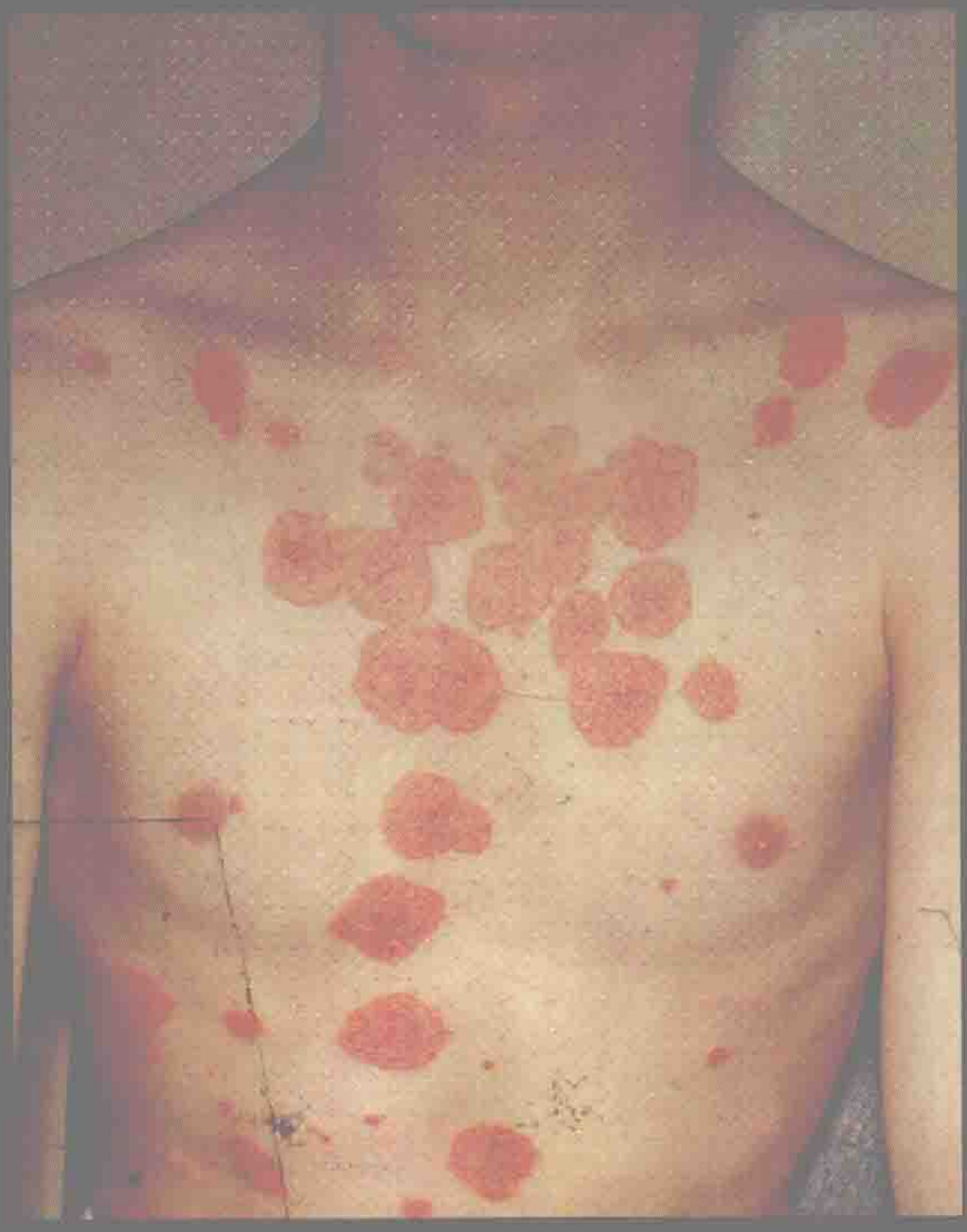
Pocket Picture Guides
to Clinical Medicine

Skin Diseases

Denis E. Sharvill



Williams & Wilkins

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Skin Diseases

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Pocket Picture Guides to Clinical Medicine

The purpose of this series is to provide essential visual information about commonly encountered diseases in a convenient practical and economic format. Each Pocket Picture Guide covers an important area of day-to-day clinical medicine. The main feature of these books is the superbly photographed color reproductions of typical clinical appearances. Other visual diagnostic information, such as X-rays, is included where appropriate. Each illustration is fully explained by a clearly written descriptive caption highlighting important diagnostic features. Tables presenting other diagnostic and differential diagnostic information are included where appropriate. A comprehensive and carefully compiled index makes each Pocket Picture Guide an easy to use source of visual reference.

An extensive series is planned and other titles in the initial group of Pocket Picture Guides are:

Infectious Diseases
Rheumatic Diseases
Sexually Transmitted Diseases
Pediatrics

Introduction

The skin is a very large organ, subject to many diseases. Most of the diseases seen in a community are of a few common types, but these will differ from country to country. Many conditions are rare and are only of academic interest to the specialist. Some, however, although not very common, are important, either because they are dangerous in themselves, or because they point to some important general illness.

This small pocket book makes no attempt to cover the whole of dermatology, but rather to illustrate pictorially some diagnostic points which have seemed important to the author in hospital practice in England. It must be realised that many common skin conditions are subtle in appearance and therefore difficult to photograph and to reproduce in print. Conversely, the temptation to include uncommon or unimportant conditions which make attractive pictures has been avoided.

Selection of material is, therefore, idiosyncratic, but it is hoped that this collection will prove useful in the differential diagnosis of skin diseases which may appear superficially very similar.

Contents

Eczema-dermatitis

The terms eczema and dermatitis are used synonymously in British dermatology. The classification of eczema and its aetiology are not discussed here.

Endogenous eczema

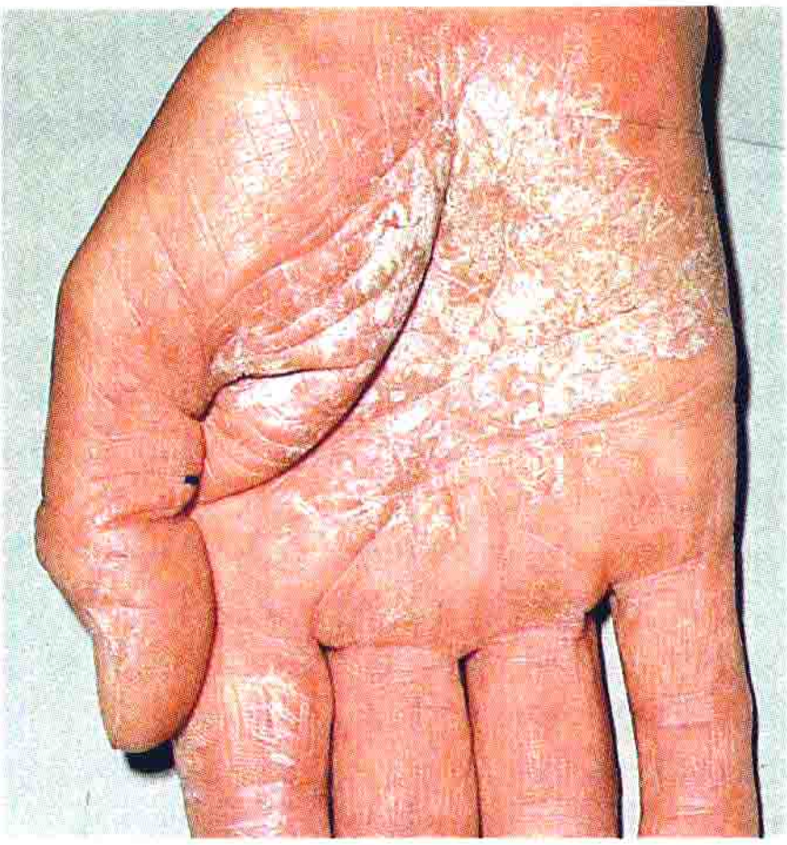

Fig. 1 Chronic hypertrophic eczema of the palm. This may be constitutional or due to friction or long-standing irritation. It may be difficult to distinguish from psoriasis (see Fig. 41).

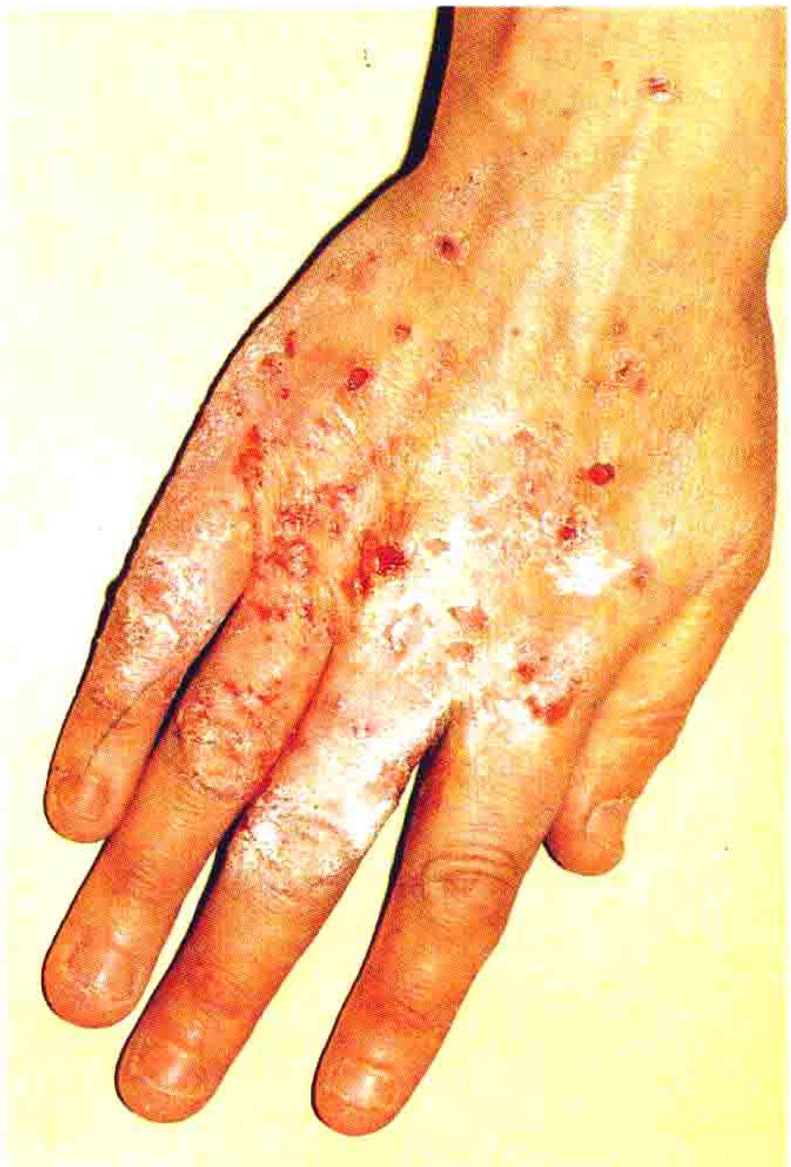

Fig. 2 Acute exacerbation of chronic atopic eczema which has been much excoriated.

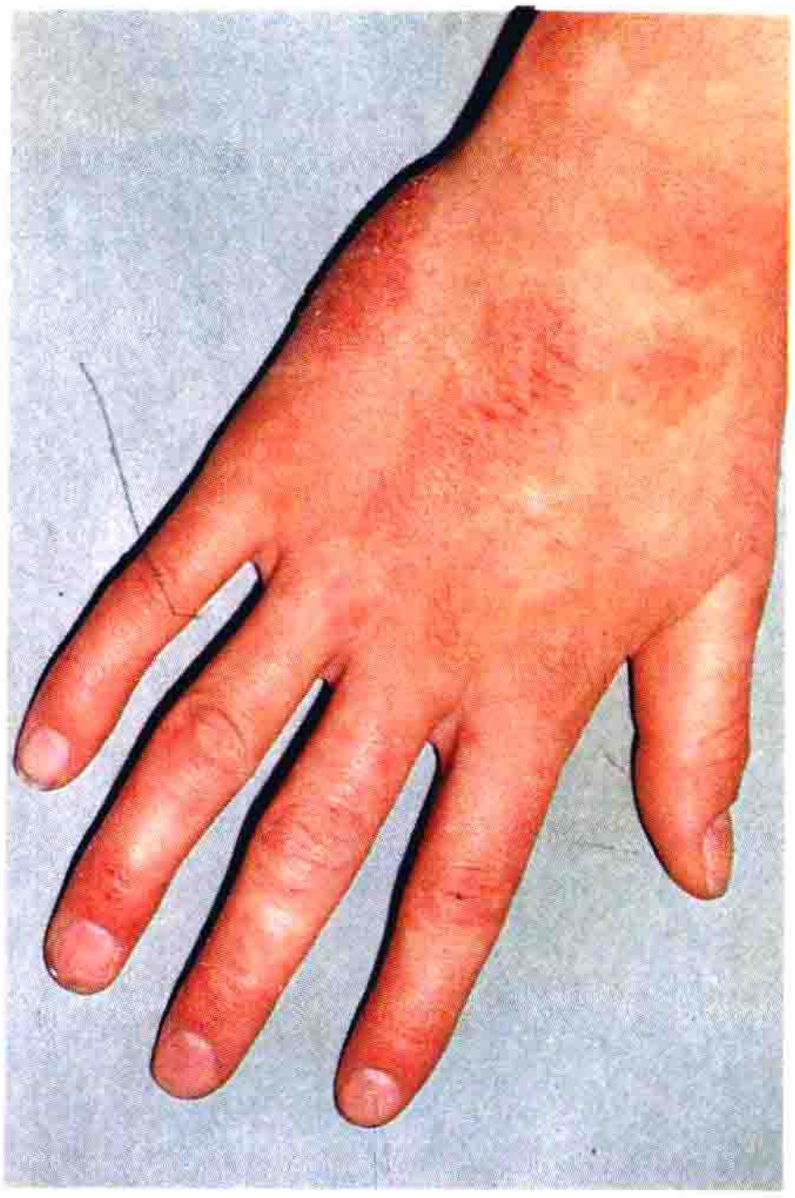

Fig. 3 Chronic dry eczema on the back of the hand of the type often seen in housewives or in any dry-skinned patients who are subjected to water, solvents etc.

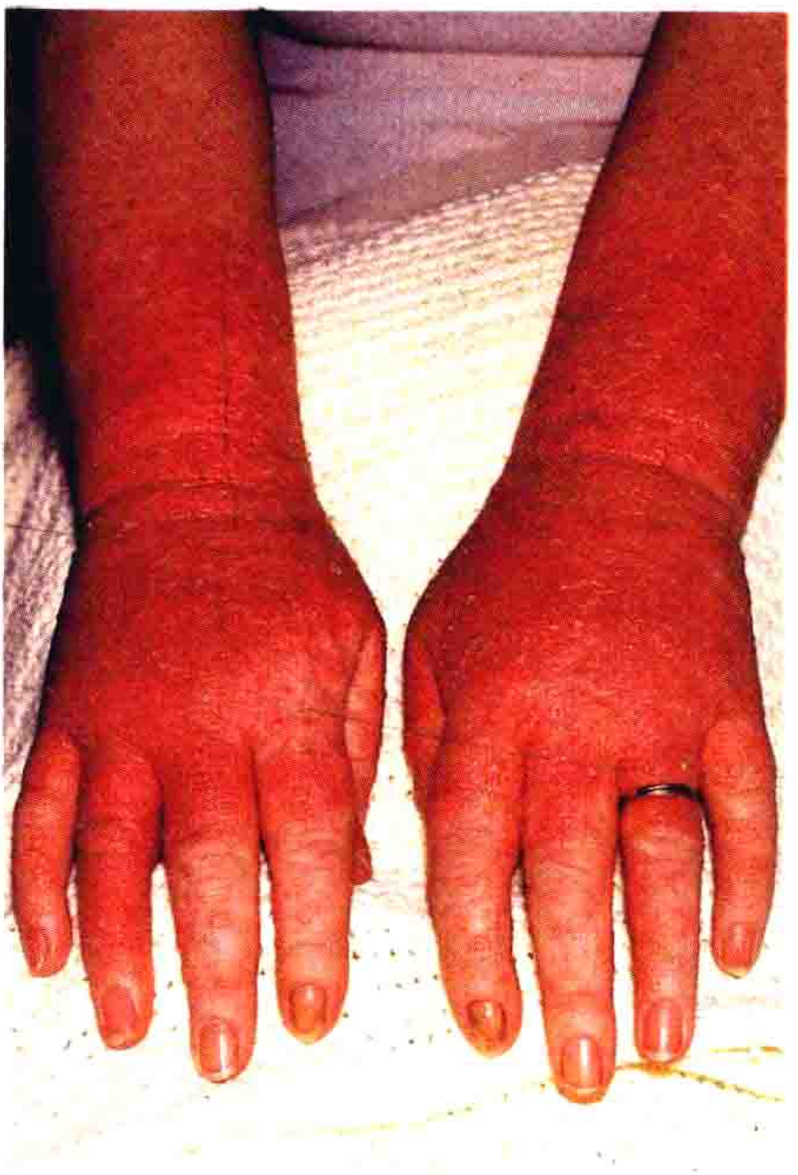

Fig. 4 Acute eczematous dermatitis of both hands and forearms which suggests a contact cause, perhaps rubber gloves.

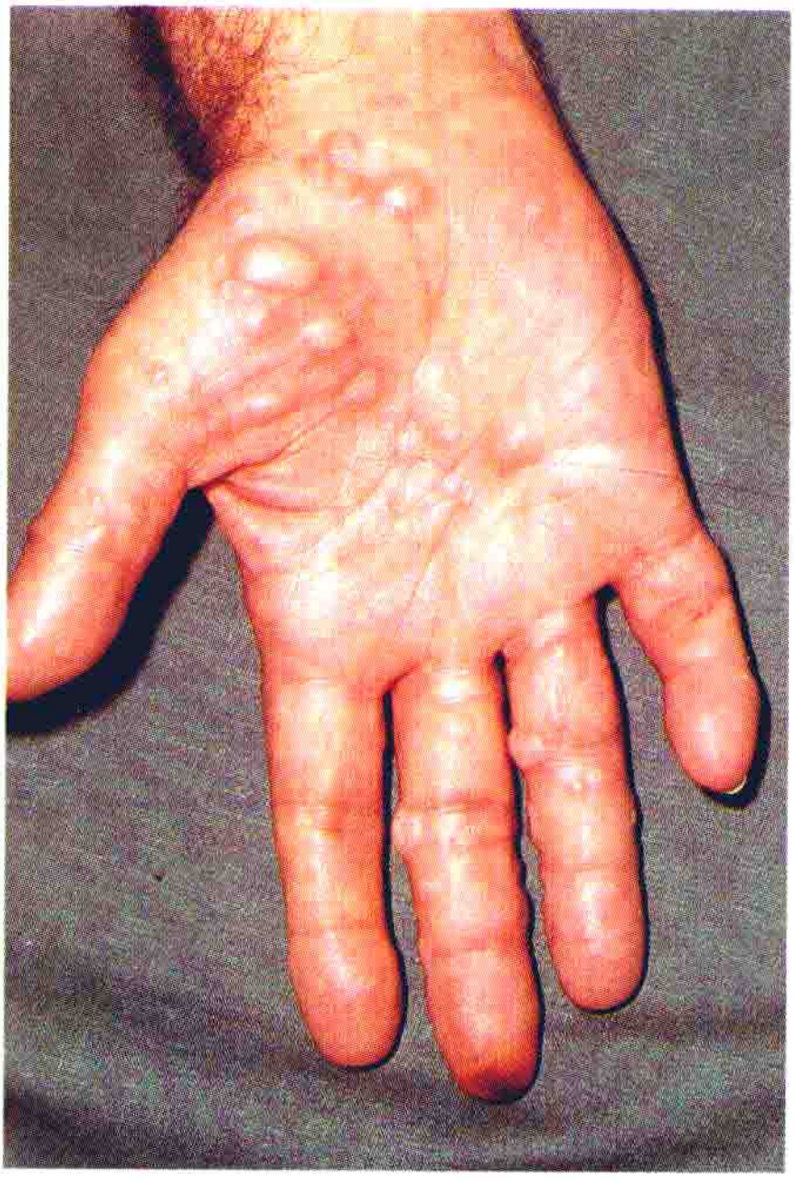

Fig. 5 Vesicular eczema of the type often called pompholyx, for which, frequently, no cause can be found. Attacks may be recurrent over many years.

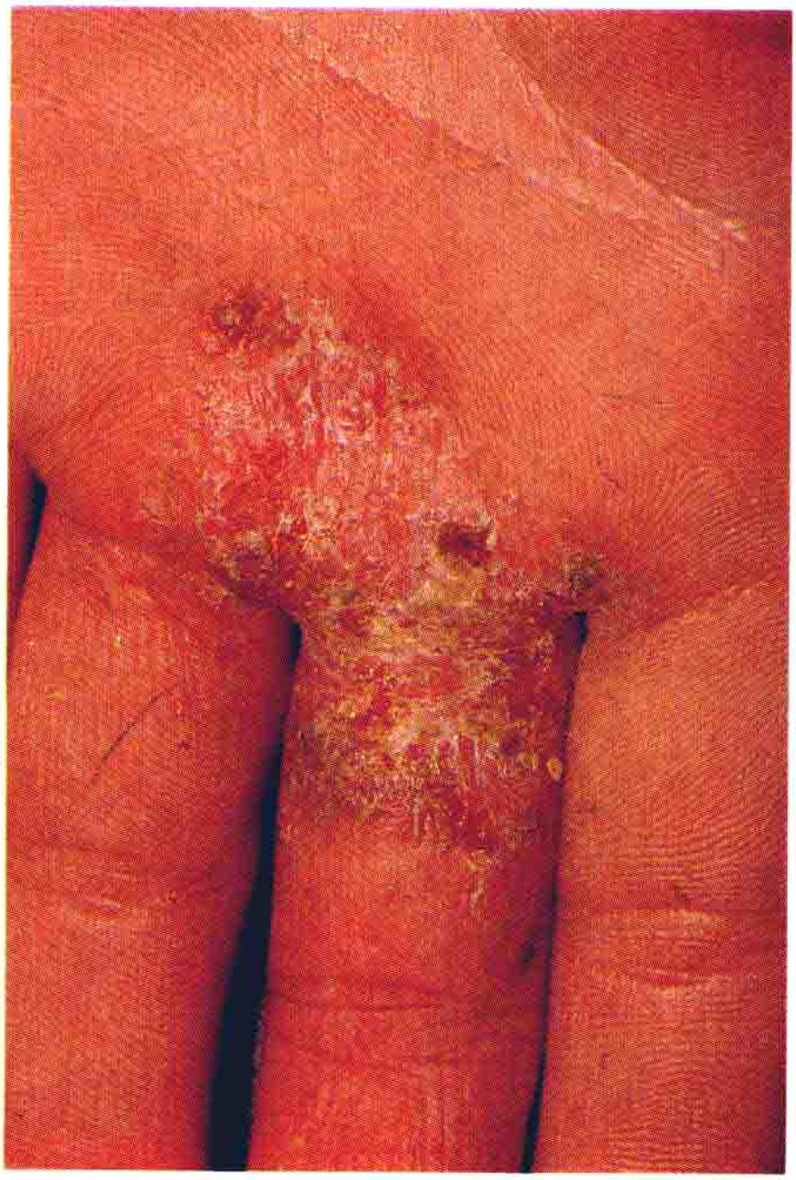

Fig. 6 Localised patch of crusted and infected eczema in an atopic child. Such patches responded readily to treatment but recurred over many months.

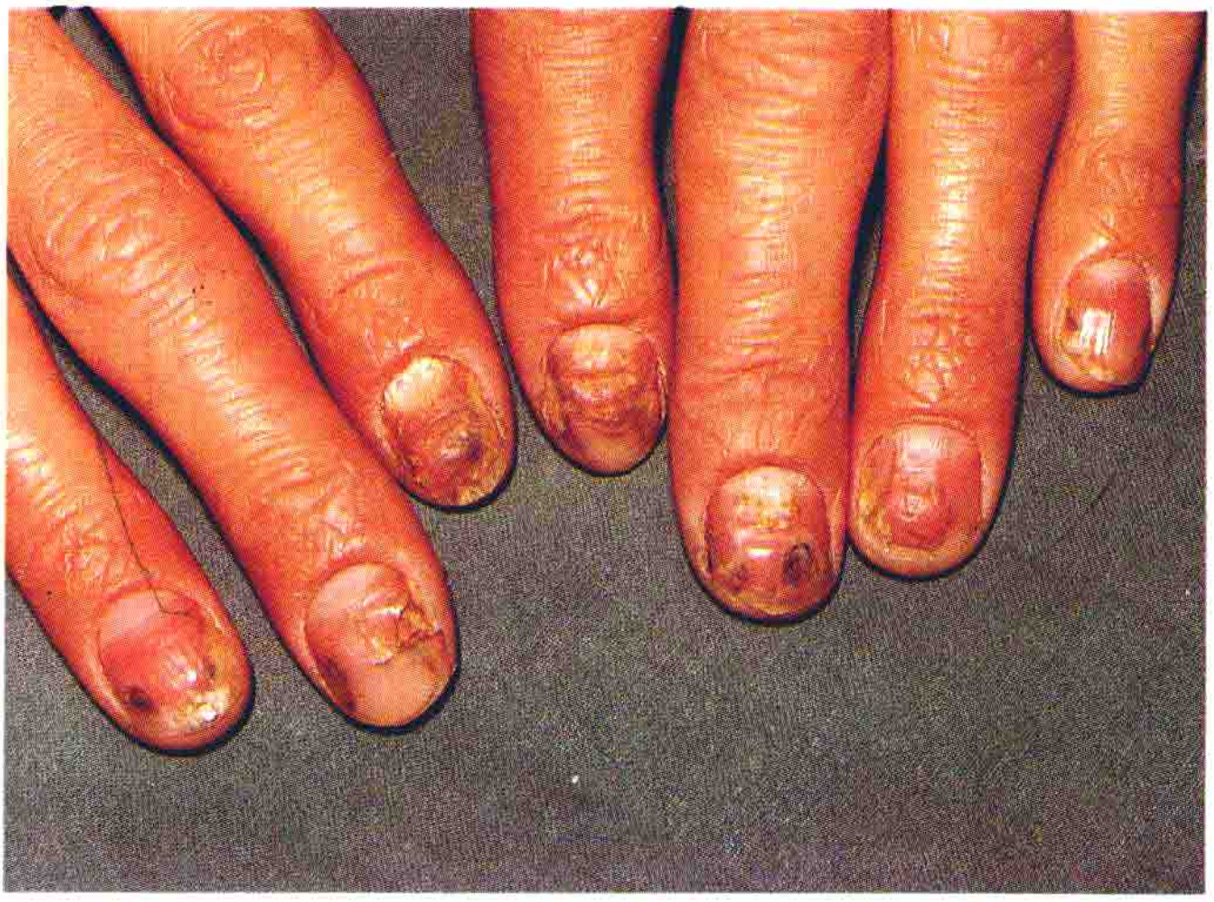

Fig. 7 Eczema of the nails. This may be caused by direct irritation of the nails or, as in this case, can be secondary to chronic eczema of the fingers. The nails themselves show transverse ridging and discoloration, which is characteristic of eczema. The diagnosis of all nail conditions is extremely difficult; this case could be mistaken for fungal infection or even for psoriasis.

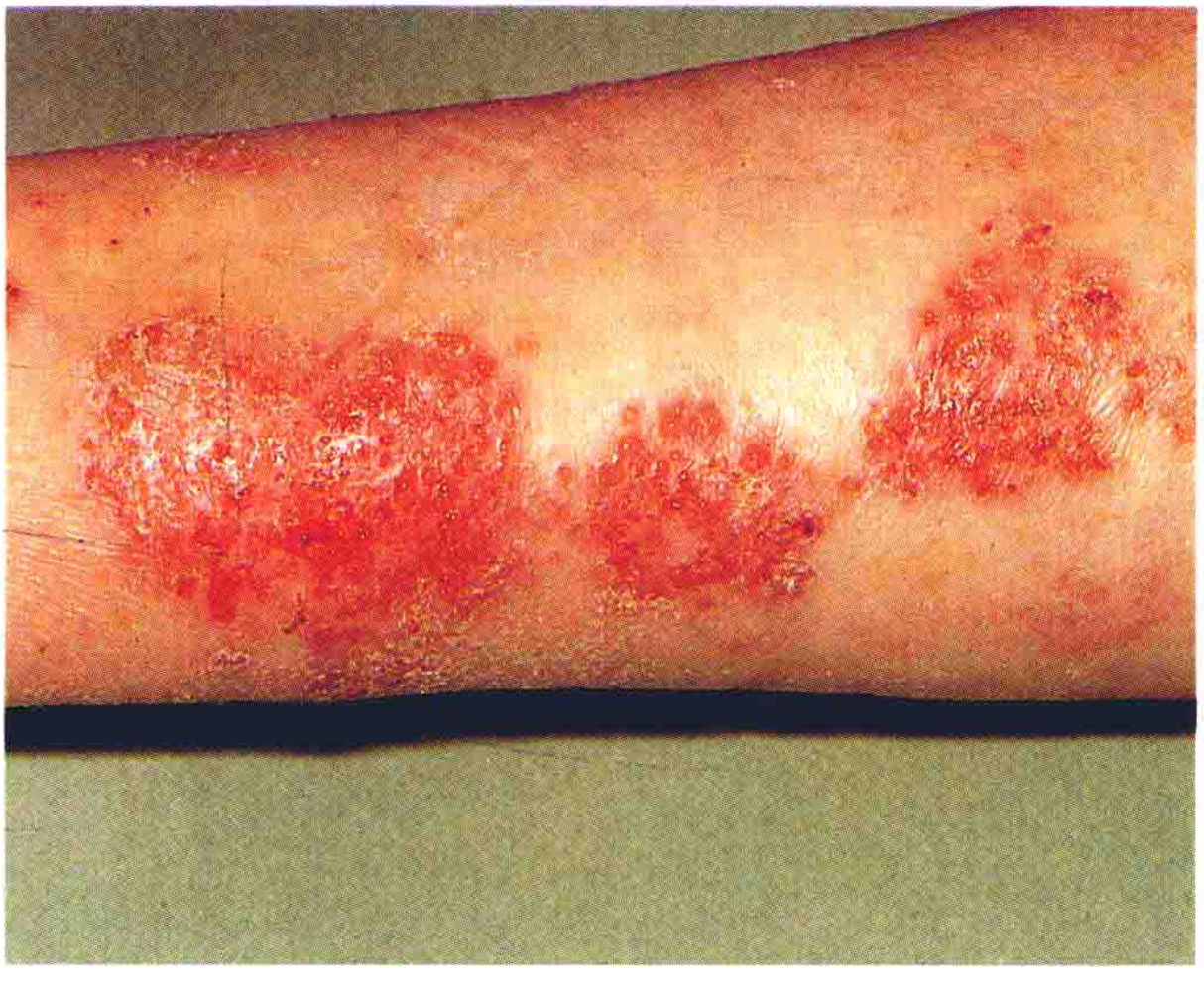

Fig. 8 An oozing, discoid or nummular type of eczema is commonly seen on the forearms and legs, running a chronic course over months or years. Although suppressive treatment is fairly successful in this sort of eczema, a cause can seldom be found.

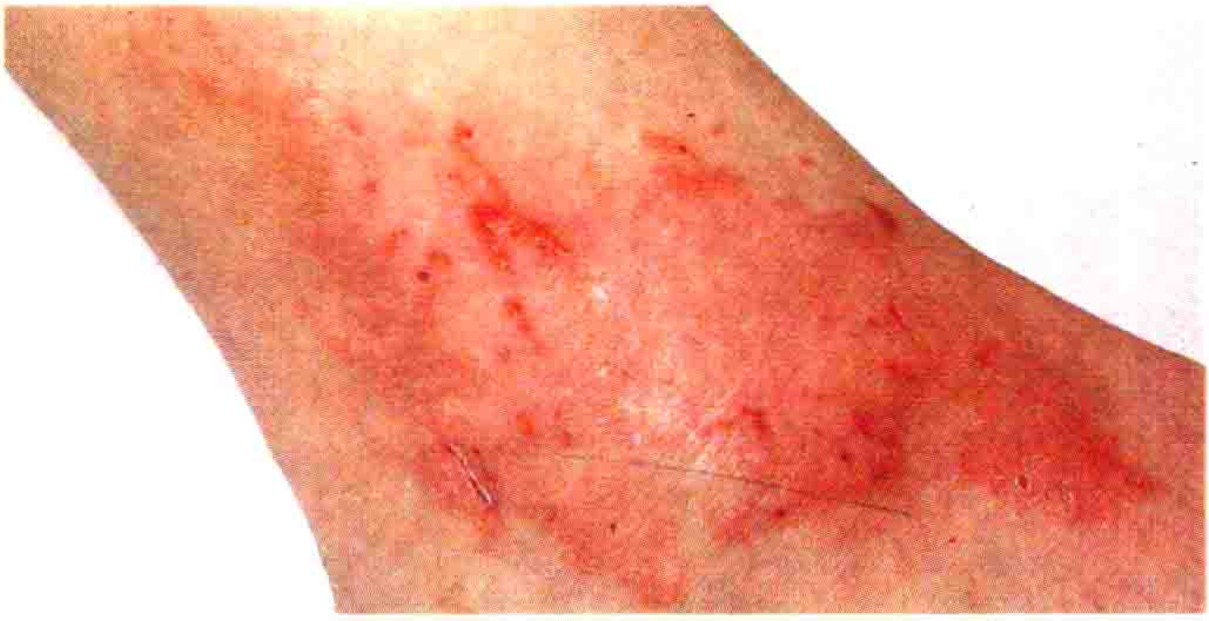

Fig. 9 Chronic excoriated and lichenified eczema of the ankle. This type of eczema is often termed neurodermatitis and is perpetuated by scratching or as here by rubbing one foot against the other leg.

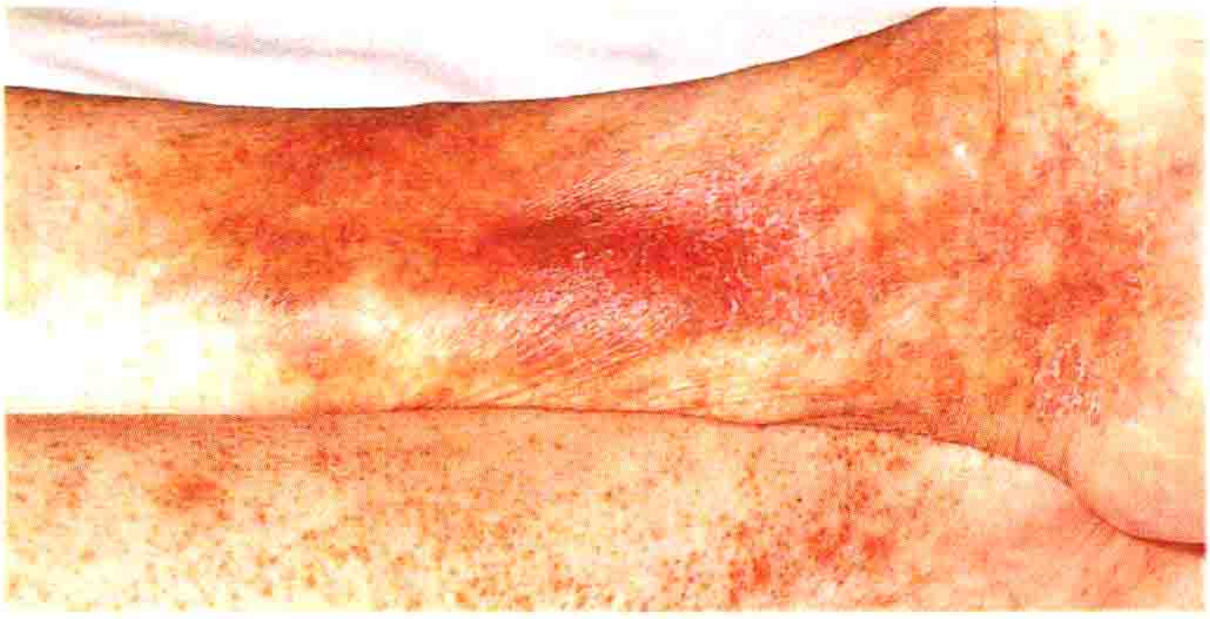

Fig. 10 This case of eczema at first appears similar to the example above, but shows chronic hypostatic pigmentation which is often wrongly called varicose eczema. It can occur in the absence of varicose veins although it does indicate circulatory deficiency of some kind.

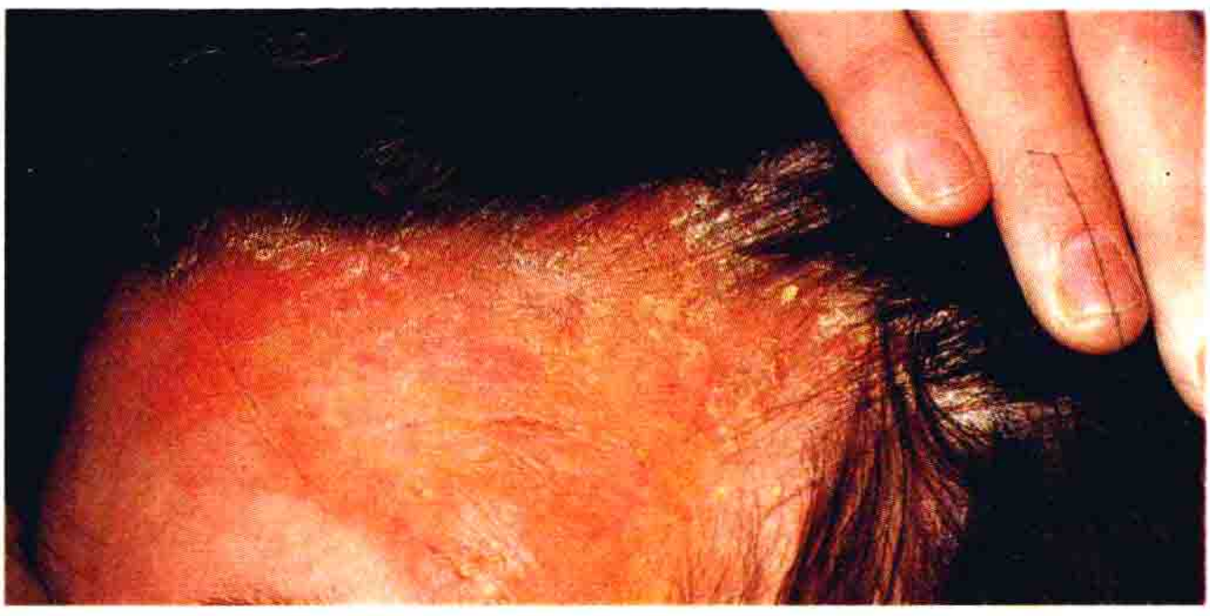

Fig .11 Seborrhoeic dermatitis of the forehead and scalp. It may be difficult, often impossible, to distinguish this from psoriasis (see Fig. 39).

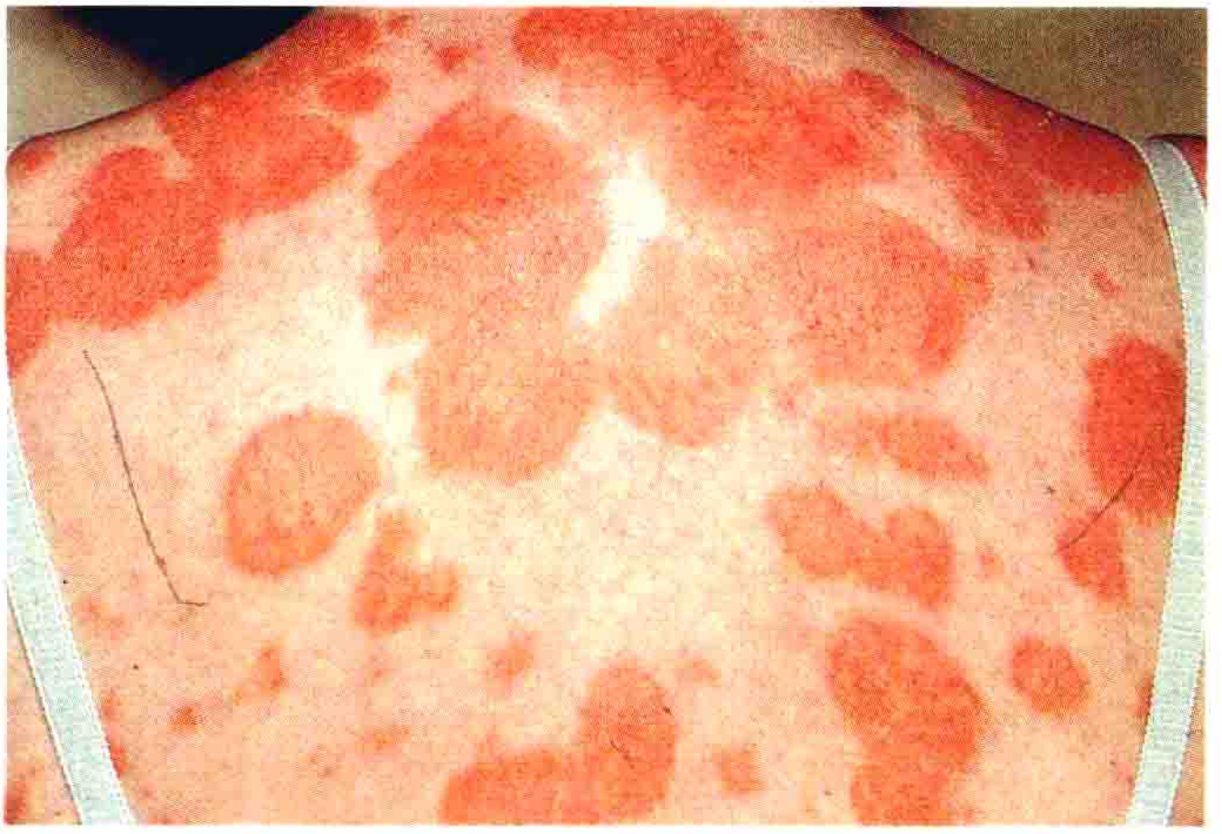

Fig. 12 Widespread discoid or petaloid eruption associated with seborrhoeic dermatitis at other sites. This cleared up rapidly with simple treatment which it would not have done if it had been psoriasis.

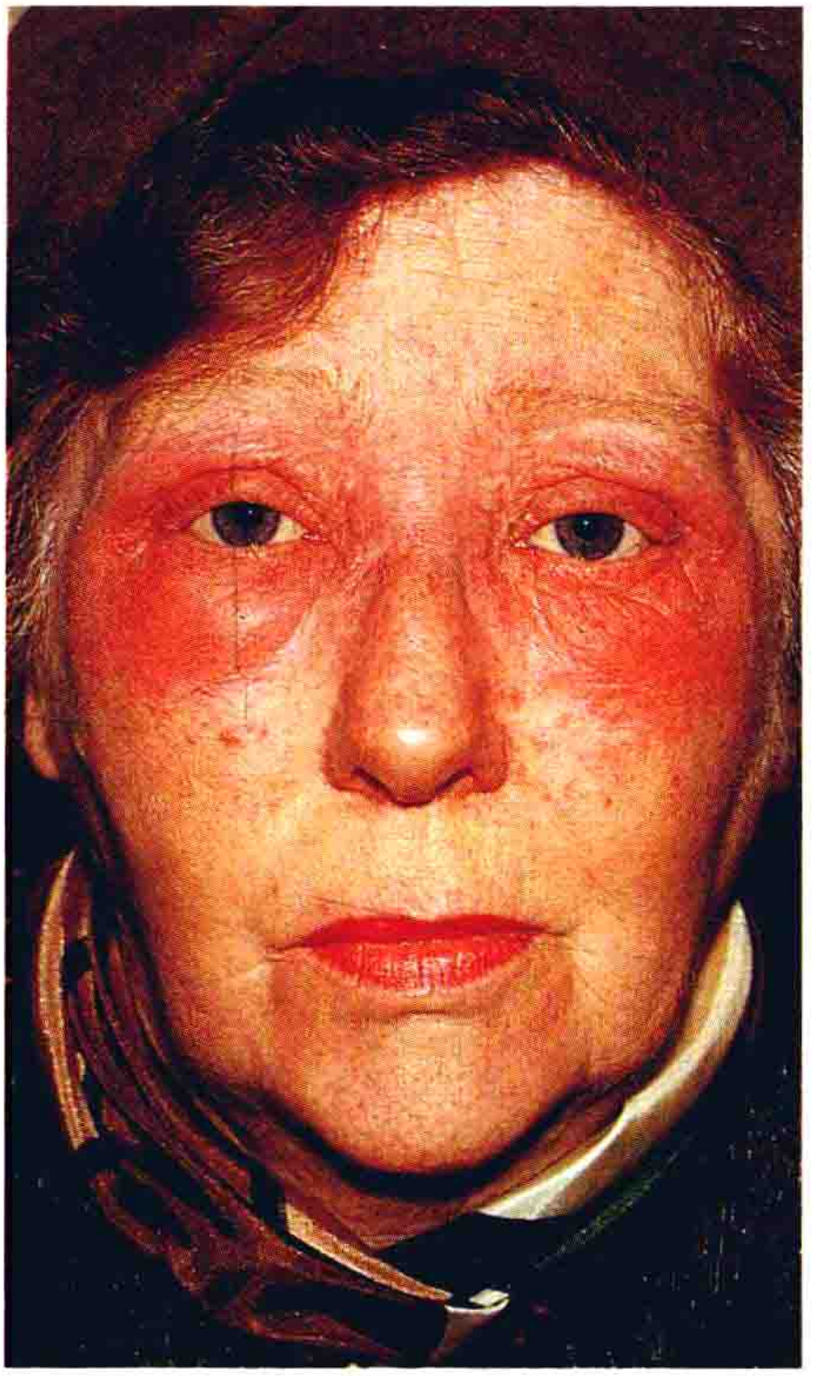

Fig. 13 Eczematous eruptions around the eyes and on the face generally can be extremely difficult to treat. Cosmetics are frequently blamed but are seldom the cause. It may be worthwhile to investigate such cases using patch testing. Active ingredients and preservatives in eye medications can cause this sort of rash and allergic sensitivity to nail varnish commonly produces a rash on the sides of the neck or on the eyelids.

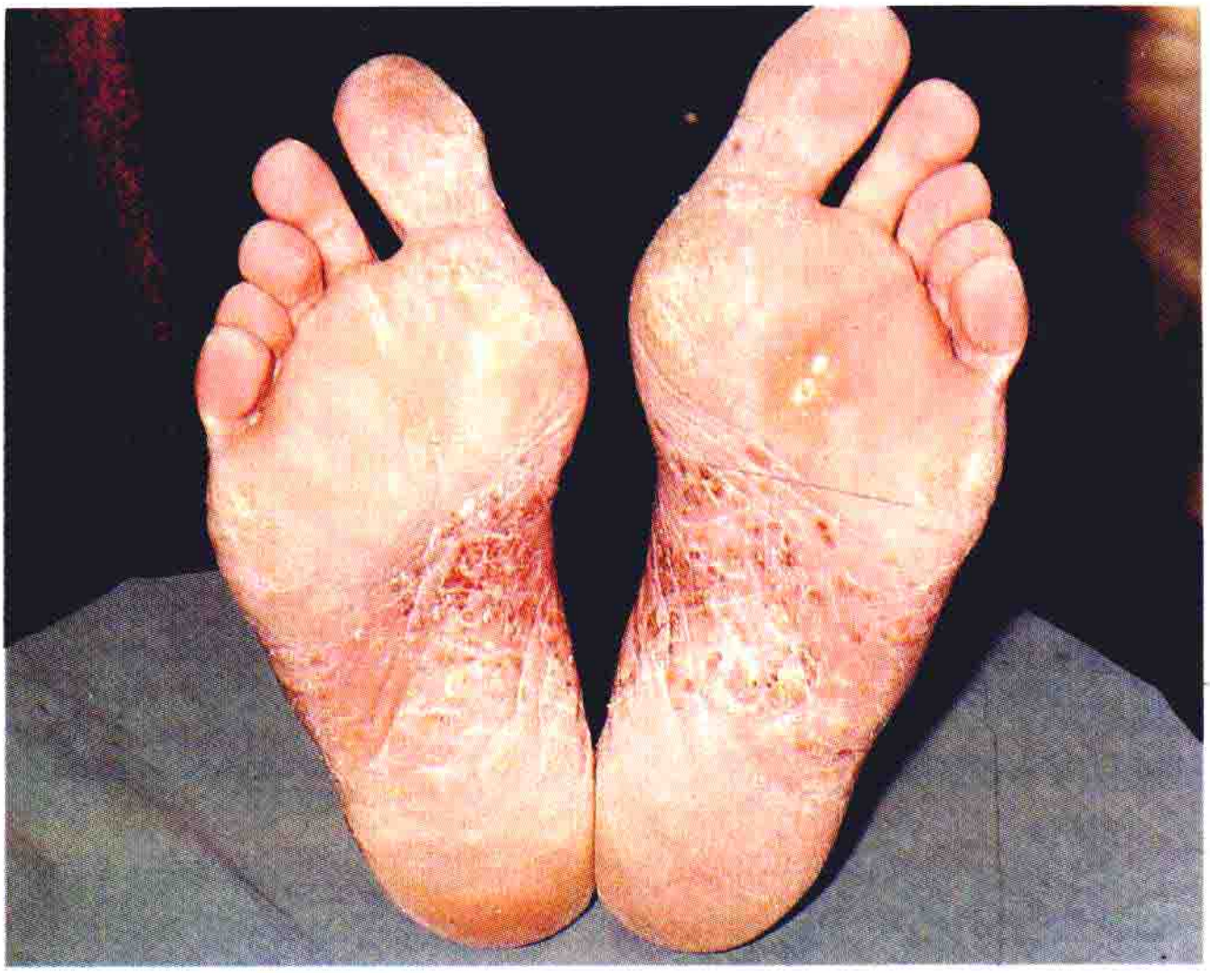

Fig. 14 Chronic vesico-pustular eczema of the central soles. This is frequently wrongly diagnosed as tinea pedis, which is not a differential diagnosis. Some dermatologists refer to all cases of this type as either pustular psoriasis, chronic palmar plantar pustulosis, recalcitrant eruption of the palms and soles, bacterid etc. Such cases are difficult to treat.

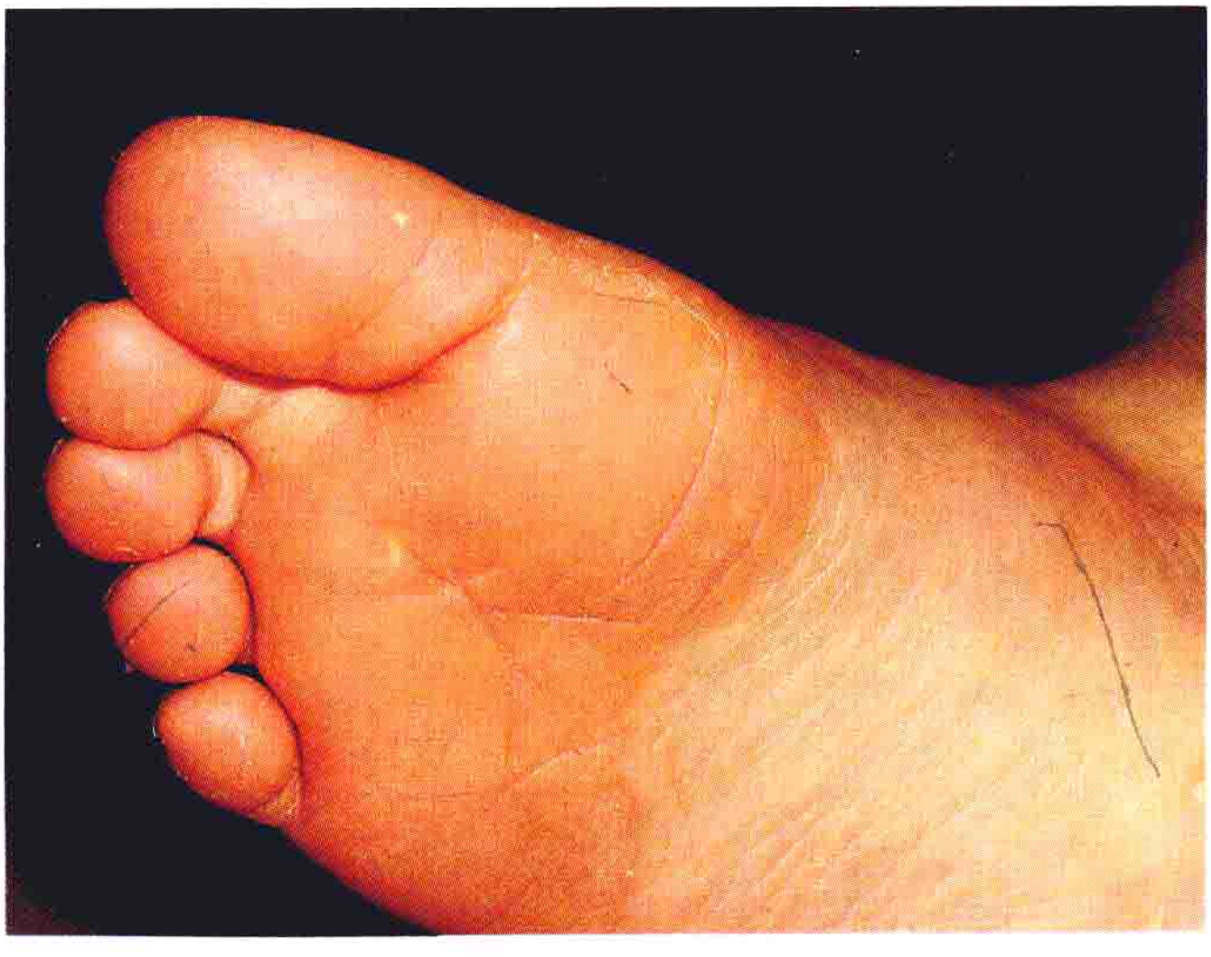

Fig. 15 Juvenile plantar dermatosis. This condition is associated with the wearing of modern non-porous footwear and has only appeared in dermatological literature in relatively recent years.

Infantile eczema

Eczema may begin at any age and in children it may cause parental concern about prognosis. In babies it is often mild and transient, yielding to simple treatment.

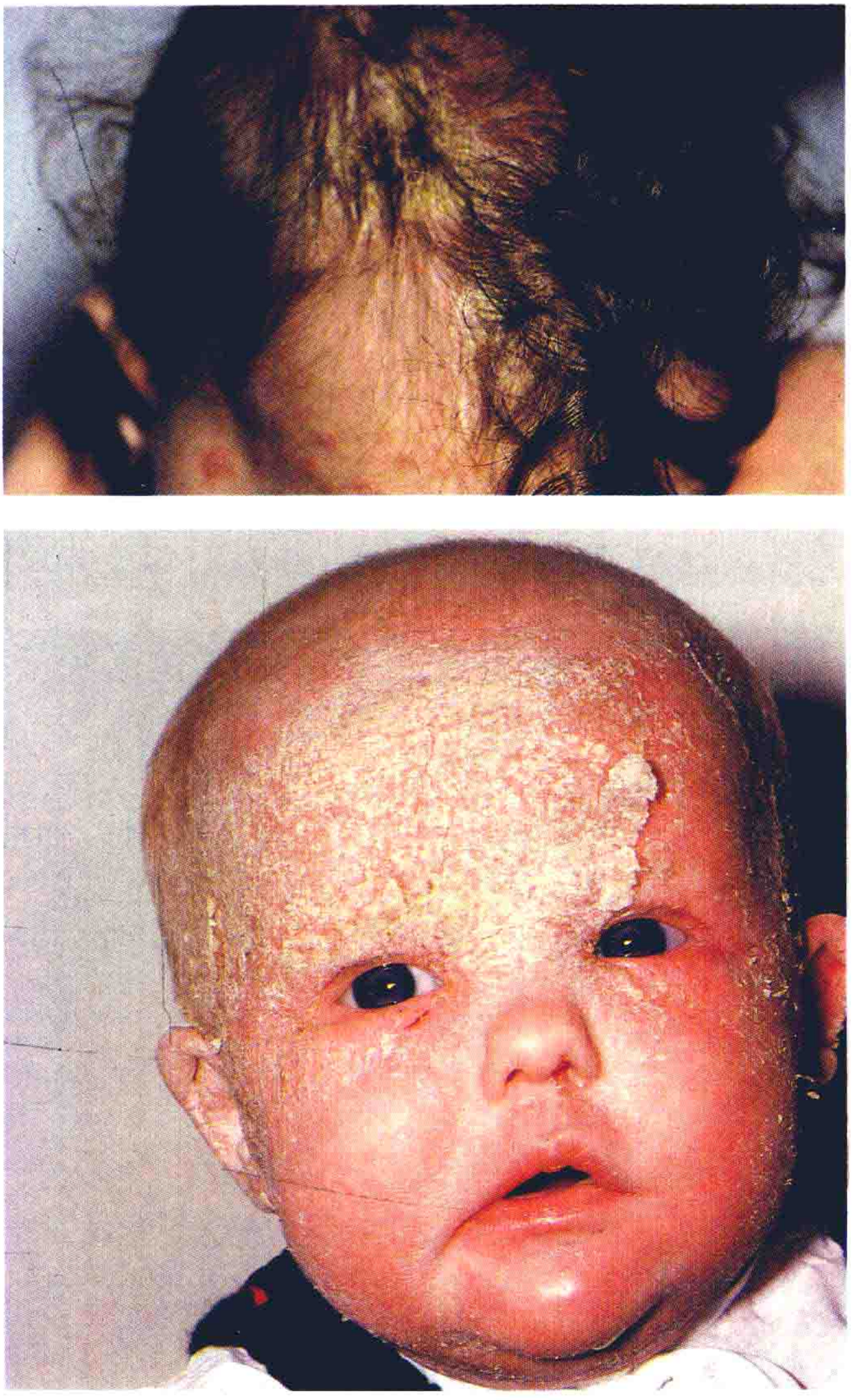

Fig. 16 'Cradle cap' (top) is common and usually no problem, but sometimes it persists and spreads to the face (bottom), indicating the beginning of atopic eczema.

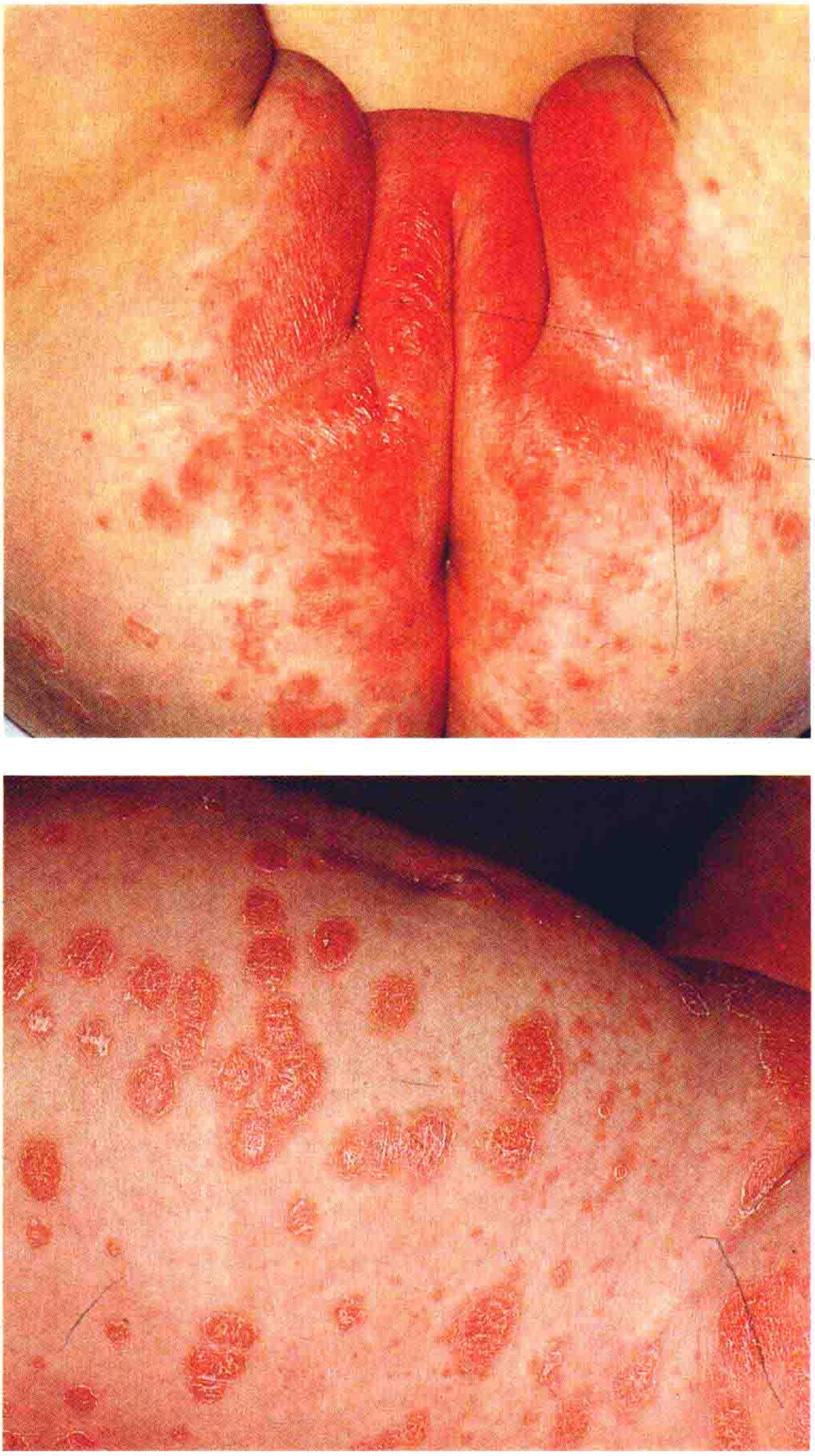

Fig. 17 Napkin rashes are commonly due to low grade infection under infrequently changed, occlusive plastic pants. This rash at first appeared to be a simple nappy rash (top), but spread (bottom) and resembled psoriasis. This type of infantile eczema looks alarming, but responds to treatment and may have a good long-term prognosis.

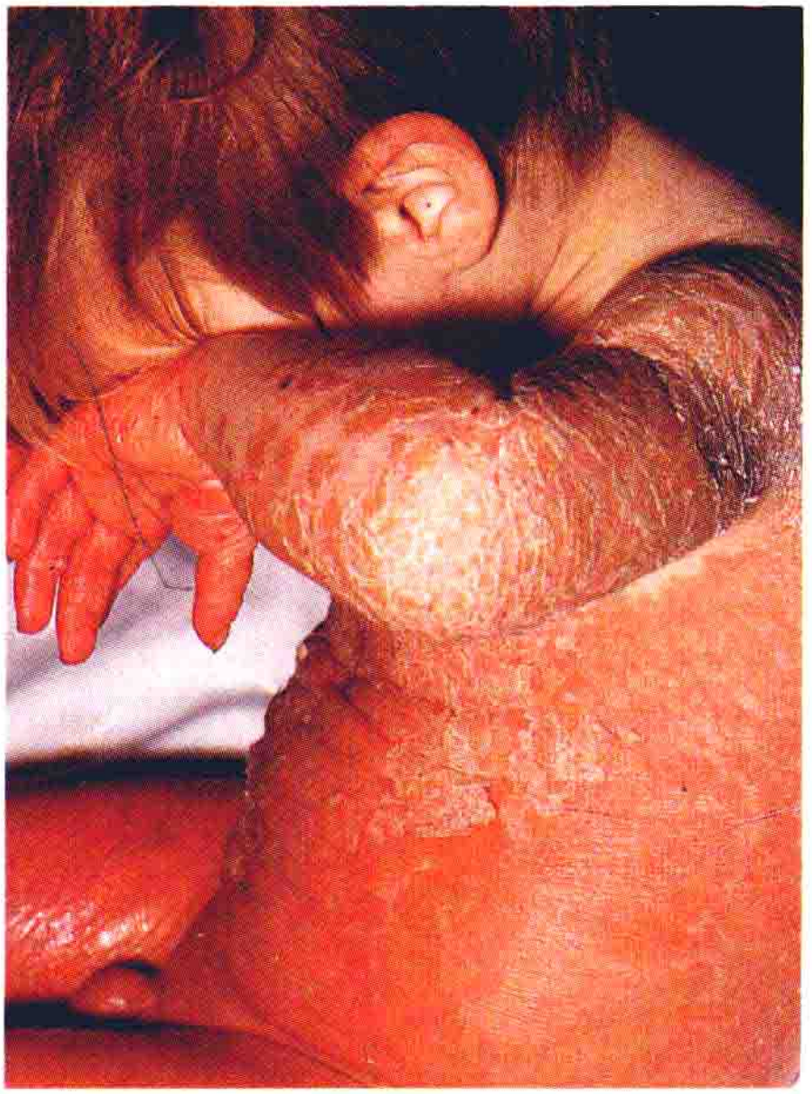

Fig. 18 The appearance of widespread, severe infantile atopic eczema with its attendant misery is unmistakable. The immediate prognosis in hospital is good, but the outcome is less certain. It is easy to make statistical statements about prognosis based on hospital figures, but much more difficult to assess an individual infant.

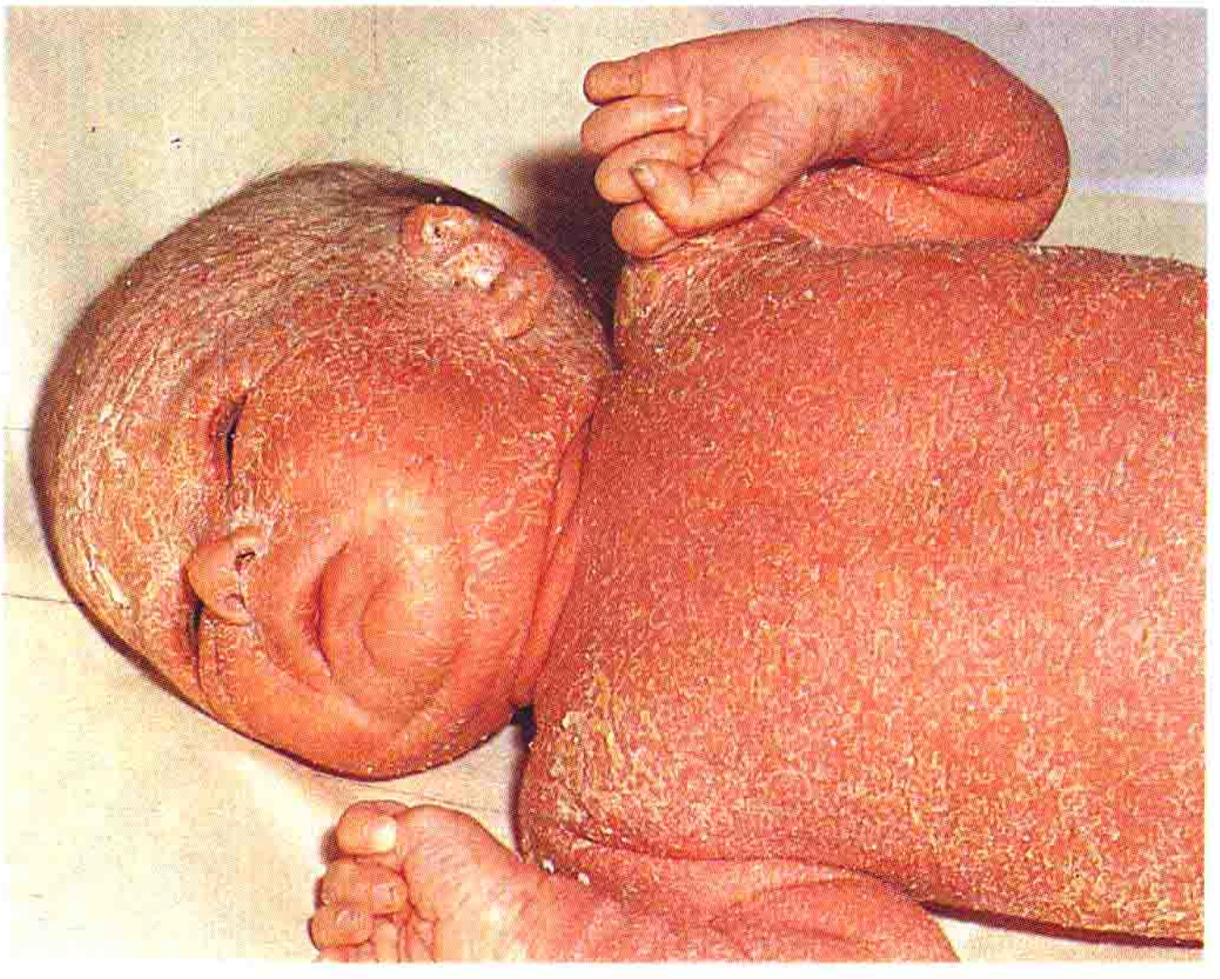

Fig. 19 Most persistent atopic eczema produces dryness and lichenification. Some infants present from the beginning with dry skin which they scratch incessantly. It is sometimes difficult to decide whether this is primary atopic eczema, or eczema secondary to ichthyosis. A careful history and follow-up usually determines the cause, but both conditions may coexist, as here.