Preparation for Medical Final Examination (LEK) Dermatological problems in Family Medicine

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Seborrhea

- Seborrheic dermatitis is a chronic inflammatory disorder affecting areas of the head (scalp and face) and body where sebaceous glands are prominent.
- All age groups may be affected and seborrhea can be chronic or intermittent.
  - On the scalp seborrhea can range from mild dandruff to thick adherent plaques.
  - Seborrhea on the face and body appears as erythema with greasy or waxy scales.
  - On the face, two common locations are around the eyebrows and nose and around the beard and mustache in men.
  - When on the body, it is found on the chest and groin.

Lichen planus

- Papular pruritic skin eruption characterized by its violaceous color and polygonal shape.
- Most frequently flat-topped papules and palques are fond on the flexor surfaces of the upper extermities, on the gentalia, around the ankels, and on the mucous membranes.
- Lichen planus is most commonly associated with hepatitis C infection and the association is strongest for the oral form of lichen planus.

Psoriasis

- Common skin disorder that most often appears as inflamed plaques coverd with a thickened, silvery-white scale. Psoriasis is divided into the nine categories, althought patient can have more than one type at the same time: plaque psoriasis, scalp psoriasi, guttate psoriasis, inverse psoriasis, palmar-plantar psoriasis, erythrodermic psoriasis, pustural psoriasis, nail psoriasis, psoriatic arthritis
- The most common area involved include: the elbows, knees, extremities, trunk, scalp, face, ears, hands, feet, genitalia and the nails.
- In most cases, diagnosis of psoriasis is based on the clinical appearance.
- Psoriasis should not be treated with oral or systematic steroids; this can precipitate a life-threatining case of generalized pustular psoriasis.

Pityraisis Rosea

- It is a common acute eruption usually affecting children and young adults: the caouse is unknown.
- It is characterized by the formation of an initial herald patch followed by development of diffuse papulosquamous rash.
- Is is difficult to identify until the appearance of characteristic, smaller, secondary lesions thaht follow Langer lines in a „christmas tree" pattern,

Rosacea

- Inflammatory disease with unknown etiology.
- Various facial manifestations occur and symptoms differ from patient to patient.

There are four type:

- Erythematotelangiectatic – intermittent central facial flushing and erythema.
- Papulopustural – acnelike papules and sterile pustules, can occur alone or in combination with the erythmea and telangiectasias.
- Rinophyma – a coarse hyperthrophy of the connective tissure and sebaceous glands of the nose
- Ocular symptoms – eyes that are itchy, burning, or dry; a gritty of foreign body sensation; and erythema, swelling or hordeolum of the eyelid.

- First-line treatment – avoidance of triggering or exacerabating factors.

Contact dermatitis

- Contact dermatitis is classified as irritant or allergic.
- Irritant occurs when the skin is exposed to environment or substance in sufficient frequency, qunatity or duration that it overcomes the barrier function of the skin.
- Allergic is delayed-type hypersesitivity reaction to a topical agent, and requires initial contact with a substance, causing a T helpercell type 2 mediated immune response in a predisposed individual.
- Common area affected are the hands, neck, eyelids, face, genitalia and legs.
- Nickel is the most common cause of allergic type.
- The key to therapy is the avoidance of irritating substances or environments and allergens.

Impetigo

- Impetigo is a bacterial infection of the epidermis caused by S.aureus and group A B-hemolytic streptococci.
- Various type of dermatitis can become secondarily infected with bacteria and the skin is then calles „impetiginized".
- Impetigo is highly infectious and the bacteria are readily transmitted from one person to another through direct contact, entering through broken skin created by: cutaneous diseases, burns, surgery, trauma, radiation therapy, insect bites.
- The peak incidence occurs during the summer and fall.
- Most patients recover without complications.
- Mupirocin ointment is the treatment of choice for small areas of impetigo and is as effective as oral antibiotics.
- Oral antibiotics are used in patients with extensive impetigo or with refractory infection – cephalosporin, penicillin.

Erysipelas

- Erysipelas is superficial bacterial skin infection that extends into the cutaneous lymphatics.
- Usually this infection is caused by S.pyogenes infection and occurs on the face or lower leg.
- Bacterial inoculation into an area of damaged skin is the initial event in developing erysipelas.
- The source of bacteria is often from the host's nasopahrynx.
- The most common complaints during the acute infection are pain, fever, chills, sweling of the skinn.
- Erysipelas may become a red, indurated tense and shiny plaque with sharply demarcated margins.
- Oral or intramuscular penicillin for 10 to 14 days is sufficient for many cases.
- A macrolide such as erythromycin or azithromycin may be used if patient is allergic to pencillin.

Furuncles and carbuncles

- Furuncles are small abscesses in the skin.
- Patient present with a painful, often fluctuant swelling in areas of friction such as the axilla, inframammary, buttocks and inner tight.
- Carbuncles is a collection of furuncles and usually occurs on the back of the neck in middle-aged and older men.
- Antibiotic thearpy should be considered if the furuncle is not yet fluctuant, or the lesion is on the face.
- Carbncles have many interconnecting sinuses and tend to recur despite drainage and antibiotics.
- Surgical drainage and resection of the lesions are often necessary.

Erythrasma

- Superficial skinn infection caused by Corynebacterium, a normal inhabitant of the skin.
- The infection typically occurs in intertriginous spaces, especially in obese, hyperhidrotic, or diabetic patients.
- Moderate itching and discomfort.
- Skin is often reddish brown and may be slightly raised with some central clearing.
- Because of the production of porphyrins by the infecting corynebacteria, Wood's light demonstrates the lesions as a coral red.
- Usually treated with topical erythromycin or clindamycin.

Tinea corporis

- Superficial dermatophyte infection of the cornified layers of skin on the trunk and extremities.
- Lesions are typically annular with central clearing and a scaling border and may be pruritic.
- Infection may be transmitted from person to person, by animals such as household pets or farm animals and through fomites.
- Because the cornified layer of the skin is involved, topical therapy is usually sufficient for localized cases.
- A topical antifunginal should be applied twice daily for minimum of 2 weeks.
- Oral antifunginal agents should be considered for first-line therapy for tinea corporis covering large are.as of the body

Tinea Pedis

- Tinea pedis or „athlete's foot" is most often caused by Trichophyton rubrum.
- Pruritic scaly soles, often with painful fissures between the toes.
- Patients may also have chronic hyperkeratotic tinea pedis, characterized by plantar erythema and hyperkeratosis (dry looking scaly feet).
- Tinea Pedis is more common in men and rarely occurs in children.
- Infection can occur through contact with infected scales on bath or pool floors.
- The treatment – application of an antifunginal cream.

Tinea Capitis

- The most common dermatophytosis in children, is an infection of the scalp and ahir follicle.
- Transmission is fostered by poor hygiene and overcrowding and can occur thorugh contaminated hats, brushes and pillowcases.
- Irregular or well-demarcated alopacia and scaling.
- Treatment: Oral griseofulvin daily for 6-8 weeks or Oral fluconazole

Tinea Versicolor

- Tinea versicolor presents with hypopigmented, pink, or brown muacules and patches with fine scale.
- Back, chest, abdomen, and upper arms.
- Tinea versicolor is caused by Malassezia furfur.
- Patients may apply slenium sulfide lotion or shampoo to the involved areas for 1 week; ketoconazole 2% shampoo may be apllied daily for 3 days and also oral fluconazol or itraconazole

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Herpes Simplex

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Herpes Simplex

- Herpes simplex virus type 1 is the most common cause of oral herpes infection – 80%.
- Herpes simplex virus type 2 is the primary pathogen in genital herpes - 70-90%.
- Both of them can cause oral or genital lesions.
- Herpes simplex virus infection can be characterized by an initial infection, episodes of latency, asymptomatic viral shedding and recurrent activation.
- Treatment: Oral antivirals including: acyclovir, valacyclovir, famciclovir

Scabies

- Scabies is caused by the mite Sarcoptes Scaberi an obligate human parasite.
- Patients present with a pruritic rash that is often worse in the night.
- Skin finding include: papules, nodules and burrows.
- Pruritic nodules around the axillae, umbilicus or on the scrotum are highly suggestive of scabies. In the children the head can also be involved.
- Burrows are pathognomonic of scabies and will be the site to find mites
- Ivermetacin is an oral treatment for resistant or crusted scabies.
- Permethrin cream is applied from the neck down (including the head when involved) and rinsed off 8 to 14 hours later. Usually this is done overnight.'

Pediculosis Capitis

- Lice are obligate human parasites transmitted by person to person contact.
- The infestation is usually detected because of intense itching and the presence of eggs or nits adherent to the hair shaft.
- Detection of a single live louse is sufficient for diagnosis of infestation.
- Because of the route of transmission, outbreaks are often seen in daycare centers, classrooms and homeless shelters.
- Effective eradication of pediculosis often requires two treatments given 7 to 10 days apart.
- Effective treatment include 1% permethrin cream rinse, pyrethrins with piperonyl butoxide shampoo and amalthion cream.
- Bedding and clothing should be washed in the hottest water possible od dry cleaned.
- Combs, barrettes and hair ornament may be soaked in hot water for 10 minutes.

Preparation for Medical Final Examination (LEK) Infectious Diseases

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Influenza

- Influenza viruses infectinf humans are classified as A, B and C (rare).
- The clinical spectrum of influenza ranges from a self-limited illness resembling the common cold to death from overwhelming viral pneumonia within a few hours.
- Adults can often date to the hour the onset of symptoms, such as throbbing headache, photophobia, myalgie, sore throat, substernal soreness, nonproductive cough.
- Children tend to have fever, rhinitis, pharyngitis, vomiting and diarrhea.
- In older patients often: high fever, nasal obstruction, lassitude and diarrhea.
- Pneumonia is the major life-threatening complication.
- Primary influenza pneumonia, which should be suspected when high fever and sypnea persist for more than several days, is more common among the elderly and immunocompromised individuals.
- Secondary bacterial pneumonia should be suspected whenever a patient who seemed to be improving takes a dramatic turn for the worse. It is most often caused by S.pneumoniae, but S.aureus is also common.
- Treatment: oseltamivir and zanamivir are currently recommended. Oseltamivir is given in a dose 75mg twice daily.

Rubeola

- Rubeola presents as maculopapular eruption. It starts on the face and spread centrifugally.
- It is caused by varicella virus.
- It is associated with cough, coryza, conjunctivitis, fever and Koplik spots (red-white-blue macules in mouth).
- Rubeola is known uncommon because of vaccinations.
- The exanthem of rubeola begins around the fourth febrile day,with discrete lesions that become confluent as they srpaed from the hairline downward, sparing the palms and soles.
- The exanthem usually lasts 4 to 6 days.
- The lesions fade gradually in order of appearance, leaving a residual yellow-tan coloration or faint desquamation.
- Combs, barrettes and hair ornament may be soaked in hot water for 10 minutes.

Rubella

- It is caused by a togavirus.
- Its exanthem characteristically has duration of 2 to 3 days.
- Rubella is associated with tender cervical lymphadenopathy.
- Another unique features is Forchhemier spots, which are pinpoint red macules over the soft palate and the uvula.

Erythema Infectiosum (Fifth Disease)

- Is caused by human parvovirus B19 and primarily affects children 3 to 12 years old.
- The prodrome syndrome may consist fo fever, anorexia, sore throat, and abdominal pain.
- After the feve resolves, the classic erythematous facial rash appears, known as „slapped cheek”.
- The exanthem progresses to a diffuse, reticular or „lacy” pattern on the extensor exteremities that may wax and wane for several weeks.

Varciella

- Is now much less common because of universal varicella vaccination of children.
- Occasionally a family physicians sees a case of breakthrough chickenpox in vaccinated children.
- Patients with variciella have fever and general malaise as a mild prodrome lasting 1 to 2 days before the rash appears.
- The rash typically begins on the face, scalp, or trunk and then spreads to the extremities.
- The lesions appear as erythematous maclues and progress to papules with an edematous base.
- The papules quickly evolve into vesicles, appearing as „dewdrop on a rose petal”
- The vesicles evolve into pustules, which become imbilicated and subsequently crust over in the esuing 8 to 12 hours.
- A defining characteristic of variciella is that lesions may be present in all stages simultaneously.
- Acyclovir is recommended for adolescents, adults, and chidren, who are taking steroids or otherwise immunocompromised.

Hand, Foot, Mouth Disease

- This common, childhood ilness usually occurs in the summer or early fall and presents as falt-topped vesicles on hand, feet, mouth, especially on palms and soles.
- Every case may not ivolve all three sites.
- Hand, foot and mouth disease is most often caused by coxsackievirus A16.
- However, a number of atypical hand-foot-and-mouth disease cases are now being reported with an expanded range of cutaneous finding that are associated with coxsackievirus A6 infection.

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Preparation for Medical Final Examination (LEK) Neurological problems in Family Medicine

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Headache

Headaches are mainly divided into:

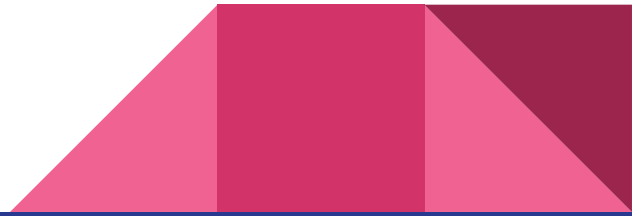
1) Primary:
- migraine with aura
- migraine without aura
- tension headache
- cluster headache

2) Secondary, which are symptoms of organic diseases

Headache

Features of the history that should warn of an ominous cause for headache include the following:

- sudden onset of headache or headache that reaches maximal intensity withing seconds or minutes of onset
- Worst (or first) headache ever
- Late onset of new headache (age after 50 y.o)
- Headache associated with fever, rash, or a stiff neck
- Progressively worsening headache
- Headache associated with mental status changes
- Headache associated with papilledema
- Headache with exertion, sexual activity, coughing or sneezing



Migraine

- Women have migraines three times as often as men,
- 90% of those with migraines have a positive family history
- Migraines can begin in childhood, and as many as 4 to 10% of school-age children have migraines.
- Migraines without aura – at least 5 attacks – fulfilling the following criteria:
- Headache attack lasting 4 to 72 hours
- Headache with at least two of the following characteristic: unilateral loacation; pulsating quality; moderate or severe intenisty (inhibits or prohibits daily activities or causes avoidance of routine); aggravated by physical activity such as walking or climbing
- During the headache, at least one of the following occurs: nusea and vomiting; photophobia and phonofhobia

Migraine

- Migraine with aura –as comparable diagnostic criteria but with and aura.
- Auras can be visual, sensory, motor or speech auras. Visual changes includes parallel zigzag lines and are often associated with scotomatous defects.
- Sensory deficits can involve an ipsilateral arm or periorbital numbness or tingling. The tongue may be involved in some patients.
- Basilar-type migraine: aura symptoms are referable to the brainstem or bilateral hemispheres, including dysarthria, vertigo, tinnitus, diplopia and bilateral paresthesias
- Retinal migraine: reversible monocular, positive or negative visual disturbances associated with migraine

Tension-type headaches

- They can be episodic or chronic.
- There is a slight female preponderance and the prevalence may be directly related to socioeconomic status.
- Chronic tension headaches can sometimes develop in migraine patients and are frequently associated with overuse of analgesic.
- Tension-types headaches require a comprehensive assessment to determine whether an comorbid conditions exacerbate the headache.
- The diagnostic criteria for episodic tension-type headaches include at least 10 previous headache episodes fulfilling the following criteria:

1. Headaches lasting for 30 minutes to 7 days, with at least two of the following pain characteristics: Pressing or tightening (non pulsating) quality

   Mild or moderate intensity, Bilateral location, No aggravation by walking, climbing stairs, or similar routine physical activity

2. Both of the following: no nausea or vomiting, photophobia or phonophobia – both absent or only one present

Cluster headaches

-Less common than migraines

- Almost 80% of patients are male

- They present with unilateral pain

- Attacks may last 15 to 180 minutes and can occur every other day to up 8 times daily. The cycle may last for 4 to 12 weeks.

-These headaches frequently are triggered by alcohol, with some nausea.

-They tend to occur at a similar time during the day or night.

-The pain is frequently in the orbital or periorbital region.

-The pain is usually extremely sharp, continuous, incapacitating.

Medication overuse headaches

Daily or almost daily headaches when medication doses are excessive or too frequent. Rebound can occur with opioids, acetaminophen, aspirin, codeine, ergotamines, and triptans.

Diffuse, bilateral, almost daily headache, often aggravated by mild physical or mental exertion. The headache is present on waking and can be associated with restlessness, nausea, forgetfulness and depression.

The key is to discontinue the overused medication and thus break the cycle. Stopping the medication may result in withdrawal symptoms and an initial periodd of increased headaches, with subsequent improvement.

Miscellaneous headaches

Episodic and chronic paroxysmal hemicrania is an unusual headache and tends to occur in women. The attacks are short, and the pain is similar to that of cluster headache.These headaches respond to indomethacin.

Posttraumatic headaches can follow a head injury, with presentation similar to that of migraine headache. These headaches may be associated with dizziness and impaired concentration.

Trigeminal neuralgia is described as a piercing, sudden, severe pain that can last for seconds to minutes in the area of the cheek or jaw and can be aggravated by chewing or talking.Treatment: carbamazepine, oxcarbazepine, baclofen and gabapentin.

Stroke

- Strokes usually occur without warning and fewer than 20% of cerebrovascular accidents are preceded by a warning transient ischemic attack.
- Stroke is defined as the sudden onset of neurologic dysfunction caused by docal central nervous system infarction, which involves brain, spinal cord, or retinal cell death caused by ischemia. Evidence of cell death can be determined by imaging, pathological data, or clinical presentation.
- TIA – transient ischemic attack – is characterized by the rapid onset of neurologic dysfunction but without permanent infarction.
- About two thirds of ischemic strokes are caused by thrombosis, and slightly less than one third are caused by embolus.

- Ischemic strokes result from many causes, including intracranial atherosclerosis: cervical carotid artery stenosis; and occlusive disease of the small penetrating arteries, leading to lacunar infarcts.

- Hemorrhagic strokes are generally related to intracranial or subarachnoid hemorrhage, with intracranial hemorrhages being more common.

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Stroke – risk factors

- **Hypertension:** patients with SBP higher than 160 and diastolic DBP higher than 95 have a fourfold increased risk of stroke. Decreasing DBP by as little as 5 reduces the realtive risk of strokes by 43%, and decrease of 10 results in 50% relative risk reduction.

- **Smoking:** cigarette smoking is and independent risk factor for stroke. The risk of stroke of subarachnoid hemorrahge is almost three times as high as for the general population. Patients who smoke should be encouraged to quit.

- **Atrial fibrillation:** the stroke risk in patients with atrial fibrillation is reduced by about two thrids when they are treated with warfain, novel oral anticoagulants (rivaroxaban, apixavan, dabigatran).

- **Hypercholesterolemia:** modest stroke risk reduction has been demonstrated by the achivement of lower lipid levels. Statin are effective for the primary prevenetion of ischmiec stroke for patients with a history of occlusive arterial disease, coronary artery disease or diabetes without a history of cerebrovascualar disease. Statins reduce the risk of ischemic stroke in hypertensive patient with multiple cardiovascular risk factors.

- **Carotid Artery Stenosis:** patients with internal carotid artery stenosis of less than 75% have an annual risk of stroke of approximately 1,3%. In contrast, patients with internal carotid stenosis greater than 75% have annual TIA risk of 7.2% and annual stroke risk of 3.3%

- **Diabetes:** patienst with diabetes who have strokes tend to be younger and have a higher incidence of intracerebral bleeding. Diabetes is and established risk factor for initial strokes, but there is no evidence that intesive control of hyperglycemia decreases the incidence of recurrent stroke.

Delerium

Delerium is a transient, global disorder of cognition and consciousness; changes in consciousness typically develop quickly and fluctuate during the day.

Hyperactive delerium – with agitation, disorientation and delusions

Hypoactive delerium – demonstrated by a lethargic patient who is difficult to arouse and engage in conversation. Most common form of delerium

Or mixed-type delerium

Dementia

Dementia is characterized by the development of an acquired impairment in memory associated with impairment in one or more cognitive domains, including executive function, language, praxis (learned motor sequences), or gnosis (ability to recognize objects, faces or other sensory information.

Dementia can be divided into four categories: Alzheimer disease (60%), dementia with Lewy bodies (15%), vascular dementia (15%) and all other caouses (10%).

Dementia – Alzheimer disease

Patients have brains that demonstrate atrophy with ventricular and sulcal enlargement. They reveal evidence of neuronal loss as well as the presence of amyloid plaques and neurofibrillay tangles.

Dementia with Lewy bodies

Dementia with Lewy bodies is similar to Alzheimer disease, but visual hallucinations and motor symptoms (similar to parkinsonism) develop early in the course of the disease. Histologically Lewy bodies are present: these are cytoplasmic inclusions found in the temporal, parietal and paralympic regions of brain.

Vascular dementia

Vascular dementia is usually divided into: multi-infarct dementia and subcortical vascular dementia.

Multi-infarct dementia should be suspected when focal, asymmetric neurologic abnormalities accompany dementia. Neuroimaging may show multiple strokes.

Subcortical vascular dementia should be suspected if the patient manifests significant problems with gait early in the course of dementia. Neuroimaging is usually normal, except for increased signal in the deep white matter – a nonspecific sign.

Seizures

Seizures are a manifestation of disturbed neurologic function and therefore are often associated with acute neurological disorders such as meningitis. In the some patients seizures are self-limited and resolve when an acute neurologic disturbance resolves. In others, the seizures persist and result in a diagnosis of epilepsy.

Seizures are usually classified as a partial or generalized.

Status epilepticus

Status epilepticus is generally defined as more than 30 minutes of unconsciousness and continuous or intermittent, generalized seizure activity. However, because most seizures last 2 minutes or less, any seizure longer than 5 minutes may progress to status epilepticus.

Bacterial Meningitis

Acute bacterial meningitis has high morbidity and mortality rates even under the best circumstances.

Most adults (85%) present with the calssic triad: fever, headache, neck stiffness. Other symptoms: vommiting (35%), seizures (30%), nuchal rigidity.

Meningismus (50%) may be subtle or makred, as with Kering sing or Brudzinski sign .

Neonates may present with poor feeding or weak sucking response, irritability, vomiting, temperature instability, diarrhea and apnea.

Nuchal rigidity and meningismus are not reliable signs in children younger than 1 year.

Risk factors include:

- History of recent open trauma, surgery, and burns
- Sinusitis
- Mastoiditis
- Alcoholism – perinatal exposure

Dizziness

It is a typical complaint of elderly patients and has a broad differential diagnosis. Dizziness is usually benign and self-limited. Nevertheless, it is a risk factor for falls and functional decline in the geriatric population.

Dizziness can be categorized as:

- Vertigo – a sensation of spinning or motion
- Presyncopal lightheadedness – a sensation of impending faint
- Disequilibrium – a sensation of unsteadiness and imbalance
- Or dizziness that cannot be adequately quantified, reported by the patients as a feeling of lightheadedness or floating sensation.

Parkinson Disease

Parkinson disease is the second most common progressice neurodegenerative disorder in the United States after Alzheimer disease.

Affects about 1% of population older than 60 years and 4-5% of those older than 85 years. The incidence is higher in men than women.

The hallmark clinical features of Parkinson disease include tremor, rigidity and bradykinesia, usually of asymmetric onset.

An asymmetric rest tremor is virtually pathognomonic of Parkinson disease.

Parkinson Disease - treatment

Dopamine agonists directly stimulate dopamine receptors, thus bypassing the presynaptic synthesis of dopamine. These medications cause less dyskinesia and fewer fluctuations than levodopa – bromocriptine.

The enzyme catechol – O – methylotransferase inhibitors prolong the dopamine response. These medications reduced total levodopa dose and improved motor sumptoms in patients with advanced disease and motor complications.

NMDA antagonists – amantadine – is useful for tremor, rigidity, and bradykinesia.