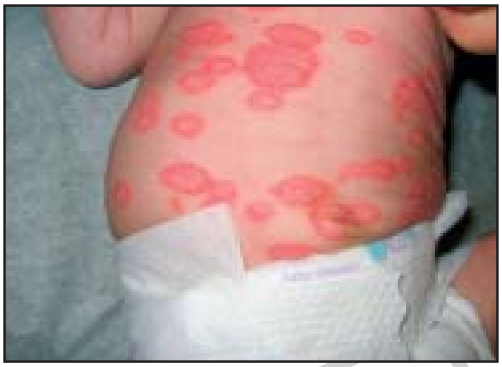
This month—5 cases:

Case 1

"Doc, my baby's all spotty!"

A four-week-old male presents to your clinic with annular, slightly scaly, erythematous plaques scattered on his abdomen, chest and face.



What is the diagnosis?

a. Tinea corporis
b. Neonatal lupus erythematosus
c. Rubella
d. Erythema toxicum neonatorum
e. Fifth disease (erythema infectiosum)

Answer

Neonatal lupus erythematosus (NLE) (**answer b**) is a rare condition characterized by annular, scaling, erythematous plaques on the head, neck and extremities within the first few months of life due to the transplacental passage of maternal autoantibodies.

This temporary form of lupus resolves spontaneously by six months of age and usually heals with little or no scarring. The most common clinical manifestations are dermatologic, cardiac, hepatic and, less commonly, hematologic abnormalities.

The incidence of congenital heart block is 15% to 30% in infants with NLE. Congenital heart block can result in congestive heart failure and the subsequent placement of a pacemaker. Most mothers at the time of childbirth are healthy and without signs or symptoms of lupus erythematosus or other collagen vascular disorders.

The type of treatment and long-term prognosis depends on the presence of underlying congenital heart abnormalities. Infants should be protected from or avoid sun exposure. The treatment of skin lesions is mild to moderate topical steroids.

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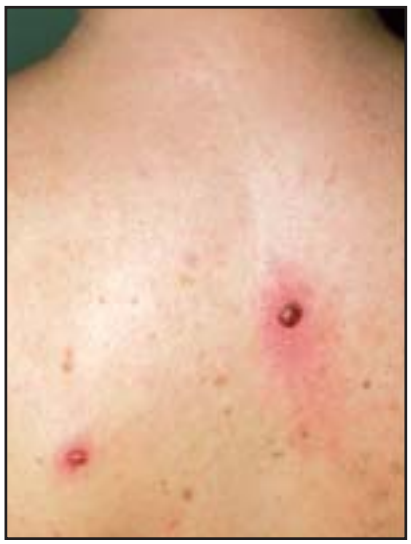
Case 2

A Mediterranean Matter

A 62-year-old, Mediterranean male with hypertension, who is otherwise healthy, presents with several red-blue papules on his upper back. These have been growing slowly over the years.



What can it be?

a. Seborrheic keratosis
b. Kaposi's sarcoma
c. Cherry angioma
d. Hemangioma
e. Lymphoma

Answer

This gentleman has *Kaposi's sarcoma* (KS) (**answer b**). KS is caused by human herpes virus 8. There are four variants of KS and they include:

- classic KS,
- African endemic KS,
- KS in iatrogenically immunosuppressed patients and
- AIDS-related epidemic KS.

Our patient has classic or chronic KS, which tends to be more common in people of Mediterranean or Jewish Ashkenazi descent.

Classic KS typically appears as a bluish-red macule on the distal lower legs. The lesion may coalesce with others and form a plaque or become nodular tumours. They may also become somewhat brown and the surface may become verrucous, hyperkeratotic and firm.

A histologic examination can be quite helpful in differentiating nodular KS from kaposiform hemangioendothelioma, angiosarcoma and spindle cell hemangioma.

The treatment of KS is dependant on the extent of the lesions and the clinical disease variant. This gentleman was bothered by the lesions and, since there were only a few lesions, he elected to have them surgically excised.

Other options include cryotherapy and laser surgery (for superficial plaques). Radiotherapy can be used for more extensive, relatively localized lesions. Systemic chemotherapy is used for rapidly progressive KS.

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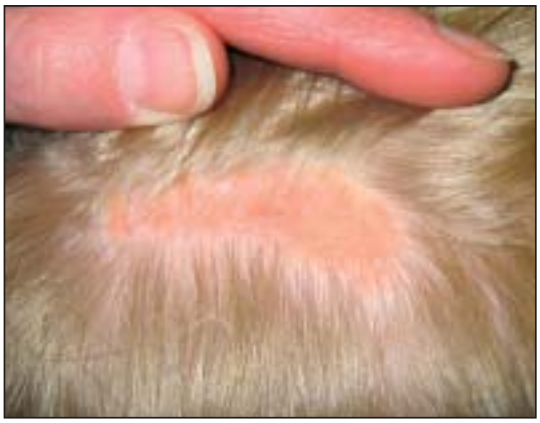
Case 3

"Mommy, what's wrong with my head?"

A five-year-old male presents with an orange plaque on his scalp. There is no hair growth within this plaque.



What do you suspect?

a. Aplasia cutis
b. Trichotillomani
c. Nevus sebaceous
d. Congenital triangular alopecia
e. Juvenile xanthogranuloma

Answer

Nevus sebaceous (**answer c**) is a sharply circumscribed, yellow-orange, verrucous plaque present at birth, most commonly on the scalp. Less commonly, the neck and face are affected. Lesions persist throughout life and are alopecic.

With age, the plaque becomes more verrucous and there is a small possibility of developing benign tumours or even basal cell carcinoma. 0.3% of newborns are affected and all races and both genders are similarly affected.

It is a clinical diagnosis, although the occasional biopsy is needed to verify the diagnosis.

Full-thickness excision near puberty has been the traditional treatment of choice, although watchful waiting and observation is also an option. The development of a papule or nodule warrants biopsy or excision.

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Case 4

Armed with Lesions

A healthy, 26-year-old female presents with asymptomatic, pinpoint lesions on her elbows and proximal forearms. She is not certain when they first appeared, but she has had them for at least a year. On closer inspection, the lesions are round and polygonal and pinkish in colour, with a smooth, flat surface.

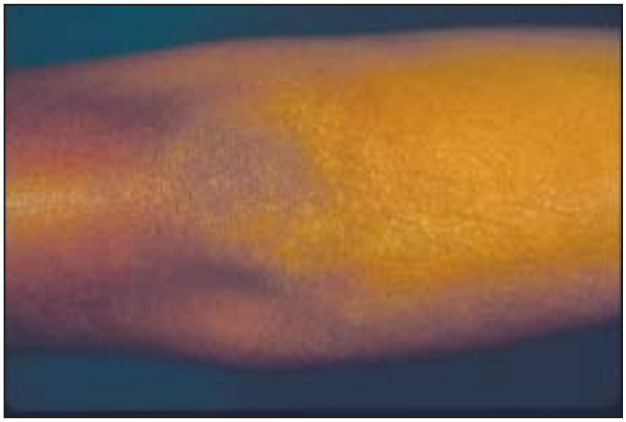
What do you think?

a. Lichen nitidus
b. Lichen planus
c. Lichen spinulosis
d. Flat warts
e. Psoriasis

Answer

Our patient has *lichen nitidus* (LN) (**answer a**). LN is an uncommon skin eruption not related to any systemic illness. It affects < 0.1% of the population and has no strong predisposition for race or age. Although most often occurring on its own, it may occur in nearly 10% of cases of lichen planus. There is rarely mild pruritus.

LN may be found on the flexor surfaces of the arms, the palmar aspect of the wrists, breasts, lower abdomen, groin and the shaft and the glans of the penis. Lesions can also occur at sites of trauma as a row of papules or a plaque. Nails (manifesting as pitting, thickening and ridging) and mucous membranes (manifesting as flat, grey-white papules) can sometimes be involved.



LN can be distinguished clinically from lichen planus by its uniformity of size, lack of violaceous colour and absence of symptoms.

LN typically has a variable course and often spontaneously resolves after several years without scarring. Individual papules can disappear while new ones appear.

Treatment is often symptomatic. Potent topical corticosteroids and oral antihistamines can help control pruritus. Recently, there have been some reports of success with topical tacrolimus. Phototherapy has been used successfully for generalized LN.

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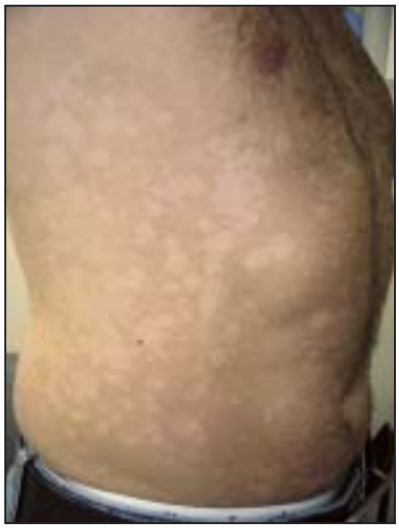
Case 5

"It's spreading!"

A 34-year-old male presents with a one-year history of a spreading, hypopigmented eruption that began on his back and now involves much of his trunk. There are also similar lesions on his neck. These lesions are well-defined, flat-topped patches and plaques with a light scale.



What would you diagnose?

a. Tinea corporis
b. Pityriasis versicolor
c. Psoriasis
d. Eczema
e. Vitiligo

Answer

This patient has *pityriasis (tinea) versicolor* (**answer b**). *Pityriasis versicolor* is a yeast infection of the skin, typically caused by the Malessezia species of fungi. It is found throughout the world and affects all ages and sexes.

The lesions are patches or thin plaques with a mild scale that can be tan (hypopigmented) or brown (hyperpigmented). Hypopigmentation is thought to result from yeast metabolites interfering with melanocyte function or decreased tanning due to the ability of the yeast to filter sunlight. It is often asymptomatic and patients are frequently concerned with the appearance.

The diagnosis can be confirmed by scraping a representative lesion and examining the scales in a potassium hydroxide slide preparation with a light microscope. A "spaghetti and meatballs" appearance of curved hyphae and clusters of round conidia of yeast makes the diagnosis. A culture is difficult and unnecessary.

Topical antimycotic treatments (*i.e.*, topical ketoconazole, 1% or 2%, or 2.5% selenium sulfide shampoo) are often successful. It is often helpful to treat all skin from the neck to the knees. The topical preparation can be applied overnight and washed off in the morning; this should be done twice weekly for two to four weeks. Other topical treatments include some over-the-counter dandruff shampoos, nystatin and salicylic acid.

For more extensive cases, such as our patient, a short course of oral antifungal therapy is often used. Our patient was treated with itraconazole, 200 mg, orally, every day for seven days, in combination with topical ciclopirox.

Recurrences can be common, especially in hot, humid climates. A weekly ketoconazole shampoo used as soap may be helpful. Patients should be advised that pigmentary changes may not resolve for months.

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