Physical Examination of Skin

History

- A careful dermatologic history is critical to interpret the physical examination findings and choose appropriate diagnostic tests
- A complete general history should be obtained, including information about prior illnesses, vaccinations, husbandry (housing, feeding practices, etc), changes in attitude and food consumption, elimination practices, exposure to other animals, and travel within the past 6–12 months
- This should be followed by a detailed dermatologic history. Use of a preprinted history form can be very useful for chronic or complicated cases. A good history is important, because many skin diseases that look similar are differentiated based on interpreting clinical signs and historical patterns.

1) the primary complaint;

2) length of time the problem has been present;

3) age at which the skin disease started (distinct age predilections are seen in many diseases, eg, demodicosis and dermatophytosis in pediatric animals and signs of atopic dermatitis in animals 1–3 yr old)

4) breed (breed predilections include a predisposition of Cocker Spaniels to primary disorders of keratinization, and of terriers to atopic dermatitis);

5) presence and severity of pruritus (including licking, rubbing, scratching, or chewing behaviors—owners often do not realize licking may be a sign of pruritus)

6) how the disease started and its progression (diseases that begin with pruritus may lead to self-trauma and subsequent development of secondary skin lesions [alopecia, seborrhea] or infections [bacterial or yeast pyoderma]

7) type and progression of lesions noted by the owner;

8)type and progression of lesions noted by the owner evidence of seasonality (suggesting fleas, allergic skin disease, or weather-related diseases)

9)) area on the body the problem was first noticed (ie, regional patterns seen in atopic dermatitis [typically the face and feet], cheyletiellosis [primarily dorsal], scabies [primarily ventral], and endocrine hair loss [usually involves the trunk and spares the head and legs]);

10) any previous treatments and the responses to such (ie, antibiotic-responsive skin diseases suggest a bacterial cause; pruritus that responds to small doses of glucocorticoids, antihistamines, or essential fatty acids suggests allergic dermatitis);

11) frequency of bathing and when the last bath was given (recent bathing may obscure or change important clinical lesions, excessive bathing and wetting of the skin can predispose to skin disease);

12) presence of fleas, ticks, or mites;

13) other contact animals (ie, evidence of contagion, which suggests fleas, scabies, cheyletiellosis, or dermatophytosis);

14) the environment of the animal (housing changes can influence the development of certain skin diseases, eg, contact dermatitis, contagious diseases);

15) signs or reports of systemic illness (endocrine [eg, hypothyroidism and hyperadrenocorticism] disorders and metabolic diseases [eg, diabetes mellitus, renal disease, liver disease] should be noted, because the skin can be the first place signs of systemic illness are noted).