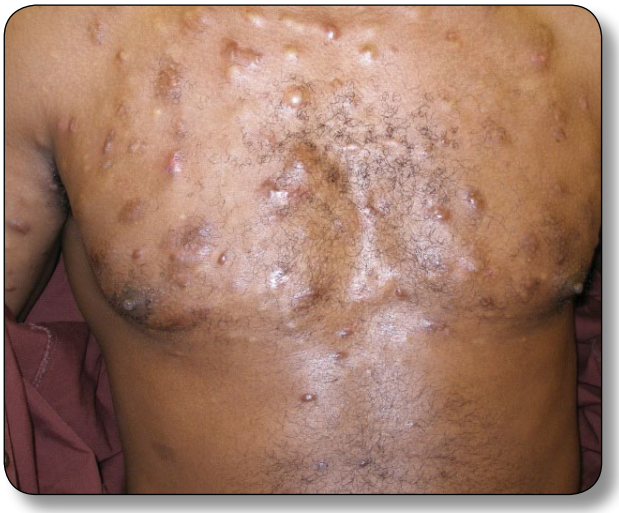
>>DIAGNOSIS AT A GLANCE

Stephen M. Schleicher, MD

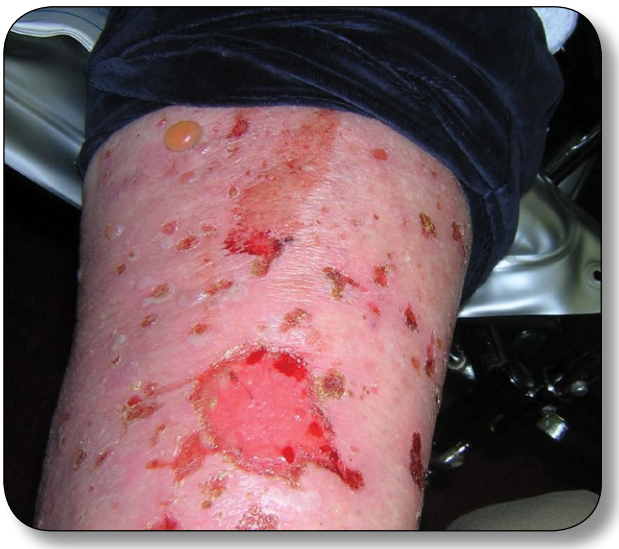
CASE 1



A 26-year-old black man seeks consultation for a condition affecting his chest, arms, and neck. The disorder has waxed and waned in intensity since his early adolescence. Oral antibiotic therapy, commenced on several occasions, has neither decreased new lesion formation nor improved existing lesions. He is unable to recall whether other family members were similarly affected. The disorder is not painful but causes considerable embarrassment to the patient. Examination reveals a multitude of smooth, flesh-colored to erythematous cystic nodules that are not tender to palpation.

What is your diagnosis?

CASE 2



A 73-year-old Hispanic woman who resides in a nursing home has a blistering eruption on her lower legs and trunk. According to the nursing staff, the condition began several months ago. Blisters appear intermittently and slowly heal with application of topical therapy. The patient reports occasional pruritus. Recently, the frequency of blister formation has increased. Examination reveals scattered bullae and multiple denuded patches.

What is your diagnosis?

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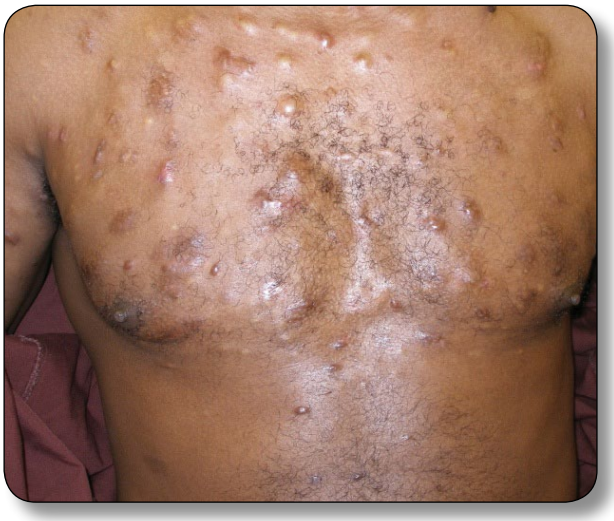
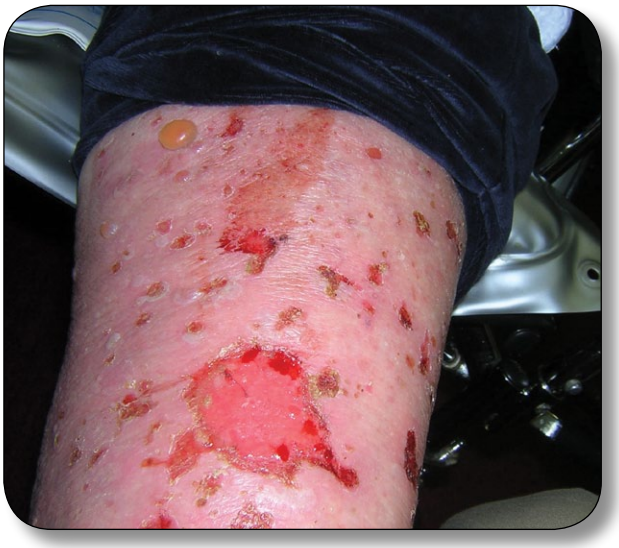
CASE 1



The patient has steatocystoma multiplex, a disorder of the pilosebaceous follicular units that features the appearance of multiple dermal cysts containing sebum. Some cases are transmitted in an autosomal dominant manner, while others are sporadic. The most commonly affected location is the chest. Usually, the cysts are asymptomatic; however, they occasionally become secondarily infected and tender. Effective treatment options are limited. Oral isotretinoin may prevent new lesion formation, but flare has been reported upon discontinuation. Surgical excision is often impractical due to the number of lesions and propensity for cosmetically unacceptable scarring. Some lesions respond to simple aspiration with a large-bore needle.

CASE 2



The diagnosis is bullous pemphigoid, a condition that accounts for the majority of autoimmune blistering skin diseases. The disorder is most frequently seen in the elderly, with nearly two-thirds of cases occurring in individuals older than 70. Without treatment, bullous pemphigoid can persist for months and even years. Diagnosis is suspected on clinical grounds (ie, the presence of bullae in an elderly patient) and is strengthened by light microscopy and direct and indirect immunofluorescence findings on biopsy. The treatment of choice for moderate to severe disease is oral steroids. To avoid rebound flare, these should be gradually tapered once remission has been achieved.

Dr. Schleicher is director of the DermDOX Center in Hazleton, Pennsylvania, a clinical instructor of dermatology at King's College in Wilkes-Barre, Pennsylvania, an associate professor of medicine at the Commonwealth Medical School in Scranton, Pennsylvania, and an adjunct assistant professor of dermatology at the University of Pennsylvania in Philadelphia. He is also a member of the EMERGENCY MEDICINE editorial board.