

Chapter 12:

Topographical dermatology



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12.1 Alopecia



Alopecia areata

Alopecia areata of the scalp is characterized by the appearance of round or oval, smooth, shiny patches of alopecia which gradually increase in size. The patches are usually homogeneously glabrous and are bordered by a peripheral scatter of short broken-off hairs known as exclamation-mark hairs. ▶

Basic Lesions: None specific

Causes: None specific



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Alopecia areata

continued

Alopecia areata of the occipital region, known as ophiasis, is more resistant to regrowth. Other hair regions can also be affected: eyebrows, eyelashes, beard, and the axillary and pubic regions. In some cases the alopecia can be generalized: this is known as alopecia totalis (scalp) and alopecia universalis (whole body).

Basic Lesions:

Causes: None specific



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Pseudopelade

Pseudopelade consists of circumscribed alopecia which varies in shape and in size, with more or less distinct limits. The skin is atrophic and adheres to the underlying tissue layers. This unusual cicatricial clinical appearance can be symptomatic of various other conditions: lupus erythematosus, lichen planus, folliculitis decalvans. Some cases are idiopathic and these are known as pseudopelade.

Basic Lesions: Atrophy; Scars

Causes: None specific



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Trichotillomania

Plucking of the hair on a large scale. In trichotillomania the alopecia has irregular, "geographic" margins which may be distinct or indefinite. The area of alopecia can be entirely glabrous or dotted with clumps of broken hairs of very different lengths, and either smooth or covered irregularly with small excoriations or crusts caused by scratching. Similar lesions can appear on the nails (onychotillomania).

Basic Lesions: None specific

Causes: Mechanical Factors



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Androgenetic alopecia

This alopecia, known generally as baldness, occurs in adulthood both in men, where it affects the temporal regions (photo) and/or the crown, and in women, where it is confined to the central area of the scalp, in a longitudinal band which extends from the forehead to the crown. In females alopecia always leaves a large number of healthy hairs which are scattered irregularly over the alopecic area.

Basic Lesions: None specific

Causes: None specific



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12.2 Mucosal diseases



Aphtae, aphthosis, Behçet's disease

Small "punched-out" ulcerations of the buccal mucosa, characterized by a yellowish base resembling the colour of fresh butter and by an erythematous inflammatory halo. Often very painful, aphthae are accompanied by lymphadenopathy.



Basic Lesions: Ulcers

Causes: None specific



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Aphthae, aphthosis, Behçet's disease

continued

Aphthae can occur on the genital mucosa (bipolar aphthosis). ▶

Basic Lesions: Ulcers

Causes: None specific



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Aphtae, aphthosis, Behçet's disease

continued

Behçet's disease is a severe condition with the additional characteristics of aphthae on the skin and an isomorphic reaction to injections.

Basic Lesions: Pustules

Causes: None specific



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Black hairy tongue

Black hairy tongue comprises hypertrophy of the villi on the upper surface of the tongue. These are loaded with oxidized keratin, which explains the brown or black colour of the lesion. It can occur after the use of certain drugs, such as antibiotics or metronidazole, for example.

Basic Lesions: Vegetations

Causes: None specific



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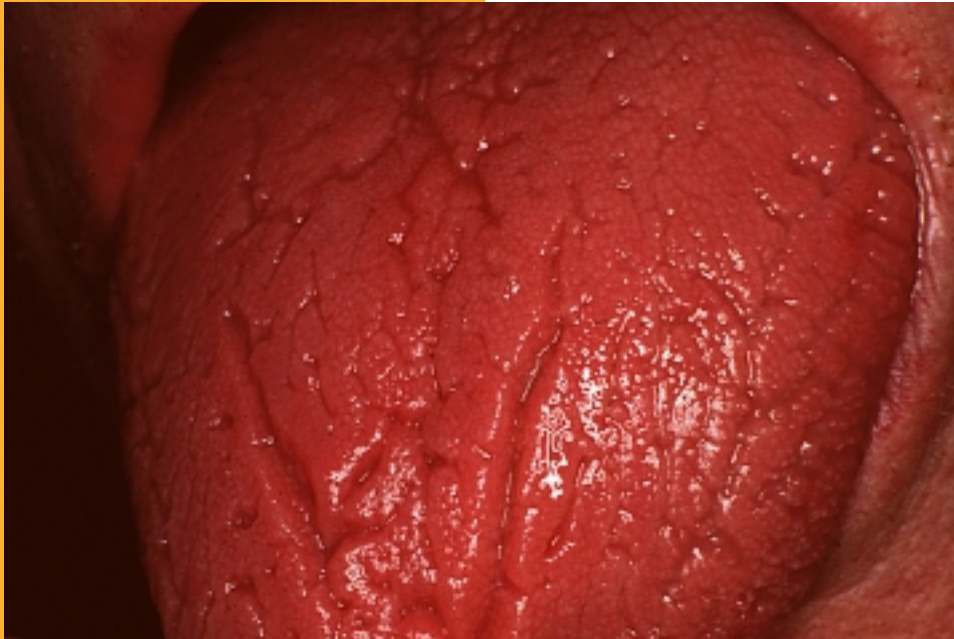
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Scrotal / fissured tongue

The upper surface of the tongue is criss-crossed by deep grooves running in various directions. The lingual papillae are often hypertrophic and inflamed. On discovery of this anatomical peculiarity the subjects often complain of a painful sensation (glossodynia).

Basic Lesions: None specific

Causes: None specific



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Geographic tongue (benign migratory glossitis)

Well-defined patches denuded of papillae, surrounded by an unobtrusive whitish border. The spread of these areas is eccentric and their appearance changes from one day to the next. This could be a variant of lingual psoriasis. Association with scrotal tongue is common.

Basic Lesions: Ulcers

Causes: None specific



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12.3 Cheilitis



Allergic contact cheilitis

Allergic contact dermatitis connected with the application of a lipstick containing balsam of Peru. The eczematous condition extends far beyond the limits of the vermilion zone of the lips, to spread out over the surrounding skin.

Basic Lesions: Erythematous Macule; Scales

Causes: Chemical Agents



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Cheilitis caused by systemic use of isotretinoin

Cheilitis caused by ingestion of isotretinoin. This is a fissured, scaly, erythematous cheilitis which is dependent on the isotretinoin dose administered. There are sometimes associated episodes of epistaxis.

Basic Lesions: Erythematous Macule; Scales; Fissures

Causes: Chemical Agents



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12.4 Miscellaneous



Darier's disease

Hereditary skin disease with a characteristic topography (sides of the face, trunk). Multiple small greyish-brown papules are observed, keratotic, dry, and very adherent. These papules can run together to form extensive brownish plaques. The lesions have a very distinct tendency to increase during the months of sunshine. ▶

Basic Lesions: Epidermal Papules; Keratoses

Causes: Sunlight, Ultraviolet Radiation



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Darier's disease

continued

Basic Lesions: None specific

Causes: Sunlight, Ultraviolet Radiation



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Ichthyosis vulgaris

Condition transmitted by a dominant gene, sometimes associated with atopic dermatitis. The whole of the skin is affected, sprinkled with small dry scales, which vary in number. Improvement during the months of sunshine is typical. Acquired ichthyosis must always make one think of a paraneoplastic syndrome (e.g. underlying Hodgkin's disease).

Basic Lesions: Scales

Causes: Sunlight, Ultraviolet Radiation



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Sex-linked (recessive) ichthyosis

Also called ichthyosis nigricans, this variant of ichthyosis is found only in boys, does not spare the major skin folds, and presents in the form of wide, adherent, blackish scales. ▶

Basic Lesions: Scales

Causes: None specific



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Sex-linked (recessive) ichthyosis

continued

Basic Lesions: Scales

Causes: None specific



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Hereditary palmoplantar keratoderma (Thost-Unna syndrome)

Appearing very early in life (between the 4th and 8th week), this palmoplantar keratoderma represents the model of a disease with autosomal dominant transmission. There are extensive yellowish keratotic plaques, accompanied by large cracks in flexural creases of the palms. This keratoderma is distinctly demarcated and does not extend to the wrist. The keratotic lesions are accentuated by an inflammatory border. There is sometimes associated hyperhidrosis.

Basic Lesions: Keratoses

Causes: None specific



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Pityriasis rubra pilaris

Association of diffuse orange-yellow palmoplantar keratoderma with a scoring of small fissures and horny follicular papules producing a grid on the skin. On palpation it feels abrasive (like emery paper). The pinkish papules are pointed at the top and surmounted by a small horny follicular plug. The course is usually chronic. Episodes of erythroderma may be seen as time goes on. ▶

Basic Lesions: Keratoses

Causes: None specific



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Pityriasis rubra pilaris *continued*

Basic Lesions: Keratoses

Causes: None specific



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Keratosis pilaris

Extremely common skin disease surrounded by a fine erythematous border, characterized by slight hyperkeratosis of the hair follicle orifices. This "condition" is transmitted by an autosomal dominant gene and is usually seen on the cheeks and the temples. ▶

Basic Lesions: Keratoses

Causes: Sunlight, Ultraviolet Radiation



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Keratosis pilaris

continued

In adults the exterior surfaces of the arms and anterior surfaces of the thigh are most frequently affected. The affected areas feel abrasive on palpation. Exposure to sunlight attenuates the condition.

Basic Lesions: Keratoses

Causes: Sunlight, Ultraviolet Radiation



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Erythema annulare centrifugum (Darier's)

Extensive annular lesions of the arms with the appearance of healing at the centre. The distinctly infiltrated erythematous margins spread slowly outwards. Having appeared suddenly, this condition has become chronic, each ring developing over several weeks at a rate of 2 to 3 mm per week. It should be noted that when two rings join together they never overlap. There is no pruritus.

It is always important to check for a possible underlying cause, though in a number of cases erythema annulare centrifugum remains idiopathic. ▶

Basic Lesions: Erythematous Macule

Causes: None specific



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Erythema annulare centrifugum (Darier's) *continued*

Among the potential causes the following should be remembered: remote infectious foci, viral diseases, Hodgkin's disease, visceral cancer, autoimmune thyroiditis, lupus erythematosus, liver disease, etc. In the present case it was viral hepatitis B which, after an acute episode, subsequently developed into chronic active hepatitis.

Basic Lesions: Erythematous Macule

Causes: None specific



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12.5 Leg ulcers



Venous leg ulcer

Extensive ulceration with pliant borders and outlines which vary from one case to the next. The base of the ulcer is granular in some places and sanious and necrotic in others. Surrounding trophic disorders are evident: gravitational purpura, atrophie blanche. ▶

Basic Lesions: Ulcers; Atrophy

Causes: None specific



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Venous leg ulcer

continued

This type of ulcer can be the result of a varicose disorder or a postphlebotic syndrome. It represents more than 80% of leg ulcer cases. It affects women most frequently and there is an evident hereditary factor. The pains vary individually in intensity and are improved by lying down.

Basic Lesions: Ulcers

Causes: None specific



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Ischaemic (arterial) leg ulcer

Punched-out ulceration which is most often unilateral. Its site is near the ankle. There is no associated trophic disorder. The pulse in the foot can be felt only with difficulty. Ischaemic ulcers develop rapidly and cause intense pain which is often aggravated by lying down. They are much less common than venous ulcers and can be found in diabetes, arteriosclerosis, or Buerger's disease.

Basic Lesions: Crusts; Ulcers

Causes: None specific



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Ulcer caused by capillaritis

Slow and relatively superficial ulceration with jagged and irregular margins. There is surrounding pigmentary and purpuric angiodermatitis, sometimes associated with small patches of atrophie blanche. The pains are often intense and persistent, and are not influenced by lying down. Diabetes and arteriosclerosis promote this condition.

Basic Lesions: Purpuric Macule; Crusts; Ulcers; Atrophy

Causes: None specific



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Neurotrophic leg ulcer (perforating ulcer)

Deep circular, punched-out ulcer found at the bearing surface of the metatarsal joint. The base is necrotic. There is no tendency towards spontaneous cicatrization. There is virtually no pain. In the present case it is caused by diabetes with a major neuropathological component. Other neurological conditions can be responsible (e.g. syringomyelia).



Basic Lesions: Ulcers

Causes: None specific



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Neurotrophic leg ulcer (perforating ulcer)

continued

Basic Lesions: Ulcers

Causes: None specific



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12.6 Pathomimicry



Skin self-mutilation simulated disease

Extensive escharotic ulceration of the back of the hand, caused intentionally with caustic soda. The margins are distinct, the angular edges and the configuration "surprising". The appearance of the lesion was very rapid and recurrences at the same site are typical. ▶

Basic Lesions: Crusts; Ulcers; Scars

Causes: Mechanical Factors



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Skin self-mutilation simulated disease

continued

The course is usually capricious, spontaneous healing retarded, and persistence indefinite. In the present case the patient acted voluntarily with intent to deceive, for her own advantage (extension of sick leave from work).

Basic Lesions: Crusts; Ulcers; Scars

Causes: Mechanical Factors



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Self-mutilation, pathomimicry

Ulceration of exogenous origin on the face, with distinct margins and "aberrant" configuration. This particular topography is rarely found in cases of disease simulation. True pathomimicry is caused by the patient who is "unconscious" of it or shows "dual consciousness". ▶

Basic Lesions: Crusts; Ulcers

Causes: Mechanical Factors



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Self-mutilation, pathomimicry

continued

Major psychological disturbances are present. There is no evident intention to take financial advantage of the condition.

Basic Lesions: Crusts; Ulcers

Causes: Mechanical Factors



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