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New or Modified Reference

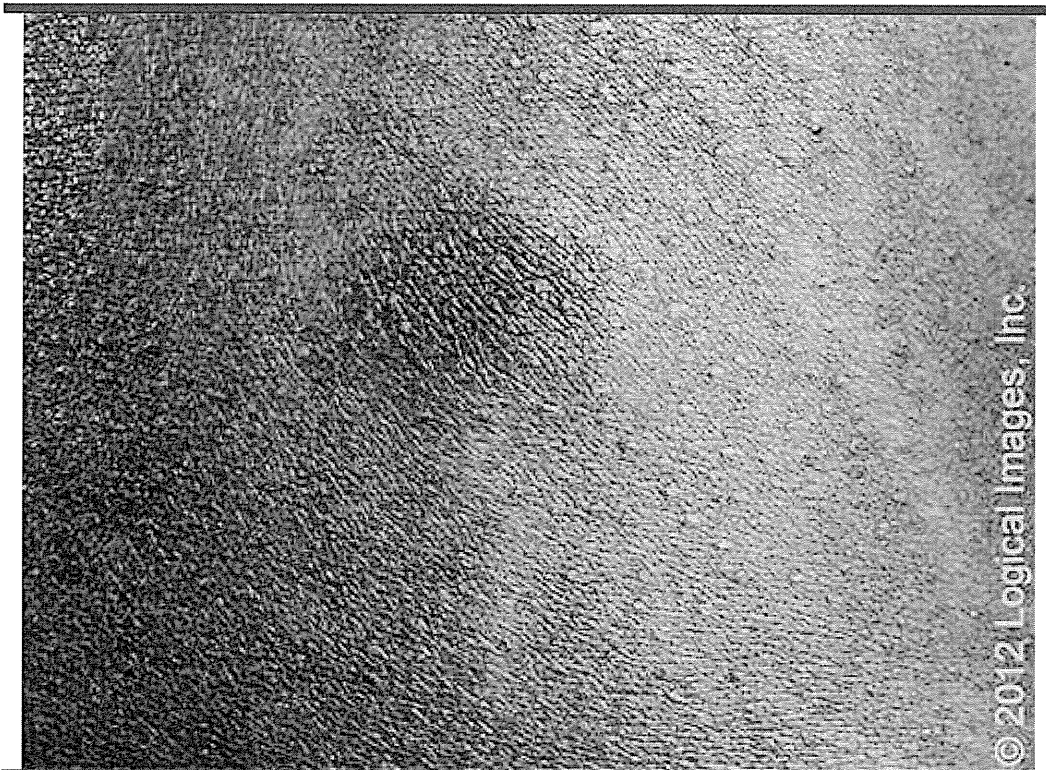
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**Graphics
picture 1A**



Fixed drug eruption



On dark skin, fixed drug eruption presents as a dark brown/slate-gray patch.

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picture 1B

Fixed drug eruption



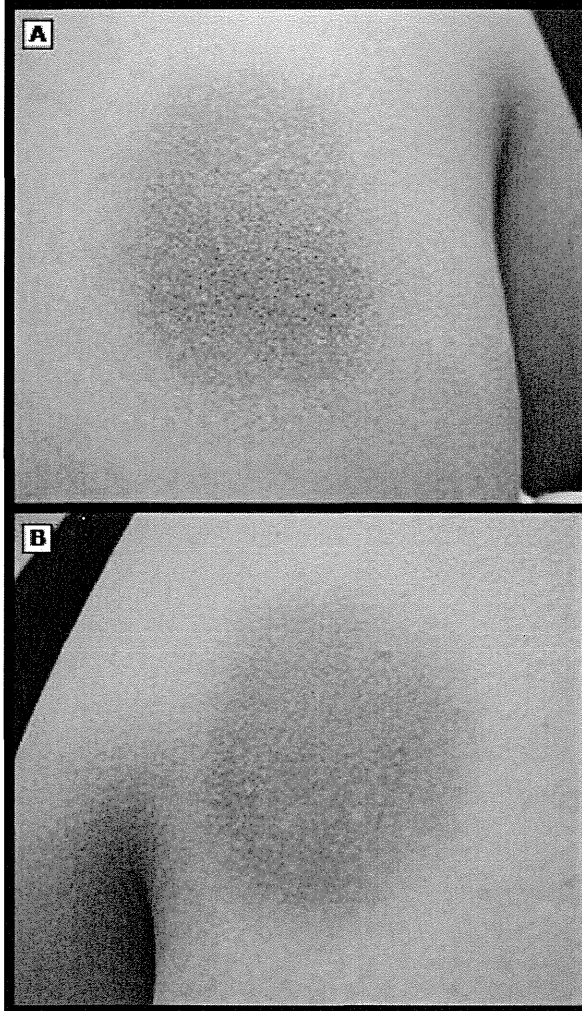
Fixed drug eruption. An oval lesion occurred at the identical site where it had occurred previously. In both episodes, the rash emerged after this patient ingested a sulfonamide antibiotic. Note the eroded blister in the center of the lesion.

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picture 1C



Fixed drug eruption



Fixed drug eruptions (A) typically resolve with postinflammatory hyperpigmentation (B).

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picture 1D

Fixed drug eruption



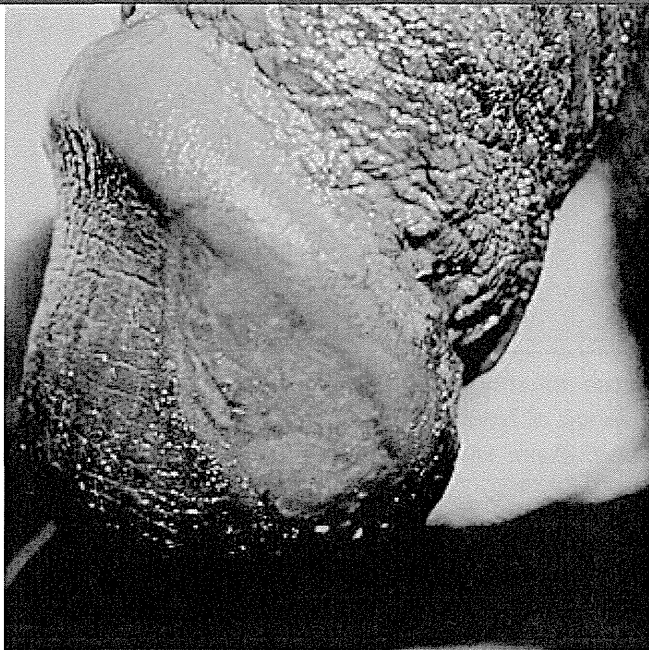
Multiple violaceous round plaques are present on the skin. A central bulla is present in one lesion.

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picture 1E



Fixed drug eruption

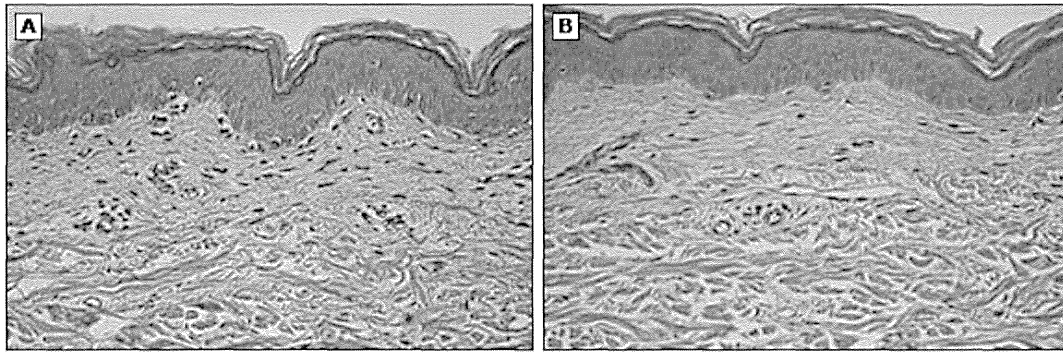


Fixed drug eruption. An oval erosion on the glans penis occurred in this patient who was taking minocycline. According to the patient, an identical lesion appeared when he was given minocycline previously.

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picture 2A

Histologic features of fixed drug eruption



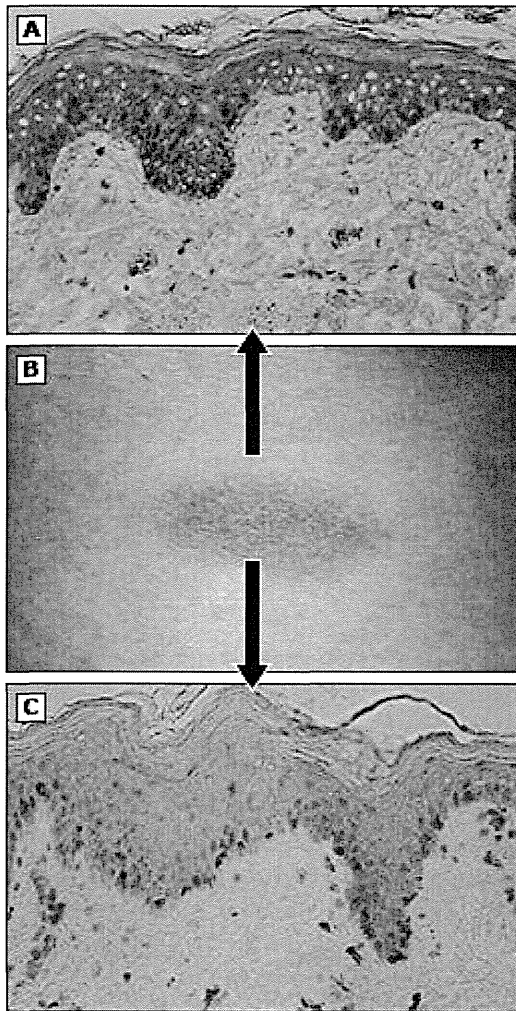
A. A small number of lymphocytes adhering to the epidermis seen in the resting lesional skin (H & E stain; $\times 66$). B. Absence of lymphocytes in the epidermis of the adjacent uninvolved perilesional skin (H & E stain; $\times 66$).

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picture 2B



Fixed drug eruption (FDE): Immunohistochemical staining of a resting lesion



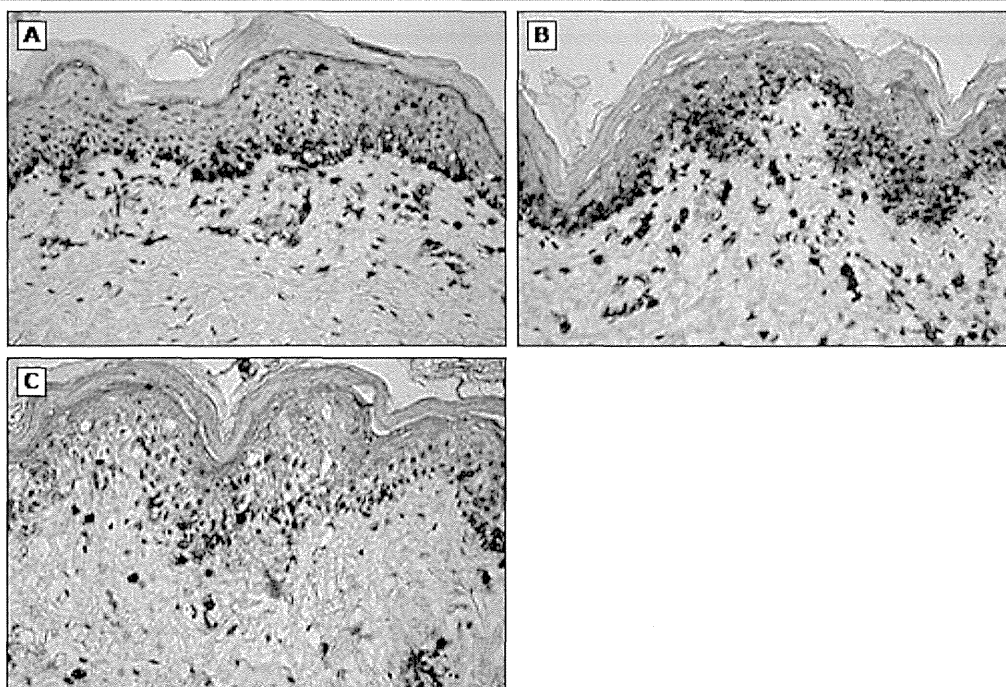
Intraepidermal CD8⁺ T cells abundantly identified in a resting FDE lesion but are absent in nonlesional skin (immunoperoxidase stain).

(A) Nonlesional skin.

(B) Resting FDE lesion.

(C) Lesional skin.

Intraepidermal CD8+ T cells in fixed drug eruption (FDE)



In situ activation of intraepidermal CD8+ T cells after clinical challenge with the causative drug (immunoperoxidase stain). Numerous intraepidermal CD8+ T cells are seen along the basal layer in the resting FDE lesion before challenge. Three hours after challenge, most of the CD8+ T cells are distributed in the lower half of the epidermis. At 24 hours, the density of CD8+ T cells declines because some undergo apoptosis at the site of extensive epidermal damage.

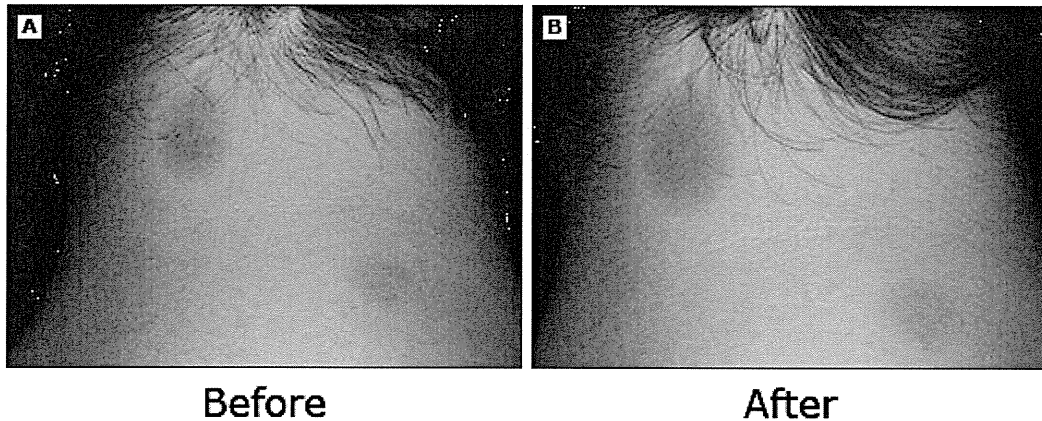
(A) Before.

(B) 3 hours.

(C) 24 hours.

picture 4

Fixed drug eruption (FDE): Lesion reactivation upon challenge with the causative drug



Typical resting hyperpigmented FDE lesions before and after clinical challenge with the causative drug: erythematous macules develop only in the pigmented lesions. The surrounding skin is unaffected.

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picture 5

Generalized bullous fixed drug eruption (FDE)



Widespread red patches with overlying large flaccid bullae in a patient with generalized fixed drug eruption, an extremely rare clinical variant of FDE.

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picture 6



Fixed drug eruption resembling erythema multiforme



A case of fixed drug eruption misdiagnosed as herpes-associated erythema multiforme. The lesions were reproduced by the administration of the suspected drug.

picture 7

Multiple (generalized) fixed drug eruption



Generalized fixed drug eruption is an uncommon variant characterized by multiple and disseminated brown macules or plaques involving the trunk and extremities.

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picture 8



Erythema dyschromicum perstans (ashy dermatosis)

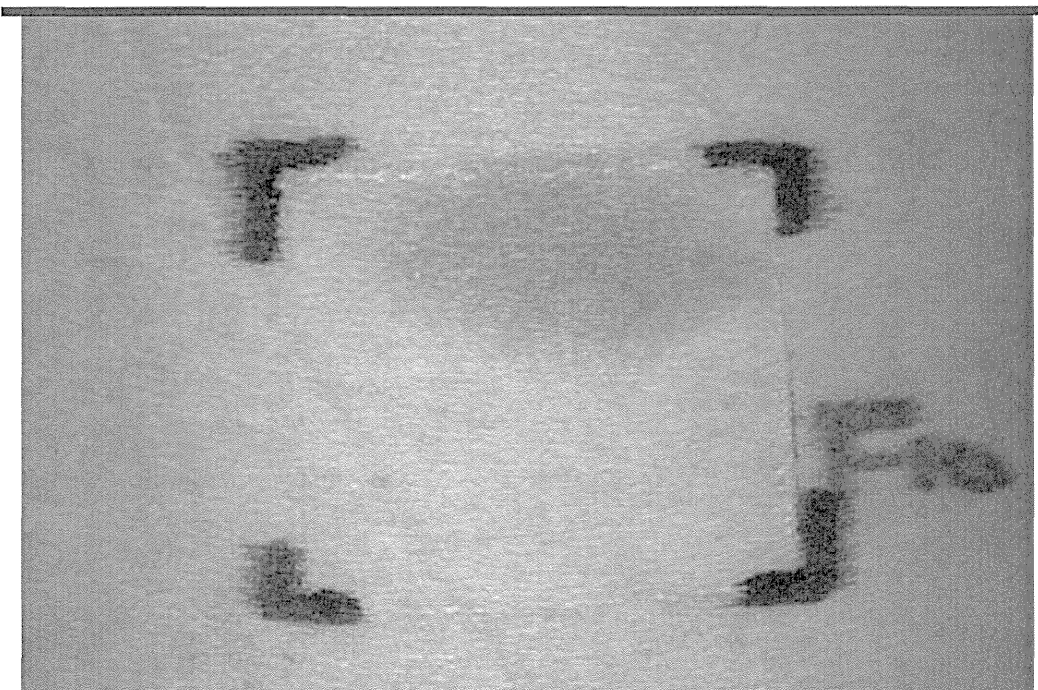


Asymptomatic gray/blue macules on the trunk and proximal extremities are characteristics of erythema dyschromicum perstans (ashy dermatosis), an acquired hypermelanosis of unknown etiology.

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picture 9

Patch testing at the site of a fixed drug eruption

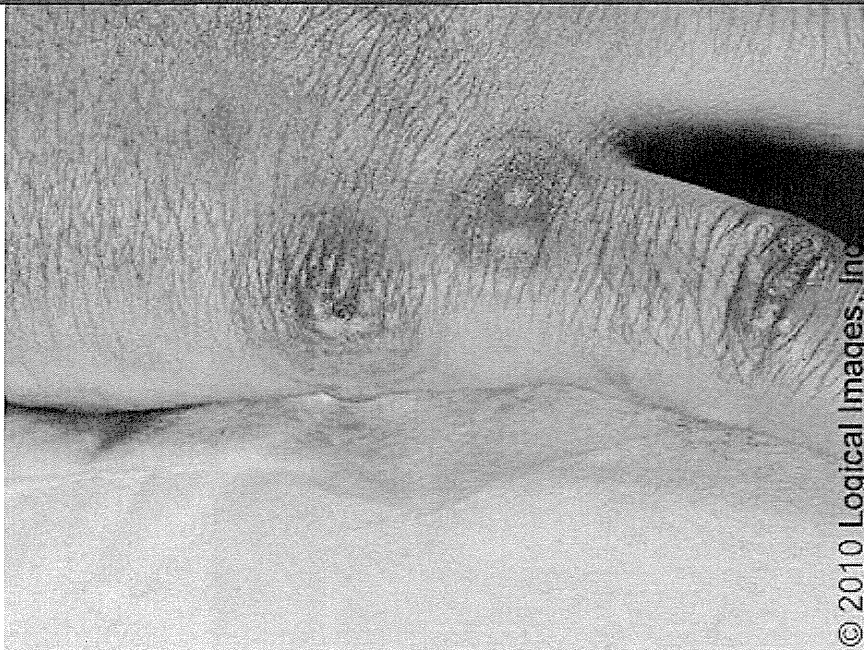


Positive patch test reaction for the causative drug 10% in petrolatum. Note the positive reaction confined to the previously involved pigmented area.

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picture 10

Target lesions of erythema multiforme

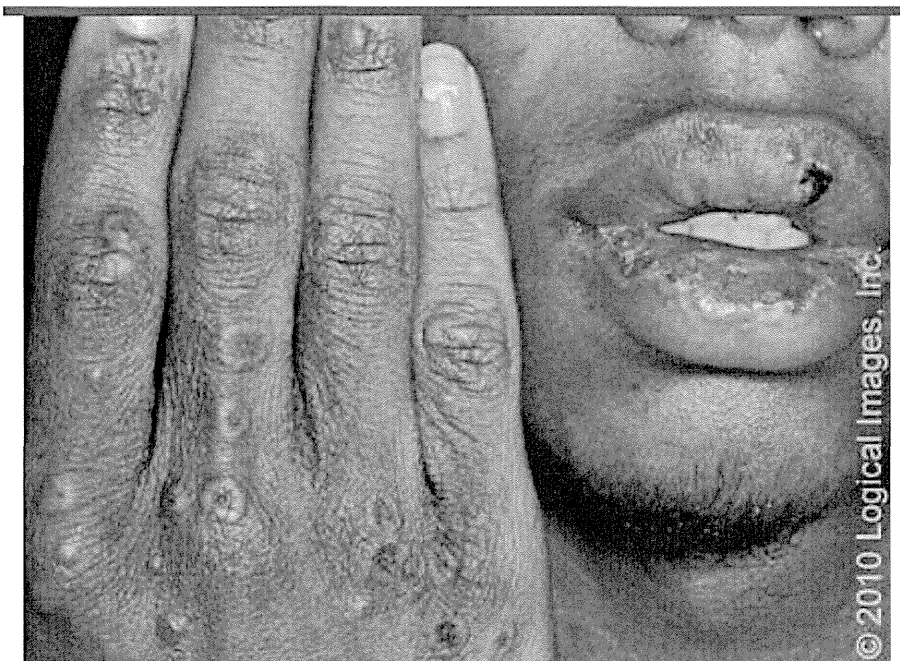


Target lesions with central bullae are present on the hand.

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picture 11

Erythema multiforme



Multiple acrally distributed target lesions and mucosal erosions are present in this patient with erythema multiforme majus.

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picture 12



Cutaneous changes of Stevens-Johnson Syndrome

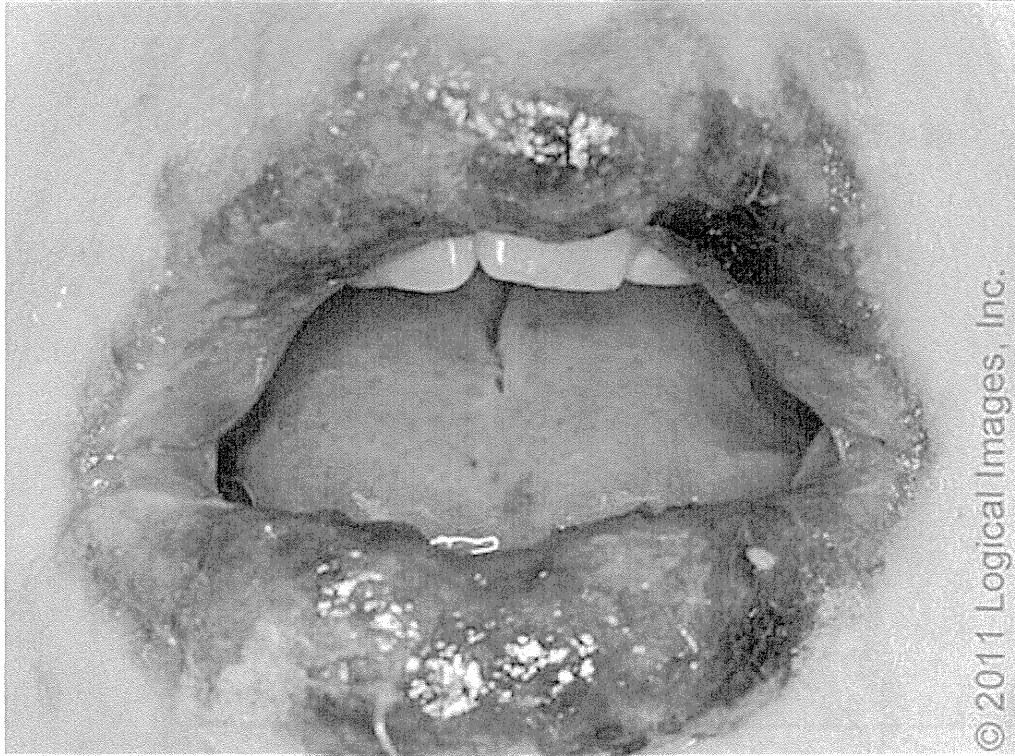


Generalized eruption of lesions that initially had a target-like appearance but then became confluent, brightly erythematous, and bullous. The patient had extensive mucous membrane involvement and tracheobronchitis.

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picture 13

Mucosal changes in Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN)



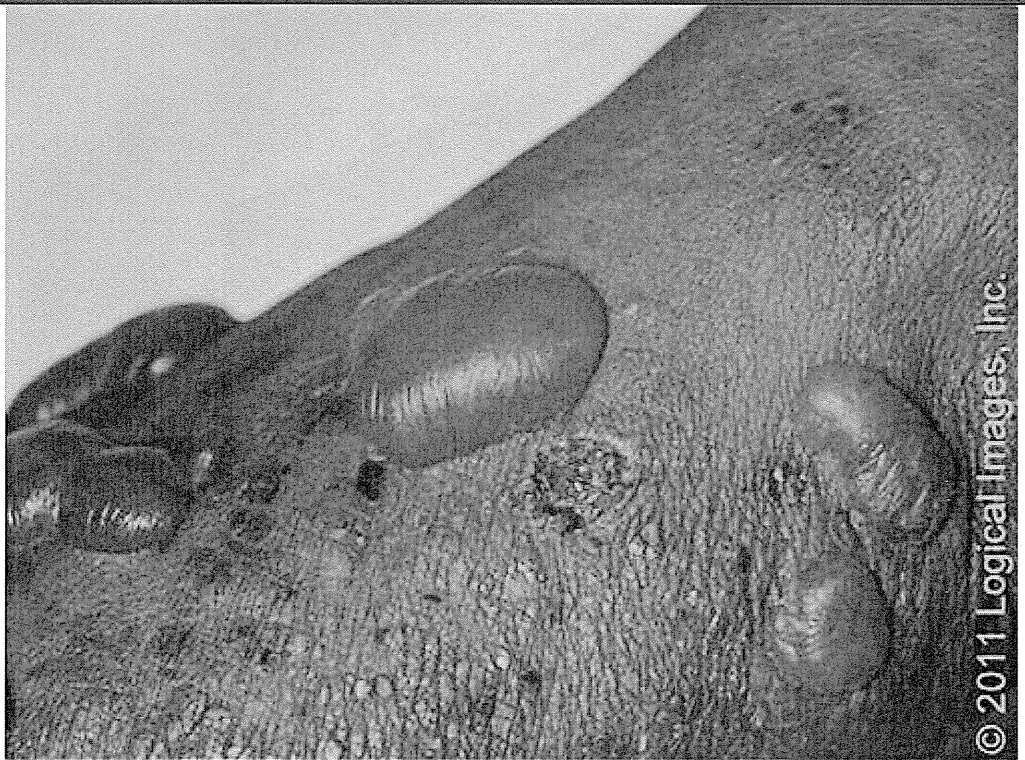
Changes similar to those observed in SJS/TEN can be observed also in erythema multiforme majus.

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picture 14



Bullous pemphigoid



Multiple tense bullae on skin with one eroded blister base.

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picture 15