TABLE 72-6 CAUSES OF FIGURATE SKIN LESIONS

- I. Primary cutaneous disorders
  - A. Tinea
  - B. Urticaria (primary in ≥90% of patients)
  - C. Granuloma annulare
  - D. Erythema annulare centrifugum
  - E. Psoriasis
- II. Systemic diseases
  - A. Migratory
    1. Erythema migrans (CDC case definition is ≥5 cm in diameter)
    2. Urticaria (≤10% of patients)
    3. Erythema gyratum repens
    4. Erythema marginatum
    5. Pustular psoriasis (generalized)
    6. Necrolytic migratory erythema (glucagonoma syndrome)[a]
  - B. Nonmigratory
    1. Sarcoidosis
    2. Subacute cutaneous lupus erythematosus
    3. Secondary syphilis
    4. Cutaneous T cell lymphoma (especially mycosis fungoides)

[a]Migratory erythema with erosions; favors lower extremities and girdle area.

Abbreviation: CDC, Centers for Disease Control and Prevention.

underlying malignancy is mandatory in a patient with this eruption. Erythema migrans is the cutaneous manifestation of Lyme disease, which is caused by the spirochete *Borrelia burgdorferi*. In the initial stage (3–30 days after tick bite), a single annular lesion is usually seen, which can expand to ≥10 cm in diameter. Within several days, up to half of the patients develop multiple smaller erythematous lesions at sites distant from the bite. Associated symptoms include fever, headache, photophobia, myalgias, arthralgias, and malar rash. Erythema marginatum is seen in patients with rheumatic fever, primarily on the trunk. Lesions are pink-red in color, flat to minimally elevated, and transient.

There are additional cutaneous diseases that present as annular eruptions but lack an obvious migratory component. Examples include *CTCL*, *subacute cutaneous lupus*, *secondary syphilis*, and *sarcoidosis* (see "Papulonodular Skin Lesions," below).

ACNE

(Table 72-7) In addition to *acne vulgaris* and *acne rosacea*, the two major forms of acne (Chap. 71), there are drugs and systemic diseases that can lead to acneiform eruptions.

Patients with the *carcinoid syndrome* have episodes of flushing of the head, neck, and sometimes the trunk. Resultant skin changes of the face, in particular telangiectasias, may mimic the clinical appearance of acne rosacea.

TABLE 72-7 CAUSES OF ACNEIFORM ERUPTIONS

- I. Primary cutaneous disorders
  - A. Acne vulgaris
  - B. Acne rosacea
- II. Drugs, e.g., anabolic steroids, glucocorticoids, lithium, EGFR[a] inhibitors, iodides
- III. Systemic diseases
  - A. Increased androgen production
    1. Adrenal origin, e.g., Cushing's disease, 21-hydroxylase deficiency
    2. Ovarian origin, e.g., polycystic ovary syndrome, ovarian hyperthecosis
  - B. Cryptococcosis, disseminated
  - C. Dimorphic fungal infections
  - D. Behçet's disease

[a]EGFR, epidermal growth factor receptor.

PUSTULAR LESIONS

Acneiform eruptions (see "Acne," above) and *folliculitis* represent the most common pustular dermatoses. An important consideration in the evaluation of follicular pustules is a determination of the associated pathogen, e.g., normal flora, *Staphylococcus aureus*, *Pseudomonas aeruginosa* ("hot tub" folliculitis), *Malassezia*, dermatophytes (Majocchi's granuloma), and *Demodex* spp. Noninfectious forms of folliculitis include HIV- or immunosuppression-associated eosinophilic folliculitis and folliculitis secondary to drugs such as glucocorticoids, lithium, and epidermal growth factor receptor (EGFR) inhibitors. Administration of high-dose systemic glucocorticoids can result in a widespread eruption of follicular pustules on the trunk, characterized by lesions in the same stage of development. With regard to underlying systemic diseases, nonfollicular-based pustules are a characteristic component of pustular psoriasis (sterile) and can be seen in septic emboli of bacterial or fungal origin (see "Purpura," below). In patients with acute generalized exanthematous pustulosis (AGEP) due primarily to medications (e.g., cephalosporins), there are large areas of erythema studded with multiple sterile pustules in addition to neutrophilia.

TELANGIECTASIAS

(Table 72-8) To distinguish the various types of telangiectasias, it is important to examine the shape and configuration of the dilated blood vessels. *Linear telangiectasias* are seen on the face of patients

TABLE 72-8 CAUSES OF TELANGIECTASIAS

- I. Primary cutaneous disorders
  - A. Linear/branching
    1. Acne rosacea
    2. Actinically damaged skin
    3. Venous hypertension
    4. Generalized essential telangiectasia
    5. Cutaneous collagenous vasculopathy
    6. Within basal cell carcinomas or cutaneous lymphoma
  - B. Poikiloderma
    1. Ionizing radiation[a]
    2. Parapsoriasis, large plaque
  - C. Spider angioma
    1. Idiopathic
    2. Pregnancy
- II. Systemic diseases
  - A. Linear/branching
    1. Carcinoid
    2. Ataxia-telangiectasia
    3. Mastocytosis
  - B. Poikiloderma
    1. Dermatomyositis
    2. Mycosis fungoides
    3. Xeroderma pigmentosum
  - C. Mat
    1. Systemic sclerosis (scleroderma)
  - D. Periungual/cuticular
    1. Lupus erythematosus
    2. Systemic sclerosis (scleroderma)
    3. Dermatomyositis
    4. Hereditary hemorrhagic telangiectasia
  - E. Papular
    1. Hereditary hemorrhagic telangiectasia
  - F. Spider angioma
    1. Cirrhosis

[a]Becoming less common.