Stuff in the skin slideshow – Interesting Skin Things 19th October 2022

Chicken pox-

Erythema around the pox-is not secondary bacterial infection. Secondary bacterial infection in chickenpox is very rare.

Most vesicles on trunk, polymorphic, differing ages, crust over.

Gianotti crosti- (GC)

Legs arms face, tummy clear

Non specific rash to lots of viruses, quite common.

GC and HFAMD (Hand Foot and Mouth) mainly spares trunk

Slapped cheek-generalised reticular rash with red cheeks

HFAMD-main differential, particularly atypical, better in a week or two-GC around for the last 4-5 years. main difference is GC will persist for weeks and weeks.

Even if looks like gone will be apparent after bath/shower.

Pityriasis lichenoides (PLEVA)

Looks like chicken pox (CP). Very Itchy. Cause unknown. Maybe viral EBV, CMV, trunk and extremities, gets better on its own. Possible hypersensitivity reaction to viruses.

Usually misdiagnosed as chicken pox.

Usually resolves in a couple of weeks. Lasts longer than CP.

Erythromycin off licence but doesn't usually need rx.

Swab of vesicle only way to know-if +ve CP, if negative PLEVA or could still be CP

Polymorphic eruption of pregnancy.

1st pregnancies.

3rd trimester.

Starts as itchy papules in stretch marks then spreads.

Important clinical feature is that the **umbilicus is spared!** (if umbilicus not spared then need to think of other conditions)

topical steroids, emollients, Antihistamines though not that helpful.

Pemphigoid gestationis-

Autoimmune blistering condition

Implications for baby

IUGR, premature delivery, baby can have transient rash

Can flare after baby been born-in 1-2 weeks after birth-vesicular rash week later.

Reoccurs in subsequent pregnancies but can skin pregnancies

Can occur on COCP

BUMPS website. https://www.medicinesinpregnancy.org/

Melasma

Non-white skin more common

Most important Rx? Avoid sun!

Even visible light can cause symptoms-tinted physical sunscreen. Zinc or iron oxide.

Avoid COCP.

Azelaic acid. (made by the yeast which causes pityriasis versicolor)

Triple therapy-hydroquinone+tretinoin+steroid Beware of ochronosis-greyish black pigmentation with hydroquinone. (Kligmans formula pignanorm)

Oral tranexamic acid-some evidence it works. Slight increase in dvts.

Chemical peels and lasers-risk of PIH (post inflammatory hyperpigmentation) so be v careful.

Skin lightening creams (bought on internet) potent steroids so beware!!

Nodulocystic acne

REFER!

Avoid tetracycline as well as Roaccutane

Start erythromycin or clarithromycin as ok to take with roaccutane (can overlap treatment as roaccutane can cause acne flare initially)

Likely need pred and blackheads treating or else they flare up-hyfrecation over closed comedones, squeeze out the blackheads. (blackheads less of a concern)

Start contraception-cocp can help with acne.

Acne fulminans-redder, systemically unwell-pick up phone and needs seeing for oral steroids.

Purpleish colour suggests not V acute

Acne fulminans-antibiotics and oral steroids-inflammatory rather than infective.

Malassezia Folliculitis – caused by yeast – treat with antifungal (responds better to oral antifungals) . Differentials – acne vulgaris , steroid acne , bacterial folliculitis

Milia -epidermal retention cysts. Common. Get them randomly but also after trauma to skin

Comedonal acne-topical retinoid is best treatment. Adapalene. Just use couple of times a week initially. Advise re photosensitivity. Avoid pregnancy-would prescribe but advise to stop if pregnant (sometimes pharmacy won't give if not on contraceptive) fine to use if not on contraceptive, no evidence of harm in pregnancy with topical retinoids but would stop due to known risk with oral retinoids , so being cautious. (Note BNF says "Females of child-bearing age must use effective contraception (oral progestogen-only contraceptives not considered effective)" but dermatology happy to prescribe without contraceptive as long as counselled patient to avoid pregnancy.

Ecchymosis-Old man ?should I stop aspirin?

Nothing to do with aspirin.

Sun damage.

Not really trauma as otherwise soles of feet and buttocks would be covered in bruises.

Due to loss of elastin and collagen. Photoageing.

Stellate pseudoscars Get white linear scars also due to sun damage. Seen in older people.

Emollients SPF

Blashcoid lines-embryological.

Blashcoid distribution.

Zoster, **lichen striatus**-see in kids

IN adults lichen planus, psoriasis or a dermatitis blashcitis . just dermatitis in a blashcoid distribution.

Old man blister on hands, had one on other hands. Some scars.

Sits in garden with hands on lap.

Pmh of haemachromatosis-liver disease

Differentials to consider : Phytophotodermatits-linear blsiters.

Polymorphic Light Eruption

Contact dermatitis

Dermatomyositis-doesn't cause scarring, doesn't recur each summer, hands on sun exposed.

Diagnosis **Porphyria cutanea tarda**- it's a liver disease rather than skin disease. Under haem. Can occur with any liver disease – not just haemachromatosis.

Man come back from work conference-abroad, went on night out. Not itchy. In areas he can't reach.

Under cooked **shitake mushrooms-flagellate dermatitis.**

(differentials to consider - some chemo drugs, juvenile dermatomyositis)

Sore red ear on a child. **Perichondritis**

Cartilage piercing gets embedded. Can't see from the front.

ENT give Ciprofloxacin not fluclox. Caused by pseudomonas hence need for Cipro. Early referral ENT as cartilage has poor blood supply and could lead to deformity- "cauliflower ear"

Differentials to consider:

Relapsing chondritis of the ear

Juvenile spring eruption-blisters itchy on top of ear

Impetigo/cellulitis

Ramsey hunt with blister

Scaly lesion on older person-**porokeratosis.** Get double line of scale on dermoscopy, coronoid lamellar

No rx works

Topical steroids if get red and sore.

Individual pink lesion on leg-**discoid eczema**

Differentials

fungal

Granuloma Annulare -no scale as not an epidermal condition

Bowen's

Can see venous HT changes suggesting age

Orange crust suggests its discoid eczema, fibre sign shows it's an active oozing crust

Swab will grow staph aureus-inflammation will settle with staph but flares as soon as stop.

Needs potent or super potent steroid. Trimovate or daktacort won't work, ok to use steroid on broken skin.

Single lesions-

BCC

Bowens (differential is superficial BCC but rx is the same) if think its fungal take a scrape and use topical antifungals for 3 weeks, when negative scrape come back and no better with AF try potent steroid for 3 weeks-anything still there BCC or bowens-treat or biopsy.

Wouldn't treat without good dermoscopy or tissue diagnosis

Amelanotic melanoma!!