Study Guide for lectures 1 and 2

* Seborrheic keratoses – be able to recognize as a “stuck-on” lesion, compared to melanocytic lesions, keloids, skin tags, etc.
* Keloids/hypertrophic scars – treatment of choice is **intralesional steroids**
* Dermatofibroma – **benign** lesion caused by trauma most commonly
* Solar lentigines – most common affected areas of the body (sun-exposed areas – face, arms, hands, legs, feet) and potential treatment options –
	+ **Cryotherapy**
	+ **Bleaching cream**
	+ **Chemical peels**
* Acne vs. Rosacea:
	+ Recognize the clinical difference between acne and rosacea – acne more common in adolescents, rosacea in young adults. Rosacea has intense background erythema. Acne has comedones – can be both open or closed but neither are present in rosacea. Both can have pustules.
	+ Boards factoid – \*\*if the question stem mentions **exacerbation** with anything that causes flushing (alcohol, spicy food, etc.), they are pointing to rosacea > acne
	+ Be able to categorize the severity and treatment of acne based on pictures – mild/moderate will get **benzoyl peroxide and a topical retinoid** + Oral antibiotics for moderate.
		- \*For scarring/nodulocystic, treatment of choice is isotretinoin (teratogenic).
* ACD vs ICD:
	+ ACD is a type 4 hypersensitivity reaction that causes vesicles and bullae on presentation
	+ ICD is a direct toxic insult to skin cells from an irritant
	+ Pay attention to the question stem to help differentiate the two – latex gloves, poison ivy, metal exposure = ACD vs harsh chemicals = ICD
	+ ACD & ICD both have characteristic distribution – from direct contact. Think streaks, sharp demarcation, etc. (i.e. outside job vs. inside job like psoriasis and atopic dermatitis)
* Physical exam signs:
	+ **Dimple sign** in dermatofibroma – dimples when pinched from scarring in dermis
	+ **Auspitz sign** in psoriasis = bleeding when scale is picked
	+ **Koebnerization** = new psoriasis lesions arise in areas of irritation/trauma (note: not exclusive to psoriasis. Koebnerization can be seen in other diseases such as molluscum, warts, vitiligo, etc.)
* Intertrigo vs. Inverse psoriasis
	+ As Dr. Crane mentioned in lecture, candida intertrigo will have satellite lesions and is treated with antifungals
	+ Inverse psoriasis has sharply demarcated plaques that are treated with topical steroids