Penegakan Diagnosis Penyakit Kulit & Kelamin

SITI AMINAH TSE
BAGIAN ILMU KESEHATAN KULIT & KELAMIN
FKIK UMY

Outline of Dermatologic Diagnosis

1. Epidemiology
2. History
3. Physical examination
4. Laboratory examination
5. Final diagnosis

Steps in dermatologic diagnosis:

1. History
2. Physical: identify the morphology of basic lesion
3. Consider clinicopathologic correlations
4. Configuration or distribution of lesions (when applicable)
5. Laboratory tests

Epidemiology

- Age
- Sex
- Race
- Occupation

History

The initial history can be abbreviated by asking four general questions:

1. How long?
2. Where affected?
3. Does it itch or other symptoms?
4. How have you treated it?

Physical examination

1. Complete skin examination is recommended at the first visit
2. Good lighting is critical
3. Describe the morphology of the eruption

- Appearance of patient: uncomfortable, well, "toxic"
- Vital sign
- Skin : 4 cardinal lesions
- Hair and nail
- Mucous membrane
- General physical examination

Physical examination

4 (Four) cardinal features of skin:

1. Type of lesions: **color**, **consistency & feel of lesion**, (anatomic component of skin affected)
2. Shape of individual lesion: annular, iris, linear, round, oval, umbilicated
3. Arrangement of multiple lesions: scattered, grouped, linear, herpetiform, zosteriform
4. Distribution (be sure examine scalp, mouth, palms, soles)
   - Extent of involvement: circumscribed, generalized, %
   - Pattern : unilateral, symmetry, exposed area, intertriginous

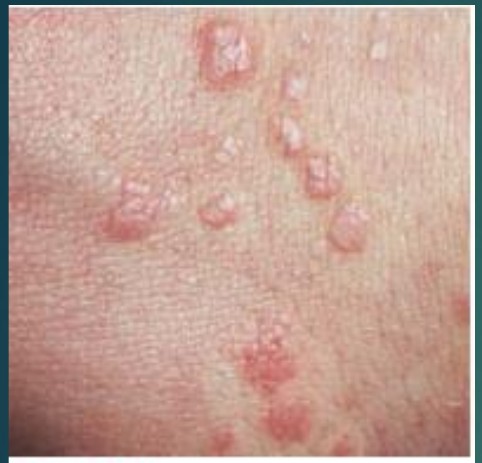
Palpation helps to:

1. Assess texture and consistency
2. Evaluate tenderness
3. Reassure patients that they are not contagious

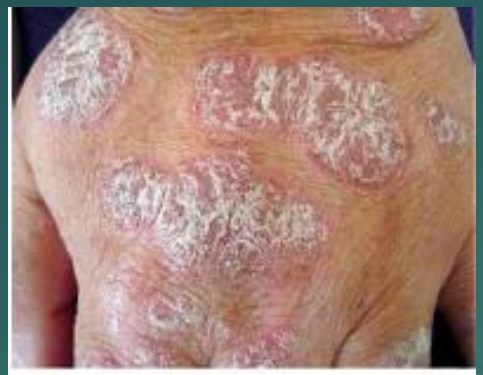
1. Primary lesions include macule, patch, papule, plaque, nodule, cyst, vesicle, pustule, ulcer, wheal, telangiectasia, burrow, and comedo
2. Secondary lesions include scale, crust, oozing, lichenification, induration, fissure, and atrophy

TABLE 4-2
Morphologic Lesions

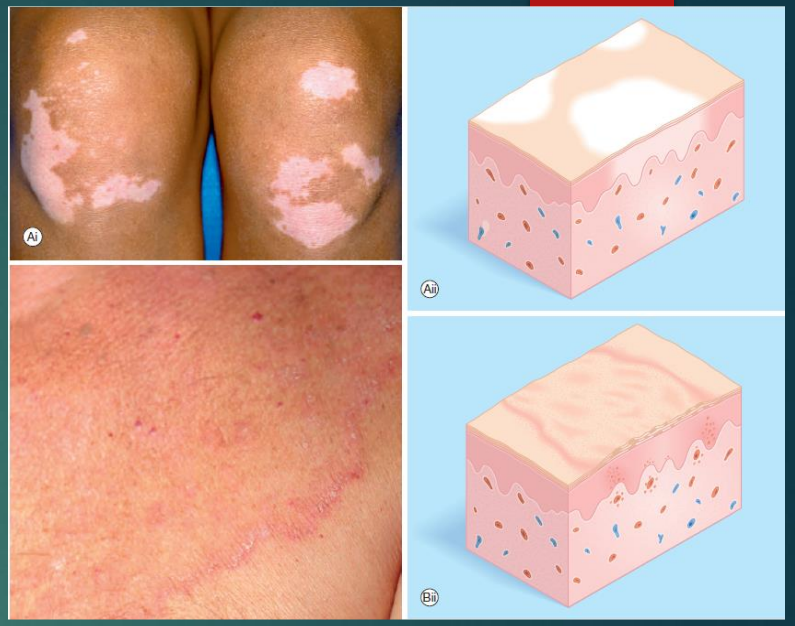
Raised	Depressed	Flat	Surface Change	Fluid Filled	Vascular
Papule	Erosion	Macule	Scale	Vesicle	Purpura
Plaque	Ulcer	Patch	Crust	Bulla	Telangiectasia
Nodule	Atrophy	Erythema	Excoriation	Pustule	Infarct
Cyst	Poikiloderma	Erythroderma	Fissure	Furuncle	
Wheal	Sinus		Lichenification	Abscess	
Scar	Striae		Keratoderma		
Comedo	Burrow		Eschar		
Horn	Sclerosis				
Calcinosis					



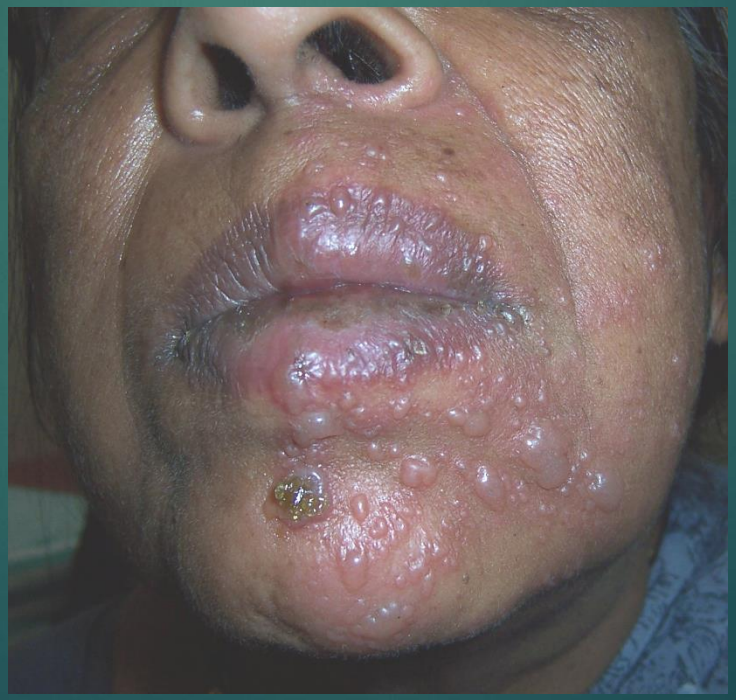
▲ **FIGURE 4-1** Papule. Multiple, well-defined papules of varying sizes are seen. Flat tops and glistening surface are characteristic of lichen planus.

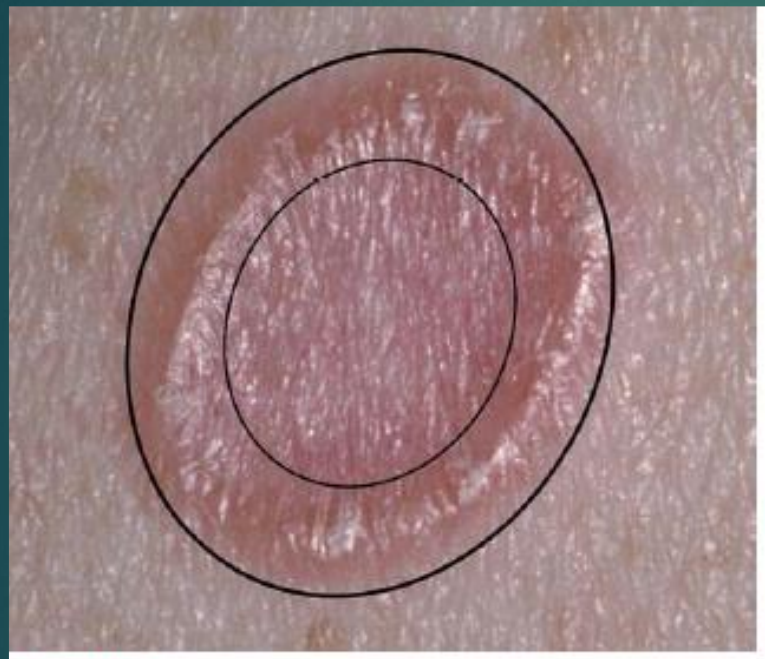


▲ **FIGURE 4-2** Plaque. Well-demarcated pink plaques with a silvery scale representing psoriasis vulgaris.

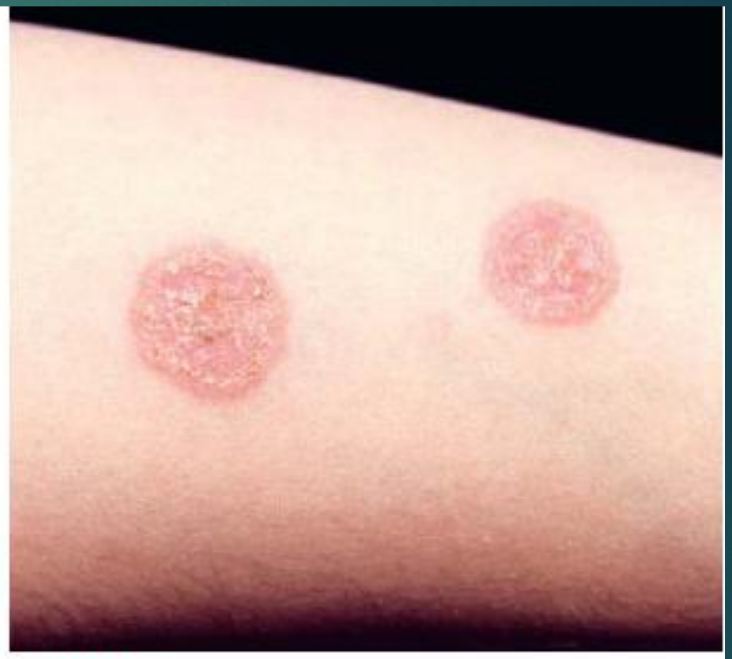


▲ **FIGURE 4-10** Erosion. Sloughing of the skin in this patient with toxic epidermal necrolysis leaves behind a large erosion.

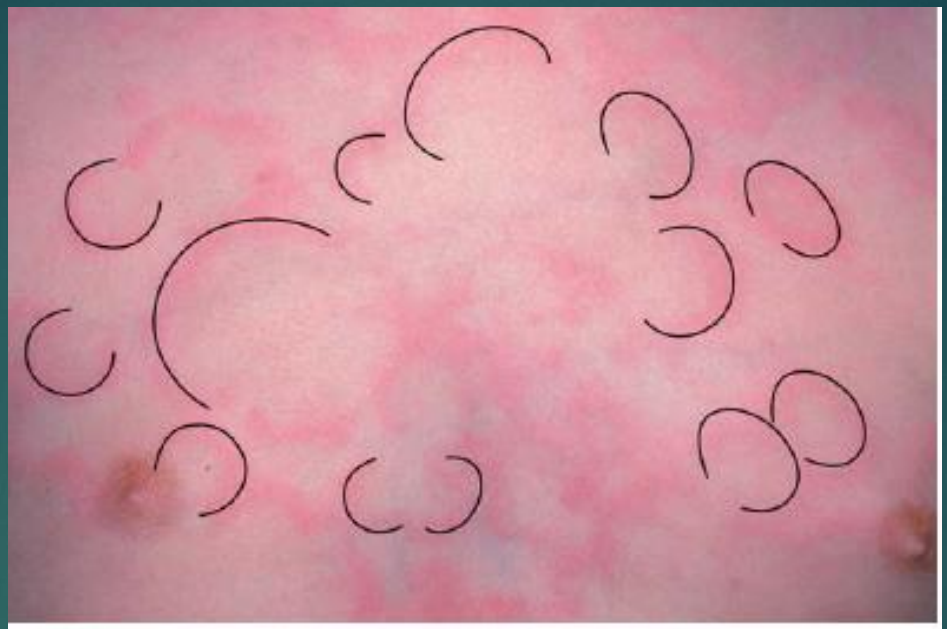




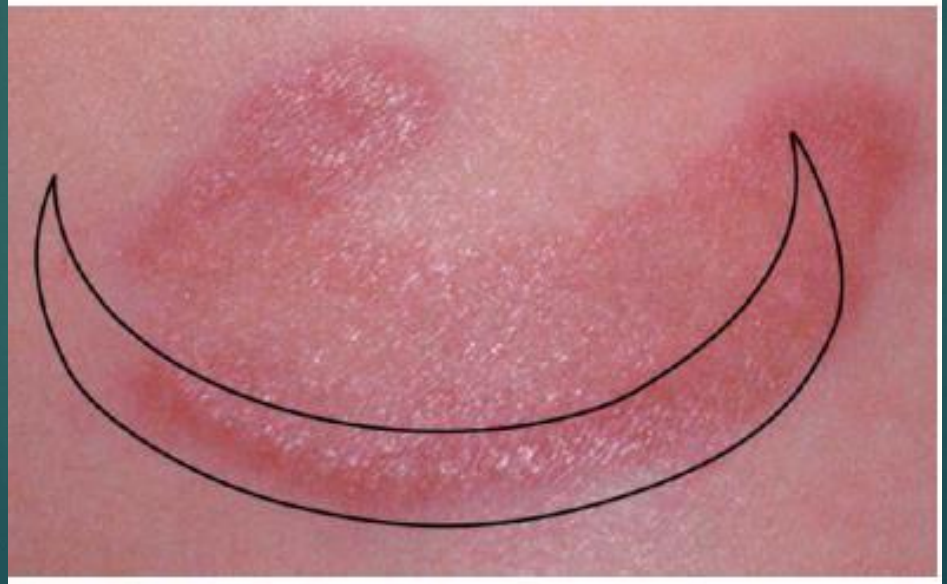
▲ **FIGURE 4-36** Annular lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



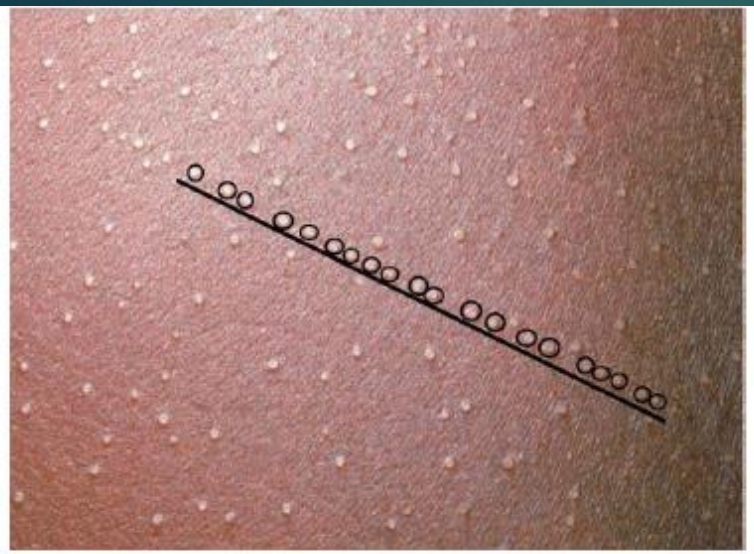
▲ **FIGURE 4-37** Nummular lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



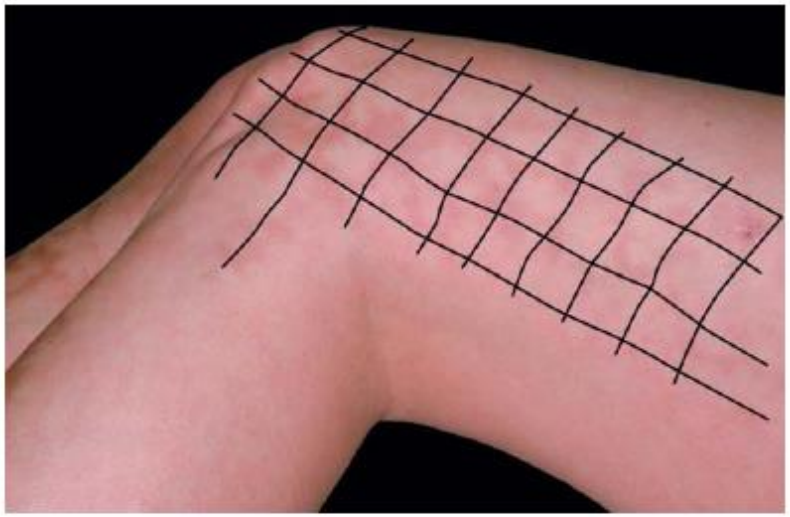
▲ **FIGURE 4-38** Polycyclic lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



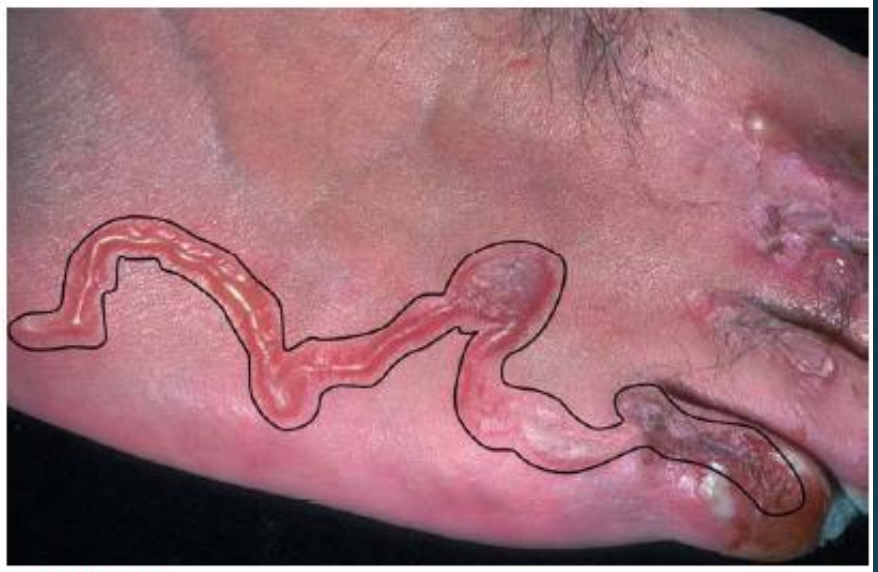
▲ **FIGURE 4-39** Arcuate lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



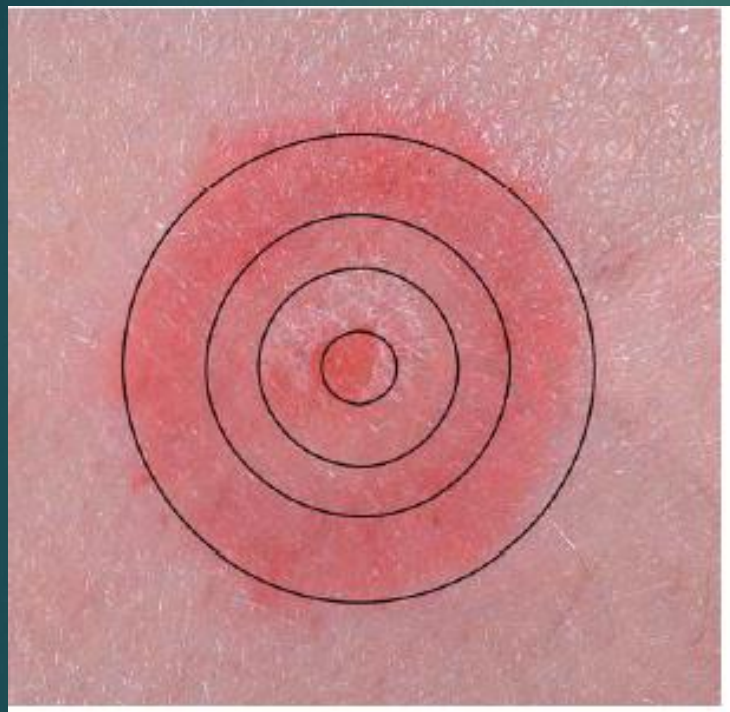
▲ **FIGURE 4-40** Linear distribution of lesions. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



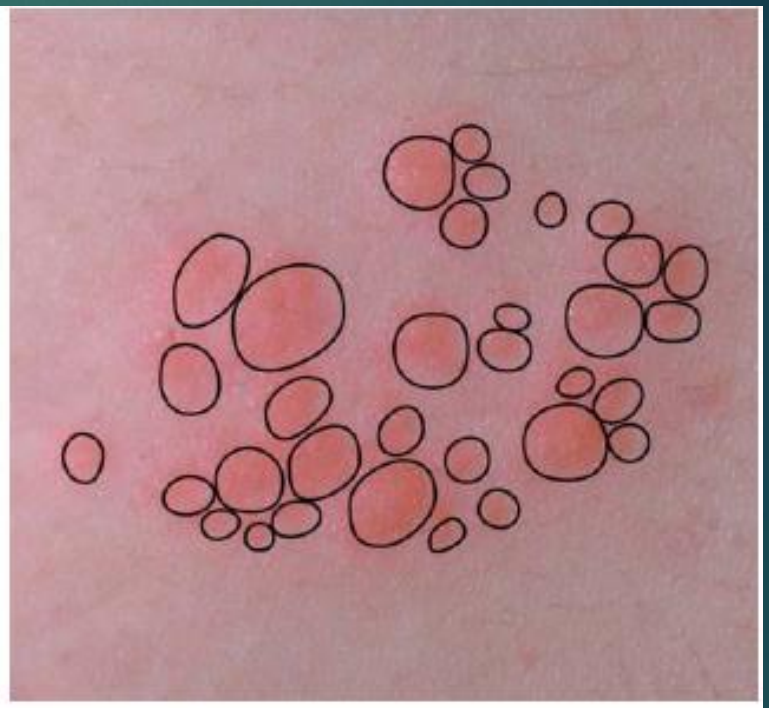
▲ **FIGURE 4-41** Reticular lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



▲ **FIGURE 4-42** Serpiginous lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)

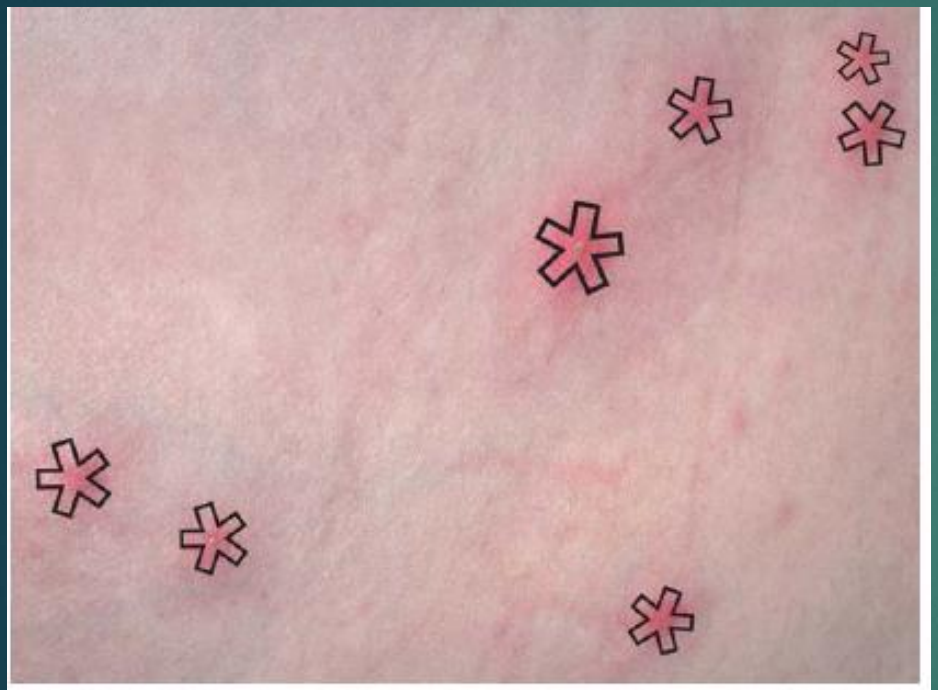


▲ **FIGURE 4-43** Targetoid lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)

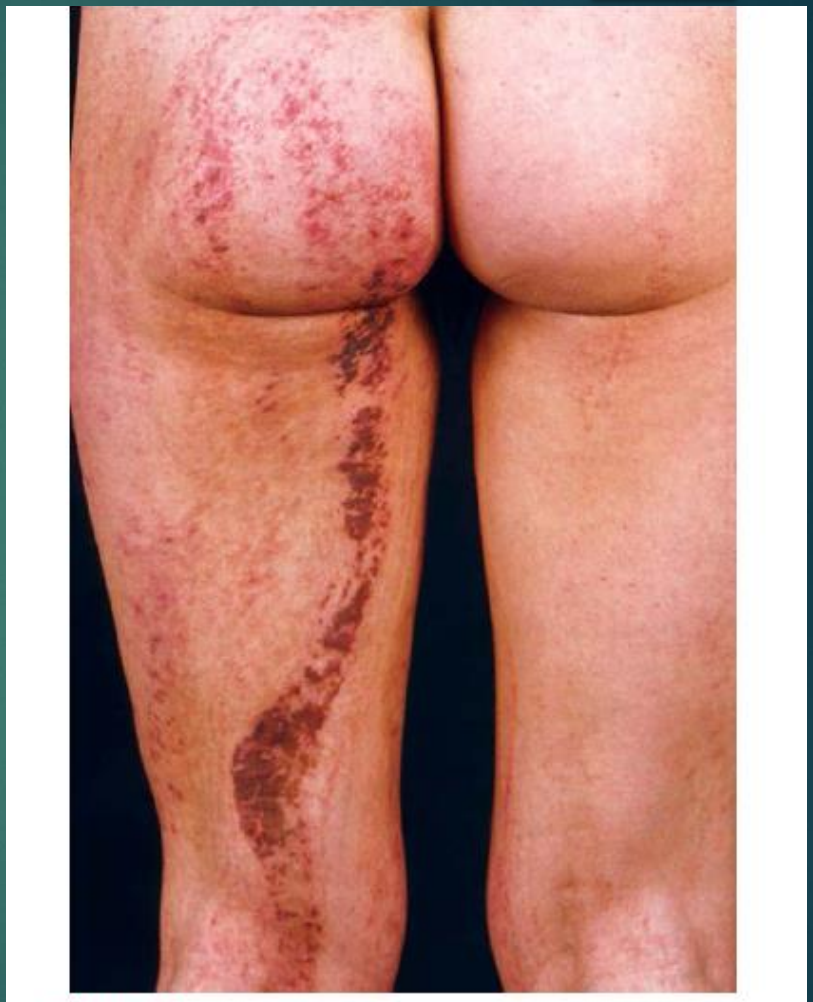


▲ **FIGURE 4-45** Grouped: clustered. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)

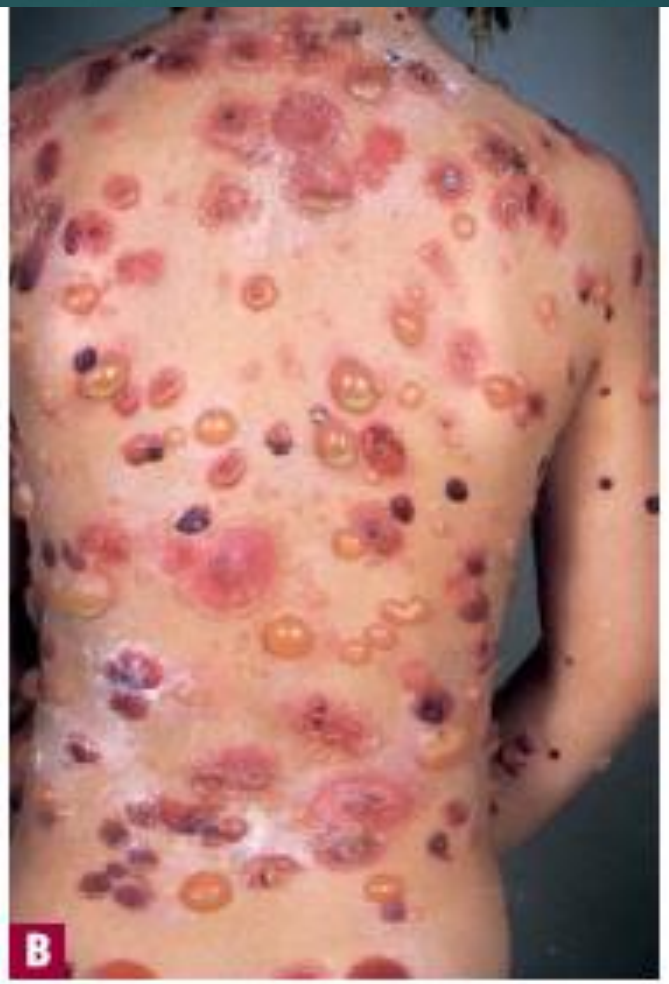
FIGURE 4-44 Whorled: marbled appearance. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



▲ **FIGURE 4-46** Scattered lesion. (Illustration by Glen Hintz, MS. Dermatology Lexicon Project.)



▲ **FIGURE 4-47** Lesions in the distribution described by Blaschko for developmental lesions.

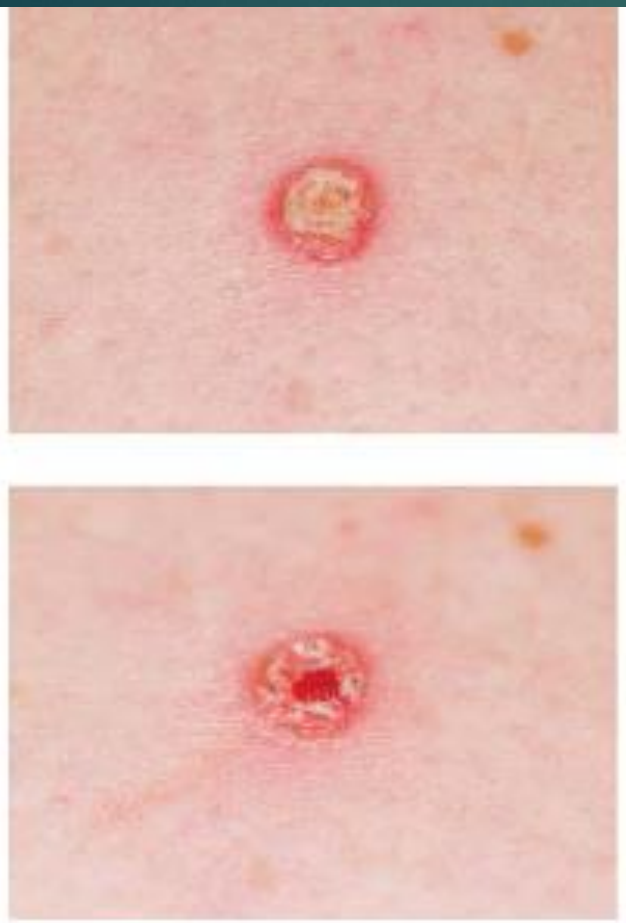


▲ **FIGURE 4-29** Vesicle (**A**) and bulla (**B**). Fragile sub-corneal translucent vesicles representing impetigo caused by a toxin-producing staphylococcus (**A**) and large tense sub-epidermal bullae filled with serous or hemorrhagic fluid in this patient with bullous pemphigoid (**B**).

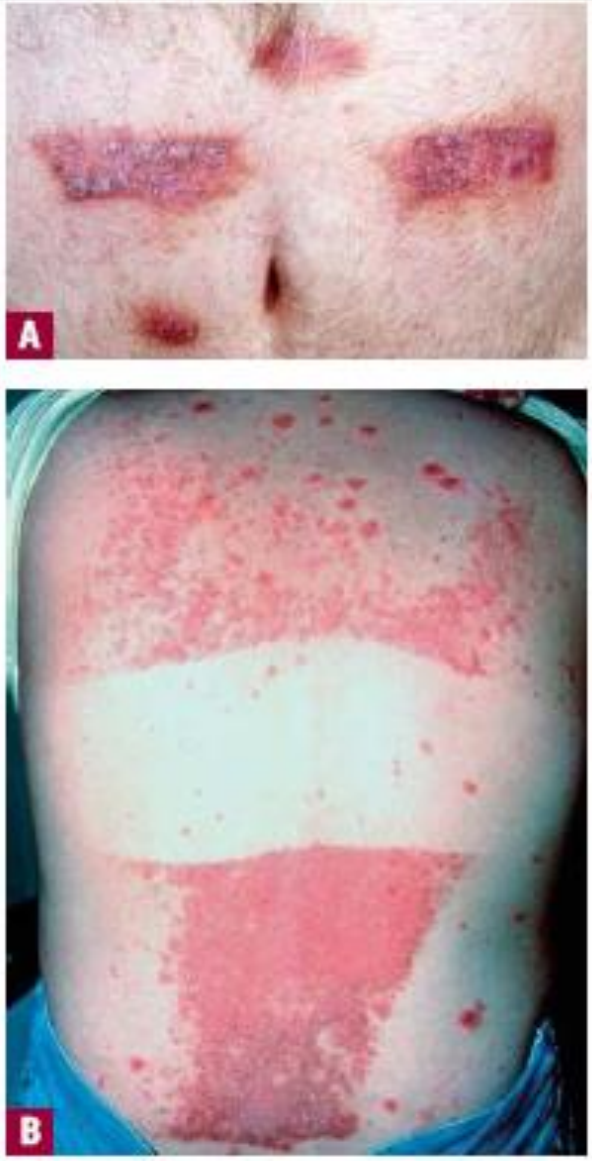
Clinical test

- **Dimple sign**: for dermathofibroma.

  Pemeriksaan : ibu jari dan dan jari telunjuk menekan pada bagian lateral lesi, adanya depresed pada bagian tengah.
- **Nikolsky sign**: for pemphigus & epidermal necrolysis.
- **Darier sign**: there is urtica after rubbing of lesion (for urticaria pigmentosa)
- **Auspitz sign**: bleeding point on the lesion after loosing of scale (for psoriasis)
- **Koebner phenomenon**



▲ **FIGURE 18-8** Auspitz sign. Note point of bleeding after scale is removed. (Photos used with permission from Dr. Johann Gudjonsson and Ms. Laura Vangoor.)



▲ **FIGURE 18-9** Koebner phenomenon. **A.** Psoriasis appearing in keratome biopsy sites 4 weeks after biopsy. (Photo used with permission from Mr. Harrold Carter.) **B.** Flare of psoriasis on the back after a sunburn. Note sparing of sun-protected areas. (Photo used with permission from Dr. James Rasmussen.)

History

- History of skin lesions
  1. When did it start?
  2. Does it itch, burn, or hurt/
  3. Where on the body did it star?
  4. How has it spread (pattern of spread?
  5. How have individual lesion change?
  6. Provocative factors?
  7. Previous treatment and response?

History

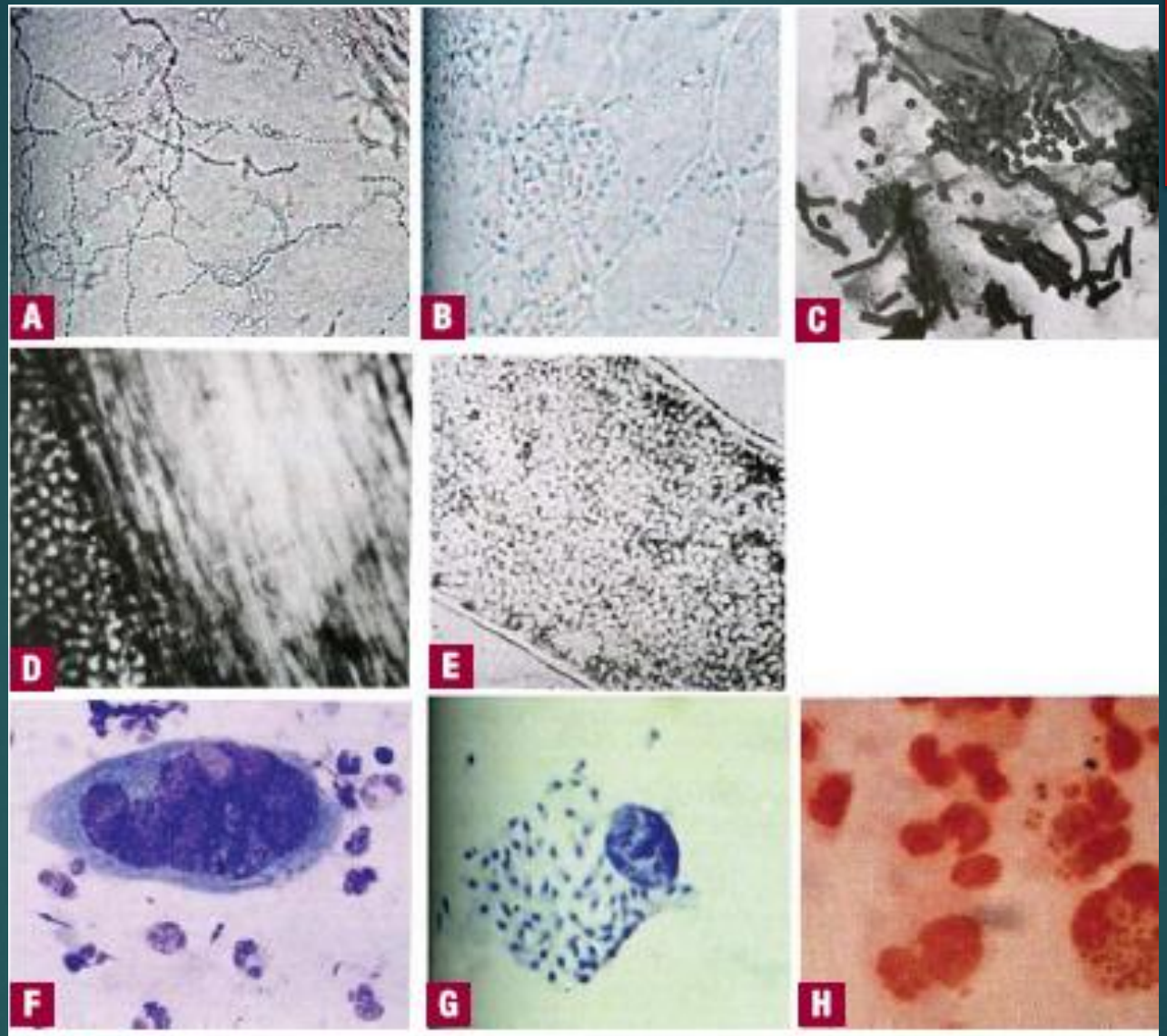
- General history of present illness (as indicated by clinical situation: constitutional and prodromal symptoms)
- Review of systems (as indicated by clinical situation: possible connection between signs and disease of other organ systems)
- Past medical history
  - Operations
  - Illnesses
  - Allergies, especially drug allergy
  - Medications
  - Habits (smoking, alcohol intake, drug abuse)
  - Atopic history

History

- Family medical history (psoriasis, atopy, xanthoma, etc)
- Social history (occupation, hobbies, exposure, travel)
- Sexual history (history of risk factors of HIV: blood transfusion, IV drugs, sexually active, sexual partners, STD)

Laboratory Examination

- Dermatopathology
  1. Light microscopy: site, process, cell types
  2. Special techniques: stain, immunofluorescence
  3. Microbiologic examination
     a. Direct microscopic examination of skin
        - 10% Potassium hidroxide (KOH)
        - Gram's stain
        - Tzanck smear
        - Dark-field examination
        - Scabies mite from burrow
     b. Culture

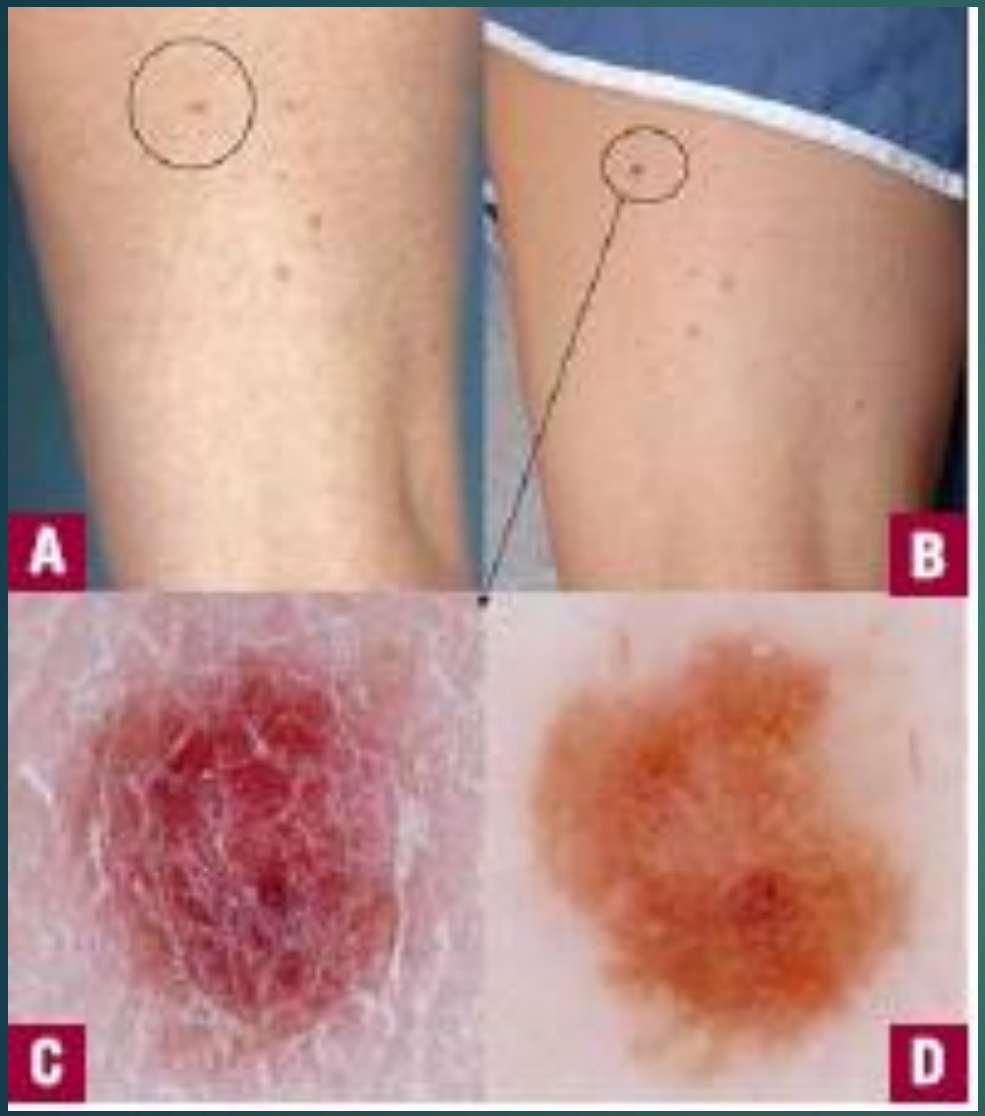


▲ **FIGURE 5-2** What to expect under the microscope: (**A**) septate hyphae in dermatophyte infection, (**B**) budding yeasts in *Candida*, (**C**) pityriasis versicolor demonstrating hyphae and spores ("spaghetti and meatballs"), (**D**) ectothrix-type tinea capitis, (**E**) endothrix-type tinea capitis, (**F**) multinucleated giant cell in herpetic infection (Tzanck smear), (**G**) *Leishmania* tissue amastigotes, and (**H**) diplococci within leukocytes in gonorrhea.

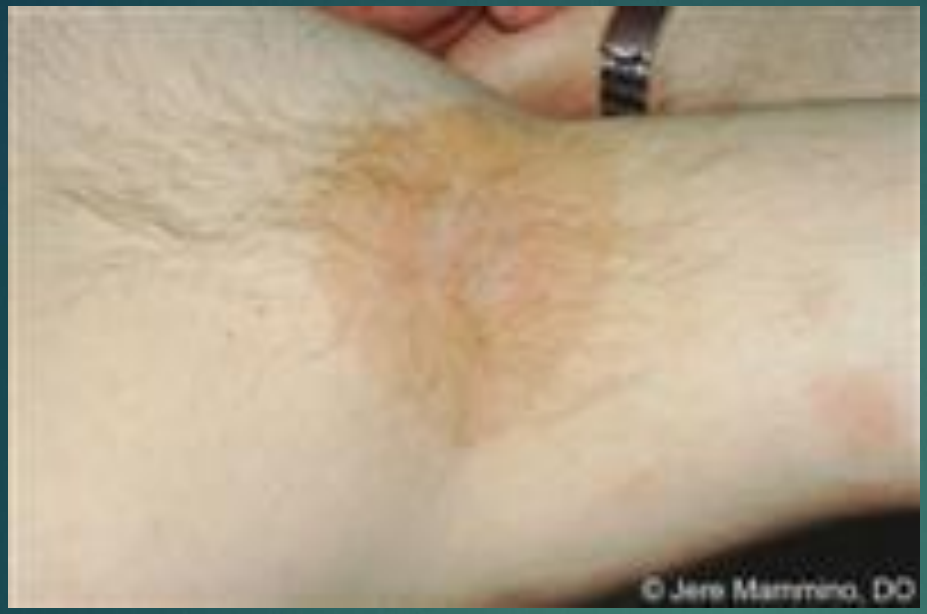
Laboratory Examination

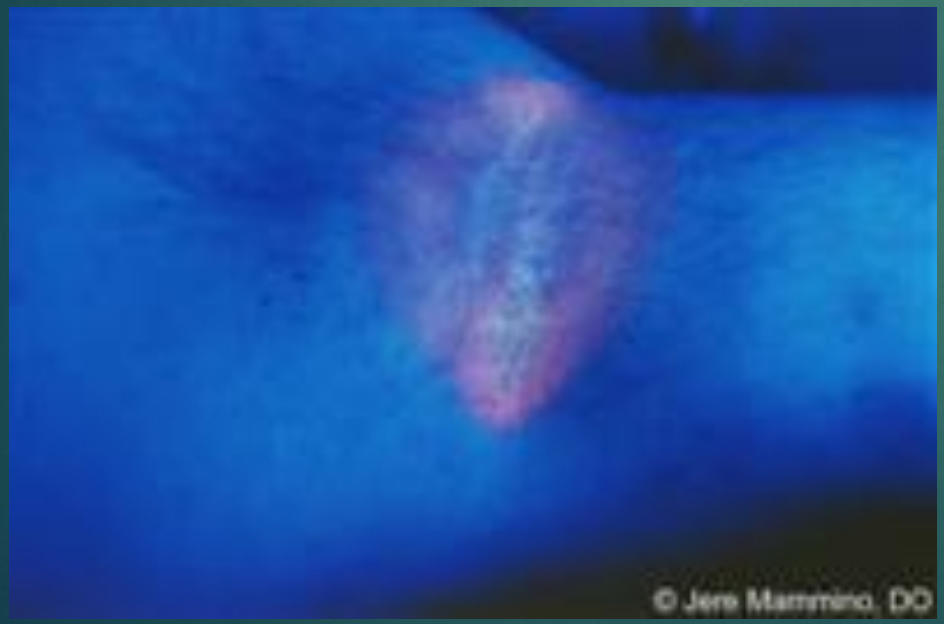
- Laboratory examination of bood
- Urinalysis: bacteria
- Stool examination: for occult blood, ova & parasites, porphyrins)
- Wood's lamp examination (320-400 nm)

  (erythrasma- coral red, Microsporum sp: green, PVC: yellow-orange, hyper/hypomelanosis)
- Dermatoscopy
- Patch testing, prick testing
- Acetowhitening- 5% acetic acid ; for genital warts

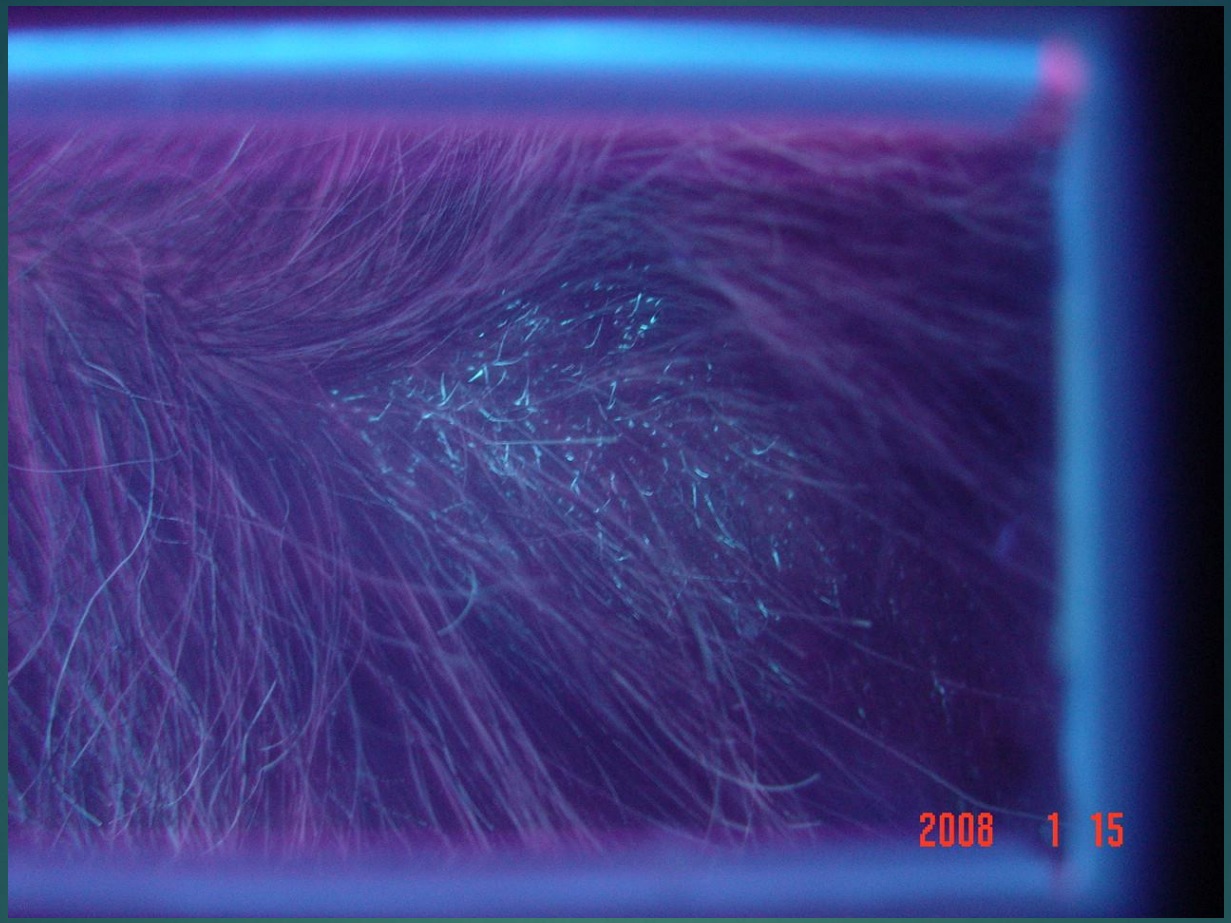


▲ **FIGURE 5-1** Visual aids to diagnosis: comparing baseline digital photography (**A**) to an image taken 3 years later (**B**), shows a lesion (*circles*) has become darker and larger. Clinical close-up image reveals a 7-mm brown-reddish papule not inherently concerning for malignancy (**C**). However, the degree of change along with dermoscopy (**D**) that shows a multi-component pattern with a negative network, irregular globules and regression, prompted an excisional biopsy. The lesion proved to be a malignant melanoma 0.5 in Breslow thickness.

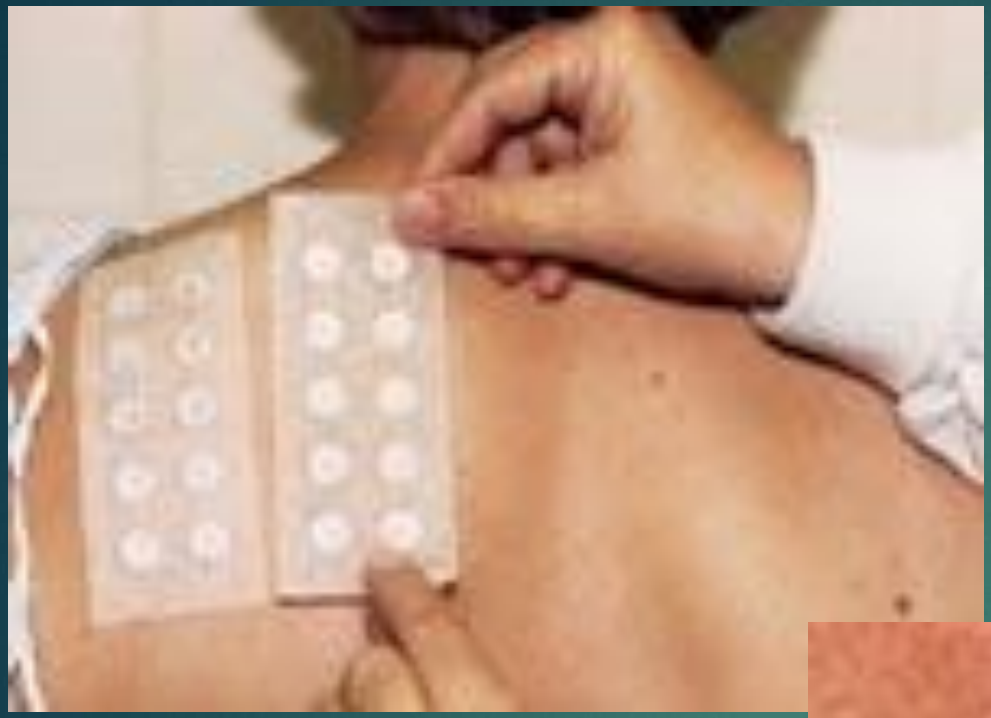


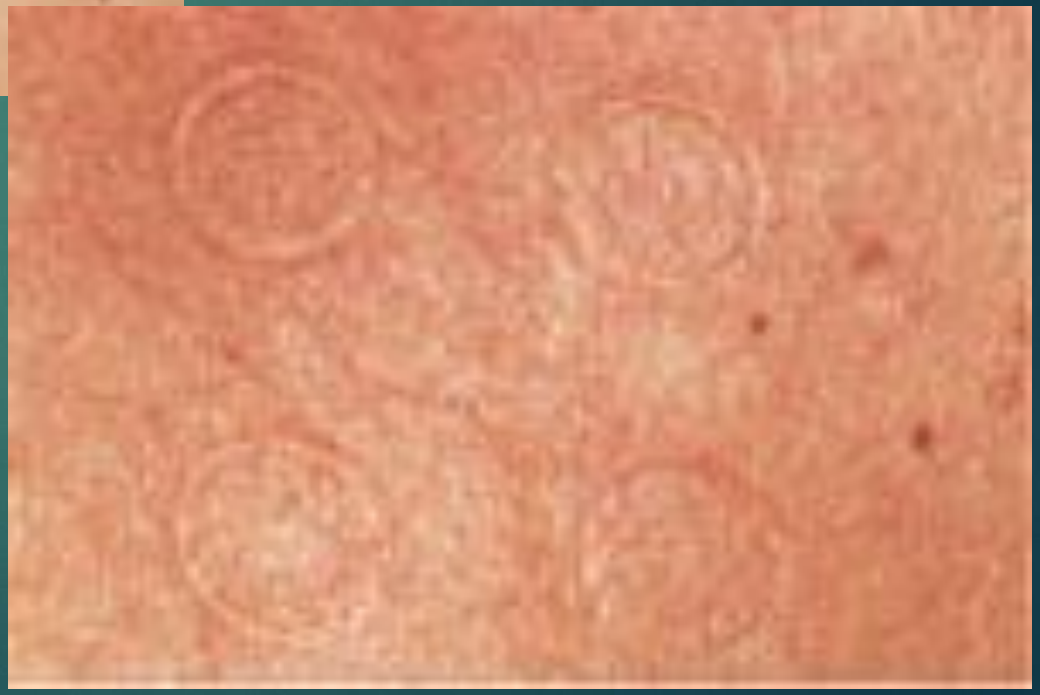


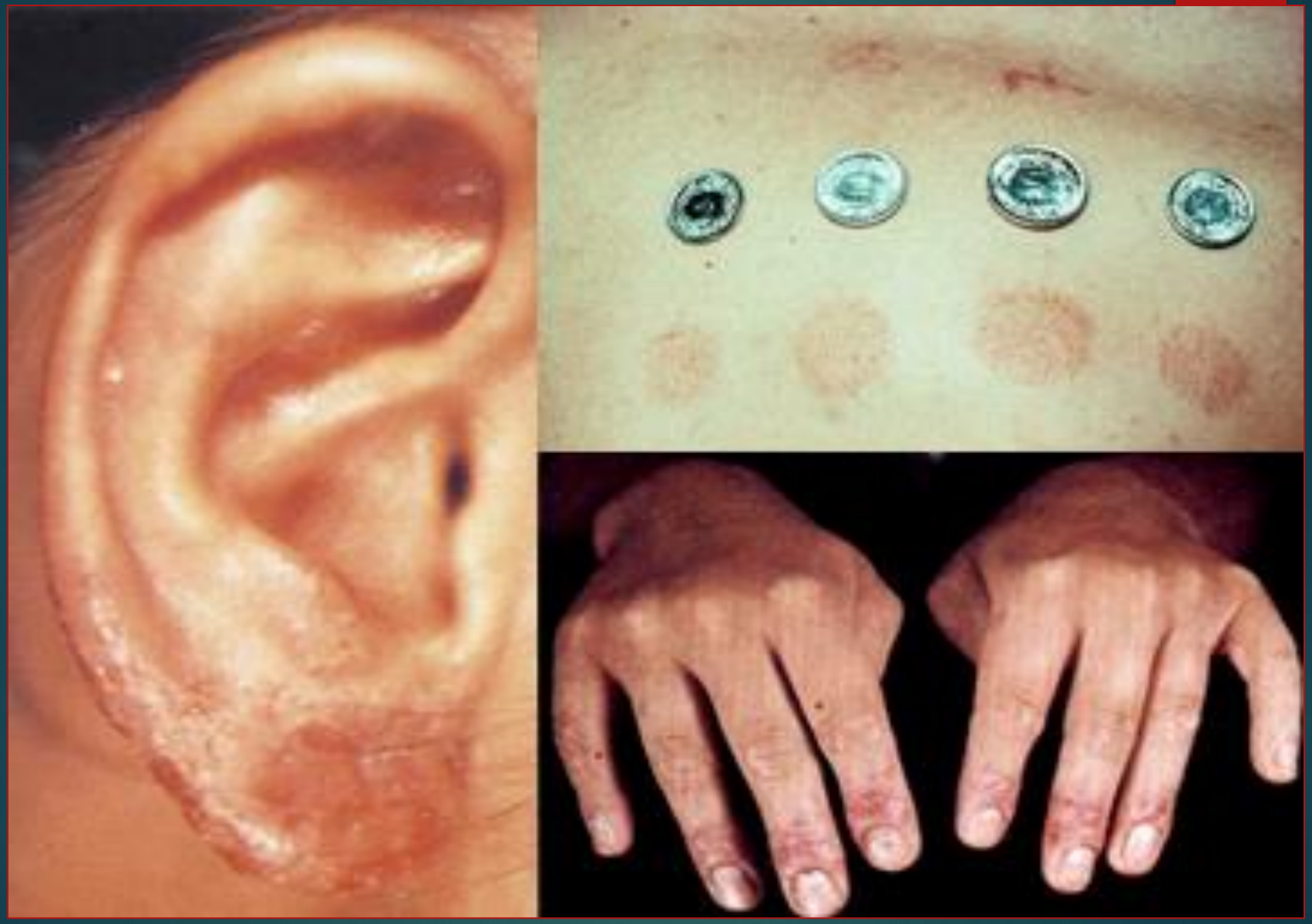
Hasil Pemeriksaan Lampu Wood pada kasus Eritrasma

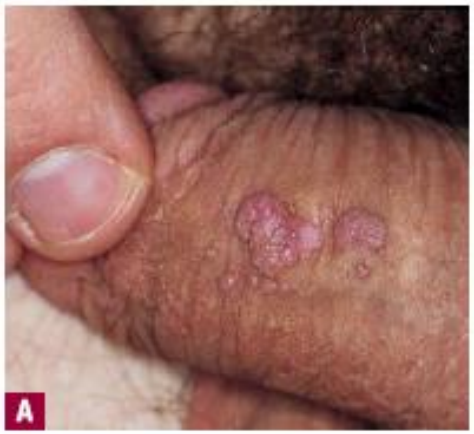


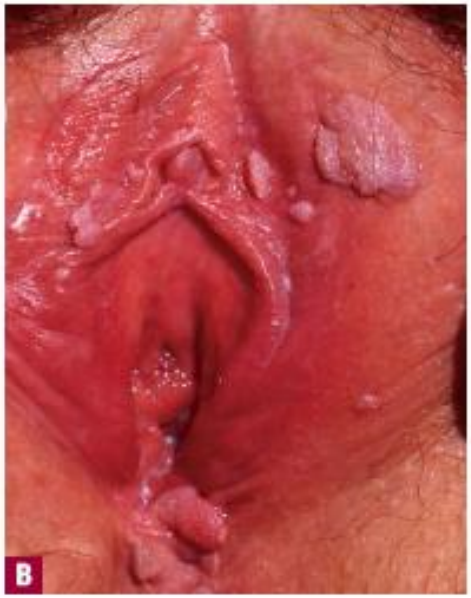
Hasil Pemeriksaan Lampu Wood pada kasus Tinea Capitis (*Microsporum sp.*)

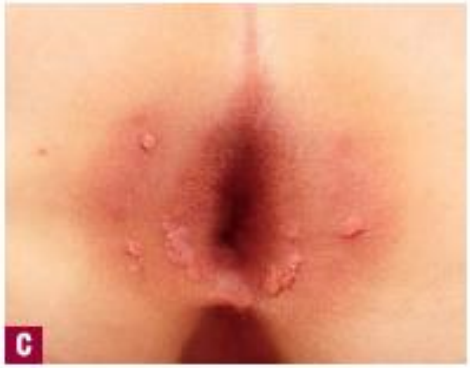


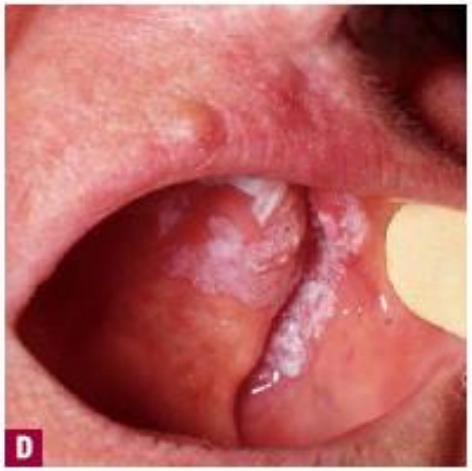




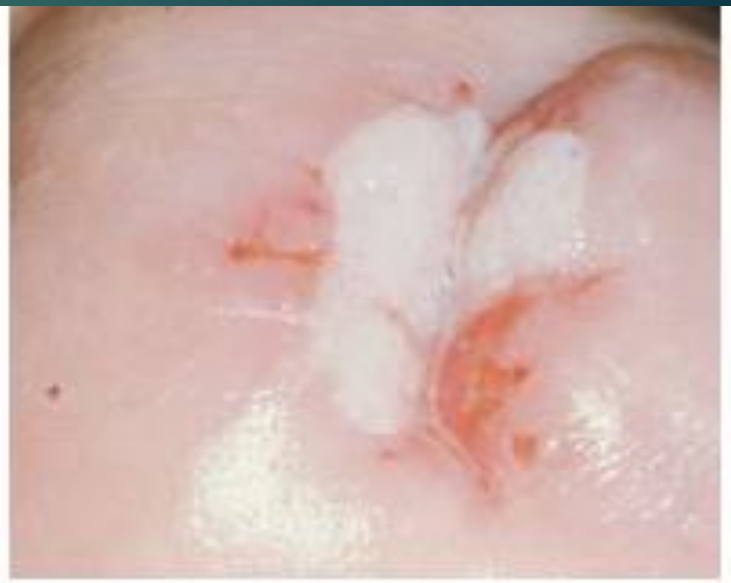








▲ **FIGURE 196-9** Mucosal wart. **A.** Multiple condylomata acuminata on the shaft of the penis. **B.** Multiple confluent condyloma on the labia minora, majora, and fourchette. **C.** Multiple perianal condylomata in an infant. He was probably infected during vaginal delivery; his mother was not aware of her infection, but examination revealed several small condylomata. **D.** Flat, irregular, whitish confluent oral warts on buccal mucosa and palate. This progressed to so-called *oral florid papillomatosis*.



▲ **FIGURE 196-12** Colposcopic view of cervical condyloma after treatment with acetic acid for visualization as white, elevated patch.

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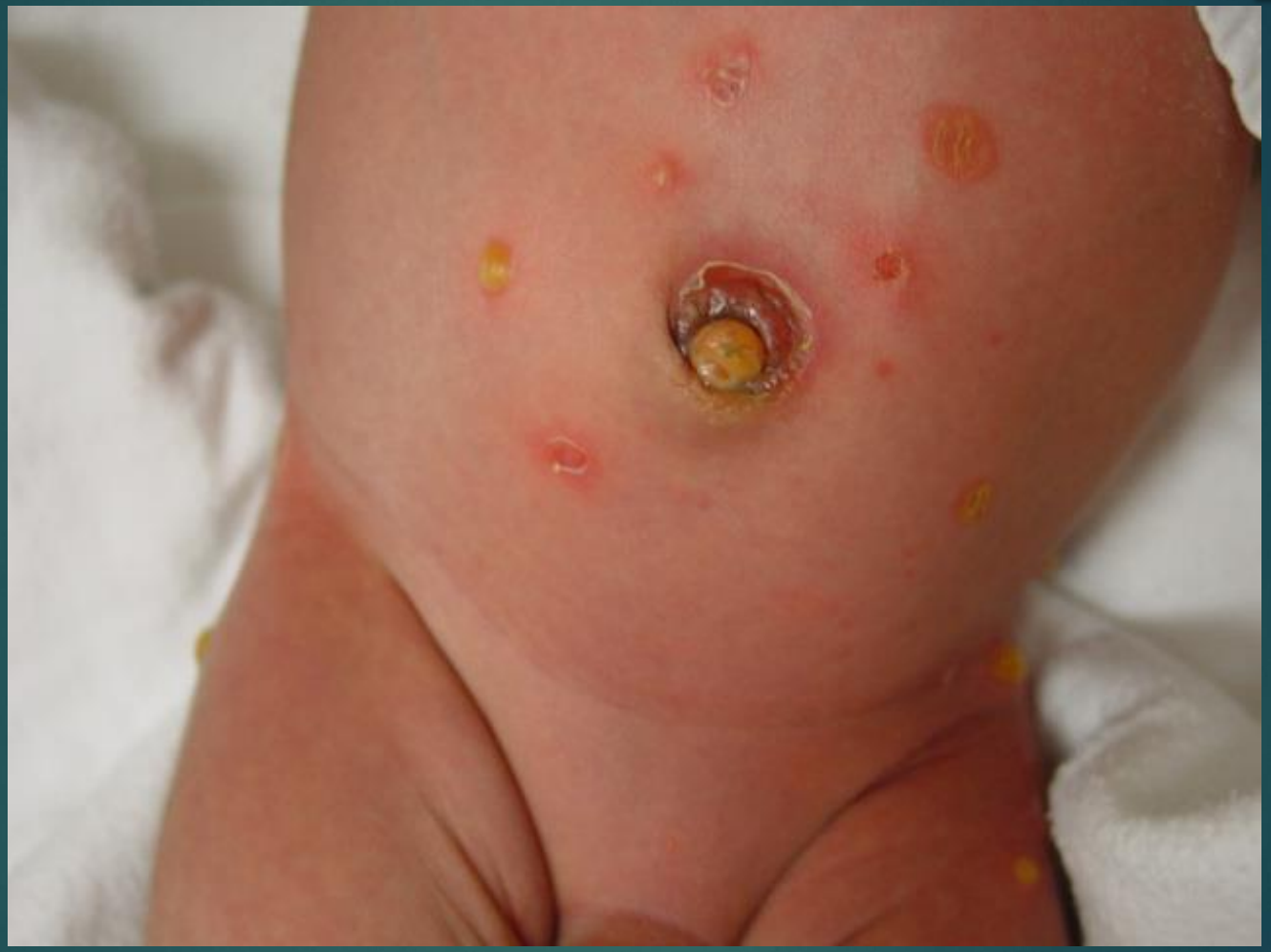

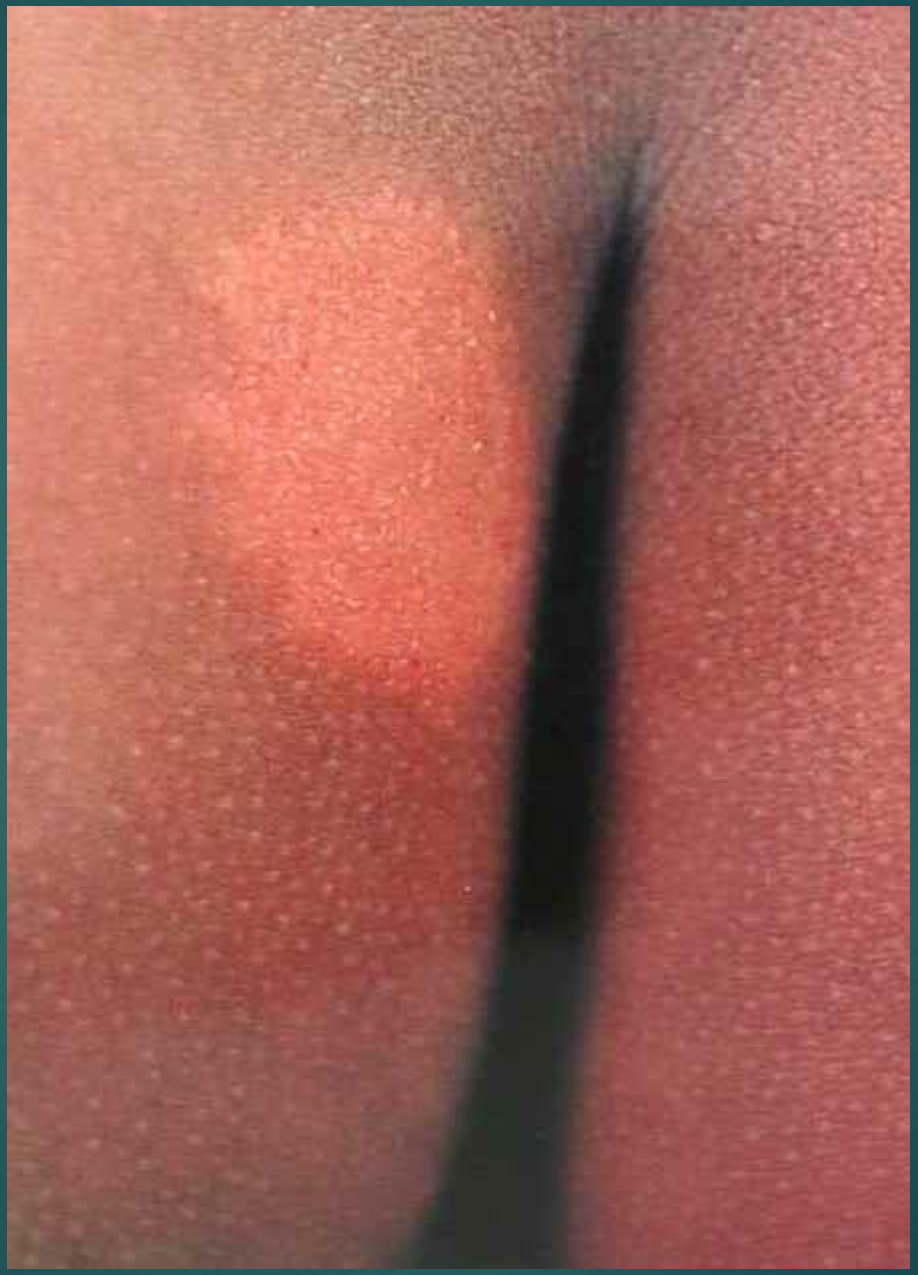

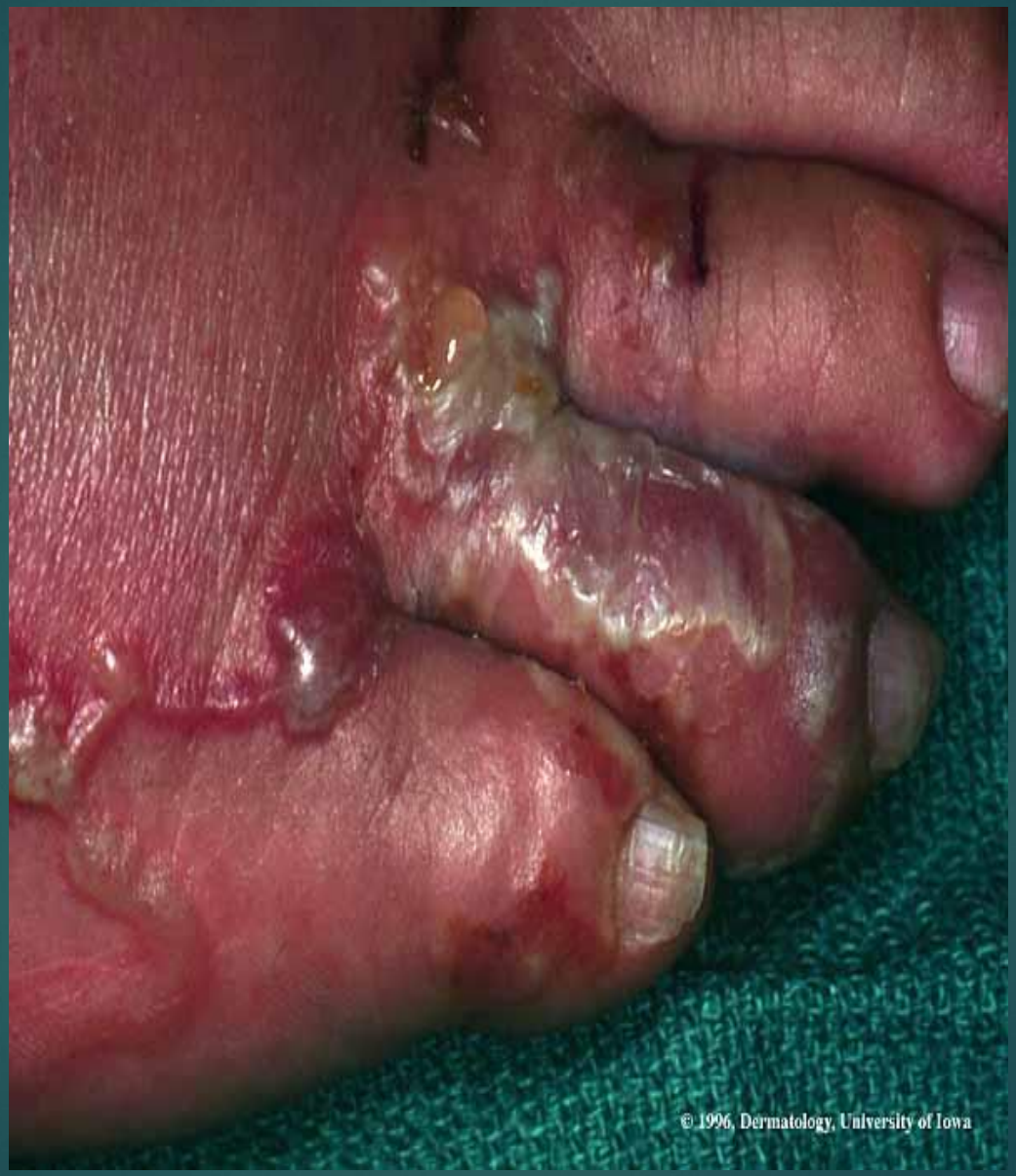
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