**Erythema Nodosum**

- This is a hypersensitivity reaction (can be to a variety of stimuli)
- Causes include:
  - Group B strep
  - Primary TB
  - Pregnancy
  - Malignancy
  - Sarcoidosis
  - SLE
  - Chlamydia
  - Leprosy
- Presentation:
  - Discrete, tender nodules that may then progress to becoming confluent
  - Most commonly on the shins
  - The lesions will tend to appear over a period of 1-2 weeks before leaving a bruise-like discoloration as they resolve (this will be complete, with no atrophy or scarring)
  - The lesions will not ulcerate

**Erythema Multiforme, Stevens-Johnson Syndrome & Toxic Epidermal Necrolysis**

- **Erythema Multiforme**:
  - This tends to have an unknown cause but HSV tends to be cited as the predilecting factor (others include infections and drugs)
  - It is self-limiting and mucosal involvement is either absent or limited to only one mucosal surface
- **Stevens-Johnson Syndrome**
  - Multifocal mucocutaneous involvement at least two mucous membranes, and histology will show only a few inflammatory cells
  - Associated with infections or examination of drugs and infections. You may also be able to identify a previous trigger
- **Toxic Epidermal Necrolysis**:
  - Severe drug-induced, there is extensive skin and mucosal necrosis with systemic toxicity
  - Histology will show full-thickness epidermal necrosis with subepidermal detachment
- **Management**: seek urgent help immediately, give supportive care to maintain hemodynamic equilibrium
- **Deaths can occur due to complications such as sepsis, electrolyte imbalance and multi-organ failure**

- **Acute Meningococcaemia**

  - This is when a gram negative diplococcus Neisseria Meningitides infection (transmitted via respiratory secretions) gets into the blood
  - Presentation:
    - Features of meningitis (headache, fever, neck stiffness)
    - Features of septicaemia (hypotension, fever, myalgia)
    - Typical non-blanching purpuric rash on the trunk and extremities (this can rapidly progress to erythromes, haemorrhagic bullae and tissue necrosis)
  - **Management**:
    - Antibiotics e.g. benzylpenicillin
    - Note you should give prophylactic antibiotics such as rifampicin to close contacts
    - Complications include septicaemic shock, DIC, multi-organ failure and death

**Erythroderma**

- This is basically 'red skin' due to exfoliative dermatitis
- It is very widespread, covering at least 90% of the body surface
- Causes include skin diseases such as psoriasis or eczema, lymphoma, drug (e.g. sulphonamides, sulphonyleues, penicillin, allopurinol, captopril) or may be entirely idiopathic
- Presentation: the skin will be inflamed, oedematous and scaly. The person will tend to be systemically unwell with lymphadenopathy and malaise
- **Management**:
  - Treat the underlying cause if known
  - Maintain skin moisture with emollients and wet-wraps
  - Topical steroids can be given to help relieve the inflammation
  - Note that there is a risk of a secondary infection developing, as well as complications such as fluid loss and electrolyte imbalance, hypothermia, high-output cardiac failure and capillary leak syndrome

**Eczema Herpaticum**

- Also known as Kaposi’s Varicelliform Eruption
- This is a serious complication of atopic eczema (and in rare cases some other skin conditions), where there is widespread eruption
- It is caused by a Herpes Simplex Virus infection
- Presentation:
  - Extensive crusted papules, blisters and erosions
  - Systemically unwell with fever and malaise
- **Management**:
  - Antivirals such as acyclovir and antibiotics for any secondary infection
  - Complications include herpes hepatitis, encephalitis, DIC and sometimes death
Necrotising Fasciitis

- This is a rapidly spreading infection of the deep fascia with secondary tissue necrosis
- Causes:
  - Group A haemolytic streptococcus/a combination of anaerobic and aerobic bacteria
  - Things like abdominal surgery and co-morbidities such as diabetes or malignancy can increase the risk of it developing
- Presentation:
  - Severe pain
  - Erythematous, blistering and necrotic skin
  - Systemically unwell with fever and tachycardia
  - Presence of crepitus (subcutaneous emphysema) on palpation
  - X-ray may show the presence of soft-tissue gas
- Management: this has a very high mortality rate and requires urgent referral for extensive surgical debridement. IV antibiotics are also required

Disseminated Intravascular Coagulation & Vasculitis

- DIC:
  - There will be a history of trauma, malignancy, sepsis, obstetric complications, transfusions or liver failure
  - There can be spontaneous bleeding from ear, nose, throat, GI tract, respiratory tract or a wound site
  - The lesions can be petechiae, ecchymoses, haemorrhagic bullae and/or tissue necrosis. The person will be systemically unwell
  - You need to do bloods (particularly clotting)
  - Treat the underlying cause, transfuse for coagulation deficiencies and anticoagulate for thrombosis
- Vasculitis:
  - There are painful lesions on dependent areas (legs, buttocks and flanks)
  - The lesions will be palpable purpura that are often painful and the person will be systemically unwell
  - You need to do bloods, urinalysis and a skin biopsy
  - Treat the underlying cause, give steroids and immunosuppressants if there is systemic involvement