

# Acquired

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Figure 45.44 'Port-wine' stain  
(courtesy of St John's Institute for Dermatology, London, UK). Figure 45.45 Campbell de Morgan spot (courtesy of Mr AR Greenbaum). Figure 45.46 Spider naevus

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**Kaposi's sarcoma** Kaposi's sarcoma is a malignant, proliferative tumour of vascular endothelial cells, which was first described in elderly Jewish men but is now most commonly associated with immune compromise after transplantation or HIV infection ( Figure 45.50 ). There appears to be a causal link with infection by human herpesvirus 8. Kaposi's sarcoma usually starts as a red-brown, indurated, plaque-like skin lesion that becomes nodular and then ulcerates. Treatment is with radiotherapy .

Figure 45.48 Glomus tumour (courtesy of St John's Institute for Dermatology, London, UK).

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**Pressure sores** These begin with tissue necrosis at a pressure point and develop into a cone-shaped volume of necrotic loss. As many as 10% of acute hospital inpatients will have some degree of pressure sore. The majority affect the elderly and patients with spinal injury or decreased sensibility; 80% of paraplegics will get a pressure sore and 8% die as a result. The pathogenesis of pressure sores revolves around unrelieved pressure: an increase in local tissue pressure above that of perfusion pressure produces ischaemic necrosis that is directly proportional to the duration and degree of pressure and inversely proportional to the area over which it is applied. Muscle and fat are more susceptible to pressure than skin. In a patient who has no predisposing factors management is aimed at debridement and repair of the defect, on the assumption that recurrence will not occur once normal function and sensibility returns. In the paraplegic patient, recurrence is likely so management should involve a multidisciplinary approach. Primary treatment involves relieving pressure (special mattress, nursing care, relief of muscle spasm and contractures), optimising nutrition, correcting anaemia and preventing infection. Surgery involves thorough debridement to promote healing and plastic surgery to reconstruct the defect.

**Ulcers** An ulcer is a discontinuity of an epithelial surface. It is characterised by destruction of the surface epithelium and a granulating base. Ulcers can be classified as non-specific, specific and malignant ( Figure 45.51 ).

**Sinus** A sinus is a blind-ending tract connecting a cavity lined with granulation tissue (often an abscess cavity) to an epithelial surface (a) (b) (c) (d) (e) Burrill Bernard Crohn , 1884–1983, gastroenterologist, Mount Sinai Hospital, New York, NY , USA, described regional ileitis in 1932. - surface ( Figure 45.52a ). Sinuses may be congenital or acquired. Congenital sinuses arise from the remnants of persistent embryonic ducts. Acquired sinuses can result from: a retained foreign body (ingrown hair or suture material); chronic infection (tuberculosis, osteomyelitis or actinomycosis); chronic inflammation (Crohn's disease); malignancy; or inadequate surgical drainage of a cavity . , Treatment of a sinus is directed at removing the underlying cause. Biopsies should always be taken from the wall of a sinus to exclude malignancy or specific infection. For specific management of the disease conditions, please refer to the appropriate chapter.

**Fistula** A fistula is an abnormal communication between two epithelium-lined surfaces ( Figure 45.52b ). This commu -

nication or tract is usually lined by granulation tissue, but may become epithelialised in chronic cases. Fistulae may be congenital (e.g. tracheo-oesophageal and branchial fistulae) or acquired (e.g. enterocutaneous complicating Crohn's disease or surgery, or arteriovenous). Management of a fistula is directed at the underlying aetiology (see the appropriate chapters).

Figure 45.51 Some characteristic shapes of the edges of ulcers. (a) Non-specific ulcer: note the shelving edge. (b) Tuberculous ulcer: note the undermined edge. (c) Basal cell carcinoma (rodent ulcer): note the rolled edge, which may exhibit small blood vessels. (d) Syphiloma: note the heaped-up, everted edge and irregular thickened base. (e) Syphilis: note the punched-out edge and thin base, which may be covered with a 'wash-leather' slough. Figure 45.52 A sinus (a) and a fistula (b); both usually arise from a preceding abscess. (a) This is a blind track, in this case a pilonidal abscess. (b) This is a track connecting two epithelium-lined surfaces, in this case a colocolocutaneous fistula from colon to skin.

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