

Picture Rounds of **Common Clinical Conditions**

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Theme of lecture:

- Discuss common clinical conditions; which are diagnosed visually.
- Although the history is important, the visual diagnosis is imperative
- You will come across all of these conditions on a regular basis
- Will do some quizzing on the diagnosis but goal is to get to the treatment as that is where the management is more nuanced and varied and will allow me to discuss more cases.
- Please share any management pearls that I don't cover and ask questions along the way

Case 1



Aphthous Stomatitis (Canker Sores)

- 3-5mm round/oval ulcers with rim of erythema and yellowish exudate
- Heal within 7-14 days
- Starts in adolescence and wanes with increasing age. Uncommon for >40 yo. to begin developing new stomatitis
- Pathogenesis likely multifactorial, including immune dysregulation leading to a proinflammatory process
- Causes: Trauma, vitamin or mineral deficiency particularly Vit B12, emotional stress, certain drugs, family history, certain foods (unlikely).

Treatment:

1. Triamcinolone dental paste 0.1%
2. 2% viscous lidocaine
3. Sucralfate suspension
4. Topical minocycline or doxycycline
5. Orajel OTC
6. Diphenhydramine liquid swish and spit
7. Aluminum hydroxide, magnesium hydroxide and simethicone suspension swish and spit (Gaviscon, Mylanta, Maalox)



Case 2



Pityriasis Rosea

- Slightly inflammatory, oval, papulosquamous lesions on the trunk and proximal areas of the extremities, lesions may have scale on the perimeter “collarette” and can have central clearing with time
- Herald or mother patch seen 50-90% of cases
- Eruption typically spreads from top down typically sparing face (atypical presentations in children)
- The key is the “Christmas tree” distribution where the long axes of these oval lesions tend to be oriented along the lines of cleavage of the skin most evident along the back

“Christmas tree distribution”



“Collarettes”



Symptoms and Etiology

- Most patients are asymptomatic except for mild pruritis
- Occasionally a prodrome of headache, malaise, and pharyngitis may occur
- Thought to be caused by virus: human herpesvirus 6, 7, and 8 have been implicated
- Not thought to be contagious

Treatment:

- Moisturizing lotion
- Topical mid-potency corticosteroids to most itchy areas only
- Oral diphenhydramine
- Oral acyclovir
- UV light therapy
- Systemic glucocorticoids

- Reassurance—No isolation requirements. Rash resolves in 2-3 months

Case 3



Tinea Versicolor

- Common superficial fungal infection
- The causative agent is a lipid-dependent yeast in the genus *Malassezia* (eg *globosa*, *sympodialis*, *furfur*)
- The term “versicolor” refers to the variable changes in pigmentation with this disorder
- The macules, patches, and then plaques can be hypopigmented, hyperpigmented, or mildly erythematous
- Typically on upper trunk and proximal extremities
- Mostly asymptomatic or mild pruritis

Hyperpigmented

Erythematous



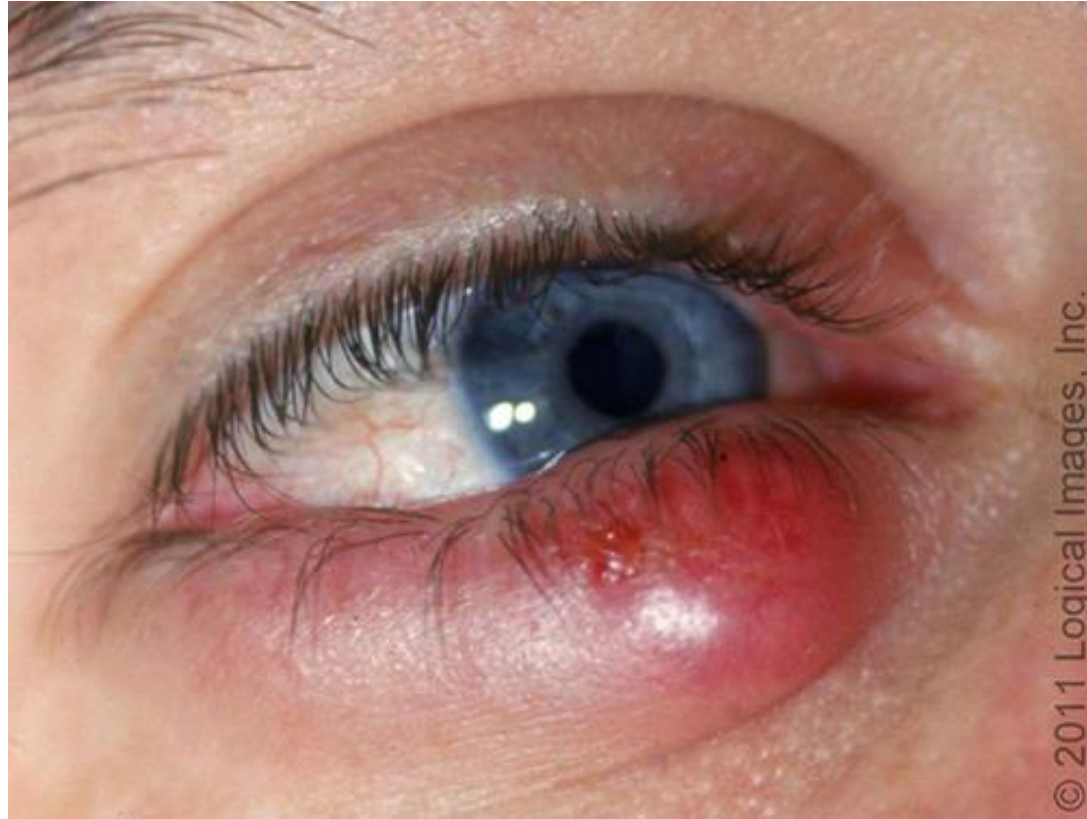
Treatment:

- Azole anti-fungal cream (clotrimazole, ketoconazole) once or twice daily for about 2 weeks
- Terbinafine 1% cream twice daily for one week
- Ketoconazole 2% shampoo 5 minute daily application X 3 days
- Selenium sulfide 2.5% shampoo 10 minute daily application for one week
- Zinc pyrithione 1-2% shampoos 5 minute daily application for two weeks
- Oral fluconazole 300mg po once weekly X 2 (take a dose, wait a couple of hours, then exercise and sweat so medicine gets into the skin and don't take shower until later)

Other pearls:

- Avoid staying in occlusive sweaty clothes prolonged
- The hypo- or hyperpigmentation may last for months following successful treatment
- In cases of hypopigmentation, sun tanned skin will make the contrast between the affected skin (because it won't tan well) and non-affected skin worse
- For patients with chronic recurrences (which occur mostly in the summer), can do prophylactic maintenance shampoos once or twice a month

Case 4



Hordeolum (Stye)

- Abscess of the eyelid presenting as a localized painful and erythematous swelling. Hordeola can be external or internal.
- External hordeola arise from glands in the eyelash follicle or lid-margin (gland of Zeis and gland of Moll)
- Internal hordeola are caused by inflammation of the meibomian gland, resulting in swelling just under the conjunctival side of the eyelid.
- Staphylococcus aureus is implicated in most cases, but hordeola can also be sterile.

External

Internal



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Treatment:

- Warm compresses: 5-10 minutes four to five times a day.
- Massage and gentle wiping of the eyelid after the warm compress may aid drainage



- May consider Erythromycin ophthalmic ointment applied to lid margin up to TID for the external hordeolums

Case 5

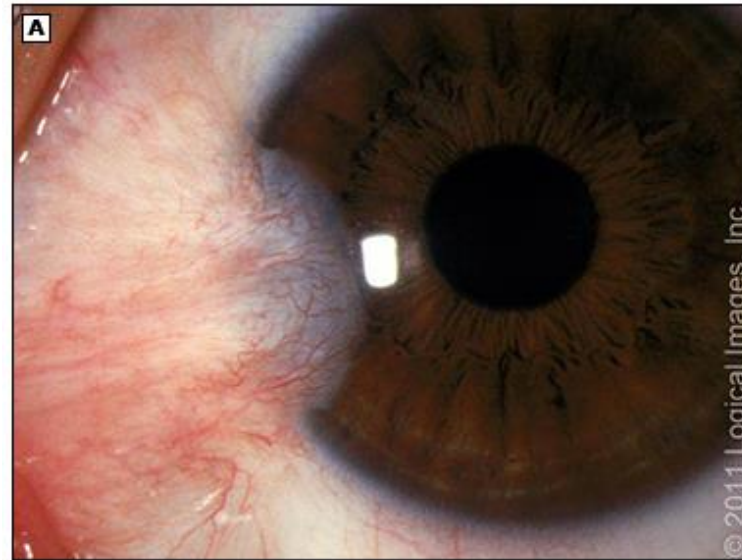


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Chalazion

- Means “hail stone” in Greek
- Painless localized eyelid swelling, non-erythematous
- Caused by obstruction of Zeis or Meibomian glands
- Hordeola sometimes transform into chalazia after inflammation resolves
- Treatment is warm compresses too
- Refer to ophthalmologist for consideration of incision and curettage or glucocorticoid injection if no resolution after several weeks

Case 6



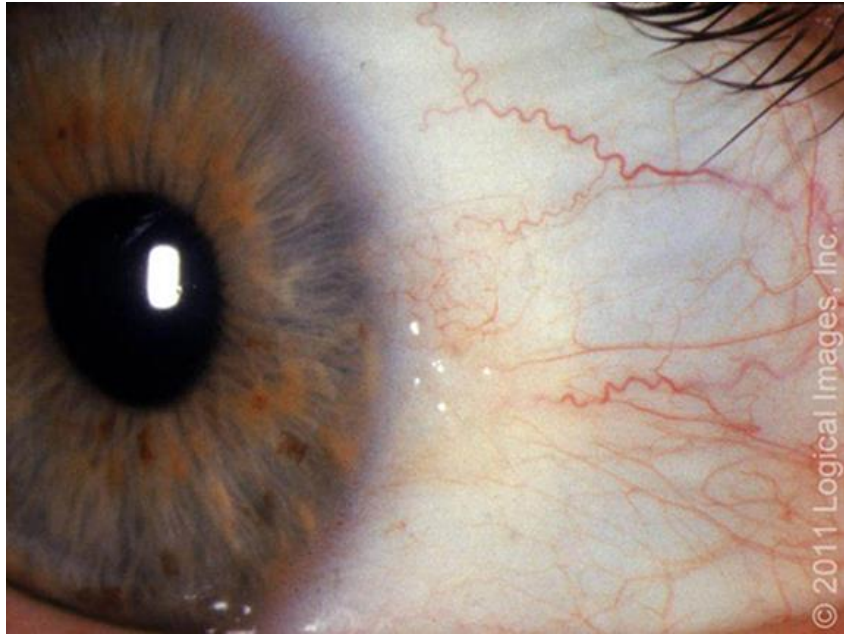
Pterygium

- Triangular wedge of fibrovascular conjunctival tissue that typically starts medially on the nasal conjunctiva and extends laterally onto the cornea.
- The etymology from (Gr. *Pterygion*) meaning "wing"
- A benign condition but can cause irritation, redness, visual disturbance when it grows onto the cornea and cosmetic disturbance.
- Causes: Ultraviolet (UV) light, abnormal genetic expression, HPV infection
- Sometimes called "Surfer's eye"

Treatment:

- Eye lubricants, artificial tears
- Avoid topical decongestants/vasoconstrictors, NSAIDs or steroids
- Wear 100% UV protection sunglasses and hats
- Ophthalmology referral if any visual disturbance, rapid growth or any suspicious lesions or patient preference

Case 7



Pinguecula

- Pinguecula is a degenerative, yellowish, slightly raised conjunctival lesion arising at the limbal conjunctiva but doesn't extend onto the corneal surface
- Etymology from the Latin word "pinguis" for fat or grease.
- Pinguecula may appear on the nasal and/or temporal conjunctiva and not necessarily wing shaped, whereas pterygium mostly appear on the nasal conjunctiva
- Management is similar to pterygium

Case 8



Chelitis

- “Lip inflammation”
- Irritant Contact Dermatitis—chronic lip licking, cold weather, low humidity, wind, irritants in lip balm products, or foods
- Allergic Contact Dermatitis—delayed hypersensitivity to lip balm products, toothpastes, mouthwashes, foods such as mango (mango peel), citrus fruit, cinnamon

Treatment:

- Remove or avoid the causative agent
- Low to mid-potency topical corticosteroids (prefer ointment) BID for 1-2 weeks
- Petrolatum (Aquaphor) can be used in combination with corticosteroids and can also be used a preventive

Case 9



Angular Cheilitis

- Inflammation at the lateral commissures of the mouth
- Caused by excessive moisture/maceration from saliva and secondary infection with *Candida albicans*, or, less commonly, *Staphylococcus aureus*.
- Common in children (drooling, thumb sucking, lip licking) and older individuals wearing dentures predisposing to drooping of the mouth and retention of saliva in the creases.
- Less common causes include B9 (folic acid), zinc, B6 (pyridoxine), B2 (riboflavin), B3 (niacin) or iron deficiencies, Type 2 DM, Sjögren syndrome, immunodeficiency, irritant/allergic reactions, and medications causing xerostomia (eg, isotretinoin, acitretin)

Treatment:

- Topical antifungal with azole (eg, clotrimazole, miconazole) BID for 1-3 weeks
- I often mix in a low potency topical corticosteroid for a week unless only mild inflammation
- Mupirocin ointment BID for 1-2 weeks if suspect Staph infection
- Preventive barrier with petrolatum to protect the skin from saliva

Case 10



Phytophotodermatitis

- A nonimmunologic skin eruption which develops after the skin comes in contact with phototoxic agents in certain plants and then is exposed to ultraviolet A (UVA) radiation
- Can present with lesions ranging from painful erythema and edema to blisters. Can be corresponding vesicles, plaques, or areas of hyperpigmentation.
- Can start within hours to days after sunlight exposure, and commonly transforms into patches of post-inflammatory hyperpigmentation which can last months to years.

Lime photodermatitis through various stages



2 DAYS



2.5 DAYS



3 DAYS



4 DAYS



1 WEEK



10 DAYS

Common plants:

- Citrus fruits (limes, lemons, grapefruit)
- Bergamot orange, bitter orange
- Celery, parsnip, parsley, dill, fennel, hogweed
- Sap of fig trees, mustard

Treatment:

- Cool compresses
- Topical corticosteroids
- Education on preventing future outbreaks

Case 11



Photodermatitis

- Similar mechanism to plants but caused by other topical agents
- Sunscreens (eg, benzophenones, cinnamates, dibenzoylmethanes)
- NSAIDs (eg, ketoprofen, diclofenac)
- Fragrances (eg, 6-methylcoumarin, musk ambrette, sandalwood oil)
- Phenothiazines (eg, promethazine, available in Europe as topical antihistamine)
- Antimicrobial agents (eg, bithionol, chlorhexidine, hexachlorophene, fenticlor)

A black and white photograph of a chalkboard. The text "Any Questions" is written in white chalk in a cursive, handwritten style. The word "Any" is on the top line, and "Questions" is on the bottom line. The chalkboard surface shows some texture and faint, illegible markings from previous writing.

Any
Questions