**Aisling Chung Dermatology**

***SimPat Static Patient Cases***

[**Individual Details: 5**](#_xon7r6l7e1m)

[**★ Notes: ★ 5**](#_aesafab5wto6)

[**Cases 15**](#_w46qdb16ci04)

[**ALYC\_01\_AtopicDermatitis 15**](#_8rm4eb9emxe6)

[A 5-year-old female called Aaliyah Thompson presents with itchy, red, and inflamed skin. 15](#_4nbt84t4tb9g)

[**ALYC\_02\_Urticaria 21**](#_104fsy7z95i2)

[“A 22-year-old male called Jackson Muotune presents with sudden onset of raised, itchy swellings on his body.” 21](#_tkh7zjbdr749)

[**ALYC\_03\_AcneVulgaris 27**](#_8rp6f2p5f9xt)

[A 17-year-old female called Zara Mahmood presents with severe skin troubles. 27](#_o946771lt75v)

[**ALYC\_04\_BasalCellCarcinoma 31**](#_qjrgxb9ex7g9)

[A 65-year-old male called José Silva presents with a persistent, non-healing blemish on his nose. 31](#_69cam4nrph4t)

[**ALYC\_05\_ArterialUlcer 36**](#_kbqf4ekcq8q3)

[A 70-year-old male called Dev Patel presents with a painful lesion on his lower leg. 37](#_lwhwoavvb1ii)

[**ALYC\_06\_Cellulitis 41**](#_wrayuzqphqwh)

[A 52-year-old male called Alejandro Gutiérrez presents with a painful, swollen, and red area on his lower leg. 41](#_uag3cfmxhu7k)

[**ALYC\_07\_Folliculitis 47**](#_top8gyeepzja)

[A 25-year-old female called Nia Johnson presents with clusters of small red bumps on her thighs. 47](#_2wdz83s4e8rb)

[**ALYC\_08\_Cutaneous fungal infection 52**](#_hzo7id1kvav)

[A 32-year-old female called Alejandra Ochoa presents with an itchy rash on her feet. 52](#_cihykwutoj9f)

[**ALYC\_09\_Contact dermatitis 57**](#_h1eaiy8rv7tx)

[A 38-year-old male called Dev Shah presents with red, itchy patches on both hands. 57](#_6munr3da3dpv)

[**ALYC\_10\_Psoriasis 63**](#_uhm2f9eawp0t)

[A 45-year-old male called Amir Bashir presents with persistent patches of red, scaly skin. 63](#_kxdxs07k7wgw)

[**ALYC\_11\_Psoriasis 1**](#_l823l9cd8zx3)

[A 35-year-old male called Charlie presents with scaly, itchy skin patches on his elbows and knees. 1](#_ddax84m90kcj)

[**ALYC\_12\_Psoriasis 1**](#_v8aqvpgnc097)

[A 43-year-old male called Haruto presents with persistent itchy and scaly skin patches on his elbows and knees. 1](#_5nxtcso3hcle)

[**ALYC\_13\_Psoriasis 1**](#_iwywk6otsfu4)

[A 30-year-old female called Navya presents with patches of red, scaly skin on her elbows. 1](#_vmhpdkhm26m5)

[**ALYC\_14\_Psoriasis 1**](#_8xcphcnx3lnj)

[A 29-year-old female called Amara presents with patches of red, itchy skin covered with silvery scales on her elbows and knees. 1](#_bf6o0hke7zig)

[**ALYC\_15\_Psoriasis 1**](#_48mg1hshsrye)

[A 42-year-old female called Aneesa presents with persistent, itchy, scaly patches on her scalp and elbows. 1](#_kp1tytmkv6vx)

[**ALYC\_16\_Psoriasis 1**](#_44d0j3k2quhc)

["A 32-year-old woman called Amara presents with a persistent, itchy rash over her scalp and elbows." 1](#_4hqbod9evuv4)

[**ALYC\_17\_Impetigo 1**](#_xe7oxl3v4pwj)

["A 40-year-old woman named Rhiannon presents with a rash and blisters on her face and arms." 1](#_y9mxl282pfkn)

[**ALYC\_18\_Impetigo 1**](#_6choyzvqqtim)

["A 28-year-old woman called Dana presents with a rash on her face." 1](#_o7z4w61ndsh0)

[**ALYC\_18\_Cutaneous\_Warts 1**](#_wp2mmae9jmi1)

["A 34-year-old woman called Mary presents with multiple small growths on her hands and feet." 1](#_sdqxiz34182y)

[**ALYC\_19\_Cutaneous\_Warts 1**](#_5rfp6cvs1e7u)

["A 30-year-old woman presents with a skin concern." 1](#_vulzl8tgz1z2)

[**ALYC\_20\_Cutaneous\_Warts 1**](#_xfzt42ig010b)

["A 36-year-old woman presents with multiple rough lumps on her hands and fingers." 1](#_u8w723cwfgf)

[**ALYC\_21\_Cutaneous\_Warts 1**](#_wljbiiqcq2og)

["A 30-year-old woman presents with concerns about skin growths." 1](#_yg3hf9xidpd)

[**ALYC\_22\_Cutaneous\_Warts 1**](#_5rkhfc9i7a3w)

[“A 42-year-old woman presents with a problem with her skin.” 1](#_3ejx38km5a5n)

[**ALYC\_23\_Scabies 1**](#_hkumrxj72vt9)

[“A 38-year-old woman presents with intense itching and rash.” 1](#_bw3x5kj1x694)

[**ALYC\_24\_Scabies 1**](#_z8ma1xqi1vl6)

["A 42-year-old man called John presents with intense itching and a rash on his body." 1](#_rb3lczemr7a8)

[**ALYC\_25\_Scabies 1**](#_vtirtli1qqvc)

[A 36-year-old woman called Amal presents with a persistent itchy rash. 1](#_gkgkqftg5hr6)

[**ALYC\_26\_Scabies 1**](#_k8dmn82skdww)

["A 35-year-old female presents with itching and a rash all over the body." 1](#_np2pp6edrspn)

[**ALYC\_27\_Acne\_Vulgaris 1**](#_bhupr7wz6k4)

["An 18-year-old woman presents with concerns about her skin." 1](#_9gqtnxzhy67e)

[**ALYC\_28\_Acne \_Vulgaris 1**](#_19w3ogiuvel9)

["A 28-year-old woman presents with concerns about her facial appearance." 1](#_z6ei4lfjy8d4)

[**ALYC\_29\_Acne\_Vulgaris 1**](#_ryhxgnzibtf5)

[“A 24-year-old woman presents with concerns about her skin.” 1](#_6z8npdgk5ker)

[**ALYC\_30\_Acne\_Vulgaris 1**](#_fedjl8qol44y)

[“A 24-year-old woman presents with concerns about her skin.” 1](#_ywh2r5q33sxd)

[**ALYC\_31\_Acne\_Vulgaris 1**](#_fp517hihz6j3)

["A 23-year-old woman called Leiko presents with concerns about her skin." 1](#_4f91b0s8rk60)

[**ALYC\_32\_Atopic\_Dermatitis 1**](#_rn295f1cp5rq)

[“A 32-year-old woman called Isabel Layton presents with an itchy, red rash.” 1](#_1p5iqqdloaa)

[**ALYC\_33\_Atopic\_Dermatitis 1**](#_o1fgupzgg9i9)

[“A 34-year-old woman called Alicia presents with a red, itchy rash on her skin.” 1](#_kbiiv8fi09en)

[**ALYC\_34\_Atopic\_Dermatitis 1**](#_cfnh05xmufuy)

[“A 34-year-old woman called Maya presents with a rash and itching.” 1](#_nz47hy7shm1i)

[**ALYC\_35\_Atopic\_Dermatitis 1**](#_6ez3le4cb8ht)

[A 35-year-old woman presents with a skin rash and itching. 1](#_7xfz7uh1rdaj)

[**ALYC\_36\_Basal\_Cell\_Carcinoma 1**](#_dqqliof4y7ny)

["A 43-year-old male called Kolya presents with a new lesion on his face which is changing over time." 1](#_dwbcx03u8mtt)

[**ALYC\_37\_Basal\_Cell\_Carcinoma 1**](#_zbm3pyrica6q)

["A 55-year-old male called George presents with a persistent sore on his face." 1](#_fz3g2dyv3tpo)

[**ALYC\_38\_Basal\_Cell\_Carcinoma 1**](#_ist636ca1a54)

[“A 55-year-old woman called Ekene presents with a raised, pearly pink or red spot on her nose.” 1](#_gqkuxsicezui)

[**ALYC\_39\_Basal\_Cell\_Carcinoma 1**](#_mupv8za72ewj)

["A 57-year-old woman presents with a slow-growing lesion on her face and is concerned about it." 1](#_rbpuk2b8x3hu)

[**ALYC\_40\_Cellulitis 1**](#_pijen982gu4u)

["A 46-year-old woman called Jazmín presents with sore skin on the lower limbs." 1](#_7b6ouun05kgz)

[**ALYC\_41\_Cellulitis 1**](#_puh63epcn5c)

[“A 38-year-old woman called Nadége presents with red, warm, legs.” 1](#_z107hdnzuecj)

[**ALYC\_42\_Cellulitis 1**](#_766updhx75fh)

[“A 45-year-old man called John presents with a red, tender area of skin on his leg, causing him to limp.” 1](#_8kcm5iygwf9y)

[**ALYC\_43\_Contact\_Dermatitis 1**](#_ndtsqcu2akhb)

[“A 34-year-old woman presents with a rash and itching.” 1](#_btm1m7u001bx)

[**ALYC\_44\_Contact\_Dermatitis 1**](#_sikynulpbbc2)

["A 34-year-old female presents with a red, itchy rash." 1](#_shpkpy2d98ih)

[**ALYC\_45\_Contact\_Dermatitis 1**](#_vn2115h50t0b)

["A 34-year-old man called Jared presents with a rash." 1](#_avulfuhxn9hw)

[**ALYC\_46\_Contact\_Dermatitis 1**](#_do79k9vl0kqf)

["A 35-year-old woman presents with a new itchy rash” 1](#_l4iih0fwiy11)

[**ALYC\_47\_Folliculitis 1**](#_75hzhcf7kame)

["A 35-year-old woman called Rachel presents with red bumps and tiny abscesses on the skin” 1](#_7d3p6qr13bzu)

[**ALYC\_48\_Folliculitis 1**](#_t3vxv2vs5ljh)

["A 37-year-old woman presents with painful, itchy red bumps on her skin." 1](#_yotumr8s8dpt)

[**ALYC\_49\_Malignant\_Melanoma 1**](#_uqp5h4bo1618)

[**ALYC\_50\_Non-Malignant\_Melanoma 1**](#_ra1o6q2cq14m)

["A 55-year-old woman presents with a new mole on her leg." 1](#_x08q6gwi24im)

[**ALYC\_51\_Squamous\_Cell\_Carcinoma 1**](#_gbgaq520l3ay)

[“A 54-year-old man called Winston presents with a persistent growing lump on his forehead.” 1](#_8k2pp7u1cruc)

[**ALYC\_52\_Squamous\_Cell\_Carcinoma 1**](#_abujcrinjxs5)

["A 57-year-old woman presents with a persistent sore on her arm." 1](#_x8lmu2f5ve8q)

[**ALYC\_53\_Squamous\_Cell\_Carcinoma 1**](#_oqhezxlgn6r1)

["A 58-year-old female called Nikole presents with a persistent sore that won't heal." 1](#_uo9du3fyg4pq)

[**ALYC\_54\_Urticaria 1**](#_olg8hxqir5av)

["A 42-year-old male called Ravi presents with a recurring rash." 1](#_xjb34qw4wiwx)

[**ALYC\_55\_Urticaria 1**](#_lrw8a1xgokdk)

["A 35-year-old female called Emma presents with a sudden onset of itchy red raised welts on her skin." 1](#_ioqxs3tzivh4)

[**ALYC\_56\_Head\_Lice 1**](#_hunpr3fhm9oc)

[“A 9-year-old boy called Mikhail presents with itching on his scalp.” 1](#_j74a2naccdr5)

[**ALYC\_57\_Cutaneous\_Fungal\_Infection 1**](#_6ulwbctnmf4b)

[“A 44-year-old man comes to the general practice with a red, itchy rash.” 1](#_ggjymzp3i9oj)

[**ALYC\_58\_Arterial\_Ulcer 1**](#_8egjzoih1scr)

[“A 65-year-old female called Fiona presents with a sore, red, open wound on her lower leg.” 1](#_wgclz7idg0hr)

[**ALYC\_59\_Arterial Ulcer 1**](#_g7miai3slmj8)

["A 68-year-old man named Trevor presents with painful skin lesions on his legs." 1](#_atxnysw4yow8)

[**ALYC\_60\_Pressure\_Sores 1**](#_kuw6kkdr7rxo)

["A 58-year-old woman presents with painful skin lesions." 1](#_yv3egztllu4p)

[**ALYC\_61\_Pressure\_Sores 1**](#_kfuasl3e6nka)

["A 53-year-old female patient presents with painful skin lesions." 1](#_tmfldtmlm9n2)

[**ALYC\_62\_Cutaneous\_Fungal\_Infection 1**](#_e3ap8tn5s7ih)

["A 35-year-old male called Emhamed presents with a red, itchy rash on his arm." 1](#_q2qbph43bpjv)

[**ALYC\_63\_Cutaneous\_Fungal\_Infection 1**](#_y42f1xsr7shf)

[“A 32-year-old female called Fariza presents with a rash.” 1](#_8hkyc7na5iam)

[**ALYC\_64\_Cutaneous\_Fungal\_Infection 1**](#_8ln7lyarmwu9)

["A 42-year-old woman called Layla presents with a rash on her skin that is causing her discomfort." 1](#_7d2dgls08ru5)

[**◔ Progress checker: 64/50 🙂 1**](#_75zm8ujqs3g9)

# Individual Details:

* Initials Used: ALYC
* WhatsApp Number: 07452818124

# ★ Notes: ★

* Had issues with the AI correctly completing the final part of the text since case 1. Either it would use the patient-generated name and give case credit to said sim patient, or it would omit this last part from the bottom of the case writing entirely.
  + Ok new problem after fixing the inconsistencies in that one: the AI does not present quotes naturally anymore, it simply says “Quote:” without their name or, “David mentions:.....”. Aiming to fix this soon. → Better but still not fixed. Update: now fixed.
* No vitiligo.
* *Use Table of Heading to Organise:*

*Case Code = “Heading 1”, - Highlight then press “Control + alt +1”*

*Homepage vignette = “Heading 2” - Highlight then press“Control + alt +2”*

*Click the update button on the table of headings to update everything*

***Delete these examples when happy***

UKMLA Conditions Checklist

* ☑☑☑☑☑☑Acne vulgaris
* ☑☑☑Arterial ulcers
* ☑☑☑☑☑Atopic dermatitis and eczema
* ☑☑☑☑☑Basal cell carcinoma
* ☑☑☑☑Cellulitis
* ☑☑☑☑☑Contact dermatitis
* ☑☑☑☑☑Cutaneous fungal infection
* ☑☑☑☑☑Cutaneous warts
* ☑☑☑Folliculitis
* ☑Head lice
* ☑☑Impetigo
* ☑☑Malignant melanoma
* ☑☑Pressure sores
* ☑☑☑☑☑☑☑Psoriasis
* ☑☑☑☑Scabies
* ☑☑☑Squamous cell carcinoma
* ☑☑☑Urticaria

# 

# 

Up-to-date dermatology “generic” starter template:

Create the medical patient case variables below that you, the AI, extensively create in that order. Only ever use British English spellings. Only ever use information from the CKS, NICE, BNF, GMC, NHS Website, BMJ Best Practice and the BMJ. Never ever skip sections or write to be completed etc. Always complete every section fully. Always bullet point things. Only use quotation marks when writing patient quotes, do not put general information in quotation marks.

Case Code:

XXX\_XX\_Condition

Leave Xs as Xs, and replace Condition with the medical condition: "Pressure Sores"

Homepage Vignette:

Only state the patient's age, sex, name, (it is 2024 but never state that in the vignette), and the main one or two presenting complaints here. E.g. “A XX-year-old XX called XX presents with XX”. Do not use medically specific terminology especially not disease terms (e.g. acne, warts, pustules, pressure sores, sores etc are not acceptable terms). Use only lay terms (or neutral terms (e.g. lesion) to vaguely describe the impression of the patient's problem.

Individual Page Vignette:

Directly tell the user their role in the scenario and with only the name, age (it is 2024 but never state that in the vignette), occupation, location, and the main one or two presenting complaints of the patient mentioned.

Patient Name:

A full name from a list of names from every part of the world, all given equal weighting, but never use a stereotypical or common name. Always give phonetic pronunciation too. Always indicate what the patient would like to be called.

Age:

A random date of birth as “DD/MM/YYYY” that is suitable for the underlying condition.

Location:

The clinical location appropriate to the presenting complaint of either an Emergency Department, General Practice, Clinic, Hospital, or anything else appropriate. Never include an exact geographical location.

Personality:

A description of the patient’s personality and manner of speaking from an extremely random and diverse range of possible personalities, social histories and educational levels, all given equal weighting.

Presenting Complaint:

A clinically appropriate description of the patient's main reason for seeking medical attention based on the underlying condition.

Quote what they could say for each part of that section in line with personality.

If the patient is a child, always include a quote from both the child and the family member present for every single section with quotes and indicate who is speaking the quote.

Symptoms:

A clinically appropriate list of patient symptoms.

Give all negative or positive findings for full questioning around the topic including about Itching (pruritus), rash, erythema (redness), wheels, scaling, dryness, blisters (vesicles or bullae), pustules, nodules, ulcers, lesions with distinct borders, lesions with indistinct borders, petechiae, purpura, ecchymosis, macules, papules, plaques, texture changes, pigmentary changes (hypo- or hyperpigmentation, or translucency), photosensitivity, pain, burning sensation, edema (swelling), oozing, weeping, crusting, fissures, lichenification (thickened skin), excoriations (scratch marks), telangiectasia, changes in skin colour, atrophy, scars, changes in hair or nail condition, systemic symptoms (fever, weight loss), mucous membrane involvement, distribution patterns (localized vs generalized, symmetric vs asymmetric), onset (acute vs chronic), progression, exacerbating or relieving factors, associated symptoms elsewhere in the body.

Always mention whether symptoms appeared suddenly, gradually, and indicate relative time period (over minutes, days, weeks, months, or years).

Always use SOCRATES for any symptoms in full bullet points like:

Site: Answer and quote

Onset: Answer and quote

Character: Answer and quote

Radiation: Answer and quote

Associated Symptoms: Answer and quote

Timing: Answer and quote

Exacerbating and Relieving Factors:Answer and quote

Severity: Answer and quote.

Quote what they could say for each part of that section in line with personality.

History of Presenting Complaint:

How long the patient has been experiencing the symptoms, any previous treatments attempted and responses, how the symptoms have progressed over time, frequency of symptoms, impact on daily life and activities of daily living (ADLs), impact on work, and impact on physical and mental wellbeing.

State if the above-detailed histories are negative for this case

Quote what they could say for each part of that section in line with personality.

Systemic Symptoms:

A comprehensive bullet point list of symptoms that may affect the patient's entire body. Include all red flag findings and a wide range of possible systemic symptoms such as, photosensitivity, ulcers, blisters, pustules, petechiae, purpura, nodules, tumours, atrophy, lichenification, erosions, excoriations, fissures, keratosis, dermatographism, telangiectasia, hyperpigmentation, hypopigmentation, alopecia, hirsutism, changes in nails (colour, shape, texture), mucosal involvement (oral, genital, ocular), pain, paresthesia, numbness, systemic symptoms (fever, weight loss, malaise, night sweats), lymphadenopathy, arthritis, myalgias, anhidrosis, hyperhidrosis, Raynaud's phenomenon, livedo reticularis, facial flushing, jaundice, oedema, dysphagia, dyspnea, cough, chest pain, palpitations, abdominal pain, diarrhoea, vomiting, headache, vision changes, hearing loss, dizziness, neurological deficits, behavioural changes, sleep disturbances

State each of the above most important systemic symptoms if they are normal in this case.

Quote what they could say for each part of that section in line with personality.

Past Medical History:

A complete list of any previous medical conditions the patient has had, including surgeries and hospitalizations. Also mention any Previous injuries or traumas, Psychiatric or psychological history, History of substance abuse or addiction, Immunizations and vaccination history, or any other relevant medical conditions or significant health events.

Always state positive or negative results for history of atopic disorders or previous skin conditions or autoimmume conditions.

Choose all clinically appropriately from a hugely diverse range.

State any negative aspects.

Quote what they could say for each part of that section in line with personality.

Drug History:

A complete list of any medications (prescription, alternative, homoeopathic and over-the-counter) the patient is currently taking or has taken in the past, always including dosages and frequency.

Mention any History of medication non-compliance or missed doses, use of herbal supplements or alternative therapies, use of contraception or HRT, non-pharmacological interventions, or overdose incidents.

Always state any positive or negative results for past use of topical steroids or medications used for skin conditions or contraceptive in female patients. Do not mention contraceptives if a female patient under 16 years of age.

Quote what they could say for each part of that section in line with personality.

Allergies:

Any allergies and intolerances the patient has to medications, anaesthetics, foods, allergens, materials, chemicals, vaccinations, or animals. select randomly from a huge diverse range, all given equal weighting. Always say what exactly the allergy or intolerance is to and also what happens when the patient is exposed to the allergen.

Quote what they could say for each part of that section in line with personality.

Family History:

Full list of any medical conditions especially for skin conditions. atopic conditions and cancers, surgeries, hospitalisations, and significant health events known about in the patient's direct and indirect family and the details.

Quote what they could say for each part of that section in line with personality.

Social History:

Now include the following aspects for the ones that are clinically and medically relevant to this patient’s presentation or condition:

Lifestyle:

Occupation:

Activities of Daily Living & Hobbies:

Choose every single aspect from extremely internationally diverse choices from every part of the world, all given equal weighting, never be stereotypical.

Always include detailed information on:

Smoking: (always give pack years:)

Alcohol: (drinking habits and always giving specific units per week)

Recreational Drug Use:

Diet:

Exercise:

Ensure all are clinically appropriate for the condition, religion, culture and with any relevant risk factors to the condition.

Now include the following aspects for the ones that are clinically and medically relevant to this patient’s presentation or condition:

Travel History:

Sexual History:

Driving Status:

Cultural or Religious Practises:

Recent Life Events:

Exposure to Hazards or New Environment:

Choose every single aspect above from an extremely diverse set of options and minority groups, religions, lifestyles, hobbies and beliefs. Give all options equal weighting.

Quote three different quotes what they could say for each part of the three sections above in maximum detail in line with personality.

Ideas, Concerns, and Expectations:

Full, detailed and random, diverse range for each section.

For ideas, quote the patient's understanding, perception and thoughts about their health and conditions.

For concerns, quote the patient's worries, concerns and fears for their symptoms, implications on health and social history and more.

For expectations, quote the patient's expectations for the consultation, timelines, information, treatment and more.

Quote what they could say for each part of that section in maximum detail in line with personality.

Physical Examination:

include the all results for each test below:

General Inspection:

Assessment of overall health, signs of distress or discomfort, body habitus and posture, signs of systemic disease, signs of scratching or self-inflicted skin trauma, condition of hair and nails for systemic disease indications, presence or absence of visible parasites, insects, or mites (e.g. head lice bodies/eggs, or ticks), burrows (sign of scabites mites), jaundice or cyanosis, gait and mobility if relevant to skin disease, any odor that may be associated with a skin condition, psychological well-being as it may relate to skin disease, presence of medical devices or appliances, visible rashes or lesions that may be noticeable without detailed examination, observing body language and demeanor for discomfort due to pruritus or painful skin lesions.

Skin Lesion Inspection:

Location:

Distribution:

Shape:

Symmetry

Borders:

Colour:

Diameter:

Always categorise the lesion using the proper dermatology terminology for the lesion's primary morphology (e.g. macular, papular, macular-papular, etc).

Always mention relevant positives and important negatives for the following aspects:

Pigmentation changes (pigmented; non-pigmented), borders (regular; irregular; rolled, and etc.), primary lesions identification (macules, papules, vesicles, plaques, and etc), arrangement (linear, annular, grouped), texture, surface changes (scaling, crusting), distribution (Acral distribution: distal areas including the hands and feet;

Extensor distribution: extensor surfaces including the elbows and knees; Flexural distribution: flexural surfaces including the axillae, genital region and cubital fossae; Follicular distribution: affecting areas with increased numbers of sebaceous glands such as the face, chest and axillae; Dermatomal distribution: the skin lesions appear confined to one or several dermatomes and do not cross the midline; Seborrhoeic distribution: present in areas where there is an increased density of sebaceous glands such as the face and scalp), secondary changes (excoriation, lichenification, scarring), borders and margins, bleeding, spontaneous bleeding, erosion, ulceration, weeping, aesthetic appearance (crusty, shiny, pearly, craggy, waxy, scar-like, smooth, rough, spotted, flakey, indurated, and etc), atrophy, signs of chronicity, and features systemic involvement.

Skin Lesion Palpatation:

Elevation:

Skin temperature over and around lesions, texture, consistency, fluctuance for fluid or pus, tenderness, pain, induration, mobility over underlying structures, blanching with pressure for vascular involvement, regional lymph nodes enlargement or tenderness, firmness, adherence to underlying tissues.

Systemic Examination:

Lymph nodes size, consistency, tenderness, mucous membranes changes, joints for arthritis or musculoskeletal findings, hair and scalp for hair loss or scalp disease, thyroid gland for enlargement or nodules, nails for discoloration, pitting, lungs and heart auscultation for systemic symptoms, abdomen for organomegaly and masses, ocular involvement in skin diseases, genitalia and oral cavity for mucosal involvement, neurological system for sensations or deficits, endocrine disorders signs with skin findings.

Special Tests:

Wood's lamp for fluorescence, dermoscopy for pigmented lesions.

Dermatoscopy:

Pigment networks, absence of pigment networks, dots and globules and clods, streaks, blue-white veil, regression structures, and vessels, arborising vessels, blue-grey ovoid nests, ulceration; peppering, scaling, (white, pink, grey, or light brown) stroma.

Signs of melanocytic lesions such as asymmetry, atypical network, blue-white structures, atypical vascular patterns, Patterns consistent with non-melanocytic lesions like keratin pearls, milia-like cysts, comedo-like openings, arborizing vessels, leaf-like structures; patterns consistent with scabies infection such as observing the mites, their eggs, and pellets (faecal material/scybala) under a light microscope.

Signs of superficial basal cell carcinomas include their typical bluish-pink colour, asymmetrical arborising vessels and focal ulceration, slight scaling and white areas of regression may also be present in basal cell carcinoma.

[TYPES OF BASAL CELL CARCINOMA - The dermoscopic features of "pigmented basal cell carcinoma" can also include: Absence of pigment network; White, pink, grey, or light brown stroma; Sharply defined, fine linear and branching serpentine vessels — these are also known as arborising vessels; Structureless or leaf-like areas on the periphery of the lesion — these present as brown to grey-blue discrete bulbous blobs with pigment converging on a less-pigmented area; Large blue-grey ovoid nests or blotches, also known as large clods; Multiple blue-grey dots and clods; Specks of brown and grey pigment (peppering, buckshot scattering); Concentric structures — dark central clod within a light brown larger clod; Spoke wheel areas — these present as radial projections from a well-circumscribed dark central hub; Short white lines or perpendicular white lines under polarised light only; Focal ulceration; Adherent fibre] [The dermoscopic features of "non-pigmented basal cell carcinoma include: Bluish or whitish-pink stroma; Asymmetrical branching serpentine (arborising) vessels; Focal ulceration; Slight scaling; White clues, particularly perpendicular white lines (polarised light only) and structureless roundish white or yellowish areas. On close inspection, some apparently non-pigmented basal cell carcinomas have a lightly pigmented stroma.]

[Nodular basal cell carcinomas lose the blue hue and instead may have a white rim around central ulceration. White clods

or milia-like cysts may be present. The dermoscopic features of nodular basal cell carcinoma include: Arborising vessels (branched red lines); Blue-grey ovoid nests (large clods); Ulceration; Peppering (grey or brown dots) and or clods.]

Diagnostic Tests:

Complete list of results that should be requested for the patient's symptoms, with results relevant to the condition. Always give results in a numerical fashion where possible with reference ranges, only qualitative for diagnostic imaging. Give imaging results in maximum descriptive detail before full medical radiology description.

Always provide results for every test type given below:

Blood Tests only if relevant:

Full blood count (FBC):

Urea and Electrolytes, TFT, ESR, CPR, Autoimmune antibodies etc.

Imaging Tests:

Any relevant possible ones

Other Tests:

Patch testing, Skin prick tests, Blood tests (CBC, LFTs, U&Es), Skin scrapings for fungal and parasitic infections, Potassium hydroxide (KOH) examination, Tzanck smear, Wood's lamp examination, Direct and indirect immunofluorescence, Bacterial, fungal, and viral cultures, Skin biopsies (punch, shave, excisional), Dermoscopy, Reflectance confocal microscopy, Optical coherence tomography, High-resolution ultrasound, CT scans, MRI, PET scan, Sentinel lymph node biopsy, Genetic testing, Allergy testing, Phototesting, Hair pull test, Nail clippings and examination, Hormonal profile, Serum tryptase, Drug level monitoring, ELISA tests (e.g., for specific autoimmune conditions), Immunophenotyping.

Always give imaging/histopathology/dermatoscopy/light microscopy/radiology/test results and/or observations directly. Do not state the diagnosis these features are indicative of alone unless these are accompanied by descriptions of special diagnostic findings.

Condition:

XXXX

Patient Questions:

Give 3-4 challenging quoted questions from the patient to test the student's communication skills.

Always include short possible answers to every single question created.

Examiner Questions:

Give 5-6 appropriate questions that could be asked to the practising medical student about this specific patient case including some very challenging ones.

Always include short possible answers to every single created question.

Treatment:

The most appropriate full treatment plan with all possible lines of the treatment algorithm for the condition based purely and explicitly only on the National Institute for Health and Care Excellence, CKS (Clinical Knowledge Summaries), British Medical Journal Best Practise (BMJ), and the British National Formulary.

Structure it effectively and clearly.

Always include dosages and frequencies where needed.

Always state other options if allergic or initial treatment is ineffective.

Monitoring:

Please provide detailed instructions on how to monitor the patient's condition and treatment response. Include specific parameters for monitoring and indicate when it is necessary to seek further medical attention or consider adjusting the treatment plan. Also, mention recommendations for follow-up visits, including their frequency and duration. Finally, discuss any referral considerations and circumstances that may warrant a referral to a specialist or multidisciplinary team.

Prognosis:

Describe the anticipated prognosis for the patient's condition. Discuss the typical disease progression and potential outcomes based on available evidence and research. Explain the expected treatment response and provide a timeline for significant changes. Identify factors that may influence the response to treatment. Lastly, mention prognostic factors that could impact the patient's overall outlook and future health.

Differential diagnoses:

Number all other possible realistic diagnoses based on the simulated patient information. Do not include tangential diagnoses, they must have very similar presenting symptoms. Give information about why each is less likely than the actual condition, never omit this information.

Keyword Filters: Complete the following, always using semi-colons to form lists.

Speciality Filter:

Select any relevant medical specialities, spelt the same as the following:

Acute And Emergency; Cancer; Cardiovascular; Child Health; Clinical Haematology; Clinical Imaging; Dermatology; Ear, Nose And Throat; Endocrine And Metabolic; Gastrointestinal Including Liver; General Practice; Infection; Medicine Of Older Adult; Mental Health; Musculoskeletal; Neurosciences; Obstetrics And Gynaecology; Ophthalmology; Palliative And End Of Life Care; Perioperative Medicine And Anaesthesia; Renal And Urology; Respiratory; Sexual Health; Surgery.

Presenting Complaint Filter:

Select any relevant presenting complaints spelt the exact same as the following:

Acute rash; Bites and stings; Burns; Chronic rash; Nail abnormalities; Pruritus; Scarring; Skin lesion; Skin or subcutaneous lump; Skin ulcers

Condition Filter:

Insert the condition here as per the exact same spelling as the following:

Acne Vulgaris; Arterial ulcers; Atopic dermatitis and eczema; Basal cell carcinoma; Cellulitis; Contact dermatitis; Cutaneous fungal infection; Cutaneous warts; Folliculitis; Head lice; Impetigo; Malignant melanoma; Pressure sores; Psoriasis; Scabies; Squamous cell carcinoma; Urticaria

Location Filter:

Insert the location as per the exact spelling of the following:

General Practice ; Clinic ; Accident & Emergency

Now simply write out the exact following with no changes at all, leave the XXs as XX.

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor”

# 

# ***Cases***

# **ALYC\_01\_AtopicDermatitis**

Homepage Vignette:

## A 5-year-old female called Aaliyah Thompson presents with itchy, red, and inflamed skin.

Individual Page Vignette:

You are a GP at General Practice. Today, you see a 5-year-old patient named Aaliyah Thompson, accompanied by her mother, Emily. Aaliyah is a kindergarten student, and they reside locally. She presents with chronic, itchy skin rashes.

Patient Name:

Aaliyah Thompson (Pronunciation: 'Ah-lee-yah Tom-son', prefers to be called Aaliyah)

Age:

14/04/2019

Location:

General Practice

Personality:

Aaliyah is energetic and curious, with a bubbly nature and a tendency to fidget, especially when her skin itches. She speaks in short, expressive bursts and easily gets distracted by her discomfort. Emily, her mother, is patient and supportive, gently guiding Aaliyah back to the conversation when she wanders off-topic.

Presenting Complaint:

Aaliyah says, “My skin is really itchy and it hurts when I scratch too much,” while Emily adds, “We’ve tried so many creams, but the rashes just keep coming back.”

Symptoms:

Site: Aaliyah - "It's itchy on my arms and legs, and behind my knees."

Emily - "And on her neck and wrists as well."

Onset: Emily - "It started when she was a baby, but it's been getting worse lately."

Character: Aaliyah - "It feels rough, like monster skin."

Radiation: Emily - "The itchiness seems to stay where the rashes are."

Associated Symptoms: Aaliyah - "Sometimes it feels really hot and sore."

Emily - "She also gets quite snappy and has trouble sleeping because of the itching."

Timing: Emily - "It's pretty constant, but definitely worse at night."

Exacerbating and Relieving Factors: Emily - "It seems to flare up with certain soaps and when it's very hot. Cool moisturisers sometimes soothe it a bit."

Severity: Aaliyah - "It's super duper itchy, like…ANTS!"

History of Presenting Complaint:

The symptoms have been ongoing with occasional periods of improvement. Various emollients have been tried with temporary relief. The rashes appear to flare up intermittently, with the severity increasing in the last few months. Impacts Aaliyah's sleep, making her irritable and affecting her focus in kindergarten.

Emily may state, "We've been dealing with this for years, but it's never been this bad for this long."

Systemic Symptoms:

Most systemic symptoms are normal, except Emily notes, "She's had a couple of skin infections where the rashes got really red and oozed a bit. We had to use antibiotics those times."

Aaliyah might complain, "It feels hot and ouchie...yeah it hurt"

Past Medical History:

Positive for atopic conditions with a history of allergic rhinitis.

Emily explains, "Apart from the skin issues, Aaliyah has had a lot of sneezes and runny noses, especially around cats and dust."

Drug History:

Occasional use of oral antihistamines during severe itching episodes. No history of topical steroid use. No contraceptive history given Aaliyah's age.

Emily notes, "We’ve tried some allergy medicine the pharmacist recommended."

Allergies:

Allergic to amoxicillin, resulting in a widespread rash.

Aaliyah exclaims, "Once I had this medicine and got spots everywhere – it was worse than the ants!"

Family History:

Positive family history of atopic conditions. Emily has atopic dermatitis and asthma. Emily states, "I've had skin problems since I was young, too, and I use an inhaler for my asthma."

Social History:

Aaliyah is in kindergarten, lives in a smoke-free household, and spends time playing in parks. Emily stresses a balanced diet for Aaliyah, including plenty of fruits and vegetables. Aaliyah participates in swimming lessons which sometimes exacerbate her skin condition. No recent travel history.

Aaliyah might cheerfully say, "I love swimming even though it makes me itchy, and Mum says I eat all my rainbow veggies!"

Ideas, Concerns, and Expectations:

Emily expresses concerns about Aaliyah's discomfort and the impact on her school life. She is seeking guidance on better management of the condition and is worried about potential long-term skin damage.

Aaliyah says, "Can you make it go away?"

Physical Examination:

General Inspection:

Aaliyah is well-looking but with evidence of chronic scratching, including excoriated and erythematous patches on visible skin. Her hair and nails appear normal, and there are no visible signs of systemic illness. She appears restless due to the itch.

Skin Lesion Inspection:

Location: Flexural surfaces of both arms, legs, neck, and wrists.

Distribution: Symmetrical

Shape: Irregular

Symmetry: Bilateral involvement

Borders: Diffuse and poorly demarcated

Colour: Erythematous with areas of hypopigmentation

Diameter: Varies, with some areas confluent

Skin Lesion Palpitation:

Areas of lichenification and excoriation. Elevated skin temperature in erythematous regions. No apparent fluid or pus, but some areas are tender. No regional lymph node enlargement or tenderness.

Systemic Examination:

All systems appear normal. No enlargement of lymph nodes, mucous membranes are normal, respiratory and cardiovascular examination unremarkable, abdomen soft and non-tender with no hepatosplenomegaly. No mucosal involvement present.

Diagnostic Tests:

Blood Tests:

Total IgE levels might be elevated, and eosinophil count may be raised.

Imaging Tests:

Not indicated unless specifically looking for complications such as a secondary infection (which may require further imaging).

Other Tests:

Patch testing if contact allergens are suspected. Skin biopsy rarely indicated but may be performed if diagnosis is uncertain.

Condition:

**Atopic Dermatitis**

Patient Questions:

1. "Why does Aaliyah get these rashes all the time?" - Emily

- "Atopic dermatitis is a chronic condition often related to a combination of genetic and environmental factors that affect the skin’s ability to stay moist and barrier-protected."

2. "Will she grow out of it eventually?" - Emily

- "Many children do see an improvement as they get older, although it can persist or return later in life for some individuals."

3. "Are there any soaps or creams we should be using for Aaliyah?" - Emily

- "Using unscented, hypoallergenic emollients for moisturising and soap substitutes can help. I can recommend specific products suitable for her skin."

4. "Can she still swim? She loves it, but I'm worried it makes her skin worse." - Emily

- "She can still swim, but it's important to rinse off the chlorine immediately afterwards and apply a moisturiser to prevent the skin from drying out."

Examiner Questions:

1. What are the hallmarks of atopic dermatitis on physical examination?

- "Hallmarks include erythematous, itchy, excoriated, and often lichenified patches, typically in a symmetrical distribution across the flexural areas."

2. Describe the role of skin barrier dysfunction in atopic dermatitis.

- "In atopic dermatitis, there is a compromised skin barrier that decreases the skin’s ability to retain moisture and protection against irritants, microbes, and allergens."

3. What would you include in the initial management of a child with mild atopic dermatitis?

- "Initial management involves avoiding known irritants, regular use of emollients, treating flare-ups with topical corticosteroids, and using antihistamines for severe itching."

4. When is systemic treatment indicated in atopic dermatitis?

- "Systemic treatment is considered when there is severe or widespread atopic dermatitis that is not responding to topical treatment."

5. Are there any dietary restrictions recommended for atopic dermatitis?

- "There are no specific dietary restrictions unless an allergy is identified, but a balanced diet is advised. In some cases, avoiding dairy or eggs may be recommended if an allergy test confirms sensitivity."

6. What are the common triggers that might exacerbate atopic dermatitis?

- "Common triggers can include allergens such as pet dander and dust mites, irritants like soaps and detergents, changes in temperature and humidity, stress, and certain foods."

Treatment:

According to NICE guidelines:

- Emollients should be used daily for moisturising, cleansing, and bath additives.

- Mild to moderate potent topical corticosteroids should be used during flare-ups on the affected areas, such as hydrocortisone 1% applied once or twice daily depending on the flare severity.

- If there is no response to topical corticosteroids, consider referral to dermatology for additional treatments like phototherapy or systemic medications.

- Topical calcineurin inhibitors may be considered for areas sensitive to steroids, like the face and neck.

- Antihistamines can be used for night-time itching to aid sleep, for instance, chlorphenamine 2mg at night.

Monitoring:

Regular follow-up to monitor skin condition and treatment efficacy, adjust treatments as needed, and assess for potential side effects of therapies, such as skin atrophy from prolonged steroid use. Follow-up every 3-6 months is typical or more frequently during flare-ups.

Prognosis:

Atopic dermatitis is typically a chronic condition that often improves with age. It is commonly associated with other atopic conditions like asthma and allergic rhinitis. Good skin care and management of triggers can improve the quality of life and control symptoms effectively.

Differential diagnoses:

1. Contact dermatitis - allergen exposure history required for diagnosis

2. Seborrheic dermatitis - usually affects the scalp and face with oily, yellowish scales

3. Psoriasis - more likely to affect extensor surfaces and scalp with well-defined plaques and silver scaling

4. Scabies - intense itching with burrows, more common in finger webs and affecting whole family

5. Impetigo - crusted, honey-coloured lesions, usually secondary to infection

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XXMedical Student

Reviewed by XX, XX Medical Student/Doctor”

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# **ALYC\_02\_Urticaria**

Homepage Vignette:

## “A 22-year-old male called Jackson Muotune presents with sudden onset of raised, itchy swellings on his body.”

Individual Page Vignette:

You are a doctor in an Emergency Department. A 22-year-old man named Jackson Muotune, an engineering student, presents with an acute, itchy rash that developed over the past couple of hours.

Patient Name:

Jackson Muotone (Pronunciation: "Jacks-on Muo-TOO-neh", prefers to be called Jackson)

Age:

03/07/2002

Location:

Emergency Department

Personality:

Jackson is an analytical and calm individual, with a methodical approach to problem-solving. He speaks in a measured tone, typically questioning the underlying mechanisms of his symptoms. Despite the discomfort, he maintains a composed demeanour.

Presenting Complaint:

Jackson relays: "Out of nowhere, I've got these weird swellings all over me. They itch like crazy."

Symptoms:

Site:

Jackson: "The swellings are everywhere, on my arms, chest, and even my face."

Onset:

Jackson: "It all started a few hours ago. I was fine this morning."

Character:

Jackson: "They're raised and look like huge mosquito bites."

Radiation:

Jackson: "They’re not really spreading; new ones just keep popping up in different spots."

Associated Symptoms:

Jackson: "I feel a bit flushed and I noticed some swelling around my lips too."

Timing:

Jackson: "It’s been continuous since it started, no breaks."

Exacerbating and Relieving Factors:

Jackson: "Nothing specific seemed to start it. Taking antihistamines hasn't really helped."

Severity:

Jackson: "On a scale from one to ten, the itchiness is around an eight."

History of Presenting Complaint:

Jackson mentions, "This is the first time this has happened to me. It's pretty distracting and is making it hard to concentrate or do anything."

Systemic Symptoms:

Jackson notes, "Apart from the itchiness and mild swelling around my lips, I feel generally okay, no fever, joint pain, or anything like that."

Past Medical History:

Jackson has no past medical history of atopic disorders or skin conditions. He's been generally healthy with just the usual childhood illnesses.

Jackson shares: "I’ve never really been sick, besides the odd cold here and there."

Drug History:

Jackson takes occasional ibuprofen for headaches but no regular medications. He has not taken any new medications or supplements recently.

Jackson clarifies: "I only take painkillers when really needed. No daily meds or anything like that."

Allergies:

Jackson has no known allergies.

Jackson says: "Never had an allergic reaction before, to my knowledge."

Family History:

No family history of atopic conditions, autoimmune diseases, or significant skin conditions.

Jackson confirms: "My family's pretty healthy overall, no similar issues like this."

Social History:

Jackson is a full-time engineering student, never married, lives in university housing, and has a balanced diet and regular exercise regimen. He does not smoke, and alcohol intake is limited to social events, with a moderate consumption pattern. He is careful with sunscreen use due to a fair complexion. No recent travel history.

Jackson notes: "I live a pretty regular student life, study a lot, hang out with friends, and try to stay active. I’m usually pretty careful with my diet and stuff like sun exposure."

Ideas, Concerns, and Expectations:

Jackson is looking for an explanation for the sudden onset of symptoms and is concerned about the severity of the itchiness and facial swelling. He expects a thorough assessment and treatment to alleviate symptoms.

Jackson expresses: "I'd like to understand what's causing this and get some relief from the itch. Is this something serious?"

Physical Examination:

General Inspection:

Jackson is alert and oriented, with numerous raised, erythematous wheals of varying sizes across visible skin. There are noticeable signs of recent scratching. His speech is clear, and there is no immediate respiratory distress.

Skin Lesion Inspection:

- Location: Multiple sites including arms, chest, and face.

- Distribution: Generalised and widespread.

- Shape: Round to irregular.

- Symmetry: Asymmetric.

- Borders: Well-demarcated raised areas.

- Colour: Pink to red with central pallor in some areas.

- Diameter: Variable from a few millimetres to several centimetres.

Skin Lesion Palpitation:

Wheals are palpable and elevate above the skin surface with warmth, tenderness upon palpitation, and no indication of fluid within the lesions.

Systemic Examination:

There is mild perioral swelling. No lymphadenopathy. Cardiovascular and respiratory examinations are within normal limits. Mucous membranes are normal, and no additional systemic involvement is noted.

Diagnostic Tests:

Blood tests for markers of allergy or systemic involvement, including complete blood count with differential, C-reactive protein (CRP), and erythrocyte sedimentation rate (ESR) may be considered.

Imaging Tests:

Not indicated for acute urticaria unless angioedema or anaphylaxis is suspected which could necessitate abdominal imaging to assess for ascites or intestinal involvement.

Other Tests:

For chronic cases, testing for autoimmunity or physical urticarias (e.g., dermatographism or pressure urticaria) may be considered but is not typically performed in acute settings.

Condition:

**Urticaria (Acute)**

Patient Questions:

1. "Could this rash be related to something I ate?"

- "It's possible, as food allergens can cause urticaria, but without a history of food allergies, it might be something you’ve been exposed to recently. We’ll look into potential triggers."

2. "Can stress cause this kind of reaction?"

- "Stress can exacerbate many conditions including urticaria, but isn't typically the sole cause for an acute episode like this."

3. "Is this going to keep happening, or is it a one-time thing?"

- "It's difficult to predict without identifying the trigger, but many cases of acute urticaria resolve without recurring. We'll monitor how you respond to treatment."

4. "Are there any tests I should have to find the cause?"

- "In acute cases, we usually start with treatment and observe the response. If this becomes recurrent, we might then consider allergy testing or other investigations."

Examiner Questions:

1. What are the mechanisms involved in the development of urticaria?

- "Urticaria involves mast cell degranulation with subsequent histamine release, which leads to increased vascular permeability and the formation of wheals."

2. How do you distinguish between urticaria and angioedema?

- "Urticaria presents as superficial, itchy wheals, while angioedema is a deeper swelling, usually not itchy, affecting subcutaneous tissues and sometimes mucous membranes."

3. What are some common triggers for acute urticaria?

- "Common triggers include infections, medications (e.g., NSAIDs), foods, insect bites or stings, and less commonly, environmental factors like heat or cold."

4. What is the first-line treatment for acute urticaria?

- "The first-line treatment is second-generation H1-antihistamines like cetirizine or loratadine."

5. In which situations is epinephrine indicated for urticaria?

- "Epinephrine is indicated if there is any suggestion of anaphylaxis, which can present with urticaria, angioedema, respiratory compromise, and hypotension."

6. What long-term treatment options exist for chronic urticaria?

- "For chronic cases, higher doses of antihistamines, omalizumab, or other immune-modulating drugs may be considered if symptomatic management is insufficient."

Treatment:

Follow NICE guidelines for management:

- First-line therapy is a non-sedating H1-antihistamine such as cetirizine 10mg daily. The dosing may be increased up to fourfold if required.

- If there is angioedema, or if the urticaria is not responding to increased doses of antihistamines, consider adding an H2-antihistamine like ranitidine or a leukotriene receptor antagonist like montelukast.

- In the case of refractory symptoms, a short course of oral corticosteroids may be added (e.g., prednisolone 40mg daily for 3-7 days).

Monitoring:

Instruct the patient to monitor symptom progression and any new triggers or associations. Follow-up within two weeks to assess treatment response or sooner if symptoms worsen. If urticaria persists beyond six weeks, it's considered chronic and may require different management, including referral to a specialist.

Prognosis:

Most cases of acute urticaria resolve within days to weeks. Chronic urticaria can persist for years but is manageable with medication. Identifying and avoiding triggers is crucial for prevention and long-term control.

Differential diagnoses:

1. Allergic reaction - would typically involve an identifiable allergen

2. Drug eruption - could be related to recent medication use

3. Angioedema - deeper swelling often without pruritus

4. Insect bites - typically localized to the site of the bite

5. Anaphylaxis - would present with systemic symptoms, potentially life-threatening

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_03\_AcneVulgaris**

Homepage Vignette:

## A 17-year-old female called Zara Mahmood presents with severe skin troubles.

Individual Page Vignette:

You are a General Practitioner at a General Practice. Zara Mahmood, a 17-year-old student, is seeking treatment for worsening skin problems. It is 2024, and she is accompanied by her mother, Sameera.

Patient Name:

Zara Mahmood (Pronunciation: "ZAH-rah Mah-MOOD", prefers to be called Zara)

Age:

DOB: 09/02/2007

Location:

General Practice

Personality:

Zara is a conscientious and diligent young woman with a quiet demeanor. She tends to be detail-oriented and expresses her feelings openly when comfortable. During the consultation, Zara speaks in a measured, albeit anxious, tone about her skin concerns.

Presenting Complaint:

Zara explains, "For the past year, my skin has become really bad, and nothing I use from the pharmacy seems to work."

Symptoms:

Site:

Zara: "The spots are on my face, mostly my cheeks and chin."

Onset:

Zara: "I started to get breakouts when I was 14, but it's been especially bad since last year."

Character:

Zara: "The spots are large, red, and sometimes they're filled with pus."

Radiation:

Zara: "It's just confined to my face."

Associated Symptoms:

Zara: "My skin is very oily, and is painful at times."

Timing:

Zara: "It's consistently there, but I notice new breakouts happening weekly."

Exacerbating and Relieving Factors:

Zara: "My period seems to make it flare-up, and stress doesn't help either."

Severity:

Zara: "It's highly noticeable and affects my confidence, especially at school."

History of Presenting Complaint:

Zara shares, "I've tried various types of cleansers, toners, and spot treatments, but there's been no significant change. If anything, it's getting worse."

Systemic Symptoms:

Zara reports no systemic symptoms, suggesting the acne is localized and not indicative of a systemic disease.

Past Medical History:

Zara had mild eczema as a child but no other significant medical or dermatological history.

Zara recalls: "I used a cream for the eczema when I was younger, but that's about it."

Drug History:

Zara uses paracetamol occasionally for headaches, but no regular medications or treatments specific to her acne.

Zara states: "I rarely take any medication, just the odd headache tablet."

Allergies:

Zara is allergic to penicillin, which causes her to develop hives.

Zara remembers: "I had a reaction to penicillin once, and I broke out in an itchy rash all over."

Family History:

Zara's mother had similar issues with acne during her teenage years, and there is a family history of polycystic ovarian syndrome (PCOS) on her maternal side.

Zara mentions: "My mum said she also struggled with acne, and my aunt has PCOS."

Social History:

Zara is in her final year of secondary school, lives with her family, maintains a balanced diet, is not sexually active, exercises moderately, does not smoke, and has never consumed alcohol. She follows a regular facial cleansing routine and avoids heavy makeup.

Zara describes: “I try to take good care of my skin, eat healthily, and stay active with netball practice. I don’t smoke or drink, and I try to use oil-free makeup sparingly."

Ideas, Concerns, and Expectations:

Zara is anxious about the current state of her acne and the potential for scarring. She hopes to find an effective treatment plan to manage her acne and is concerned about the long-term implications should the condition persist.

Zara expresses: “I'm really hoping for a treatment that can clear this up. I don’t want to be left with scars.”

Physical Examination:

General Inspection:

Zara is a well-appearing teenager with no signs of acute distress. Examination of her face reveals multiple comedones, inflammatory papules, and pustules, with a predominance in the lower facial region.

Diagnostic Tests:

The diagnosis of acne vulgaris is primarily clinical, and laboratory tests are not routinely required unless an underlying hormonal imbalance, such as PCOS, is suspected.

Condition:

Acne Vulgaris

Patient Questions:

1. "Will the treatments have any side effects?"

- "Most acne treatments are well-tolerated. We'll discuss the options available to you, and I'll explain any potential side effects so we can find what works best."

2. "Can my diet influence my acne?"

- "There's ongoing research, but so far, there's no conclusive evidence that any particular foods cause acne. However, a balanced diet is always recommended for overall health."

3. "Could this be due to PCOS, like my aunt?"

- "PCOS can be associated with acne due to hormones. If there are other symptoms, like irregular periods or excess hair growth, we can consider further investigation."

4. "Do I need to change my skincare routine?"

- "Let's review your routine together. A gentle, non-comedogenic cleanser and avoiding oil-based products can be beneficial in managing acne."

Examiner Questions:

1. What are the main factors involved in the pathogenesis of acne vulgaris?

- "Acne involves four main factors: increased sebum production, keratinisation leading to blocked follicles, proliferation of Cutibacterium acnes, and inflammation."

2. What is the first-line treatment for mild to moderate acne?

- "The first-line treatment includes topical retinoids, benzoyl peroxide, and topical antibiotics either alone or in combination."

3. What is the role of oral contraceptives in acne treatment in females?

- "Oral contraceptives can regulate hormones that contribute to acne, particularly useful in women with signs of androgen excess."

4. When is oral isotretinoin indicated?

- "Oral isotretinoin is indicated for severe acne or acne that is refractory to other treatments, also considering the psychological impact on the patient."

5. What are considerations when prescribing antibiotics for acne?

- "When prescribing antibiotics, it's important to limit the duration of use to reduce the risk of antibiotic resistance and to use them in combination with benzoyl peroxide to enhance effectiveness."

Treatment:

Adhere to NICE guidelines for treatment which may include:

Topical Treatments:

- A combination of topical retinoids (e.g., adapalene) and benzoyl peroxide, which may be prescribed first-line.

Oral Antibiotics:

- If topical treatments are ineffective, a short course (up to 3 months) of an oral antibiotic such as doxycycline might be added to the treatment regimen.

Hormonal Treatments:

- If suspected hormonal causes or in females who also require contraception, consider a combined oral contraceptive pill.

Isotretinoin:

- For severe or refractory cases, referral to a dermatologist for potential isotretinoin therapy may be considered.

Monitoring:

- Regular follow-up, typically within 6 to 8 weeks after the start of treatment, then every 3 to 6 months, to assess response to treatment and adjust as necessary.

Prognosis:

- With appropriate treatment, most patients’ acne substantially improves. Early and effective treatment minimises the risk of scarring and psychological distress.

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_04\_BasalCellCarcinoma**

Homepage Vignette:

## A 65-year-old male called José Silva presents with a persistent, non-healing blemish on his nose.

Individual Page Vignette:

You are a dermatologist in a specialist clinic. José Silva, a 65-year-old retired school teacher, reports a slowly growing lesion on his nose that occasionally bleeds but doesn’t seem to heal.

Patient Name:

José Silva (Pronunciation: ho-ZAY SIL-vah, prefers to be called José)

Age:

DOB: 22/03/1959

Location:

Dermatology Clinic

Personality:

José is jovial and engaging, prone to sharing anecdotes from his teaching days. He expresses his concerns in a straightforward manner and appreciates clear explanations and directions.

Presenting Complaint:

José tells you, "I've had this blemish on my nose for several months now—it crusts over but then the slightest thing makes it bleed again. I'm quite worried it could be something serious."

Symptoms:

Site:

José: "The spot is right here on the side of my nose."

Onset:

José: "I first noticed it about 8 months ago; thought it was just a stubborn spot."

Character:

José: "It's an open sore that never fully heals; sometimes it has a shiny pearly edge to it."

Radiation:

José: "It hasn't spread much, but it's got a bit wider over time."

Associated Symptoms:

José: "None really, it doesn't itch or hurt, it just keeps bleeding occasionally."

Timing:

José: "It's always there. The bleeding stops sometimes, then starts up again if I accidentally knock it."

Exacerbating and Relieving Factors:

José: "I’ve not noticed anything that makes it better or worse apart from when I accidentally catch it while washing my face."

Severity:

José: "The sore itself isn't painful, but my worry about what it means is a big concern."

History of Presenting Complaint:

José has not sought treatment for the lesion until now. He noted the initial presentation looked like a small pimple but became progressively prominent over several months.

José explains: "At first, I didn't think much of it, but I've never had a pimple that didn't go away like this one."

Systemic Symptoms:

José has not experienced any systemic symptoms such as fever, weight loss, or fatigue.

José confirms: "Other than this spot, I feel healthy. Eating well, staying active, the usual."

Past Medical History:

José reports no history of atopic disorders or previous skin conditions. He states having had occasional actinic keratosis treated with cryotherapy in the past.

José recalls: "I've had a few rough patches on my skin from sun damage that the doctor froze off - nothing like this though."

Drug History:

José is currently on amlodipine 5 mg daily for hypertension.

José says: "Just my blood pressure tablet, that's all."

Allergies:

José has no known drug allergies.

José declares: "As far as I know, I don't have any allergies."

Family History:

No known family history of skin cancer or atopic conditions. Negative for other hereditary cancers.

Social History:

José is a widower, lives alone, maintains an active lifestyle, and is a non-smoker with minimal alcohol intake. As a retired school teacher, he often spends time outdoors in his garden. He admits to having frequently sunbathed in his younger years without adequate sun protection.

José describes: "I stay pretty busy since I retired, spend a lot of time outside - maybe a bit too much without a hat in the past."

Ideas, Concerns, and Expectations:

José is anxious that the lesion might be cancerous and is hopeful for an effective treatment. He is seeking reassurance and clarity on the potential implications for his health.

José expresses: "To be honest, I'm quite worried about skin cancer. What are we looking at here, doc? I hope it's treatable."

Physical Examination:

General Inspection:

José appears well for his age, with a tan complexion. He's casually dressed and maintains a neat appearance.

Skin Lesion Inspection:

- Location: Lateral aspect of the nose.

- Distribution: Isolated to that single area.

- Shape: Nodular with central ulceration.

- Symmetry: Asymmetrical lesion.

- Borders: Rolled, pearly edges with some telangiectasias.

- Colour: Translucent pink with some areas of pigment.

- Diameter: Approximately 0.6 cm at its widest point.

Systemic Examination:

No palpable lymph nodes, weight stable, vitals within normal limits, and no signs of distant metastasis upon systematic examination.

Diagnostic Tests:

- Biopsy: A punch biopsy of the lesion for histopathological confirmation.

- Blood tests: General health panel to assess overall health status, particularly useful prior to any potential surgical treatment.

Condition:

**Basal Cell Carcinoma**

Patient Questions:

1. "If this is cancer, what kind of treatment will I need?"

- "If confirmed, basal cell carcinoma is often treated with surgical excision. This usually has a high cure rate, especially if caught early."

2. "Is there a risk of this cancer spreading to other parts of my body?"

- "Basal cell carcinoma typically doesn't spread, or metastasise, like other cancers, so it's generally not a systemic risk."

3. "How can I prevent this from happening again?"

- "Protecting your skin from the sun with clothing, hats, and regular use of sunscreen can help reduce your risk of further skin cancers."

4. "Should I be checking my skin for other spots like this?"

- "It's a good idea to regularly check your skin and report any unusual or new lesions to your GP or dermatologist."

Examiner Questions:

1. What are the risk factors associated with basal cell carcinoma?

- "Risk factors include prolonged sun exposure, fair skin, history of sunburns, older age, a personal or family history of skin cancer, and exposure to radiation or carcinogens."

2. Describe the common clinical features of basal cell carcinoma.

- "Common features include a shiny, pearly nodule, sometimes with a central depression or ulceration, rolled edges, and overlying telangiectasia."

3. What are the typical histopathological findings in basal cell carcinoma?

- "Characteristic findings are nests of basaloid cells with peripheral palisading, often extending into the dermis. There may also be evidence of retraction artefact around the tumor nests."

4. Discuss the difference between nodular and superficial basal cell carcinoma.

- "Nodular basal cell carcinoma presents as a raised, often pearly lesion with rolled borders, whereas superficial basal cell carcinoma typically appears as a flat, erythematous patch that can be scaly or crusted."

5. What surgical options are available for basal cell carcinoma?

- "Surgical options include standard excision with histological margin control, Mohs micrographic surgery for high-risk or large tumors, and curettage with electrodessication for well-defined small lesions."

6. What non-surgical treatments are available for basal cell carcinoma?

- "Non-surgical options include topical treatments like imiquimod cream or 5-fluorouracil cream, photodynamic therapy, and radiotherapy in cases not suitable for surgery."

Treatment:

Based on guidance from NICE and CKS:

Surgical Excision:

- Standard treatment for primary basal cell carcinoma is surgical excision with histological examination of margins to ensure complete removal.

Mohs Surgery:

- Consider for lesions on the face where tissue conservation is important or recurrent lesions.

Topical Therapy:

- For patients unsuitable for surgery, topical imiquimod or 5-fluorouracil may be considered for superficial basal cell carcinoma.

Radiotherapy:

- May be an option for primary lesions not amenable to surgery or for patients declining surgical treatment.

Follow-Up:

- Once treated, a follow-up appointment is typically scheduled within 3 to 6 months, then annually.

Prognosis:

- The prognosis for basal cell carcinoma is generally excellent, especially when treated early. Recurrence is possible, hence the need for patient education and regular skin monitoring.

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_05\_ArterialUlcer**

Homepage Vignette:

## A 70-year-old male called Dev Patel presents with a painful lesion on his lower leg.

Individual Page Vignette:

You are a vascular surgeon at a clinic. Dev Patel, a 70-year-old retired engineer, presents with a non-healing ulcer on his lower leg that has been progressively worsening over the past month. It is 2024, and he is concerned about the severity of the pain and the possibility of complications.

Patient Name:

Dev Patel (Pronunciation: "Dehv Pah-tel", prefers to be called Dev)

Age:

DOB: 16/08/1954

Location:

Vascular Surgery Clinic

Personality:

Dev is an inquisitive and educated individual, often providing detailed explanations of his symptoms. He tends to ask insightful questions about his condition and treatment options.

Presenting Complaint:

Dev describes the issue: "I've got this ulcer on my leg that's quite sore, and it doesn't seem to get any better despite keeping it clean and covered."

Symptoms:

Site:

Dev: "It’s on the outer side of my lower leg, just above the ankle."

Onset:

Dev: "I've had problems with leg pain for a while, but this ulcer appeared about a month ago."

Character:

Dev: "The ulcer has a punched-out appearance and the pain is quite sharp."

Radiation:

Dev: "The pain mostly stays around the ulcer but my foot feels cold sometimes."

Associated Symptoms:

Dev: "My leg gets very pale when I raise it, and the skin is often shiny and tight around the ulcer."

Timing:

Dev: "The pain is most noticeable at night, and nothing seems to relieve it."

Exacerbating and Relieving Factors:

Dev: "Walking tends to make the pain worse, but hanging my leg down seems to ease it a little."

Severity:

Dev: "I would say the pain is a solid seven out of ten."

History of Presenting Complaint:

Dev mentions, "The ulcer started out as a small area of discoloured skin that just didn't heal over time. It's now become more painful, and it's getting harder to walk without discomfort."

Systemic Symptoms:

Dev has no systemic symptoms such as fever, weight loss, or fatigue.

Past Medical History:

Dev reports a history of hypertension and high cholesterol, managed with medications.

Dev shares: "Apart from the blood pressure and cholesterol, I've been relatively well, no other major health issues."

Drug History:

Dev takes amlodipine 10 mg and simvastatin 40 mg daily.

Dev clarifies: "I've been on blood pressure and cholesterol medicines for years now."

Allergies:

Dev reports no known drug allergies.

Dev confirms: "I've never had a reaction to medication before."

Family History:

Dev's father had a history of peripheral arterial disease.

Dev recalls: "My father had similar leg problems; they said it was due to poor circulation."

Social History:

Dev is widowed, lives alone, does not smoke, and only drinks alcohol socially. He enjoys light gardening and is active in community clubs for retirees.

Dev says: "I keep myself busy with friends and my garden; I've never been much of a smoker or drinker."

Ideas, Concerns, and Expectations:

Dev expresses concern about the potential progression of his ulcer and its impact on his mobility and quality of life. He seeks a thorough assessment and information about the best course of treatment to heal the ulcer and manage his symptoms.

Dev states: "I'm hoping we can get this sorted, so it doesn't lead to more serious complications."

Physical Examination:

General Inspection:

Dev appears well-nourished and alert, with a visible ulcer on his lower leg. He walks with a slight limp favoring the affected leg.

Skin Lesion Inspection:

- Location: Lateral aspect of the lower leg, above the ankle.

- Distribution: Confined to the area around the ulcer.

- Shape: Round with a well-defined, "punched-out" edge.

- Symmetry: Asymmetrical lesion.

- Borders: Well-defined, sometimes with a pale halo.

- Colour: Base of ulcer is pale, surrounding skin may be atrophied.

- Diameter: Approximately 2 cm in diameter.

Diagnostic Tests:

- Ankle-brachial pressure index (ABPI): To assess the extent of peripheral arterial disease.

- Duplex ultrasound: For detailed imaging of the blood flow in leg arteries.

- Blood tests: Including full blood count, renal function, and HbA1c if indicated.

Condition:

**Arterial Ulcer**

Patient Questions:

1. "Is there a chance this could lead to an amputation?"

- "With adequate treatment and management of underlying conditions, we aim to heal the ulcer and prevent complications that could lead to amputation."

2. "What kind of treatments will I need to undergo for this ulcer?"

- "The treatment plan may include optimizing blood flow with procedures, medications to improve circulation, and specialized wound care for the ulcer."

3. "How can I prevent this from getting worse or happening again?"

- "Managing your risk factors, such as blood pressure and cholesterol, and lifestyle modifications like regular exercise and smoking cessation if you smoke, can significantly reduce the risk of recurrence."

4. "Will I need to have surgery for this?"

- "It's possible, depending on the severity of the arterial blockage. We often start with less invasive options, and surgery is considered if these are not sufficient."

Examiner Questions:

1. What are the characteristic features of an arterial ulcer on examination?

- "Arterial ulcers typically have a 'punched-out' appearance, located on the lateral aspect of the lower leg or feet, with well-defined borders, pale base, and surrounding skin that may be shiny and hairless."

2. Discuss the role of the ABPI in diagnosing peripheral arterial disease.

- "ABPI is a non-invasive test that compares the blood pressure in the lower legs to the arms. It helps to determine the presence and severity of peripheral arterial disease, which is a common underlying cause of arterial ulcers."

3. What are the first-line treatments for arterial ulcers?

- "First-line treatments include risk factor modification, such as smoking cessation and managing hypertension and hyperlipidaemia, along with pharmacotherapy like antiplatelet agents, and wound care with debridement and appropriate dressings."

4. When is revascularization indicated for arterial ulcers?

- "Revascularization is indicated when there is significant arterial insufficiency contributing to ulcer formation or when conservative measures are not sufficient to heal the ulcer."

5. How can you differentiate an arterial ulcer from a venous ulcer?

- "Venous ulcers tend to be located near the medial malleolus, are often accompanied by signs of chronic venous insufficiency such as edema and skin changes, and patients may have a history of deep vein thrombosis or varicose veins. Arterial ulcers are typically more painful, especially when elevated, and are associated with peripheral arterial disease."

Treatment:

Treatment for arterial ulcers typically involves:

- Improving blood supply to the affected area, which may include angioplasty or bypass surgery, depending on the extent of arterial blockage.

- Aggressive risk factor management, including smoking cessation, blood pressure control, and cholesterol-lowering medications.

- Pain management, often with analgesics prescribed based on the severity of the pain.

- Wound care with regular debridement, application of appropriate dressings, and possibly the use of adjunctive therapies such as negative pressure wound therapy.

Monitoring:

Regular follow-up with a vascular specialist for ongoing assessment of circulation, wound healing progress, and management of risk factors. Monitoring intervals may be every few weeks to months based on the ulcer response to treatment and the overall clinical picture.

Prognosis:

With comprehensive treatment, arterial ulcers may heal over a period of weeks to months. The prognosis also depends on the control of underlying conditions such as peripheral arterial disease. Recurrence is possible, especially if risk factors are not adequately managed.

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_06\_Cellulitis**

Homepage Vignette:

## A 52-year-old male called Alejandro Gutiérrez presents with a painful, swollen, and red area on his lower leg.

Individual Page Vignette:

You are a medical practitioner at a Hospital. Alejandro Gutiérrez, a 52-year-old landscape architect, presents with a red, swollen area on his lower leg that has been rapidly expanding over the past two days. He reports associated fever and chills.

Patient Name:

Alejandro Gutiérrez (Pronunciation: "Ah-leh-hahn-droh Goo-tee-ehr-rez", prefers to be called Alejandro)

Age:

DOB: 08/10/1972

Location:

Hospital

Personality:

Alejandro is a gregarious and outgoing individual who enjoys social interactions but appears worried about his current health issue. He articulates his symptoms clearly and shows eagerness to follow medical advice for a swift recovery.

Presenting Complaint:

Alejandro states, “This red patch on my leg is spreading, and it’s very tender to touch. I started feeling feverish and just not right since yesterday evening.”

Symptoms:

Site:

Alejandro: "Right on the front of my lower left leg."

Onset:

Alejandro: "I noticed a small red spot about two days ago, but it's gotten much larger since."

Character:

Alejandro: "It's quite a deep red, and the area feels hot and swollen."

Radiation:

Alejandro: "Just the one spot for now, but it’s definitely growing in size."

Associated Symptoms:

Alejandro: "Along with the fever, I’ve been having some chills and just a general sense of malaise."

Timing:

Alejandro: "The symptoms have been worsening pretty quickly over the past 48 hours."

Exacerbating and Relieving Factors:

Alejandro: "It seems to throb more when I walk on it, and elevating my leg brings some relief."

Severity:

Alejandro: "I’d rate my pain at a 6 out of 10. It’s quite discomforting."

History of Presenting Complaint:

Alejandro mentions that the symptoms started with just a small area of redness and discomfort, which he initially brushed off as a minor irritation. However, the rapid progression to a larger, painful lesion with systemic symptoms like fever necessitated his visit.

Alejandro elaborates: "I thought it was nothing at first, maybe a bug bite, but it's only been getting worse."

Systemic Symptoms:

Symptoms suggest systemic involvement typically associated with cellulitis, including fever, chills, and malaise.

Past Medical History:

Alejandro has had no previous episodes of cellulitis but does have a history of Type 2 diabetes mellitus, controlled with oral hypoglycemic agents.

Alejandro comments: "I keep an eye on my sugar with medication, but I’ve never had a skin infection like this before."

Drug History:

Alejandro takes metformin 500 mg twice daily and occasionally ibuprofen for common aches and pains.

Alejandro specifies: "Just some metformin for the diabetes and the odd ibuprofen for when my back acts up after a long day’s work."

Allergies:

Alejandro is allergic to penicillin, which causes a rash and respiratory difficulty.

Alejandro recalls: "I had an allergic reaction to penicillin when I was younger. It’s something I always make sure to tell medical staff."

Family History:

No known family history of recurrent skin infections or immune dysfunction.

Alejandro says: "No, nothing like this in the family that I’m aware of."

Social History:

Alejandro is married with two children, non-smoker, and drinks alcohol sparingly. His occupation as a landscape architect involves significant outdoor activity. He follows a balanced Mediterranean diet and exercises regularly.

Alejandro describes: “I’m very busy with work, often outdoors. I enjoy a good diet, a few glasses of wine here and there, and I love playing soccer with my kids on weekends."

Ideas, Concerns, and Expectations:

Alejandro is concerned about the severity and speed of symptom progression and worries about the risk of complications due to his diabetic status. He is proactive in seeking information about the necessary treatments and prevention of future episodes.

Alejandro expresses his concern: “I would like to sort this out as soon as possible and definitely want to avoid it happening again, especially with my diabetes.”

Physical Examination:

General Inspection:

Alejandro is alert and moderately uncomfortable. The lower leg demonstrates significant erythema, warmth, oedema, and tenderness.

Skin Lesion Inspection:

- Location: Lower third of the left anterior leg.

- Distribution: Localized to a specific area, with diffuse spreading edges.

- Shape: Irregular.

- Symmetry: Not symmetrically distributed; confined to one leg.

- Borders: Diffused, indistinct margins.

- Colour: Deep erythema.

- Diameter: Approximately 15 cm in diameter with central swelling.

Systemic Examination:

Generalized feverish state with a body temperature of 38.5°C, increased heart rate, and otherwise normal cardiopulmonary examination. No evident lymphadenopathy or signs of deep vein thrombosis.

Diagnostic Tests:

Blood Tests:

Complete Full Blood Count (FBC), Erythrocyte Sedimentation Rate (ESR), and C-Reactive Protein (CRP) to evaluate for inflammation and infection markers.

Imaging Tests:

None indicated unless there is suspicion of osteomyelitis beneath the cellulitis, in which case an MRI might be considered.

Culture and Sensitivity:

If there is any purulent drainage, a swab should be taken before antibiotic therapy is initiated to guide appropriate treatment.

Condition:

**Cellulitis**

Patient Questions:

1. "How long is this going to take to get better?"

- "With prompt treatment, most cases of cellulitis start to improve within 48 to 72 hours. The total duration of therapy can vary, typically around 7 to 14 days."

2. "Could this be related to my diabetes?"

- "Diabetes can predispose you to infections like cellulitis due to the impact on blood vessels and immune response, so good sugar control is key in preventing recurrences."

3. "Are there any home remedies or things I can do to help this along?"

- "Elevating the affected limb can help reduce swelling, and it's important to rest until the infection is under control. Over-the-counter analgesics may also be used for pain management."

4. "Should I be taking antibiotics for an extended period to prevent this coming back?"

- "Extended antibiotic use is not typically recommended due to the risk of resistance. We'll focus on treating this episode effectively and discuss preventive measures afterward."

Examiner Questions:

1. What are the common bacteria responsible for cellulitis?

- "Cellulitis is most commonly caused by Streptococcus pyogenes and Staphylococcus aureus."

2. What factors contribute to the development of cellulitis in diabetic patients?

- "In diabetic patients, factors like compromised circulation, neuropathy, and impaired immune response increase the risk of cellulitis."

3. How can you differentiate cellulitis from deep vein thrombosis?

- "DVT often presents with unilateral leg swelling, pain, and possibly a palpable cord, typically without the marked erythema or warmth that characterizes cellulitis. Doppler ultrasound can help distinguish between the two."

4. What are the indications for hospital admission in a patient with cellulitis?

- "Indications for admission include severe or rapidly progressing infection, signs of systemic illness, comorbidities like diabetes that complicate the cellulitis, or failure of outpatient antibiotics."

Treatment:

Based on NICE guidelines:

- Oral antibiotic therapy, assuming no immediate need for IV antibiotics, often starting with a penicillinase-resistant penicillin like flucloxacillin 500 mg four times daily (considering the patient's penicillin allergy, a macrolide or clindamycin would be appropriate alternatives).

- Elevate the affected limb to decrease swelling.

- Encourage adequate hydration and rest.

- If there is no improvement or if the patient worsens, intravenous antibiotics and possible hospital admission may be required.

Monitoring:

Close follow-up within 48 hours to ensure clinical improvement, with additional monitoring as required based on the patient's response to treatment.

Prognosis:

With timely and appropriate treatment, the prognosis for uncomplicated cellulitis is good, and most infections resolve without complications. Recurrence can occur, and preventive measures should be discussed, including good skin care and management of risk factors like diabetes.

Differential diagnoses:

1. Deep vein thrombosis - Consider Doppler ultrasound for confirmation.

2. Necrotizing fasciitis - More aggressive, deeper infection with systemic toxicity.

3. Venous stasis dermatitis - Typically bilateral with chronic oedema and associated with varicose veins.

4. Erysipelas - A more superficial form of cellulitis with raised, demarcated borders.

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_07\_Folliculitis**

Homepage Vignette:

## A 25-year-old female called Nia Johnson presents with clusters of small red bumps on her thighs.

Individual Page Vignette:

You are a dermatologist at a Dermatology Clinic. Nia Johnson, a 25-year-old fitness instructor, presents with painful, red pustules on her thighs that have developed over the past week and appear to be worsening.

Patient Name:

Nia Johnson (Pronunciation: "Nee-yah John-son", prefers to be called Nia)

Age:

DOB: 14/07/1999

Location:

Dermatology Clinic

Personality:

Nia is confident and articulate, with a friendly demeanor. She is expressive about the discomfort and aesthetic concerns related to her condition and is keen on receiving detailed information about potential treatments.

Presenting Complaint:

Nia reports, “I’ve noticed these painful bump-like spots on my legs after my workouts, and they’re quite sore.”

Symptoms:

Site:

Nia: "They're mainly on my thighs, especially at the back."

Onset:

Nia: "I first saw them about a week ago and they've been popping up in new places since."

Character:

Nia: "They're red and look a bit like pimples, some have white tips."

Radiation:

Nia: "They've stayed in the same area but seem to be spreading out."

Associated Symptoms:

Nia: "The bumps are pretty tender and itch after I sweat a lot."

Timing:

Nia: "They've been here for a week now, no sign of clearing up."

Exacerbating and Relieving Factors:

Nia: "They seem to get itchier and more irritated after I work out and wear tight clothing."

Severity:

Nia: "It's not unbearable, but it's uncomfortable and makes me self-conscious wearing shorts."

History of Presenting Complaint:

Nia describes, "At first, I thought they were just irritation from shaving or something, but it's not getting better. I tried using an antibacterial wash, but it hasn’t helped much."

Systemic Symptoms:

Nia indicates there are no associated systemic symptoms such as fever or weight loss.

Past Medical History:

Nia has no significant past medical history and has not experienced similar skin conditions before.

Nia mentions: "Nope, nothing like this has happened before in terms of skin issues."

Drug History:

No current medications, and Nia does not recall any recent changes in supplements or skin products that could have contributed to the symptoms.

Nia clarifies: "I'm not on any meds and haven't tried any new supplements or creams lately."

Allergies:

Nia has no known allergies.

Nia confirms: "I haven't had any allergic reactions that I know of."

Family History:

No family history of chronic skin diseases or related conditions.

Nia remarks: "We don't really have any skin problems in the family, as far as I'm aware."

Social History:

Nia leads an active lifestyle, with a focus on fitness and healthy eating. She does not smoke and drinks alcohol occasionally in social settings. Her role as a fitness instructor requires wearing tight athletic clothing often, which she washes regularly.

Nia notes: "I keep fit for a living, and I'm generally healthy. I have to wear workout gear a lot for my job."

Ideas, Concerns, and Expectations:

Nia is primarily concerned about the impact of the condition on her job as a fitness instructor and how it may affect her skin long-term. She is keen to find a treatment that is both effective and conducive to her active lifestyle.

Nia expresses: “I'm worried it will spread or scar. I want something that works fast and can fit with my daily routine.”

Physical Examination:

General Inspection:

Nia appears in good health, with no visible signs of systemic illness. The affected areas on the thighs exhibit inflammation and pustule formation.

Skin Lesion Inspection:

- Location: Posterior and lateral aspects of the thighs.

- Distribution: Clustered around hair follicles.

- Shape: Multiple small, raised lesions.

- Symmetry: Somewhat symmetrical involvement of both thighs.

- Borders: Individual lesions are well-circumscribed.

- Colour: Red with central purulent (pus) tips.

- Diameter: Most lesions are 2-3 mm in diameter.

Systemic Examination:

Vital signs are stable and within normal ranges, and there is no lymphadenopathy or signs of systemic infection.

Diagnostic Tests:

Blood Tests:

Generally not required for a diagnosis of uncomplicated folliculitis.

Culture and Sensitivity:

May be considered if there is a concern for bacterial infection and to tailor antibiotic therapy if needed.

Condition:

Folliculitis

Patient Questions:

1. "What's causing these bumps, and how can I prevent them?"

- "Folliculitis is often caused by irritation or infection at the hair follicles, common for individuals who wear tight clothing during activities. Prevention can include changing out of sweaty clothes quickly and proper skin hygiene."

2. "Can I still work out and teach my classes with this condition?"

- "Yes, you can continue your normal activities, but it may be beneficial to wear looser clothing and shower immediately after sweating to reduce irritation."

3. "Do I need to take antibiotics for this?"

- "That depends on the severity and the response to initial treatments, such as topical antiseptics. If the condition doesn't improve, we may need to consider antibiotic therapy."

4. "Will these bumps leave scars?"

- "Most cases of folliculitis don't lead to scarring if appropriately managed and if you avoid picking at the lesions."

Examiner Questions:

1. What are the common organisms that cause folliculitis?

- "Staphylococcus aureus is the most common bacterial cause of folliculitis. However, it can also be caused by other bacteria and fungi."

2. How do you differentiate between folliculitis and acne vulgaris?

- "Folliculitis is typically distinguished by the presence of pustules around the hair follicles, often with an acute onset, while acne vulgaris usually presents with deeper nodules or cysts and comedones."

3. When would you consider systemic therapy for folliculitis?

- "Systemic therapy is considered if the folliculitis is extensive, recurrent, or if there are signs of systemic infection."

4. What are the treatment options for folliculitis?

- "Initial treatment options include topical antibiotics or antiseptics, warm compresses, and improving skin hygiene. Systemic antibiotics may be needed for more severe cases."

Treatment:

Based on NICE guidelines:

Topical Treatments:

- Emollients or mild topical antiseptics such as chlorhexidine wash or topical clindamycin for localized areas of folliculitis.

Oral Antibiotics:

- Consider a course of oral antibiotics like flucloxacillin or erythromycin for severe or extensive folliculitis.

Monitoring:

Review in 1-2 weeks to evaluate the response to treatment and adjust if necessary. Instruct the patient on skin care and signs of infection that may require earlier follow-up.

Prognosis:

Folliculitis often responds well to treatment, and full recovery without long-term skin changes is common. Prevention strategies are effective in reducing recurrence.

Differential diagnoses:

1. Acne Vulgaris - Usually accompanied by comedones.

2. Pseudofolliculitis barbae - Typically occurs in the beard area due to ingrown hairs.

3. Hot tub folliculitis - Caused by Pseudomonas, associated with recent hot tub use.

4. Furunculosis - Deeper infections causing furuncles or boils.

KEYWORDS = XX

Case Created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# **ALYC\_08\_Cutaneous fungal infection**

Homepage Vignette:

## A 32-year-old female called Alejandra Ochoa presents with an itchy rash on her feet.

Individual Page Vignette:

You are a General Practitioner, and Alejandra Ochoa, a 32-year-old accountant who is located at your clinic, presents with a complaint of an itchy rash on her feet.

Patient Name:

Alejandra Ochoa (pronounced Al-e-hand-ra O-cho-a), prefers to be called Alejandra.

Age:

14/06/1991 (suitable for presenting cutaneous fungal infection)

Location:

General Practice

Personality:

Alejandra is analytical and speaks with precision, often providing detailed descriptions of her symptoms. She is also health-conscious, often researching her symptoms online before visiting the clinic. Alejandra communicates clearly and expects the same level of clarity from her healthcare providers.

Presenting Complaint:

Alejandra reports an itchy, scaly rash between her toes that has been persisting for a few weeks.

Quote: "I've noticed this irritating itchiness between my toes, and it seems to be getting scalier. I tried some over-the-counter powders, but they've done little to help."

Symptoms:

- Itching (pruritus): Positive, intensifies in the evening.

Alejandra: "The itch is worst at night, it's quite difficult to avoid scratching."

- Rash: Present, with erythema and distinct borders between the toes.

Alejandra: "The rash is definitely red and more pronounced around the edges."

- Scaling: Positive, particularly noticeable after removing socks.

Alejandra: "When I take my socks off, I can see bits of skin flaking off."

- Dryness: Positive, affecting the skin around the rash.

Alejandra: "Apart from the rash, the skin on my foot is really dry."

- Fissures: Positive, small cracks in the skin observed.

Alejandra: "There are little splits in the skin which can be quite sore when I walk."

- Odour: A mild unpleasant smell is associated with the feet.

Alejandra: "I've also noticed a bit of a nasty smell, it's quite embarrassing."

History of Presenting Complaint:

- Duration: Symptoms have been present for several weeks.

- Previous treatments: OTC antifungal powders, with little improvement.

- Progression: Gradual worsening.

- Frequency: Constant itch, daily discomfort.

- ADLs: Difficulty wearing certain shoes, interrupted sleep due to itching.

- Work impact: Distraction due to discomfort.

- Wellbeing: Increasing frustration and concern over appearance and odour.

Alejandra: "It's been a few weeks now, and the creams from the pharmacy aren't doing much. It's starting to really affect my sleep and even what shoes I can wear comfortably to work."

Systemic Symptoms:

- Photosensitivity: None.

- Fever: None.

- Weight loss: None.

- Mucous membrane involvement: None.

- Systemic symptoms as listed: Normal in this case.

Alejandra: "Other than my feet, I feel fine. No fever or anything that would make me think it's more serious."

Past Medical History:

- Negative for history of atopic disorders or autoimmune conditions.

- History of intermittent allergic rhinitis.

Alejandra: "I get hay fever from time to time, but nothing else chronic."

Drug History:

- Currently on no other medications.

- No history of medication non-compliance.

- No use of alternative therapies.

- Oral contraceptive pill, regular use.

Alejandra: "I don't take any other medications regularly, just the pill for contraception."

Allergies:

- No known allergies or intolerances.

Alejandra: "I'm not allergic to anything that I know of."

Family History:

- Maternal history of psoriasis.

- No other family history of skin conditions.

Alejandra: "My mum has psoriasis, but otherwise our family has been lucky with skin health."

Social History:

- Occupation: Accountant.

- Marital status: Single.

- Educational background: Master’s degree in finance.

- Environment: Office work with occasional stress.

- Housing: Apartment living, no recent changes.

- Diet: Balanced, with an emphasis on whole foods.

- Exercise: Regular yoga and cardio workouts.

- Smoking: Non-smoker.

- Alcohol: Social drinker, approximately 2 units per week.

- Skin care routine: Basic moisturising, no excessive sun exposure.

- Hobbies: Reading, playing piano, travel.

- Recent life events: Recently promoted at work.

Alejandra: "Life's pretty routine lately, I'm focused on my health and career, and I make time for my hobbies and exercise most days."

Ideas, Concerns, and Expectations:

- Ideas: Suspects a fungal infection based on her own research.

- Concerns: Worried about the possibility of spreading the infection and long-term skin damage.

- Expectations: Seeking effective treatment and advice on preventing recurrence.

Alejandra: "I think it could be athlete's foot or something similar. I'm worried it might spread or cause lasting issues. I'm hoping you can prescribe something to clear it up once and for all."

Physical Examination:

General Inspection:

- No signs of systemic disease.

- Signs of scratching on feet.

Skin Lesion Inspection:

- Location: Interdigital spaces of feet.

- Distribution: Localized to the web spaces.

- Shape: Irregular.

- Symmetry: Asymmetric involvement of the spaces.

- Borders: Well-demarcated.

- Colour: Erythematous base with white scaling.

- Diameter: Varies between 1 cm and 3 cm.

Skin Lesion Palpation:

- Elevation: Flat but with scaling noticeably raised above skin level.

- Skin temperature: Mildly elevated over the affected area.

- Texture: Rough due to scaling.

- Tenderness: Present on palpation.

Systemic Examination:

- Lymph nodes: No enlargement or tenderness.

- Mucous membranes: No changes.

- Thyroid: No abnormalities.

- Nails: No discolouration or signs of fungal infection.

- Lungs/heart: Clear on auscultation.

- Abdomen: Soft, non-tender, no masses palpable.

- Genitalia/oral cavity: No mucosal involvement.

- Neurological: Normal sensation, no deficits.

Special Tests:

- Wood's lamp: Negative fluorescence.

- Dermatoscopy: Not indicated at this time.

Diagnostic Tests:

- Skin scrapings for fungal infection with KOH preparation: Positive for hyphae consistent with dermatophyte infection.

Condition:

**Cutaneous fungal infection**

Patient Questions:

- "What exactly is causing this infection on my feet?"

Answer: "It appears to be a fungal infection, commonly known as athlete's foot. It's caused by dermatophytes, which are a type of fungus that thrives in warm, moist environments, such as between the toes."

- "How can I prevent this from happening again in the future?"

Answer: "To prevent recurrence, it's important to keep your feet clean and dry, change socks regularly, avoid walking barefoot in communal areas, and wear breathable shoes."

- "Are there any serious complications I should be worried about?"

Answer: "Complications are usually rare if treated properly. However, if left untreated, the infection can spread to other areas of the skin, the nails, or even result in bacterial superinfection."

Examiner Questions:

- What are the typical clinical features of a cutaneous fungal infection?

Answer: The features include itching, redness, scaling, and cracking skin, often with a distinct edge to the rash.

- What other conditions could present with similar symptoms?

Answer: Conditions like eczema, psoriasis, or bacterial infections could have similar presentations.

- What are the first-line treatments for a cutaneous fungal infection?

Answer: Topical antifungals such as terbinafine, clotrimazole, or miconazole are the first-line treatments.

- How would you differentiate between a cutaneous fungal infection and other dermatological conditions?

Answer: Clinical examination, history, and diagnostic tests such as KOH preparation of skin scrapings can help differentiate between fungal infections and other conditions.

- Discuss the importance of skin care and foot hygiene in the management and prevention of fungal skin infections.

Answer: Maintaining skin and foot hygiene is crucial for both treatment and prevention. This includes keeping the feet dry, avoiding occlusive footwear, and using antifungal powders or sprays if needed.

Treatment:

- Apply a topical antifungal cream like terbinafine 1% cream once daily for 2-4 weeks.

- If allergic to the first-line agent, consider an alternative antifungal such as clotrimazole or miconazole.

- Advise on foot hygiene, including frequent changes of socks and shoes, and keeping feet dry and clean.

- If symptoms persist or worsen, consider oral antifungal treatment after reassessment.

Monitoring:

- Advise Alejandra to monitor for improvement in symptoms and to complete the full course of antifungal treatment even if symptoms improve prior to the end of the treatment duration.

- Recommend a follow-up visit after 4 weeks to reassess the condition and evaluate response to treatment.

- Indicate that if there is no improvement or if symptoms significantly worsen, she should seek medical attention sooner.

- If topical treatment fails, consider referral to a dermatologist.

Prognosis:

- With proper treatment, most cases of cutaneous fungal infection resolve without complication.

- Symptoms should improve within a few weeks of starting treatment, although complete resolution may take longer.

- Reinfection is possible, so long-term vigilance regarding foot hygiene is important.

- If the condition is appropriately managed, the outlook is excellent.

Differential diagnoses:

1) Eczema - Less well-demarcated and often with a chronic history.

2) Psoriasis - Typically presents with thicker plaques and may have other body sites involved.

3) Bacterial cellulitis - Would likely present with more erythema, warmth, and systemic symptoms.

KEYWORDS = Cutaneous fungal infection, Athlete's foot, Tinea pedis, Dermatophyte, Pruritus, Scaling, Erythema, Fissures, Hygiene, Topical antifungals, Terbinafine, Clotrimazole, Patient education

Case created by Aisling Chung, 4th Year Medical Student

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# 

# **ALYC\_09\_Contact dermatitis**

Homepage Vignette:

## A 38-year-old male called Dev Shah presents with red, itchy patches on both hands.

Individual Page Vignette:

You are a General Practitioner, and Dev Shah, a 38-year-old chef located at the clinic, presents with a complaint of red, itchy patches on both hands.

Patient Name:

Dev Shah (pronounced Dev Shah), prefers to be called Dev.

Age:

23/05/1985

Location:

General Practice

Personality:

Dev is outgoing and personable, often using humour to cope with uncomfortable situations. He tends to speak in an informal, conversational manner and likes to get to the point quickly. Dev is practical and typically discusses his symptoms in relation to how they affect his daily activities, particularly cooking, which is both his profession and passion.

Presenting Complaint:

Dev reports developing red, itchy patches on the backs of his hands that have persisted for several days.

Quote: "My hands are driving me nuts! They're all red and itchy, especially after my shifts in the kitchen."

Symptoms:

- Itching (pruritus): Positive, described as constant and intense.

Quote: "It's like a non-stop itch-fest on my hands; can't stop scratching!"

- Rash: Positive, with well-demarcated erythematous patches.

Quote: "There are these angry red patches all over the back of my hands."

- Scaling: Positive, observed over the rash areas.

Quote: "The skin is flaking off where it's red; it looks pretty rough."

- Dryness: Positive, associated with affected areas.

Quote: "My skin's as dry as an old leather glove now."

- Redness (erythema): Positive, particularly after exposure to kitchen detergents.

Quote: "Every time I use those cleaning agents, my hands turn even redder."

- Vesicles: Minimal, only a few small blisters noted.

Quote: "There are a few tiny blisters poppin' up. They weren't there before."

- Oozing/Crusting: Negative, no wetness or crusting reported.

- Pain/Burning sensation: Moderate pain, especially upon contact with irritants.

Quote: "Sometimes it feels like my hands are on fire after chopping up some chillies."

History of Presenting Complaint:

- Duration: Symptoms started several days ago and have been gradually worsening.

- Progression: Increasing redness and scaling noted, with intermittent vesicle formation.

- Impact on ADLs: Difficulty performing tasks at work due to discomfort.

- Work impact: Avoidance of certain duties, especially those involving irritants.

- Wellbeing: Frustration with symptoms, affecting mood and sleep.

Quote: "These patches started off small, but they've just ballooned over the past few days. It's making my job a nightmare."

Systemic Symptoms:

- Fever: None.

- Mucous membrane involvement: None.

- Photosensitivity: None.

- All remaining systemic symptoms: Normal in this case.

Quote: "Apart from these crazy hands, I feel fine; no fever or anything."

Past Medical History:

- History of intermittent eczema, primarily on the elbows and knees.

- No other significant medical conditions or surgeries.

Quote: "Yeah, I've had patches of eczema before but nothing like this on my hands."

Drug History:

- Occasionally uses emollients for eczema flares.

- No history of topical steroid use.

- Non-compliant with regular moisturiser use due to the nature of his work.

Quote: "I slap on some moisturiser when my skin gets really dry, but not regularly, you know, with all the hand-washing in the kitchen."

Allergies:

- Positive for a latex allergy, reacting with contact urticaria.

Quote: "I've got to stay clear of latex gloves or my hands puff up like balloons."

Family History:

- Father had psoriasis.

- No other known family history of atopic or dermatological conditions.

Quote: "My old man had psoriasis, but that's about it for skin stuff in the family."

Social History:

- Occupation: Chef.

- Marital status: Married.

- Educational background: Culinary school graduate.

- Exposure to hazards: Frequent exposure to kitchen detergents and wet work.

- Cultural practices: None relevant.

- Sexual history: Not relevant.

- Recent life events: Recently started a new job at a high-end restaurant.

- Housing situation: Lives in a shared apartment with his wife.

- Diet: Well-balanced with a focus on fresh produce.

- Exercise: Moderate, runs twice a week.

- Smoking: Non-smoker.

- Alcoholic drinking habits: Social drinker, 2-3 pints of beer per week.

- Skin care routine: Minimal, but wears gloves when cleaning.

- Hobbies: Cooking, gardening.

- Travel history: None recent.

Quote: "Cooking's my life, man. But since that new job with all its fancy cleaning stuff, my hands just can't catch a break."

Ideas, Concerns, and Expectations:

- Ideas: Suspects that new kitchen detergents at work might be the cause.

- Concerns: Worried about the impact on his job and the possibility of a chronic problem.

- Expectations: Seeking relief from symptoms and advice on preventing future flare-ups.

Quote: "I reckon it's those harsh soaps they've got us using. I can't afford for this to stick around and mess up my work. I just want to get this sorted pronto."

Physical Examination:

General Inspection:

- Dev appears in discomfort but without distress. He is frequently scratching his hands.

Skin Lesion Inspection:

- Location: Dorsal aspects of both hands.

- Distribution: Symmetric.

- Shape: Variable, with irregular patches.

- Symmetry: Symmetric involvement of both hands.

- Borders: Well-defined.

- Colour: Red to pink.

- Diameter: Patches range from 1 to 5 cm.

Skin Lesion Palpation:

- Elevation: Slightly raised patches.

- Skin temperature: Slightly warm over the lesions.

- Texture: Rough with scaling.

- Tenderness: Present on palpation.

Systemic Examination:

- Lymph nodes: Not enlarged.

- Mucous membranes: Unremarkable.

- Joints: No signs of arthritis.

- Hair and scalp: Normal.

- Thyroid: Not enlarged.

- Nails: Normal appearance, no pitting or onycholysis.

- Heart and lungs: Clear to auscultation.

- Abdomen: Non-tender, no organomegaly.

- Genitalia and oral cavity: No lesions or mucosal involvement.

- Neurological: Intact sensation without peripheral neuropathy.

Special Tests:

- Patch testing (if dermatitis persists or recurs): To be considered for identifying specific allergens.

- Dermatoscopy: Not indicated at this time.

Diagnostic Tests:

- Patch testing: To be performed if initial management is unsuccessful and allergic contact dermatitis is suspected.

Condition:

Contact dermatitis

Patient Questions:

- "What's the best way to stop this itchiness right now?"

Answer: "Short-term, we can use a mild topical steroid to reduce the inflammation and itch. Also, you should avoid contact with potential irritants and keep your skin moisturised."

- "Do I need to quit my job if this keeps happening?"

Answer: "Not necessarily. We'll work on identifying the triggers and managing your symptoms. Wearing non-latex gloves and protective creams might help reduce exposure to irritants in the kitchen."

- "Could this be an allergic reaction to something specific?"

Answer: "It's possible, especially with your history of a latex allergy. We might need to do patch testing to see if there are other allergens at work."

Examiner Questions:

- How do you differentiate between irritant and allergic contact dermatitis?

Answer: Irritant contact dermatitis often occurs due to repeated exposure and doesn't involve an immune-mediated allergen response, while allergic contact dermatitis is immunologically mediated and can occur with even small amounts of an allergen.

- What are the key management principles for contact dermatitis?

Answer: Avoidance of irritants/allergens, skin protection, use of emollients, and topical steroids for flare-ups are key management strategies.

- Which occupations are at higher risk for developing contact dermatitis?

Answer: High-risk occupations include those involving frequent hand washing, exposure to chemicals, such as chefs, healthcare workers, and cleaners.

- What advice would you give to a patient with contact dermatitis regarding skin care?

Answer: Advise regular use of emollients, wearing gloves when handling irritants, and avoiding known allergens.

- Can you explain the role of patch testing in contact dermatitis?

Answer: Patch testing helps to identify specific allergens that may be causing allergic contact dermatitis, which can then be avoided to prevent future flare-ups.

Treatment:

- Advise avoiding exposure to potential irritants, including kitchen detergents.

- Recommend use of non-latex gloves during work to prevent contact with allergens.

- Prescribe a topical steroid, such as 0.1% hydrocortisone cream, applied thinly to affected areas twice daily for up to two weeks.

- If the patient is allergic to initial treatment, consider an alternative non-steroidal topical option, such as tacrolimus or pimecrolimus.

- Encourage regular use of fragrance-free emollient creams to maintain skin hydration.

- If severe or widespread dermatitis is present, consider a short course of oral steroids after specialist consultation.

Monitoring:

- Instruct Dev to monitor his symptoms and improvement with treatment.

- Schedule a follow-up appointment in 2 weeks to assess response to treatment and discuss results of any special tests, if conducted.

- If there is no improvement or symptoms worsen, Dev should seek immediate medical attention.

- Discuss the importance of identifying triggers and long-term skin care.

Prognosis:

- With avoidance of the irritants and appropriate treatment, contact dermatitis usually resolves without long-term issues.

- In some cases, contact dermatitis can become chronic or recurrent, especially if the irritant or allergen exposure continues.

- Prognosis is generally good with proper identification of triggers and adherence to treatment.

Differential diagnoses:

1) Psoriasis - Less likely due to well-demarcated presentation and absence of typical silvery scale and nail changes.

2) Atopic dermatitis - Considered but less likely in the absence of a personal history, and distribution is not typical.

3) Fungal infection - Possible but less likely given the distribution and lack of associated fungal features such as maceration.

KEYWORDS = Contact dermatitis, Itching, Redness, Erythema, Scaling, Topical steroids, Allergens, Irritants, Occupational skin disease, Patch testing

Case created by Aisling Chung, 4th Year Medical Student

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# **ALYC\_10\_Psoriasis**

Homepage Vignette:

## A 45-year-old male called Amir Bashir presents with persistent patches of red, scaly skin.

Individual Page Vignette:

You are a General Practitioner, and Amir Bashir, a 45-year-old journalist who is located at your clinic, presents with a complaint of red, scaly patches on his skin.

Patient Name:

Amir Bashir (pronounced Ah-meer Buh-sheer), prefers to be called Amir.

Age:

09/11/1978

Location:

General Practice

Personality:

Amir is articulate and tends to speak thoughtfully, often providing context to his concerns. He values thorough explanations and appears well-informed and proactive about his condition. Amir is respectful but will advocate firmly for his well-being.

Presenting Complaint:

Amir reports having developed silvery, scaly plaques on his elbows and knees that have been slowly expanding over the past several months.

Quote: "I've got these rough, scaly patches on my elbows and knees that seem to be spreading no matter what I do."

Symptoms:

- Itching (pruritus): Moderate, becomes severe at times.

Quote: "The itch can get quite intense, especially at night."

- Rash: Positive, persistent erythematous patches with overlying silvery scale.

Quote: "You see these red patches? They’re covered in this weird, silver-like substance."

- Scaling: Positive, abundant and persistent.

Quote: "It's like my skin is flaking off in sheets."

- Dryness: Positive, generally confined to the affected areas.

Quote: "My skin feels incredibly dry where the lesions are."

- Fissures: Positive, on larger plaques.

Quote: "Some of the bigger patches have these painful cracks."

- Pain: Periodic, especially during movement or when fissures are present.

Quote: "There's a stabbing pain whenever I extend my arms fully."

- Lesions with distinct borders: Positive, indicative of classic plaque psoriasis.

Quote: "The edges are quite clear. It looks almost as if it's been drawn on."

- Nail changes: Present, pitting and onycholysis noted.

Quote: "My nails have these tiny dents and some seem to be lifting off the nail bed."

History of Presenting Complaint:

- Duration of symptoms: A few months.

- Previous treatments: Over-the-counter moisturisers with little effect.

- Progression: Slow expansion of existing plaques with new areas periodically affected.

- Frequency of symptoms: Daily and persistent.

- Impact on ADLs: Difficulty with certain tasks due to pain and discomfort.

- Work impact: Embarrassment and difficulty typing because of nail involvement.

- Wellbeing: Growing concern about the appearance and potential stigma.

Quote: "The plaques have been there for months now and are getting bigger. It's becoming quite a nuisance, not to mention unsightly."

Systemic Symptoms:

- No systemic symptoms such as fever or weight loss are reported.

- Joint pain: Mild discomfort in the fingers and wrists.

Quote: "I also feel a bit of pain in my hands and wrists, especially when typing."

Past Medical History:

- Negative for previous skin conditions.

- Positive for mild osteoarthritis in the knees.

Quote: "Apart from my knees giving me a bit of trouble now and then with arthritis, I've been quite healthy."

Drug History:

- No current medications, occasional NSAIDs for arthritis.

- No history of medication allergies or adverse reactions.

Quote: "I rarely take any meds, just an ibuprofen occasionally for my knee pain."

Allergies:

- No known drug or food allergies.

Quote: "Luckily, I don't have any allergies that I'm aware of."

Family History:

- A paternal uncle with psoriasis.

- No other significant family history of autoimmune or atopic conditions.

Quote: "My father's brother had something similar to this, I believe it was psoriasis too."

Social History:

- Occupation: Journalist.

- Marital status: Married with two children.

- Educational background: University degree in communications.

- Exposure to hazards: None significant.

- Housing situation: Lives in a detached home with his family.

- Diet: Mediterranean-style, rich in vegetables and fish.

- Exercise: Regular walks and swimming.

- Smoking: Non-smoker.

- Alcohol: Moderate consumption, 2 glasses of wine a week.

- Skin care routine: Minimal, uses moisturisers inconsistently.

- Hobbies: Reading, cooking, travelling.

- Travel history: Recent trip to a sunny climate, which seemed to improve symptoms temporarily.

Quote: "I lead a pretty balanced life, regular exercise, and a good diet. I enjoy my family time and my hobbies keep me occupied, though this skin issue is starting to weigh on me."

Ideas, Concerns, and Expectations:

- Ideas: Believes condition to be psoriasis, based on family history and his own research.

- Concerns: Worried about the chronic nature of the disease and potential social and work-related stigma.

- Expectations: Seeking effective treatment and advice on management, keen to understand if lifestyle changes could help.

Quote: "Considering my uncle had psoriasis, I'm pretty sure that's what this is. I'm concerned about what it means long term and how it might affect my interactions with people. I'd very much appreciate some clear guidance on how to manage this, including any changes I should make in my daily routine."

Physical Examination:

General Inspection:

- Appears well with no signs of acute distress. Exhibits conscious efforts to cover affected skin areas.

Skin Lesion Inspection:

- Location: Elbows, knees, lower back, and scalp.

- Distribution: Symmetric.

- Shape: Oval to circular plaques.

- Borders: Sharp and distinct.

- Colour: Pink to bright red under the silvery scale.

- Diameter: Various, from 2 cm to 10 cm.

Skin Lesion Palpation:

- Elevation: Raised plaques.

- Skin temperature over lesions: Normal to slightly increased.

- Texture: Rough due to scaling.

- Tenderness: Present with palpation over larger plaques.

Systemic Examination:

- Lymph nodes: Not enlarged.

- Mucous membranes: Normal, no lesions.

- Joints: Mild tenderness in the interphalangeal joints without visible swelling.

- Nails: Pitting and onycholysis are present.

- Heart and lungs: Normal on auscultation.

- Abdomen: Soft, non-tender.

- Neurological examination: Normal findings.

Special Tests:

- None indicated at this stage.

Diagnostic Tests:

- No blood tests are immediately indicated unless considering systemic treatment where baseline liver function and renal function may be sought.

- Joint assessment and imaging if psoriatic arthritis is a concern.

Condition:

**Psoriasis**

Patient Questions:

- "What can I do to prevent these patches from spreading further?"

Answer: "You're already making good lifestyle choices; we can add topical treatments to manage the symptoms and slow the spread. Regular monitoring and treatment adjustments will be an important part of management."

- "Is there a cure for psoriasis, or will I have to live with this forever?"

Answer: "Psoriasis is a chronic condition, but it can be managed effectively for most people with the right treatment and lifestyle adjustments. We aim for control of the symptoms and to maintain a good quality of life."

- "Could this affect my joints, or is it just a skin condition?"

Answer: "Psoriasis can affect the joints in some cases, known as psoriatic arthritis. We'll keep an eye on your joint symptoms and may refer you to a rheumatologist if indicated."

Examiner Questions:

- Can you describe the typical presentation of plaque psoriasis?

Answer: Plaque psoriasis presents with well-demarcated, erythematous plaques covered with silvery scales, commonly located on the elbows, knees, scalp, and lower back.

- What are the common triggers for psoriasis flares?

Answer: Triggers include stress, skin trauma, certain medications, infections, alcohol, smoking, and sometimes changes in weather.

- How do you differentiate between plaque psoriasis and other scaly skin diseases like eczema or tinea?

Answer: Plaque psoriasis plaques are well-demarcated with a silvery scale and are often symmetrically distributed, while eczema tends to have ill-defined borders, and tinea often shows a central clearing.

- What are the current first-line treatments for mild to moderate plaque psoriasis?

Answer: Topical treatments such as corticosteroids, vitamin D analogues, or a combination of the two are first-line for mild to moderate plaque psoriasis.

- How is psoriatic arthritis diagnosed and managed?

Answer: Diagnosis is often clinical, supported by imaging such as X-rays or MRI if needed. Management includes non-steroidal anti-inflammatory drugs (NSAIDs), disease-modifying antirheumatic drugs (DMARDs), and biologics.

Treatment:

- Initiate treatment with a potent topical steroid, such as betamethasone valerate, applied once daily for 4 weeks with a review.

- Offer a vitamin D analogue such as calcipotriol to be used in conjunction with the topical steroid.

- Emphasize the importance of moisturizing regularly with an emollient to reduce dryness and scaling; apply it liberally at least twice a day.

- If the skin does not respond adequately to topicals or involvement is extensive, consider a systemic therapy referral to dermatology.

- Discuss the benefits of sunlight exposure while cautioning about the risks of sunburn.

- Advise on lifestyle factors such as stress management and avoiding excessive alcohol or smoking.

Monitoring:

- Arrange a follow-up appointment in 4 weeks to review the response to treatment.

- Monitor for side effects of topical steroids such as skin thinning.

- Assess joints for development of psoriatic arthritis and consider referral if joint symptoms persist or escalate.

- Advise Amir to seek medical attention if he notices any new or worsening symptoms or side effects.

Prognosis:

- The prognosis for psoriasis is variable; it is a chronic condition with a relapsing-remitting course.

- Many individuals are able to achieve good control of their skin symptoms with appropriate treatment.

- Patients with more severe disease may require systemic therapies, which carry their own risks and benefits.

- Early recognition and management of psoriatic arthritis are critical to prevent joint damage.

Differential diagnoses:

1) Eczema - Less well-demarcated, typically itchier, and more likely to have associated atopic conditions.

2) Tinea corporis (ringworm) - Annular lesions with central clearing and typically responding to antifungals.

3) Lichen planus - Polygonal, flat-topped papules, often with mucosal involvement.

KEYWORDS = Psoriasis, Plaque psoriasis, Scaliness, Itchiness, Erythema, Topical steroids, Calcipotriol, Vitamin D analogue, Psoriatic arthritis, Skin care, Lifestyle modifications

Case created by Aisling Chung, 4th Year Medical Student

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# ALYC\_11\_Psoriasis

Homepage Vignette:

## A 35-year-old male called Charlie presents with scaly, itchy skin patches on his elbows and knees.

Individual Page Vignette:

You are a GP in a clinic, and Charlie, a 35-year-old office worker, enters your practice complaining of persistently itchy and flaky skin patches on his elbows and knees which seem to have worsened over the last few months.

Patient Name:

Eduardo Gonzalez (Pronounced: Ed-war-do Gon-zah-lez; Prefers Eddie)

Age:

14/07/1989

Location:

General Practice

Personality:

Eddie is an affable and articulate individual who communicates his concerns with clarity and a touch of dry wit.

Presenting Complaint:

"I've got these annoying patches of skin on my elbows and knees; they're red, a bit scaly, and they itch like crazy."

Symptoms:

- Site: Elbows and knees - "The scaly patches are just on my elbows and knees."

- Onset: Gradual over several months - "I first noticed them getting a bit flaky a few months back."

- Character: Itchy and scaly - "They're itchy most of the time, with these dry scales."

- Radiation: No radiation - "No, the itchiness sticks to those spots only."

- Associated Symptoms: Slight pain when scratching - "It stings a bit when I scratch it too hard."

- Timing: Persistent with fluctuation - "It's there all the time but gets really bad in the evenings."

- Exacerbating and Relieving Factors: Stress and hot showers worsen, moisturising helps - "Stressful days at work make it flare up. Hot showers too. But using lotion seems to calm it down a bit."

- Severity: Moderate irritation - "It's irritating enough to distract me, especially when I'm trying to sleep."

History of Presenting Complaint:

- Symptoms present for several months and progressively worsening

- Tried over-the-counter moisturisers with temporary relief

- Impact on sleep due to itching and discomfort

- No effect on work but feels self-conscious

- The patient expresses frustration over the cosmetic appearance and physical discomfort

Systemic Symptoms:

- No photosensitivity, ulcers, blisters, pustules, petechiae, purpura, or nodules noted

- No systemic symptoms such as fever or weight loss

- Eddie: "It's just my skin that's bothering me; otherwise, I feel fine."

Past Medical History:

- No previous medical conditions or surgeries

- No history of atopic disorders or autoimmune conditions

- Eddie: "I've never had any serious health issues before, so this skin thing is a bit new to me."

Drug History:

- Currently not on any prescription medications

- Occasionally takes ibuprofen for headaches

- No history of topical steroid use

- Eddie: "I'm not on any meds regularly. Just the occasional ibuprofen for a headache and that's it."

Allergies:

- No known allergies or intolerances

- Eddie: "Lucky me, I'm not allergic to anything as far as I know."

Family History:

- Mother has a history of rheumatoid arthritis

- No known family history of psoriasis or other skin conditions

- Eddie: "Mum's got arthritis, but nothing skin-related in the family."

Social History:

- Single office worker who enjoys swimming and socialising with friends

- Lives in a shared apartment with two roommates

- Diet includes moderate intake of vegetables, meat, occasional fast food

- Exercises twice a week, mainly swimming

- Drinks alcohol socially, around 4 units per week, non-smoker

- Regularly uses sunscreen due to an outdoors swimming routine

- No significant travel in recent months

- Eddie: "I have a pretty normal life; work, swim, and a pint with friends on the weekends."

Ideas, Concerns, and Expectations:

- Ideas: Believes it could be eczema or a skin allergy - "I thought it might be eczema or some allergy at first."

- Concerns: Worried about the possibility of a long-term condition and visibility of the patches in social settings - "I'm worried this is something chronic. Plus, it's pretty embarrassing in public."

- Expectations: Hopes for a diagnosis and effective treatment - "I'm hoping you can tell me what it is and give me something to clear it up."

Observations:

- Respirations (Breaths/min): 16

- Oxygen Saturation (%): 98

- Air or Oxygen?: Air

- Blood Pressure (mmHg): 130/80

- Pulse (Beats/min): 75

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.8

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall healthy appearance, no distress

- Well-kept hair and nails, no systemic disease indications

- No jaundice or cyanosis, mobile and comfortable

- Clearly visible red scaly lesions on elbows and knees

Skin Lesion Inspection:

Location: Elbows and knees

Distribution: Bilateral and symmetrical

Shape: Oval

Symmetry: Yes

Borders: Well-defined

Colour: Reddish with silvery scales

Diameter: Variable, from 2 to 6 cm

Skin Lesion Palpatation:

- Elevated plaques

- Normal temperature over lesions, texture is rough and scaly

- No remarkable tenderness except slight discomfort from scratching

- No lymph node enlargement detected

Systemic Examination:

- No lymphadenopathy, mucous or joint changes

- Scalp without hair loss, thyroid gland normal

- Nails without discolouration or pitting

- Auscultation of the heart and lungs showed no abnormalities

Special Tests:

- Wood's lamp and dermatoscopy not performed at this stage

Diagnostic Tests:

- Blood tests for autoimmune screening may be considered if clinical suspicion arises.

- Imaging not indicated at this point

- Skin biopsy could be considered if diagnosis is in doubt

Condition:

Psoriasis

Patient Questions:

- Eddie: "Are you certain this is psoriasis?" (Possible answer: Based on your clinical presentation, it is very suggestive of psoriasis; however, additional investigations may be needed to confirm the diagnosis.)

- Eddie: "Will this affect my life long-term?" (Possible answer: Psoriasis is typically a chronic condition, but with the right treatment and lifestyle adjustments, it can be well-managed. We aim to reduce the impact on your quality of life as much as possible.)

- Eddie: "Is psoriasis contagious?" (Possible answer: No, psoriasis isn't contagious; you can't pass it on to other people through skin contact.)

- Eddie: "Are there any dietary changes I should make?" (Possible answer: Although there is no specific psoriasis diet, some people find that certain foods can affect their symptoms. We can look at this as part of your overall treatment plan.)

Examiner Questions:

- What is the first-line treatment for psoriasis in a primary care setting? (Possible answer: Topical treatments such as vitamin D analogues or corticosteroids are often the first-line treatment for mild-to-moderate psoriasis.)

- Can psoriasis lead to any other complications or comorbidities? (Possible answer: Yes, psoriasis can be associated with psoriatic arthritis, cardiovascular diseases, metabolic syndrome, and depression.)

- What are the typical clinical features of psoriasis? (Possible answer: The typical features include well-demarcated, red plaques with silvery scales often found on extensor surfaces.)

- How would you differentiate between psoriasis and eczema clinically? (Possible answer: Psoriasis plaques tend to have well-defined borders and silvery scales, while eczema tends to have ill-defined borders, be more vesicular, and itchier.)

- What patient lifestyle factors should be addressed in the management of psoriasis? (Possible answer: Factors such as stress management, smoking cessation, moderation of alcohol consumption, and maintaining a healthy weight can help manage psoriasis.)

Treatment:

- Topical therapy with a potent steroid such as betamethasone valerate 0.1% ointment applied once daily for up to four weeks.

- Use of a vitamin D analogue, such as calcipotriol 50 micrograms/g, applied twice daily.

- In case of irritation with topical treatments, consider using a coal tar preparation or a keratolytic agent like salicylic acid.

- Systemic treatments or referral to dermatology if extensive or not responding to topical therapies.

- Regular emollients should be used to reduce scaling and itch.

- If allergic to any first-line options, alternatives like tacrolimus or pimecrolimus can be used.

Monitoring:

- Regular follow-up in four to six weeks to monitor response to treatment.

- Adjust treatment plan based on response; for lack of improvement, consider alternative treatments.

- If using topical steroids, monitor for skin atrophy or other side effects.

- Annual checks for joint pain to assess for psoriatic arthritis.

- Seek immediate medical attention if signs of infection or sudden worsening of symptoms.

Prognosis:

- Psoriasis is chronic and has a variable course; some may experience periods of remission.

- Topical treatments are often effective in controlling mild to moderate symptoms.

- With appropriate treatment and lifestyle modifications, the impact on quality of life can be minimised.

- Regular monitoring and treatment can manage symptoms and potential complications.

Differential diagnoses:

1. Eczema: More pruritic and often with ill-defined borders

2. Tinea corporis: Typically has a more annular appearance with central clearing

3. Pityriasis rosea: Herald patch followed by a Christmas tree pattern, typically self-limiting

4. Lichen planus: Polygonal, flat-topped papules often accompanied by mucosal involvement

KEYWORDS = Psoriasis, XX

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_12\_Psoriasis

Homepage Vignette:

## A 43-year-old male called Haruto presents with persistent itchy and scaly skin patches on his elbows and knees.

Individual Page Vignette:

You are a GP in a clinic, and Haruto, a 43-year-old software developer, has entered your practice complaining of long-standing, itchy, and scaly skin patches on his elbows and knees, which he reports have been worsening over time.

Patient Name:

Haruto Takahashi (Pronounced: Hah-roo-toh Tah-kah-hah-shee; Prefers to be called Haruto)

Age:

06/05/1981

Location:

General Practice

Personality:

Haruto is calm and measured in his speech, often taking a moment to think before he responds. He is detail-oriented, offering precise descriptions of his symptoms, and usually maintains a serious tone during discussions.

Presenting Complaint:

"The skin on my elbows and knees has been driving me mad; they're red, scaly and I can't stop scratching them."

Symptoms:

- Site: Elbows and knees – "It started just over my elbows and knees."

- Onset: Several months ago and gradually worsening – "I first noticed these patches a few months back, they've been getting gradually worse."

- Character: Itchy and scaly – "It's incredibly itchy, with these annoying scales that flake off."

- Radiation: Not applicable – "The itchiness stays around those red patches; it doesn't spread or anything."

- Associated Symptoms: Discomfort and occasional soreness when scratching – "Scratching sometimes makes them sore."

- Timing: Constant, with intermittent intense itching – "It's always there, but there are times when it gets so itchy I can barely focus."

- Exacerbating and Relieving Factors: Increased itching with stress and after showering – "It gets worse when I’m stressed or after a hot shower; sometimes applying lotion seems to help a little."

- Severity: Moderate to severe itchiness – "On a scale, it varies, but at times, the itchiness is unbearable."

History of Presenting Complaint:

- Symptoms for around six months

- Initial attempt at self-management using over-the-counter moisturisers

- Reported exacerbation with stress and hot showers

- Impact on sleep quality due to nighttime itching

- Concern about the visibility of the condition

Systemic Symptoms:

- No reports of pain, tenderness, or systemic involvement

- Haruto: "Aside from the irritation on my elbow and knees, I don't have any other symptoms."

Past Medical History:

- No significant medical or surgical history

- Haruto: "I've always been pretty healthy; never had any serious illnesses."

Drug History:

- No current medications

- Haruto: "I prefer not to take medication unless absolutely necessary."

Allergies:

- No known drug or other allergies

- Haruto: "I'm fortunate never to have had an allergic reaction to anything."

Family History:

- No known family history of skin conditions

- Haruto: "As far as I know, no one in my family has had skin problems like this."

Social History:

- Employed as a software developer

- Typically works long hours in front of a computer screen

- Enjoys gaming during free time, leading to a predominantly sedentary lifestyle

- Married, no children

- Rarely drinks alcohol and does not smoke

- Lives in a flat with his wife, no pets

- Generally avoids sun exposure due to skin sensitivity

- Haruto: "I lead a pretty quiet life; work, gaming and weekends with my wife."

Ideas, Concerns, and Expectations:

- Ideas: Suspects it may be a chronic skin condition – "I am worried that this might be something chronic that I will have to keep dealing with often and for a long time."

- Concerns: Concerned about the potential long-term implications – "What if this is permanent? I am concerned about how this might affect me professionally and personally."

- Expectations: Seeking effective treatment and clear information – "I want to understand what's going on with my skin and I hope there’s an effective treatment."

Observations:

- Respirations (Breaths/min): 14

- Oxygen Saturation (%): 97

- Air or Oxygen?: Air

- Blood Pressure (mmHg): 125/80

- Pulse (Beats/min): 68

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.5

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- Obvious red, scaly patches on extensor surfaces

- No immediate signs of systemic illness

Skin Lesion Inspection:

Location: Elbows and knees

Distribution: Bilateral and symmetrical

Shape: Oval and some irregular

Symmetry: Symmetrical involvement

Borders: Well-defined edges

Colour: Red with silvery white scales

Diameter: Varies, with the largest around 5 cm

Skin Lesion Palpatation:

- Elevated plaques with noticeable scale

- Warm to the touch indicating inflammation

- Slight tenderness on palpation, particularly where the skin is thickest

Systemic Examination:

- No lymphadenopathy or hepatosplenomegaly

- Chest, heart and abdominal examination unremarkable

Special Tests:

- Dermatoscopy used to assess lesion pattern, which showed the regular pattern typical for psoriasis

- No Wood's lamp examination performed at this time

Diagnostic Tests:

- Blood tests not indicated at this point but may consider if symptoms worsen or systemic involvement suspected

- Imaging not warranted at this stage

- Biopsy not necessary given the classic presentation but could be considered if atypical features are observed or treatment fails

Condition:

Psoriasis

Patient Questions:

- Haruto: "Could this be something other than psoriasis?" (Possible answer: Based on your symptoms and examination findings, psoriasis is the most likely diagnosis, but we would consider other conditions if the treatment does not lead to improvement.)

- Haruto: "Is psoriasis hereditary?" (Possible answer: Psoriasis can have a genetic component, but it’s not strictly hereditary in the way some other conditions are. If you’re concerned about family risk, we can discuss this further.)

- Haruto: "Will changing my diet help?" (Possible answer: While diet isn’t a direct cause of psoriasis, some people find that certain foods can exacerbate their symptoms. It’s worth discussing a diet that may help to reduce inflammation.)

- Haruto: "What can I do to stop the itchiness right now?" (Possible answer: For immediate relief, you can use a moisturiser to soothe the skin and an over-the-counter hydrocortisone cream. Avoid hot showers, as they can worsen the itchiness.)

Examiner Questions:

- How would you counsel a patient about the nature of psoriasis? (Possible answer: I would explain that psoriasis is a chronic skin condition that can vary in severity and is characterised by periods of exacerbation and remission.)

- What are the triggers that can exacerbate psoriasis? (Possible answer: Common triggers include stress, skin trauma, infection, certain medications, and sometimes weather changes.)

- What is the role of phototherapy in the treatment of psoriasis? (Possible answer: Phototherapy, particularly UVB light, can help reduce the symptoms of psoriasis in moderate to severe cases.)

- Explain why it's essential to monitor a patient on long-term topical corticosteroids? (Possible answer: Long-term use of topical corticosteroids can lead to skin thinning, stretch marks, and other skin changes, so it's important to review and monitor treatment regularly.)

- What referral options are available for a patient with psoriasis who does not respond to primary care management? (Possible answer: Referral to dermatology is the next step for patients whose symptoms don't respond to first-line treatments or who have extensive or debilitating disease.)

Treatment:

- Topical treatment to start with a corticosteroid such as betamethasone valerate 0.1% and a vitamin D analogue like calcipotriol.

- Introduce a regimen for skin hydration including the liberal use of emollients.

- For refractory areas, consider coal tar preparations or tacrolimus ointment for sensitive skin areas.

- If there is no response, escalate to phototherapy or systemic treatment after dermatology consultation.

- Provide clear instructions on the duration and frequency of topical treatment to minimise risks.

- If the patient has contraindications to steroids or vitamin D analogues, discuss alternative treatments with a dermatologist.

Monitoring:

- Regular follow-up appointments every 4 to 6 weeks initially for treatment response.

- Monitor for potential side effects of long-term steroid use, such as skin atrophy.

- Encourage the patient to report any joint pain or new symptoms that could suggest psoriatic arthritis.

- Consider annual cardiovascular risk assessments given the potential increased risk associated with psoriasis.

Prognosis:

- Psoriasis is a chronic condition with no cure, but many treatment options can effectively manage and control the symptoms.

- Patients may experience periods of remission.

- Early treatment initiation and adherence to therapy can significantly improve the quality of life and prevent complications.

Differential diagnoses:

1. Eczema - Less well-defined borders and different itch pattern

2. Tinea corporis - Normally has a central clearing and responds to antifungal treatment

3. Lichen Planus - Typically presents with flat-topped papules and can affect mucous membranes

4. Seborrhoeic Dermatitis - Often involves the scalp and has a more greasy scale

KEYWORDS = Psoriasis, XX

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_13\_Psoriasis

Homepage Vignette:

### A 30-year-old female called Navya presents with patches of red, scaly skin on her elbows.

Individual Page Vignette:

You are a GP at a local clinic, and Navya, a 30-year-old teacher, has come to your office troubled by red, scaly patches on her elbows which she says have been present for a few months and are becoming increasingly itchy and uncomfortable.

Patient Name:

Navya Kaur (Pronounced: Nav-yah K-our; Prefers to be called Navya)

Age:

03/04/1994

Location:

Clinic

Personality:

Navya is direct and forthright, often speaking assertively about her concerns. She has a questioning nature and prefers to engage in detailed discussions about her condition.

Presenting Complaint:

"It's really frustrating; these red patches on my elbows just won't go away, and they’re so flaky and itchy."

Symptoms:

- Site: Elbows - "The problem is right here on my elbows."

- Onset: Gradual onset several months ago - "I started noticing these patches a few months ago, they’ve slowly gotten worse."

- Character: Itchy and scaly - "These patches are itchy most of the time and the skin is flaky."

- Radiation: Does not radiate - "The itchiness stays put; it doesn't spread anywhere else."

- Associated Symptoms: Occasional soreness - "They sometimes feel sore if I've been scratching a lot."

- Timing: Persistent with occasional flare-ups - "It seems to be there all the time, but some days are worse than others."

- Exacerbating and Relieving Factors: Worse with hot showers and at night - "Hot showers definitely make it more itchy. It eases a bit when I cool down my skin or apply moisturiser."

- Severity: Moderate itchiness - "The itchiness gets quite bad, especially when I'm trying to focus on work."

History of Presenting Complaint:

- Experienced consistent symptoms for approximately 6 months

- Self-treated with over-the-counter emollients with minimal improvement

- Symptoms worsen at night and after hot showers

- Impact on quality of sleep due to itchiness

- Starting to affect self-esteem and comfort in social situations due to visibility and need to scratch

Systemic Symptoms:

- No reported symptoms such as fever, weight loss, or widespread rashes

- Navya: "Apart from these annoying patches on my elbows, the rest of me feels fine."

Past Medical History:

- Generally healthy with no chronic medical conditions or prior surgeries

- No history of similar skin conditions or atopic disorders

- Navya: "I've been pretty healthy most of my life; I've never had skin issues before this."

Drug History:

- No regular medications are taken

- Occasional use of NSAIDs for menstrual cramps

- Navya: "I don't take a lot of medicines, just the odd painkiller now and then."

Allergies:

- No known medication or food allergies

- Navya: "I'm not allergic to anything that I'm aware of."

Family History:

- No family history of psoriasis

- A maternal aunt has eczema

- Navya: "My family has no history of psoriasis, just my aunt has eczema."

Social History:

- Primary school teacher with a bachelor's degree in education

- Lives in a city apartment with her husband

- Social drinker, with consumption of around 3 units of alcohol per week

- Non-smoker, leads a mostly sedentary lifestyle due to job demands

- Enjoys yoga and reading in her spare time

- Diet primarily consists of home-cooked meals with moderate consumption of vegetables and meat

- No recent travel or known exposure to environmental hazards

- Navya: "As a teacher, I have a mixed routine; it’s structured but can be stressful. In my downtime, I love decompressing with a yoga session or a good book."

Ideas, Concerns, and Expectations:

- Ideas: Naval believes the condition may be stress-related or due to a dietary issue - "Could this be from stress, or something I'm eating?"

- Concerns: Worried about a long-term condition affecting her appearance and quality of life - "I'm scared this won't go away and it will always be a problem."

- Expectations: Naval expects a clear diagnosis and an effective treatment plan - "I'm hoping you can give me something that clears it up for good."

Observations:

- Respirations (Breaths/min): 14

- Oxygen Saturation (%): 98%

- Air or Oxygen?: Air

- Blood Pressure (mmHg): 128/78

- Pulse (Beats/min): 72

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.6

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- No signs of acute distress

- Healthy appearance apart from dermatological complaints

Skin Lesion Inspection:

Location: Elbows

Distribution: Bilateral

Shape: Rounded to oval

Symmetry: Yes

Borders: Discernible, sharp

Colour: Reddish-pink with white scales

Diameter: Approximately 2-5 cm across

Skin Lesion Palpation:

- Raised, well-demarcated plaques

- Warmth over the lesions indicating inflammation

- No notable tenderness except for slight discomfort due to scale removal

Systemic Examination:

- No peripheral lymphadenopathy

- Thoracic, cardiac, and abdominal examination all normal

- Musculoskeletal examination unremarkable with full range of motion

Special Tests:

- Dermatoscopy not performed at this consultation but may be considered if diagnosis is unclear in the future

Diagnostic Tests:

- As the clinical presentation is highly suggestive of psoriasis, no specific blood tests are indicated at this time

- Skin biopsy is not routinely performed unless the clinical diagnosis is unclear or treatment fails

Condition:

Psoriasis

Patient Questions:

- Navya: "Is this definitely psoriasis, or could it be something else?" (Possible answer: Your symptoms and the appearance of the lesions are very characteristic of psoriasis; however, if they don't respond to treatment, we may reconsider and carry out further investigations.)

- Navya: "How long will I need to use the treatments before I start seeing results?" (Possible answer: You may begin to see improvement in your symptoms within a few weeks, but it's essential to continue treatment as prescribed to achieve the best results.)

- Navya: "Could this have been triggered by my diet or stress?" (Possible answer: Stress can worsen psoriasis, and while diet doesn't directly cause psoriasis, it can impact overall health and potentially affect the severity of symptoms.)

- Navya: "What can I do to avoid flare-ups in the future?" (Possible answer: Along with adhering to the treatment plan, it's helpful to maintain a healthy lifestyle with balanced nutrition, regular exercise, stress management, and avoiding known triggers like hot showers.)

Examiner Questions:

- How is psoriasis typically managed in the primary care setting? (Possible answer: Initial management typically involves topical treatments such as corticosteroids, vitamin D analogues, and emollients, as well as patient education on lifestyle modifications.)

- What is the significance of treating psoriasis early? (Possible answer: Early treatment is important to alleviate symptoms, prevent complications, and improve overall quality of life.)

- How should a primary care physician monitor a patient on topical steroids? (Possible answer: Monitoring should include checking for skin atrophy, telangiectasias, and effectiveness of the treatment, and ensuring that steroid use is not excessive.)

- What are some potential comorbidities associated with psoriasis? (Possible answer: Patients with psoriasis are at increased risk for psoriatic arthritis, cardiovascular disease, metabolic syndrome, and depression.)

- When should a patient with psoriasis be referred to a dermatologist? (Possible answer: Referral is warranted if the diagnosis is uncertain, if the disease is widespread or severe, or if symptoms are not responding to initial therapy.)

Treatment:

- Initiate treatment with topical corticosteroids such as mometasone furoate once daily for up to 4 weeks.

- Use vitamin D analogue calcipotriol twice daily as adjunctive therapy.

- Advise liberal use of emollients to maintain skin hydration.

- If symptoms are extensive or not responsive to topical treatments, consider referral to dermatology for systemic treatments such as methotrexate or biologic agents.

- Provide education on the chronic nature of psoriasis and the importance of regular treatment and follow-up.

Monitoring:

- Arrange follow-up within 4 weeks to assess response to treatment and skin condition.

- Advise patients to report any side effects of the treatments, especially skin thinning from long-term steroid use.

- Suggest routine follow-ups every 6 months to monitor disease activity and modify treatment if necessary.

- Encourage self-monitoring for any joint pain, and if present, to report for evaluation for psoriatic arthritis.

Prognosis:

- Psoriasis is a chronic, relapsing condition, and while the skin lesions can be effectively managed with treatment, there may be periods of exacerbation.

- The condition involves a risk of developing comorbidities including psoriatic arthritis, which emphasises the need for regular monitoring.

- Education on the importance of adherence to treatment and follow-up is crucial for a positive long-term outcome.

Differential diagnoses:

1. Dermatitis Herpetiformis – Associated with gluten sensitivity and typically responds to a gluten-free diet.

2. Lichen Planus – Features flat-topped, purple plaques and often involves mucous membranes.

3. Pityriasis Rosea – Presents with a 'herald patch' followed by a more diffuse eruption in a 'Christmas tree' pattern.

4. Secondary Syphilis – Can present with similar skin changes but usually includes systemic symptoms and requires serologic confirmation.

KEYWORDS = Psoriasis, XX

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

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# ALYC\_14\_Psoriasis

Homepage Vignette:

## A 29-year-old female called Amara presents with patches of red, itchy skin covered with silvery scales on her elbows and knees.

Individual Page Vignette:

You are a GP at a general practice clinic, and today you're seeing Amara, a 29-year-old journalist, who reports that for several months, she has been experiencing itchy, scaly patches on her elbows and knees which seem to worsen during periods of stress.

Patient Name:

Amara Chaudhry (Pronounced: Ah-ma-rah Ch-ow-dh-ree; Prefers to be called Amara)

Age:

15/02/1995

Location:

General Practice

Personality:

Amara is an engaging and expressive individual, with a tendency to articulate her concerns using vivid language and imagery. She often draws upon her experiences to formulate questions and express her concerns.

Presenting Complaint:

"Look at this, my skin is flaring up like crazy, and these scales on my arms and legs are absolutely maddening. It's as though my skin is just continually shedding and it's driving me up the wall!"

Symptoms:

- Site: Elbows and knees - "It's mainly on my elbows and knees where these red splotches have set up camp."

- Onset: Slow onset, a few months ago - "This started subtly a few months back. At first, I thought it was just dry skin."

- Character: Itchy and scaly - "Feels like there's an incessant prickle under my skin and over it, this unsightly layer of scales."

- Radiation: None - "The itchiness sticks right where those red patches are; doesn't travel anywhere else."

- Associated Symptoms: Bleeding when scratching - "If I give in to the itch and scratch, sometimes it gets so bad that it bleeds a little."

- Timing: Constant, with flare-ups - "The itch is always there, a nuisance really, but there are times when it's like a flare goes off and it becomes unbearable."

- Exacerbating and Relieving Factors: Worsens with stress and alcohol - "During tight deadlines or after a night out drinking, I wake up to a full-on scale-fest, but keeping them moisturised seems to help a tad."

- Severity: Moderate to severe itchiness - "The itch can get pretty intense, like an 8 out of 10 on the bother scale."

History of Presenting Complaint:

- Persistence of symptoms for several months

- Temporary relief from over-the-counter emollients and cool showers

- Noticeable increase in discomfort when under work stress or after consuming alcohol

- No previous professional consultation or treatment attempt for these symptoms

Systemic Symptoms:

- No signs of systemic involvement such as fever or weight loss

- Amara: "Thankfully, it's just the skin that's the issue, the rest of me is functioning as it should."

Past Medical History:

- Asthma during childhood, no recent episodes

- No major illnesses or hospital admissions

- Amara: "Used to carry an inhaler as a kid for asthma, but it's been ages since I needed anything like that."

Drug History:

- No prescription medications

- Uses paracetamol occasionally for headaches

- Amara: "I'm not on any meds, just a paracetamol here and there when a headache crops up."

Allergies:

- No known allergies

- Amara: "No, I don't puff up or itch from anything... well, except for whatever is causing this skin drama."

Family History:

- Mother has hypothyroidism

- Uncle has type 2 diabetes

- No known family history of skin conditions

- Amara: "Mum deals with thyroid stuff, and an uncle with diabetes, but skin issues? That seems to be my solo act."

Social History:

- Full-time journalist, often dealing with deadlines

- Single, lives in an apartment alone

- Casual drinker, about 3 to 4 drinks per week

- Non-smoker, no recreational drug use

- No pets or known environmental allergens exposure

- Enjoys yoga and tries to maintain a balanced diet

- Amara: "As a journalist, my work life can be pretty hectic, good thing is I have my yoga sessions to keep me balanced. I live solo and prefer a glass of wine to unwind once in a while."

Ideas, Concerns, and Expectations:

- Ideas: Suspects stress or lifestyle may be contributing factors - "Is my over-the-top schedule to blame for this? Or perhaps I need to be stricter with my diet or booze?"

- Concerns: Worried about the permanency and possible spread of the condition - "I can't fathom living with this forever. What if it spreads or keeps getting worse? It's not the most glamorous look for someone my age."

- Expectations: Seeks treatment to alleviate symptoms and long-term management - "I expect us to tackle this head-on, find me a solution that eases this itch and keeps these scales at bay, ideally without slathering heaps of chemicals on my skin."

Observations:

- Respirations (Breaths/min): 16

- Oxygen Saturation (%): 99%

- Air or Oxygen?: Air

- Blood Pressure (mmHg): 115/75

- Pulse (Beats/min): 70

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.7

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- General appearance is well-nourished and alert

- Noticeable discomfort from scratching the affected areas

Skin Lesion Inspection:

Location: Elbows and knees

Distribution: Bilateral and symmetrical

Shape: Oval

Symmetry: Symmetric

Borders: Well-defined

Colour: Erythematous background with silvery-white scaling

Diameter: Ranging from 2 to 6 cm

Skin Lesion Palpation:

- Raised plaques with definite borders

- Normal temperature around the plaques, rough texture due to scales

- Mild tenderness when pressure is applied, mainly due to scratching

Systemic Examination:

- No evidence of lymphadenopathy or joint swelling

- Abdomen soft and non-tender, no organomegaly

- Cardiovascular and respiratory examinations normal

Special Tests:

- No special tests like Wood's lamp or dermoscopy performed at this stage

Diagnostic Tests:

- Not indicated at present given the characteristic clinical presentation

Condition:

Psoriasis

Patient Questions:

- Amara: "Is there a chance this isn't psoriasis, that something else is causing these symptoms?" (Possible answer: Psoriasis is the most likely diagnosis given your description and the appearance of your skin, but we can consider other possibilities if your symptoms do not respond to treatment.)

- Amara: "What lifestyle changes should I make to improve my symptoms?" (Possible answer: It's beneficial to reduce stress where possible, maintain good skin care with regular moisturising, and limit alcohol intake as it can exacerbate psoriasis.)

- Amara: "Are there any natural remedies I can try alongside medical treatment?" (Possible answer: Some people find relief with aloe vera, omega-3 fatty acids, or turmeric supplements, but it's important to combine these with conventional treatments for the best outcome.)

- Amara: "How will this affect my day-to-day life in the long term?" (Possible answer: With good management, many people with psoriasis maintain a high quality of life. It's about finding the right treatment balance and making beneficial lifestyle adjustments.)

Examiner Questions:

- What are the common triggers that could exacerbate psoriasis? (Possible answer: Common triggers for psoriasis flare-ups include stress, infection, some medications, alcohol consumption, and trauma to the skin.)

- How do you approach treatment for a patient with mild to moderate psoriasis in primary care? (Possible answer: Start with topical treatments such as corticosteroids or vitamin D analogues, combined with emollients for skin hydration, and patient education on lifestyle modifications that can help manage symptoms.)

- What kind of follow-up is necessary for a patient with a new diagnosis of psoriasis? (Possible answer: Follow-up in primary care should include assessment of treatment response, possible side effects, and the impact on quality of life, with a plan for regular monitoring and escalation of treatment if necessary.)

- What are the signs and symptoms that indicate psoriatic arthritis in a patient with psoriasis? (Possible answer: Look for joint pain, stiffness, especially in the morning, swelling in the fingers or toes, and pain in the tendons or ligaments.)

- When should a patient with psoriasis be referred to a specialist? (Possible answer: Referral to a dermatologist is warranted if the psoriasis is severe, not adequately controlled with primary care management, significantly impacts the patient’s quality of life, or if there is a suspected development of psoriatic arthritis.)

Treatment:

- Start with a potent topical corticosteroid, such as betamethasone dipropionate 0.05%, once daily for up to 4 weeks on the affected areas.

- Add a vitamin D analogue, like calcipotriol 50 mcg/g, applied twice daily.

- Emphasise the importance of regular application of emollients throughout the day to reduce scaling and itching.

- In case of intolerance or poor response, explore other topical treatments such as tacrolimus or pimecrolimus for sensitive areas, or the use of keratolytics.

- If topical therapies are ineffective or if the psoriasis is widespread, consider a referral to dermatology for systemic treatments such as methotrexate or biologics.

Monitoring:

- Schedule a follow-up in 4 weeks to evaluate the response to treatment and adjust as necessary.

- Educate on the signs to watch for regarding potential side effects of topical steroids, such as skin thinning.

- Advise regular self-inspection of the skin for new or worsening lesions and to report any joint pain or discomfort that could indicate psoriatic arthritis.

- Longer-term follow-up appointments should be made every 3 to 6 months to monitor disease activity and treatment efficacy.

Prognosis:

- Psoriasis is a chronic disease with a variable course that includes periods of remission and exacerbation.

- Timely and consistent treatment can result in significant symptom relief and improvement in the quality of life.

- The presence of joint pain or other systemic symptoms may indicate the development of psoriatic arthritis, which impacts the overall prognosis and management.

KEYWORDS = Psoriasis, XX

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_15\_Psoriasis

Homepage Vignette:

## A 42-year-old female called Aneesa presents with persistent, itchy, scaly patches on her scalp and elbows.

Individual Page Vignette:

You are a General Practitioner, and Aneesa, a 42-year-old accountant, has come to your practice complaining of itchy, scaly patches on her scalp and elbows that have been persistent for the past year and seem resistant to over-the-counter treatments.

Patient Name:

Aneesa Parveen (Pronounced: Ah-nee-sah Par-veen; Prefers to be called Aneesa)

Age:

24/08/1982

Location:

Clinic

Personality:

Aneesa is precise and concise in her communication, often getting straight to the point. She displays a rational approach to her health concerns but also shows visible signs of stress regarding her symptoms.

Presenting Complaint:

"It's these irritating, scaly patches on my scalp and elbows; they're always itchy, and no matter what I do, they don't seem to go away."

Symptoms:

- Site: Scalp and elbows - "The scales are mostly on my scalp, and then there's this rough patch on each elbow."

- Onset: Began approximately one year ago - "These skin issues started popping up about a year ago."

- Character: Itchy and scaly - "It feels rough, like sandpaper, and it itches endlessly."

- Radiation: None - "The itchiness doesn't really go beyond the areas where the patches are."

- Associated Symptoms: Occasional bleeding from scratching - "Sometimes I scratch so much that it bleeds a little, especially on the scalp."

- Timing: Constant presence, with varying degrees of itchiness - "The patches are always there, but some days it's itchier than others."

- Exacerbating and Relieving Factors: Stress and dry weather make it worse, moisturising provides temporary relief - "Stress at work definitely triggers it, and dry weather isn't helping. I get some relief when I apply moisturiser."

- Severity: The itchiness can be intense - "There are days when it's so severe that I can't concentrate on anything else."

History of Presenting Complaint:

- Initial appearance of symptoms around a year ago and has been static with periods of worsening

- Unsuccessful treatment with various over-the-counter moisturising and anti-itch creams

- Significant impact on sleep quality and self-confidence, particularly in professional settings

Systemic Symptoms:

- No systemic symptoms such as fever or malaise

- Aneesa: "Apart from the issues with my skin, I don't have any other health complaints."

Past Medical History:

- Generally healthy with an unremarkable medical history

- Aneesa: "I've been pretty healthy throughout my life, no serious illnesses or conditions."

Drug History:

- No current prescription medication use

- Aneesa: "I don't take any regular medicine, just the lotions and creams for my skin."

Allergies:

- No known allergies to medications or foods

- Aneesa: "I've not had any allergic reactions to medicines or foods, thankfully."

Family History:

- Father has hypertension

- No known family history of psoriasis or dermatological conditions

- Aneesa: "My dad has high blood pressure, but as for skin problems, there's nothing in the family that I know of."

Social History:

- Works as an accountant, which involves long hours during tax season

- Married with two teenage children

- Non-drinker and non-smoker

- Enjoys light exercise, such as walking, a few times a week

- Aneesa: "It's usually busy at work, and with the kids, I don't get much spare time. I try to keep active with walks when the weather is nice."

Ideas, Concerns, and Expectations:

- Ideas: Thinks it may be a severe form of dandruff or eczema - "Could this just be very bad dandruff or maybe eczema?"

- Concerns: Anxious about the chronic nature of the symptoms and the lack of improvement - "I'm worried that this isn't going to go away. It's really affecting my day-to-day life now."

- Expectations: Hopes for a definitive diagnosis and an effective treatment plan - "I need to know what this is and get something that's actually going to work for me."

Observations:

- Respirations (Breaths/min): 18

- Oxygen Saturation (%): 97%

- Air or Oxygen?: Air

- Blood Pressure (mmHg): 130/85

- Pulse (Beats/min): 78

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.9

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- No signs of acute illness or distress

- Visible scaly patches on exposed areas

Skin Lesion Inspection:

Location: Scalp and elbows

Distribution: Localised to specific areas

Shape: Irregularly circular

Symmetry: Bilateral symmetry on elbows

Borders: Well-defined on the elbows, diffuse at the scalp's hairline

Colour: Light red with white flaky scales

Diameter: Various sizes, largest being 5 cm on the elbow

Skin Lesion Palpation:

- Elevated plaques with a rough texture

- Warmth over the lesions, denoting inflammatory activity

- Minimal tenderness despite the frequent itching and scratching

Systemic Examination:

- No peripheral lymphadenopathy

- Abdominal examination normal, thyroid unremarkable

- Chest auscultation clear, heart sounds normal

Special Tests:

- Dermatoscopy might be indicated if typical treatments are ineffective and alternative diagnoses are considered

- No other special tests performed at the present visit

Diagnostic Tests:

- Blood tests and imaging not indicated at this stage

- Skin biopsy may be performed later if there is no response to standard treatment or if the diagnosis is in doubt

Condition:

Psoriasis

Patient Questions:

- Aneesa: "What could be the cause of these patches if it's not dandruff or a simple skin irritation?" (Possible answer: The cause of psoriasis is not fully understood, but it's believed to be related to an immune system issue that causes rapid skin cell turnover, leading to these patches. It's not related to dandruff, but it can look similar.)

- Aneesa: "Will the treatment you're prescribing get rid of these patches completely?" (Possible answer: Treatment aims to manage the condition and relieve symptoms. Many people experience a significant reduction in the appearance of patches, although complete clearance isn't guaranteed.)

- Aneesa: "Could this condition affect other areas of my body?" (Possible answer: Psoriasis can affect different areas, but the treatment will help to manage and possibly prevent the spread to other sites.)

- Aneesa: "Is there a chance that my children could develop this condition?" (Possible answer: Psoriasis can run in families, but it doesn't mean your children will definitely develop it. There's a genetic aspect, but environmental factors also play a big role.)

Examiner Questions:

- How does psoriasis typically present and how is it diagnosed? (Possible answer: Psoriasis often presents as well-defined red patches with silvery scales, generally on extensor surfaces. Diagnosis is usually clinical, based on history and examination, but a biopsy can confirm if needed.)

- What are the first-line treatments for mild to moderate psoriasis? (Possible answer: Initial treatments include topical steroids and vitamin D analogues, as well as regular moisturising and avoidance of known triggers.)

- How do you monitor the progression of psoriasis in primary care? (Possible answer: Regular follow-up visits to assess the effectiveness of treatment, skin examination to monitor the extent and severity of plaques, and evaluation of any potential side effects from treatment.)

- What are the indications for referral to a dermatologist in a patient with psoriasis? (Possible answer: Referral is indicated if psoriasis is extensive, not responding to topical treatments, or if the patient develops psoriatic arthritis or other complications.)

- If a patient presents with joint pain and a history of psoriasis, what would your next steps be? (Possible answer: The patient should be evaluated for psoriatic arthritis, and if suspected, referral to rheumatology may be necessary. Investigations can include inflammatory markers, rheumatoid factor, and imaging of the affected joints.)

Treatment:

- Commence topical treatment with a high-potency corticosteroid such as clobetasol propionate 0.05% ointment applied to affected areas once daily for up to 4 weeks, then taper as symptoms improve.

- Add a vitamin D analogue like calcipotriol cream applied twice daily to complement the steroid treatment.

- Prescribe a medicated shampoo containing coal tar or salicylic acid for scalp psoriasis.

- Strongly advise consistent and liberal use of emollients to reduce dryness and alleviate itching.

- If there's no improvement or if Aneesa develops extensive psoriasis, consider systemic treatments after referral to a dermatologist.

Monitoring:

- Follow-up appointment in 4 weeks to assess the response to treatment.

- Monitor for side effects of long-term topical steroid use, including skin thinning and telangiectasia.

- Advise Aneesa to seek immediate care if she experiences any signs of infection or a sudden worsening of her symptoms.

- Discuss the need for regular appointments every 3-6 months to review and potentially update the treatment plan.

Prognosis:

- Psoriasis is a chronic condition with periods of exacerbation and remissions.

- Ongoing treatment can offer significant control over the symptoms and can improve the quality of life.

- There is no cure for psoriasis, but many people can achieve clearance or near-clearance of their skin with appropriate therapy.

Differential diagnoses:

1. Seborrhoeic Dermatitis - Also involves scale but typically has a greasy appearance, often limited to sebaceous gland-rich areas.

2. Lichen Planus - Can be itchy with purple, polygonal, flat-topped papules but lacks the silvery scale of psoriasis and has a distinct wrist involvement and mucosal changes.

3. Tinea Capitis on the scalp - Involves hair-bearing areas and is usually associated with hair loss and scaling, but confirmed with fungal elements on microscopy or culture.

4. Discoid Lupus Erythematosus - Typically presents with disc-shaped, red, inflamed patches with a tendency to scar, diagnosed by biopsy showing interface dermatitis with a full thickness inflammatory infiltrate.

KEYWORDS = Psoriasis

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by TBC, Medical Student

Reviewed by TBC, Medical Student/Doctor

# **ALYC\_16\_Psoriasis**

Homepage Vignette:

## "A 32-year-old woman called Amara presents with a persistent, itchy rash over her scalp and elbows."

Individual Page Vignette:

You are a General Practitioner (GP) seeing a new patient. Amara, 32-year-old female, office manager, from the local area, presents with a persistent, itchy rash over her scalp and elbows.

Patient Name: Amara Mukherjee (Amara: Uh-MAH-ruh)

Age: 03/04/1992

Location: General Practice

Personality: Amara is a soft-spoken, well-mannered individual with a calm and friendly demeanour. She appears slightly anxious about her skin condition but is eager to receive help and improve her symptoms.

Presenting Complaint:

Symptoms:

- Site: Scalp and elbows

- Onset: Persistent

- Character: Itchy rash

- Radiation: ---

- Associated Symptoms: Dry, scaly skin

- Timing: Chronic

- Exacerbating and Relieving Factors: ---

- Severity: Mild to moderate

Amara: "I've had this persistent, itchy rash on my scalp and elbows for a long time. It's really bothering me, and it keeps flaking and itching. It's becoming difficult to manage."

History of Presenting Complaint:

Amara has been experiencing the symptoms for several months. She has not attempted any specific treatments and reports a gradual worsening of her symptoms. She notes that the rash has impacted her daily life and work, causing discomfort and affecting her self-esteem. Her mental wellbeing has also been affected due to the persistent nature of the rash.

Negative aspects of the histories are negative for this case.

Systemic Symptoms:

- No systemic symptoms to report.

Past Medical History:

Negative for previous skin conditions or autoimmune conditions.

Drug History:

Amara occasionally uses over-the-counter moisturisers and has not had prior use of topical steroids. She has no known allergies to medications.

Allergies:

Amara has no known allergies to medications or other allergens.

Family History:

Negative for significant medical conditions related to skin conditions.

Social History:

- Occupation: Office manager

- Lifestyle: Maintains a healthy lifestyle, regular exercise

- Diet: Balanced diet, avoids known triggers

- Habits: Non-smoker, social drinker

- Hobbies: Enjoys hiking and cycling

- Travel: No recent international travel

- Sun exposure: Moderate, regular use of sunscreen

Ideas, Concerns, and Expectations:

Ideas:

Amara expresses concern that the rash may be a long-term problem.

Amara: "I'm worried that this rash will be something I have to deal with for a long time."

Concerns:

Amara is concerned that the rash may have a significant impact on her daily life and self-esteem.

Amara: "I'm concerned about how this rash affects my daily life and how it makes me feel about my appearance."

Expectations:

Amara hopes to receive an accurate diagnosis and effective treatment plan to manage the rash and improve her quality of life.

Amara: "I hope to get a clear understanding of what's causing this rash and find an effective treatment plan."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Air

Blood Pressure (mmHg): 120/70

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

General Inspection:

Amara appears well, slightly anxious about the rash. No visible signs of distress or systemic disease. No obvious signs of scratching or self-inflicted skin trauma.

Skin Lesion Inspection:

- Location: Scalp and elbows

- Distribution: Localized

- Shape: Scaling, plaques

- Symmetry: Asymmetric

- Borders: Well-defined

- Colour: Pink to red

- Diameter: Varied

Special Tests:

Wood's lamp: No fluorescence observed.

Dermatoscopy: Evidence of erythema and plaques on the scalp.

Diagnostic Tests:

Complete blood count, urea and electrolytes, and thyroid function tests are within normal limits.

Condition:

Psoriasis

Patient Questions:

1. Amara: "Could this rash be a sign of something more serious?"

- Doctor: "There's a possibility, but we'll investigate further and work on making it better."

2. Amara: "Will the treatment be able to make this rash go away completely?"

- Doctor: "Our goal is to find a treatment plan to improve the rash significantly."

3. Amara: "Is there anything that I'm doing that's making this rash worse?"

- Doctor: "Sometimes, certain factors can impact skin conditions, but we'll discuss this in detail as we work through your treatment plan."

Examiner Questions:

1. What are the typical distribution patterns of psoriasis?

- Psoriasis commonly affects the scalp, elbows, knees, and lower back.

2. How does psoriasis commonly present on the skin?

- Psoriasis presents with well-defined plaques with silvery scales.

3. What are the trigger factors for psoriasis flares?

- Trigger factors may include stress, skin injury, infections, and certain medications.

4. How can psoriasis be effectively managed in primary care?

- Management may involve the use of topical treatments, phototherapy, and systemic agents in some cases.

5. What are the potential comorbidities associated with psoriasis?

- Comorbidities can include psoriatic arthritis, cardiovascular disease, and metabolic syndrome.

Treatment:

The treatment plan for Amara includes:

1. Emollients for moisturising, applied generously and frequently.

2. Topical treatments with a combination of potent corticosteroid and vitamin D analogue for scaling and inflammation.

3. Referral to dermatology for consideration of phototherapy or systemic agents if the response is inadequate or generalized.

Monitoring:

Amara should monitor her symptoms regularly and follow up in 4 weeks. Any worsening of symptoms or lack of improvement should prompt a follow-up visit.

Prognosis:

With appropriate management, the prognosis for psoriasis is generally good. However, it may be a chronic condition with periods of remission and flare-ups. The response to treatment can vary among individuals.

Differential diagnoses:

1. Atopic dermatitis

2. Seborrheic dermatitis

3. Contact dermatitis

4. Tinea corporis

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin lesion

Condition Filter:

Psoriasis

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_17\_Impetigo

Homepage Vignette:

## "A 40-year-old woman named Rhiannon presents with a rash and blisters on her face and arms."

Individual Page Vignette:

"You are a dermatologist. Rhiannon is a 40-year-old fashion designer, who presents with a rash and blisters on her face and arms."

Patient Name:

Rhiannon McAdams (Ri-an-on Mih-kad-ams); she would like to be called Rhiannon.

Age:

12/03/1984

Location:

Dermatology Clinic

Personality:

Rhiannon is an outgoing and creative individual. She speaks in an enthusiastic and expressive manner, often using hand gestures. She pays great attention to detail and is very fashion-conscious. Rhiannon is approachable, but can be a bit anxious about her appearance due to her occupation in the fashion industry.

Presenting Complaint:

Rhiannon reports: "Doctor, I have red, itchy rashes and blisters on my face and arms. It's really noticeable as it's affecting my work and confidence. It's been spreading and it's becoming quite painful now."

Symptoms:

Site: Face and arms

Onset: Gradual, spreading from the face to the arms

Character: Red, itchy rashes and blisters

Radiation: Localized to face and arms

Associated Symptoms: Pain

Timing: Getting progressively worse

Exacerbating and Relieving Factors: Worsens with exposure to irritants, improves with rest

Severity: Mild to moderate

History of Presenting Complaint:

Rhiannon relates, "It started a couple of weeks ago and hasn't improved with over-the-counter creams. It's making it hard to focus on my designs with the discomfort. I've had some difficulty with sleep as well. It's definitely getting in the way of my work."

Systemic Symptoms:

All findings described are normal in this case.

Past Medical History:

Negative for previous skin conditions.

Drug History:

Rhiannon has no history of past use of topical steroids or medications used for skin conditions.

Allergies:

Rhiannon is allergic to amoxicillin, causing a rash and dizziness.

Family History:

There is no known family history of skin conditions.

Social History:

Lifestyle: Fashion Designer

Occupation: Fashion designer

Activities of Daily Living & Hobbies: Rhiannon takes fashion design very seriously and spends long hours working on her designs.

Rhiannon states, "I'm concerned about the impact this rash is having on my work. My designs are very important to me and I need to look presentable as a fashion designer. I'm also worried about how long it will take for this to heal and the implications it may have on my skin in the future. My expectations are to receive effective treatment so that I can resume my work quickly."

Physical Examination:

General Inspection: Rhiannon is visibly anxious and is scratching her arms. She is well-kempt, dressed in fashionable attire.

Skin Lesion Inspection:

- Location: Face and arms

- Shape: Circular

- Colour: Red with areas of yellow crusting

- Bilateral Symmetry: Present on both sides

Skin Lesion Palpatation: Skin temperature over and around lesions is raised, with tenderness and induration. Lymph nodes in the neck are palpable but not enlarged.

Systemic Examination: No abnormal findings.

Diagnostic Tests:

Blood Tests: Complete blood count (CBC) reveals mild leukocytosis; otherwise, all tests are in the normal range.

Imaging Tests: Not indicated in this case.

Other Tests: Skin scrapings reveal Staphylococcus aureus.

Condition:

Impetigo

Patient Questions:

1. "What could have caused this rash, doctor?"

- "The rash could be due to a bacterial infection or exposure to irritants such as soaps or detergents."

2. "Is there a cure for this condition, or will it be a lifelong problem?"

- "Impetigo can be effectively treated with antibiotics. With proper care, it is not a lifelong problem."

3. "Would the treatment affect my ability to work on my designs?"

- "The treatment should not affect your ability to work, but it's important to keep the affected area clean and avoid irritants."

Examiner Questions:

1. What are the typical risk factors for developing impetigo?

- Poor hygiene, close contact with infected individuals, and skin injuries are common risk factors.

2. How would you address Rhiannon's concerns about the impact of impetigo on her career as a fashion designer?

- I would reassure Rhiannon that with prompt treatment and proper care, the rash should heal without affecting her career in the long term.

3. What are the most common causative organisms for impetigo?

- Impetigo is commonly caused by Staphylococcus aureus and Streptococcus pyogenes.

4. How would you approach the treatment of impetigo in a patient who is allergic to penicillin?

- For penicillin-allergic patients, alternative antibiotics such as erythromycin, clindamycin, or a cephalosporin could be considered.

5. What measures can be taken to promote healing and prevent recurrence of impetigo?

- It's important to keep the affected area clean, avoid scratching, and practice good hand hygiene to prevent infecting others or spreading the infection to other areas of the body.

Treatment:

1. Topical antiseptic such as chlorhexidine for skin cleansing.

2. Oral antibiotics: flucloxacillin 500 mg to be taken four times a day for seven days.

3. Regular cleaning and dressing of sores.

4. Advise on maintaining good personal hygiene to prevent the spread of infection.

Monitoring:

Advise Rhiannon to monitor the progression of the rash and report any signs of worsening. A follow-up visit is scheduled in one week to assess the response to treatment.

Prognosis:

With the prescribed treatment and good wound care, impetigo typically resolves within 2 to 3 weeks. Proper hygiene can help prevent recurrence.

Differential Diagnoses:

1. Dermatitis, such as atopic dermatitis

2. Allergic contact dermatitis

3. Eczema

4. Fungal skin infection

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Skin lesion; Acute rash; Pruritus

Condition Filter:

Impetigo

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by TBC, Medical Student

Reviewed by TBC, Medical Student/Doctor

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# **ALYC\_18\_Impetigo**

Homepage Vignette:

## "A 28-year-old woman called Dana presents with a rash on her face."

Individual Page Vignette:

"You are a general practice physician. You are seeing Dana, a 28-year-old woman, who presents with a rash on her face."

Patient Name:

Dana Nikolova (Da-na Ni-ko-lo-va); she prefers to be called Dana

Age:

05/11/1995

Location:

General Practice

Personality:

Dana is a warm and friendly individual with a relaxed and easy-going manner of speaking. She is articulate and expresses herself clearly, showing a strong understanding of her symptoms and concerns.

Presenting Complaint:

Dana presents with an itchy, red rash on her face, described as "I have this itchy rash on my face that I've not been able to get rid of. It's very frustrating and really affecting how I feel about myself."

Symptoms:

Itching (pruritus): Present; "It's very itchy and uncomfortable."

Rash: Present; "I have this rash on my face."

Erythema (redness): Present; "My face is quite red in certain areas."

Scaling: Present; "There's some dry, flaky skin in parts."

Dryness: Present; "It's really dry in certain areas."

Blisters (vesicles or bullae): Absent

Pustules: Absent

Ulcers: Absent

Lesions with distinct borders: Present; "The rash has clear and defined borders."

Exacerbating Factors: "It gets worse when I use certain skincare products."

Severity: "The itchiness is quite severe at times."

History of Presenting Complaint:

The rash has been present for 2 weeks. Dana initially tried over-the-counter facial creams, but they did not improve her condition. She reports that the rash is slowly spreading and is becoming increasingly uncomfortable. The symptoms are bothering her during daily activities, and she is becoming self-conscious about her appearance.

Systemic Symptoms:

The patient denies any systemic symptoms such as fever, weight loss, or other constitutional symptoms. She does not report any additional symptoms elsewhere in the body.

Past Medical History:

Negative for any medical conditions, surgeries, or hospitalizations. No history of atopic disorders, previous skin conditions, or autoimmune conditions.

Drug History:

Dana is not currently taking any medications and has no history of using topical steroids or medications for skin conditions.

Allergies:

Dana has a known allergy to penicillin, causing a severe skin rash and difficulty breathing when exposed to the medication.

Family History:

Negative family history for skin conditions, atopic disorders, and cancers.

Social History:

Lifestyle: Non-smoker, moderate alcohol consumption

Occupation: Retail manager

Activities of Daily Living & Hobbies: Regular exercise, healthy balanced diet, no recreational drug use

Smoking: N/A

Alcohol: Moderate consumption (6 units per week)

Recreational Drug Use: Negative

Diet: Balanced and healthy

Exercise: Regular

Travel History: No recent travel

Sexual History: No relevant information

Driving Status: Full driving license

Cultural or Religious Practises: No relevant information

Recent Life Events: No significant events

Exposure to Hazards or New Environment: No recent exposure

Ideas, Concerns, and Expectations:

Ideas: "I think something must have triggered this rash; it's very unusual for me."

Concerns: "I'm a little worried that it's going to get much worse if it continues spreading."

Expectations: "I hope to receive a clear understanding of what's going on and how I can treat this effectively. I would like to get rid of this rash as soon as possible."

Physical Examination:

General Inspection: No signs of distress or discomfort. No significant systemic findings. No medical devices present. No noticeable odor.

Skin Lesion Inspection:

- Location: Primarily on the cheeks and forehead

- Distribution: Bilateral symmetric distribution

- Shape: The lesions are macular-papular

- Symmetry: Symmetrical distribution

- Borders: Clear and well-defined

- Colour: Erythematous

- Diameter: Multiple lesions, averaging 2-3 cm

Skin Lesion Palpation:

- No elevation

- No changes in skin temperature

- No tenderness or pain

- Firm consistency

Systemic Examination: Unremarkable

Special Tests: None required at this time

Diagnostic Tests:

No further diagnostic tests were required based on the clinical presentation.

Patient Questions:

1. "Is there anything I should be avoiding or using on my skin at the moment?"

- Yes, avoiding any potential triggers and gentle skincare can help.

2. "How long will it take for the rash to start improving with treatment?"

- Improvement can be seen in a few weeks with appropriate treatment.

3. "Should I be concerned about this spreading to other areas of my body?"

- It's unlikely, but monitoring is important.

Examiner Questions:

1. "What is the most common infectious cause of impetigo?"

- Staphylococcus aureus.

2. "Could you describe the primary lesion morphology in impetigo?"

- Non-vesicular, moist, crusted lesion.

3. "What self-care measures have you attempted for the rash, and what were the results?"

- I tried over-the-counter creams, but they didn't work.

4. "What are the most common areas affected by impetigo, and how is the rash typically distributed?"

- Impetigo can occur anywhere, and it's important to note it's usually distributed non-symmetrically and involves isolated lesions.

5. "Are there any systemic symptoms associated with impetigo?"

- No, systemic symptoms are typically absent in impetigo.

Treatment:

1. Gentamicin cream 0.1% applied 3 times daily for 7 days.

2. Chlorhexidine 4% liquid compression for affected areas twice daily for 7 days.

3. Advise to practice thorough hand hygiene.

Alternative:

- Oral flucloxacillin 500 mg 4 times daily for 7 days if topical therapy is ineffective; refer to dermatology if no improvement.

Monitoring:

Dana should monitor for signs of improvement in the rash, including reduced redness and scaling. If there is no improvement within 7 days, she should seek a follow-up appointment. Dana should return to the clinic in 1 week for reassessment and further management.

Prognosis:

Impetigo has an excellent prognosis with appropriate treatment. The rash is expected to improve within a few weeks, and systemic symptoms are generally absent. Factors such as gentle skincare and appropriate hygiene can further support a full recovery.

Differential diagnoses:

1. Atopic dermatitis and eczema

2. Contact dermatitis

3. Cutaneous fungal infection

Speciality Filter:

General Practice

Presenting Complaint Filter:

Acute rash

Condition Filter:

Impetigo

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by TBC, Medical Student

Reviewed by TBC, Medical Student/Doctor

# ALYC\_18\_Cutaneous\_Warts

Homepage Vignette:

## "A 34-year-old woman called Mary presents with multiple small growths on her hands and feet."

Individual Page Vignette:

As a medical student, you are required to take a detailed history and perform a physical examination on a 34-year-old woman named Mary, who is a school teacher. She is currently at a local clinic and is seeking help for the multiple small growths on her hands and feet.

Patient Name:

Mary Morency (Muh-R-ee Mor-ehn-see)

She would like to be called Mary.

Age:

22/06/1990

Location:

Clinic

Personality:

Mary is a friendly, outgoing, and chatty individual. She is optimistic and open to sharing her concerns and expectations during the consultation. She speaks with a confident tone, eager to understand her condition better and work towards a solution.

Presenting Complaint:

Mary reports, “I have these little rough bumps growing on my hands and feet. They've been bothering me for some time now, and I just can't seem to get rid of them. It's really started to bother me lately – especially when I wear my sandals in the summer!”

Symptoms:

• Site: Hands and feet

• Character: Small, rough growths

• Associated Symptoms: Mild discomfort when walking

• Timing: Ongoing

• Impact on daily life: Affects choice of footwear

• Progression: Worsening over time

History of Presenting Complaint:

Mary reports that she has had these symptoms for around 2 years. She has tried over-the-counter wart treatments from the pharmacy, which provided temporary relief but did not eliminate the growths. The symptoms have gradually worsened over time and now start to cause mild discomfort when walking. Mary also indicates that the condition has begun to impact her choice of footwear and overall quality of life to some extent.

Systemic Symptoms:

All systemic symptoms are negative for this case.

Past Medical History:

Negative, overall healthy

Drug History:

Treatment with an over-the-counter salicylic acid wart treatment, recently used to try and eliminate the growths.

Allergies:

Mary has no known allergies.

Family History:

Positive family history for autoimmune skin conditions and thyroid disorders.

Social History:

• Occupation: School teacher

• Smoking: Non-smoker

• Alcohol: Occasionally, 2 units per week

• Recreation Drug Use: Negative

• Diet: Well-balanced diet

• Exercise: Regular gym-goer

Ideas, Concerns, and Expectations:

Mary has a good understanding of her symptoms. She is concerned about the worsening discomfort and the impact on her lifestyle. She expects a treatment plan that is effective but doesn't want to undergo any procedures that might require her to take time off work.

Physical Examination:

General Inspection:

Mary appears in good overall health.

Skin Lesion Inspection:

• Location: Multiple, found on hands and feet

• Distribution: Bilateral

• Shape: Irregular

• Symmetry: Asymmetrical

• Borders: Diffuse

• Colour: Light brown

• Diameter: Small, approximately 3-5mm

Physical Examination (cont'd):

Skin Lesion Palpation:

Most are non-tender on palpation, irregular texture

Systemic Examination:

Lymph nodes, joints, hair, and nail examination are unremarkable.

Diagnostic Tests:

Skin biopsy: benign vascular papillomatosis consistent with verruca vulgaris.

Blood Tests: Within normal limits

Patient Questions:

1. "Can my condition be treated without affecting my work schedule?"

• Yes, we will consider treatment options that have minimal impact on your routine.

2. "Are there any lifestyle changes I need to make to manage this effectively?"

• We will discuss preventive measures to minimize discomfort and recurrence.

3. "Will the treatment be a lengthy process, and how soon can I expect results?"

• The treatment plan aims for effectiveness with minimal downtime, but regular follow-up visits will be needed to monitor the progress.

Examiner Questions:

1. Can you describe the appearance of the growths in detail, including color, size, and texture?

• They are small, light brown, irregularly shaped growths, about 3-5mm in diameter with a rough texture.

2. What is your approach to discussing lifestyle modifications and preventive measures with Mary?

• I would begin by engaging Mary in a collaborative discussion, eliciting her understanding and preferences, and then tailor recommendations according to her needs and daily routine.

3. What treatment options would you consider for managing Mary's condition, and what would you prioritize?

• I would prioritize discussing the various treatment options and their impact on Mary's work schedule, keeping in mind her expectation to continue work without significant interruption.

Treatment:

Initial treatment options will consist of:

• Cryotherapy with liquid nitrogen

• Topical salicylic acid treatment

Referral for more specific, invasive treatment will depend on the initial response.

Monitoring:

Monitoring will include regular follow-up visits, with specific attention to the progression or regression of the growths. Any signs of potential adverse effects from treatment will warrant seeking further medical attention.

Prognosis:

With the appropriate treatment, the verruca vulgaris is likely to resolve, and Mary can expect an improvement in symptoms within a few weeks. However, there is also a possibility of recurrence, which will necessitate ongoing preventive measures and regular monitoring.

Differential diagnoses:

1. Calluses and corns: Less likely due to the atypical shape and color of the growths.

2. Molluscum contagiosum: Unlikely due to the rough texture and absence of central umbilication.

3. Seborrheic keratosis: Less likely due to the location and texture of the lesions.

4. Squamous cell carcinoma: Lesser concern given the benign nature and lack of suspicious features.

Speciality Filter:

Dermatology; General Practice; Clinic

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Cutaneous warts

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_19\_Cutaneous\_Warts

Homepage Vignette:

## "A 30-year-old woman presents with a skin concern."

Individual Page Vignette:

"You are a general practitioner (GP) at a clinic. You are about to see a 30-year-old woman named Amina Khalifa, who works as a chef. She is presenting with concerns about her skin."

Patient Name:

Amina Khalifa (Ah-mee-nah Kha-lee-fa); she would like to be called Amina.

Age:

30 years old, DOB: 01/05/1994

Location:

Clinic

Personality:

Amina is an articulate and inquisitive individual with a calm and composed manner of speaking. She is well-educated, polite, and has a keen attention to detail. She expresses herself clearly and concisely, preferring to be thorough in the description of her symptoms.

Presenting Complaint:

Amina has attended the clinic due to "small rough lumps on the back of my hand and fingers that do not seem to be going away. They are not itchy and don't cause me any discomfort, but I am concerned about them and want to have them checked."

Symptoms:

- Site: Back of hand and fingers

- Onset: Insidious

- Character: Small rough lumps

- Associated Symptoms: No itching or discomfort

- Timing: Ongoing

- Severity: Concerning to Amina, although she experiences no physical discomfort

- History of Presenting Complaint: Amina reports that the small rough lumps appeared on the back of her hand and fingers approximately six months ago. She has not initiated any treatments. The lumps have not resolved or changed in size in that time. She is concerned about the persistent appearance of these lumps and is seeking reassurance and evaluation.

Systemic Symptoms:

- Normal in this case

Past Medical History:

- Negative for previous skin conditions, auto-immune conditions, and atopic disorders

- No significant medical conditions or previous surgeries

Drug History:

- Amina does not take any regular medications or have a history of using topical steroids or medications for skin conditions.

Allergies:

- Amina reports no known allergies or intolerances.

Family History:

- Negative for any skin disorders or significant medical history in the family

Social History:

- Lifestyle: Amina has a balanced lifestyle, enjoying cooking, reading, and regular exercise with good attention to her diet.

- Occupation: She works as a chef and is dedicated to her job.

- Smoking: Negative

- Alcohol: She drinks alcohol occasionally, approximately 4 units per week

- Recreational Drug Use: Negative

- Occupational and environmental exposure: Amina reports no significant exposure to chemicals or environmental hazards.

- Travel History: Amina has not travelled recently to any areas of concern.

- Cultural or Religious Practices: Amina follows no specific cultural or religious practices that relate to her presenting complaint.

Ideas, Concerns, and Expectations:

- Ideas: Amina expresses her understanding of the issue as an unexplained skin concern that has caused her worry but no physical discomfort.

- Concerns: Amina is concerned about the presence and persistence of these lumps, although she does not experience any physical symptoms.

- Expectations: Amina is looking for reassurance and an evaluation to determine the nature of the lumps and a plan for management or reassurance regarding the benign nature of the lesions.

Physical Examination:

- The skin examination showed small, firm, hyperkeratotic papules on the back of Amina's hand and fingers.

- No other relevant findings were noted during the examination.

Diagnostic Tests:

- None required at this stage as the diagnosis of cutaneous warts can be made clinically. No further specific tests or investigations are necessary unless the diagnosis is uncertain or if a biopsy for histological confirmation is required.

Patient Questions:

1. "What are these lumps on my skin caused by?" - Cutaneous warts caused by the human papillomavirus.

2. "Is there a risk of spreading these lumps to others or other parts of my body?" - Yes, you can spread them to other parts of your body or to others through direct skin-to-skin contact.

3. "How long will it take for these lumps to disappear?" - Warts may clear up spontaneously within months to years, but they can be treated to speed up resolution.

Examiner Questions:

1. What are the common treatments available for cutaneous warts? - Options include salicylic acid, cryotherapy, topical medications, or minor surgical procedures.

2. How do you counsel the patient about preventing the spread of cutaneous warts? - Advising on good hand hygiene and avoiding direct contact or sharing items with the affected area.

3. What is the typical appearance of cutaneous warts, and what are the clinical features you should recognize in primary care? - They are firm, hyperkeratotic papules or nodules with a rough, pebble-like surface; may have small black dots. They may cause pain if they are on the soles of the feet.

4. What advice do you give on follow-up for a patient with cutaneous warts? - Patients need follow-up if the warts are treatment-resistant or if they are causing discomfort. Typically, follow-up is scheduled within 2-3 months to assess treatment response.

5. What are the possible complications of cutaneous warts? - There is a risk of long-term cosmetic disfigurement, particularly if left untreated.

6. Are there any specific instances in which you would consider referring the patient to a dermatologist? - Referral may be necessary if the diagnosis is uncertain, there is uncertainty about the management, or if the warts are resistant to primary care treatment.

Treatment:

Initial treatment options for cutaneous warts may include:

- Salicylic acid 12-50%

- Apply once daily at home

- Continue for up to 12 weeks, success rates may be up to 70%

- Cryotherapy

- Liquid nitrogen spray for up to 10 seconds

- Repeat sessions every 2-3 weeks, 3-4 sessions in total

- Success rates similar to salicylic acid

Other options include:

- Topical imiquimod

- Topical retinoids

- Minor surgical procedures, cautery, or laser therapy

- Referral for resistant warts or non-primary care treatments

Monitoring:

Advise the patient to monitor for any changes in the appearance of the warts or if they are causing increased discomfort or pain. Follow-up should be scheduled within 2-3 months for an assessment of treatment response. In case of treatment failure or worsening symptoms, the patient should seek further medical attention or be referred to a dermatologist.

Prognosis:

Cutaneous warts often spontaneously resolve without treatment. However, some may persist for months to years. Treatment can significantly expedite resolution, but there is a risk of recurrence. Prognosis is generally good, and any disfigurement resulting from the wart should resolve.

Differential diagnoses:

1. Seborrheic keratosis

2. Molluscum contagiosum

3. Sebaceous hyperplasia

4. Epidermal nevus

5. Squamous cell carcinoma-in-situ

Keyword Filters:

- Speciality Filter: Dermatology; General Practice

- Presenting Complaint Filter: Skin lesion

- Condition Filter: Cutaneous warts

- Location Filter: Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

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# ALYC\_20\_Cutaneous\_Warts

Homepage Vignette:

## "A 36-year-old woman presents with multiple rough lumps on her hands and fingers."

Individual Page Vignette:

"As a medical student, you are tasked with evaluating Londiwe Maire, a 36-year-old woman who works as a teacher. She is here today for assessment of rough lumps on her hands and fingers."

Patient Name:

Londiwe Maire, pronounced (LON-dee-way MAA-reh); she prefers to be called Londiwe.

Age:

09/05/1988

Location:

General Practice

Personality:

Londiwe is an extroverted and optimistic individual. She speaks enthusiastically and is very vocal about her health concerns.

Presenting Complaint:

"Londiwe exclaims, 'I have these growths all over my hands and fingers. They feel rough to the touch and don't look very nice.'"

Symptoms:

- Site: Hands and fingers

- Onset: 'I first noticed them about 6 months ago.'

- Character: 'They are hard and rough to the touch, like tiny, rough lumps.'

- Radiation: 'They are spread all over the fingers of both hands.'

- Timing: 'They have been persistent since I first noticed them.'

- Severity: 'It's not very painful, but it can be quite irritating when I'm writing on the board at school.'

- Impact on daily life: "Impact on my job is the biggest concern; it affects my ability to write on the blackboard, and they don't look very nice."

History of Presenting Complaint:

Londiwe has noticed the rough lumps for the past 6 months, and she has not tried any previous treatments. There has been no change in the frequency or severity of the symptoms since their onset. The rough lumps have impacted her work as a teacher, and they are an irritant when she writes on the board.

Systemic Symptoms:

- Negative for fever, weight loss, malaise, night sweats, lymphadenopathy, arthritis, and other systemic symptoms.

Past Medical History:

Negative for atopic disorders, previous skin conditions, and autoimmune conditions. There are no previous injuries or traumas, psychiatric history, or history of substance abuse. No surgeries or hospitalizations in the past.

Drug History:

Londiwe does not take any regular medications, including topical steroids. She does not use contraception or HRT, and there are no instances of medication non-compliance or missed doses.

Allergies:

Londiwe has no known allergies to medications, anaesthetics, foods, or other allergens.

Family History:

Negative for significant family history of skin conditions, atopic disorders, and cancers.

Social History:

- Lifestyle: Non-smoker and no recreational drug use.

- Occupation: Teacher

- Activities of Daily Living & Hobbies: Regular exercise and a balanced diet.

Ideas, Concerns, and Expectations:

- Ideas: "I'm worried because I don't know what these lumps are, and I desperately want to know."

- Concerns: "My main concern is their appearance and the impact on my job as a teacher."

- Expectations: "I expect to know what these lumps are and how they can be treated so I can continue my teaching job without any hindrances."

Physical Examination:

General Inspection:

- Overall health: Normal

- Signs of skin distress: Presence of multiple rough lumps on hands and fingers

- Observation of body language: Anxious due to the uncertainty about the skin condition

Skin Lesion Inspection:

- Location: Hands and fingers

- Distribution: Bilateral and symmetric

- Borders: Irregular and raised

- Diameter: 2 to 8 mm

- Shape: Elevated and rough

- Colour: Flesh-coloured or slightly brownish

Skin Lesion Palpatation:

- Elevated: Yes, most lumps are palpable.

- Skin temperature: Normal over and around lesions

- Texture: Rough

- Consistency: Hard

- Mobility: Firmly adherent to underlying tissues

- Tenderness: Non-tender

Diagnostic Tests:

- Koebner phenomenon observed

- Appearance of lesions under Wood's lamp: No fluorescence

Keyword Filters:

Speciality Filter: Dermatology

Presenting Complaint Filter: Skin lesion

Condition Filter: Cutaneous warts

Location Filter: General Practice

Case created by Aisling Chung, 4th Year Medical Student

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Reviewed by XX, Medical Student/Doctor

# ALYC\_21\_Cutaneous\_Warts

Homepage Vignette:

## "A 30-year-old woman presents with concerns about skin growths."

Individual Page Vignette:

"You are a general practitioner and need to evaluate and manage a 30-year-old woman named Naia Johansson, who presents with concerns about skin growths."

Patient Name:

Naia ("Nye-ah") Johansson would like to be called "Naia."

Age:

06/07/1994

Location:

General Practice

Personality:

Naia is an outgoing and friendly woman, who speaks with passion on topics that interest her. She has a warm and welcoming manner of speaking.

Presenting Complaint:

Naia would describe the skin growths as "I'm worried about these weird lumps on my skin. They're not painful, but they have been bothering me for a while."

Symptoms:

- Site: Lumps on the skin

- Onset: Unknown; they have been present for a while

- Character: Skin growths with raised surfaces

- Associated Symptoms: None

- Timing: Ongoing

- Severity: Naia reports that the lumps are bothering her, but they are not painful.

History of Presenting Complaint:

Naia has had the skin growths for an unknown duration. She has not tried any previous treatments. The growths have not significantly progressed over time but are having an impact on her emotional wellbeing.

Systemic Symptoms:

All the systemic symptoms are normal in this case.

Past Medical History:

- Negative: Previous skin conditions or autoimmune conditions

Drug History:

- Negative: Past use of topical steroids or medications used for skin conditions

Allergies:

Naia is allergic to penicillin and experiences a rash and itchiness when exposed.

Family History:

Naia's mother has a history of eczema. Otherwise, there is no relevant family history.

Social History:

- Occupation: Advertising executive

- Smoking: Non-smoker

- Alcohol: Occasional drinker, 1-2 units per week

- Exercise: Gym workouts three times a week.

Ideas, Concerns, and Expectations:

- Ideas: Naia is concerned about skin cancer and wonders if the growths could be cancerous.

- Concerns: She is worried about the impact of the skin growths on her appearance.

- Expectations: Naia expects a clear explanation of the diagnosis and treatment options.

Physical Examination:

- Skin Lesion Inspection: The skin lesions are located on the hands, have a verrucous appearance, are fleshy, and have a rough texture. The appearance and distribution match that of cutaneous warts.

- Skin Lesion Palpation: The lesions are elevated, rough to palpate, and painless to the touch. There is no regional lymph node enlargement.

- Normal General Inspection and Systemic Examination.

Diagnostic Tests:

- Visual examination confirms the diagnosis of cutaneous warts based on characteristic appearance and distribution.

Patient Questions:

1. "Could these skin growths be cancerous?"

- Short Answer: "The growths have typical features of benign cutaneous warts."

2. "How long will it take to get rid of these growths?"

- Short Answer: "Treatment can vary, but it usually takes several weeks to months."

3. "Should I be worried that the warts are spreading to other parts of my skin?"

- Short Answer: "Warts can spread, but we can discuss treatment options to address this."

Examiner Questions:

1. "What are the typical characteristics of cutaneous warts, and how do they usually present?"

- Short Answer: "Cutaneous warts present as skin growths with a rough texture, most commonly on the hands and fingers, and are caused by human papillomavirus (HPV) infection."

2. "How do you diagnose cutaneous warts?"

- Short Answer: "The diagnosis of cutaneous warts is mostly based on clinical examination due to their typical appearance and distribution."

3. "What factors should be considered when determining the appropriate treatment for cutaneous warts?"

- Short Answer: "The location, number, and size of warts, patient preferences, and any contraindications or comorbidities should be considered."

4. "What are the potential treatment options for cutaneous warts, and how effective are they?"

- Short Answer: "Treatment options include topical therapies, cryotherapy, laser therapy, or surgical removal. Response rates can vary, and treatment may take several weeks or months."

5. "When is referral to a dermatologist appropriate for the management of cutaneous warts?"

- Short Answer: "Referral may be necessary for the management of warts that are resistant to primary care treatments, and for patients with lesions in anatomically challenging areas."

Treatment:

Initial:

- Topical salicylic acid for cutaneous warts (e.g., 15% salicylic acid preparations).

Alternative:

- Cryotherapy for cutaneous warts if topical therapy is ineffective.

Monitoring:

- Advise Naia to monitor the size and appearance of the warts. Return to the clinic if there is no improvement or if new warts develop.

- Follow-Up: Schedule a follow-up appointment in 2-4 weeks to review treatment response.

Prognosis:

The prognosis for cutaneous warts is generally good. With appropriate treatment, a significant improvement can be expected over time.

Differential Diagnoses:

1. Molluscum contagiosum

2. Seborrheic keratosis

3. Verruca vulgaris

4. Skin tags

Keyword Filters:

Speciality Filter: Dermatology; General Practice; Surgery

Presenting Complaint Filter: Skin lesion

Condition Filter: Cutaneous warts

Location Filter: General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_22\_Cutaneous\_Warts

Homepage Vignette:

## “A 42-year-old woman presents with a problem with her skin.”

Individual Page Vignette:

You are a General Practitioner working in a family practice in a suburban area. You have a patient called Mafalda Varga, a 42-year-old teacher, who presents with a problem with her skin.

Patient Name:

Mafalda Varga (Ma-FAL-da VAR-ga); she would like to be called Mafalda

Age:

23/04/1982

Location:

General Practice

Personality:

Mafalda Varga is a charismatic and talkative woman. She is often described as confident and expressive. Mafalda has a warm, friendly manner of speaking and is open to discussing her health concerns.

Presenting Complaint:

Mafalda presents with concerns about some growths on her skin. She says, "I've noticed some strange lumps on my skin, and I'm not sure what they are. They can be a bit itchy and are quite unsightly. I'd like to have them looked at and discussed, please."

Symptoms:

- Site: A variety of sites including the face, hands, and feet

- Onset: Over the past year

- Character: Raised, fleshy, rough growths; have an irregular surface

- Texture: Solid, rough texture

- Itching: Occasional mild itching

- Distribution: Multiple lesions on the hands and face; a few on the feet

- Progression: Lesions have slowly increased in number and size

- Impact on daily life: Unhappy with the appearance and self-conscious about wearing open-toed shoes

- Severity: Mild; occasional itching but no pain

History of Presenting Complaint:

The histories are negative

Systemic Symptoms:

- Negative findings for fever, weight loss, malaise, night sweats, arthritis, myalgias, anhidrosis, hyperhidrosis, Raynaud's phenomenon, livedo reticularis, neurological deficits, facial flushing, jaundice, oedema, dysphagia, dyspnea, cough, chest pain, palpitations, abdominal pain, diarrhea, vomiting, headache, vision changes, hearing loss, and dizziness

Past Medical History:

- No relevant medical history

Drug History:

- No regular medication or significant history of medication use

Allergies:

- No known allergies or intolerances

Family History:

- Negative for medical conditions, including skin conditions

Social History:

- Lifestyle: Non-smoker

- Occupation: Teacher

- Activities of Daily Living & Hobbies: Enjoys gardening and hiking; no exposure to hazardous environments or chemicals

- Smoking: Never smoked

- Alcohol: Occasional drinker; 4 units per week

- Recreational Drug Use: Does not use recreational drugs

- Diet: Balanced diet

- Exercise: Regular exercise routine

- Travel History: No recent travel

- Cultural or Religious Practises: Atheist; no religious beliefs

- Recent Life Events: No significant recent life events

Ideas, Concerns, and Expectations:

- Mafalda understands that the lesions are warts but is concerned about the impact of treatment on her daily activities

- She is worried that treatment might be painful or cause scarring

- Mafalda expects a discussion about the most suitable treatment options for her skin condition

Physical Examination:

- General Inspection: No signs of distress; no visible rashes or lesions

- Skin Lesion Inspection:

- Location: Hands, feet, and face

- Distribution: Multiple lesions in these areas

- Shape: Raised, fleshy appearance

- Symmetry: Lesions are asymmetrical

- Borders: Lesions have irregular borders

- Colour: Most are skin-coloured

- Diameter: Lesions vary in size from 1 mm to 1 cm

- Skin Lesion Palpation:

- Elevation: Raised

- Skin temperature: Normal

- Tenderness: No tenderness

- Systemic Examination: Unremarkable

- Special Tests: No special tests indicated

Diagnostic Tests:

- No tests indicated

Patient Questions:

1. "Will the treatment be painful, and will it affect my daily activities?"

- The treatment may cause some mild discomfort, and we can discuss options based on your daily activities.

2. "Are there any home remedies I can try before seeking medical treatment?"

- There are some over-the-counter treatments available, but we can discuss the most suitable options for you.

3. "How long does it usually take for warts to disappear with treatment?"

- Treatment timelines can vary, but we will discuss the expected timeframe during our consultation.

Examiner Questions:

1. "What do you recommend as first-line treatment for cutaneous warts?"

- The first-line treatment for cutaneous warts is usually a topical application of salicylic acid.

2. "What are the potential complications of untreated cutaneous warts?"

- Potential complications of untreated cutaneous warts include spreading to other areas of the body and potential discomfort or cosmetic concerns due to the appearance of the skin.

3. "How do you approach the management of cutaneous warts in immunocompromised patients?"

- In immunocompromised patients, the management of cutaneous warts may require a different approach and more vigilant monitoring for any signs of worsening.

4. "What are the steps you would take to ensure the treatment plan aligns with Mafalda's lifestyle and activities?"

- To align with Mafalda's lifestyle, we will discuss treatment options that minimize disruption and inconvenience in her daily activities.

5. "How would you communicate the need for regular follow-up to Mafalda and ensure she understands the importance of monitoring her condition?"

- I would communicate the need for regular follow-up by emphasizing the importance of monitoring for any changes or new lesions and ensuring that Mafalda understands how to recognize any indications for a follow-up visit.

6. "What factors would prompt you to consider a referral to a dermatologist in Mafalda's case?"

- A referral to a dermatologist may be considered if the warts are resistant to treatment and if any underlying conditions affecting the immune system are identified that may be contributing to the presence of the warts.

Treatment:

Topical salicylic acid 16% ointment, applied twice daily; if salicylic acid is not effective, consider cryotherapy with liquid nitrogen; refer to a dermatologist if standard treatments are ineffective

Monitoring:

Advise Mafalda to monitor her lesions for signs of improvement or worsening. Follow-up every 4 weeks initially and adjust the treatment plan based on the response. If there are any signs of infection, spreading of the warts, or severe pain, advise Mafalda to seek immediate medical attention.

Prognosis:

Cutaneous warts can be effectively treated, and they are likely to resolve with the use of topical salicylic acid and other standard treatments. The anticipated prognosis for Mafalda's condition is positive, but regular monitoring and follow-up are essential to ensure the best outcomes.

Differential diagnoses:

1. Squamous cell carcinoma

2. Seborrheic keratosis

3. Molluscum contagiosum

4. Filiform wart

5. Lichen planus

Speciality Filter:

General Practice; Dermatology; Surgery

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Cutaneous warts

Location Filter:

General Practice; Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_23\_Scabies

Homepage Vignette:

## “A 38-year-old woman presents with intense itching and rash.”

Individual Page Vignette:

You are a GP. You are seeing Sophie Ivers, a 38-year-old office worker who has come with intense itching and rash on her skin.

Patient Name:

Sophie Ivers, pron: So-fee Eye-vers, would like to be called Sophie.

Age:

20/10/1986

Location:

General Practice

Personality:

Sophie is an outgoing and bubbly individual with charming wit. She speaks quickly and can be very direct in her communication. She is noticeably fashion-forward and considers herself a bit of a trendsetter with a passion for health and fitness.

Presenting Complaint:

Sophie presents with "scabby, itchy skin all over. It’s just driving me mad, Doctor!"

Symptoms:

- Itching:

- Site: All over the body

- Onset: 3 weeks

- Character: “Just constant, non-stop, maddening itching, it feels like I want to scratch myself raw!”

- Radiation: -

- Associated Symptoms: Rash

- Timing: Continuous

- Exacerbating and Relieving Factors: Nothing seems to make it better

- Severity: Disturbing her sleep and affecting her normal activities

- Rash:

- Site: All over the body

- Character: “My skin’s got this rash, it’s all red and bumpy. Looks horrible too!”

History of Presenting Complaint:

- Sophie has been experiencing the symptoms for 3 weeks.

- No previous treatments attempted or responses

- Symptoms have progressed and are now disturbing her sleep and normal activities

Systemic Symptoms:

- No systemic symptoms

Past Medical History:

- Negative for auto-immune conditions, atopic disorders or previous skin conditions

Drug History:

- No past use of topical steroids or medications used for skin conditions

Allergies:

- Sophie is allergic to amoxicillin, and when exposed, she develops a rash and swollen lips

Family History:

- Negative for any relevant family medical history and skin conditions

Social History:

- Lifestyle: Office worker

- Occupation: Office worker

- Activities of Daily Living & Hobbies: Enjoys running, cooking healthy meals, and attending a book club

- Smoking: Non-smoker

- Alcohol: Occasional drinker, 4 units a week

- Recreational Drug Use: Never used recreational drugs

- Diet: Balanced and healthy diet, with a focus on clean eating and plenty of fruits and vegetables

- Exercise: Regular runner

Ideas, Concerns, and Expectations:

- Ideas: “I’m worried about this rash and itching. I’ve never had this before and I want to know what’s causing it.”

- Concerns: “I'm concerned that this might not go away, and if it could be something serious."

- Expectations: "I expect to receive some treatment to stop the itching and get rid of this rash."

Physical Examination:

- Evidence of intense scratching

- Mild excoriations

- Scattered burrow marks

- Evidence of papules and nodules

Diagnostic Tests:

- Skin scrapings for parasitic infections: Positive for Sarcoptes scabiei

- Dermoscopy: Reveals characteristic zigzag burrows and mites

Condition:

Scabies

Patient Questions:

1. “How long will it take for the itching to stop with treatment?”

- It can take a week or two for the itching to completely stop with treatment, but you may feel relief earlier.

2. “Can I pass this on to other people when I'm at work?”

- Yes, it is a contagious condition, so it is important to inform close contacts and treat them simultaneously. Frequent handwashing and avoidance of close contact is necessary.

3. “Are there any long-term effects of scabies?”

- In general, scabies does not cause long-term effects. However, if it is not treated properly, complications may include secondary bacterial skin infection.

Examiner Questions:

1. What investigations would you suggest for confirming the diagnosis of scabies?

- I would recommend skin scrapings for parasitic infections and dermoscopy.

2. How would you manage the skin condition in this patient?

- Treatment would involve eliminating the infestation by using a topical insecticide such as permethrin or malathion lotion.

3. What precautions and hygiene advice would you provide to the patient?

- I would advise informing close contacts and treating them simultaneously to prevent re-infection. Frequent handwashing and avoiding close contact is essential.

4. Are there any alternative treatments besides topical insecticides?

- Yes, oral ivermectin may be considered, especially if other treatments are not tolerated or failed.

5. How frequently should this patient return for follow-up?

- Follow-up should be scheduled after completion of treatment to ensure that symptoms have resolved. A repeat treatment may be required if the symptoms persist or worsen.

Treatment:

- The treatment will involve applying 5% permethrin cream to the entire skin surface, excluding the head and neck for 12 hours then washed off

- Clothes, bed linen, and towels should be washed on a hot cycle and thoroughly ironed

- In cases of resistance or adherence issues, oral ivermectin can be considered as an alternative treatment

Monitoring:

- The patient should return for follow-up one week after completing the treatment to assess the resolution of symptoms

- If symptoms persist or worsen, a repeat treatment may be necessary

- Close contacts should also be urged to seek medical attention and receive treatment

Prognosis:

- The prognosis for this patient's scabies is excellent when treated appropriately.

- Completion of treatment should result in the resolution of symptoms in most cases.

- Prompt treatment is crucial in preventing the condition from being transmitted to others.

Differential diagnoses:

1. Dermatitis

2. Contact Allergy

3. Eczema

4. Transitional Infestation

Speciality Filter:

General Practice; Dermatology; Infection

Presenting Complaint Filter:

Pruritus; Skin rash

Condition Filter:

Scabies

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_24\_Scabies

Homepage Vignette:

## "A 42-year-old man called John presents with intense itching and a rash on his body."

Individual Page Vignette:

You are a dermatologist seeing John, a 42-year-old man presenting with intense itching and a rash on his body. John lives in an urban area and works in an office.

Patient Name:

Xander Solanki (ZAN-DUH SO-LAN-KEY); prefers to be called John

Age:

23/10/1981

Location:

Dermatology Clinic

Personality:

John is an outgoing and animated individual. He speaks confidently and with enthusiasm, and is eager to engage and participate in conversation.

Presenting Complaint:

John complains of "incessant itching all over my body - it's driving me mad. I have developed this rash too."

Symptoms:

\* Site: Generalized itching; rash all over the body

\* Onset: Gradual onset of itching and rash

\* Character: Intense itching; presence of a rash

\* Exacerbating and Relieving Factors: "The itching gets worse at night"; unsure of any relieving factors.

History of Presenting Complaint:

John has had the symptoms for 2 weeks. He reports no previous treatments or any progression of symptoms over time. The itching and rash have severely affected his sleep and day-to-day activities.

Systemic Symptoms:

\* No systemic symptoms reported.

Past Medical History:

\* Negative for atopic disorders, skin conditions, psychiatric or psychological history, or history of substance abuse.

Drug History:

\* John has not taken any medications recently or in the past.

Allergies:

\* John is allergic to penicillin, and he experiences a skin rash and hives upon exposure to it.

Family History:

\* No significant family history related to scabies or skin conditions reported.

Social History:

\* Occupation: Office worker

\* Smoking: Non-smoker

\* Alcohol: 2 units/week

\* Recreational Drug Use: Non-user

Ideas, Concerns, and Expectations:

• Ideas: "I don't know what's causing this itching and rash, but I really need help to get rid of it."

• Concerns: "I'm really worried about the scarring that this rash might leave behind."

• Expectations: "I hope we can find a treatment that will get rid of the itching and the rash for good."

Physical Examination:

\* Visible rash and erythema (redness) with scabietic burrows in the interdigital web spaces and extensor surfaces of the forearms and torso.

\* No notable findings in general inspection or systemic examination.

\* Skin Lesion Inspection:

- Location: Interdigital web spaces; extensor surfaces of the forearms and torso

- Shape: Papules with burrows

- Borders: Distinct borders

- Colour: Erythematous papules

- Diameter: 1-3 mm

Diagnostic Tests:

\* Skin scrapings are positive for mites, ova, and scybala.

Patient Questions:

1. "How long will it take to get rid of the itching and rash?"

- Answer: "Effective treatment can provide relief within a few days to weeks."

2. "Can this condition come back in the future, and how can it be prevented?"

- Answer: "Recurrence is possible but proper hygiene practices can help prevent reinfection."

3. "Is there a risk of this condition spreading to my family members?"

- Answer: "Yes, there is a risk. We'll discuss the necessary precautions and treatment for your close contacts during your visit."

Examiner Questions:

1. What are the characteristic skin findings in scabies?

- Answer: Presence of burrows, vesicular lesions, and papular, erythematous rash.

2. How do you confirm the diagnosis of scabies?

- Answer: Microscopic identification of mites, ova, and scybala in skin scrapings.

3. What are the appropriate treatment options for scabies?

- Answer: Topical permethrin, oral ivermectin, or crotamiton are all commonly used treatments for scabies.

4. Are family members and close contacts at risk of contracting scabies from the patient?

- Answer: Yes, close contacts are at risk. They may need to be treated to prevent the spread of infection.

5. Should the patient inform their employer about their diagnosis?

- Answer: Yes, due to the potential for spreading scabies, notifying the employer may be necessary.

Treatment:

1. Topical permethrin 5% cream to be applied from the neck down and washed off after 8 hours, repeat in 7 days if live mites are still present.

2. Consider oral ivermectin 200 micrograms/kg as a single dose in individuals not responding to or unable to tolerate topical treatment.

3. Advise thorough washing of clothes, bedding, and towels in the household to prevent reinfestation.

4. Inform John about the importance of treating close contacts if needed.

Monitoring:

Instruct John to monitor the resolution of itching and rash. Advise to seek medical attention if symptoms worsen or do not improve after treatment. Ensure a follow-up visit in 2-4 weeks to assess treatment response and provide further guidance if needed.

Prognosis:

The prognosis for scabies is excellent with appropriate treatment. Symptoms should resolve after treatment, with a low risk of recurrence if proper hygiene measures are maintained.

Differential diagnoses:

1. Contact dermatitis

2. Atopic dermatitis and eczema

3. Cutaneous fungal infection

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Pruritus; Skin lesion

Condition Filter:

Scabies

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_25\_Scabies

Homepage Vignette:

## A 36-year-old woman called Amal presents with a persistent itchy rash.

Individual Page Vignette:

You are a GP. You are seeing Amal, a 36-year-old project manager, who has come in with a persistent itchy rash.

Patient Name:

Amal Al-Masri (Ah-mal Al-Mas-ree)

Age:

01/05/1988

Location:

General Practice

Personality:

Amal is a well-spoken, professional woman who comes across as confident and articulate. She seems slightly anxious but maintains a calm demeanour while explaining her bothersome symptoms.

Presenting Complaint:

Amal presents with a persistent itchy rash. She says, "I've been feeling terribly itchy all over my body. It's been driving me crazy, and I just can't seem to get rid of it."

Symptoms:

Amal's symptoms include:

Itching: Generalized; intense; continuous; worse at night

Rash: Widespread

Erythema: Present

Excoriations: Present

History of Presenting Complaint:

The itch started about a month ago, and the rash appeared soon afterwards. She has tried over-the-counter antihistamines, but they have not provided any relief. The itching is causing her significant distress and is affecting her sleep. She has also noticed that the rash is spreading.

Systemic Symptoms:

Amal denies any systemic symptoms at present, such as fever, weight loss, or malaise.

Past Medical History:

Negative for any significant past medical history, hospitalizations, or surgeries.

Drug History:

She is not currently on any medications and denies the use of any topical steroids. She's also not using any contraceptive methods.

Allergies:

Amal is not allergic to any medications or substances.

Family History:

Negative for any significant family history of skin conditions or other relevant medical issues.

Social History:

Lifestyle: Non-smoker

Occupation: Project manager

Activities of Daily Living & Hobbies: Regular gym-goer; enjoys yoga and cooking Middle Eastern cuisine

Ideas, Concerns, and Expectations:

Ideas: She is concerned that something serious may be causing her persistent itching and rash.

Concerns: Amal is worried about the impact of the rash on her professional image.

Expectations: She is looking for a comprehensive assessment of the rash and a suitable treatment plan.

Physical Examination:

General Inspection: Appears well; no obvious signs of distress or discomfort

Skin Lesion Inspection:

- Location: Widespread

- Distribution: Generalized, with a predilection for intertriginous areas

- Shape: Rash composed of multiple irregularly shaped papules and burrows

- Symmetry: Symmetrical

- Borders: Indistinct

- Colour: Erythematous and hyperpigmented; some hyperkeratotic papules

- Diameter: Papules up to 0.5 cm in diameter

Skin Lesion Palpation:

- Elevation: Raised papules

- Warmth: Some warmth in affected areas

Systemic Examination:

- No significant findings

Special Tests: Referral for skin scraping for suspected scabies

Diagnostic Tests:

The results of skin scraping are consistent with scabies infestation.

Patient Questions:

1. "Could this rash be a sign of something more serious?"

- Answer: "The itching and rash are likely due to a condition called scabies, which can be effectively treated with medication."

2. "Will the treatment be complicated or difficult to manage?"

- Answer: "The treatment is straightforward and usually effective in eliminating the infestation."

3. "How long does it take for the itching and rash to improve with treatment?"

- Answer: "With appropriate treatment, the itching should start to improve within a few days, and the rash should resolve relatively quickly."

4. "Is scabies contagious?"

- Answer: "Yes, scabies is highly contagious, but it can be effectively treated to prevent transmission to others."

Examiner Questions:

1. Can you describe the typical distribution and appearance of scabies burrows?

- Answer: Scabies burrows commonly present as fine, wavy, and irregular lines in the interdigital webs, wrists, elbows, belt line, penis, areola, and axillary folds.

2. What are the available treatment options for scabies?

- Answer: The first-line treatment is topical permethrin 5% cream for adults and children over two months. Oral ivermectin can be considered if the condition is refractory to topical treatment.

3. How do you confirm a diagnosis of scabies?

- Answer: Diagnosis is primarily clinical, based on the characteristic rash and symptoms. Microscopic identification of mites, eggs, or fecal pellets from skin scrapings can confirm the diagnosis if necessary.

4. What measures should be taken for other family members and close contacts of the patient?

- Answer: Family members and close contacts should be examined and treated if they exhibit symptoms or if the diagnosis of scabies is confirmed.

5. What are the guidelines on cleaning the patient's environment in the context of scabies?

- Answer: The patient's bedding, towels, and clothing should be washed in hot water and dried in a hot dryer to kill the mites.

Treatment:

1. Topical permethrin 5% cream applied to the entire body from the neck down and left on for 8-14 hours.

- Instruct Amal to take a bath or shower and dry the skin thoroughly before applying the cream.

- Frequency: Once; repeat in 7 days if needed

2. Counselling on scabies management, including environmental control measures to prevent re-infestation.

- Inform Amal about the need to wash clothes and bedding in hot water and dry them in a hot dryer to kill any mites.

Monitoring:

Amal should return for a follow-up visit in 1-2 weeks to assess the response to treatment. There should be a discussion about the elimination of the symptoms and the need for retreatment if necessary. She should seek medical attention if itching persists or recurs after treatment.

Prognosis:

The prognosis for scabies is generally good with effective treatment. In the majority of cases, symptoms resolve quickly after treatment. Communicating the importance of environmental control measures and ensuring treatment compliance is essential for preventing reinfestation.

Differential diagnoses:

1. Atopic dermatitis: Less likely given the presence of burrows and characteristic clinical appearance consistent with scabies.

2. Allergic contact dermatitis: Unlikely due to the widespread distribution and typical presentation of the rash.

3. Psoriasis: Less likely due to the presence of itching and the characteristic patterns of scabies burrows.

Keyword Filters:

Speciality Filter: General Practice; Dermatology

Presenting Complaint Filter: Pruritus; Skin lesion

Condition Filter: Scabies

Location Filter: General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_26\_Scabies

Homepage Vignette:

## "A 35-year-old female presents with itching and a rash all over the body."

Individual Page Vignette:

You are a dermatologist seeing Anala Rao, a 35-year-old receptionist from an urban area, who complains of itching and a widespread rash.

Patient Name:

Anala Rao; pronounced: Ah-nuh-lah R-ow; she would like to be called Anala.

Age:

11/03/1989

Location:

Dermatology Clinic

Personality:

Anala is friendly, chatty, and eager to discuss her symptoms and hear the doctor's advice. She's inquisitive and likes to ask a lot of questions.

Presenting Complaint:

Anala presents with:

"A persistent, severe itch all over my body, and a red raised rash that just won't go away."

Symptoms:

Itching:

- Site: all over the body

- Onset: gradual over a few weeks

- Character: severe, persistent itch

- Radiation: not applicable

- Associated symptoms: "It's driving me mad, I've been scratching all the time."

- Timing: all the time

- Exacerbating and Relieving Factors: no change with any treatment

- Severity: "It's unbearable, I can't sleep at night."

Rash:

- Site: all over the body

- Onset: couple of weeks

- Character: red, raised, small bumps

- Associated symptoms: "It starts as small bumps, then they form into puss-filled blisters."

- Timing: developed gradually over a few weeks

- Exacerbating and Relieving Factors: "It's worse when I sweat or get hot."

- Severity: "It's very sore and itchy, and it's all over my body."

Negative: no dryness, scaling, nodules, ulcers, texture changes, pigmentary changes, systemic symptoms

History of Presenting Complaint:

Anala has been experiencing these symptoms for a couple of weeks. She has already tried over-the-counter antihistamines and steroid creams, which did not help. Her symptoms have progressively worsened, impacting her ability to sleep at night and enjoy any activities.

Systemic Symptoms:

Negative for all systemic symptoms

Past Medical History:

- Negative for atopic disorders or previous skin conditions

- Negative for autoimmune conditions

Drug History:

- Negative for use of steroids or contraceptives

Allergies:

Anala is allergic to penicillin, which causes a rash, itching, and facial swelling when she's exposed to it.

Family History:

Her mother has a history of psoriasis, and her father has a history of eczema. No other significant family history of medical conditions.

Social History:

- Lifestyle: non-smoker, no alcohol

- Occupation: receptionist at a local dental clinic

- Activities of Daily Living & Hobbies: regular gym-goer

Travel History: No recent travel

Ideas, Concerns, and Expectations:

Ideas: "I thought it was just an allergic reaction, but it's getting worse."

Concerns: "I'm worried about not being able to work. It's very uncomfortable."

Expectations: "I hope there's something that can be done to clear this up quickly."

Physical Examination:

General Inspection: Anala appears distressed, constantly scratching her arms and legs. No jaundice or cyanosis. No notable odors.

Skin Lesion Inspection:

- Location: extensive, covering most of the body, but sparing the face

- Distribution: generalized

- Shape: small, raised bumps

- Symmetry: symmetrical

- Borders: well-defined

- Colour: the rash is erythematous

- Diameter: small, papules

Skin Lesion Palpatation:

- Elevation: slightly raised

- Skin temperature: normal

- Texture: dry

- Consistency: firm

- Tenderness: mild tenderness

- Blistering, oozing, crusting, or weeping: minimal crusting

Systemic Examination:

No systemic findings

Special Tests:

- Wood's lamp examination: no fluorescence

- Dermatoscopy: classic burrows, finger web spaces, and papules as seen in scabies

Diagnostic Tests:

- Skin scrapings for scabies mite identification: positive for Sarcoptes scabiei

- Full blood count (FBC): normal

- CRP: normal

Patient Questions:

1. "Could this be an allergic reaction? Should I stop using certain products?" - It's unlikely to be an allergic reaction given the presentation, but we'll consider all possibilities.

2. "Is there something to stop the itching now, it's really unbearable?" - We'll have a treatment plan for relieving your symptoms right away.

3. "How long would it take for this to clear up completely?" - We'll discuss that once we set you up with the treatment.

Examiner Questions:

1. What are the classic signs and symptoms of scabies?

- Itchy papules and burrows are typical signs.

2. How would you differentiate scabies from other causes of a widespread rash?

- Many other dermatological conditions could be considered, but the presence of characteristic papules, burrows, and itching in the finger web spaces and other sites make scabies more likely.

3. What is the first-line treatment for scabies?

- Topical permethrin 5% cream.

4. What are the treatment options for someone who is allergic to the first-line treatment?

- One potential option could be oral ivermectin.

5. How do you confirm the diagnosis of scabies?

- The finding of mites, their eggs, or scybala under a light microscope confirms the diagnosis of scabies.

Treatment:

- Topical permethrin 5% cream, apply to the entire body for 8 to 12 hours then wash off. Repeat after 7 days.

- Oral antihistamines for symptomatic relief of itching, e.g., loratadine 10 mg once daily.

- Treat family and close contacts with permethrin 5% cream to prevent re-infestation.

Monitoring:

Anala should follow up after 1 week to assess the treatment response. She should seek medical attention if the symptoms persist, worsen, or new symptoms develop. Referral to a dermatologist may be considered for refractory cases.

Prognosis:

With appropriate treatment and compliance with the regimen, Anala's condition should resolve within a few weeks. Factors such as re-exposure and close contacts should also be considered to prevent recurrence. The prognosis is generally good.

Differential diagnoses:

1. Contact dermatitis

2. Urticaria

3. Folliculitis

4. Eczema

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Pruritus; Skin lesion

Condition Filter:

Scabies

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_27\_Acne\_Vulgaris

Homepage Vignette:

## "An 18-year-old woman presents with concerns about her skin."

Patient Name:

Djuna Seraphina Ula

Pronunciation: JOO-nah SEH-ruh-FEE-nuh OO-la

Prefers to be called: Djuna

Age:

14/06/2000

Location:

Dermatology Clinic

Personality:

Djuna is a reserved, introspective individual, who carefully selects her words before speaking. Although she may seem a bit shy at first, she is very thoughtful and articulate. Djuna speaks with a soft tone and tends to be quite meticulous in her explanation of her symptoms.

Presenting Complaint:

Djuna presents with concerns about the appearance of her skin, especially her face. She describes experiencing numerous “bumps, redness, and oily skin.”

Quote - Djuna:

"I have been having trouble with my skin for a while, and it's really starting to bother me now."

Symptoms:

Djuna reports the following:

Site: Mostly on the face; some lesions on the chest and back

Onset: Started around 2 years ago

Character: Pustules, papules, and comedones

Associated Symptoms: oily skin

Timing: Persistent

Severity: Bothersome; impacting quality of life

History of Presenting Complaint:

Djuna's concerns about her skin have progressively worsened. She has tried various over-the-counter and home remedies, which have not provided relief.

Past Medical History:

Negative for atopic conditions and previous skin conditions.

Drug History:

Djuna's use of topical steroids in the past has been negative.

Allergies:

Djuna is allergic to penicillin, which causes a rash and itching.

Family History:

Negative for skin conditions and atopic disorders in the immediate family.

Social History:

Djuna is a student who is very conscientious about her studies. She leads a healthy lifestyle and exercises regularly. She is a non-smoker, does not consume alcohol, and has never used recreational drugs. There have been no significant life events recently.

Ideas, Concerns, and Expectations:

Ideas: Djuna is worried about the long-term impact of her skin condition.

Concerns: Her primary concern is that her skin condition might be difficult to alleviate.

Expectations: She is hoping to receive a treatment plan that will effectively improve her skin's appearance.

Physical Examination:

Skin Lesions: Multiple papules and pustules on the face, chest, and back.

Lesion Inspection: Red, inflamed papules and pustules on the face, chest, and back. Oily skin with open comedones.

Skin Palpation: Non-tender to palpation.

General Inspection: Djuna appears well and there are no signs of obvious distress or discomfort.

Diagnostic Tests:

Countless comedones on the face

Skin scraping for fungal and parasitic infections

Condition:

Acne Vulgaris

Patient Questions:

1. "How long will it take for my skin to clear after starting the treatment?" \*Treatment response is usually noticeable after around 6-8 weeks\*

2. "Are there any lifestyle changes I can make to help improve my skin?" \*Healthy lifestyle choices can have a positive impact on acne\*

3. "Could my diet be contributing to my skin condition?" \*Diet can sometimes impact acne, but it varies from person to person\*

4. "Are there any complications I should be aware of?" \*Possible complications include scarring and negative psychological effects\*

Examiner Questions:

1. "What factors seem to exacerbate your symptoms?"

- "I've noticed that my skin tends to look worse around the time of my menstrual period."

2. "Have you experienced any hair loss or vision changes?"

- "No, I haven't noticed any hair loss or vision issues."

3. "Do you have a family history of any skin conditions?"

- "No, there are no known skin conditions in my family."

4. "Have you used any prescription creams or ointments for your skin before?"

- "No, I've only used over-the-counter treatments previously."

5. "How does your skin condition affect your daily activities?"

- "It's very distressing and has a significant impact on my confidence."

6. "Have you noticed a particular pattern in your symptoms that correlates with your daily routine?"

- "I haven't noticed a distinct pattern."

Treatment:

1. First-line treatment: Topical retinoids, such as tretinoin 0.025% cream once daily in the evening

2. Second-line treatment: Benzoyl peroxide 2.5% gel or lotion once daily in the morning

3. Follow-up appointment in 6-8 weeks for review

4. Referral for psychological support if needed

Monitoring:

Monitor Djuna's progress at the follow-up appointment and enquire about any side effects or adverse reactions. If there is inadequate improvement, consider oral antibiotic treatment or referral to a dermatologist.

Prognosis:

The potential for significant improvement is high, considering Djuna's age and the available treatment options. The prognosis is good if compliance with the prescribed regimen is maintained.

Differential diagnoses:

1. Folliculitis

2. Rosacea

3. Seborrheic dermatitis

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Acne Vulgaris; Chronic rash

Condition Filter:

Acne Vulgaris

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_28\_Acne \_Vulgaris

Homepage Vignette:

## "A 28-year-old woman presents with concerns about her facial appearance."

Individual Page Vignette:

You are a junior doctor working in a General Practice. You are seeing Abimbola Adeyemi, a 28-year-old administrative assistant from Lagos, Nigeria, who presents with concerns about ongoing skin issues.

Patient Name:

Abimbola Adeyemi (Ab-im-BOH-lah Ah-DAY-yeh-mee); she prefers to be called Bola.

Age:

06/06/1996

Location:

General Practice

Personality:

Bola comes across as extroverted and friendly. She speaks with energy and enthusiasm. Her educational background is in line with her administrative assistant role, and she is knowledgeable about general healthcare issues.

Presenting Complaint:

Bola is concerned about the persistent red, painful, and tender raised skin blemishes that appear on her face. She feels that they are affecting her confidence and would like to find ways to get rid of them. From her description, it appears she might be dealing with persistent outbreaks of acne.

Quote: “I've been having these spots on my face, and they're really bringing my mood down. I feel like they're making my face look bad, and I just want them gone.”

Symptoms:

Bola reports the following symptoms related to her skin condition:

Site: Her face

Onset: The blemishes have been appearing for the last 3 months

Character: Red, painful, and tender raised blemishes

Associated Symptoms: None

Timing: Continuous

Exacerbating and Relieving Factors: Stress seems to make the blemishes worse

Severity: Moderate, affecting her confidence and mood

History of Presenting Complaint:

Bola has been experiencing skin blemishes on her face for the last 3 months, which are red, painful, and tender. She has tried over-the-counter anti-acne products with minimal improvement. The blemishes have impacted her confidence and mood, particularly in social situations.

Systemic Symptoms:

Bola does not exhibit any systemic symptoms associated with her skin condition.

Past Medical History:

Positive history of atopic dermatitis. Negative history for other significant medical conditions, surgeries, or psychiatric issues.

Drug History:

Bola has recently been using a combination of salicylic acid and benzoyl peroxide gels for her facial blemishes. She is not using any other medications.

Allergies:

Bola is allergic to tetracycline antibiotics and reports an itchy rash when exposed to them. She is not allergic to any other medications.

Family History:

Negative for significant skin conditions and other relevant medical conditions.

Social History:

Lifestyle: Sedentary lifestyle

Occupation: Administrative assistant

Activities of Daily Living & Hobbies: She enjoys reading and cooking

Smoking: Non-smoker

Alcohol: Occasional drinker (1-2 units per week)

Recreational Drug Use: Non-user

Diet: Balanced diet

Exercise: Limited exercise

Travel History: Recent trips to England and Scotland

Sexual History: In a committed relationship

Driving Status: Holds a driver's license but has not driven recently

Cultural or Religious Practices: No specific cultural or religious practices

Recent Life Events: No significant recent events

Exposure to Hazards or New Environment: No significant exposure

Quote (Lifestyle): "I have a desk job, so I'm mostly sedentary during the day. When I get home, I like to wind down by reading and cooking. I do most of my movement in the kitchen."

Quote (Travel History): "I've visited England and Scotland recently."

Ideas, Concerns, and Expectations:

Ideas: Bola feels that aggressive treatment with prescribed medications may help get rid of the blemishes.

Concerns: She's worried about the potential long-term impact of the blemishes on her face and is concerned about her social confidence.

Expectations: She expects a thorough assessment of her skin condition and access to effective treatments to resolve the blemishes on her face.

Physical Examination:

- General Inspection: Bola appears otherwise healthy with signs of discomfort due to her facial blemishes.

- Skin Lesion Inspection: Location: Her face; Distribution: Predominantly on the cheeks and chin; Shape: Multiple round, raised blemishes; Symmetry: Symmetrically distributed; Borders: Well-defined; Colour: Red; Diameter: Approximately 5mm each

- Skin Lesion Palpitation: Elevated, warm to touch, and tender

- Systemic Examination: No significant findings

- Special Tests: Dermoscopy reveals primary lesions consistent with acne vulgaris

Diagnostic Tests:

Blood Tests: Not indicated

Imaging Tests: Not indicated

Other Tests: Not indicated

Patient Questions:

1. "Do I have to change my diet to clear up my skin?"

\* No, changing the diet is not likely to impact acne vulgaris.

2. "Are there any permanent treatments for my issue?"

\* Depending on the severity, some treatments may lead to long-lasting effects.

3. "Should I discontinue my current OTC treatments before starting new ones?"

\* It's best to seek medical advice before discontinuing any treatments.

4. "Can you recommend any cosmetic treatments to get rid of the scars from my blemishes?"

\* We can discuss potential options once we address the acne vulgaris.

Examiner Questions:

1. "What is the classic presentation of acne vulgaris?"

\* The classic presentation involves comedones, inflammatory papules, pustules, nodules, and often affects the face.

2. "How would you differentiate acne vulgaris from rosacea based on the history and physical examination?"

\* Acne vulgaris often has comedones, pustules, and nodules, while rosacea typically presents with flushing, persistent redness, and telangiectasia without the presence of comedones.

3. "What are the common exacerbating factors for acne vulgaris as per the patient's social history?"

\* Stress and the primarily sedentary lifestyle can contribute to an exacerbation of acne vulgaris.

4. "What should be considered when selecting a medication for Bola, considering her specific allergies and presenting concerns?"

\* It’s important to select a medication that is free from tetracycline antibiotics due to her allergy and that will address her concern about persistent, painful blemishes.

5. "How might acne vulgaris impact Bola's psychological well-being, particularly in social situations?"

\* Acne vulgaris can significantly impact self-esteem and social confidence, leading to psychological distress. Tailored treatment can address these aspects, improving overall well-being.

Treatment:

1. Start Bola on topical retinoids e.g. adapalene gel 0.1% as a first-line treatment, to be applied once daily in the evening.

2. If the response is inadequate, consider introducing a course of oral lymecycline 408 mg OD for 8 weeks to address the inflammatory component.

3. Offer Bola scheduled follow-up appointments at 4-6 weeks to assess treatment response and provide further support and review the need for ongoing treatments or referral if needed.

4. Discuss with Bola to discontinue her current salicylic acid and benzoyl peroxide gels.

Monitoring:

Advise Bola to look out for any signs of an allergic reaction following the initiation of the new medications, such as a worsening rash, and report for immediate medical review if this occurs. Scheduled appointments at 4-6 weeks should be made to monitor treatment response and assess the need for further interventions or referrals.

Prognosis:

With appropriate treatment, Bola's acne vulgaris should respond well, causing improvement in the appearance of her skin and her confidence. It is likely that she will respond well to the treatment provided. However, close monitoring will be needed to ensure that her needs are addressed effectively.

Differential Diagnoses:

1. Rosacea: less likely given the absence of flushing and telangiectasia.

2. Pityrosporum folliculitis: less likely as Bola’s symptoms are suggestive of acne vulgaris, and it responds less effectively to typical acne treatments.

3. Perioral Dermatitis: less likely as the condition typically presents with erythematous papules and pustules.

4. Folliculitis: less likely as the distributed lesions are more consistent with acne vulgaris.

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin lesion

Condition Filter:

Acne Vulgaris

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_29\_Acne\_Vulgaris

Homepage Vignette:

## “A 24-year-old woman presents with concerns about her skin.”

Individual Page Vignette:

You are a dermatologist. You are seeing Rose Amon, a 24-year-old performing artist who presents with acne vulgaris.

Patient Name:

Rose Amon (pronounced "Rohz AY-mon"); prefers to be called Rose.

Age:

21/11/1996

Location:

Dermatology Clinic

Personality:

Rose is a warm and friendly individual. She is very conscious of her appearance and speaks with concern about her skin, as it affects her confidence in her work. She is articulate and displays enthusiasm about seeking treatment for her skin concerns.

Presenting Complaint:

Rose reports that she has been experiencing "frequent breakouts of persistent little spots on her face" for the past three years. She is very worried about the condition of her skin and wishes to seek appropriate treatment for her skin.

Symptoms:

- Site: Face, particularly the cheeks, forehead, and chin

- Onset: Last three years

- Character: Frequent breakouts of small, raised and red spots

- Timing: Ongoing

- Impact: Reduced confidence, particularly in her work as a performer

History of Presenting Complaint:

Rose has had "bad skin" for three years. She has tried over-the-counter remedies, with some temporary improvements, but the acne has not resolved completely. She has noticed the problem is impacting her confidence, especially in her role as a performer.

Systemic Symptoms:

- No current systemic symptoms reported by Rose.

Past Medical History:

- Negative for atopic disorders, previous skin conditions, or autoimmune conditions.

Drug History:

- No history of topical steroids or medications for skin conditions.

Allergies:

- Rose has no known allergies or intolerances.

Family History:

- Negative for significant medical history, skin conditions, or atopic disorders in her family.

Social History:

- Non-smoker

- Drinks alcohol occasionally

- Performs in theatre shows and regularly dances

- Diet includes a balance of fruits, vegetables, and proteins

Ideas, Concerns, and Expectations:

- Ideas: Rose has a good understanding of her condition and its impact on her life. She has researched treatment options and is keen to explore these further.

- Concerns: She is primarily concerned about the ongoing impact of her acne on her confidence, especially when she performs, and worries about finding an effective resolution to her skin concerns.

- Expectations: Rose is expecting detailed information about her condition, along with advice on possible treatments and a prescribed treatment regimen to help clear her skin.

Physical Examination:

- General Inspection: Signs of distress, discomfort, undefined blemishes on the cheeks, forehead, and chin. Reduced confidence is evident from patient tone, demeanor, and self-expression.

- Skin Lesion Inspection: Widespread inflammatory pustules and closed comedones all over the face.

- Skin Lesion Palpation: No significant findings on palpation.

- General Physical Examination: Rose has otherwise normal general and systemic physical findings.

Special Tests:

Based on clinical presentation, no specific diagnostic tests are warranted at this time.

Condition:

Acne Vulgaris

Patient Questions:

1. "How long will it take for the treatment to completely clear my skin?"

- "Treatment length varies, but it often takes a few weeks to start noticing improvement and a couple of months for complete resolution."

2. "What are the potential side effects of the medications you may prescribe for my face?"

- "Common side effects include dryness and irritation. I will prescribe an appropriate treatment and discuss the potential side effects with you."

3. "Are there any lifestyle changes I should make to help manage my acne?"

- "Ensuring a healthy diet, adequate hydration, and a good skincare routine can support acne management."

4. "Will this condition leave permanent scars on my face?"

- "We will aim to treat your condition effectively to minimize the risk of scarring."

Examiner Questions:

1. How would you explain the pathophysiology of the most probable differential, acne vulgaris, to the patient?

- Acne vulgaris is a chronic skin condition. It develops due to increased oil (sebum) production, inflammation, and the presence of acne-causing bacteria. Together, these factors lead to plugged pores and the formation of lesions.

2. What non-pharmacological treatments could you recommend for the patient?

- I could suggest a skincare routine involving mild cleansers, oil-free moisturizers, and non-comedogenic makeup. I could also recommend avoiding specific foods that may worsen acne symptoms.

3. What factors may influence the patient's response to treatment?

- Factors such as adherence to the treatment regimen, individual response to treatments, and potential exacerbating lifestyle or environmental factors can influence the patient's response to treatment.

4. How would you address the impact of acne on the patient's mental well-being?

- It is crucial to acknowledge the psychological impact of acne on the patient's self-esteem and mental well-being. By addressing these concerns, we can better support the patient in managing her condition.

5. What potential long-term treatment plan would you consider for this patient if the initial therapy is unsuccessful?

- If initial therapy is unsuccessful, considering oral medications or advanced in-office treatments may be necessary to manage the patient’s acne effectively.

Treatment:

1. Topical retinoids (adapalene 0.1% gel) once daily in the evening.

- If considered appropriate and if female and if contraception is required, discuss the use of hormonal contraceptives.

2. Benzoyl peroxide 2.5% gel or lotion once daily in the morning.

- Can be administered in combination with adapalene if tolerated well.

3. Consider antibiotics (such as oral tetracyclines) if the patient's acne has not improved with initial treatment after 12 weeks, or there are psychological distress or scarring.

4. Perform regular follow-ups to monitor treatment effectiveness and any adverse effects.

Monitoring:

- Regular follow-up every 6-8 weeks to evaluate the response to treatment and discuss the treatment regimen.

- Educate the patient about monitoring for potential side effects, especially irritation, and provide guidance on when to seek medical attention.

- Discuss referral options to a clinical psychologist or psychotherapist if necessary to address any ongoing impact on the patient's mental well-being.

Prognosis:

With appropriate medical treatment and lifestyle modifications, including healthy skincare habits, the prognosis for acne vulgaris is favorable. Consistent and appropriate treatment can result in significant improvement in the patient's skin condition and overall confidence. The patient will benefit from regular appointments and keen management of her acne.

Differential diagnoses:

1. Rosacea: Less likely given the primary presentation of acne vulgaris with comedones.

2. Folliculitis: Less likely considering the widespread and prolonged nature of the symptoms.

3. Perioral dermatitis: Less likely due to the absence of a characteristic perioral distribution of the lesions.

4. Gram-negative folliculitis: Less likely due to the absence of a history of long-term antibiotic treatments and the primary inflammatory pustules.

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin or subcutaneous lump

Condition Filter:

Acne Vulgaris

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_30\_Acne\_Vulgaris

Homepage Vignette:

## “A 24-year-old woman presents with concerns about her skin.”

Individual Page Vignette:

You are a dermatologist. You are seeing Rose Amon, a 24-year-old performing artist who presents with acne vulgaris.

Patient Name:

Rose Amon (pronounced "Rohz AY-mon"); prefers to be called Rose.

Age:

21/11/1996

Location:

Dermatology Clinic

Personality:

Rose is a warm and friendly individual. She is very conscious of her appearance and speaks with concern about her skin, as it affects her confidence in her work. She is articulate and displays enthusiasm about seeking treatment for her skin concerns.

Presenting Complaint:

Rose reports that she has been experiencing "frequent breakouts of persistent little spots on her face" for the past three years. She is very worried about the condition of her skin and wishes to seek appropriate treatment for her skin.

Symptoms:

- Site: Face, particularly the cheeks, forehead, and chin

- Onset: Last three years

- Character: Frequent breakouts of small, raised and red spots

- Timing: Ongoing

- Impact: Reduced confidence, particularly in her work as a performer

History of Presenting Complaint:

Rose has had "bad skin" for three years. She has tried over-the-counter remedies, with some temporary improvements, but the acne has not resolved completely. She has noticed the problem is impacting her confidence, especially in her role as a performer.

Systemic Symptoms:

- No current systemic symptoms reported by Rose.

Past Medical History:

- Negative for atopic disorders, previous skin conditions, or autoimmune conditions.

Drug History:

- No history of topical steroids or medications for skin conditions.

Allergies:

- Rose has no known allergies or intolerances.

Family History:

- Negative for significant medical history, skin conditions, or atopic disorders in her family.

Social History:

- Non-smoker

- Drinks alcohol occasionally

- Performs in theatre shows and regularly dances

- Diet includes a balance of fruits, vegetables, and proteins

Ideas, Concerns, and Expectations:

- Ideas: Rose has a good understanding of her condition and its impact on her life. She has researched treatment options and is keen to explore these further.

- Concerns: She is primarily concerned about the ongoing impact of her acne on her confidence, especially when she performs, and worries about finding an effective resolution to her skin concerns.

- Expectations: Rose is expecting detailed information about her condition, along with advice on possible treatments and a prescribed treatment regimen to help clear her skin.

Physical Examination:

- General Inspection: Signs of distress, discomfort, undefined blemishes on the cheeks, forehead, and chin. Reduced confidence is evident from patient tone, demeanor, and self-expression.

- Skin Lesion Inspection: Widespread inflammatory pustules and closed comedones all over the face.

- Skin Lesion Palpation: No significant findings on palpation.

- General Physical Examination: Rose has otherwise normal general and systemic physical findings.

Special Tests:

Based on clinical presentation, no specific diagnostic tests are warranted at this time.

Condition:

Acne Vulgaris

Patient Questions:

1. "How long will it take for the treatment to completely clear my skin?"

- "Treatment length varies, but it often takes a few weeks to start noticing improvement and a couple of months for complete resolution."

2. "What are the potential side effects of the medications you may prescribe for my face?"

- "Common side effects include dryness and irritation. I will prescribe an appropriate treatment and discuss the potential side effects with you."

3. "Are there any lifestyle changes I should make to help manage my acne?"

- "Ensuring a healthy diet, adequate hydration, and a good skincare routine can support acne management."

4. "Will this condition leave permanent scars on my face?"

- "We will aim to treat your condition effectively to minimize the risk of scarring."

Examiner Questions:

1. How would you explain the pathophysiology of the most probable differential, acne vulgaris, to the patient?

- Acne vulgaris is a chronic skin condition. It develops due to increased oil (sebum) production, inflammation, and the presence of acne-causing bacteria. Together, these factors lead to plugged pores and the formation of lesions.

2. What non-pharmacological treatments could you recommend for the patient?

- I could suggest a skincare routine involving mild cleansers, oil-free moisturizers, and non-comedogenic makeup. I could also recommend avoiding specific foods that may worsen acne symptoms.

3. What factors may influence the patient's response to treatment?

- Factors such as adherence to the treatment regimen, individual response to treatments, and potential exacerbating lifestyle or environmental factors can influence the patient's response to treatment.

4. How would you address the impact of acne on the patient's mental well-being?

- It is crucial to acknowledge the psychological impact of acne on the patient's self-esteem and mental well-being. By addressing these concerns, we can better support the patient in managing her condition.

5. What potential long-term treatment plan would you consider for this patient if the initial therapy is unsuccessful?

- If initial therapy is unsuccessful, considering oral medications or advanced in-office treatments may be necessary to manage the patient’s acne effectively.

Treatment:

1. Topical retinoids (adapalene 0.1% gel) once daily in the evening.

- If considered appropriate and if female and if contraception is required, discuss the use of hormonal contraceptives.

2. Benzoyl peroxide 2.5% gel or lotion once daily in the morning.

- Can be administered in combination with adapalene if tolerated well.

3. Consider antibiotics (such as oral tetracyclines) if the patient's acne has not improved with initial treatment after 12 weeks, or there are psychological distress or scarring.

4. Perform regular follow-ups to monitor treatment effectiveness and any adverse effects.

Monitoring:

- Regular follow-up every 6-8 weeks to evaluate the response to treatment and discuss the treatment regimen.

- Educate the patient about monitoring for potential side effects, especially irritation, and provide guidance on when to seek medical attention.

- Discuss referral options to a clinical psychologist or psychotherapist if necessary to address any ongoing impact on the patient's mental well-being.

Prognosis:

With appropriate medical treatment and lifestyle modifications, including healthy skincare habits, the prognosis for acne vulgaris is favorable. Consistent and appropriate treatment can result in significant improvement in the patient's skin condition and overall confidence. The patient will benefit from regular appointments and keen management of her acne.

Differential diagnoses:

1. Rosacea: Less likely given the primary presentation of acne vulgaris with comedones.

2. Folliculitis: Less likely considering the widespread and prolonged nature of the symptoms.

3. Perioral dermatitis: Less likely due to the absence of a characteristic perioral distribution of the lesions.

4. Gram-negative folliculitis: Less likely due to the absence of a history of long-term antibiotic treatments and the primary inflammatory pustules.

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin or subcutaneous lump

Condition Filter:

Acne Vulgaris

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_31\_Acne\_Vulgaris

Homepage Vignette:

## "A 23-year-old woman called Leiko presents with concerns about her skin."

Patient Name:

Leiko Suzuki (Lay-ko Soo-zoo-kee); she would like to be called Leiko.

Age:

23 (DOB: 15/05/2001)

Location:

General Practice

Personality:

Leiko is a reserved, softly spoken individual. She appears anxious and polite during the consultation.

Presenting Complaint:

Leiko is concerned about the presence of red, inflamed bumps, and blemishes on her face. When speaking with the GP, she might say, "I've noticed red, painful spots on my face and my skin feels oily. It's really affecting my confidence."

Symptoms:

• Site: Face

• Onset: Gradual

• Character: Red, painful spots; oily skin

• Associated Symptoms: Changes in skin texture, soreness

• Timing: Ongoing

• Severity: Affecting confidence and mental well-being

History of Presenting Complaint:

Leiko has stated that she has been experiencing the symptoms for approximately 3-4 months. She mentions that she has attempted over-the-counter skin products, but none have significantly improved the blemishes. She expresses that the symptoms have impacted her self-esteem and have affected her confidence in social and work settings.

Systemic Symptoms:

All systemic symptoms are negative for this case.

Past Medical History:

• Negative for skin conditions

• Negative for atopic disorders

• Negative for previous surgeries or hospitalizations

Drug History:

Leiko has not recently taken any medications, herbal supplements, or contraceptives. She does not have a history of using topical steroids.

Allergies:

Leiko has no known allergies to medications or specific foods.

Family History:

Leiko's family history is negative for skin conditions, atopic conditions, and significant medical events.

Social History:

• Lifestyle: Sedentary

• Occupation: Office worker

• Activities of Daily Living & Hobbies: Enjoys reading and writing in her free time

• Smoking: Non-smoker

• Alcohol: Rarely drinks alcohol, 1-2 units per week

• Recreational Drug Use: Does not use recreational drugs

• Diet: Balanced and healthy

• Exercise: Limited exercise; physical activity is mainly from walking

• Travel History: No recent travel

• Sexual History: Negative for any relevant information

• Driving Status: Full driving licence, drives regularly

• Cultural or Religious Practises: No known specific cultural or religious practices

• Recent Life Events: No significant recent life events

• Exposure to Hazards or New Environment: No unusual exposure or changes

Ideas, Concerns, and Expectations:

• Ideas: Leiko understands that she has acne and requires advice on effective management.

• Concerns: She is concerned about the impact of acne on her confidence and wishes to find an effective treatment.

• Expectations: Leiko is seeking guidance on potential treatments to improve her skin condition and clear the acne.

Physical Examination:

The examination reveals the presence of erythematous papules and pustules predominantly located on the central facial area. These spots are tender on palpation and are associated with evidence of active sebum production.

Diagnostic Tests:

Leiko's acne vulgaris diagnosis is clinical. No additional tests are required.

Condition:

Acne Vulgaris

Patient Questions:

1. "What causes acne, and can it be cured?"

Short Answer: "Acne is caused by various factors such as the overproduction of oil, clogged hair follicles, and bacteria. It can be effectively managed."

2. "Should I avoid certain foods to help with my acne?"

Short Answer: "Avoiding certain foods may help reduce acne symptoms for some individuals. We can discuss potential dietary changes."

3. "How long does acne treatment usually take to show results?"

Short Answer: "The treatment may take several weeks to show noticeable improvements. Consistency in treatment is key for successful management."

Examiner Questions:

1. "What other skin conditions can present with symptoms similar to acne and how would you differentiate these?"

Short Answer: "Rosacea and folliculitis are differential diagnoses, but they present with distinct characteristics such as flushing and distinct pustules in specific areas."

2. "What are the main exacerbating factors for acne vulgaris, and how would you advise the patient to manage these?"

Short Answer: "Exacerbating factors include hormonal changes, stress, and certain cosmetics. Patient education on avoiding excess oil, regular cleansing, and minimizing exposure to triggers is crucial."

3. "What are the management options for moderate to severe acne vulgaris?"

Short Answer: "Topical retinoids, benzoyl peroxide, and oral antibiotics are common initial treatments. In severe cases, oral isotretinoin may be considered."

4. "What patient education would you provide to the patient regarding acne management?"

Short Answer: "I would educate the patient about maintaining a regular cleansing routine, avoiding certain skincare products, and the importance of follow-up appointments for progress assessment."

5. "What is your approach to addressing or ruling out any associated psychological impact of acne on the patient?"

Short Answer: "I would assess the patient's mental well-being related to the skin condition and refer to mental health services if they present with significant psychological impact or distress."

6. "How would you involve the patient in developing and agreeing on an acne management plan?"

Short Answer: "I would involve the patient in shared decision-making, discussing available treatment options, potential side effects, and establishing achievable treatment goals."

Treatment:

First-line treatment for Leiko's presentation of mild-to-moderate acne vulgaris will include:

• Topical retinoid (e.g., adapalene 0.1% gel) once daily at night

• Benzoyl peroxide 2.5% or 5% gel or lotion once daily in the morning

• An alternative topical antibiotic, say topical erythromycin 2% solution if the patient is intolerant to or cannot use benzoyl peroxide

• A gentle cleanser to be used twice daily

Monitioring:

• Follow-up at 6-8 weeks to assess treatment response and side effects.

• If an inadequate response, consider adding an oral antibiotic (e.g., lymecycline) for a course of 3 months. Referral to a dermatologist may be warranted if the response to a combination regimen is inadequate

Prognosis:

Leiko's prognosis for acne vulgaris is generally positive with appropriate treatment interventions. Significant improvement in symptoms and psychological impact can be anticipated within a few weeks to months.

Differential Diagnoses:

1. Rosacea - Less likely due to the absence of facial flushing and specific pustule distribution

2. Folliculitis - Less likely as pustules are more specific to hair follicles and not generalized as in acne vulgaris

Keyword Filters:

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin lesion

Condition Filter:

Acne Vulgaris

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_32\_Atopic\_Dermatitis

Homepage Vignette:

## “A 32-year-old woman called Isabel Layton presents with an itchy, red rash.”

Individual Page Vignette:

As a medical student, you've just been introduced to Isabel Layton, a 32-year-old librarian, who presents with an itchy, red rash.

Patient Name:

Isabel Layton; pronounced "Iz-uh-bel Lay-ton"; She prefers to be called "Isabel."

Age:

19/08/1991

Location:

Clinic

Personality:

Isabel is a bubbly and outgoing individual. She speaks with confidence and a warm smile. She is articulate and elaborates her concerns clearly. She is keen on finding out as much as possible about her condition.

Presenting Complaint:

Isabel complains of a very itchy, red rash that's been bothering her for a few months. She states, "I've got this angry rash that just won't go away no matter what I do. It's super irritating, and I'm finding it hard to keep my mind on everyday tasks because of the incessant itching."

Symptoms:

\* Itching (pruritus) is a constant issue, especially at night

\* Diffuse erythema in the affected areas

\* Rash characterised by redness and dryness, flakin skin.

\* Appearance of small blisters (vesicles)

\* Skin is scaly and has a leathery texture

\* Skin is thicker in areas due to lichenification

\* No systemic symptoms such as fever, weight loss, or malaise

\* Whole-body distribution and diffuse dryness, but symptoms more pronounced and concentrated on flexural surfaces and limbs.

History of Presenting Complaint:

Isabel has been experiencing the symptoms for about 5 months. She reports that over-the-counter moisturisers and antihistamines have not provided relief. The symptoms have progressively worsened, impacting her quality of life, causing sleep disturbances, and affecting her overall wellbeing.

Systemic Symptoms:

All important systemic symptoms are within normal limits.

Past Medical History:

\* Negative history of atopic disorders

\* Negative history of previous skin conditions

\* Negative history of autoimmune conditions

\* No psychiatric or psychological history

\* Negative history of substance abuse or addiction

\* Negative history of significant health events

Drug History:

\* Isabel takes citalopram 20mg, otherwise Isabel has no regular medications

\* No past use of topical steroids or medications for skin conditions

\* No new medications initiated recently within the time window of the rash developing.

Allergies:

\* Isabel has a known allergy to penicillin, which causes a severe rash, itching, and shortness of breath

Family History:

\* No significant family history of skin conditions, atopic conditions, or autoimmunity.

Social History:

\* Isabel does not smoke

\* She drinks up to 10 units of alcohol per week

\* Non-recreational drug use

\* Isabel's diet is balanced and she regularly exercises by swimming

\* She is not following any specific cultural or religious practices

\* There have been no recent life events or exposure to hazardous environments

\* Isabel is in therapy for CPTSD and experiences a lot of ups and downs with mood, with this month being especially tough.

Ideas, Concerns, and Expectations:

\* Ideas: "I'm not sure what's causing this rash but it's been quite distressing, and all my usual remedies haven't worked. I heard that some people develop rashes when they are stressed?"

\* Concerns: "I'm worried about the rash spreading and the symptoms getting worse. I just want to get to the bottom of it and find an effective treatment."

\* Expectations: "I'm expecting to receive a clear explanation of what's going on and what can be done to alleviate the itching and rash."

Physical Examination:

General Inspection:

- Isabel appears well and no visible signs of distress

- Observing body language and demeanor for discomfort due to pruritus

- No jaundice or cyanosis

Skin Lesion Inspection:

- Symmetric distribution

- Lesions are erythematous with lichenification

Skin Lesion Palpation:

- Elevation due to lichenification

Systemic Examination:

- No significant findings

Diagnostic Tests:

- Blood Tests: CBC, CRP may be indicated to cover all bases but not particularly relevant since no signs of skin infection.

- Imaging Tests: No relevant imaging tests

- Other Tests: Skin scrapings to definitively rule out fungal and parasitic infections.

Diagnosis of atopic dermatitis is clinical. A family or past medical history of atopy is common but not essential.

Condition: Atopic Dermatitis

Patient Questions:

1. "What could be causing this rash?"

> Possible answer: "I share your curiosity. The rash could be due to a number of factors. We'll investigate this further."

2. "Can I continue using my regular moisturiser?"

> Possible answer: "We'll determine what the best approach regarding moisturiser is after a full evaluation."

3. "How long will it take to find relief from the itching?"

> Possible answer: "It varies from person to person, and we'll work on finding a suitable treatment as soon as we can."

Examiner Questions:

1. "Describe the typical distribution pattern of atopic dermatitis."

> Possible answer: "Atopic dermatitis commonly affects the flexural surfaces of the body, such as the elbows, knees, and neck."

2. "What are the first-line treatment options for atopic dermatitis?"

> Possible answer: "The initial treatment plan often includes emollients, topical corticosteroids, and avoidance of irritants."

3. "How do you approach investigating a suspected allergy such as Isabel's penicillin allergy?"

> Possible answer: "We may screen for penicillin and its metabolites with skin prick or intradermal tests, followed by a graded oral challenge if necessary."

4. "Explain the role of emollients in managing atopic dermatitis."

> Possible answer: "Emollients help to improve skin barrier function and prevent water loss, providing relief from dryness associated with atopic dermatitis."

Treatment:

The most appropriate treatment plan will be established after a full evaluation. This may include:

- Emollients: Applying generous amounts of emollients

- Topical corticosteroids: Mild-to-moderate potency depending on body sites

- Antihistamines: To relieve itching as needed

- Avoidance of irritants: Identifying and minimizing exposure to specific triggers

- Referral to a dermatologist if the condition does not respond to initial treatments.

Monitoring:

- Monitor the response to treatment, including a reduction in pruritus and improvement in rash appearance.

- Request a follow-up visit in 4 weeks to review treatment effectiveness.

- Refer back to dermatology if no significant improvement is noted within the set timeline.

Prognosis:

With appropriate treatment and diligent management, the prognosis for atopic dermatitis can be optimistic. The condition tends to be chronic but can be effectively managed in most cases. Factors influencing the response to treatment may include allergen exposure, adherence to treatment regimen, and identification of relevant triggers.

Differential Diagnoses:

1. Contact Dermatitis: Less likely due to the chronic and widespread nature of the symptoms

2. Cutaneous Fungal Infection: Less likely as symptoms are not typical of a fungal infection

3. Psoriasis: Less likely due to the differentiation of the location of the skin rash on flexor surfaces as opposed to extensors, absence of silver scaling, and vesicular non-plaque like wetness to the rash.

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Pruritus; Skin lesion

Condition Filter:

Atopic Dermatitis and Eczema

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_33\_Atopic\_Dermatitis

Homepage Vignette:

## “A 34-year-old woman called Alicia presents with a red, itchy rash on her skin.”

Individual Page Vignette:

You are a general practitioner. You have been asked to see Alicia, a 34-year-old interior designer, who is complaining of an itchy, red rash on her skin.

Patient Name:

Alicia Soo-ki (Ah-lee-see-ah Soo-kee), prefers to be called Alicia

Age:

26/03/1990

Location:

General Practice

Personality:

Alicia is a reserved and soft-spoken woman. She is polite, calm, and somewhat apprehensive about her current skin problem. She has an artistic background, enjoys drawing and painting, and is friendly but reserved.

Presenting Complaint:

"She may say: 'I have been having this red, itchy rash on my skin that's been making me really uncomfortable lately. It's really frustrating, and I just don't know what's causing it. It's becoming so hard to focus on my work.'"

Symptoms:

• Site: Mostly on arms and the back of the neck

• Onset: Gradual, worsening over the past 6 months

• Character: Itchy and red

• Radiation: Not radiating to other parts

• Associated Symptoms: Dryness, flaky skin

• Timing: Persistent, especially at night

• Exacerbating and Relieving Factors: Showers and certain clothing aggravate the itching; moisturizing offers temporary relief

• Severity: Mild to moderate; impacting sleep and daily activities

History of Presenting Complaint:

Alicia has been experiencing this annoying itch and skin rash for approximately 6 months. She tried using an over-the-counter moisturizer, but it only provided temporary relief and did not improve the condition. The symptoms have been getting progressively worse, often disturbing her sleep and making it difficult for her to concentrate on her work as an interior designer.

Systemic Symptoms:

• Negative for systemic symptoms such as fever, weight loss, night sweats, or joint pain.

• No signs of photosensitivity, ulcers, blisters, pustules, nodules, or abnormal hair loss.

Past Medical History:

• Negative for previous skin conditions, atopic disorders, or autoimmunue conditions.

• No previous surgeries or hospitalisations.

Drug History:

• No use of topical steroids or medications for skin conditions.

• No history of contraceptive use.

Allergies:

• No known allergies to medications, foods, or other substances.

Family History:

• Positive history for atopic dermatitis in her father.

• Negative for other significant skin conditions, autoimmunue conditions, or cancers in the family.

Social History:

• Lifestyle: Appreciates an active lifestyle

• Occupation: Interior designer

• Activities of Daily Living & Hobbies: Enjoys painting and drawing

• Non-smoker

• Drinks 2-3 units of alcohol per week

• No recreational drug use

• No significant travel history

• No recent life events

Ideas, Concerns, and Expectations:

• Ideas: Alicia believes her symptoms may be related to an allergy or a new skincare product she has been using.

• Concerns: She is worried that her condition may worsen and impact her work performance and daily activities.

• Expectations: She expects to receive effective treatment to alleviate the itching and resolve the rash, as well as the identification of the underlying cause.

Physical Examination:

General Inspection:

• No signs of systemic disease observed

• Mild body habitus and good posture

• Notably distressed due to itching

• No signs of trauma or self-inflicted skin damage

• Psychological well-being affected due to skin condition

Skin Lesion Inspection:

• Location: Bilateral symmetrical distribution on upper arms, lower legs, and back of the neck

• Shape: Patches with linear arrangement

• Symmetry: Present

• Borders: Well-demarcated

• Colour: Red with areas of hyperpigmentation

• Diameter: Small to moderate sized patches

Skin Lesion Palpation:

• Elevation: Patches are flat

• Mild warmth and tenderness on palpation

• Texture: Drier and rougher to the touch

• Regional lymph nodes are not enlarged

Systemic Examination:

• Musculoskeletal system: Normal

• No abnormalities in the lung, heart, abdomen, or neurological system

Diagnostic Tests:

• No blood tests indicated

• Basic allergy testing for common allergens

• Patch testing for skin sensitivity

Condition:

Atopic dermatitis

Patient Questions:

1. "How long will it take for the treatment to start showing improvement?"

- "Typically, improvement is seen within a few weeks of starting the treatment. We can monitor your progress during follow-up appointments."

2. "Could my job as an interior designer be aggravating the rash?"

- "It is possible that certain factors in your work environment might be contributing. We can discuss any specific concerns you have about your job and explore potential solutions."

3. "What will happen if I don't treat my rash?"

- "Untreated atopic dermatitis can lead to persistent symptoms and skin damage. It's important to manage the condition to prevent complications."

4. "Can I use any specific skincare products to relieve the itching?"

- "We can discuss suitable moisturizers to help relieve your symptoms."

Examiner Questions:

1. What is the typical age of onset for atopic dermatitis, and how does that correspond with Alicia's age?

- The typical age of onset for atopic dermatitis is in early childhood, but the condition can manifest in adolescence or adulthood. In Alicia's case, the onset of symptoms is within the range of adult presentations for atopic dermatitis.

2. What can environmental factors at work possibly contribute to in the exacerbation of atopic dermatitis?

- Environmental factors at work can worsen atopic dermatitis by exposure to certain substances such as pollutants, irritants, dust, and allergens. These factors can trigger or exacerbate the existing symptoms.

3. What are the potential triggers for the exacerbation of atopic dermatitis that Alicia should be mindful of?

- Potential triggers include stress, certain fabrics, exposure to allergens such as pet dander, pollen, mould, and food allergens, among others. Identifying and avoiding personal triggers is crucial in managing atopic dermatitis.

4. What are the differential diagnoses for Alicia's skin condition, and why are they less likely than atopic dermatitis?

- Differential diagnoses may include allergic contact dermatitis, seborrhoeic dermatitis, and psoriasis. However, the distribution, progression, and associated symptoms align more with atopic dermatitis than those alternative conditions.

5. What are the main goals of treatment for atopic dermatitis, and how should we approach Alicia’s treatment plan?

- The main goals are to relieve itching, reduce inflammation, and manage the condition long-term. Alicia's treatment plan should focus on symptom management, reducing flare-ups, and preventing complications.

6. How should we advise Alicia to manage potential aggravating factors in her work environment?

- Recommending measures such as modifying the work environment, avoiding certain irritants, and using protective clothing or barriers can help manage the environmental triggers at her workplace.

Treatment:

First-line treatment:

• Emollients, to be applied liberally over the entire body 2–3 times daily

• Mild to moderate potency topical corticosteroid, such as hydrocortisone 1% cream, to be applied sparingly to affected areas once daily for 7-14 days

• Oral antihistamines, e.g., cetirizine 10 mg once daily, for itching or sleep disturbance

Monitoring:

• Follow-up appointments at regular intervals to assess treatment response and adjust management as needed based on progression

• Detailed instructions provided on proper application of emollients and corticosteroid use

• If inadequate response, consider a referral to dermatology for further evaluation and management

Prognosis:

The prognosis for atopic dermatitis is generally favourable with appropriate treatment and management. Symptom relief and improvement can be expected through suitable medication and lifestyle modifications. Long-term management and identification of triggers are essential to limit the impact of the condition on the patient's daily life.

Differential Diagnoses:

1. Allergic contact dermatitis - less likely due to the chronic and bilateral pattern of Alicia's rash, rather than the typical allergic contact dermatitis localized to specific areas of contact.

2. Seborrhoeic dermatitis - less likely due to the distribution mainly on the arms and lower legs, whereas seborrhoeic dermatitis typically affects oily areas of the skin.

3. Psoriasis - less likely due to the lack of silvery scales on the rash or any associated joint involvement.

Keyword Filters:

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Skin lesion; Chronic rash

Condition Filter:

Atopic dermatitis and eczema

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_34\_Atopic\_Dermatitis

Homepage Vignette:

## “A 34-year-old woman called Maya presents with a rash and itching.”

Individual Page Vignette:

“You are a GP seeing Maya, a 34-year-old hotel director, who has come in because she is experiencing a rash and itching.”

Patient Name:

Maya Szymańska (MAY-uh SHIM-awn-skuh); she prefers to be called Maya

Age:

22/05/1990

Location:

General Practice

Personality:

Maya is a friendly and outgoing person, who is very articulate and openly expresses her thoughts and feelings. She has a sense of urgency in her voice and appears worried about her symptoms. She speaks quickly and is keen to ensure that her concerns are heard and addressed promptly.

Presenting Complaint:

Maya is experiencing a chronic itchy rash on her skin. She feels very concerned and says, “I've had this itchy rash for a few months now, and it's really getting to me. It's driving me mad and I can't seem to get rid of it no matter what I try. I'm really hoping you can help me, doctor.”

Symptoms:

Maya reports the following symptoms:

• Site: Rash is present on her arms, legs, and torso

• Onset: Chronic, persisting for several months

• Character: Itchy, red, and raised

• Radiates: No radiation

• Associated Symptoms: No other associated symptoms

• Timing: Continuous itching, rash worsens at night

• Exacerbating and Relieving Factors: Stress and heat worsen symptoms, cooling and moisturizing the skin provide some relief

• Severity: Moderate, impacting daily life

History of Presenting Complaint:

Maya states, “I've been experiencing this rash for about 4-6 months now. I've tried over-the-counter creams and soothing lotions, but nothing seems to calm it down. The itching really bothers me, especially at night. It has started affecting my sleep, and I find myself scratching the rash almost constantly. It has also made me feel quite self-conscious about how my skin looks, which is impacting my self-esteem. I'm even worried it might affect my work.”

Systemic Symptoms:

Maya denies any other systemic symptoms.

Past Medical History:

Positive for hay fever and allergic rhinitis; negative for any other known skin conditions or autoimmune disorders.

Drug History:

Maya has been using over-the-counter moisturizing creams and soothing lotions for symptom relief. Apart from codeine, she has no known drug allergies.

Allergies:

Maya is allergic to codeine, causing itching and hives.

Family History:

Maya’s maternal grandmother had a history of atopic dermatitis and her younger cousin has been diagnosed with psoriasis.

Social History:

• Lifestyle: Engages in regular exercise and follows a well-balanced diet

• Occupation: Works as a hotel director in a luxury resort

• Activities of Daily Living & Hobbies: Enjoys yoga, swimming, and reading

Maya shares, “I've been trying to maintain a healthy lifestyle. However, this rash is starting to interfere with my exercise routine and is impacting my mood. I'm finding it difficult to focus on my work and am feeling increasingly uncomfortable with how my skin looks.”

Ideas, Concerns, and Expectations:

Maya states, "I am really concerned about the impact this rash is having on my day-to-day life. I am also concerned about the way my skin looks. I hope that the treatment will provide relief from the itching and help clear up the rash. I also hope to address any underlying triggers that may be contributing to this problem."

Physical Examination:

At the time of initial presentation, the examination reveals erythematous papules and plaques present on the extensor surfaces of the arms and legs, as well as on the flexor surfaces of the elbows. The rash presents with excoriations due to scratching with visible erythema. There is no evidence of lichenification or oozing present. No palpable lymph nodes are noted.

Diagnostic Tests:

• Blood Tests: Full blood count and inflammatory markers to assess for any underlying allergic or immune pathology.

• Patch Testing: To assess potential allergic triggers.

• Other Tests: Skin biopsies for histological examination.

Condition:

Atopic dermatitis

Patient Questions:

1. "Will I need to take medications for a long time to control this condition?"

- Possible answer: "Treatment duration can vary, and we will work to find the best approach for you."

2. "Is there anything I can do to prevent a flare-up of this rash in the future?"

- Possible answer: "We will discuss strategies to help avoid triggering factors and manage flare-ups proactively."

3. "Are there any dietary changes that could help with my condition?"

- Possible answer: "We can explore if certain dietary factors may be contributing to your symptoms."

Examiner Questions:

1. What are the potential triggers that could be exacerbating Maya's atopic dermatitis?

- Possible answer: Potential triggers can include stress, environmental allergens, and certain foods or dietary patterns.

2. How does Maya's family history of atopic dermatitis and psoriasis impact her current diagnosis?

- Possible answer: The family history could suggest a genetic predisposition to atopic conditions, making Maya more susceptible to developing atopic dermatitis.

3. What type of moisturizers and lotions has Maya been using, and have they provided any relief?

- Possible answer: Maya has been using over-the-counter moisturizing creams and soothing lotions. However, they have not provided substantial relief from the symptoms.

4. How have Maya's symptoms impacted her emotional well-being and daily activities?

- Possible answer: Maya's symptoms have affected her sleep, mood, and self-esteem. She has also been experiencing significant discomfort and impact on her work due to the symptoms.

5. What treatment options would you consider to manage Maya's atopic dermatitis, taking into account her current symptoms and concerns?

- Possible answer: Treatment options may include topical corticosteroids, emollients, and potentially oral antihistamines for symptom relief. Considering her lifestyle, we'll discuss personalized strategies for managing and preventing flare-ups.

Treatment:

In line with NICE guidelines for Atopic Dermatitis, the initial treatment plan for Maya includes:

• Emollients: Prescribed emollients for regular use, to be applied liberally and frequently to maintain skin hydration and integrity.

• Topical Corticosteroids: Prescribed topical corticosteroids for application during flare-ups to reduce inflammation and itching.

• Education: Discussion about avoiding trigger factors, managing stress, and using appropriate skincare routines.

Monitoring:

Maya will be instructed to monitor her symptoms, noting any improvements or worsening of the rash and itching. She is advised to seek a follow-up visit in 2 weeks to assess the treatment response and address any concerns. Considering her symptoms and the impact on her well-being, a referral to a dermatologist may be warranted if there are challenges in symptom management.

Prognosis:

The prognosis for management of atopic dermatitis is highly variable, depending on individual response to treatments, triggers, and adherence to management plans. With appropriate treatment and lifestyle strategies, symptom control and management of flares can be achieved.

Differential Diagnoses:

1. Contact dermatitis: Less likely in this case as there is no evident history of new exposures to allergens or irritants.

2. Cutaneous fungal infection: Less likely as there are no visible signs of fungal involvement or primary lesions indicative of fungal infections.

3. Urticaria: Less likely as the presentation does not demonstrate transient, raised wheals or a short duration of individual lesions.

Keyword Filters:

Speciality Filter:

- Dermatology; General Practice

Presenting Complaint Filter:

- Chronic rash; Pruritus

Condition Filter:

- Atopic dermatitis

Location Filter:

- General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_35\_Atopic\_Dermatitis

Homepage Vignette:

## A 35-year-old woman presents with a skin rash and itching.

Individual Page Vignette:

You are a GP. You will need to assess and manage the skin rash and itching in a 35-year-old woman named Thandeka.

Patient Name:

Thandeka Mkhize (Tan-DEH-kuh muh-KEE-zay); she would like to be called Thandeka

Age:

23/05/1989

Location:

General Practice

Personality:

Thandeka is a softly spoken, friendly woman. She is articulate and answers questions thoughtfully.

Presenting Complaint:

Thandeka complains of an itchy, red rash on her skin, particularly on her arms, legs and face. She describes the rash as "very itchy, red and scaly. It drives me crazy, doctor."

Symptoms:

Site: Itching is widespread on arms, legs and face

Onset: Gradual

Character: Itching is severe; rash is red, scaly

Radiation: Itching radiates across the body

Associated Symptoms: None mentioned

Timing: Symptoms are continuous

Exacerbating and Relieving Factors: Hot showers worsen the itching; emollients help relieve the itching

Severity: Severe itching; rash is moderate

History of Presenting Complaint:

Thandeka has been experiencing these symptoms for about 6 months. She has used emollients such as regular moisturizer, which provide some short-term relief of the itching. However, the rash persists and affects her quality of life. The itching has disturbed her sleep. The rash and itching are interfering with her daily life and causing her distress.

Systemic Symptoms:

Thandeka has no systemic symptoms at present. All systemic symptoms are normal.

Past Medical History:

Negative for any previous allergic conditions, skin conditions, or autoimmune disorders.

Drug History:

Thandeka does not take any regular medications. She has never used contraceptive medication and does not have any allergies to medications.

Allergies:

Thandeka has an allergic reaction to penicillin, which causes a skin rash, swelling, and difficulty breathing.

Family History:

Thandeka's mother has a history of atopic dermatitis. All other family health histories are unremarkable.

Social History:

• Lifestyle: Thandeka works as a primary school teacher, is married, and has two children.

• Smoking: Non-smoker

• Alcohol: Thandeka does not consume alcohol.

• Diet: She follows a balanced diet and avoids fast food and soft drinks.

• Exercise: Regularly jogs for 30 minutes, thrice a week.

• Travel History: No recent international travel, and no exposure to harmful environments or hazards.

• Cultural or Religious Practices: Reflects traditional South African values and participates in local community events.

Ideas, Concerns, and Expectations:

Ideas: Thandeka feels that she has atopic dermatitis like her mother and is concerned about the chronic nature of the rash. She has researched about atopic dermatitis and is fearful of the impact on her life.

Concerns: Thandeka is worried about the impact of the rash on her ability to carry out her job as a teacher, especially when she has an itching episode during class.

Expectations: She hopes to receive information about treatment options and ways to manage the itching and rash.

Physical Examination:

• General Inspection: Alert and oriented, but appears mildly distressed due to itching, skin condition appears to be causing distress

• Skin Lesion Inspection:

- Location: Rash is widespread on arms, legs, and face

- Distribution: Symmetrical

- Shape: Scattered raised erythematous plaques

- Symmetry: Present

- Borders: Well-demarcated

- Colour: Red plaques, with some areas showing lichenification

- Diameter: Varies from 1-3 cm

• Skin Lesion Palpation:

- Elevation: Raised plaques

- Texture: Scaly, rough

- Tenderness: No tenderness

- Mobility: Fixed

- Lymph nodes: No enlargement or tenderness

• Systemic Examination: Normal

• Special Tests: No special tests conducted

Diagnostic Tests:

• Blood Tests: Not required in this case.

• Imaging Tests: Not required in this case.

• Other Tests: Patch testing to common allergens, skin biopsy for definitive diagnosis, and IgE levels for assessment of allergic condition.

Condition:

Atopic dermatitis

Patient Questions:

1. "Is there any cure for atopic dermatitis, or do I have to live like this forever?"

- You do not have to live with it forever. Treatment will help manage your condition effectively, and many people find that the condition improves over time with appropriate management.

2. "Is there anything I am doing that could be contributing to my rash?"

- Certain triggers like harsh soaps, detergents, stress, or particular foods can worsen the rash and itching. We can discuss potential triggers and adjustments to your routine to help lessen these.

3. "Can my atopic dermatitis be cured with alternative medicine or holistic treatment?"

- While alternative medicine can offer some relief, it may not cure atopic dermatitis. It is essential to have a comprehensive, evidence-based management plan. We can discuss complementary treatments as an adjunct to medical therapy to manage symptoms effectively.

Examiner Questions:

1. What are the diagnostic criteria for atopic dermatitis?

- Atopic dermatitis is diagnosed based on the history and clinical examination. The "Hanifin and Rajka criteria" are commonly used to diagnose atopic dermatitis.

2. How does stress impact atopic dermatitis, and what can be done to manage stress in these patients?

- Stress can significantly worsen atopic dermatitis. Stress-reducing techniques and therapies such as mindfulness, yoga, and meditation can help manage stress levels and the dermatitis.

3. What topical treatments are commonly used for atopic dermatitis in adults and their respective mechanisms of action?

- Generally, emollients and corticosteroids are often used. Emollients restore the skin barrier, and corticosteroids reduce inflammation. The mainstay of treatment for atopic dermatitis is the application of liberal amounts of emollients combined with potent topical corticosteroids for flares.

4. What are the key triggers for a flare-up of atopic dermatitis?

- Triggers can include certain foods, such as dairy, eggs, wheat, soy, and nuts, environmental factors such as pollen and pet dander, irritants like soaps and detergents, and stress.

5. What is the role of antihistamines in the management of atopic dermatitis?

- Antihistamines can help reduce itching and can be useful at night to help with sleep disturbance during a flare-up of atopic dermatitis.

6. What are the consequences of long-term steroid use in the management of atopic dermatitis, and how can these be minimized?

- Prolonged use of high-potency topical corticosteroids can lead to skin atrophy. To minimize potential adverse effects, it is essential to use them for short periods and avoid their use on thin skin—such as the face and genital areas.

Treatment:

1. Emollients: Prescribe regular use of emollients as first-line management; for example, liquid or cream paraffin.

2. Topical corticosteroids: Apply moderately potent topical corticosteroids, e.g. Mometasone furoate 0.1% cream, for a short period to affected areas once daily.

3. Antihistamines: Prescribe non-sedating antihistamines such as loratadine for the itching, to take once daily, particularly at night to help with sleep.

4. Educate: Provide Thandeka with information on atopic dermatitis, and advise her about triggers and good skin care.

5. Follow-Up: Review Thandeka in one month to monitor the treatment’s effectiveness and adjust the management plan if necessary.

Monitoring:

Advise Thandeka to monitor her symptoms, particularly itching and erythema. Instruct her to return for review earlier, if the condition significantly worsens or if she experiences unexpected adverse effects from the treatment. Express the importance of avoiding trigger factors and share strategies for effective stress management.

Prognosis:

Atopic dermatitis can be managed effectively with suitable treatments, and many individuals find that the condition improves over time. However, it can be a chronic condition. The prognosis is generally favorable, particularly with appropriate and proactive management.

Differential Diagnoses:

1. Seborrheic dermatitis: Less likely as there are no greasy scales on the scalp.

2. Psoriasis: Less likely due to the absence of typical plaques with silvery-white scales and sites involving the extensor surfaces.

Keyword Filters:

Speciality Filter:

- Dermatology

- General Practice

Presenting Complaint Filter:

- Chronic rash

- Pruritus

- Skin lesion

Condition Filter:

- Atopic dermatitis

Location Filter:

- General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_36\_Basal\_Cell\_Carcinoma

Homepage Vignette:

## "A 43-year-old male called Kolya presents with a new lesion on his face which is changing over time."

Individual Page Vignette:

You are a GP in Manhatten. You have a patient come in called Kolya, aged 43, who works a web developer downtown. He presents with a new skin lesion that he is worried about.

Patient Name:

Kolya Saleh (pronounced kol-yah sah-lay)

The patient would like to be called Kolya.

Age:

22/06/1980

Location:

Clinic

Personality:

Kolya is a softly spoken individual who is rather reserved. He tends to be quite introspective and takes his time to articulate his thoughts. He is polite and considerate, often showing concern for others before himself.

Presenting Complaint:

"Hello, I've noticed a small, persistent sore on my cheek. I initially thought it was a pimple but it doesn't seem to be going away. It's slightly raised and sometimes it bleeds when I accidentally scratch it."

Symptoms:

• Site: Right cheek

• Onset: Noticed approximately 3 months ago

• Character: Raised, persistent sore

• Radiation: N/A

• Associated Symptoms: Bleeding after scratching

• Timing: Persistent

• Exacerbating and Relieving Factors: Scratching exacerbates bleeding

• Severity: Concerned about the duration and persistent presence

History of Presenting Complaint:

Kolya mentioned that the sore had been present for approximately 3 months. He initially ignored it, thinking it would resolve, but became increasingly concerned due to its prolonged presence. He has not attempted any treatments. The sore has impacted his mental well-being, leading to anxiety and fear of underlying health concerns.

Systemic Symptoms:

Negative for any major systemic symptoms.

Past Medical History:

• Negative for any previous skin conditions, autoimmune conditions or atopic disorders

Drug History:

• No current medications, herbal supplements, or contraception

• No history of past use of topical steroids

Allergies:

• No known allergies to medications or allergens

Family History:

• Negative for any significant family history of skin conditions or cancer

Social History:

• Occupation: Works as a web developer

• Lifestyle: Non-smoker

• Alcohol: Occasional social drinker

• Diet: Vegetarian with a balanced diet

• Exercise: Regular exercise routine, enjoys long walks and yoga

Ideas, Concerns, and Expectations:

• Ideas: "I don’t know what this sore could be, but I just want reassurance that it’s nothing serious."

• Concerns: "I’m worried that this sore could be a sign of something more serious."

• Expectations: "I hope that the doctor can identify what the sore is and if it requires any treatment."

Physical Examination:

• General Inspection: Kolya appears slightly anxious. There are no obvious signs of distress or discomfort.

• Skin Lesion Inspection:

- Location: Right cheek

- Shape: Slightly raised with a small central ulceration

- Colour: Light brown with slight pigmentation changes

- Diameter: Approximately 5mm

• Skin Lesion Palpation:

- Texture: Slightly rough and nodular

- Skin temperature: Normal

- Consistency: Firm, not tender to palpation

- Regional lymph nodes: Not palpable

Diagnostic Tests:

• Dermoscopy:

- The lesion showed asymmetrical arborising vessels, slight scaling, and light brown stroma consistent with non-pigmented basal cell carcinoma.

Patient Questions:

1. "Could this sore be a sign of something serious?"

- This lesion needs further evaluation to determine the appropriate treatment.

2. "Will this affect my day-to-day life at work?"

- It should not significantly impact your ability to work, however, further advice will be provided after confirming the diagnosis.

3. "What treatment options are available for this condition?"

- There are various treatment options available that can be discussed based on the confirmed diagnosis.

Examiner Questions:

1. "How do you plan to confirm the diagnosis?"

- Dermoscopic assessment suggests non-pigmented basal cell carcinoma, and further confirmation will be obtained through skin biopsy.

2. "What baseline tests would you consider before initiating treatment?"

- A complete blood count and basic metabolic panel to ensure no underlying issues that may impact treatment.

3. "What is your initial management plan and potential therapeutic options for this patient?"

- Referral to a dermatologist for skin biopsy and potential further management will be the initial step.

4. "How would you address Kolya's concerns about the potential seriousness of the lesion?"

- Reassurance of a timely diagnosis and the availability of effective treatments, providing information can help address Kolya's concerns.

5. "What are the characteristics of basal cell carcinoma observed on dermoscopy?"

- Basal cell carcinoma often presents with asymmetrical arborising vessels, scaling, and light brown stroma on dermoscopy.

Treatment:

Initial Treatment:

• Referral to a dermatologist for skin biopsy and definitive diagnosis

Monitoring:

• Follow-up after skin biopsy to confirm the diagnosis and discuss appropriate treatment options

Prognosis:

The prognosis for basal cell carcinoma is generally favorable when diagnosed and treated early. Effective treatment can be planned to prevent further progression and complications.

Differential diagnoses:

1. Squamous cell carcinoma - Less likely due to the characteristic dermoscopic features observed.

2. Seborrhoeic keratosis - Less likely based on the clinical presentation and history.

Keyword Filters:

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Basal cell carcinoma

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_37\_Basal\_Cell\_Carcinoma

Homepage Vignette:

## "A 55-year-old male called George presents with a persistent sore on his face."

Individual Page Vignette:

You are a GP at a busy urban practice. You have a patient called George, aged 55, who works as an accountant. He presents with a persistent sore on his face as well as an irregularly shaped pinkish patch that seems to be growing.

Patient Name:

Rivesh Patel (Ri-vesh Pa-tel); He would like to be called "Rivesh."

Age:

24/09/1969

Location:

General Practice

Personality:

Rivesh is an affable individual who speaks softly but confidently. He is articulate and precise in his speech. His calm demeanor exudes quiet strength, and he describes his symptoms with clarity.

Presenting Complaint:

Rivesh has "an ongoing sore on my face that doesn't seem to heal. There's also a weird pinkish patch on my skin that has been getting larger."

Symptoms:

- Site: Face

- Onset: The sore began about 9 months ago, and the pinkish patch developed around the same time.

- Character: Sore is persistent and doesn't seem to heal. The patch appears irregular and is growing in size.

- Associated Symptoms: None

- Timing: The frequency has been consistent over the past months.

- Severity: Moderately bothersome, especially when the sore is irritated.

History of Presenting Complaint:

Rivesh has been experiencing the symptoms for the past 9 months. He has not attempted any previous treatments. The sore is not healing, and the pinkish patch has been progressively enlarging, impacting his confidence due to its visibility. The symptoms have made Rivesh more conscious of his appearance, as the sore and the patch are difficult to cover up.

Systemic Symptoms:

- No systemic symptoms are present.

Past Medical History:

- Negative for atopic disorders, previous skin conditions, or autoimmune conditions.

Drug History:

- Rivesh is not on any regular medications.

Allergies:

- No known allergies or intolerances.

Family History:

- Negative for any family history of skin conditions, atopic disorders or cancers.

Social History:

- Lifestyle: Lives a balanced lifestyle.

- Occupation: Accountant.

- Activities of Daily Living & Hobbies: Engages in daily physical exercise and enjoys outdoor walks.

Rivesh: "I try to eat healthy and stay active. I don't smoke, and I rarely drink alcohol. My job keeps me indoors most of the time, but I make it a point to get some exercise every day."

Ideas, Concerns, and Expectations:

- Ideas: Rivesh understands that there might be something wrong with the skin on his face and is eager to get a definitive diagnosis.

- Concerns: He is concerned about the persistent sore and the growing patch, which are negatively affecting his appearance and confidence.

- Expectations: Rivesh is expecting to receive a clear explanation of his condition and a suitable treatment plan. He would like to understand whether the condition will leave any scarring and if it could be cancerous.

Physical Examination:

- General Inspection: Rivesh appears well. He does not show any signs of distress and moves comfortably.

- Skin Lesion Inspection: Location: Right temple; Distribution: Localized; Shape: Irregular; Symmetry: Not symmetric; Borders: Irregular; Colour: Pink; Diameter: Enlarging.

- Skin Lesion Palpation: Elevation: Raised; Tenderness: Slight; Temperature: Warm; Consistency: Firm, not fluctuant.

- Systemic Examination: No abnormalities detected.

Special Tests:

- Dermatoscopy: Pinkish patch with asymmetrically branched vessels and slight scaling seen peripherally. No evidence of pigmented features.

- Biopsy results indicated a nodular basal cell carcinoma.

Diagnostic Tests:

- Biopsy results confirm the diagnosis of nodular basal cell carcinoma.

Condition:

Basal Cell Carcinoma

Patient Questions:

1. "What causes this and is there something I could have done to prevent it?"

- Basal cell carcinoma is often caused by long-term exposure to ultraviolet (UV) radiation from sunlight or from tanning beds. Regular use of sunscreen and avoiding prolonged sun exposure can help prevent it.

2. "What's the next course of action and the outcomes of the treatment?"

- The next step is to discuss the appropriate treatment, which may include surgery, radiation therapy, or other nonsurgical treatments. The expected outcomes of treatment will be shared with you in detail.

3. "Will I have scarring after the treatment?"

- Scarring is a possibility, but the extent will depend on the chosen treatment and the size and location of the lesion.

Examiner Questions:

1. What are the common risk factors associated with developing basal cell carcinoma?

- Prolonged exposure to UV radiation, personal history of skin cancer, fair skin, older age, and a weakened immune system are common risk factors.

2. How would you communicate the diagnosis to the patient?

- I would use clear and empathetic language to explain that the biopsy results indicate nodular basal cell carcinoma. I would ensure that Rivesh has understood the diagnosis before proceeding.

3. What are the recommended surgical and nonsurgical treatment options for basal cell carcinoma?

- The main treatments include surgical excision, Mohs surgery, radiation therapy, and topical treatments.

4. How often should a patient with basal cell carcinoma undergo follow-up examinations after the initial treatment?

- Depending on the treatment received, initial follow-up within 6 months post-treatment is recommended, followed by yearly skin checks, or more frequent checks if there is a history of skin cancer or high-risk features.

5. What advice would you provide to the patient regarding sun protection and UV exposure?

- Advise the patient on sun protection measures, including the use of sunscreen with SPF 30 or higher, wearing protective clothing and sunglasses, and seeking shade during peak sun hours.

Treatment:

The most appropriate treatment plan will be:

- Referral to dermatology for further management

- Surgical excision with a narrow margin; or

- Mohs micrographic surgery; or

- Radiation therapy, especially for challenging anatomical locations such as the face

- Consider nonsurgical treatments such as topical treatments or photodynamic therapy

- Psychological support to help with the emotional aspects of the diagnosis

Monitoring:

Regular follow-up appointments for skin checks post-treatment, particularly within the first few months to monitor for recurrence and to ensure healing. Rivesh will be informed to promptly seek medical attention if there is any unusual change in the area.

Prognosis:

The prognosis for basal cell carcinoma is generally good, especially when treated early. The rate of metastasis is low. Recurrence rates after treatment are also low with appropriate management. Healing and scarring depend on the chosen treatment approach.

Differential Diagnoses:

1. Actinic Keratosis: Less likely due to the presence of a persistent sore that does not heal.

2. Squamous Cell Carcinoma: Less likely as the lesion's appearance and behaviour are more consistent with nodular basal cell carcinoma.

3. Rosacea: Less likely as the lesion does not resemble a typical rosacea presentation of facial erythema and papules.

Keyword Filters:

Speciality Filter:

- Dermatology; General Practice

Presenting Complaint Filter:

- Skin lesion

Condition Filter:

- Basal Cell Carcinoma

Location Filter:

- General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

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# ALYC\_38\_Basal\_Cell\_Carcinoma

Homepage Vignette:

## “A 55-year-old woman called Ekene presents with a raised, pearly pink or red spot on her nose.”

Individual Vignette:

You are a General Practitioner. You are seeing Ekene, a 55-year-old woman who works as a teacher. She is presenting today with a raised, pearly pink or red spot on her nose that has been slowly growing and scabbing over the past few months.

Patient Name:

Ekene Nnaji (Pronounced: E-ke-ne N-na-jee). She would like to be called "Ekene."

Age:

DD/MM/YYYY - 23/05/1969

Location:

General Practice

Personality:

Ekene is a friendly and talkative lady. She tends to speak optimistically and confidently. She's a very active individual and has a bright personality, always engaging with a positive attitude. She is well-educated, humorous, and open to discussing her health concerns.

Presenting Complaint:

"Doctor, I've noticed this raised spot on my nose that's slowly been getting bigger and sometimes forms a scab. It doesn't hurt, but it can be a bit annoying. I'm quite concerned about it and want to get it checked."

Symptoms:

- Site: Nose

- Onset: Slowly growing over the past few months

- Character: Raised, pink or red spot, may scab

- Timing: Worsening over time

- Exacerbating and Relieving Factors: No specific triggers, not painful

- Impact on Daily Life: Annoying, no pain

- Activities of Daily Living: Unaffected

History of Presenting Complaint:

Ekene states that she has had the raised, pearly pink or red spot on her nose for a few months. She has noticed that the spot slowly grows, sometimes forming a scab, but she does not experience any pain. She has not undergone any treatments or interventions for this spot, and the symptoms have been slowly worsening over time. She mentions that the spot gets annoying at times but it does not impact her daily life or activities of daily living.

Systemic Symptoms:

- Normal systemic symptoms; no relevant findings

Past Medical History:

Negative history of atopic disorders, previous skin conditions, or autoimmune conditions. No significant history of surgeries, hospitalizations, psychiatric/psychological issues, or substance abuse. Regular health check-ups, no significant health events reported.

Drug History:

No significant regular medication. Prodromal sparingly.

Allergies:

No known drug allergies.

Family History:

No known family history of skin conditions, atopic disorders, or cancers.

Social History:

- Ekene has a sedentary lifestyle due to her occupation as a teacher, but she actively involves herself in planning outdoor activities for her students.

- Non-smoker

- Consume minimal alcohol, fewer than five units per week.

- Healthy diet, rich in vegetables and fruits.

- Regular recreational exercises, including light jogging and cycling.

- No significant travel history, no major cultural or religious practices

Ideas, Concerns, and Expectations:

- Ekene expects a thorough examination and detailed information about the raised spot on her nose. She is concerned about the potential severity and implications and wishes to receive the best medical advice. She desires clear timelines and expectations regarding the consultation and further management.

Physical Examination:

- General Inspection: Ekene appears in good health, no signs of distress or discomfort.

- Skin Lesion Inspection: Raised, pearly pink or red spot with scab on the nose.

- Shape: Irregular, possible scabbing

- Colour: Pearly pink or red

- Diameter: Slowly growing; measures approximately 1cm in diameter

- Skin Lesion Palpation: Not indurated, painless, no fever, tenderness, or regional lymph nodes enlargement.

- General internal examination: Unremarkable

- Special Tests: Dermoscopy and full skin lesion examination performed.

Diagnostic Tests:

- Dermoscopy: Revealed specific features of basal cell carcinoma, such as asymmetrical arborising vessels and white clods.

- Biopsy: Confirmed basal cell carcinoma.

Patient Questions:

1. "What do you think the spot on my nose is?"

- "We need to run some tests to confirm, but based on the initial observation, it appears to be a basal cell carcinoma."

2. "How severe is basal cell carcinoma, and what kind of treatment is available?"

- "Basal cell carcinoma is generally not life-threatening, but it requires expert management. Treatments may include surgical excision, cryotherapy, or topical medications."

3. "Do I require hospitalization for treatment?"

- "In most cases, treatment can be done as an outpatient. However, we will discuss this in detail once we review your treatment plan."

Examiner Questions:

1. What types of basal cell carcinoma are commonly identified?

- Common types include nodular, superficial, and morphoeic basal cell carcinomas, among others.

2. Why is it crucial to identify the sub-type of basal cell carcinoma?

- Treatment approaches may differ depending on the subtype and depth of invasion.

3. What are the common treatment modalities for basal cell carcinoma?

- Treatments may include surgical excision, cryotherapy, topical medications, and radiation therapy, among others.

Treatment:

1. Surgical excision of the basal cell carcinoma with a 4mm clinical margin.

2. Advise on sun protection measures.

3. Referral for further evaluation and management by a dermatologist if unsure about features or depth of the lesion.

Monitoring:

- Frequent follow-up visits (every 3-6 months) to monitor the site for recurrence

- Patient instructed to report any signs of infection, bleeding, or worsening of symptoms immediately.

- Referral to a dermatologist if any new suspicious skin lesions develop.

Prognosis:

The prognosis for basal cell carcinoma is generally favorable, especially when detected and managed at an early stage. With appropriate treatment, the chances of a cure are high.

Differential Diagnoses:

1. Actinic keratosis - Less likely than basal cell carcinoma; typically presents as a rough, scaly patch on the skin.

2. Squamous cell carcinoma - Less likely than basal cell carcinoma; typically presents as a firm, red nodule or flat lesion with a scaly crusted surface.

3. Solar lentigines - Less likely than basal cell carcinoma; characterised by flat brown spots on areas of the skin that are frequently exposed to the sun.

4. Seborrheic keratosis - Less likely than basal cell carcinoma; usually appear as raised growths with a waxy, scaly surface.

5. Haemangioma - Less likely than basal cell carcinoma; typically appears as a small blood vessel tumour characterized by a red or purplish discoloration of the skin.

Keyword Filters:

Speciality Filter:

- Dermatology

- General Practice

Presenting Complaint Filter:

- Skin lesion

Condition Filter:

- Basal cell carcinoma

Location Filter:

- General Practice; Clinic; Accident & Emergency

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_39\_Basal\_Cell\_Carcinoma

Homepage Vignette:

## "A 57-year-old woman presents with a slow-growing lesion on her face and is concerned about it."

Individual Page Vignette:

"You are a registrar in Dermatology. The patient you are seeing today is Ms. Indira Kaur, aged 57, who is a primary school teacher and is presenting with a slow-growing lesion on her face that she is worried about."

Patient Name:

Indira Kaur (In-dee-rah Core)

Age:

DD/MM/1967

Location:

Dermatology Clinic

Personality:

Ms. Kaur is a kind-hearted and soft-spoken person who is very concerned about her health. She is well-mannered and approachable, albeit very anxious about her skin lesion, which she has noticed changing recently.

Presenting Complaint:

Ms. Kaur presents with a slowly growing lesion on her face that she is concerned about.

Quote:

"Well, lately I've noticed this patch on my face growing a bit and changing in colour. It's nothing painful at all, just a bit worrying."

Symptoms:

Site: Right cheek

Onset: Over the past 12 months

Character: Slowly growing lesion, non-painful

Associated Symptoms: None

Exacerbating and Relieving Factors: None

Severity: Non-painful, but concerning

History of Presenting Complaint:

Ms. Kaur has had the lesion for approximately 12 months, and she has noticed changes in its size and colour over this time. She has not sought any previous treatments for this lesion before, and she reports no significant impact on her daily life or activities.

Systemic Symptoms:

No systemic symptoms present; the examination reveals no signs of systemic involvement.

Past Medical History:

Negative for any previous skin conditions, autoimmune conditions, or other significant health events.

Drug History:

Negative for previous topical steroids or medications used for skin conditions.

Allergies:

Ms. Kaur has no known allergies to medications or substances.

Family History:

Negative family history of skin conditions, atopic disorders, or cancers.

Social History:

Non-smoker and non-drinker; no history of recreational drug use.

Quote:

"I don't really have much time for hobbies, apart from reading during the evenings. My lifestyle is quite sedentary due to my teaching job."

Ideas, Concerns, and Expectations:

Ideas: Ms. Kaur is concerned that the lesion on her face could be serious given the changes she has noted over the past year. She is open to exploring various options to address it, but she is also anxious about the diagnosis.

Concerns: Ms. Kaur is worried about the potential implications of the lesion and fears it could be something more serious. She is also concerned about potential scarring from any treatment.

Expectations: Ms. Kaur hopes to receive a clear explanation of her condition and any potential treatments available. She would like to feel reassured about the situation.

Physical Examination:

Skin Lesion Inspection:

- Location: Right cheek

- Distribution: Isolated

- Shape: Nodular

- Symmetry: Asymmetrical

- Borders: Irregular

- Colour: Mixed pink with darker pigmentation, and a pearly border

- Diameter: 1.5 cm

Special Tests:

Complete excisional biopsy sent to the pathology department. Results reveal nodular basal cell carcinoma.

Diagnostic Tests:

Basal cell carcinoma confirmed via histopathology following the excisional biopsy.

Patient Questions:

1. How serious is my condition?

- Answer: Basal cell carcinoma can have serious implications; however, it usually has a good prognosis when treated early.

2. Will I need further surgery?

- Answer: We can discuss further treatment options after the biopsy result is available.

3. Can basal cell carcinoma spread to other parts of the body?

- Answer: Basal cell carcinoma is usually slow-growing and tends not to spread, although it can grow larger and affect surrounding tissue if left untreated.

Examiner Questions:

1. What are the typical features of basal cell carcinoma?

- Answer: Typical features of basal cell carcinoma include a pearly border and mixed pigmentation on the skin lesion, as well as asymmetry and irregular borders.

2. What are the best options for treating basal cell carcinoma?

- Answer: Surgical excision is the preferred treatment for basal cell carcinoma. Other options include Mohs surgery, cryotherapy, curettage and electrodesiccation, and topical medications in some cases.

3. How common is recurrence following treatment for basal cell carcinoma?

- Answer: The recurrence of basal cell carcinoma following surgical excision is relatively uncommon, with a low risk if the lesion is removed entirely.

4. What are the major risk factors for basal cell carcinoma?

- Answer: Major risk factors include chronic sun exposure, indoor tanning, skin that burns easily, fair skin, a family history of skin cancer, and a past history of skin cancer.

5. Which subtypes of basal cell carcinoma have distinct dermoscopic features?

- Answer: Pigmented basal cell carcinoma and nodular basal cell carcinoma have distinct dermoscopic features, including absence of pigment, serpentine vessels, and focal ulceration in the case of nodular basal cell carcinoma.

Treatment:

1. Complete surgical excision of the basal cell carcinoma with a 4 mm margin.

2. Close monitoring and regular follow-up by a dermatologist to monitor for any signs of recurrence post-excision.

Monitoring:

Ms. Kaur will be monitored for recurrent basal cell carcinoma through regular follow-up appointments every 3-6 months for the first year post-treatment. Any new skin lesions or changes to the scar site should be reported for thorough examination.

Prognosis:

Early diagnosis and treatment of basal cell carcinoma usually result in an excellent prognosis, with a very low risk of recurrence in most cases. Regular monitoring is important for ensuring complete recovery and managing any signs of recurrence.

Differential diagnoses:

1. Squamous cell carcinoma - Less likely due to the smooth and pearly texture of the lesion and its slow growth.

2. Malignant melanoma - Less likely due to the absence of pigmented lesions and other typical signs associated with melanoma.

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Basal cell carcinoma

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_40\_Cellulitis

Homepage Vignette:

## "A 46-year-old woman called Jazmín presents with sore skin on the lower limbs."

Individual Page Vignette:

"You are a General Practitioner. Your patient is called Jazmín Lopez, a 46-year-old female office manager who lives in an urban area. She presents with red, swollen, and painful areas of skin."

Patient Name:

Jazmín Lopez; pronounced as "haz-meen"; she prefers to be called "Jazmín."

Age:

04/06/1978

Location:

General Practice

Personality:

Jazmín is friendly, polite, and cooperative with a positive attitude. She speaks confidently and is eager to find solutions. She presents as articulate, detail-oriented, and expresses determination to get better. Jazmín describes her symptoms in a clear, logical manner.

Presenting Complaint:

Jazmín states, "I've got this red, swollen skin on my legs that's painful and feels hot, which is weird I think. It's uncomfortable and affecting my life quite a lot."

Symptoms:

- Site: Skin on the legs and lower limbs

- Onset: 3 days ago

- Character: Redness, tenderness

- Radiation: None

- Associated Symptoms: Fever, warmth to the touch, pain

- Timing: Worsened progressively

- Exacerbating and Relieving Factors: Increased pain when walking or touching it, relieved by elevating the legs

- Severity: Moderate to severe

History of Presenting Complaint:

Jazmín has been experiencing the symptoms for three days, with progressive worsening. She has not tried any treatments and reports a significant impact on her mobility and the ability to carry out daily activities.

Systemic Symptoms:

- No systemic symptoms reported by Jazmín for this case.

Past Medical History:

- Negative for atopic disorders or previous skin conditions.

Drug History:

- Jazmín is not currently taking any medications.

Allergies:

- Jazmín has no known allergies to medications.

Family History:

- Negative for medical conditions related to skin disorders.

Social History:

- Jazmín is a non-smoker with a balanced diet and regular exercise. She rarely consumes alcohol and denies any recreational drug use. Jazmín's recent life events include a change in her exercise routine, and her occupation involves sitting for long periods due to her office job.

Ideas, Concerns, and Expectations:

- Ideas: Jazmín seeks to understand the cause of this skin condition and wishes to find effective treatment as soon as possible.

- Concerns: Jazmín is worried about the impact of her symptoms on her work and personal life, expressing concerns about the pain and discomfort she is experiencing.

- Expectations: She expects the consultation to provide a clear diagnosis and an effective treatment plan.

Physical Examination:

- General Inspection: Jazmín appears well; there are no signs of distress or other abnormalities. The body habitus is normal. Due to the fact that the symptoms are on her legs, she is comfortable wearing shorts to facilitate examination.

- Skin Lesion Inspection:

- Location: Bilateral lower limbs

- Distribution: Symmetric

- Shape: N/A

- Symmetry: Symmetric

- Borders: Very well demarcated

- Colour: Bright red

- Diameter: N/A

- Skin Lesion Palpation:

- Elevation: Skin is slightly raised

- Slightly warm to the touch

- Skin temperature over and around lesions increased

- Systemic Examination: Unremarkable

Diagnostic Tests:

- Blood Tests: N/A

- Imaging Tests: N/A

- Other Tests: N/A

Condition: Cellulitis

Patient Questions:

1. "Is there a specific cause for this condition?"

- "Cellulitis is usually caused by bacteria that penetrate the skin. It's important to assess the affected areas."

2. "What treatment options are available?"

- "Treatment usually involves antibiotics and supportive care. We will discuss the options in detail."

3. "How long will it take for me to recover?"

- "This will depend on your response to treatment and the severity of the infection. We will monitor your progress closely."

Examiner Questions:

1. "What are the common risk factors and predisposing conditions for Cellulitis?"

- "Common risk factors include skin injuries, diabetes, lymphoedema, and immunocompromised states."

2. "What are the most important aspects to consider when prescribing antibiotics for Cellulitis?"

- "When selecting an antibiotic, consideration should be given to the site of infection, severity of illness, and risk factors for resistant bacteria."

3. "How would you explain the prognosis to the patient in a clear and understandable manner?"

- "I would explain that the prognosis is generally good with prompt treatment. However, there is a risk of complications if not managed effectively."

4. "What are your referral considerations for this patient?"

- "Referral considerations may include cases of severe Cellulitis, facial Cellulitis, and persistent symptoms despite appropriate treatment."

5. "How would you counsel the patient on wound care and prevention of Cellulitis recurrence?"

- "I would provide guidance on wound care, including keeping the affected area clean and covered and seeking immediate care for any new skin injuries."

Treatment:

- Antibiotic therapy, such as flucloxacillin, 500 mg–1 g every 6 hours for 5-14 days. Consider clindamycin, cephalexin, or erythromycin if allergic to penicillin.

- Pain relief, with simple analgesics such as paracetamol or ibuprofen. Consider codeine or tramadol if pain is severe.

- Advise Jazmín to elevate affected legs and use warm compresses to alleviate discomfort.

- Educate on the importance of maintaining skin integrity and to seek medical attention if symptoms worsen.

Monitoring:

Advise Jazmín to monitor her symptoms daily, specifically watching for changes in redness, pain, and warmth. If her condition worsens, she should seek medical attention promptly. Follow-up is required within 48 hours to monitor the response to treatment.

Prognosis:

The prognosis is generally good with appropriate antibiotic treatment. Early intervention and fairly prompt response to treatment can prevent complications such as abscess formation or progression to necrotizing fasciitis.

Differential diagnoses:

1. Erysipelas: Cellulitis was favoured over erysipelas due to the diffuse nature affecting the lower limbs, whereas erysipelas typically has well-defined borders. The patient does not present with associated systemic symptoms.

2. Deep vein thrombosis: While cellulitis may present with warmth and erythema, other signs such as swelling and tenderness may be present. However, the lack of isolated swelling and absence of associated systemic symptoms make this less likely as the sole explanation for the symptoms.

3. Contact dermatitis: The absence of any clear, precipitating localized exposure and the rapid progression of symptoms without improvement following exposure make contact dermatitis a less likely cause.

4. Arterial insufficiency: The bilateral nature of symptoms and lack of a prior history of peripheral vascular disease or diabetes make this less likely.

Speciality Filter:

Dermatology; General Practice; Infectious Diseases; Vascular Surgery

Presenting Complaint Filter:

Acute rash; Skin lesion; Skin ulcers

Condition Filter:

Cellulitis

Location Filter:

General Practice; Clinic; Emergency Department

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_41\_Cellulitis

Homepage Vignette:

## “A 38-year-old woman called Nadége presents with red, warm, legs.”

Individual Page Vignette:

You are a GP. Nadége, a 38-year-old project manager from London, presents to your general practice with a painful patches on her leg.

Patient Name:

Nadége Piaf; pronounced "Na-dayj Pee-ahf". She would like to be called Nadége.

Age:

24/05/1986

Location:

General Practice

Personality:

Nadége is articulate and expressive. She is a natural leader, approachable and truthful. She is ambitious, determined, organized, and thorough in her approach to work and life. She is thoughtful, measured, and circumspect in decision-making. She speaks softly but firmly.

Presenting Complaint:

"The rash is so warm and painful. The skin feels tight and swollen. It is not feeling right."

Symptoms:

• Site: Lower leg

• Onset: Has been present for the past 2 days

• Character: Red, warm, painful, and swollen

• Radiation: No radiation

• Associated Symptoms: Feels general malaise

• Timing: Constant

• Exacerbating and Relieving Factors: No relief, warmth and fever make it worse

• Severity: Severe

History of Presenting Complaint:

Nadége reports that the rash has been present for the past 2 days having developed on her lower leg. She has not tried any treatments yet. Nadége reports that the symptoms have progressed and the skin feels tight, swollen, and painful. The skin problem is impacting her activities of daily living and causing general malaise.

Systemic Symptoms:

• No fever

• No weight loss

• No malaise

• No lymphadenopathy

• No arthritis

• No neurological deficits

• No other systemic symptoms present

Past Medical History:

• Negative for atopic disorders

• Negative for previous skin conditions and autoimmune conditions

Drug History:

• Negative for past use of topical steroids or medications used for skin conditions

Allergies:

• No known allergies

Family History:

• Negative for any skin conditions, atopic conditions, cancers, surgeries, or significant health events in the family

Social History:

• Lifestyle: Sedentary lifestyle

• Occupation: Project manager

• Activities of Daily Living & Hobbies: No regular exercise routine; Relaxing with music.

• Smoking: Never smoked

• Alcohol: 10 units/week

• Recreational Drug Use: No use

Ideas, Concerns, and Expectations:

• Ideas: Thinks it could be a simple rash

• Concerns: Worries the rash may be an infection setting in

• Expectations: Expects to be prescribed a strong antiseptic for the affected leg

Physical Examination:

• General Inspection: No signs of distress, good posture, no signs of systemic disease

• Skin Lesion Inspection: Red, warm, painful, swollen patch on the lower leg; non-migratory

• Skin Lesion Palpation: Elevated, warm, tender, indurated, firm

• Systemic Examination: No lymphadenopathy, no mucosal involvement, no abnormal findings

• Special Tests: No specific testing ordered at this stage

Diagnostic Tests:

• Blood Tests: Not indicated at this stage

• Imaging Tests: Not indicated at this stage

• Other Tests: No specific testing ordered at this stage

Condition:

Cellulitis

Patient Questions:

1. "What's causing this rash?"

- "It could be a skin infection called cellulitis."

2. "Is it contagious?"

- "No, cellulitis is not contagious. It's a bacterial infection of the skin."

3. "How long does cellulitis take to heal?"

- "With early treatment, cellulitis often heals within 7 to 10 days."

Examiner Questions:

1. What are the risk factors for developing cellulitis?

- Risk factors include injury, skin conditions such as eczema, weakened immune system, diabetes, and obesity.

2. How does cellulitis differ from a skin abscess?

- Cellulitis involves a spreading red, swollen, and painful area; a skin abscess is usually a collection of pus under the skin.

3. What are the common bacteria responsible for causing cellulitis?

- Staphylococcus and Streptococcus bacteria are the most common causes of cellulitis.

4. What would be your management plan for a patient with severe cellulitis?

- A good approach would include immediate antibiotics, pain relief, and instructions to elevate the affected leg.

5. What are the key differences in the presentation of cellulitis and a deep vein thrombosis?

- Cellulitis usually presents with warmth, swelling, redness, and tenderness in the affected area. Deep vein thrombosis presents with unilateral leg swelling and pain.

Treatment:

• Prescribe oral antibiotics: For example, co-amoxiclav 625 mg three times a day for 7-10 days.

• Advise elevation of the leg

• Ongoing monitoring

Monitoring:

Instruct Nadége to monitor for any worsening symptoms such as increased pain, redness, and fever as this may warrant early review. Recommend a follow-up appointment in 48 hours to assess treatment response.

Prognosis:

Cellulitis generally responds well to treatment. With early intervention, healing is expected within 7 to 10 days.

Differential Diagnoses:

1. Erysipelas - less likely due to the absence of a sharply demarcated raised edge

2. Venous insufficiency - less likely as the affected area is tender, warm, and erythematous, typical of cellulitis

3. Lymphangitis - less likely given the absence of streaks leading away from the red area, and no enlarged or tender regional lymph nodes

Keyword Filters:

Speciality Filter:

- General Practice

Presenting Complaint Filter:

- Acute rash

Condition Filter:

- Cellulitis

Location Filter:

- General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_42\_Cellulitis

Homepage Vignette:

## “A 45-year-old man called John presents with a red, tender area of skin on his leg, causing him to limp.”

Individual Page Vignette:

You are the dermatologist. You are currently based at a Dermatology Clinic in Cairo. John is a 45-year-old male construction worker who presents with a red, swollen area of skin on his lower leg. He presents with difficulty walking and appears to be in discomfort.

Patient Name:

The patient would like to be called Kian Hunter. Phonetic pronunciation: "Kee-an Hun-ter."

Age: 02/09/1979

Location: Dermatology Clinic

Personality:

Kian appears to be friendly and outspoken, with a strong sense of humour. He speaks with an informal tone and is verbally expressive.

Presenting Complaint:

Kian's main reason for seeking medical attention is the "large red patch on my leg that really hurts. I can barely walk because of it."

Symptoms:

Site: Lower leg;

Onset: Over a few days;

Character: Swollen, tender, red;

Associated Symptoms: "It feels warm and I've been having some feverish chills";

Timing: Gradually became more painful;

Exacerbating and Relieving Factors: "It really hurts when I touch it or try to put weight on it";

Severity: Making it hard to walk and affecting my job as a construction worker.

History of Presenting Complaint:

Kian has been experiencing the symptoms for "about a week," and the condition has gradually become more painful. He has not attempted any treatments. The symptoms are severely impacting his job as a construction worker and his mobility due to the pain.

Systemic Symptoms:

All systemic symptoms related to the case are normal.

Past Medical History:

Negative for any previous skin conditions or autoimmune conditions. Negative for any significant medical conditions, surgeries, or psychiatric history.

Drug History:

Negative for past use of medications for skin conditions or topical steroids. No history of non-compliance or missed medication doses. Taking no current medications.

Allergies:

Kian has an allergy to penicillin, causing a rash and itching.

Family History:

Negative for any significant skin conditions, atopic conditions, or cancers.

Social History:

Occupation: Construction worker;

Smoking: 15 pack years;

Alcohol: 14 units per week;

No recreational drug use;

Regular exercise;

No recent travel history;

No unusual exposure to hazards or new environments.

Ideas, Concerns, and Expectations:

Ideas: Kian is concerned about his leg pain and wants to know what could be causing it.

Concerns: He is worried that his condition may affect his ability to continue working.

Expectations: Kian expects to receive detailed information about the cause of his symptoms and effective treatment to alleviate the pain.

Physical Examination:

General Inspection: Alert and oriented, in discomfort, struggling to walk, no medical devices noted, red, swollen area of skin on his lower leg.

Skin lesion inspection:

Location: Lower leg;

Distribution: Localized;

Shape: Irregular;

Symmetry: Asymmetrical;

Borders: Indistinct;

Colour: Red, with areas of dark red and swelling;

Diameter: Approximately 10 cm;

Skin Lesion Palpation: Warm, tender, slightly fluctuant;

Systemic Examination: Normal findings for the systemic examination.

Condition:

Cellulitis would be the clinical diagnosis.

Patient Questions:

1. "Could this be related to an infection, and does it require antibiotics?"

Answer: "Yes, cellulitis is often caused by a bacterial infection, and antibiotics may be necessary."

2. "Will I need to take time off work?"

Answer: "If the cellulitis is extensive or you have difficulty walking, you may need time off work until the condition improves."

3. "Can I do anything to prevent future episodes?"

Answer: "Maintaining good skin hygiene and promptly treating any wounds or injuries can help reduce the risk of recurrence."

Examiner Questions:

1. "What are the common risk factors for developing cellulitis?"

The most common risk factors include a history of skin injuries, skin conditions like eczema, previous episodes of cellulitis, immunosuppression, and obesity.

2. "How would you differentiate cellulitis from erysipelas on examination?"

Cellulitis typically has a poorly defined margin, while erysipelas has well-defined margins. Additionally, erysipelas appears as a raised, well-demarcated, brightly erythematous rash.

3. "What is the typical causative agent for cellulitis and what antibiotics would you consider for initial treatment?"

Cellulitis is often caused by Streptococcus or Staphylococcus species. Initial antibiotics may include flucloxacillin or erythromycin.

4. "When do you consider hospital admission for a patient with cellulitis?"

Hospital admission is necessary for severe cellulitis, the presence of systemic symptoms, immunocompromised individuals, or when oral antibiotics may not be appropriate.

5. "What are the potential complications of untreated or severe cellulitis?"

Complications may include abscess formation, lymphangitis, sepsis, and, in severe cases, necrotizing fasciitis.

6. "How would you advise the patient on self-care measures while managing cellulitis at home?"

Encourage the patient to practice good skin hygiene, keep affected areas elevated, and apply warm compresses to reduce discomfort and inflammation.

Treatment:

The patient will be prescribed a 7-10 day course of oral flucloxacillin 500 mg four times daily. Provide advice on elevating the affected leg, applying warm compresses, and resting the affected limb. Advise on monitoring for symptoms of worsening infection and complications. Refer to the need for hospital admission if the infection worsens or if there is any deterioration in the patient's general condition.

Monitoring:

Advise the patient to monitor for fever, increasing redness, spreading of the area of cellulitis, and the development of systemic symptoms. Instruct to seek urgent medical attention if any significant deterioration is noted. Arrange a follow-up appointment in 48 hours to monitor progress and treatment response.

Prognosis:

The prognosis for cellulitis is generally good with appropriate antibiotic treatment. Improvement is expected within 2-3 days of starting antibiotics. Factors such as immunosuppression and the presence of comorbidities may influence the response to treatment.

Differential diagnoses:

1. Erysipelas: Less likely due to the poorly defined margins typically seen in cellulitis.

2. Stasis dermatitis: Less likely given the acute onset and significant pain associated with the lesion.

Speciality Filter:

Dermatology; Acute And Emergency

Presenting Complaint Filter:

Skin lesion; Acute rash; Pruritus

Condition Filter:

Cellulitis

Location Filter:

Clinic; Accident & Emergency

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_43\_Contact\_Dermatitis

Homepage Vignette:

## “A 34-year-old woman presents with a rash and itching.”

Individual Page Vignette:

You are a dermatologist. You are seeing Ms. Seona MacLeod, a 34-year-old artist from Glasgow, who presents with a rash and itching.

Patient Name:

Seona MacLeod (Shaw-na Mah-Cloud); She would like to be called Seona.

Age:

14/07/1990

Location:

Dermatology clinic

Personality:

Seona is softly spoken and appears anxious. She is polite and expresses a degree of shyness.

Presenting Complaint:

Seona complains of a rash that has spread on her skin, accompanied by severe itching.

Quote: "I have this rash that's itching so much. I'm really quite worried about it, to be honest."

Symptoms:

\* Site: Bilateral upper limbs, neck

\* Onset: Over the past 2 weeks

\* Character: Erythematous, blisters, severe itching

\* Radiation: None

\* Associated Symptoms: None

\* Timing: All day, worse in the evening

\* Exacerbating and Relieving Factors: Worsened by water and certain fabrics

\* Severity: Severe

History of Presenting Complaint:

Seona has been experiencing the symptoms for around 2 weeks. She has tried to soothe the rash by applying calamine lotion, but this has not helped. The rash and itching have progressively worsened over time, impacting her ability to paint, which has caused Seona significant distress.

Systemic Symptoms:

All normal

Past Medical History:

- Negative for atopic disorders

- Negative for previous skin conditions

- Negative for autoimmune conditions

Drug History:

Seona does not take any regular medications. She has no history of using topical steroids or medications used for skin conditions.

Allergies:

\* Penicillin - Causes a severe rash and shortness of breath

\* Latex - Causes severe dermatitis

Family History:

- Negative for skin conditions

- Negative for autoimmune conditions

Social History:

- Seona is a non-smoker

- She drinks 6 units of alcohol per week

- Seona has no history of recreational drug use

- She follows a mainly plant-based diet

- Regularly practices yoga

Ideas, Concerns, and Expectations:

\* Ideas: "I don't know what's causing this rash..."

\* Concerns: "I'm worried that I won't be able to paint if this keeps getting worse..."

\* Expectations: "I hope that we can find out what is wrong and treat it quickly."

Physical Examination:

- General Inspection: Anxious but no other significant findings

- Skin Lesion Inspection:

\* Location: Bilateral arms and neck;

\* Distribution: Symmetrical;

\* Shape: Round;

\* Symmetry: Symmetrical

\* Borders: Well-defined

\* Colour: Erythematous

\* Diameter: 2–4 cm

- Skin Lesion Palpatation:

\* Skin temperature: Normal

\* Texture: Rough

\* Tenderness: Tender

Diagnostic Tests:

- Blood Tests: Normal

- Imaging Tests: None

- Other Tests:

\* Patch testing: Results pending

Condition:

Contact Dermatitis

Patient Questions:

1. "What could have caused this rash?"

\* Answer: It's possible that you have come into contact with an irritant or allergen, such as soap, jewellery, or cleaning products, or the paint used recently.

2. "Will the itching and rash ever go away?"

\* Answer: With proper management and by avoiding the offending substance, the rash and itching should improve over time.

3. "Could the rash be due to an underlying skin condition?"

\* Answer: It's possible, and we will conduct tests to rule out other potential conditions.

Examiner Questions:

1. "What are the typical triggers for contact dermatitis?"

\* The most common triggers include soaps, detergents, cosmetics, metals, and certain fabrics.

2. "How do you differentiate between irritant contact dermatitis and allergic contact dermatitis?"

\* Irritant contact dermatitis is caused by direct damage to the skin, while allergic contact dermatitis occurs when there is a reaction to a substance.

3. "What treatment options are most effective for managing contact dermatitis?"

\* The mainstays of treatment include identifying and avoiding the cause, using emollients, and in some cases, corticosteroids.

4. "When should a patch test be considered for a patient presenting with contact dermatitis?"

\* A patch test is considered when an allergy to a specific substance is suspected and will help identify the potential allergen.

5. "Are there long-term complications associated with untreated contact dermatitis?"

\* Chronic untreated contact dermatitis can lead to skin thickening, pigmentation changes, and an increased likelihood of developing other skin conditions.

Treatment:

- Identify and avoid the causative agent

- Emollients: Apply liberally 4-6 times daily

- Topical corticosteroid: Hydrocortisone 1% cream, apply twice daily for up to 7 days to affected areas

- Oral antihistamines: Loratadine 10 mg daily

Monitoring:

- Monitor the improvement of the rash and itching once the causative agent is avoided and the treatment plan is followed

- Follow-up in 2 weeks to assess response to treatment

Prognosis:

- Prognosis is generally good with proper management and avoidance of the offending substance

- Symptoms are expected to improve and resolve with the current treatment plan

Differential diagnoses:

1. Atopic dermatitis and eczema - Less likely due to the acute onset and absence of personal or family history of atopic conditions.

2. Psoriasis - Less likely due to the presence of vesicles and the absence of silvery plaques

3. Scabies - Less likely due to the bilateral distribution and lack of typical burrow marks

4. Urticaria - Less likely due to the persistence of the lesions and lack of a hive-like appearance

Keyword Filters:

Speciality Filter: Dermatology

Presenting Complaint Filter: Chronic rash; Pruritus

Condition Filter: Contact dermatitis

Location Filter: Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_44\_Contact\_Dermatitis

Homepage Vignette:

## "A 34-year-old female presents with a red, itchy rash."

Individual Page Vignette:

You are a General Practitioner and the patient's primary healthcare provider. You are seeing Ms. Aziza Jara, a 34-year-old receptionist, who has presented with a red, itchy rash.

Patient Name:

Aziza Jara (A-zee-zah JAH-rah); she would like to be called Aziza.

Age:

Date of birth: 20/09/1989

Location:

General Practice

Personality:

Ms. Aziza Jara is a friendly and respectful individual. She has a calm demeanor and speaks with consideration for others.

Presenting Complaint:

"'I have this red, itchy rash. It's been bothering me for a few weeks now. It seems to get worse in the evenings after work.'"

Symptoms:

\* Itching (pruritus): Present; worse in the evenings

\* Rash: Present

\* Erythema (redness): Present

\* Dryness: Some dryness reported

Site:

"The rash is mainly on my forearms and lower legs."

Onset:

"The rash appeared a few weeks ago."

Character:

"It's very itchy. The red patches are dry and a bit scaly in some areas."

Timing:

"It seems to get worse in the evenings after work."

Exacerbating and Relieving Factors:

"Seems to get worse after work, but it's better on weekends."

Severity:

"The itching is quite intense sometimes."

History of Presenting Complaint:

Ms. Jara has been experiencing the symptoms for the past few weeks. She has tried using over-the-counter antihistamines, which have provided relief but not resolved the rash. She reports that the rash has progressively worsened over time, causing significant discomfort and impacting her after-work activities and sleep.

Systemic Symptoms:

\* No systemic symptoms reported.

Past Medical History:

\* Negative for atopic disorders or previous skin conditions or autoimmune conditions

\* No significant previous medical conditions or surgeries

Drug History:

\* Ms. Jara does not take any regular medications.

\* No history of topical steroids or contraceptive use

Allergies:

\* No known allergies or intolerances

Family History:

\* Negative for significant family history of skin conditions

Social History:

\* Lifestyle: Lives with partner and daughter; working as a receptionist

\* Occupation: Receptionist

\* Activities of Daily Living & Hobbies: Enjoys cooking and spending time with family. Has recently started doing at-home nail art for herself and daughter.

Ideas, Concerns, and Expectations:

\* Ideas: Ms. Jara believes the rash may be related to an allergy or sensitivity.

\* Concerns: She is concerned about the impact of the rash on her daily life and is worried about its persistent nature.

\* Expectations: Ms. Jara would like to find the cause of the rash and receive effective treatment as soon as possible.

Physical Examination:

General Inspection:

\* Ms. Jara appears comfortable with no obvious distress.

\* No signs of systemic disease observed.

\* Mild signs of scratching present.

Skin Lesion Inspection:

\* Location: Rash mainly on forearms and lower legs.

\* Shape: Discrete, red, scaly patches

\* Borders: Well-defined borders

\* Colour: Reddish erythema

\* Diameter: Variable sizes

Skin Lesion Palpation:

\* Some thickening and scaling observed.

\* Skin appears dry and rough in affected areas.

Special Tests:

\* Awaiting results of skin scrapings for fungal and parasitic infections.

\* No significant findings on initial visual examination.

Diagnostic Tests:

\* Pending skin scrapings for fungal and parasitic infections. Await results for further assessment and treatment planning.

Patient Questions:

1. "What could be causing this rash?"

- It could be a reaction to certain allergens or irritants.

2. "How long will it take to receive the test results and start treatment?"

- It might take a few days to receive the results, and once we have them, we can discuss the treatment plan.

3. "Could I have inadvertently exposed myself to something at work?"

- It's definitely a possibility. We can explore any potential workplace allergens or irritants.

4. "Is there a possibility that my family might be affected by this as well?"

- It's not common, but we can discuss ways to minimize the risk of potential exposure for your family.

Examiner Questions:

1. What is the distribution of the rash on Ms. Jara's body?

- The rash is mainly on her forearms and lower legs.

2. Can you describe the borders of the rash?

- The rash has well-defined borders.

3. Are there any other systemic symptoms Ms. Jara has reported?

- No, there are no other systemic symptoms reported.

4. Have you explored potential occupational exposures that may be causing the rash?

- Yes, we've discussed the possibility of workplace-related exposures for the rash.

5. What are Ms. Jara's expectations for the treatment plan?

- She is hoping to identify the cause of the rash and receive effective treatment as soon as possible.

Treatment:

1. Supportive care including application of frequent moisturizers to keep the affected areas hydrated.

2. Avoidance of suspected irritants or allergens.

3. Once results are available, discussion of potential treatment options such as topical corticosteroids or other anti-inflammatory agents.

Monitoring:

The patient should be advised to monitor the affected areas for changes in symptoms over time. Any worsening symptoms or signs of infection should prompt an urgent review. Follow-up in 7-10 days to review test results and discuss the treatment plan.

Prognosis:

The prognosis is good with appropriate identification of the causative factors and avoidance or treatment of irritants/allergens. Timely treatment can lead to significant improvement in the rash and relief from itching.

Differential diagnoses:

1. Allergic contact dermatitis - Likely, considering the distribution and symptoms. Occupational factors should also be considered.

2. Irritant contact dermatitis - Possible due to potential irritants encountered in Ms. Jara's work environment.

3. Fungal infection - Pending results of skin scrapings.

Keyword Filters:

Speciality Filter:

General Practice

Presenting Complaint Filter:

Chronic rash; Pruritus; Skin lesion

Condition Filter:

Contact dermatitis

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_45\_Contact\_Dermatitis

Homepage Vignette:

## "A 34-year-old man called Jared presents with a rash."

Individual Page Vignette:

You are a dermatologist and you have been called by Jared, a 34-year-old fencing instructor from a local village. He has a skin rash that he is concerned about and would like your expertise to address the issue.

Patient Name:

Jared Moritz (JAY-rid MOR-its); he would like to be called Jared.

Age:

17/09/1990

Location:

Hospital

Personality:

Jared is an outgoing and friendly young man. He speaks with enthusiasm, gestures animatedly, and maintains good eye contact. He is passionate about being a fencing instructor and is involved in the local community.

Presenting Complaint:

Jared complains “I've got this rash on my hands, and it just won’t go away. It’s getting really itchy and uncomfortable, and it’s making it hard to work with my equipment."

Symptoms:

Site: The rash is on the dorsal aspect of both hands

Onset: Jared noticed the rash about 3 weeks ago

Character: Dry, itchy rash

Radiation: No radiation to anywhere else

Associated Symptoms: Discomfort and difficulty working due to the itching rash

Timing: Symptoms appeared gradually over the course of a few days

Exacerbating Factors: Using fencing equipment, exposure to water

Severity: The itching is moderate, and the rash is causing a significant impact on his work

History of Presenting Complaint:

Jared has had the rash for about 3 weeks. He initially tried over-the-counter hydrocortisone cream, which provided some relief but did not fully resolve the rash. Over the past week, the rash has become increasingly itchy and uncomfortable, affecting his ability to work effectively and participate in other activities.

Systemic Symptoms:

“No, there's nothing else bothering me, just this rash really.”

Past Medical History:

Negative for previous skin conditions or auto-immune conditions.

Drug History:

He has not taken any medications recently.

Allergies:

No known allergies to medications, anaesthetics, foods, or other allergens.

Family History:

Negative for skin conditions and autoimmune conditions.

Social History:

Lifestyle: Jared is an enthusiastic fencing instructor and often participates in local competitions and events.

Occupation: Fencing instructor

Activities of Daily Living & Hobbies: Enjoys teaching fencing, participating in fencing competitions, and engaging in outdoor activities.

Ideas, Concerns, and Expectations:

Ideas: Jared mentions “This rash is driving me mad. I just want to get rid of it so I can get back to work.”

Concerns: He expresses concern that the rash will continue to interfere with his work and hobbies.

Expectations: Jared expects to have the rash fully resolved and is hoping for a quick solution.

Physical Examination:

General Inspection: Anxious facial expression; scratching his hands; unkempt fingernails; eager to show the rash and the discomfort it is causing him.

Skin Lesion Inspection:

- Location: Dorsal aspect of both hands

- Distribution: Bilateral hand rash

- Shape: Annular and nummular patches

- Symmetry: Symmetrical

- Borders: Ill-defined

- Colour: Red to pink

- Diameter: Various sizes from 5mm to 2cm

Skin Lesion Palpation:

- Elevation: Flat, slightly scaly

- Temperature: Warm

- Texture: Rough, slightly scaly

- Consistency: Firm

- Tenderness: Itchy, but not painful

- Regional lymph nodes: Not enlarged or tender

Systemic Examination:

Skin findings only.

Condition:

Contact Dermatitis

Patient Questions:

1. "Can I still participate in this weekend's fencing competition with this rash?"

- No, it would be best to avoid irritating the rash further by participating in the competition.

2. "Does this rash mean I have to stop teaching fencing?"

- Not necessarily, a management plan will be put in place to help clear the rash.

3. "What could have caused this rash to suddenly appear?"

- It may be due to exposure to potential irritants or allergens in your environment.

4. "Is there a permanent cure for this type of rash?"

- The aim is to avoid future exposures to irritants or allergens to prevent reoccurrence.

Examiner Questions:

1. What are the typical irritants or allergens causing contact dermatitis?

- Irritants include detergents, acids, and solvents, while allergens can be metals, fragrances, and some preservatives.

2. How would you advise Jared regarding hand hygiene with this rash?

- Jared should be advised to avoid excessive hand washing and use of hand sanitizer, as these can worsen the rash.

3. Can the presence of lichenification help narrow down the diagnosis?

- Yes, lichenification suggests the rash is chronic and that it may be either allergic or irritant in nature.

4. When is patch testing indicated in cases of suspected contact dermatitis?

- Patch testing is indicated when an allergic cause is suspected, particularly if the rash has been present for a while and does not improve with avoidance of potential irritants.

5. What are the treatment options for managing contact dermatitis?

- For acute cases like Jared’s, treatment options include emollients, topical corticosteroids, and avoidance of potential irritants.

6. What additional precautions may be needed for Jared as a fencing instructor?

- Jared should be educated about the potential irritants and allergens in the equipment he uses and be advised on preventive measures to avoid them.

Treatment:

- Advise on avoiding potential irritants or allergens

- Non-prescription emollients to relieve symptoms

- Potent topical corticosteroids, e.g. clobetasol propionate ointment 0.05% once a day for 2 weeks

- Oral antihistamines for itching

- Referral for patch testing if the rash persists

Monitoring:

Follow-up in 2 weeks to assess treatment response and potential need for patch testing.

Prognosis:

The rash is likely to improve with the avoidance of irritants or allergens. However, without identifying and avoiding the causative substances, recurrences are possible.

Differential diagnoses:

1. Atopic Dermatitis or Eczema: Less likely due to the abrupt onset following possible exposure to irritants or allergens

2. Irritant Contact Dermatitis: Possible, but less likely than Allergic Contact Dermatitis based on the appearance of the rash and lack of immediate association with an irritant

Keyword Filters:

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Chronic rash

Condition Filter:

Contact dermatitis

Location Filter:

Hospital

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_46\_Contact\_Dermatitis

Homepage Vignette:

## "A 35-year-old woman presents with a new itchy rash”

Individual Page Vignette:

You are a junior doctor working in a General Practice. A 35-year-old woman named Yumiko Takahashi presents with a new itchy rash that bothers her greatly.

Patient Name:

Yumiko Takahashi (YOO-mee-koh TAH-kah-HAH-shee)

Age:

03/08/1989

Location:

General Practice

Personality:

Yumiko is soft-spoken, polite, and appears quite anxious. She tends to fidget and stutters a little when speaking due to feeling flustered.

Presenting Complaint:

Yumiko mentions itchy skin which comes on suddenly and disrupts her life and is a distraction from work.

Symptoms:

- Itching (pruritus): Present; Yumiko says, "The itching is so intense and unbearable; I feel like there are bugs crawling under my skin."

- Rash: Present, appeared suddenly after contact with a specific substance. Yumiko says, "My skin gets red and bumpy almost right away."

- Erythema (redness): Present

- Texture changes: None mentioned

- Vesicles or bullae: Absent

- Blisters: Absent

- Dryness: Absent

- Scaling: Minimal scaling noticed by Yumiko

- Pustules: Absent

- Systemic symptoms: None mentioned

History of Presenting Complaint:

Yumiko states, "It's been happening for a few weeks now, and it's getting worse. I've been avoiding using the new detergent, but accidentally touched some, and the rash has remained for days." She also mentions avoiding similar symptoms in the past by stopping the use of a specific fabric softener.

Systemic Symptoms:

- No other systemic symptoms are reported.

Past Medical History:

- No previous skin conditions, autoimmune diseases, or atopic disorders mentioned

Drug History:

- No use of topical medications, particularly for skin conditions, reported

Allergies:

- Yumiko has a history of allergy and skin reactions to certain detergents and fabric softeners. She states, "Whenever I use them, my skin turns red and itchy."

Family History:

- No relevant family history mentioned

Social History:

- Yumiko is a stay-at-home mother, an animal lover, and enjoys painting and gardening in her free time.

- No significant smoking, alcohol, or recreational drug use

- Diet: Balanced and nutritious diet

- No relevant travel history, recent life events, or exposure to new environments mentioned

- No history of exposure to hazards

Ideas, Concerns, and Expectations:

- Ideas: Yumiko believes that certain substances, like detergents, are inducing these rashes. "Every time I touch that new laundry detergent, my skin feels itchy and gets red within minutes.”

- Concerns: Yumiko is worried about the potential continuous exposure to the irritants and its effects on her skin.

- Expectations: Yumiko hopes to identify the specific irritants and receive guidance on how to avoid them.

Physical Examination:

- General Inspection: Appears anxious and agitated, no specific signs of distress

- Skin Lesion Inspection: Localized to the hands, presenting with erythematous, edematous plaques with a few vesicles. Some excoriations are present.

- Skin Lesion Palpation: Lesions are tender and prominent. No induration or fluctuance present.

- Systemic Examination: Otherwise normal

Diagnostic Tests:

- No specific tests ordered at this point

Condition:

Contact Dermatitis

Patient Questions:

1. "Could this rash be something very serious and involve internal organs?"

- Answer: "It's unlikely, but it's essential to make an accurate diagnosis."

2. "Is there any way for me to avoid having an allergic reaction without giving up all my favourite detergents and soaps?"

- Answer: "There are potential methods, such as changing the brand or selecting specific hypoallergenic products."

3. "What type of treatment are you considering for this allergic reaction?"

- Answer: "Most likely, a combination of topical medications."

Examiner Questions:

1. "What are the potential irritants that should be initially discussed with Yumiko?"

- Answer: Initial irritants to consider discussing are detergents, soaps, and any recent changes to household products.

2. "What are the principles of management for contact dermatitis?"

- Answer: Principles include identifying and avoiding the irritant, using emollients, applying topical corticosteroids, and sometimes oral antihistamines.

3. "How important is it to involve the patient in the management plan for contact dermatitis?"

- Answer: It’s crucial for the patient to be involved, as they can help identify triggers and modify their household and personal product usage.

4. "What are the differences between irritant and allergic contact dermatitis, and how may this information impact management?"

- Answer: Irritant contact dermatitis results from exposure to substances that are in most cases harmful to the skin, while allergic contact dermatitis results from a delayed type IV hypersensitivity reaction to allergens. This information may impact management by guiding the identification and avoidance of specific triggers in the patient's home and environment.

5. "What considerations are required in the management of contact dermatitis in a patient who has allergies to certain topical medications?"

- Answer: In such patients, it would be necessary to avoid the allergenic topical medications and opt for suitable alternatives, such as medications belonging to other drug classes.

Treatment:

- Advise Yumiko to avoid irritants that induce the rash.

- Recommend emollients, such as white soft paraffin, to reduce dryness and maintain skin hydration.

- Prescribe a potent or super-potent corticosteroid cream for application to the hand lesions twice a day for up to two weeks. A milder corticosteroid cream could be used for ongoing management.

- Instruct Yumiko on the proper application and adverse effects of corticosteroid creams, highlighting the risks of long-term use.

- Advise Yumiko to consider alternatives to the products which trigger her symptoms.

Monitoring:

- Advise Yumiko to monitor for a decrease in the frequency and severity of itching and redness.

- Instruct Yumiko to seek further medical attention if there is no improvement or if the condition worsens.

Prognosis:

- With identified triggers and avoidance, the prognosis is anticipated to be excellent. Adherence to recommended alterations in household and personal products is essential for ongoing avoidance of outbreaks.

Differential diagnoses:

1. Atopic dermatitis and eczema - Less likely due to localized rash upon exposure to specific substances and recurrence upon re-exposure.

2. Arterial ulcers - Unlikely due to the acute nature of the rash and lack of symptoms of chronic arterial insufficiency. Furthermore, the clinical appearance is inconsistent.

3. Cutaneous fungal infection - Less likely as fungal infections usually present differently with symptoms such as scaling and confetti-like hyperpigmentation.

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Acute rash; Pruritus

Condition Filter:

Contact Dermatitis

Location Filter:

General Practice; Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_47\_Folliculitis

Homepage Vignette:

## "A 35-year-old woman called Rachel presents with red bumps and tiny abscesses on the skin”

Individual Page Vignette:

As a medical student, you are asked to see Rachel for her presenting complaint of red bumps on the skin. She is currently at the local walk-in clinic."

Patient Name:

Rachel Afolayan (Surname: A-foll-ay-an). She prefers to be called Rachel.

Age:

17/05/1989

Location:

Clinic

Personality:

Rachel is friendly and speaks politely. She often uses formal language and is keen on providing detailed information about her symptoms and experiences. She speaks slowly, giving clear information about her situation.

Presenting Complaint:

Rachel presents with a rash which is painful as well as itchy.

Symptoms:

Site: On her legs and buttocks

Onset: Gradual over the past month

Character: Painful, itchy red bumps, and small abscesses around hair follicles

Associated Symptoms: "They are tender, and I've noticed some itching and occasionally a bit of pus coming out"

Timing: The rash has been present for the past month

Exacerbating and Relieving Factors: Exacerbated by heat and sweat; no specific relief measures

Severity: The itching is mild, and the pain is moderate when touched

History of Presenting Complaint:

The rash has been present for the past month. She has tried an over-the-counter antiseptic wash and corticosteroid cream, which provided some relief but did not resolve the rash. The rash is impacting her daily life and causing her discomfort, especially when exercising due to sweating and friction of clothing on the affected areas.

Systemic Symptoms:

All systemic symptoms are normal in this case.

Past Medical History:

Negative for previous skin conditions, autoimmume or atopic disorders, psychiatric or psychological history, and significant health events.

Drug History:

She does not take any regular medications or contraceptives but has occasionally used over-the-counter steroid creams for her previous encounter with a rash.

Allergies:

Rachel has a documented allergy to amoxicillin, which causes her to develop a rash.

Family History:

Negative for skin conditions or significant health events.

Social History:

Smoking: Never smoked

Alcohol: Occasional drinker, with 1-2 units per week

Recreational Drug Use: No use

Diet: Balanced and varied diet

Exercise: Regular exercise; Rachel enjoys yoga and jogging

Ideas, Concerns, and Expectations:

Ideas: "I am concerned this rash will continue spreading and would like to find out the cause."

Concerns: "I'm worried this could be something really serious, especially given it's not clearing up with anything I've tried."

Expectations: "I hope you find out what's causing my rash and provide a treatment that will clear it up completely."

Physical Examination:

General Inspection: Unremarkable

Skin Lesion Inspection: Red, inflamed and painful papules and pustules mainly located on her legs and buttocks. Some lesions show pustule formation.

Skin Lesion Palpatation: Lesions are painful, and some exhibit fluctuance indicating pustule formation.

Systemic Examination: Normal examination of the systemic exam elements

Diagnostic Tests:

Physical examination findings indicative of folliculitis.

No specific diagnostic tests necessary based on the clinical picture.

Patient Questions:

1. "What do you think might have caused this rash?"

Answer: "It's possible that folliculitis is responsible for your symptoms."

2. "How long will it take for the rash to clear up with treatment?"

Answer: "The treatment generally provides relief within a few days to a few weeks."

3. "Can I continue my exercise routine while undergoing treatment?"

Answer: "It's best to avoid excessive sweating or friction in the affected area while undergoing treatment."

Examiner Questions:

1. What is the differential diagnosis for Rachel's presentation?

Answer: "The differential diagnosis includes bacterial folliculitis, fungal folliculitis, eczematous folliculitis, and pseudofolliculitis barbae."

2. How would you effectively communicate the diagnosis and treatment plan to Rachel given her concerns?

Answer: "I would inform Rachel about the diagnosis of folliculitis and explain the treatment options, discussing potential outcomes and timelines."

3. What are the complications of folliculitis, and how would you counsel Rachel about these implications?

Answer: "Complications may include chronic folliculitis or the development of furuncles or carbuncles. I would counsel Rachel about the importance of seeking care to prevent these complications."

4. What measures can Rachel take to reduce the risk of reoccurrence of folliculitis?

Answer: "I would advise her to avoid excessive heat and sweating, wear loose-fitting clothing, and practice good skin hygiene to reduce the risk of reoccurrence."

5."When is a referral to a dermatologist necessary for a case of folliculitis?

Answer: "A referral may be necessary in cases where folliculitis is recurrent, severe, or does not respond to initial treatments."

Treatment:

First-line treatment:

- Topical antibacterial wash, twice daily

- Avoid tight clothing and maintain good skin hygiene

- If severe, a short course of oral antibiotics may be necessary. Refer to a dermatologist if there is no improvement with initial treatments.

Monitoring:

Monitor the rash for improvement after initiating treatment. Instruct the patient to follow up if there is no improvement after a week or if new lesions develop. If severe or recurrent, consider referral to a dermatologist for further management.

Prognosis:

The prognosis for folliculitis is generally good, with appropriate treatment leading to resolution of symptoms. Reoccurrence can be minimized through adherence to good skin hygiene practices and avoiding risk factors.

Differential diagnoses:

1. Bacterial folliculitis: less likely given the lack of response to over-the-counter antibacterial wash

2. Fungal folliculitis: less likely due to the lack of association with prior fungal infections

3. Eczematous folliculitis: less likely due to the discomfort and pustule formation in lesions typical of eczema

4. Pseudofolliculitis barbae: less likely due to the distribution of the lesions

Keyword Filters:

Speciality Filter:

Dermatology; General Practice;

Presenting Complaint Filter:

Acute rash; Skin lesion; Skin ulcers

Condition Filter:

Folliculitis

Location Filter:

Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_48\_Folliculitis

Homepage Vignette:

## "A 37-year-old woman presents with painful, itchy red bumps on her skin."

Individual Page Vignette:

"As a medical student, you are required to take a history from Asuka Chinda, a 37-year-old office secretary, who is presenting with painful, itchy red bumps on her skin."

Patient Name:

Asuka Chinda (Ah-soo-kah Chin-dah), would like to be called "Asuka"

Age:

09/11/1986

Location:

Dermatology Clinic

Personality:

Asuka Chinda is a confident and friendly individual who speaks calmly and thoughtfully. She is highly articulate and provides detailed descriptions of her symptoms, displaying a proactive and informed approach to her health.

Presenting Complaint:

Asuka reports, "I've been having trouble with these painful bumps on my skin that just won't go away. The itching is driving me mad, and it's really affecting my day-to-day life."

Symptoms:

Site: Sporadic on the skin, mainly on the chest, back, and lower limbs

Onset: Symptoms have been gradually appearing over the past 3-4 weeks

Character: Itchy, painful red bumps

Associated Symptoms: Mild fever and discomfort

Timing: Symptoms appeared gradually over the past month

Exacerbating and Relieving Factors: Itching worsens when in warm conditions; cooling the skin temporarily eases symptoms

Severity: Moderate to severe itching and pain

History of Presenting Complaint:

Asuka reports experiencing the symptoms for the past month. She has tried over-the-counter creams and cold compresses, with minimal relief. The symptoms have gradually worsened and are interfering with her daily activities.

Systemic Symptoms:

No systemic symptoms reported. All are normal.

Past Medical History:

Negative for previous history of skin conditions, atopic disorders, or autoimmune conditions.

Drug History:

No current medications, past use of steroid cream without relief.

Allergies:

Asuka is allergic to penicillin, causing a severe rash and swelling on exposure.

Family History:

Negative for significant skin conditions or relevant health events.

Social History:

Smoking: Non-smoker

Alcohol: Light drinker, consuming 3 units per week

Recreational Drug Use: None

Diet: Balanced diet, regular hydration

Exercise: Engages in regular walking and yoga for exercise and relaxation

Other: No relevant travel history, no significant recent life events, hobbies include gardening and reading

Ideas, Concerns, and Expectations:

Ideas: Asuka understands her condition as a skin problem but wants to know more about its cause and potential treatment options.

Concerns: Worries about the impact of the symptoms on her work and daily life.

Expectations: Expects to receive a clear explanation of the condition, along with effective treatment to relieve her symptoms.

Physical Examination:

General Inspection: Asuka appears generally well, no signs of distress noted.

Skin Lesion Inspection:

- Location: Chest, back, lower limbs

- Shape: Papular and sporadic

- Colour: Red

Skin Lesion Palpation:

- Elevation: Some raised lesions noted

- Tenderness: Lesions appear tender to palpation

Systemic Examination: No abnormalities noted in the systemic examination

Special Tests:

No special tests ordered at this stage.

Diagnostic Tests:

No diagnostic tests ordered at this stage.

Condition:

Folliculitis

Patient Questions:

1. "What could be causing these symptoms?"

- "The symptoms you're experiencing could be due to a skin condition called folliculitis, which is an inflammation of the hair follicles caused by bacterial or fungal infections."

2. "How long will it take for the bumps to go away?"

- "The duration of healing can vary, but with appropriate treatment, we aim to relieve your symptoms as soon as possible."

3. "Are there any complications associated with this condition?"

- "Folliculitis can cause recurrent infections and scarring, but with appropriate management, these complications can be minimized."

Examiner Questions:

1. What are the common causes of folliculitis?

- Common causes include bacterial (Staphylococcus aureus) or fungal (Malassezia) infections of the hair follicles, and irritants such as oils or friction.

2. How do you plan to manage Asuka's symptoms?

- We plan to start with topical or oral antibiotics, and we may consider other treatments if the initial approach is not effective.

3. What lifestyle modifications would you recommend to prevent a recurrence of folliculitis?

- I would recommend good personal hygiene practices, such as regular bathing, and avoiding oil-based or greasy cosmetic products.

4. Discuss the potential for complications in a case of folliculitis.

- Complications can include chronic folliculitis, deep-seated skin infections, and scarring, particularly in cases of recurrent or severe folliculitis.

5. What differential diagnoses would you consider for Asuka's symptoms?

- Differential diagnoses include acne, miliaria (prickly heat), and carbuncles, which should be ruled out based on the presentation and examination findings.

Treatment:

1. Advise Asuka to take warm baths and gently clean the affected areas twice daily with a mild soap. Pat the skin dry and avoid rubbing the affected areas.

2. Prescribe a 5-day course of oral antibiotics, such as flucloxacillin 500 mg four times a day, to address the suspected bacterial infection.

3. Prescribe a topical antiseptic or antibiotic cream, such as mupirocin 2% for application to the affected areas three times a day, as an addition to oral antibiotics.

4. Advise Asuka to avoid tight clothing or any activity that may cause friction to the affected areas.

5. Ensure a routine follow-up appointment after completion of the antibiotic course or sooner if symptoms persist or worsen.

Monitoring:

Advise Asuka to monitor the affected areas for any changes in the appearance or severity of symptoms. If the condition worsens or if new symptoms arise, she should seek medical attention promptly. Schedule a follow-up appointment in 5-7 days to assess the response to treatment.

Prognosis:

The prognosis for Asuka's condition is generally good with appropriate treatment. With the prescribed course of antibiotics and regular monitoring, her symptoms are likely to improve within a week. However, if the condition worsens or recurs, long-term treatment plans may be required.

Differential diagnoses:

1. Acne Vulgaris: Less likely as the presentation and distribution of lesions are not consistent with acne.

2. Miliaria (Prickly Heat): Less likely due to the presence of tenderness and pain, which is not typical of miliaria.

3. Carbuncles: Less likely given the sporadic nature of the lesions, which does not align with typical carbuncle presentation.

Keyword Filters:

Speciality Filter:

- Dermatology; General Practice

Presenting Complaint Filter:

- Pruritus; Skin lesion; Acute rash

Condition Filter:

- Folliculitis

Location Filter:

- Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_49\_Malignant\_Melanoma

Homepage Vignette:

"A 50-year-old male named Raphael presents with a suspicious mole on his back and concerns about skin changes."

Individual Page Vignette:

You are a GP named Dr. Smith. You encounter Raphael, a 50-year-old male, who is concerned about a suspicious mole on his back.

Patient Name:

Raphael Calixte (Ray-feel Cah-leegs-tay) would like to be called Raphael.

Age:

25/09/1974

Location:

General Practice

Personality:

Raphael is a soft-spoken and calm individual. He is attentive and thoughtful, often pausing to consider his words. Despite his reserved nature, he is friendly and appreciates a thoughtful approach to his concerns.

Presenting Complaint:

Raphael states, "I've noticed a changing mole on my back. It's become larger and started to itch. I'm quite worried about it and would like some reassurance."

Symptoms:

- Site: Mole on the back

- Onset: Gradual, over a few months

- Character: Changes in size and itching

- Radiation: None

- Associated Symptoms: None

- Timing: Progressed over a few months

- Exacerbating and Relieving Factors: Itching causes discomfort

- Severity: Moderate, causing concern

History of Presenting Complaint:

Raphael reports that over several months, the mole on his back has increased in size and started to itch. He has not tried any treatments and mentions that it has become bothersome, causing him distress and worry.

Systemic Symptoms:

There are no other significant systemic symptoms to report.

Past Medical History:

Negative for previous skin conditions or significant health events.

Drug History:

Raphael states, "I don't take any medications regularly. Occasionally, I take over-the-counter pain relief for headaches."

Allergies:

Raphael has a known allergy to penicillin, which causes a skin rash and itching upon exposure.

Family History:

Negative for skin conditions and other significant health events.

Social History:

- Lifestyle: Lives a moderate-paced lifestyle, enjoys outdoor activities.

- Occupation: Office-based work

- Activities of Daily Living & Hobbies: Regular exercise, spends free time in the garden and enjoys walking in nature.

Ideas, Concerns, and Expectations:

Ideas: "I believe this mole is changing, and I'm worried it could be something serious."

Concerns: "I'm concerned about the potential implications of these changes and what it could mean for my health."

Expectations: "I hope for a thorough assessment and guidance on the next steps. Reassurance and clarity about the situation would be much appreciated."

Physical Examination:

The mole on Raphael's back is visibly irregular in shape and has increased in size. Upon palpation, it is slightly raised, with irregular borders. No other concerning skin lesions are noted on examination. General inspection reveals an otherwise well-appearing patient.

Diagnostic Tests:

- Dermoscopy: Features irregular pigmentation and asymmetric structures.

- Skin Biopsy: Confirmed diagnosis of malignant melanoma.

Condition:

Malignant Melanoma

Patient Questions:

1. "What are the potential treatment options for melanoma?"

- "Treatment options usually include surgery, immunotherapy, targeted therapy, and sometimes chemotherapy, depending on the stage and type of melanoma."

2. "Is my family at higher risk for melanoma due to my diagnosis?"

- "There may be a slightly increased risk for close family members, so sun protection and regular skin checks are recommended for your family members."

3. "How will melanoma impact my daily life?"

- "Treatment for melanoma may have implications on your daily life, and we will work together to support you through the process."

Examiner Questions:

1. What are the key features of malignant melanoma on dermatoscopy?

- Irregular pigmentation, asymmetric structures, and an irregular vascular pattern are often observed in malignant melanoma.

2. How would you approach offering support to a patient who has received a diagnosis of malignant melanoma?

- Compassionate communication, education about the condition, and providing psychological support are essential. We must ensure the patient feels supported throughout their care.

3. What are the potential risk factors for the development of malignant melanoma?

- Risk factors include sun exposure, family history of melanoma, having many moles, fair skin, and a history of severe sunburns.

4. What are the different treatment modalities for malignant melanoma at various stages?

- Treatment options include surgery, immunotherapy, targeted therapy, and chemotherapy, administered based on the specific characteristics and stage of the melanoma.

5. What are the key differences between benign and malignant skin lesions, and how are these differences clinically significant?

- Malignant skin lesions often have irregular borders, an irregular shape, color variation, and asymmetry. Recognizing these features is crucial for the early detection and management of malignant lesions.

Treatment:

Initial Treatment:

- Surgical excision of the melanoma lesion with wide margins

- Consideration for sentinel lymph node biopsy

- Referral to a specialist multidisciplinary team for further management

Monitoring:

Regular follow-up appointments, including skin checks, imaging studies, and blood tests to monitor for disease progression. Referrals for psychological support if necessary.

Prognosis:

Early-stage melanoma is often curable with appropriate treatment. The 5-year survival rate for early-stage melanoma is high. Regular monitoring and adherence to treatment recommendations are crucial for the best outcome.

Differential Diagnoses:

1. Benign melanocytic nevus (moles): Less likely due to the changes in size and symptoms such as itching, indicating a potential malignant process.

2. Seborrheic keratosis: Unlikely due to the atypical features of the lesion and changes over time.

Keyword Filters:

Speciality Filter:

General Practice; Dermatology; Cancer

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Malignant Melanoma

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# 

# ALYC\_50\_Non-Malignant\_Melanoma

Homepage Vignette:

## "A 55-year-old woman presents with a new mole on her leg."

Individual Page Vignette:

You are a GP and are seeing Ms. Xena Waters, a 55-year-old office manager, who presents with a new mole on her leg.

Patient Name:

Xena Waters (pronounced ZEE-nuh)

She would like to be called "Xena."

Age: 55

DOB: 04/07/1969

Location:

General Practice

Personality:

Xena is a confident, articulate, and assertive individual. She speaks clearly and confidently, asking many questions with assurance in her voice. She is knowledgeable about her health and is eager to engage in a detailed discussion about her symptoms and possible diagnoses.

Presenting Complaint:

"I've noticed a new mole on my leg, and I'm concerned about it. I keep reading about skin cancer, and I want to make sure I get it checked out."

Symptoms:

- Site: Single mole on the right leg

- Onset: Gradual

- Character: Raised and dark mole

- Associated Symptoms: No associated symptoms

- Timing: Noticed a few weeks ago

- Severity: N/A

History of Presenting Complaint:

Xena noticed the new mole on her leg a few weeks ago. She did not have any previous treatments for this mole. The mole has progressed over time, and the concern has impacted her overall worry about her health.

Systemic Symptoms:

All systemic symptoms are within normal limits for this case.

Past Medical History:

- Negative history of skin conditions

- Negative autoimmune conditions

- Negative history of atopic disorders

- Negative psychiatric or psychological history

- No previous significant surgeries or hospitalizations

Drug History:

- Xena is not currently taking any medications.

- She has no history of medication non-compliance or missed doses.

- Denies the use of herbal supplements or alternative therapies.

- No history of contraception or HRT.

Allergies:

- No known allergies to medications, foods, or environmental factors.

Family History:

- No significant family history of skin conditions, atopic conditions, or cancers.

Social History:

- Non-smoker

- Drinks alcohol occasionally (3 units per week)

- No recreational drug use

- Vegetarian diet

- Regular exercise (jogging and swimming)

- Office-based job with regular exercise

Ideas, Concerns, and Expectations:

- Ideas: Xena hopes to understand the cause of the mole and explore potential diagnoses.

- Concerns: She is worried that the mole may indicate skin cancer.

- Expectations: She expects a thorough evaluation and consideration of all potential diagnoses. She is looking for reassurance and peace of mind.

Physical Examination:

- General Inspection: No significant signs of distress or abnormalities.

- Skin Lesion Inspection: The mole is located on the distal aspect of the right leg, raised, symmetrical, with regular borders, and approximately 6mm in diameter. It is uniformly pigmented.

- Skin Lesion Palpation: The lesion is soft, non-tender, and has a slightly higher temperature compared to surrounding skin. Lymph nodes are not palpable.

- Systemic Examination: Normal findings on systemic examination.

- Special Tests: Referral for dermatoscopy and a skin biopsy.

Diagnostic Tests:

- Dermatoscopy: Exhibits asymmetric globules, pigment network, and vascular patterns consistent with melanocytic nevus.

- Skin Biopsy: The histopathology report shows benign features consistent with a common melanocytic nevus.

Condition:

Non-malignant Melanoma

Patient Questions:

1. "Could this mole be skin cancer?"

- A: The mole appears benign at this stage.

2. "Should I be worried about other moles on my body?"

- A: Regular self-examination and monitoring are important, but there is no cause for immediate concern.

3. "What can I do to prevent skin cancer?"

- A: Protecting your skin from UV radiation, conducting regular self-examinations, and seeing your doctor for annual skin checks are important.

4. "What are the future risks if I develop skin cancer?"

- A: Early detection and treatment offer an excellent prognosis.

Examiner Questions:

1. What are the common risk factors for malignant melanoma?

- Risk factors include UV exposure, history of severe sunburns, fair skin, and a family history of melanoma.

2. How is malignant melanoma typically diagnosed?

- Diagnosis is confirmed through skin examination, dermatoscopy, and biopsy.

3. What is the treatment plan for this patient?

- Treatment typically involves surgical excision for confirmed malignant melanoma. Excisional biopsy can be curative for most early-stage melanomas.

4. What is the prognosis for early-stage malignant melanoma?

- Prognosis is generally good for early-stage melanomas, with a high likelihood of cure.

5. Are there any alternative non-invasive diagnostic tools that could be considered?

- Dermatoscopy and reflectance confocal microscopy are often used for non-invasive evaluation of suspicious skin lesions.

6. What are the potential complications if this lesion were to progress to an invasive melanoma?

- Advanced melanoma can metastasize to other organs and result in life-threatening illness. Regular monitoring and early intervention are essential.

Treatment:

1. Surgical excision including 0.5 cm margins around the lesion. The excised mole will be sent for histological assessment.

2. Referral to a dermatologist for further assessment and follow-up.

3. Advise regular self-examination and sun protection measures.

4. Educate about the ABCDEs of melanoma for monitoring suspicious skin lesions.

5. Additional treatment may be indicated based on the histological findings from the excised mole.

Monitoring:

- Regular self-examination and monitoring of any new or changing moles or skin lesions.

- Annual skin checks with the GP and dermatologist.

- Immediate follow-up if new or changing moles are identified.

- Immediate follow-up for any suspicious skin lesions developing in the future.

Prognosis:

The prognosis for early-stage malignant melanoma is generally excellent, with a high likelihood of cure following surgical excision. Regular monitoring and self-examination are crucial. The patient has an excellent prognosis given the benign nature of the lesion with a lack of concerning histopathological features.

Differential Diagnoses:

1. Dysplastic nevus: Less likely given the benign features of the mole and lack of atypical characteristics.

2. Seborrheic keratosis: Less likely due to the asymmetry and pigmented nature of the lesion.

3. Basal cell carcinoma: Less likely as the lesion exhibits features consistent with a benign melanocytic nevus.

4. Blue nevus: Less likely due to the concern for developing melanoma and the history of changing lesion characteristics.

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Malignant melanoma

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_51\_Squamous\_Cell\_Carcinoma

Homepage Vignette:

## “A 54-year-old man called Winston presents with a persistent growing lump on his forehead.”

Individual Page Vignette:

You are the physician for Mr. Winston Jacobs, a 54-year-old electrician, who is presenting with a persistent growing lump on his forehead.

Patient Name:

Winston Jacobs (WIN-stuhn Jacobz); he would like to be called Winston.

Age:

02/04/1970

Location:

General Practice

Personality:

Winston is an outgoing and diligent man who is passionate about his work as an electrician. He uses informal language and often starts conversations with light-hearted jokes and anecdotes.

Presenting Complaint:

Winston has noticed a persistent lump on his forehead that has been slowly growing over the past few months. He finds it concerning and wants to get it checked.

Quote: "I've had this growth on my forehead for a while now, doc. It's been getting bigger, and I'm quite worried about it. I'd appreciate it if you could have a look."

Symptoms:

The following symptoms are reported by the patient:

• Site: Forehead; "Yeah, it's right in the middle of my forehead, just above my eyebrows."

• Onset: Gradual; "It started off really small, like a pimple, and then just kept getting bigger."

• Character: Firm lump; "It feels like a smooth, firm bump under my skin."

• Associated Symptoms: None; "I haven't had any other symptoms with it, just the lump."

• Timing: Progressive over the past few months; "It's been growing for a while now, slowly but consistently."

• Severity: Concerning, given the size; "The size and the fact that it just doesn't seem to go away really concerns me."

History of Presenting Complaint:

The lump has been progressively growing over the past few months. Winston hasn't tried any treatments for it before, and it is impacting his confidence and desire to seek medical care.

Systemic Symptoms:

• Generalized malaise: Negative

• Weight loss: Negative

• Fever: Negative

• Night sweats: Negative

• Lymphadenopathy: Negative

Past Medical History:

• No significant past medical conditions or surgeries.

• No previous injuries or traumas.

• No history of psychiatric or psychological conditions.

• No history of substance abuse or addiction.

Drug History:

• No current medications.

• No known drug allergies.

Family History:

• Acute and Emergency

• Dermatology

• Cancer

• Surgery

Social History:

• Winston is a non-smoker.

• He consumes alcohol occasionally, with a few units per week.

• He has a balanced diet and engages in regular exercise.

• No history of significant travel, recent life events, or hazardous exposure.

Ideas, Concerns, and Expectations:

- Ideas: Winston has minimal knowledge about lump conditions, and he is unsure about what the growth on his forehead could be.

- Concerns: He is worried about the increasing size of the lump and is concerned about its implications on his health.

- Expectations: Winston is seeking a clear understanding of the cause of the lump and potential treatment options. He also hopes to alleviate his concerns about it.

Physical Examination:

During the physical examination:

• General Inspection: Winston appears comfortable and in good overall health. No signs of systemic disease.

• Skin Lesion Inspection:

- Location: Forehead

- Distribution: Solitary

- Shape: Oval

- Borders: Well-defined

- Colour: Flesh-coloured

- Diameter: Approximately 2 cm

• Skin Lesion Palpation: The lesion is firm and non-tender with no associated skin temperature changes. No regional lymphadenopathy is noted.

• Systemic Examination: No other significant findings on systemic examination.

Diagnostic Tests:

• Biopsy: Results confirm well-differentiated squamous cell carcinoma.

• MRI Scan of the head and neck: No evidence of metastasis.

Condition:

Squamous Cell Carcinoma

Patient Questions:

1. "What are the potential treatments for squamous cell carcinoma, doc? Is surgery the best option?"

- "We will discuss the treatment options together, including surgery or other alternatives, based on your specific diagnosis."

2. "How likely is it that the cancer has spread to other areas of my body?"

- "It's important to discuss this in detail and conduct the necessary tests to determine the stage of your cancer and potential spread."

3. "Will the tumor need to be removed? What are the possibilities for scarring after treatment?"

- "Removal of the tumor and potential for scarring are important aspects to discuss, and we will explore options to minimize scarring during treatment."

Examiner Questions:

1. Could you describe the typical progression of squamous cell carcinoma and potential treatment outcomes?

- The typical progression involves local invasion and potential spread to regional lymph nodes. Treatment options may include surgery, radiotherapy, or chemotherapy based on the stage and presence of metastasis.

2. What are some factors that may contribute to the development of squamous cell carcinoma in an individual?

- Factors such as chronic sun exposure, immunosuppression, ultraviolet radiation exposure, and older age can contribute to the development of squamous cell carcinoma.

3. How would you manage patient concerns about potential scarring after treatment for squamous cell carcinoma?

- It is essential to address the patient's concerns and discuss cosmetic outcomes post-treatment. This should include a detailed explanation of the surgical approach and options for minimizing scarring.

4. What is the role of imaging, such as MRI scans, in patients with squamous cell carcinoma?

- Imaging, including MRI scans, can provide valuable information about the extent of the tumor, potential spread, and involvement of adjacent structures, aiding in staging and treatment planning.

5. In cases of squamous cell carcinoma, when should a multidisciplinary approach be considered for patient management?

- A multidisciplinary approach is crucial in cases where complex treatment decisions, including surgery, radiation, or systemic therapy, need to be made. It is essential for comprehensive patient care.

Treatment:

First-line management:

- Surgical excision of the squamous cell carcinoma, ensuring an adequate radial margin.

- Sentinel lymph node biopsy (SLNB) to assess regional lymph node involvement.

- Reconstruction as necessary, considering cosmetic outcomes.

- Referral to oncology for consideration of adjuvant radiotherapy based on SLNB findings.

Monitoring:

- Regular follow-up appointments to assess the surgical site, healing, and any potential complications.

- Surveillance for recurrence or metastasis through physical examinations and imaging as per oncology recommendations.

Prognosis:

- For squamous cell carcinoma, the prognosis depends significantly on the tumor size, depth of invasion, involvement of regional lymph nodes, and spread. Treatment response and overall patient health may influence outcomes.

Differential diagnoses:

1. Basal cell carcinoma – Less likely, as this patient's lesion shows increasing size and firm consistency.

2. Seborrheic keratosis – Less likely, given the progression and nature of the lesion.

3. Dermatofibroma – Less likely, considering the patient's presentation.

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Squamous cell carcinoma

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_52\_Squamous\_Cell\_Carcinoma

Homepage Vignette:

## "A 57-year-old woman presents with a persistent sore on her arm."

Individual vignette:

You are the dermatologist responsible for Ms. Minori Pekkanen, a 57 year old office worker who is presenting with a persistent growing lump on the forehead.

Patient Name: Minori Pekkanen (Mih-NO-ree PEK-uh-nen)

Prefers to be called: Minori

Age: 18/06/1967

Location: Hospital

Personality: Minori is softly spoken, reserved, and polite. She is quite anxious about her current health concerns but is trying to stay optimistic.

Presenting Complaint: Minori has noticed a slowly enlarging, painless, but persistent sore on her arm. It looks like a wart, and she is worried about it.

Quote: "I've noticed this strange, painless sore on my arm. It's getting bigger, and it's really starting to worry me."

Symptoms:

- Site: Left arm

- Onset: Gradual progression over several months

- Character: Enlarging, painless sore

- Associated Symptoms: None

- Timing: Started several months ago

- Severity: Increasing concern due to the sore getting larger

History of Presenting Complaint: Minori has had the sore for several months, and it has slowly been getting larger. It is causing her increasing distress and impacting her daily life.

Systemic Symptoms:

- Minori does not have any other systemic symptoms.

Past Medical History:

- Minori has no past medical history and has not had any surgeries or hospitalizations in the past.

Drug History:

- Minori does not take any medications or supplements.

Allergies:

- Minori has no known allergies to medications or substances.

Family History:

- There are no significant skin conditions, atopic disorders, or cancers in Minori's family.

Social History:

- Lifestyle: Non-smoker, moderate alcohol use

- Occupation: Office administrator

- Activities of Daily Living & Hobbies: Enjoys gardening and knitting

Quote: "I've never had any skin problems before, and I take care of my health. I don't smoke, and I only drink occasionally."

Ideas, Concerns, and Expectations:

- Ideas: Minori has some concerns that it could be a severe skin problem, but she is hopeful that it is something treatable.

- Concerns: She is worried that the sore may be cancerous and is anxious about the implications for her health.

- Expectations: Minori hopes to receive a clear diagnosis and to discuss all the available treatment options.

Quote: "I'm really hoping that it's nothing too serious, but I'm quite anxious that it could be a sign of something dangerous."

Physical Examination:

The sore on Minori's arm is well-circumscribed, wart-like, and is approximately 1cm in diameter.

Skin Lesion Inspection:

- Location: Left arm

- Distribution: Solitary lesion

- Shape: Round

- Symmetry: Symmetrical

- Borders: Well-defined

- Colour: Brown

- Diameter: 1cm

Diagnostic Tests:

- The lesion was biopsied and the histopathological examination confirmed squamous cell carcinoma.

Patient Questions:

1. "Is there a chance that this could be something benign?"

- "The initial history and examination findings raise a concern for a more serious condition. A biopsy has been performed and will provide us with a definitive answer."

2. "What are the treatment options for this condition?"

- "The treatment could include surgical excision to remove the lesion."

3. "Is there a possibility of the sore spreading to other parts of the body?"

- "There is a low risk, and early treatment will mitigate that risk."

4. "What is the prognosis of this condition?"

- "The prognosis is generally good with early diagnosis and treatment."

Examiner Questions:

1. What are the distinguishing features of squamous cell carcinoma?

- Distinguishing features include a well-circumscribed, raised, and scaly lesion that tends to bleed easily.

2. How will you explain the need for a biopsy to the patient?

- I will explain to the patient that a biopsy is needed to provide a definitive diagnosis and will help ensure the most appropriate treatment is pursued.

3. What are the key methods of treatment for this condition?

- Treatment often involves the surgical excision of the lesion, which is curative in the majority of cases.

4. How would you support the patient emotionally given the anxiety around the diagnosis?

- I will offer reassurance, empathy, and open communication with the patient to help address her concerns and keep her informed throughout the process.

Treatment:

The most appropriate treatment plan includes surgical excision of the lesion. Should this be unsuccessful or if there's concern with a wider area of skin affected, Mohs micrographic surgery or radiotherapy may be considered.

Monitoring:

Monitor for recurrence and any new skin lesions. If symptoms persist, additional biopsies and imaging studies may be necessary. Arrange follow-up appointments at regular intervals to check the arm and screen for any new skin lesions or recurrences.

Consider referral to a dermatologist for ongoing care if needed.

Prognosis:

With treatment, the prognosis for squamous cell carcinoma is generally favorable, especially when diagnosed and treated early. The lesion is usually curative by simple surgical excision and has an excellent outlook with minimal risk of metastasis.

Differential diagnoses:

1. Basal cell carcinoma: Less likely due to the specific characteristics of the lesion and the histopathological findings

2. Malignant melanoma: Less likely due to the visible symptoms and the histopathological findings

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin lesion

Condition Filter:

Squamous cell carcinoma

Location Filter:

Hospital

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_53\_Squamous\_Cell\_Carcinoma

Homepage Vignette:

## "A 58-year-old female called Nikole presents with a persistent sore that won't heal."

Individual Page Vignette:

You are a medical student and your patient's name is Nikole Jordan. She is a 58-year-old retired florist from a rural location presenting with a persistent sore that won't heal.

Patient Name:

Nikole Jordan; pronounced: "NI-kol JOR-dan." She would like to be called "Nikole."

Age:

05/11/1965

Location:

General Practice

Personality:

Nikole is an upbeat and articulate individual who is very focused and attentive in her interactions. She speaks with warmth and a caring tone, always eager to engage in productive conversations and build rapport with others.

Presenting Complaint:

Nikole reports a persistent sore on her skin that just won't seem to heal. She says: “It's getting on my nerves, and I'm worried something might be wrong."

Symptoms:

- Site: Skin on the upper left arm

- Onset: Gradual, over the past 5 months

- Character: Painful sore that won't heal

- Radiation: Pain is localized to the sore

- Associated Symptoms: None

- Timing: Continuous

- Exacerbating and Relieving Factors: Sore worsens with movement

- Severity: Moderate, impacting daily activities

History of Presenting Complaint:

Nikole has been battling with the persistent sore on her arm for the past 5 months. She has not attempted any treatments and reports that the sore seems to gradually worsen over time. The sore has impacted her daily life by causing discomfort, particularly when moving her arm.

Systemic Symptoms:

All systemic symptoms are normal in this case.

Past Medical History:

Positive: None

Negative: Previous skin conditions, autoimmune conditions, and atopic disorders.

Drug History:

Nikole currently takes no medications and has no history of steroid or contraceptive use.

Allergies:

Nikole has no known allergies or intolerances.

Family History:

Nikole's family has no history of skin conditions, autoimmune conditions, or cancers.

Social History:

- Lifestyle: Retired, lives alone

- Occupation: Retired florist

- Activities of Daily Living & Hobbies: Enjoys gardening, walking, reading

- Smoking: Non-smoker

- Alcohol: Rarely drinks, <1 unit per week

- Recreational Drug Use: None

- Diet: Healthy and balanced diet

- Exercise: Walking regularly

- Travel History: Recent trip to visit a family member

- Sexual History: No current partner

- Driving Status: Holds a valid driving license

- Cultural or Religious Practises: Active member of her local church

- Recent Life Events: No significant recent events

- Exposure to Hazards or New Environment: No significant exposures

Ideas, Concerns, and Expectations:

- Ideas: "I'm worried that the sore might be something serious."

- Concerns: "I'm concerned about the pain I'm experiencing and how it's affecting my daily life."

- Expectations: "I hope to get a clear understanding of what's happening and what needs to be done to address it."

Physical Examination:

- General Inspection: Nikole appears well, no signs of distress, visible sore on upper left arm

- Skin Lesion Inspection:

- Location: Upper left arm

- Distribution: Localized

- Shape: Irregular

- Symmetry: Asymmetrical

- Borders: Ill-defined

- Colour: Reddish with some darkened areas

- Diameter: Approximately 3cm

- Systemic Examination: No abnormalities detected

Diagnostic Tests:

- Imaging Tests: Dermoscopy - correlation indicates possibility of Squamous Cell Carcinoma.

- Other Tests: Skin biopsy - Histopathology findings confirm Squamous Cell Carcinoma diagnosis.

Condition:

Squamous Cell Carcinoma

Patient Questions:

1. "Could the sore be cancer?"

- Yes, it's important for us to conduct further tests to understand the nature of the sore.

2. "Do you think the pain will go away after treatment?"

- Yes, we will discuss pain management options to address that.

3. "Could the sore be spreading elsewhere on my body?"

- We will closely monitor the situation and take appropriate measures to address it if needed.

Examiner Questions:

1. Can you define Squamous Cell Carcinoma and its typical presentation?

- Squamous Cell Carcinoma is a type of skin cancer that often presents as a persistent, non-healing ulcer or sore.

2. What are the risk factors associated with Squamous Cell Carcinoma?

- Exposure to ultraviolet (UV) radiation, fair skin, history of chronic skin damage, and a weakened immune system are common risk factors.

3. How would you explain the diagnosis and prognosis to the patient?

- I will explain the condition as a form of skin cancer that must be treated promptly. I will discuss the treatment approach and potential outcomes with the patient while providing reassurance.

4. What are the treatment options for Squamous Cell Carcinoma?

- Treatment may involve surgical removal, radiation therapy, photodynamic therapy, topical medications, or chemotherapy, depending on the size and location of the lesion.

5. How would you approach discussions about prevention and monitoring with the patient?

- I will provide advice on sun protection and regular skin checks. We will discuss the importance of early detection and seeking medical attention if any concerning changes occur.

6. Can you discuss the potential psychosocial impact of a diagnosis of Squamous Cell Carcinoma?

- A diagnosis of skin cancer can have significant psychological effects. Supportive care and counseling should be considered as part of the management plan.

Treatment:

Initial Treatment:

1. Surgical excision of the lesion

2. High SPF sunscreen

Monitoring:

After surgical excision, monitor for any signs of recurrence. Regular follow-up appointments every 3-6 months for monitoring.

Prognosis:

The prognosis for Squamous Cell Carcinoma is generally good when detected and treated early. Regular monitoring and sun protection practices are essential for long-term management.

Differential diagnoses:

1. Basal Cell Carcinoma - less likely due to the characteristic appearance of the lesion indicating Squamous Cell Carcinoma.

2. Pyoderma Gangrenosum - less likely due to the lack of specific clinical features and systemic symptoms suggestive of Squamous Cell Carcinoma.

3. Actinic Keratosis - less likely due to the atypical appearance and gradual progression of the lesion which is more indicative of Squamous Cell Carcinoma.

Keyword Filters:

Speciality Filter: Dermatology; Oncology; General Practice

Presenting Complaint Filter: Skin lesion; Skin ulcers

Condition Filter: Squamous cell carcinoma

Location Filter: General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_54\_Urticaria

Homepage Vignette:

## "A 42-year-old male called Ravi presents with a recurring rash."

Individual Page Vignette:

You are a general practitioner and Mr. Ravi, a 42-year-old male, is visiting the practice with a recurring rash.

Patient Name:

Ravi Singh (Rah-vee Singh)

Age:

10/06/1982

Location:

General Practice

Personality:

Ravi is a soft-spoken, polite man who is involved in his community. He presents as friendly and forthcoming, speaking openly and candidly about his condition.

Presenting Complaint:

Ravi complains of a recurring rash on various parts of his body, associated with intense itching.

Quote: "I've had this recurring annoying rash that's been driving me mad with all the itching."

Symptoms:

- Site: The rash has appeared on Ravi's trunk, limbs, and face.

- Onset: The rash appeared gradually over the past 6 months.

- Character: The rash is characterized by small red patches that come and go.

- Associated Symptoms: Intense itching; no pain

- Timing: The rash has been recurring for the past 6 months

- Severity: The itching is severe, particularly at night

History of Presenting Complaint:

Ravi reports that he has been dealing with the recurring rash for 6 months. He states that he has tried over-the-counter antihistamines, but they only provide temporary relief. The symptoms have gradually gotten worse over this period, significantly impacting his quality of life and ability to sleep at night.

Systemic Symptoms:

All systemic symptoms are normal in this case.

Past Medical History:

Negative for atopic disorders, previous skin conditions, and autoimmune conditions

Drug History:

Medications: Ravi takes over-the-counter antihistamines occasionally for the itching

Allergies:

Ravi has an allergy to penicillin, which causes a rash and itching upon exposure.

Family History:

Negative for relevant conditions.

Social History:

- Occupation: School teacher

- Lifestyle: Non-smoker; occasional alcohol use; regular exercise routine

- Activities of Daily Living & Hobbies: Enjoys reading and spending time with family

Quote:

"I'd say I'm generally healthy. My job keeps me active, and I enjoy spending time with my family and being involved in community activities."

Ideas, Concerns, and Expectations:

- Ideas: Ravi expresses uncertainty about what could be causing the rash.

- Concerns: He is worried about the impact of the symptoms on his daily life and is looking for long-term relief.

- Expectations: Ravi hopes to find out the cause of the rash and receive effective treatment to manage the symptoms.

Physical Examination:

General Inspection:

- Ravi appears well-nourished and in no apparent distress

- No visible rashes are noted on general inspection

Skin Lesion Inspection:

- No visible skin lesions are observed

Diagnostic Tests:

No diagnostic tests are necessary at this stage.

Condition:

Urticaria

Patient Questions:

1. "Could this recurring rash be a sign of something more serious?"

Answer: "It's possible, but we need to conduct further examinations to determine the cause."

2. "How long do you think it will take to find a solution to this recurring rash?"

Answer: "It's difficult to predict, but we will work to identify a solution efficiently."

3. "Are there dietary changes I could make to alleviate this rash?"

Answer: "Dietary adjustments may help in some cases, but we'll discuss this further once we have a clearer understanding of the condition."

Examiner Questions:

1. "What is your approach to verifying the cause of Ravi's recurring rash?"

Answer: "I would begin by conducting a thorough physical examination to look for any visible manifestations of the rash. Further history taking and possible testing may be necessary."

2. "How would you address Ravi's concern about the impact of the rash on his daily life?"

Answer: "I would discuss various treatment options with Ravi, aiming to find a solution that can effectively manage his symptoms and improve his quality of life."

3. "What further questions would you ask Ravi to get a clearer picture of his current symptoms?"

Answer: "I would inquire about potential triggers or activities that have been associated with the worsening of the rash. Additionally, I would explore any recent changes in skincare products or activities that could be contributing to the symptoms."

4. "How might Ravi's occupation and lifestyle contribute to his recurring rash?"

Answer: "As a school teacher, Ravi may come into contact with various allergens or irritants. Understanding his daily environment and activities can help identify potential triggers for the rash."

5. "How would you address Ravi's concerns about the long-term management of his condition?"

Answer: "I would assure Ravi that we are committed to finding a long-term solution for his condition. A proactive approach to assessment and treatment will be our focus in addressing his concerns."

Treatment:

1. Advise Ravi to avoid known triggers or exacerbating factors such as particular food allergies or irritants.

2. Prescribe a non-sedating H1 antihistamine, such as loratadine, for the urticarial rash at the standard dose of 10 mg once daily.

3. Counseling Ravi on self-care measures, such as avoiding triggers, wearing loose clothing, regular moisturising and use of cool compresses to alleviate itching.

Monitoring:

- Schedule a follow-up visit after 4 weeks to assess the response to treatment.

- Monitor the progression of the rash and any new symptoms that may develop.

- In the event of severe or persistent symptoms, consider referral to a dermatologist.

Prognosis:

Ravi's prognosis is good, as urticaria is generally a manageable condition. With appropriate treatment and trigger avoidance, his symptoms should improve. However, ongoing monitoring and possible adjustments to treatment may be necessary to ensure long-term management of the condition.

Differential Diagnoses:

1. Atopic dermatitis and eczema: Less likely as this usually presents with dry, itchy, red skin patches, different from how Ravi's rash presents.

2. Cutaneous fungal infection: Less likely as fungal infections typically present as red, scaly skin patches associated with itching.

3. Contact dermatitis: Less likely as this condition is typically triggered by contact with an allergen or irritant.

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Pruritus; Chronic rash

Condition Filter:

Urticaria

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# 

# ALYC\_55\_Urticaria

Homepage Vignette:

## "A 35-year-old female called Emma presents with a sudden onset of itchy red raised welts on her skin."

Patient Name:

Ying Hui Chou (pronounced YING Hwee CHOO); goes by Hui

Age:

17/09/1989

Location:

General Practice

Personality:

Hui is a soft-spoken young woman, with a gentle and reserved nature. She appears shy and exhibits polite manners when talking to others.

Presenting Complaint:

Hui has been experiencing acute onset of widespread itchy raised red welts (hives) on her skin, which have appeared suddenly and are causing significant discomfort. When asked, Hui says, "I've been so itchy, and these red rashes are making me really uncomfortable. I don't know what's happening, but I feel quite worried."

Symptoms:

- Site: Widespread rash involving the trunk, arms, and legs

- Onset: Sudden onset over a few hours

- Character: Itchy, red welts

- Radiation: The rash has spread from the trunk to the arms and legs

- Associated Symptoms: No associated symptoms

- Timing: Symptoms appeared over a few hours

- Exacerbating and Relieving Factors: Itching worsens with scratching

- Severity: The itching is significantly bothering her

When asked, Hui says, "I noticed the rash started this morning. It's suddenly started spreading all over my body. It's really itchy, especially when I'm hot or anxious."

History of Presenting Complaint:

Hui has been experiencing the onset of the itchy red welts earlier today, and she has not tried any treatments yet. Her symptoms have suddenly progressed, and she finds it challenging to complete her everyday activities due to the intense itching. She shares, "I've never had anything like this before. It's spreading, and I'm finding it very hard to focus on anything else as the itching is so distracting."

Systemic Symptoms:

The patient denies any systemic symptoms or significant red flag findings.

Past Medical History:

Hui has no significant past medical history, is not taking any regular medications, and has never experienced a similar skin condition before. She does not have any history of atopic disorders.

Drug History:

The patient takes no medications and has no history of using topical steroids or contraceptive pills.

Allergies:

Hui has no known allergies or intolerances to foods, medications, or environmental allergens.

Family History:

The family history is negative for any significant skin conditions, atopic disorders, or autoimmune conditions.

Social History:

Lifestyle: Student

Occupation: N/A

Activities of Daily Living & Hobbies: Enjoys reading and painting in her free time

Smoking: Never smoked

Alcohol: Doesn't drink alcohol

Recreational Drug Use: None

Diet: Healthy and balanced

Exercise: Regular exercise routine

Travel History: No recent travel history

Sexual History: Not sexually active

Driving Status: Learner's permit

Cultural or Religious Practices: N/A

Recent Life Events: No significant life events

Exposure to Hazards or New Environment: No known exposure to new environments

Hui may ask, "Do you think there's anything in particular I need to change about my lifestyle to address my symptoms?"

Ideas, Concerns, and Expectations:

Ideas: Hui believes that the itching and rashes might be due to an allergic reaction to something she may have encountered.

Concerns: Hui is worried about the appearance of the rash and hopes it isn't a sign of a more serious underlying condition.

Expectations: She expects the doctor to provide a clear explanation of her condition and to help her with the itching and rashes. She would also like to know how long they may persist.

Physical Examination:

General Inspection: Hui appears uncomfortable due to itching but is otherwise well. No signs of distress or systemic disease noted during the examination.

Skin Lesion Inspection:

- Location: Widespread distribution on trunk, arms, and legs

- Distribution: Generalized

- Shape: Irregular

- Symmetry: Asymmetrical

- Borders: Indistinct

- Colour: Red

- Diameter: Rashes of varying sizes

Skin Lesion Palpation:

- Elevation: Slightly elevated

Systemic Examination:

No remarkable findings noted during systemic examination.

Special Tests:

There is no indication for any special tests at this time.

Diagnostic Tests:

No specific diagnostic tests are performed, as the symptoms and clinical presentation are consistent with urticaria.

Condition:

Urticaria

Patient Questions:

1. "Could this rash be due to something I recently ate?"

- The cause of urticaria can be varied, including food allergens, but it's not always related to diet.

2. "Will the itching go away with some over-the-counter creams?"

- Over-the-counter antihistamine medications can help with the itching, but they may not be sufficient for all cases of urticaria.

3. "Is there a specific allergy test I should consider for finding the cause of these rashes?"

- Allergy testing may be considered if the condition persists and the cause is unclear.

4. "How long will it take for these rashes to go away on their own?"

- Urticaria symptoms can resolve fairly quickly in some cases, but it varies for each individual.

Examiner Questions:

1. What are the main treatment goals in the management of urticaria?

- The main treatment goals include relieving the itching and resolving the rash.

2. How do you differentiate acute urticaria from chronic urticaria?

- Acute urticaria typically lasts less than 6 weeks, often due to allergies or infections, while chronic urticaria lasts for more than 6 weeks and can be idiopathic.

3. What laboratory tests would you consider in the evaluation of urticaria?

- In an acute presentation with no systemic symptoms, laboratory tests may not always be necessary. However, if chronic urticaria is suspected, tests may include a complete blood count, erythrocyte sedimentation rate, C-reactive protein level, and possibly others to identify an underlying cause.

4. When would you consider a referral for a patient with urticaria?

- Referral to a dermatologist or allergy specialist is typically considered for patients with chronic urticaria who do not respond to initial treatments.

5. What are some non-pharmacological measures that can help manage the symptoms of urticaria?

- Avoiding triggers, maintaining a cool environment, and wearing loose, breathable clothing may help alleviate symptoms. Stress management techniques and lifestyle modifications can also be beneficial.

6. Can you describe the difference between urticaria and angioedema?

- Urticaria presents as raised, red, itchy welts on the skin, while angioedema involves swelling of the deeper layers of the skin, often in the lips, eyelids, or genitals.

Treatment:

1. Provide reassurance and advise Hui to avoid known triggers.

2. Prescribe a second-generation non-sedating oral antihistamine such as cetirizine 10 mg once daily for relief of itching.

3. Educate Hui about when to seek further medical attention and advise a follow-up in 2 weeks if symptoms persist.

4. Counsel Hui regarding stress management and the potential role of stress in urticaria.

Monitoring:

Advise Hui to monitor for any progression or persistence of symptoms and to seek medical attention if there are any concerning developments. Recommend a follow-up visit in 2 weeks to re-evaluate her condition and response to the treatment.

Prognosis:

The prognosis for urticaria is generally good, and symptoms tend to resolve within a short period. However, if the condition becomes chronic, further evaluation and management may be necessary. Factors such as stress and dietary triggers can influence the response to treatment.

Differential diagnoses:

1. Allergic reaction: less likely due to no recent exposure to known allergens and sudden onset in multiple areas

2. Viral exanthem: less likely due to absence of systemic symptoms and itchiness component

3. Scabies: less likely due to absence of burrows and presence of widespread, sudden onset red welts

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Acute rash; Skin or subcutaneous lump

Condition Filter:

Urticaria

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_56\_Head\_Lice

Homepage Vignette:

## “A 9-year-old boy called Mikhail presents with itching on his scalp.”

Individual Page Vignette:

You are a medical student based on General Practice placement and your patient is Mikhail who is a 9-year-old student, he is currently in London and is complaining about scalp itching.

Patient Name:

Mikhail Yakupov (Mee-kah-eel Yah-coop-off)

Age:

07/09/2015

Location:

General Practice

Personality:

Mikhail is a lively, talkative 9-year-old boy who is friendly, curious, and expressive. He speaks with excitement and in an inquisitive manner. He enjoys playing football and video games, and loves asking questions.

Presenting Complaint:

Mikhail complains, “My head is itching a lot, it doesn't stop, and it's making me feel uncomfortable.”

Symptoms:

Itching (pruritus) is the main symptom on the scalp

• Site: Scalp

• Onset: "It's been itching for a few weeks now, ever since I saw a friend in school scratching his head."

• Character: "It feels annoying, like something is crawling on my head."

• Association with lesions: No sores, redness, or scaling

• Timing: Gradual onset, lasting all day

• Severity: "It's really bad, I can't concentrate in class and I can't sleep at night because of it."

History of Presenting Complaint:

This is the first time Mikhail has experienced itching to this extent. No previous treatments have been attempted, and the symptoms have progressed gradually over the past few weeks. The itching is causing discomfort in his daily life.

Systemic Symptoms:

No fever, weight loss, systemic rashes, mucous membrane involvement, or general malaise.

Past Medical History:

Negative for any chronic conditions, surgeries, or significant health events.

Drug History:

Negative for any medications or supplements.

Allergies:

Mikhail has no known allergies to medications, foods, or environmental factors.

Family History:

There is no family history of head lice, atopic conditions, or significant skin diseases. No one is unwell at home at the present time.

Social History:

Lifestyle: Regular activity levels; strong interest in football and video games

Smoking: Not applicable

Alcohol: Not applicable

Recreational Drug Use: Not applicable

Diet: Balanced diet with no special restrictions

Exercise: Involved in football practice

Travel History: No recent travel

Sexual History: Not applicable (due to age)

Driving Status: Not applicable (due to age)

Cultural or Religious Practices: No specific cultural practices mentioned

Recent Life Events: No significant recent life events that could be related to the itching

Exposure to Hazards or New Environment: Negative

Ideas, Concerns, and Expectations:

Ideas: Mikhail thinks he may have an allergy to a shampoo or the weather change might be causing this.

Concerns: Mikhail is worried that the itching will not go away and will affect his studies.

Expectations: Mikhail hopes for a quick solution to the itching so he can comfortably focus on his studies and football.

Physical Examination:

General Inspection:

Mikhail looks healthy and well. No signs of distress.

Skin Examination:

Visible lice or eggs found on head examination. No evidence of redness, scaling, or sores on the scalp.

• Location: Scalp

• Distribution: Diffuse

• Visible lice and eggs; negative for scaling and sores

• No noticeable changes in hair condition

Systemic Examination:

Unremarkable, with no signs of systemic involvement or red flags.

Special Tests:

Positive for lice or nits on visual inspection. No other special tests required based on the patient history and examination findings.

Condition:

Head Lice

Patient Questions:

1. "Can I keep going to school with my head like this?"

- There’s no problem with continuing school while we treat this condition.

2. "Is there a special shampoo I need to use?"

- Yes, we will prescribe a special shampoo for you to use to treat the head lice.

3. "Can my friends get this too?"

- It’s possible, which is why we need to treat it as soon as possible.

4. "How long will it take to get rid of these lice?"

- The treatment will take a week to fully clear up the lice.

Examiner Questions:

1. What is the first-line treatment for head lice?

- The first-line treatment is to use insecticidal lotions or shampoos applied to the hair and scalp.

2. How can you prevent the spread of head lice to others?

- Avoid head-to-head contact, do not share personal items, and notify close contacts to check for symptoms.

3. What are the potential causes of persistent head lice infestation, and how can you address them?

- Resistance to treatment and reinfestation from untreated contacts can cause persistence. Addressing close contacts can help prevent reinfestation.

4. What are the potential complications of untreated head lice infestation?

- The potential complications include secondary skin infections due to scratching and social or psychological distress.

5. What non-pharmacological measures can be used in conjunction with treatment to manage lice infestation?

- Regularly washing and drying linens, using hot water, and vacuuming upholstered furniture and floors are non-pharmacological measures that can help manage lice infestations.

Treatment:

First-line treatment:

• Use 0.5% or 1% malathion aqueous lotion to treat the head lice. Apply according to the manufacturer's instructions and repeat after 7 days if necessary.

• Advise scheduling a follow-up to ensure complete resolution.

Monitoring:

Monitor for resolution of itching and reduction in the presence of lice after the initial and repeat application. Advise follow-up after 14 days if itching persists or lice are still present.

Prognosis:

The prognosis for head lice is excellent. With appropriate treatment, itching and infestation can resolve completely within days to weeks. Prevention of reinfestation from close contacts is essential for complete resolution.

Differential Diagnoses:

1. Folliculitis: Less likely as there are no visible sores, pustules, or inflammation on the scalp.

2. Dry Scalp: Less likely as the itching is persistent and not associated with scalp dryness alone.

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Pruritus; Skin lesion; Chronic rash

Condition Filter:

Head lice

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_57\_Cutaneous\_Fungal\_Infection

Homepage Vignette:

## “A 44-year-old man comes to the general practice with a red, itchy rash.”

Individual Page Vignette:

You are a GP seeing a 44-year-old man named Nabil Adebayo with a red, itchy rash on his skin.

Patient Name:

Nabil Adebayo (Pronounced: Nah-beel Ah-deh-buy-yo); "You can call me Nabil."

Age:

02/03/1980

Location:

General Practice

Personality:

Nabil is a friendly, outgoing man with a positive attitude. He speaks with enthusiasm and a rather loud voice. His educational level is secondary school, but he is very well-informed about his health. He is an electrician and enjoys spending his free time with his family and playing football with friends.

Presenting Complaint:

Nabil presents with an itchy, red rash on his skin.

Symptoms:

Nabil reports the following symptoms:

- Site: His upper back, chest and abdomen mainly

- Onset: It appeared gradually over the last few weeks

- Character: "My skin is red and very itchy. I keep scratching, but nothing seems to help."

- Radiation: No radiation

- Associated Symptoms: None

- Timing: He reports that the rash continues to worsen over time

- Exacerbating and Relieving Factors: He says that scratching the affected skin worsens the itch

- Severity: He describes the itching as severe

History of Presenting Complaint:

The rash has been present for a few weeks and has progressively worsened. He has tried over-the-counter antihistamines, but they have not provided any relief. The rash is significantly affecting his sleep, and Nabil has been missing work because of it.

Systemic Symptoms:

Nabil denies any systemic symptoms.

Past Medical History:

Negative for any previous history of skin conditions or autoimmune conditions. He has no significant history of previous medical conditions, psychiatric history, or history of traumas.

Drug History:

He takes no regular prescription or over-the-counter medications. He denies any history of using topical steroids or medications for skin conditions.

Allergies:

Nabil reports no known allergies to medications, foods, or environmental triggers.

Family History:

Negative for significant family history of skin conditions, atopic disorders, or other significant medical conditions.

Social History:

- Lifestyle: Non-smoker; consumes 14 units of alcohol per week; engages in regular exercise through football; healthy diet

- Occupation: Electrician

- Activities of Daily Living & Hobbies: Enjoys spending time with his family, playing football, and socializing with friends.

Ideas, Concerns, and Expectations:

- Ideas: Nabil believes that the rash could be a result of an allergy to something in his environment.

- Concerns: His main concern is finding a solution for the rash, as it is affecting his ability to work and disrupting his sleep.

- Expectations: He expects to receive a diagnosis and effective treatment for his rash.

Physical Examination:

General Inspection: Nabil appears well, no signs of distress are noted. He does not exhibit any visible parasites.

Skin Lesion Inspection:

- Location: Upper back, chest, abdomen

- Shape: Round and oval shaped

- Symmetry: Bilateral, symmetric distribution

- Borders: Regular

- Colour: Red

- Diameter: Various sizes, average 3-4 cm

Skin Lesion Palpation: No elevation, lesion temperature is normal, lesions are not tender to the touch.

Condition:

Cutaneous Fungal Infection

Patient Questions:

1. "Could this rash be due to something I'm eating?"

- Answer: "It's possible, but we will need to explore all possible causes to determine the root of the issue."

2. "Should I be worried about this rash spreading to other parts of my body?"

- Answer: "We will work to identify the cause and provide appropriate treatment to manage and prevent the spread of the rash."

3. "Do you think this is due to a viral infection?"

- Answer: "It's unlikely, but I will conduct the necessary tests to confirm the cause."

Examiner Questions:

1. What are the potential risk factors for a cutaneous fungal infection?

- Answer: Risk factors include warm, humid climates, excessive sweating, and a weakened immune system.

2. How does a cutaneous fungal infection differ from other skin conditions such as psoriasis or eczema?

- Answer: The characteristics of the lesions, as well as the accompanying symptoms, are different in cutaneous fungal infections compared to psoriasis or eczema.

3. What type of treatment would you recommend for a cutaneous fungal infection?

- Answer: I would suggest antifungal medications, topical agents, and measures to minimize excess moisture in the affected areas as part of the treatment plan.

Treatment:

- Advise Nabil to keep affected areas clean and dry

- Prescribe a topical antifungal, such as clotrimazole or miconazole

- If over-the-counter treatments are not effective, prescribe oral antifungal medication, such as fluconazole

- If necessary, refer to a dermatologist for further evaluation and treatment

Monitoring:

- Instruct Nabil to monitor his response to the prescribed antifungal treatment, noting any improvement in the rash or itching

- Advise him to follow up in 2 weeks to assess treatment response

- Refer for additional evaluation if the rash persists or worsens despite treatment

Prognosis:

The prognosis for a cutaneous fungal infection is generally good with appropriate treatment. Symptoms are likely to improve with antifungal treatment, and the condition is manageable with proper hygiene and lifestyle modifications.

Differential Diagnoses:

1. Contact dermatitis: Less likely as there are no known exposures to irritants or allergens

2. Atopic dermatitis: Less likely due to the absence of a history of eczema or atopic conditions

3. Bacterial skin infection: Less likely as there are no signs of pustules or significant inflammation.

Speciality Filter:

General Practice; Dermatology

Presenting Complaint Filter:

Chronic rash; Pruritus; Skin lesion

Condition Filter:

Cutaneous Fungal Infection

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_58\_Arterial\_Ulcer

Homepage Vignette:

## “A 65-year-old female called Fiona presents with a sore, red, open wound on her lower leg.”

Individual Page Vignette:

You are a general practice medical student. You are seeing Fiona, a 65-year-old retired florist, who presents with a sore, red, open wound on her lower leg.

Patient Name:

Fiona MacDonald; "Please call me Fiona."

Age:

13/04/1959

Location:

General Practice

Personality:

Fiona is softly spoken and polite. She is cheerful and sociable, chatting easily about her hobbies and her flower garden. A retired florist, Fiona is calm and patient, but she is worried and a little anxious about her leg wound.

Presenting Complaint:

Fiona has a sore, red, open wound on her lower leg.

Quote: "I'm just very worried about this wound on my leg. It's very sore and just won't heal. It's a real nuisance."

Symptoms:

Site: Lower leg; mainly anterior aspect

Onset: Has been present for 6 months

Character: Non-healing, painful, red, open

Radiation: None

Associated Symptoms: None

Timing: Wound not healing; constant pain

Exacerbating and Relieving Factors: No relief with rest or elevation

Severity: Moderately painful

Negative for Itching, rash, erythema, wheels, scaling, dryness, blisters, pustules, nodules, ulcers, lesions with distinct borders, lesions with indistinct borders, petechiae, purpura, ecchymosis, macules, papules, plaques, texture changes, pigmentary changes, photosensitivity, burning sensation, oozing, weeping, fissures, lichenification, excoriations, telangiectasia, atrophy, scars, changes in hair or nail condition, systemic symptoms, mucous membrane involvement

History of Presenting Complaint:

Fiona reports that the wound has been present for 6 months. She has tried over-the-counter wound dressings and elevating her leg at home. The pain has worsened over time, making it difficult for her to walk or stand for long periods.

Quote: "The wound just won't heal and the pain is getting worse. It's making it really hard for me to do things around the house."

Systemic Symptoms:

Negative for systemic symptoms, such as fever, weight loss, night sweats, lymphadenopathy, or musculoskeletal findings.

Past Medical History:

Negative for any significant history of atopic disorders, previous skin conditions, or autoimmune conditions. Negative for any recent surgeries or hospitalizations. No previous injuries or traumas. Negative for psychiatric or psychological history, history of substance abuse or addiction, and significant past medical conditions.

Drug History:

Fiona is not taking any current medications. She does not have a history of medication use for skin conditions or topical steroids.

Allergies:

Fiona has a known allergy to penicillin, which causes rash and itching.

Quote: "I had a nasty rash and itching when I took penicillin long ago. It wasn't nice."

Family History:

Fiona's family has a history of arthritis, but no significant history of atopic conditions, cancers, surgeries, or hospitalizations.

Social History:

Lifestyle: Retired florist

Occupation: Retired

Activities of Daily Living & Hobbies: Gardening; looks after her flower garden; likes to knit

Smoking: Non-smoker

Alcohol: Rarely drinks; occasional glass of wine with dinner

Recreational Drug Use: None

Diet: Balanced diet with plenty of vegetables and fruit

Exercise: Walks around her garden for exercise; some light stretches and yoga

Travel History: No recent travel history

Sexual History: Not applicable

Driving Status: Has a valid driver's license

Cultural or Religious Practises: No specific cultural or religious practices

Recent Life Events: No recent significant life events

Exposure to Hazards or New Environment: Lives in a well-kept, safe community

Quote: "I love gardening and flowers. That's my main hobby. My grandchildren visit me often and we enjoy spending time together in my garden."

Ideas, Concerns, and Expectations:

Ideas: Fiona hopes to find out the cause of her leg wound and understand why it's not healing.

Concerns: Fiona is worried about the increasing pain and limited mobility due to the wound.

Expectations: Fiona expects to receive effective treatment for her non-healing wound and wants to understand ways to manage the pain better.

Quote: "I hope we can get to the bottom of whatever is causing this wound and find a way to make it better. The pain is really bothering me."

Physical Examination:

General Inspection: Fiona appears generally well. She has a non-healing wound on the anterior aspect of her lower leg. She walks with a slight limp and exhibits signs of discomfort due to the pain.

Skin Lesion Inspection:

Location: Right, anterior lower leg

Distribution: Localized to the anterior lower leg; wound appears deep

Shape: Irregular shape with surrounding erythema

Symmetry: Asymmetrical

Borders: Indistinct, with signs of irregular tissue breakdown

Colour: Red and slightly blackened

Diameter: Approximately 3 cm in diameter

Skin Lesion Palpatation:

Elevation: Wound is non-elevated, appears deep

Skin temperature: Warm to touch over and around the wound

Texture: Granulation tissue seen; surrounding skin is soft

Consistency: Firm; non-boggy

Tenderness: Wound is tender to palpation

Blanching with pressure: Some blanching; wound is weeping

Lymph nodes: No palpable enlargement or tenderness in regional lymph nodes

Neurological system: Normal sensation in the surrounding area

Special Tests:

Wood's lamp examination: No significant findings

Dermatoscopy: Wound exhibits evidence of granulation tissue

Signs of superficial basal cell carcinoma: No signs observed

Diagnostic Tests:

Blood Tests: Full blood count - Within normal range

Imaging Tests: Lower leg ultrasound - Reveals findings suggestive of arterial insufficiency

Other Tests: Skin biopsy - Pending; looking for evidence of underlying arterial disease

Patient Questions:

1. Patient: "Why isn't my wound healing? I'm doing everything I can to take care of it."

Possible answer: "We'll investigate further to understand the cause and provide effective treatment."

2. Patient: "Will I need surgery for this wound?"

Possible answer: "We will explore all options for treatment and discuss them with you."

3. Patient: "What can I do to manage my pain and discomfort while the wound heals?"

Possible answer: "We will discuss pain management strategies to help you feel more comfortable."

Examiner Questions:

1. What is the most likely diagnosis for Fiona's non-healing wound?

Answer: Arterial ulcer

2. How does the wound's appearance and location support the diagnosis?

Answer: The irregular shape, indistinct borders, and presence of granulation tissue are indicative of an arterial ulcer.

3. What are the potential complications of an arterial ulcer?

Answer: Infection, tissue necrosis, and potential gangrene are potential complications.

4. What are the mainstay treatment options for arterial ulcers?

Answer: Topical management, debridement, compression therapy, and managing underlying arterial insufficiency are key aspects of management.

5. What is the specific test used for diagnosis and staging of arterial ulcers?

Answer: Lower leg ultrasound is used for diagnosis and staging.

6. Why is it crucial to monitor the patient for signs of infection and non-healing wounds in cases of arterial ulcers?

Answer: Monitoring for complications and treatment response is essential due to the potential development of infections and non-healing wounds.

Treatment:

Topical management: Use of emollients and dressings; avoid occlusive dressings

Debridement: Remove non-viable tissue as required

Pain management: Oral analgesics; assess for symptoms of peripheral arterial disease and refer if indicated

Compression therapy: Apply graduated compression bandages to the affected leg

Referral: Urgent referral to vascular specialist for further assessment and management if no clinical response

Monitoring:

Regular follow-up appointments to check wound healing progress

Assess signs of infection, pain levels, and improvement in mobility

Monitor for symptoms of arterial insufficiency or peripheral arterial disease

Consider wound care nurse input if needed

Prognosis:

With appropriate management, the arterial ulcer can improve over several months.

The prognosis depends on the underlying arterial insufficiency and the patient's ability to comply with treatment.

Regular monitoring and adherence to treatment regimens are crucial for a positive outcome.

Differential diagnoses:

1. Venous ulcer - Less likely, as the wound site and characteristics are more indicative of arterial insufficiency.

2. Diabetic foot ulcer - Less likely, as there is no history of diabetes or peripheral neuropathy in the patient.

3. Skin cancer - Less likely, as the wound characteristics and distribution are not typical for malignant lesions.

4. Necrotising fasciitis - Unlikely, as the patient does not exhibit systemic symptoms of severe infection often seen in this condition.

Keyword Filters:

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Skin ulcers

Condition Filter:

Arterial ulcers

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_59\_Arterial Ulcer

Homepage Vignette:

## "A 68-year-old man named Trevor presents with painful skin lesions on his legs."

Individual Page Vignette:

You are a dermatologist. Mr. Trevor Davies is a 68-year-old retired engineer from rural Wales who presents with painful skin sores.

Patient Name:

Mr. Trevor Davies, pronounced as "TREV-ur DAY-veez"; he would like to be called Trevor.

Age:

06/11/1956

Location:

General Practice

Personality:

Mr. Davies is an affable and chatty gentleman. He speaks gently and walks with a slight limp due to knee pain.

Presenting Complaint:

Mr. Davies complains of painful skin sores on his lower legs that are not healing well.

Quote: "I've been struggling with these awful sores on my legs for far too long now. The pain is really getting to me, you know."

Symptoms:

Mr. Davies complains of the following symptoms:

- Site: Bilateral lower legs

- Onset: Gradual over the past 6 months

- Character: Painful, red, and tender sores

- Associated Symptoms: Severe leg pain and difficulty walking

- Timing: Persistent

- Exacerbating Factors: Pain worsens when standing or walking

- Severity: Moderate to severe

History of Presenting Complaint:

History of presenting complaint includes:

- Gradual onset over the past 6 months

- No previous treatments attempted

- Symptoms have been worsening over time

- Significant impact on daily life, including mobility issues

Quote: "It's been about six months since these sores started showing up and they seem to be getting worse. I have a hard time walking because of the pain."

Systemic Symptoms:

There are no abnormal findings in the systemic symptoms in this case.

Past Medical History:

- Osteoarthritis

- No history of atopic disorders, previous skin conditions, or autoimmune conditions

Drug History:

- Paracetamol 1 g QDS for knee pain.

Quote: "I take paracetamol for my knee pain, but that's about it. I've never really tried anything else."

Allergies:

No known drug allergies.

Family History:

His family history is negative for skin conditions, atopic disorders, and cancers.

Social History:

- Retired engineer

- Non-smoker

- Occasional alcohol drinker

- No recreational drug use

- Balanced diet

- Limited exercise due to knee pain

- No recent travel history

Ideas, Concerns, and Expectations:

- Concerns: Mr. Davies is concerned about the persistent open sores on his legs and the associated pain, which is limiting his mobility.

- Expectations: He would like to have a definitive diagnosis and effective treatment for his symptoms.

Quote:

Ideas: "I think something is really wrong here. These sores don’t seem to be healing at all."

Concerns: "I'm really worried about not being able to walk properly because of this. I need to be mobile."

Expectations: "I expect you to figure out what's going on and help me get rid of the pain."

Physical Examination:

General Inspection:

- Comfortable at rest, grimaces with movement

- BMI within normal range

- No signs of systemic disease

- No visible parasites or insects

- No visible rashes or lesions besides the lower legs

Skin Lesion Inspection:

- Location: Bilateral lower legs

- Distribution: Symmetrical

- Shape: Irregular

- Colour: Deep red and diffusely erthymatous around the site

- Diameter: Varied

Quote:

"I can see these sores are all over the lower part of my legs and they are really painful."

Skin Lesion Palpation:

- Tenderness on palpation

- Warm to touch

- Elevation: None

Systemic Examination:

- Palpable lymph nodes not enlarged

- No signs of systemic disease

Special Tests:

- Dermoscopy: Red, inflamed lesions with uneven borders and scaling

Diagnostic Tests:

- No relevant test results available

Condition:

Arterial Ulcers

Patient Questions:

1. "Will these sores ever heal?"

- Answer: "We will work to improve the healing process as much as possible."

2. "Can this condition become life-threatening?"

- Answer: "It's important to manage this condition to prevent complications."

3. "What treatments are available for arterial ulcers?"

- Answer: "There are several methods we can use to help with healing and managing the pain."

Examiner Questions:

1. "What are the risk factors for developing arterial ulcers?"

- Answer: "Peripheral vascular disease, smoking, and diabetes are common risk factors."

2. "What are the key differential diagnoses for arterial ulcers?"

- Answer: "Venous ulcers and neuropathic ulcers are the main differentials."

3. "How do you assess the severity of arterial ulcers?"

- Answer: "The severity of arterial ulcers can be assessed using the Rutherford classification."

4. "What is the first-line treatment for arterial ulcers?"

- Answer: "Optimising wound care, controlling risk factors, and in some cases, revascularisation."

5. "What is the typical appearance of arterial ulcers?"

- Answer: "Arterial ulcers are usually pale and necrotic, often with well-defined edges and might be painful."

Treatment:

First-line treatment:

- Optimise wound care, which includes debridement of necrotic tissue and application of dressings to maintain a moist wound environment.

- Control the risk factors, including regular podiatry care, smoking cessation, control of blood pressure and blood sugar levels in patients with diabetes, and lipid-lowering therapy.

- Pain management with regular analgesia.

Monitoring:

- Regular wound review

- Monitoring of glycemic control and lipid profile

- Regular pain assessment

- Review every 1-2 weeks in the initial phase

Prognosis:

- The prognosis depends on the underlying arterial insufficiency and successful management of risk factors.

- If the underlying arterial insufficiency is not addressed, arterial ulcers can become non-healing and necrotic.

- However, with appropriate management, healing is achievable in many patients.

Differential diagnoses:

1. Venous ulcers

- Less likely in this case due to the lack of signs of venous insufficiency on examination and the presence of risk factors for arterial disease.

2. Diabetic ulcers

- Less likely as the patient does not have a long-standing history of diabetes or overt symptoms of neuropathy.

Speciality Filter:

Dermatology; General Practice; Surgery.

Presenting Complaint Filter:

Chronic rash; Skin ulcers

Condition Filter:

Arterial ulcers

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_60\_Pressure\_Sores

Homepage Vignette:

## "A 58-year-old woman presents with painful skin lesions."

Individual Page Vignette:

As a medical student, your role is to take a thorough history and perform a physical examination on Anneka Zoelle, a 58-year-old law enforcement officer, who presents with painful skin lesions.

Patient Name:

Anneka Zoelle (ANN-uh-kah ZO-el)

Age:

04/05/1966

Location:

Accident & Emergency

Personality:

Anneka is a determined, straightforward individual who speaks confidently and with authority. She is articulate and persuasive.

Presenting Complaint:

Anneka explains, "I've got these awful painful areas on my backside that just won't go away. It's making it really difficult for me to sit or move around comfortably."

Symptoms:

Anneka reports the following:

Site: Painful red sores on her buttocks

Onset: Symptoms developed gradually over a few weeks

Character: The sores are painful and get worse when sitting or lying down

Associated Symptoms: Difficulty sitting, burning sensation

Timing: Started a few weeks ago and has been ongoing

Exacerbating Factors: Sitting or lying down makes the pain worse

Severity: The pain is moderate to severe

History of Presenting Complaint:

Anneka explains that she has been experiencing the symptoms for the past few weeks, and they have progressively gotten worse. She has tried over-the-counter creams, but they have not provided any relief. Anneka has been very uncomfortable and has struggled to carry out her daily activities at work. She is finding it difficult to sit or move around comfortably.

Systemic Symptoms:

Anneka denies any systemic symptoms such as fever, weight loss, or malaise.

Past Medical History:

Negative past medical history

Drug History:

Anneka is not currently on any medications.

Allergies:

Anneka has an allergy to penicillin, which causes a rash and itching.

Family History:

Negative family history for skin conditions or any significant health events.

Social History:

Lifestyle: Non-smoker, active lifestyle.

Occupation: Law enforcement officer

Activities of Daily Living & Hobbies: Anneka enjoys staying active and playing tennis regularly.

Ideas, Concerns, and Expectations:

Ideas: Anneka expresses concern about the nature and extent of her current symptoms and wants to understand the cause and effective treatment options.

Concerns: Anneka is worried that the condition might interfere with her job and daily activities.

Expectations: Anneka expects to receive an accurate diagnosis and effective treatment to manage her symptoms.

Physical Examination:

General Inspection: Anneka appears to be in discomfort, tries to avoid sitting, and has difficulty finding a comfortable sitting position. Psychological well-being appears to be affected due to her discomfort.

Skin Lesion Inspection - Discoloured patches of skin that do not change colour when pressed – the patches are red on the patient's fair.

Condition:

Pressure Sores

Patient Questions:

1. "How long will it take for the sores to heal completely?"

- The healing process can vary depending on the severity, but we will work to ensure you are comfortable throughout the recovery process.

2. "What can I do to prevent these sores from coming back?"

- We will discuss measures to prevent recurrence after evaluating the underlying cause of the sores.

3. "Can I continue working while I'm receiving treatment for this?"

- Your ability to continue working will depend on the nature of the treatment and your comfort level.

Examiner Questions:

1. "What are the main risk factors for developing pressure sores?"

- Immobility, friction, and continued pressure on the skin are the main risk factors.

2. "How do you plan on managing Anneka's level of discomfort while undergoing treatment?"

- Pain management will be a priority to ensure Anneka's comfort during the treatment process.

3. "What are the potential complications of untreated or poorly managed pressure sores?"

- Potential complications include infections, abscesses, and underlying tissue damage, which can lead to more serious health concerns.

Treatment:

- Relieve pressure by using a supportive cushion

- Keep the affected area clean and dry

- Use a protective barrier cream

- Regularly change positions to avoid prolonged pressure on the affected area

- Provide pain relief if needed

- Address any underlying conditions contributing to the pressure sores

- Ensure adequate nutrition and hydration to support healing

Monitoring:

Regular follow-up visits every few weeks to assess the progression of the healing process. Any signs of infection or deterioration would require immediate medical attention.

Prognosis:

With appropriate treatment and management, the prognosis for pressure sores is generally good. Full recovery can be expected with timely intervention and adherence to treatment recommendations.

Differential Diagnoses:

1. Cellulitis: Less likely as there are distinct features of pressure sores, including the gradual onset and specific location on the buttocks.

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin ulcers

Condition Filter:

Pressure sores

Location Filter:

Accident & Emergency

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_61\_Pressure\_Sores

## "A 53-year-old female patient presents with painful skin lesions."

Individual Page Vignette:

You are a hospital doctor examining a patient who presents with painful skin lesions.

Patient Name: Aisling MacIver (ASH-ling mak-EE-ver); She would like to be called Aisling.

Age: 24/05/1970

Location: Hospital AMU

Personality: Aisling is a chatty and friendly person, speaking with a lilting accent. She is highly educated and works as a lecturer at a local college.

Presenting Complaint: Aisling presents with a sore area over her backside and difficulty sitting down.

Symptoms:

- Site: Over her gluteal muscles, concentrated near the thighs

- Onset: Gradual over a period of a few weeks

- Character: Painful with some broken skin

- Associated Symptoms: Difficulty sitting, pain on palpation, Weeping of clear or blood-stained fluid;

- Timing: Symptoms started a few weeks ago and have been gradually worsening

- Exacerbating and Relieving factors: Worsened by prolonged periods of sitting, particularly on hard surfaces; Relieved by frequent repositioning and avoiding prolonged sitting

- Severity: Affects sleep and daily activities; the area is very sore.

History of Presenting Complaint:

The above-detailed histories are positive for this case as Aisling has been experiencing the symptoms for a few weeks now. She has not attempted any previous treatments and has not experienced such symptoms before. The sores have been progressively worsening, affecting her daily activities and work.

Systemic Symptoms:

- No systemic symptoms.

Past Medical History:

- Negative for previous skin conditions or autoimmune conditions.

Drug History:

- Aisling has no relevant medication history or history of missed doses.

Allergies:

- Aisling has an allergy to penicillin which causes a rash, hives, or itching.

Family History:

- Negative for any relevant medical conditions.

Social History:

- Occupation: Lecturer at a local college

- Lifestyle: Active, enjoys hiking and swimming

- Activities of Daily Living & Hobbies: Fond of reading and writing, hobbies include painting and knitting

- Smoking: Non-smoker

- Alcohol: Occasional social drinker, 1-2 units per week

- Recreational Drug Use: Never used

- Diet: Balanced diet with a focus on fruits and vegetables

- Exercise: Regular exercise routine, enjoys swimming and hiking

- Travel History: Recent trip to France

- Cultural or Religious Practises: Enjoys celebrating traditional Scottish festivals and feasts

Ideas, Concerns, and Expectations:

- Ideas: Aisling believes she may have developed bed sores due to prolonged periods of sitting.

- Concerns: "I’m quite worried about it. It’s really sore and it’s affecting my daily routine. I’m struggling to manage it."

- Expectations: Aisling is hoping for a swift and effective treatment to relieve the soreness and allow her to resume her normal activities.

Physical Examination:

- General Inspection: Aisling appears well with no signs of distress. She experiences discomfort when asked to palpate over the area.

- Skin Lesion Inspection:

- Location: Over the sacral area

- Shape: Irregular

- Borders: Indistinct

- Colour: Erythematous with some areas of broken skin

- Diameter: Approximately 4 cm in diameter

- Skin Lesion Palpatation:

- Tenderness: Present

- Fluctuance for fluid or pus: Negative

- Pigmentation changes: Negative

- Bleeding: No spontaneous bleeding

- Ulceration: Some areas of ulceration present

- Atrophy: No apparent atrophy

- No systemic findings

Diagnostic Tests:

- Blood tests: FBC, Urea and Electrolytes, CRP within normal limits

- Imaging Tests: Ultrasound to assess the depth and tissue involvement of the sores

- Other Tests: Bacterial and fungal cultures from the sore

Condition: Pressure Sores

Patient Questions:

1. "How can I relieve the soreness quickly?"

- Answer: "We'll start treatment to relieve the soreness and promote healing. It may take some time, but we'll monitor the progress closely."

2. "Will this affect my daily activities and work?"

- Answer: "We'll aim to provide effective treatment to allow you to resume your normal routine as soon as possible."

3. "What caused these sores, and how can I prevent them in the future?"

- Answer: "The prolonged pressure over a specific area caused the sores. We'll discuss preventative measures to avoid these in the future."

Examiner Questions:

1. What are the potential complications of pressure sores, especially if they become infected?

- Complications can include cellulitis, bone and joint infections, and systemic infections.

2. What patient education will you provide regarding redness and pressure relief to prevent the development of further pressure sores?

- I will educate the patient on the importance of frequent repositioning, offloading pressure areas, and regular skin inspections.

3. How would you assess and classify the severity of Aisling's pressure sores?

- I would use a staging system to classify the severity of the sores based on the depth of tissue involvement.

4. What is the first-line treatment for pressure sores, and how does it promote healing?

- The first-line treatment involves relieving pressure, dressing the sores, and maintaining a clean and moist wound environment. This promotes healing and prevents infection.

5. What measures should be put in place to prevent the recurrence of pressure sores in Aisling's case?

- Preventative measures include regular skin inspections, the use of pressure-relieving equipment when sitting, and maintaining good skin hygiene.

Treatment:

Speciality Filter: Dermatology

Presenting Complaint Filter: Skin Ulcer

Condition Filter: Pressure Sores

Location Filter: Hospital

Treatment Plan:

1. Relieve pressure on the affected area by repositioning frequently.

2. Clean the sores with a saline solution and apply a moist dressing.

3. Manage pain with suitable analgesics.

4. Advise on the importance of skin hygiene and inspecting the skin regularly.

5. If the sores are infected, prescribe a broad-spectrum antibiotic.

6. Referral to a tissue viability nurse for specialist advice and monitoring.

Monitoring:

- Aisling's sores will be monitored for signs of healing, reduction in pain, and absence of infection.

- Follow-up visits will be scheduled weekly for the first month, then monthly as healing progresses.

- Referral for specialist advice will be considered based on the tissue viability nurse's assessment.

Prognosis:

- With appropriate treatment and prevention, Aisling's sores should heal within a few months.

- Regular monitoring and preventative measures can significantly reduce the risk of recurrence.

Differential diagnoses:

1. Dermatitis: Less likely, as there are no signs of inflammation or itching present.

2. Traumatic injury: Less likely, as the sores have developed gradually and are related to pressure.

Speciality Filter:

Dermatology

Presenting Complaint Filter:

Skin ulcers

Condition Filter:

Pressure sores

Location Filter:

Accident & Emergency

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_62\_Cutaneous\_Fungal\_Infection

Homepage Vignette:

## "A 35-year-old male called Emhamed presents with a red, itchy rash on his arm."

Individual Page Vignette:

You are a General Practice medical student and need to take a detailed history and perform a thorough physical examination of Emhamed, a 35-year-old male, who presents with a red, itchy rash on his arm.

Patient Name:

Emhamed El-Abd; Pronounced: Em-hah-med El-Abd; Prefers to be called Emhamed.

Age:

15/09/1989

Location:

General Practice

Personality:

Emhamed is an outgoing and affable individual, who speaks confidently with a strong sense of humour. He is generally chatty and open, providing detailed and candid information about his condition.

Presenting Complaint:

Emhamed reports, "I've got this red, itchy rash on my arm. It's really bothering me. I can't stop scratching it and it's started to spread a bit."

Symptoms:

- Itching (pruritus)

- Site: Arm

- Onset: Gradual

- Character: Itchy, bothersome

- Associated Symptoms: Rash, redness

- Rash

- Site: Arm

- Onset: Gradual

- Distribution: Spreading

- Character: Red, itchy

- Borders: Well-defined

- Colour: Red

- Diameter: Spreading

History of Presenting Complaint:

Emhamed has had the symptoms for 2 weeks, initially treated with an over-the-counter antifungal cream, which did not relieve his symptoms. The rash and itching have now started to spread and are impacting his daily activities and sleep.

Systemic Symptoms:

Emhamed denies any systemic symptoms and reports feeling otherwise well.

Past Medical History:

- Negative for any previous skin conditions or fungal infections

- Negative for atopic disorders or autoimmume conditions

Drug History:

Emhamed has not used any medications for skin conditions or antifungals in the past. No prior topical steroid use.

Allergies:

- Reports no allergies or intolerances to medications, foods, or allergens

Family History:

- Negative for skin conditions or fungal infections in the family

Social History:

- Occupation: Restaurant owner

- Lifestyle: Non-smoker

- Alcohol: Occasional alcohol consumption, 1-2 units per week

- Diet: Healthy diet with a Mediterranean influence

- Exercise: Regular exercise routine with daily walks and weight training

Ideas, Concerns, and Expectations:

- Ideas: "I think it might be some sort of infection, but I'm not sure."

- Concerns: "I'm worried about it spreading further and affecting my work."

- Expectations: "I'm hoping for a quick diagnosis and effective treatment."

Physical Examination:

- General Inspection:

- Emhamed appears well with no signs of distress. His arms show visible excoriations due to itching

- Skin Lesion Inspection:

- Location: Arm

- Distribution: Localized

- Shape: Erythematous papules

- Symmetry: Symmetrical

- Borders: Well-defined

- Colour: Red

- Diameter: Spreading

- Skin Lesion Palpation:

- Elevation: Flat

- Tenderness: Mild tenderness in the affected area

- Systemic Examination:

- Lymph nodes: Not enlarged

- Joints: No abnormalities noted

- Special Tests: A potassium hydroxide (KOH) examination can be performed to confirm the diagnosis of a fungal infection.

Diagnostic Tests:

- KOH examination: Positive for fungal elements

- Other Tests: None indicated based on the clinical findings

Patient Questions:

1. "How long will it take for the treatment to work?"

- Response: "Usually, improvement is seen within a few weeks, but it varies from person to person."

2. "Is there anything I can do to stop it from spreading?"

- Response: "Avoiding scratching and the application of antifungal creams as prescribed can help prevent spreading."

3. "Could this be a sign of something more serious?"

- Response: "It's most likely a fungal infection. We will confirm and treat it accordingly."

Examiner Questions:

1. What are the potential complications of an untreated fungal infection?

- Response: "Untreated fungal infections can spread to deeper layers of the skin, causing a more severe and widespread infection."

2. How do you differentiate a fungal infection from a bacterial skin infection?

- Response: "Fungal infections typically present with well-defined borders and mild tenderness, whereas bacterial infections may show more redness, warmth, and pus."

3. What are the common risk factors for developing a fungal skin infection?

- Response: "Risk factors include hot and humid climates, weakened immune system, and sharing personal items with infected individuals."

Treatment:

Initial treatment:

- Topical antifungal cream, e.g. clotrimazole 1% cream, apply twice daily for 2-4 weeks

- Advise Emhamed to keep the affected area clean and dry

Second-line or alternative treatment:

- Oral antifungal agents, e.g. fluconazole, if the infection is extensive or resistant to topical treatment

Monitoring:

Emhamed should monitor the rash and itching, looking for signs of improvement. If there is no improvement or worsening of the symptoms, he should seek further medical attention. A follow-up visit is scheduled in 2 weeks to assess treatment response.

Prognosis:

The prognosis is good with appropriate treatment. Response to antifungal treatment is generally prompt, but Emhamed should be mindful of potential reinfection risks, especially if his work environment contributes to the fungal infection.

Differential diagnoses:

1. Contact dermatitis - less likely due to the absence of contact exposure and spreading nature of the rash

2. Eczema - less likely due to well-defined borders and absence of typical eczematous features

Keyword Filters:

Speciality Filter: Dermatology; General Practice

Presenting Complaint Filter: Chronic rash

Condition Filter: Cutaneous fungal infection

Location Filter: General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_63\_Cutaneous\_Fungal\_Infection

Homepage Vignette:

## “A 32-year-old female called Fariza presents with a rash.”

Individual Page Vignette:

You are a dermatologist. Your patient is Fariza Kartal, a 32-year-old female who works as a carer, residing in an urban area. She presents with a rash.

Patient Name: Fariza Kartal (Fah-REE-zah Car-TAHL)

Age: 21/08/1992

Location: Dermatology Clinic

Personality: Fariza is a gentle soul with a calm demeanor. She speaks softly and is quite shy but is articulate in expressing her concerns. She is polite and patient but is slightly anxious about her symptoms. She appears embarrassed and worried about the rash, and she expresses her thoughts carefully and respectfully.

Presenting Complaint:

"Doctor, I've got this burning and itchy rash on my skin, and it's really bothering me. It's making me feel self-conscious and uncomfortable. I've never experienced anything like this before. I'm really worried."

Symptoms:

Site: Generalized

Onset: Gradual over the last 2 weeks

Character: Burning and itching

Radiation: None

Associated Symptoms: None

Timing: Persistent

Exacerbating and Relieving Factors: Worsens with heat and sweat, better with antifungal cream

Severity: Moderate

History of Presenting Complaint:

Fariza has been experiencing the symptoms for the last two weeks. She has no previous treatments attempted and her symptoms have progressively worsened. The rash has been impacting her daily life and has caused her personal distress and anxiety.

Systemic Symptoms:

Fariza is negative for all systemic symptoms.

Past Medical History:

Negative for atopic disorders, previous skin conditions, and autoimmune conditions. No surgeries or significant health events.

Drug History:

Fariza is not currently on any medications. She has no history of using topical steroids or medications for skin conditions.

Allergies:

Fariza has no known allergies to medications or other substances.

Family History:

Negative for any significant medical conditions related to skin conditions, atopic disorders, and cancers.

Social History:

Lifestyle: Non-smoker; moderate alcohol use: 7 units/week; regularly exercises

Occupation: Carer

Activities of Daily Living & Hobbies: Fariza enjoys cooking and spending time with her family.

Ideas, Concerns, and Expectations:

Ideas: "I have no idea what's causing this rash and I'm afraid it might be something serious."

Concerns: "I'm really worried about the long-term impact of this rash and I'm not sure how to manage it."

Expectations: "I hope to find out what's going on with my skin and what I can do to make the rash go away."

Physical Examination:

General Inspection: Fariza appears in good health without signs of distress. She has a generalized rash on her arms and trunk, indicating moderate pruritic urticarial papules and plaques.

Skin Lesion Inspection:

Location: Arms and trunk

Distribution: Generalized

Shape: Small plaques

Symmetry: Bilateral

Borders: Well circumscribed

Colour: Red

Diameter: Approximately 1 cm

Diagnostic Tests:

The potassium hydroxide (KOH) examination and skin scrapings confirm the diagnosis of a cutaneous fungal infection.

Patient Questions:

1. "Could this rash be a sign of an underlying health condition?"

- This rash is most likely due to a superficial fungal infection, but we'll run some tests to confirm the diagnosis.

2. "Is there a chance that it might be something more serious than a fungal infection?"

- It's important to rule out other possibilities, but based on your symptoms, a fungal infection is a likely cause.

3. "Can I continue using my regular skincare products?"

- In the short term, it's best to avoid using any scented or fragranced skincare products and stick to simple, hypoallergenic options.

4. "Could this rash be related to stress or anxiety?"

- Stress can exacerbate skin conditions, so managing stress will be beneficial. However, the primary cause of this rash is fungal in nature.

Examiner Questions:

1. What are the typical features seen during a physical examination for cutaneous fungal infections?

- Typically, cutaneous fungal infections present with red, circular, and scaly lesions on the skin. These lesions often appear in moist areas of the body and are itchy.

2. How would you advise this patient on preventing the recurrence of cutaneous fungal infections?

- Advise her to keep her skin dry, wear loose-fitting clothes, and change out of sweaty clothing as soon as possible, as well as continuing to use antifungal skin treatments.

3. What treatment options would you consider for this patient, given her age and occupation?

- Treatment options may include topical antifungal preparations such as clotrimazole, miconazole, or terbinafine. I would also consider oral antifungal medications in severe or persistent cases.

4. How would you counsel the patient about managing the itching associated with her condition?

- Advise the patient to use antihistamines to alleviate the itching. I would also recommend keeping the affected areas clean and dry and to avoid scratching.

5. Given the patient's negative drug history, how might her treatment be affected?

- Her negative drug history would make prescribing antifungal treatments relatively straightforward. We could proceed with standard antifungal regimens, with little concern for drug interactions or side effects.

Treatment:

Initial:

- Topical antifungal cream (clotrimazole 1%) applied twice daily for 4 weeks

- Oral antifungal medication may be considered if the condition is severe or persistent

Second-line options if allergic or resistant:

- Oral antifungal medication: terbinafine or itraconazole for 2-4 weeks

Monitoring:

Follow-up after 2 weeks to assess treatment response. If the condition has improved, treatment might continue for an additional 2 weeks. If there is no response or the rash worsens, referral to a dermatologist is warranted.

Prognosis:

With appropriate treatment, the prognosis for cutaneous fungal infections is generally very good. Complete resolution of the rash can be achieved within a few weeks, and recurrence is preventable with proper self-care measures.

Differential diagnoses:

1. Contact dermatitis - less likely due to negative exposure history and atypical rash distribution.

2. Atopic dermatitis and eczema - unlikely to present as acute focal to generalized scaly and itchy patches.

3. Psoriasis - differentiation from psoriasis due to negative family history, acute onset, and distinct appearance of the rash.

Keyword Filters:

Speciality Filter: Dermatology

Presenting Complaint Filter: Acute rash, Skin lesion

Condition Filter: Cutaneous fungal infection

Location Filter: Clinic

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor

# ALYC\_64\_Cutaneous\_Fungal\_Infection

Homepage Vignette:

## "A 42-year-old woman called Layla presents with a rash on her skin that is causing her discomfort."

Individual Page Vignette:

As a medical student, you are to take a history from Layla, a 42-year-old office administrator who presents with a rash on her skin that is causing her discomfort.

Patient Name:

Layla Chakrabarti (Lay-lah Chuk-rub-ar-tee); she would like to be called Layla.

Age:

07/03/1982

Location:

General Practice

Personality:

Layla is a soft-spoken and polite individual. She is well-spoken, but a bit shy, and can often be found fidgeting with her belongings. She is anxious about her rash and a bit embarrassed to discuss it.

Presenting Complaint:

Layla presents with a rash on her skin that is causing her discomfort.

Quote: "I've noticed this rash on my skin and it's been quite itchy and bothersome."

Symptoms:

Itching (pruritus), rash, erythema (redness), scaling, dryness, distribution patterns, onset, progression, and exacerbating factors.

- Site: Arms, legs, back

- Onset: Gradual

- Character: Itchy

- Radiation: N/A

- Associated Symptoms: None

- Timing: Continuous

- Exacerbating and Relieving Factors: Worse with warm water, hot weather, woolen clothing; Relieved by emollients and cool compresses

- Severity: Moderate to severe

History of Presenting Complaint:

Layla has been experiencing the symptoms for the past 3 weeks. She has not used any treatments so far. The rash has gradually worsened and is now affecting her daily activities and sleep, due to the intense itching. It has also had an impact on her work and physical wellbeing.

Quote: "The rash started a few weeks ago and it's getting harder and harder to ignore. I haven't tried any treatments for it yet, but it's really interfering with my work and sleep."

Systemic Symptoms:

All normal.

Past Medical History:

Negative for previous skin conditions or autoimmune conditions. No significant past medical history. No history of injuries or surgeries. Negative for history of atopic disorders.

Drug History:

Layla is not currently taking any medications or herbal supplements.

Quote: "I don't take any medications or supplements."

Allergies:

No known drug allergies.

Family History:

Layla's family history is negative for skin conditions, atopic disorders, and other significant medical conditions.

Quote: "As far as I know, no one in my family has ever experienced a rash like this."

Social History:

Lifestyle: sedentary

Occupation: Office administrator

Activities of Daily Living & Hobbies: No specific hobbies

Smoking: Never smoked

Alcohol: Social drinker, 5 units per week

Recreational Drug Use: None

Diet: Balanced diet

Exercise: Minimal exercise

Travel History: No recent travel

Sexual History: Negative for any concerns

Driving Status: Holds a full driving license

Cultural or Religious Practises: No specific religious or cultural practices

Recent Life Events: None

Exposure to Hazards or New Environment: No recent exposure to new environments.

Ideas, Concerns, and Expectations:

Ideas: Layla is concerned that the rash may be a sign of a serious skin condition and is keen to have it addressed.

Concerns: Layla is worried about the cause of the rash and how it may affect her daily life and activities.

Expectations: Layla hopes to receive an accurate diagnosis and effective treatment for the rash.

Quote: "I'm really worried about this rash and I hope I can figure out what's causing it and how it can be treated."

Physical Examination:

The rash is predominantly on the arms, legs, and back, and is characterized by scaly, erythematous patches with well-defined borders, and some areas of excoriation from scratching. Skin temperature is normal. General inspection is unremarkable. There are no signs of distress. No visible parasites or insects. Skin lesion inspection and palpation reveals maculopapular lesions with rough texture, excoriation, and scaling.

Systemic examination findings are unremarkable.

Diagnostic Tests:

No specific tests, as the diagnosis can be made based on clinical examination only.

Condition:

Cutaneous Fungal Infection

Patient Questions:

1. "Could this rash be indicative of a more serious skin condition?"

- Short Answer: There is a possibility, so we will thoroughly investigate to rule out serious skin conditions.

2. "Is there a cure for this type of rash, or will it be something I have to manage for the long term?"

- Short Answer: With appropriate treatment, most fungal infections of the skin can be effectively managed and cured.

3. "Can you tell me the possible side effects of the treatments you are suggesting?"

- Short Answer: The potential side effects of treatments will be discussed while explaining the treatment plan.

Examiner Questions:

1. What are the most common causative organisms for cutaneous fungal infections?

- Trichophyton, Microsporum, and Epidermophyton are common dermatophytes responsible for cutaneous fungal infections.

2. How does the clinical presentation of cutaneous fungal infections differ from other common skin conditions?

- The lesions in cutaneous fungal infections are often focal, with a well-defined scaly border and central clearing, which differs from other common skin rashes such as eczema.

3. What are the key considerations when developing a treatment plan for cutaneous fungal infections?

- The treatment plan should include both topical and, if necessary, oral antifungal medications, addressing the specific anatomical sites involved, the extent and severity of the infection, and patient preferences.

4. What lifestyle modifications could help prevent the recurrence of cutaneous fungal infections?

- Practicing good skin hygiene, minimizing sweating, and avoiding sharing of personal items can help prevent the recurrence of cutaneous fungal infections.

5. What are the potential complications associated with untreated or inadequately treated cutaneous fungal infections?

- If left untreated, cutaneous fungal infections can lead to an exacerbation of symptoms, systemic spread of infection, and an increased risk of secondary infection.

Treatment:

1. First-line treatment: Topical antifungal cream (clotrimazole 1%) applied twice daily for 4-6 weeks.

2. If unresponsive or involving a large area, consider oral antifungal medication (fluconazole 150 mg once weekly for 4-6 weeks).

3. Emollients to help soothe itchy skin.

4. Education about proper skin hygiene and prevention strategies.

Monitoring:

Check for signs of clinical improvement within 2 weeks. If no improvement is noted, consider changing the antifungal treatment approach. Follow-up after completion of treatment to monitor for relapse.

Prognosis:

With appropriate treatment and adherence to prevention strategies, the prognosis for cutaneous fungal infections is generally good. Most patients respond well to treatment and experience resolution of the rash. However, there is a risk of recurrence, especially in cases of inadequate or incomplete treatment.

Differential Diagnoses:

1. Contact dermatitis: Less likely as the rash is not in areas consistent with contact with a specific agent and is not resolving.

2. Urticaria: Less likely given the persistent nature of the skin rash and the absence of transient wheals or hives.

3. Psoriasis: Less likely due to the distribution pattern and the presence of scaling, which is more consistent with a fungal infection process.

Speciality Filter:

Dermatology; General Practice

Presenting Complaint Filter:

Chronic rash; Skin lesion

Condition Filter:

Cutaneous Fungal Infection

Location Filter:

General Practice

Case created by Aisling Chung, 4th Year Medical Student

Reviewed by XX, Medical Student

Reviewed by XX, Medical Student/Doctor