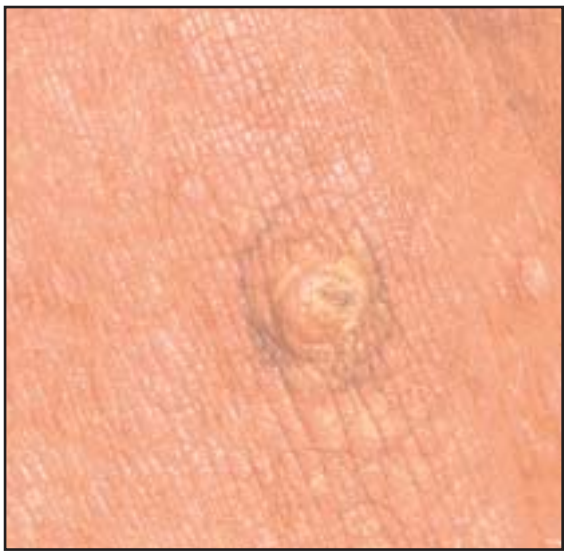
Case 1

"Should I be worried?"

A 63-year-old man presents with a two-month history of a rapidly proliferating, indurated, dome-shaped nodule on his face. It doesn't seem to have change in size in the past two weeks.



What is the diagnosis?

a. Keratoacanthoma
b. Squamous cell carcinoma
c. Bacterial abscess
d. Basal cell carcinoma
e. Nodular granuloma annulare

Answer

This patient has a *keratoacanthoma* **(Answer a)**, an odd type of lesion that erupts suddenly and takes on the characteristics of a squamous cell carcinoma (SCC) before disappearing, all within a period of two to six months. A typical lesion has steep sides and a central horny plug. It is very important to distinguish this lesion from a SCC, as the implications are much different. Biopsies should be deep enough to include subcutaneous fat, either by total excision or by transverse biopsy through the centre of the lesion.

If the clinical diagnosis is obvious, watchful waiting to ensure the lesion resolves is all that is required. Otherwise, the entire tumour can be treated surgically (curettage or excision), with radiotherapy, or with intralesional fluorouracil or methotrexate.

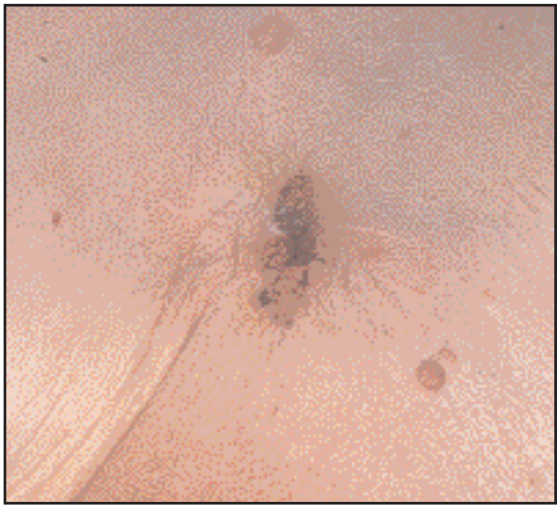
This month—7 cases:

John Kraft, BSc, is a third-year medical student, University of Toronto; Carrie Lynde, BSc, is a third-year law student, University of Western Ontario; and Charles Lynde, MD, FRCP(C), is a dermatologist, Toronto, Ontario.

Case 2

"It itches!"

A 68-year-old woman presents with a solitary chronic, erythematous, scaly lesion which has been slowly enlarging for the past several years. She experiences slight itching and notes scaling upon scratching. You notice the lesion has a slightly raised edge.



What is the diagnosis?

a. Bowen's disease
b. Superficial basal cell carcinoma
c. Eczema
d. Psoriasis
e. Tinea corporis

Answer

Eczema and tinea corporis are less likely diagnoses, as there is only slight itching and no increased scaling or papules at the lesion's edge. Psoriasis, which illicits profuse silver scales on scratching, tends to prefer the knees, elbows, and scalp. Bowen's disease is certainly a possibility, but the characteristics of the lesion's edge are the real clue.

Superficial basal cell carcinomas **(Answer b)** tend to have a slightly raised edge. A deep biopsy is sufficient to make the diagnosis. These tumours (as well as micronodular, morpheaform, and infiltrating types of basal cell carcinoma) tend to show a diffuse growth pattern and are more likely to recur, compared with the more common nodular type. Long-term followup is essential.

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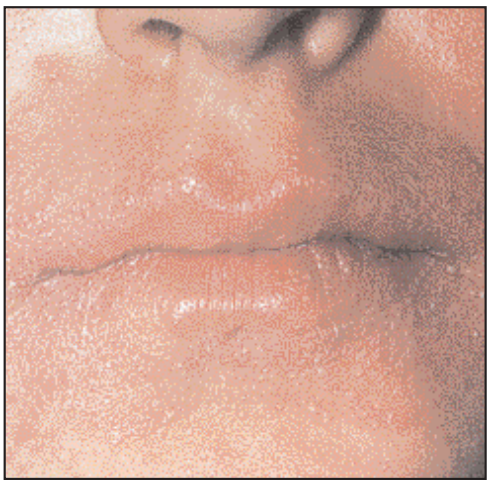
Case 3

Does the Corticosteroid Play a Role?

A healthy 22-year-old man presents with chronic, erythematous lesions around the mouth. The rim around the vermilion border of the lips is spared. He is currently applying a topical corticosteroid to his face to control his atopic dermatitis.



How would you manage this patient?

a. Recommend the patient stop applying the steroid
b. Topical metronidazole
c. Prescribe a more potent topical steroid to reduce the inflammation
d. Systemic tetracycline
e. a, b, and d

Answer

This young man has perioral dermatitis, a condition that is more common in females, affecting young adults (15 to 40) who have been applying potent topical corticosteroids to the face.

The lesions are typically minute (< 1 mm) red papules and pustules appearing around the mouth, often sparing the skin immediately adjacent to the lips. It sometimes occurs around the eyes and there need not necessarily be a history of steroid use.

As inappropriate use of potent topical corticosteroids is the main exacerbating factor, patients should stop applying the medication.

Topical metronidazole (0.75% gel or 10% cream) applied to the area twice daily often helps. Another option is systemic tetracycline, 500 mg twice daily, until lesions clear, followed by a two-month tapering dose **(Answer e)**.

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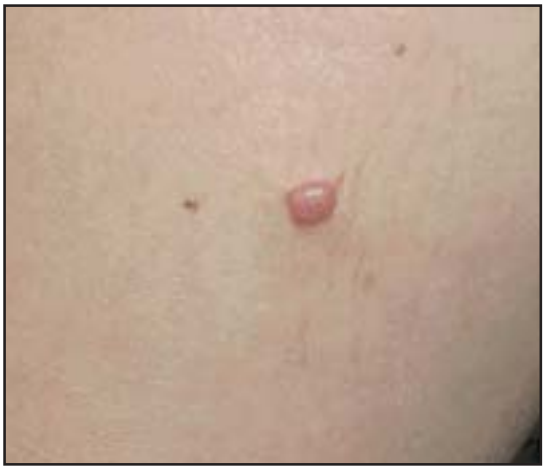
Case 4

"What's on my thigh?"



A palpable red lesion persists on the left thigh of a 24-year-old woman.

What is your diagnosis?

a. Petechiae
b. Cherry angioma
c. Hemangioma
d. Amelanotic melanoma
e. Nevus

Answer

Cherry angioma **(Answer b)** are round to oval, bright red, dome-shaped papules ranging in size from a tiny speck to several millimetres in size. Usually located on the torso and extremities, but not on the face, they may be single or multiply in number with age.

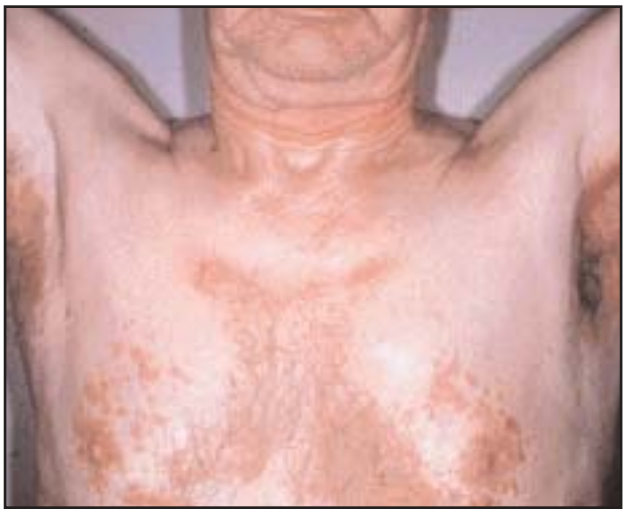
Generally, they persist and occur equally in both sexes. As they are benign and asymptomatic, these lesions can be left alone. If traumatized, or if the patient wishes, they may be cauterized.

Stanley Wine, MD, FRCPC, is a dermatologist, Toronto, Ontario.

Case 5

"Doc, get this off my chest!"

A 65-year-old man presents with erythematous, poorly-defined plaques on his chest and in both axillae. He is otherwise healthy.



What is your diagnosis?

a. Psoriasis
b. Rosacea
c. Atopic dermatitis
d. Tinea
e. Seborrheic dermatitis

Answer

This patient has *seborrheic dermatitis* **(Answer e)**, a condition characterized by an inflammatory, erythematous, and scaling eruption localized in the seborrheic areas (*i.e.*, scalp, nasolabial folds, eye brows/lashes, bridge of nose, ears).

The plaques are sharply demarcated and are often covered with a greasy scale. While diagnosis may be challenging when it occurs spontaneously with psoriasis and/or rosacea, fine scaling in the scalp is a helpful clue to diagnosing the condition.

Seborrheic dermatitis is a chronic relapsing condition that responds to a variety of suppressive therapies, but there is no definitive cure. Patients should be educated regarding preventative measures, such as good facial hygene.

Scalp involvement with scaling can be treated with shampoos containing ketoconazole or selenium sulphide. Facial involvement responds to mild corticosteroids, but take the usual precautions when applying to the face so as to avoid adverse effects (*i.e.*, steroid rosacea, perioral dermatitis). The new topical immunomodulators, such as tacrolimus and pimecrolimus, may also be beneficial.

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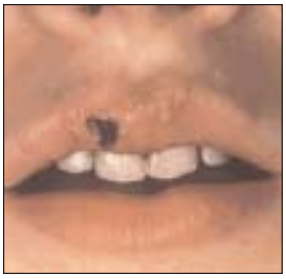
Case 6

What's the Link?



A 13-year-old boy presents with multiple, small, grouped vesicles on and around his lips. He was diagnosed with recurrent herpes simplex.

Herpes simplex is differentiated from impetigo by the presence of all of the following, except:

a. Prodromal pain
b. History of recurrent episodes
c. Initial vesicles containing clear fluid
d. Culture for group A beta haemolytic streptococcus is negative
e. Honey-coloured crusts

Answer

Herpes simplex tends to recur on the lips if the primary infection is in the mouth. Prior to the development of vesicles, there is a prodromal feeling of burning, tingling, or itching. It is very important patients recognize this feeling as prompt initiation of oral antivirals (*e.g.*, acyclovir, famcyclovir, valacyclovir) is much more effective; once the vesicles appear, the effect of the antivirals will be close to nil.

The vesicles form due to viral multiplication in the epidermal cells. Vesicles then burst, crust, and heal without scarring in seven to 10 days. Precipitating factors include stress, sunlight, fever ('cold sores'), and menstruation.

Impetigo also starts as small vesicles that quickly rupture to form *honey-coloured crusts* **(Answer e)**.

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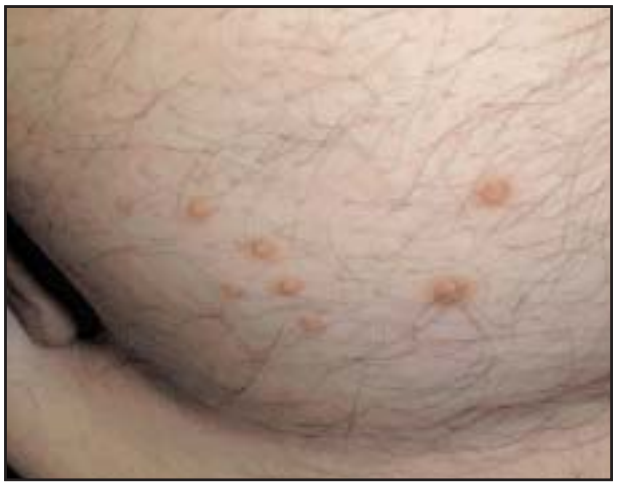
Case 7

"Is it the insulin?"

A 60-year-old diabetic, who has been on insulin for 20 years, noticed lesions have appeared at a favourite injection site on the right lower abdomen over the past eight months.



What is your diagnosis?

a. Furuncles
b. Insulin reaction
c. Ingrown hairs
d. Nevi
e. Molluscum contagiousum

Answer

Molluscum contagiousum **(Answer e)** is a benign, virus-induced lesion of the skin. Small, discreet flesh-coloured, pearly, umbilicated papules occur singularly or in groups. In adults, inoculation of the genitals, lower abdomen, and upper thighs is most commonly due to sexual contact.

While the lesions may involute, light curettage revealing a cheesy inclusion body is quick and efficient without scaring. Liquid nitrogen and topical canthardin are also favourite treatments. CME

Stanley Wine, MD, FRCPC, is a dermatologist, Toronto, Ontario.