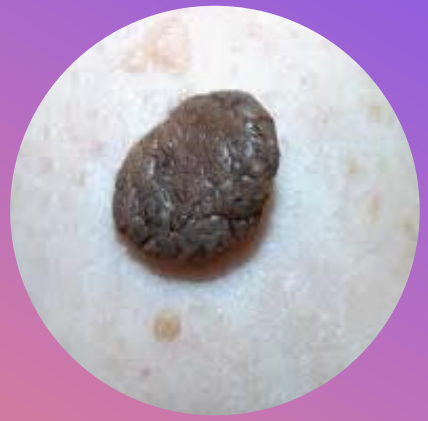


DERMATOLOGY VISUAL REVIEW: IMPORTANT HORSES AND ZEBRAS FOR THE PRIMARY CARE PROVIDER

Kathy Sofen Guerra, PA-C

Mohs Surgery and Dermatology

Elgin, IL

DISCLOSURES

- Declaration Statement: I have relevant relationships with consulting for Leo Pharmaceuticals and SUN Pharmaceuticals within the last 24 months.

EDUCATIONAL OBJECTIVES

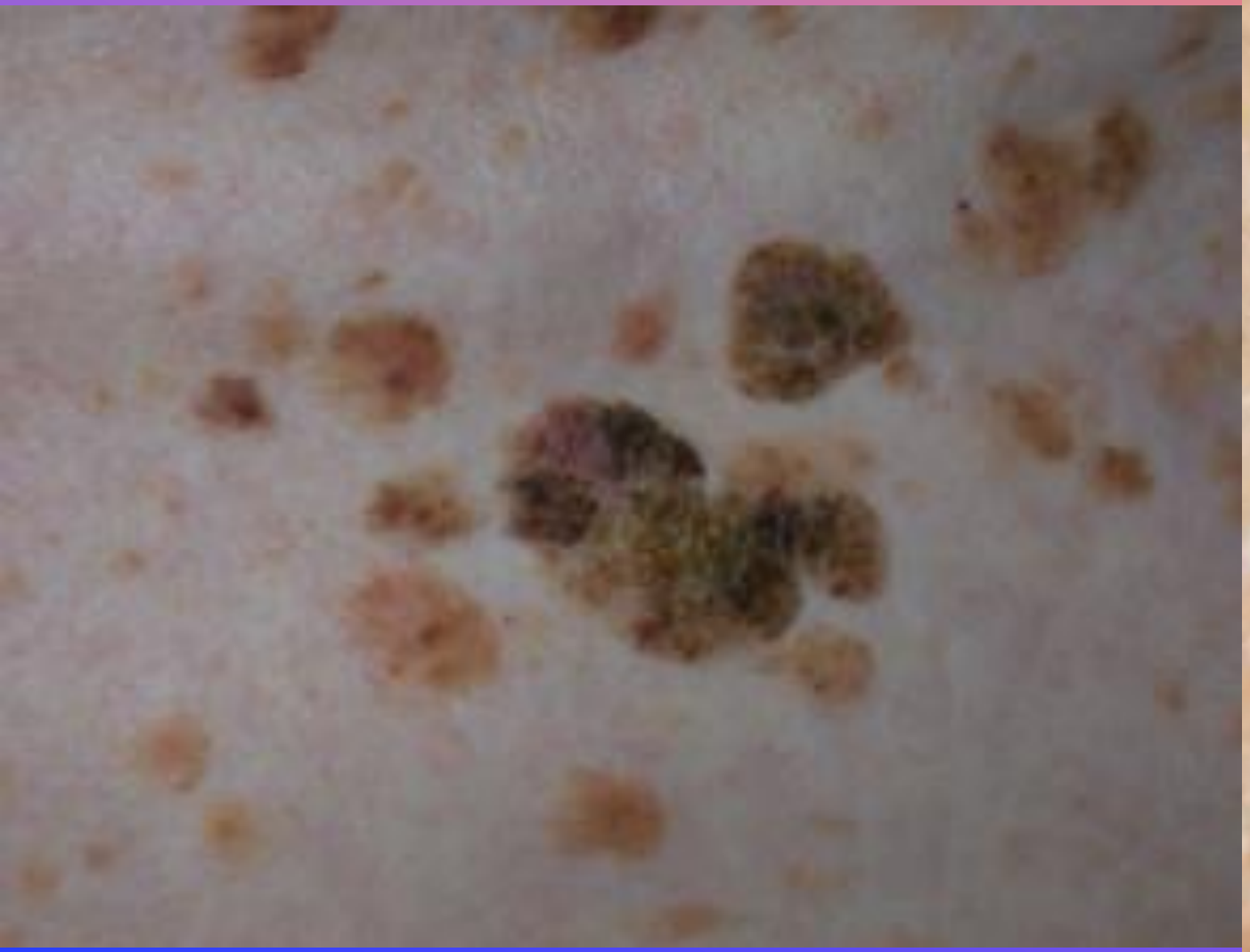
At the conclusion of this session, participants should be able to:

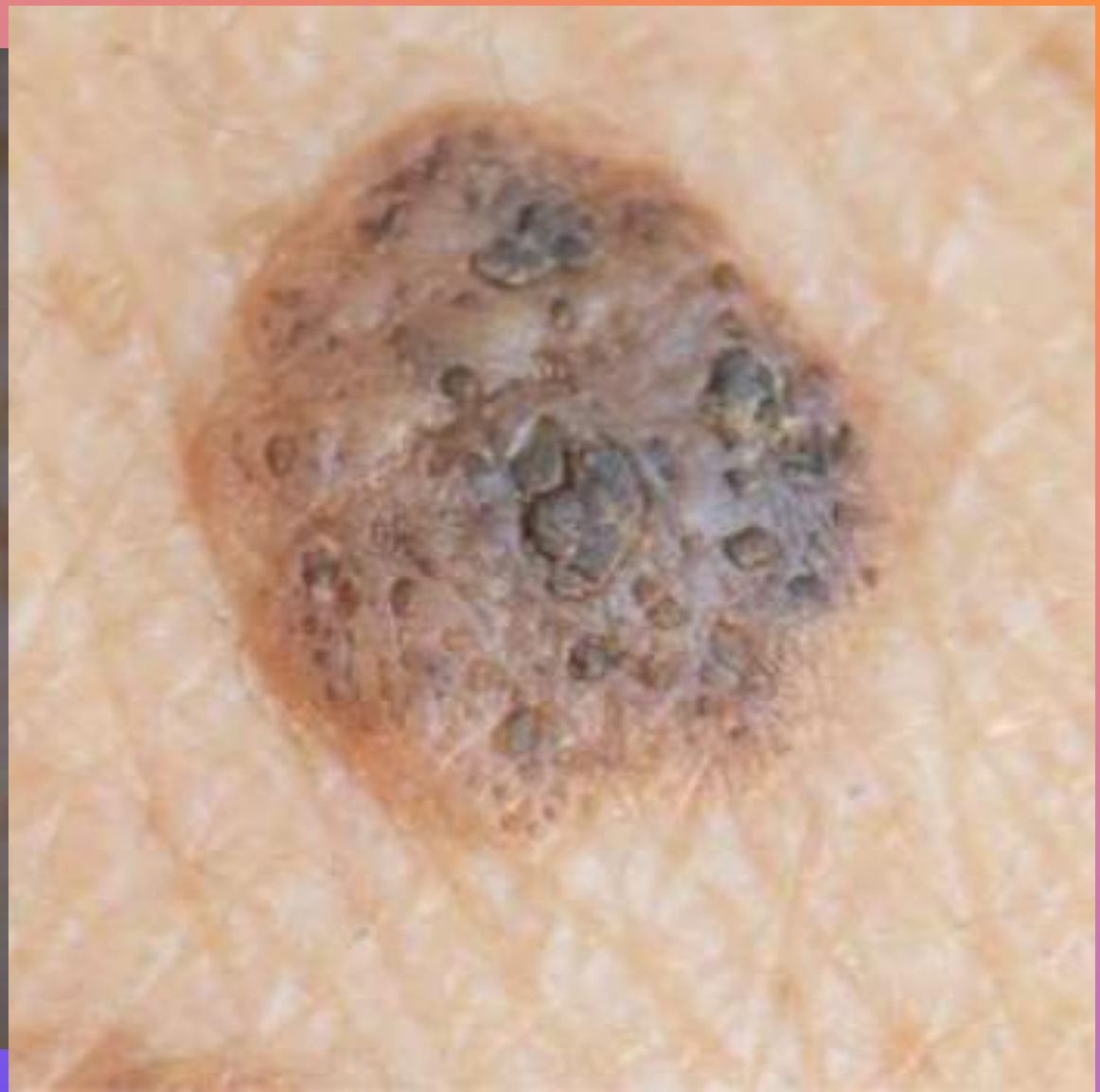
- Discuss features of morphologically similar skin diseases and common pitfalls that are encountered on examination

- Review referral patterns

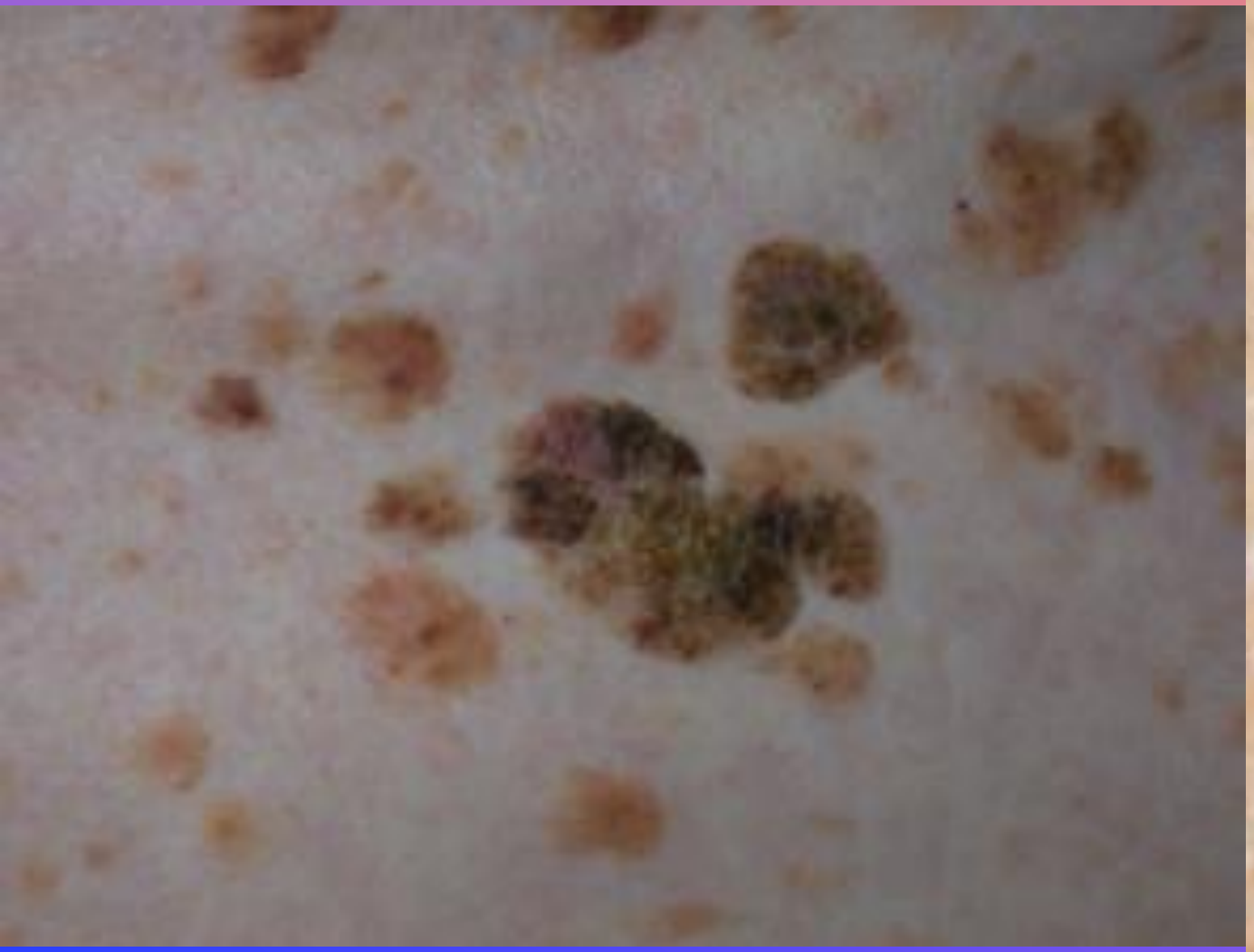
- Provide a brief overview of treatment only, the focus of this lecture will be mainly visual recognition cues

WHAT IS IT?

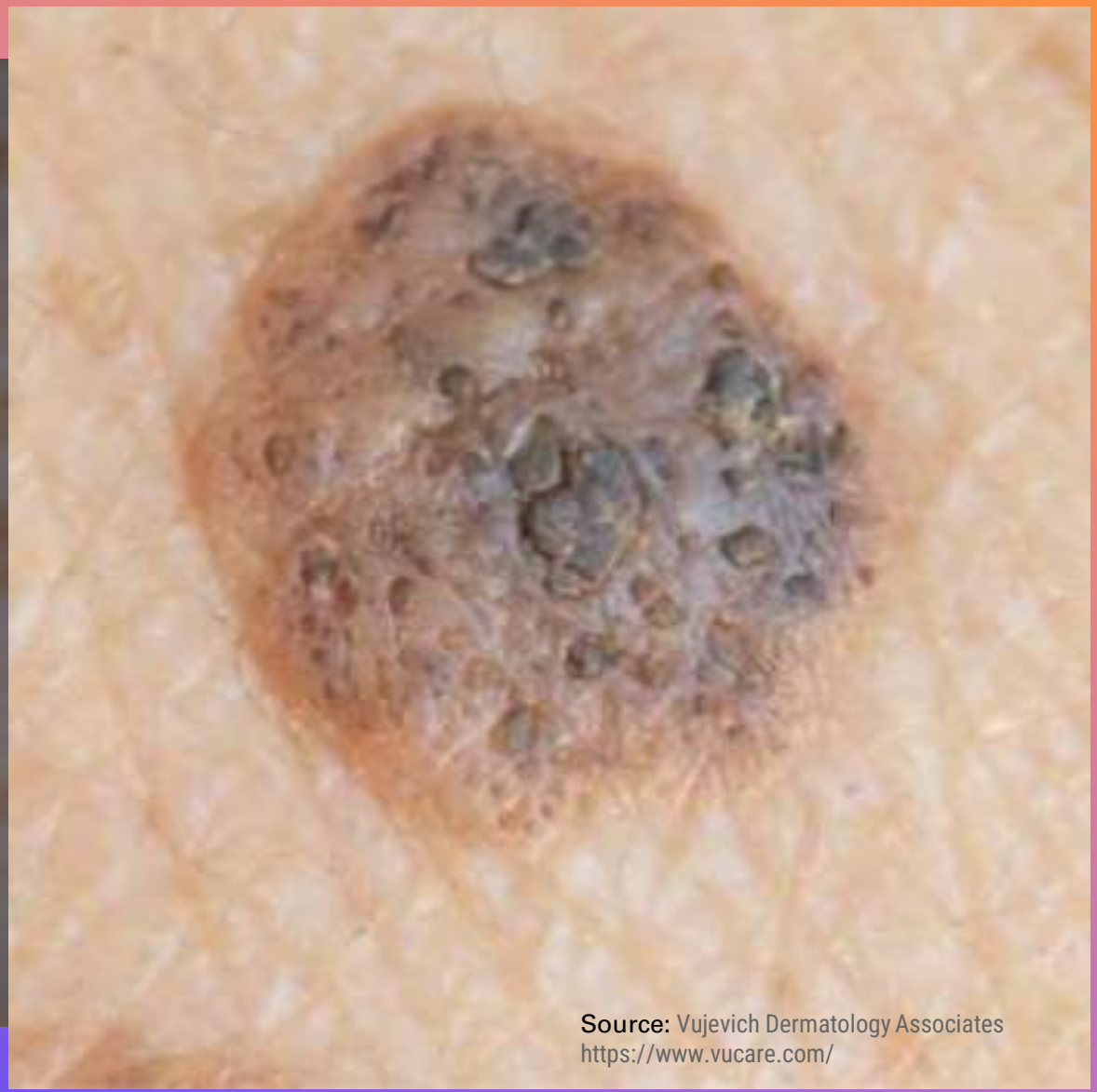




SEBORRHEIC KERATOSES



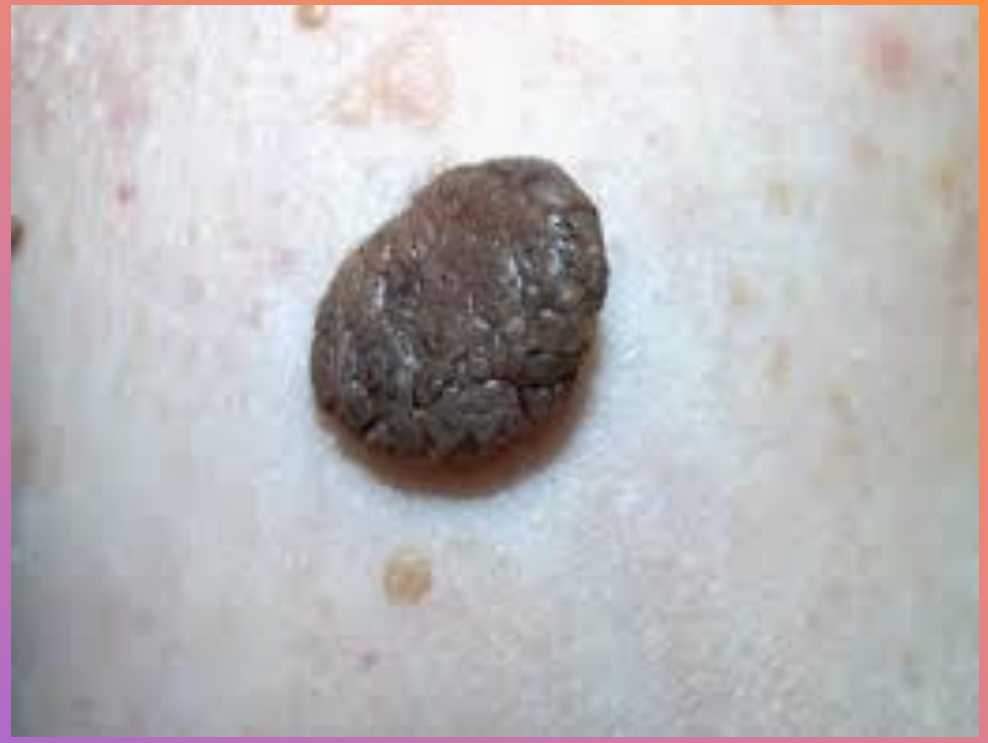
Source: DermnetNZ



Source: Vujevich Dermatology Associates
https://www.vucare.com/

SEBORRHEIC KERATOSES CHARACTERISTICS

- Well demarcated scaly papules
- “stuck-on” appearance
- Older patients, can start in 30s-40s
- Trunk, face, proximal extremities
- Contain horn pseudocysts
- No Rx required
- Can use LN2 or shave removal
- Fave product recommendation: OTC lactic acid 15% lotion to lesions: lactic acid can smooth, soften SKs so patients don’t pick!
- REASSURANCE!



Source https://dermnetnz.org/cme/lesions/benign-keratinocytic-and-adnexal-lesions

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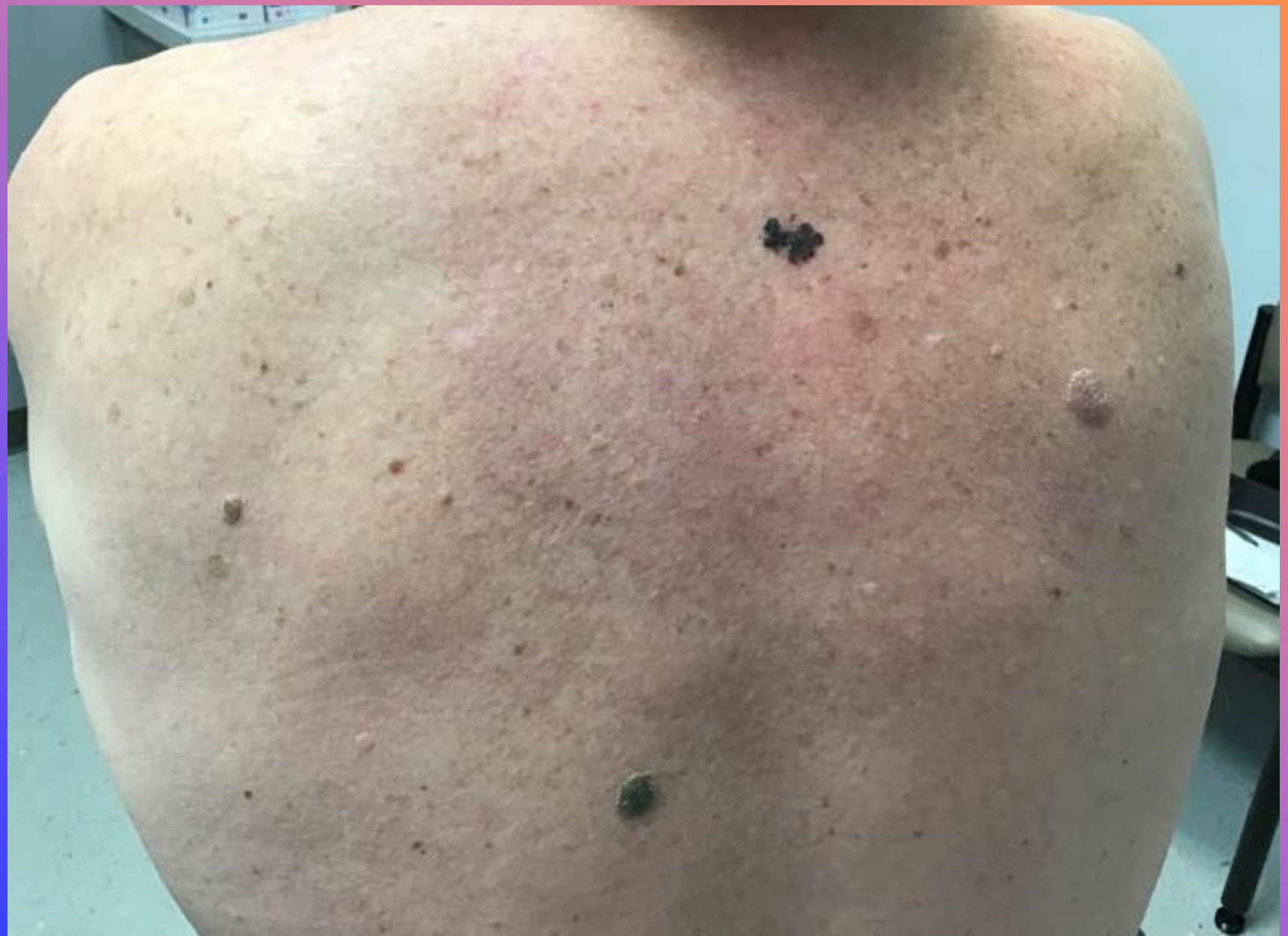
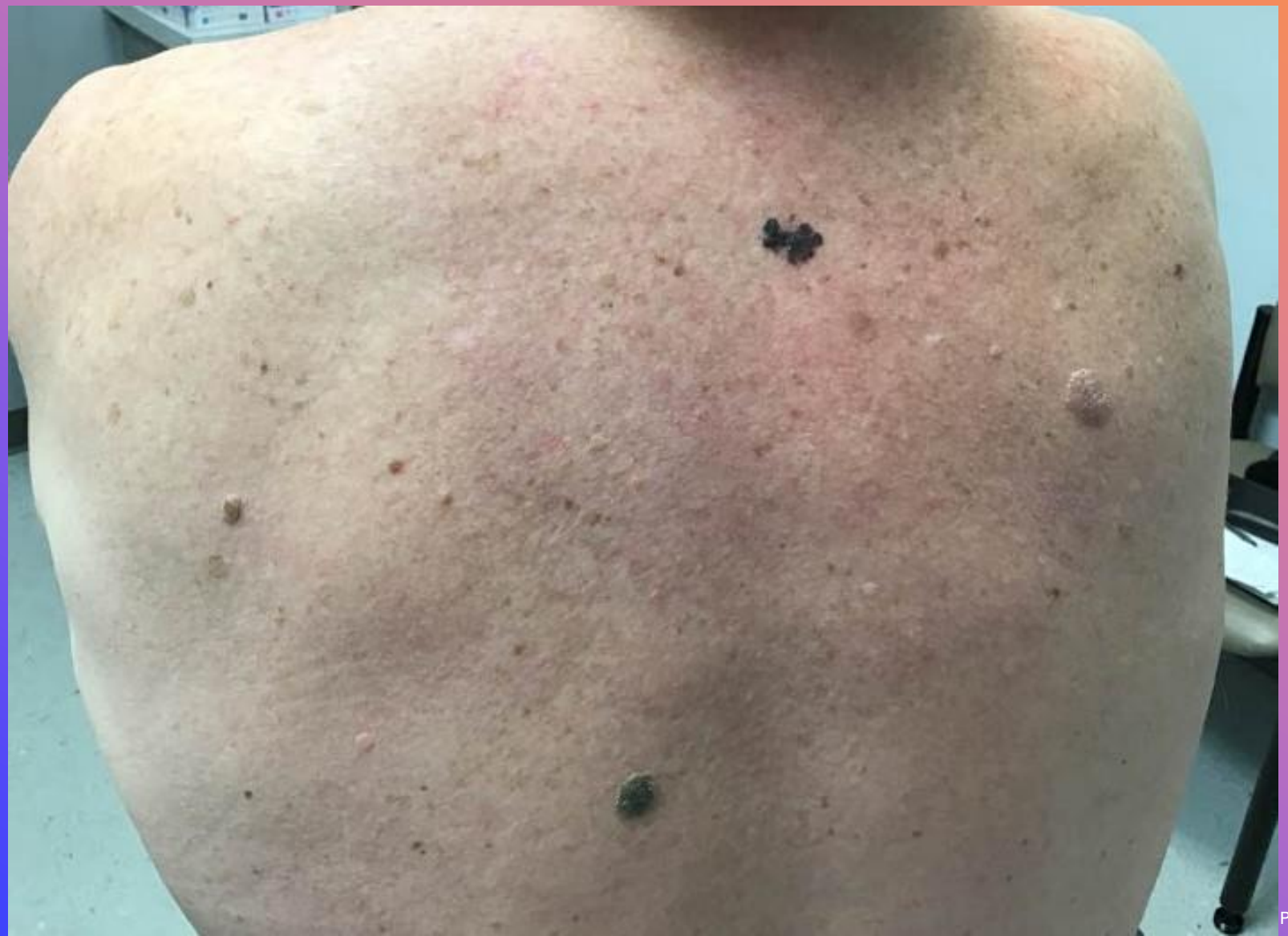
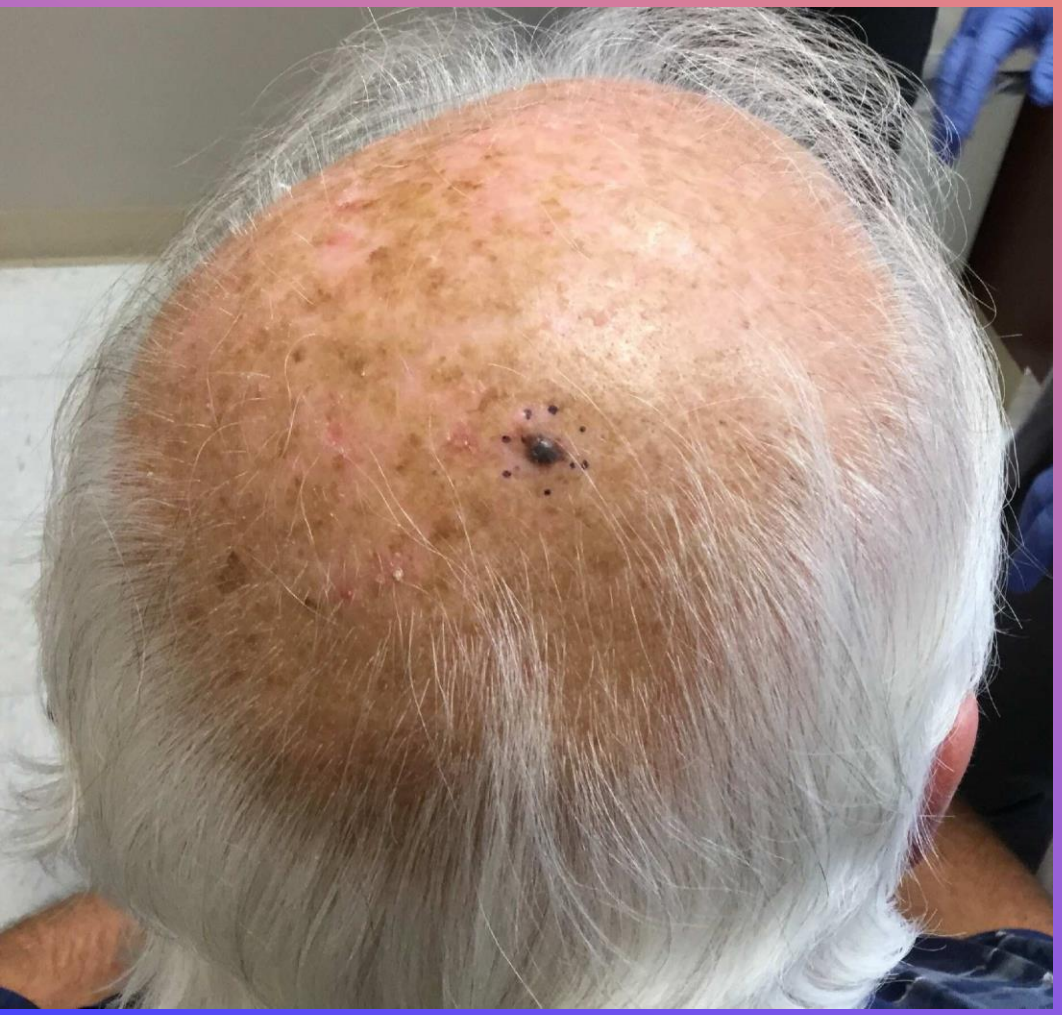


MELANOMA (AND SKS)

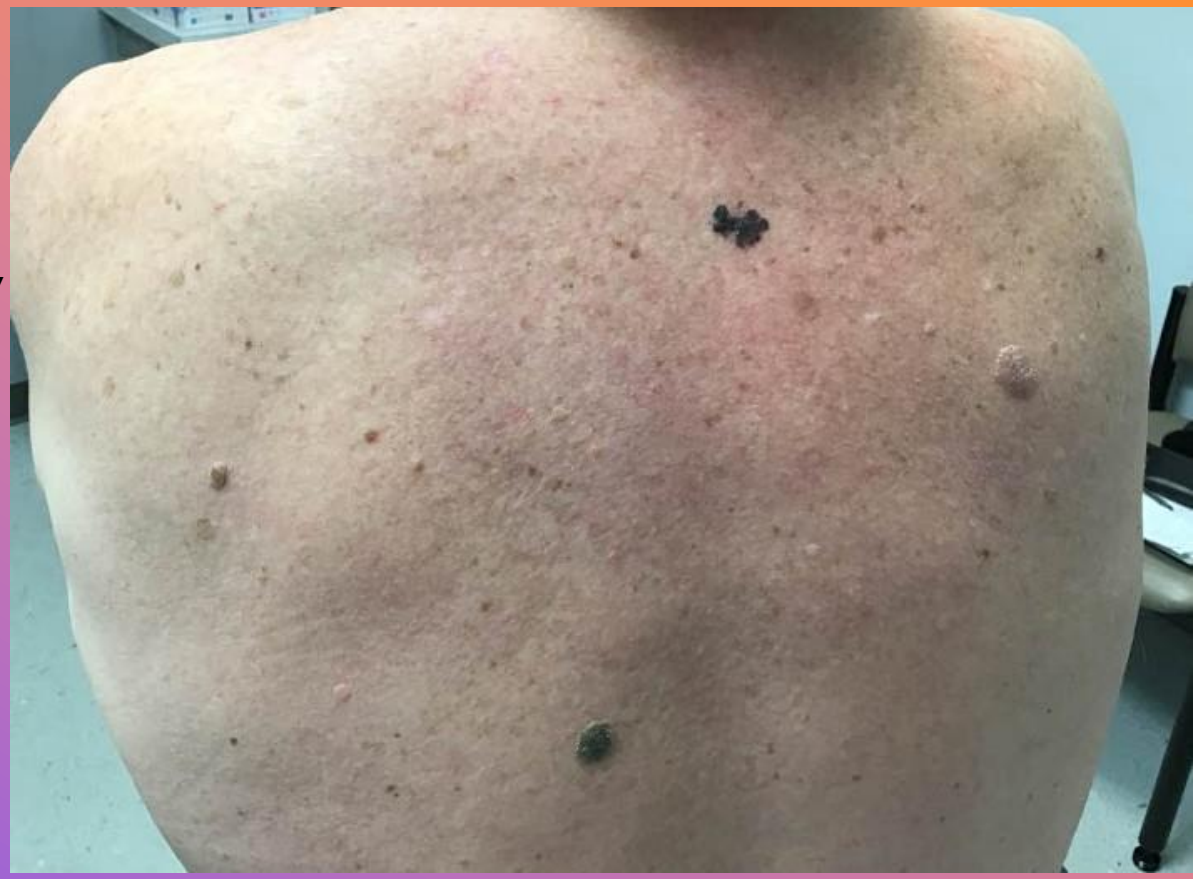


Patient of Mohs Surgery and Dermatology

MELANOMA



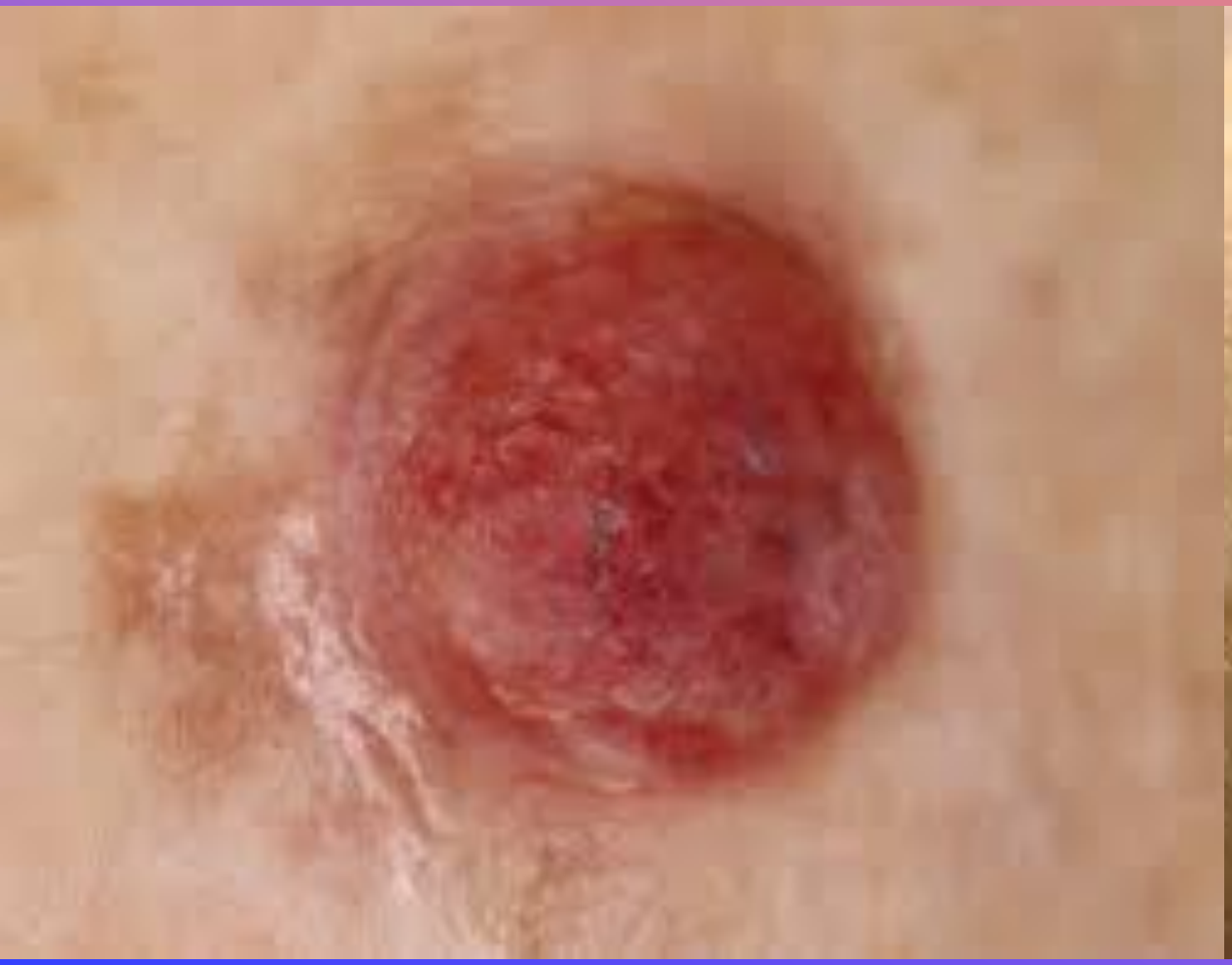
Asymmetry
Border
Color
Diameter
Evolving

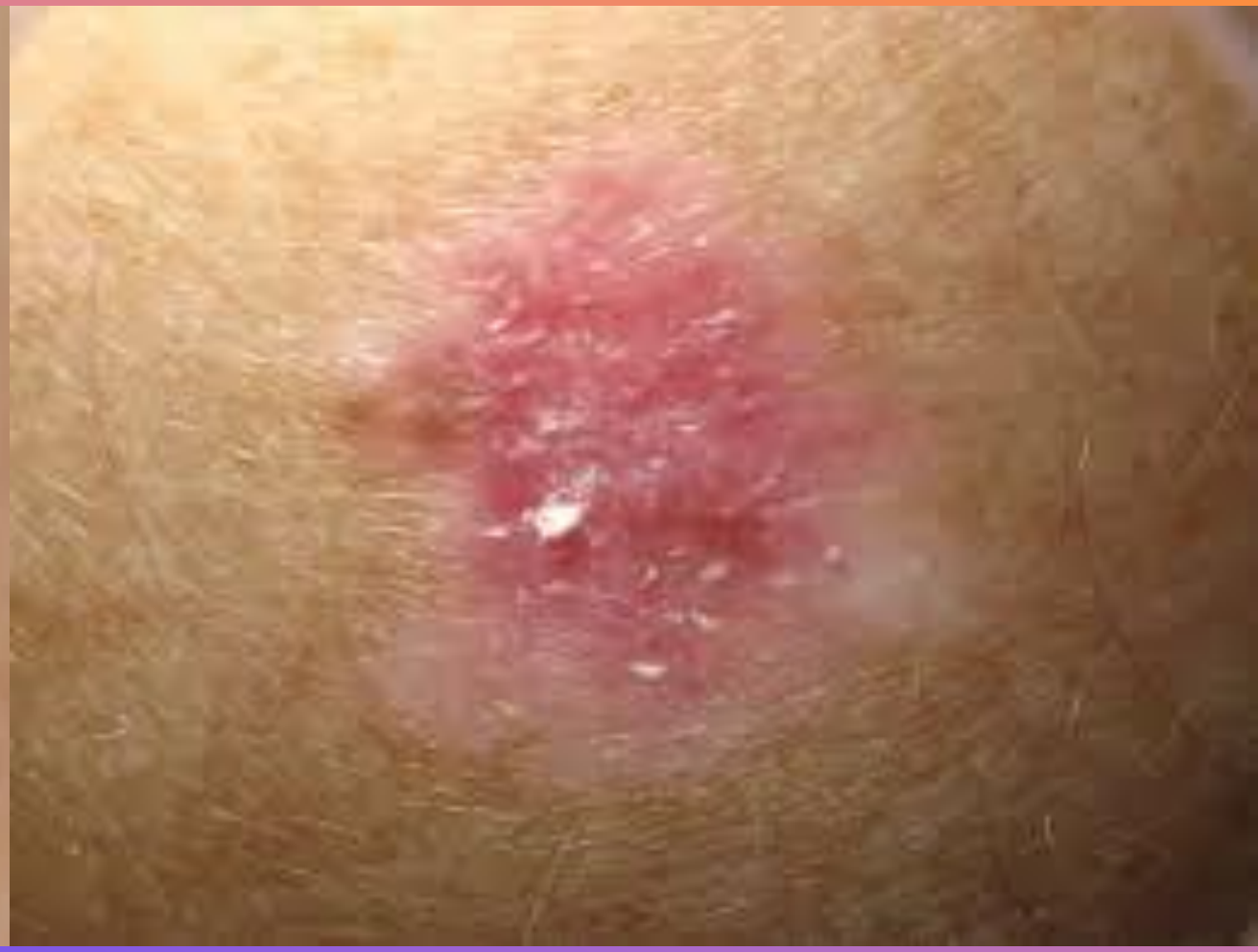


- Check scalps!
- Check groins, vulvas and buttocks!
- Just because a mole is big, does not make it a melanoma

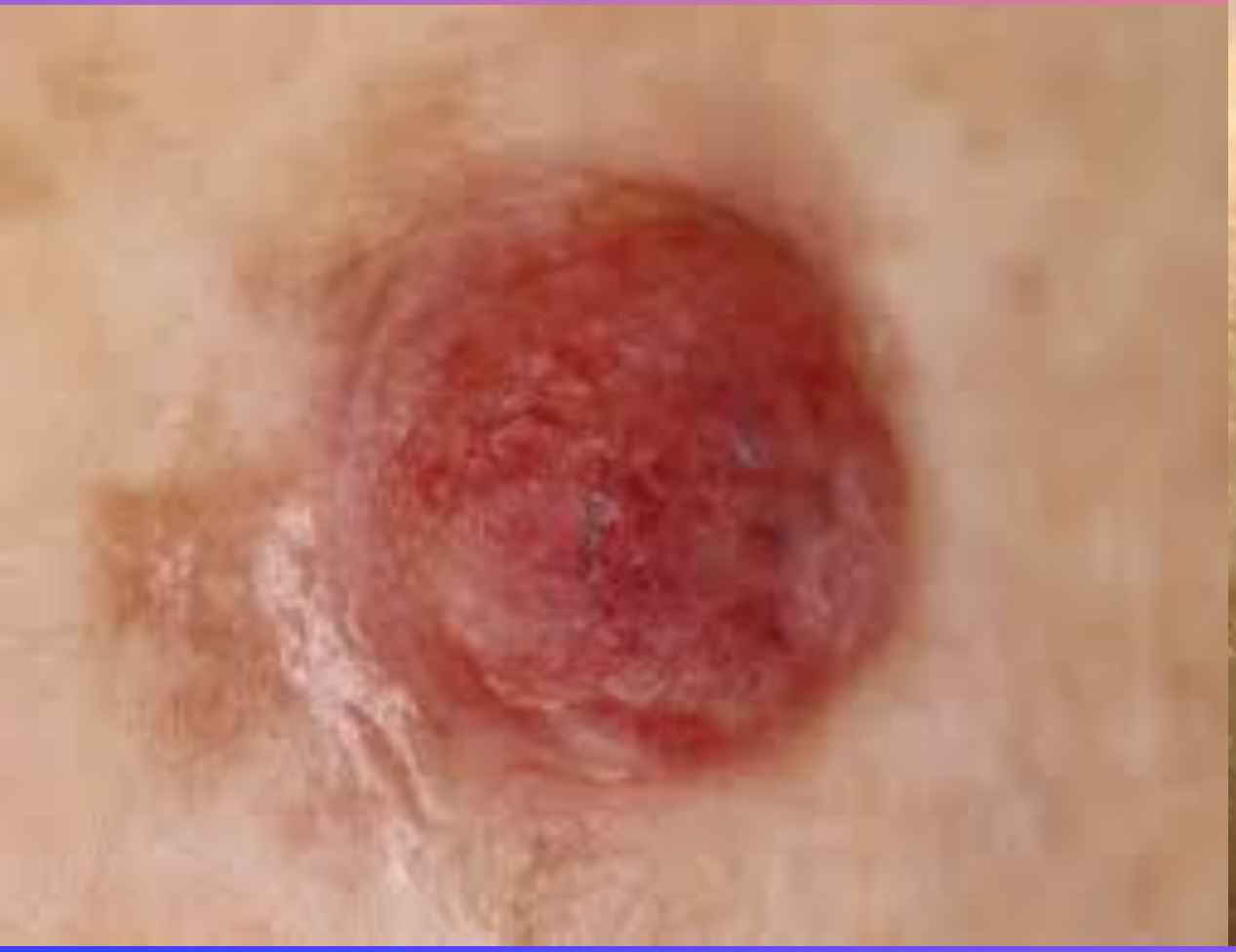
- Refer for biopsy if unsure because we often do DEEP scoop biopsies for suspected melanomas or excisional biopsies

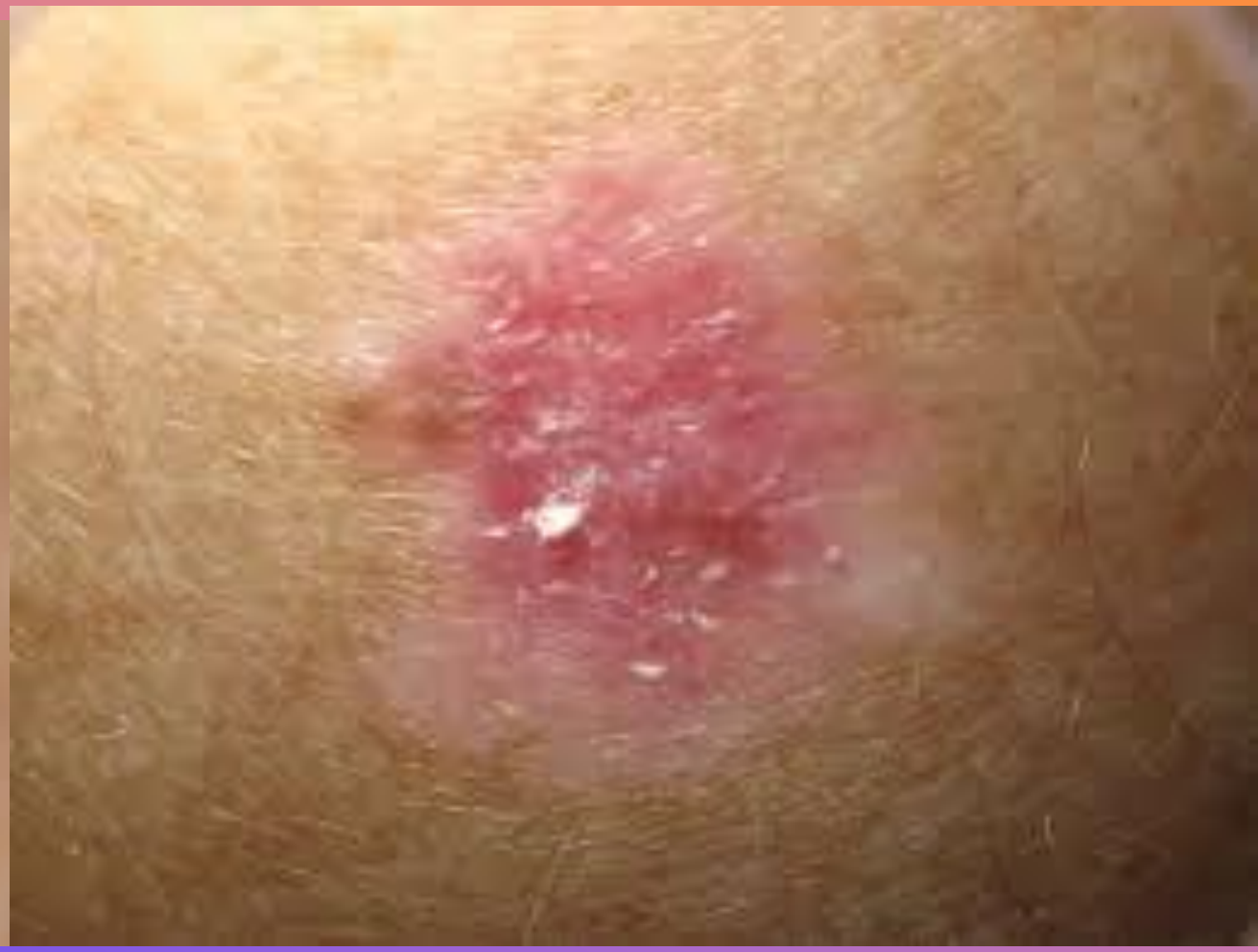
WHAT IS IT?





AMELANOTIC MELANOMA

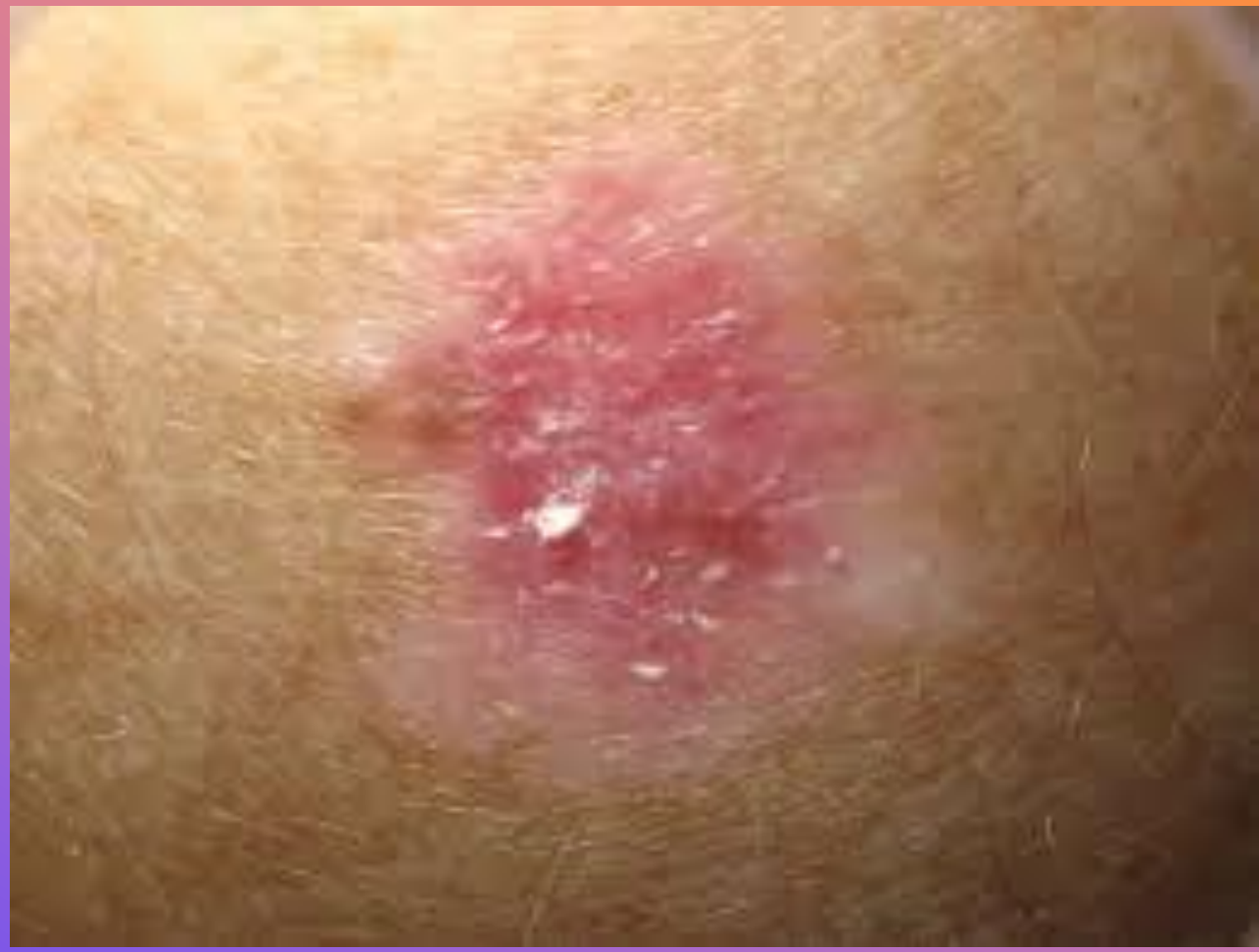




Source: Dermnetnz: amelanotic melanoma images https://dermnetnz.org/#gsc.tab=1&gsc.q=amelanotic%20melanoma

AMELANOTIC MELANOMA

- Pink or red papule or plaque
- Usually has a small amount of pigment
- Often diagnosed late
- Clinically resemble BCC
- When in doubt, refer or if you are comfortable do a biopsy (may leave a scar)



Source: Dermnetnz: amelanotic melanoma images
https://dermnetnz.org/#gsc.tab=1&gsc.q=amelanotic%20melanoma

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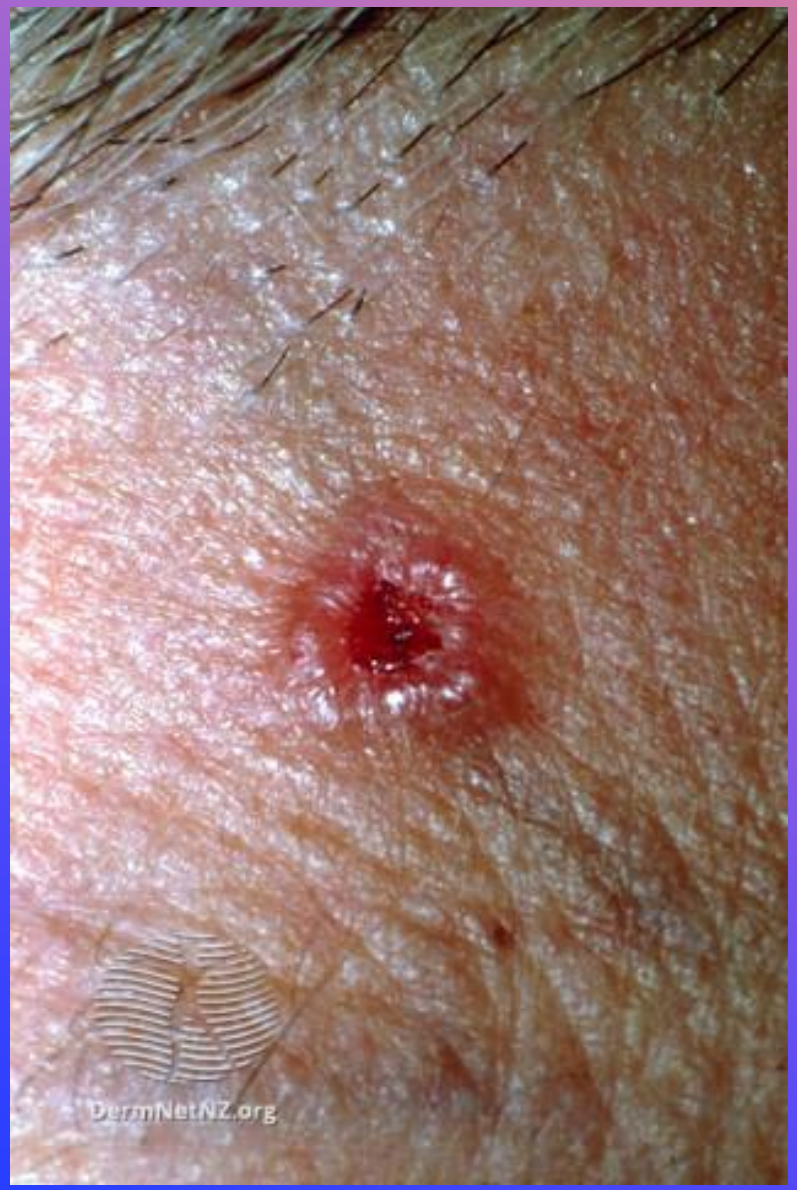
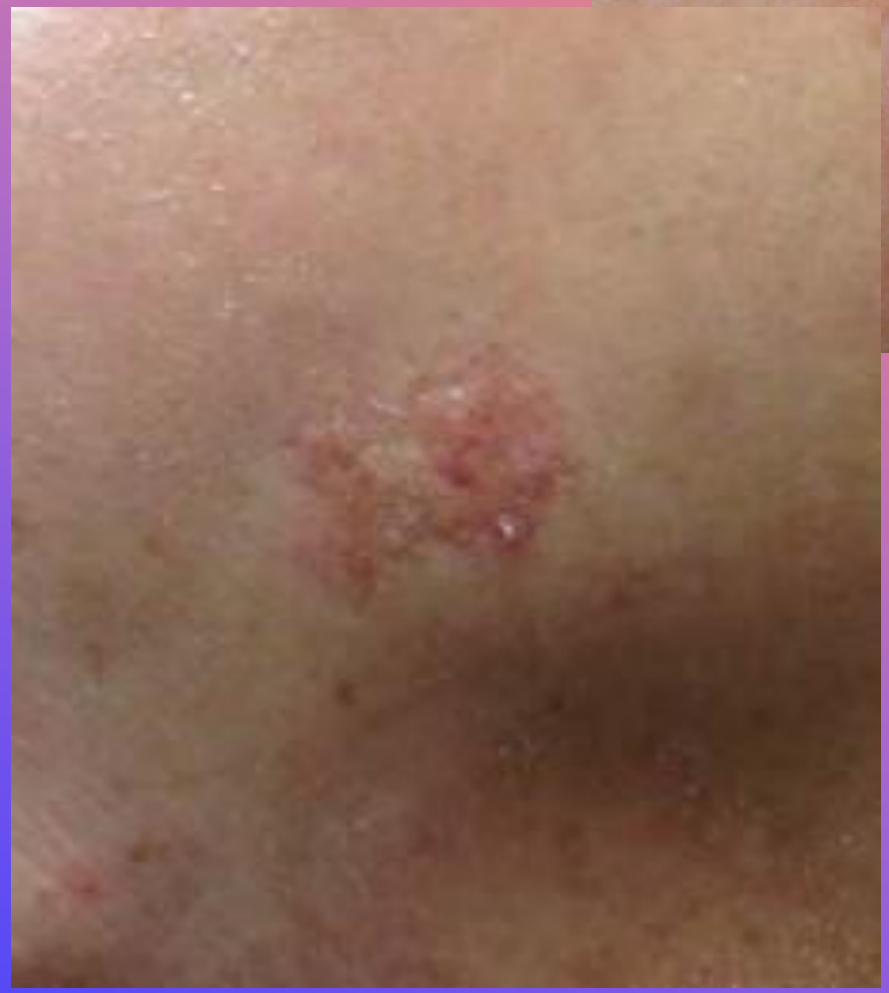
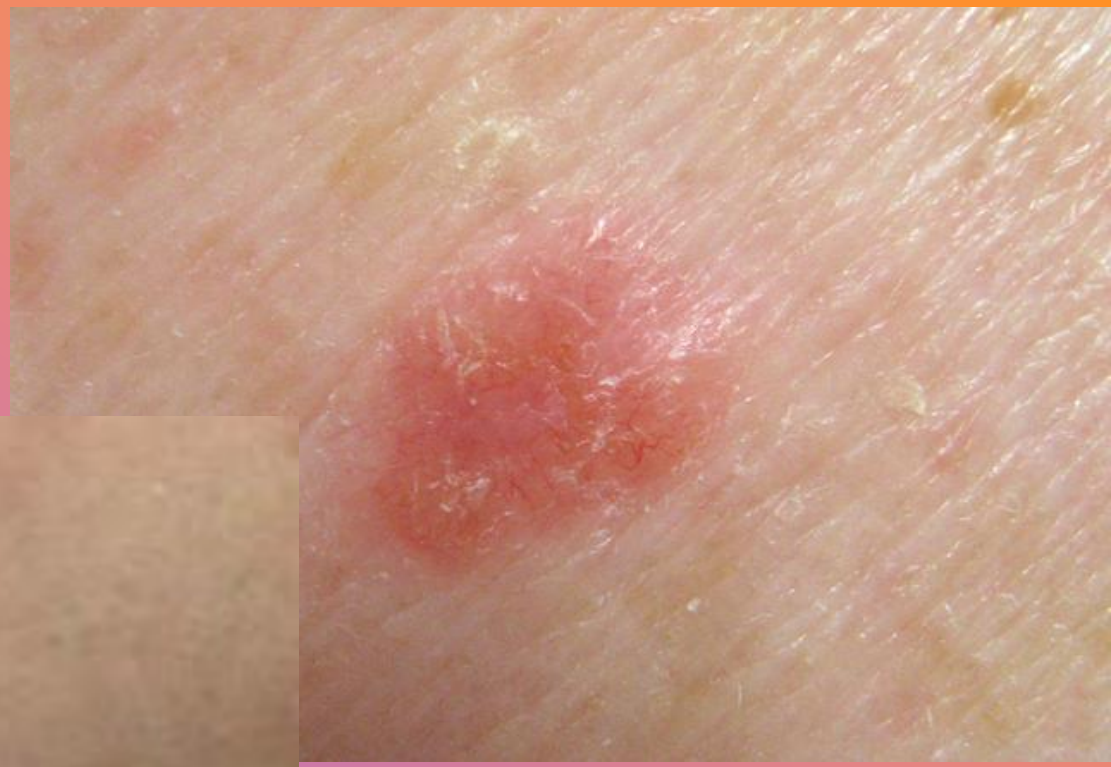
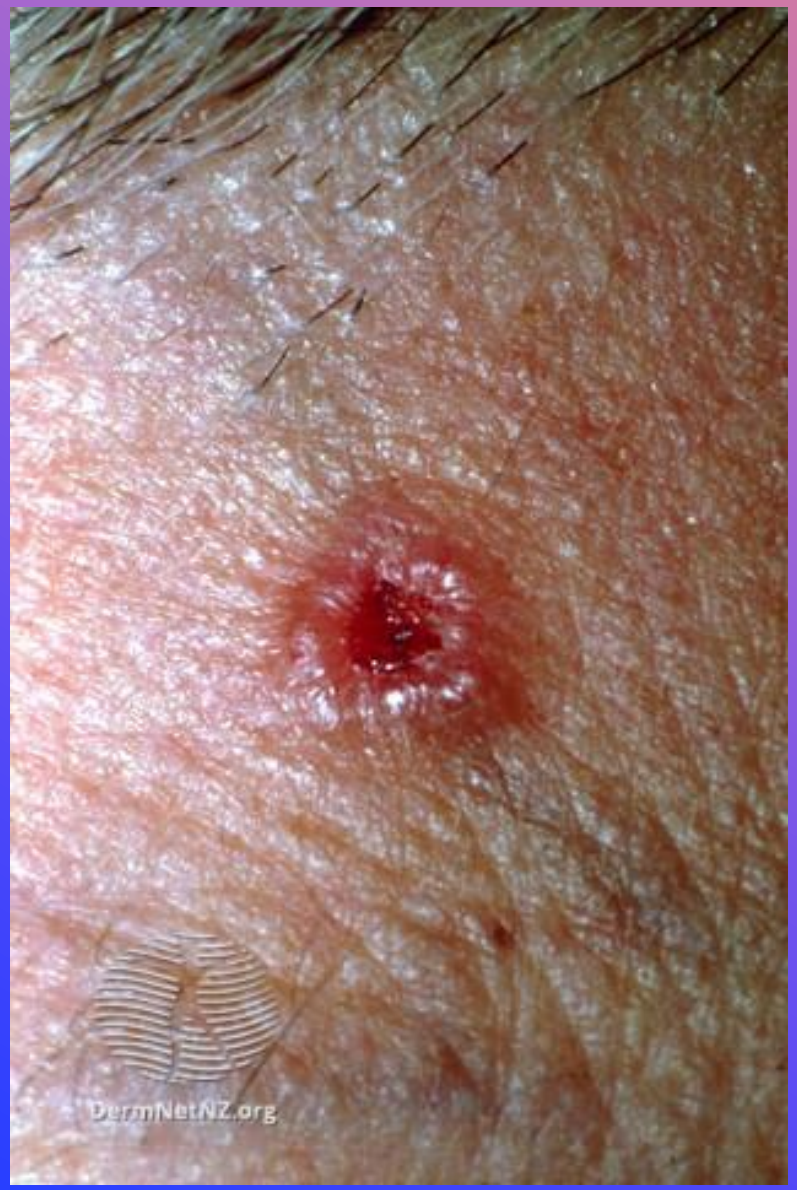
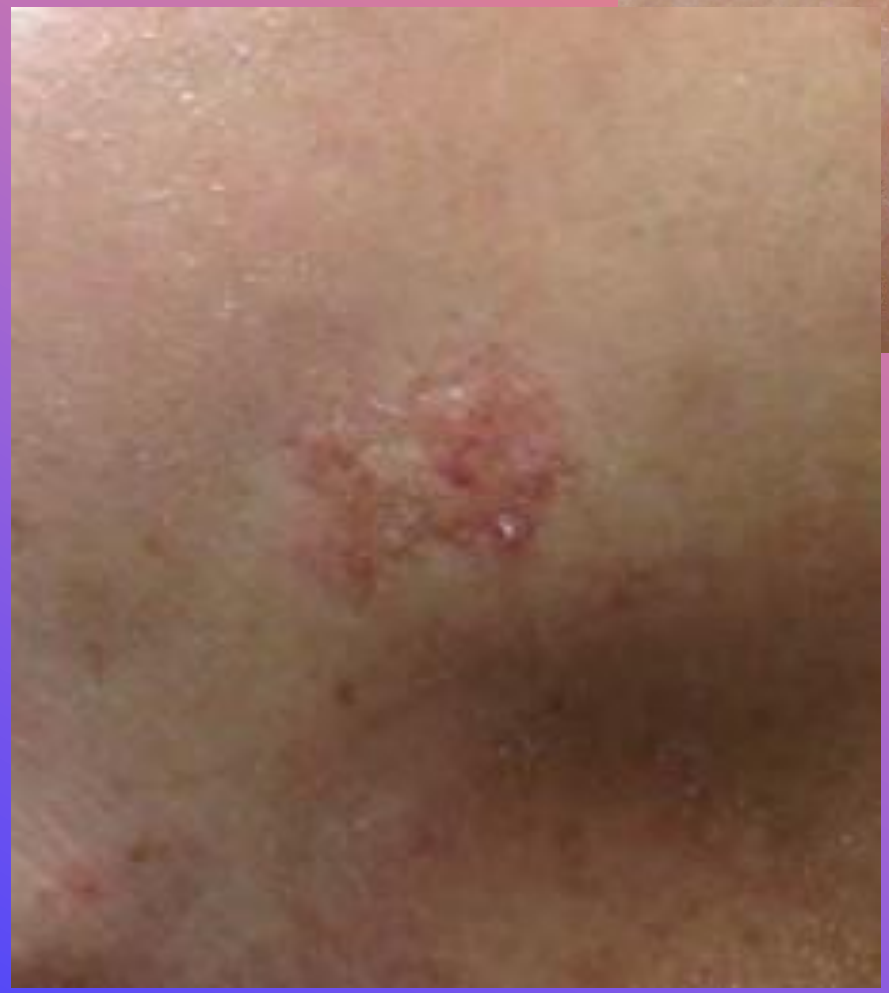


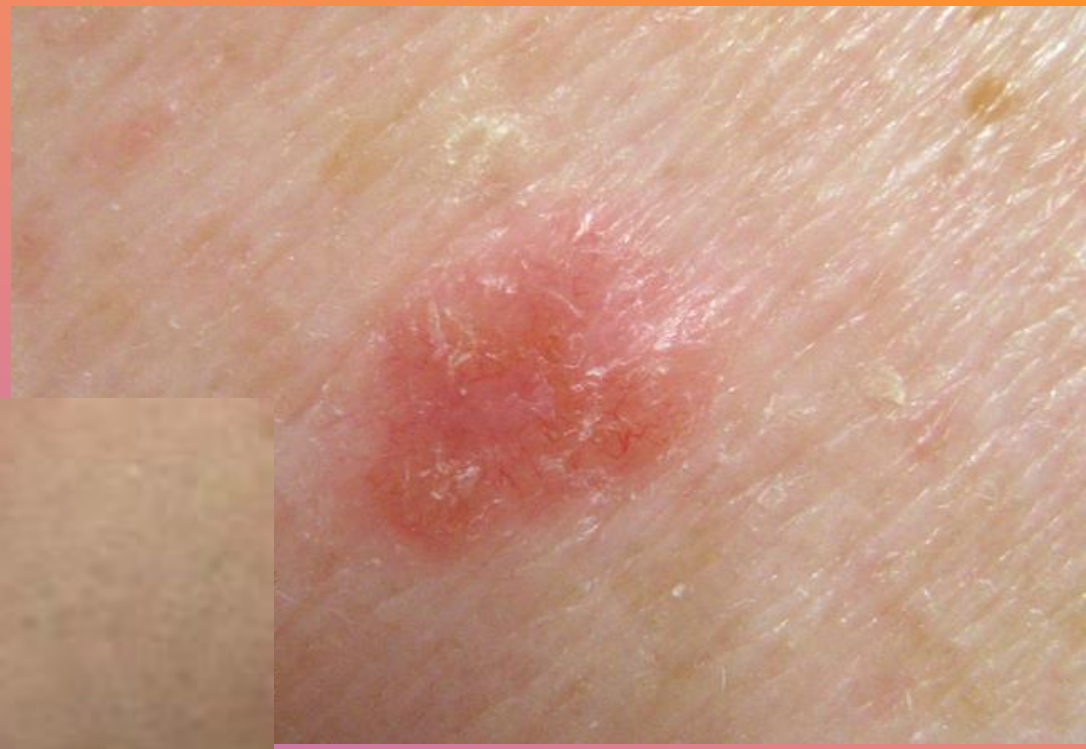




BASAL CELL CARCINOMA







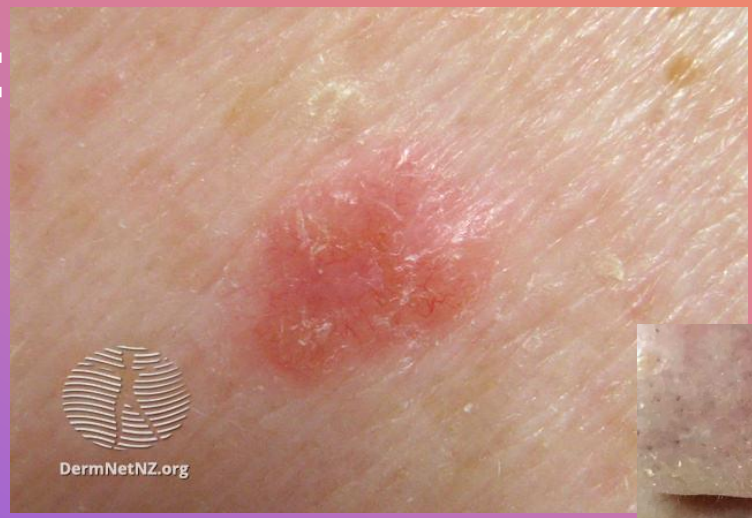
https://dermnetnz.org/topics/nodular-bcc-images
Mohs Surgery and Dermatology Patient

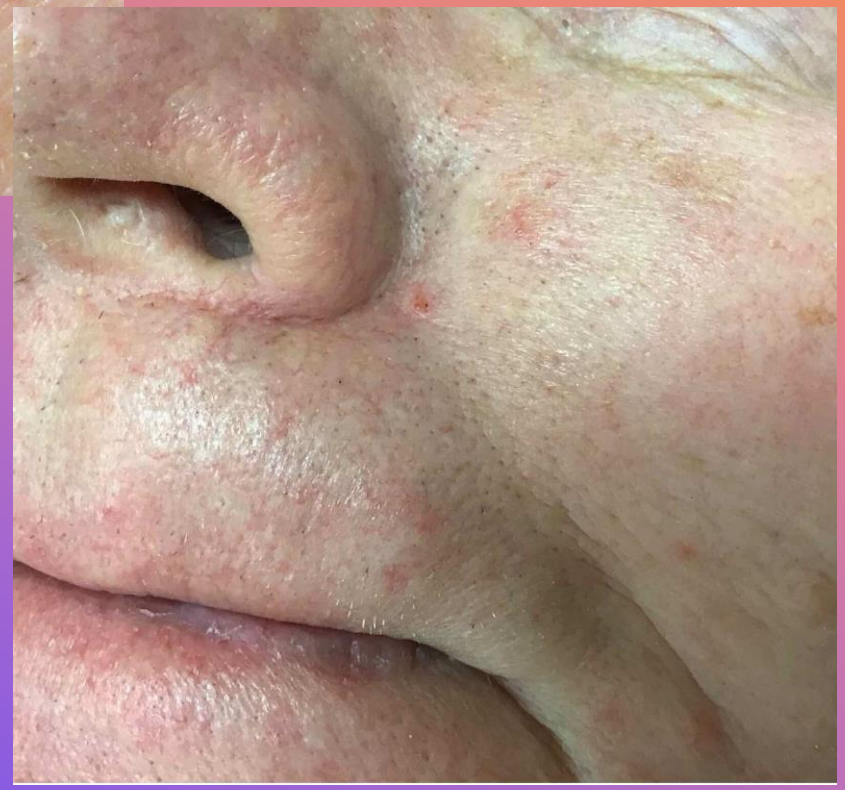
BASAL CELL CARCINOMA

Many Clinical Forms:

- Nodular
- Superficial
- Pigmented
- Morpheaform (less regular and do not have well-defined edges, aggressive subtype)

- They won't always be "textbook" with vessels





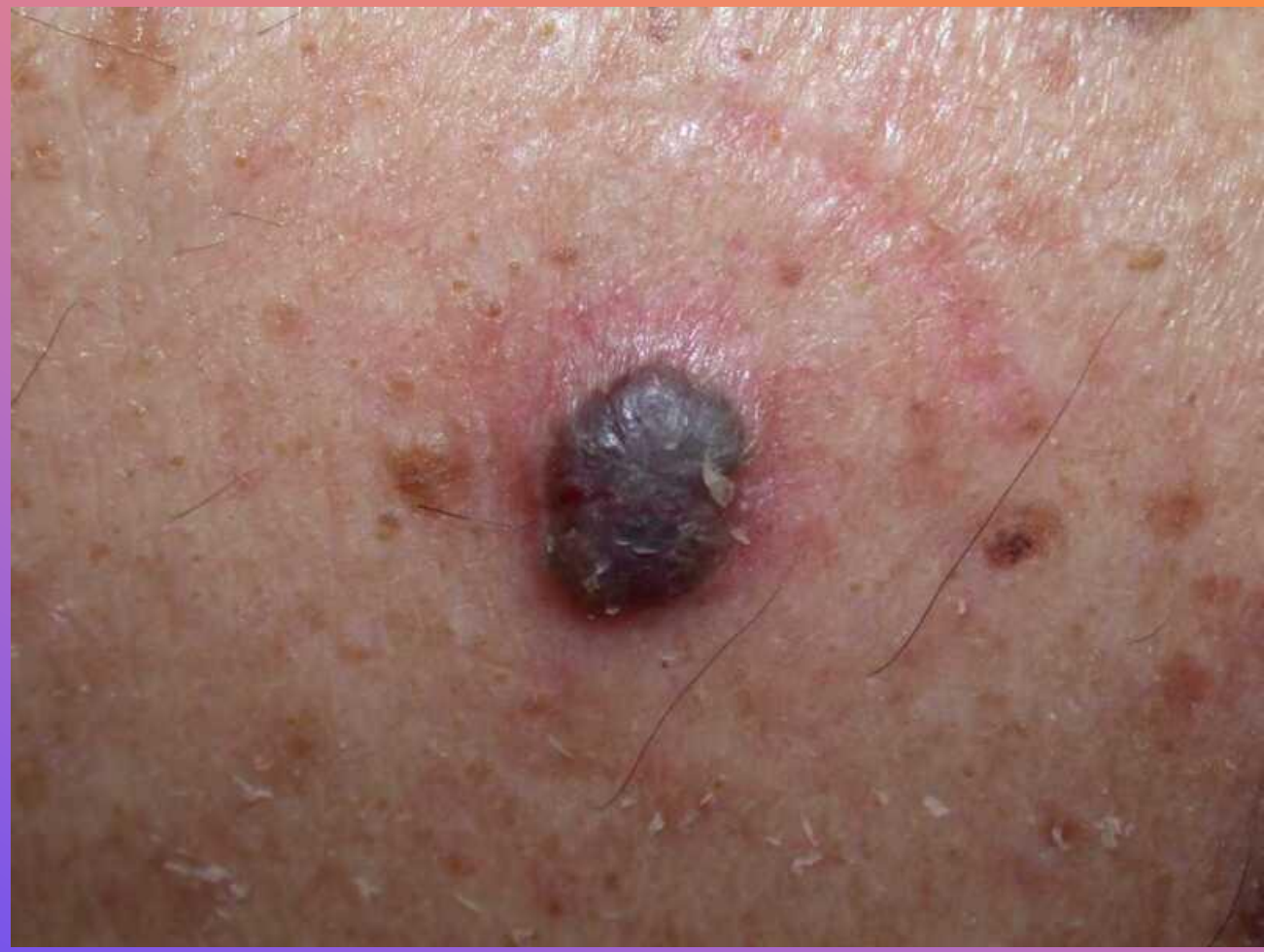
Mohs Surgery and Dermatology Patient

BASAL CELL CARCINOMA

Treatment Varies

Refer for:

- Excision
- Cryosurgery
- Mohs Surgery
- Radiation
- Electrodessication & Curettage (ED&C)



https://www.ncbi.nlm.nih.gov/books/NBK470301/figure/article-29088.image.f2/?report=objectonly

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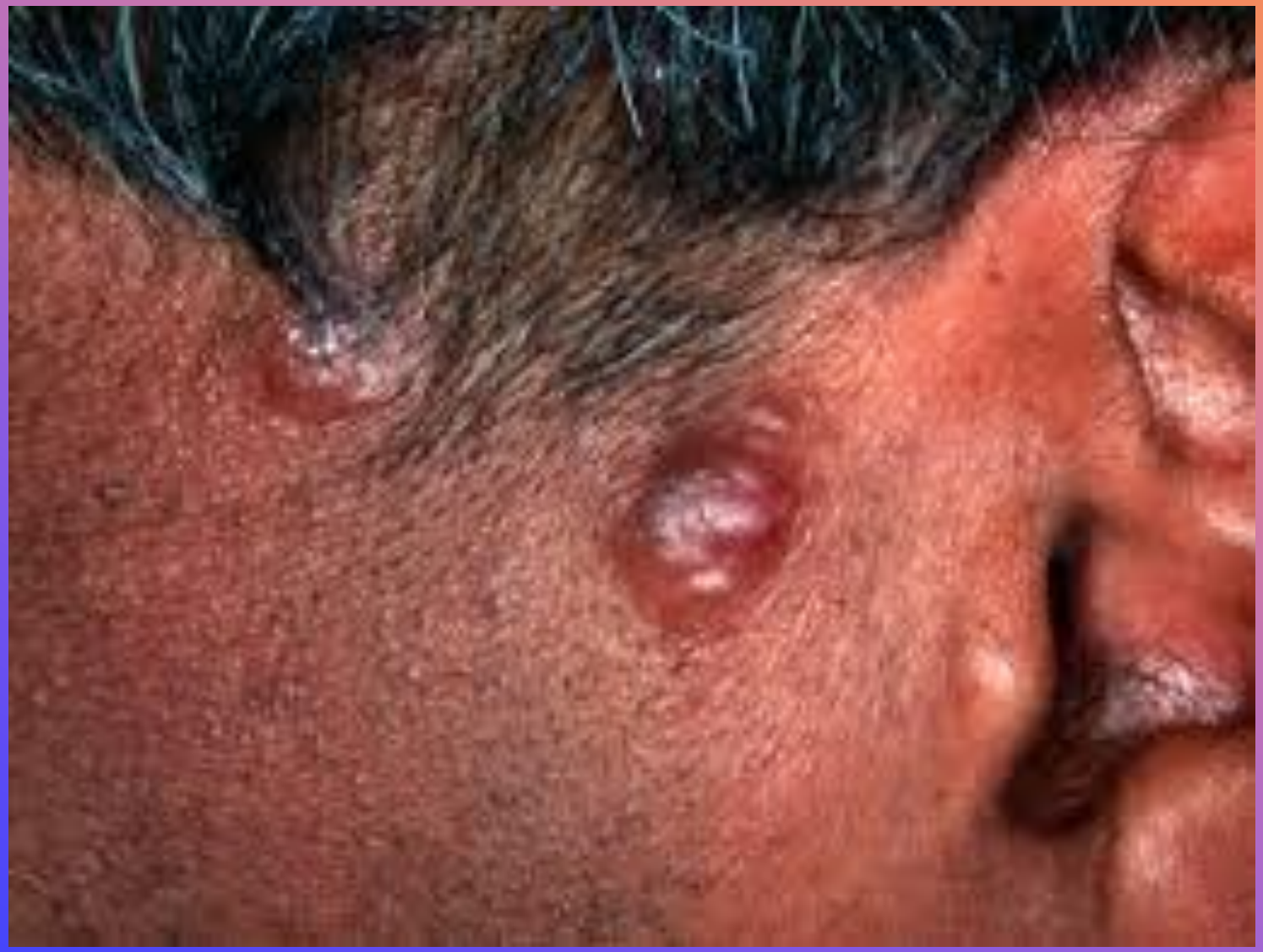
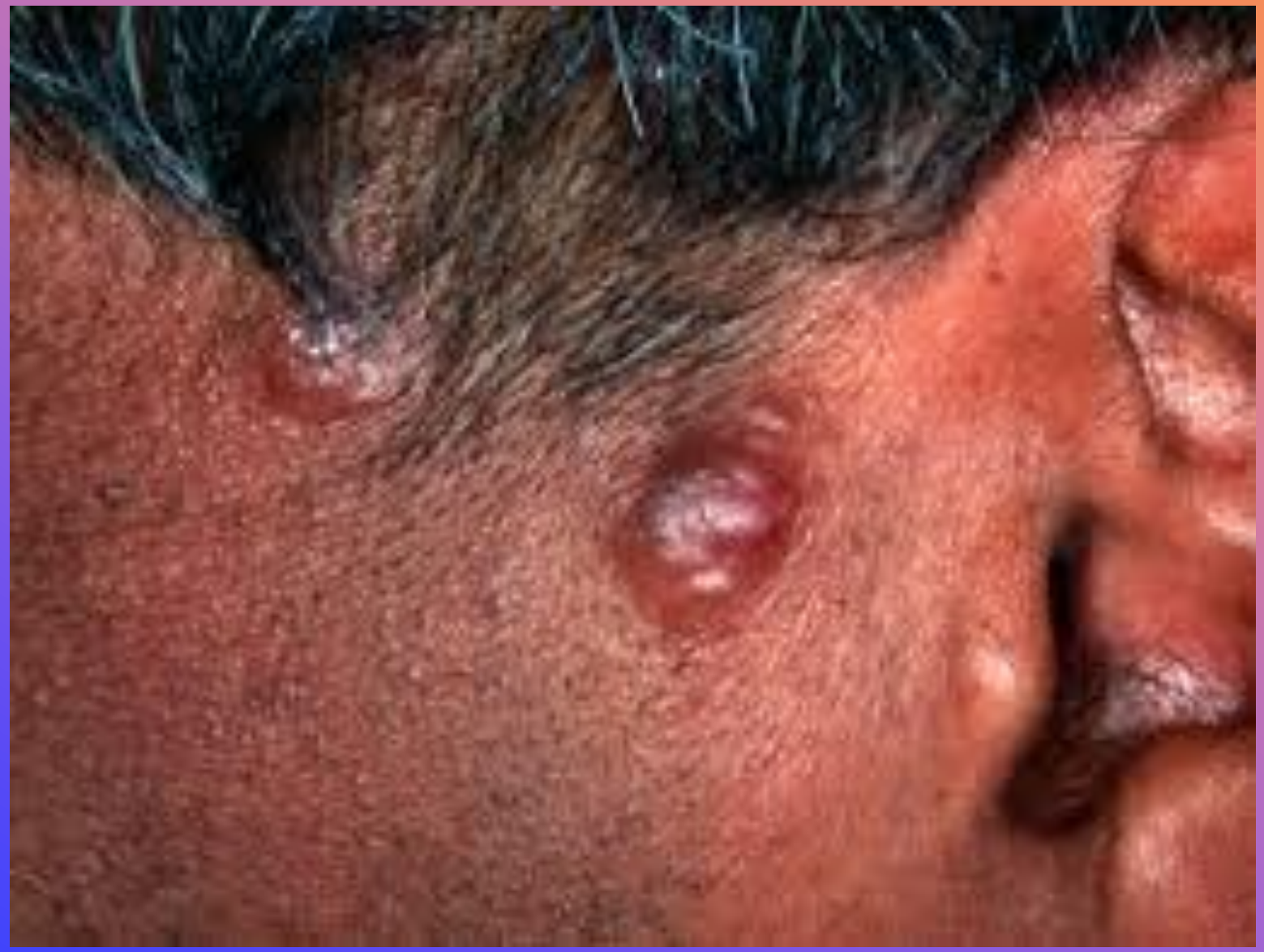


Source: DermnetNZ

CUTANEOUS B-CELL LYMPHOMA

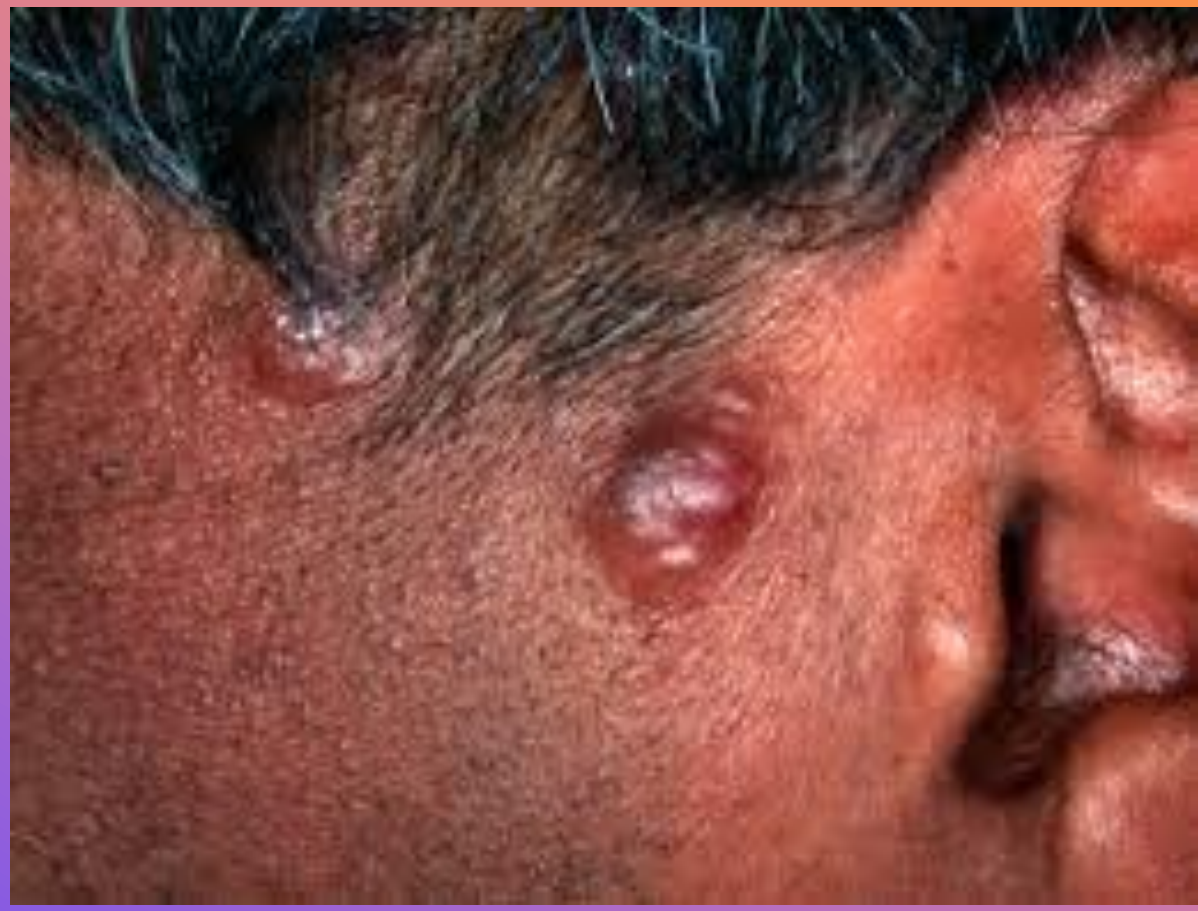


Source: DermnetNZ

CUTANEOUS B-CELL LYMPHOMA

- Erythematous papules, nodules, or tumors
- Occur anywhere
- Middle aged to elderly
- Primary cutaneous lesions - good prognosis
- Secondary (metastatic) lesions - poor prognosis
- REFER for Biopsy

to Derm → Oncology



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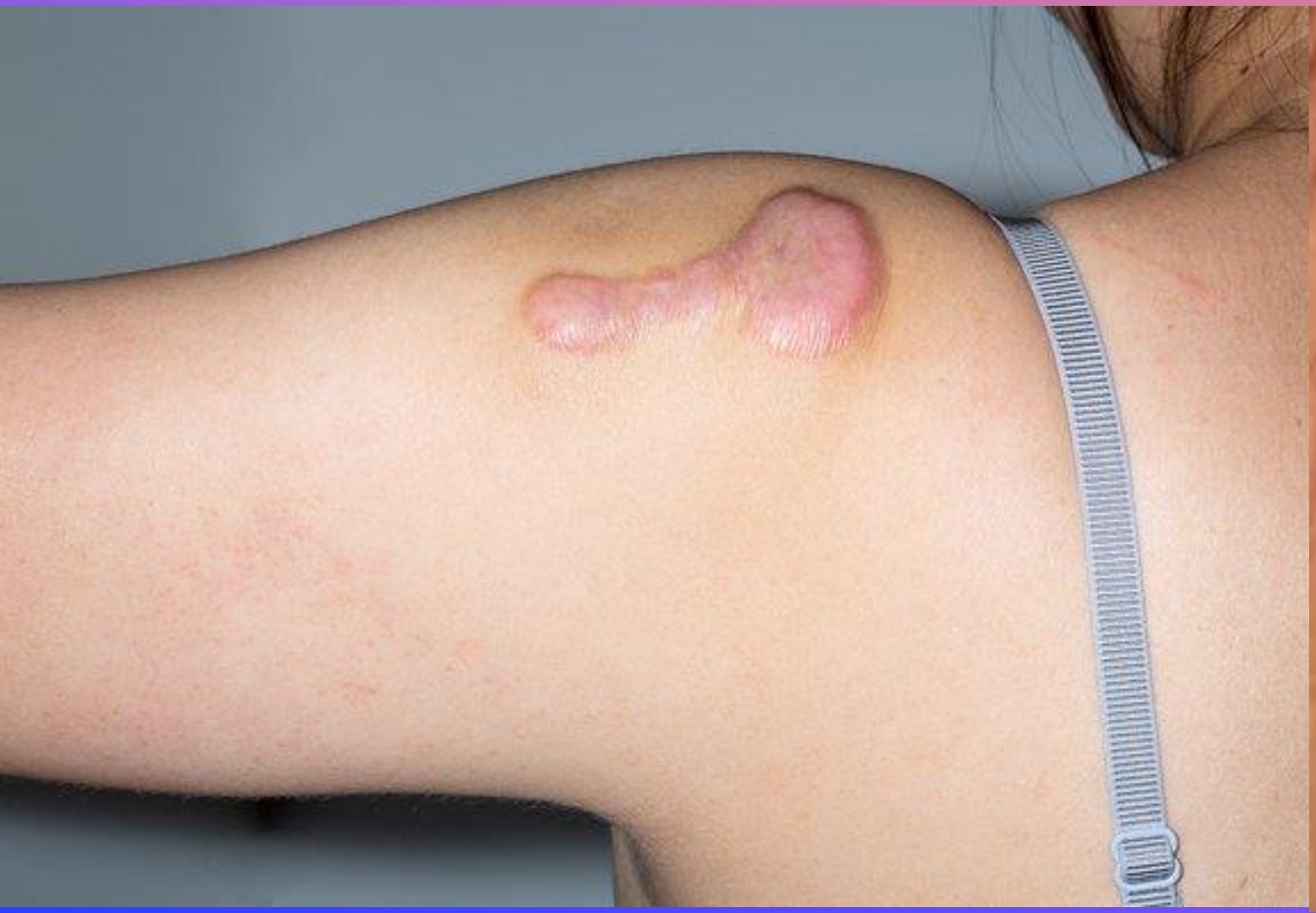
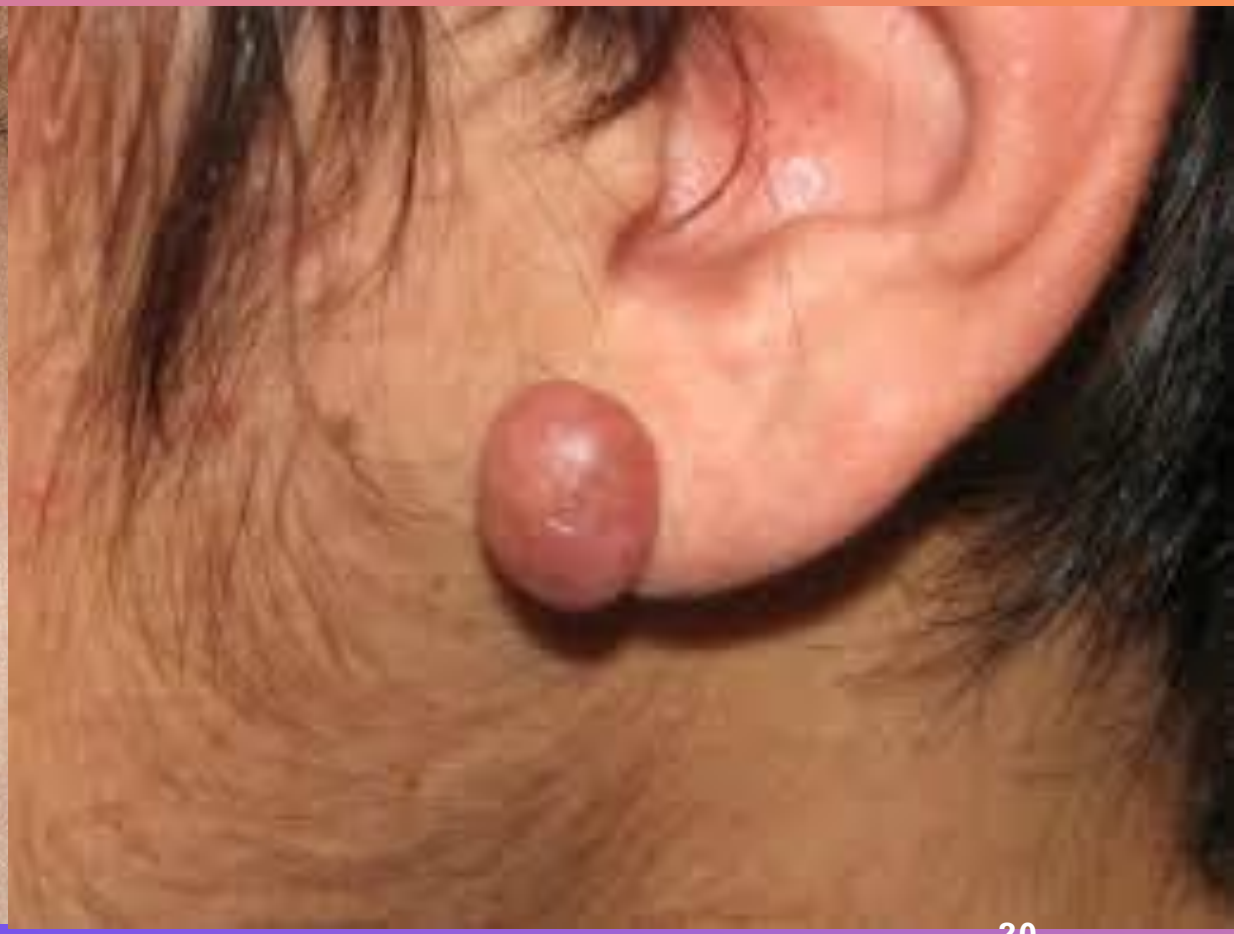
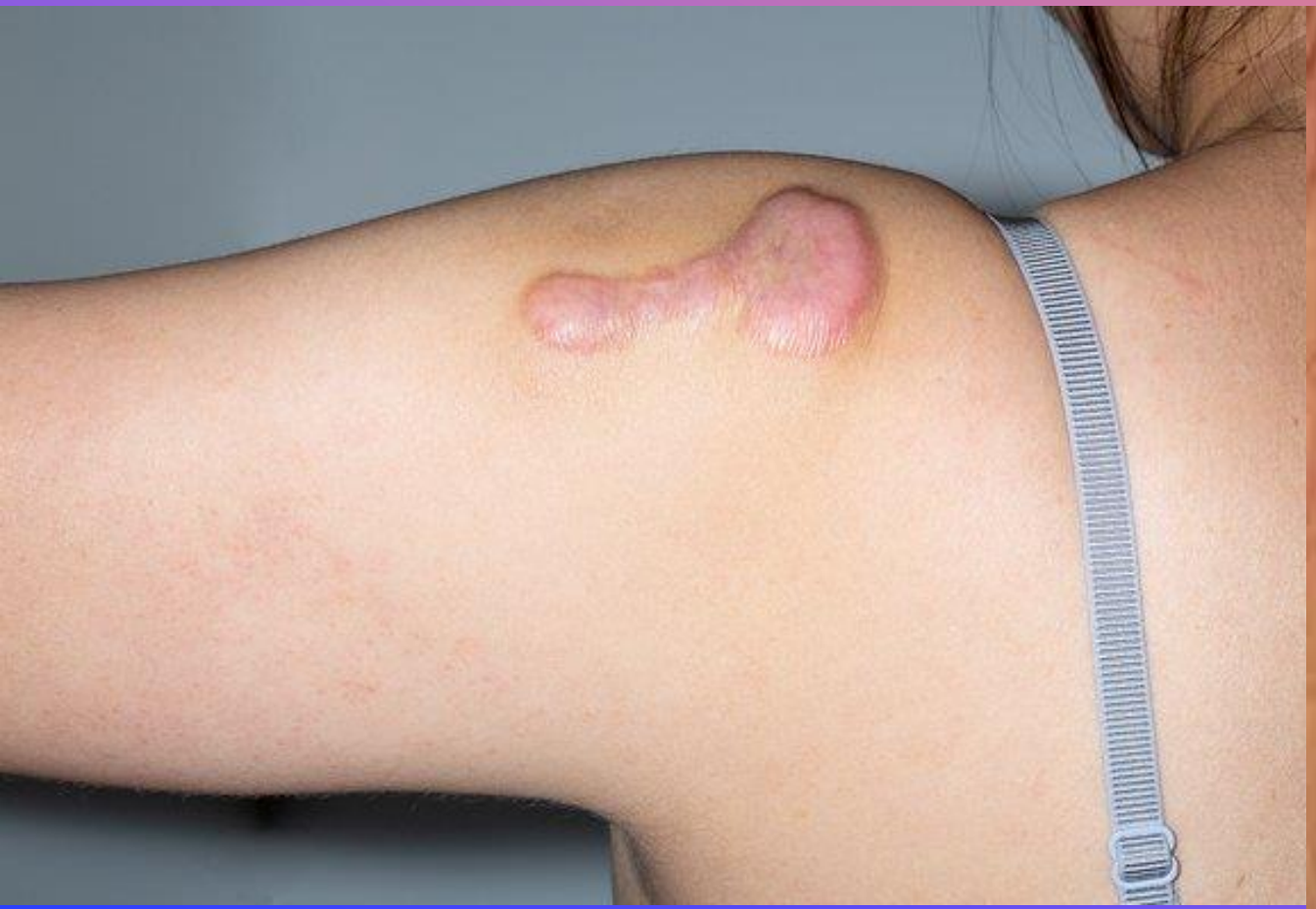
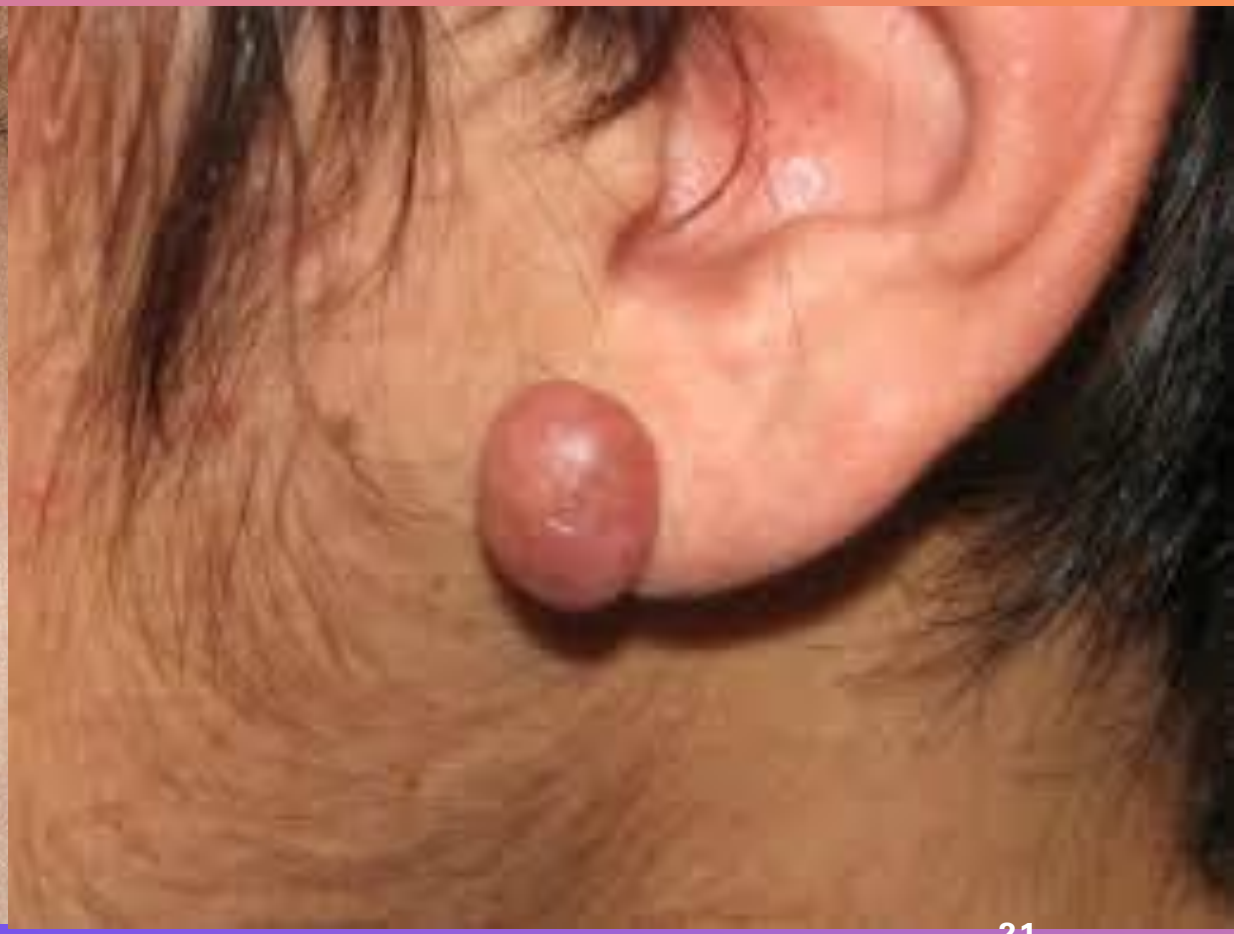




KELOIDS



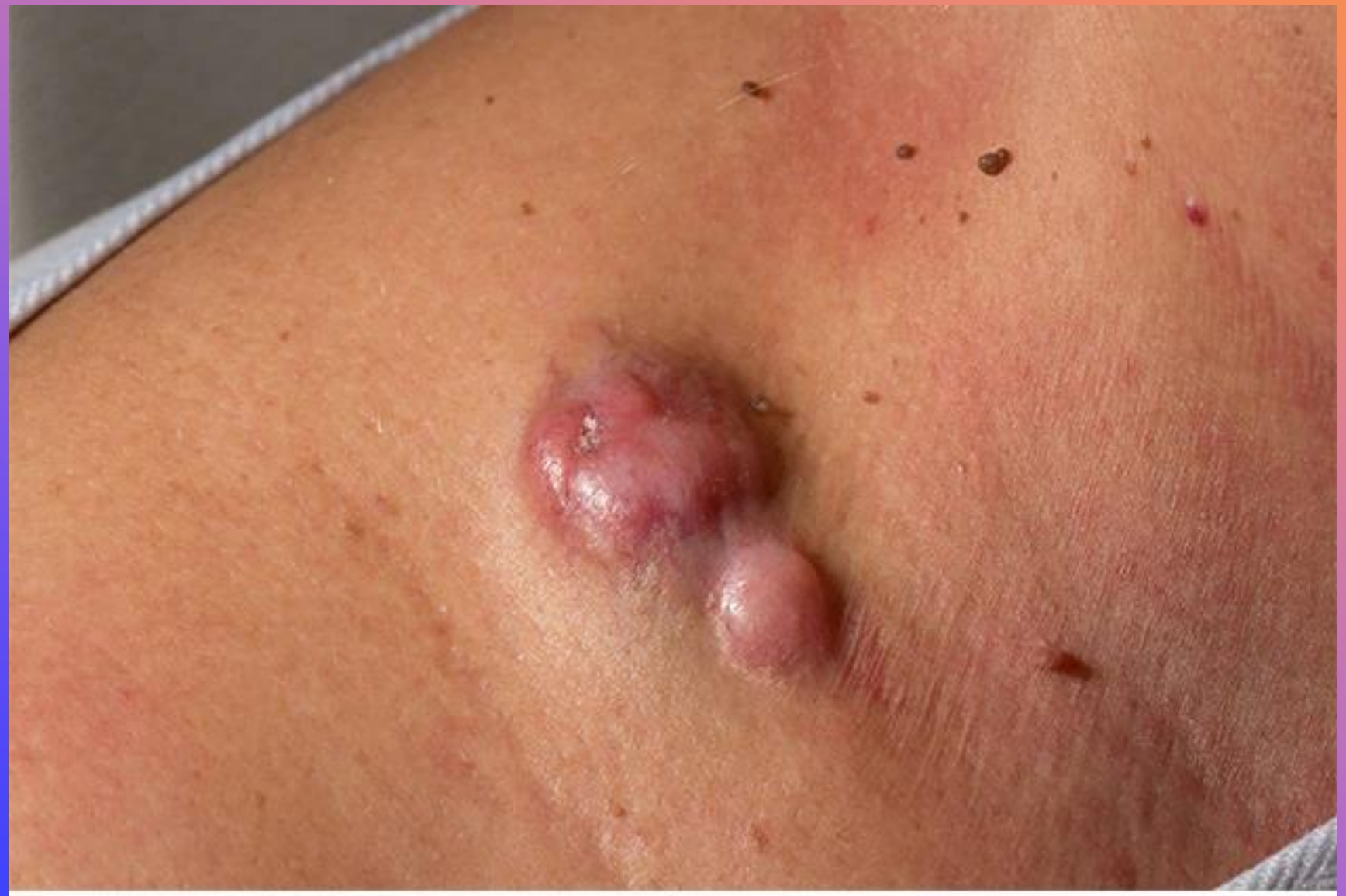


Source: NHS UK https://www.nhs.uk/conditions/keloid-scars/

KELOID CHARACTERISTICS

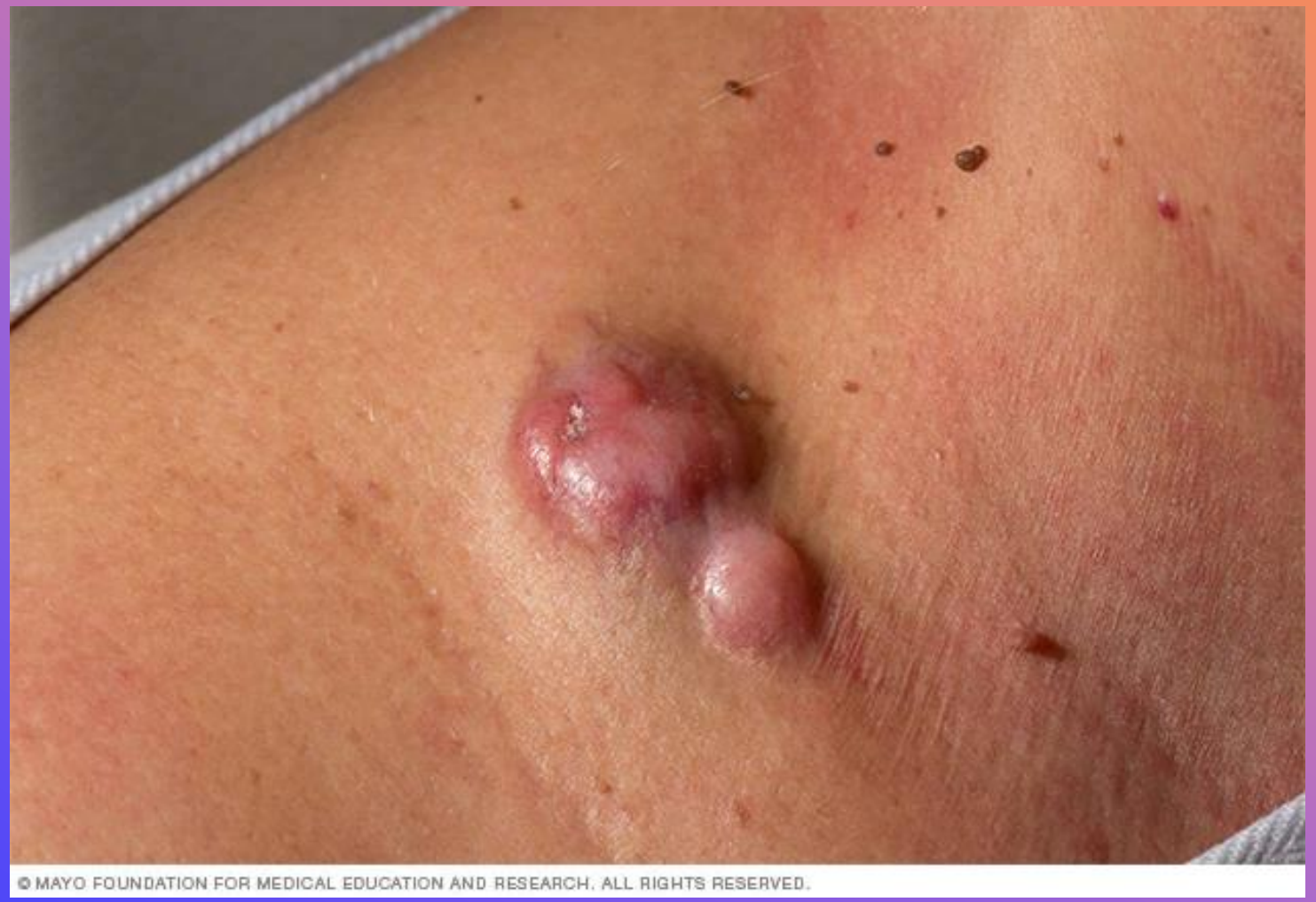
- Thick, erythematous papule, plaque, or nodule
- Usually a result of trauma or acne
- Lesion extends beyond the borders of initial injury
- Often pruritic or painful
- Tx: Intralesional Kenalog, Excision followed by imiquimod, or superficial radiation, cryotherapy

WHAT IS IT?



Source: Mayo Foundation

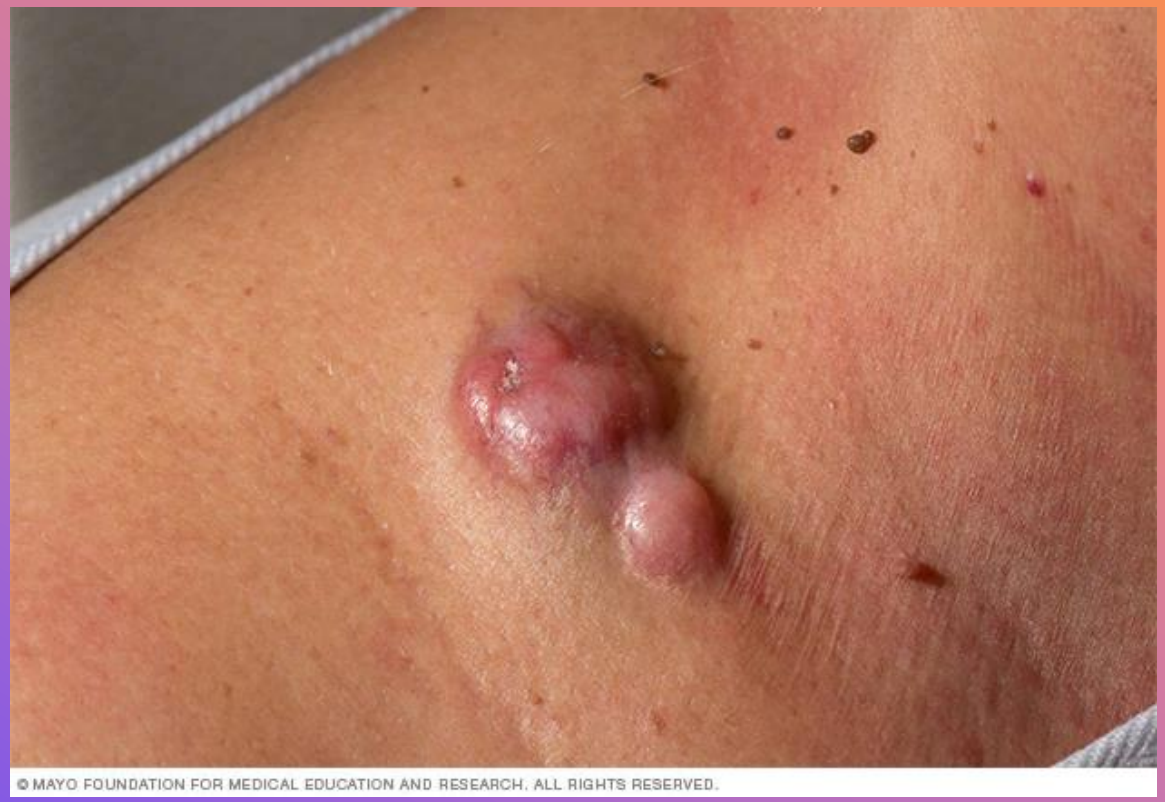
DERMATOFIBROSARCOMA PROTUBERANS (DFSP)



https://www.mayoclinic.org/diseases-conditions/nonmelanoma-skin-cancer/multimedia/img-20341923

DFSP CHARACTERISTICS

- Slowly growing, keloidal, irregular plaque on trunk or proximal extremities
- Rarely metastasizes
- Often recurs after wide local excision
- Mohs surgery is treatment of choice



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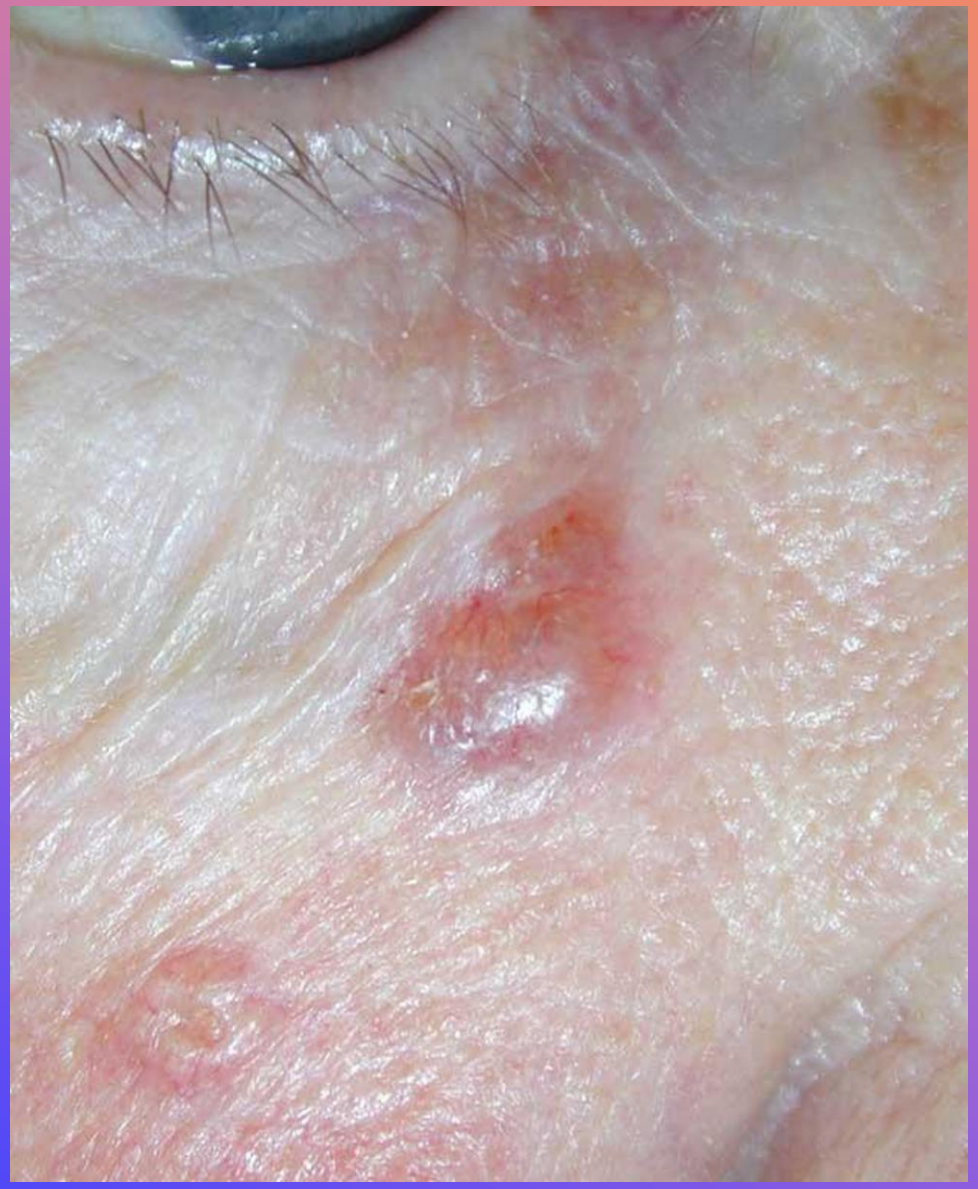
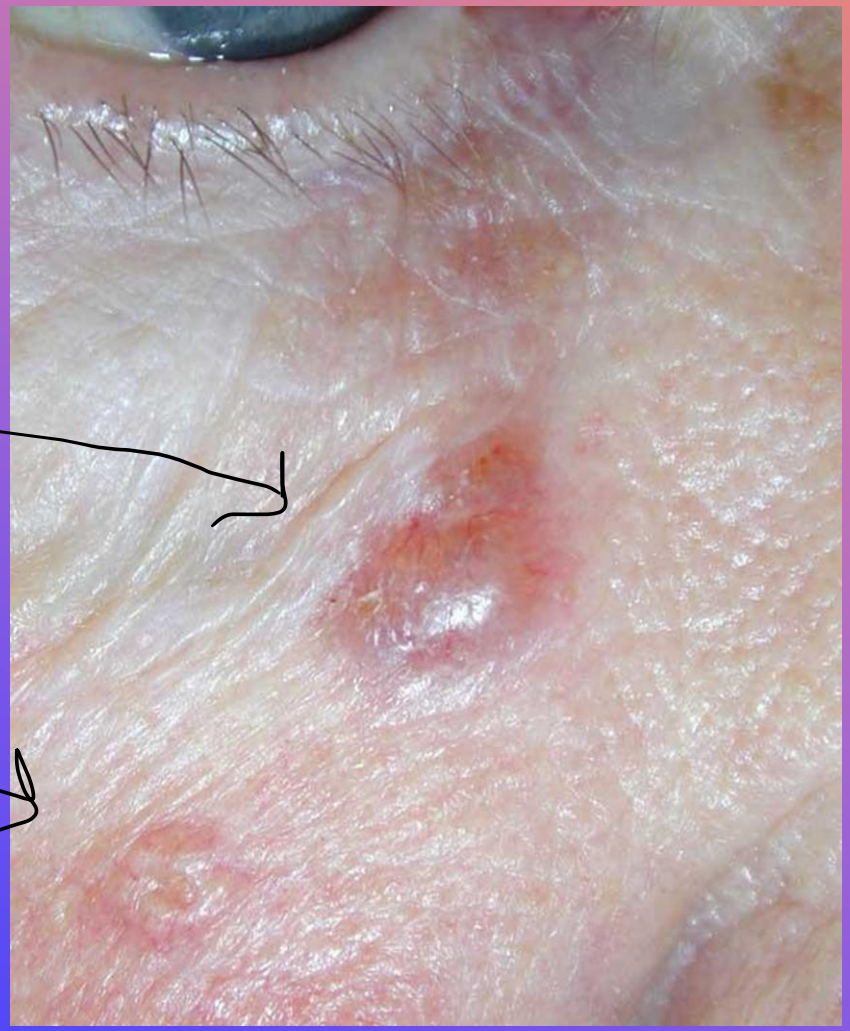


BASAL CELL CARCINOMA (BCC) AND SEBACEOUS HYPERPLASIA (SH)

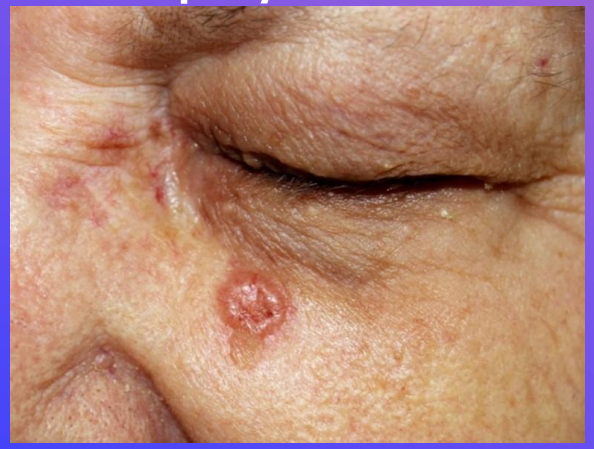


Source: Dr. Opel with pt permission

CHARACTERISTICS: "CLASSIC" BCC AND SH

BCC

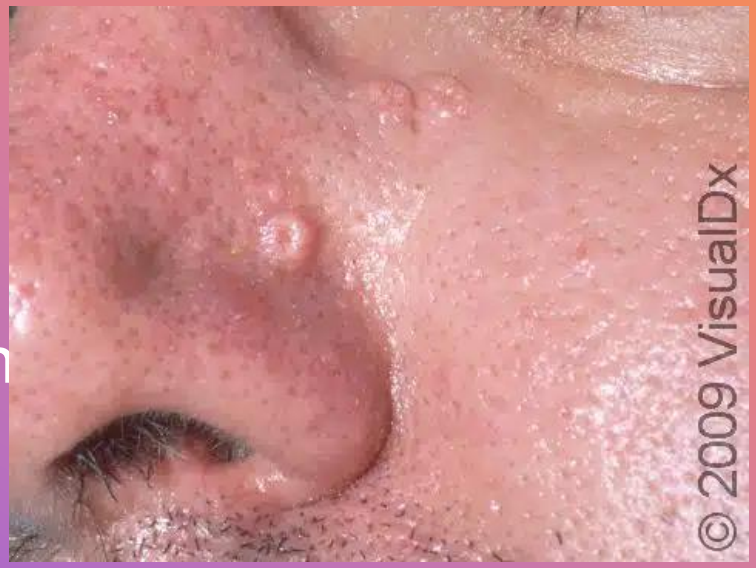
- Pearly papule with telangiectasia
- More friable (bleeds, scabs)
- Refer for biopsy



https://pcmedproject.com/dermatology/basal-cell-carcinoma-clinical-presentation-and-management/

SH

- Yellow papule w/ telangiectasia
- Central dell
- Usually central face
- Sun exposed skin
- Reassurance
- Tx: light hyfrecation



https://skinsight.com/skin-conditions/sebaceous-hyperplasia/

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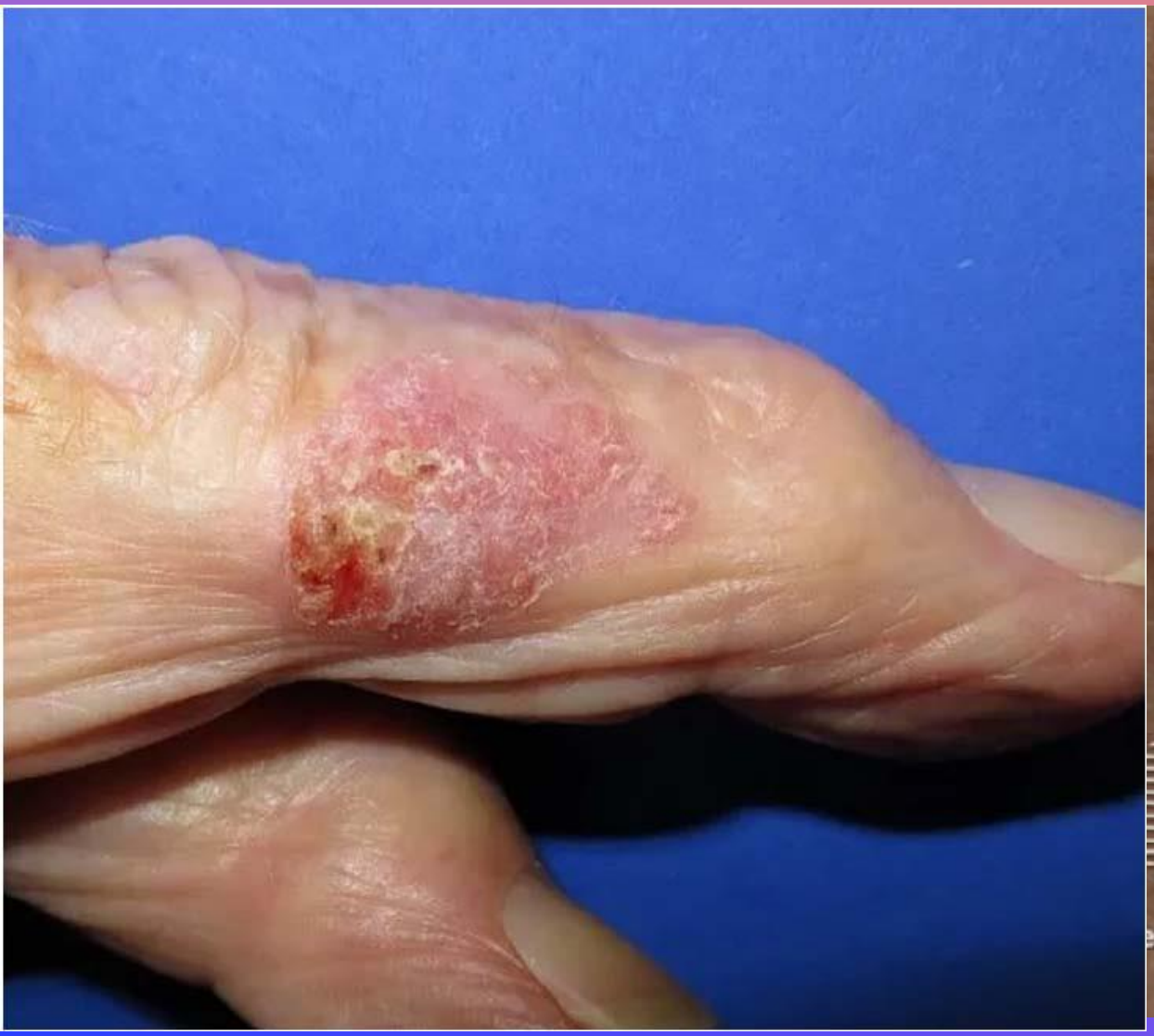
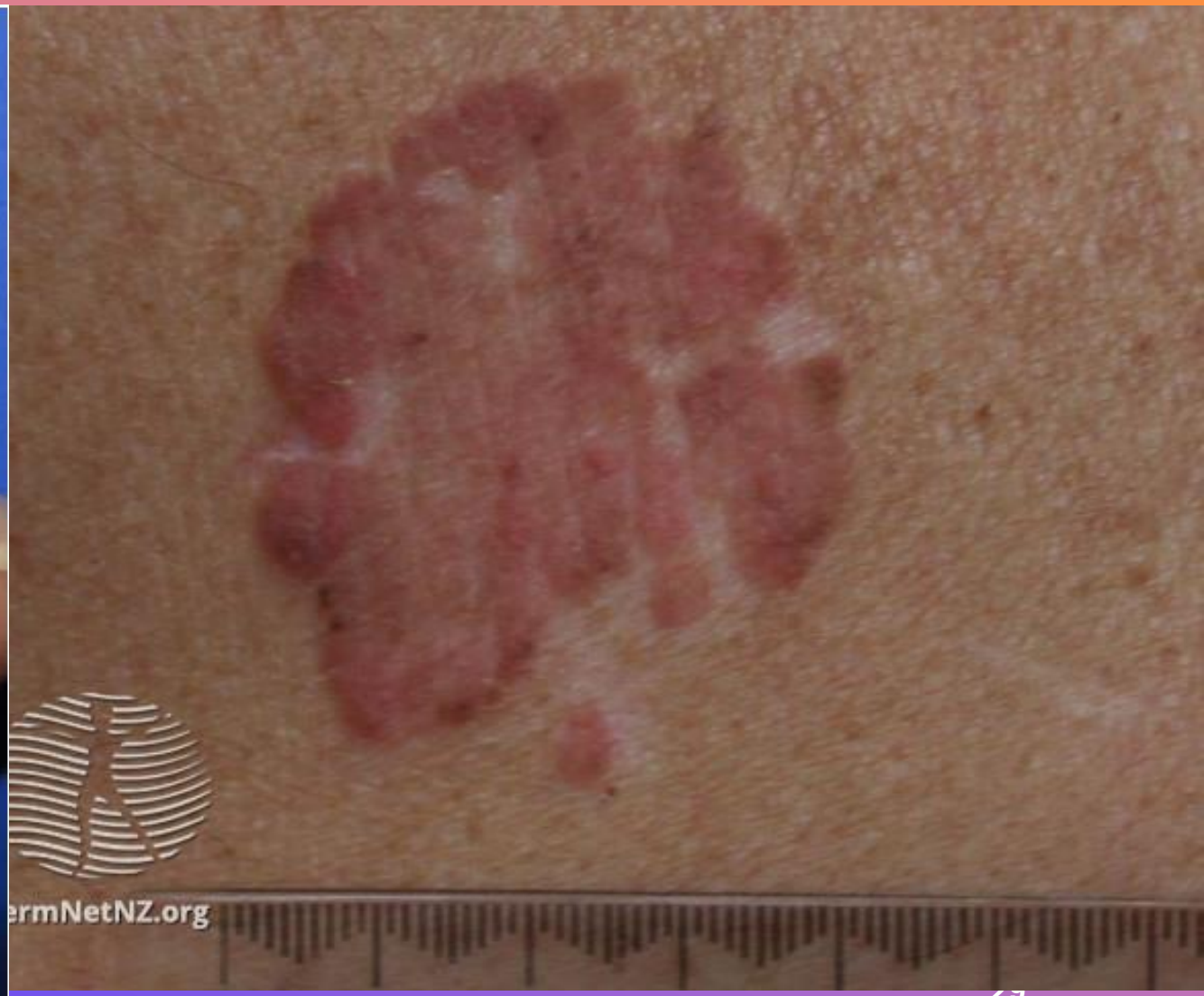
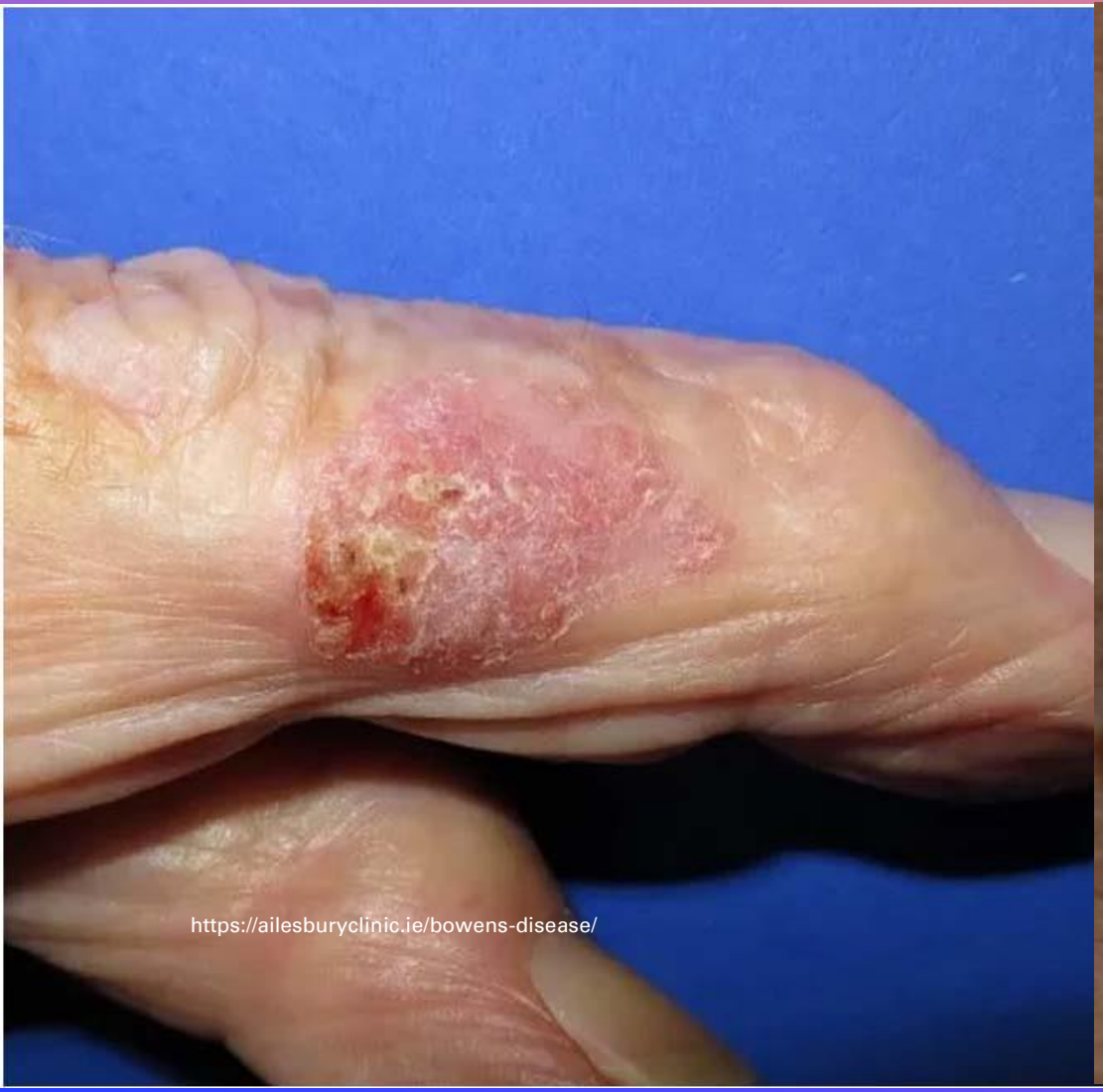
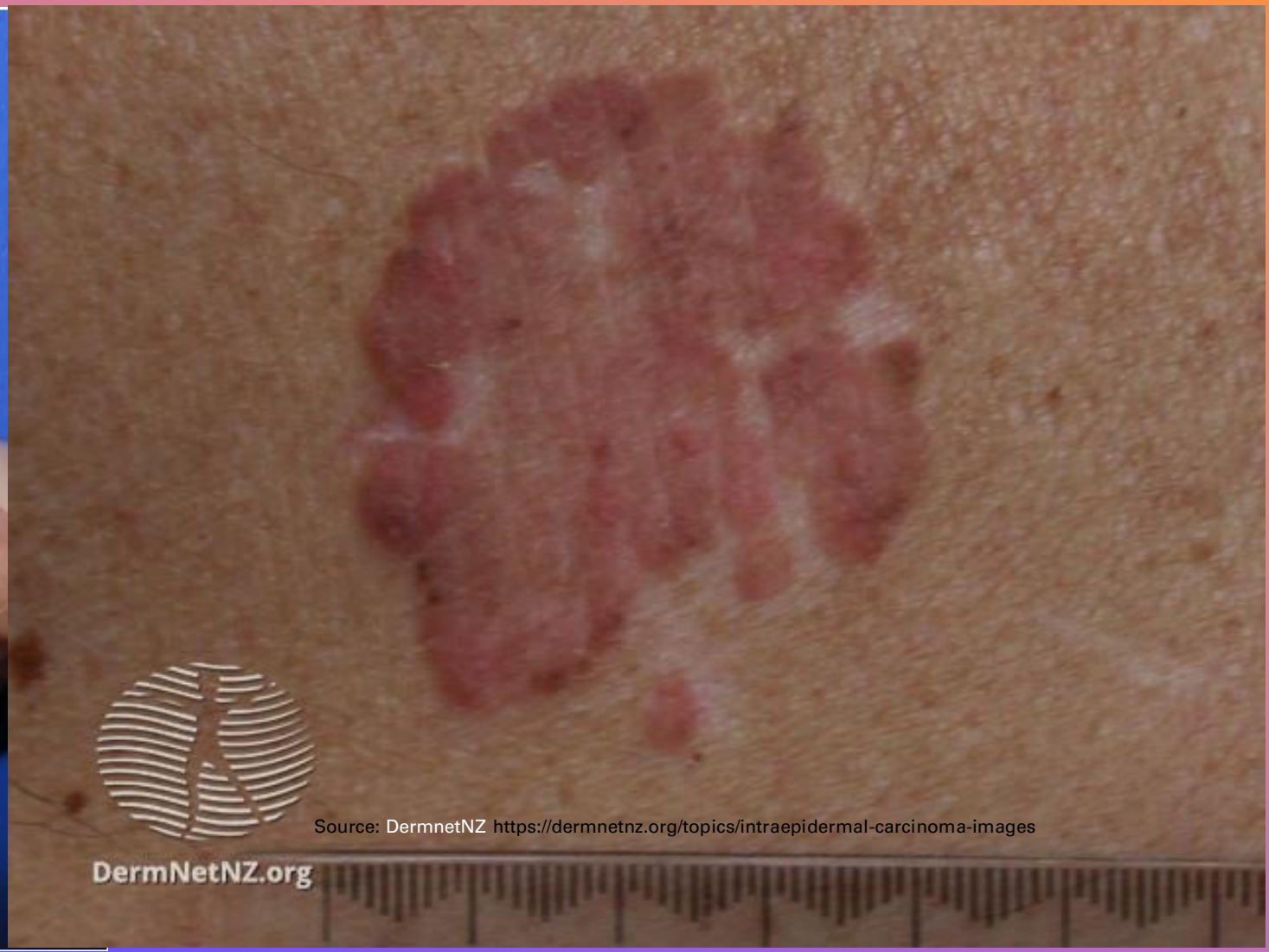




BOWEN'S DISEASE (SQUAMOUS CELL CARCINOMA IN SITU)



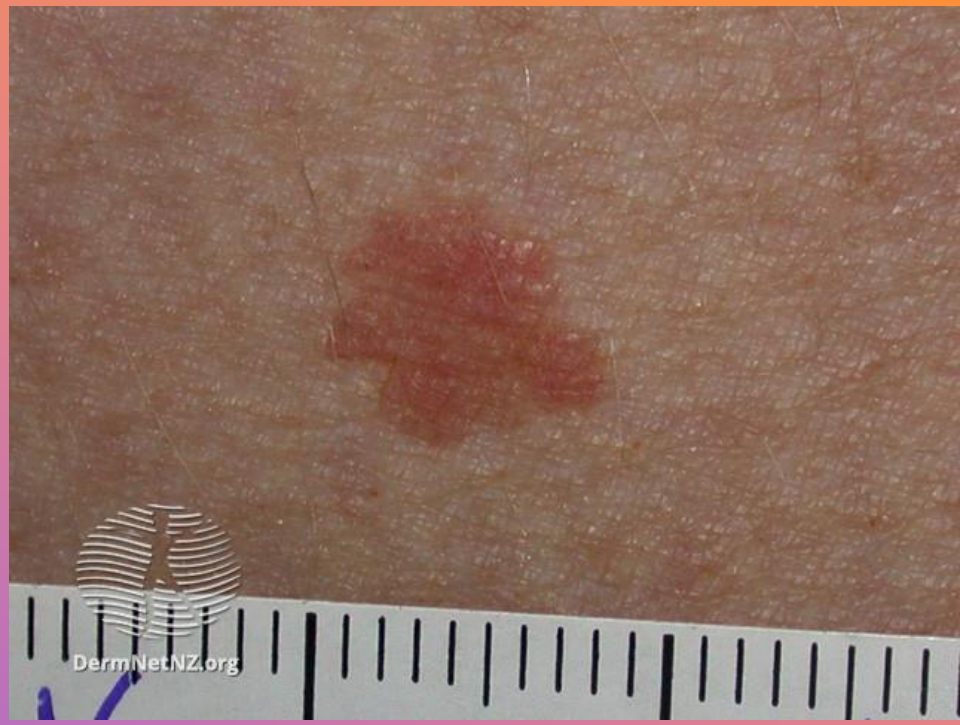
https://ailesburyclinic.ie/bowens-disease/



Source: DermnetNZ https://dermnetnz.org/topics/intraepidermal-carcinoma-images

BOWEN'S DISEASE CHARACTERISTICS

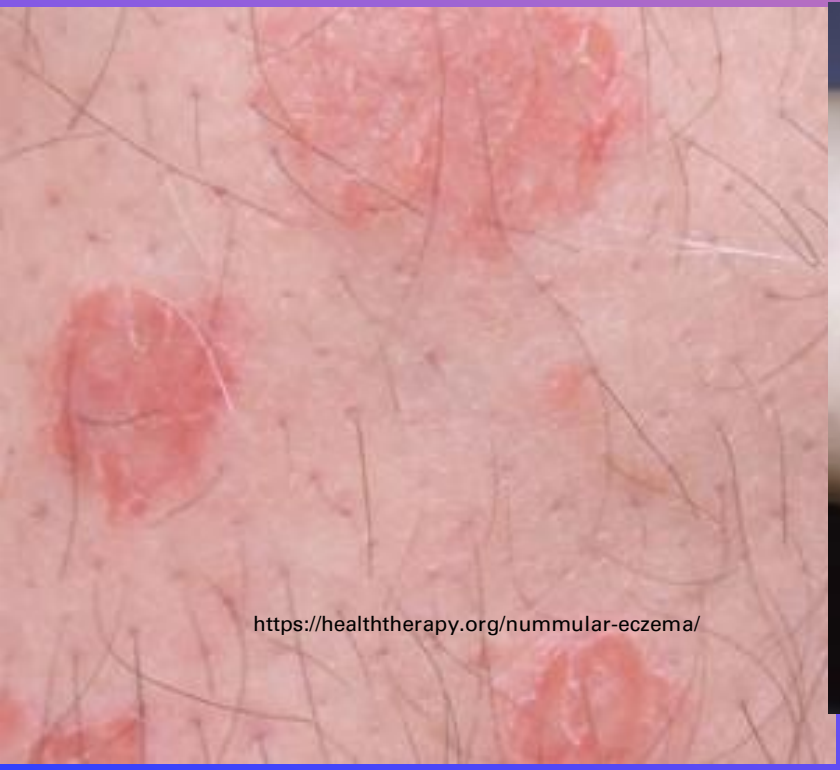
- Red scaly papule or plaque
- Well demarcated, scalloped border
- Found anywhere on body, including non sun- exposed areas
- Most often diagnosed on sun-exposed sites of the ears, face, hands and lower legs. When there are multiple plaques, distribution is not symmetrical (unlike psoriasis)
- HOT TIP: often misdiagnosed as a rash – refer for solitary rashes!



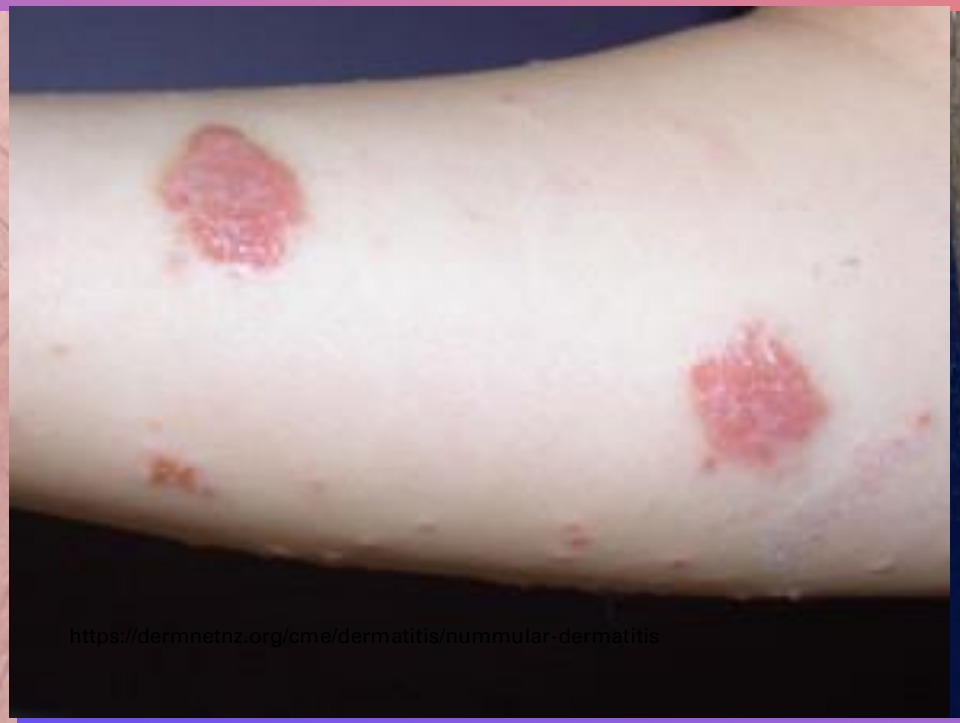
https://dermnetnz.org/topics/intraepidermal-carcinoma-images

- Tx: Refer for excision, Mohs or ED&C

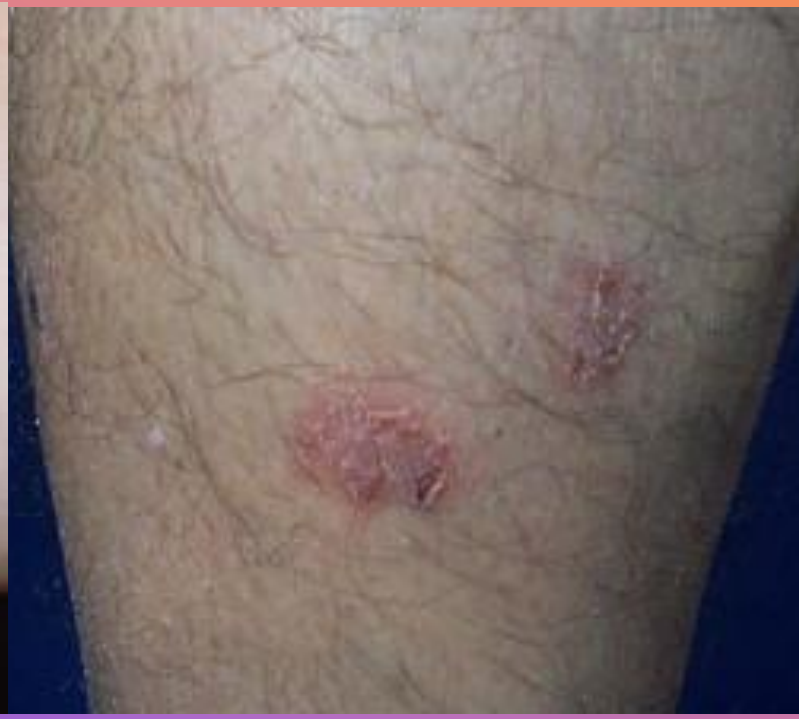
WHAT IS IT?



https://healththerapy.org/nummular-eczema/

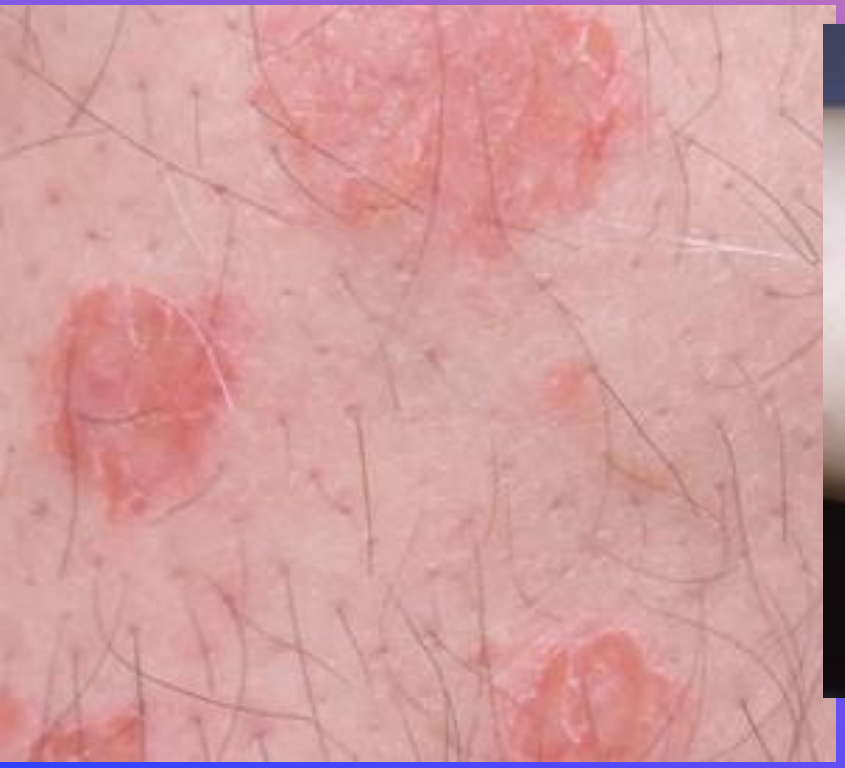


https://dermnetnz.org/cme/dermatitis/nummular-dermatitis

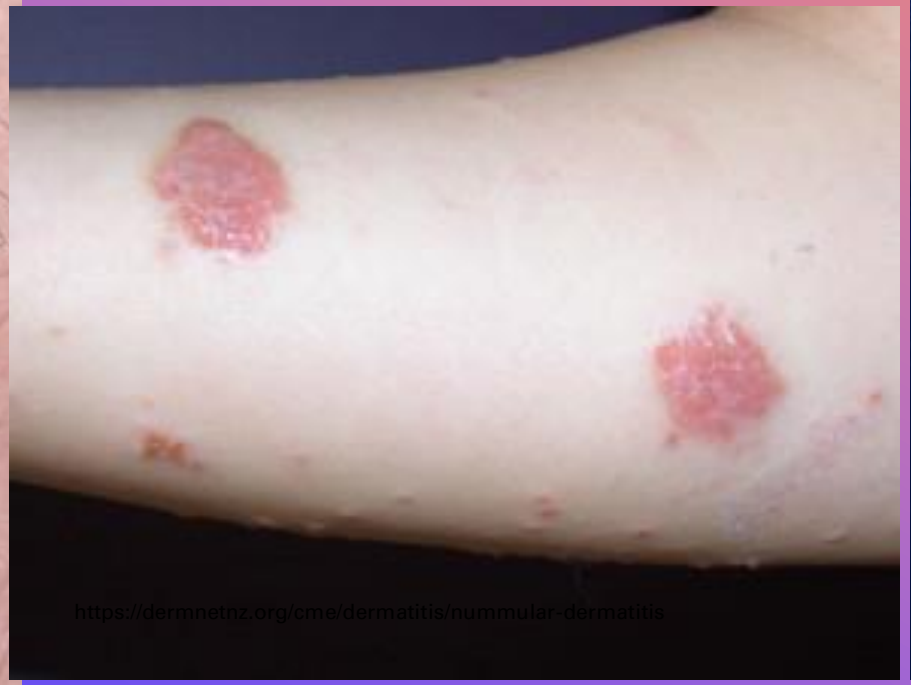


https://dermnetnz.org/cme/dermatitis/nummular-dermatitis

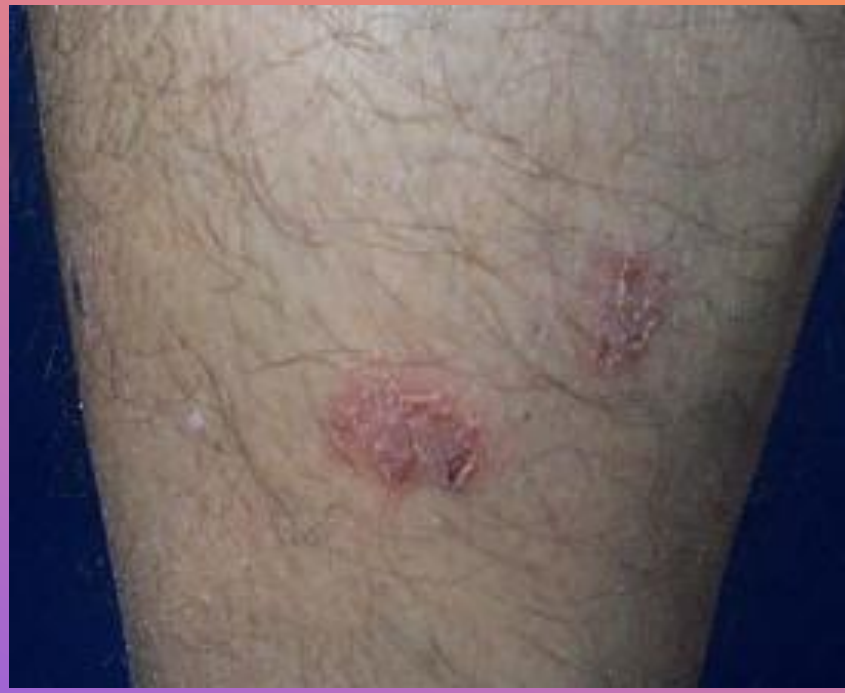
NUMMULAR ECZEMA



https://healththerapy.org/nummular-eczema/



https://dermnetnz.org/cme/dermatitis/nummular-dermatitis



https://dermnetnz.org/cme/dermatitis/nummular-dermatitis

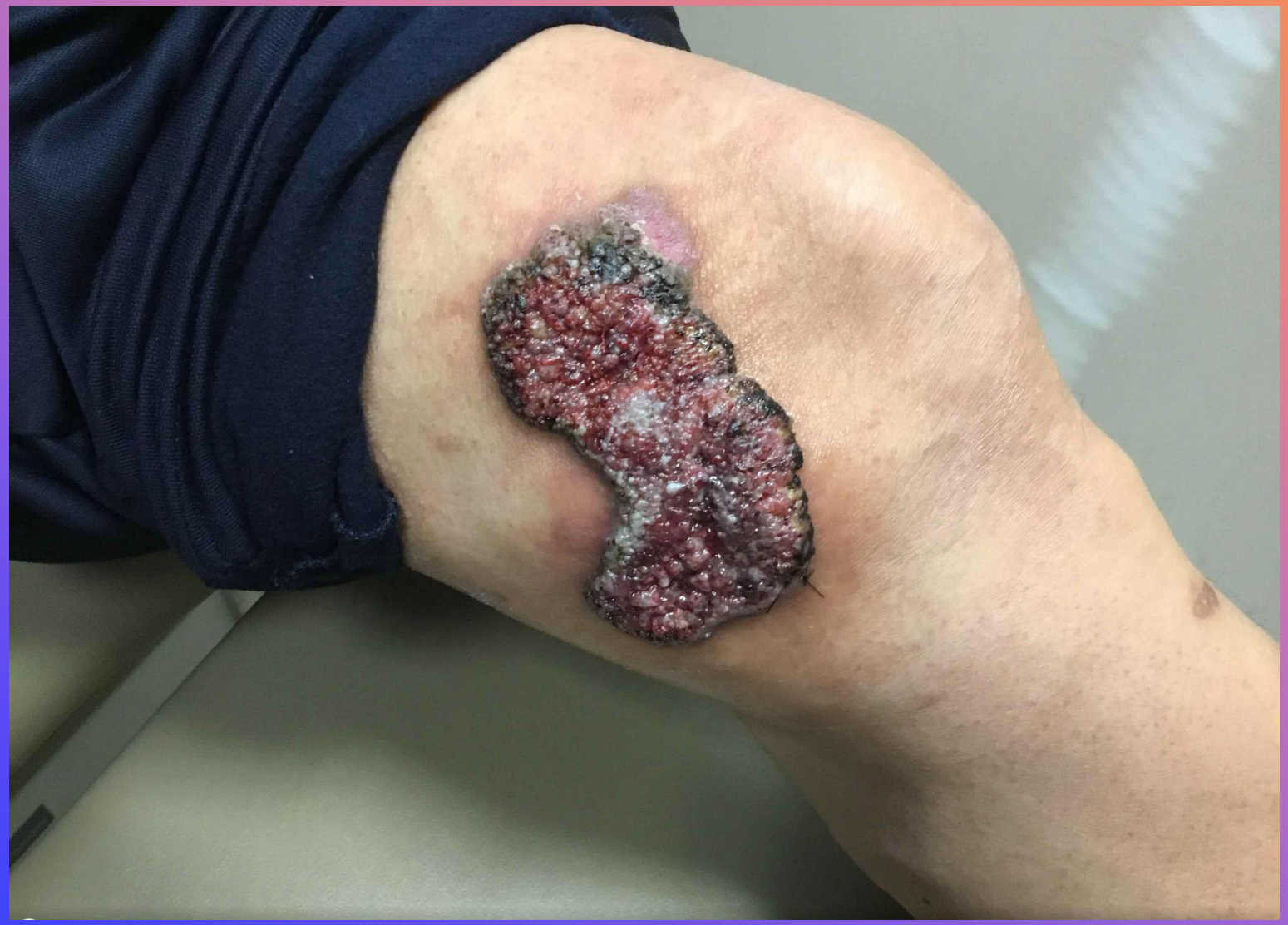
NUMMULAR ECZEMA CHRACTERISTICS

- “Coin-like” papules and plaques on trunk and extremities
- Characterized by poorly demarcated red, dry areas with fine scale
- Background of xerosis “eczematous appearance”
- Pruritic
- Fall and winter mostly
- Multiple lesions without distinct rim of scale differentiate this from tinea
- DON’T GIVE LOTRISONE

https://gladskin.com/blogs/resources/types-of-eczema-nummular-eczema

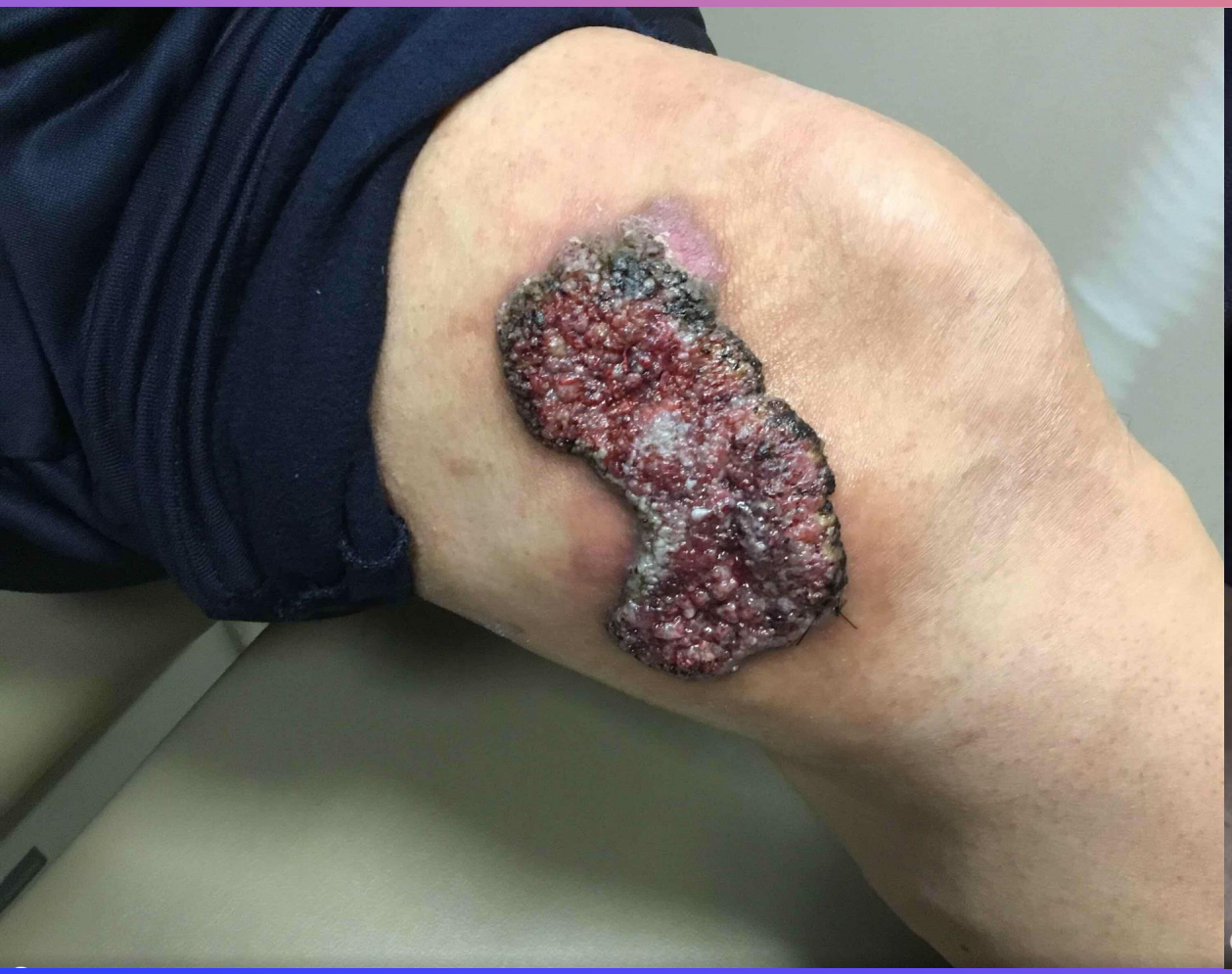
WHAT IS IT?

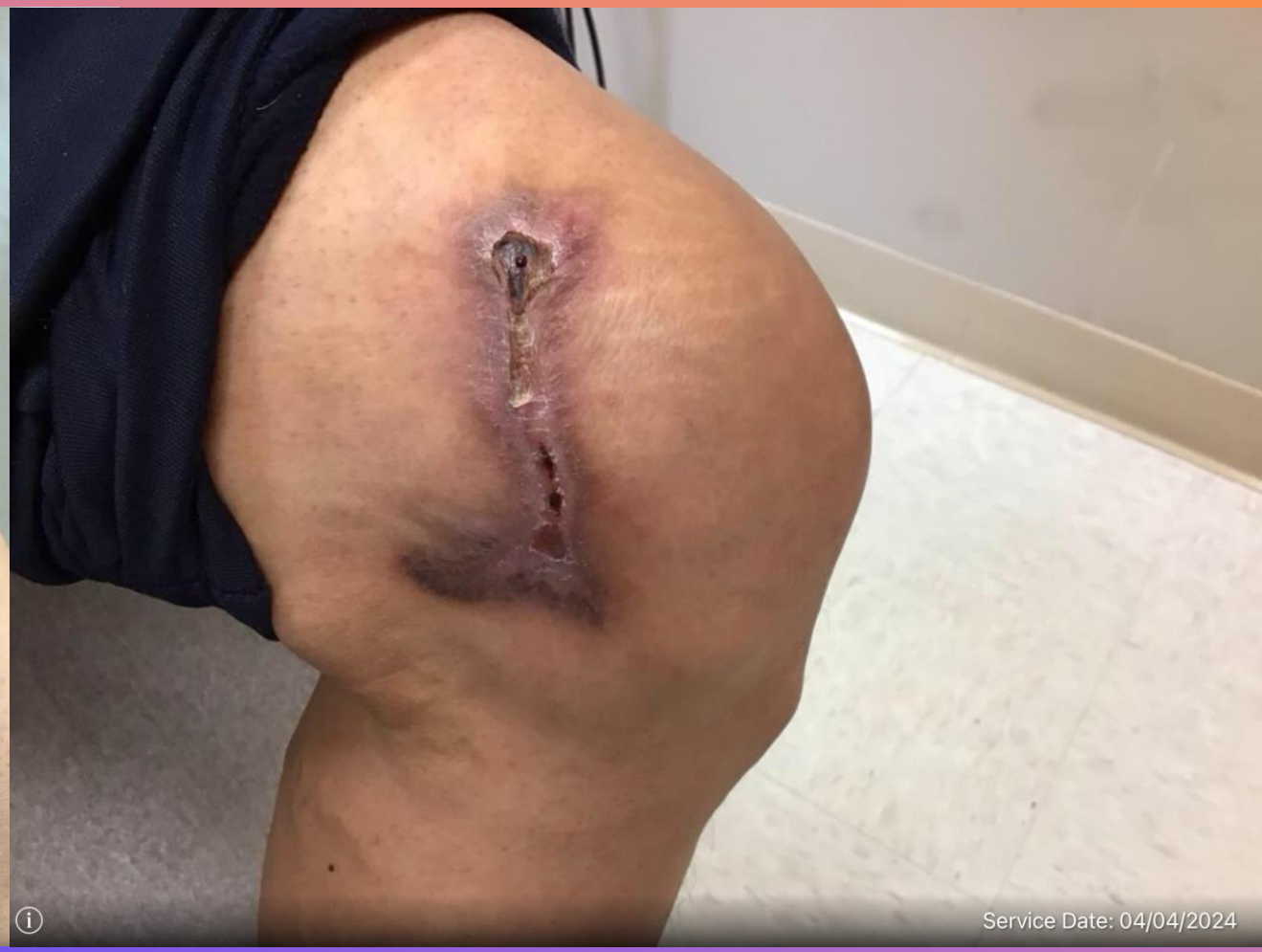
ZEBRA!



BLASTOMYCOSIS

ZEBRA!





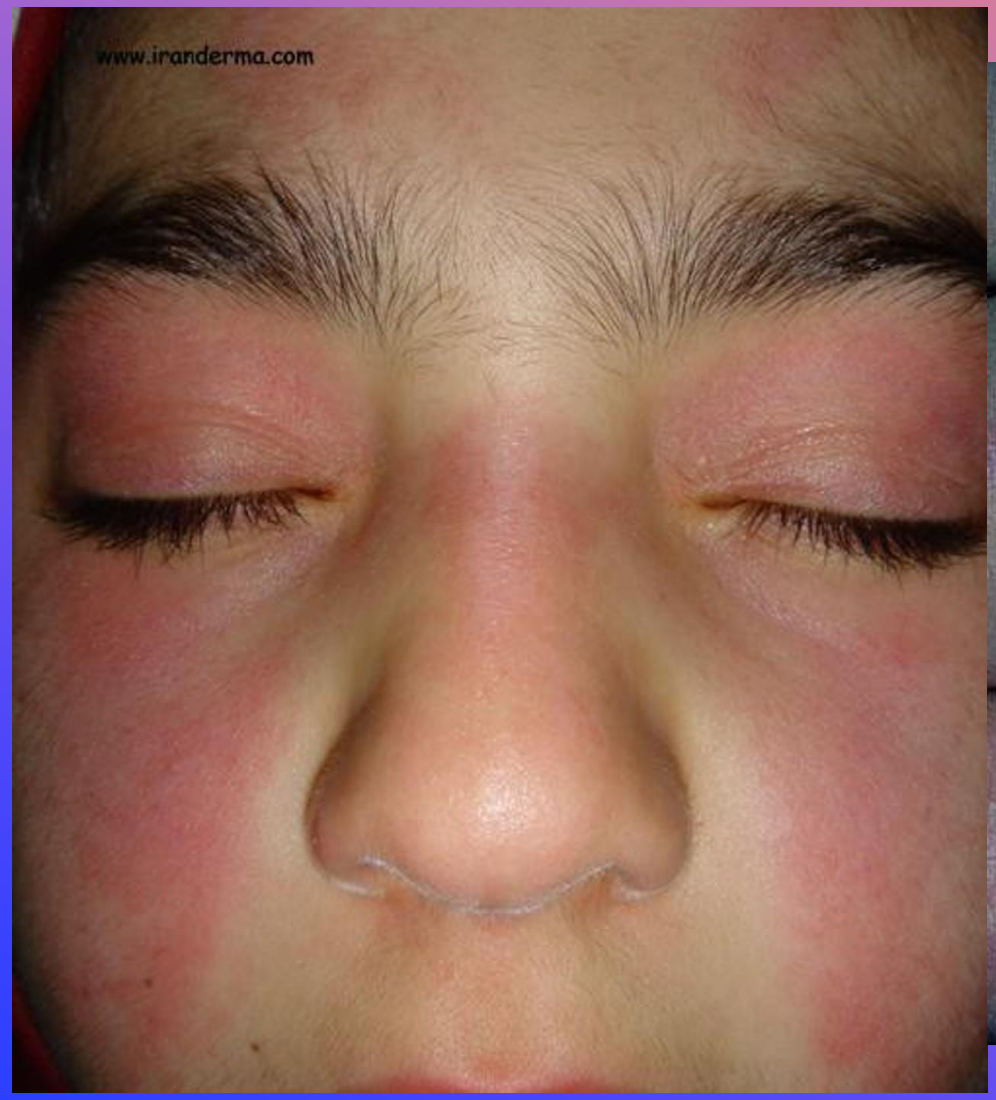
Presentation/After Punch Bx for Tissue Culture

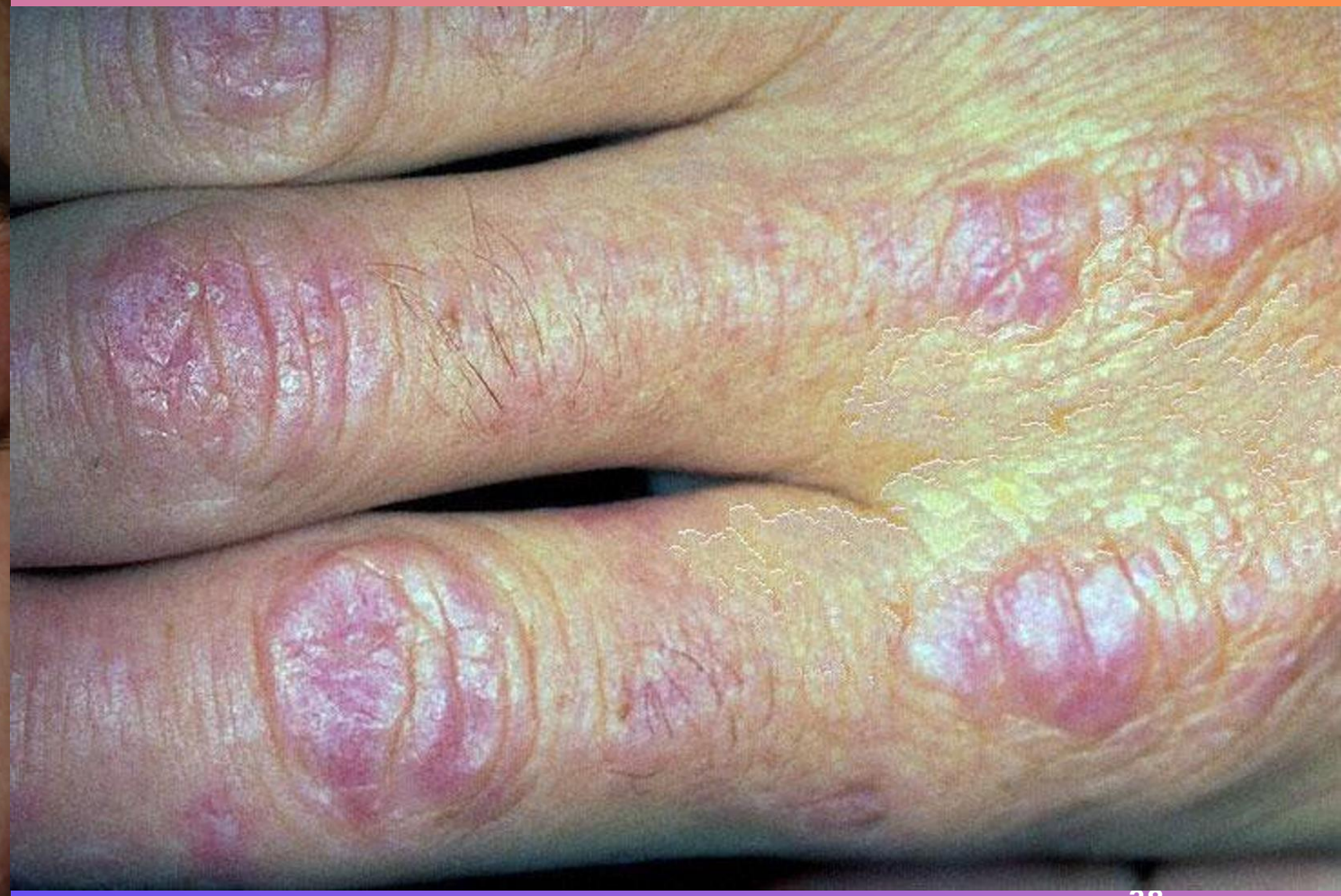
4 months of Itraconazole (still ongoing)

BLASTOMYCOSIS CHARACTERISTICS

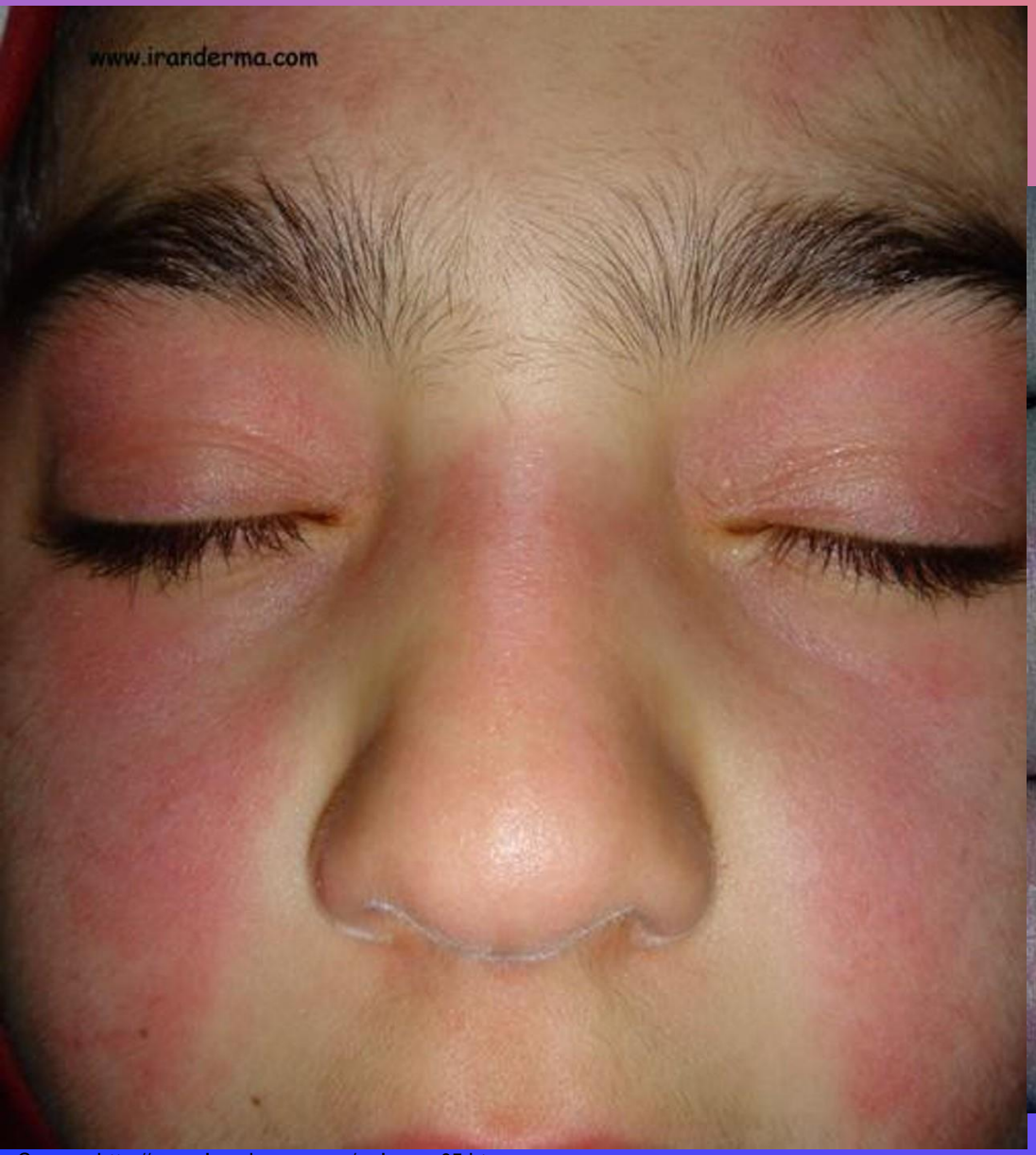
- Skin disease is the second most common manifestation of blastomycosis after pneumonia.
- You can get blastomycosis by contact with moist soil, most commonly where there is rotting wood and leaves.
- Usually a verrucous plaque, can mimic a squamous cell
- Usually spread from blood, very few are from direct inoculation.
  - REFER! Biopsy plus tissue cultures were needed for this diagnosis
  - You never know what's going to walk in the door, so be ready!
    - We referred to infectious disease to rule out systemic infection, he is on itraconazole and lesion is melting away!

WHAT IS IT?

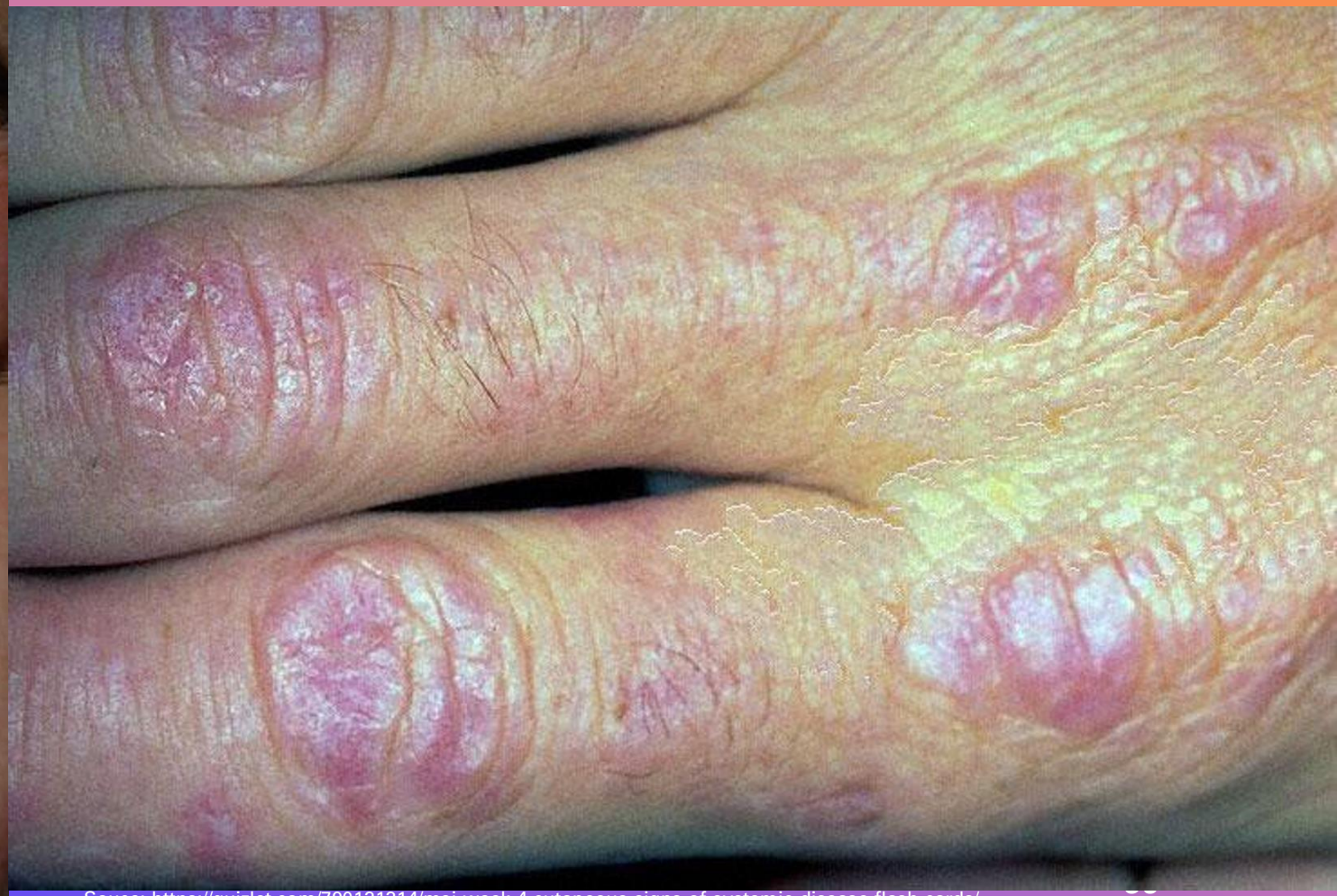




DERMATOMYOSITIS (DM)



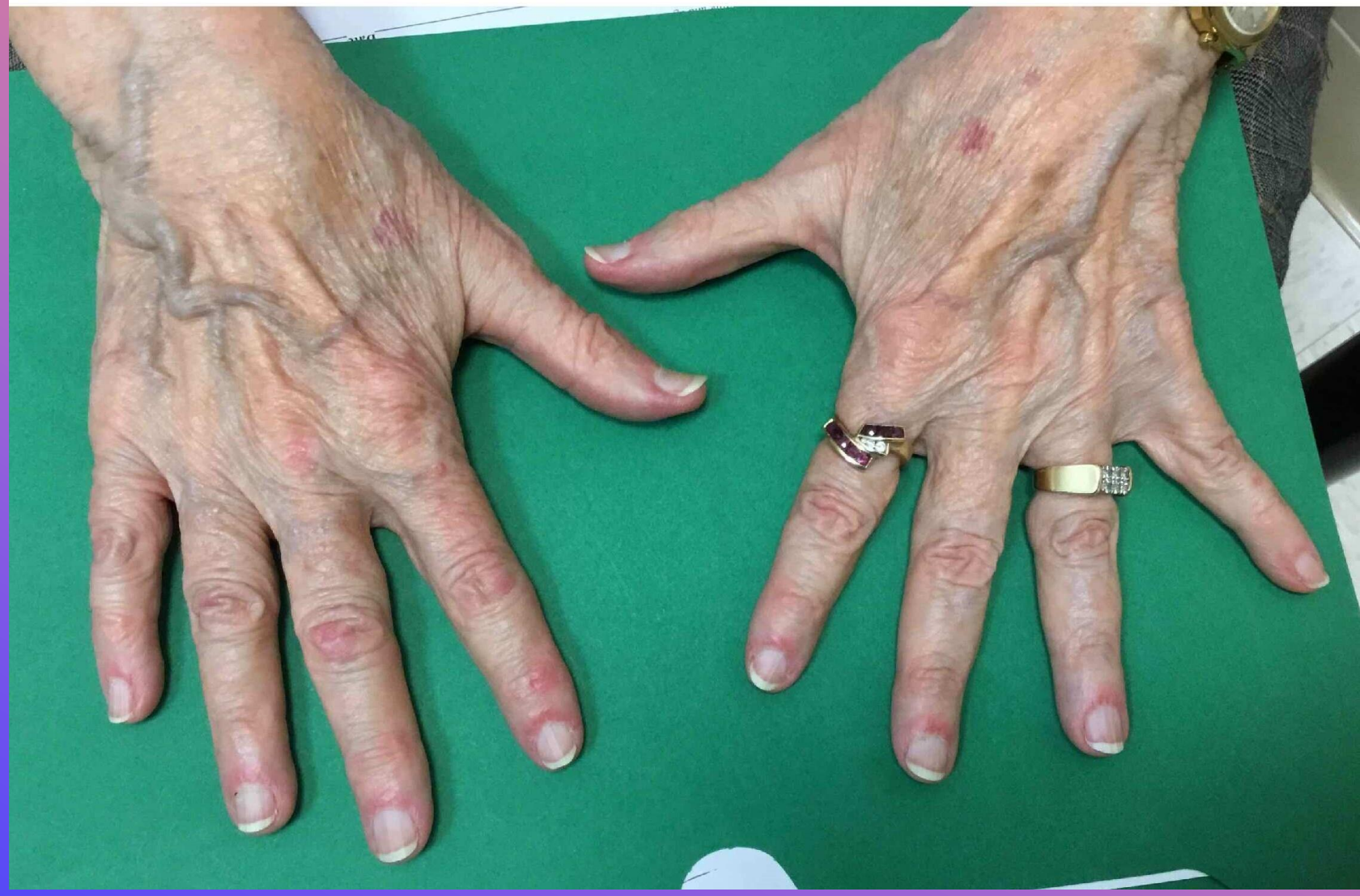
Source: http://www.iranderma.com/quiz-mar05.htm



Souce: https://quizlet.com/790131314/msi-week-4-cutaneous-signs-of-systemic-disease-flash-cards/

DERMATOMYOSITIS (DM) CHARACTERISTICS

- Violaceous erythema of lids (heliotrope rash)
- Photodistribution
- Erythema on upper back (shawl sign) and hands
- Papules over IP joints
  - (Gottron's papules)
- Dilated capillary loops on nail folds



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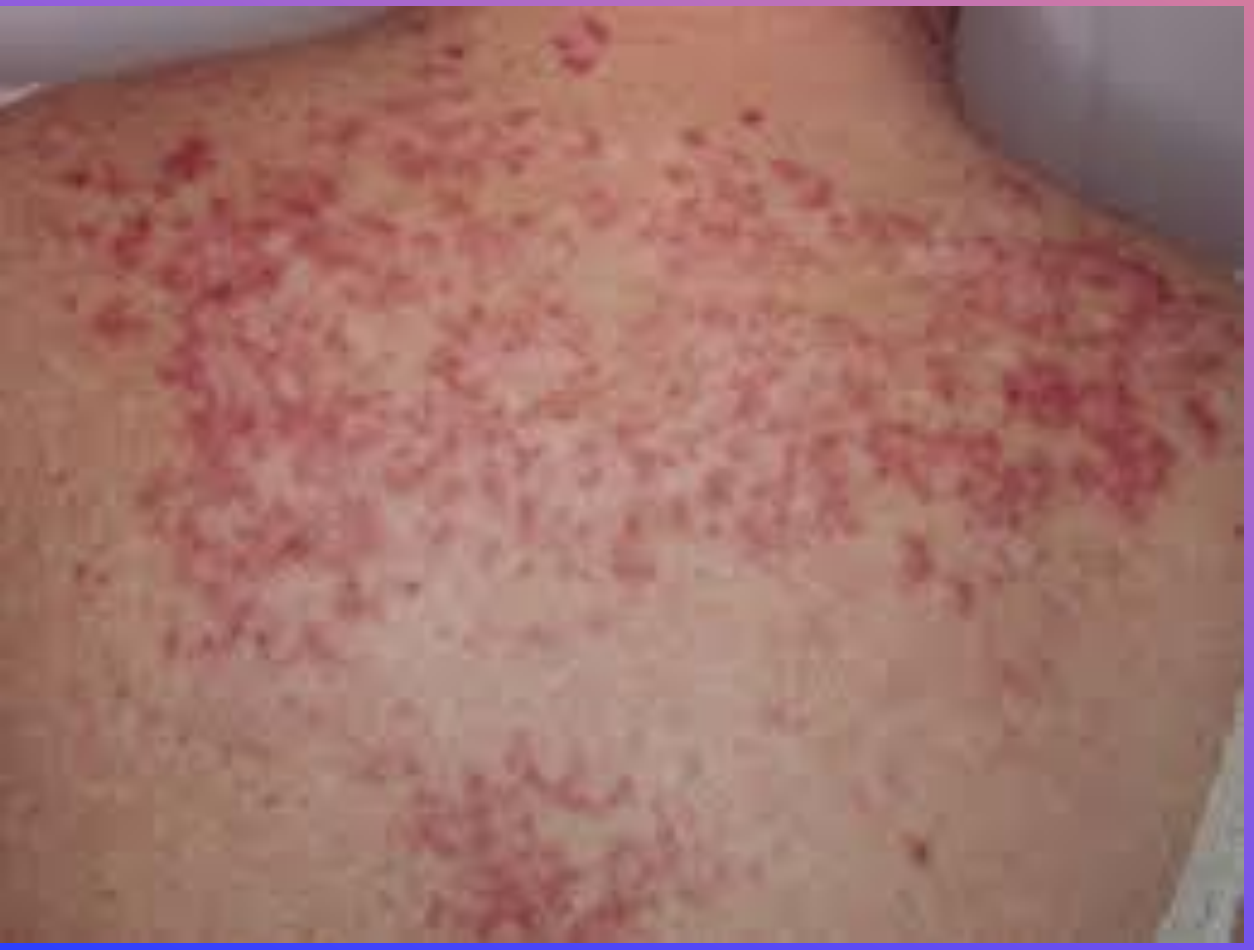
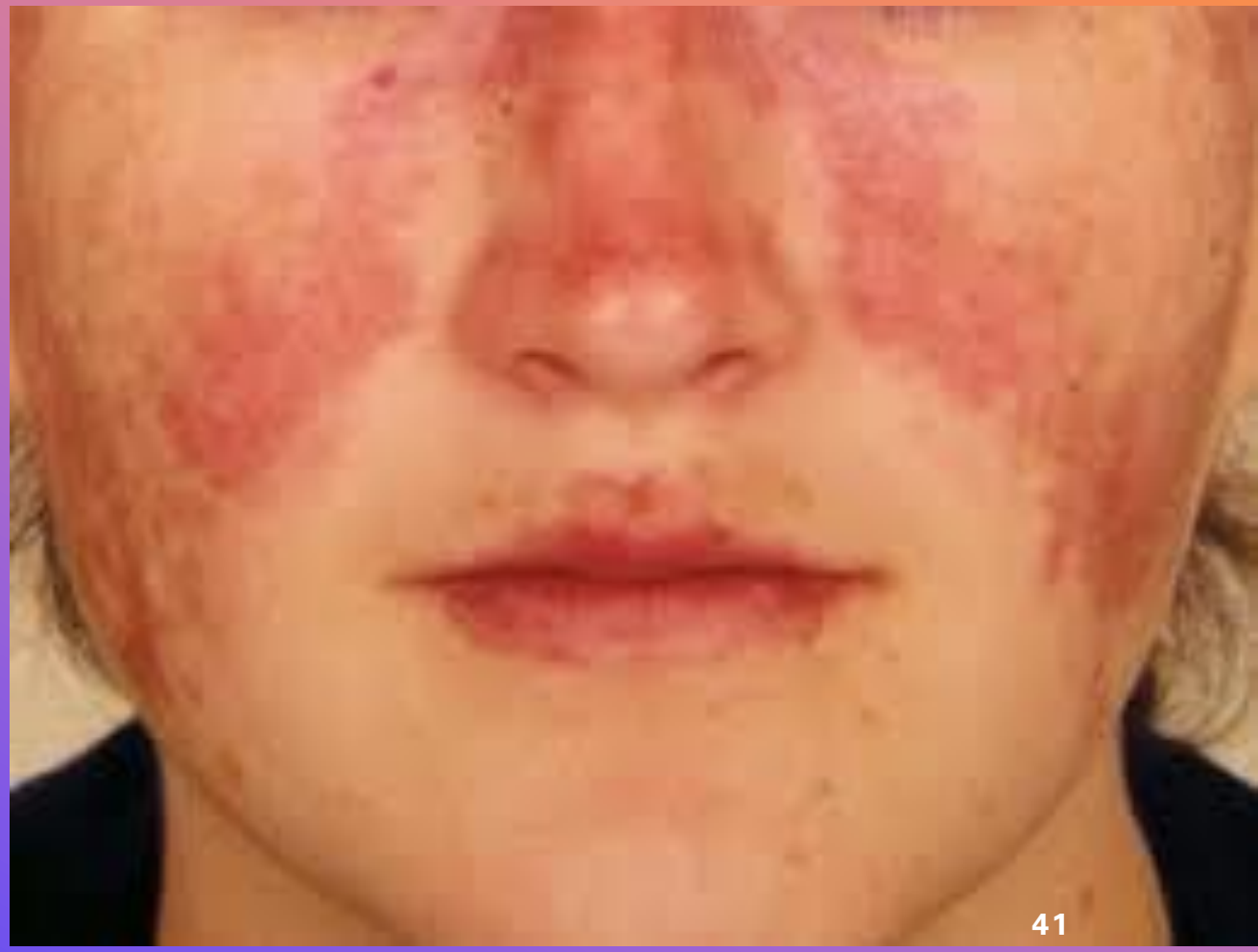
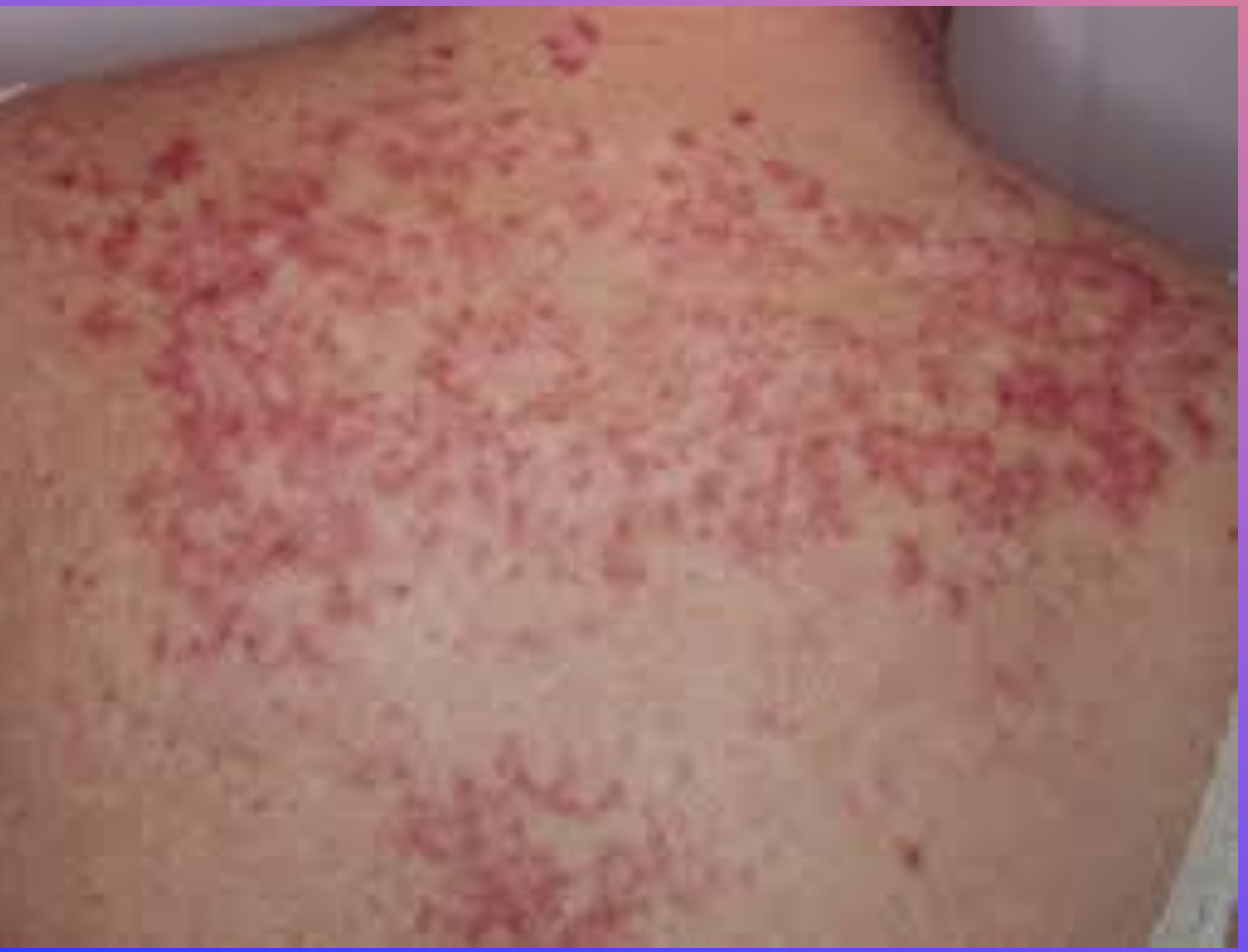
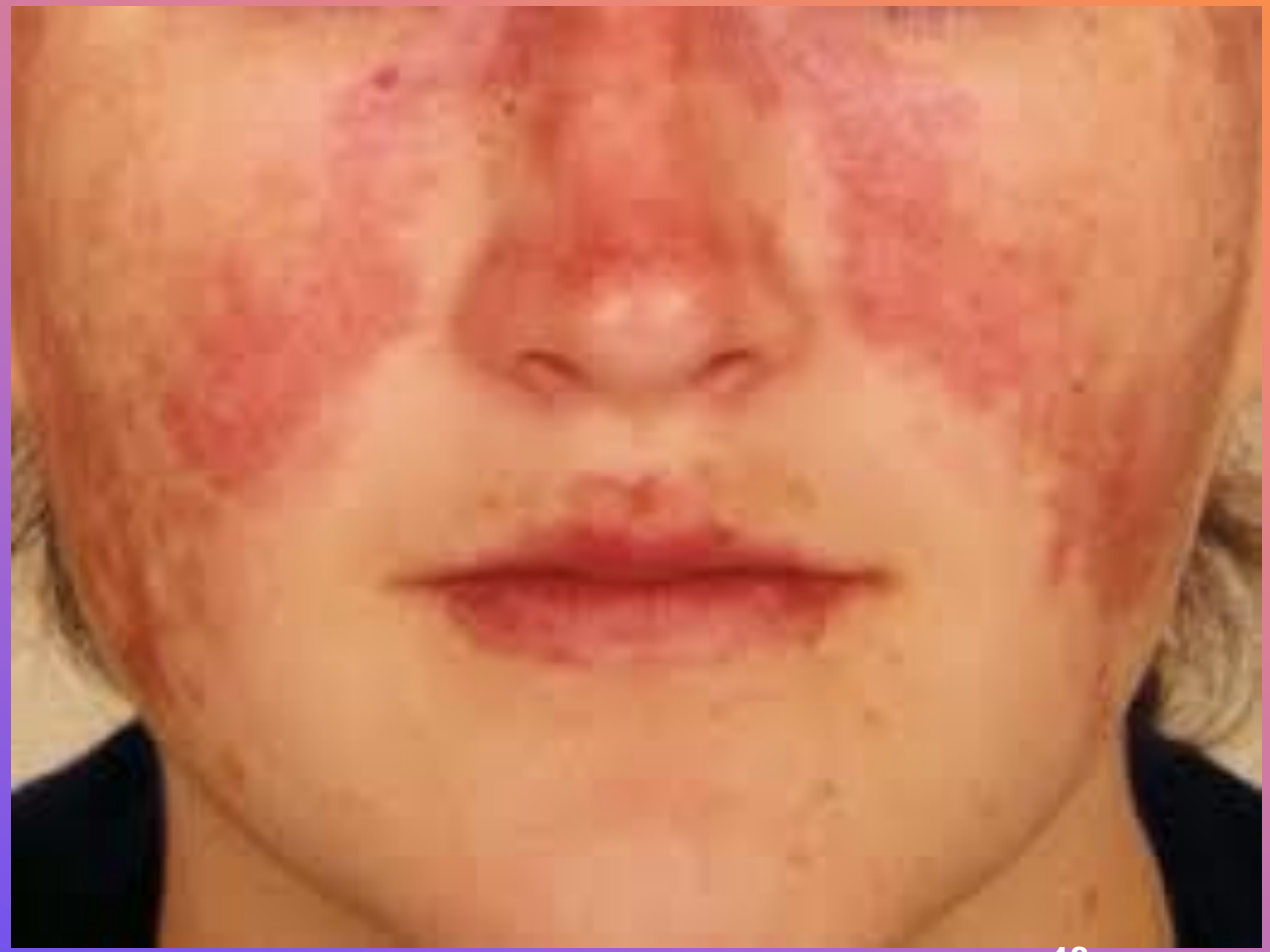




SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

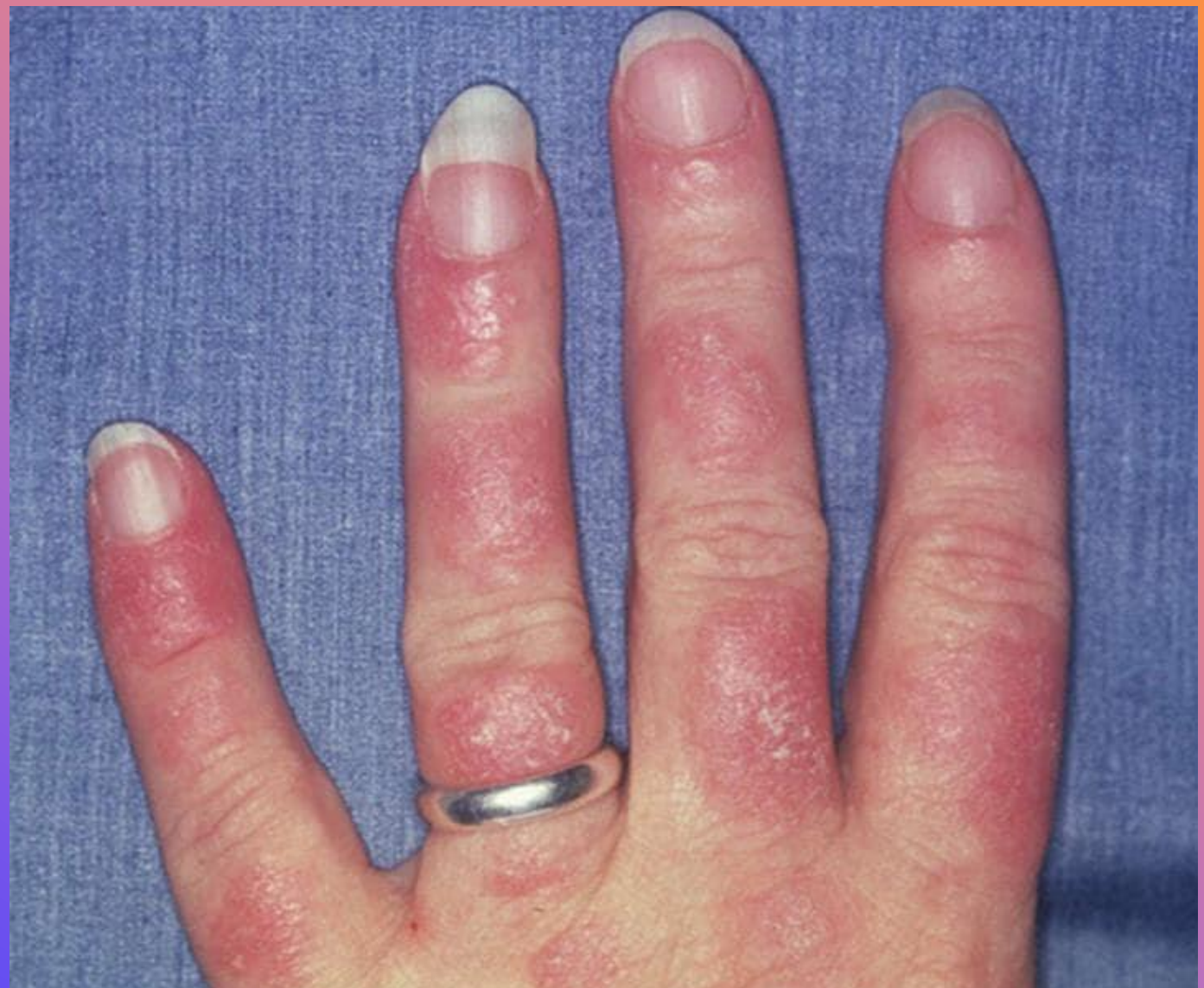




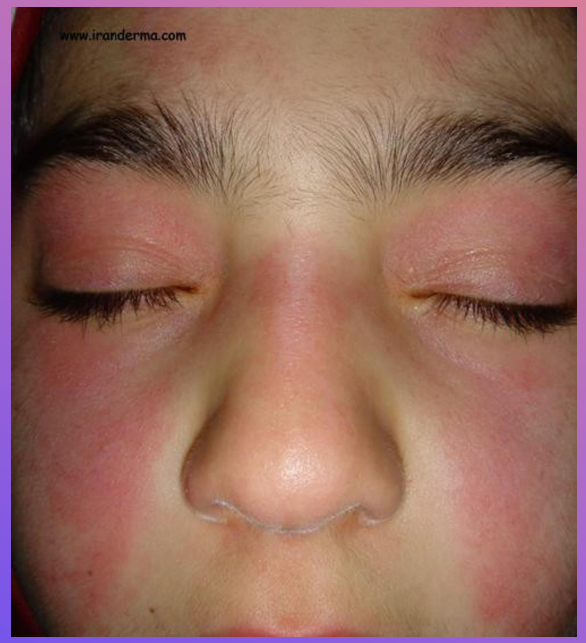
https://dermnetnz.org/topics/subacute-cutaneous-lupus-erythematosus

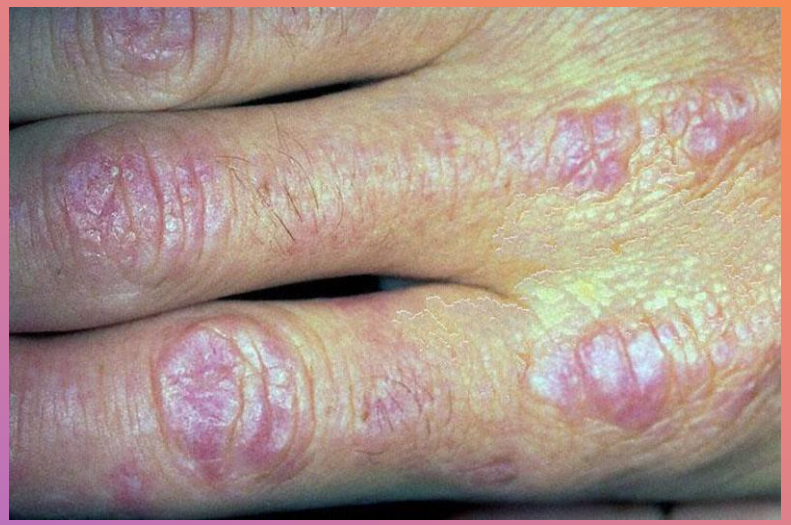
SLE CHARACTERISTICS

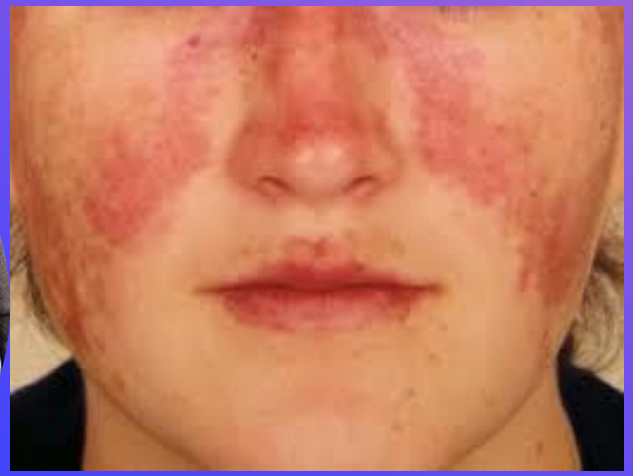
- Photodistributed scaly plaques
- “Butterfly Rash”
- Rash over phalanges,
  - knuckles spared
- **Dilated periungual capillary loops**
- Oral ulcers
- Refer to Derm or Rheum

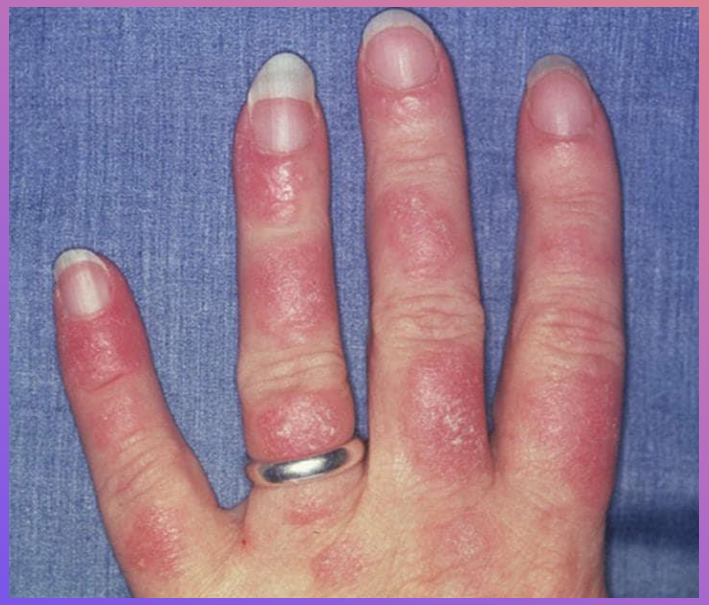


DM VS SLE









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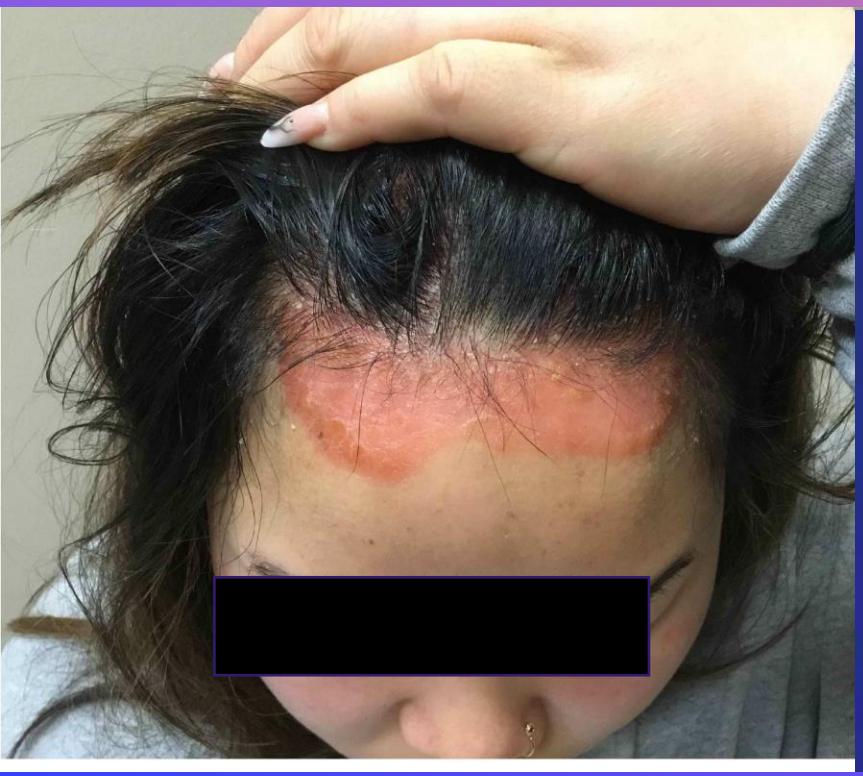
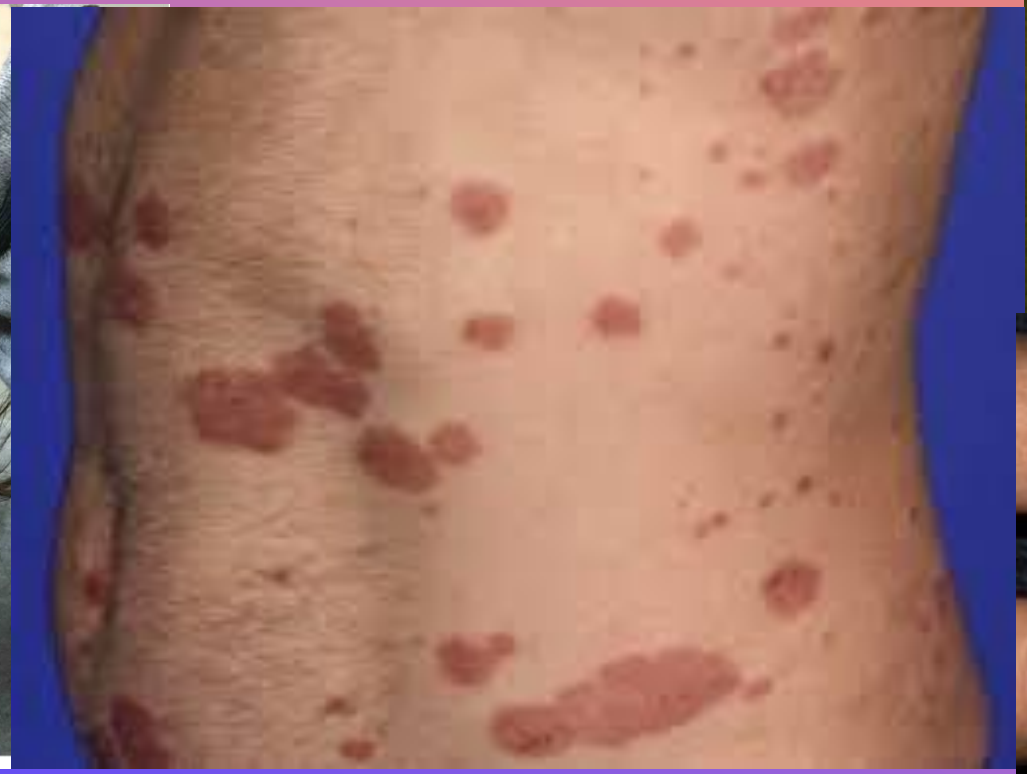
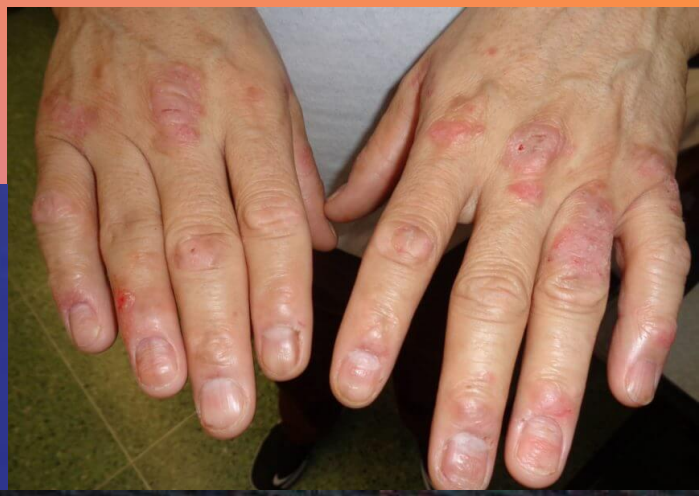
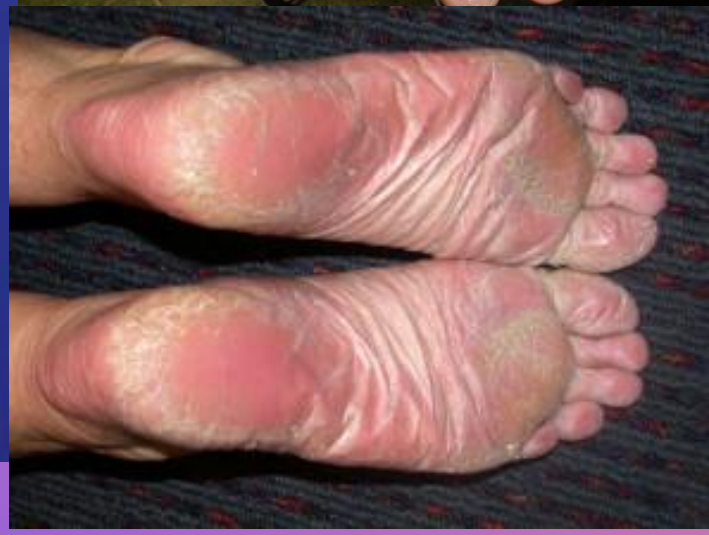
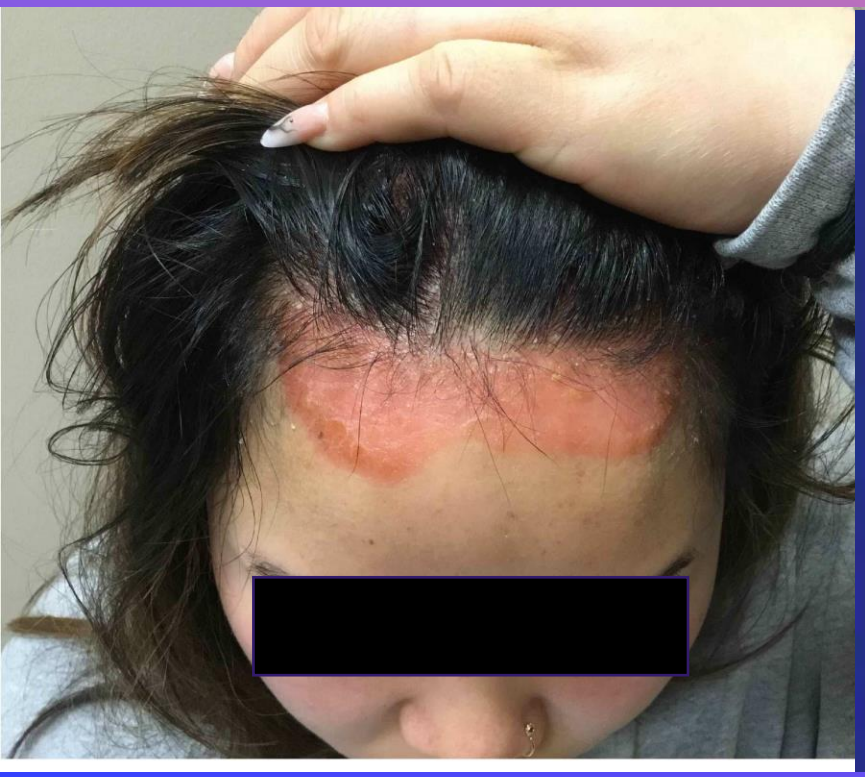


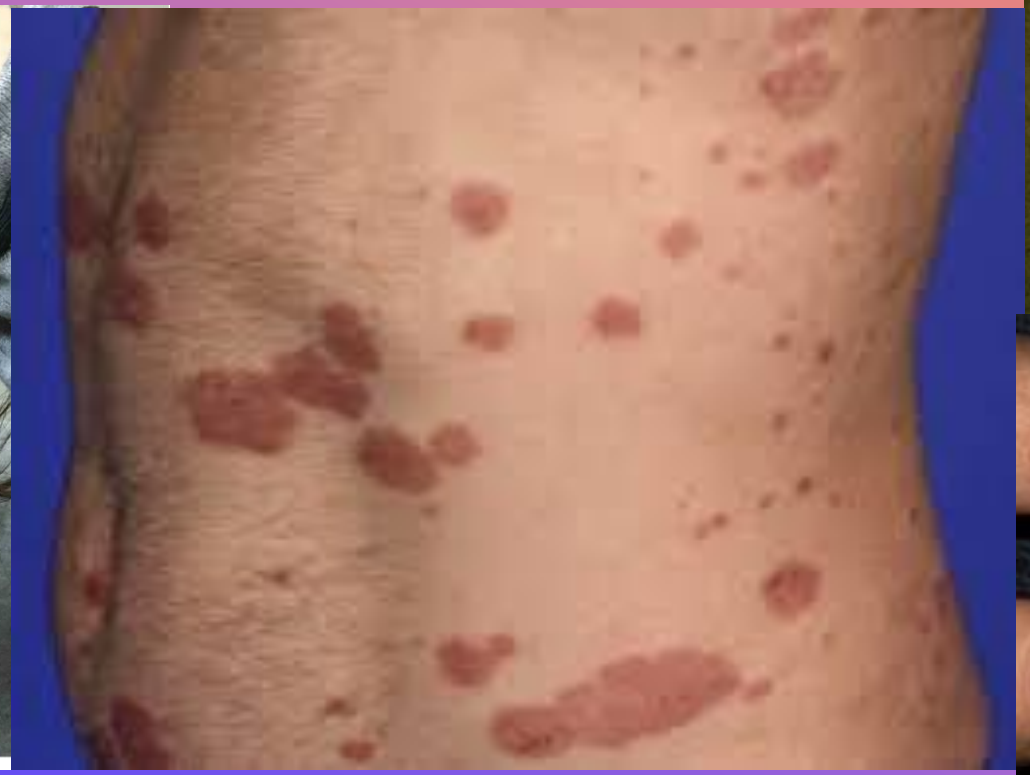


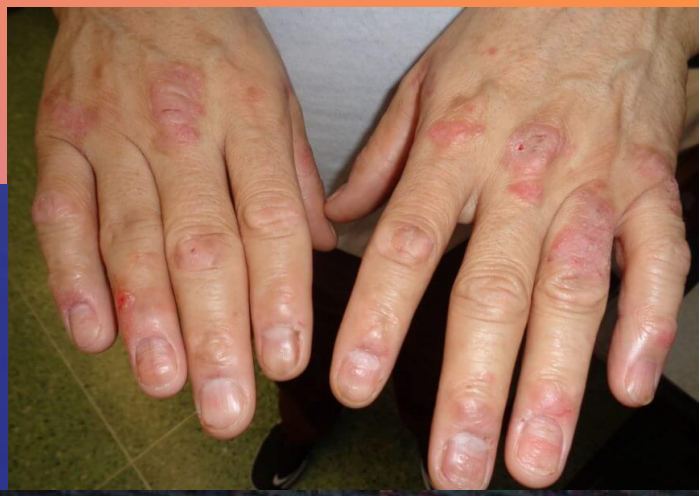


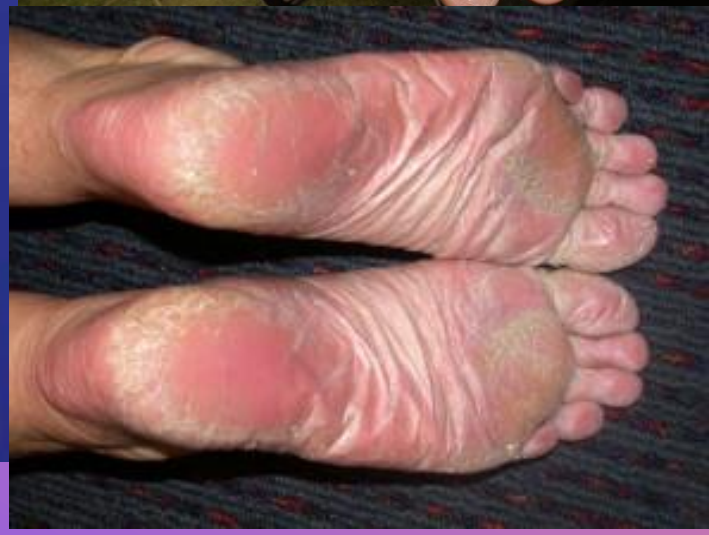


PSORIASIS





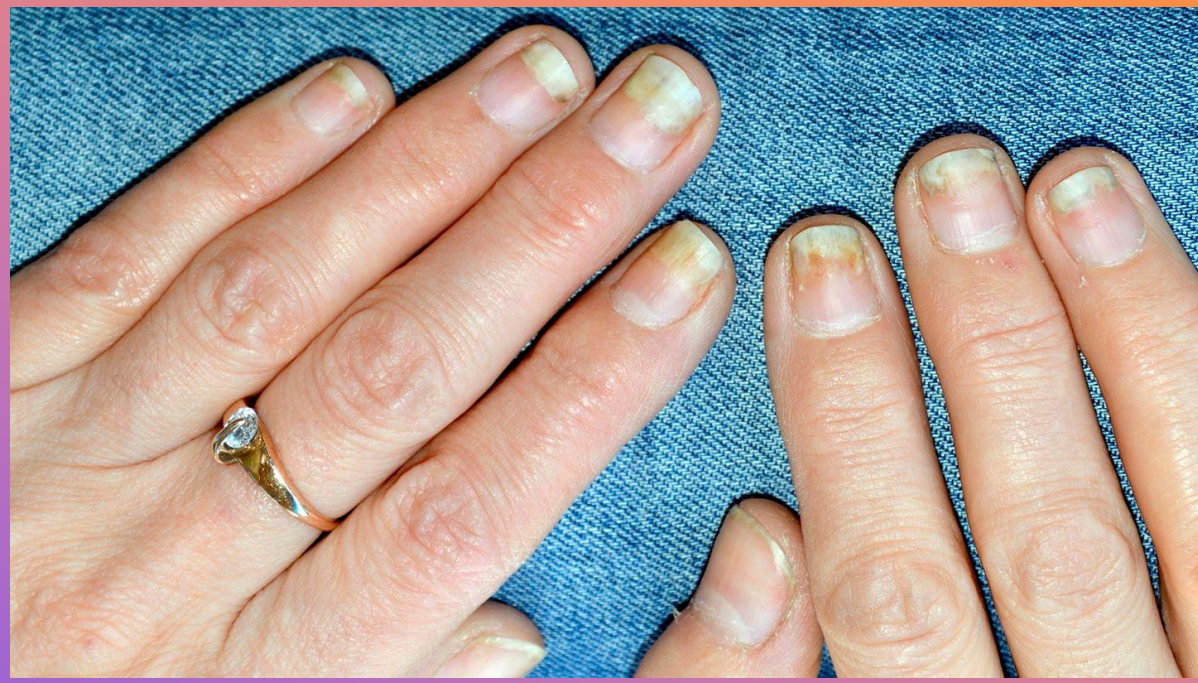




https://dermnetnz.org/#gsc.tab=1&gsc.q=psoriasis%20plaques%20&gsc.page=3

PSORIASIS CHARACTERISTICS

- Well demarcated scaly plaques on elbows, knees, scalp, trunk, extremities, genitals
- Scaling, fissuring hands and feet
- Nail changes (onycholysis, pitting, oil drop spots)
- PCP Perspective: can always start with a topical steroid from but many new, effective topical nonsteroid treatments as well as orals, biologics. Passion of mine!



https://www.everydayhealth.com/psoriatic-arthritis/living-with/psoriatic-arthritis-nail-care/

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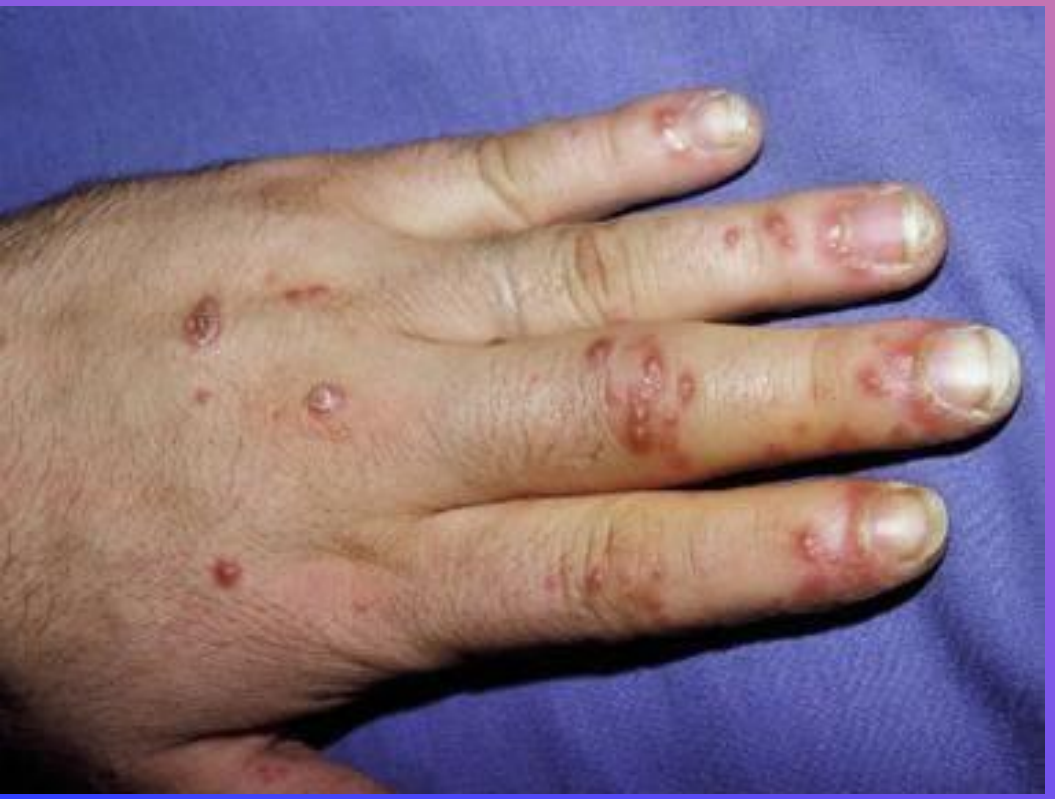
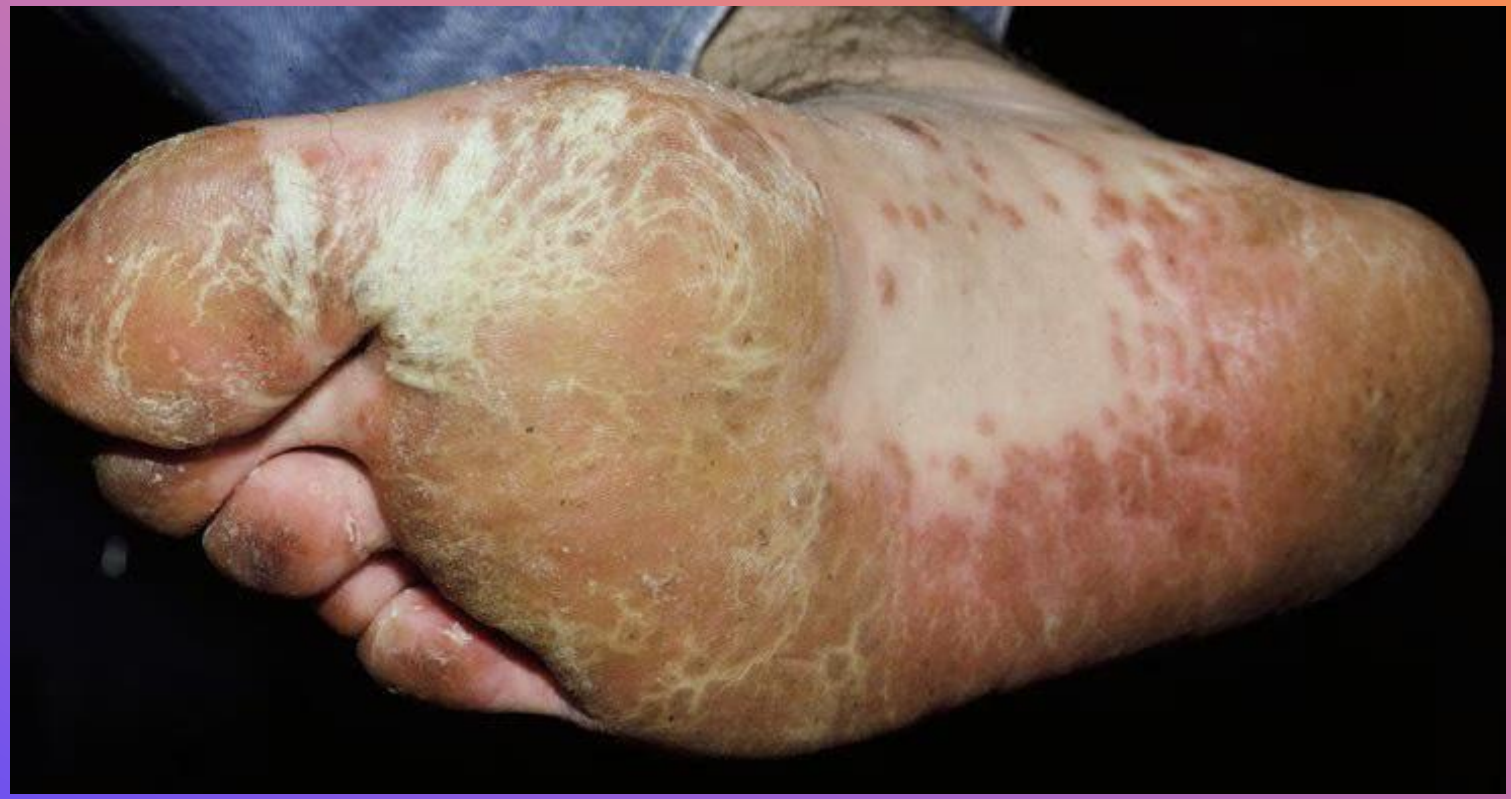
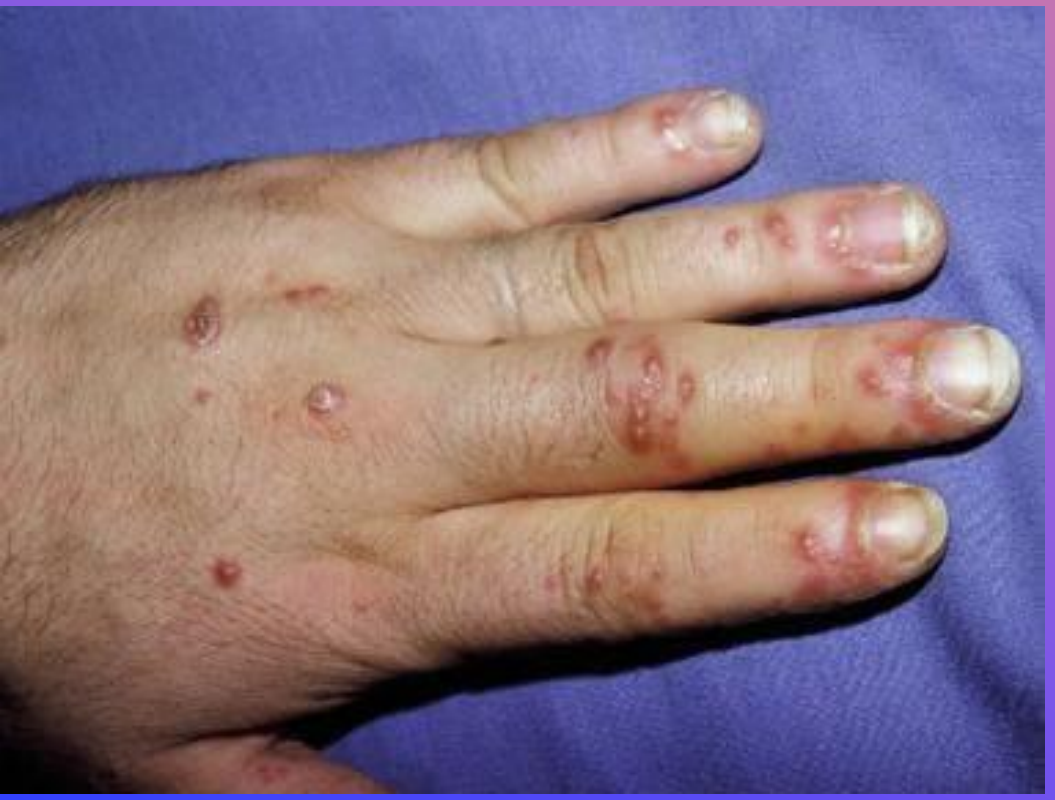
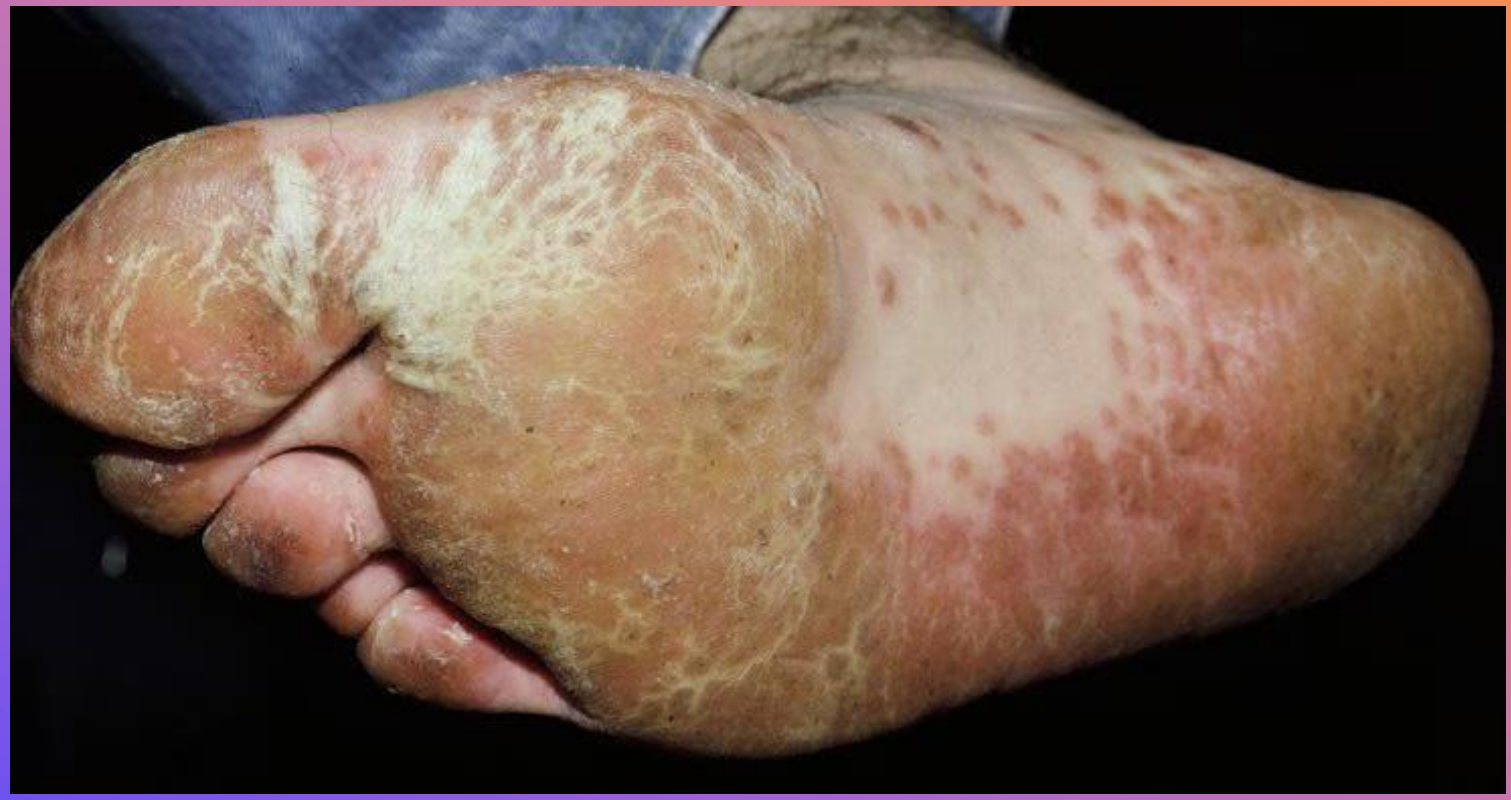




REITER'S DISEASE/ REACTIVE ARTHRITIS

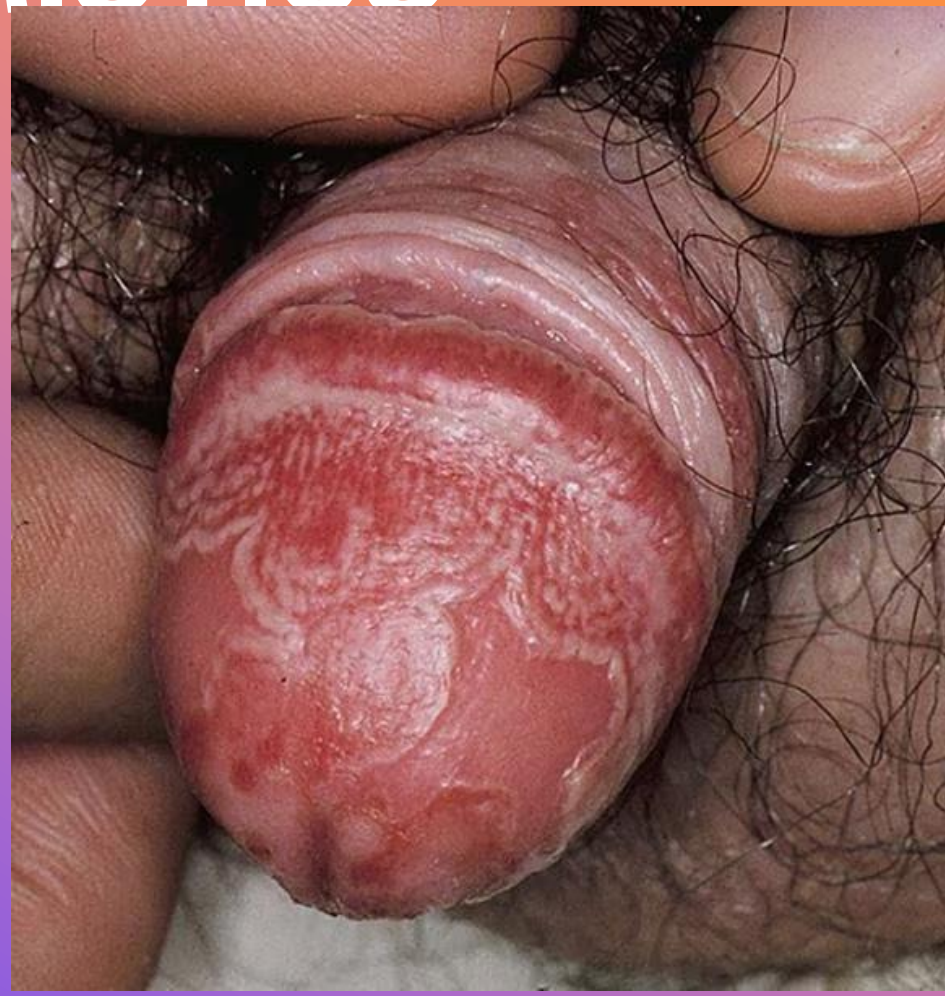




https://emedicine.medscape.com/article/331347-overview#:~:text=Reactive%20arthritis%20(ReA)%20is%20an,in%20response%20to%20an%20infection.&text=ReA%20has%20been%20associated%20with,(especially%20with%20Chlamydia%20trachomatis)

REITER'S DISEASE/REACTIVE ARTHRITIS CHARACTERISTICS

- Reactive Arthritis – formerly Reiter's Syndrome
  - Autoimmine, in response to an infection
    - Associated with *Shigella, Salmonella, Campylobacter,* and other organisms, as well as with GU infections (especially with *Chlamydia trachomatis*).
    - Some cases reported after Covid 19
- Arthritis, urethritis, uveitis, oral ulcers
- Balanitis circinata
- Keratoderma blenorrhagica (thickening of feet)
- Psoriasis like lesions on the trunk and extremities
- *"Can't eat, can't see, can't pee, can't climb a tree"*



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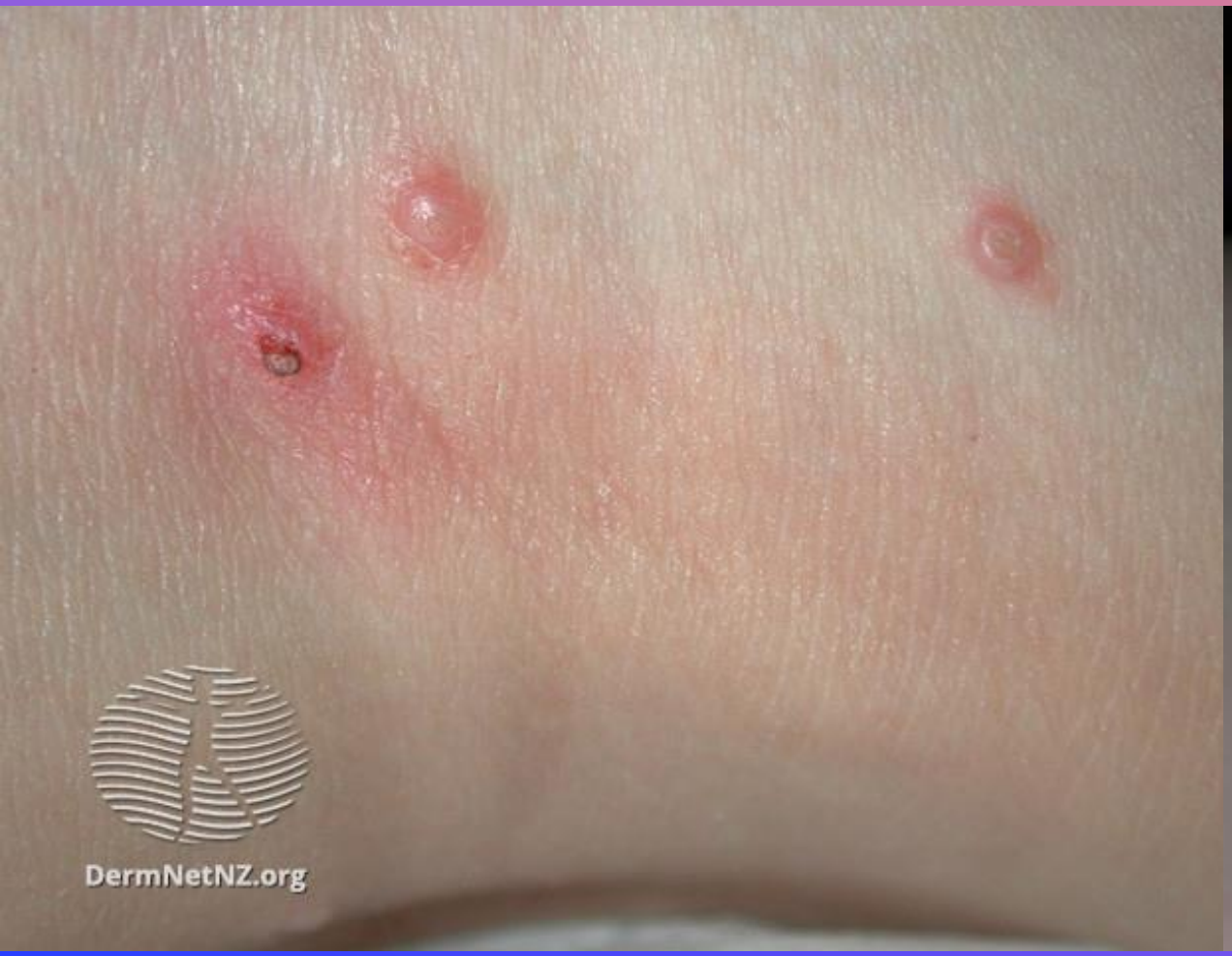
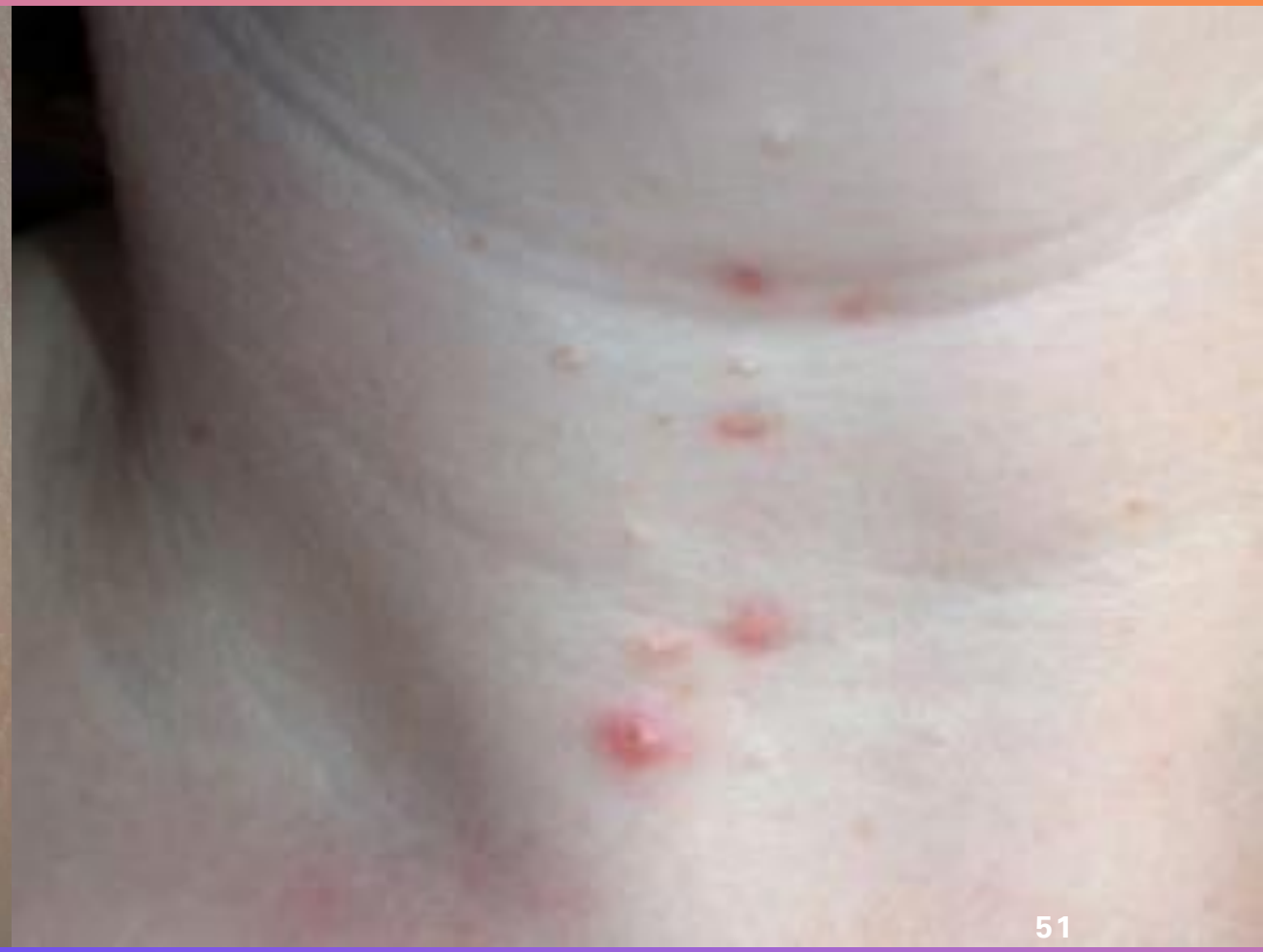
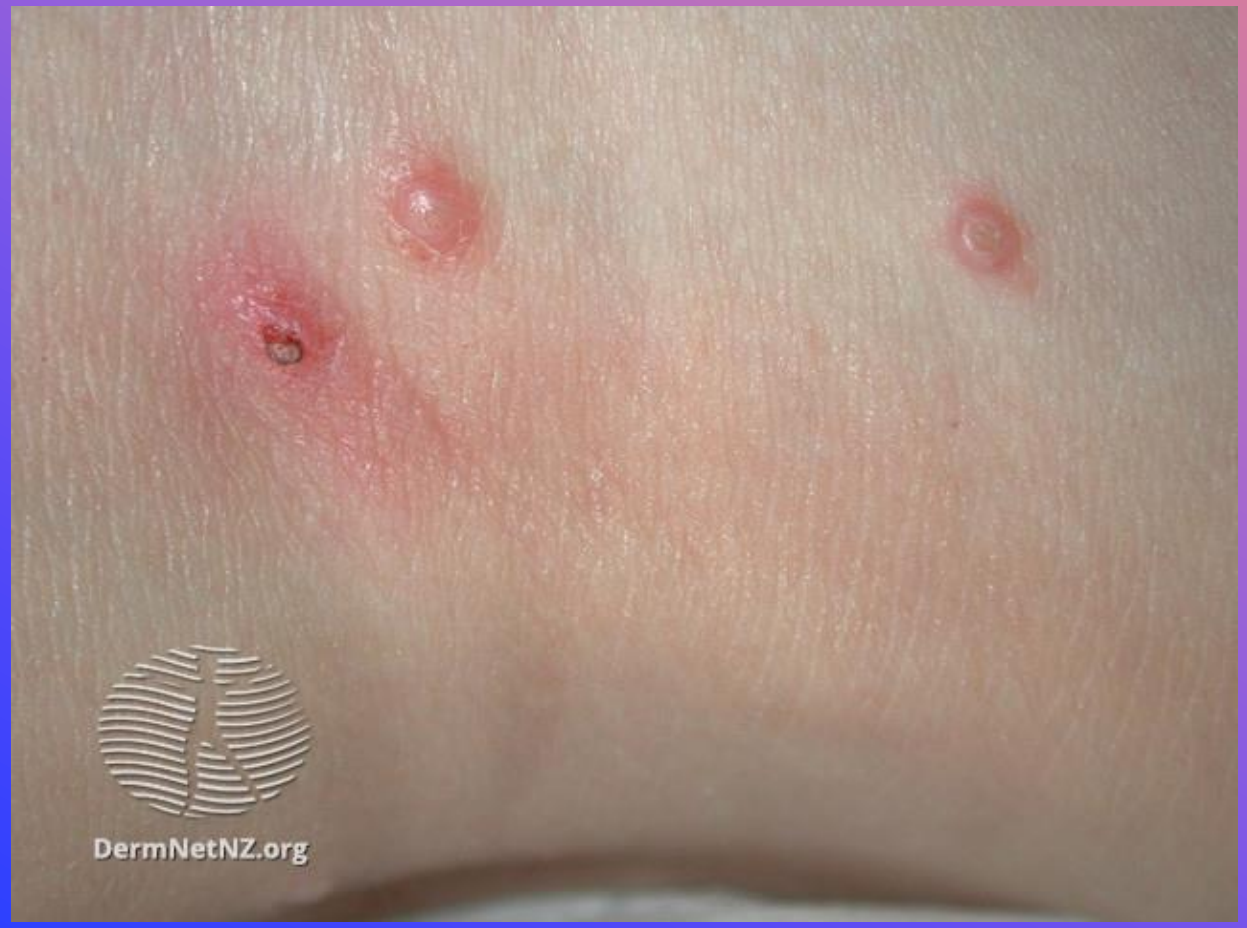
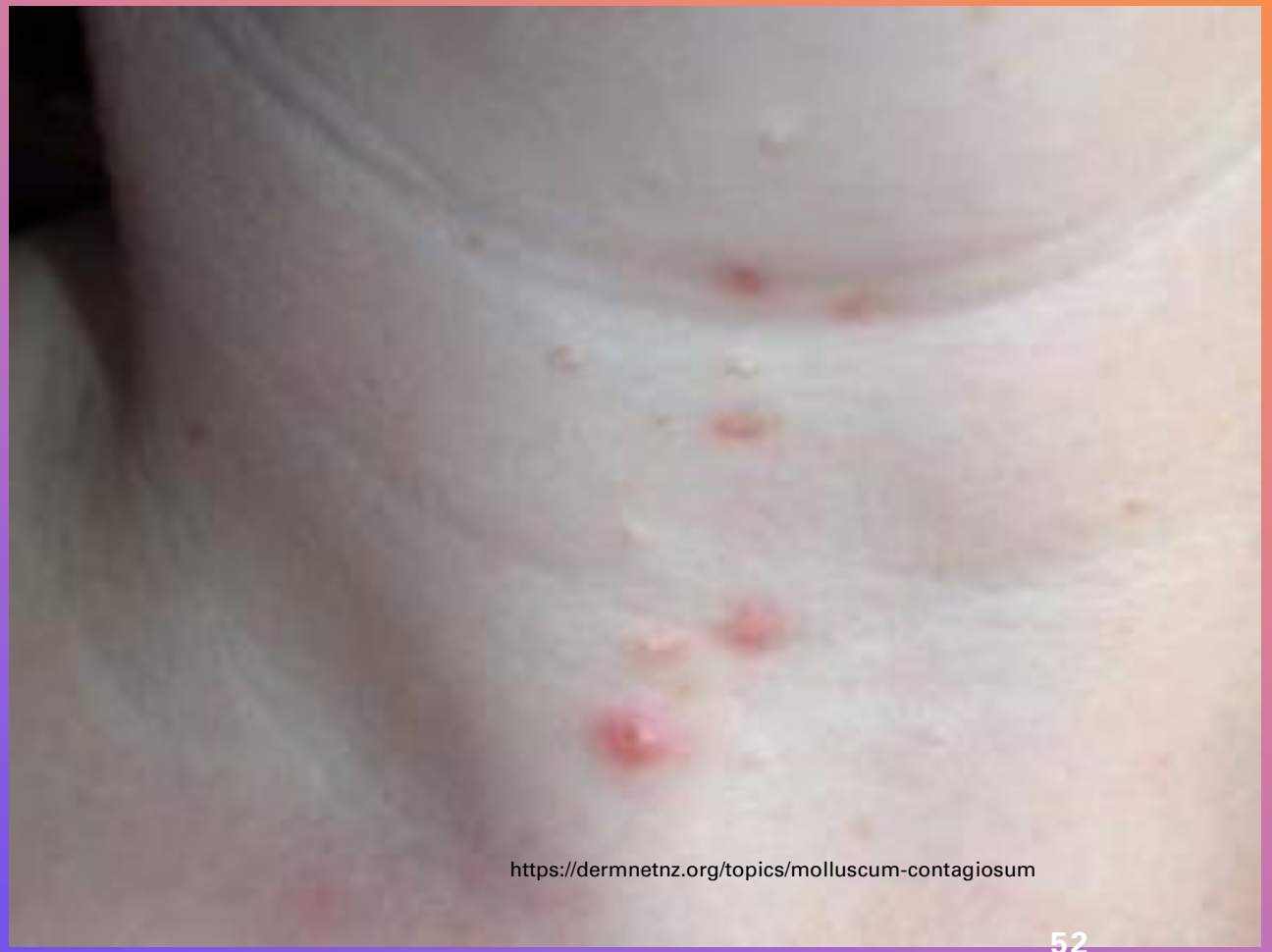
WHAT IS IT?





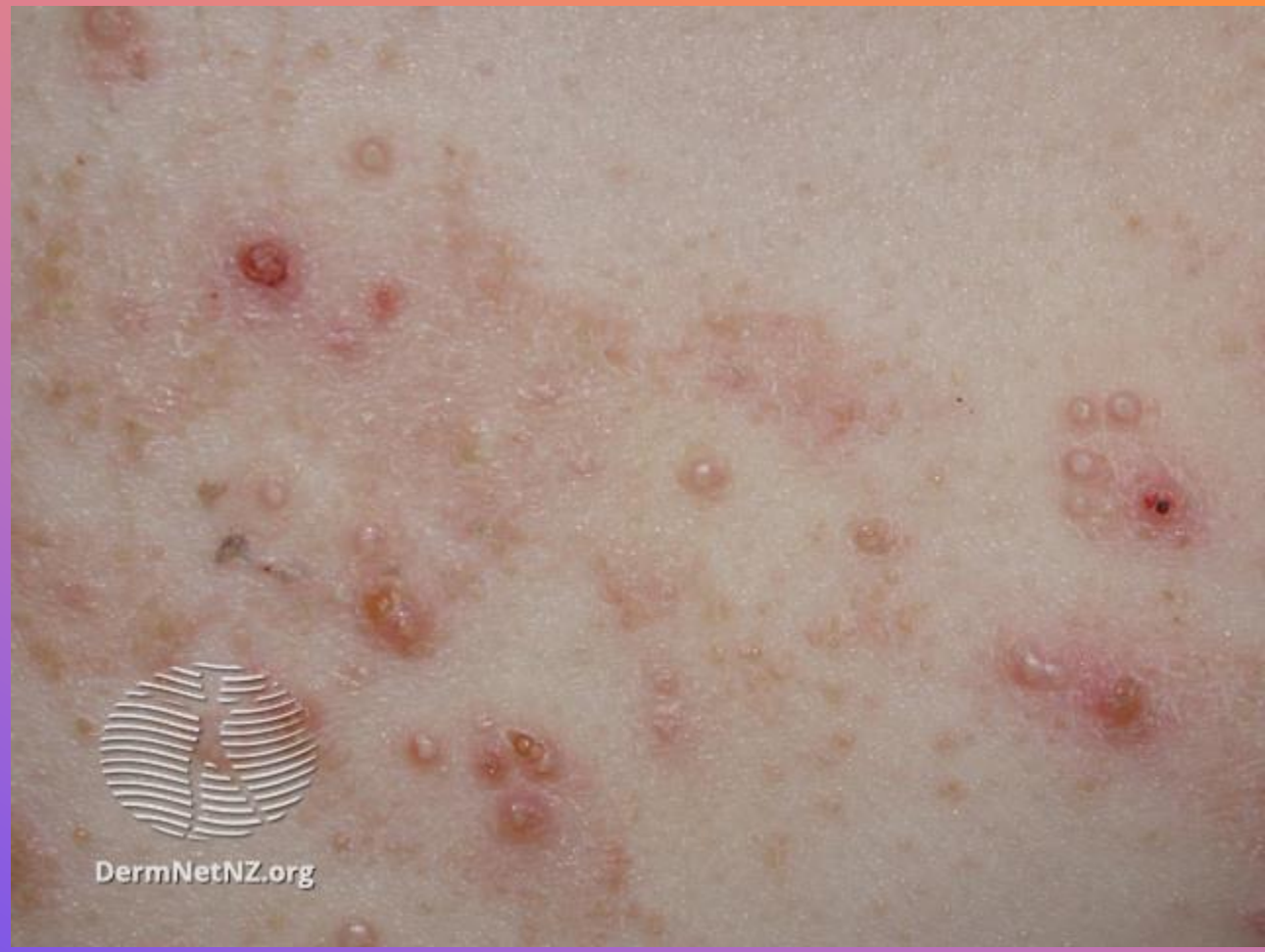
MOLLUSCUM CONTAGIOSUM





MOLLUSCUM CONTAGIOSUM

- Flesh colored umbilicated papules in any location
- Younger individuals
- Adults – usually genital distribution
- Spread rapidly
- Will eventually spontaneously resolve
- HOT TIP: TREAT UNDERLYING ECZEMA FIRST
- Refer to Derm for Tx with Cantharidin, curettage, light LN2 or new tx: berdazimer gel



https://dermnetnz.org/topics/molluscum-contagiosum

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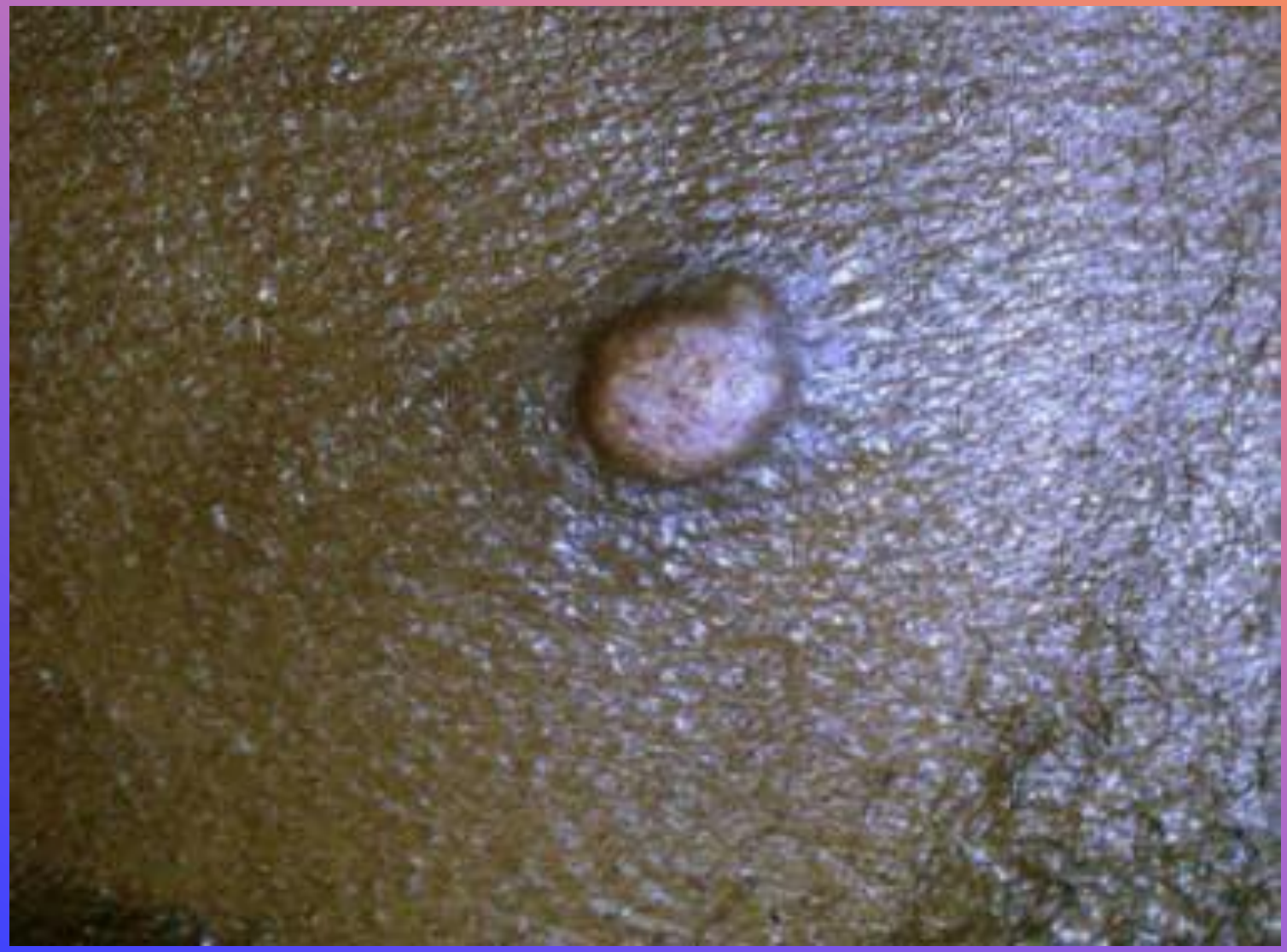
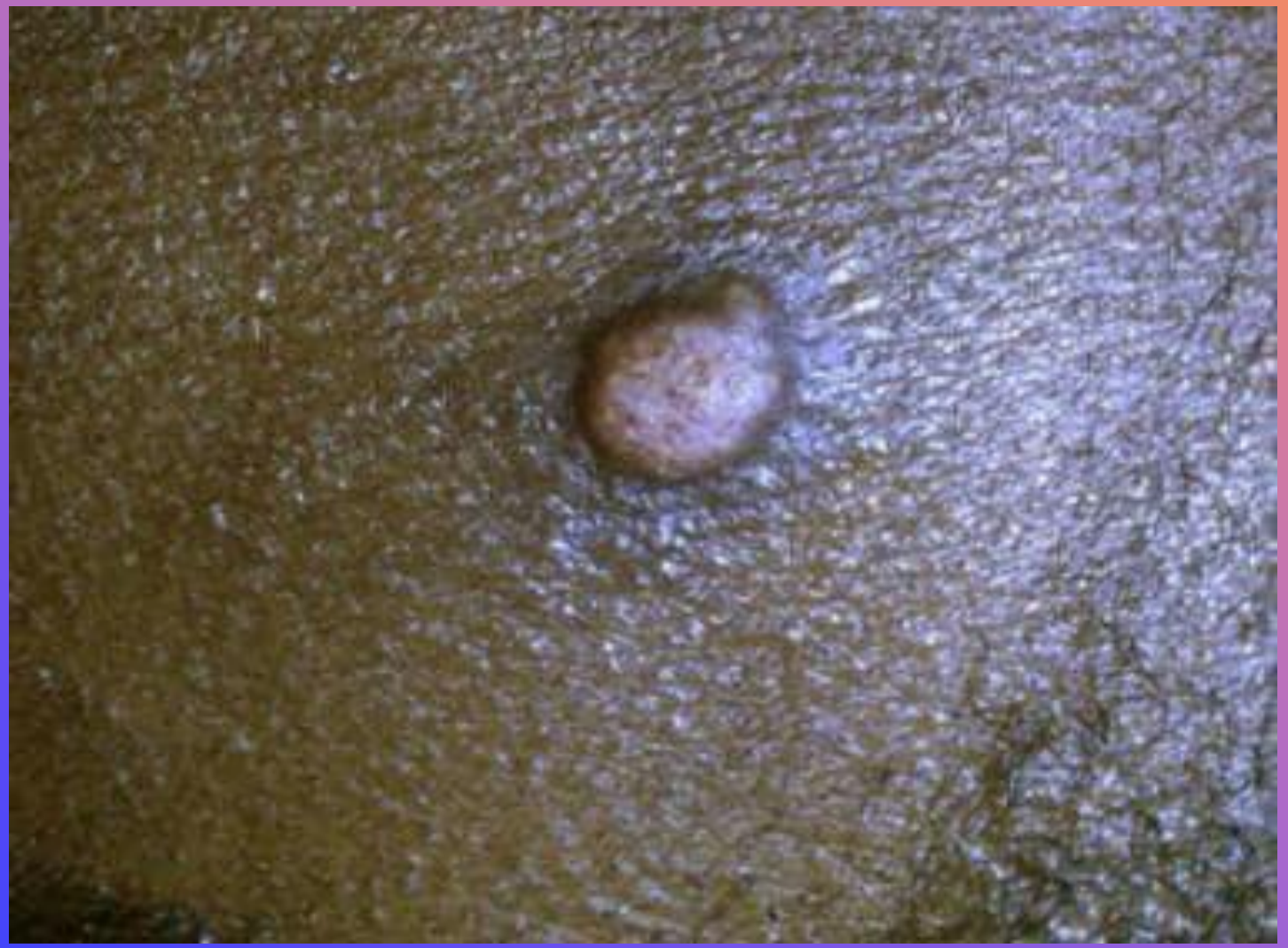


COCCIDIOMYCOSES

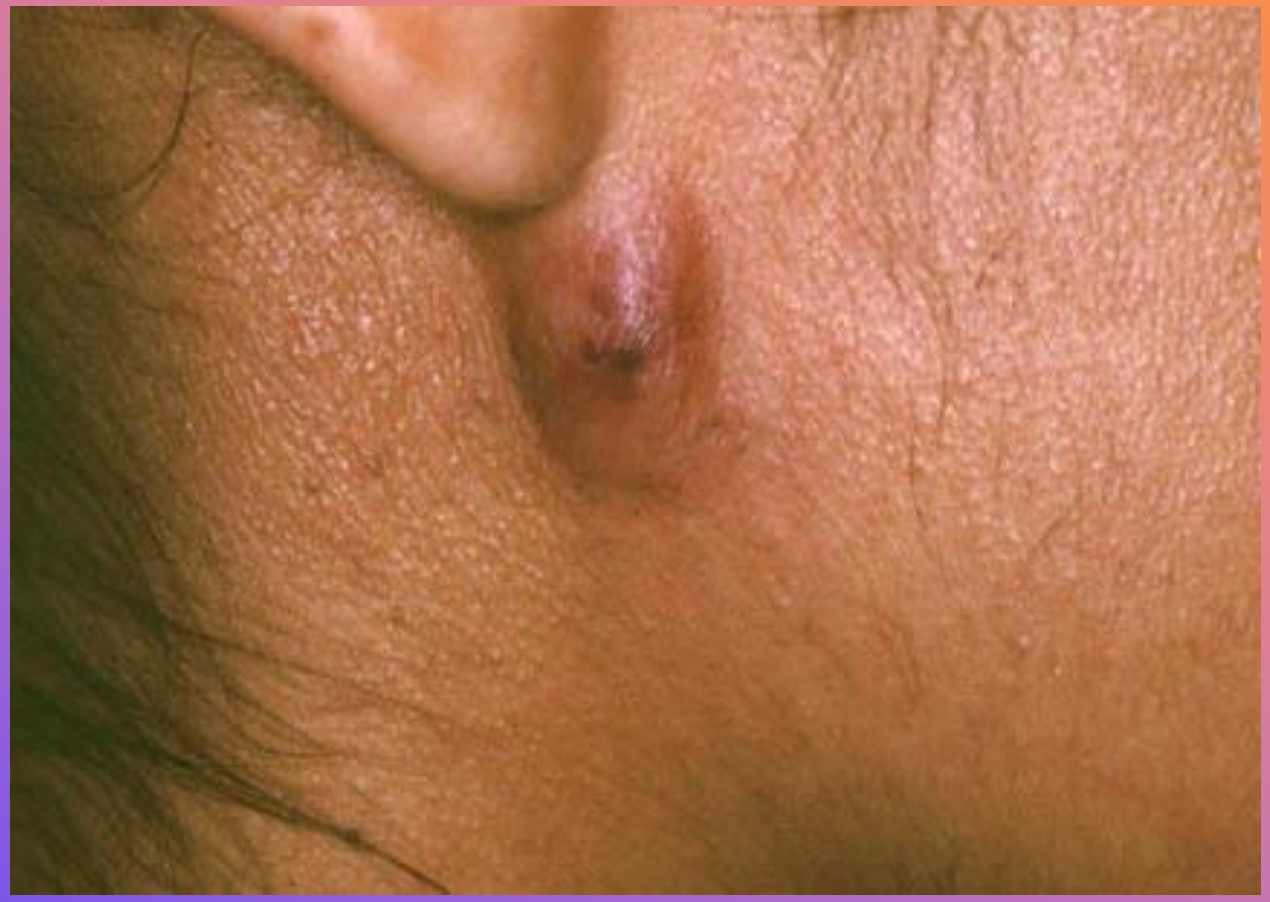
ZEBRA!



https://emedicine.medscape.com/article/910570-differential

COCCIDIOMYCOSES

- “San Joaquin Valley Fever”
- Considered one of the most infectious fungal infections
- Molluscum-like lesions in an immunosuppressed individual
- Associated with AIDS



https://emedicine.medscape.com/article/1092017-overview

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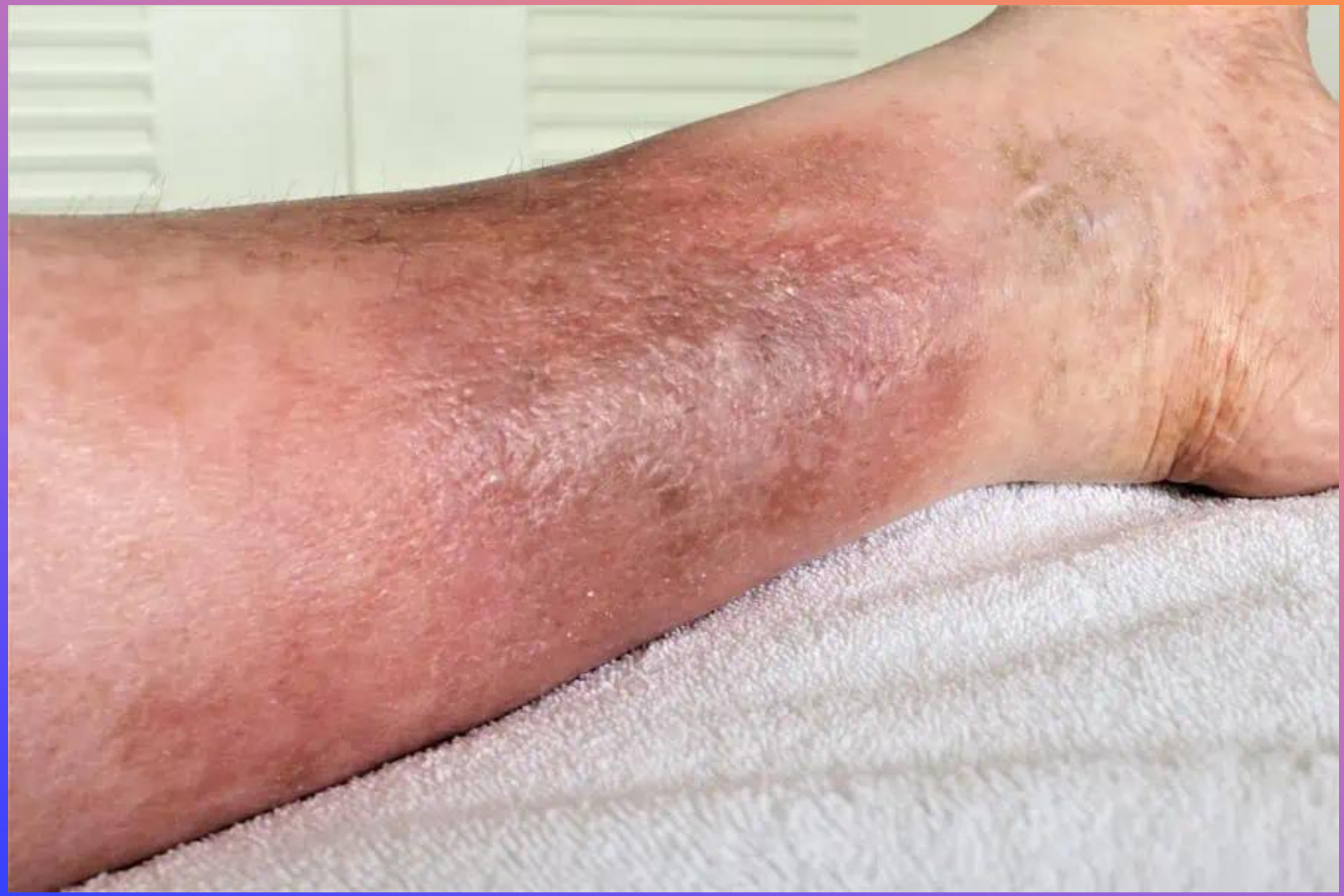
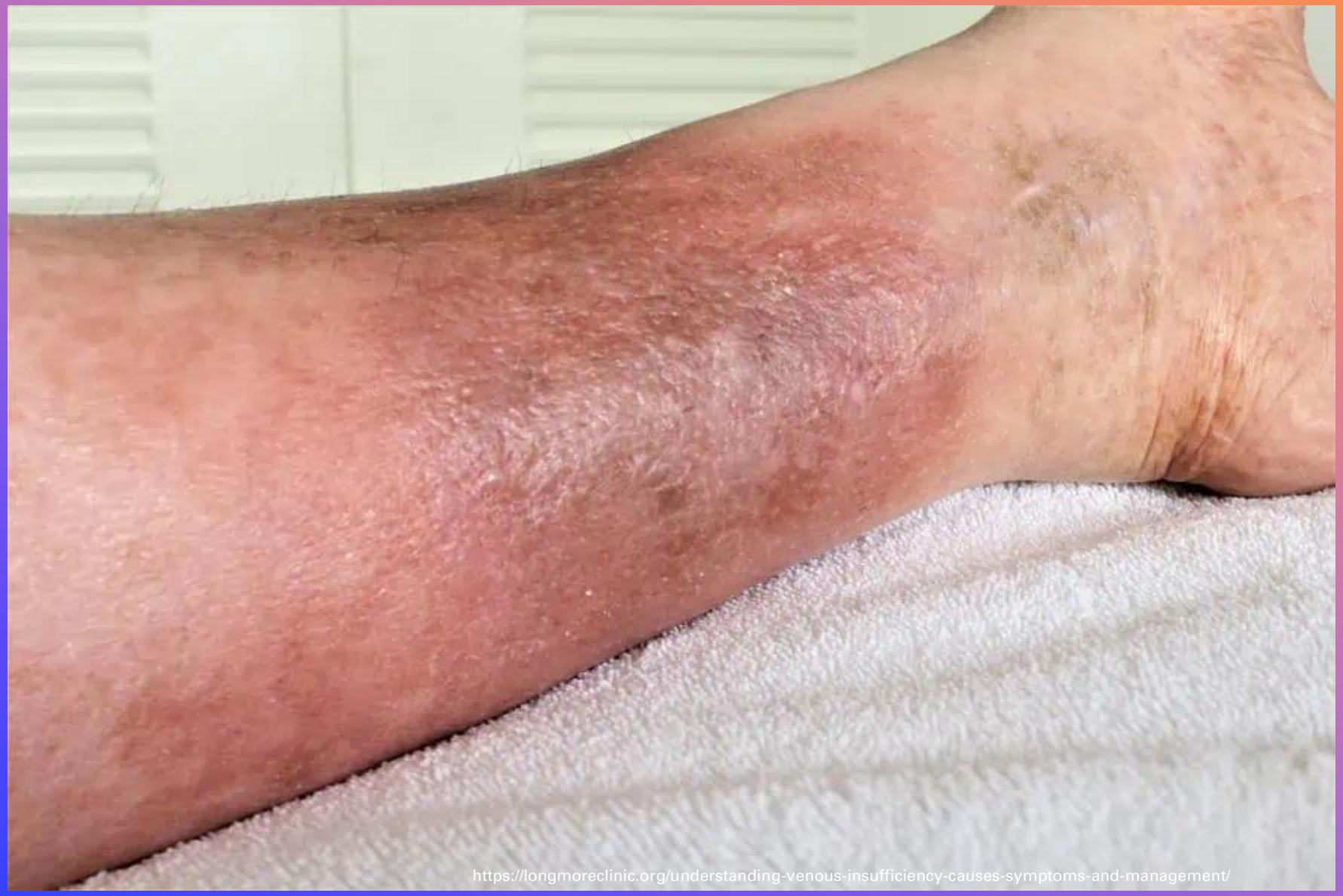


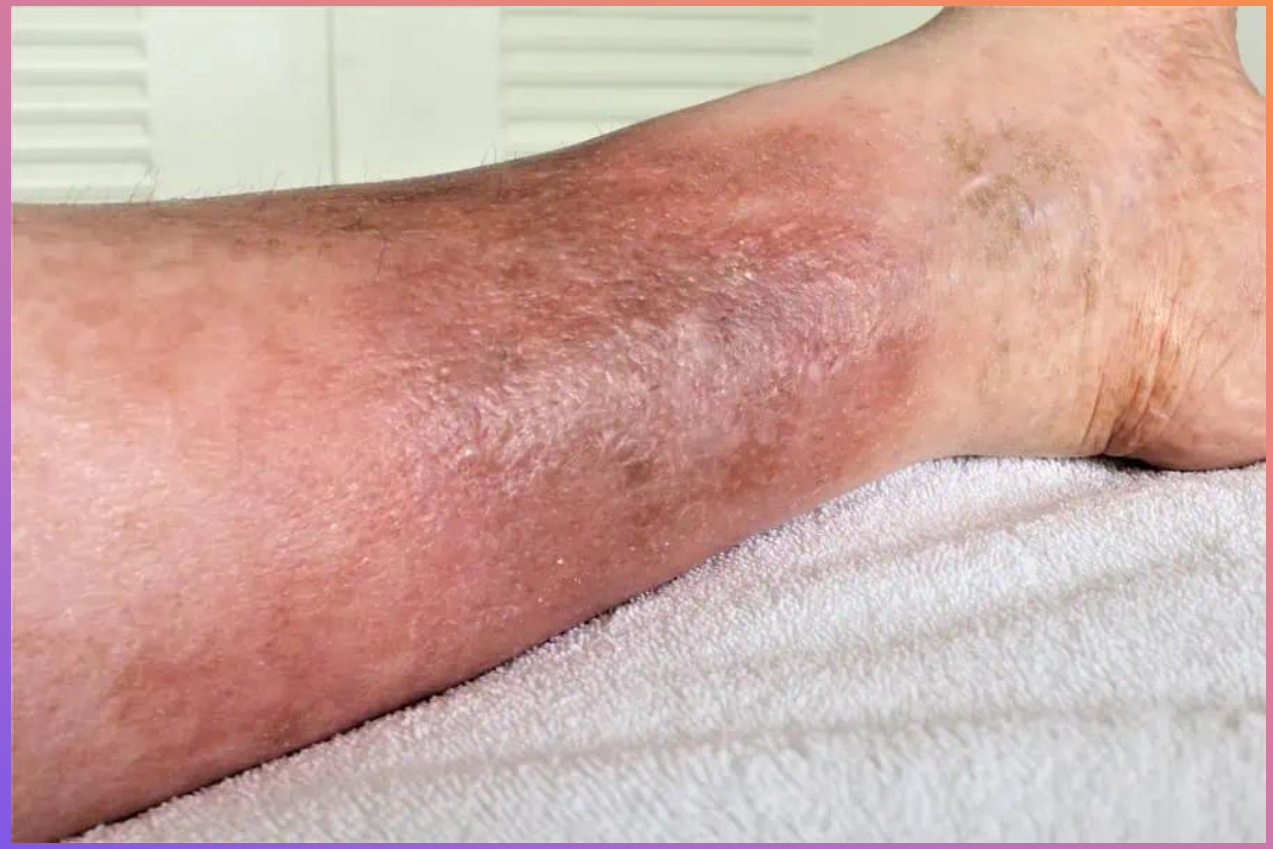
STASIS DERMATITIS



https://longmoreclinic.org/understanding-venous-insufficiency-causes-symptoms-and-management/

STASIS DERMATITIS CHARACTERISTICS

- Brown scaly plaques
- Mild erythema, minimal tenderness
- Not warm
- May itch
- Background of edema
- Usually bilateral
- Tx: Treat underlying cause of edema, moisturizers like ammonium lactate or Lac-Hydrin, topical steroids for itch; compression stockings



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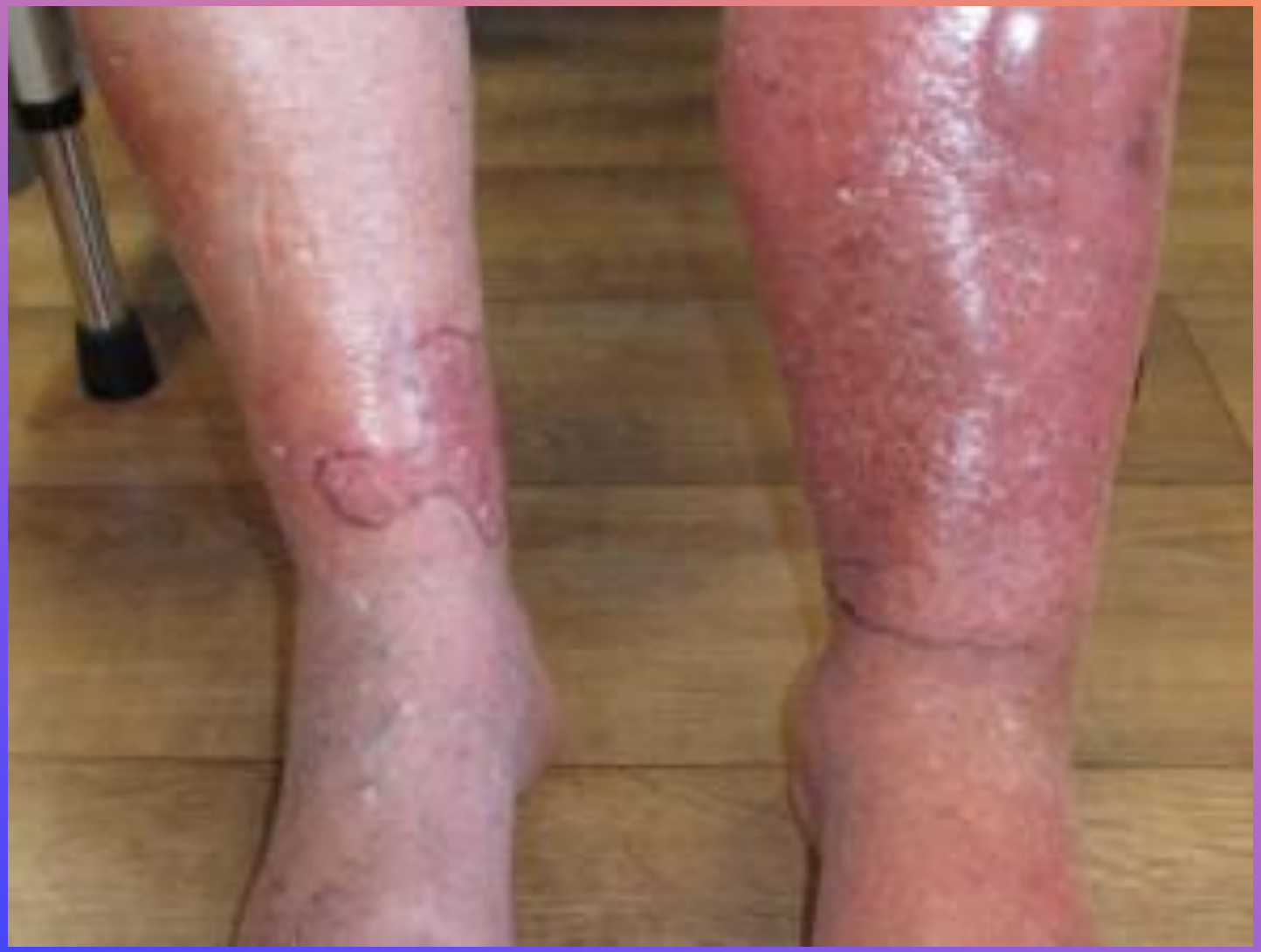
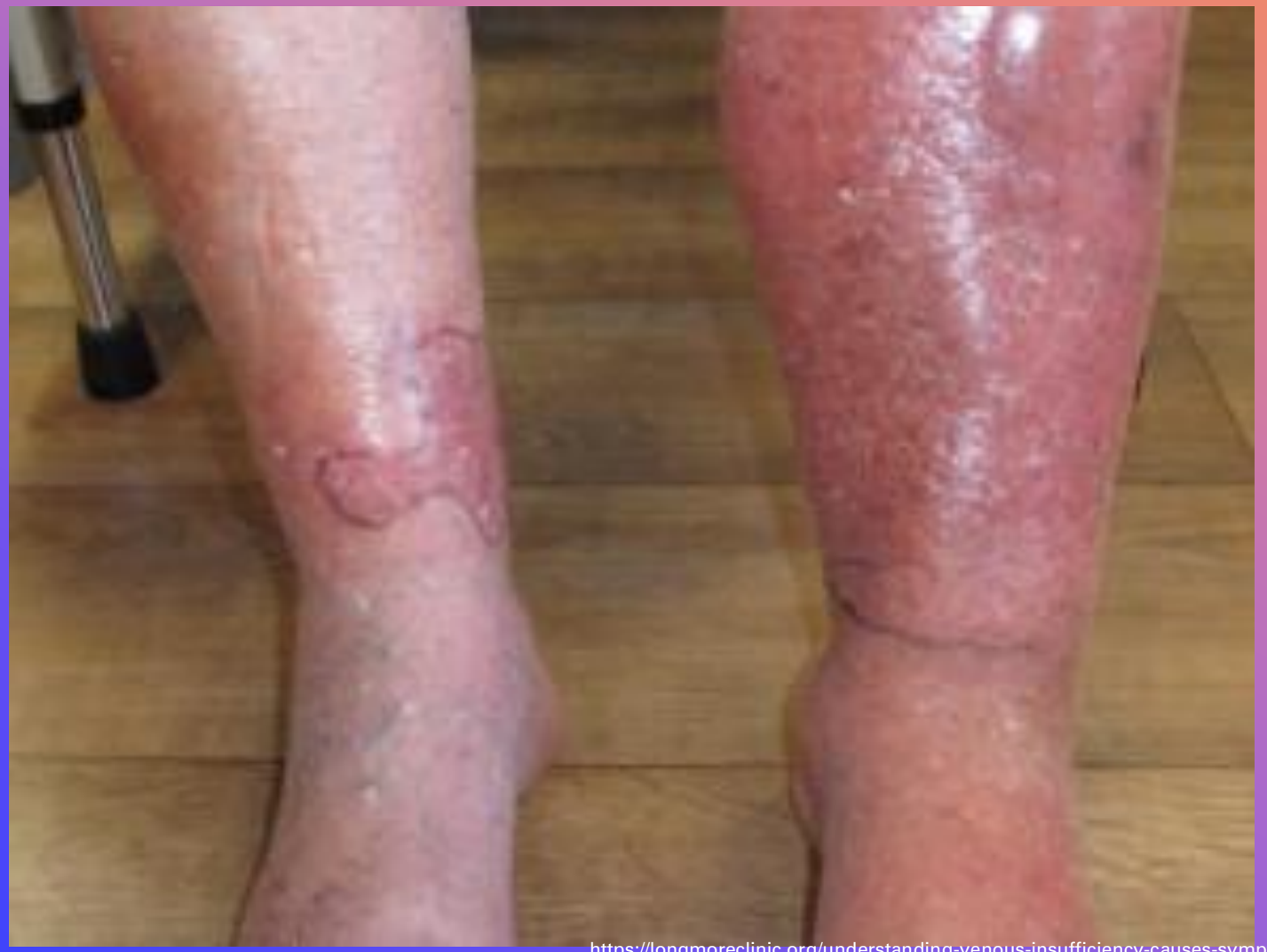


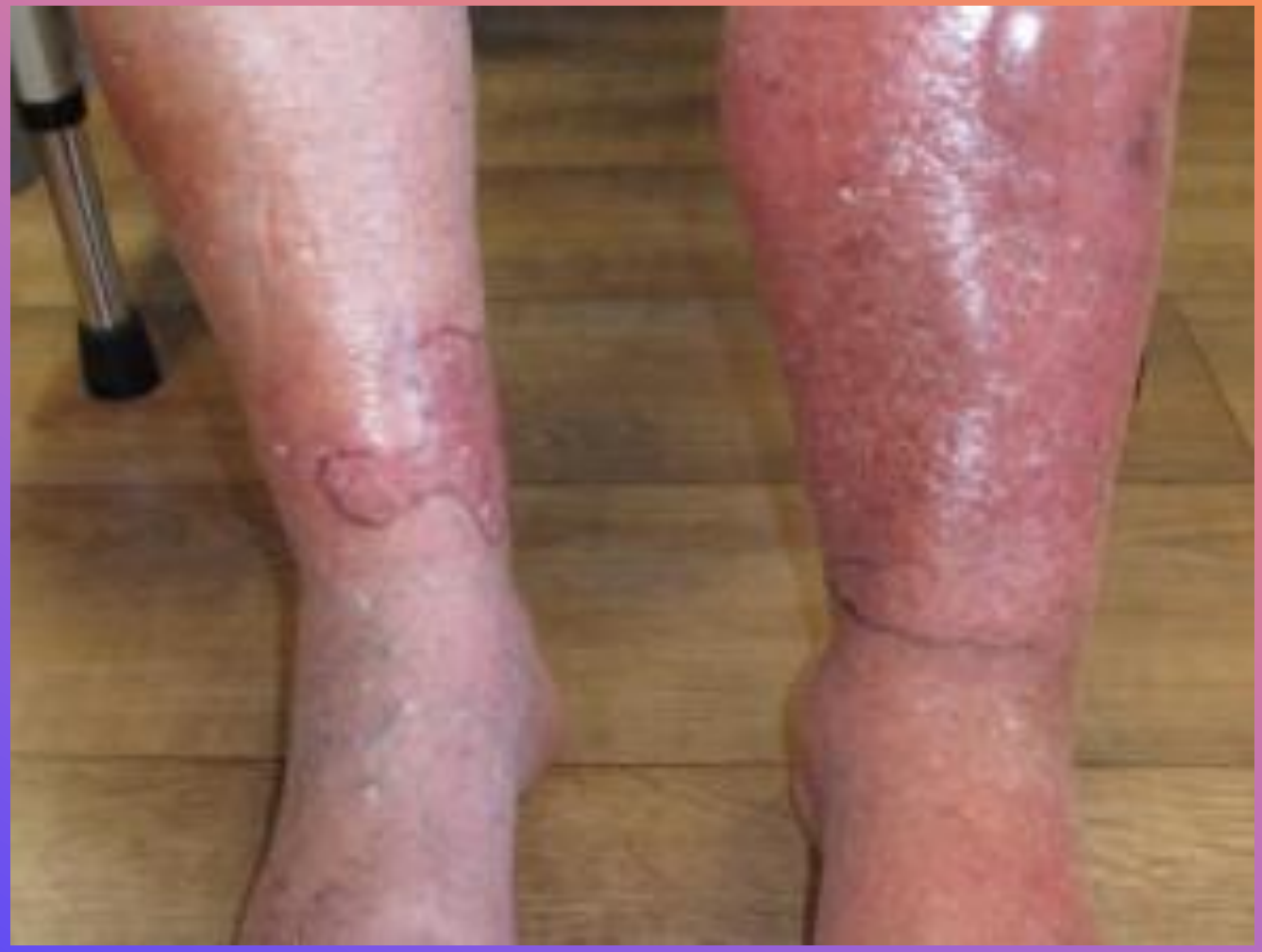
CELLULITIS



https://longmoreclinic.org/understanding-venous-insufficiency-causes-symptoms-and-management/

CELLULITIS CHARACTERISTICS

- Erythematous, tender, unilateral plaques
- Warm to touch
- May have constitutional symptoms (fever)
- Leukocytosis
- Elevated ESR
- Tx: Antibiotics



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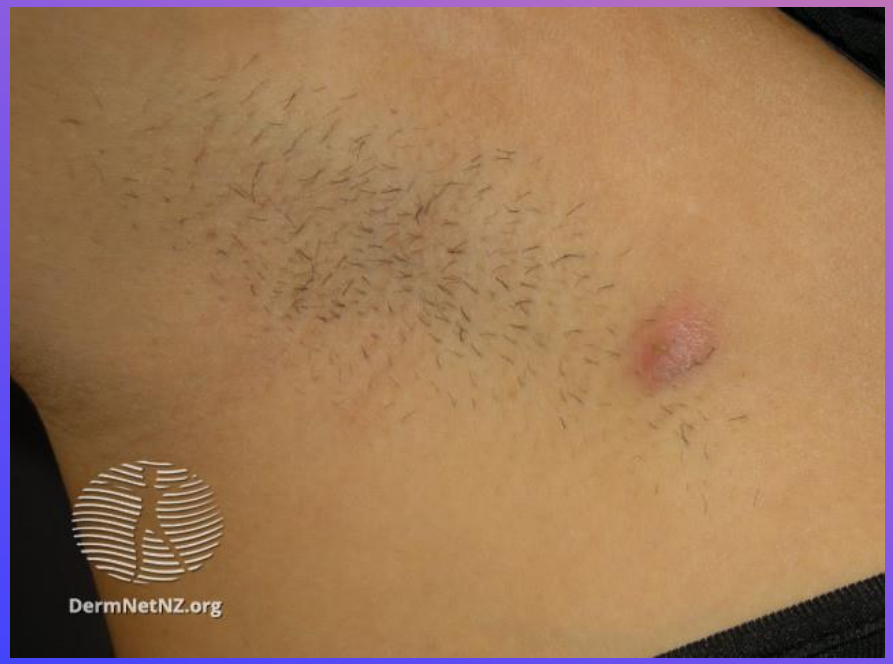
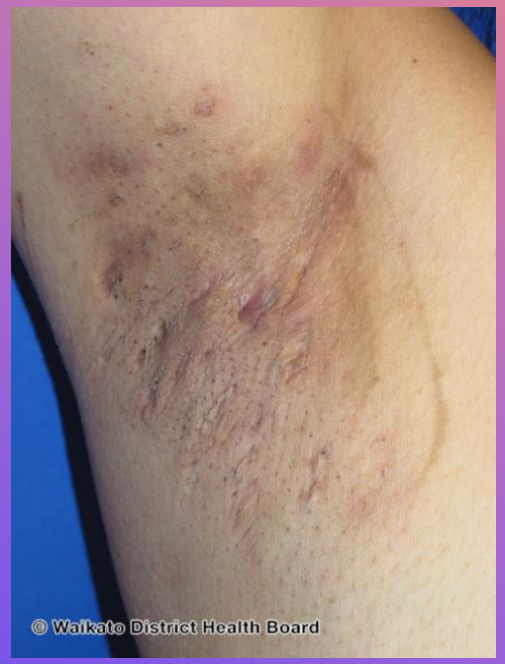
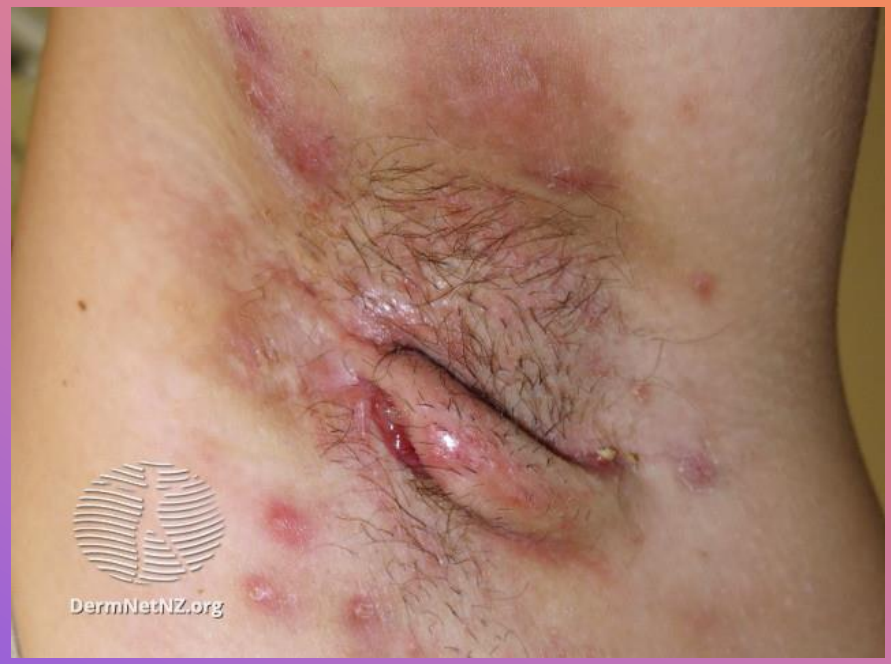
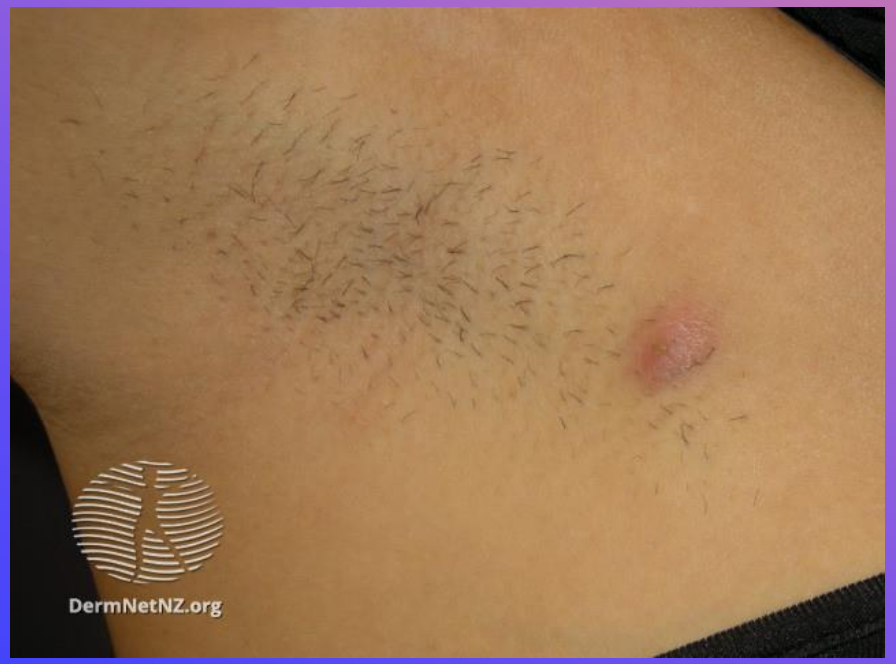

DermNetNZ.org

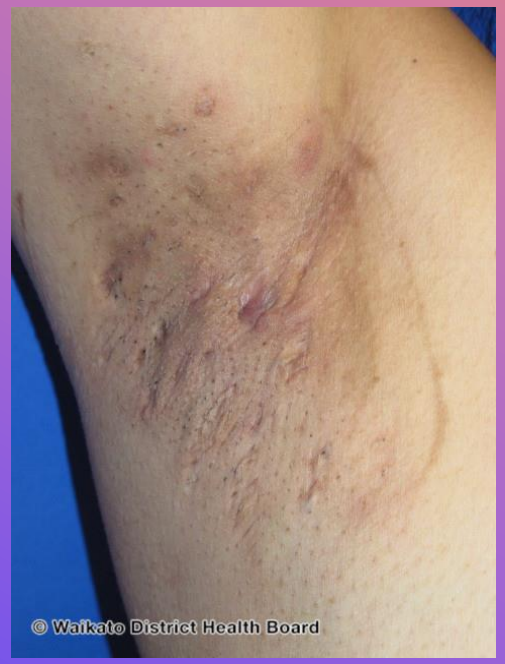

© Waikato District Health Board


DermNetNZ.org

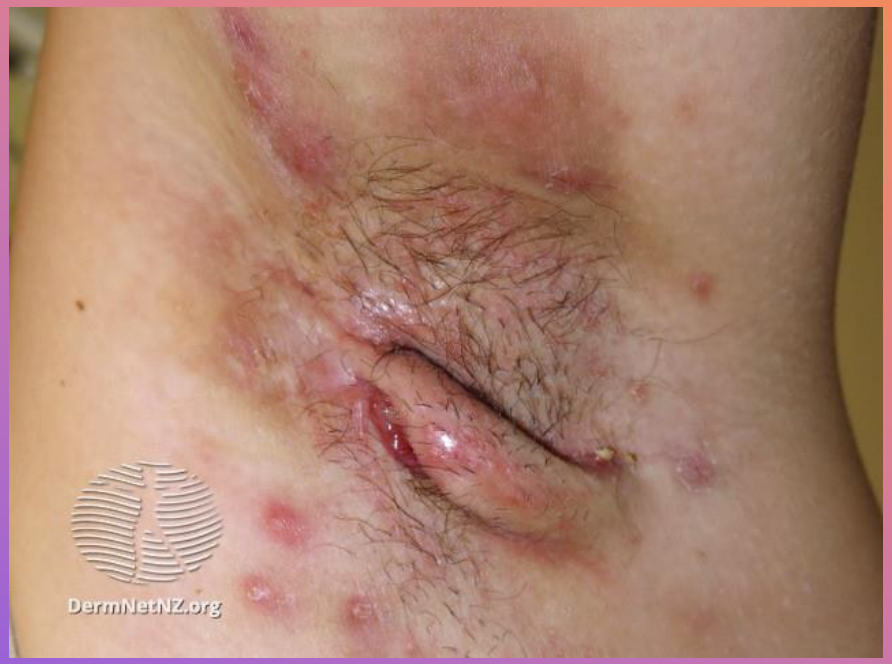
HIDRADENITIS SUPPURATIVA



Hurley Stage I



Hurley Stage II



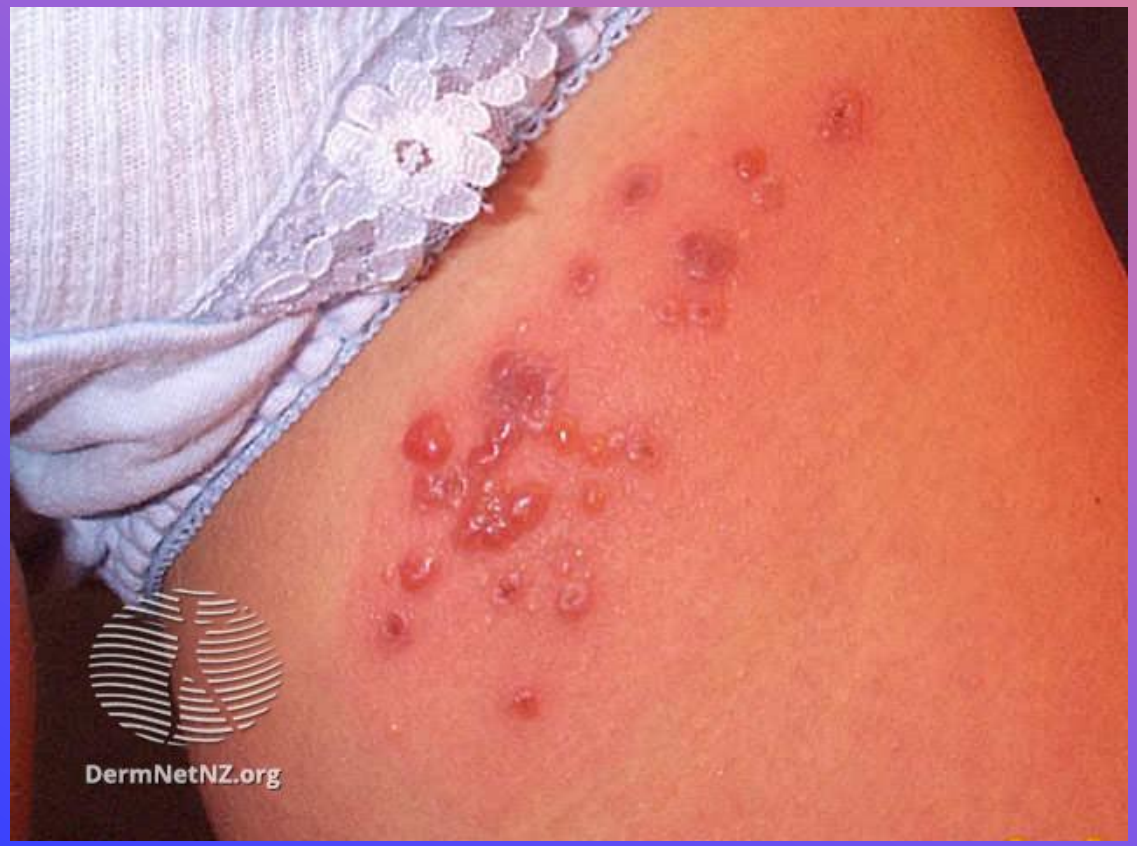
Source: https://dermnetnz.org/topics/hidradenitis-suppurativa

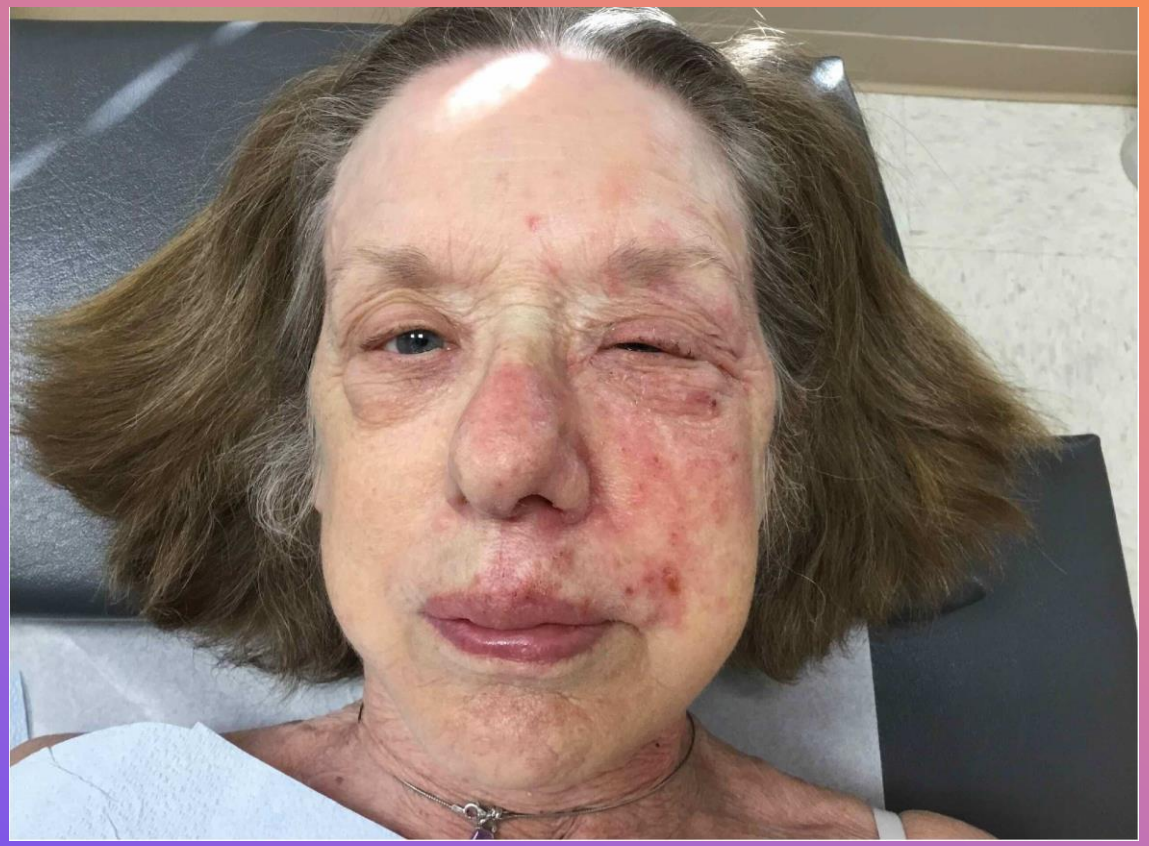
Hurley Stage III

HS CHARACTERISTICS

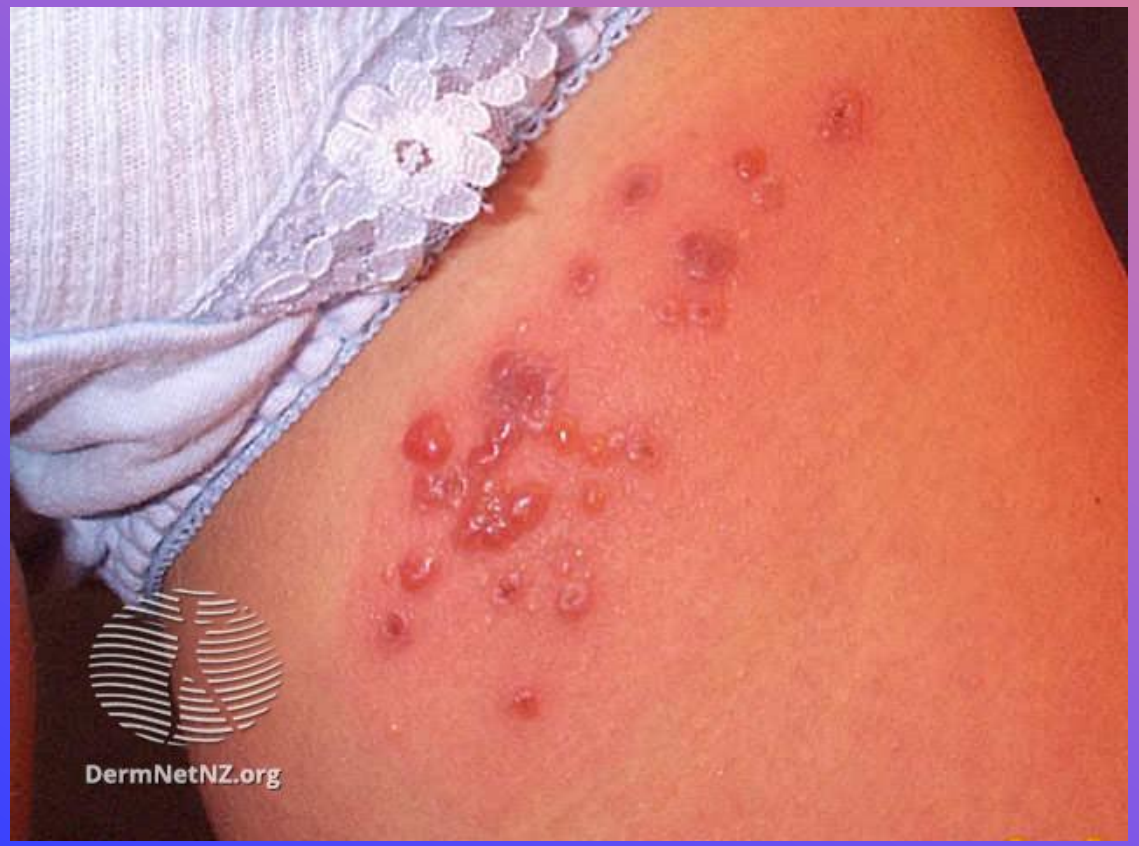
- **KEY FEATURES: Double headed black heads, inflamed lesions, scarring - INVERSE ACNE**
- Inflammatory nodules and sterile abscesses that target apocrine gland bearing sites (axilla, anogenital, breast folds)
- F>M
- Rx: wt loss, abx, ILK, incision and drainage, REFER for inc anti TNF, IL-17, surgery

WHAT IS IT?

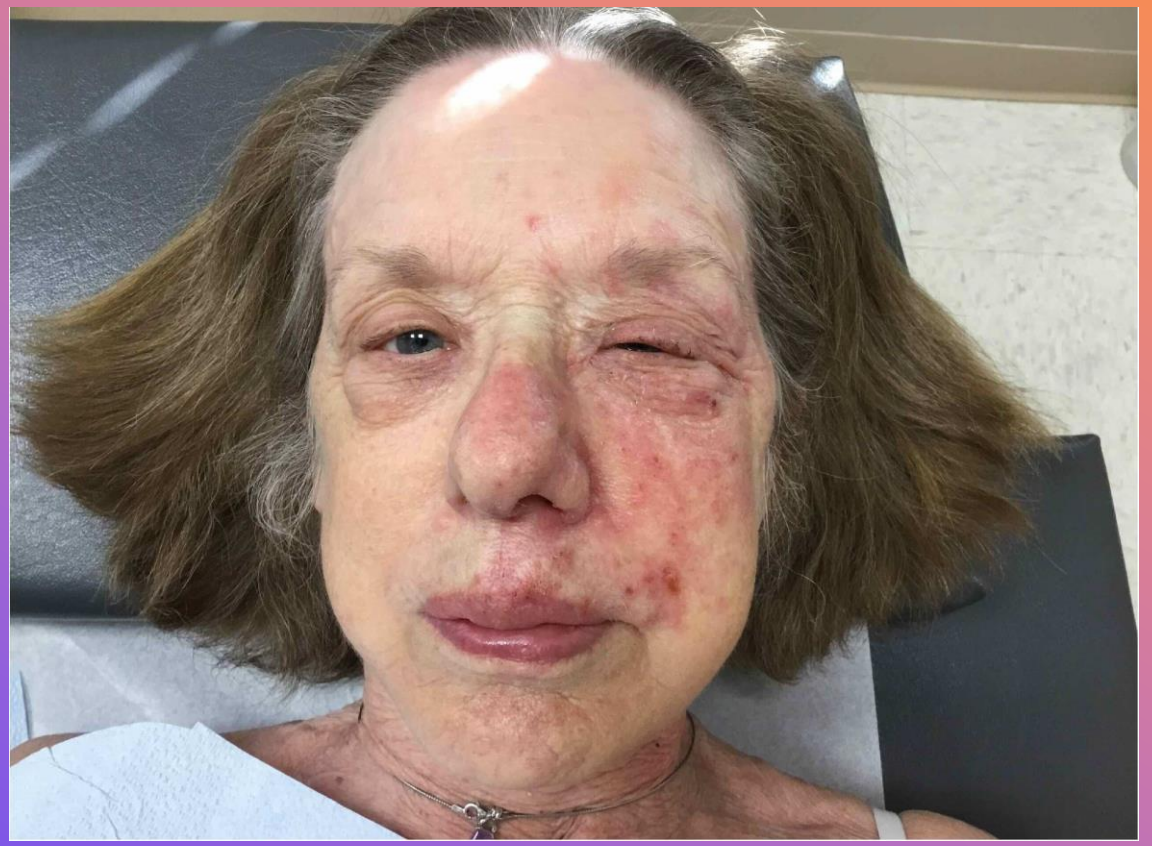




HERPES ZOSTER (VARICELLA)



Source: DermnetNZ/herpeszoster

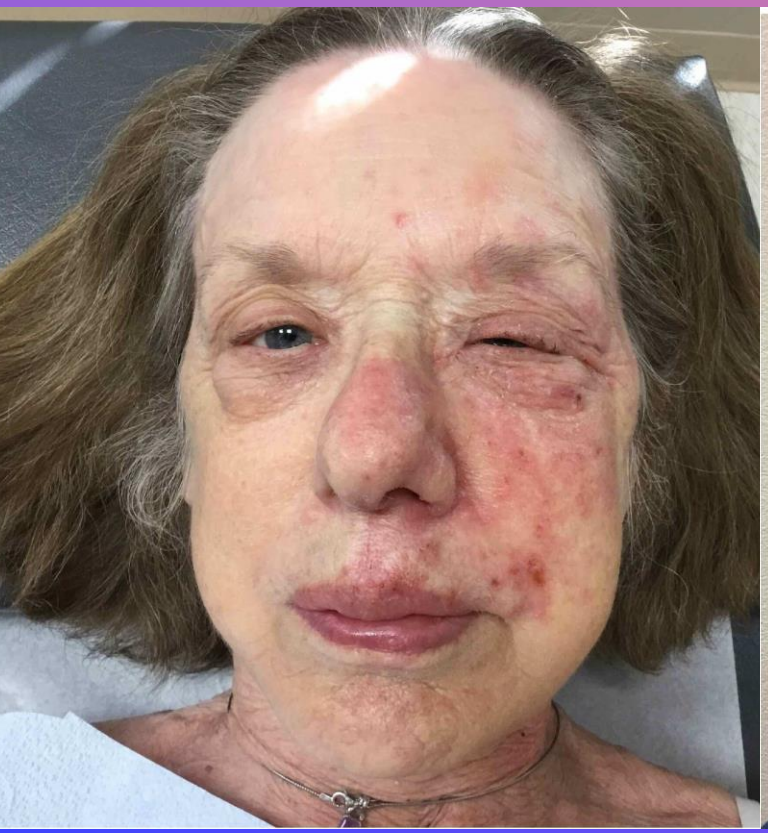


Patient of Mohs Surgery and Dermatology

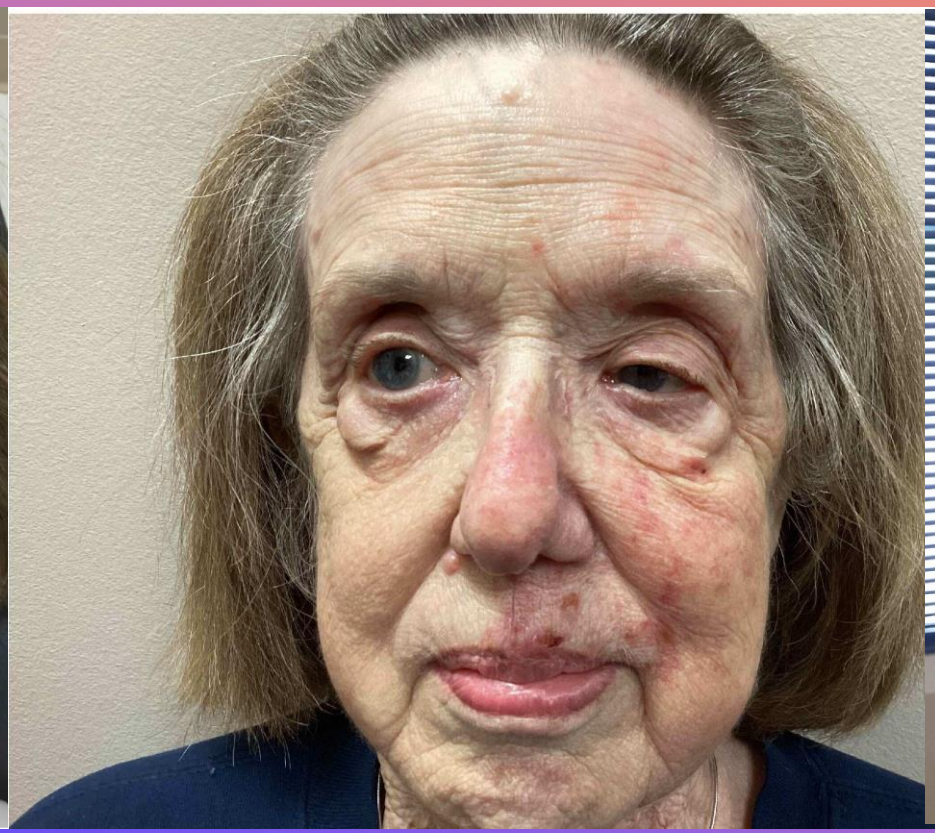
HERPES ZOSTER (VARICELLA) CHARACTERISTICS

- Erythematous papules and grouped vesicles typically in a single dermatome or several contiguous dermatomes
- High morbidity and mortality of VZV in immunocompromised
- Early initiation of antiviral treatment is crucial
- Infectious 1 to 2 days before skin lesions appear until all of the vesicles have crusted
- New recombinant vaccine: Shingrix

ZOSTER COURSE OF TREATMENT



Initial Presentation



2 weeks of Tx

2 months later

Patient consent for use of photos given

TIPS AND PEARLS

- Common things are common
- SKs are BENIGN! We get many referrals from PCP for these and if you are not sure, always best to refer but look closely, Does it have a “stuck on” appearance? Does it have little horny cysts?
- When in doubt, and if you are comfortable with it, start with a biopsy

TIPS AND PEARLS

- If it's a rash and it's unresponsive, and you don't have access to derm, do a punch biopsy to get full thickness, (Eczema vs psoriasis, tinea vs eczema, can at least get a PAS so you are headed on the right path)
  - Can also do a KOH prep if you are trained on this and/or have microscope access
- Don't give Lotrisone (Clotrimazole/betamethasone)! Do a trial of one x 2 weeks then the other for 2 weeks.
- Don't give continuous refills of Lotrisone or high potency topical steroids, they often get overused. Counseling on overuse of TCS can start with PCP

QUESTIONS?

- Only scratching the surface here, many common derm presentations not covered here like acne, warts, other rashes, etc

REFERENCES

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3. Lichenoid Drug eruptions: https://www.visualdx.com/visualdx/diagnosis/lichenoid+drug+eruption?diagnosisId=51448&moduleId=101

THANK YOU

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