Head, Shoulders, Knees, and Toes!

From Head to Toe:
Hair Loss to Nail Changes
Interesting Findings In Between

Laura Bush DMSc. PA-C

Head, Shoulders, Knees, and Toes

We'll go from head to toe, exploring skin disorders everywhere in between.

We will examine common issues you may encounter from the scalp to the feet with tips and tricks for easy recognition to evaluate, treat, or refer.

We will look at hair loss, seborrheic dermatitis, inverse psoriasis, erythrasma, warts, molluscum, nail disorders, and more.

This lecture will move quickly through the largest organ, the skin, and keep you on your toes!

Head, Shoulders, Knees and Toes

- Hair loss
- Seborrheic dermatitis- Is it dandruff?
- Or is it psoriasis?
- Axillary conditions
- Knees warts, molluscum, psoriasis
- Toes and nail

Head

- Hair loss
- Seborrheic dermatitis- Is it dandruff?
- Scalp psoriasis?
- Tinea Capitis

"Please Stop All Hair Issues Immediately."

- Physical Hair care practices
- Stress
- Hormones
- Autoimmune
- Inflammatory conditions
- Infections



"Please Stop All Hair Issues Immediately."

- **P**hysical Hair care practices- Traction Alopecia
- **S**tress- Telogen Effluvium
- **H**ormones- Androgenetic
- **A**utoimmune- Alopecia Areata
- **I**nflammatory conditions- Frontal Fibrosing alopecia and CCCA
- **I**nfections- Syphilis and Tinea Capitis

PHYSICAL-HAIR CARE PRACTICES TRACTION ALOPECIA



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Evaluation and Treatment

- Risk factors: Hair extensions, styling
- DDX: FFA
- Clue: Fringe sign
- Tx: TAC injections, topical steroid, avoid wearing styles that pull hair, topical/oral minoxidil

Stress-Telogen Effluvium



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https://dermnetnz.org/assets/Uploads/site-age-specific/pregnancy-02.jpg

- Increased shedding/thinning
- Educations, stress, pregnancy
- Usually resolves in several hair cycles

HORMONES- ANDROGENETIC MALE PATTERNED

Male Pattern Baldness (Androgenetic Alopecia)

- Affects ~50% of men by age 50
- Gradual thinning at temples and crown
- Cause: Genetic + androgen-driven (DHT ↠ follicle miniaturization)
- Diagnosis: Clinical; consider dermoscopy if unclear
- Treatment Options:
  - Topical minoxidil (OTC)
  - Oral finasteride (Rx) Oral minoxidil (RX)
- Consider derm referral for laser or transplant
- Counseling: Start early: 3–6 months to see improvement



Photo Courtesy of Laura Bush PA-C

HORMONES- ANDROGENETIC FEMALE PATTERNED

- Most common cause of chronic, non-scarring hair loss in women.
- Progressive thinning over central scalp with preserved frontal hairline.
- Follicular miniaturization driven by genetic and hormonal factors.
- Family history often present.
- No scarring, inflammation, or sudden shedding.
- Ludwig scale helps classify severity (Type I–III).

HORMONES- ANDROGENETIC FEMALE PATTERNED

Labs:

- TSH, ferritin, vitamin D
- Check testosterone/androgens- if signs of hyperandrogenism (acne, hirsutism, irregular periods).

Treatment:

- OTC topical minoxidil 5% foam daily **Counsel on initial shedding (first 2–4 weeks) and delayed response (3–6 months)
- Considering oral antiandrogens (e.g., spironolactone, finasteride).
- Oral minoxidil
- PRP, transplant, refer

Autoimmune- Alopecia Areata

- Non-scarring hair loss targeting hair follicles.
- Sudden, well-defined round patches of hair loss.
- Affects scalp, eyebrows, lashes, beard, or body hair.
- Smooth, normal scalp skin—no scaling or inflammation.

- Nail changes in ~10–20% (pitting, trachyonychia).
- May be associated w/ other autoimmune diseases or family Hx.



Photo Courtesy of Fayette Area Dermatology Laura Bush PA-C

AUTOIMMUNE- ALOPECIA AREATA

Clinical Patterns

- Patch-type AA: Most common; localized round or oval bald spots.
- Alopecia totalis: Complete scalp hair loss.
- Alopecia universalis: Total loss of scalp and body hair.
- Ophiasis pattern: Band-like loss at occipital/temporal scalp—harder to treat.





Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

AUTOIMMUNE- ALOPECIA AREATA

Treatment:

- First-line for patch-type: High-potency topical steroids (e.g., clobetasol)
- Intralesional triamcinolone for small patches (derm referral)
- Facial areas: topical calcineurin inhibitors
- Supportive: Gentle hair care, cosmetic camouflage, mental health support

Refer:

- Extensive scalp involvement, rapid progression or eyebrow/lash loss

Patient Education:

- Unpredictable—spontaneous regrowth possible.
- No scarring = potential for regrowth.

Inflammatory Conditions- Frontal Fibrosing Alopecia and CCCA

- Primary lymphocytic cicatricial alopecia(lichen planopilaris)
- Pathogenesis-autoimmune attack on hair follicles + hormonal influence
- Progressive recession of the frontal and temporal hairline
- Loss of follicular openings with perifollicular erythema and scale
- Often includes eyebrow loss and body hair thinning
- Frequently affects postmenopausal women but can affect younger women/men





Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

INFLAMMATORY CONDITIONS FRONTAL FIBROSING ALOPECIA

Pearls:

- Early diagnosis is essential to prevent permanent scarring
- Lonely hairs, lack of sun damage
- Common triggers/associations: sunscreens, facial products, thyroid disease, autoimmune



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Treatment:

- High-potency topical steroids to active borders
- Topical calcineurin inhibitors for maintenance or steroid-sparing
- Intralesional triamcinolone into inflamed margins
- Oral doxycycline for anti-inflammatory benefit (not for infection)
- Low-dose oral minoxidil

Inflammatory Conditions
Frontal Fibrosing Alopecia

- If you see perifollicular scale that doesn't brush off, think scarring alopecia until proven otherwise
- Eyebrow thinning with frontal hairline recession almost always means FFA
- Pain, tightness, or burning = active disease
- Photograph every visit to track subtle progression
- Start treatment early and aggressively when inflammation is active



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Infections Tinea Capitis



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- Patchy hair loss with short, broken hairs is your first big clue
- Look for black dots—they're fractured hairs at the follicular opening
- Scaling of the scalp often resembles stubborn seborrheic dermatitis
- Occipital or posterior cervical lymphadenopathy
- Kerion = boggy, tender plaque- easy to mistake for an abscess

INFECTIONS?

Seborrheic Dermatitis



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Flaky, white-yellow scale on scalp, brows, nasolabial folds, beard
- Erythematous patches with greasy appearance
- Itching can range from mild to significant
- Worsens with stress, cold weather, illness
- Often seen in Down Syndrome, dementia

Ears

- Look behind the ears for psoriasis or seborrheic dermatitis
- Look in the ears for psoriasis or seborrheic dermatitis
- If you see scarring don't forget lupus
- Lesion? Malignancy
- Tender lesion? CNH

Ears

- Seborrheic Dermatitis
- Psoriasis
- Malignancy
- CNH
- Keloid
- Franks sign

EARS-SEBORRHEIC DERMATITIS

Clinical Diagnosis

- Scale lifts easily; hair remains intact
- Rule out psoriasis if plaques are sharply demarcated or thicker
- Consider HIV testing in severe, sudden, or recalcitrant cases

Treatment

- Antifungal shampoos: ketoconazole, ciclopirox, selenium sulfide
- Topical steroids: short courses for flares
- Topical calcineurin inhibitors for facial involvement
- Roflumilast (new)

EARS-PSORIASIS

- Thick, dry scale inside the conchal bowl, behind the ears, or along the ear canal
- Sharply demarcated erythematous plaques
- Painful fissures behind the ear (retroauricular) are common
- Itching, burning, or a "plugged" sensation in the canal

Diagnosis

- Scale thick, dry, and doesn't lift easily
- Look for scalp plaques, nail pitting, elbow/knee involvement
- Differentiate from seborrheic dermatitis (greasier, thinner scale)
- Consider fungal culture only if appearance is atypical or treatment fails



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EARS-PSORIASIS

Treatment

- Topical steroids: low to mid potency for external ear, avoid deep canal
- Topical vitamin D analogs for maintenance
- Topical calcineurin inhibitors for thin skin or long-term facial
- Topical Roflumilast
- Topical Tapinarof
- Mineral oil - soften heavy scale
- Treat scalp aggressively



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Ears-Malignancy



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Look on helical rim
- Bleeds
- Non-healing



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Ears-Chondrodermatitis Nodularis Helicis



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- Painful, firm 3–8 mm nodule on the helix or antihelix
- Focal tenderness is the classic finding—patients often can't sleep on that side
- Central crust or ulcer with surrounding erythema
- History of chronic pressure (sleeping on one side, headphones, helmets)
- Mostly in men, anyone with pressure on the ear is at risk
- Rule out BCC or SCC if atypical, growing, or fails to improve

EARS-CHONDRODERMATITIS NODULARIS HELICIS



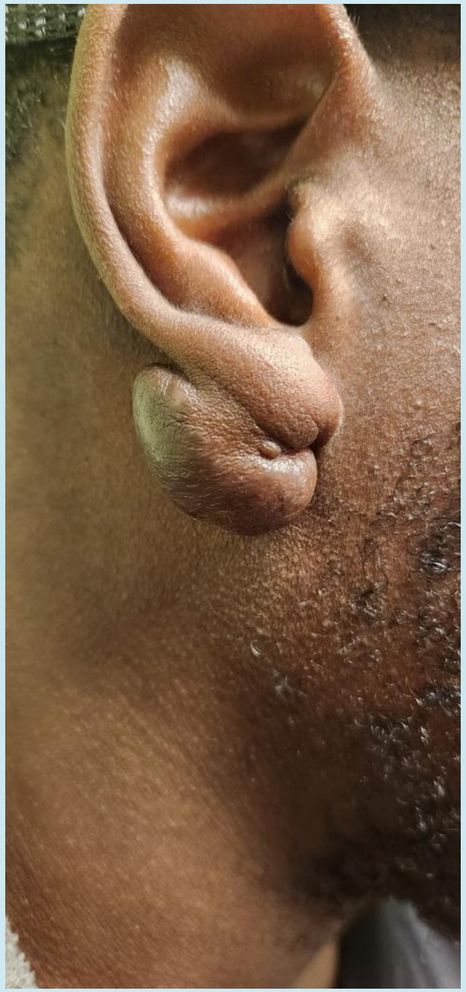
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Treatment:

- Foam donut pad, memory-foam pillow, or cutout pillow
- Counsel patients to offload pressure night
- Topical steroids only if inflammation is present
- Cryotherapy for early lesions
- Steroid tape/Intralesional steroid
- Shave bx if uncertain

Ears- Keloids

- Benign, fibrous overgrowth of scar tissue
- Site of skin injury, most
- Commonly following ear piercing or trauma
- Keloids extend beyond the boundaries of original wound
- Do not regress spontaneously



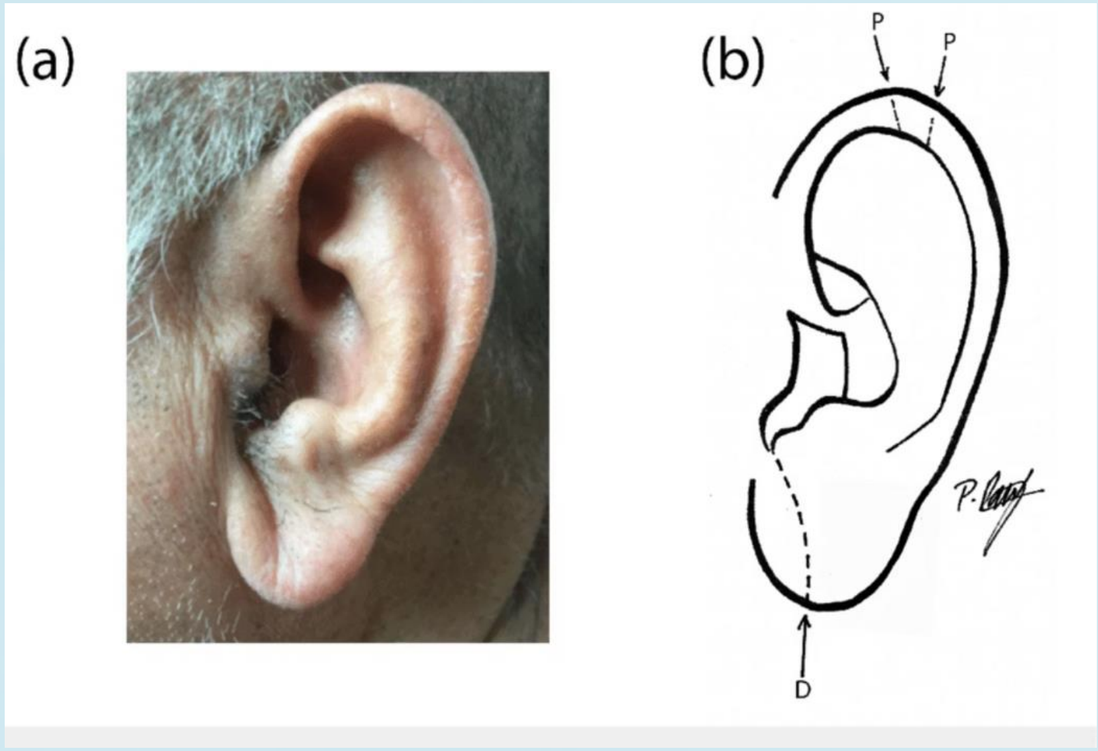
Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Ears-Franks Sign



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Frank's sign, diagonal earlobe crease
- Crease in the earlobe that extends from the tragus to the back edge of the ear
- Higher risk of cardiovascular events
- Unknown cause, theory suggest micro-vascular disease in the middle ear lobe (end-artery)



Pathmarajah P, Rowland Payne C. Paired Ear Creases of the Helix (PECH): A Possible Physical Sign. *Cureus*. 2017;9(11):e1884. doi:10.7759/cureus.1884

Eyelids- Xanthelasma



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https://dermnetnz.org/imagedetail/19250-xanthelasma



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~ half of all cases are linked to high lipid levels (hyperlipidemia) or genetic cholesterol disorders. Can occur w/ normal cholesterol

associated with an increased risk of coronary artery disease, atherosclerosis, and heart attacks.
Dx distinctive yellow plaques.

Will not go away on their own. Removal options include surgical excision, laser, or cryotherapy

Neck: Acanthosis Nigracans

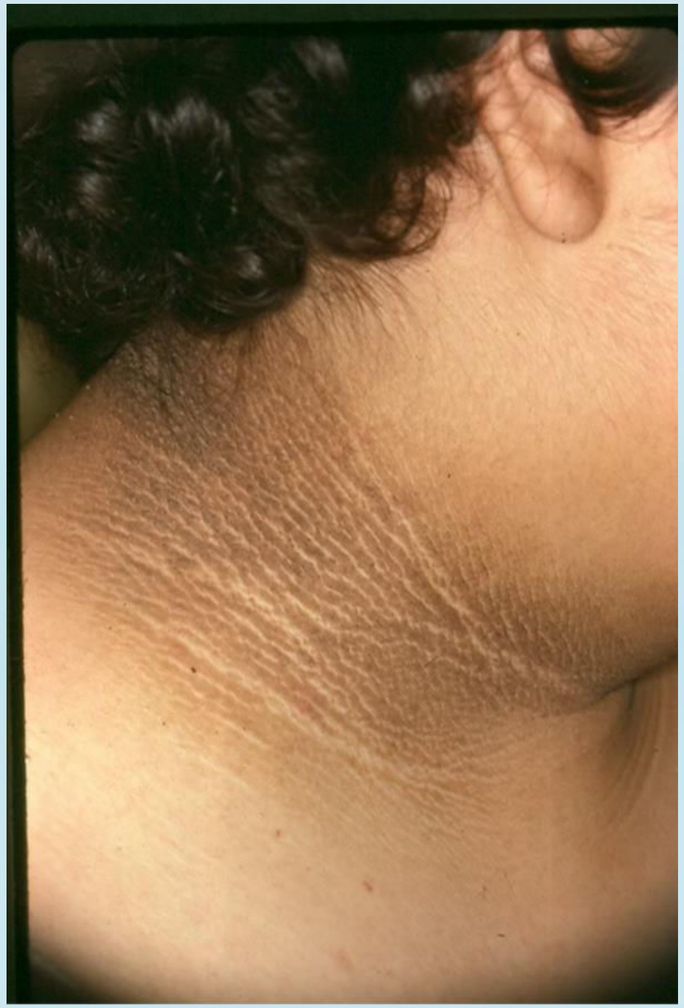


Photo Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Velvety, thickened, hyperpigmented
- Most common at neck, axillae, groin, back, knuckles
- Texture is the giveaway
- Often associated with skin tags and obesity
- Usually asymptomatic, cosmetic
- Tx- improve causal condition, topical retinoids, keratolytic agents (salicylic/glycolic), fish oil

Neck: Acanthosis Nigracans



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Linked to obesity, insulin resistance and PCOS-screen for DM
- Medication causes: high-dose niacin, OCP, prednisone
- Sudden severe extensive: r/o malignancy-rare (GI-related, especially gastric)
- Differentiate postinflammatory hyperpigmentation (normal texture),

  Addison's (diffuse darkening)
- Tx- improve causal condition, topical retinoids, keratolytic agents

  (salicylic/glycolic), fish oil

HEAD....SHOULDERS
LET'S LOOK AT WHAT IS HIDING IN THE FOLD

Axillary conditions:

- Inverse Psoriasis
- Acanthosis nigricans
- Erythrasma
- Hidradenitis Suppurativa
- Skin tags

Let's look at what is hiding in the fold: Axillary Conditions



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Axillary Conditions
Erythrasma

- Well-defined reddish-brown patches in intertriginous areas
- Common sites: groin, inner thighs, axillae, toe webs
- Fine scale with a smooth, slightly shiny surface
- Usually mild or no itch
- Chronic, slowly enlarging patches
- Wood's lamp: coral-red fluorescence (classic clue)



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https://dermnetnz.org/assets/Uploads/bacterial/erythrasma3.jpg

AXILLARY CONDITIONS: ERYTHRASMA

Treatment:

- Topical antibiotics:
  - Clindamycin lotion/Erythromycin gel
  - Benzoyl peroxide wash
- Address underlying factors: weight, heat, sweat
  - Keep folds dry
  - Reduce friction and moisture



https://dermnetnz.org/assets/Uploads/bacterial/erythrasma07.jpg

Axillary Conditions: Hidradenitis Suppurativa

HS is a clinical diagnosis

Three criteria:

- Typical lesions (painful nodules, abscesses, draining sinus tracts, scarring)

- Predilection for intertriginous areas (axillae, groin, inframammary, buttocks)

- Chronicity recurrence (≥ 2 episodes over 6 months)



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https://dermnetnz.org/imagedetail/16951-hidradenitis-suppurativa-of-axilla

Stage I: solitary or multiple nodules without sinus tracts or scarring

Stage ii: recurrent nodules with sinus tract formation and some scarring

Stage iii: diffuse or near-diffuse involvement with interconnected tracts and scarring

Diagnosis is clinical, look for history of boils, double comedones



https://dermnetnz.org/assets/Uploads/hs-axilla-044.jpg



Photos courtesy of

Laura Bush DMSc. PA-C

Fayette Area Dermatology

Fayetteville, Ga.

Diagnosis is clinical, look for nodules, draining abscesses and scarring.







Photos courtesy of Dirk M. Elston, MD

Professor and Chairman

Department of Dermatology and Dermatologic Surgery

Medical University of SC Charleston

Photos courtesy of

Laura Bush DMSc. PA-C

Fayette Area Dermatology

Fayetteville, Ga.

HEAD, SHOULDERS..... ELBOWS

Psoriasis



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LICHEN PLANUS

The P’s of Lichen planus

- Pruritic
- Purple
- Polygonal
- Papules
- Planar (flat topped)
- Papillated (lacy) top - Wickham striae Characteristic Skin Lesions

Location: wrists, ankles forearms, lower legs (Nail, oral and scalp variants)

Treatment targets itching and inflammation- topical corticosteroids, topical calcineurin inhibitors or antihistamines. Oral steroids, hydroxychloroquine



https://dermnetnz.org/imagedetail/1521-papular-lichen-planus

Head, shoulders..... knees!

- Verruca
- Psoriasis
- Molluscum contagiosum
- Eczema

Knees: Psoriasis



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Knees: Molluscum Contagiosum



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https://dermnetnz.org/imagedetail/19122-molluscum-contagiosum

Knees: Verruca



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Knees: Eczema



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Knees to Toes (Lower Leg)

- Stasis dermatitis
- Nummular eczema
- Psoriasis
- Capillaritis
- Idiopathic Hypomelanosis Guttate
- Tinea Pedis

Head, Shoulders, Knees, and..... Toes!

Knees to toes (lower leg)

- Stasis dermatitis
- Nummular eczema
- Necrobiasis Lipodica Diabecorum
- Psoriasis
- Capillaritis
- Idiopathic Hypomelanosis Guttate
- Tinea Pedis

Head, Shoulders, Knees, and..... Toes!

KNEES TO TOES (LOWER LEG)

Stasis dermatitis

- Erythematous, brown, or violaceous patches on lower legs and ankles
- Pitting edema and aching legs that worsen through the day
- Scaling, weeping, crusting; may resemble eczema or cellulitis
- Hyperpigmentation from chronic hemosiderin deposition
- Lipodermatosclerosis in long-standing disease (woody, indurated skin)
- Clinical diagnosis strongly supported by signs of venous insufficiency
- Look for varicosities, edema, and chronic skin changes



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Head, Shoulders, Knees, and..... Toes!

KNEES TO TOES (LOWER LEG)

Treatment:

- Compression therapy is the cornerstone
- Topical steroids for flares; mid-potency generally adequate
- Gentle skin care: emollients, fragrance-free cleansers
- Treat ulcers- wound care and infection control
- Elevate of legs
- Address underlying venous disease (referral to vascular if needed)

Head, Shoulders, Knees, and..... Toes!

Capillaritis (Pigmented Purpuric Dermatoses)

- Diagnosis is clinical-Rusty-brown, cayenne-pepper-like pinpoint macules
- Usually bilateral on lower legs and ankles
- Schambergs disease
- Non-blanching but completely non-tender



https://dermnetnz.org/imagedetail/9593-capillaritis

Head, Shoulders, Knees, and..... Toes!

Capillaritis (Pigmented Purpuric Dermatoses)

- Often asymptomatic; No edema, no warmth, and no systemic symptoms mild itch
- Pigment persists even after inflammation fades
- R/O vasculitis, thrombocytopenia, stasis dermatitis
- If uncertain: CBC, platelets, PT/INR, or venous ultrasound (if warranted)



https://dermnetnz.org/imagedetail/9593-capillaritis

Head, Shoulders, Knees, and..... Toes!

CAPILLARITIS (PIGMENTED PURPURIC DERMATOSES)

Treatment

- Reassurance: benign, cosmetic, often chronic
- Reduce leg dependency: leg elevation, avoid prolonged standing
- Light compression stockings to improve venous tone
- Topical steroids for itching only (not required for pigment)
- Vitamin C + Rutin supplementation may help reduce capillary fragility
- Address triggers: heat, exercise, tight socks, prolonged standing

Pearls

- Bilateral symmetric "cayenne pepper" speckling = almost always capillaritis
- Does NOT ulcerate or swell—if you see those, think stasis or vasculitis

Head, Shoulders, Knees, and.....

KNEES TO TOES (LOWER LEG)

Idiopathic Hypomelanosis Guttate



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

- Small white macules, 2–5 mm, smooth and well-defined
- Common on shins, forearms, shoulders, and upper back
- Asymptomatic and non-scaly
- More common in women and increases with age
- Cosmetically bothersome

Head, Shoulders, Knees, and.....
KNEES TO TOES (LOWER LEG)
TOES!

Nummular Eczema



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Head, Shoulders, Knees, and..... Toes!

Necrobiasis Lipodica Diabecorum

ra



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- *Granulomatous skin disorder typically described on the shin of diabetics*
- *Rare ~1%*
- *Diagnosis is clinical*

Head, Shoulders, Knees, and..... Toes!

KNEES TO TOES (LOWER LEG)

Necrobiasis Lipodica Diabecorum

Treatment:

- Corticosteroids- topical or Intralesional
- Topical calcineurin inhibitors
- Phototherapy

Chronic, spontaneous resolution has occurred



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Head, Shoulders, Knees, and.....

Tinea Pedis



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https://dermnetnz.org/assets/Uploads/fungal/tpsev.jpg

- Itchy, scaling rash on feet; often worsens with sweat and occlusion
- Interdigital type: maceration, peeling, fissures between toes
- Moccasin type: diffuse dry scale on soles and sides of feet
- Vesicular type: grouped vesicles on arch/plantar surface
- Often coexists with onychomycosis

Head, Shoulders, Knees, and..... Toes!

TINEA PEDIS

Diagnosis- clinical based on classic distribution and scale

- KOH prep shows branching hyphae
- Consider fungal culture if recurrent



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Treatment

- Topical antifungals: terbinafine, butenafine, ketoconazole
- Oral antifungals for severe, moccasin-type, or recalcitrant (terbinafine)
- Dry thoroughly between toes; open-toed shoes, use moisture-wicking
- Treat toenails if coexistent onychomycosis is driving reinfection
- Consider household transmission (showers, floors, shared footwear)
- Recurrence is common if footwear isn't disinfected or replaced

Head, Shoulders, Knees, and..... Toes!

Psoriasis







Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Head, Shoulders, Knees, and..... Toes!

Nails

- Onychomycosis
- Psoriatic nails
- Melanonychia
- Subungual hematoma
- Melanoma
- Brittle nails

Head, Shoulders, Knees, and..... Toes!

NAILS-ONYCHOMYCOSIS



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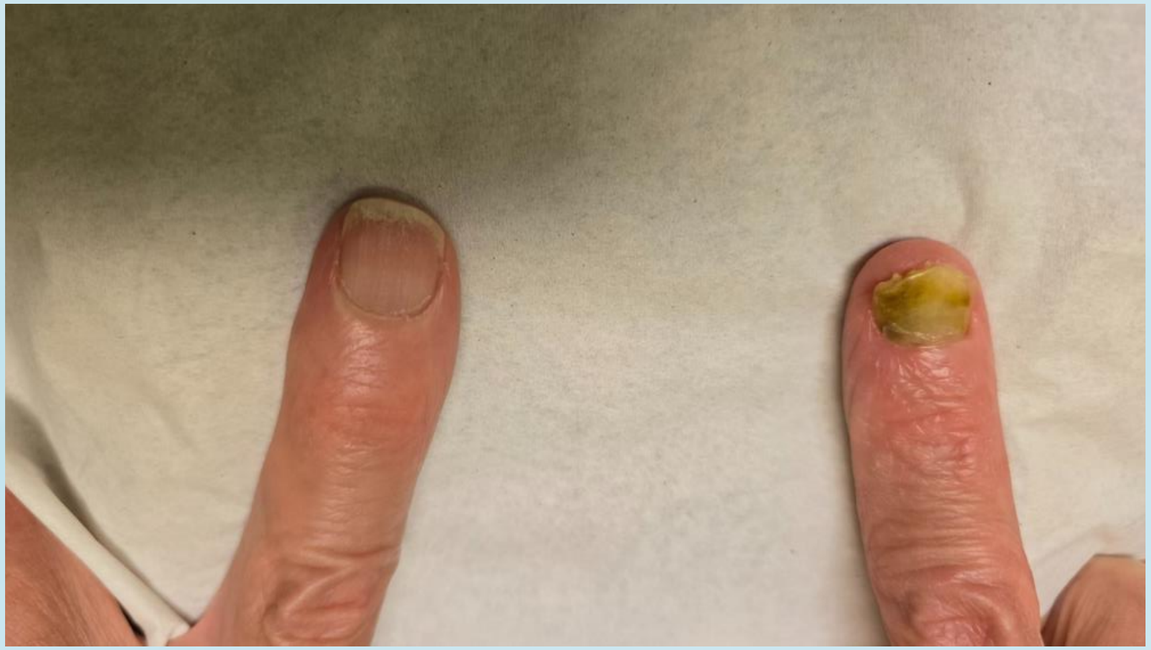
- Thickened, yellow or white, brittle nails
- Subungual debris and onycholysis (nail lifting)
- Distal–lateral pattern is most common
- Often coexists with tinea pedis

Diagnosis

- Clinical suspicion appearance + history
- KOH subungual debris, Fungal culture, PAS
- R/O: nail psoriasis, trauma, lichen planus, age-related nail dystrophy

Head, Shoulders, Knees, and..... Toes!

NAILS-ONYCHOMYCOSIS



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Treatment

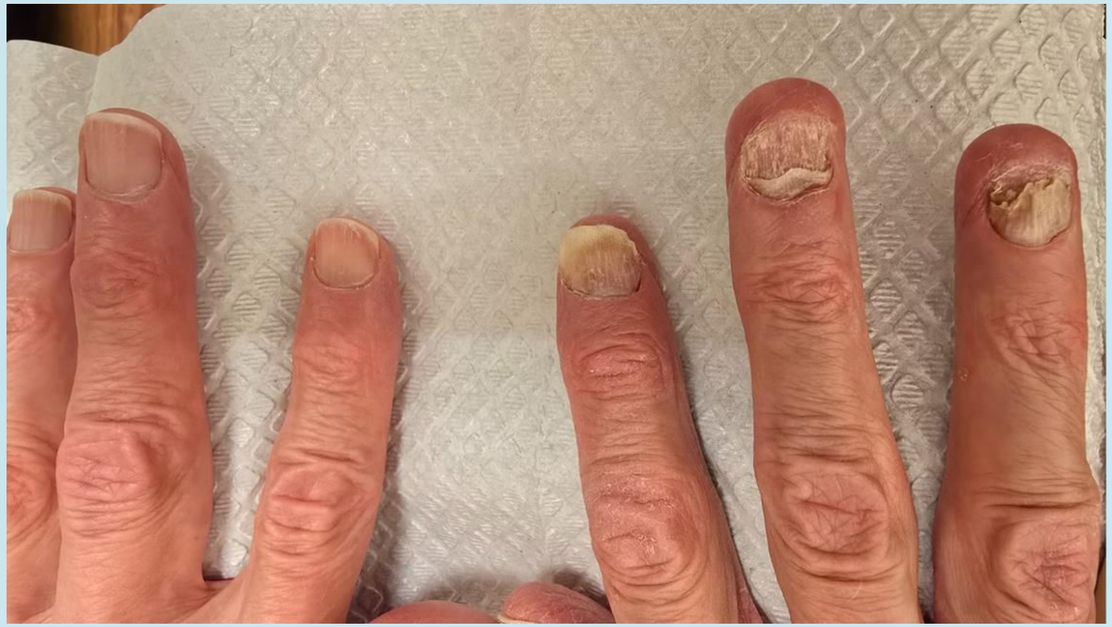
- Topical (mild or superficial disease):
- Efinaconazole 10 percent
- Tavaborole 5 percent
- Ciclopirox lacquer

Oral (best outcomes):

- Terbinafine: first-line for dermatophytes (6 wks fingernails, 12 wks toenails)
- Itraconazole
- Baseline liver tests recommended before starting systemic therapy
- Improvement can take 6 to 12 months

Head, Shoulders, Knees, and..... Toes!

NAILS - PSORIATIC NAILS

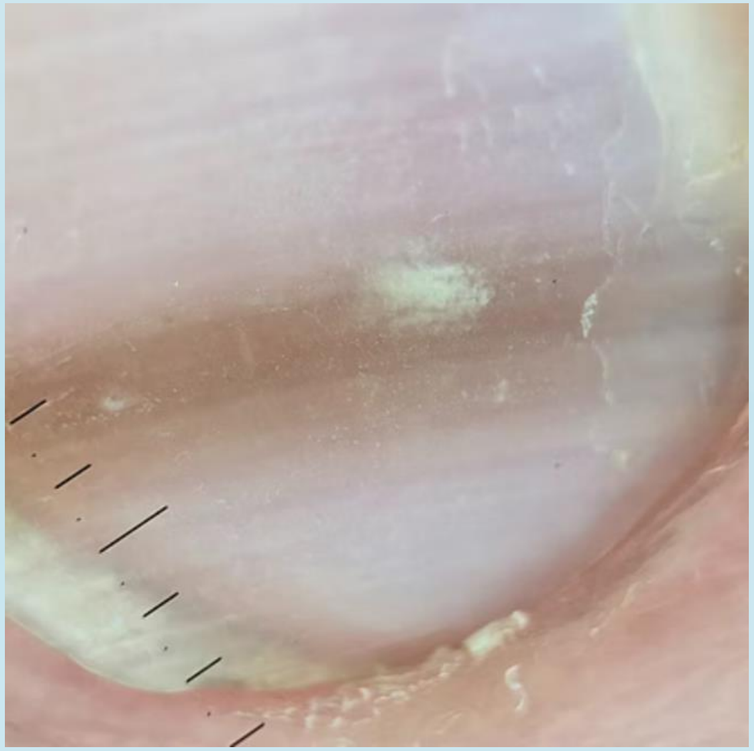


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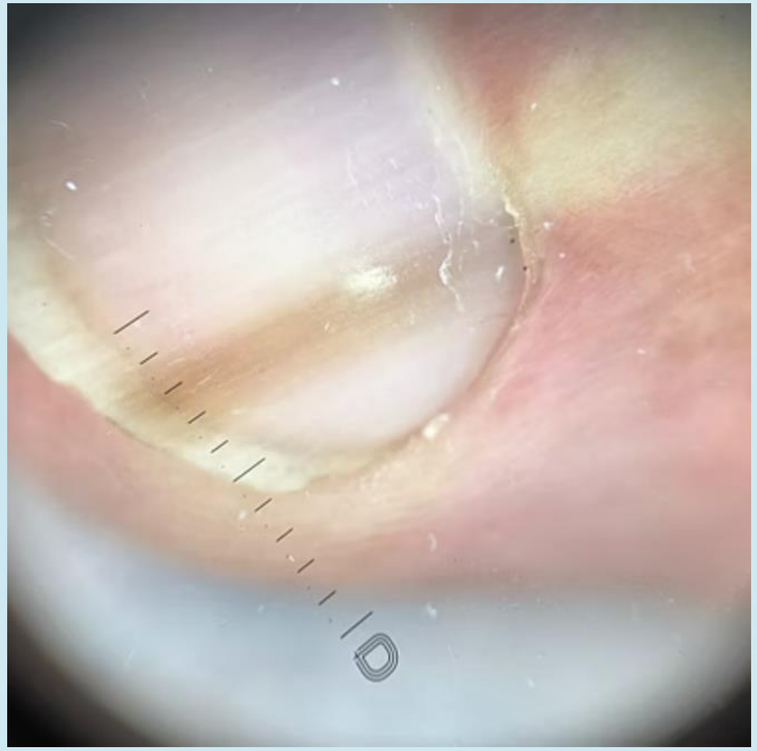


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Head, Shoulders, Knees, and..... Toes!
NAILS- MELONYCHIA







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Head, Shoulders, Knees, and..... Toes!

NAILS- SUBUNGAL HEMATOMA

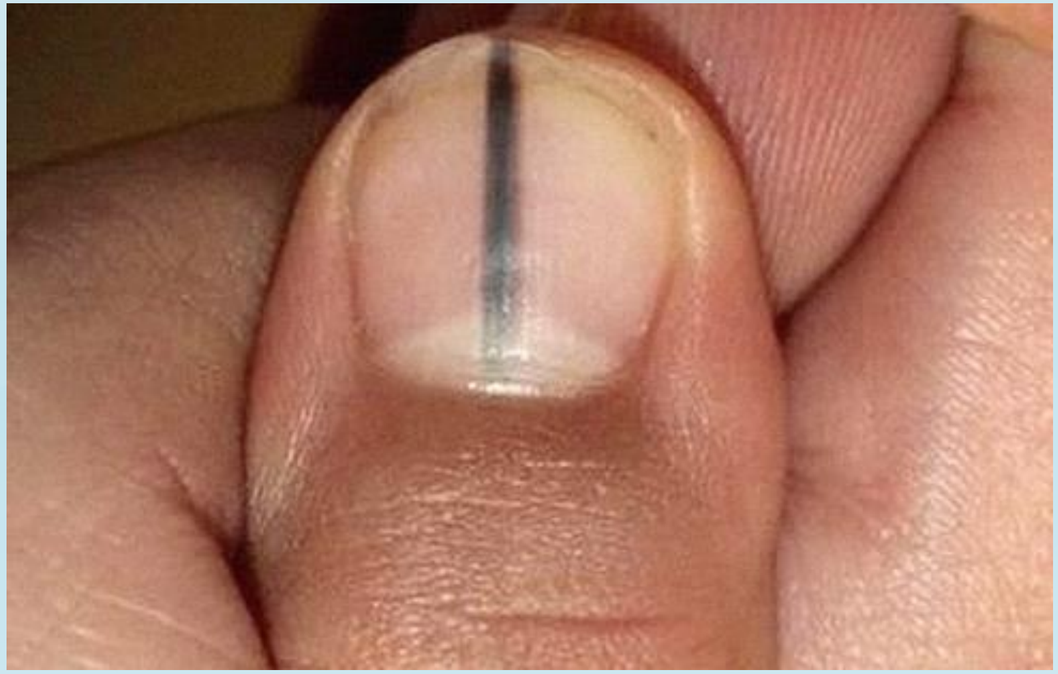




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Head, Shoulders, Knees, and.....

Nails - MELANOMA



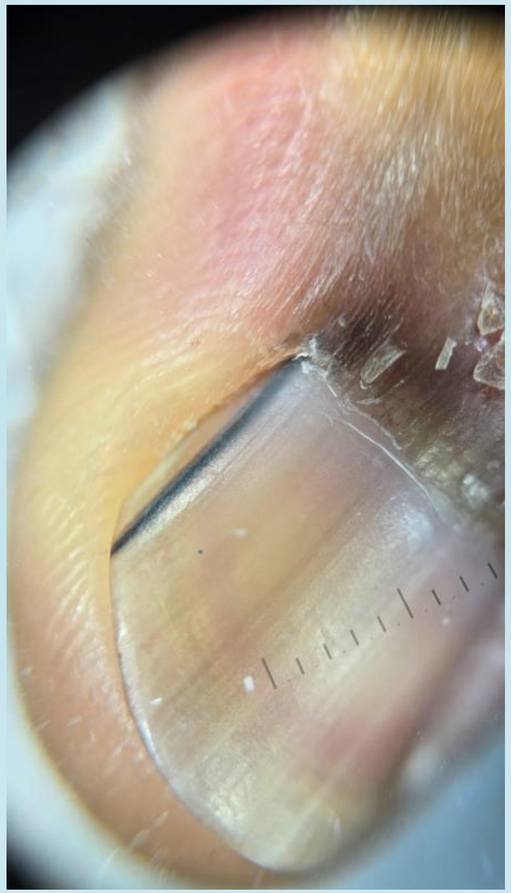
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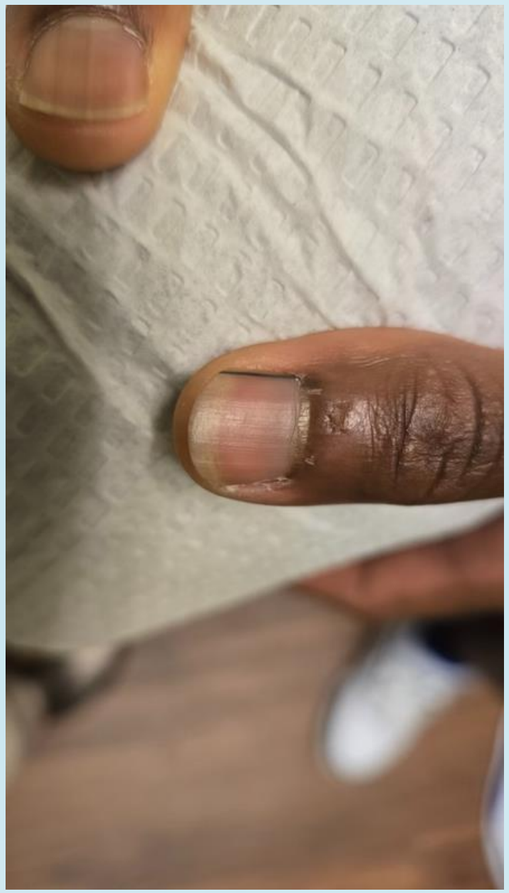
- Asymmetric, irregular, or widening
- Dark brown/black band ≥3 mm
- Hutchinson sign: pigment spread proximal/ lateral nailfolds
- Nail dystrophy: splitting, thinning, lifting, or ulceration
- Usually a single nail (thumb, big toe most common)
- Can present as amelanotic (pink/red)mimicking infection or trauma

***Diagnosis-Biopsy

Head, Shoulders, Knees, and..... Toes!

Nails- Melanoma or Benign Nevus??

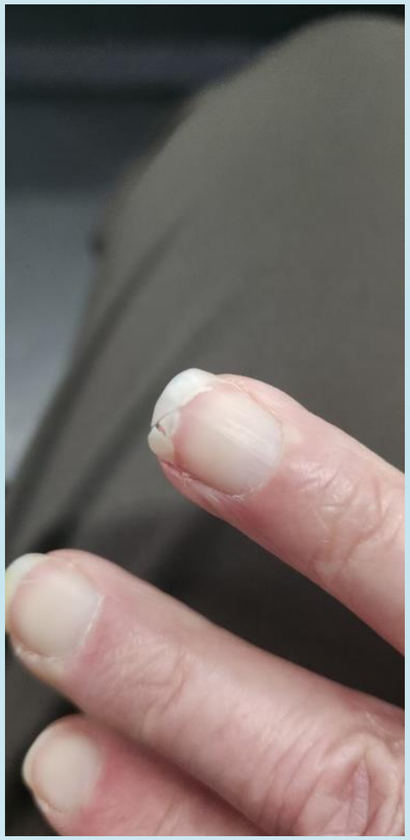




Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Head, Shoulders, Knees, and..... Toes!

NAILS- BRITTLE NAILS



Photos Courtesy of Fayette Area Dermatology Laura Bush PA-C

Causes:

- Frequent water exposure (handwashing, cleaning)
- Harsh chemicals (nail polish remover, detergents)
- Aging and decreased moisture retention
- Nutritional deficiencies (biotin, iron)
- Thyroid disorders
- Underlying skin conditions (psoriasis, lichen planus)

Treatment:

- Moisturize regularly (petroleum jelly, thick creams)
- Avoid prolonged water exposure, wear gloves
- Limit harsh chemicals and nail polish remover
- Biotin supplementation (2.5 mg daily)
- Keep nails short and filed smooth
- Address underlying medical conditions

Head, Shoulders, Knees, and..... Toes!

Feet-Plantar warts



https://dermnetnz.org/assets/Uploads/viral/s/wart13.jpg



https://dermnetnz.org/assets/Uploads/viral/s/wart14.jpg

88.2% complete remission rate for refractory warts that failed to respond to traditional, destructive therapies like cryotherapy or salicylic acid.

Researchers hypothesize that the highly concentrated salt draws fluid out of the wart cells, helps restore the body's natural antimicrobial peptide activity, and boosts local immune responses against the virus

Caution in Diabetes or if unsure of dx

You need a lot of salt - medium size soak of 4 cups of solution, you will need about 1.5 cups of salt

ELSEVIER

Journal of the American Academy of Dermatology

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Original article

Saturated saline immersion for the treatment of refractory plantar warts: An open-label, one-arm, single-center trial

Yinglin Xu BM [a], Tingting Li MD [a], Xinzheng Liang MD [b], Siyuan Jia MD [c], Li Wang BPharm [d], Zhaohua Zhu PhD [e], Lei Yu MD [a], Tangde Zhang MD [a]

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Background

Treating plantar warts (PWs) presents a significant challenge due to frequent treatment failures and recurrences. Current therapeutic approaches, such as salicylic acid, cryotherapy, and laser treatment, are destructive. There is a lack of painless and noninvasive treatment options for PWs.



Thank You