

Name That Rash or Lesion: Dermatology Across Lifespan

Wendy L. Wright,
DNP, ANP-BC, FNP-BC, FAANP, FAAN, FNAP
Adult/Family Nurse Practitioner
Owner – Wright & Associates Family Healthcare
@Amherst
Owner – Wright & Associates Family Healthcare
@Concord
Owner – Partners in Healthcare Education

Wright, 2021

1

1

Objectives

- Upon completion of this program, the participant will be able to:
 - Identify various dermatology conditions.
 - Determine those conditions that warrant a referral.
 - Develop an appropriate plan for evaluation, treatment and follow-up individuals with dermatologic complaints.

Wright, 2021

2

2

Fifth's Disease (Erythema Infectiosum)

- Human Parvovirus B19
 - Occurs in epidemics
 - Occurs year round: Peak incidence is late winter and early spring
- Most common in individuals between 5-15 years of age
 - Period of communicability believed to be from exposure to outbreak of rash
 - Incubation period: 5-10 days
 - Can cause harm to pregnant women and individuals who are immunocompromised

Wright, 2021

3

3

Fifth's Disease (Erythema Infectiosum)

- Low grade temp, malaise, sore throat
 - May occur but are less common
- 3 distinct phases
 - Facial redness for up to 4 days
 - Fishnet like rash within 2 days after facial redness
 - Fever, itching, and petechiae
 - Petechiae stop abruptly at the wrists and ankles
 - Hands and feet only

Wright, 2021

4

4

Fifth's Disease (Erythema Infectiosum)

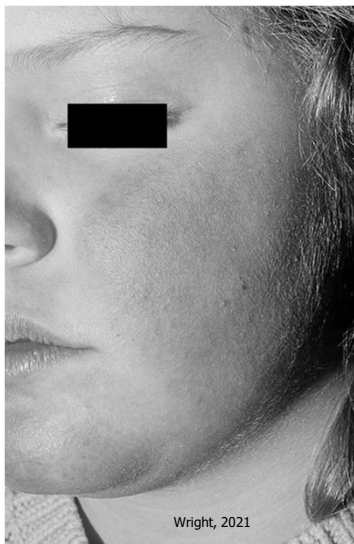
- Physical Examination Findings
 - Low grade temperature
 - Erythematous cheeks
 - Nontender and well-defined borders
 - Netlike rash
 - Erythematous lesions with peripheral white rims
 - Rash-remits and recurs over 2 week period
 - Petecchiae on hands and feet

Wright, 2021

5

5

Fifth's Disease



Wright, 2021

6

6



■ Fifth's Disease

Wright, 2021

7

Fifth's Disease



Wright, 2021

8

8

Fifth's Disease (Erythema Infectiosum)

■ Diagnosis/Plan

- Parvovirus IgM and IgG
- IgM=Miserable and is present in the blood from the onset up to 6 months
- IgG=Gone and is present beginning at day 8 of infection and lasts for a lifetime
- CBC-May show a decreased wbc count

Wright, 2021

9

9

Fifth's Disease (Erythema Infectiosum)

■ Diagnosis/Plan

- Was contagious before rash appeared therefore, no isolation needed
 - Spread via respiratory droplets
- Symptomatic treatment
- Patient education-l.e. contagion, handwashing
- Can cause aplastic crisis in individuals with hemolytic anemias
- Concern regarding: miscarriage, fetal hydrops
- Adults: arthralgias

Wright, 2021

10

10

Hand, Foot, and Mouth Disease (Coxsackie Virus)

- Caused by the coxsackie virus A16
- Most common in children
- 2-6 day incubation period
- Occurs most often in late summer-early fall
- Symptoms
 - Low grade fever, sore throat, and generalized malaise
 - Last for 1-2 days and precede the skin lesions
 - 20% of children will experience lymphadenopathy

11

cdc.gov

- From November 7, 2011, to February 29, 2012, CDC received reports of 63 persons with signs and symptoms of HFMD or with fever and atypical rash in Alabama (38 cases), California (seven), Connecticut (one), and Nevada (17).
- Coxsackievirus A6 (CVA6) was detected in 25 (74%) of those 34 patients
- Rash and fever were more severe, and hospitalization was more common than with typical HFMD.
- Signs of HFMD included fever (48 patients [76%]); rash on the hands or feet, or in the mouth (42 [67%]); and rash on the arms or legs (29 [46%]), face (26 [41%]), buttocks (22 [35%]), and trunk (12 [19%])
- Of 46 patients with rash variables reported, the rash typically was maculopapular; vesicles were reported in 32 (70%) patients
- Of the 63 patients, 51 (81%) sought care from a clinician, and 12 (19%) were hospitalized. Reasons for hospitalization varied and included dehydration and/or severe pain
- No deaths were reported

Wright, 2021

12

12

Hand, Foot, and Mouth Disease – A6

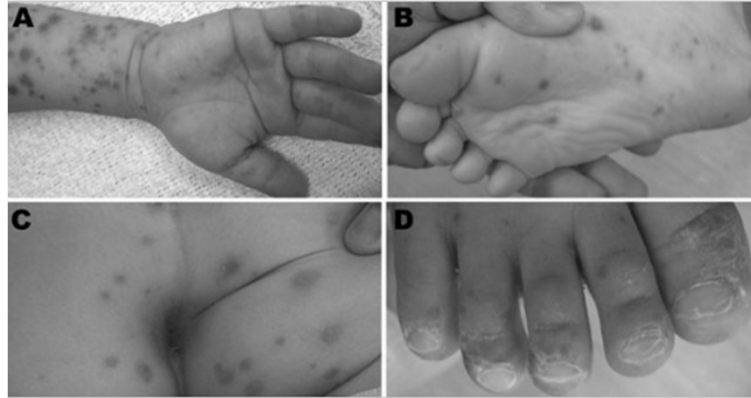


Figure. Typical clinical manifestations of hand, foot, and mouth disease associated with coxsackievirus CVA6 in Shizuoka, Japan, June-July, 2011. A) Hand and arm of a 2.5-year-old boy; B) foot and C) buttocks of a 6-year-old boy; D) nail matrix of a 20-month old boy.

Wright, 2021
<http://wwwnc.cdc.gov/eid/article/18/2/11-1147-fl.htm> accessed 05-01-2013

13

13

Hand, Foot, and Mouth Disease (Coxsackie Virus)

- Physical Examination Findings
 - Oral lesions are usually the first to appear
 - 90% will have
 - Look like canker sores; yellow ulcers with red halos
 - Small and not too painful
 - Within 24 hours, lesions appear on the hands and feet
 - 3-7 mm, red, flat, macular lesions that rapidly become pale, white and oval with a surrounding red halo
 - Resolve within 7 days

Wright, 2021

14

14

Hand, Foot, and Mouth Disease (Coxsackie Virus)

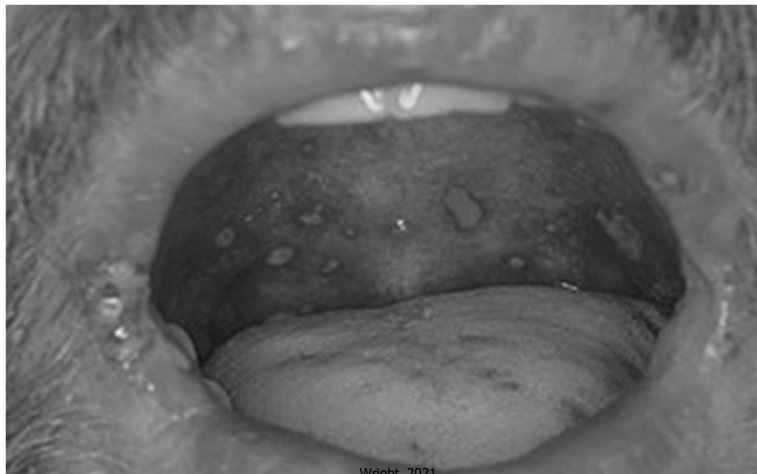
- Physical Examination Findings
 - Hand/feet lesions
 - As they evolve – may evolve to form small thick gray vesicles on a red base
 - May feel like slivers or be itchy

Wright, 2021

15

15

Hand Foot and Mouth Disease



Wright, 2021

16

16

Hand Foot and Mouth Disease



Wright, 2021

17

17

Hand, Foot, and Mouth Disease (Coxsackie Virus)

■ Plan

- Diagnostic: None
- Therapeutic
 - acetaminophen
 - Warm baths
 - Benzalkonium chloride/benzocaine/zinc chloride (Orajel)
 - Diphenhydramine/aluminum hydroxide/magnesium hydroxide (Benadryl/Maalox)

Wright, 2021

18

18

Hand, Foot, and Mouth Disease (Coxsackie Virus)

■ Plan

– Educational

- Very contagious (2d before -2 days after eruption begins)
- Entire illness usually lasts from 2 days – 1 week
- Reassurance
- No scarring

Wright, 2021

19

19

Pityriasis Rosea

■ Etiology

- Common, benign skin eruption
- Etiology unknown but believed to be viral
- Small epidemics occur at frat houses and military bases
- Females more frequently affected
- 75% occur in individuals between 10 and 35; highest incidence: adolescents
- 2% have a recurrence
- Most common during winter months

20

20

Pityriasis Rosea

■ Symptoms

- Rash initially begins as a herald patch
- Often mistaken for ringworm
- 29% have a recent history of a viral infection
- Asymptomatic, salmon colored, slightly itchy rash

■ Signs

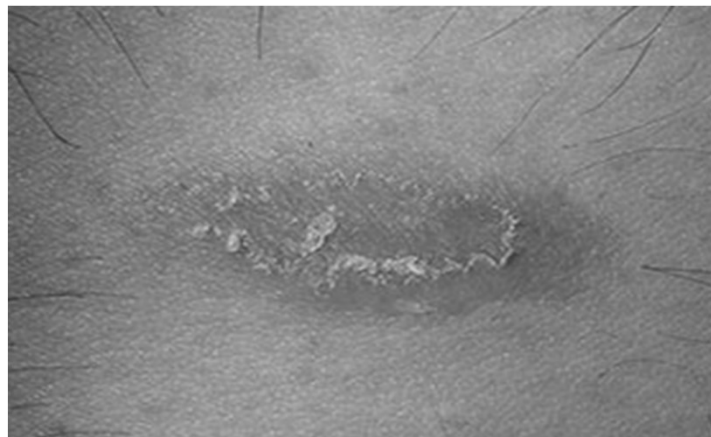
- Prodrome of malaise, sore throat, and fever may precede
- Herald patch: 2-10cm oval-round lesion appears first
- Most common location is the trunk or proximal extremities

Wright, 2021

21

21

Pityriasis Rosea

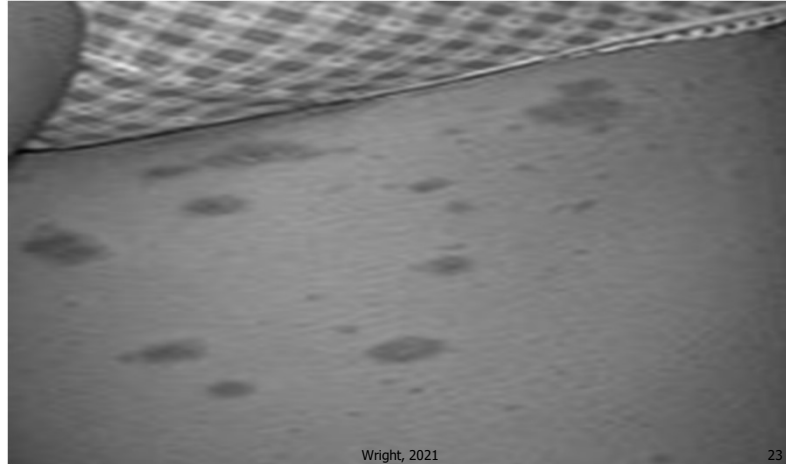


Wright, 2021

22

22

Pityriasis Rosea



Wright, 2021

23

23

Pityriasis Rosea

- Signs
 - Eruptive phase
 - Small lesions appear over a period of 1-2 weeks
 - Fine, wrinkled scale
 - Symmetric
 - Along skin lines
 - Looks like a drooping pine tree
 - Few lesions-hundreds
 - Lesions are longest in horizontal dimension

Wright, 2021

24

24

Pityriasis Rosea

- Signs (continued)
 - 7-14 days after the herald patch
 - Lesions are on the trunk and proximal extremities
 - Can also be on the face

Wright, 2021

25

25

Pityriasis Rosea

- Diagnosis
 - History and physical examination
- Plan
 - Diagnostic
 - Can do a punch biopsy if etiology uncertain
 - Pathology is often nondiagnostic
 - Report: spongiosis and perivascular round cell infiltrate
 - Consider an RPR to rule-out syphilis

Wright, 2021

26

26

Pityriasis Rosea

- Plan
 - Therapeutic
 - Antihistamine
 - Topical steroids
 - Short course of steroids although, may not respond
 - Sun exposure
 - Moisturize
 - Educational
 - Benign condition that will resolve on own
 - May take 3 months to completely resolve
 - No known effects on the pregnant woman
 - Reassurance

Wright, 2021

27

27

Contact Dermatitis: Rhus Dermatitis

- Rhus Dermatitis
 - Poison ivy, poison oak and poison sumac produce more cases of contact dermatitis than all other contactants combined
 - Occurs when contact is made between the leaf or internal parts of the roots and stem and the individual
 - Can occur when individual touches plant or an animal does and then touches human
 - Eruption can occur within 8 hours of the contact but may take up to 1 week to occur

Wright, 2021

28

28

Clinical Pearls

- Poison ivy is not spread by scratching
- No oleoresin is found in the vesicles and therefore, can not be spread by scratching
- Lesions will appear where initial contact with plant occurred
- Resin needed to be washed from skin within 15 minutes of exposure to decrease risk of condition

Wright, 2021

29

29

Clinical Presentation

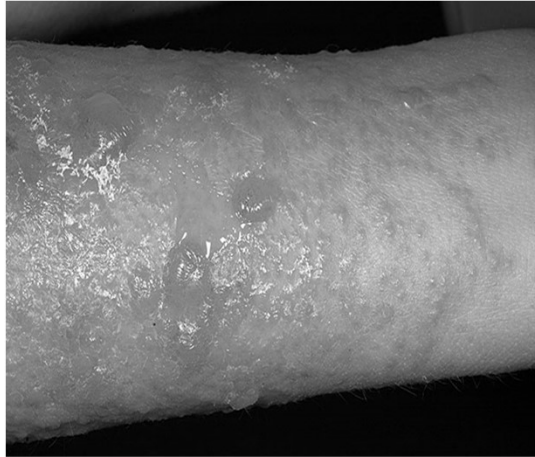
- Clinical presentation
 - Characteristic linear appearing vesicles are likely to appear first
 - Often surrounded by erythema
 - Intensely itchy
 - Lesions often erupt for a period of 1 week and will last for up to 2 weeks
 - More extensive and widespread presentation can occur with animal exposures or burning of the plants / smoke exposure

Wright, 2021

30

30

Contact Dermatitis

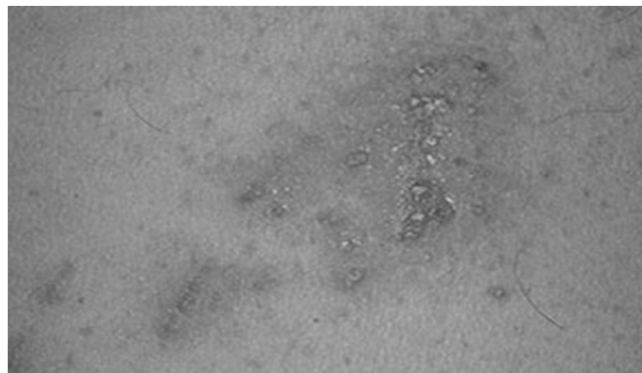


Wright, 2021

31

31

Contact Dermatitis



Wright, 2021

32

32

Treatment

- Cool compresses 15 – 30 minutes three times daily
- Topical calamine or caladryl lotions
- OTC washes – binds urushiol oil and removes from body/blisters
 - 75% decrease in itching and rash within 24 hours per package
- Colloidal oatmeal baths once daily

Wright, 2021

33

33

Treatment

- Oral antihistamines
 - May wish to use sedating antihistamines at bedtime
- Topical corticosteroids
 - Avoid usage on the face
- Oral prednisone vs. injectable triamcinolone or similar (20% or more of body affected or face/genitalia/hands)
 - 20 mg two times daily x 7 days
 - Triamcinolone (Kenalog) 40 mg injection (IM)

Wright, 2021

34

34

Follow-up

- Monitor for secondary infections
- Impetigo
 - Staph vs. strep
 - MRSA
- Education:
 - Lesions will decrease over a 2 week period
 - May continue to erupt over 48 hours despite steroid administration
 - Not spreading lesions with rubbing or scratching

Wright, 2021

35

35

Hot Tub Folliculitis

- Inflammation of the hair follicle
- Caused by infection which occurs within 8 hours – 5 days of using contaminated hot tub or whirlpool
- Unfortunately, showering after exposure provides no protection
- *Pseudomonas* is the most common cause of hot tub folliculitis
- May also be caused by Staphylococcus, but unusual
 - MSSA or MRSA

Wright, 2021

36

36

Clinical Presentation

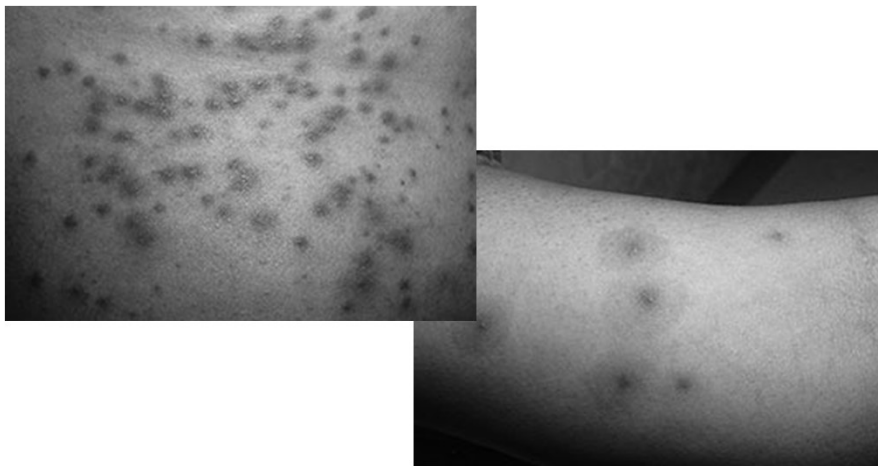
- One or more pustules may first appear
- Fever may or may not be present; usually low grade if it does occur
- Malaise and fatigue may accompany the outbreak
- Pustules may have wide rims of erythema

Wright, 2021

37

37

Hot Tub Folliculitis



Wright, 2021

38

38

Treatment

- Culture of lesions is likely warranted
- White vinegar wet compresses – 20 minutes on three x daily may provide significant benefit
- Oral Antibiotics
 - Ciprofloxacin is preferred agent if hot tub folliculitis is suspected due to pseudomonas coverage
- Discuss contagiousness
 - No evidence that it is spread person - person

Wright, 2021

39

39

Case Study

- S:TM is a 64-year-old Caucasian male who presents with a painful rash located on his right buttock.
 - Describes the rash as red and blistered
 - Has been present x 96 hours and is in for an evaluation because the pain is severe.
 - Pain is “9” on 0 – 10 scale. Has tried oral OTC medications without significant improvement. Pain is described as a burning sensation; deep in his buttock.
 - Denies precipitating factors. Pain began approx 2 days before the rash appeared. Denies fever, chills, new soaps, lotions, changes in medications.
- Medications: atorvastatin 40 mg 1 po qhs; amlodipine 5 mg 1 po qhs; loratidine 10mg 1 po qd; aspirin 81 mg 1 po qam; various vitamins

Wright, 2021

40

40

Case Study

- Allergies: NKDA
- PMH: dyslipidemia; hypertension; obesity, allergic rhinitis
- Social history: 30 pack year history of cigarette smoking; none x 10 years; Machinist; happily married x 40+ years

Wright, 2021

41

41

Case Study

- O: T:97.8; P: 94; R:18; BP: 148/90
 - Skin: p/w/d; approximately 15-20 vesicles located on right buttock overlying an erythematous base; vesicles are clustered but without obvious pattern; no streaking, petechiae. Few scattered vesicles on posterior aspect of right thigh; no lesions on left buttock or leg
 - Hips: FROM: no tenderness, erythema, masses

Wright, 2021

42

42

Case Study

- O: PE continued
 - Back: From: no tenderness, erythema, masses
 - Abdomen: Soft, large; + BS; no masses, tenderness, hsm
 - Neuro: intact including light touch, pain, vibratory to right lower extremity; heel, toe walking intact
 - + Allodynia
 - Clothing, light touch, cool object
 - + Hyperalgesia
 - Painful stimuli elicited significant pain

Wright, 2021

43

43

Examples of Herpes Zoster

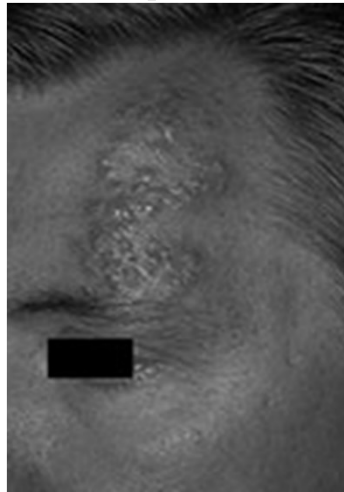


Wright, 2021

44

44

Herpes Zoster



Wright, 2021

45

45

Acute Herpes Zoster



Wright, 2021
© Dr P. Marazzi, Science Photo Library. Image used with permission.

46

46

Herpes Zoster

- Highly contagious DNA virus which during the varicella infection (primary infection) gains access into the dorsal root ganglia
- Virus remains dormant for decades and is reactivated when an insult occurs to the individual's immune system
 - Examples: HIV, chemotherapy, illness, stress, corticosteroid usage

Wright, 2021

47

47

Incidence and Prevalence

- 3 million cases of chickenpox yearly
 - Disease of childhood
- 600,000 - 1 million cases of herpes zoster each year in the United States
 - Tends to be more of a disease of aging
 - By age 80, 20% of us will have zoster at some point in our lifetime
 - Men = Women

www.niaid.nih.gov/shingles/cq.htm

Wright, 2021

48

48

Risk Factors

- Increasing age (50-60 years and beyond)
- Varicella infection when < 2 years of age
- Immunosuppression
- Stress (controversial)
- Trauma
- Malignancies
 - 25% of patients with Hodgkin's will develop zoster¹

¹Stankus, S. et. Al. Management of Herpes Zoster and Postherpetic Neuralgia. Am Fam Physician 2000;61:2437-44, 2447-8)

49

49

Goals of Treatment

- Treat acute viral infection
 - Shorten course
 - Reduce lesions
- Treat acute pain
- Prevent complications
 - Postherpetic neuralgia

Wright, 2021

50

50

Acute Treatment Options

- Antiviral
 - Goal: Reduce viral reproduction
- Corticosteroids
 - Initially postulated that these reduce viral replication; recent studies have not found this to be true
 - However, they do decrease pain
- Pain Management
 - Topical agents
 - Anti-inflammatory agents
 - Narcotics
- Postherpetic neuralgia prevention

Wright, 2021
www.aad.org/pamphlets/herpesZoster.html

51

51

Antiviral Treatment Options

- Ideally, want to begin within the first 72 hours of the eruption as benefits may be reduced if started after that
- These medications decrease duration of the rash and severity of the pain
 - Studies vary as to how much these products actually reduce the incidence of post-herpetic neuralgia

Stankus, S. et. Al. Management of Herpes Zoster and Postherpetic Neuralgia. Am Fam Physician 2000;61:2437-44, 2447-8)

Wright, 2021

52

52

Controlled Trials of Antiviral Agents in Herpes Zoster

% of patients with PHN at:	3 months	6 months
Acyclovir vs. Placebo	25% vs. 54%	15% vs. 35%
Valacyclovir vs. Acyclovir	31% vs. 38%	19.9% vs. 25.7%
Famciclovir vs. Placebo	34.9% vs. 49.2%	19.5% vs. 40.3%

Adapted from Johnson RW. J Antimicrob Chemother. 2001;47:1-8.

53

53

Pain

- Pain associated with herpes zoster can range from mild – severe
- Clinician must tailor pain medication options based upon individual presentation

Wright, 2021

54

54

Pain Management

■ Topical Agents

- Calamine lotion to lesions 2 – 3x/day
- Betadine to lesions qd
- Capsaicin cream once lesions crusted 3 – 5x/day
- Topical lidocaine 5% patch for 12 hours at a time once lesions are crusted

¹Stankus, S. et. Al. Management of Herpes Zoster and Postherpetic Neuralgia. Am Fam Physician 2000;61:2437-44, 2447-8)

55

Acute Pain Management

■ Oral Agents

- Acetaminophen
 - Has not been shown to be effective in trials)
- Ibuprofen or similar
 - Not likely to be effective with neuropathic pain

■ Nerve Blocks

- Have been shown to be effective for many individuals with severe pain in some trials; other trials - ineffective

Wright, 2021

56

56

And...the use of medications such as TCA's, gabapentin, pregabalin, oxycodone and tramadol during the acute phase of HZ decrease pain but also may also reduce the risk of PHN

Wright, 2021

57

57

Follow-up

- Monitor for secondary infections
- Monitor for evidence of postherpetic neuralgia
- Monitor for adverse impact on quality of life

Wright, 2021

58

58

Two Sets of Guidelines

- IDSA
 - <http://www.idsociety.org/lyme>
- ILADS
 - http://www.ilads.org/files/ILADS_Guidelines.pdf

Wright, 2021

59

59

Erythema Chronicum Migrans

- Etiology
 - Caused by a spirochete called *Borrelia Burgdorferi*
 - Transmitted by the bite of certain ticks (deer, white-footed mouse)
 - 1st cases were in 1975 in Lyme, Connecticut
 - Affects many systems
 - Children more often affected than adults

Wright, 2021 60

60

This is NOT a Lyme Bearing Tick



Wright, 2021

61

61

Lyme Bearing Tick



Wright, 2021

62

62

Erythema Chronicum Migrans

■ Symptoms

- 3-21 days after bite
- Rash (present in 72-80% of cases)-slightly itchy
- Lasts 3-4 weeks
- Mild flu like symptoms (50% of time)
- Migratory joint pain
- Neurological and cardiac symptoms
- Arthritis, chronic neurological symptoms

Wright, 2021

63

63

Erythema Chronicum Migrans

■ Signs

– Rash:

- Begins as a papule at the site of the bite
- Flat, blanches with pressure
- Expands to form a ring of central clearing
- No scaling
- Slightly tender

– Arthralgias:

- Asymmetric joint erythema, warmth, edema
- Knee is most common location

Wright, 2021

64

64

Erythema Migrans



Wright, 2021⁶⁵

65

Erythema Migrans



Wright, 2021⁶⁶

66

Summer 2009



Wright, 2021

67

67

Erythema Chronicum Migrans

- Signs
 - Systemic symptoms
 - Facial palsy
 - Meningitis
 - Carditis

Wright, 2021

68

68

Erythema Chronicum Migrans

■ Plan

– Diagnostic:

■ Sed rate: usually normal

■ Lyme Titer

– IGM: Appears first: 3-6 weeks after infection begins

– IGG: Positive in blood for 16 months

– High rate of false negatives early in the disease

■ Lyme Western Blot

Wright, 2021⁶⁹

69

Per ILADS

- “Diagnosis of Lyme disease by two-tier confirmation fails to detect up to 90% of cases and does not distinguish between acute, chronic, or resolved infection”
- “The Centers for Disease Control and Prevention (CDC) considers a western blot positive if at least 5 of 10 immunoglobulin G (IgG) bands or 2 of 3 immunoglobulin M (IgM) bands are positive. However, other definitions for western blot confirmation have been proposed to improve the test sensitivity. In fact, several studies showed that sensitivity and specificity for both the IgM and IgG western blot range from 92 to 96% when only two specific bands are positive”
 - Lyme specific bands: 31, 34, and 39

http://www.ilads.org/lyme_disease/treatment_guidelines_clearing_ilads.html

Accessed 12/20/2013

70

70

Erythema Migrans: IDSA 2020

- 10 days of doxycycline is sufficient
- For children or those unable to tolerate doxycycline, 14 days of amoxicillin or cefuroxime is recommended

<https://www.healio.com/news/infectious-disease/20201204/qa-lyme-disease-guidelines-updated-for-first-time-in-14-years> accessed 01-19-2021

Wright, 2021

71

71

Prophylactic Treatment

- Prophylactic antibiotic therapy should be given only to adults and children within 72 hours of removal of an identified high-risk tick bite
 - If a tick bite cannot be classified with a high level of certainty as a high-risk bite, a wait-and-watch approach is recommended.
 - A tick bite is considered to be high-risk only if it meets the following 3 criteria: the tick bite was from (a) an identified *Ixodes* spp. vector species, (b) it occurred in a highly endemic area, and (c) the tick was attached for ≥ 36 hours

<https://onlinelibrary.wiley.com/doi/10.1002/art.41562>

72

ILADS

- Believe in Chronic Lyme Disease
- Treatment may be continued as long as needed to treat symptoms
- Alternative recommendations are made:
 - Doxycycline 100-200 mg bid or TCN 500 mg 1 bid
 - Clarithromycin 500 mg 1 po bid along with hydroxychloroquine 200 mg 1 two times daily
 - Azithromycin 500 mg once daily

Wright, 2021

73

73

Necrotizing Fasciitis

- Severe, deep, necrotizing infection
- Involves subcutaneous tissue down into the muscles
- Spreads rapidly
- Caused by Group A Beta Hemolytic Strep, Staph, Pseudomonas, E Coli
- Mortality: 8-70% depending upon organism and rapidity of treatment
- Disfigurement common

Wright, 2021

74

74

Necrotizing Fasciitis

■ Symptoms

- Usually occurs after surgery, traumatic wounds, injection sites, cutaneous sores
- Generalized body aches, fever, irritability
- Key: Red area of skin that is severely painful (It is out of proportion to findings)
- Leg is most common location

■ Physical Examination Findings

- 1st appears as local area of redness that looks like cellulitis

Wright, 2021

75

75

Necrotizing Fasciitis

■ Physical Examination Findings

- Tender
- Bullae with purulent center which ruptures quickly
- Black eschar appears and the pain decreases
- Systemic symptoms begin

Wright, 2021

76

76

Necrotizing Fasciitis



Bullae: Below these lesions is necrotic tissue

77

77

Necrotizing Fasciitis

■ Plan

- Diagnosis: Culture of wounds, blood cultures, biopsy of area, CBC with differential, urinalysis
- Therapeutic: HOSPITAL ADMISSION
- Educational: Good wound hygiene

Wright, 2021

78

78

Stevens-Johnson Syndrome

- Distinct, acute hypersensitivity syndrome
- Many causes: Drugs, bacteria, viruses, foods, immunizations
- Also known as Bullous Erythema Multiforme
- Stevens-Johnson Syndrome is thought to represent the most severe of the erythema multiforme spectrum
- Two stages
 - Prodrome which lasts 1-14 days
 - 2nd stage: mucosal involvement where at least 2 mucousal surfaces are involved (oral, conjunctival, urethral)

Wright, 2021

79

79

Stevens-Johnson Syndrome

- Mortality: 5-25%
- Long-term complications are common
- Face almost always involved and mouth always involved
- Entire course: 3-4 weeks
- Most common in children aged 2 - 10

Wright, 2021

80

80

Stevens-Johnson Syndrome

- Symptoms
 - Constitutional symptoms such as fever, headache, sore throat, nausea, vomiting, chest pain, and cough
- Physical Examination Findings
 - Vesicles that are extensive and hemorrhagic
 - Bullae rupture leaving ulcerations which are covered with membranes
 - Leave large areas of necrosis and skin peels
 - Lesions on the conjunctiva

Wright, 2021

81

81

Erythema Multiforme



Wright, 2021

82

82

Erythema Multiforme



Wright, 2021

83

83

Stevens-Johnson Syndrome



Wright, 2021

84

84

Stevens-Johnson Syndrome



Wright, 2021

85

85

Stevens-Johnson Syndrome

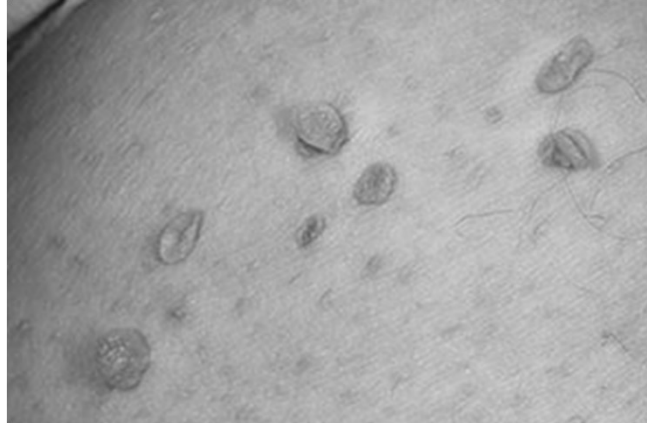
- Plan
 - Must rule-out staphylococcal scalded skin syndrome
 - Therapeutic: HOSPITALIZATION with early ophthalmological evaluation
 - Steroids are controversial
 - Others in family may be genetically susceptible
 - Never take these medications again

Wright, 2021

86

86

Diagnosis? Linked with _____?



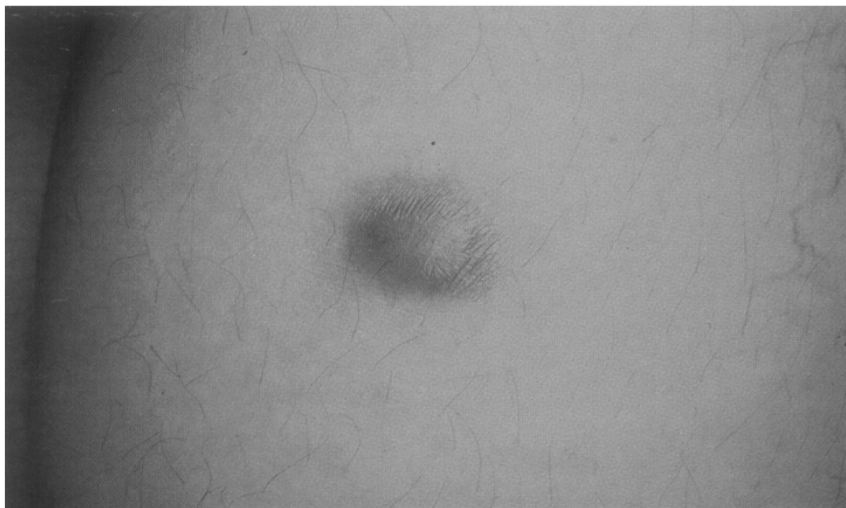
Wright, 2021

87



87

Dermatofibroma



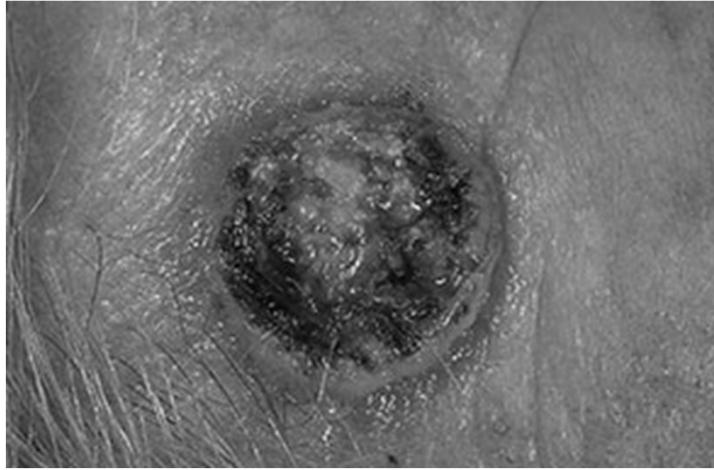
Wright, 2021

88



88

Squamous Cell Carcinoma



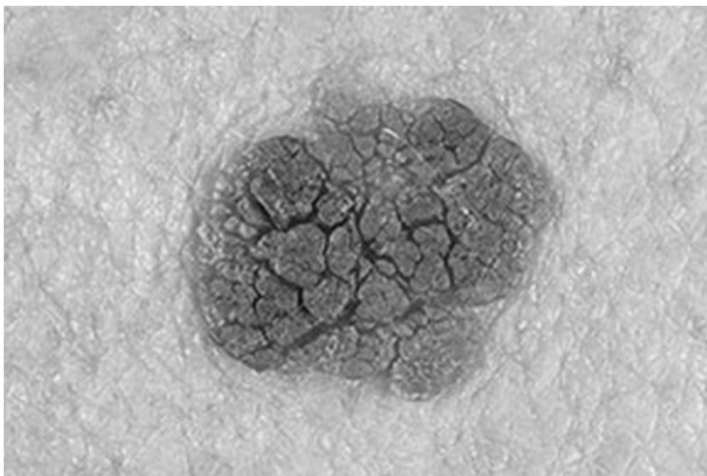
Wright, 2021

89



89

Seborrheic Keratosis



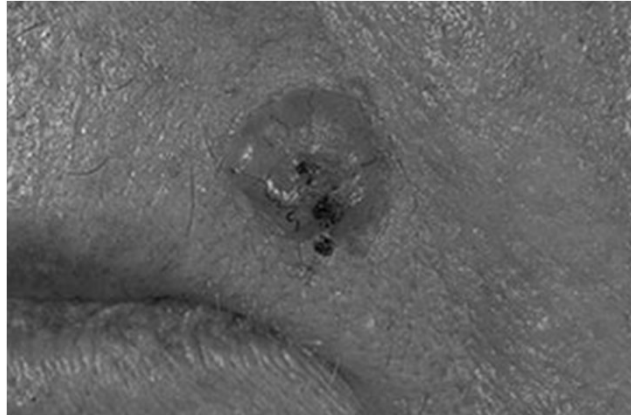
Wright, 2021

90



90

Basal Cell Carcinoma



Wright, 2021

91



91

Malignant Melanoma



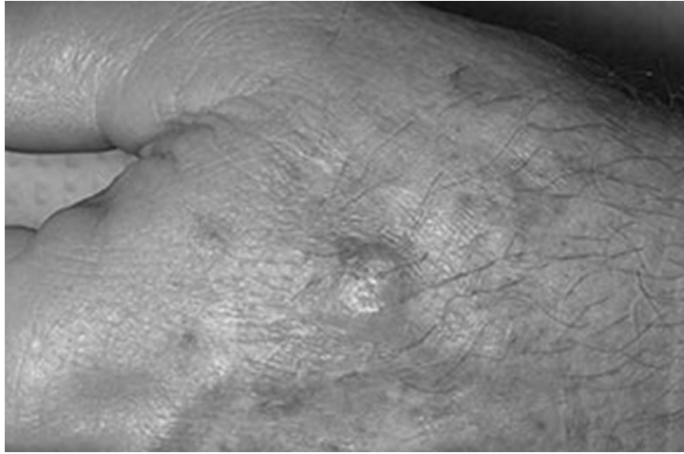
Wright, 2021

92



92

Squamous Cell Carcinoma



Wright, 2021

93



93

Molluscum Contagiosum



Wright, 2021

94



94

Bowen's Disease

- Form of SCC
- Erythematous, scaly patch



Wright, 2021

95

95

What Do These Have In Common?



Wright, 2021

96

96

Key References

- Bologna, Jean, Joseph L. Jorizzo, and Ronald P. Rapini. *Dermatology*. 2nd ed. St. Louis, Mo.: Mosby/Elsevier, 2008. Print.
- Habif, Thomas P.. *Skin disease: diagnosis and treatment*. 2nd ed. Philadelphia: Elsevier Mosby, 2005. Print.
- Hunter, J. A. A., John Savin, and Mark V. Dahl. *Clinical dermatology*. 3rd ed. Malden, Mass.: Blackwell Science, 2002. Print.

Wright, 2021

97

97

Thank You!

**I Would Be Happy To
Entertain Any Questions**

Wright, 2021

98

98

**Wendy L. Wright,
DNP, ANP-BC, FAANP, FAAN, FNAP**

email: WendyARNP@aol.com

Wright, 2021

99

99