FITZPATRICK'S DERMATOLOGY 9TH EDITION



VOLUME 1



Sewon Kang Masayuki Amagai Anna L. Bruckner Alexander H. Enk David J. Margolis Amy J. McMichael Jeffrey S. Orringer

Fitzpatrick's Dermatology

SEWON KANG, MD, MPH

Noxell Professor and Chair Department of Dermatology Johns Hopkins School of Medicine Dermatologist-in-Chief Johns Hopkins Hospital Baltimore, Maryland

MASAYUKI AMAGAI, MD, PhD

Professor and Chair Department of Dermatology Keio University School of Medicine Tokyo, Japan

ANNA L. BRUCKNER, MD, MSCS

Associate Professor of Dermatology and Pediatrics University of Colorado School of Medicine Section Head, Pediatric Dermatology Children's Hospital Colorado Aurora, Colorado

ALEXANDER H. ENK, MD

Professor and Chair Department of Dermatology University of Heidelberg Heidelberg, Germany

DAVID J. MARGOLIS, MD, PhD

Professor of Dermatology and Epidemiology Department of Dermatology Department of Biostatistics and Epidemiology University of Pennsylvania Perelman School of Medicine Philadelphia, Pennsylvania

AMY J. McMICHAEL, MD

Professor and Chair Department of Dermatology Wake Forest University School of Medicine Winston-Salem, North Carolina

JEFFREY S. ORRINGER, MD

Professor and Chief Division of Cosmetic Dermatology Department of Dermatology University of Michigan Ann Arbor, Michigan

Fitzpatrick's Dermatology

Ninth Edition

EDITORS SEWON KANG, MD, MPH MASAYUKI AMAGAI, MD, PhD ANNA L. BRUCKNER, MD, MSCS ALEXANDER H. ENK, MD DAVID J. MARGOLIS, MD, PhD AMY J. McMICHAEL, MD JEFFREY S. ORRINGER, MD

VOLUME I



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CONTRIBUTORS

Sumaira Z. Aasi, MD

Clinical Professor, Dermatology, Clinical Professor (By Courtesy), Surgery–Plastic and Reconstructive Surgery, Dermatology–North Campus, Stanford University, Redwood City, California [201]

George Agak, PhD

Research Scientist, Dermatology/ Medicine, David Geffen School of Medicine at UCLA, Los Angeles, California [78]

Christine S. Ahn, MD

Resident Physician, Wake Forest School of Medicine, Winston Salem, North Carolina [46]

Iris Ahronowitz, MD

Assistant Professor of Clinical Dermatology, Keck School of Medicine, University of Southern California, Los Angeles, California [161]

Murad Alam, MD, MSCI, MBA

Professor of Dermatology, Otolaryngology, and Surgery, Vice-Chair, Department of Dermatology, Chief, Section of Cutaneous and Aesthetic Surgery, Director, Micrographic Surgery and Dermatologic Oncology Fellowship, Northwestern University, Chicago, Illinois [211]

Afsaneh Alavi, MSc, MD, FRCPC

Assistant Professor of Dermatology, Women's College Hospital, University of Toronto, Toronto, Ontario, Canada [149]

Theodore J. Alkousakis, MD

Assistant Clinical Professor, University of Colorado School of Medicine, Medical Director, Adult Dermatology, Aurora, Colorado [140]

Tina S. Alster, MD

Director, Washington Institute of Dermatologic Laser Surgery, Clinical Professor of Dermatology, Georgetown University Medical Center, Washington, DC [209]

Masayuki Amagai, MD, PhD

Professor and Chair, Department of Dermatology, Keio University School of Medicine, Tokyo, Japan [14]

Erin H. Amerson, MD

Associate Professor, University of California, San Francisco, Department of Dermatology, San Francisco, California [1]

Karl E. Anderson, MD, FACP

Departments of Preventive Medicine and Community Health, and Internal Medicine (Division of Gastroenterology and Hepatology), University of Texas Medical Branch, Galveston, Texas [124]

Grant J. Anhalt, MD

Professor of Dermatology and Pathology, Department of Dermatology, Johns Hopkins Hospital, Baltimore, Maryland [53]

Jack L. Arbiser, MD, PhD

Emory University School of Medicine, Department of Dermatology, Atlanta Veterans Affairs Medical Center, Atlanta, Georgia [195]

Roberto Arenas, MD

Mycology Section, Dr. Manuel Gea Gonzalez General Hospital, Mexico City, Mexico [158]

Adam B. Aronson, MD

Resident Physician, Dermatology, University of Iowa Carver College of Medicine, Iowa City, Iowa [128]

Iris K. Aronson, MD

University of Illinois at Chicago, Chicago, Illinois [73]

Arif Aslam, MBChB, MRCP (UK), MRCGP, MRCP (Dermatology)

Consultant Dermatologist and Mohs Surgeon, St Helens and Knowsley Teachings Hospitals NHS Trust, St Helens, United Kingdom [201]

Edwin J. Asturias, MD

The Jules Amer Chair in Community Pediatrics, Children's Hospital Colorado, Associate Professor of Pediatrics and Epidemiology, Division of Pediatric Infectious Diseases, University of Colorado School of Medicine, Center for Global Health, Colorado School of Public Health, Aurora, Colorado [169]

Martine Bagot, MD, PhD

Department of Dermatology, Hôpital Saint-Louis, Paris, France [119, 120]

Fanny Ballieux, MD

Resident, Center for Vascular Anomalies, Division of Plastic Surgery, Cliniques Universitaires St Luc and University of Louvain, Brussels, Belgium [147]

Robert Baran, MD

Honorary Professor, Nail Disease Center, Cannes, France [205]

Raymond L. Barnhill, MD

Professor, Department of Pathology, Institut Curie, and University of Paris Descartes Faculty of Medicine, Paris, France, Department of Pathology, Paris, France [71]

Leslie Baumann, MD

Board Certified Dermatologist, Baumann Cosmetic and Research Institute, Miami, Florida [207]

J. David Beckham, MD

Associate Professor, Director of the Infectious Disease Fellowship Training Program, Division of Adult Infectious Diseases, University of Colorado School of Medicine, Denver, Colorado [169]

Carola Berking, MD

Department of Dermatology, University Hospital Munich, Ludwig-Maximilian University (LMU), Munich, Germany [110]

Christopher Bichakjian, MD

Department of Dermatology, University of Michigan Health System, Ann Arbor, Michigan [202]

Carol M. Black, MD, FRCP

Centre for Rheumatology and Connective Tissue Diseases, UCL Medical School, Royal Free Hospital, London, United Kingdom [63]

Ulrike Blume-Peytavi, MD

Department of Dermatology and Allergy, Charité-Universitätsmedizin, Berlin, Germany [85]

Mark Boguniewicz, MD

Professor, Division of Allergy and Immunology, Department of Pediatrics, National Jewish Health and University of Colorado School of Medicine, Denver, Colorado [22]

Michael Y. Bonner, BA

Emory University School of Medicine, Department of Dermatology, Atlanta, Georgia [195]

Laurence M. Boon, MD, PhD

Coordinator of the Center for vascular Anomalies, Division of Plastic Surgery, Cliniques Universitaires St Luc and Human Molecular Genetics, de Duve Institute, University of Louvain, Brussels, Belgium [147]

Vladimir Botchkarev, MD, PhD, FRSB

Professor and Deputy Director, Centre for Skin Sciences, University of Bradford, United Kingdom, Adjunct Professor, Department of Dermatology, Boston University School of Medicine, Boston, Massachusetts [7]

Francisco G. Bravo, MD

Associate Professor of Dermatology and Pathology, Universidad Peruana Cayetano Heredia, Lima, Peru [158, 171]

Thomas Brenn, MD, PhD

Consultant Dermatopathologist and Honorary Senior Lecturer, Department of Pathology NHS Lothian University Hospitals Trust and the University of Edinburgh, Edinburgh, United Kingdom [122]

Norbert H. Brockmeyer

Walk In Ruhr (WIR) Center for Sexual Health and Medicine, Department of Dermatology, Venerology and Allergology, Ruhr-Universität Bochum, Bochum, Germany [172, 173]

Anna L. Bruckner, MD, MSCS

Associate Professor of Dermatology and Pediatrics, University of Colorado School of Medicine, Section Head, Pediatric Dermatology, Children's Hospital Colorado, Aurora, Colorado [49]

Leena Bruckner-Tuderman, MD, PhD

Professor and Chair of Dermatology, Medical Center-University of Freiburg, Freiburg, Germany [15]

Marie-Charlotte Brüggen, MD, PhD

Department of Dermatology, University Hospital Zurich, Zurich, Switzerland [10]

Jörg Buddenkotte, MD, PhD

Academic Research Scientist, Department of Dermatology and Venereology, Hamad Medical Corporation, Doha, Qatar [79]

Susan Burgin, MD

Assistant Professor, Beth Israel Deaconness Medical Center, Harvard Medical School, Department of Dermatology, Boston, Massachusetts [1]

Craig G. Burkhart, MD Sylvania, Ohio [178]

Craig N. Burkhart, MD

The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina [178]

Klaus J. Busam, MD

Professor of Pathology and Laboratory Medicine, Weill Medical College of Cornell University, Department of Dermatopathology and Pathology, Memorial Sloan Kettering Cancer Center, New York, New York [115]

Jeffrey Callen, MD

Professor of Medicine (Dermatology), University of Louisville, Chief, Division of Dermatology, Louisville, Kentucky [192]

Avrom Caplan, MD

Department of Dermatology, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania [184]

Michael A. Cardis, MD

Department of Dermatology, Washington Hospital Center/ Georgetown University, Washington, DC [156]

Arival Cardoso de Brito, MD, PhD

Full Professor, Dermatology, Pará Federal University, Belém, Pará, Brazil [159]

Leslie Castelo-Soccio, MD, PhD

Assistant Professor of Pediatrics and Dermatology, The Children's Hospital of Philadelphia and University of Pennsylvania Perlman School of Medicine, Philadelphia, Pennsylvania [89]

Kelly B. Cha, MD, PhD

Department of Dermatology, University of Michigan Health System, Ann Arbor, Michigan [202]

Manasmon

Chairatchaneeboon, MD

Clinical Instructor in Dermatology, Department of Dermatology, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok, Thailand [134]

Mary Wu Chang, MD

Clinical Professor of Dermatology and Pediatrics, University of Connecticut School of Medicine, Farmington, Connecticut [103, 104]

Joel Charrow, MD

Professor of Pediatrics, Feinberg School of Medicine, Northwestern University, Ann and Robert H. Lurie Children's Hospital of Chicago, Division of Genetics, Birth Defects and Metabolism, Chicago, Illinois [135]

Mei Chen, PhD

Director, USC Laboratories for Investigative Dermatology, The Keck School of Medicine, University of Southern California, Los Angeles, California [56]

Suephy C. Chen, MD, MS

Vice Chair and Associate Professor of Dermatology, Emory University School of Medicine, Atlanta, Georgia [107]

Carol Cheng, MD

Assistant Clinical Professor of Dermatology/Medicine, David Geffen School of Medicine at UCLA, Los Angeles, California [78]

Contributors

Andy Chern, MD, MPH

Captain, Medical Corps, United States Army, Associate Program Director, Occupational and Environmental Medicine Residency Program, Uniformed Services University of the Health Sciences, F. Edward Hébert School of Medicine, Department of Preventive Medicine and Biostatistics, Bethesda, Maryland [27]

Casey M. Chern, MD

Captain, Medical Corps, United States Army, Dermatology Resident, National Capital Consortium Dermatology Residency Program, Walter Reed National Military Medical Center, Bethesda, Maryland [27]

Anna L. Chien, MD

Assistant Professor, Department of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [106, 185]

Keith A. Choate, MD, PhD

Professor of Dermatology, Genetics and Pathology, Yale University School of Medicine, New Haven, Connecticut [47]

Conroy Chow, MD

Assistant Professor, Department of Dermatology, Loma Linda University, Loma Linda, California [114]

Luisa Christensen, MD

Center for Medical Mycology, University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio [188]

Sean R. Christensen, MD, PhD

Assistant Professor of Dermatology, Section of Dermatologic Surgery, Yale University School of Medicine, New Haven, Connecticut [204]

Angela M. Christiano, PhD

Department of Dermatology, Department of Genetics and Development, Columbia University, New York, New York [18]

Emily Y. Chu, MD, PhD

Assistant Professor of Dermatology, Hospital of the University of Pennsylvania, Perelman School of Medicine, Philadelphia, Pennsylvania [2]

Jin Ho Chung, MD, PhD

Professor and Chairman, Department of Dermatology, Seoul National University College of Medicine, Seoul, Korea [197]

Matthew Clark, MD

Dermatology Resident, University of Michigan Department of Dermatology, Ann Arbor, Michigan [31]

Roger Clark, DO

Assistant Professor of Medicine, Tufts Medical Center, Brigham and Women's Faulkner Hospital, Boston, Massachusetts [179]

Olivier Cogrel, MD

Dermatologic Surgery and Laser Unit, Dermatology Department, CHU Bordeaux, Hôpital Saint-André, Bordeaux, France [205]

Bernard A. Cohen, MD

Johns Hopkins Hospital Baltimore, Maryland [178]

Jeffrey I. Cohen, MD

Chief, Laboratory of Infectious Diseases, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland [164]

Philip R. Cohen, MD

Professor of Dermatology, University of California San Diego School of Medicine, San Diego, California [36]

Sean C. Condon, MD

Department of Dermatology, Cleveland Clinic, Cleveland, Ohio [186]

Melissa I. Costner, MD

Associate Clinical Professor, Dermatology, UT Southwestern Medical School, North Dallas Dermatology Associates, Dallas, Texas [61]

George Cotsarelis, MD

Milton B. Hartzell Professor and Chair, Department of Dermatology, Perelman School of Medicine University of Pennsylvania, Director, Program on Epithelial Regeneration and Stem Cells, University of Pennsylvania Institute for Regenerative Medicine, Philadelphia, Pennsylvania [7]

Edward W. Cowen, MD

Head, Dermatology Consultation Service, Dermatology Branch, Center for Cancer Research, National Cancer Institute, National Institutes of Health, Bethesda, Maryland [129]

Lauren N. Craddock, MD

Department of Dermatology, University of Wisconsin-Madison, Madison, Wisconsin [160]

Ponciano D. Cruz, Jr., MD

Distinguished Professor, Paul Bergstresser Endowed Chair in Dermatology, Department of Dermatology, The University of Texas, Chief of Dermatology, North Texas Veterans Affairs Medical Center, Dallas, Texas [24]

Jonathan D. Cuda, MD

Assistant Professor of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [108, 115]

Donna A. Culton, MD, PhD

Department of Dermatology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina [54]

Nika Cyrus, MD

Department of Dermatology, Parkland Health and Hospital System, Dallas, Texas [64]

Adilson da Costa, MD

Emory University School of Medicine, Department of Dermatology, Atlanta, Georgia [195]

Jennifer S. Daly, MD

Clinical Chief, Infectious Diseases and Immunology, Professor of Medicine, Microbiology and Physiological Systems, University of Massachusetts Medical School, Worcester, Massachusetts [182]

Thomas N. Darling, MD, PhD

Professor and Chair of Dermatology, Uniformed Services University of the Health Sciences, Bethesda, Maryland [136]

Mark D. P. Davis, MD

Professor of Dermatology, Mayo Clinic College of Medicine, Department of Dermatology, Rochester, Minnesota [144]

Robert S. Dawe, MBChB, MD(Glasg), FRCP(Edin)

Consultant Dermatologist and Honorary Reader in Dermatology, Department of Dermatology and Photobiology Unit, NHS Tayside and University of Dundee, Dundee, Scotland [95]

Roy H. Decker, MD, PhD

Associate Professor, Vice Chair and Director of Clinical Research, Department of Therapeutic Radiology, Yale School of Medicine, New Haven, Connecticut [200]

Christopher P. Denton, PhD, FRCP

Centre for Rheumatology and Connective Tissue Diseases, UCL Medical School, Royal Free Hospital, London, United Kingdom [63]

Garrett T. Desman, MD

Assistant Professor of Pathology and Dermatology, Icahn School of Medicine at Mount Sinai, New York, New York [71]

Luis A. Diaz, MD

Department of Dermatology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina [54]

John J. DiGiovanna, MD

Senior Research Physician, DNA Repair Section, Dermatology Branch, Center for Cancer Research, National Cancer Institute, National Institutes of Health, Bethesda, Maryland [130]

Andrzej A. Dlugosz, MD

Poth Professor of Cutaneous Oncology, Departments of Dermatology and Cell and Developmental Biology, University of Michigan Medical School, Ann Arbor, Michigan [19]

Lisa M. Donofrio, MD

Associate Clinical Professor, Department of Dermatology, Yale School of Medicine, Yale University, New Haven, Connecticut [215]

Jeffrey S. Dover, MD, FRCPC

SkinCare Physicians, Chestnut Hill, Massachusetts [208]

Lyn McDivitt Duncan, MD

Professor of Pathology, Harvard Medical School, Chief, Dermatopathology Unit, Department of Pathology, Massachusetts General Hospital, Boston, Massachusetts [109]

Jonathan A. Dyer, MD

Associate Professor of Dermatology and Child Health, Departments of Dermatology and Child Health, University of Missouri, Columbia, Missouri [72]

Lawrence F. Eichenfield, MD

Chief, Pediatric and Adolescent Dermatology, Professor of Dermatology and Pediatrics, Vice Chair, Department of Dermatology, University of California, San Diego School of Medicine, San Diego, California [22]

James T. Elder, MD, PhD

Kirk D. Wuepper Professor of Molecular Genetic Dermatology, Department of Dermatology, University of Michigan, Ann Arbor, Ann Arbor, Michigan [28]

Rosalie Elenitsas, MD

Professor of Dermatology, Director of Dermatopathology, Hospital of the University of Pennsylvania, Perelman School of Medicine, Philadelphia, Pennsylvania [2]

Dana L. Ellis, MD

Clinical Instructor, Department of Dermatology, Yale School of Medicine, Yale University, New Haven, Connecticut [215]

Craig A. Elmets, MD

Professor and Emeritus Chair, Department of Dermatology, University of Alabama at Birmingham, The Birmingham VA Medical Center, Birmingham, Alabama [198]

Joseph C. English III, MD

Professor of Dermatology, University of Pittsburgh, Department of Dermatology, UPMC North Hills Dermatology, Wexford, Pennsylvania [155]

Alexander H. Enk, MD

Professor and Chair, Department of Dermatology, University of Heidelberg, Heidelberg, Germany [116]

Ervin H. Epstein, Jr., MD

Children's Hospital of Oakland Research Institute, UCSF, Oakland, California [111]

Khaled Ezzedine, MD, PhD

Professor, Department of Dermatology, Hôpital Henri Mondor, EA EpiDermE (Epidémiologie en Dermatologie et Evaluation des Thérapeutiques), UPEC-Université Paris-Est Créteil, Créteil, France [76, 171]

Janet A. Fairley, MD

John S. Strauss Professor and Chair, Department of Dermatology, University of Iowa Carver College of Medicine, Iowa City, Iowa [128]

Steven R. Feldman, MD, PhD

Department of Dermatology, Wake Forest University School of Medicine, Winston-Salem, North Carolina [183]

Nicole Fett, MD, MSCE

Associate Professor of Dermatology, Department of Dermatology, Oregon Health and Science University, Portland, Oregon [184]

David Fiorentino, MD, PhD

Professor in the Department of Dermatology and the Department of Immunology and Rheumatology at Stanford University School of Medicine, Redwood City, California [62]

David E. Fisher, MD, PhD

Edward Wigglesworth Professor and Chairman, Department of Dermatology, Harvard Medical School, Director, Melanoma Program MGH Cancer Center, Director, Cutaneous Biology Research Center, Massachusetts General Hospital, Boston, Massachusetts [20]

Joachim W. Fluhr, MD

Oberarzt, Charité-Universitätsmedizin Berlin, Klinik für Dermatologie, Venerologie und Allergologie, Berlin, Germany [96]

John A. Flynn, MD, MBA, MEd

Professor and Associate Dean of Medicine, Johns Hopkins University, Baltimore, Maryland [65]

Ruth K. Foreman, MD, PhD

Instructor of Pathology, Harvard Medical School, Dermatopathology Unit, Department of Pathology, Massachusetts General Hospital, Boston, Massachusetts [109]

Amy K. Forrestel, MD

University of Pennsylvania, Department of Dermatology, Philadelphia, Pennsylvania [133]

Camille Francès, MD

AP-HP, Hôpital Tenon, Université Paris VI, Service de Dermatologie-Allergologie, Paris, France [69]

Nicholas Frank, MD

Dermatology Resident, Vanderbilt University Medical Center, Department of Internal Medicine, Division of Dermatology, Nashville, Tennessee [101]

Esther E. Freeman, MD, PhD

Assistant Professor of Dermatology, Harvard University Medical School, Director, Global Health Dermatology, Massachusetts General Hospital, Department of Dermatology, Boston, Massachusetts [168]

Lars E. French, MD

Professor and Chairman, Department of Dermatology, University of Zurich, Zurich, Switzerland [39]

Sheila Fallon Friedlander, MD

Professor of Dermatology and Pediatrics, University of California, San Diego School of Medicine, Rady Children's Hospital, San Diego, San Diego, California [166]

Adam J. Friedman, MD

Associate Professor of Dermatology, Director of Translational Research, Residency Program Director, Department of Dermatology, George Washington School of Medicine and Health Sciences, Washington, DC [154]

Daniel P. Friedmann, MD

Westlake Dermatology Clinical Research Center, Westlake Dermatology and Cosmetic Surgery, Austin, Texas [212]

Ramsay L. Fuleihan, MD

Professor of Pediatrics, Northwestern University Feinberg School of Medicine, Chicago, Illinois [132]

Abhimanyu Garg, MD

Professor of Internal Medicine, Chief, Division of Nutrition and Metabolic Diseases, Department of Internal Medicine and the Center for Human Nutrition, Distinguished Chair in Human Nutrition Research, Dallas, Texas [74]

Luis Garza, MD, PhD

Associate Professor, Department of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [4]

Mahmoud Ghannoum, PhD, EMBA

Center for Medical Mycology, University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio [188]

Dee Anna Glaser, MD

Interim Chair and Professor, Director Cosmetic and Laser Surgery, Director of Clinical Research, Department of Dermatology, Saint Louis University School of Medicine, St. Louis, Missouri [81]

Richard G. Glogau, MD

Clinical Professor of Dermatology, University of California, San Francisco, San Francisco, California [216]

Sergij Goerdt, MD

Professor of Dermatology, Chair of Dermatology, Department of Dermatology, Venereology and Allergology, University Medical Center and Medical Faculty Mannheim, University of Heidelberg, Mannheim, Germany [117]

Carolyn Goh, MD

Assistant Clinical Professor of Dermatology/Medicine, David Geffen School of Medicine at UCLA, Los Angeles, California [78]

Chee Leok Goh, MD, MBBS, M. Med (Int. Med), MRCP (UK), FRCP (Edin), Hon FACD, FAMS (Dermatology) Clinical Professor, National Skin

Centre, Singapore [187]

Leonard H. Goldberg, MD

DermSurgery Associates, Houston, Texas [206]

Peter D. Gorevic, MD

Professor of Medicine, Division of Rheumatology, Icahn School of Medicine at Mount Sinai, New York, New York [125]

Eric W. Gou, MD

Department of Internal Medicine, Division of Gastroenterology and Hepatology, University of Texas Medical Branch, Galveston, Texas [124]

Emmy M. Graber, MD, MBA

Dermatologist, The Dermatology Institute of Boston, Boston, Massachusetts [78, 80]

Dorothy Katherine Grange, MD

Professor of Pediatrics, Division of Genetics and Genomic Medicine, Department of Pediatrics, Washington University School of Medicine, St. Louis, Missouri [131]

Clayton B. Green MD, PhD

The Marshfield Clinic, Marshfield, Wisconsin [98]

Justin J. Green, MD

Division of Dermatology, Cooper Medical School of Rowan University, Camden, New Jersey [180]

Roy C. Grekin, MD

Professor of Dermatology, Director, Dermatologic Surgery and Laser Center, University of California, San Francisco, San Francisco, California [114]

Annie Grossberg, MD

Associate Director, Dermatology Residency Program, Assistant Professor, Departments of Dermatology and Pediatrics, Johns Hopkins University, Baltimore, Maryland [102]

Alexandra Gruber-Wackernagel, MD

Medical University of Graz, Research Unit for Photodermatology, Department of Dermatology, Medical University of Graz, Graz, Austria [92]

Johann E. Gudjonsson, MD, PhD

Assistant Professor, Department of Dermatology, Frances and Kenneth Eisenberg Emerging Scholar of the Taubman Medical Research Institute, University of Michigan, Ann Arbor, Michigan [11, 28, 31]

Cheryl J. Gustafson, MD

St. Vincent Carmel Medical Center, Carmel, Indiana [214]

Eva N. Hadaschik, MD

Department of Dermatology, University Hospital Heidelberg, Heidelberg, Germany [112]

Ellen S. Haddock, AB, MBA

University of California, San Diego School of Medicine, La Jolla, California [166]

Alexandra Haden, MD

Assistant Professor of Clinical Dermatology, Department of Dermatology, University of Southern California, Los Angeles, California [143]

Adele Haimovic, MD

SkinCare Physicians, Chestnut Hill, Massachusetts [203]

Russell P. Hall III, MD

J. Lamar Callaway Professor, Department of Dermatology, Duke University Medical Center, Durham, North Carolina [58]

Analisa V. Halpern, MD

Division of Dermatology, Cooper Medical School of Rowan University, Camden, New Jersey [180]

Eckart Haneke, MD, PhD

Clinical Professor (em) of Dermatology, Department of Dermatology, Inselspital, University of Berne, Bern, Switzerland [91]

C. William Hanke, MD, MPH, FACP

St. Vincent Carmel Medical Center, Carmel, Indiana [214]

John E. Harris, MD, PhD

Associate Professor, University of Massachusetts Medical School, Worcester, Massachusetts [76]

Takashi Hashimoto, MD

Professor and Director, Kurume University Institute of Cutaneous Cell Biology, Kurume, Fukuoka, Japan [57]

Jessica C. Hassel, MD

Section Head, DermatoOncology, Department of Dermatology and National Center for Tumor Diseases, University Hospital Heidelberg, Heidelberg, Germany [116]

Roderick J. Hay, DM, FRCP, FRCPath, FMedSci

Professor, Department of Dermatology, Kings College Hospital, Denmark Hill, London, United Kingdom [162]

Masahiro Hayashi, MD, PhD

Associate Professor of Dermatology, Yamagata University Faculty of Medicine, Yamagata, Japan [75]

Kara Heelan, MB BCh, BAO

Dermatology Department, University College London Hospitals, London, United Kingdom [45]

Cara Hennings, MD

University of Tennessee/Erlanger Medical Center, Chattanooga, Tennessee [101]

Markus V. Heppt, MD

Department of Dermatology, University Hospital Munich, Ludwig-Maximilian University, Munich, Germany [110]

Warren R. Heymann, MD

Division of Dermatology, Cooper Medical School of Rowan University, Camden, New Jersey [180]

Michihiro Hide, MD, PhD

Department of Dermatology, Institute of Biomedical and Health Sciences, Hiroshima University, Hiroshima, Japan [41]

Whitney A. High, MD, JD, MEng

Associate Professor of Dermatology and Pathology, University of Colorado School of Medicine, Director of Dermatopathology (Dermatology), Aurora, Colorado [140]

Takaaki Hiragun, MD, PhD

Department of Dermatology, Institute of Biomedical and Health Sciences, Hiroshima University, Hiroshima, Japan [41]

Allen W. Ho, MD, PhD

Resident Physician, Department of Dermatology, Harvard Medical School, Boston, Massachusetts [12]

Melissa B. Hoffman, MD

Resident, Dermatology, Wake Forest School of Medicine, Winston Salem, North Carolina [174]

Jeremy S. Honaker, CNP, PhD

Assistant Professor, Department of Dermatology, Case Western Reserve University, Cleveland, Ohio [190]

Herbert Hönigsmann, MD

Professor of Dermatology, Emeritus Chairman, Department of Dermatology, Medical University of Vienna, Vienna, Austria [38, 199]

Alain Hovnanian, MD, PhD

Professor of Genetics, Department of Genetics, Imagine Institute for Genetic Diseases, Necker Hospital for Sick Children, University Paris Descartes-Sorbonne Paris Cité, Paris, France [50]

Josie Howard, MD

Clinical Faculty, Departments of Psychiatry and Dermatology, University of California, San Francisco, San Francisco, California [100]

Jeffrey T. S. Hsu, MD

Clinical Assistant Professor, Department of Dermatology, University of Illinois College of Medicine at Chicago, Co-Director of Dermatologic, Laser and Cosmetic Surgery, The Dermatology Institute of DuPage Medical Group, Naperville, Illinois [212]

Linden Hu, MD

Professor of Microbiology and Medicine, Tufts University School of Medicine, Boston, Massachusetts [179]

William W. Huang, MD, MPH

Associate Professor of Dermatology, Residency Program Director, Wake Forest School of Medicine, Winston Salem, North Carolina [46]

Raegan Hunt, MD, PhD

Assistant Professor of Dermatology and Pediatrics, Texas Children's Hospital, Baylor College of Medicine, Houston, Texas [103]

Sam T. Hwang, MD, PhD

Department of Dermatology, University of California Davis School of Medicine, Sacramento, California [193]

Omer Ibrahim, MD

SkinCare Physicians, Chestnut Hill, Massachusetts [208]

Alan D. Irvine, MD, DSc

Paediatric Dermatology and National Children's Research Centre, Our Lady's Children's Hospital Crumlin, Dublin, Clinical Medicine, Trinity College, Dublin, Ireland [51]

Carlos M. Isada, MD

Department of Infectious Disease, Cleveland Clinic, Cleveland, Ohio [186]

Contributors

Heidi T. Jacobe, MD, MSCS

Associate Professor, Department of Dermatology, UT Southwestern Medical Center, Dallas, Texas [64]

Tarannum Jaleel, MD

Instructor, Department of Dermatology, Duke Medical Center, Durham, North Carolina [198]

Camila K. Janniger, MD

Clinical Professor, Dermatology, Rutgers New Jersey Medical School, Englewood, New Jersey [182]

Andrew Johnston, PhD

Department of Dermatology University of Michigan School of Medicine, Ann Arbor, Michigan [193]

Steven R. Jones, MD

Ciccarone Center for the Prevention of Heart Disease, Division of Cardiology, Department of Medicine, Johns Hopkins Hospital, Baltimore Maryland [126]

Natanel Jourabchi, MD

Resident Dermatology Physician, Johns Hopkins School of Medicine, Baltimore, Maryland [37]

Andrea Kalus, MD

Associate Professor, University of Washington School of Medicine, Division of Dermatology, Seattle, Washington [137]

Sewon Kang, MD, MPH

Noxell Professor & Chair, Department of Dermatology, Johns Hopkins School of Medicine, Dermatologist-in-Chief, Johns Hopkins Hospital, Baltimore, Maryland [106, 185]

Varvara Kanti, MD

Department of Dermatology and Allergy, Charité-Universitätsmedizin, Berlin, Germany [85]

Kenneth A. Katz, MD, MSc, MSCE

Department of Dermatology, Kaiser Permanente, San Francisco, California [107]

Stephen I. Katz, MD, PhD

National Institute of Arthritis and Musculoskeletal and Skin Diseases, Bethesda, Maryland [59]

Werner Kempf, MD

Kempf and Pfaltz, Histologische Diagnostik, Department of Dermatology, University Hospital Zurich, Zurich, Switzerland [120]

Michelle L. Kerns, MD

Research Fellow, Department of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [106]

Jay S. Keystone, MD, MSc (CTM), FRCPC

Professor of Medicine, University of Toronto, Tropical Disease Unit, Division of Infectious Diseases, Toronto General Hospital, Toronto, Ontario, Canada [177]

Ellen J. Kim, MD

Sandra J. Lazarus Associate Professor in Dermatology, Department of Dermatology, Perelman School of Medicine at the University of Pennsylvania, Perelman Center for Advanced Medicine, Philadelphia, Pennsylvania [134]

Jenny Kim, MD, PhD

Professor of Dermatology/ Medicine/Nutrition, David Geffen School of Medicine at UCLA, Los Angeles, California [78]

Robert S. Kirsner, MD, PhD

Chairman and Harvey Blank Professor, Department of Dermatology and Cutaneous Surgery, Professor, Department of Public Health Sciences, University of Miami Miller School of Medicine, Miami, Florida [149]

Robert Knobler, MD

Associate Professor of Dermatology, Department of Dermatology, Medical University of Vienna, Vienna, Austria [199]

Krzysztof Kobielak, MD, PhD

Group Leader of Laboratory of Stem Cells, Development and Tissue Regeneration, Centre of New Technologies, University of Warsaw, Warsaw, Poland, Principal Investigator, Department of Developmental and Cell Biology, University of California, Irvine, Irvine, California [8]

Heidi H. Kong, MD, MHSc

Investigator, Dermatology Branch, Center for Cancer Research, National Cancer Institute, National Institutes of Health, Dermatology Branch Bethesda, Maryland [16]

John Y. M. Koo, MD

Professor, Psoriasis, Phototherapy, and Skin Treatment Center and Psychodermatology Clinic, Department of Dermatology, University of California San Francisco, San Francisco, California [100]

Neil J. Korman, MD, PhD

Professor, Department of Dermatology, Case Western Reserve University, Cleveland, Ohio [190]

Kenneth H. Kraemer, MD

Chief, DNA Repair Section, Dermatology Branch, Center for Cancer Research, National Cancer Institute, National Institutes of Health, Bethesda, Maryland [130]

Thomas Krieg, MD, FRCP

Department of Dermatology and Venerology, University of Cologne, Cologne, Germany [63]

Daniela Kroshinksy, MD, MPH

Associate Professor, Harvard Medical School, Director of Inpatient Dermatology, Director of Pediatric Dermatology, Massachusetts General Hospital / MassGeneral Hospital for Children, Boston, Massachusetts [153]

Akiharu Kubo, MD, PhD

Department of Dermatology, Keio University School of Medicine, Tokyo, Japan [14]

Thomas S. Kupper, MD

Thomas B. Fitzpatrick Professor, Department of Dermatology, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts [12]

Anastasia O. Kurta, DO

Dermatology Resident, Department of Dermatology, Saint Louis University School of Medicine, St Louis, Missouri [81]

Drew Kurtzman, MD

Assistant Professor of Medicine (Dermatology), Director, Connective Tissue Disease Clinic, Director, Immunobullous Disease Clinic, The University of Arizona, Tucson, Arizona [145, 192]

Razelle Kurzrock, MD

Professor of Medicine and Chief, Division of Hematology and Oncology; Senior Deputy Center Director, Clinical Science; and Director, Center for Personalized Cancer Therapy and Clinical Trials Office, University of California, San Diego Moores Cancer Center, San Diego, California [36]

Heinz Kutzner, MD

Dermatopathology Friedrichshafen, Friedrichshafen, Germany [121]

Shawn G. Kwatra, MD

Department of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [196]

Avery LaChance, MD, MPH

Dermatology Resident, Harvard Combined Dermatology Residency Training Program, Massachusetts General Hospital, Boston, Massachusetts [153]

Eden Pappo Lake, MD

University of Illinois at Chicago, Chicago, Illinois [73]

Stephan Lautenschlager, MD

Associate Professor University of Zurich, Chairman Outpatient Clinic of Dermatology and Venereology, City Hospital Triemli, Zurich, Switzerland [172, 173]

Gerald S. Lazarus, MD

Professor of Dermatology and Medicine, Johns Hopkins School of Medicine, Baltimore, Maryland [37]

Terry Lechler, PhD

Associate Professor of Dermatology, Duke University Medical Center, Durham, North Carolina [5]

David J. Leffell, MD

David Paige Smith Professor of Dermatology and Professor of Surgery (Otolaryngology and Plastic), Section Chief of Dermatologic Surgery, Yale University School of Medicine, New Haven, Connecticut [204]

Aimee L. Leonard, MD

New England Dermatology and Laser Center, Springfield, Massachusetts [214]

Kieron Leslie, MBBS, DTM&H, FRCP

Professor of Clinical Dermatology, Dermatology Department, University of California, San Francisco, San Francisco, California [161]

Donald Y. M. Leung, MD, PhD

Department of Pediatrics, National Jewish Health, University of Colorado Denver, Denver, Colorado [22]

Benjamin Levi, MD

Director, Burn, Wound and Regenerative Medicine Laboratory, Assistant Professor of Surgery, Ann Arbor, Michigan [99]

Myron J. Levin, MD

Section of Pediatric Infectious Diseases, Department of Pediatrics, University of Colorado School of Medicine, Aurora, Colorado [165]

Matthew Lewis, MD, MPH

Clinical Assistant Professor in the Department of Dermatology at Stanford University School of Medicine, Redwood City, California [62]

Maryam Liaqat, MD

Division of Dermatology, Cooper Medical School of Rowan University, Camden, New Jersey [180]

Henry W. Lim, MD

Emeritus Chair, Department of Dermatology, Henry Ford Hospital, Senior Vice President for Academic Affairs, Henry Ford Health System, Detroit, Michigan [97]

Dan Lipsker, MD, PhD

Professor of Dermatology, Faculté de Medicine, Université de Strasbourg and Clinique Dermatologique, Hôpitaux Universitaires, Strasbourg, France [146]

Adam D. Lipworth, MD

Assistant Professor of Dermatology, Harvard University Medical School, Director, Program for Infectious Diseases of the Skin, Director of Clinical Care Redesign, Dermatology, Brigham and Women's Hospital, Boston, Massachusetts [168]

Robert Listernick, MD

Professor of Pediatrics, Feinberg School of Medicine, Northwestern University, Ann and Robert H. Lurie Children's Hospital of Chicago, Division of General Academic Pediatrics, Chicago, Illinois [135]

Zhi Liu, PhD

Department of Dermatology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina [54]

Robert Loewe, MD

Associate Professor, Department of Dermatology, Medical University Vienna, Vienna, Austria [9]

Anke S. Lonsdorf, MD

Department of Dermatology, University Hospital Heidelberg, Heidelberg, Germany [112]

Manisha Loss, MD

Department of Dermatology Johns Hopkins School of Medicine, Baltimore, Maryland [196]

Thomas A. Luger, MD

Center of Chronic Pruritus, Department of Dermatology, University of Münster, Münster, Germany [21]

Boris D. Lushniak, MD, MPH

Rear Admiral, United States Public Health Service (Retired), Professor and Chair, Preventive Medicine and Biostatistics, Uniformed Services University of the Health Sciences, F. Edward Hébert School of Medicine, Department of Preventive Medicine and Biostatistics, Bethesda, Maryland [27]

Catherine Maari, MD, FRCPC

Associate Clinical Professor, Division of Dermatology, Montreal University Health Center, University of Montreal, CHU Sainte-Justine, Montreal, Quebec, Canada [70]

Kelly M. MacArthur, MD

Chief Resident, Department of Dermatology, Johns Hopkins University, Baltimore, Maryland [102, 118]

Howard I. Maibach, MD

Department of Dermatology, University of California, San Francisco School of Medicine, San Francisco, California [183]

Aaron R. Mangold, MD

Assistant Professor of Dermatology, Mayo Clinic, Scottsdale, Arizona [32, 33]

Matthew D. Mansh, MD

Resident in Dermatology, University of Minnesota, Minneapolis, Minnesota [107]

Richard Marchell, MD

Associate Professor of Dermatology and Dermatologic Surgery, Residency Program Director, Medical University of South Carolina, Charleston, South Carolina [35]

David J. Margolis, MD, PhD

Professor of Dermatology and Epidemiology, Department of Dermatology, Department of Biostatistics and Epidemiology, University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania [3, 151]

M. Peter Marinkovich, MD

Attending Physician, VA Palo Alto Health Care System, Associate Professor and Director, Blistering Disease Clinic, Department of Dermatology, Program in Epithelial Biology, Stanford University School of Medicine, Stanford, California [60]

Seth S. Martin, MD, MHS

Ciccarone Center for the Prevention of Heart Disease, Division of Cardiology, Department of Medicine, Johns Hopkins Hospital, Baltimore Maryland [126]

Kathryn J. Martires, MD

Clinical Assistant Professor, Department of Dermatology, Stanford University School of Medicine, Palo Alto, California [129]

Erin F. D. Mathes, MD

Associate Professor of Clinical Dermatology, University of California, San Francisco, San Francisco, California [163]

Marcus Maurer, MD

Charité–Universitätsmedizin Berlin, Department of Dermatology and Allergy, Berlin, Germany [96]

Aubriana McEvoy

University of Washington, Seattle, Washington [113]

John A. McGrath, MBBS, PhD

St John's Institute of Dermatology, King's College London, London, United Kingdom [18]

Sean McGregor, DO

Resident physician, Wake Forest University School of Medicine, Winston-Salem, North Carolina [175]

Bridget E. McIlwee, DO

Dermatology Resident, Division of Dermatology University of North Texas Health Science Center, Fort Worth, Texas [209]

Amy J. McMichael, MD

Professor and Chair, Department of Dermatology, Wake Forest University School of Medicine, Winston-Salem, North Carolina [90]

Atul B. Mehta, MA, MB, BChir, MD, FRCP, FRCPath

Professor, University College London, Royal Free Campus and Royal Free London NHS Foundation Trust, London, United Kingdom [127]

Thomas Mentzel, MD

Consultant Dermatopathologist and Associated Professor, Dermatopathologie Bodensee, Friedrichshafen, Germany [122]

Peter A. Merkel, MD, MPH

Chief, Division of Rheumatology, Professor of Medicine and Epidemiology, University of Pennsylvania, Philadelphia, Pennsylvania [139]

Robert G. Micheletti, MD

University of Pennsylvania, Department of Dermatology, Philadelphia, Pennsylvania [133]

Ashley N. Millard, MD

Marshfield Clinic, Marshfield, Wisconsin [98]

David Michael Miller, MD, PhD

Clinical Fellow in Medicine, Division of Hematology/ Oncology, Beth Israel Deaconess Medical Center, Clinical Associate, Department of Dermatology, Massachusetts General Hospital, Boston, Massachusetts [194]

Jami L. Miller, MD

Department of Internal Medicine, Division of Dermatology, Vanderbilt University Medical Center, Nashville, Tennessee [101]

Lloyd S. Miller, MD, PhD

Associate Professor of Dermatology, Infectious Diseases and Orthopaedic Surgery, Johns Hopkins School of Medicine, Baltimore, Maryland [150]

Leonard M. Milstone, MD

Professor Emeritus of Dermatology, Yale University School of Medicine, New Haven, Connecticut [47]

Daniel Mimouni, MD

Associate Professor of Dermatology, Department of Dermatology, Beilinson Hospital, Petach Tikva, Israel, Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel [53]

Vineet Mishra, MD

Assistant Clinical Professor, Division of Dermatology and Cutaneous Surgery, The University of Texas Health Science Center at San Antonio, San Antonio, Texas [212]

Maja Mockenhaupt, MD, PhD

Dokumentationszentrum schwerer Hautreaktionen (dZh), Department of Dermatology, Medical Center, University of Freiburg, Freiburg, Germany, Dokumentationszentrum schwerer Hautreaktionen (dZh), Department of Dermatology, Medical Center and Medical Faculty, University of Freiburg, Freiburg, Germany [43, 44]

Robert L. Modlin, MD, PhD

Klein Professor of Dermatology, Distinguished Professor of Medicine and Microbiology, Immunology and Molecular Genetics, Chief, Division of Dermatology, Vice Chair for Cutaneous Medicine and Dermatology Research, David Geffen School of Medicine, UCLA Med-Derm, Los Angeles, California [11]

Pia Moinzadeh, MD

Department of Dermatology and Venerology, University of Cologne, Cologne, Germany [63]

Paul A. Monach, MD, PhD

Division of Rheumatology, Immunology, and Allergy, Brigham and Women's Hospital, Chief, Rheumatology Section, VA Boston Healthcare System, Boston, Massachusetts [139]

Gary Monheit, MD

Total Skin and Beauty Dermatology, Birmingham, Alabama [213]

Robert F. Moore, MD

Resident in Anatomic Pathology, Department of Pathology, Johns Hopkins Hospital, Baltimore, Maryland [115]

Breanne Mordorski, BA

Nanodermatology Research Fellow, Department of Medicine (Division of Dermatology), Albert Einstein College of Medicine, Bronx, New York [154]

Hansgeorg Müller, MD

Dermatopathology Friedrichshafen, Friedrichshafen, Germany [121]

Keisuke Nagao, MD, PhD

Dermatology Branch, National Institutes of Health, Bethesda, Maryland [13]

Mio Nakamura, MD

Clinical Research Fellow, Psoriasis, Phototherapy, and Skin Treatment Center, Department of Dermatology, University of California, San Francisco, San Francisco, California [100]

Zeena Y. Nawas, MD

University of Texas Health Science Center, Houston, Texas [191]

Susan T. Nedorost, MD

Professor, Dermatology and Environmental Health Sciences, Case Western Reserve University, Director, Graduate Medical Education, University Hospitals Cleveland Medical Center, Cleveland, Ohio [25]

Isaac M. Neuhaus, MD

Associate Professor of Dermatology, University of California, San Francisco, San Francisco, California [114]

Sabrina A. Newman, MD

Assistant Professor of Dermatology, Director, Inpatient Dermatology, University of Colorado School of Medicine, Anschutz Medical Campus, Aurora, Colorado [148]

Paul Nghiem, MD, PhD

University of Washington, Seattle, Washington [113]

Quynh-Giao Nguyen, MD

Baylor College of Medicine, Houston, Texas [191]

Matilda W. Nicholas, MD, PhD

Assistant Professor, Department of Dermatology, Duke University Medical Center, Duke University Medical Center, Durham, North Carolina [58]

Elizabeth L. Nieman, MD

Assistant Professor of Dermatology, Division of Dermatology, Department of Medicine, Washington University School of Medicine, St. Louis, Missouri [131]

Scott A. Norton, MD, MPH, MSc

Chief of Dermatology, Children's National Medical Center, Washington, DC [156]

Cathal O'Connor, MD

Paediatric Dermatology, Our Lady's Children's Hospital, National Children's Research Centre, Our Lady's Children's Hospital Crumlin, Dublin [51]

Grainne M. O'Regan, PhD, FRCPI

Paediatric Dermatology, Our Lady's Children's Hospital, National Children's Research Centre, Our Lady's Children's Hospital Crumlin, Dublin [51]

Manabu Ohyama, MD, PhD

Professor and Chairman, Department of Dermatology, Kyorin University School of Medicine, Tokyo, Japan [86]

Ginette A. Okoye, MD

Assistant Professor of Dermatology, Johns Hopkins School of Medicine, Baltimore, Maryland [84]

Ana-Maria Orbai, MD, MHS

Assistant Professor of Medicine, Director Psoriatic Arthritis Program, Johns Hopkins Arthritis Center, Johns Hopkins School of Medicine, Division of Rheumatology, Baltimore, Maryland [65]

Anthony E. Oro, MD, PhD

Department of Dermatology, Stanford University, School of Medicine, Redwood City, California [111]

Jeffrey S. Orringer, MD

Professor and Chief, Division of Cosmetic Dermatology, Department of Dermatology, University of Michigan, Ann Arbor, Michigan [210]

Catherine H. Orteu, MBBS, BSc, MD, FRCP

University College London, Royal Free Campus and Royal Free London NHS Foundation Trust, London, United Kingdom [127]

Stephen M. Ostrowski, MD, PhD

Instructor of Dermatology, Harvard Medical School, Department of Dermatology, Cutaneous Biology Research Center, Massachusetts General Hospital, Boston, Massachusetts [20]

Nina Otberg, MD

Hair Clinic, Skin and Laser Center Potsdam, Potsdam, Germany, Otberg Medical, Hair Transplant Center Berlin–Potsdam, Berlin, Germany [87, 88]

Michael N. Oxman, MD

Division of Infectious Diseases, Department of Medicine, University of California, San Diego and Infectious Diseases Section, Medical Service, Veterans Affairs San Diego Healthcare System, San Diego, California [165]

Vikash S. Oza, MD

Assistant Professor of Dermatology and Pediatrics, The Ronald O. Perelman Department of Dermatology, New York University School of Medicine, New York, New York [163]

Amy S. Paller, MD

Walter J. Hamlin Professor and Chair, Department of Dermatology, Professor of Pediatrics, Northwestern University Feinberg School of Medicine, Chicago, Illinois [132]

Jiun Yit Pan, MBBS, MCI (NUS), GDOM (NUS), DTM&H (Lond), FRCP (Edin)

Dermatologist, National Skin Centre, Singapore [187]

Amit G. Pandya, MD

Department of Dermatology, The University of Texas, Southwestern Medical Center, Dallas, Texas [77]

Deepa Patel, BS

Clinical Research Fellow, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania [89]

Aimee S. Payne, MD, PhD

Associate Professor of Dermatology, University of Pennsylvania, Philadelphia, Pennsylvania [15, 52]

David R. Pearson, MD

Assistant Professor of Dermatology, University of Minnesota School of Medicine, Minneapolis, Minnesota [151]

David H. Peng, MD, MPH

Chair, Department of Dermatology, University of Southern California, Los Angeles, California [143]

Manuel P. Pereira, MD, PhD

Center of Chronic Pruritus, Department of Dermatology, University of Münster, Münster, Germany [21]

Powell Perng, MD

Johns Hopkins School of Medicine, Department of Dermatology, Baltimore, Maryland [83]

Peter Petzelbauer, MD

Professor of Microvascular Research, Department of Dermatology, Medical University Vienna, Vienna, Austria [9]

Robert G. Phelps, MD

Professor, Departments of Dermatology and Pathology, Icahn School of Medicine at Mount Sinai, New York, New York [125]

Rita O. Pichardo, MD

Associate Professor of Dermatology, Wake Forest University School of Medicine, Winston-Salem, North Carolina [174, 175]

Warren W. Piette, MD

Chair, Division of Dermatology, Department of Medicine, John H Stroger, Jr. Hospital of Cook County, Professor, Department of Dermatology, Rush University Medical Center, Chicago, Illinois [66]

Mark R. Pittelkow, MD

Professor of Dermatology, Mayo Clinic, Chair of Dermatology, Scottsdale, Arizona [32, 33, 67]

Jordan S. Pober, MD, PhD

Bayer Professor of Translational Medicine and Professor of Immunobiology, Pathology and Dermatology, Department of Immunobiology, Yale School of Medicine, New Haven, Connecticut [9]

Brian P. Pollack, MD, PhD

Assistant Professor, Departments of Dermatology and Pathology/ Laboratory Medicine, Emory University School of Medicine, The Atlanta VA Medical Center, Atlanta, Georgia [198]

Miriam Keltz Pomeranz, MD

Associate Professor of Dermatology, The Ronald O. Perelman Department of Dermatology, New York University School of Medicine, Chief of Dermatology, NYC Health + Hospitals/Bellevue, New York, New York [105]

Julie Powell, MD, FRCPC

Clinical Professor, Dermatology and Pediatrics, University of Montreal, Director, Pediatric Dermatology, CHU Sainte-Justine, Montreal, Quebec, Canada [70]

Julie S. Prendiville, MB, FRCPC

Clinical Professor in Pediatrics, University of British Columbia, Head, Division of Pediatric Dermatology, BC Children's Hospital, Vancouver, British Columbia, Canada [34]

Katherine Püttgen, MD

Assistant Professor of Dermatology and Pediatrics, Johns Hopkins University, Baltimore, Maryland [118]

Sophia Rangwala, MD

Fellow, Dermatopathology, Johns Hopkins School of Medicine, Baltimore, Maryland [108]

Caroline L. Rao, MD

Assistant Professor, Department of Dermatology, Duke University Medical Center, Duke University Medical Center, Durham, North Carolina [58]

Bobby Y. Reddy, MD

Clinical Fellow, Department of Dermatology, Wellman Center for Photomedicine, Massachusetts General Hospital, Boston, Massachusetts [194]

Michelle Rodrigues, MBBS (Hons), FACD

Chroma Dermatology, Melbourne, Australia, Department of Dermatology, St Vincent's Hospital, Fitzroy, Victoria, Australia [77]

Thomas E. Rohrer, MD

SkinCare Physicians, Chestnut Hill, Massachusetts [203]

Misha Rosenbach, MD

Assistant Professor, Dermatology and Internal Medicine Associate Program Director, Dermatology Residency Director, Inpatient Dermatology Consult Service Director, Cutaneous Sarcoidosis Clinic, Perelman Center for Advanced Medicine, Dermatology Administration, Philadelphia, Pennsylvania [155]

Jean-Claude Roujeau MD, PhD

Emeritus Professor of Dermatology, Université Paris-Est Créteil (UPEC), Créteil, France, Department of Dermatology, Université Paris-Est Créteil, Créteil, France [43, 44]

Anne H. Rowley, MD

Professor of Pediatrics and of Microbiology/Immunology, Feinberg School of Medicine, Northwestern University Attending Physician, Division of Infectious Diseases, Ann and Robert H. Lurie Children's Hospital of Chicago, Chicago, Illinois [142]

Thomas M. Rünger, MD, PhD

Professor of Dermatology, Pathology, and Laboratory Medicine, Department of Dermatology, Boston University School of Medicine, Boston, Massachusetts [17, 130]

Arturo P. Saavedra, MD, PhD

Associate Professor of Dermatology, Harvard University Medical School, Vice-Chairman for Clinical Affairs and Medical Director, Massachusetts General Hospital, Boston, Massachusetts [168]

Mohammed D. Saleem, MD, MPH

Department of Dermatology, Wake Forest University School of Medicine, Winston-Salem, North Carolina [183]

Iman Salem, MD

Center for Medical Mycology, University Hospitals Cleveland Medical Center, Case Western Reserve University, Cleveland, Ohio [188]

Claudio Guedes Salgado, MD, PhD

Associate Professor, Pará Federal University, President of the Brazilian Leprosy Society, Marituba, Pará, Brazil [159]

Ubirajara Imbiriba Salgado, MD

Full Professor, Dermatology, Pará State University, Belém, Pará, Brazil [159]

Liat Samuelov, MD

Senior Physician, Department of Dermatology, Tel-Aviv Sourasky Medical Center, Tel-Aviv, Israel [48]

Khaled S. Sanber, MD, PhD

Baylor College of Medicine, Houston, Texas [191]

Inbal Sander, MD

Assistant Professor of Dermatology and Pathology, Johns Hopkins School of Medicine, Baltimore, Maryland [83]

Julio C. Sartori-Valinotti, MD

Assistant Professor of Medicine and Dermatology, Mayo Clinic College of Medicine, Department of Dermatology, Rochester, Minnesota [144]

Vasanth Sathiyakumar, MD

Ciccarone Center for the Prevention of Heart Disease, Division of Cardiology, Department of Medicine, Johns Hopkins Hospital, Baltimore Maryland [126]

Takashi K. Satoh, MD, PhD, MSc

Postdoctoral Research Fellow, Department of Dermatology University of Zurich, Zurich,

Jean-Hilaire Saurat, MD

Switzerland [39]

Professor Emeritus, University of Geneva, Genève, Switzerland [185]

April Schachtel, MD

Dermatology Resident, University of Washington School of Medicine, Division of Dermatology, Seattle, Washington [137]

Knut Schäkel, MD

Professor and Vice Chair of Dermatology, Department of Dermatology, University Hospital, Ruprecht-Karls-University Heidelberg, Heidelberg, Germany [29]

Mark Jordan Scharf, MD

Clinical Professor of Dermatology, University of Massachusetts Medical School, Worcester, Massachusetts [182]

Stefan M. Schieke, MD

Assistant Professor, Department of Dermatology, School of Medicine and Public Health, University of Wisconsin-Madison, Medical Science Center, Madison, Wisconsin [30, 160]

Gabriel Schlager, MD

Department of Dermatology, University Hospital Munich, Ludwig-Maximilian University, Munich, Germany [110]

Kenneth E. Schmader, MD

Duke University Medical Center and Geriatric Research Education and Clinical Center (GRECC), Durham VA Medical Center. Durham, North Carolina [165]

Astrid Schmieder, MD

Senior Consultant, Section Head, Allergology, Psoriasis Competence Center, Department of Dermatology, Venereology and Allergology, University Medical Center and Medical Faculty Mannheim, University of Heidelberg, Mannheim, Germany [117]

Robert A. Schwartz, MD, MPH, DSc (Hon), FRCP Edin, FAAD

Professor and Head, Dermatology, Professor of Medicine, Professor of Pediatrics, Professor of Pathology, Rutgers New Jersey Medical School, Visiting Professor, Rutgers School of Public Affairs and Administration, Honorary Professor, China Medical University, Shenyang, China [181, 182]

Aisha Sethi, MD

Associate Professor of Dermatology, Director Yale Dermatology Global Health Program, Department of Dermatology, Yale University School of Medicine, New Haven, Connecticut [157]

Kara N. Shah, MD, PhD

Kenwood Dermatology, Cincinnati, Ohio [103]

Jerry Shapiro, MD, FRCPC

Hair Clinic, The Ronald. O. Perelman Department of Dermatology, New York University School of Medicine, New York, New York [87, 88]

Neil H. Shear, MD, PhD

Division of Dermatology, Department of Medicine, Sunnybrook Health Sciences Centre, University of Toronto, Division of Dermatology, Department of Medicine, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada [45]

Jessica M. Sheehan, MD

Derick Dermatology, Northbrook, Illinois [203]

Michael P. Sheehan, MD

Dermatology Physicians, Columbus, Indiana [24]

Hiroshi Shimizu, MD, PhD

Professor and Chairman, Department of Dermatology, Hokkaido University Graduate School of Medicine, Sapporo, Japan [40]

Kanade Shinkai, MD, PhD

Associate Professor, University of California, San Francisco, Department of Dermatology, San Francisco, California [1]

Cathryn Sibbald, BScPhm, MD

Department of Dermatology, Sunnybrook Health Sciences Centre, University of Toronto, Division of Dermatology, Department of Medicine, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada [45]

Daniel Asz Sigall, MD

Mycology Section, Dr. Manuel Gea Gonzalez General Hospital, Mexico City, Mexico [158]

Jonathan I. Silverberg, MD, PhD, MPH

Assistant Professor of Dermatology, Preventive Medicine and Medical Social Sciences, Northwestern University Feinberg School of Medicine, Director, Northwestern Medicine Multidisciplinary Eczema Center, Director, Patch Testing Clinic, Northwestern Memorial Hospital, Chicago, Illinois [23]

Eric L. Simpson, MD, MCR

Department of Dermatology, Oregon Health and Science University, Portland, Oregon [22]

Noah Smith, MD

Department of Dermatology, University of Michigan Health System, Ann Arbor, Michigan [202]

Contributors

Clayton J. Sontheimer, MD

Acting Assistant Professor, Pediatric Rheumatology, University of Washington School of Medicine, Seattle Children's Hospital, Seattle, Washington [61]

Richard D. Sontheimer, MD

Professor, Dermatology, University of Utah School of Medicine, Salt Lake City, Utah [61]

Nicholas A. Soter, MD

Professor of Dermatology, New York University School of Medicine, Medical Director, Skin and Cancer Unit, Tisch Hospital, New York, New York [138]

John Stewart Spencer, PhD

Associate Professor, Microbiology, Immunology and Pathology, Colorado State University, Fort Collins, Colorado [159]

Eli Sprecher, MD, PhD

Professor and Chair, Department of Dermatology, Tel Aviv Sourasky Medical Center, Tel-Aviv, Israel and Department of Human Molecular Genetics and Biochemistry, Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel, Tel Aviv, Israel [48]

Rudolf Stadler, MD, PhD

University Clinic for Dermatology, Johannes Wesling Medical Centre, University of Bochum, Minden, Germany [119, 120]

Sonja Ständer, MD

Center of Chronic Pruritus, Department of Dermatology, University of Münster, Münster, Germany [21]

John R. Stanley, MD

Professor, Department of Dermatology, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania [52]

William G. Stebbins, MD

Vanderbilt University, Nashville, Tennessee [214]

Christopher J. Steen, MD, FAAD Portland, Maine [181]

Martin Steinhoff, MD, PhD

Chairman, Department of Dermatology and Venereology, Hamad Medical Corporation, Doha, Qatar, Clinical Professor, Weill-Cornell University-Qatar, School of Medicine, and Qatar University, Medical School, Doha, Qatar, Professor, UCD Charles Institute for Translational Dermatology, University College Dublin, Dublin, Ireland [79]

Jane C. Sterling, MB, BChir, MA, FRCP, PhD

Cambridge University Hospitals NHS Foundation Trust, Department of Dermatology, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust, Cambridge, United Kingdom [167]

Georg Stingl, MD

Professor and Chair, Division of Immunology, Allergy and Infectious Diseases (DIAID), Department of Dermatology, Medical University of Vienna, Vienna, Austria [10]

Erik J. Stratman, MD

Clinical Professor, Department of Dermatology, University of Wisconsin School of Medicine and Public Health, Marshfield, Wisconsin [98]

Lindsay C. Strowd, MD

Assistant Professor of Dermatology, Wake Forest University School of Medicine, Winston-Salem, North Carolina [175]

Dae Hun Suh, MD, PhD

Professor, Department of Dermatology, Seoul National University College of Medicine, Acne and Rosacea Research Laboratory, Seoul National University Hospital, Seoul, South Korea [26]

Kathryn N. Suh, MD, FRCPC

Associate Professor of Medicine, University of Ottawa, Division of Infectious Diseases The Ottawa Hospital, Ottawa, Ontario, Canada [177]

Tamio Suzuki, MD, PhD

Professor and Chairman of Dermatology, Yamagata University Faculty of Medicine, Yamagata, Japan [75]

Rolf-Markus Szeimies, MD, PhD

Professor of Dermatology, Department of Dermatology and Allergology Klinikum Vest Academic Teaching Hospital Ruhr-University of Bochum, Recklinghausen, Germany [199]

Yoshikazu Takada, PhD

Department of Dermatology, University of California Davis School of Medicine, Sacramento, California [193]

Shunsuke Takahagi, MD, PhD

Department of Dermatology, Institute of Biomedical and Health Sciences, Hiroshima University, Hiroshima, Japan [41]

Junko Takeshita, MD, PhD, MSCE

Assistant Professor of Dermatology and Epidemiology, Department of Dermatology, Department of Biostatistics and Epidemiology, University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania [3]

Carolina Talhari, MD

Associate Professor of Dermatology, State University of Amazonas, Manaos, Brazil [171]

Jean Y. Tang, MD, PhD

Department of Dermatology, Stanford University, School of Medicine, Redwood City, California [111]

Akiko Tanikawa, MD, PhD

Assistant Professor, Department of Dermatology, Keio University School of Medicine, Tokyo, Japan [68]

Janis M. Taube, MD

Associate Professor of Dermatology, Johns Hopkins School of Medicine, Section Head, Dermatopathology, Baltimore, Maryland [108]

Bailey Tayebi, MD, MBA

Total Skin and Beauty Dermatology, Birmingham, Alabama [213]

Michael D. Tharp, MD

The Clark W. Finnerud, MD Professor and Chair, Department of Dermatology, Rush University Medical Center, Chicago, Illinois [42, 189]

Diane M. Thiboutot, MD

Professor of Dermatology, Associate Dean of Clinical and Translational Research Education, Penn State University College of Medicine, Hershey, Pennsylvania [78, 80]

Thusanth Thuraisingam, MD, PhD

Division of Dermatology, McGill University, Montreal, Quebec, Canada [90]

Kenneth J. Tomecki, MD

Department of Dermatology, Cleveland Clinic, Cleveland, Ohio [186]

Franz Trautinger, MD

Professor of Dermatology and Venereology, Karl Landsteiner University of Health Sciences, Chairman, Department of Dermatology and Venereology, University Hospital of St. Pölten, St. Pölten, Austria [38]

Jeffrey B. Travers, MD, PhD

Chair of Pharmacology and Toxicology, Professor of Dermatology, Boonshoft School of Medicine at Wright State University, Dayton, Ohio [152]

Kenneth Y. Tsai, MD, PhD

Associate Member, Departments of Anatomic Pathology and Tumor Biology, Section Head, Non-Melanoma Skin Cancer and Treatment, Donald A. Adam Melanoma and Skin Cancer Center of Excellence, Moffitt Cancer Center, Tampa, Florida [19]

Hensin Tsao, MD, PhD

Professor of Dermatology, Head, Skin Cancer Genetics Laboratory/ Wellman Center for Photomedicine, Director, Massachusetts General Hospital Melanoma and Pigmented Lesion Center/Department of Dermatology, Director, Massachusetts General Hospital Melanoma Genetics Program/ MGH Cancer Center, Boston, Massachusetts [194]

Susan A. Tuddenham, MD, MPH

Division of Infectious Diseases, Bayview Medical Center, Johns Hopkins University, Baltimore, Maryland [170]

Jake E. Turrentine, MD

Assistant Professor, Division of Dermatology, Department of Medicine, Augusta University, Augusta, Georgia [24]

Stephen K. Tyring, MD, PhD

University of Texas Health Science Center, Houston, Texas [191]

Mark C. Udey, MD, PhD

Dermatology Branch, National Institutes of Health, Bethesda, Maryland [13]

Hideyuki Ujiie, MD, PhD

Assistant Professor, Department of Dermatology, Hokkaido University Graduate School of Medicine, Sapporo, Japan [40]

Robin H. Unger, MD

American Board of Hair Restoration Surgery, International Society of Hair Restoration Surgeons, Assistant Clinical Professor, Dermatology, Mt. Sinai School of Medicine, New York, New York [217]

Walter P. Unger, MD, FRCP (C)

American Board of Dermatology, American Board of Hair Restoration Surgery, International Society of Hair Restoration Surgeons, Clinical Professor, Dermatology, Mt. Sinai School of Medicine, New York, New York [217]

Jochen Utikal, MD

Professor of Dermatology, Section Head Dermato-Oncology, Skin Cancer Unit, German Cancer Research Center (DKFZ), Department of Dermatology, Venereology and Allergology University Medical Center and Medical Faculty Mannheim, University of Heidelberg, Mannheim, Germany [117]

Anders Vahlquist, MD

Professor, Department of Medical Sciences, Dermatology and Venereology, Uppsala University, Uppsala, Sweden [185]

Travis Vandergriff, MD

Assistant Professor of Dermatology and Pathology, Director of Dermatopathology, UT Southwestern Medical Center, Dallas, Texas [93, 94]

Miikka Vikkula, MD, PhD

Head of Laboratory of Human Molecular Genetics, de Duve Institute, University of Louvain, Brussels, Belgium [147]

Ruth Ann Vleugels, MD, MPH

Associate Professor, Harvard Medical School, Director, Autoimmune Skin Diseases Program, Director, Connective Tissue Diseases Clinic, Department of Dermatology, Brigham and Women's Hospital, Boston, Massachusetts [145, 192]

Esther von Stebut, MD

Associate Professor of Dermatology and Infectious Diseases, Department for Dermatology, University Medical Center, Johannes Gutenberg-University, Mainz, Germany [176]

John J. Voorhees, MD, FRPC

Duncan and Ella Poth Distinguished Professor and Chairman, Department of Dermatology, University of Michigan Medical School, Ann Arbor, Michigan [185]

Justin J. Vujevich, MD

Vujevich Dermatology Associates, Pittsburgh, Pennsylvania [206]

Etienne C. E. Wang, BA(Hons), MBBS, MA, MPhil

National Skin Center, Singapore, Department of Dermatology, Columbia University, New York, New York [18]

Stewart Wang, MD, PhD

Professor, Department of Surgery, Chief, Burn Surgery, Division of Plastic Surgery, Department of Surgery, University of Michigan Health Systems, Ann Arbor, Michigan [99]

Roger H. Weenig, MD

Associated Skin Care Specialists, Fridley, Minnesota [67]

Karsten Weller, MD

Department of Dermatology and Allergy, Allergie-Centrum-Charité, Charité-Universitätsmedizin Berlin, Berlin, Germany [96]

Victoria Werth, MD

Professor of Dermatology, Department of Dermatology, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania [184]

Chikoti M. Wheat, MD

Johns Hopkins School of Medicine, Baltimore, Maryland [178]

Contributors

Lynn D. Wilson, MD, MPH, FASTRO

Professor, Vice Chairman and Clinical Director, Department of Therapeutic Radiology, Yale School of Medicine, New Haven, Connecticut [200]

Lauren E. Wiznia, MD

The Ronald O. Perelman Department of Dermatology, New York University School of Medicine, New York, New York [105]

Peter Wolf, MD

Professor of Dermatology and Bioimmunotherapy, Vice Chair of the Department of Dermatology, Medical University of Graz, Research Unit for Photodermatology, Department of Dermatology, Medical University of Graz, Graz, Austria [92]

Gary S. Wood, MD

Johnson Professor and Chairman, Department of Dermatology, School of Medicine and Public Health, University of Wisconsin-Madison, Madison, Wisconsin [30]

David T. Woodley, MD

Professor and Emeritus Founding Chair, Department of Dermatology, The Keck School of Medicine, University of Southern California, Los Angeles, California [56]

Sophie M. Worobec, MD

University of Illinois at Chicago, Chicago, Illinois [73]

Albert C. Yan, MD, FAAP, FAAD

Chief, Section of Pediatric Dermatology, Children's Hospital of Philadelphia, Professor, Pediatrics and Dermatology, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, Pennsylvania [123]

Kim B. Yancey, MD

Professor and Chair, Department of Dermatology, University of Texas Southwestern Medical Center, Dallas, Texas [55]

Howa Yeung, MD

Chief Resident in Dermatology, Emory University School of Medicine, Atlanta, Georgia [107]

Andrea L. Zaenglein, MD

Professor of Dermatology and Pediatrics, Penn State College of Medicine, Penn State/ Hershey Medical Center, Hershey, Pennsylvania [78, 80]

Jonathan M. Zenilman, MD

Division of Infectious Diseases, Bayview Medical Center, Johns Hopkins University, Baltimore, Maryland [170]

Christos C. Zouboulis, MD, PhD

Departments of Dermatology, Venereology, Allergology and Immunology, Dessau Medical Center, Brandenburg Medical School Theodor Fontane, Dessau, Germany [6, 82, 141] This page intentionally left blank

PREFACE

A much-treasured legacy of Dr. Thomas B. Fitzpatrick, who served as editor-in-chief for the first four editions of the book, Fitzpatrick's Dermatology in General Medicine (DIGM) has always aimed to be a comprehensive source of information for those interested in the clinical and basic science of dermatology. Indeed, from the very first edition of Fitzpatrick's DIGM, printed in 1971, this authoritative textbook has been grounded in science. We have continued this tradition in the ninth edition of the book whilst rearranging the discussion to make it more reader friendly and to minimize repetition. With coverage of subject matters expanding beyond General Medicine, we have appropriately modified the book title to Fitzpatrick's Dermatology. Important general basic science concepts are extensively covered in dedicated chapters appearing in an early section of the book, allowing subsequent clinical chapters to focus on relevant disease-specific pathophysiology in addition to clinical features, diagnosis, clinical course, and management.

Dermatology is a particularly visual specialty. In the preparation of this edition of the book, we have placed special emphasis on display items (in the form of clinical images, tables, and algorithmic summaries), as we strongly believe that these components are vital for the complete understanding of all readers, but particularly for those in training. What better way to optimize the visual content provided in our chapters than to seek input from trainees themselves? We had trainees review every chapter and provide feedback on additional display items they would find useful. To further enhance the utility of this gold-standard textbook we have also improved the indexing. A good index is imperative to allow readers, including busy practicing clinicians, to easily and quickly find the particular information about a concept, condition, or therapy that they are interested in at any given time. We hope that you agree the improved indexing allows you to achieve this aim.

No modern textbook is complete without an online presence. The ninth edition is also available in the online format, and we plan to regularly post online updates to the book as new studies and/or guide-lines are published. You will also have access to other useful features in the online version of *Fitzpatrick's Dermatology* on *AccessMedicine.com*.

Finally, as a completely new group of editors that is diverse in expertise and international in location of practice, we have endeavored to build on the achievements of previous editorial groups led by Drs. Thomas B. Fitzpatrick, Irwin M. Freedberg, Klaus Wolff, and Lowell A. Goldsmith, whilst providing fresh insight into the content, new thinking regarding the optimal structure of the book, and ultimately helping the book to evolve into the most relevant resource for the modern practicing or trainee dermatologist or skin biologist.

> Sewon Kang Masayuki Amagai Anna L. Bruckner Alexander H. Enk David J. Margolis Amy J. McMichael Jeffrey S. Orringer

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With regard to visual elements, we owe much gratitude to Noori Kim and Hester Lim who took the time to carefully read every individual chapter and provide detailed feedback on what additional display items they thought would aid the reader. With more than 200 chapters included in the book, we appreciate the sheer enormity of this task and their dedication to attention to detail.

As a completely new editorial board, we are very grateful for the engagement, advice, and encouragement afforded to us by the previous editor-in-chief Lowell A. Goldsmith. We truly appreciate the time and effort he invested to enable the smooth transition of editorial direction for the new edition of this much-loved book.

A special shout-out to Karen Edmonson, our straight-talking and very patient senior editor at

McGraw-Hill Education who kept the whole editorial team motivated and helped to bring our ideas to fruition, and to our editorial project manager Bryony Mearns, who helped to coordinate submission and review of the 217 chapters, keep on top of the status of each chapter, and encourage authors and editors to progress with their book-related tasks. We also appreciate the efforts of Kim Davis and Sonam Arora who expertly coordinated everything from submission of the finalized chapters to the McGraw-Hill team through to print publication.

Finally, we are truly grateful for the understanding and patience of our families. Without their support, this textbook would never have been completed. A book like *Fitzpatrick's Dermatology* demands many evening and weekend hours that would normally be spent with loved ones, and we thank them for allowing us to dedicate many of these hours to *Fitzpatrick's Dermatology*.

> Sewon Kang Masayuki Amagai Anna L. Bruckner Alexander H. Enk David J. Margolis Amy J. McMichael Jeffrey S. Orringer

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Foundations of Clinical Dermatology

Chapter 1 :: Fundamentals of Clinical Dermatology: Morphology and Special Clinical Considerations

:: Erin H. Amerson, Susan Burgin, & Kanade Shinkai

AT-A-GLANCE

- Skin diseases have characteristic morphology and distribution.
- Morphologic characteristics and reaction patterns of the skin suggest disease pathophysiology, helping focus the differential diagnosis.
- The history is indispensable in elucidating complex diagnoses.
- Knowledge and appropriate use of dermatologic terminology is essential.
- The comprehensive mucocutaneous examination, including hair and nails, should always be performed.

THE ART AND SCIENCE OF DERMATOLOGIC DIAGNOSIS

The diagnosis and treatment of cutaneous diseases requires the physician's ability to recognize the primary lesions and reaction patterns of the skin, and to put these visual clues into context with the patient's history and overall health. In this chapter, we discuss a fundamental approach to the patient presenting with a skin problem. We introduce the technical vocabulary of dermatologic description, also known as morphology. Accurately identifying morphology is an essential step in generating a differential diagnosis. Use of standard dermatologic terminology is also critical for effective clinical documentation, research, and communication with other health care providers.

PART 🗸

The process of examining and describing skin lesions requires perception of subtle details: appreciation of a specific hue of erythema, a shape or distribution, or the presence of characteristic findings on nails or mucous membranes often hold the key to the correct diagnosis. Repeated patient encounters help to train the eye to recognize such patterns. With time and experience, the physician can associate clinical skin findings with histopathologic features, enabling a rich understanding of the pathophysiology of skin disease, as well as clinical-pathologic correlation.

APPROACH TO THE PATIENT

HISTORY

Dermatology is a visual specialty, and some skin conditions may be diagnosed at a glance. History may be crucial in complex cases, such as the patient with rash and fever, or the patient with generalized pruritus. There is therapeutic value in receiving a patient's narrative thread, as they feel heard, and they may reveal information relevant to treatment choice or invite opportunities for education and reassurance. In practice, many dermatologists take a brief history, perform a physical examination, then undertake more detailed questioning based on the differential diagnosis that the examination suggests.

In taking a history from a patient presenting with a new skin complaint, the physician's primary goal is to establish a diagnosis, with a secondary goal of evaluating the patient as a candidate for therapy. In patients whose diagnosis is already established, the physician's goals are to reevaluate the original diagnosis, monitor disease progress and complications, and modify treatment accordingly.

Table 1-1 presents an approach to obtaining the history in a patient presenting with a skin problem. The physician may choose to customize the history depending on whether the chief complaint is a growth or an eruption, a nail or hair disorder, or another condition, and whether it is a new problem or a followup visit for an ongoing condition.

PHYSICAL EXAMINATION

SCOPE OF THE COMPLETE CUTANEOUS EXAMINATION

The complete cutaneous examination includes inspection of the entire skin surface, including oftenoverlooked areas such as the scalp, eyelids, ears, genitals, buttocks, perineum, and interdigital spaces; the hair; the nails; and the mucous membranes of the eyes, nose, mouth, genitals, and anus. Patients presenting with a highly focused complaint, such as a single wart or acne, may not require a comprehensive skin examination in routine clinical practice. There are many advantages to performing a complete cutaneous examination, including identification of potentially harmful lesions, such as skin cancers, providing reassurance for benign skin findings, locating additional diagnostic clues (Wickham's striae on the buccal mucosa in lichen planus, for instance), opportunities for patient education (eg, lentigines are a sign of sun damage and suggest the need for improved sun protection), and an opportunity to convey the physician's concern about the patient's skin health through a thorough examination. A thorough evaluation increases the possibility of making a diagnosis at the bedside and mitigates the risk of overlooking another diagnosis. A guide to performing the physical examination of the patient presenting with a skin problem is presented in Table 1-2.

IDEAL CONDITIONS FOR THE COMPLETE SKIN EXAMINATION

A complete skin examination is most effective when performed under ideal conditions. Excellent lighting, preferably bright, natural light, is paramount; without good lighting, subtle but important details may be missed. The patient should be fully undressed, and gowned with additional draping, if desired.

TABLE 1-1 History Taking in Dermatologic Diagnosis

Chief Complaint and History of the Present Illness

- Duration: When the condition was first noted and dates of recurrences or remissions
- Timing: Constant, intermittent, worst at night, worst in winter
- Evolution: How the condition has changed or progressed over time
- Location: Where lesions were first noted, and how they have spread, if applicable
- Symptoms: Pruritus, pain, bleeding, nonhealing, change of preexisting skin lesions, associated with fever or other systemic signs
- Severity: Ask patient to rate severity of pain or pruritus on a 10-point scale to follow severity over time
- Ameliorating and Exacerbating Factors: Sun exposure, heat, cold, trauma, exposures (such as chemicals, medications, cosmetics, perfumes, plants, or metals), relation to menses or pregnancy
- Preceding illness, new medications, new topical products, or exposures
- Therapies tried, including nonprescription or home remedies, and response to therapy
- Prior similar problems, prior diagnosis, results of biopsies or other studies performed

Medical History

- A history of all chronic illnesses, particularly those that may manifest in the skin, (diabetes, renal and hepatic disease, infection with HIV or other viruses, polycystic ovarian syndrome, lupus, thyroid disease) and those that are associated with skin disease (asthma, allergies)
- History of surgical procedures, including organ transplantation
- Immunosuppression: iatrogenic, infectious, or inherited
- Pregnancies
- Psychiatric disease
- History of blistering sunburns, exposure to arsenic or ionizing radiation
- Medication History: A detailed history, including prescriptions, nonprescription medications, vitamins, dietary supplements, herbal remedies, with particular attention to those medications started recently
- Allergies: To medications, foods, environmental antigens, and contactants
- Social History: Occupation, hobbies and leisure activities, alcohol and tobacco use, illicit drug use, sexual history (including high-risk activities for sexually transmitted diseases), diet, bathing habits, pets, living conditions (eg, alone, with family, homeless, in an institution), history of travel or residence in endemic areas for infectious diseases, cultural or religious practices
- Family History: Of skin disease, atopy (atopic dermatitis, asthma, hay fever) or skin cancer
- Review of Systems: May be focused or comprehensive depending on the diagnosis (asking about specific symptoms that may accompany a dermatologic condition, such as joint symptoms in psoriasis; asking a comprehensive ROS in the setting of cutaneous signs of systemic disease such as palpable purpura)

Underwear, socks, shoes, makeup, and eyeglasses should be removed. The examining table should be at a comfortable height, with a head that reclines, an extendable footrest, and gynecologic stirrups. The examining room should be at a comfortable temperature for the lightly dressed patient. It should contain a sink for hand washing and disinfecting hand foam, as patients are reassured by seeing their physician wash

TABLE 1-2

Physical Examination in Dermatologic Diagnosis

General Impression of the Patient

Well or ill

- Obese, cachectic, or normal weight
- Skin Color: Degree of pigmentation, pallor (anemia), jaundice
- Skin Temperature: Warm, cool, or clammy
- Skin Surface Characteristics: Xerosis (dryness), seborrhea (excessive oil), turgor, hyper- or hypohidrosis (excessive or decreased sweating), and texture
- Degree of Photoaging: Lentigines, actinic purpura, rhytides

Morphology

- Define the primary lesion
- Describe their color, texture
- Describe any secondary changes
- Describe their shape and configuration
- Describe the Distribution of Lesions: Localized (isolated), grouped, regional, generalized, universal, symmetrical, sun-exposed, flexural, extensor extremities, acral, intertriginous, dermatomal, follicular

Aspects of General Physical Examination That May Be Helpful

- Vital signs
- Abdominal examination for hepatosplenomegaly
- Pulses
- Lymph node examination (especially in cases of suspected infection and malignancy)

hands before the examination. If the patient and physician are of opposite genders, having a chaperone in the room may be required.

RECOMMENDED TOOLS FOR THE COMPLETE SKIN EXAMINATION

Although the physician's eyes and hands are the only essential tools for examination of the skin, the following are often useful and highly recommended:

- A magnifying tool such as a loupe, magnifying glass, and/or dermatoscope.
- A bright focused light such as a flashlight or penlight.
- Glass slides for diascopy and viral direct fluorescent antibody (DFA) testing, fungal scrapings and touch preparations, Tzanck smears, scabies prep.
- Alcohol pads to remove scale or surface oil.
- Gauze pads or tissues with water for removing makeup.
- Gloves: when any contagious condition is suspected, when contact with body fluids is possible, when examining mucous membranes and genital areas, and when performing any procedure.
- A ruler for measuring lesions.
- No. 15 and No. 11 scalpel blades for scraping and incising lesions, respectively.
- Diagnostic solutions: potassium hydroxide solution, oil, Tzanck smear, bacterial, viral, and fungal culture media.
- A camera for photographic documentation.
- A Wood lamp (365 nm) for highlighting subtle pigmentary changes.

TECHNIQUE OF THE DERMATOLOGIC PHYSICAL EXAMINATION

Consistency in a comprehensive mucocutaneous examination is essential to ensure that no areas are overlooked. One approach to the complete skin examination is presented here. First, observe the patient at a distance for general impressions (eg, asymmetry due to a stroke, cachexia, jaundice). Next, examine the patient in a systematic way, usually from head to toe, uncovering one area at a time to preserve patient modesty. Move the patient and the illumination as needed for the best view of each body area. Sometimes side lighting best reveals depth and details of skin lesion borders. Palpate lesions to determine whether they are soft, firm, tender, or fluid-filled. A magnifier worn on the head leaves both hands free for palpation of lesions. Certain lesions, especially pigmented lesions, are best examined with a dermatoscope to identify characteristic concerning features. Mucosal sites should be carefully examined with additional illumination with a penlight or flashlight. During the examination, patients may be reassured by the physician's reporting of benign lesions as they are encountered.

Special examination techniques for hair and nail disorders are discussed in Chaps. 85 through 91.

After completing the examination, it is important to document the skin findings, including the type of lesions and their locations, either descriptively or on a body map. Specific documentation using photography and triangulation based on anatomic landmarks is particularly important for lesions suspicious for skin malignancy undergoing biopsy, so that the exact location may be found and definitively treated at a later date.

INTRODUCTION TO MORPHOLOGY

Joseph Jakob von Plenck's (1738–1807) and Robert Willan's (1757–1812) work in defining basic morphologic terminology laid the foundation for the description and comparison of fundamental lesions, thereby facilitating characterization and recognition of skin disease.

The eminent dermatology professors Wolff and Johnson have asserted: to read words, one must recognize letters; to read the skin, one must recognize the basic lesions. The "letters," or elemental building blocks of morphology, are the primary lesion and secondary (epidermal) change. The skilled clinician uses macroscopic characteristics noted on examination to understand where and what types of microscopic pathologic changes are present, achieving clinical-pathologic correlation. For example, flat-topped or planar papules and plaques tend to be processes affecting the epidermis and superficial dermis, while dome-shaped or nodular lesions often exhibit deeper infiltration into the dermis or subcutis. Scaling or crusting indicates that the epidermis is affected, while a smooth, intact surface on a palpable lesion reflects a purely dermal or subcutaneous process.

The combination of primary morphology and secondary change (or absence of secondary change) determine a diagnostic category, also known as the "reaction pattern." For example, when the primary lesion is a circumscribed papule or plaque with scale, it likely falls into the "papulosquamous" reaction pattern, which suggests a specific set of diagnostic possibilities. Once the reaction pattern has been determined, a differential diagnosis comes into focus. This differential diagnosis may be further honed by other lesional characteristics, including shape or color, and the arrangement of lesions in relationship to one another (configuration) and on the body (distribution).

It is important for the dermatologist in training to be aware that variation and ambiguity in definitions of morphologic terms exist among the dermatology community. For example, in dermatology textbooks, a papule has been described as no greater than 1 cm in size, no less than 0.5 cm, or ranging from the size of a pinhead to that of a split pea. In this chapter, the authors have selected definitions that reduce the subjectivity inherent in some morphologic frameworks.

PRIMARY MORPHOLOGY

The primary morphology describes 3 lesional characteristics: size, topography, and the character of contents (Table 1-3). The primary morphology should be the "noun" which all other "adjectives" (such as color, shape, size, texture) describe. A macule or patch is not palpable (a color change only) and raised or depressed lesions that are palpable are papules or plaques. Erosions and ulcerations may be primary or secondary.

TABLE 1-3 Primary Morphology					
PRIMARY LESION	SIZE	TOPOGRAPHY	CONTENTS		
Macule	<1 cm	Flat	N/A (color change only)		
Patch	≥1 cm	Flat	N/A (color change only)		
Papule	<1 cm	Raised/Depressed	Solid		
Plaque	≥1 cm	Raised/Depressed	Solid		
Nodule	≥1 cm	Raised	Solid or fluid		
Vesicle	<1 cm	Raised	Fluid (serum, blood, lymph)		
Bulla	≥1 cm	Raised	Fluid (serum, blood, lymph)		
Pustule	<1 cm	Raised	Fluid (pus)		
Erosion	Any	Depressed	N/A		
Ulceration	Any	Depressed	N/A		



Figure 1-1 Macule, petechiae.

FLAT (NONPALPABLE) PRIMARY LESIONS

Macule: A macule is flat, even with the surface level of surrounding skin or mucous membranes, and perceptible only as an area of color different from the surrounding skin or mucous membrane. Macules are less than 1 cm in size (Fig. 1-1).

Patch: A patch, like a macule, is a flat area of skin or mucous membranes with a different color from its surrounding. Patches are 1 cm or larger in size (Fig. 1-2).

RAISED (PALPABLE) PRIMARY LESIONS

Papule: A papule is an elevated or depressed lesion less than 1 cm in size, which may be solid or cystic. Among other characteristics, papules may be further described by their topography. Some examples include papules that are sessile, pedunculated, domeshaped, flat-topped, filiform, mammillated, acuminate (conical), or umbilicated (Fig. 1-3).



Figure 1-2 Patch, fixed drug eruption.



Figure 1-3 Papule, lichen nitidus.

Plaque: A plaque is a solid plateau-like elevation or depression that has a diameter of 1 cm or larger (Fig. 1-4).

Nodule: A nodule is a palpable lesion greater than 1 cm with a domed, spherical or ovoid shape. They may be solid or cystic. Depending on the anatomic component(s) primarily involved, nodules are of 5 main types: (1) epidermal, (2) epidermal–dermal, (3) dermal, (4) dermal–subdermal, and (5) subcutaneous. Texture is an important additional feature of nodules: firm, soft, boggy, fluctuant, etc. Similarly, different surfaces of nodules, such as smooth, keratotic, ulcerated, or fungating, also help direct diagnostic considerations (Fig. 1-5). *Tumor*, also sometimes included under the heading of nodule, may be used to describe a more irregularly shaped mass, benign or malignant.

FLUID-FILLED PRIMARY LESIONS

Vesicle and Bulla: A vesicle is a fluid-filled papule smaller than 1 cm (Fig. 1-6), whereas a bulla (blister) measures 1 cm or larger (Fig. 1-7). By definition, the wall is thin and translucent enough to visualize the contents, which may be clear, serous, or hemorrhagic.



Figure 1-4 Plaque, psoriasis.



Figure 1-5 Nodule, lymphoma cutis.

Vesicles and bullae arise from cleavage at various levels of the epidermis (intraepidermal) or the dermalepidermal interface (subepidermal), sometimes extending into the dermis. The tenseness or flaccidity of the vesicle or bulla may help determine the depth of the split. However, reliable differentiation requires histopathologic examination of the blister edge.

Pustule: A pustule is a circumscribed, raised papule in the epidermis or infundibulum containing visible pus. The purulent exudate, composed of leukocytes with or without cellular debris, may contain organisms or may be sterile. The exudate may be white, yellow, or greenish-yellow in color. Pustules may vary in size and, in certain situations, may coalesce to form "lakes" of pus. When associated with hair follicles, pustules may appear conical and contain a hair in the center (Fig. 1-8).



Figure 1-6 Vesicle, bullous lupus erythematosus. Note brown incipient crusts marking the sites of earlier blisters now ruptured.



Figure 1-7 Vesicles and bullae, linear IgA disease.

SECONDARY CHANGE (EPIDERMAL OR SURFACE CHANGE)

Scale is a macroscopic finding indicating a change in the epidermis, usually the stratum corneum. Scale may have many different descriptive characteristics, for instance, soft, rough, gritty, bran-like, or micaceous (Table 1-4).

Crust describes dried fluid on the skin's surface due to serum, blood, pus, or a combination. When crust is round or oval, it points to the former presence of a vesicle, bulla or pustule (as seen in Fig. 1-6). Linear or angulated crusts are indicative of excoriations. Other specialized types of crust include eschar, which is dry, adherent, and dark red-purple, brown, or black in color and signals skin necrosis (Fig. 1-11), or fibrin, which is a soft, yellow crust on the surface of some ulcers.

Lichenification is a thickening and accentuation of the skin lines that results from repeated rubbing or scratching of the skin. It is found primarily in chronic eczematous processes or neurogenic processes (Fig. 1-12).

Types of Scale			
TYPE OF SCALE	DESCRIPTION		
Craquelé/xerotic	Desquamation giving the appearance of dried, cracked skin. Combination of hyperkeratosis and fissuring, which appears like the cracked bed of a dry river.		
Cutaneous horn	Conical projection of compact stratum corneum.		
Exfoliative/ desquamative	Scales split off from the epidermis in finer scales or in sheets.		
Follicular	Scales appear as keratotic plugs, spines, or filaments.		
Gritty	Densely adherent scale with a sandpaper texture.		
lchthyosiform	Scales are regular, polygonal plates arranged in parallel rows or diamond patterns (fish-like, tessellated, Fig. 1-9).		
Keratotic/ hyperkeratotic	Scales appear as thick, compact, adherent layers of stratum corneum.		
Lamellar	Scales are thin large plates or shields attached in the middle and looser around the edges.		
Pityriasiform	Scale is small and branny.		
Psoriasiform (micaceous and ostraceous)	Scale is silvery and brittle and forms thin plates in several loose sheets, like mica (micaceous scale). Large scales may accumulate in heaps, giving the appearance of an oyster shell (ostraceous scale, Fig. 1-10).		
Seborrheic	Scales are thick, waxy or greasy, yellow-to- brown, flakes.		
Shellac-like	Scale is shiny with a sheet-like desquamating edge, like peeling paint		
Wickham striae	Scale appears as a lacy white pattern overlying violaceous flat-topped papules.		

TABLE 1-4

Atrophy of the epidermis results in a shiny quality with "cigarette-paper" wrinkling. Atrophy of the dermis results in a depressed lesion.

A *fissure* is a linear loss of continuity of the skin's surface or mucosa that results from excessive tension



Figure 1-8 Pustule, pustular psoriasis.



Figure 1-9 Ichthyosiform scale, ichthyosis vulgaris.



Figure 1-10 Ostraceous scale, psoriasis.

or decreased elasticity of the involved tissue. Fissures frequently occur on the palms and soles where the thick stratum corneum is least expandable.

OTHER LESIONAL CHARACTERISTICS

In addition to primary morphology, other features of lesions can be important in narrowing a differential diagnosis; sometimes, these other characteristics are the most important determinants of the differential. For instance, the most notable feature of a rash or lesion might be its shape or distribution, which points the clinician to a specific list of possible diagnoses.

COLOR

Perhaps the most important additional feature of a lesion other than primary morphology is color. The experienced dermatologist will notice subtle variations in hue and saturation of a particular color, and can ascribe meaning to these variations. The most



Figure 1-11 Eschar overlying stellate purpura, calciphylaxis.



Figure 1-12 Lichenification, lichen simplex chronicus.

common types of color on the skin are variations in brown (hyperpigmentation) and red (erythema), which will be discussed in depth below. Other colors and their histopathologic correlations are described in Table 1-5.

Brown: Brown color is most often representative of melanin, either within melanocytes or outside of melanocytes. Less frequently, a brown hue also may be caused by deposition of other pigments, cells, or materials in the dermis (such as deposition of hemosiderin, amyloid, or mucin; certain types of inflammation, including inflammation that is granulomatous, histiocytic, plasmacytic, or mixed). Mast cells induce melanin production in the overlying epidermis, often leading to brown color overlying the focus of mast cells in the dermis. Melanin in the epidermis, whether contained within or outside of melanocytes, appears tan to muddy brown; when it is very concentrated, as in some nevi or melanomas or heavily pigmented seborrheic keratoses, it may appear brown-black. Melanin in the dermis, either within melanocytes or extracellular, may appear brown, gray, or blue. This gray-blue color results from the "Tyndall effect," named for the 19th-century physicist John Tyndall, who described the preferential transmission of longer wavelengths (blue photospectrum) when particles are suspended in a medium (in this case, melanin or other brown pigment suspended in the dermis). Differentiation between epidermal and dermal melanin also can be aided by a Wood lamp, which accentuates epidermal but not dermal melanin.

Oxidized keratin, (within an infundibular cyst, for instance) and foreign pigmentation (such as tattoos) can also exhibit the Tyndall effect when located in the dermis.

When the epidermis is inflamed or damaged, melanin often drops to into the dermis. Therefore, many subacute, chronic, or recently resolved epidermal inflammatory diseases or injuries have a brown or graybrown tone. The more constitutive pigment in an individual's skin, the more prominent these changes will be.

Red: Also known as "erythema," red can have infinite hues. Pale red, pink, or purple may result from

TABLE 1-5					
Implications of Color Changes in Altered Skin					
COLOR	PATHOLOGY	DIAGNOSTIC EXAMPLES			
White	Reduced or absent melanin synthesis	Tinea versicolor, vitiligo			
	Keratin	Milium			
	Calcium deposit	Calcinosis cutis			
	Scar	Atrophie blanche			
Black	Dense melanin	Melanoma			
	Intraepidermal hemorrhage	Talon noir			
	Necrosis	Cutaneous anthrax			
	Oxidized keratin (brown to black)	Open comedone			
Brown	Melanin	Melanocytic nevus, melasma			
Red-brown	Hemosiderin ("cayenne pepper")	Pigmented purpuric dermatosis			
	Granulomatous inflammation ("apple jelly")	Sarcoidosis (Fig. 1-15)			
	Histiocytic inflammation	Langerhans cell histiocytosis			
	Mixed inflammation	Granuloma faciale			
	Plasmacytic inflammation ("copper"- or "ham"-colored)	Secondary syphilis			
	Mast cell inflammation	Urticaria pigmentosa			
	Mucin deposition	Pretibial myxedema			
	Amyloid deposition	Lichen amyloidosis			
	Infiltration with smooth muscle	Cutaneous leiomyoma			
	Subacute or chronic epidermal inflammation	Subacute lupus erythematosus			
Red	Vascular dilation or congestion	Erysipelas			
	Neutrophilic inflammation	Sweet syndrome			
	Vascular neoplasm	Cherry angioma			
Pink or salmon	Acute inflammation with dilation of superficial dermal vessels	Eczema, drug eruptions, urticaria, pityriasis rubra pilaris, psoriasis			
Orange	Granulomatous inflammation with histiocytes having abundant cytoplasm	Juvenile xanthogranuloma			
Yellow	Pus	Folliculitis			
	Lipid	Xanthelasma			
	Histiocytic inflammation	Necrobiosis lipoidica (Fig. 1-16)			
	Elastolysis	Pseudoxanthoma elasticum			
	Sebaceous glands	Sebaceous hyperplasia			
	Bilirubin	Jaundice			
Green	Deep hemosiderin	Ecchymosis			
	Pyocyanin pigment	Pseudomonas infection			
	Myeloperoxidase	Chloroma			
	Tissue eosinophilia	Wells syndrome			
Blue/gray	Deep dermal melanin	Blue nevus			
	Deep deposition of other pigment	Argyria, tattoo			
Violet to lilac	Acute lymphocytic inflammation with dilation of deep dermal blood vessels	Borders of evolving morphea, dermatomyositis, lichen planus			
Plum	Vascular neoplasm	Kaposi sarcoma			
	Dense lymphocytic inflammation	Lymphoma cutis			
	Malignant neoplasm	Nodular amelanotic melanoma			
	Hemorrhage	Ecchymosis			

inflammation leading to hyperemia (subtle vascular dilation). More saturated red to purple can indicate intense hyperemia or vascular congestion (also called rubor, as seen in erysipelas); even more saturated red to purple hue can result from the either malformed or ectopic blood vessels (Fig. 1-13) or extravasated erythrocytes (petechiae or purpura, see "vascular reaction pattern" below). Variations in the hue of erythema are vast



Figure 1-13 Purple papules, Kaposi sarcoma.

and provide subtle clues to the type of inflammation present. True red is often associated with neutrophilic inflammation (as seen in cellulitis or Sweet syndrome); red-purple (violaceous erythema, Fig. 1-14) with lymphocytic inflammation (lymphoma cutis, connective tissue disease, interface reactions such as lichen planus). Granulomatous inflammation may appear red-brown (sarcoidosis, marked by the classis "apple jelly" color seen in Fig. 1-15, or a juvenile xanthogranuloma) to orange or yellow (Fig. 1-16, necrobiosis lipoidica). One major caveat is that the true hue of erythema is easiest to visualize in acute conditions affecting fair skin. Subacute or chronic conditions, particularly with epidermal involvement, will have epidermal alteration causing epidermal pigment drop-out into the dermis, making lesions appear more brown or gray. Hemorrhage can also alter the hue, making lesions appear more purple.

SHAPE AND CONFIGURATION OF LESIONS

"Shape" describes an individual macule, patch, papule, or plaque; "configuration" refers to shapes made from the arrangement of individual primary lesions in



Figure 1-15 Apple-jelly sign, sarcoidosis.

relation to one another. For example, *annular* or *linear* may be the shape of a single plaque, or a configuration of discrete papules. *Demarcation* refers to the edge of an individual lesion and whether it is sharply defined from or blends into the surrounding skin.

Annular: Ring-shaped; implies that the edge of the lesion has a color and/or texture change that is more prominent on the leading edge than the center (as seen in granuloma annulare, tinea corporis, erythema annulare centrifugum) (Fig. 1-17).

Round/Nummular/Discoid: Coin-shaped; solid circle or oval; usually with uniform morphology



Figure 1-14 Violaceous Gottron papules, dermatomyositis.



Figure 1-16 Yellow, necrobiosis lipoidica diabeticorum.