Emergent and Urgent Dermatology, Eruptions, and Wound Care

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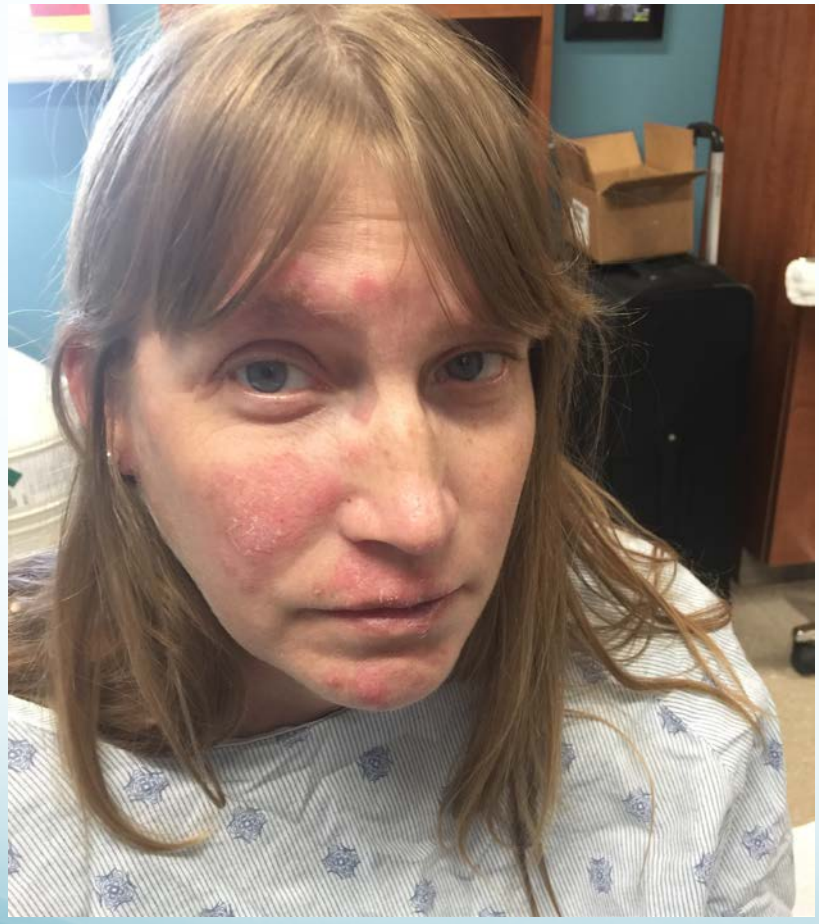
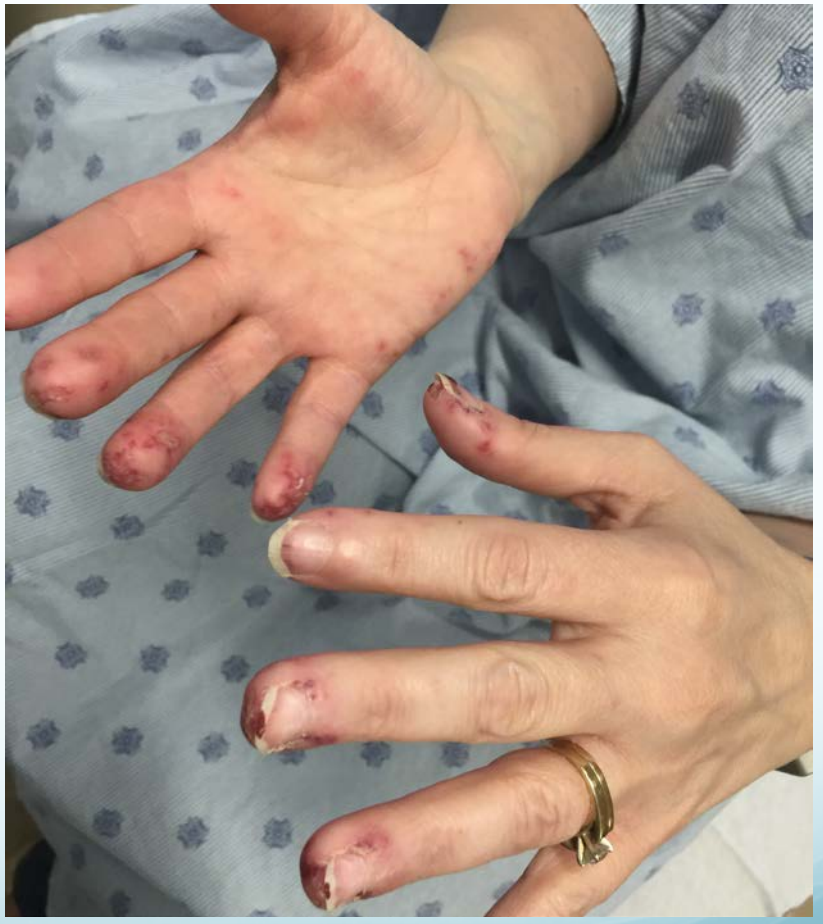
Acute Cutaneous Lupus





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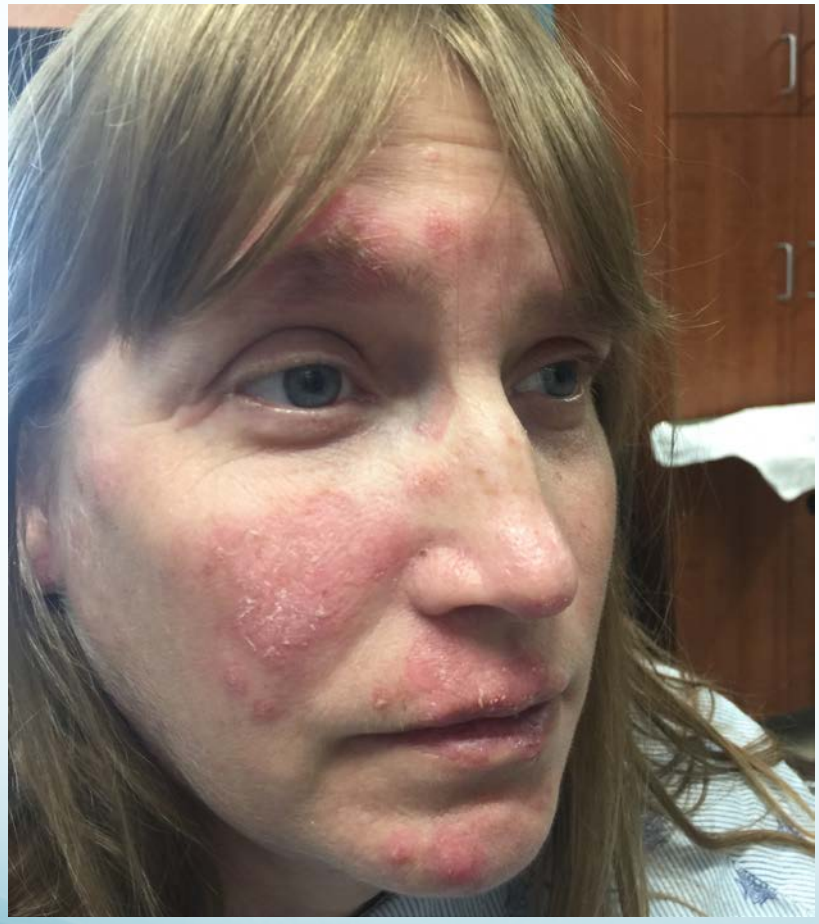
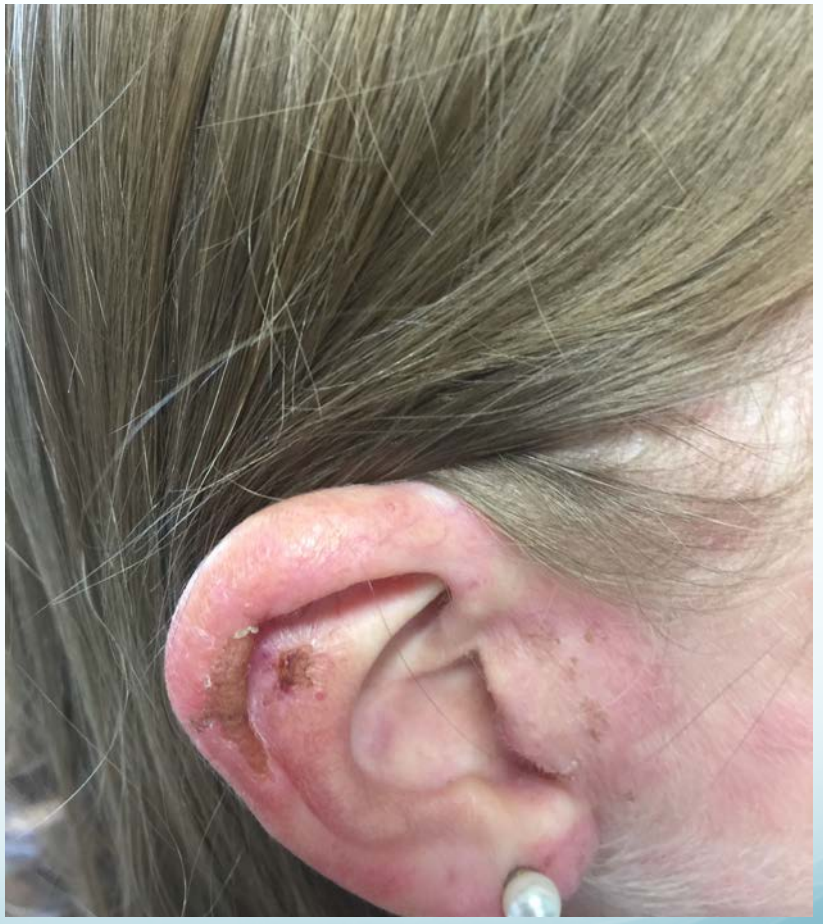
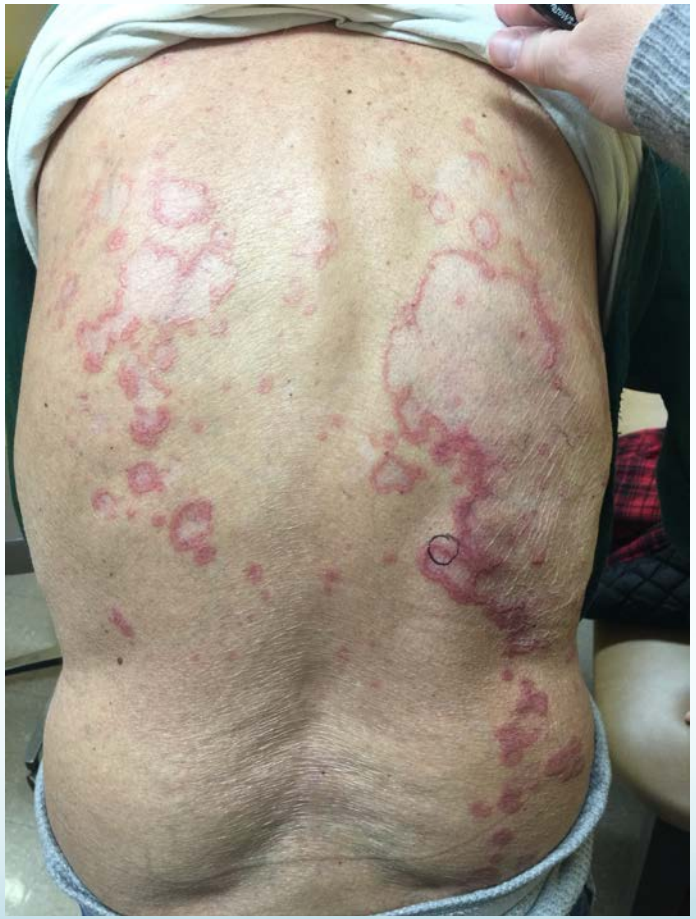




Acute Cutaneous Lupus

- ANA positive, Anti Ro, La Positive
- Photo distributive
- Need Systemic Work up
- Initial tx, systemic corticosteroids, SPF
- Antimalarials following negative G6PD

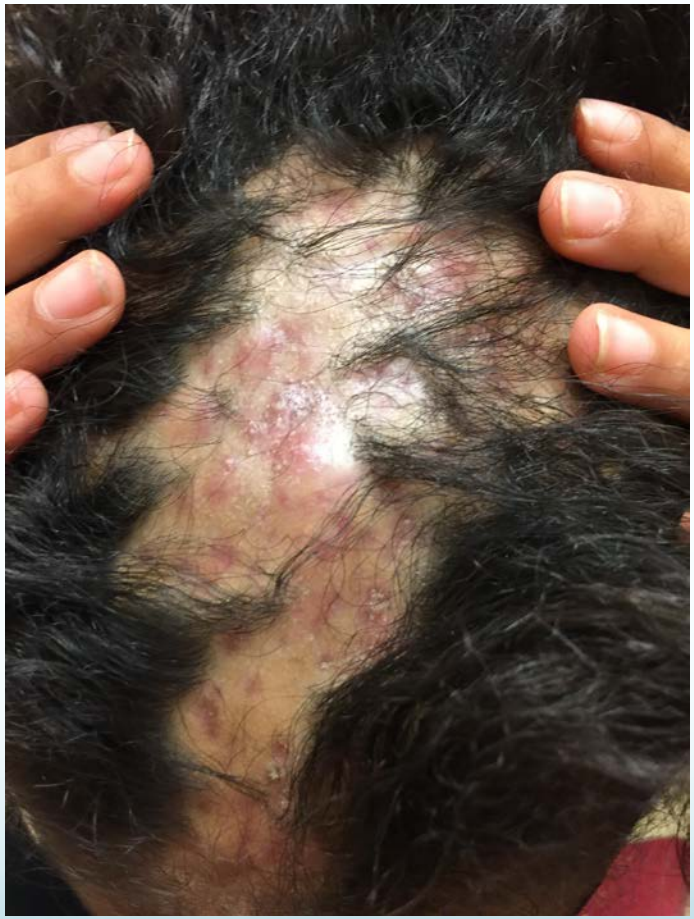
Subacute Cutaneous Lupus



Subacute Sutaneous Lupus Erythematosis

- ANA negative, Ro and La positive
- Fewer systemic symptoms
- Less systemic co morbidities
- Corticosteroids and steroid sparing agents, spf

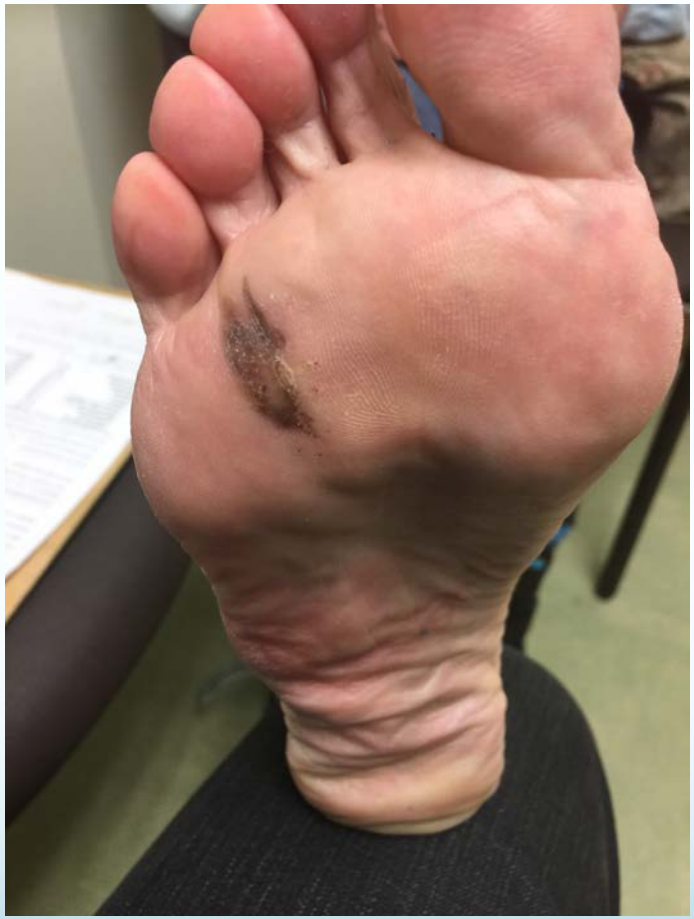
Discoid Lupus



Discoid lupus

- ANA, Ro and La negative
- Usually not systemic
- Scarring and Scaling alopecia
- Photo distributed
- Treatment include systemic, topical and intralesional corticosteroids, steroid sparing agents

Acral Lentiginous Melanoma



Acral Lentiginous Melanoma

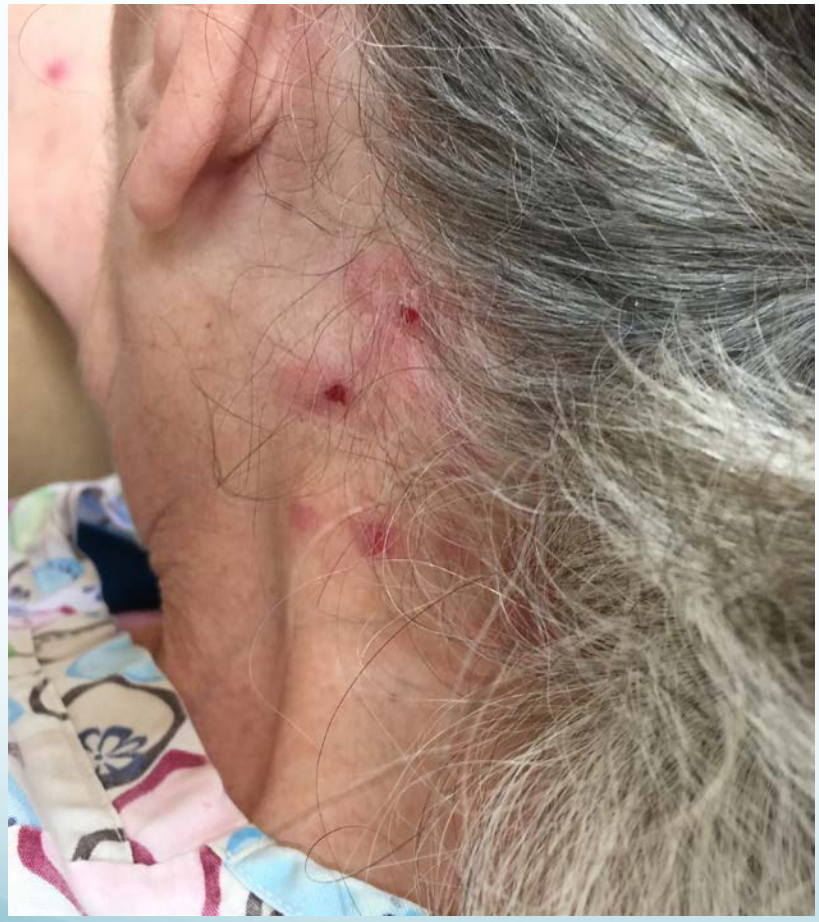
- Highest morbidity and Mortality of the Melanomas
- Due to delay in Diagnosis
- Bob Marley's demise
- Breslow depth
- Work up and wide excision based on Breslow depth
- FSE monthly by patient, quarterly by physician
- Excision, not biopsy

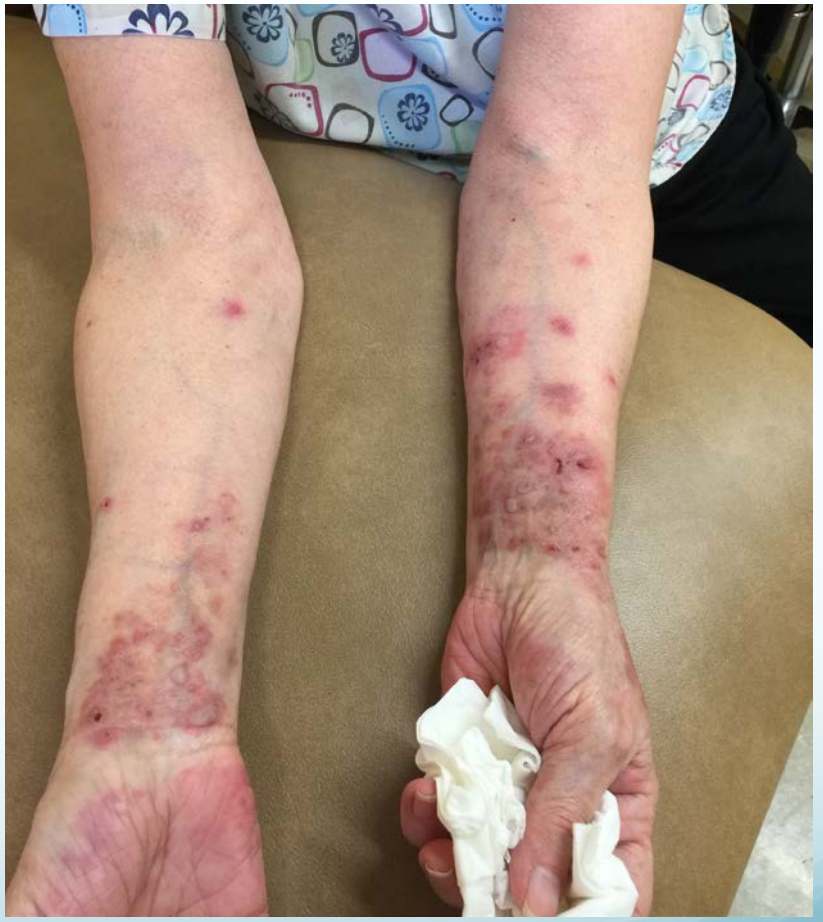
Congential Nevus

Congential (Hairy) Nevus

- Very low malignant risk
- High parental concern
- Watch for changes

Bullous Pemphigoid

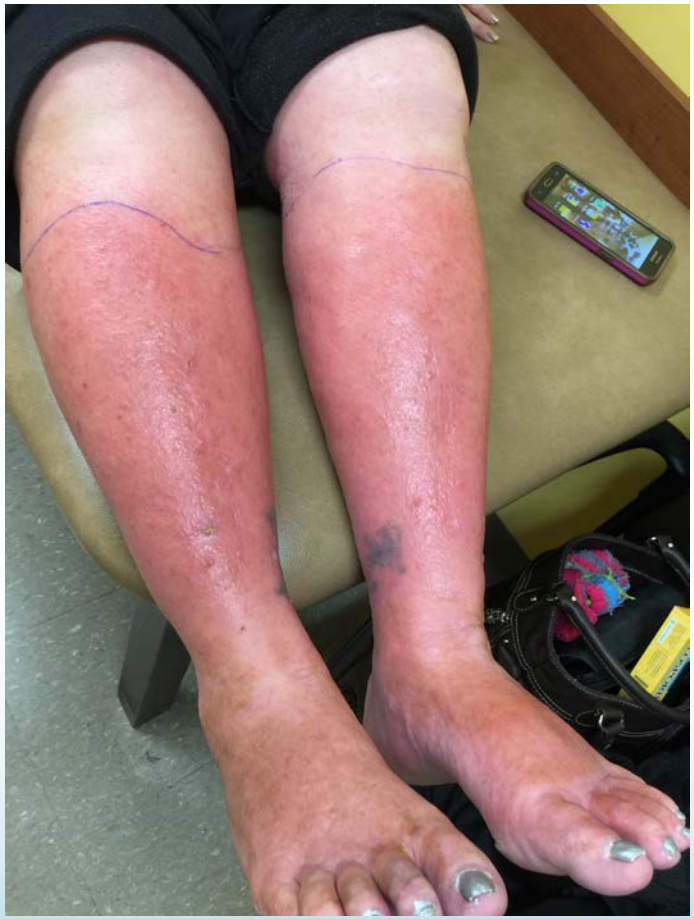




Bullous Pemphigoid

- Differentiate from Pemphigus, a far more serious Dx
- H & E and DIF biopsy
- Systemic corticosteroids
- Steroid Sparing agents
- Often burns out

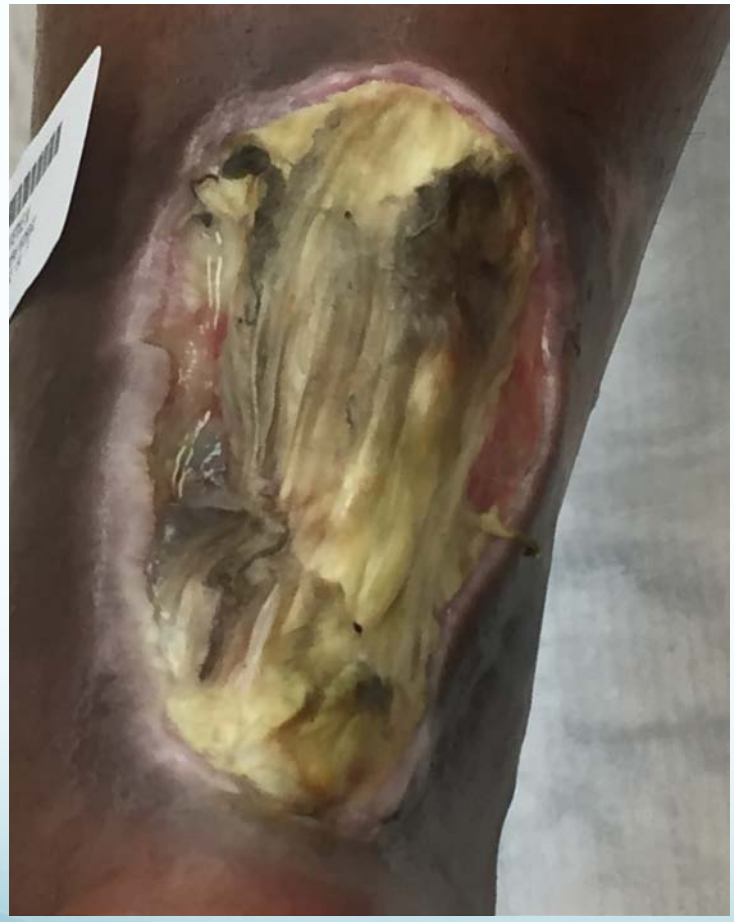
Stasis dermatitis

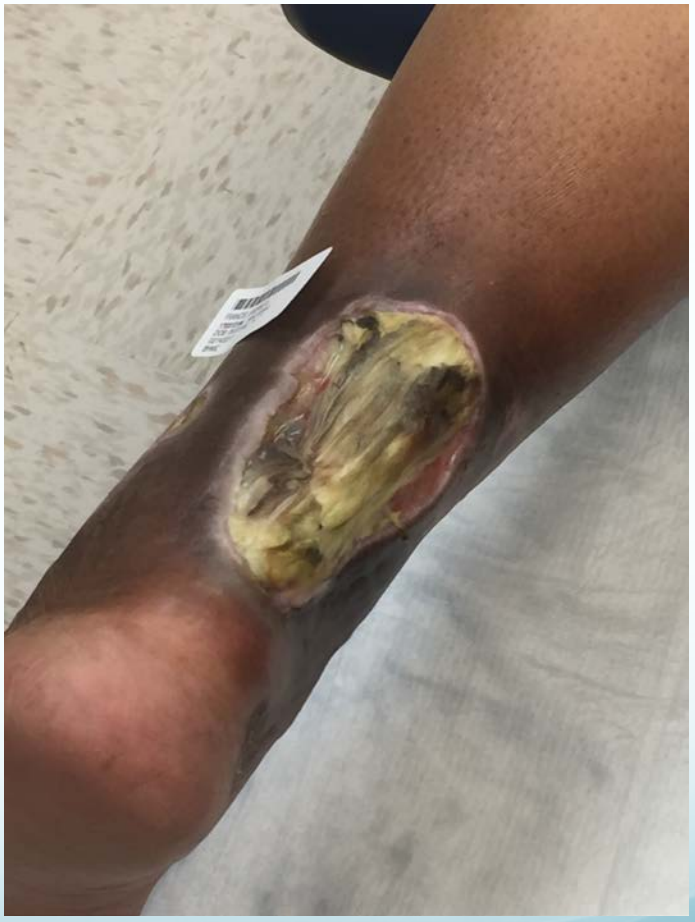


Stasis dermatitis

- Chronic
- Circulatory Compromise
- Compression Essential
- Work up for Co morbidities
- Prevention of Ulcerations

Necrotic Ulcers





Leg Ulcers

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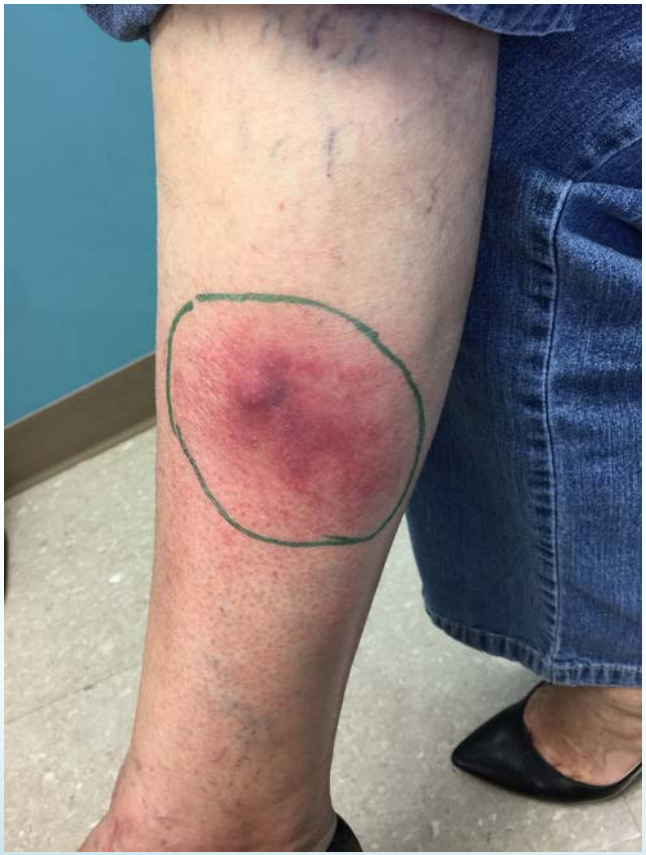
-Leg ulcers are symptoms, not diagnoses

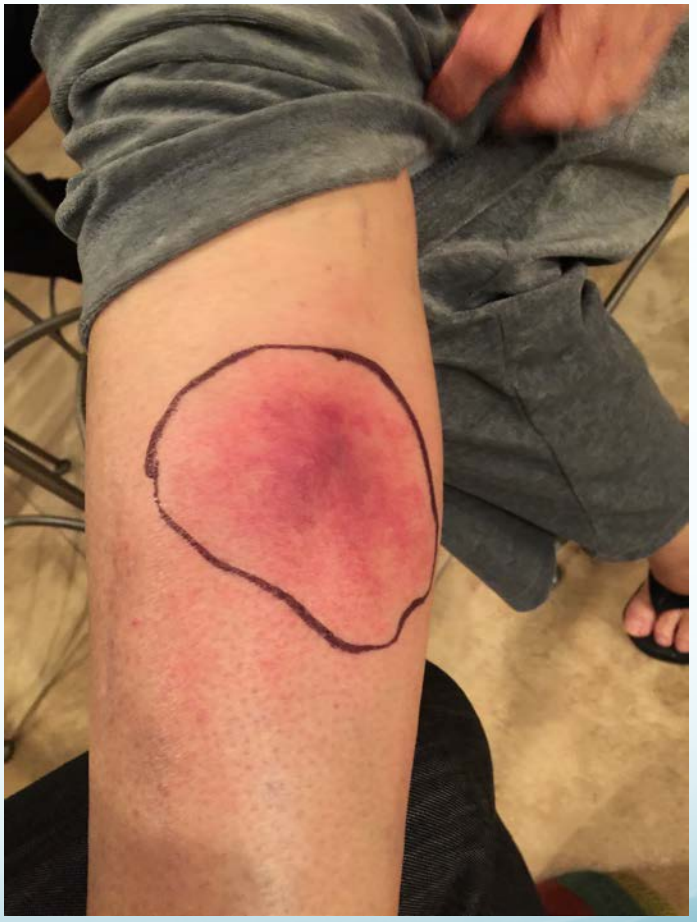
-treatment based on etiology

-biopsy if treatment not effective

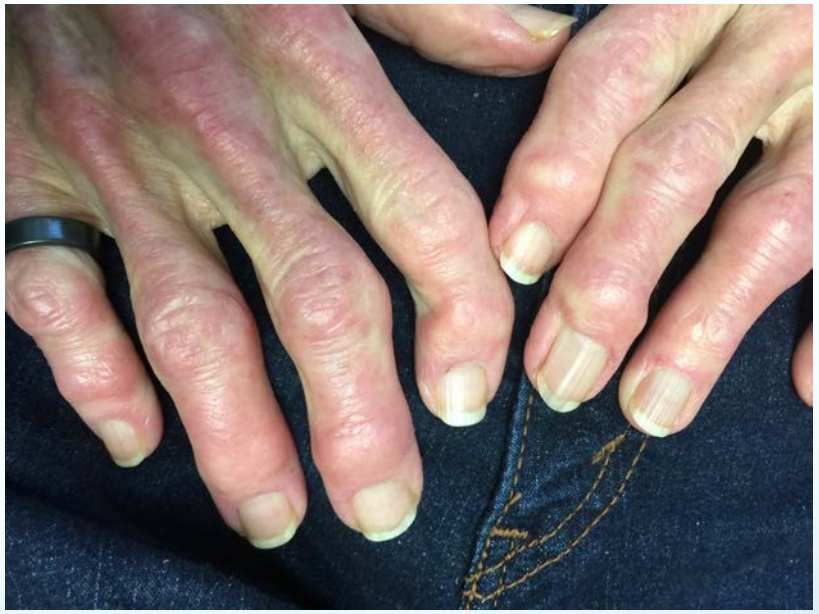
-work up for co morbidities (malignancy, trauma, diabetes, PVD, abuse, et al

The magic changing ink





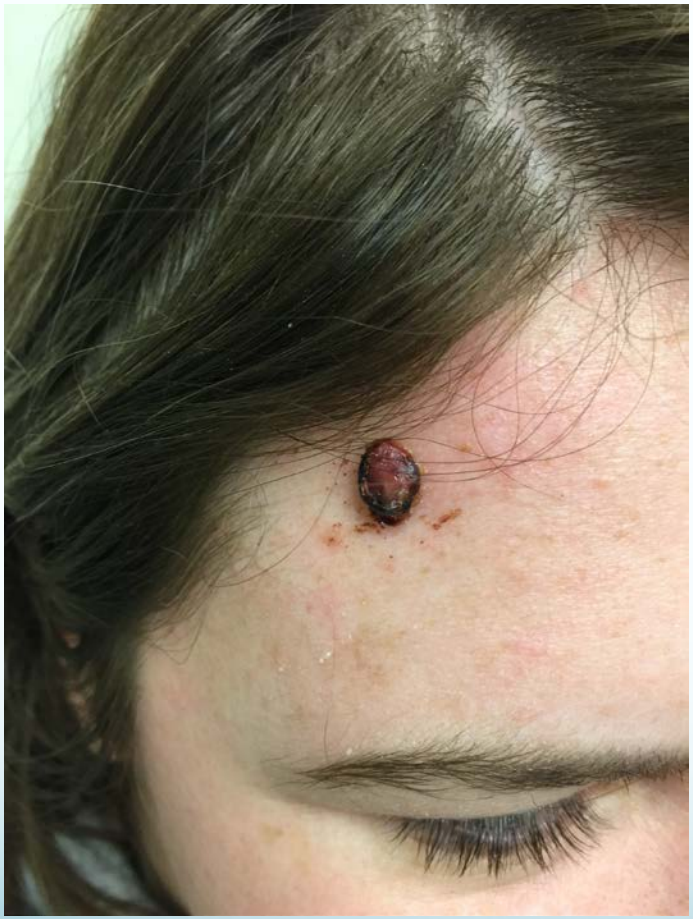
Dermatomyositis

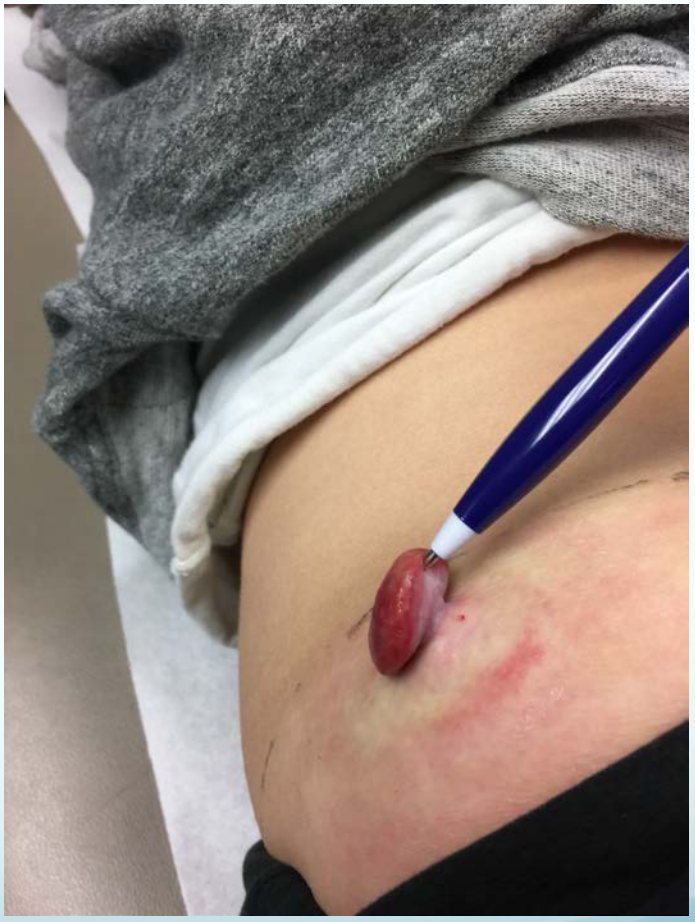


Dermatomyositis

- Classic but subtle clinical presentation, including Heliotrope rash, shawl sign, gottron's papule
- Work up essential: CK, Aldolase, LDH, etc
- 50% with associated malignancy
- Biopsy confirmation
- Treatment systemic corticosteroids, steroid sparing agents, spf, others

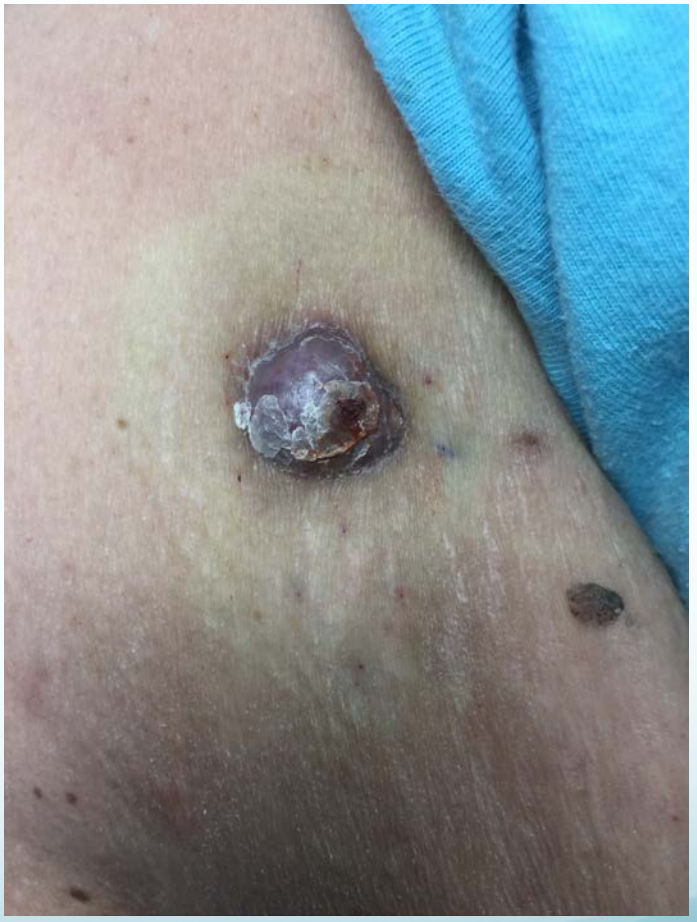
Pyogenic Granuloma





Etiology often trauma and microtrauma. Surgical treatment asap

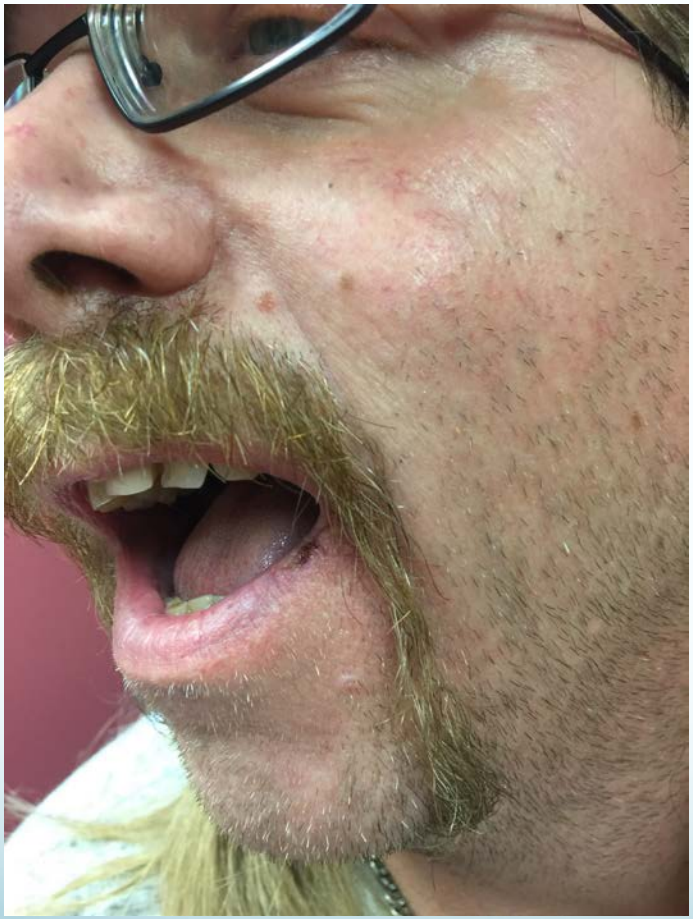
Foreign Body Granuloma

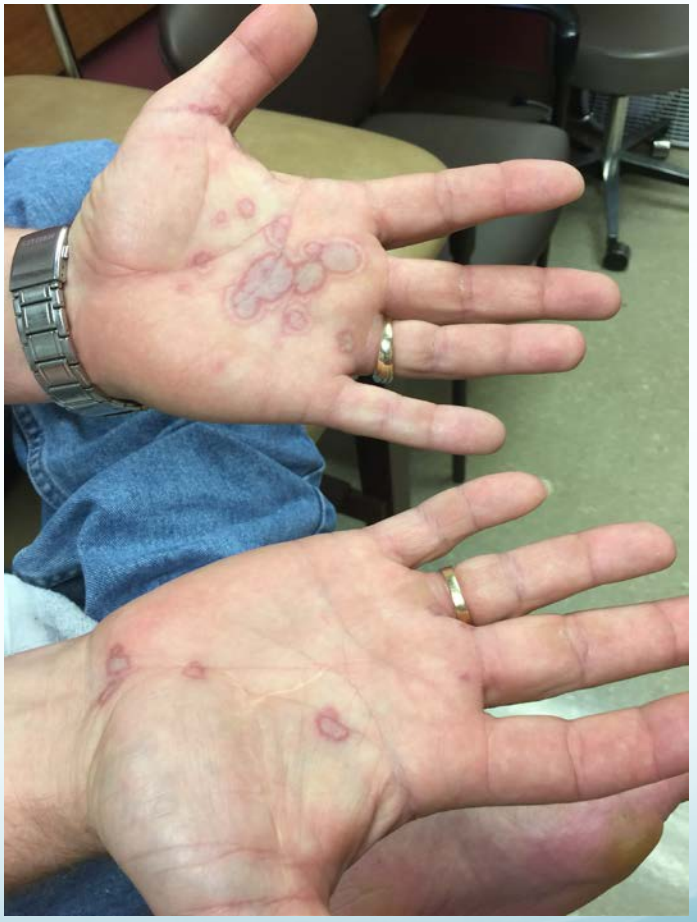


Foreign Body Granuloma

- History of injury important
- Can be recent, usually remote

Erythema Multiforme Minor

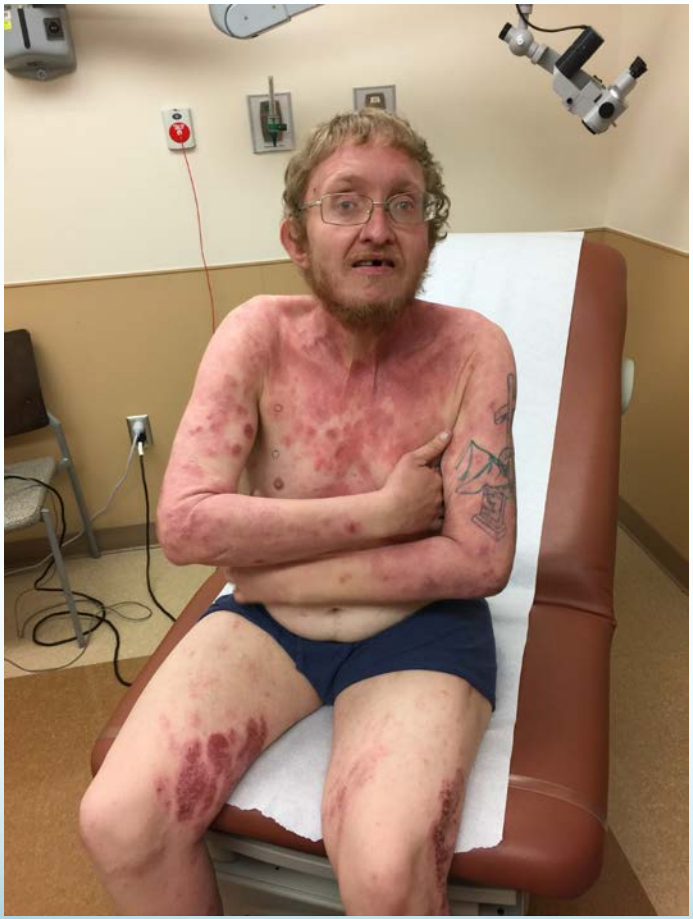


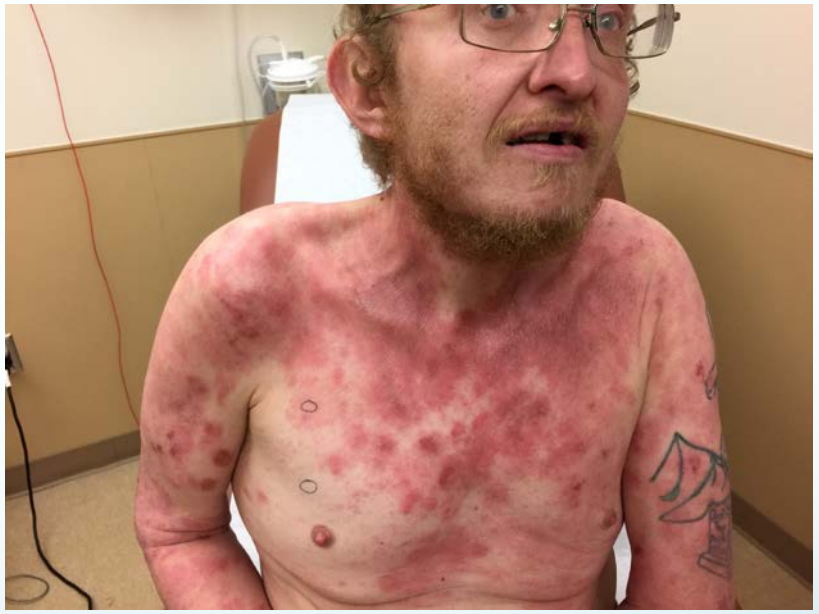


Erythema Multiforme Minor

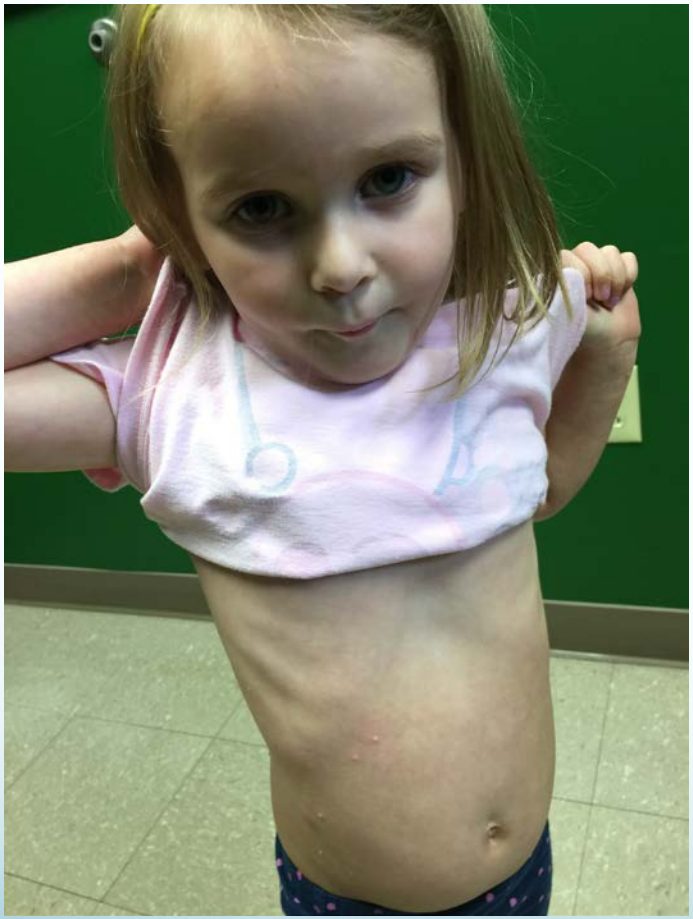
- Usually due to Drug reactions or HSV
- Treatment directed at etiology
- Palms, soles, mucous membranes.
- Often recurrent, esp if HSV induced
- Avoidance of offending drug (sulfonyl ureas, bactrim) and/or supressive anti virals

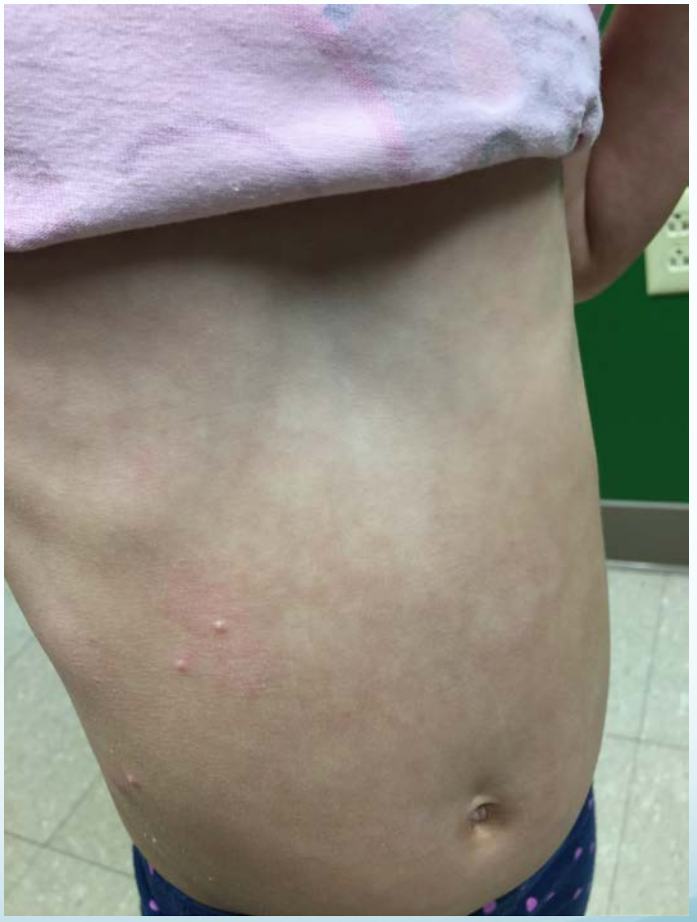
EM Major/SJS





Molluscum contagiosum

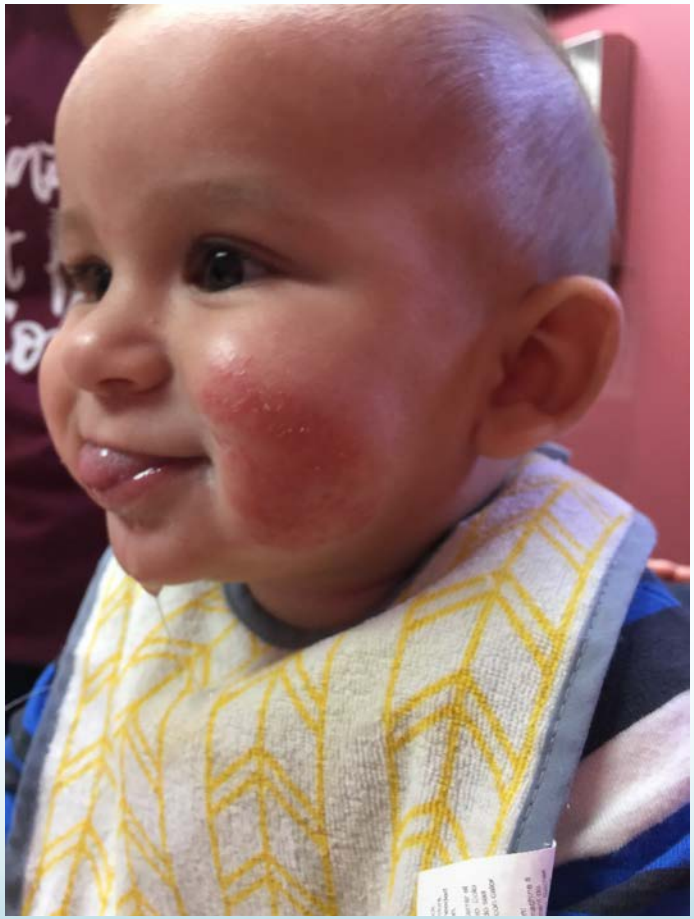




Molluscum contagiosum

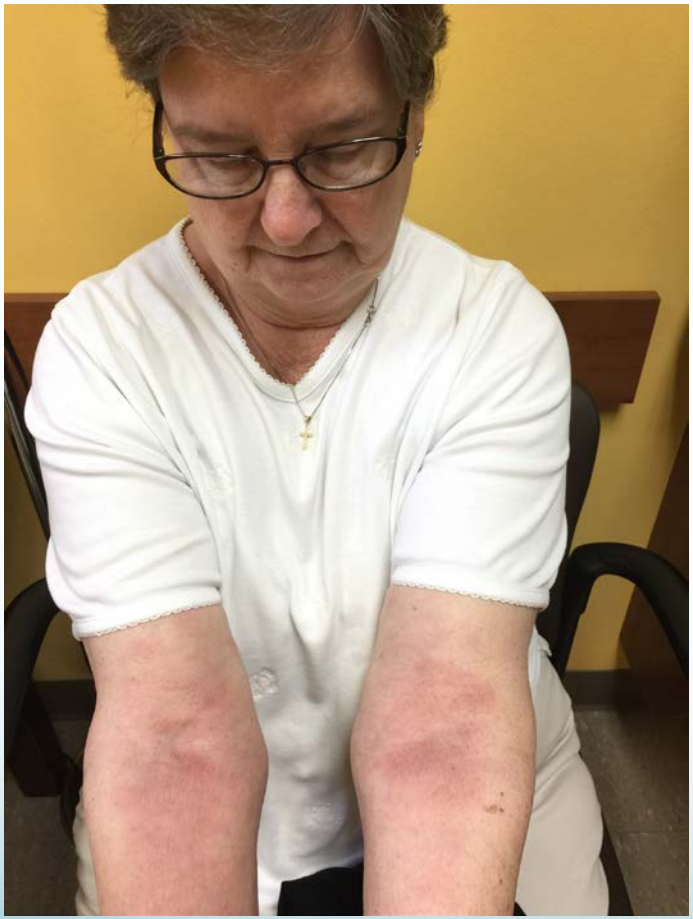
- In toddlers, almost always associated with atopic dermatitis.
- If fewer than 10, treat the AD first
- If greater than 10, treat the MC
- If associated with wrestling, sports, STD, treat the MC

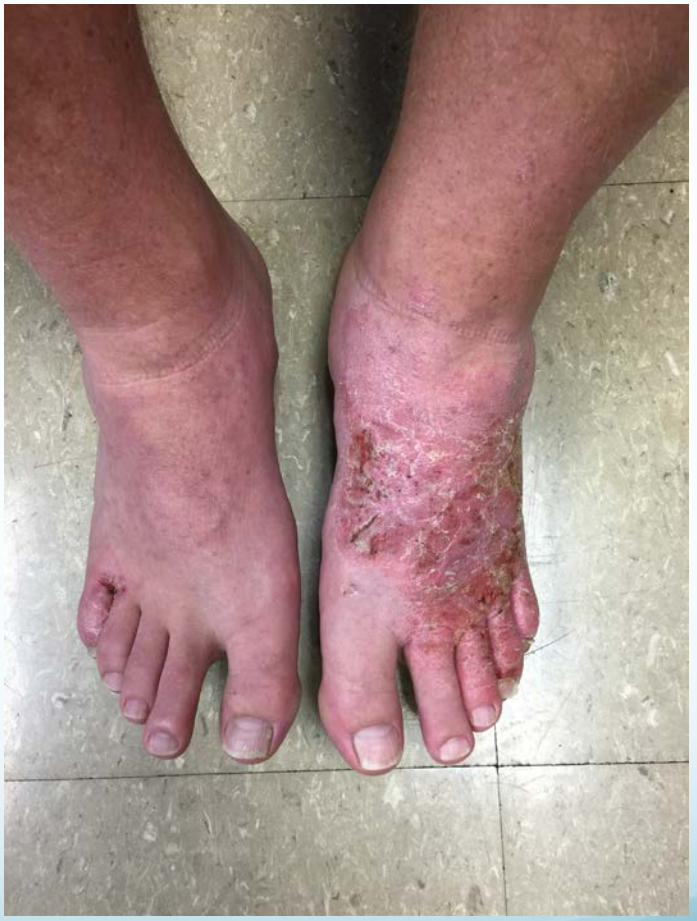
Atopic dermatitis



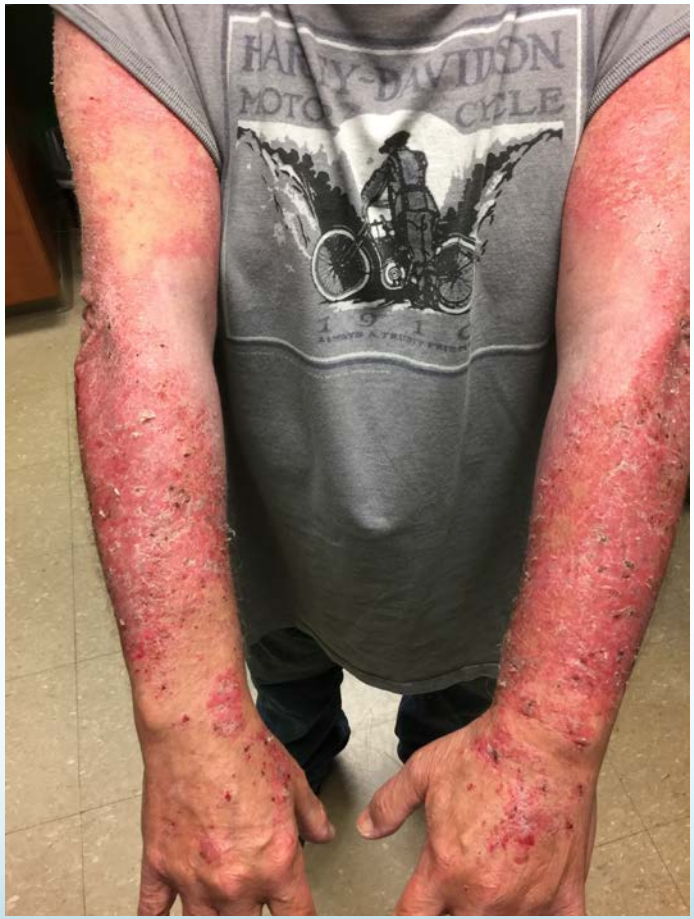
Atopic Dermatitis

- A lifestyle, not a tube of hydrocortisone
- Increased risk of Bacterial, viral, fungal and parasitic skin infections
- Associated allergy, otitis, asthma
- Treatment: steroid sparing agents, emollients, mild cleaners, food, mild detergents, anti pruritics, bleach baths. Limited corticosteroids





Pityriasis alba

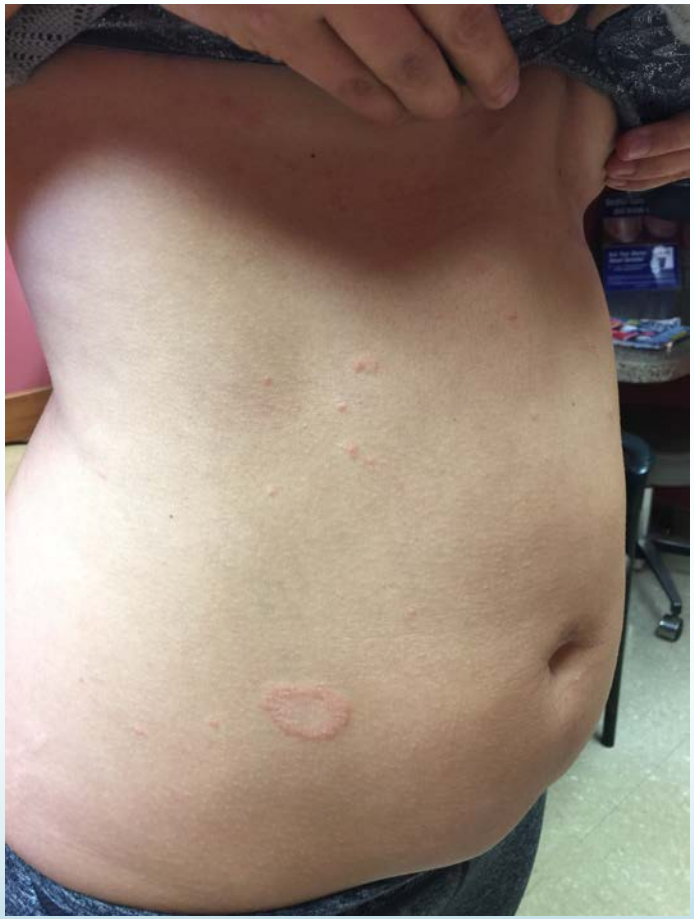


Cellulitis

Cellulits

- Usually staph or strep
- Community acquired vs Hospital acquired MRSA
- Topical, oral, systemic antibiotics
- History of prior manipulation, puncture, penetration with home sterilized safety pins, awls, needles, razors

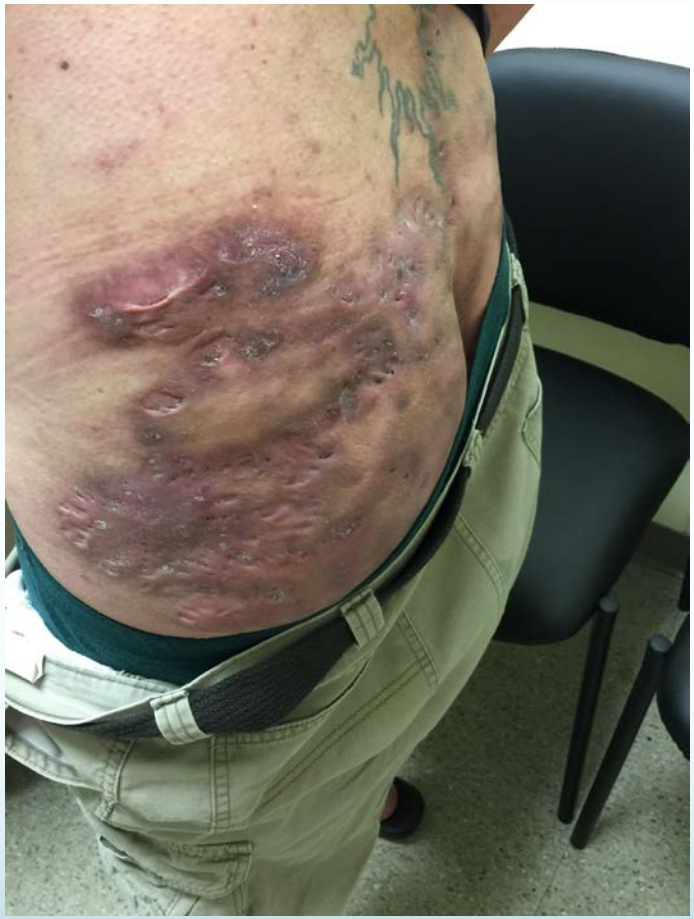
Pityriasis Rosea



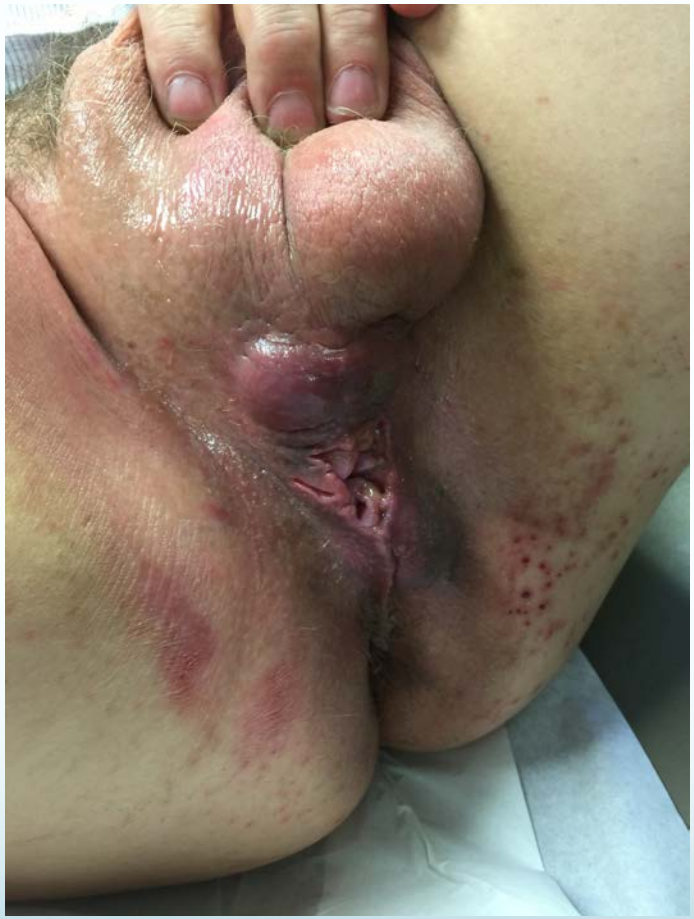
Pityriasis Rosea

- Herald Patch
- Self limited
- Pruritis variable
- Rx supportive, accurate diagnosis
- DDX includes parapsoriasis, guttate psoriasis, tinea, et al

Hidradenitis supprativa



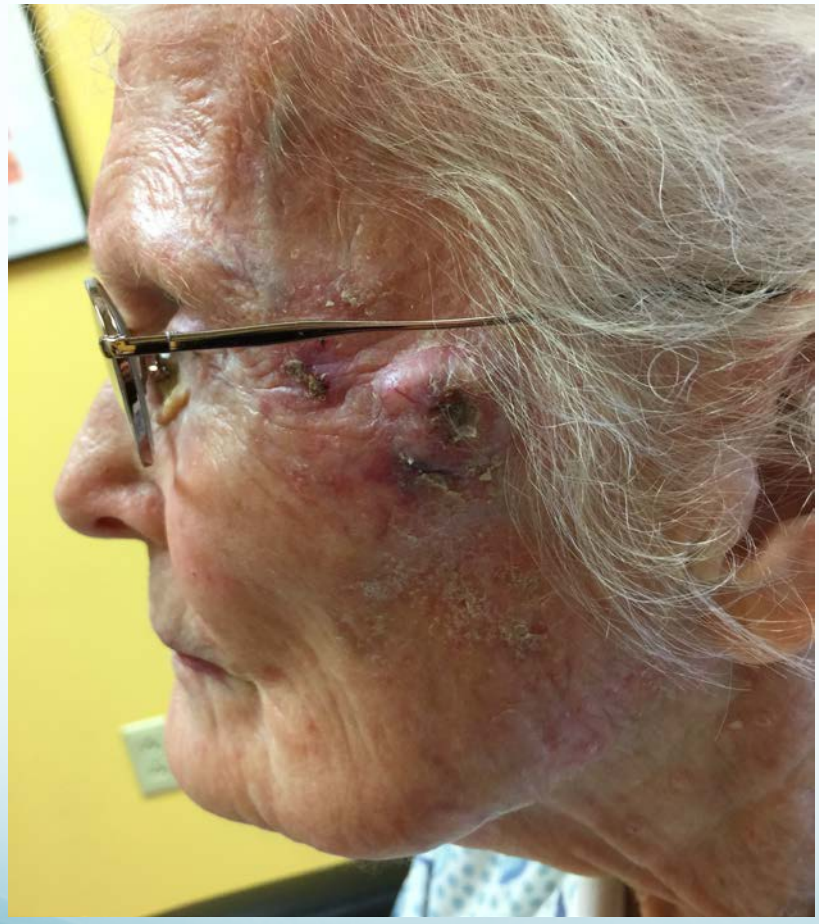
Hidradenitis supprativa

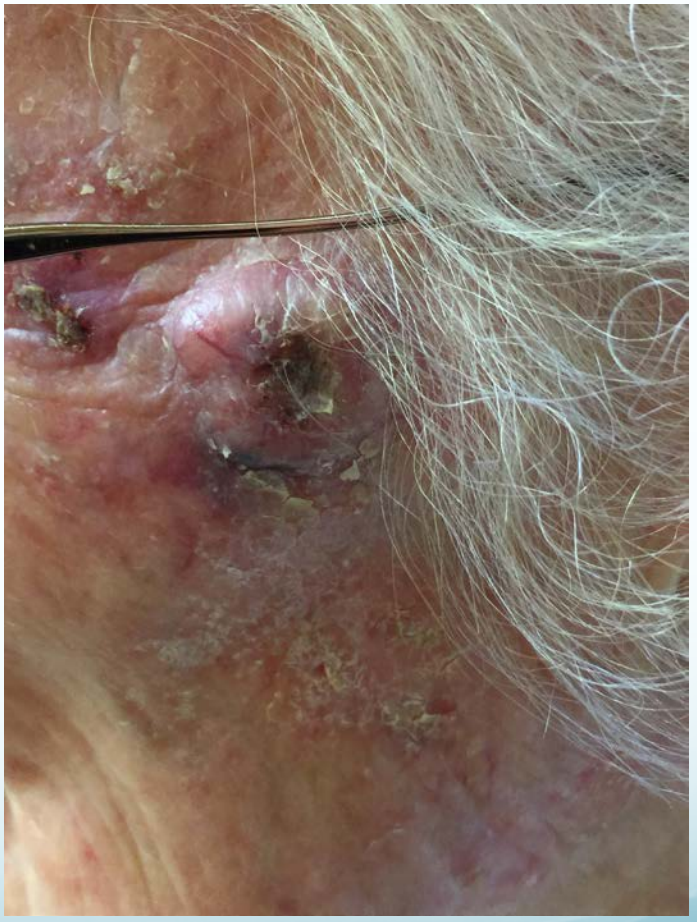


Hidradenitis Supprativa

- Symptoms progressive and can be debilitating
- Surgical tx as a LAST resort
- TNF alfa inhibitors are first line treatment
- Alternative tx include isotretinoin, rifampin, minocyline, spirinolactone, surgery

Basal Cell Carcinoma

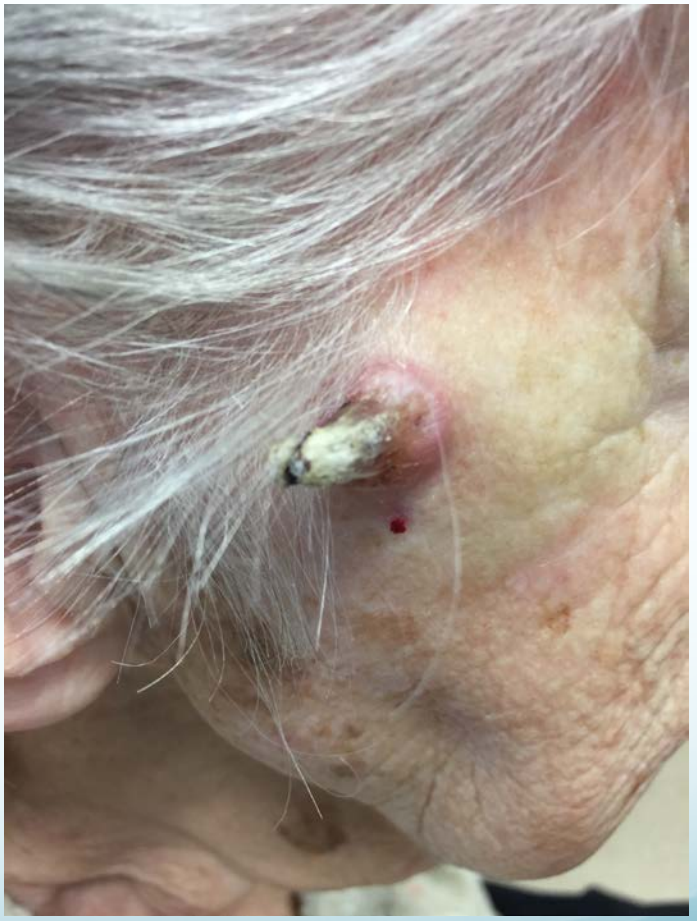




Basal Cell Carcinoma

- Most common Human Malignancy > 1,000,000/year
- Rare metastasis
- Surgical excision is ToC
- Radiation, MOHS, ED&C, Imiquimod, vismodegib

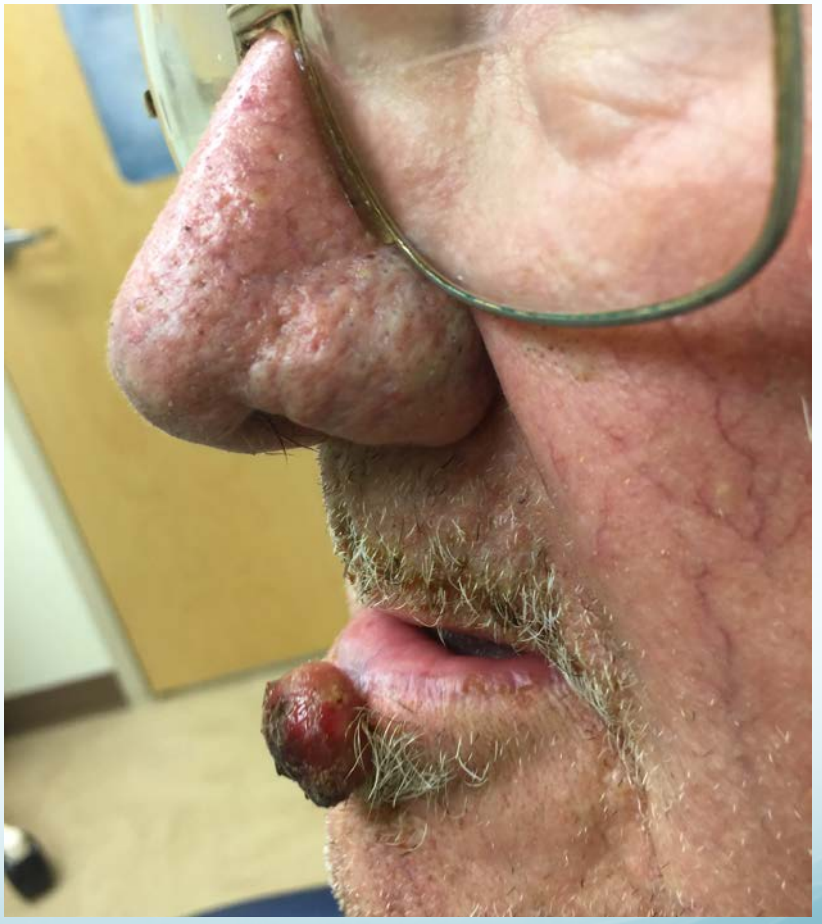
SCC



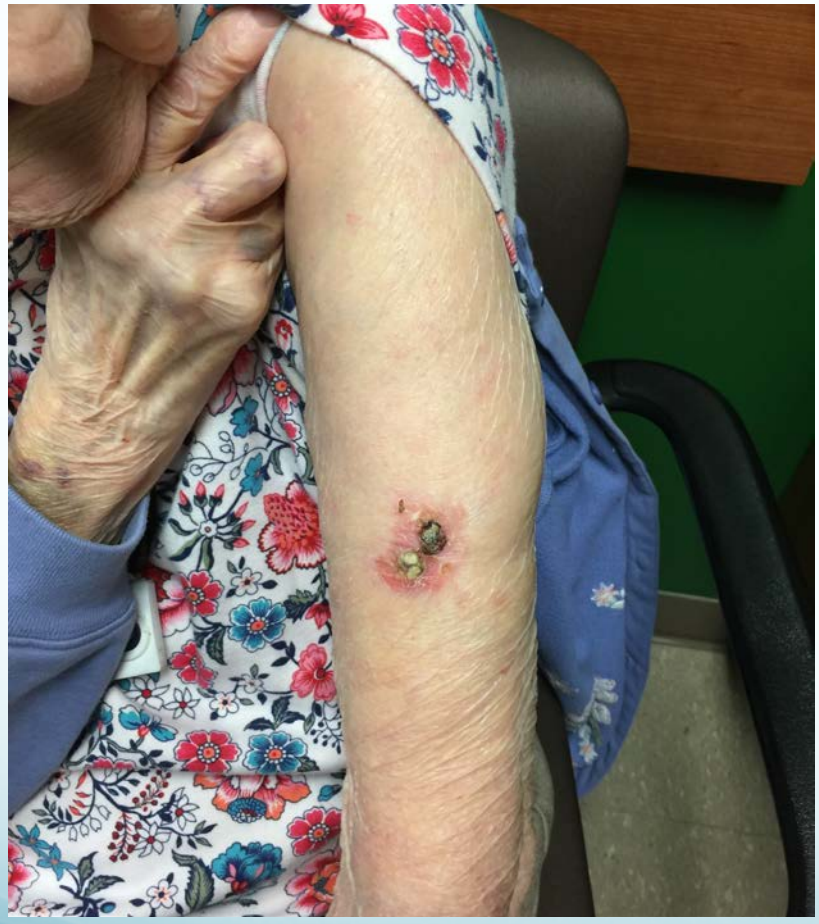
Squamous Cell Carcinoma

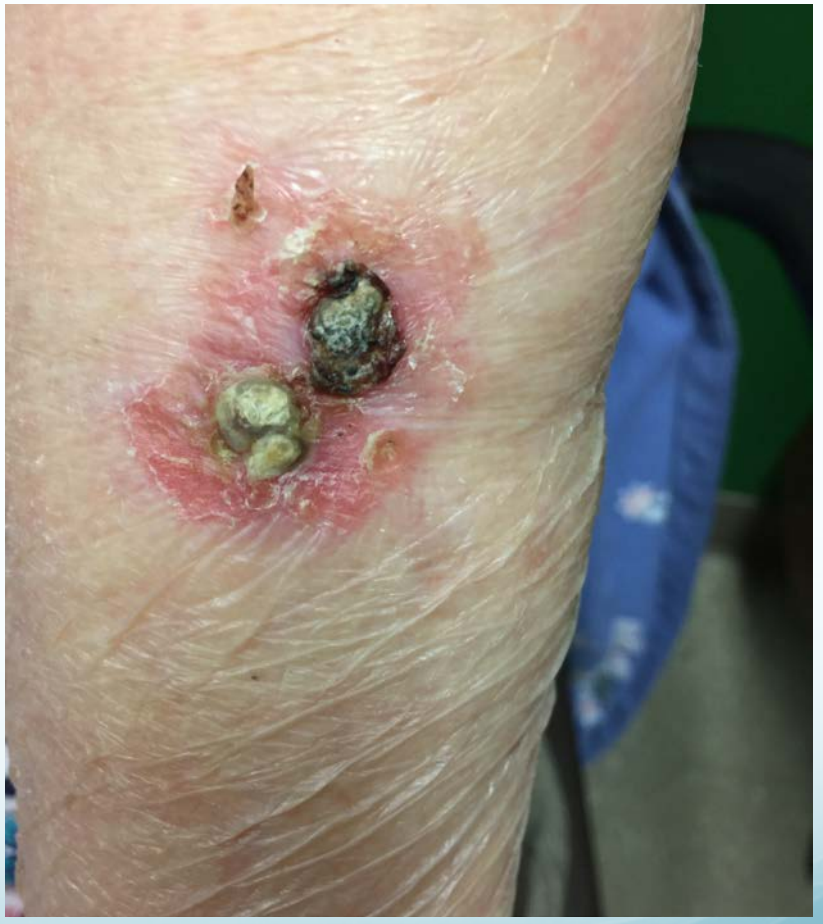
- Slightly higher risk of metastasis, particularly of hands, face, scalp and neck
- Surgical treatment ASAP
- Clean margins
- SPF
- Frequent FSE
- In immunocompent host, usually sun exposed

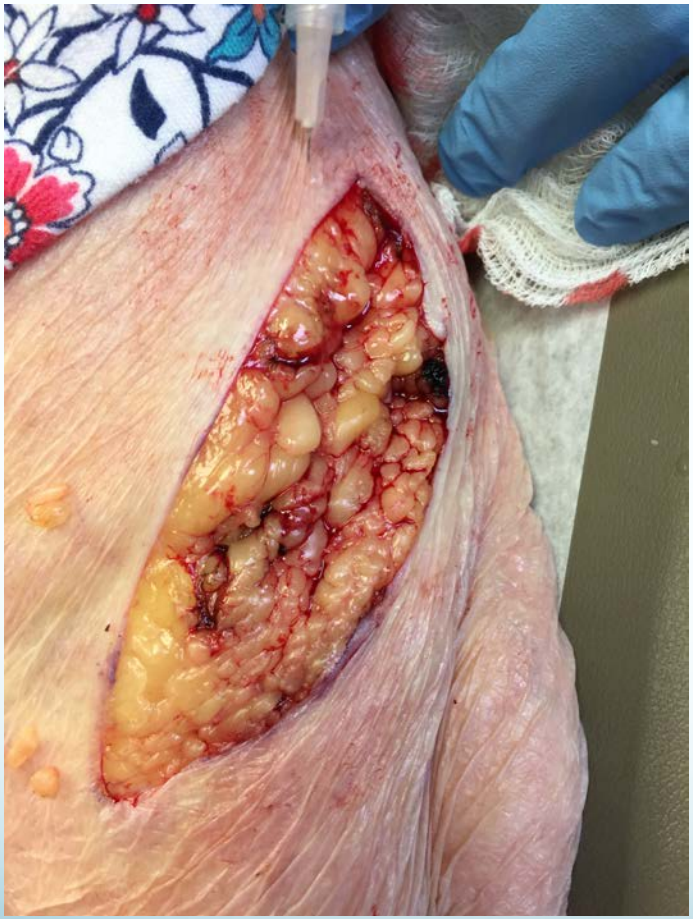
Squamous Cell Carcinoma

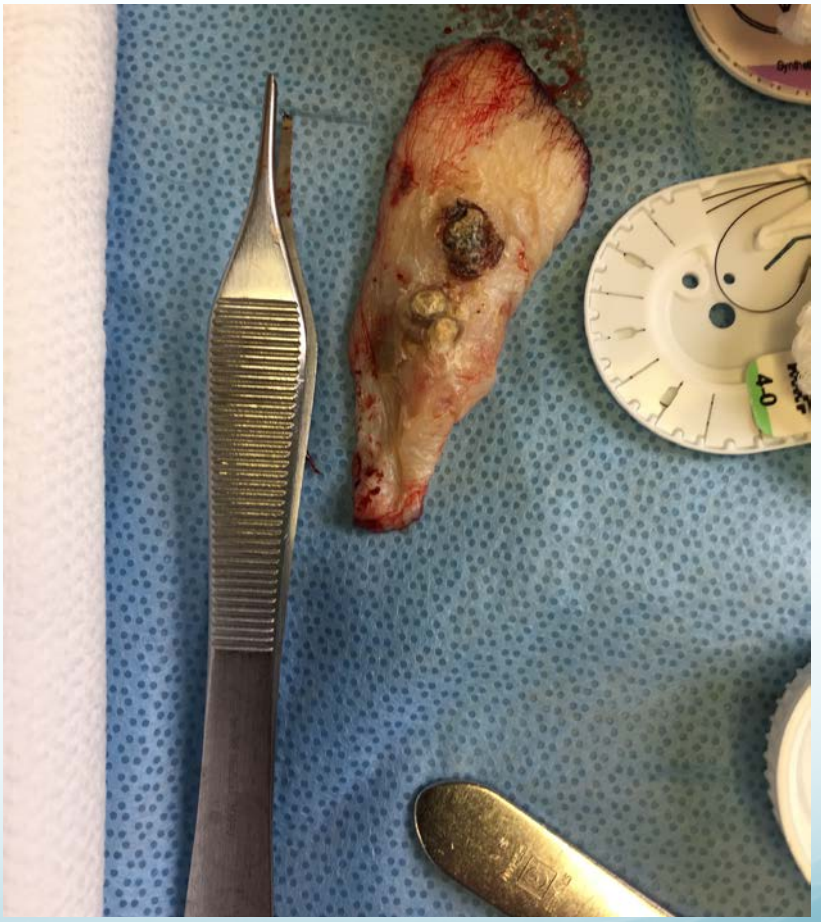


Squamous Cell Carcinoma





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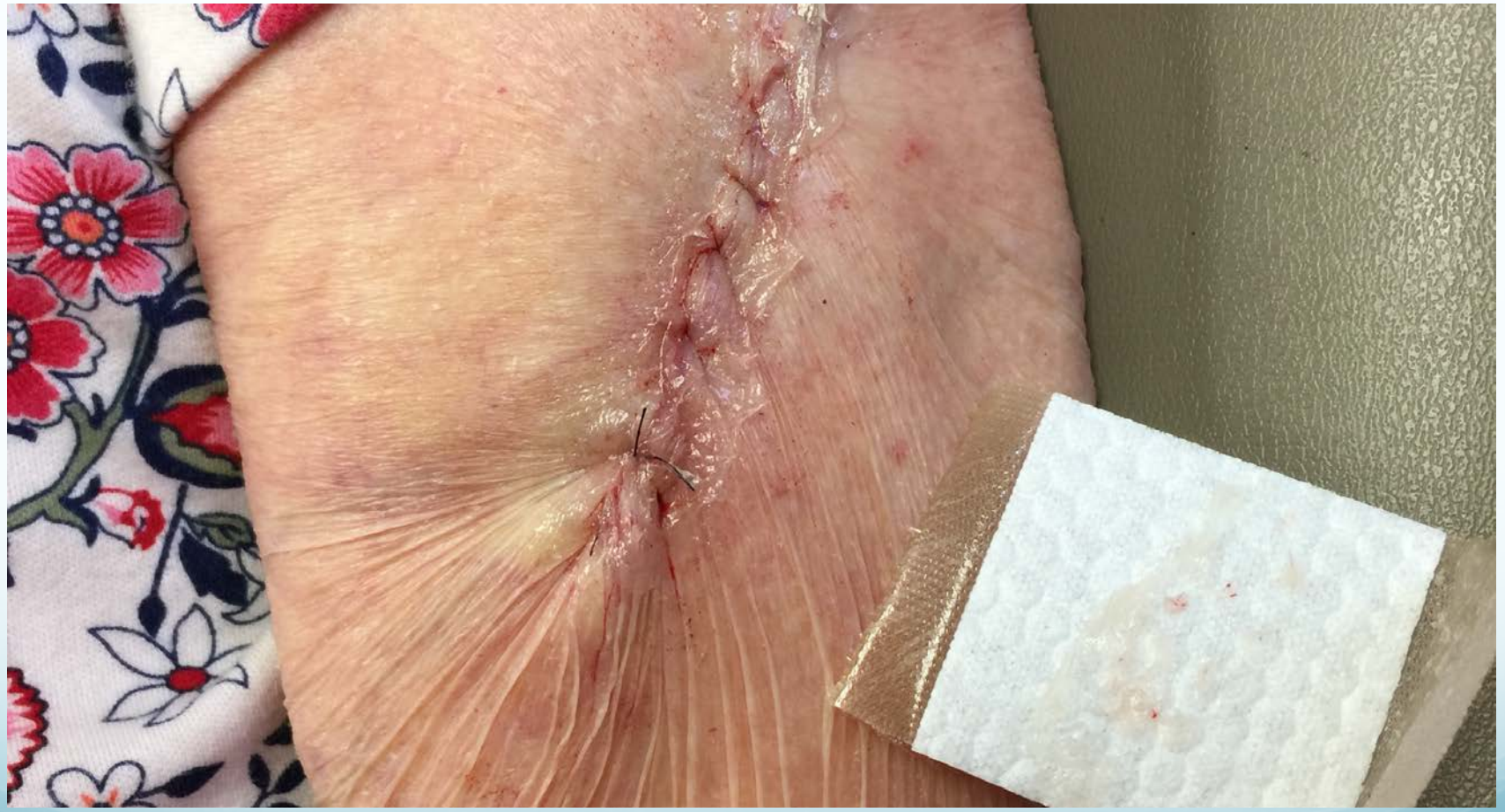
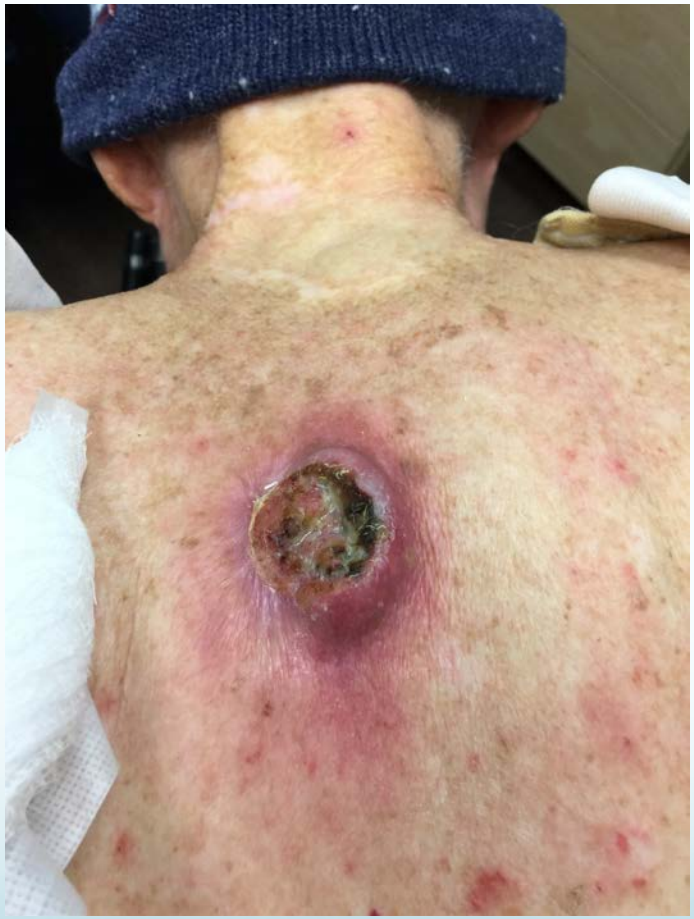


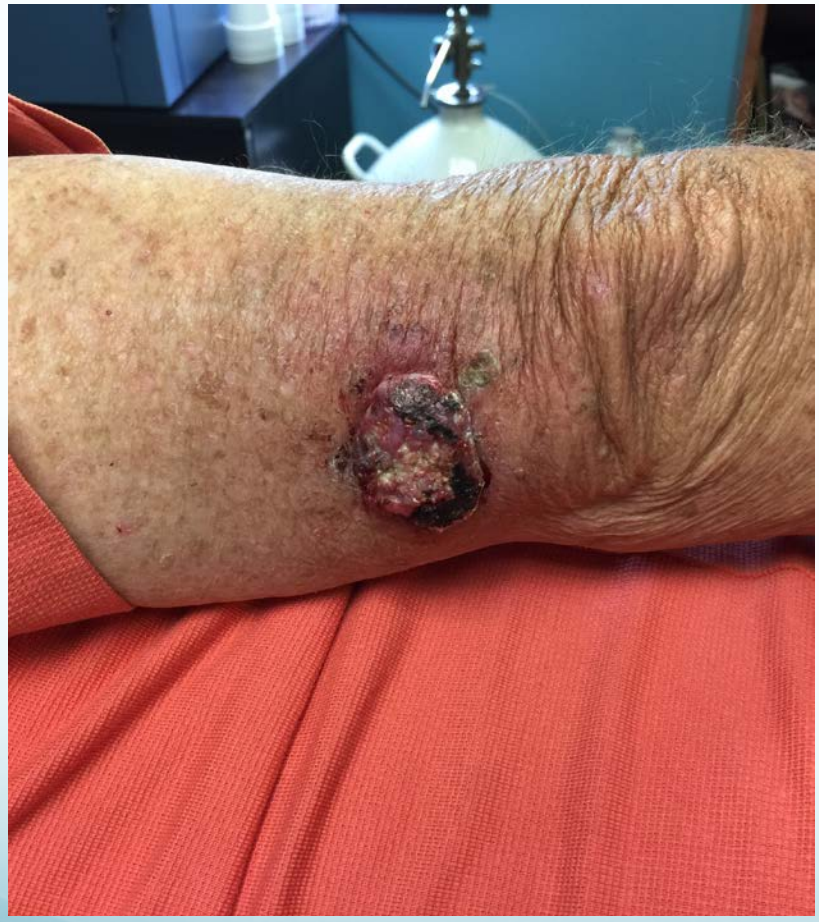
Systemic Malignancy Metastatic to Skin

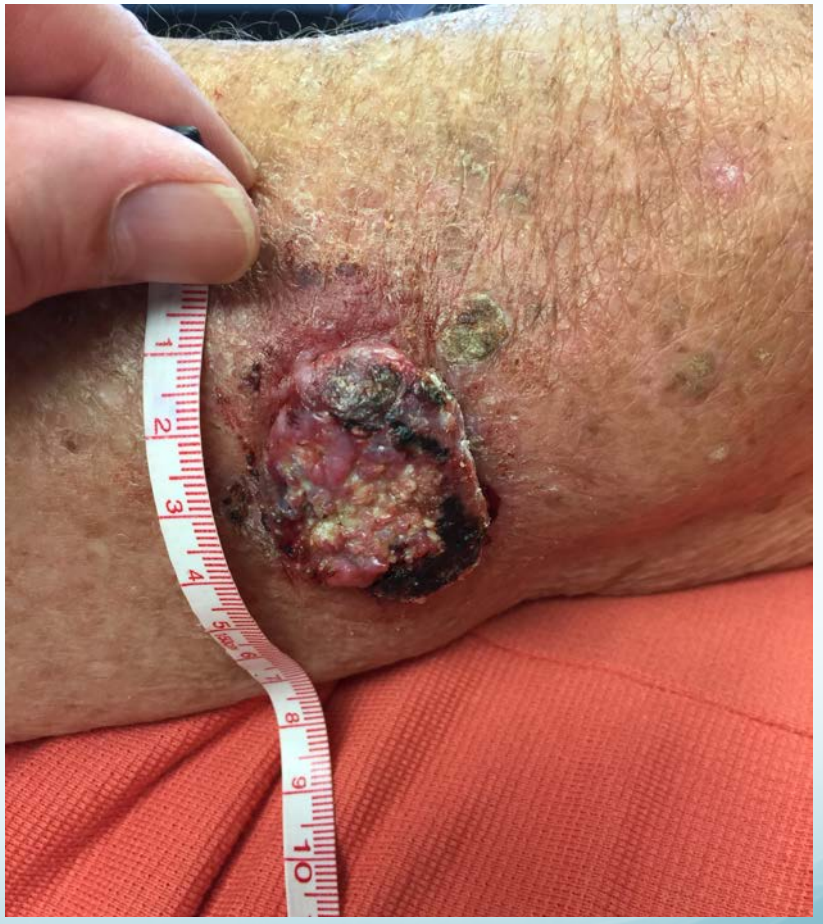


Systemic Malignancy Metastatic to skin

- Occasionally primary malignancy is previously unknown
- Almost all systemic malignancies known to metastasize to skin
- History is irregularly irregular

Squamous Cell Carcinoma in the immunocompromised patient

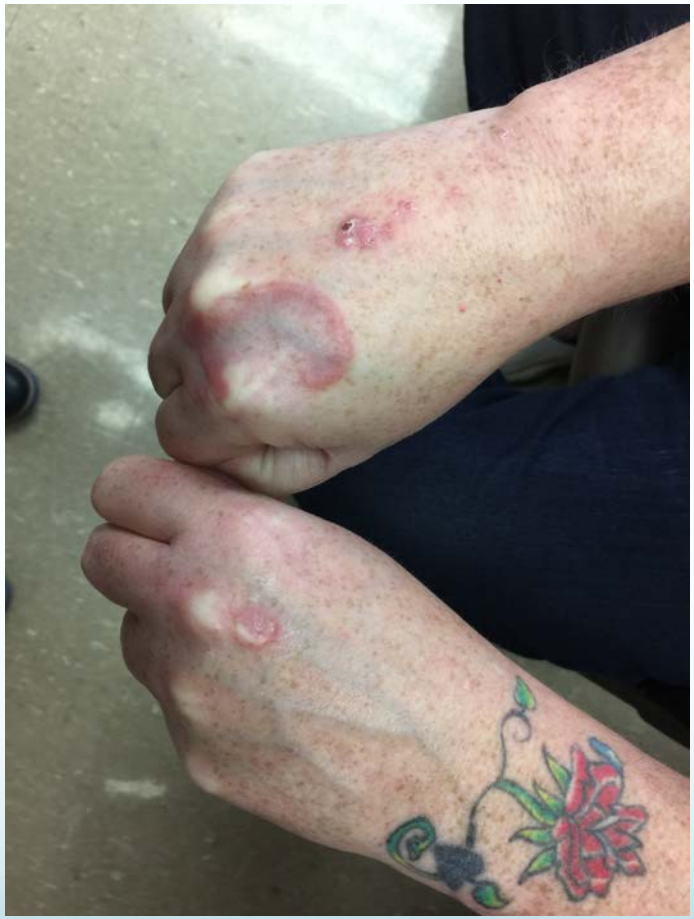




SCC in Immunocompromised patients

- Often in solid organ transplant patients, those on chemotherapy, or systemic immunosuppressants
- Metastatic rate higher
- Clinical presentation often more aggressive

Granuloma Annulare



Granuloma Annulare

- Distinct presentations in pediatrics vs adult pts
- Often confused with tinea (no scale with GA)
- Can be associated with DM

Tinea Capitis with Kerion

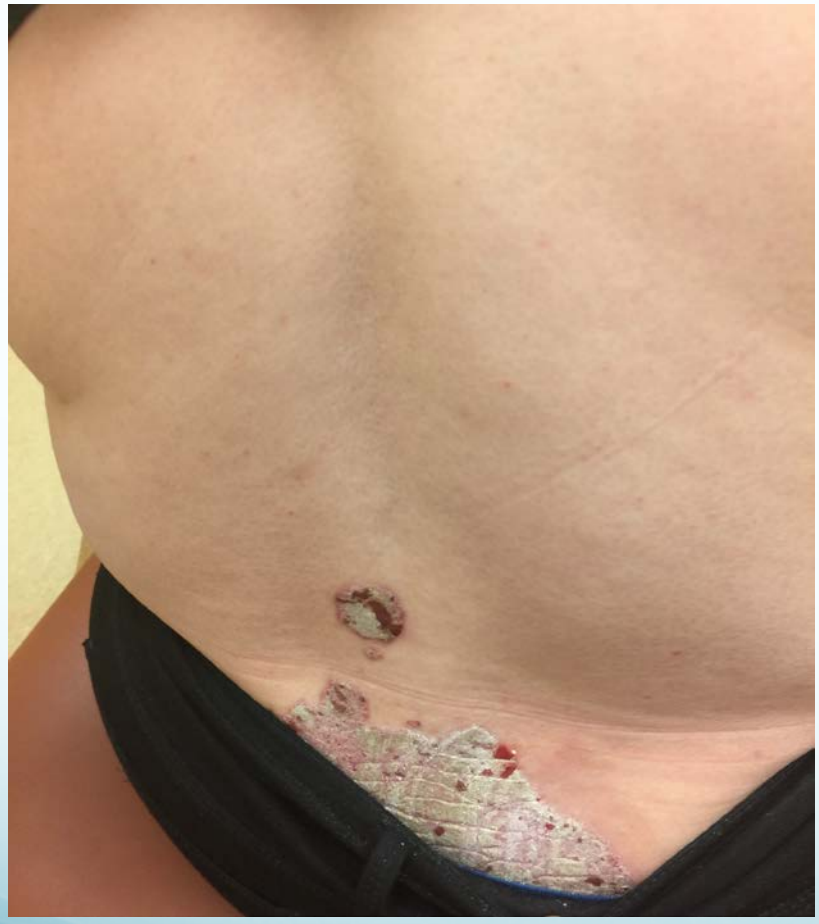
Tinea Capitis with Kerion

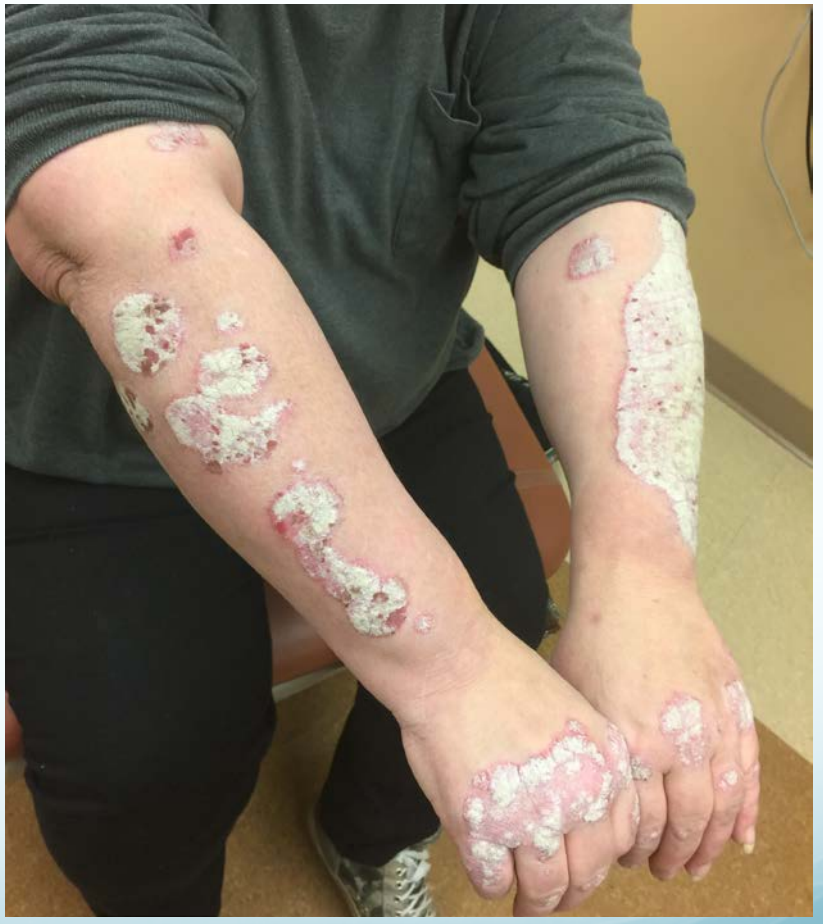
- Epidermophyton, Microsporum and Trichophyton spp are causative organisms
- Usually associated with regional adenopathy
- Tinea capitis requires oral treatment
- Griseofulvin 20mg/kg x 6 weeks, terbinafine by weight
- Kerion is a late sequellae.
- Power of a Nickel (Powerofanickel.org) and DOcare

Epidermal Inclusion cyst

Topical therapy, vs ILK, vs Excision

Plaque Psoriasis





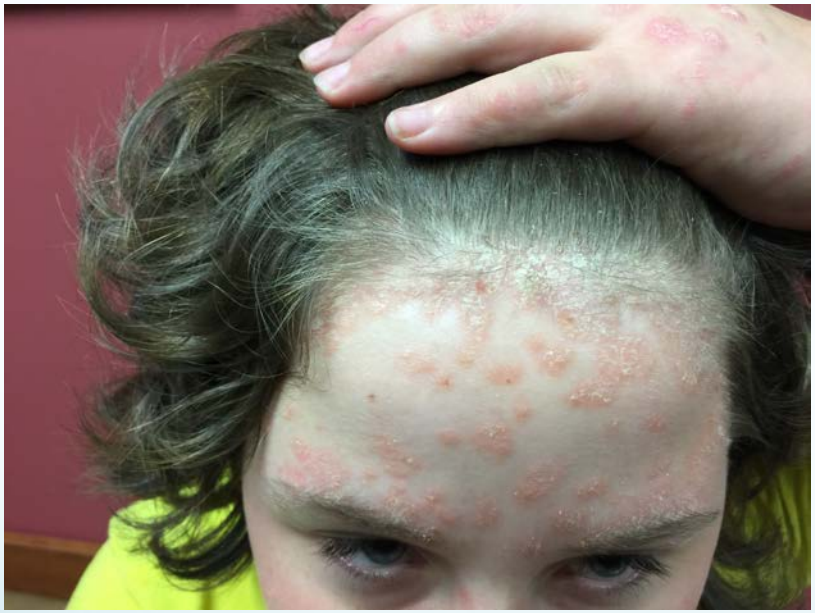
Plaque Psoriasis

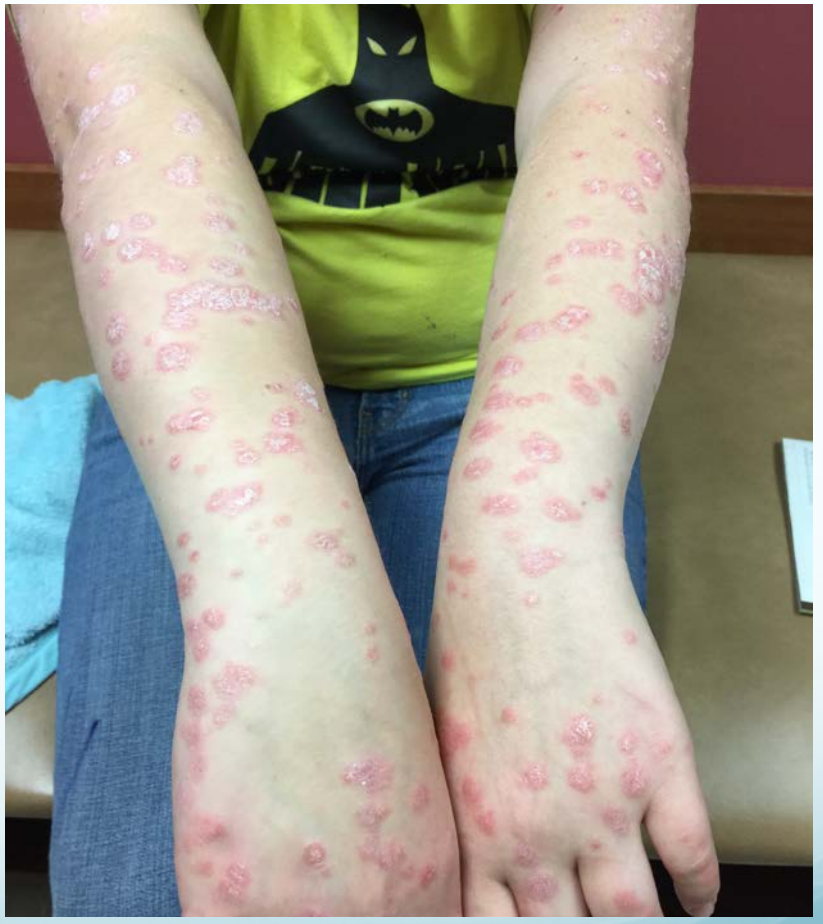
Treatment Options for BSA > 10%

- Narrowband UVB
- Methotrexate
- Acetretin
- Apremilast (PDE 4 inhibitors)
- Biologics
- Combinaiton theraby

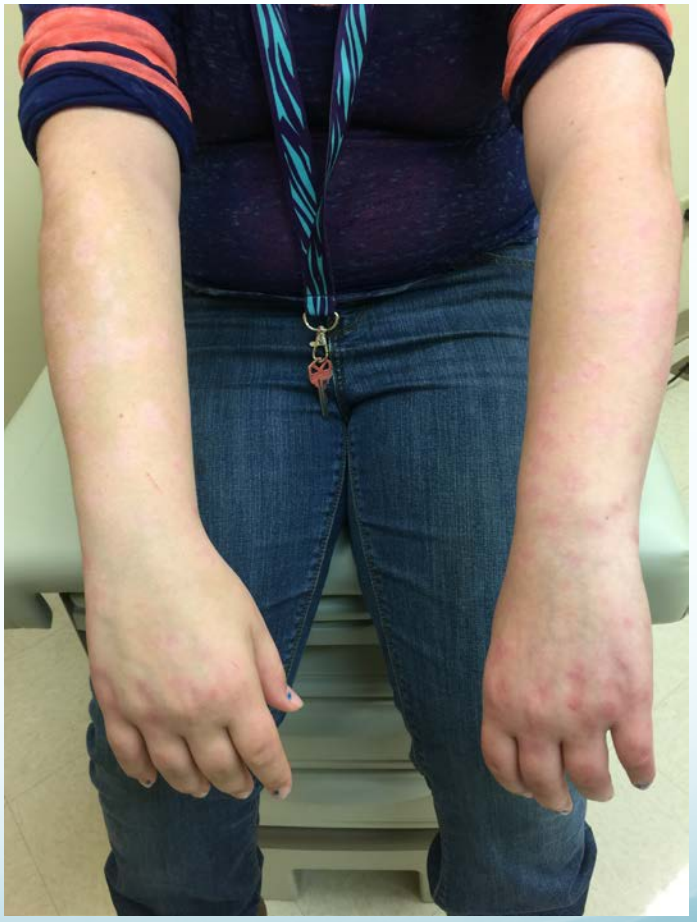
Sebopsoriasis with Isomorphic phenoenon

Pediatric psoriasis

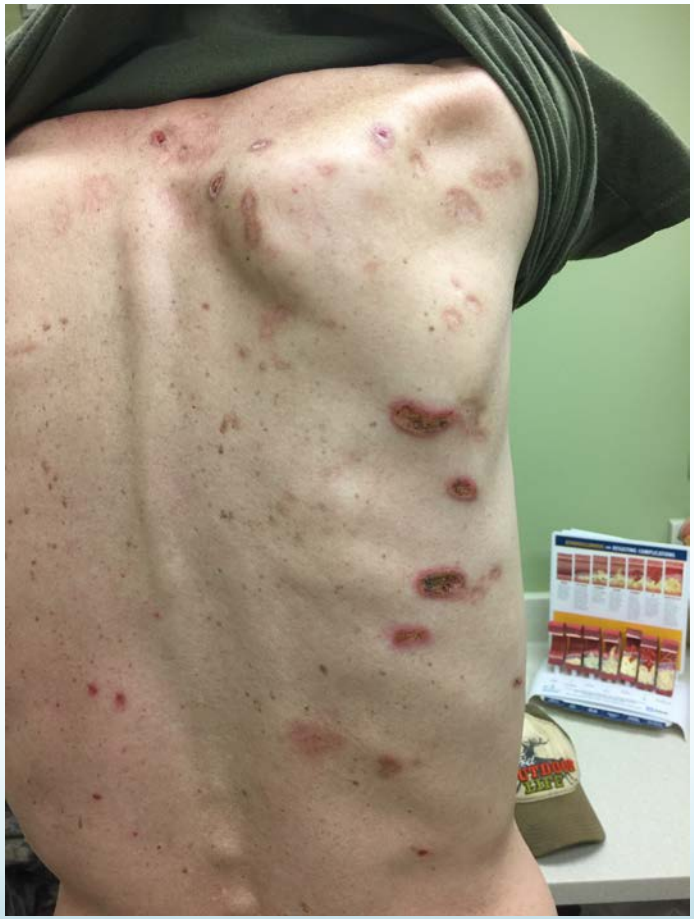




One month of adalimumab



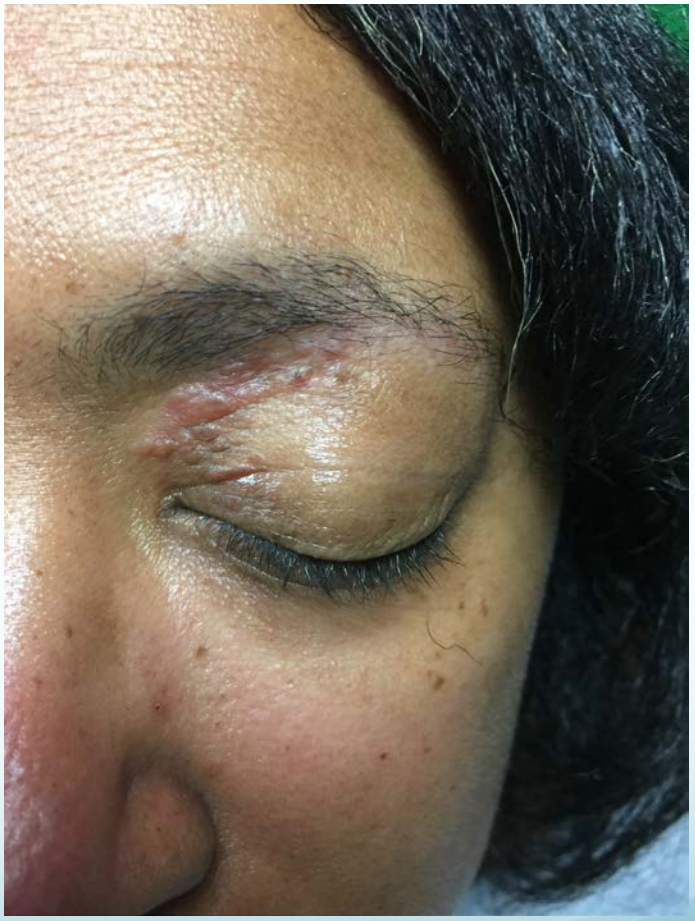
Compulsive excoriation



Compulsive Excoriation/Neurodermatitis

- Rarely a primary dermatitis
- Often require multidisciplinary approach
- Recognition of the patients participation in the disease
- Elimination of the picking/scratching/digging
- Often requires psychoactive agents (doxepin, fluvoxamine, benzodiazapines)

Cutaneous Sarcoid



Diabetic foot disease