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■ ■REFERENCES Banerjee T et al: High dietary acid load predicts ESRD among adults with CKD. J Am Soc Nephrol 26:1693, 2015. Berend K et al: Physiological approach to assessment of acid-base disturbances. N Engl J Med 371:1434, 2014. Hamm LL, Dubose TD: Disorders of acid-base balance. In Brenner and Rector’s The Kidney, 11th ed. Yu A et al (eds). Philadelphia, Elsevier, 2020, pp 496–536. Kraut JA, Madias NE: Metabolic acidosis of CKD: An update. Am J Kidney Dis 67:307, 2016. Kraut JA, Madias NE: Re-evaluation of the normal range of serum total CO2 concentration. Clin J Am Soc Nephrol 13:343, 2018. Palmer BF, Clegg DJ: Electrolyte and acid–base disturbances in patients with diabetes mellitus. N Engl J Med 373:548, 2015. Wesson DE et al: Mechanisms of metabolic acidosis-induced kidney injury in chronic kidney disease. J Am Soc Nephrol 31:469, 2020. Section 8 Alterations in the Skin Kim B. Yancey, Thomas J. Lawley

Approach to the Patient

with a Skin Disorder The challenge of examining the skin lies in distinguishing normal from abnormal findings, distinguishing significant findings from trivial ones, and integrating pertinent signs and symptoms into an appropri ate differential diagnosis. The fact that the largest organ in the body is visible is both an advantage and a disadvantage to those who examine it. It is advantageous because no special instrumentation is necessary and because the skin can be biopsied with little morbidity. However, the casual observer can be misled by a variety of stimuli and overlook important, subtle signs of skin or systemic disease. For instance, the sometimes minor differences in color and shape that distinguish a melanoma (Fig. 59-1) from a benign nevomelanocytic nevus (Fig. 59-2) can be difficult to recognize. A variety of descriptive terms have been developed that characterize cutaneous lesions (Tables 59-1, 59-2, and 59-3; Fig. 59-3), thereby aiding in their interpretation and in the formulation of a differential diagnosis (Table 59-4). For example, the FIGURE 59-1 Superficial spreading melanoma. This is the most common type of melanoma. Such lesions usually demonstrate asymmetry, border irregularity, color variegation (black, blue, brown, pink, and white), a diameter >6 mm, and a history of change (e.g., an increase in size or development of associated symptoms such as pruritus or pain).

Approach to the Patient with a Skin Disorder CHAPTER 59 FIGURE 59-2 Nevomelanocytic nevus. Nevi are benign proliferations of nevomelanocytes characterized by regularly shaped hyperpigmented macules or papules of a uniform color. TABLE 59-1 Description of Primary Skin

Lesions Macule: A flat, colored lesion, <2 cm in diameter, not raised above the surface

of the surrounding skin. A “freckle,” or ephelid, is a prototypical pigmented macule. Patch: A large (>2 cm) flat lesion with a color different from the surrounding skin. This differs from a macule only in size. Papule: A small, solid lesion, <0.5 cm in diameter, raised above the surface of the surrounding skin and thus palpable (e.g., a closed comedone, or whitehead, in acne). Nodule: A larger (0.5–5.0 cm), firm lesion raised above the surface of the surrounding skin. This differs from a papule only in size (e.g., a large dermal nevomelanocytic nevus). Tumor: A solid, raised growth >5 cm in diameter. Plaque: A large (>1 cm), flat-topped, raised lesion; edges may either be distinct (e.g., in psoriasis) or gradually blend with surrounding skin (e.g., in eczematous dermatitis). Vesicle: A small, fluid-filled lesion, <0.5 cm in diameter, raised above the plane of surrounding skin. Fluid is often visible, and the lesions are translucent (e.g., vesicles in allergic contact dermatitis caused by Toxicodendron [poison ivy]). Pustule: A vesicle filled with leukocytes. Note: The presence of pustules does not necessarily signify the existence of an infection. Bulla: A fluid-filled, raised, often translucent lesion >0.5 cm in diameter. Wheal: A raised, erythematous, edematous papule or plaque, usually representing short-lived vasodilation and vasopermeability. Telangiectasia: A dilated, superficial blood vessel. TABLE 59-2 Description of Secondary Skin Lesions Lichenification: A distinctive thickening of the skin that is characterized by accentuated skinfold markings. Scale: Excessive accumulation of stratum corneum. Crust: Dried exudate of body fluids that may be either yellow (i.e., serous crust) or red (i.e., hemorrhagic crust). Erosion: Loss of epidermis without an associated loss of dermis. Ulcer: Loss of epidermis and at least a portion of the underlying dermis. Excoriation: Linear, angular erosions that may be covered by crust and are caused by scratching. Atrophy: An acquired loss of substance. In the skin, this may appear as a depression with intact epidermis (i.e., loss of dermal or subcutaneous tissue) or as sites of shiny, delicate, wrinkled lesions (i.e., epidermal atrophy). Scar: A change in the skin secondary to trauma or inflammation. Sites may be erythematous, hypopigmented, or hyperpigmented depending on their age or character. Sites on hair-bearing areas may be characterized by destruction of hair follicles.

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