

# Approach to the clinical dermatologic diagnosis

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## INTRODUCTION

The initial approach to the patient presenting with a skin problem requires a detailed history of the current skin complaint and a complete skin examination ( [figure 1A-B](#)) [1]. In many cases, the patient's general medical history may be relevant to the diagnosis of skin disorders. Although the history and visual aspects are of primary importance in the recognition of skin diseases, sometimes additional tests (eg, laboratory tests, skin biopsy) are required for accurate diagnosis. (See "[Office-based dermatologic diagnostic procedures](#)" and "[Skin biopsy techniques](#)".)

This topic will discuss the general approach to dermatologic diagnosis. The approach to the patient with specific skin signs and symptoms is discussed separately. Skin biopsy techniques are discussed separately. Laboratory tests used to refine or confirm a dermatologic diagnosis are discussed in relevant topics. The approach to the patient with hair or nail abnormalities or oral lesions is also discussed separately.

- (See "[Approach to the patient with cutaneous blisters](#)".)
- (See "[Pruritus: Etiology and patient evaluation](#)".)
- (See "[Acquired hyperpigmentation disorders](#)".)
- (See "[Congenital and inherited hyperpigmentation disorders](#)".)

- (See "Acquired hypopigmentation disorders other than vitiligo".)
  - (See "Approach to the patient with facial erythema".)
  - (See "Approach to the patient with pustular skin lesions".)
  - (See "Skin biopsy techniques".)
  - (See "Evaluation and diagnosis of hair loss".)
  - (See "Approach to the patient with a scalp disorder".)
  - (See "Overview of nail disorders".)
  - (See "Oral lesions".)
  - (See "Approach to the patient with retiform (angulated) purpura".)
  - (See "Approach to the patient with annular skin lesions".)
  - (See "Approach to the patient with an intertriginous skin disorder".)
  - (See "Approach to the differential diagnosis of leg ulcers".)
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## HISTORY

The most important initial questions to ask patients with a skin problem include the following:

- How long has the eruption or lesion been present?
- How did it look when it first appeared, and how is it now different?
- Where did it first appear, and where is it now?
- What associated symptoms, such as itching, stinging, tenderness, or pain, are associated with the lesion?
- Are any other family members affected or have a similar history?
- Has the patient ever had this rash or lesion before? If so, what treatment was used, and what was the response?
- What does the patient think caused the rash or lesions?

- What does the patient think exacerbates or alleviates the rash or lesions?
- What is the patient's usual skin care regimen?
- Is anything new or different (eg, medications, personal care products, occupational or recreational exposures)?
- How does the skin problem impact the patient's life?
- What treatments have been used, and what was the response, this time and previously?

Additional questions that may be helpful include:

- Does the patient have any acute or chronic medical conditions?
- What medications does the patient take currently, what have they recently taken, including over-the-counter and herbal therapies?
- Is there a family history of skin disorders or skin cancer?
- Has there been any increase in stress in their life?
- What is the social history, including occupation, hobbies, travel?
- Does the patient have any allergies?
- Does the patient have pets?
- Does the patient have risk factors for sexually transmitted diseases?

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## PHYSICAL EXAMINATION

The physical examination of a patient with a skin complaint, which includes visual inspection and palpation of the skin and sometimes additional examination aided by a Wood's lamp or a dermatoscope, is aimed at assessing the following:

- Morphology of individual lesions (type of lesion)
- Distribution of lesions
- Color
- Consistency and feel
- Number of lesions present

- Arrangement of multiple lesions (eg, scattered, clustered, grouped, linear, zosteriform, or coalescing)

**Visual inspection** — The patient should always be examined in a good light and with a magnifying lens, if necessary. Ideally, the entire skin should be examined in every patient, particularly if the diagnosis is in doubt, as this may reveal lesions that are more representative and have not been modified by secondary changes [1]. Moreover, a full-body skin examination, including nails, hair, and mucosal surfaces, may reveal a lesion or eruption of which the patient may be unaware.

Patients may occasionally provide self-taken digital images of skin lesions or eruptions. They may be useful in assessing changes over time or documenting evanescent eruptions, such as urticaria.

For the experienced clinician, visual inspection may sometimes provide an instant diagnosis. However, such apparently effortless pattern recognition is actually an extremely complex "nonanalytical reasoning" process where the individual components are analyzed separately [1-3].

Knowing which conditions are more frequently diagnosed can assist the clinician in arriving at the most likely diagnosis for a given patient. In the United States, the top 10 most common dermatologic conditions seen by dermatologists and nondermatologists between 2001 and 2010 were acne, actinic keratosis, nonmelanoma skin cancer, benign tumors, contact dermatitis, seborrheic keratosis, viral warts, psoriasis, rosacea, and epidermoid cyst [4].

**Examination of darkly pigmented skin** — The examination of patients with moderately to darkly pigmented skin (Fitzpatrick skin types IV to VI ( [table 1](#))) requires a degree of clinical experience because the amount of pigmentation clearly influences the characteristics of certain skin lesions. In patients with darkly pigmented skin, most dermatoses induce darkening or lightening of the skin that affect our perception of the color of the lesion and overwhelm other clinical manifestations [5]:

- Erythema may be particularly challenging to detect in individuals with darkly pigmented skin, as it may appear dark brown or violaceous instead of pink or red, as typically seen in patients with lightly pigmented skin. As an example, rosacea may be underdiagnosed in patients with darker skin tones because erythema and telangiectasias are more difficult to appreciate in darker skin ( [picture 1](#)) [6].
- The typical erythematous and scaly lesions of eczema may appear as scaly lesions with a grayish, violaceous, or dark brown hue ( [picture 2A-B](#)). Hyperpigmented areas may be

mistaken for postinflammatory hyperpigmentation, when in fact they are a marker of active inflammation.

- Wheals of urticaria appear skin-colored or paler because dermal edema lightens the skin ([picture 3A-B](#)). Papules may be pale or dark according to the degree of edema or the presence of acanthosis or hyperkeratosis, which mask the natural pigmentation.
- Purpura may be difficult to detect, as it may be obscured by the skin color ([picture 4A](#)).
- Dry skin may have a whitish or ashy color and a reduction in skin shininess ([picture 5](#)).
- Postinflammatory hypopigmentation ([picture 6](#)) and hyperpigmentation ([picture 7A](#)) are exaggerated in darkly pigmented skin compared with lighter skin.

**Palpation of the skin** — In addition to visual examination, palpation of skin lesions has a central role in the diagnosis of skin diseases [7]. Intact skin can be palpated without gloves after hands are sanitized or washed. Gloves should be worn when palpating nonintact skin and for the examination of the mouth, genital, and perineal region.

Palpation provides information on the quality of scale or keratosis, texture changes, and skin temperature, and detects consistency, induration, tenderness, depth, and fixation of a lesion. Exerting pressure on the skin can demonstrate edema, blanching, or dermal defects. Examples of the usefulness of skin palpation include:

- In morphea or scleroderma, dermal fibrosis can be felt as skin induration on palpation, where visual inspection would detect only nonspecific hypo- or hyperpigmentation. (See "[Pathogenesis, clinical manifestations, and diagnosis of morphea \(localized scleroderma\) in adults](#)".)
- Thin actinic keratoses are more easily "felt" than seen. (See "[Actinic keratosis: Epidemiology, clinical features, and diagnosis](#)".)
- In a patient presenting with bullae, applying shearing forces to the skin can show skin detachment, as in the Nikolsky sign in pemphigus. (See "[Approach to the patient with cutaneous blisters](#)", section on '[Nikolsky sign](#)').
- Stroking or rubbing with a tongue blade can demonstrate dermographism or urtication of mast cell lesions (Darier's sign). (See "[Physical \(inducible\) forms of urticaria](#)", section on '[Dermographism](#)' and "[Mastocytosis \(cutaneous and systemic\) in adults: Epidemiology, pathogenesis, clinical manifestations, and diagnosis](#)", section on '[Darier's sign](#)').

- Olfactory clues may help establish a diagnosis in rare cases. For instance, the epidermolytic ichthyoses have a distinctive odor, as does pseudomonas infection.
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## ADDITIONAL EXAMINATION

**Wood's light examination** — A Wood's light is a hand-held source of ultraviolet light from which virtually all visible rays have been excluded by a Wood's (nickel oxide) filter. Under Wood's light, variations in epidermal pigmentation are more apparent than under visible light, and some microorganisms may emit a fluorescence. As an example, the depigmented areas of vitiligo are greatly enhanced under Wood's light, and erythrasma patches may appear as pink fluorescent areas. (See "[Office-based dermatologic diagnostic procedures](#)", section on '['Wood's lamp examination \(black light'\)](#)'.)

**Dermoscopic examination** — Dermoscopy, also known as dermatoscopy or epiluminescence microscopy, is a skin examination technique performed with a handheld instrument called a dermatoscope. The procedure allows for the visualization of subsurface skin structures in the epidermis, dermoepidermal junction, and upper dermis that are usually not visible to the naked eye ( [picture 8A-B](#)).

Dermoscopy is primarily used for the examination of pigmented skin lesions but can also assist clinicians in assessing many nonpigmented skin lesions [8-10]. In general dermatology and in primary care practices, the primary purpose of dermoscopy is the evaluation of pigmented and nonpigmented skin lesions to decide whether or not a lesion should be biopsied or referred [11,12].

Dermoscopy requires some formal training to be effectively practiced [13,14]. Online tutorials on dermoscopy can be found at [www.dermnetnz.org](http://www.dermnetnz.org), [www.dermoscopy-ids.org](http://www.dermoscopy-ids.org), or <https://dermoscopedia.org>.

The principles of dermoscopy and dermoscopic examination of cutaneous lesions are discussed in detail separately. (See "[Overview of dermoscopy](#)" and "[Dermoscopic evaluation of skin lesions](#)" and "[Dermoscopy of facial lesions](#)" and "[Dermoscopy of mucosal lesions](#)" and "[Dermoscopy of pigmented lesions of the palms and soles](#)" and "[Overview of dermoscopy of the hair and scalp](#)" and "[Dermoscopy of nail pigmentation](#)" and "[Dermoscopy of nonpigmented nail lesions](#)".)

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## LESION MORPHOLOGY AND DISTRIBUTION

Two of the most useful characteristics that aid in forming a differential diagnosis are the morphology of individual lesions (type of lesion) and distribution of lesions. The arrangement of lesions in relationship to each other, the color of lesions, and the consistency and feel of lesions also add important information.

**Primary lesions** — Primary lesions represent the initial pathologic change. The terms used to describe primary skin lesions include the following:

- **Macules** – Macules are nonpalpable lesions <1 cm that vary in pigmentation from the surrounding skin ([picture 9A-C](#)). Patches are nonpalpable lesions >1 cm. These lesions are flush with the surrounding skin. The differential diagnosis of macules is shown in the table ([table 2](#)).
- **Papules** – Papules are palpable, discrete lesions measuring <1 cm in diameter ([picture 10](#)). They may be isolated or grouped. The differential diagnosis of papules is shown in the table ([table 3](#)).
- **Plaques** – Plaques are elevated lesions that are >1 cm in diameter. Plaques may be formed by a confluence of papules ([picture 11A-B](#)). The differential diagnosis of plaques is shown in the table ([table 4](#)).
- **Nodules** – Nodules are palpable, solid or cystic, discrete lesions measuring between 1 and 2 cm in diameter. Tumors are solid or cystic, discrete lesions measuring >2 cm in diameter. These lesions may be isolated or grouped and may or may not have surface changes ([picture 12A-B](#)). The differential diagnosis of tumors and nodules is shown in the table ([table 5](#)). (See "[Overview of benign lesions of the skin](#)".)
- **Telangiectasia** – Telangiectasia is a dilated, superficial blood vessel ([picture 13](#)).
- **Purpura** – Purpura are red-purple lesions that do not blanch under pressure, resulting from the extravasation of blood from cutaneous vessels into the skin. Purpuric lesions can be macular or raised (palpable purpura) ([picture 4A-D](#)). Petechiae are pinpoint, purpuric lesions 1 to 2 mm in diameter ([picture 14A-B](#)). Ecchymoses (bruises) are larger extravasations of blood ([picture 15](#)).
- **Pustules** – Pustules are small, circumscribed skin papules containing purulent material ([picture 16A-B](#)). The differential diagnosis of pustules is shown in the table ([table 6](#)).
- **Vesicles** – Vesicles are small (<1 cm in diameter), circumscribed skin papules containing clear serous or hemorrhagic fluid ([picture 17](#)). Bullae are large (>1 cm in diameter) vesicles. The differential diagnosis of vesicles and bullae is shown in the table ([table 7](#)).

- **Wheals** – Wheals are irregularly shaped, elevated, edematous skin areas that may be erythematous or paler than surrounding skin ( [picture 3A-C](#)). The borders of a wheal are well demarcated but not stable; they may move to adjacent, unininvolved areas over periods of hours.
- **Scale** – Scale is flakes on the skin surface formed by desiccated, thin plates of cornified epidermal cells ( [picture 18A-B](#)).
- **Atrophy** – Atrophy is a depression from the surface of the skin caused by underlying loss of epidermal or dermal substance ( [picture 19A-B](#)).
- **Hyperpigmentation** – Hyperpigmentation is increased skin pigment ( [picture 7A-B](#)); hypopigmentation is decreased skin pigment ( [picture 20](#)). Depigmentation is total loss of skin pigment ( [picture 21](#)).

**Secondary lesions** — Secondary lesions of the skin represent evolved changes from the skin disorder, due to secondary external forces, such as scratching, picking, infection, or healing. Examples include:

- **Excoriation** – Excoriation describes superficial, often linear skin erosion caused by scratching ( [picture 22A-B](#)).
- **Lichenification** – Lichenification is dry, leathery thickening of the skin with exaggerated skin markings secondary to chronic inflammation caused by scratching or other irritation ( [picture 2B-E](#)).
- **Edema** – Edema is swelling due to accumulation of water in tissue ( [picture 23](#)).
- **Scale** – Scale describes superficial epidermal cells that are dead and cast off from the skin ( [picture 24](#)).
- **Crust** – Crust is dried exudate of serum, blood, sebum, or purulent material on the surface of the skin, a "scab" ( [picture 25](#)).
- **Fissure** – Fissure is a deep skin split extending into the dermis ( [picture 26](#)).
- **Erosion** – Erosion is a superficial, focal loss of part of the epidermis ( [picture 27A-B](#)). Ulceration is focal loss of the epidermis extending into the dermis. Lesions may heal with scarring ( [picture 28](#)). The differential diagnosis of erosions and ulcers is shown in the table ( [table 8](#)).

- **Scar** – Scar is fibrous tissue that replaces normal dermal or subcutaneous tissue after skin injury ([picture 29](#)).

**Lesion distribution** — The location of one or multiple skin lesions and the arrangement of multiple lesions in relation to each other can suggest a particular diagnosis. Initial differential diagnoses based on typical distributions of common skin dermatoses are summarized in the table ([table 9](#)) and shown graphically in the figures ([figure 1A-B](#)).

Common arrangements of lesions are:

- Clustered, as seen in herpes simplex infections ([picture 17](#))
- Grouped, as seen in dermatitis herpetiformis ([picture 30A-B](#)) and granuloma annulare ([picture 31](#))
- Linear, as seen in contact dermatitis ([picture 32](#) and [picture 33](#)) and morphea ([picture 34A-B](#))
- Zosteriform, as seen in herpes zoster infection ([picture 35A-C](#)) and metastatic breast carcinoma
- Coalescing or confluent, as seen in psoriasis and viral exanthems ([picture 36](#))

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## SUMMARY

- **Initial approach** – The initial approach to the patient presenting with a skin problem requires a detailed history of the current skin complaint, medical and medication history, and a full body skin examination, including the scalp, nails, and mucosal surfaces.
- **History of the skin lesion/eruption** – Key questions for the patient include the time of onset, duration, location, evolution, and symptoms of the rash or lesion. Additional information on family history, occupational exposures, comorbidities, medications, and social or psychologic factors may be helpful. (See '[History](#)' above.)
- **Physical examination** – The patient should always be examined in a good light and with a magnifying lens, if necessary. The physical examination includes visual inspection and palpation of the skin. The morphology, arrangement, and distribution of the lesions are cardinal features to be identified by visual inspection and palpation. (See '[Visual inspection](#)' above and '[Palpation of the skin](#)' above.)

- **Examination of darkly pigmented skin** – The examination of patients with moderately to darkly pigmented skin requires a degree of clinical experience because the amount of pigmentation influences the characteristics of certain skin lesions. As an example, in individuals with darkly pigmented skin, the typical erythematous and scaly lesions of eczema may appear dark brown, black, or violaceous ( [picture 2A-B](#)). (See '[Examination of darkly pigmented skin](#)' above.)
- **Additional examination** – Sometimes, the clinical examination requires additional examination, aided by a Wood's lamp or a dermatoscope:
  - **Wood's light examination** – Under Wood's light, variations in epidermal pigmentation are more apparent than under visible light, and some microorganisms may emit a fluorescence. (See "[Office-based dermatologic diagnostic procedures](#)", section on '[Wood's lamp examination \(black light\)](#)').
  - **Dermoscopic examination** – Dermoscopy is a skin examination technique performed with a handheld instrument called a dermatoscope, which allows for the visualization of subsurface skin structures in the epidermis, dermoepidermal junction, and upper dermis not visible to the naked eye ( [picture 8A-B](#)). (See "[Dermoscopic evaluation of skin lesions](#)").
- **Lesion morphology and distribution** – The morphology, arrangement, and distribution of the lesions are cardinal features to be identified by visual inspection and palpation. In many cases, the location of one or multiple skin lesions and the arrangement of multiple lesions in relation to each other can suggest a particular diagnosis ( [table 9](#) and [figure 1A-B](#)). (See '[Lesion morphology and distribution](#)' above.)

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## ACKNOWLEDGMENT

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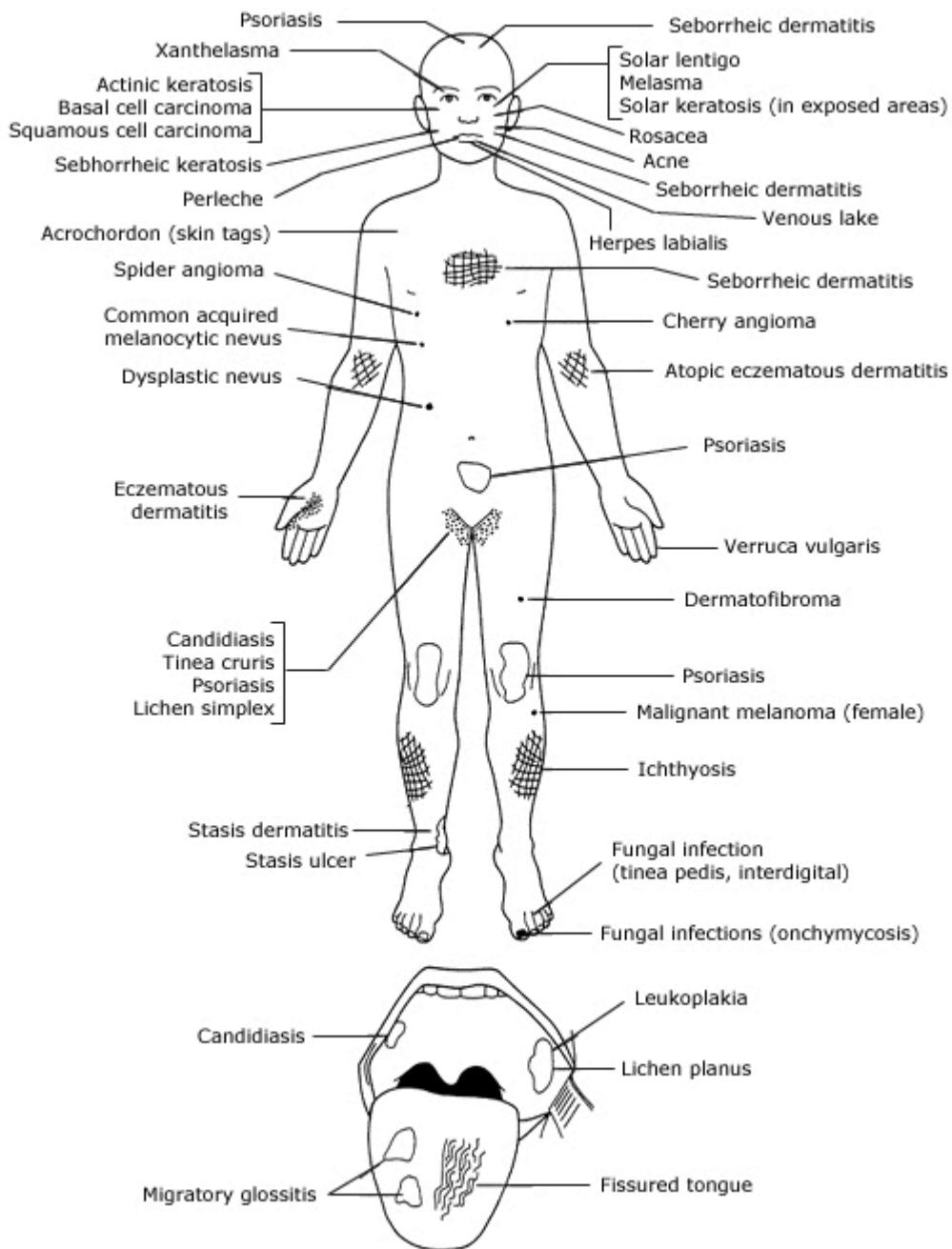
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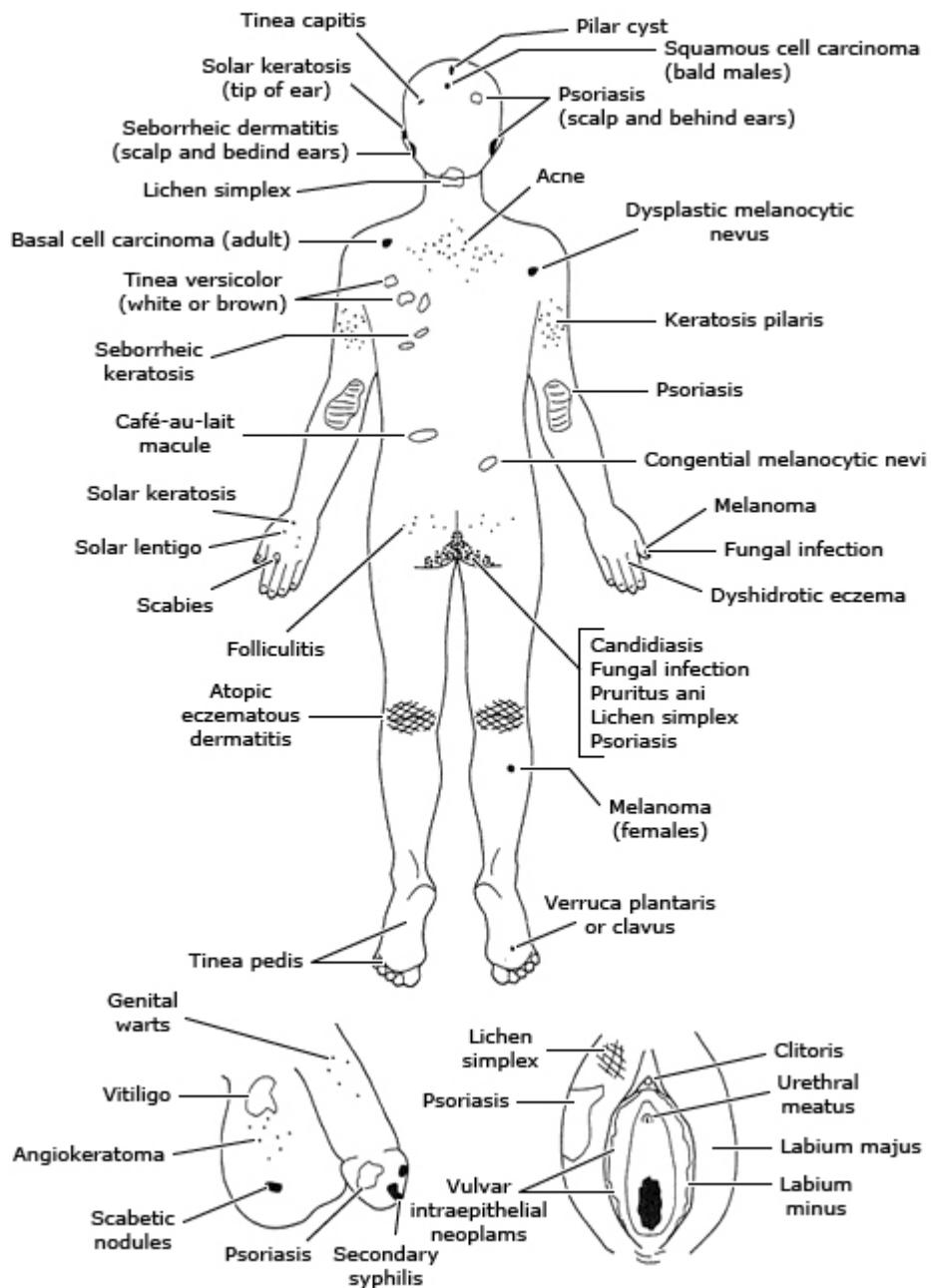
## GRAPHICS

### Common disorders encountered during the physical examination of skin, front view



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# Common disorders encountered during the physical examination of skin, back view



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## Fitzpatrick skin phototypes

Skin type	Reaction to sun exposure*
I	Always burns, never tans
II	Always burns, minimal tan
III	Burns minimally, gradually tans
IV	Burns minimally, tans well
V	Very rarely burns, tans profusely
VI	Never burns, tans deeply

NOTE: Slight variations on the definitions of the phototypes appear in the literature. Progression from type I to type VI often correlates with increasing baseline skin pigmentation.

\* After the first one hour of sun exposure on previously unexposed skin on the first day of spring.

Graphic 60541 Version 6.0

## Papulopustular rosacea



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Inflammatory papules are present on the nose.

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Graphic 63008 Version 6.0

## Atopic dermatitis



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Atopic dermatitis involving the sides of the neck. Note the scaling and characteristic reticular pigmentation.

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Graphic 102395 Version 5.0

## Atopic dermatitis



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Hyperpigmented, slightly scaly patches and lichenified plaques are present in the popliteal fossae of this patient with atopic dermatitis.

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Graphic 68215 Version 8.0

## Urticaria



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A well-circumscribed plaque, slightly lighter than the surrounding skin, is visible on the neck of this patient with urticaria.

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Graphic 101336 Version 4.0

## Urticaria



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Large, well-circumscribed plaques on the chest of this patient with urticaria.

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Graphic 101337 Version 4.0

## Henoch-Schönlein purpura



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Purpuric lesions are clearly visible on the plantar surface but less obvious on the lower leg in this patient with Henoch-Schönlein purpura.

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Graphic 101339 Version 5.0

## Xerosis (dry skin)



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Reduced skin shininess and ashy appearance in this patient with extreme skin dryness.

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Graphic 101381 Version 4.0

## Postinflammatory hypopigmentation in a patient with psoriasis



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Macular hypopigmented lesions are present on the back of this patient after resolution of plaque psoriasis.

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Graphic 101382 Version 4.0

## Postinflammatory hyperpigmentation and scarring in acne vulgaris



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Multiple hyperpigmented macules and scars on the lower face of a woman with acne vulgaris.

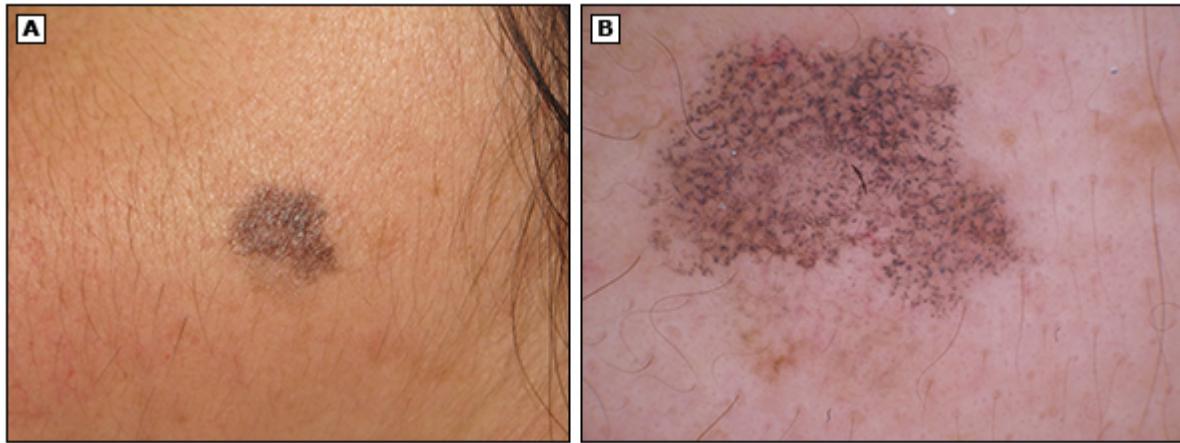
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Graphic 58817 Version 6.0

## Clinical and dermoscopic image of lichen planus-like keratosis



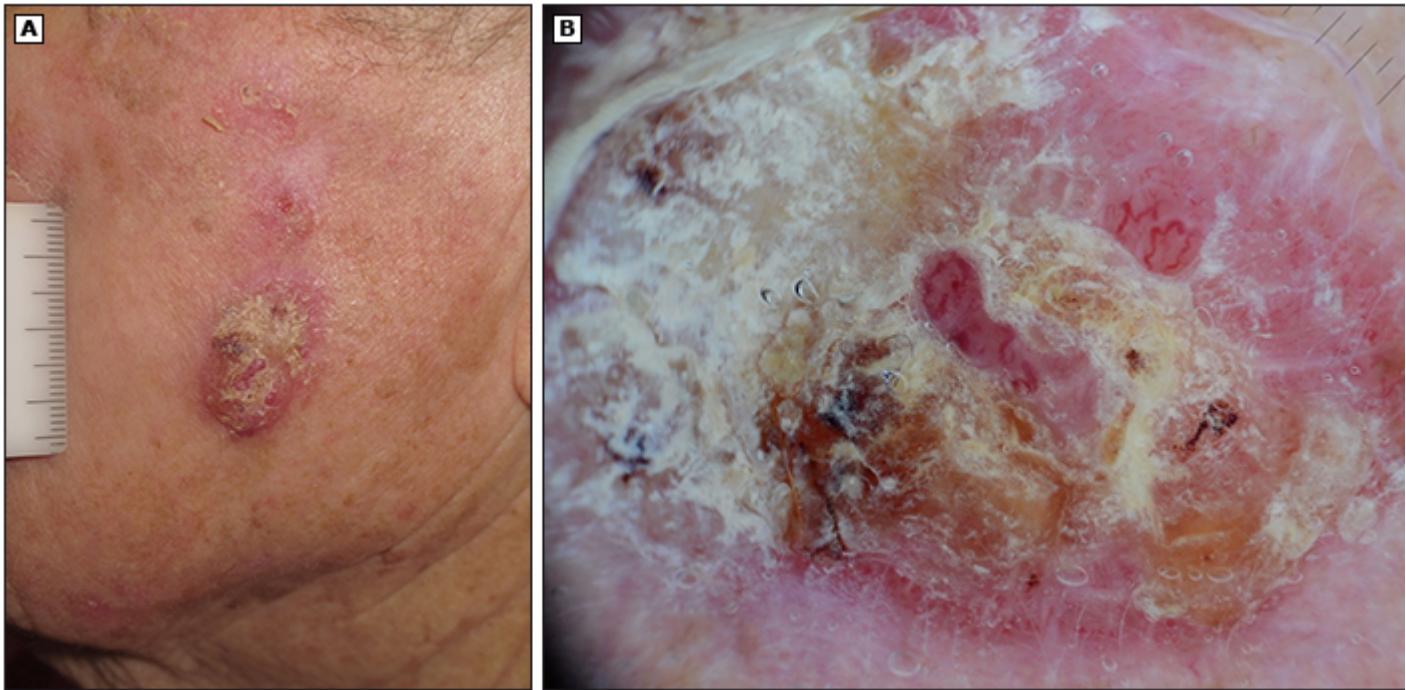
(A) Lichen planus-like keratosis, also called lichenoid keratosis, presenting as a solitary, gray to brown papule or plaque on the face.

(B) On dermoscopy, coarse, large, and partially confluent gray dots are seen.

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Graphic 96329 Version 2.0

## Clinical and dermoscopic images of Merkel cell carcinoma



(A) Merkel cell carcinoma presenting as a red nodule with scaling on the cheek of this patient. Note the background sun-damaged skin.

(B) Dermoscopy shows a polymorphous, vascular pattern composed of linear vessels over a pink background. White scales are also present.

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Graphic 102595 Version 2.0

## Vitiligo



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Depigmented macular lesions in a patient with vitiligo.

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Graphic 101356 Version 3.0

## Viral exanthem



Multiple erythematous macules are present on the skin of this patient with a viral exanthem.

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Graphic 58169 Version 8.0

## Solar lentigines presenting as brown macules on the dorsum of the hand



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Multiple brown macules are present on the dorsal hand.

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Graphic 61452 Version 7.0

## Examples of skin disorders presenting with macular lesions

<b>Erythematous macules</b>	<b>Hyperpigmented macules</b>
Drug eruption	Nevi
Viral exanthem	Fixed drug eruption
Secondary syphilis	Postinflammatory
Rheumatic fever	Ephelis (freckle)
<b>Photodistributed macules</b>	Lentigo
Drugs	Schamberg's purpura
Dermatomyositis	Nevus
Lupus erythematosus	Mongolian spot
Porphyria cutanea tarda	Purpura
Polymorphous light eruption	Stasis dermatitis
<b>Hypopigmented macules</b>	Melasma
Postinflammatory	Melanoma
Tinea versicolor	Ochronosis
Vitiligo	Mastocytosis
Halo nevus	Café-au-lait spot
Sarcoidosis	
Tuberous sclerosis	
Cutaneous T cell lymphoma	
Leprosy	

Graphic 61066 Version 4.0

## Dermatosis papulosa nigra



Multiple hyperpigmented papules are present on the face of this patient with dermatosis papulosa nigra.

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Graphic 73398 Version 7.0

## Examples of skin disorders presenting with papular lesions

Isolated papules	Papular eruptions
Acrochordon	Acne rosacea
Actinic keratosis	Acne vulgaris
Angiofibroma	Appendageal tumors (usually benign)
Appendageal tumors (benign or malignant)	Arthropod bite
Bacillary angiomatosis	Bacillary angiomatosis
Basal cell carcinoma	Dermatomyositis
Chondrodermatitis nodularis helicis	Drug eruption
Dermatofibroma	Eczematous dermatitis
Fungal infections (early)	Flat warts
Hemangioma	Folliculitis
Keratoacanthoma	Granuloma annulare
Melanoma	Keratosis pilaris
Milia	Lichen nitidus
Molluscum contagiosum	Lichen planus
Neurofibroma	Lichen sclerosus
Nevus	Lupus erythematosus
Pyogenic granuloma	Lymphoma
Sebaceous hyperplasia	Miliaria
Seborrheic keratosis	Molluscum contagiosum
Squamous cell carcinoma	Neurofibromatosis
Venous lake	Pediculosis corporis
Wart	Perioral dermatitis
	Pityriasis rosea
	Polymorphous light eruption
	Psoriasis
	Sarcoidosis
	Sarcoma
	Scabies
	Syphilis

---

Urticaria

---

Vasculitis

---

Viral exanthem

---

Xanthoma

---

Graphic 61037 Version 4.0

## Plaque psoriasis



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An erythematous plaque with coarse scale is present on the knee of this patient with psoriasis.

---

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Graphic 54581 Version 8.0

## Chronic plaque psoriasis



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Multiple large plaques with silver scale on the back.

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---

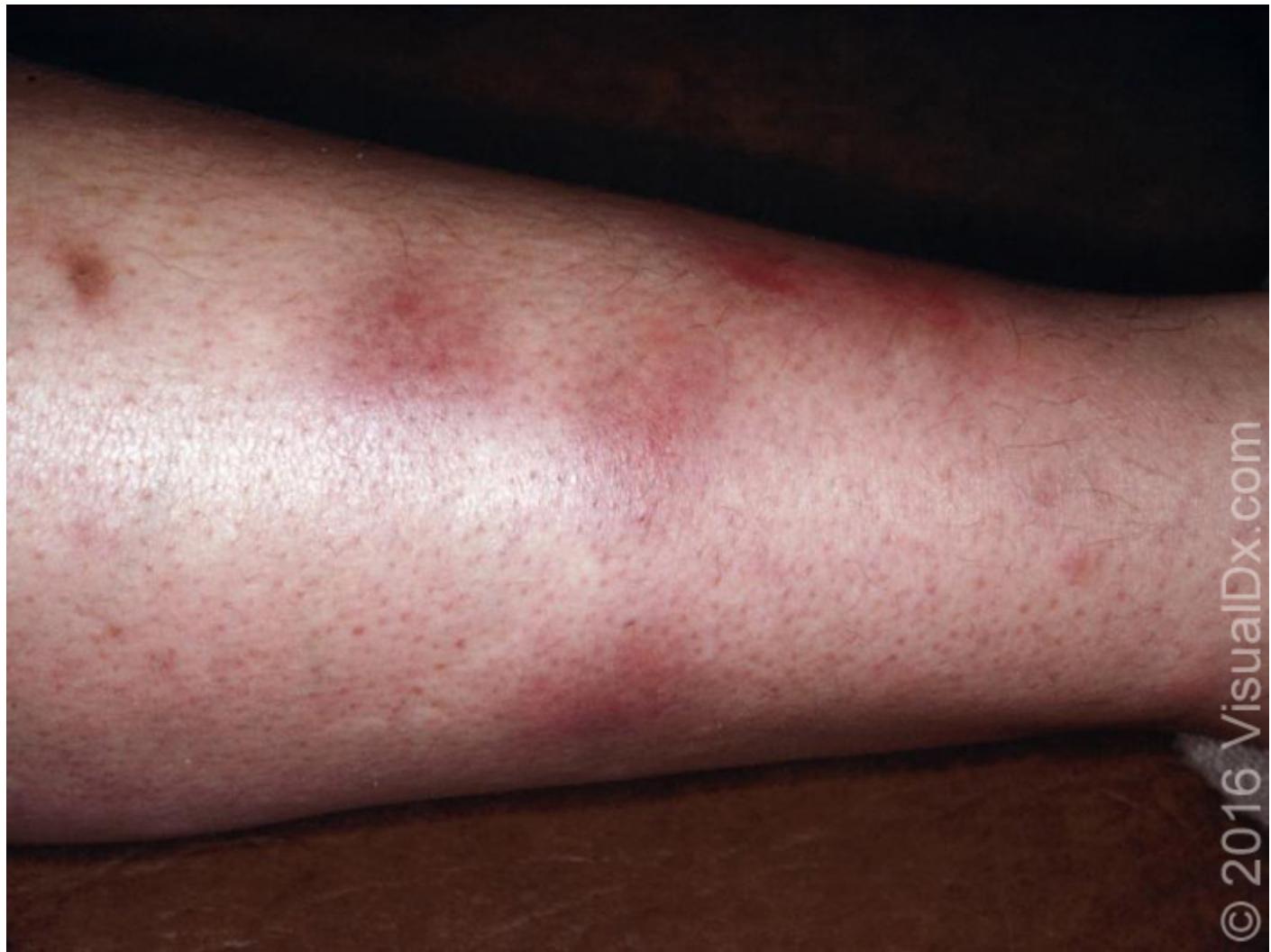
Graphic 99437 Version 3.0

## Examples of skin disorders presenting with plaque-like lesions

Acanthosis nigricans	Lymphoma (cutaneous T cell)
Candidiasis	Morphea
Cellulitis	Myxedema
Deep fungal infections	Necrobiosis lipoidica diabetorum
Dermatomyositis	Paget's disease
Diaper dermatitis	Pityriasis rosea
Eczematous dermatitis	Psoriasis
Erythrasma	Sarcoidosis
Tinea infections	Seborrheic dermatitis
Granuloma annulare	Sweet's syndrome
Ichthyosis	Syphilis
Lichen planus	Tinea versicolor
Lichen sclerosus	Vasculitis
Lupus erythematosus	Xanthelasma
Lyme disease	

Graphic 68549 Version 3.0

## Erythema nodosum



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Multiple erythematous nodules on the lower leg.

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Graphic 108925 Version 3.0

## Multiple lipomas



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Nodules are present on the arm of this patient with multiple lipomas.

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---

Graphic 61498 Version 7.0

## Examples of skin disorders presenting with nodules and tumors

Acrochordon	Lymphoma (cutaneous)
Angioma	Melanoma
Appendageal tumors	Metastatic carcinoma
Basal cell carcinoma	Neurofibroma
Callus/clavus	Nevus
Chondrodermatitis nodularis helicis	Prurigo nodularis
Dermatofibroma	Pyogenic granuloma
Dermatofibrosarcoma	Seborrheic keratosis
Erythema nodosum	Squamous cell carcinoma
Hidradenitis suppurativa	Syphilis
Histiocytosis	Tuberous sclerosis
Inclusion cyst	Venous lake
Kaposi's sarcoma	Wart
Keloid	Xanthoma
Lipoma	

Graphic 70150 Version 3.0

## Telangiectasias



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Multiple telangiectasias are present on the nose.

---

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Graphic 71614 Version 7.0

## **Henoch-Schönlein purpura**



Palpable, purpuric lesions on the legs of a child with Henoch-Schönlein purpura.

---

*Courtesy of Moise L Levy, MD.*

---

Graphic 102281 Version 2.0

## IgA vasculitis (Henoch-Schönlein purpura)



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Palpable purpura in IgA vasculitis. Multiple nonblanchable papules and plaques on the buttocks and legs.

---

IgA: immunoglobulin A.

---

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Graphic 79783 Version 9.0

## IgA vasculitis (Henoch-Schönlein purpura)



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Palpable purpura on the lower legs and feet.

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IgA: immunoglobulin A.

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Graphic 122867 Version 2.0

## Petechiae



*Courtesy of Leslie Raffini, MD.*

---

Graphic 73905 Version 2.0

**Dorsal hand edema and purpuric rash in a child with immunoglobulin A vasculitis (Henoch-Schönlein purpura)**



Graphic 98550 Version 2.0

## Ecchymosis following prairie rattlesnake envenomation



Ecchymosis following prairie rattlesnake (*Crotalus viridis*) envenomation. This picture shows the extent of ecchymosis 24 hours after the bite in a 4-year-old child who was bitten while walking in a field behind a tractor.

---

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Graphic 122496 Version 2.0

## Acne vulgaris with inflamed papules and pustules



Erythematous papules and pustules on the cheek and neck.

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Graphic 70809 Version 8.0

## Folliculitis



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Small, inflammatory papules and pustules are present in this patient with folliculitis. Postinflammatory hyperpigmentation is also present.

---

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---

Graphic 62930 Version 7.0

## Examples of skin disorders presenting with pustules

Acne vulgaris
Arthropod bite (fire ants)
Drug eruption
Eosinophilic folliculitis
Erythema toxicum neonatorum
Folliculitis
Fungal or yeast infections (especially tinea capitis and Majocchi's granuloma)
Furunculosis
Gonorrhea (disseminated)
Herpes simplex/zoster
Impetigo
Keratosis pilaris
Neonatal pustulosis
Pseudofolliculitis barbae
Pustular psoriasis
Pyoderma gangrenosum
Rosacea/perioral dermatitis
Syphilis
Varicella

Graphic 56796 Version 4.0

## Herpes simplex infection



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Grouped vesicles on erythematous background are characteristic of recurrent herpes simplex infection.

---

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---

Graphic 115618 Version 2.0

## Examples of skin disorders presenting with vesicles or bullae

Bullous disease in diabetes	Herpes zoster
Bullous pemphigoid	Id reaction
Burn	Impetigo
Cellulitis	Insect bite reaction
Congenital syphilis	Lichen planus
Contact dermatitis	Lupus erythematosus (bulloous)
Dermatitis herpetiformis	Pemphigus vulgaris/foliaceus
Eczema (especially hand/foot)	Porphyria cutanea tarda
Epidermolysis bullosa	Scabies
Erythema multiforme	Staphylococcal scalded skin
Fixed drug eruption	Streptococcal toxic shock
Fungal infections (especially tinea pedis)	Toxic epidermal necrolysis
Hand, foot, and mouth disease	Varicella
Herpes gestationis	Vasculitis
Herpes simplex	

Graphic 78295 Version 4.0

## Urticaria



Skin-colored wheals are present.

---

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Graphic 50151 Version 2.0

## Chronic plaque psoriasis



Annular psoriasis plaque.

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Graphic 113142 Version 1.0

## Chronic plaque psoriasis



Thick scale on the temporal scalp.

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Graphic 113138 Version 2.0

## Extragenital lichen sclerosus



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Multiple white, atrophic plaques are present on the chest.

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Graphic 60332 Version 6.0

## Extragenital lichen sclerosus



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Atrophic plaques with mottled hyperpigmentation are present on the shoulder and arm.

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Graphic 51592 Version 6.0

## Lichenoid drug eruption (drug-induced lichen planus)



Hyperpigmentation following the resolution of lichenoid drug eruption.

---

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Graphic 83771 Version 9.0

## Pityriasis alba



Hypopigmented macules are present on the face of this young patient with pityriasis alba.

---

*Copyright © Nicole Sorensen, RN, Dermatlas; <http://www.dermatlas.org>.*

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Graphic 60866 Version 8.0

## Segmental vitiligo



Segmental vitiligo: patches of depigmentation on the anterior trunk.

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Graphic 72369 Version 3.0

## Excoriations



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Linear excoriations (secondary to scratching) are present.

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Graphic 73387 Version 6.0

## Factitial dermatitis



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Excoriated lesions and postinflammatory hyperpigmentation in a patient with factitial dermatitis.

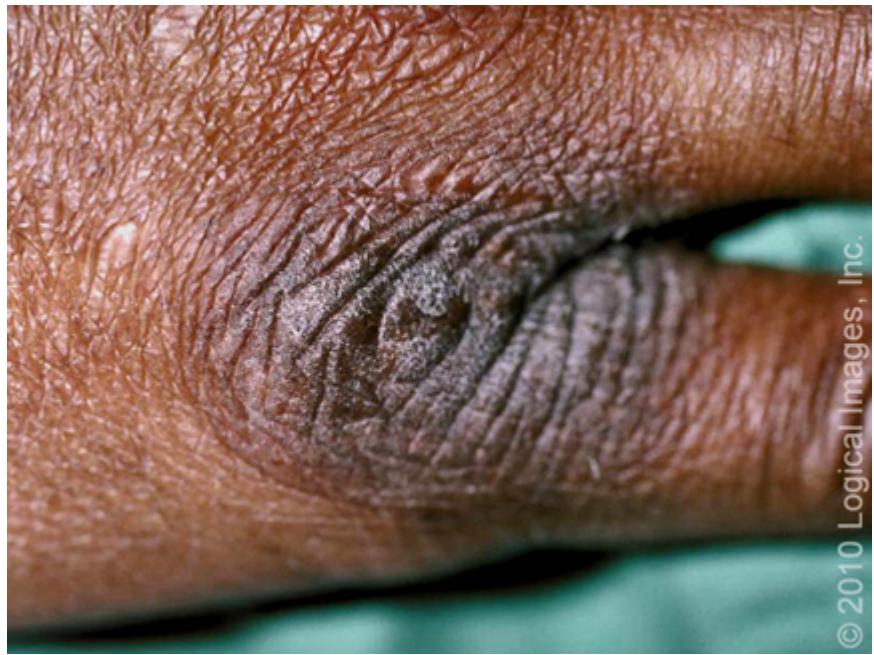
---

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Graphic 101359 Version 3.0

## Lichenification



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Thickened skin with accentuated skin lines is present in this patient who chronically rubbed and scratched this area.

---

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Graphic 80745 Version 7.0

## Adult atopic dermatitis



Chronic atopic dermatitis with lichenification (skin thickening and enhancement of skin markings) of the knee flexures in a 22-year-old female.

---

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Graphic 64525 Version 5.0

## Adult chronic atopic dermatitis



Lichenified, hyperpigmented plaque in the elbow flexure of a 35-year-old female with atopic dermatitis.

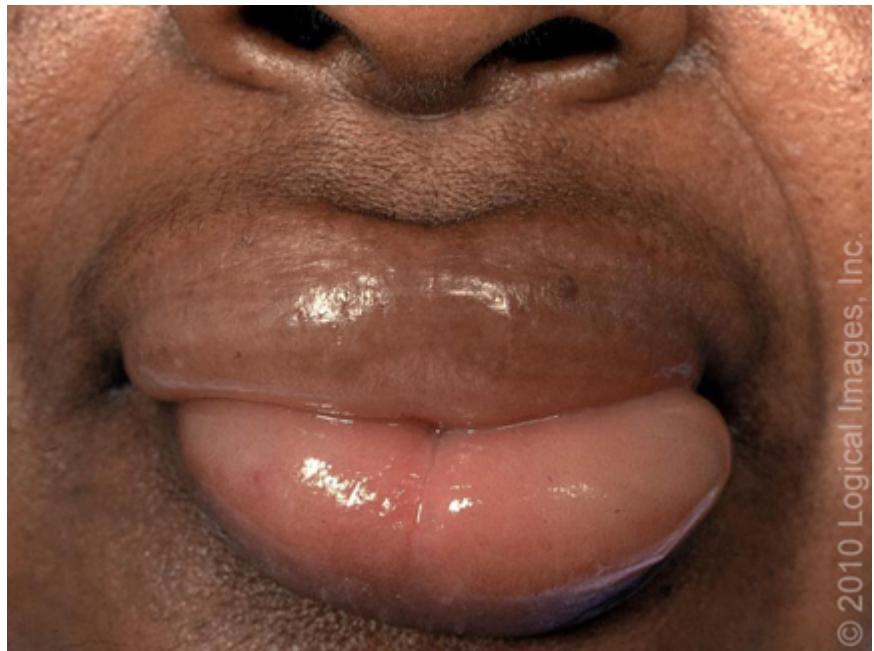
---

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Graphic 55375 Version 6.0

## Angioedema of the lips



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Graphic 57090 Version 7.0

## Scale



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Actinic keratosis. Scale overlies erythematous macules.

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Graphic 68198 Version 8.0

## Impetigo



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Crusted lesions in a patient with impetigo.

---

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Graphic 82281 Version 5.0

## Hyperkeratotic hand eczema



© University  
Department  
[www.dermis.net](http://www.dermis.net)

Chronic, hyperkeratotic, and fissured hand eczema in a 69-year-old male patient.

---

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Graphic 95750 Version 3.0

## Erosions



Multiple shallow erosions are present in areas of sloughed skin in this patient with toxic epidermal necrolysis.

---

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Graphic 57242 Version 7.0

## Toxic epidermal necrolysis



Multiple bullae and areas of denuded epidermis are present.

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Graphic 59418 Version 10.0

## **Pyoderma gangrenosum**



Peristomal pyoderma gangrenosum is caused by an inflammatory process that produces severe and painful skin ulcerations.

---

*Courtesy of Dorothy B Doughty, MN, RN, CWOCN, FAAN.*

---

Graphic 72285 Version 2.0

## Examples of skin lesions presenting with erosions and ulcers

Mouth	Genital	Other
Aphthae	Balanitis	Basal cell carcinoma
Avitaminosis	Candidiasis	Bullous pemphigoid
Burn	Chancroid	Ecthyma
Candidiasis	Diaper dermatitis	Erythema multiforme
Epidermolysis bullosa	Erythema multiforme	Ischemia
Erythema multiforme	Fixed drug eruption	Necrobiosis lipoidica
Hand, foot, and mouth disease	Fungal infections (tinea cruris)	Pemphigus vulgaris
Herpangina	Herpes simplex	Porphyria cutanea tarda
Herpes simplex	Intertrigo	Pyoderma gangrenosum
Lichen planus	Lichen planus	Spider bite
Lupus erythematosus	Lichen sclerosus	Squamous cell carcinoma
Pemphigus vulgaris	Lymphogranuloma venereum	Stasis ulcer
Perlèche	Squamous cell carcinoma	Toxic epidermal necrosis
Toxic epidermal necrolysis	Syphilis	

Graphic 74110 Version 4.0

## Dissecting cellulitis of the scalp



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Extensive scarring in a patient with dissecting cellulitis of the scalp.

---

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Graphic 81039 Version 5.0

## Typical distributions of select skin and mucosal disorders

Flexural distribution	Mouth
Acanthosis nigricans	Mucous cysts
Atopic dermatitis (older children and adults)	Leukoplakia
Bullous pemphigoid	Fordyce spots
Extensor distribution	Pyogenic granuloma
Psoriasis	Squamous cell carcinoma
Atopic dermatitis (infants)	Kaposi's sarcoma
Dermatitis herpetiformis	Axillae
Xanthomas	Acanthosis nigricans
Feet/hands	Hidradenitis suppurativa
Eczema	Impetigo
Tinea infections and "id" reactions	Hailey-Hailey disease
Erythema multiforme	Acrochordon
Wrists/ankles	Folliculitis
Lichen planus	Erythrasma
Scabies	Contact dermatitis
Contact dermatitis	Buttocks/anal
Eczema	Folliculitis
Photodistributed	Psoriasis
Lupus erythematosus	Hidradenitis suppurativa
Photodrug eruption	Lichen sclerosus et atrophicus
Dermatomyositis	Streptococcal cellulitis
Pellagra	Kawasaki disease
Porphyria cutanea tarda	Scalp
Polymorphous light eruption	Seborrheic dermatitis
	Contact dermatitis
	Tinea capitis and kerion
	Discoid lupus
	Psoriasis

Graphic 59080 Version 5.0

## Dermatitis herpetiformis



Multiple inflammatory papules and vesicles are present near the elbow.

---

*Courtesy of Scott Florell, MD, Department of Dermatology, University of Utah.*

---

Graphic 86768 Version 3.0

## Dermatitis herpetiformis



Erythematous papules and vesicles are present on the knee.

---

Graphic 86749 Version 2.0

## Disseminated granuloma annulare

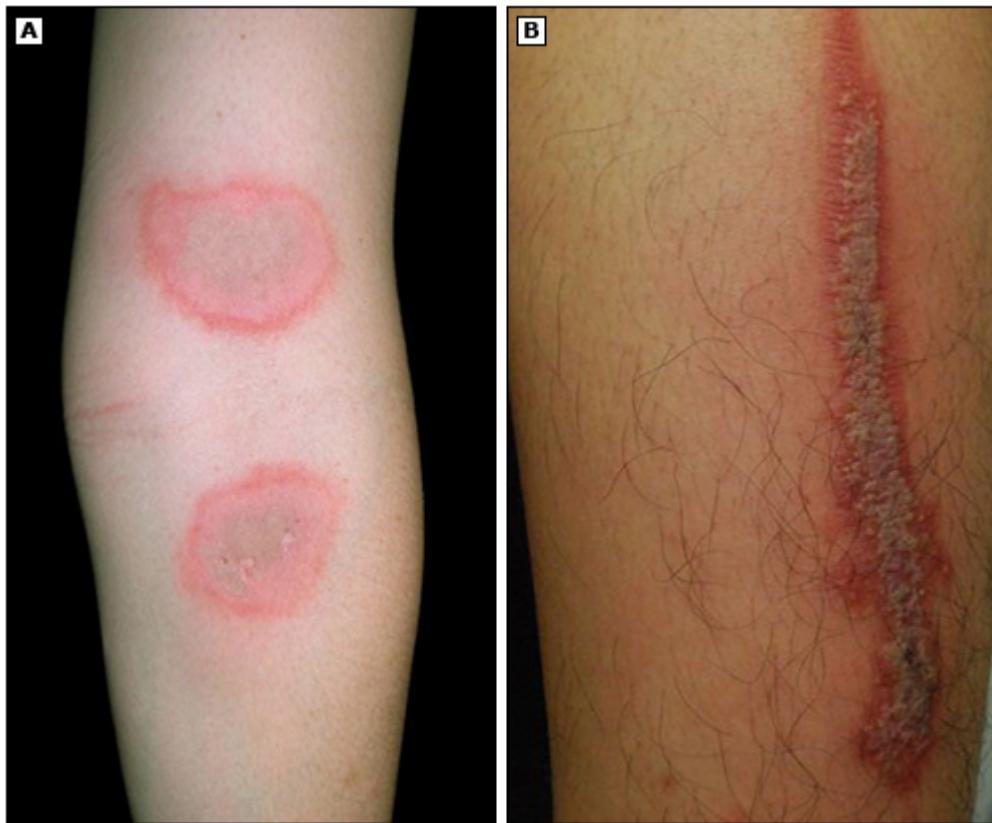


This 60-year-old patient with disseminated granuloma annulare presented with hundreds of erythematous papules and plaques on the medial arms, medial thighs, and buttocks. None of the lesions showed central clearing.

---

Graphic 51459 Version 3.0

## Acute irritant contact dermatitis



*Paederus* dermatitis. Acute contact dermatitis may occur after accidental exposure to an insect belonging to the genus *Paederus*, common in the tropical regions. The insect does not sting or bite, but accidental crushing may release its hemolymph that contains pederin, a potent vesicant.

(A) Well-defined, erythematous patches with central hyperpigmentation and vesicles in a kissing lesion fashion.

(B) Well-defined, linear, erythematous patch with central vesicles and pustules.

---

(A) Courtesy of Kulthanon K Siriraj Hospital, Mahidol University, Bangkok, Thailand.

(B) Courtesy of Wanitphakdeedecha R Siriraj Hospital, Mahidol University, Bangkok, Thailand.

---

## Berloque dermatitis



This adolescent developed hyperpigmented streaks from a photosensitizer in his sunscreen. After several days of erythema, the red patches became dark brown.

---

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Graphic 81457 Version 7.0

## Linear morphea



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A shiny, sclerotic, hyperpigmented plaque is present in a linear distribution on the arm.

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Graphic 51218 Version 6.0

## Linear morphea



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Linear morphea in a child presenting as a midline band of skin atrophy and hyperpigmentation on the forehead and scalp.

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Graphic 115807 Version 2.0

## **Herpes zoster**



*Courtesy of Vaibhav Parekh, MD, MBA.*

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Graphic 65213 Version 1.0

## Herpes zoster



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Grouped vesicles and underlying erythema are present on the back.

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Graphic 58282 Version 6.0

## **Herpes zoster**



*Courtesy of Vaibhav Parekh, MD, MBA.*

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Graphic 52440 Version 1.0

## Atypical hand, foot, and mouth disease caused by coxsackievirus A6 in adults



Dermatologic and mucosal manifestations of hand, foot, and mouth disease among military personnel, demonstrating:

- (A) Extensive and confluent purpuric and hemorrhagic crusted papules and plaques on the foot and anterior shin.
- (B) Erythematous papules and erosions on the palate.
- (C) Grouped purpuric papules on the hand.
- (D) Similar lesions with extensive involvement of the extensor aspects of the upper extremities — September 18, 2015.

---

Reproduced from: Banta J, Lenz B, Pawlak M, et al. Notes from the Field: Outbreak of Hand, Foot, and Mouth Disease Caused by Coxsackievirus A6 Among Basic Military Trainees - Texas, 2015. MMWR Morb Mortal Wkly Rep 2016; 65:678.

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