
Goodheart's Photoguide of Common Skin Disorders

Diagnosis and
Management

SECOND EDITION

Goodheart's Photoguide of Common Skin Disorders

Diagnosis and
Management

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To Karen, David, and Bernie and to my mother, Rose Goodheart

In certain situations, however, determining the precise cause maybe of vital importance. Examples include the appearance of a viral exzntnem in a pregnant woman or in immuno compromised patient. It is also important to distinguish viral exzn-thems from rushes caused by treatable bacterial infections. In certain situations, however, determining the precise cause maybe of vital importance.

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INTRODUCTION

Illustrated Glossary

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Lesions

PRIMARY LESIONS



Macules. Vitiligo

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and Heari

No, or Maybe

Patch. Vascular nervus

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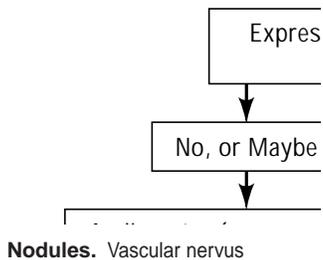
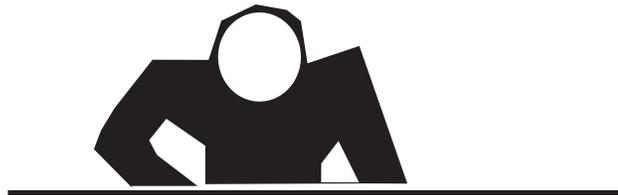
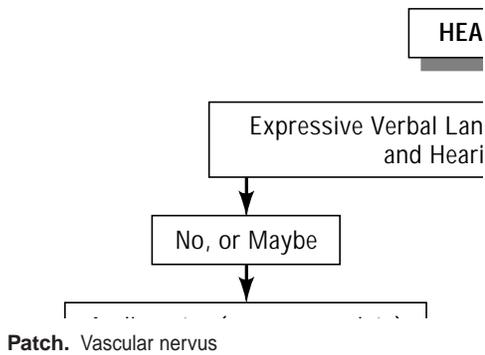
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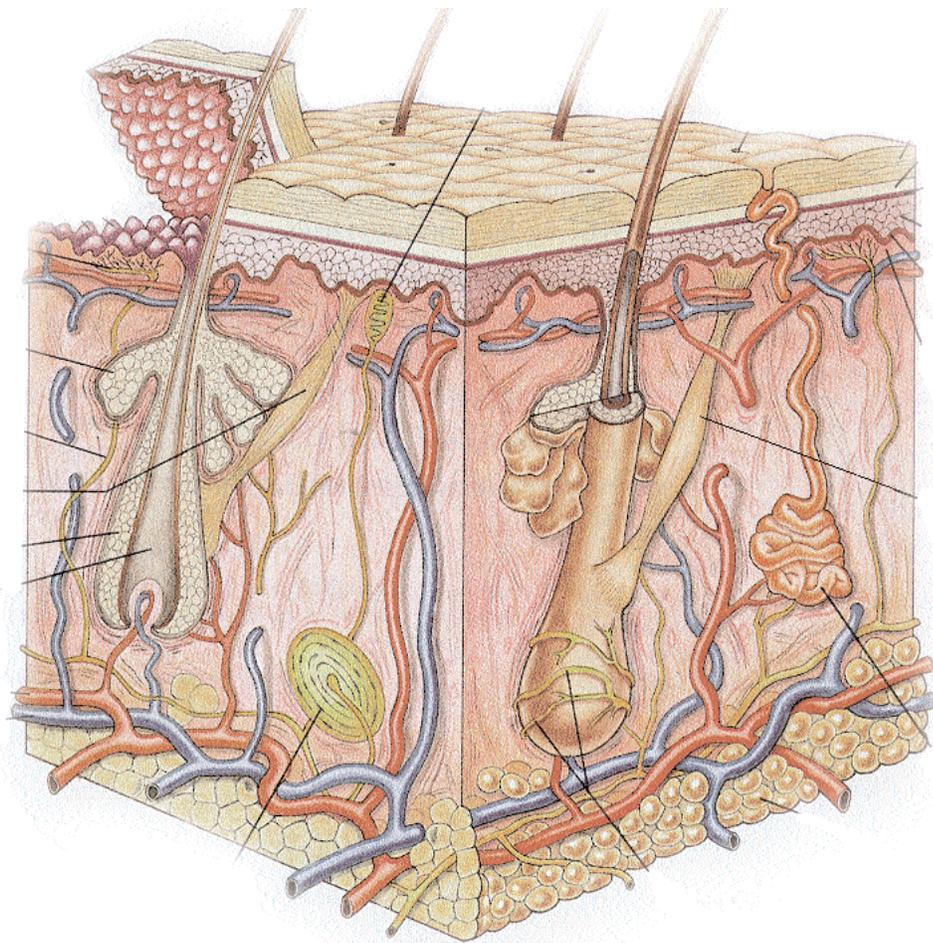
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PART FOUR

Common Skin Conditions: Diagnosis and Treatment



Cutaneous Manifestations of Systematic Disease

Petr G. Burk and P. Goodheart

Overview

BASICS

- Skin cancer is the most common cancer in the United States, and basal cell carcinoma (BCC) is, by far, the most common type of skin cancer.
- A BCC is locally invasive and destructive, but it is rare for one to metastasize.
- As with SCC and solar keratoses, BCCs are introduced by ultraviolet radiation in susceptible individuals.

Etiology

In certain situations, however, determining the precise cause may be of vital importance. Examples include the appearance of a viral exanthem in a pregnant woman or in immunocompromised patient. It is also important to distinguish viral exanthems from rashes caused by treatable bacterial infections.

Description of lesions

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CLINICAL VARIANTS

- **Superficial BCC** (FIGURE 22.18) occurs as a scaly erythematous patch with a threadlike border.
 - The lesions tend to be indolent, asymptomatic, and the least aggressive of BCCs.

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BASAL CELL CARCINOMA



FIGURE 22.14 Nodular basal cell carcinoma (BCC). Pearly papule with ulceration (rodent ulcer)

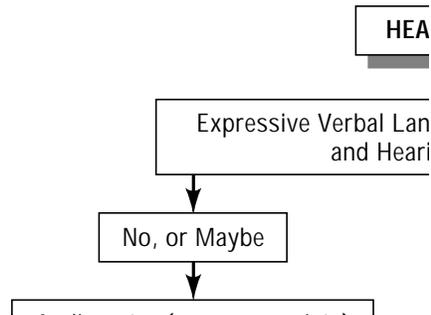


FIGURE 22.15 Close-up view of Figure 22.14. Rolled borders with telangiectasias.



FIGURE 22.16 Typical location of basal cell carcinoma (BCC). Note the central crust, telangiectasias, and pearly, rolled border.



FIGURE 22.17 Pigmented basal cell carcinoma (BCC). Note the pearly, waxy surface.

BASICS

- Skin cancer is the most common cancer in the United States, and basal cell carcinoma (BCC) is, by far, the most common type of skin cancer.
- A BCC is locally invasive and destructive, but it is rare for one to metastasize.
- As with SCC and solar keratoses, BCCs are introduced by ultraviolet radiation in susceptible individuals.
- **Risk factor** for BCC include the following:
 - Age older than 40 years
 - Male sex
 - positive family history of BCC
 - Light complexion with poor tanning ability
- As with SCC and solar keratoses, BCCs are rare in blacks and Asians.

DESCRIPTION OF LESIONS

- Nodular BCC is the most common type (FIGURE 22.14 and 22.15).
- The lesion may be a pearly papule or nodule, often with ulcer and scale crust (rodent ulcer)
- There may be rolled borders with telangiectasias (FIGURE 22.16).
- The lesion may be waxy, semitranslucent, or pink in color, or
- Brownish to blue-black in pigmented BCC (FIGURE 22.17).

DISTRIBUTION OF LESIONS

- Lesions occur on the head and neck in 85% of all affected patients.
- Lesions occur on sun-exposed areas (e.g., face [cheeks, forehead, lower face, and especially on the nose], periorbital area, and back of neck).

CLINICAL MANIFESTATIONS

- Lesions are often ignored, asymptomatic, slow growing, and may bleed.
- In time, lesions may ulcerate (e.g., the “sore that will not heal”).
- Pigmented BCC occurs more commonly in darkly pigmented individuals.

DIAGNOSIS

- Diagnosis is generally made by shave or excisional biopsy.

CLINICAL VARIANTS

- **Superficial BCC** (FIGURE 22.18) occurs as a scaly erythematous patch with a threadlike border.
 - The lesions tend to be indolent, asymptomatic, and the least aggressive of BCCs.
 - Lesions are often multiple, occurring primarily on the trunk and proximal extremities.
 - When solitary, a lesion of superficial BCC may resemble psoriasis, eczema, seborrheic keratosis, or Bowen’s disease (SCC in situ).
 - There is no clear association between superficial BCC and sun exposure

- **Morpheaform BCC** is the least common and the most aggressive form of BCC.
 - Lesions appear as whitish, scarred atrophic plaques with surrounding telangiectasia (FIGURE 22.19).
 - The margins of these lesions are often difficult to evaluate clinically; similar to icebergs, what is seen on the surface is not always what lies under the surface.
 Consequently, morpheaform BCCs are generally more difficult to treat than other BCCs.

DIFFERENTIAL DIAGNOSIS

- SCC
- Solar keratosis
- Sebaceous hyperplasia (see Chapter 21, “Benign Skin Neoplasms”.)
- Angiofibroma (fibrous papule of the nose, FIGURE 22.20), which may be clinically indistinguishable from BCC
- Nodular melanoma or seborrheic keratosis, which may be difficult to distinguish from pigmented BCC

MANAGEMENT

- Prevention (see Appendix 2) is achieved by sun avoidance, use of sunscreens with sun protection factor (SPF) of at least 15, and wearing protective clothing. Patients should learn skin self-examination and have annual skin examination by a physician.
- Treatment (See Chapter 27, “Highly Specialized Procedures”) is achieved by the following:
 - Electrodesiccation and curettage
 - Cryosurgery with LN₂, which is excellent for selected eyelid lesions
 - Excision, permitting histologic diagnosis of margins
 - Micrographic (Moh’s) surgery for morpheaform, recurrent, or large lesions and for lesions in danger zones (e.g., the nasolabial area, around the eyes, behind the ears, in the ear canal, on the scalp)
 - Radiation therapy for elderly patients or for those who are physically unable to undergo excisional surgery
 - Topical 5-FU therapy for multiple superficial BCCs

POINTS TO REMEMBER

- Almost 50% of patients with BCC have another BCC within 5 years.
- Patients with BCC have an increased risk for melanoma.
- Patients should always be undressed for adequate examination of the skin.



FIGURE 22.18 Superficial basal carcinoma (BCC) resembles a psoriatic plaque and Bowen's disease.



FIGURE 22.19 Morpheaform basal cell carcinoma (BCC). Whitish atrophic plaque with surrounding telangiectasias and pearly papules surrounding the telangiectasias.

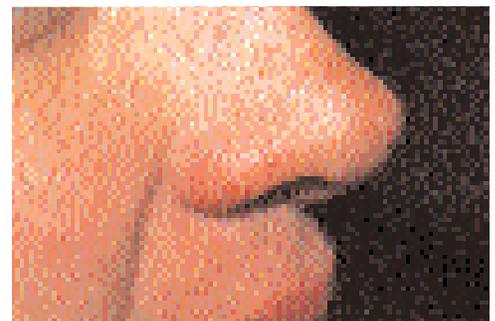


FIGURE 22.20 Angiofibroma (fibrous papule of the nose). Note small papules with telangiectasias.



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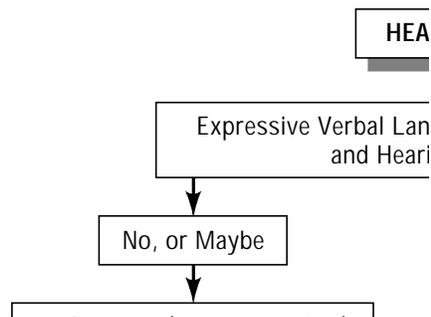


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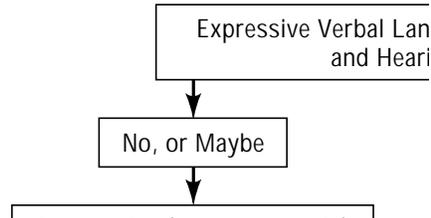


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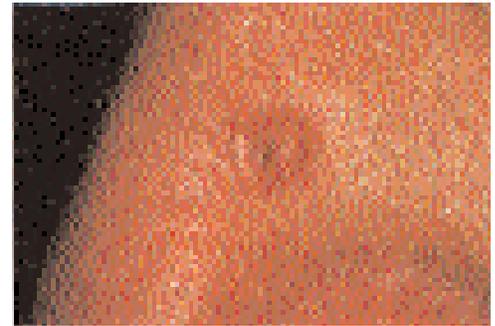


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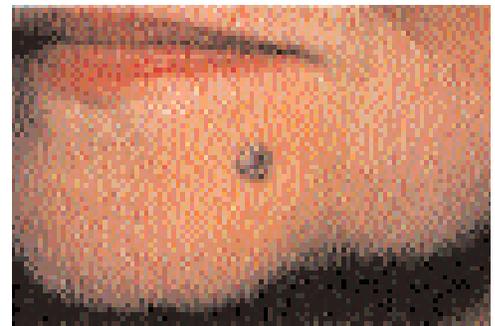


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- Pigmented BCC occurs more commonly in darkly pigmented individuals.
- Lesions occur on sun-exposed areas (e.g., face [cheeks, forehead, lower face, and especially on the nose], periorbital area, and back of neck).

ACNE FORMULARY TOPICAL AGENTS

The following agents should provide more than enough treatment options for the condition discussed in this book

POTENCY	GENERIC NAME	BRAND NAME
SUPERPOTENT	Hydrocortisone	Hytone, Cortaid, Cortizone
	Flurandrenoline	Cordran Tape
	Diflorasone diacetate, ointment	Psorcon
VERY STRONG	Flucidinide crem, ointment	Lide
	Desoximetasone gel	Cordran Tape
	Hydrocortisone crem	Psorcon
STRONG	Hydrocortisone	Hytone, Cortaid, Cortizone
	Flurandrenoline	Cordran Tape
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CLASSIFICATION, STRENGTH, AND VEHICLE OF SOME COMMONLY USED TOPICAL STEROIDS

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A P P E N D I X

Handouts

👉 EL PIE DEL ATLETA (TINA PEDIS)

LA INFECCION AGUDA DE MEMBRANA DEL DEDO

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El tratamiento

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MALIGNANT MELANOMA

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