Differentiating Dermatological Diagnosis and Treatment

The authors present a systematic approach to examining and treating inflammatory skin conditions.

Objectives

1) To provide a systematic approach to examining and treating inflammatory skin conditions

2) To discuss the most common skin conditions seen in the podiatric practitioner's office

3) To discuss the first line treatment for inflammatory skin disorders

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*Following this article, an answer sheet and full set of instructions are provided (p. 182).—**Editor***

By Tracey C. Vlahovic, DPM, FAPWCA and Michelle Oliver, BA

A patient first presenting with a red, scaly, itchy foot or leg can prove to be a challenge to diagnose and manage. When faced with a patient with an inflammatory skin condition in the office, the podiatric physician should have a systematic approach to arrive at a baseline differential diagnosis: observe, ask, and apply an algorithm.

Observe

Upon entering the treatment room, the practitioner should notice the color, shape, and size in addition to laterality of the lesions on the lower extremity. Primary and secondary lesions (Table 1) should be used to describe the rash appropriately, both in the chart and in correspondence to other physicians. When looking at the shape of the lesions, it is helpful to determine if they were self-induced by the patient (excoriation by a fingernail) or naturally caused (a plantar heel fissure). One should document if the lesions are plantar foot, dorsal foot, or proximal on the lower leg. Nail involvement should be noted. Finally, the fingernails and dorsum and palmar aspects of the hands should be examined as many skin dermatoses mirror the pedal involvement there.

Plaque psoriasis presents as an erythematous plaque with a silvery scale.

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Ask

Questions that will help form differential diagnoses should be asked while completing the physical exam of the skin. Often, the patient will answer a question that will help direct the diagnosis. Beyond asking the history of present illness, past medical history and family history, the podiatric physician should consider asking if there is a personal or family history of allergic rhinitis, sensitive skin, asthma or skin cancer. The patient should be asked if he has ever seen a dermatologist before and if he has any skin lesions or "rashes" anywhere else on the body that may or may not be similar to what is seen on the feet.

TABLE 1

Primary Skin Lesions:
- Macule
- Patch
- Plaque
- Nodule
- Vesicle
- Bullae
- Wheal
- Telangiectasia

Secondary Skin Lesions:
- Ulcer
- Atrophy
- Scale
- Crust
- Erosion
- Excoriation
- Scar
- Lichenification

Unfortunately, most patients do not correlate what is happening on the rest of the body to what is manifesting on the plantar aspect of the feet. It is the physician's responsibility to ask the questions in order to make that connection. It is helpful to ask if the skin has ever been biopsied (for example, "did you have a piece of skin removed and then have stitches?"). A skin scraping for KOH that was completed by another physician does not count as a proper biopsy to base the diagnosis on, as a biopsy of inflammatory skin disorders should include the dermis from a pathology perspective.

Other questions to consider asking patients are the color of socks they wear (azo dyes in blue socks can be a potential allergen), occupation, and any associated daily hazards. Also, one should ask about both over-the-counter and homeopathic or natural treatment options they have tried. In order to plan for a possible in-office biopsy during that visit, it is important to ask what the natural progression of the lesions has been and where the newest crops of lesions are.

Trans-epidermal water loss is the newest target in the dermatological pharmaceutical armamentarium in order to reduce skin flares and comfort the patient with an inflammatory skin dermatosis.

Now that basic observation and questioning have occurred, it's important to delve more deeply into the chief complaint and examine the skin fully. Common skin signs of inflammation are calor (heat), rubor (redness), tumor (swelling) and pruritis (itching), which ultimately point to skin barrier dysfunction. The skin barrier, which is stratum corneum with the lipid-enriched extracellular matrix surrounding the corneocytes, is the body's protective wall and regulates homeostasis, trans-epidermal water loss, and prevents entry of foreign particles and pathogens into the body. Trans-epidermal water loss is the newest target in the dermatological pharmaceutical armamentarium in order to reduce skin flares and comfort the patient with an inflammatory skin dermatosis.

Apply an Algorithm

To begin formulating a differential diagnosis, there is a basic algorithm to follow for treating the most common skin disorders encountered in the office: is it a plaque, scale, or zebra? (Table 2) A well-defined and geometric shaped plaque is often psoriasis, but eczema and lichen planus also must be considered. Circular, serpiginous scales are most often tinea but xerosis should be ruled out. Remember that tinea pedis is KOH positive and may involve both the interspaces and the plantar foot. Any papules, vesicles or other skin markings are considered "zebras" for this algorithm's purpose.

Following the above algorithm, the most common inflammatory skin conditions the podiatric practitioner will encounter are as follows:

TABLE 2
Algorithm

Plaque→ Consider psoriasis, lichen planus, eczema

Scale→ Consider xerosis, tinea pedis, ichythosis, non-inflamed to mildly inflamed psoriasis and eczema

Zebra→ Blisters? Bullous diabeticorum, pemphigus, drug reaction
Target lesions? Erythema multiforme minor, drug reaction

Plaque

Plaque psoriasis presents as an erythematous plaque with a silvery scale. These lesions are geographic, bilateral, and symmetrical, and typically occur on the extensor surfaces. The plaques can also be pruritic and affect joints as well as the nails dur-

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ing the progression of the disease. Psoriasis can develop either in childhood or as an adult. Besides plaque psoriasis, pustular psoriasis appears as sterile pustules on the plantar foot.

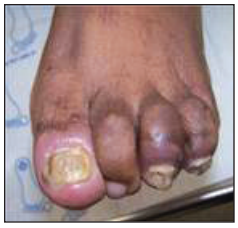

Figure 1: Nail disease in psoriasis

Plantar plaque and pustular psoriasis are frequently misdiagnosed as either vesicular or moccasin tinea pedis. Due to the fissuring that often accompanies psoriatic plaques, it has also been misdiagnosed as xerosis. If the patient's current treatment consists of either an oral or topical antifungal, and isn't improving the skin condition within the appropriate time frame, a biopsy of the skin, in order to determine if a topical steroid should be used, is warranted. Upon examination of one patient, the hands were also involved. A skin biopsy of the plantar foot lesion revealed psoriasis, and the patient was started

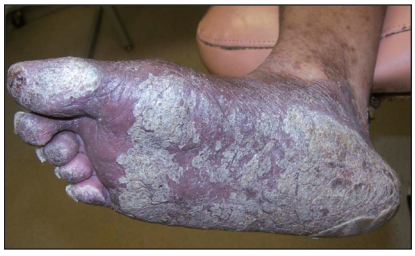

Figure 2: Psoriasis upon first presentation

on first-line therapy: topical corticosteroids.

Also, if the patient only presents with onychomycosis-like nail involvement and has not responded to oral antifungals, a diagnosis of psoriatic nail disease should be considered. Another clue to aid in the diagnosis of psoriatic nails includes examining for the presence of erythema peri-ungually, onycholysis, and pitting (Figure 1).[1] Patients may also present with the

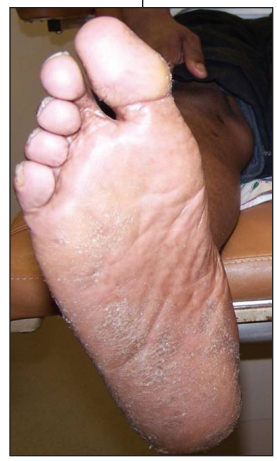

Figure 3: Psoriasis upon one month of using topical steroid therapy

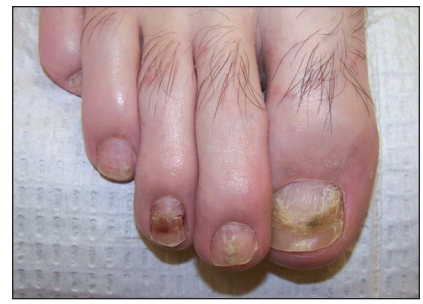

Figure 4: Nail involvement in lichen planus

arthritic component of psoriasis which may manifest in dactylitis of the digits (sausage toes), enthesitis of the Achilles tendon, and distal interphalangeal joint involvement.

Case Example #1

A young male patient presented to the clinic with a pruritic and scaly plantar rash (Figures 2-3) that was mis-diagnosed as tinea pedis at the emergency department. He had presented there for painful fissures on his feet that prevented him from walking properly. He was given oral ketoconazole at the ED and then presented to the office. A punch biopsy was taken confirming the clinical suspicion of psoriasis, and topical corticosteroid therapy was implemented. The patient healed uneventfully from the acute flare and presents periodically for maintenance treatment.

If the patient presents with circular papules or plaques with little or no scale that extend proximally from the foot, the differential diagnosis of psoriasis that should be considered is lichen planus. Lichen planus is characteristic of the "P's": plentiful, pruritic, purple, polished, popular and planar lesions that are bilateral and symmetrical.

> ***Lichen planus is characteristic of the "P's": plentiful, pruritic, purple, polished, popular and planar lesions that are bilateral and symmetrical.***

Wickham's striae, which is the fine white lacy overlay on the plaques, may also be seen. This skin condition can be so pruritic that activities of daily living may be compromised. It may also affect the toenails, appearing anywhere from a proximal subungual onychomycosis-like presentation to a thinning of the nail with a 'wing' of skin or pteryigium pointing distally (Figure 4).[1] Nail involvement should be treated im-

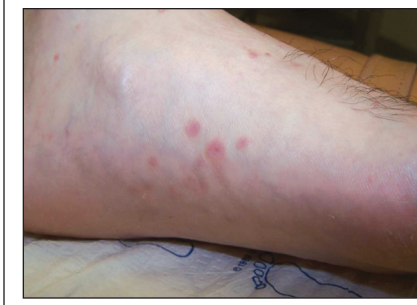

Figure 5: Pedal lichen planus

mediately as it can irreversibly scar the nail unit. Lichen planus can also form lesions in the mouth.[2]

Case Example #2

A young male presented with numerous small plaques and papules that were extremely pruritic (Figure 5). He had been diagnosed with tinea pedis, and had tried over-the-counter antifungals with no improvement. During his office visit, the extent of involvement of the nails and oral cavity were noted and a diagnosis of lichen planus was made.

In addition to psoriasis and lichen planus, a scaly erythematous rash with fissures could also be an eczematous reaction pattern. Defined plaques may or may not be present, but eczema should be a differential diagnosis when considering psoriasis. An eczematous reaction that is often seen is atopic dermatitis. This is usually inherited, as

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patients will present with a personal or family history of asthma, hay fever, and skin rash appropriate for their age. It is often described as an "itch that gets a rash" and can't be described as having a primary lesion as is the case with psoriasis and lichen planus.[3]

Atopic dermatitis, like the other forms of eczema, can be described as having an acute, sub-acute, and chronic stage of the disease. During the acute phase, patients experience intense pruritus with an erythematous scaling and oozing skin rash. Clinically, this can also appear as dry skin eczema, contact dermatitis, stasis dermatitis or even a dermatophyte infection. Subacute forms of atopic dermatitis present with less pruritus, erythema, scaling, and fissured skin rash.

Chronic eczema presents with pruritus, hyper- and hypopigmented plaques of previous inflamed skin, scaly and lichenified skin. Due to the severe skin barrier disruption in all forms of atopic dermatitis, these patients are susceptible to secondary bacterial infections and this should be considered in the treatment plan. Overall, differential diagnosis for atopic dermatitis include: tinea pedis, contact dermatitis, lichen simplex chronicus (chronic form of atopic) and dyshidrosiform eczema.

Since stasis dermatitis is the most common cause of an id reaction on the palmar aspect of the hand, it is important for the physician to examine the hands to aid in the diagnosis.

If the patient doesn't fit into having the "triad" of atopic dermatitis, other types of eczema should be considered. Allergic contact dermatitis can occur when a patient has developed sensitivity to a product (detergent, soap, glue, dye) after using it for a length of time. Allergic contact dermatitis is a result of an antigen-antibody reaction that presents eight to twenty-eight days after initial introduction to the allergen. Contrary to belief, a contact dermatitis can occur on the plantar feet and doesn't have to be bilateral and symmetrical.

Patch Test

The patch test done in an allergist's or dermatologist's office will assist in pin-pointing the allergen causing the reaction. When patients have a history of chronic venous insufficiency with skin that becomes indurated, inflamed, and pruritic, venous stasis dermatitis is the standard diagnosis. Since stasis dermatitis is the most common cause of an id reaction on the palmar aspect of the hand, it is important for the physician to examine the hands to aid in the diagnosis. Lastly, dyshidrotic eczema is a specific condition that should not be an overall term applied to any inflamed skin condition. Contrary to its name, it is not linked to sweat gland dysfunction. Dyshidrotic eczema (pompholyx) characteristically has pruritic tapioca pudding-like blisters on the palmar aspect of the hands with minimal foot involvement.[4] This can be a self-limiting condition; however, most patients have debilitating pain and fissuring that can be difficult to treat.

Asteatotic eczema is also seen in patients with dementia who bathe frequently.

Case Example #3

A female patient presented with denuded and inflamed skin on the anterior tibia (Figure 6). She reported that this began after the use of triple antibiotic ointment. Upon further history and examination of the patient, a working diagnosis of allergic contact dermatitis to the preservatives in triple antibiotic ointment was made. The drug was removed from the patient's regimen, and topical steroids were given. The patient's inflamed skin resolved in four weeks.

Scale

Xerotic, or dry skin, should have scales present within the skin lines on the plantar foot. Moccasin tinea pedis, on the other hand, usually presents with small serpiginous scales plantarly. The most common form of dry skin that is KOH negative encountered on the lower extremity is termed asteatotic or xerotic eczema. It can also be termed erythema craquele. This is commonly known as "winter itch" due to its increased severity especially during the winter months in the northern part of the United States.

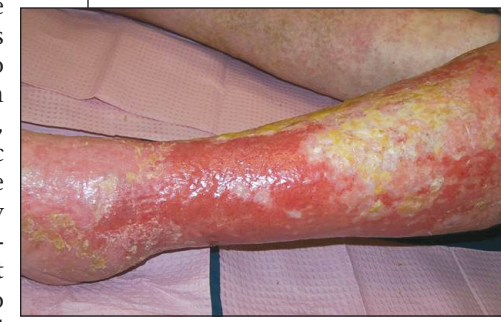

Figure 6: Allergic contact dermatitis

Asteatotic eczema commonly presents on the anterior aspect of the leg as pruritic, annular, scaling patches. This condition is frequently misdiagnosed as tinea corporis, but is

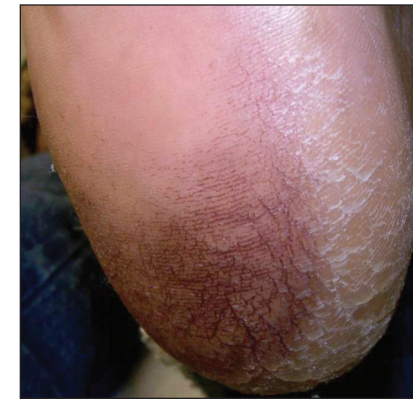

Figure 7: keratoderma climacterum

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KOH negative. Asteatotic eczema is also seen in patients with dementia who bathe frequently. Patients can also develop dry, cracked heels plantarly which is known as keratoderma climacterum (Figure 7).

In addition to these environmental causes of dry skin, the most common inherited form is ichthyosis vulgaris. These patients present with fish scale-like dryness that may improve with age. Ichthyosis vulgaris can also be acquired and may be associated with diabetes, renal disease, and various types of cancer.

Dyshidrotic eczema (pompholyx) characteristically has pruritic tapioca pudding-like blisters on the palmar aspect of the hands with minimal foot involvement.

Circular scales with serpiginous borders are often diagnosed as tinea pedis, but other skin conditions that present as small circular, scaly rimmed lesions are pityriasis rosea and secondary syphilis. There have also been instances of plantar psoriasis presenting as scaly skin with no erythema.

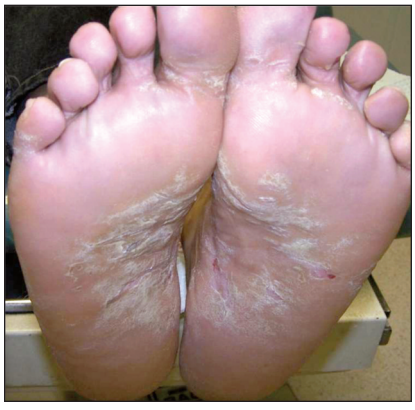

Figure 8: Psoriatic Scale plantarly

Case Example #4

A female patient presented to the clinic for a second opinion. She had been previously diagnosed as having xerosis, but continued to have extreme pruritus that was not controlled by any topical medication. Her plantar feet had a localized plaque with scale in the medial arch with no underlying erythema (Figure 8). A biopsy helped to diagnose her with psoriasis and the appropriate therapy commenced.

Zebra

If vesicles, bulla, or other skin lesions are present, the podiatric physician should consider several other diagnoses. A diabetic patient who presents with tense blisters that seem to appear overnight, most likely has bullosis diabeticorum.[5] Bullosis diabeticorum may have little inflammation present and may heal uneventfully if the patient doesn't pop or scratch them. Bullous pemphigoid, commonly seen in older adults in nursing homes, will present with subepidermal blisters that originally were urticarial plaques that turned into tense bullae. These lesions are located widespread throughout the body on flexural surfaces.

A diabetic patient who presents with tense blisters that seem to appear overnight, most likely has bullosis diabeticorum. Pemphigus vulgaris is a chronic disease affecting adults which can be life-threatening due to its lesions beginning in the mouth and affecting the oro-pharyngeal area.

Nikolsky's sign, or exfoliation of the upper layers of epidermis upon rubbing of the skin, is negative and these lesions can crust, pigment, but not scar unless excoriated into an ulcer. Pemphigus vulgaris is a chronic disease affecting adults which can be life-threatening due to its lesions beginning in the mouth and affecting the oropharyngeal area. Flacid bullae then progress to the face, neck, chest, groin and intertriginous areas. These are tender lesions and are usually Nikolsky's sign positive.

If patients have target lesions with three zones of color (center lesion surrounded by a clear zone, and followed by a red border) associated with circular papules and/or plaques with mild scaling; one must consider erythema multiforme minor. This is associated after a manifestation of herpes simplex (recent cold sore or genital lesion) and the target lesions may present on the feet.[6] Drug reactions may also present as target-like lesions with less defined target zones of color on the lower extremity.

First-Line Treatment Options

When treating a condition that is fungal, bacterial, or inflammatory in nature, the podiatric practitioner should use the appropriate drug, but if one is unsure of the cause, a biopsy of the skin lesion should be completed. Inflammatory skin conditions often warrant topical corticosteroid therapy as a first line method in treatment.

It is useful to avoid combination steroid-antifungal drugs or methylprednisolone dose packs as these may create a quick fix, but ultimately can cause frustration for the dermatological patient. The rebound effect from the dose pack can be potentially debilitating by causing a dermatitis that is worse than the original reaction, and the dose pack itself isn't the same as prescribing a true prednisone taper.

When in doubt, the first line therapy for an inflammatory skin dermatosis should be a topical steroid and a skin moisturizer or keratolytic (such as urea or lactic acid).

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The stage (acute, sub-acute, and chronic) of the skin disorder and the length of time the condition presents will aid in the level of topical steroid which should be used.

For the severe, acute inflammatory skin concerns, Class 1 drugs should be used for two weeks consecutively. Some examples of Class 1 steroids include: clobetasol (Clobex, Olux, Temovate), betamethasone (Diprolene), diflorasone (Psorcon), halobetasol (Ultravate), fluocinonide (Vanos).

In the author's experience, no refills are given due to the side-effects of using a Class I steroid for longer than fourteen days. Side-effects include skin thinning or atrophy which can lead to stretch marks, telangiectasias, and hypopigmentation, to name a few. It is helpful to titrate down from a Class 1 steroid to a mid-potency preparation after that initial two week period.

For example, one could have the patient use a Class 1 steroid on Monday, Wednesday, and Friday with the mid-potency topical steroid for the days in between.

The fairly new skin barrier protection emollient moisturizers (Impruv lotion, Mimyx, Atopiclair) should be added to decrease transepidermal water loss and decrease flares.[7] If the patient is in the sub-acute or chronic stage and a topical steroid is warranted for the level of irritation and pruritus present, the practitioner should prescribe the appropriate steroid class (Table 3).

TABLE 3
Topical Steroid Classes

Class I: Ultra potent
Class II: Potent
Class III: Upper mid-strength
Class IV: Mid-strength
Class V: Lower-mid strength
Class VI: Mild
Class VII: Least potent (hydrocortisone)

Adapted from the National Psoriasis Foundation Topical Steroids Potency Chart

Side-effects of using a Class I steroid for longer than fourteen days include skin thinning or atrophy which can lead to stretch marks, telangiectasias, and hypopigmentation.

The goal in treating inflammatory conditions is to ultimately have the patient use little to no topical steroid, and use the previously mentioned skin moisturizers as maintenance, if possible. If the patient does not respond to the topical steroid as predicted, further consideration of other diagnoses should be given and a biopsy should be planned. If this is not within the comfort zone of the practitioner, he should then refer the patient for a dermatology consult.

Overall, inflammatory skin dermatoses can be challenging and frustrating for both the practitioner and patient. By doing a thorough history and skin exam, the astute practitioner can create a working list of differential diagnoses that can be further changed by both reaction to treatment and, of course, a biopsy result. ■

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When in doubt, the first line therapy for an inflammatory skin dermatosis should be a topical steroid and a skin moisturizer or keratolytic (such as urea or lactic acid).

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EXAMINATION

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See answer sheet on page 183.

1) All of the following are primary lesions EXCEPT:
- A) macule
- B) bulla
- C) tumor
- D) scale

2) In plaque psoriasis, which of the following best describes the lesion?:
- A) plaque with silver scale
- B) plaque with yellow scale
- C) plaque with pustules
- D) plaque with peeling inside edge

3) The pustules in palmar/plantar psoriasis are filled with:
- A) sterile fluid
- B) staph aureus
- C) pseudomonas
- D) strep

4) Lichen planus can be described by all of the following EXCEPT:
- A) Peachy
- B) Pruritic
- C) Purple
- D) Papular

5) The best differential diagnosis for plantar psoriasis is:
- A) atopic dermatitis
- B) herpes simplex
- C) erythema multiforme
- D) neurotic excoriations

6) The most common cause of an ID reaction is:
- A) Atopic dermatitis (eczema)
- B) Irritant contact dermatitis
- C) Stasis dermatitis
- D) Lichen simplex chronicus

7) Which of the following doesn't the patient need to have to diagnose of atopic dermatitis (eczema)?
- A) paronychia of great toe
- B) personal history of asthma, runny nose, skin rash
- C) pruritis
- D) chronic relapsing course

8) Asteatotic Eczema (Eczema craquele) is associated with:
- A) children
- B) high humidity
- C) frequent bathing
- D) hyperhidrosis

9) Bullosa diabeticorum (diabetic bullae) usually appear as ____ blisters on the lower extremity.
- A) tense
- B) flaccid
- C) pus-filled
- D) hemorrhagic

10) Pemphigus vulgaris lesions most commonly begin in this location:
- A) Pretibial
- B) Soles
- C) Thighs
- D) Mouth

11) Which of the following is a Class 1 steroid?:
- A) Psorcon (diflorasone)
- B) Cortaid (hydrocortisone)
- C) Aclovate (aclometasone)
- D) Kenalog (triamcinolone)

12) Contact dermatitis:
- A) is bilateral and symmetrical
- B) intensity varies on each limb
- C) only involves vesicles
- D) never itches

13) Dyshidrosic eczema (pompholyx):
- A) is linked to sweat glands
- B) occurs mostly on the hands
- C) first appears as pustules
- D) is a drug reaction

14) One of the side-effects of using a Class 1 topical steroid consecutively over the initial two-week period is:
- A) lichenification
- B) scar formation
- C) atrophy
- D) hyperkeratosis

15) Which of the following is a secondary skin lesion?
- A) telangiectasia
- B) scale
- C) papule
- D) patch

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EXAMINATION

(cont'd)

16) The new skin barrier moisturizers help to reduce flare by:

A) decreasing trans-epidermal water loss
B) increasing trans-epidermal water loss
C) decreasing T-cell lymphocyte involvement
D) increasing T-cell lymphocyte involvement

17) The target lesion in erythema multiforme minor has __ zone(s) of color:

A) 1
B) 2
C) 3
D) 4

18) A differential diagnosis for tinea pedis would be:

A) pityriasis rosea
B) erythema multiforme minor
C) nevi
D) stretch mark

19) Dyshidrotic eczema has vesicles that can be described as:

A) grapefruit-like
B) tapioca-like
C) peau d'orange-like
D) raspberry-like

20) The latest treatment for inflammatory skin dermatoses involves prescribing:

A) a topical steroid and a moisturizer
B) a topical steroid and an NSAID
C) a topical steroid and sunscreen
D) a topical steroid and diphenhydramine

See answer sheet on page 183.

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Enrollment/Testing Information and Answer Sheet

Continuing Medical Education

Note: If you are mailing your answer sheet, you must complete all info. on the front and back of this page and mail with your credit card information to: ***Podiatry Management*, P.O. Box 490, East Islip, NY 11730.**

TESTING, GRADING AND PAYMENT INSTRUCTIONS

(1) Each participant achieving a passing grade of 70% or higher on any examination will receive an official computer form stating the number of CE credits earned. This form should be safeguarded and may be used as documentation of credits earned.

(2) Participants receiving a failing grade on any exam will be notified and permitted to take one re-examination at no extra cost.

(3) All answers should be recorded on the answer form below. For each question, decide which choice is the best answer, and circle the letter representing your choice.

(4) Complete all other information on the front and back of this page.

(5) Choose one out of the 3 options for testgrading: mail-in, fax, or phone. To select the type of service that best suits your needs, please read the following section, "Test Grading Options".

TEST GRADING OPTIONS

Mail-In Grading

To receive your CME certificate, complete all information and mail with your credit card information to:

Podiatry Management
P.O. Box 490, East Islip, NY 11730

There is **no charge** for the mail-in service if you have already enrolled in the annual exam CPME program, and we receive this exam during your current enrollment period. If you are not enrolled, please send $20.00 per exam, or $139 to cover all 10 exams (thus saving $61* over the cost of 10 individual exam fees).

Facsimile Grading

To receive your CPME certificate, complete all information and fax 24 hours a day to 1-631-563-1907. Your CPME certificate will be dated and mailed within 48 hours. This service is available for $2.50 per exam if you are currently enrolled in the annual 10-exam CPME program (and this exam falls within your enrollment period), and can be charged to your Visa, MasterCard, or American Express.

If you are *not* enrolled in the annual 10-exam CPME program, the fee is $20 per exam.

Phone-In Grading

You may also complete your exam by using the toll-free service. Call 1-800-232-4422 from 10 a.m. to 5 p.m. EST, Monday through Friday. Your CPME certificate will be dated the same day you call and mailed within 48 hours. There is a $2.50 charge for this service if you are currently enrolled in the annual 10-exam CPME program (and this exam falls within your enrollment period), and this fee can be charged to your Visa, Mastercard, American Express, or Discover. If you are not currently enrolled, the fee is $20 per exam. When you call, please have ready:

1. Program number (Month and Year)
2. The answers to the test
3. Your social security number
4. Credit card information

In the event you require additional CPME information, please contact PMS, Inc., at **1-631-563-1604**.

ENROLLMENT FORM & ANSWER SHEET

Please print clearly...Certificate will be issued from information below.

Name _____ Soc. Sec. #_____
Please Print: FIRST MI LAST

Address_____

City_____State_____Zip_____

Charge to: _____Visa _____ MasterCard _____ American Express

Card #_____Exp. Date_____

Note: Credit card is the only method of payment. Checks are no longer accepted.

Signature_____Soc. Sec.#_____Daytime Phone_____

State License(s)_____Is this a new address? Yes_____ No_____

Check one: _____ I am currently enrolled. (If faxing or phoning in your answer form please note that $2.50 will be charged to your credit card.)

_____ I am not enrolled. Enclosed is my credit card information. Please charge my credit card $20.00 for each exam submitted. (plus $2.50 for each exam if submitting by fax or phone).

_____ I am not enrolled and I wish to enroll for 10 courses at $139.00 (thus saving me $61 over the cost of 10 individual exam fees). I understand there will be an additional fee of $2.50 for any exam I wish to submit via fax or phone.

Over, please

ENROLLMENT FORM & ANSWER SHEET (cont'd)

EXAM #4/10
Differentiating Dermatological Diagnosis and Treatment
(Vlahovic and Oliver)

Circle:

1.	A	B	C	D	11.	A	B	C	D
2.	A	B	C	D	12.	A	B	C	D
3.	A	B	C	D	13.	A	B	C	D
4.	A	B	C	D	14.	A	B	C	D
5.	A	B	C	D	15.	A	B	C	D
6.	A	B	C	D	16.	A	B	C	D
7.	A	B	C	D	17.	A	B	C	D
8.	A	B	C	D	18.	A	B	C	D
9.	A	B	C	D	19.	A	B	C	D
10.	A	B	C	D	20.	A	B	C	D

LESSON EVALUATION

Please indicate the date you completed this exam

_____

How much time did it take you to complete the lesson?

_____ hours _____minutes

How well did this lesson achieve its educational objectives?

_____Very well _____Well

_____Somewhat _____Not at all

What overall grade would you assign this lesson?

A B C D

Degree_____

Additional comments and suggestions for future exams:

_____

_____

_____

_____

_____

_____