



Case 1

“Get rid of these growths!”

This 62-year-old man has noted growths on his face.

What do they represent?

- a. Basal cell carcinomata
- b. Adult acne
- c. Syringomata
- d. Sebaceous hyperplasia
- e. Sebaceous cysts



Answer

Sebaceous hyperplasia (answer d) can be recognized by its round configuration and central dell, which is the follicular infundibulum of the sebaceous gland.

It is not a tumour, but an enlargement of the sebaceous lobule. The yellowish tinge helps to distinguish it from a basal cell carcinoma.

They can be quite numerous and are scattered on the face, the forehead and the chin. If the lesion is solitary and large, a biopsy to exclude a basal cell carcinoma may be warranted.

Electro-dessication is helpful in removing the lesions, but they may recur with time.

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

This month—4 cases:

1. “Get rid of these growths!”
2. A Problem with Plaques
3. A Nuisance on the Knee
4. “Doc, what’s on my back?”



Case 2

A Problem with Plaques

This 50-year-old man presents with thick, erythematous plaques widespread over his entire body. The largest plaque, measuring approximately 20 cm in diameter, is found on his back.

The plaques are covered by a fine, whitish scale, which, when scratched off, reveals pinpoint bleeding.

What do you suspect?

- Nummular eczema
- Erythrodermic psoriasis
- Cutaneous lupus
- Chronic plaque psoriasis
- Dermatophyte infection

Answer

Psoriasis is a disorder of keratinocyte differentiation grouped in the papulosquamous skin disorders group. The pathophysiology consists of a markedly decreased epidermal transit time with a subsequent overproduction of immature keratinocytes and an immunologic reaction driven by TH1 cells.

There are multiple presentations of this skin disease, including the most common form, *chronic plaque psoriasis* (**answer d**) and more serious variants including guttate, erythrodermic, and generalized and localized pustular psoriasis.

In chronic plaque psoriasis, large sharply demarcated plaques with silvery scale are found most commonly on the elbows, knees, scalp, gluteal cleft, behind the ears and around the umbilicus.



The skin lesions are characterized by the Auspitz sign, which refers to the pinpoint drops of blood present when the scale is scraped off, and the Koebner phenomenon, the propensity of lesions to form in areas of skin trauma.

Treatment consists of topical agents, including topical steroids, tar, anthralin, calcipotriene, topical retinoids, such as tazarotene, and keratolytics, such as salicylic acid. For widespread lesions, phototherapy with UVB or psoralen plus UVA can be very effective.

For more serious disease, systemic therapy with oral retinoids, namely acitretin, and immunosuppressive agents, such as methotrexate and cyclosporine can be used.

The newest group of agents aimed at interfering with the TH1 cytokine response are immunomodulating drugs, such as infliximab and etanercept.

Monika Winnicki, MD, is a first-year resident, family medicine program, McMaster University, Hamilton, Ontario. She has a strong interest in dermatology.



Case 3

A Nuisance on the Knee

This teenaged boy presents with a 1.5 cm, shiny lesion on his knee, which appeared after a cut on his knee healed.

He is concerned about the appearance of the lesion and wants to know if anything can be done about it.

What can this be?

- a. Dermatofibroma
- b. Hypertrophic scar
- c. Compound nevus
- d. Keloid scar
- e. Hemangioma

Answer

This lesion represents a *hypertrophic scar* (answer b). Both hypertrophic scars and keloids represent overexuberant fibrous repair processes, usually at the site of previous injuries, but rarely arising spontaneously. The difference between the two is that a hypertrophic scar is confined to the original area of injury, while a keloid extends beyond the site to invade adjacent tissue.

This healing reaction occurs more commonly in African Americans and on certain body sites, such as over the sternum, ear lobes and back.

Hypertrophic scars usually appear as shiny tan to bright red to sometimes bluish papules or nodules. They often become elevated, but remain confined to the dimensions of the original injury and tend to regress with time.



Keloids, however, extend from the original injury in a claw-like manner, may become more nodular and hard and continue to enlarge over time. This is especially troubling on the face or ear area.

For those who are prone to developing these scars, preventing unneeded procedures, such as piercings, is the best solution.

Treatment of existing lesions remains a challenge. Intralesional steroid injections with triamcinolone alone or in combination with cryotherapy may be effective and can be done in the office. Silicone cream and a gel sheet can sometimes be beneficial and are easy to use. Excision of the lesion may yield an even worse scar but excision with postsurgical radiotherapy can be used for truly difficult scars.

Monika Winnicki, MD, is a first-year resident, family medicine program, McMaster University, Hamilton, Ontario. She has a strong interest in dermatology.

Elizabeth Hampel, an international medical graduate, is finishing her clinical clerkship at McMaster University, Hamilton, Ontario. One of her interests is dermatology.



Case 4

“Doc, what’s on my back?”

A 22-year-old woman presents with an irregular, erythematous lesion on her back. On palpation the lesion is firm. The patient complains that it is painful and pruritic.

What is the likely diagnosis?

- a. Neurofibroma
- b. Keloid scarring
- c. Granuloma annulare
- d. Haemangioma
- e. Dermatofibrosarcoma protuberans

Answer

This patient has *keloid scarring* (answer b). A biopsy may be necessary to distinguish keloid scarring from other conditions, such as dermatofibrosarcoma protuberans (a unique fibrohistiocytic tumour).

Prevention is an important aspect of treatment. Closing wounds with minimal tension and inflammation is critical, as well as informing patients who are prone to keloids to avoid unnecessary cosmetic surgery.

Intralesional corticosteroids (triamcinolone acetonide, 10 mg to 40 mg/ml) administered intralesionally at four to six week intervals is the treatment of choice.



Other options include occlusive dressings, compression, radiation therapy and cryotherapy. Excision is rarely useful as keloids tend to recur.

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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.