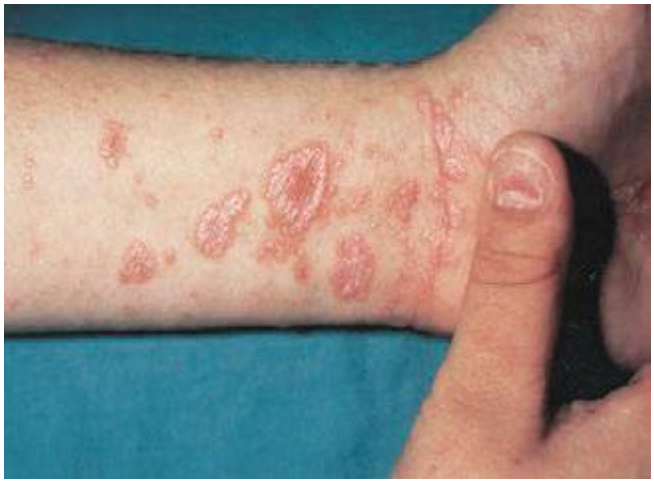

FIGURE 71-5 Lichen planus. An example of lichen planus showing multiple flat-topped, violaceous papules and plaques. Nail dystrophy, as seen in this patient's thumbnail, may also be a feature. *(Courtesy of Robert Swerlick, MD; with permission.)*

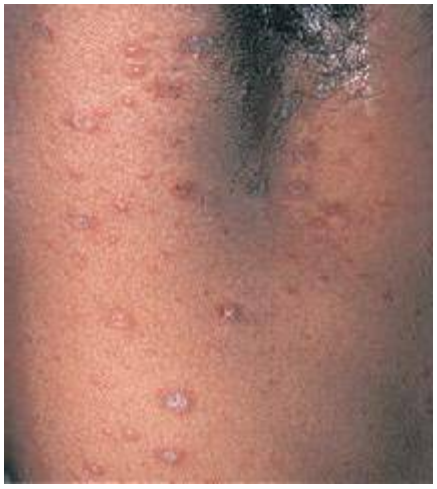

FIGURE 71-6 Pityriasis rosea. In this patient with pityriasis rosea, multiple round to oval erythematous patches with fine central scale are distributed along the skin tension lines on the trunk.

LICHEN PLANUS

Lichen planus (LP) is a papulosquamous disorder that may affect the skin, scalp, nails, and mucous membranes. The primary cutaneous lesions are pruritic, polygonal, flat-topped, violaceous papules. Close examination of the surface of these papules often reveals a network of gray lines (*Wickham's striae*). The skin lesions may occur anywhere but have a predilection for the wrists, shins, lower back, and genitalia (Fig. 71-5). Involvement of the scalp (*lichen planopilaris*) may lead to scarring alopecia, and nail involvement may lead to permanent deformity or loss of fingernails and toenails. LP commonly involves mucous membranes, particularly the buccal mucosa, where it can present on a spectrum ranging from a mild, white, reticulate eruption of the mucosa to a severe, erosive stomatitis. Erosive stomatitis may persist for years and may be linked to an increased risk of oral squamous cell carcinoma. Cutaneous eruptions clinically resembling LP have been observed after administration of numerous drugs, including thiazide diuretics, gold, antimalarial agents, penicillamine, and phenothiazines, and in patients with skin lesions of chronic graft-versus-host disease. In addition, LP may be associated with hepatitis C infection. The course of LP is variable, but most patients have spontaneous remissions 6 months to 2 years after the onset of disease. Topical glucocorticoids are the mainstay of therapy.

PITYRIASIS ROSEA

Pityriasis rosea (PR) is a papulosquamous eruption of unknown etiology occurring more commonly in the spring and fall. Its first manifestation is the development of a 2- to 6-cm annular lesion (the herald patch). This is followed in a few days to a few weeks by the appearance of many smaller annular or papular lesions with a predilection to occur on the trunk (Fig. 71-6). The lesions are generally oval, with their long axis parallel to the skinfold lines. Individual lesions may range in color from red to brown and have a trailing scale. PR shares many clinical features with the eruption of secondary syphilis, but palm and sole lesions are extremely rare in PR and common in secondary syphilis. The eruption tends to be moderately pruritic and lasts 3–8 weeks. Treatment is directed at alleviating pruritus and consists of oral antihistamines; mid-potency topical glucocorticoids; and, in some cases, UVB phototherapy.

CUTANEOUS INFECTIONS (TABLE 71-5)

IMPETIGO, ECTHYMA, AND FURUNCULOSIS

Impetigo is a common superficial bacterial infection of skin caused most often by *S. aureus* (Chap. 172) and in some cases by group A β-hemolytic streptococci (Chap. 173). The primary lesion is a superficial pustule that ruptures and forms a characteristic yellow-brown honey-colored crust (see Fig. 173-3). Lesions may occur on normal skin (primary infection) or in areas already affected by another skin disease (secondary infection). Lesions caused by staphylococci may be tense, clear bullae, and this less common form of the disease is called *bullous impetigo*. Blisters are caused by the production of exfoliative toxin by *S. aureus* phage type II. This is the same toxin responsible for staphylococcal scalded-skin syndrome, often resulting in dramatic loss of the superficial epidermis due to blistering. The latter syndrome is much more common in children than in adults; however, it should be considered along with toxic epidermal necrolysis and severe drug eruptions in patients with widespread blistering of the skin. *Ecthyma* is a deep non-bullous variant of impetigo that causes punched-out ulcerative lesions. It is more often caused by a primary or secondary infection with *Streptococcus pyogenes*. Ecthyma is a deeper infection than typical impetigo and resolves with scars. Treatment of both ecthyma and impetigo involves gentle debridement of adherent crusts, which is facilitated by the use of soaks and topical antibiotics in conjunction with appropriate oral antibiotics.

Furunculosis is also caused by *S. aureus*, and this disorder has gained prominence in the last decade because of CA-MRSA. A furuncle, or boil, is a painful, erythematous nodule that can occur on any cutaneous surface. The lesions may be solitary but are most often multiple. Patients frequently believe they have been bitten by spiders or insects. Family members or close contacts may also be affected. Furuncles can rupture and drain spontaneously or may need incision and drainage, which may be adequate therapy for small solitary furuncles without cellulitis or systemic symptoms. Whenever possible, lesional material should be sent for culture. Current recommendations for methicillin-sensitive infections are β-lactam antibiotics. Therapy for CA-MRSA was discussed previously (see "Atopic Dermatitis"). Warm compresses and nasal mupirocin are helpful therapeutic additions. Severe infections may require IV antibiotics.

ERYSIPELAS AND CELLULITIS

See Chap. 156.

DERMATOPHYTOSIS

Dermatophytes are fungi that infect skin, hair, and nails and include members of the genera *Trichophyton*, *Microsporum*, and *Epidermophyton* (Chap. 243). *Tinea corporis*, or infection of the relatively hairless skin of the body (glabrous skin), may have a variable appearance depending on the extent of the associated inflammatory reaction. Typical infections consist of erythematous, scaly plaques, with an annular appearance that accounts for the common name "ringworm." Deep inflammatory nodules or granulomas occur in