# *Color Atlas of Skin Diseases*

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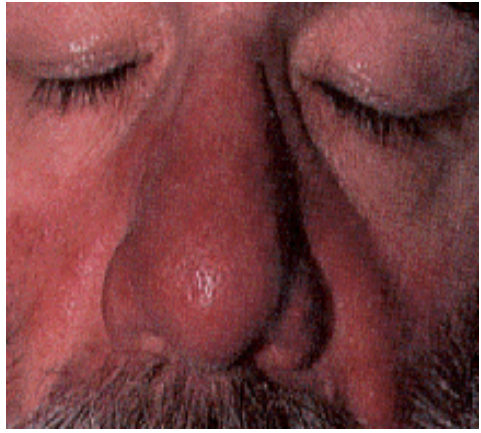
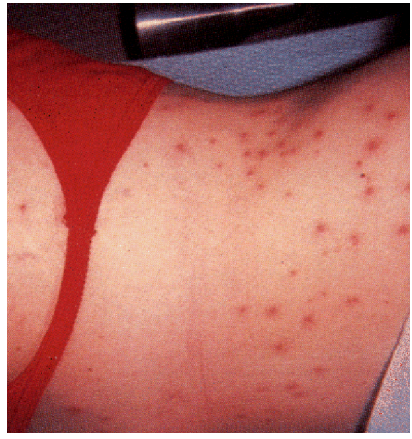
**Rosacea**



Rosacea is a congestive blushing and flushing reaction of the central areas of the face. It is usually associated with an acneiform component (papules, pustules, and oily skin). It usually occurs in middle-aged and older people. The cheeks, nose, and chin, on the entire face, may have a rosy hue. Burning or stinging often accompanies episodes of flushing. It is much more common than lupus erythematosus, with which it is often confused. Rosacea is distinguished from acne by age, the presence of the vascular component, and the absence of comedones.

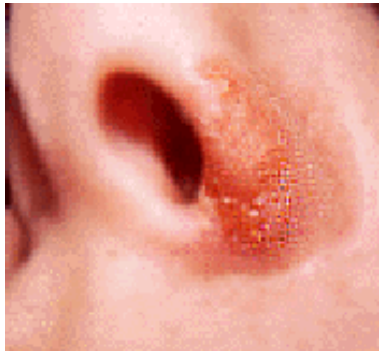
**Folliculitis**



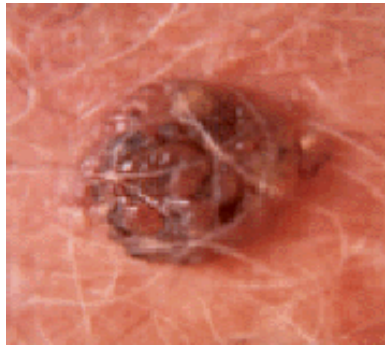
Folliculitis is characterized by red-ringed papules and pustules at hair follicles. Gram-negative folliculitis may be spread by contaminated hot tubs. Gram stain and culture will help to differentiate bacterial from non-bacterial folliculitis. History is important for pinpointing the cause of non-bacterial folliculitis.

**Impetigo**

Superficial honey-colored serous crusts are characteristic of this disorder. It is usually caused by a staphylococcus infection. Culture is rarely reliable.

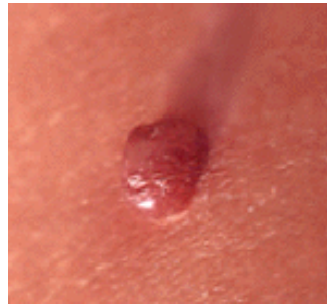


**Seborrheic Keratoses**



These lesions are benign overgrowths of epithelium, largely appearing on the torso, face, and neck. They are seen on almost every-one over the age of 50. The borders are typically irregular, and they range in color from beige or gray-white to very dark brown. These "barnacles" of older skin can number only a few to as many as hundreds. Although often raised and dry, they can be flatter and greasier (seborrheic) in texture.

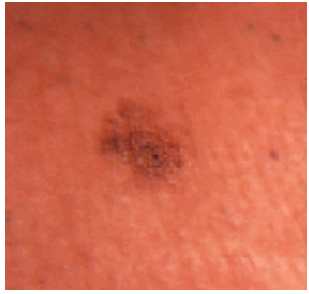
**Granuloma Pyogenicum**



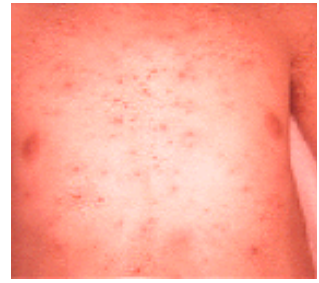
This is a vascular reactive nodule that develops as a response to a minor injury. The overgrowth of capillaries leads to a raised red lump which bleeds profusely when torn.

**Lentigo Simplex**

These lesions occur on sun-exposed skin, especially face, arms, and hands. Lesions are flat, and pigmented in shades of brown, with characteristically sharp borders. They tend to fade with sun avoidance.



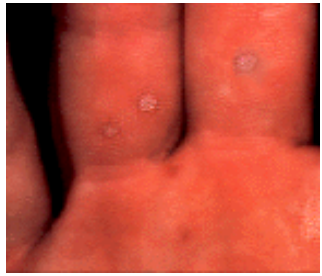
**Varicella**



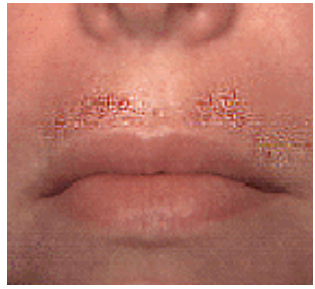
Chicken Pox
The rash is pruritic and most prominent on the face, scalp and trunk. It appears as multitudes of red-ringed papules and vesicles in varying stages of development. Crusts eventually form and slough off in 7 to 14 days. Nondermatomal distribution and lesions of varying stages distinguish primary varicella from herpes zoster. Fever and malaise may be mild in children and much more severe in adults.

**Hand, Foot, and Mouth Disease**

The disorder is characterized by stomatitis and vesicular rash on palms of hands and soles of feet. It is caused by Coxsackieviruses A5, 10, 16. The development of mouth sores is most troublesome to adults. The skin lesions are vesicopustules, 0.5 to 5 mm, red-ringed, more oval than round, on palms, sides of fingers and soles.

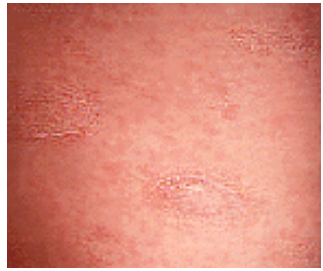


**Verruca Plana**



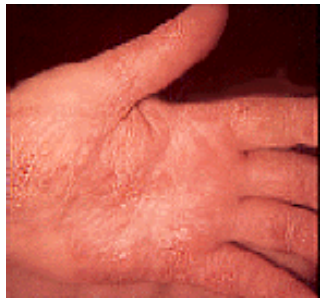
The numerous discrete lesions, closely set, usually occur on face, dorsa of hands and shins. Lesions are flat-topped, slightly elevated, well demarcated, generally flesh-colored, with a matte-smooth surface. Lesions tend to spontaneously disappear.

**Pityriasis Rosea**



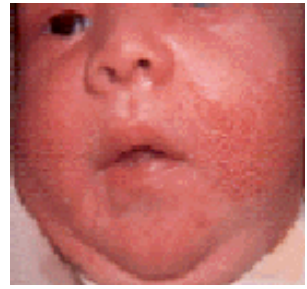
This disorder is a common, but unexplainable, reaction. The initial lesion, "herald patch", is red and scaly, followed in 1 to 2 weeks by widespread, oval, scaling, fawn-colored macules 4 to 5 mm in diameter over the trunk and proximal extremities. Pityriasis rosea is usually an acute self-limiting illness that lasts 4 to 8 weeks. It is not highly infectious.

**Vesicular Hand Dermatitis**



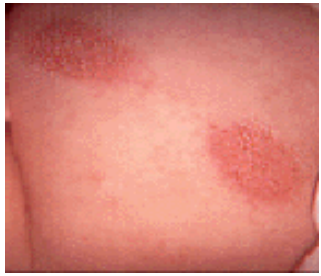
This disorder is a severely pruritic reaction in individuals with a personal or family history of allergic manifestations. It is characterized by flares of congestion resulting in deep and superficial blisters, followed by peeling, scaling, and a dry, reddened surface. Flares generally result from contact with irritants, but stress is also a significant factor.

**Seborrheic Dermatitis**



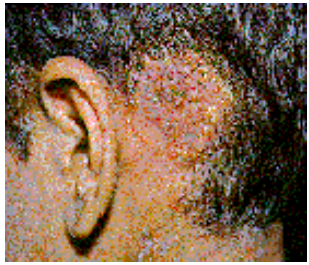
Seborrheic dermatitis is generally limited to the scalp; however, dry scales and underlying erythema can occur on the face, ears, chest, back, and body folds. Skin may be dry or oily. In infants, a widespread reaction is associated with minimal discomfort. The yeast organism, Pityrosporum, may be a factor. Mild scaling without any erythema is often termed simple dandruff. Tinea capitis may simulate dandruff or seborrheic dermatitis, and scrapings should be taken for KOH examination and fungal culture, especially in children, if hair loss is present.

**Nummular Dermatitis**



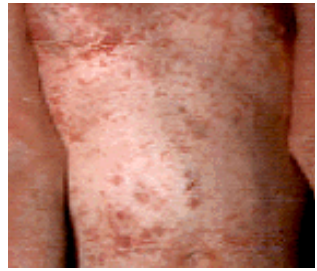
A pruritic dermatosis, characterized by round to oval (coin-shaped) areas of vesiculation, superficial crusting, and redness. Number of lesions varies from few to many. More often this is a symmetrical pattern in young adults. Not related to atopic dermatitis.

**Tinea Capitis**



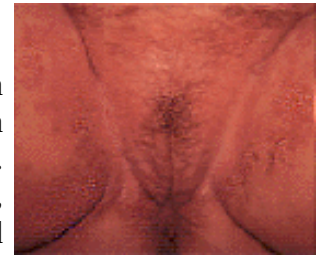
Along with hair loss, the scalp surface shows seborrheic dermatitis-like scaling, impetigo-like crusting, pustules, inflammatory nodules or kerion. Identify tinea with KOH culture onto a fungal media. No longer a disease confined to children. If infection suspected, all family members should be examined.

**Tinea Versicolor**



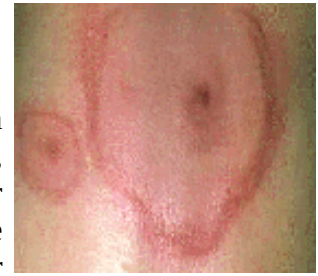
Asymptomatic to mildly itchy macules that scale readily on scraping. Lesions, usually occur on the trunk, but may appear on upper arms, neck, face, and groin. Caused by a yeast organism, Pityrosporum orbiculare. Altered pigmentation can be very subtle to obvious, both hypo and hyperpigmented. KOH shows characteristic spores and hyphae. Fungal culture is not useful.

**Candidiasis**



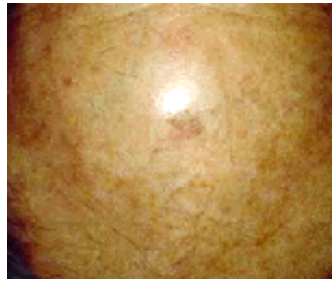
Common normal flora, but it may become an opportunistic pathogen widespread in patients with AIDS and other immunosuppressed patients. Mucocutaneous candidiasis occurs on the vulva, anus, breast or groin folds. Superficial denuded beefy red areas with or without scattered satellite vesicopustules with marginal scaling. Microscopic examination with 10% KOH reveals budding spores and short hyphae.

**Erythema Chronicum Migrans**



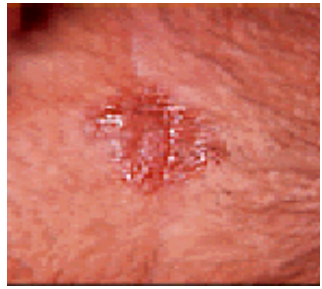
Lyme Disease
Caused by the spirochete Borrelia burgdorferi, which is transmitted to humans by a deer tick bite, infection, is characterized by erythema migrans. A flat or slightly raised red lesion appears at the site. The reaction can become quite large, is generally circular in shape, and can show several concentric rings (target pattern). Erythema migrans is often accompanied by flu-like illness with fever, chills, and myalgias. At this stage, laboratory tests are not reliable.

**Actinic Keratoses**



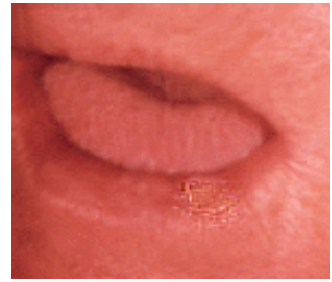
Actinic keratoses are single or multiple, flesh-colored or slightly hyperpigmented, dry, rough, scaly lesions which occur on skin exposed to the sun. Cells are atypical, and they are considered to be pre-malignant because some may eventually become squamous cell cancers.

**Basal Cell Carcinoma**



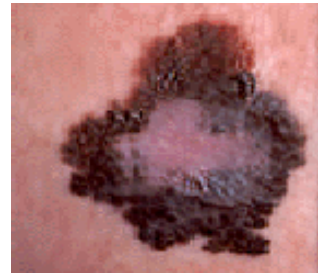
This lesion represents 90% of skin cancers. Basal cell carcinoma is the most common cancer. On the face, it usually starts as a reddened papule or nodule with a smooth surface and a translucent, pearly quality. Because of a poorly formed stroma, it is fragile and often bleeds. On the torso, the lesion has an irregular surface, bright red color, sometimes scaly, with a distinct edge. Histologic examination is required.

**Squamous Cell Carcinoma**



This lesion usually appears on skin that shows other significant changes of chronic sun exposure. Especially prevalent in fair-skinned people who sunburn easily and tan poorly. It may arise out of actinic keratoses. Characteristically, the lesion appears fairly rapidly as a small red, conical, hard nodule. Should it appear on the mucus membrane or lip area, it behaves much more aggressively and can be fatal. Histologic examination is required.

**Malignant Melanoma**

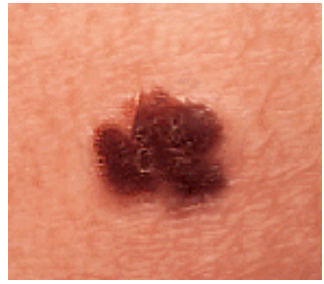


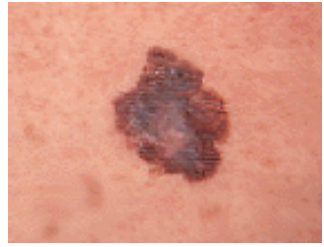
Recognized through the mnemonic, "A-B-C-D:" Asymmetry of contour, irregularity of Border and Color, and Diameter larger than 6 mm. Melanomas vary from macules to nodules. Color ranges from flesh tints to pitch black and mixtures of white, blue, purple, and red. Any pigmented skin lesion with recent change in appearance should be suspected.

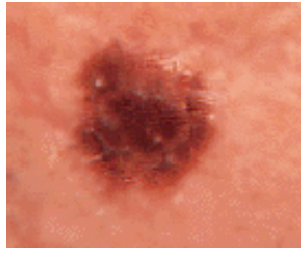
Malignant melanoma can exist in a superficial spreading mode for years and still be curable by excision with 1 to 2 cm margins. Once a vertical growth phase develops, rapid spread through blood and lymph vessels occurs. Histologic examination is required.

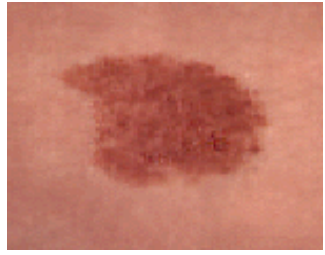
**Atypical Moles**

Dysplastic change implies abnormal cell development, which does not necessarily imply precancerous change. These atypical moles, show irregular outlines, and different shades and patterns of brown color. If they appear in a person with a family history of melanoma and are multiple in number, the incidence of cancer developing reaches 100%. If they are sporadic in pattern and number, they should be photographed and reexamined regularly. Histopathologic examination is required.

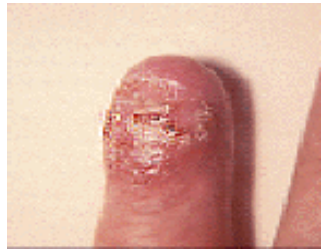






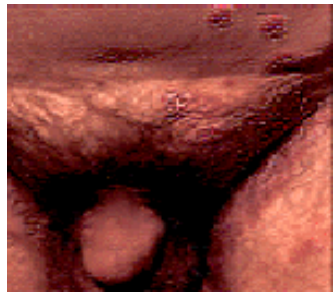


**Psoriasis of the Nails**



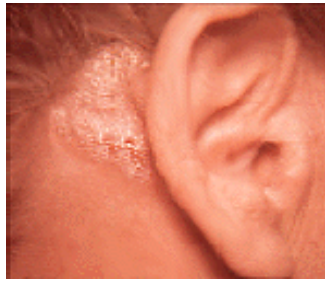
Pitting of nail surface with spots of white to yellow-brown (oil droplets) reflects psoriatic changes in the nail matrix and nail bed respectively. Distally, there are irregular onycholysis, splitting, and dystrophic changes. Onycholysis may simulate onychomycosis; therefore, fungal culture will be valuable in diagnosis.

**Intertriginous Psoriasis**



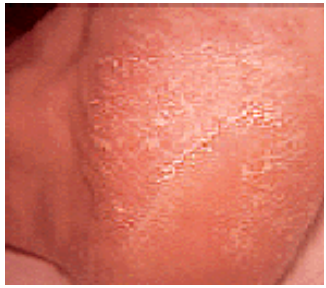
Sebopsoriasis
The skin fold areas are shades of red and orange, with mild to severe itching. The characteristic sign is the uniform appearance (unlike tinea) and distinct border (unlike candida). Generally, a complete skin exam will reveal other signs of psoriasis.

**Psoriasis of the Scalp**



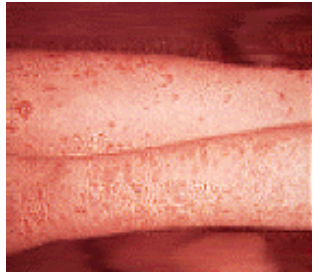
The lesions are red, sharply defined plaques covered with thick silvery scales. This distinguishes psoriasis from the diffuse or patchy redness and scaling of seborrheic dermatitis.

**Pustular Psoriasis**



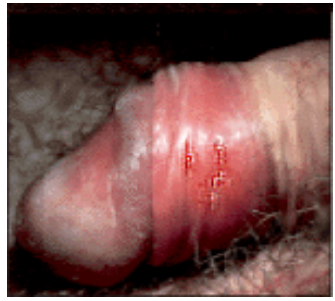
Generally, a chronic, disabling condition of the palms and soles, it can also be a part of a very severe generalized reaction.

**Guttate Psoriasis**



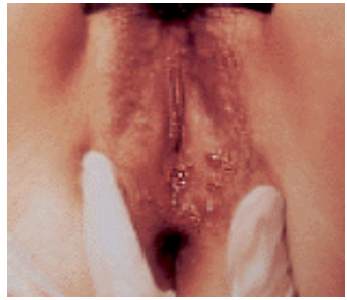
A form of psoriasis characterized by the rapid development of myriad small lesions, 3 to 10 mm in diameter, on all areas of the body, especially the extremities. More often seen in young people.

**Herpes Simplex, Penis**



Red, sharply marginated, grouped vesicles usually become crusted sores within 48 hours. Typical distribution includes prepuce, coronal sulcus, glans, shaft. Deep aching pain of the perineum may occur 2 to 3 days before appearance of the skin lesions. Itchy and painful, lesions generally recur in the same location.

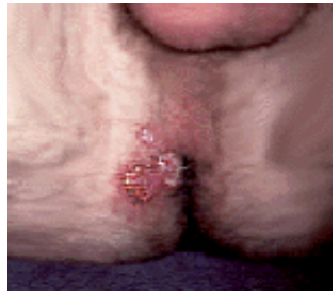
**Herpes Simplex, Vulva**



Painful, recurrent, grouped vesicles. Viral shedding occurs even when no lesions are present. This sexually transmitted disease can complicate pregnancy.

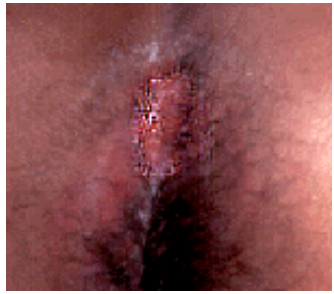
**Herpes Simplex, Perineum**

Recurrence of painful sores is a diagnostic sign.

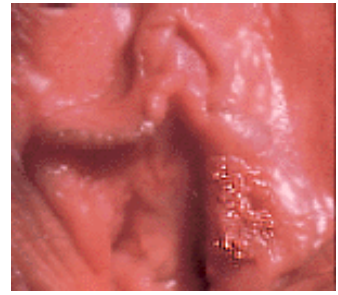


**Herpes Simplex in AIDS**

Lesion in the perianal area becomes a deeply ulcerated, very painful, disabling infection.



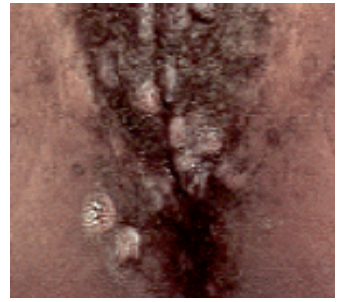
**Condyloma Acuminatum**



Genital Warts

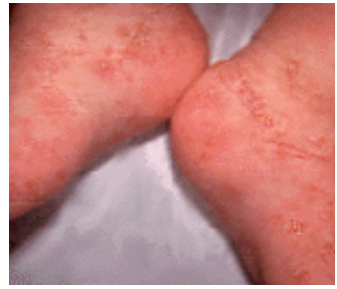
Highly contagious and sexually transmitted, soft, skin-colored, fleshy warts can be pin-head papules or cauliflower-like masses that are caused by the human papilloma virus. On the vulva, perianal area, vaginal walls, cervix, or on the shaft of the penis, warts can be raised clusters and obviously wart-like, or so small they only become recognizable after application of 5% acetic acid (vinegar) for ten minutes. Lesions must be distinguished from condylomata lata caused by syphilis. Diagnosis of syphilis is based on a positive serologic test or discovery of Treponema pallidum on darkfield examination.

**Secondary Syphilis**



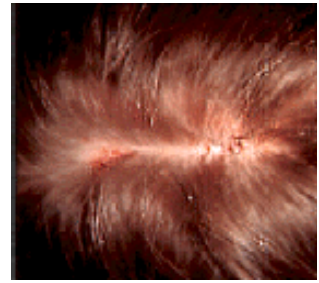
Generalized maculopapular eruptions are most common, although lesions may be pustular or follicular as well (or combinations of any of these types). Condylomata lata are raised, weeping papules on the moist areas of the skin and mucous membranes. The patient generally feels sick, can have regional lymphadenopathy, but complains only of minimal itching. Diagnosis of syphilis is based on a positive serologic test or discovery of Treponema pallidum on darkfield microscopy.

**Scabies**



Scabies is a common dermatitis caused by infestation with Sarcoptes scabiei. The entire family may be affected. Skin lesions are scattered groups of pruritic vesicles and pustules in "runs" or "burrows" on the sides of the fingers, palms, wrists, elbows, axillae, as well as around the waist and groin. Itching occurs almost exclusively at night. Microscopic examination of a scraping will reveal scabies mites, ova, and feces.

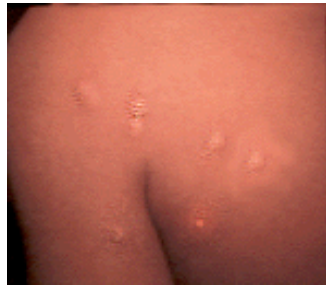
**Pediculosis**



Lice

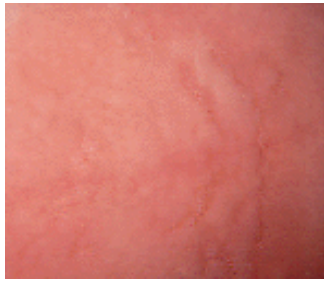
Pediculosis is a parasitic infestation of the skin of the scalp, trunk, or pubic areas. Itching may be very intense and scratching may result in deep excoriations over the affected area. Head lice are easiest to see above the ears and at the nape of the neck. The nits (egg sacs) are attached to hairs, close to the skin. Body lice deposit visible nits on vellus hair. Head and body lice are similar in appearance and are 3 to 4 mm long.

**Papular Urticaria**



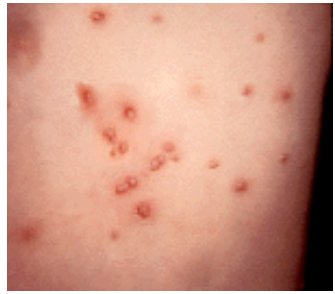
Almost exclusively in children, this is a widespread reaction to insect bites such as fleas, bedbugs, chiggers, or gnats, and may persist for long periods. The tendency will fade with onset of adolescence.

**Urticaria**



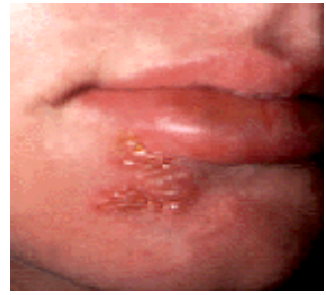
Usually intensely itching intradermal vascular reaction (wheals or hives). No epidermal changes such as scaling, papules, or blisters. More often has an unknown, nonspecific etiology, but can be related to medications, foods, and similar vascular-stimulating agents. Laboratory studies are not likely to be helpful in evaluation unless there are suggestive findings in the history and physical examination.

**Molluscum Contagiosum**



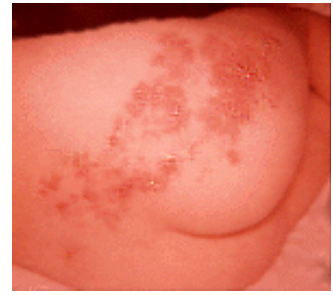
Caused by a large pox virus, these smooth-walled, dome-shaped, pearly papules, 2 to
5 mm in size, have an umbilicated center. Occasionally a significant inflammatory reaction will occur. Principal sites are face, hands, lower abdomen, and genitals. A common viral infection seen in AIDS. It is more difficult to eradicate in these patients.

**Herpes Simplex**



Small red-ringed blisters can occur anywhere, especially around oral and genital areas. Associated and often preceded by burning and stinging. Regional lymph nodes may be swollen and tender. Blisters rupture early, leaving serous crusts which can then become secondarily infected. Viral cultures and ELISA are positive.

**Herpes Zoster**



Red-ringed blisters occur in a dermatomal distribution of a nerve root. Papules change to vesicles which become pustules before crusting. New lesions appear for up to one week. Regional lymph glands may be tender and swollen. Since this is primarily a nerve infection with secondary skin manifestations, it is preceded, accompanied, and followed by pain. In elderly patients, it is often severe and prolonged. In immunosuppressed patients, herpes zoster may disseminate, producing lesions beyond the dermatome, visceral lesions, and encephalitis. Disseminated Zoster is a serious, sometimes life-threatening complication.