>>DIAGNOSIS AT A GLANCE

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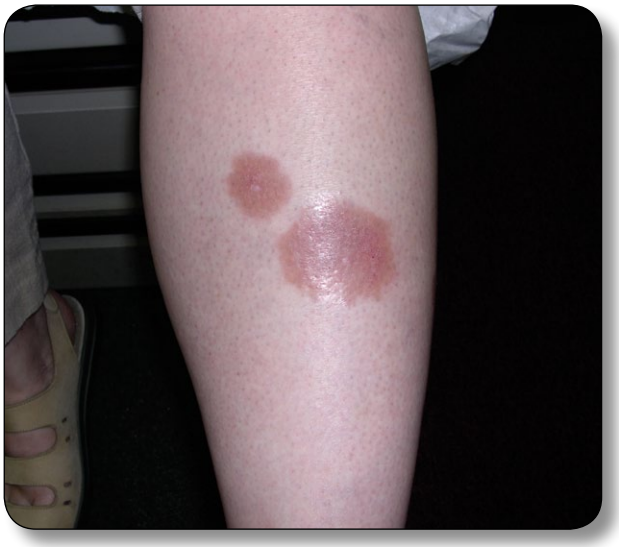
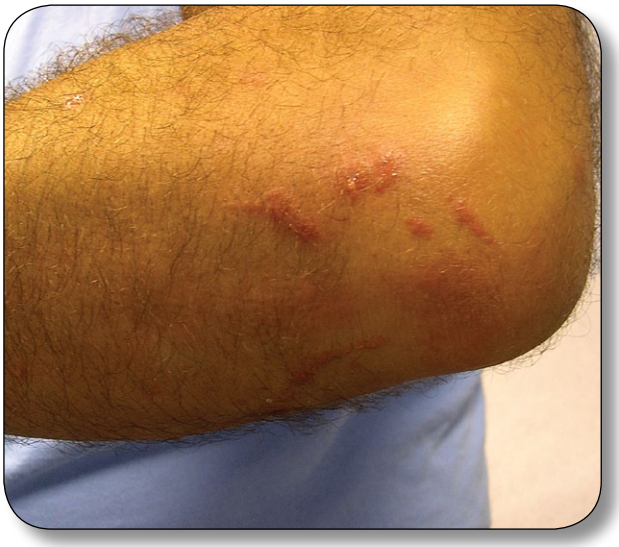
CASE 1



A 63-year-old woman presents with lesions on her left shin. She reports that she first noted them approximately 3 months ago, and they have been progressively enlarging in diameter. They are asymptomatic except for infrequent mild pruritus. She gives a history of hypothyroidism, hypertension, and "borderline" diabetes. Physical examination reveals two well-circumscribed, waxy, yellow-brown, scaly patches. No similar lesions are noted elsewhere.

What is your diagnosis?

CASE 2



A 34-year-old man presents with an elbow rash that arose 2 days ago. He spent the previous weekend camping. The eruption is extremely pruritic and seems to be spreading. He reports having tried OTC anti-itch creams, which proved ineffectual. His medical history is unremarkable. Physical examination reveals linear, erythematous vesicular patches on the affected area.

What is your diagnosis?

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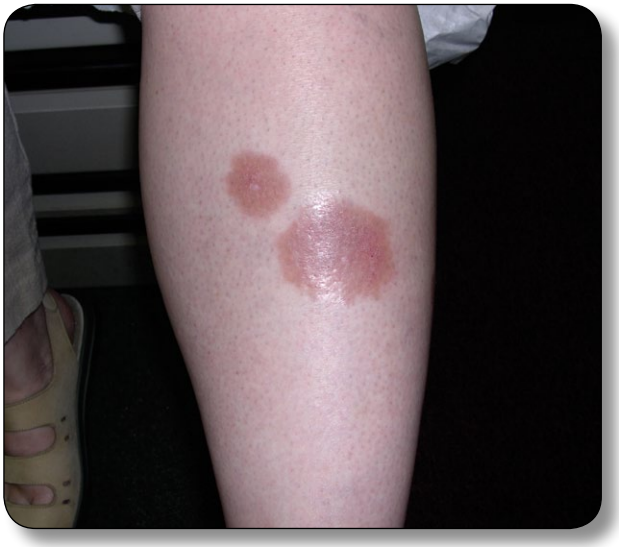
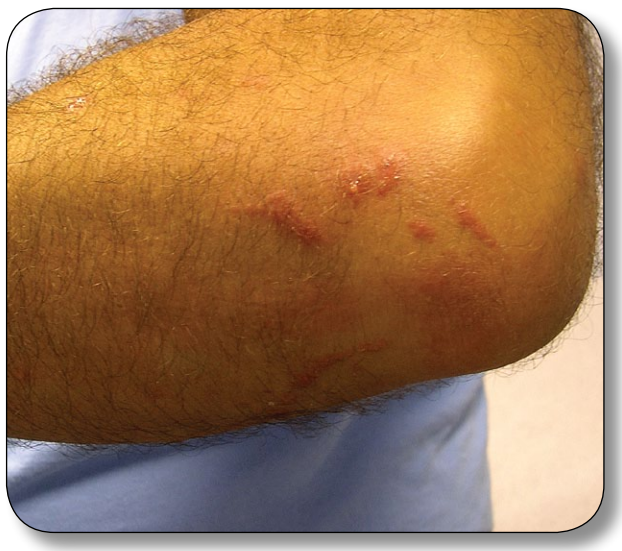
CASE 1



Punch biopsy confirmed the clinical suspicion of necrobiosis lipoidica diabeticorum (NLD). This is a relatively uncommon cutaneous manifestation of diabetes mellitus that is characterized by well-defined, yellowish, atrophic, telangiectatic patches found primarily on the shins. Ulceration can occur following trauma. In patients with diabetes, control of blood glucose levels usually does not have a significant effect on the course of NLD. First-line therapy includes potent topical steroids for early lesions and intralesional steroids injected into active advancing edges of established lesions. Treatment often yields unsatisfactory results, and lesions may persist for decades.

CASE 2



Rhus dermatitis is a type of contact dermatitis resulting from exposure to plants in the *Rhus* genus of the Anacardiaceae family. Plants included in this classification are poison ivy, poison oak, and poison sumac. In the United States, the *Rhus* genus is the most common cause of contact dermatitis. This rash is typically erythematous, contains blisters, and manifests in a linear or circular pattern. The most commonly affected sites are exposed areas on the arms, legs, and face. Treatment is with ultrapotent topical steroids, although extensive cases may require oral steroids as well.

Dr. Schleicher is director of the DermDOX Center in Hazleton, Pennsylvania, a clinical instructor of dermatology at the Philadelphia College of Osteopathic Medicine and King's College in Wilkes-Barre, Pennsylvania, and an associate professor of medicine at the Commonwealth Medical School in Scranton, Pennsylvania. He is also a member of the EMERGENCY MEDICINE editorial board. **Dr. Levine** is a dermatology resident at St. John's Episcopal Hospital in Far Rockaway, New York.