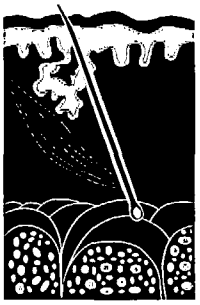

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Introduction

SEVERAL DECADES AGO, infectious diseases appeared to be conquered. An aggressive global vaccination program had eradicated smallpox, and measles was slated for global eradication. However, many new pathogens have become prominent during the past few decades, and now and in the future dermatologists will need to update continually their knowledge of cutaneous infections as the host, the pathogens, and antimicrobial therapies evolve.

A major shift in the practice of dermatology has been toward a variety of surgical procedures. Although antibiotics may be indicated for some patients undergoing dermatologic procedures, recommendations to date have not specifically addressed patients undergoing dermatologic surgery. In this issue, Dr Hirschmann reviews the literature and indications for antibiotic prophylaxis in dermatologic practice.

Lyme disease was first reported in 1909 by Atzelius in Sweden, where the cutaneous manifestations have been prominent. In the United States Lyme disease was first reported in 1976 after an outbreak of erythema migrans and arthritis in Lyme, CT. Lyme disease can be difficult to diagnose early because of the spectrum of clinical manifestations and lack of reliable laboratory tests. Dr Melski reports on the newer aspects of Lyme disease, including diagnosis and management.

During the past decade, the number of immunocompromised individuals has increased dramatically. Human immunodeficiency virus (HIV), first detected 2 decades ago in the United States, has infected >40 million individuals worldwide. An increasing number of individuals experience immunocompromise associated with cancer chemotherapy, therapy of immunologically mediated disease, solid organ and bone marrow transplantation, and old age. This issue offers a review of the management of mucocutaneous infections in the immune compromised host.

Currently in the United States few hospitals or academic dermatology departments have inpatient services for dermatologic disorders, due to fiscal restraints of medical insurers. Most dermatologic consultations in US hospitalized patients focus on concerns of infection or adverse cutaneous drug reactions. Dr Jones and myself review some such cases, including opportunistic infections in HIV-infected patients, calciphylaxis (commonly mistaken for cellulitis) in diabetics with renal failure, pyoderma gangrenosum and acute febrile neutrophilic dermatosis (Sweet's syndrome), and lipodermatosclerosis (commonly thought to be unilateral or bilateral cellulitis) in patients with chronic venous insufficiency.

It is our hope that this issue of *Seminars in Cutaneous Medicine and Surgery* will serve as an update on cutaneous infections in this age of evolving infectious diseases.

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