PODCAST No. 12

INTRODUCTIONS:

FEEDBACK:

TOPIC: Dermatology history and examination requested by Prof Wright

TIP: When taking photos, aim to take at least one close up for detail of the lesion and one at a distance to give perspective

DISCUSSION:

History

Presenting complaint Nature, site and duration of problem

History of presenting complaint

- Initial appearance and evolution of lesion
- Symptoms (particularly itch and pain, bleeding, blistering)
- Aggravating and relieving factors
- Previous and current treatments (effective or not)
- Recent contact (eg c.pox), stressful events, illness and travel
- History of sunburn

Past medical history

- History of atopy i.e. asthma, allergic rhinitis, eczema
- History of skin cancer and suspicious skin lesions

Family history

- Family history of skin disease

Social history

- Occupation (including skin contacts at work)
- Improvement of lesions when away from work

Medication and allergies

Impact on quality of life –*sleep/self conscious/low mood*

Examining the skin

• There are four important principles in performing a good examination of the skin:

INSPECT, DESCRIBE, PALPATE and SYSTEMATIC CHECK (nails and hair)

INSPECT in general

- General observation
- Site and number of lesion(s)
- If multiple, pattern of distribution and configuration

Are they:

- localised (e.g. a mole, tinea*)?*
- widespread (e.g. chicken pox)?
- if widespread, is it symmetrical and, if so, central (pityriasis rosea) or peripheral eg HSP?
- does it involve the flexures (e.g. atopic eczema)?
- does it involve the extensor aspects (e.g. psoriasis)?
- is it limited to sun-exposed sites? Pellagra
- is it linear? Eg koebner phenomenon in scars
- Pressure areas-buttocks/heels
- is it regional (e.g. groin or axilla-hydradenitis)?
- does it follow a dermatomal (corresponding to root nerve distribution) pattern (e.g. shingles)?

DESCRIBE

SCAM

S= size/shape

- Discrete Individual lesions separated from each other
- Confluent Lesions merging together
- Linear In a line
- Target Concentric rings (like a dartboard) *erythema multiforme*
- Annular Like a circle or ring *Ringworm*
- Discoid / A coin-shaped/round lesion *Discoid eczema*

C=colour

- Erythema Redness (due to inflammation and vasodilatation) which blanches on pressure ***Palmar erythema***
- Purpura Red or purple colour (due to bleeding into the skin or mucous membrane) which does not blanch on pressure – petechiae (small pinpoint macules) and ecchymoses (larger bruise-like patches) *eg HSP/meningococcal*

- Hypo- pigmentation Area(s) of paler skin *Pityriasis versicolor or post eczema inflammation*
- De- pigmentation White skin due to absence of melanin *vitiligo/leprosy*
- Hyper- pigmentation Darker skin which may be due to various causes *(e.g. Melasma)*

A= Associated secondary change

- Excoriation Loss of epidermis following trauma eczema/itch
- Lichenification Well-defined roughening of skin with accentuation of skin markings eczema
- Scales Flakes of stratum corneum psoriasis
- Crust Rough surface consisting of dried serum, blood, bacteria and cellular debris that has exuded through an eroded epidermis (e.g. impetigo)
- Scar New fibrous tissue which occurs post-wound healing, and may be atrophic (thinning), hypertrophic (hyperproliferation within wound boundary), or keloidal (hyperproliferation beyond wound boundary)
- Ulcer Loss of epidermis and dermis (heals with scarring)
- Fissure An epidermal crack often due to excess dryness
- Striae Linear areas which progress from purple to pink to white, with the histopathological appearance of a scar (associated with excessive steroid usage and glucocorticoid production, growth spurts and pregnancy)

M=morphology (structure)

- Macule A flat area of altered colour eg freckle
- Patch Larger flat area of altered colour or texture eg port wine stain, large birth mark
- Papule Solid raised lesion < 0.5cm in diameter Xanthomata (cholesterol)
- Nodule Solid raised lesion >0.5cm in diameter with a deeper component (pyogenic granuloma)
- Plaque Palpable scaling raised lesion >0.5cm in diameter eg psoriasis
- Vesicle Raised, clear fluid-filled lesion <0.5cm in diameter eg c.pox
- Bulla Raised, clear fluid-filled lesion >0.5cm in diameter blister eg from insect bite/friction
- Pustule Pus-containing lesion <0.5cm in diameter eg acne
- Abscess Localised accumulation of pus in the dermis or subcutaneous tissues eg paronychia
- W(h)eal Transient raised lesion due to dermal oedema e.g. urticaria/nettle stings
- Boil/Furuncle Staphylococcal infection around or within a hair follicle
- Carbuncle Staphylococcal infection of adjacent hair follicles (multiple boils/furuncles)

With moles, remember ABCD (the presence of any of these features increase the likelihood of melanoma):

- Asymmetry (lack of mirror image in any of the four quadrants)
- Irregular Border
- Two or more Colours within the lesion
- Diameter > 6mm

PALPATE the individual lesion

- Surface
- Consistency –hard/soft
- Mobility
- Tenderness
- Temperature

*S*YSTEMATIC CHECK Examine the nails, scalp, hair & mucous membranes and consider general examination of all systems

In order to describe, record and communicate examination findings accurately, it is important to learn the appropriate terminology. This also helps the dermatology volunteers give accurate and helpful advice.

GOODBYES: