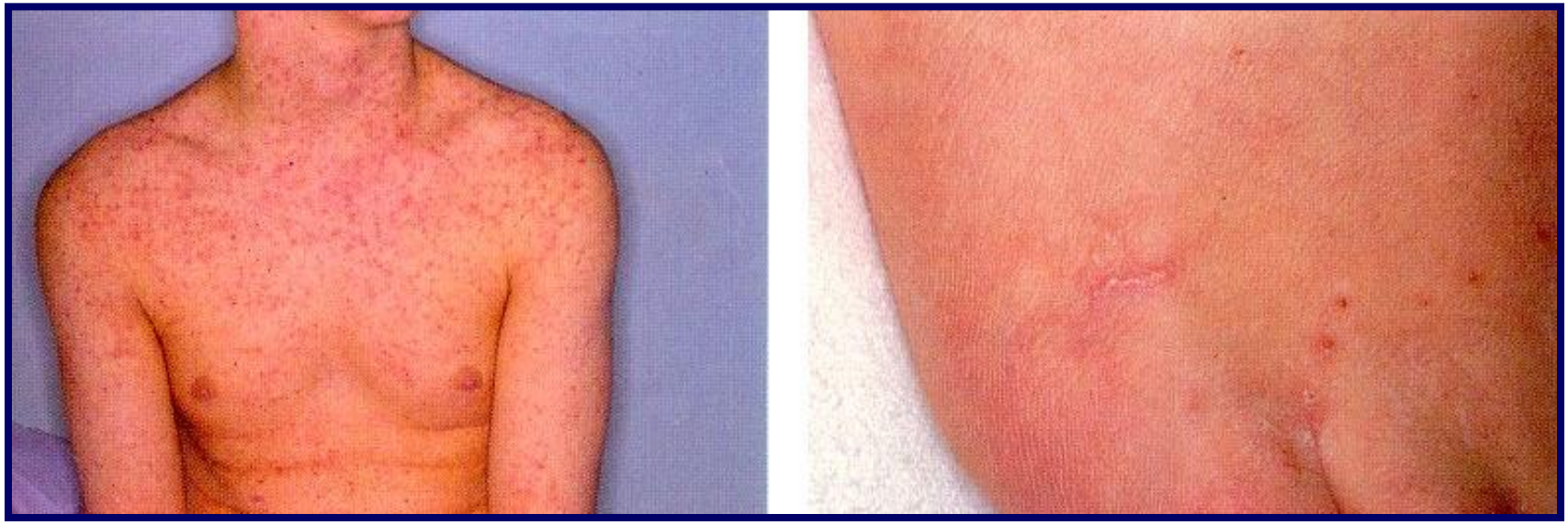
Q.2 What is the distribution of the rash ?

Q.3 What organism is responsible ?

Q.4 What is the source ?

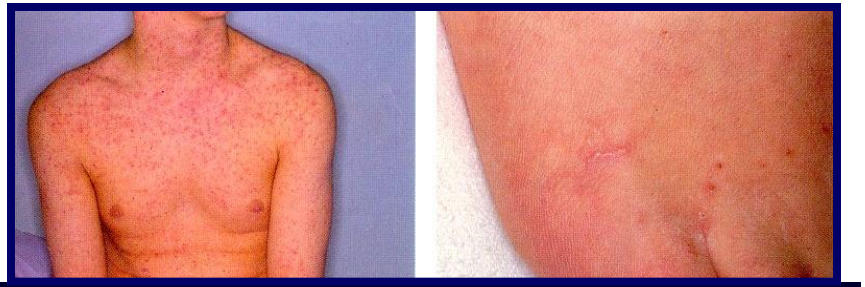
Q.5 How is it spread & How is it treated ?

Scabies



Widespread pruritis rash of scabies. Characteristic burrow of scabies..

Scabies



A2. The rash is particularly prominent around interdigital spaces on backs of hands, wrists, groins, breast, umbilicus, penis and buttocks.

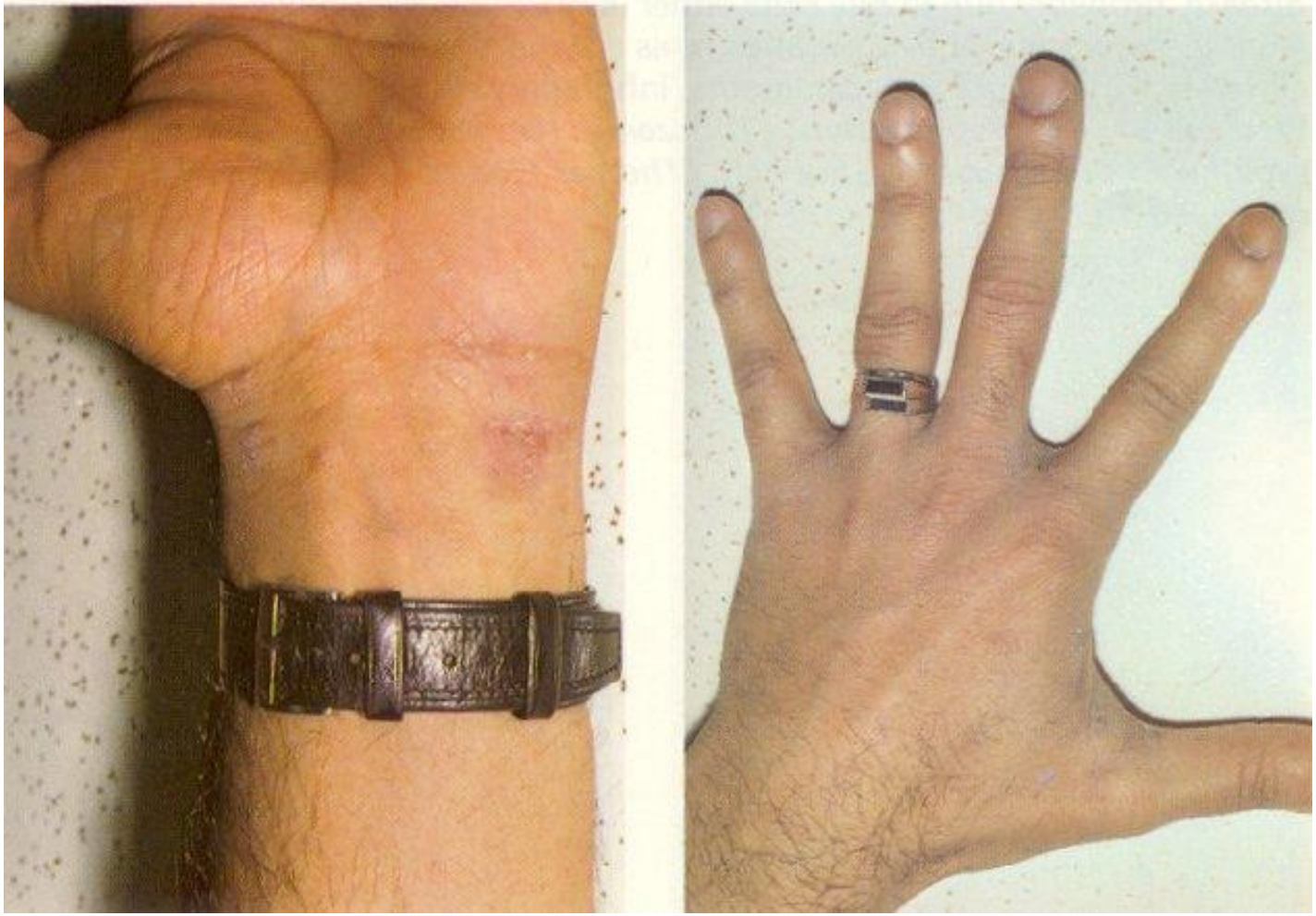
A3. The organism is responsible is mite, sarcoptes scabies.

A4. The source is human, animal mites do not establish themselves in man.

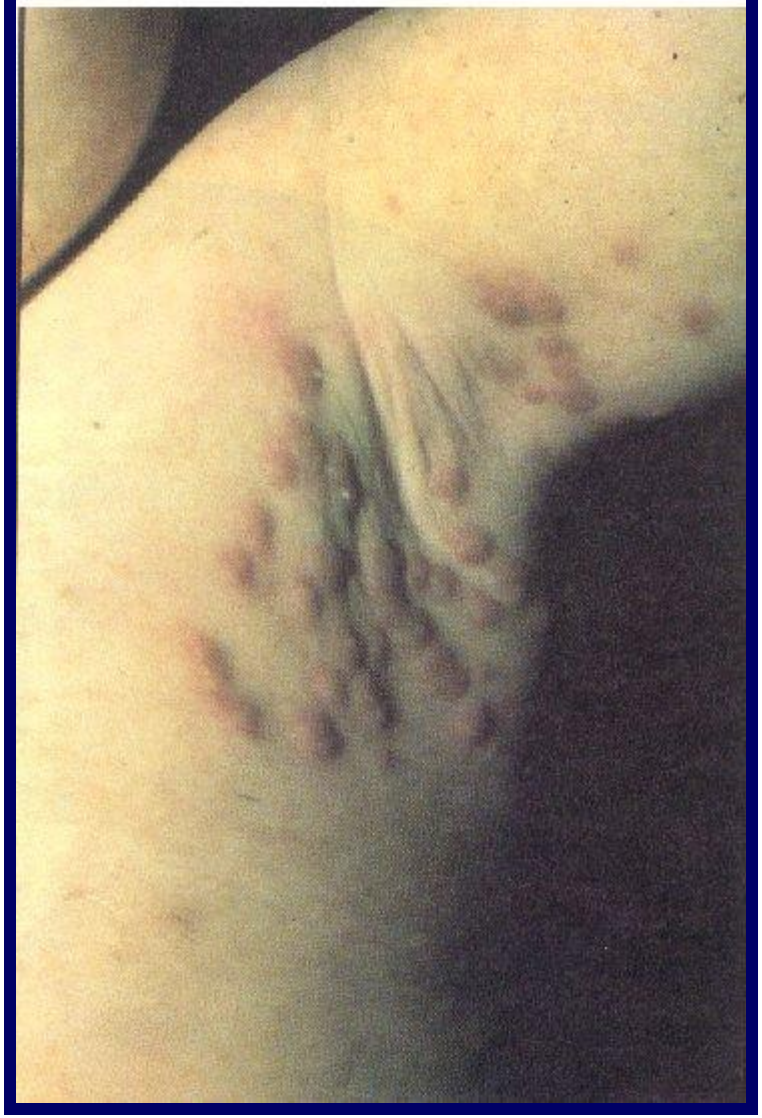
A5. It spreads usually be direct contact but also by bedding and clothing if infestation is severe, sexual contact.

Treatment by two application of an anti scabies lotion (Benzyl benzoate and gamma benzene hexachloride) to the whole skin suffice below the chin, on two occasions 24 hours apart for patient and contacts. Pruritus can take up to 2 weeks to settle antipruritic agents can be used.

Scabies



Scabies



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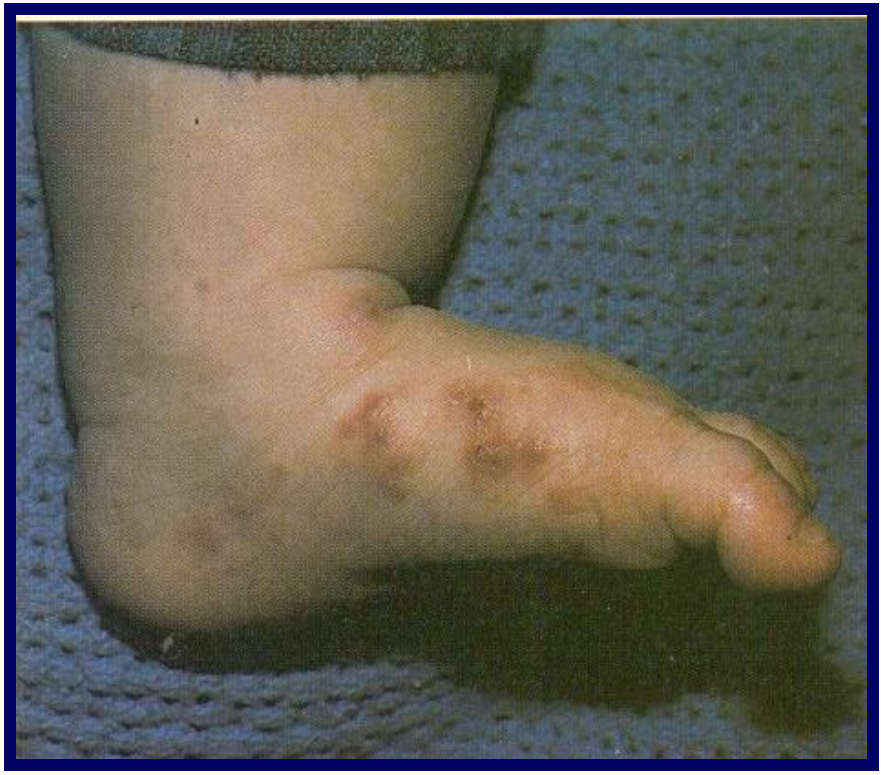
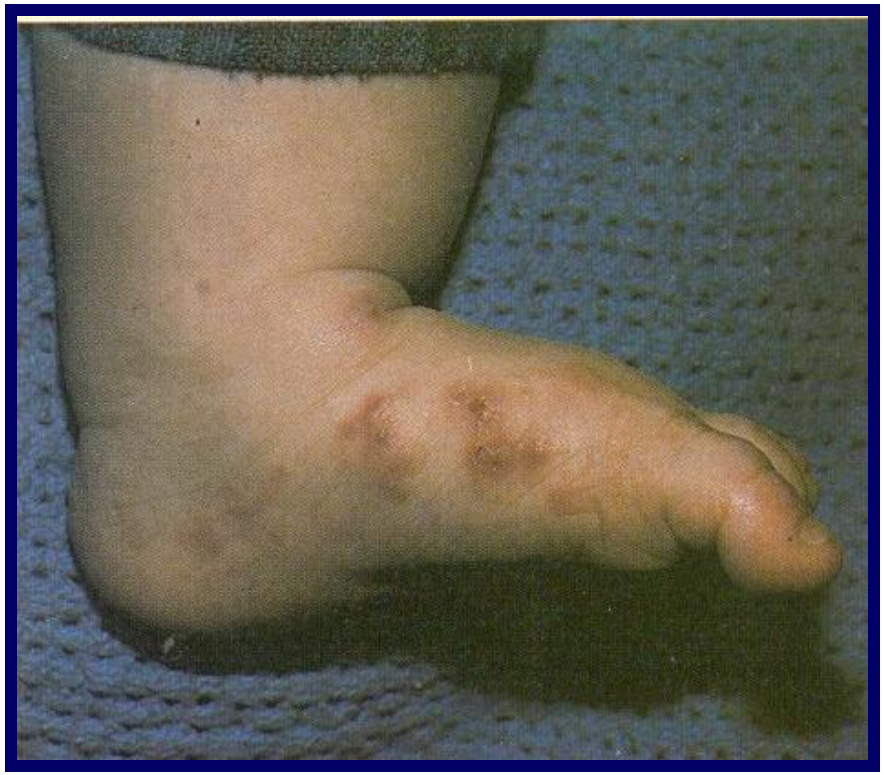


This little boy was brought to the clinic by his mother because he has spots on his feet and an itchy rash over his body

Q1. What is the diagnosis?

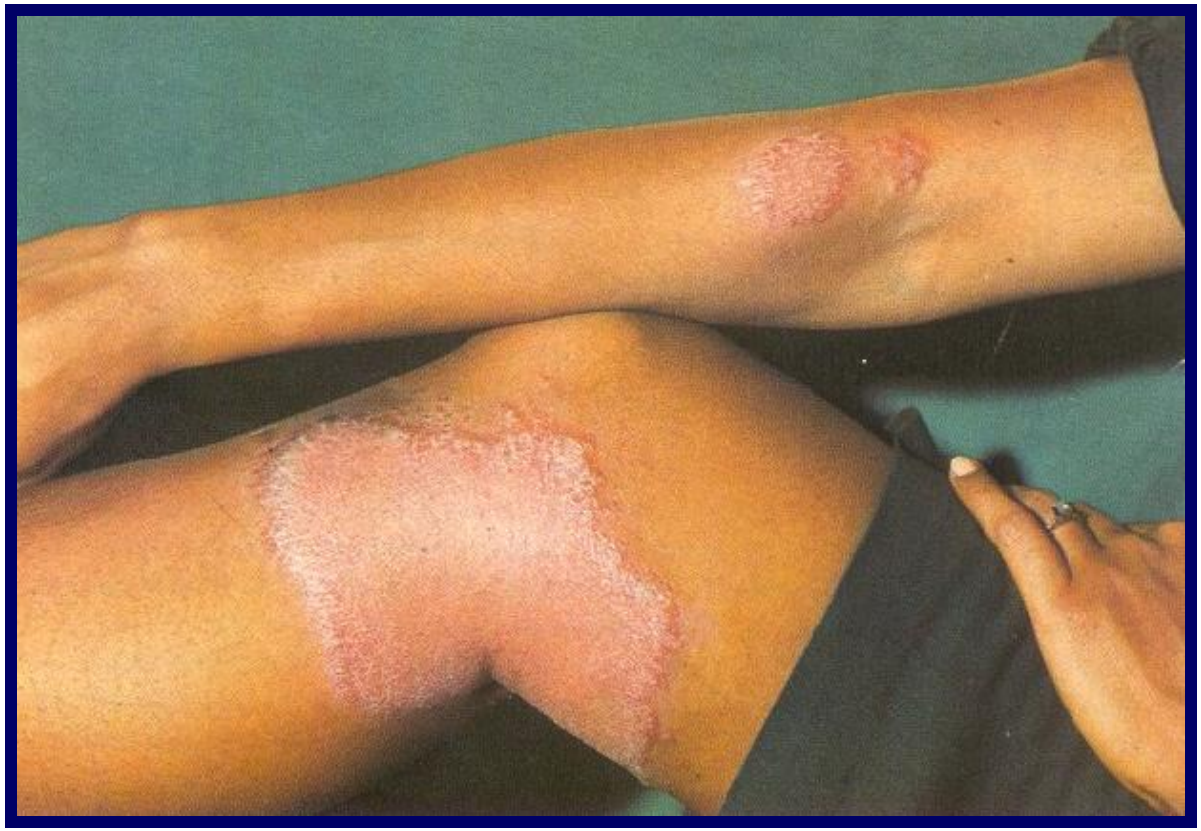
Q2. What is the treatment?

Scabies



Treatment by two application of an anti scabies lotion (Benzyl benzoate and gamma benzene hexachloride) to the whole skin suffice below the chin, on two occasions 24 hours apart for patient and contacts

46



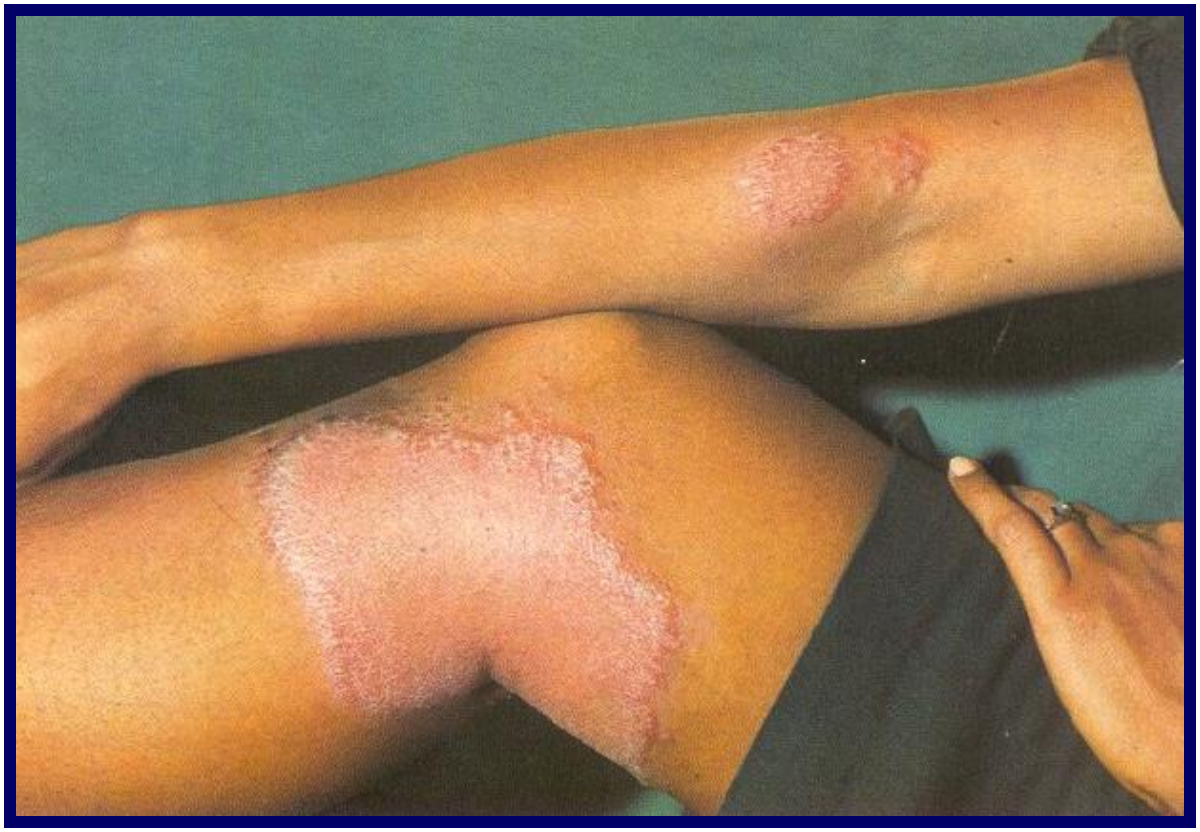
Depigmented areas with hyposthesia

Q1. What is the diagnosis?

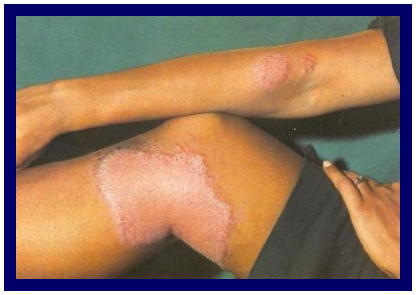
Q2. Mention 3 possible investigations

Q3. What is the treatment?

Tuberculoid leprosy



Tuberculoid leprosy

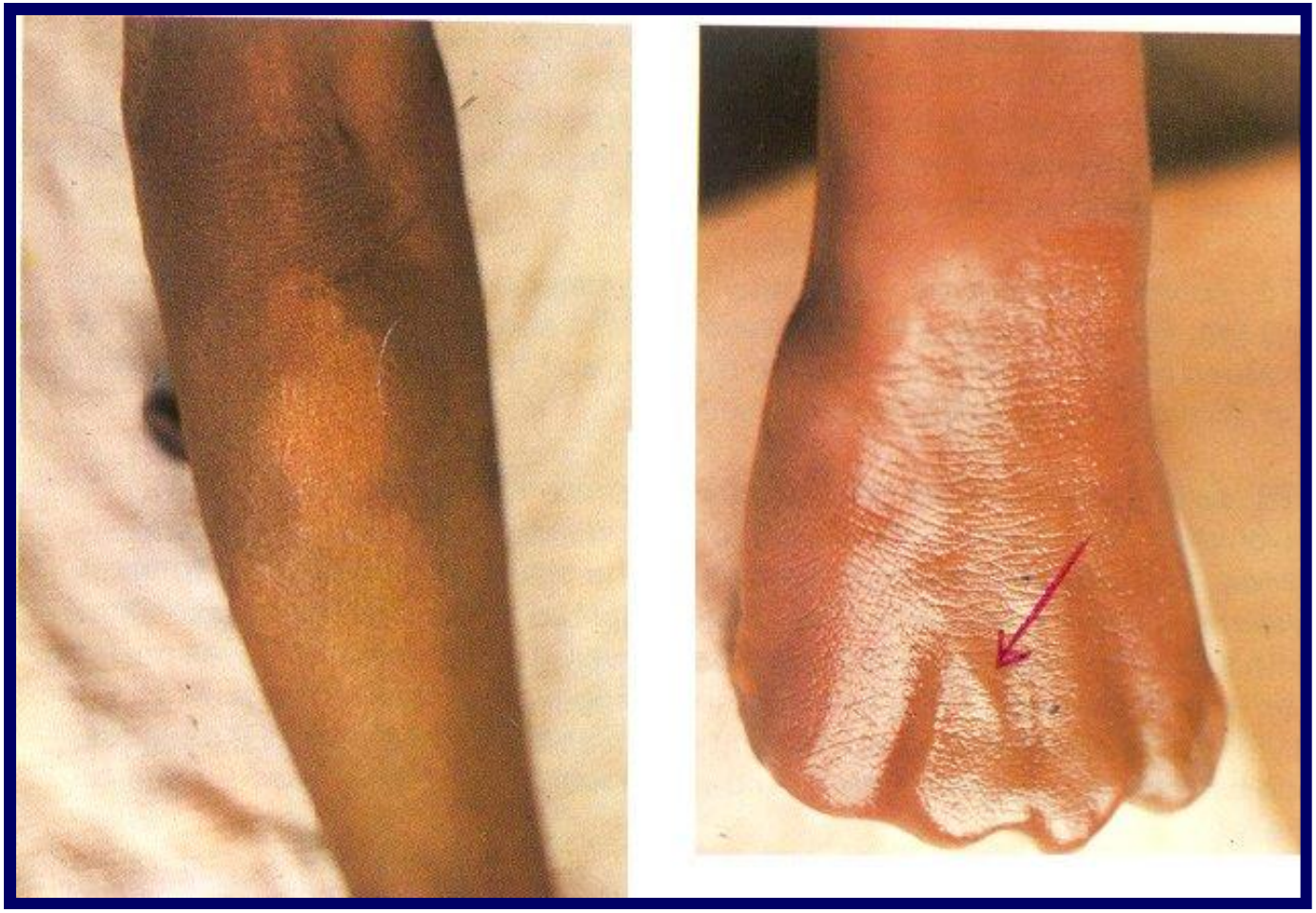


Presentation: There are various cutaneous manifestations. A common presentation is depigmented areas, which may be anaesthetic or have thickened nerves in the vicinity. Leprosy is one of the few conditions that can cause thickened nerves.

A2. Investigations: The clinical presentation may be diagnostic. Biopsy may reveal characteristic appearances with non-caseating granulomata. If immunity is low and leprosy rampant, then smears taken from the nose may be full of bacilli. *Mycobacterium* leprae favor parts of the body at a temperature lower than core body temperature.

A3. Treatment: Specialist advice is mandatory. The organism is sensitive to dapsone and rifampicin. However, rapid killing may result in sudden changes of host immunity with dramatic 'upgrading' reactions.

Tuberculoid leprosy



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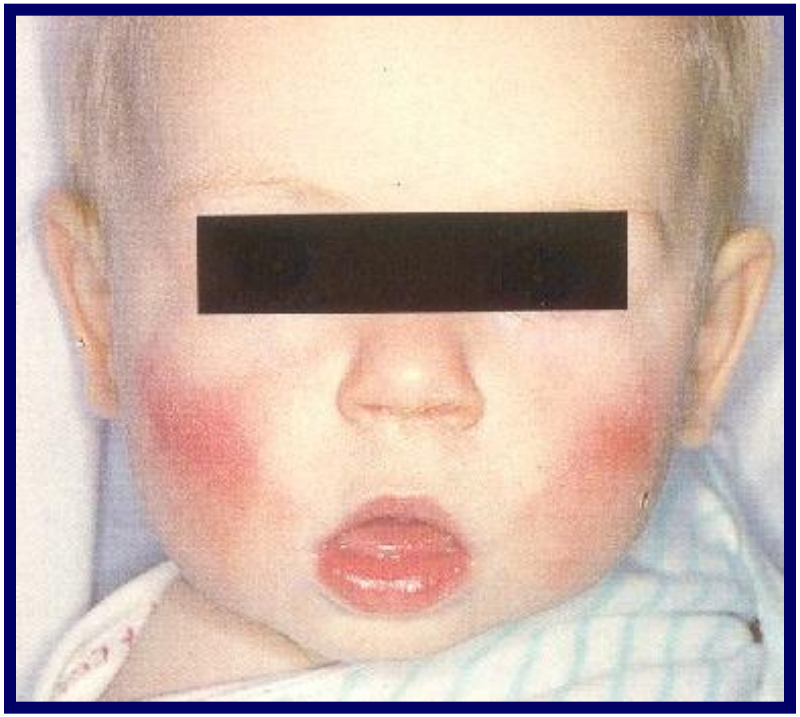
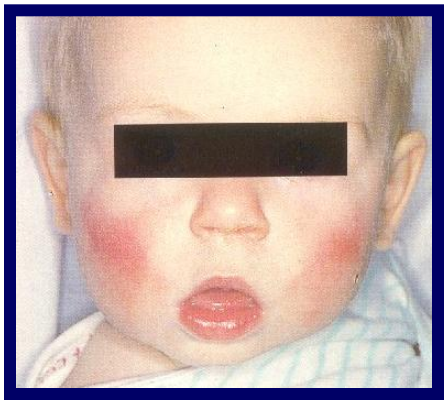


2-year-old child presented with low-grade fever and vague malaise with a rash on the arms and chest for a few days

Q1. What is the likely diagnosis?

Q2. What is your management?

Fifth Disease
(Slapped Cheek Syndrome)



Presentation: Low-grade fever and vague malaise in children with a rash on the arms and chest for a few days. For the next 1-2 months a rash on the cheeks returns if the child is exposed to the wind or sun. Small epidermis occur, usually in school. Adults, particularly women, may develop a transitory arthralgia or arthritis usually affecting the hand joints, but this generally resolves. An aplastic crisis can be precipitated in patients with sickle cell disease or other haematological abnormalities

Investigations: Usually none are required. Serological tests (IgM) for the causative parvovirus are available

Treatment: Reassurance & symptomatic treatment if required

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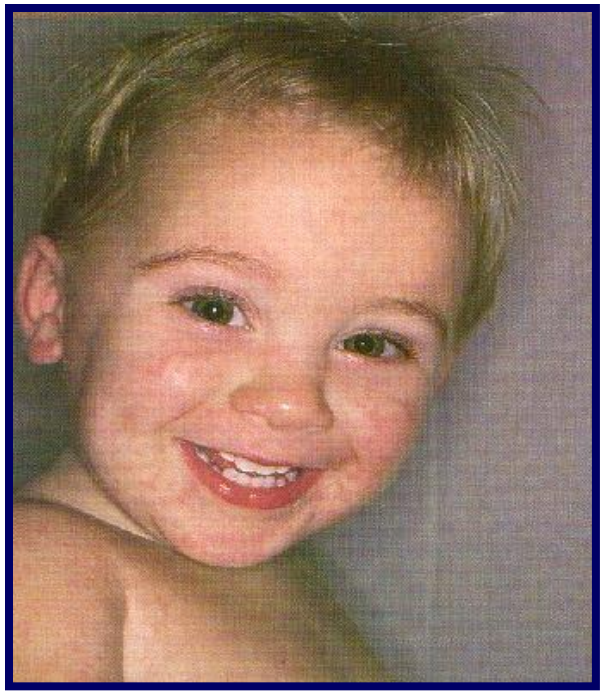
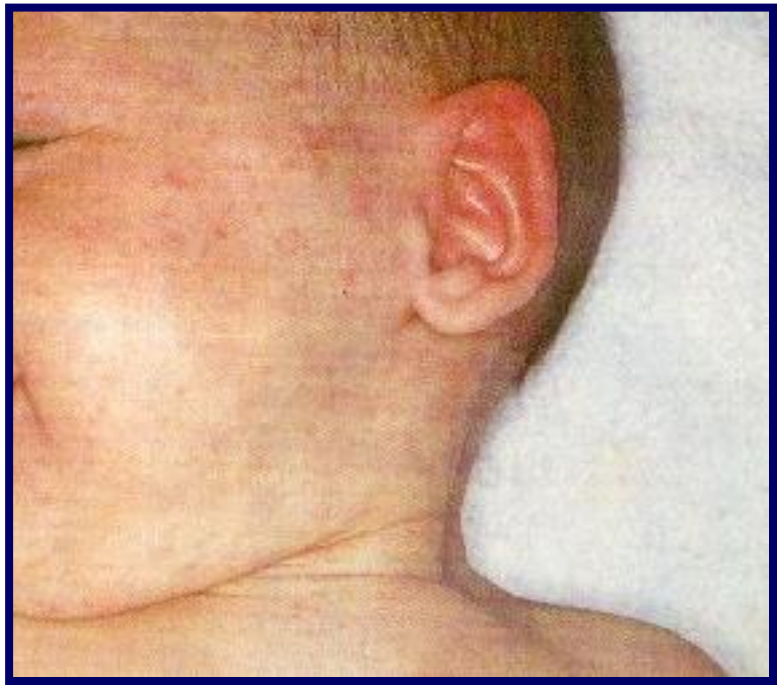


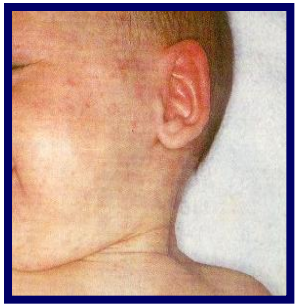


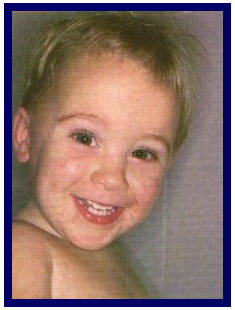
3 year-old child presented with high fever for a few days

Q1. What is the likely diagnosis?

Q2. What is your management?

Sixth Disease (Roseola Infantum)





Presentation: Usually in children aged 6 months to 3 years. There is fever, occasionally high for a few days. There may be cervical node enlargement and as the patient's temperature falls, up to 48 hours later, a maculo-papular rash can appear on the trunk or neck. The rash usually lasts a few hours or days. Children are generally well, although febrile convulsions can occur in the febrile stage.

Investigations: Not usually required. Herpes virus type 6 is the cause, but no laboratory test is available yet.

Treatment: Symptomatic treatment with paracetamol for the fever is usually all that required

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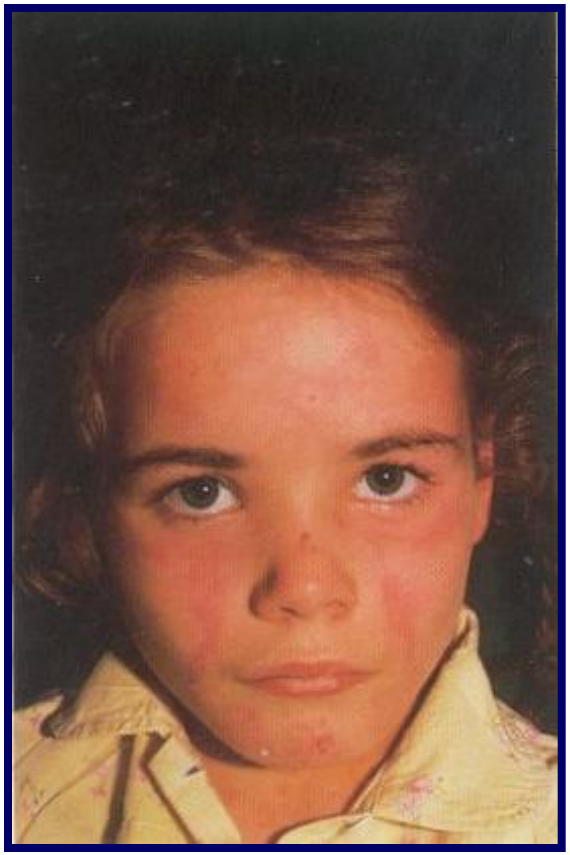
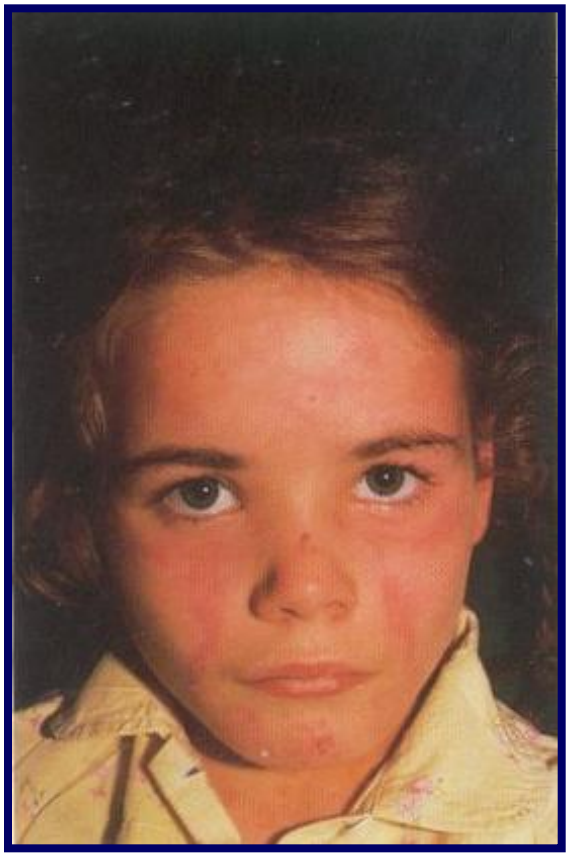


This 12-year-old girl was admitted with fever, tachycardia and arthralgia

Q1. What physical sign is shown?

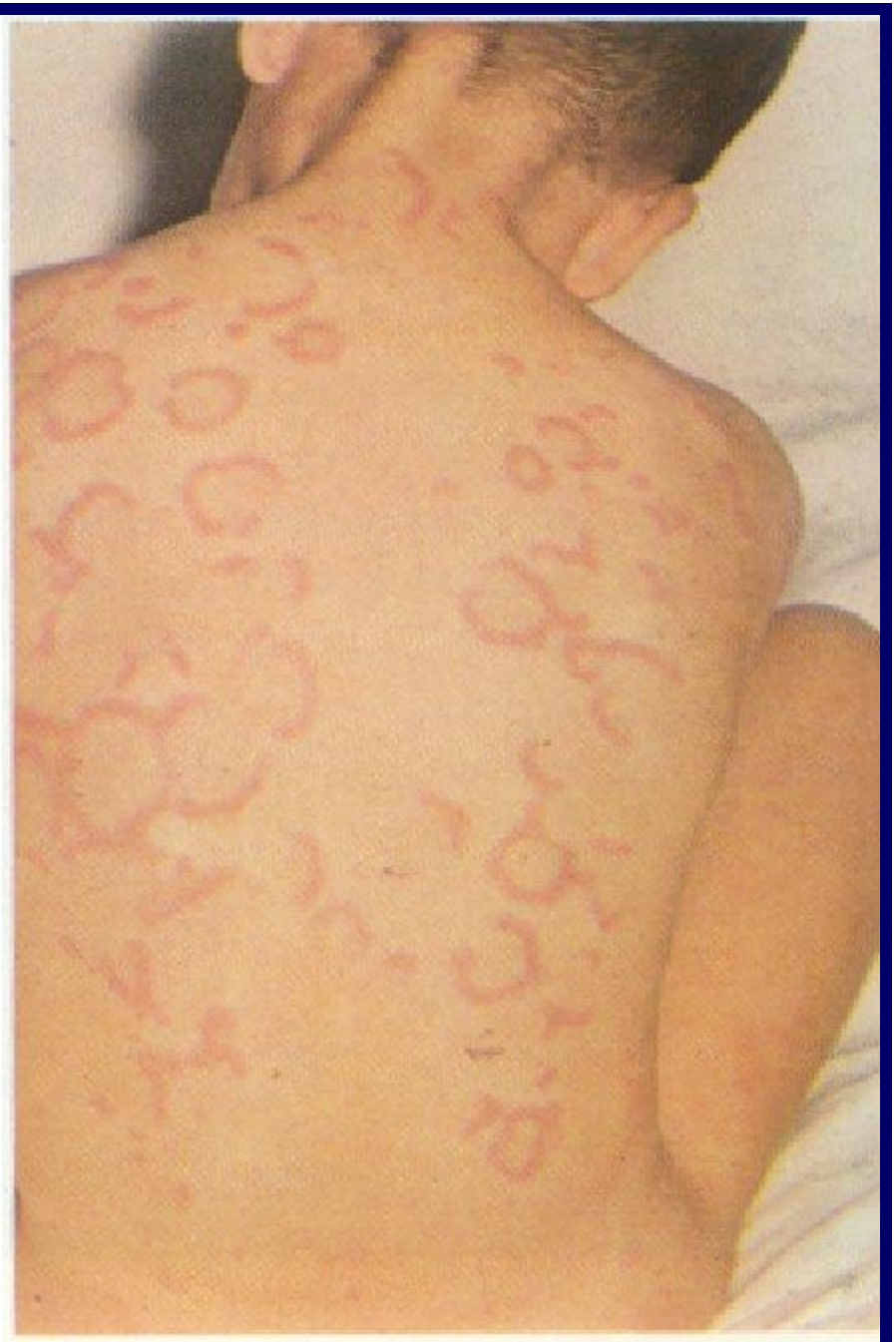
Q2. What is the underlynig cause?

Erythema marginatum



A2. Infection with *Streptococcus pyogene*

Erythema marginatum



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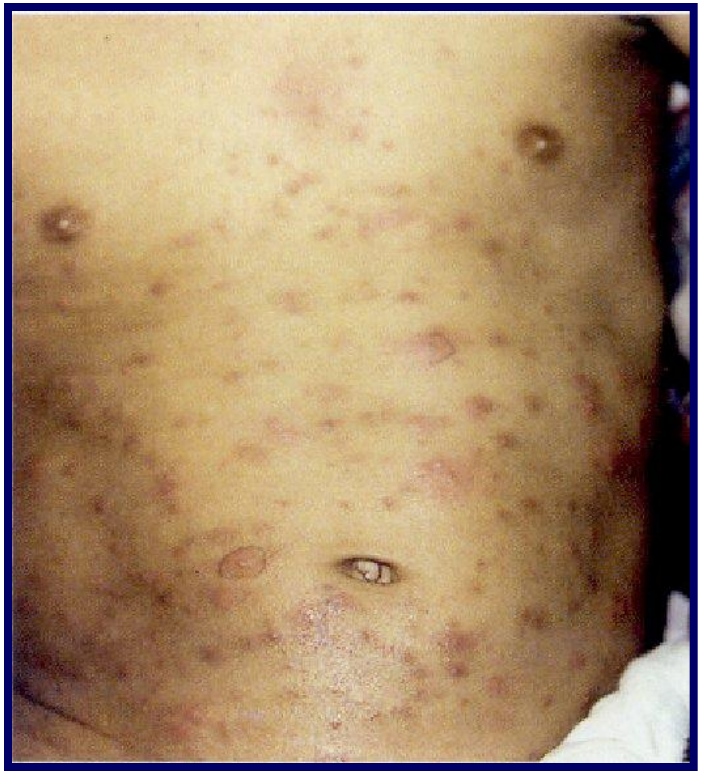


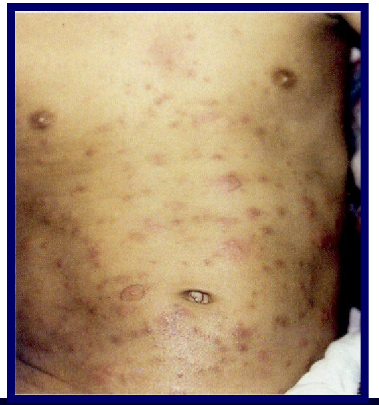
This child is brought in by his grandmother, who thinks he may have chicken pox. The rash started with a few small lesions but then spread rapidly over his trunk. They are not on his limbs or face.

Q 1. Is this chickenpox?

Q 2. What activity would it he useful to ask about?

Q 3. How would you manage this condition?

Folliculitis



A2. Due to its distribution, it may well be related to the child having been in a hot tub. The most common causative organism in relation to this is Pseudomonas aeruginosa.

A3. The recommended treatment is either dicioxacillin (25 mg/kg in divided doses) for 5-7 days or cephalexin if the patient is sensitive to penicillin.' It would be worth- while enquiring about this in the history. The rash in this distribution often appears about three days after using the hot tub. A swab from one of the lesions, in an attempt to culture the organism, would guide treatment.

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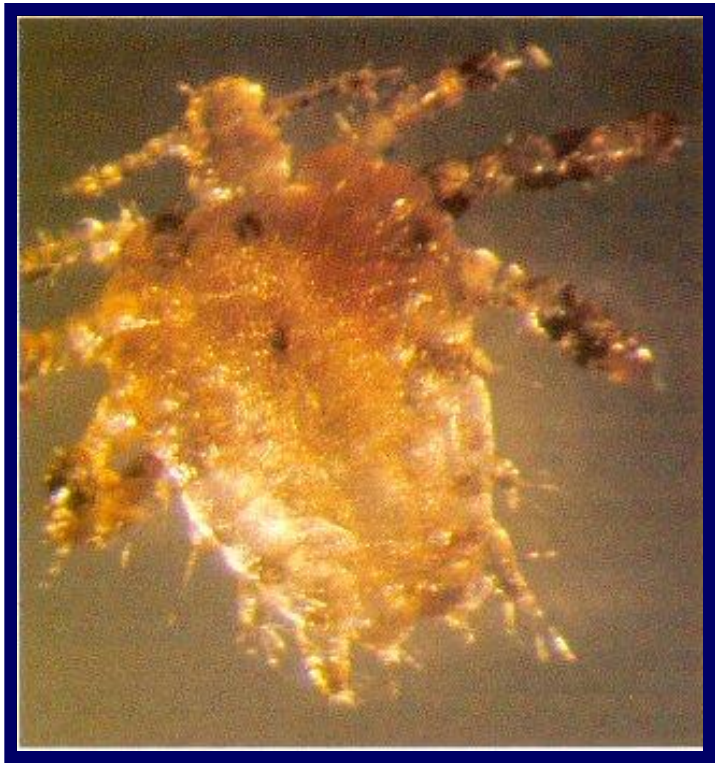
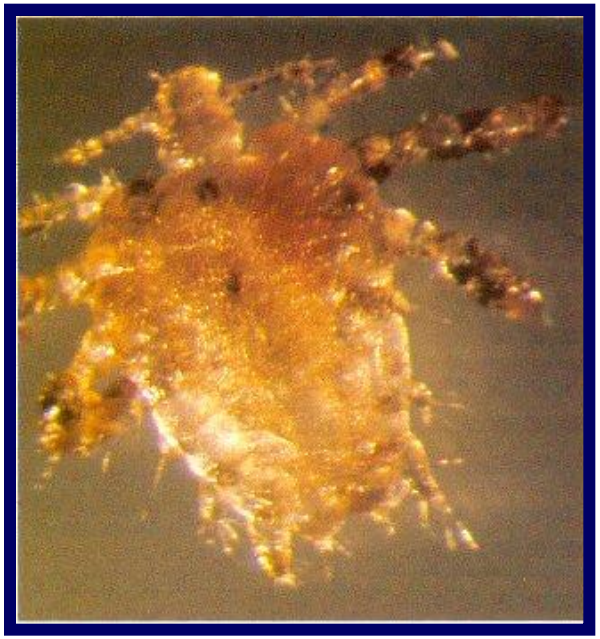


A 8-year-old child complains of intense itching of her scalp especially at Occipital area. Local examination of the hair as seen in the picture.

Q1. What are you seeing, ?

Q2. What is the management ?

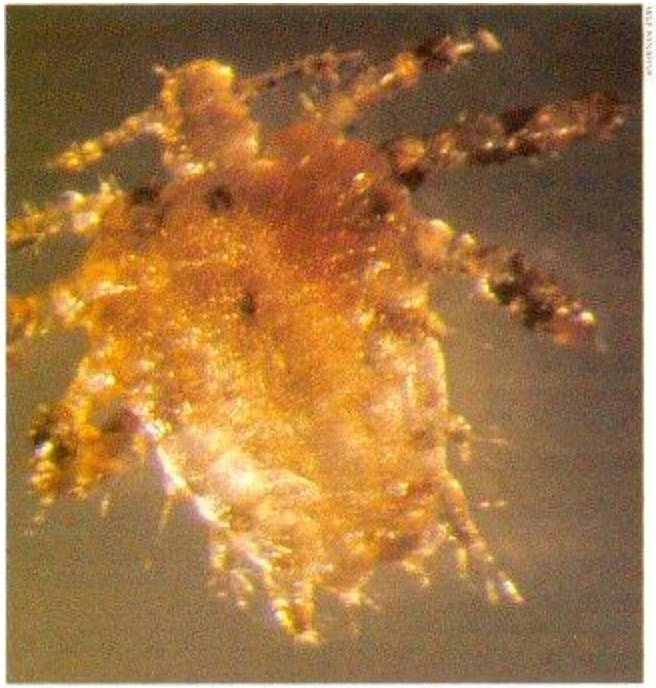
Head lice (Pediculosis capitis)



A.2. Gamma benzen hexachloride (Lindane) shampoo left for 5 minutes and rinsed out.

Lindane lotion is left on over night and rinsed out.

Nit removal.



The head louse:

Physical evidence of living lice is required before treatment begins, but they con be difficult to detect

Head lice need relatively prolonged head-to-bead contact. Estimates suggest it takes of least 30 seconds for lice to move from one beside to another

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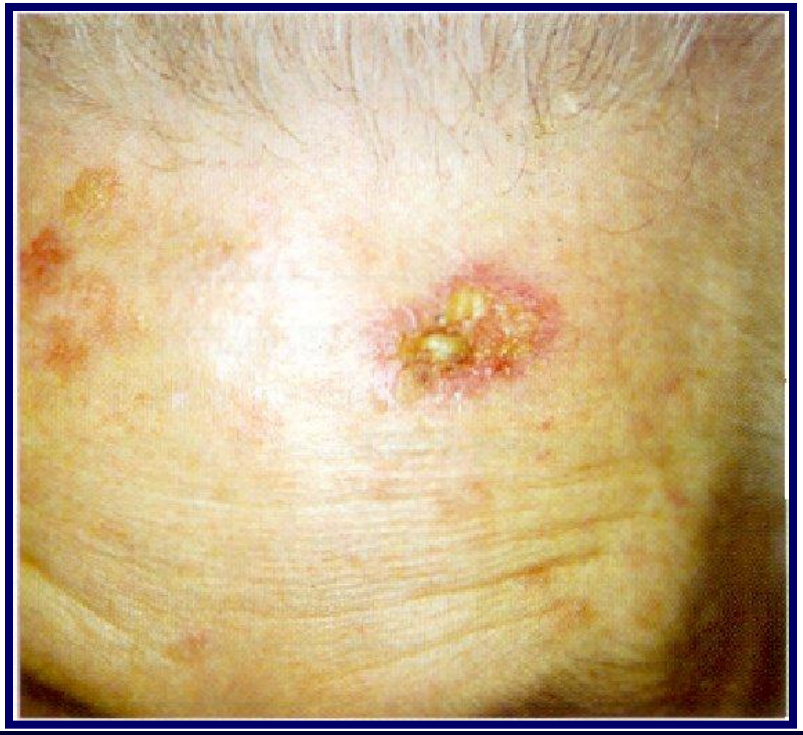


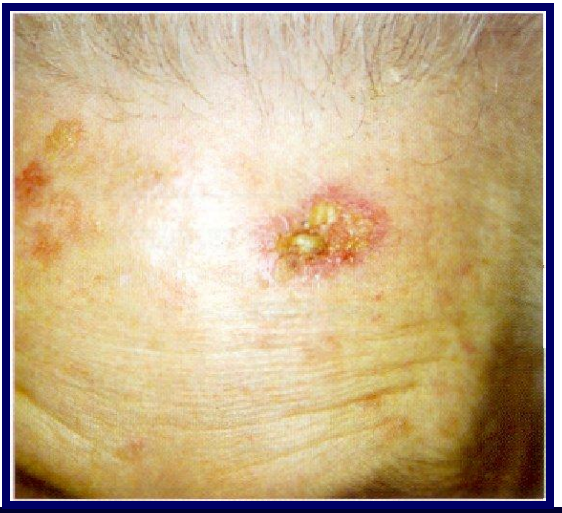
A 79 year old woman presented with lesions located on her forehead. These were associated with an area of increased vascularity which were partially covered with adherent yellow crusts, the removal of which sometimes caused bleeding.

Q1. What is the diagnosis?

Q2. Is there a potential for malignancy?

Q3. What treatment is indicated Treatment:

Actinic solar keratosis



A2. Yes, after several years a small percentage of these lesions may degenerate into squamous cell carcinomas.

A3. as these lesions mostly result from sun damage, prevention with sunscreens, hats etc, is very important to minimize further damage. & most solar keratosis respond to local application to the lesions of 5%, 5-fluorouracil cream over a period of several days. Resistant lesions should be treated with liquid nitrogen.

* nodular lesions should be excised, large nodular lesions more than 0.5 cm in diameter should be sent for histopathology.

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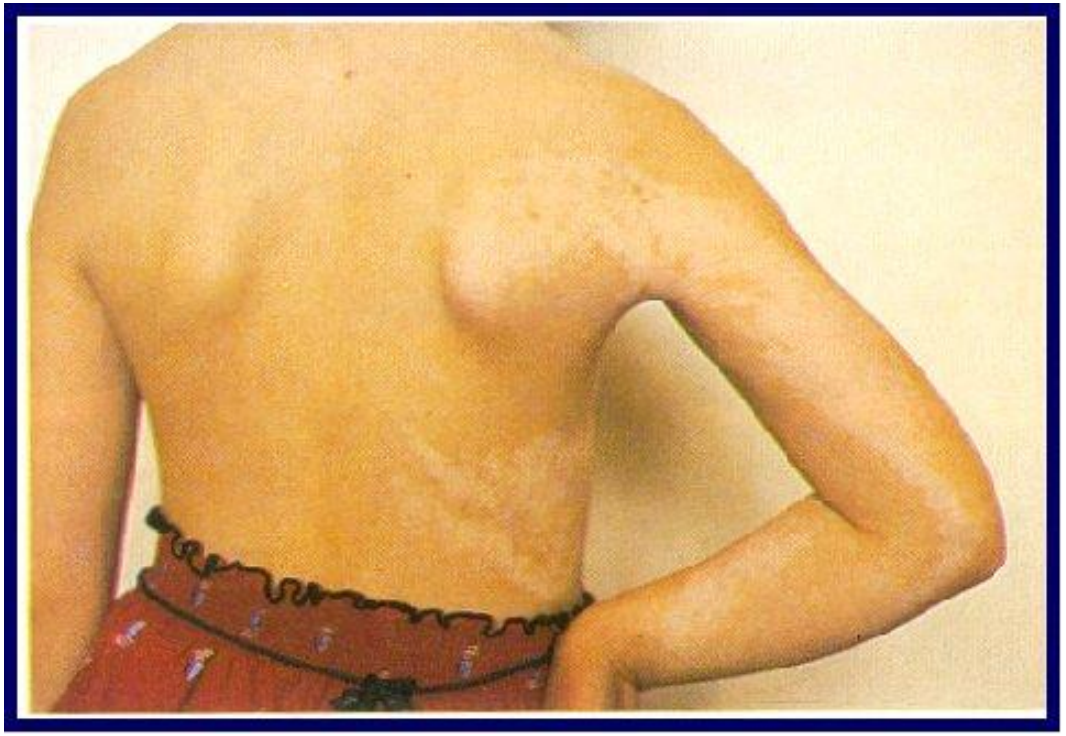


This 8-year-old child bas bad these pale areas on her trunk and am since birth. Apart from requiring orthodontic treatment, she is well and is receiving no medication.

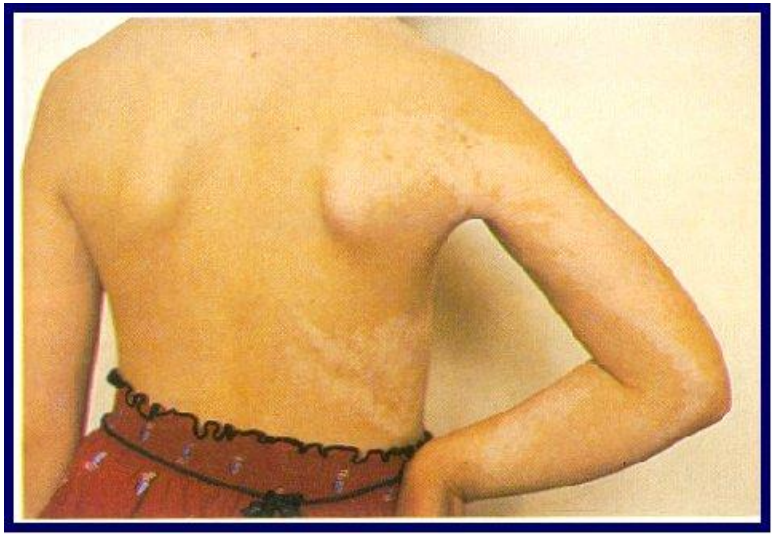
Q1. What is the diagnosis?

Q2. What associated abnormalities may be encountered?

Q3. What is the prognosis?

the inheritance is uncertain.

Hypomelnosis of Ito



A2. Seizure disorders and mental retardation.

A3. The pale areas tend to darken.

Over 60% of patients have noncutancous abnormalities, particularly seizure disorders or mental retardation. Ocular problems, such as strabismus, and musculoskeletal malformations, such as hypertelorism, are also common. The teeth may be dysplastic, peg-like, and widely or irregularly spaced. Girls are affected twice as often as boys, but the inheritance is uncertain.

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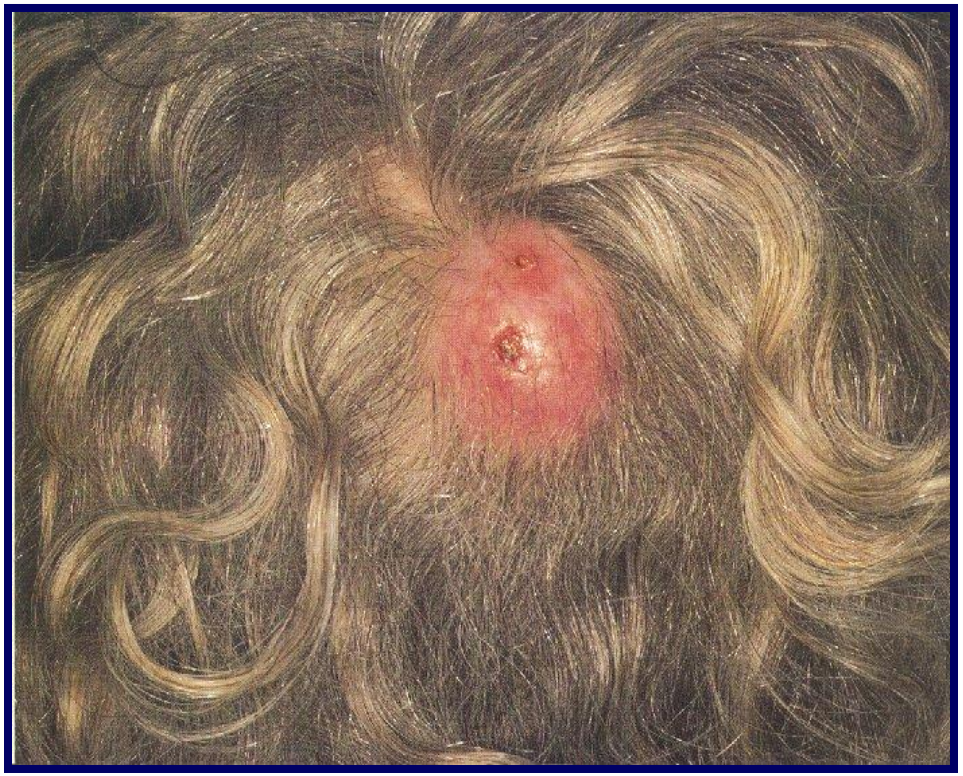

Sebaceous cyst of the scalp

clinically infected

Many clinically infected cyst proves sterile on culture

55

Scalded hand in a toddler