



**Figure 343. Leprosy, lepromatous, histiocytoid type.** In lepromatous leprosy, nodular infiltration of the face, ears, and elsewhere may occur. The eyebrows may be progressively lost. Note the nodular infiltration of the ear in this teenage Peruvian girl. (Courtesy of James Steger, MD.)



**Figure 344. Leprosy, borderline tuberculoid.** Note the multiple, hypopigmented lesions. (Courtesy of James Steger, MD.)



**Figure 345. Leishmaniasis, ulcer.**

An inflammatory red-brown papulonodule develops initially at the site of a bite by the sand fly, usually on the face, neck, or arms. The incubation period is usually several months but may be from a few days to over a year. The lesion enlarges to a crusted nodule. The crust may then fall off, leaving a large ulcer (as shown here on the arm) that later heals with a scar.



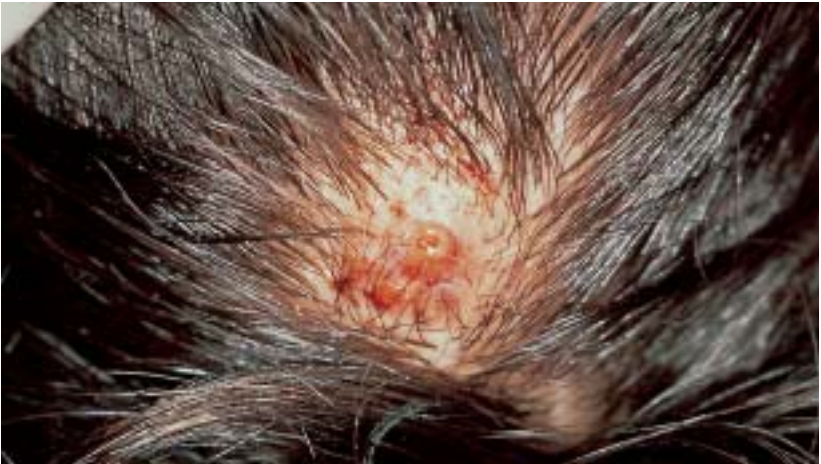
**Figure 346. Leishmaniasis, nasal destruction.** In a small percentage of cases, infection by *Leishmania brasiliensis* may spread to the nasopharyngeal mucosa, causing significant destruction. (Courtesy of James Steger, MD.)



**Figure 347. Pinta, tertiary stage.** Pinta is a cutaneous disease with multiple stages caused by the non-venereal spirochete *Treponema carateum*. It is the most benign of the spirochetel diseases, causing primarily skin changes. Pinta has mostly disappeared worldwide except for some areas of Brazil. One case was recently described in Austria, imported possibly from Cuba. In the primary stage of pinta, a minute macule or papule develops at the site of inoculation and spreads to form a large (10–12.5 cm), poorly defined, erythematous infiltrated plaque. In the secondary stage, pintids form that are red, violaceous, blue, brown, gray, or black papulosquamous plaques. They may fade and relapse, forming polycyclic lesions. In the tertiary or late dyschromic stage of pinta, which occurs months to a decade after the pintids, depigmented patches develop as shown here. (Courtesy of James Steger, MD.)



**Figure 348. Myiasis.** Cutaneous myiasis is a temporary infestation of the skin with fly larvae order Diptera, e.g. *Dermatobia hominis*, and is a common disease endemic in tropical zones. The adult female lays eggs on the ground that hatch to first-stage larvae. They then penetrate the skin of a warm-blooded animal (e.g. a human lying on the ground or sand) and mature to adult larvae. The larvae then fall to the ground and turn into flies.



**Figure 349. Myiasis.** Clinically, one sees multiple, scattered red, papulonodules much like furuncles that may drain a serosanguinous fluid (**Figure 349**, bottom). (Courtesy of Stacy Smith, MD.)

# SEXUALLY TRANSMITTED AND OTHER GENITAL DISEASES



**Figure 350. Molluscum contagiosum.** Lesions of molluscum on the lower abdomen and groin of adults are often transmitted during sexual contact. In contrast, genital lesions in children in most cases are innocently obtained. (See also **Figure 91.**)



**Figure 351. Herpes genitalis, male.** Most cases of herpes of the genitalia are caused by HSV-2, but some are caused by HSV-1. The classic appearance of grouped vesicles on an erythematous base is usually not seen. Instead, localized pain, erosions, or erythema may be the only features. Primary infection can be

painful, and individual outbreaks usually last from several days to a week. Recurrent episodes are often of shorter duration. Over time, recurrences tend to be less frequent. Stressful events of at least 7 days' duration significantly predict recurrences. Asymptomatic shedding is an important factor in spread of the disease.



**Figure 352. Herpes genitalis, female.** (Courtesy of Michael O Murphy, MD.)





**Figure 353. Condyloma acuminata, penis.** The term condyloma (knuckle) acuminata (pointed) was originally coined to describe the often pointed or exuberant morphology of this condition in contrast to the syphilitic lesions of condyloma lata. The cutaneous lesions are caused by infection by the human papilloma virus (HPV). This is the most common sexually transmitted disease. HPV infection is associated with dysplasia or frank malignancy of the uterine cervix in women. The HPV types can be separated into low (6, 11), intermediate (31, 33, 35), and high risk (16, 18). The term bowenoid papulosis is used when the histologic picture of a lesion resembles Bowen's diseases. Clinically, one sees smooth or papillomatous papules or nodules on the penis, scrotum, perianally, and on the skin of the groin in men. In women, lesions may occur on the vulva, labia, intravaginally, or on the cervix. Lesions may be flesh-colored, tan, or brown. All patients with genital lesions should have a perianal exam to exclude perianal involvement.



**Figure 354. Condyloma acuminata, perianal.** The viral particles causing perianal condyloma may have originated from warts elsewhere on the body and been transmitted via the patient's own hands, or they may have been contracted during anal sex. (See also **Figure 93**.)



**Figure 355. Vulvar intraepithelial neoplasia III.** In the female genitalia, condyloma acuminata and bowenoid papulosis are sometimes grouped under the term vulvar intraepithelial neoplasia, and the atypia graded from I to III. Erythematous or pigmented, smooth or papillomatous papules, sometimes coalescent into nodules, are characteristic. Human papilloma virus, especially type 16, has been found in a significant percentage of lesions, and thus the patient should be monitored for atypia of the uterine cervix. (Courtesy of Paul Koonings, MD.)



**Figure 356. Primary syphilis, chancre.** Syphilis is caused by *Treponema pallidum*. In primary syphilis, solitary or multiple, painless ulcers or erosions called chancres occur. They tend to remain superficial but may become indurated. In women, the chancres may occur in the vagina or on the cervix and go unnoticed. Chancres may occur at other sites of inoculation (e.g. the anus in a homosexual man, the mouth after oral sex). (Courtesy of Department of Dermatology, University of California San Diego.)



**Figure 357. Secondary syphilis, papulosquamous lesions, soles.**

Approximately 6 weeks after the chancre, malaise, headache, fever, lymphadenopathy, and a mucocutaneous eruption develop. A widespread papulosquamous eruption of ham-to-copper-hued lesions with a predilection for the palms and soles is characteristic. Scale, when present, tends to be located at the periphery. Necrotic or nodular forms occur. (Courtesy of Theodore Sebastien, MD.)



**Figure 358. Secondary syphilis, moth-eaten alopecia.** Patchy, 'moth-eaten' alopecia affects the scalp, eyebrows, eyelashes, and beard. (Courtesy of Stacy Smith, MD.)



**Figure 359. Secondary syphilis, mucous patch.** Whitish-gray papules and plaques may occur on the tongue, or other mucous membrane surfaces.



**Figure 360. Secondary syphilis, condyloma lata, perianal.** These lesions are teeming with *Treponema pallidum*.





**Figure 361. Tertiary syphilis.** The cutaneous lesions of tertiary syphilis (gummas) are often polycyclic or serpiginous with central ulceration or clearing. These granulomatous lesions are usually painless but may be locally destructive. Gummatous lesions may develop internally as well. (Courtesy of Department of Dermatology, University of California San Diego.)



**Figure 362. Chancroid** is a common cause of genital ulcers worldwide. The Gram-negative bacillus *Haemophilus ducreyi* has a 'school of fish' appearance on smear. Clinically, the lesions tend to be painful and foul smelling. (Courtesy of Michael O Murphy, MD.)



**Figure 363. Granuloma inguinale** is an indolent, progressive, ulcerative, and granulomatous disease of the genitalia caused by the Gram-negative bacterium *Calymmatobacterium granulomatis*. Giemsa or Wright's stain of a tissue smear or skin biopsy specimen shows intracytoplasmic inclusion bodies (Donovan bodies) within histiocytes. The ulcer tends to be beefy yet asymptomatic with exuberant granulation tissue.

One other infectious agent classically causes a genital erosion: *Chlamydia trachomatis* causes lymphogranuloma venereum. The genital lesion typically is a small erosion that goes unnoticed. One to two weeks later, firm lymphadenopathy develops. The classic 'groove' sign is created by enlarged inguinal and femoral nodes separated by Poupart's ligament.



**Figure 364. Pearly penile papules.** Two or three rows of uniform, flesh-colored papules running circumferentially about the corona are characteristic. Onset is typically noted in the 20s and 30s. These papules may be mistaken for warts but are not infectious.



**Figure 365. Tyson's glands**, or prominent sebaceous glands, are commonly seen along the shaft of the penis. They are ectopic sebaceous glands and appear unassociated with the hair follicle. Knowledge of their existence helps prevent confusion with condyloma. They appear as 1–2 mm uniform papules at the base of hairs and are seen in about one third of men. They may number more than 100 and are more common on the ventral surface.



**Figure 366. Zoon's balanitis**, also known as balanitis plasmocellularis, is an uncommon, benign, idiopathic inflammatory condition of older, uncircumcised men. A moist, shiny, erythematous, well-demarcated plaque on the glans penis in an older uncircumcised male is characteristic.



**Figure 367. Behçet's disease, vulva.**

Behçet's syndrome is an inflammatory condition whose most characteristic features are recurrent oral and genital ulcerations. Ocular, arthritic, neurological, vascular, GI, and pulmonary lesions may occur as well. The oral ulcerations resemble aphthosis. The genital ulcerations may affect the labia, vaginal introitus, or scrotum. Deep, tender nodules of the shins resembling erythema nodosum are not uncommon. Scattered inflammatory, acneiform papules and pustules may be seen. Uncommon cutaneous manifestations include polyarteritis nodosa, Sweet's syndrome-like lesions, pyoderma gangrenosum-like lesions, erythema multiforme-like lesions, infiltrated erythema, palpable purpura, hemorrhagic bulla, superficial migratory thrombophlebitis, extragenital ulcerations, thrombophlebitis, and pathergy. Nail fold capillary abnormalities are present in most patients with Behçet's disease.



**Figure 368. Behçet's disease, scrotum.** (Courtesy of Erkan Alpsoy, MD.)

# VIRAL INFECTIONS



**Figure 369. Herpes labialis, primary.** This crusting, vesicular, primary herpes simplex virus (HSV) infection of the lips and/or the oropharynx is most common in children. Fever and lymphadenopathy may occur. HSV-1 is the predominant pathogen.



**Figure 370. Herpes labialis, recurrent.** Pain or tingling followed by grouped vesicles on an erythematous base on the lip, typically centered on the vermilion border but also on nearby sites, is characteristic of this recurrent infection by HSV. Triggering factors for herpes labialis include dental work, fever, UV radiation, local trauma, mental stress, or menstruation.