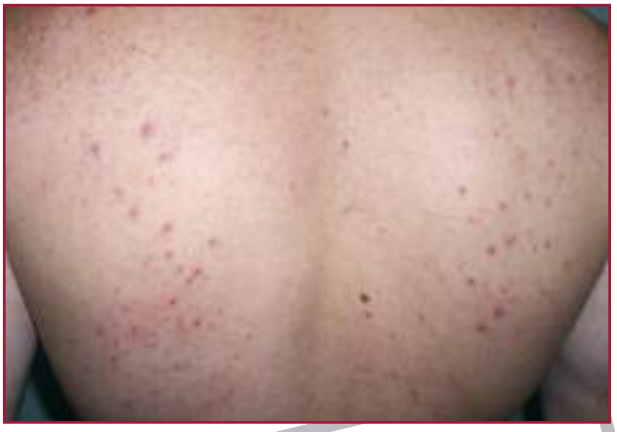
This month – 5 cases:

Case 1

Tender Skin Lesions

This gentleman presents with skin lesions which he has had on his back for the last two years. They are not itchy, but the big ones are tender on deep touch.



What is your diagnosis?

a. Pityriasis rosea
b. Seborrheic keratosis
c. Actinic keratosis
d. Acne vulgaris
e. Acne rosacea

Answer

Acne vulgaris (**answer d**) may be defined broadly as any condition that begins with the microcomedone. This would encompass:

- acne vulgaris,
- neonatal and infantile acne and
- acne fulminans.

However, rosacea and its variants would not encompass the above mentioned. Even though rosacea appear acneiform (*i.e.*, as erythematous papules and pustules on the face), no comedones are seen.

Acne vulgaris is a clinical diagnosis. The presence of open or closed comedones in an adolescent patient usually confirms it. If a patient presents with only pustules on the face, a bacterial culture may be required to exclude bacterial folliculitis.

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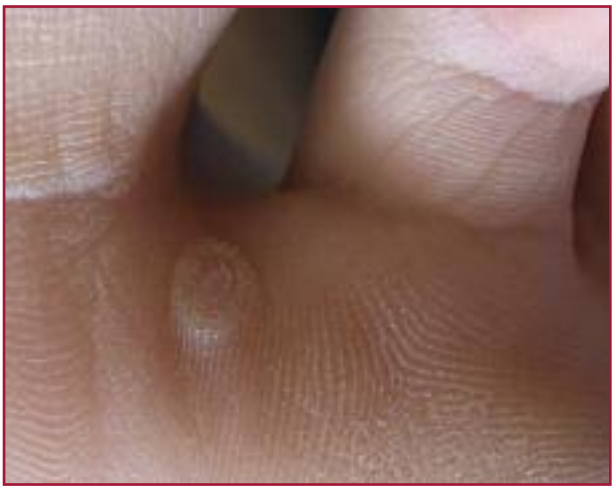
Hayder Kubba graduated from the University of Baghdad, where he initially trained as a Trauma Surgeon. He moved to Britain, where he received his FRCS and worked as an ER Physician before specializing in Family Medicine. He is currently a Family Practitioner in Mississauga, Ontario.

Case 2

A New Growth

This male presents with a recent onset, asymptomatic papule on the sole of his foot.



What is your diagnosis?

a. Dermatofibroma
b. Dermal nevus
c. Pyogenic granuloma
d. Keratoacanthoma
e. Verruca vulgaris (common wart)

Answer

Verruca vulgaris or the common wart (**answer e**) typically presents as a firm, flesh-coloured, hyperkeratotic papule with a rough surface. Characteristic brown or black dots, due to thrombosed capillaries, are often seen on the surface and are considered pathognomonic.

Common warts can occur on any skin or mucosal surface, but most often develop on the hands, knees and feet. They are usually asymptomatic, but can be of significant cosmetic concern.

Common warts are caused by HPV. They have a wide prevalence yet are seen with increased frequency in school-aged children and immunocompromised individuals. Transmission is via direct/indirect contact or autoinoculation.

Diagnosis is usually made based on clinical appearance. If uncertain, a skin biopsy can be performed.

Treatment is not always necessary as approximately 65% of cases will resolve spontaneously within two years. However, for those which do not resolve spontaneously, treatment remains difficult as resistance and recurrence are common and multiple modalities are often required. Some of the more common treatment options include:

- topical keratolytic agents (salicylic acid) with or without occlusion with duct tape,
- cryotherapy with liquid nitrogen,
- contact allergens (*e.g.*, diphenylcyclopropenone),
- topical caustic agents (*e.g.*, trichloroacetic acid),
- intralesional bleomycin,
- intralesional immunotherapy using mumps, *Candida* or *Trichophyton* antigens,
- podophyllotoxin and cantharidin,
- vascular or ablative laser treatment,
- electrodesiccation and curettage,
- excision (especially for single warts) and
- photodynamic therapy, *etc.*

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Case 3

A Bleeding Lesion

A six-month-old infant presents with an ulcerated reddish lesion on the nape of his neck. The lesion was first noticed at two-weeks-of-age. It then became protuberant. The lesion bled profusely on several occasions.

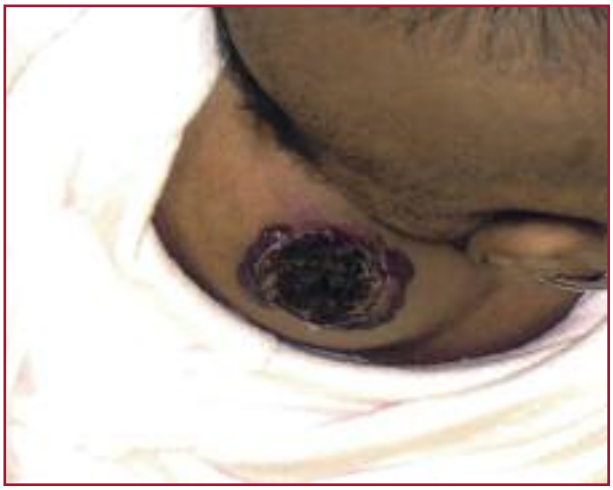
What is your diagnosis?

a. Hemangioma of infancy
b. Nevus flammeus
c. Venous malformation
d. Salmon patch

Answer

Hemangioma of infancy (**answer a**) is a proliferative hamartoma of vascular endothelium. The lesion usually appears in the first few weeks of life as an area of pallor, followed by a telangiectatic patch. The lesion then grows rapidly in the first three to six months of life. Superficial lesions are bright red, protuberant and sharply demarcated and are often referred to as "strawberry hemangiomas" or "capillary hemangiomas." Deep lesions are bluish and dome-shaped. Infantile hemangiomas continue to grow until nine- to 12-months-of-age, at which time the growth rate slows down to parallel the growth of the child.

Involution begins in most cases by the time the child is three- to four-years-old. A central graying of the lesion and shrinkage in size are the visible stages of this process. Half of these lesions will show complete involution by the time a child reaches age five; 70% will have disappeared by age seven and 95% will have regressed by ages 10 to 12. When involution is complete, the skin looks completely normal; partial involution may leave an atrophic scar with a few telangiectatic vessels.



Other complications include hemorrhage, ulceration, disfigurement and vital structure compromise.

The majority of infantile hemangiomas require no treatment. Indications for active intervention include:

- severe or recurrent hemorrhage, unresponsive to treatment,
- threatening ulceration in areas where serious complications might ensue,
- interference with vital structures and
- significant disfigurement.

Treatment options include systemic or intralesional corticosteroids, interferon-α, pulsed-dye laser and surgical resection.

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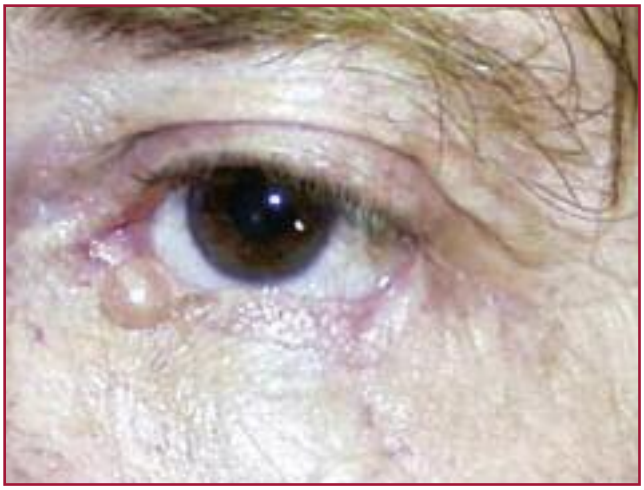
Case 4

A Cystic Papule

A 54-year-old male presents with a small, clear, cystic papule filled with watery fluid, which had been present for several months. The lesion is on his left lower eyelid and measures approximately 4 mm by 5 mm. The patient denies any diplopia, vision loss, or any other lesions on his face or body. Otherwise, he is healthy without any complaints. His family history is unremarkable.



What is your diagnosis?

a. Epidermal inclusion cyst
b. Mucoid cyst
c. Hidrocystoma
d. Lymphangioma

Answer

A hidrocystoma (**answer c**), eccrine and apocrine are rare cystic lesions that form benign tumours of the sweat glands. They present as two distinct types: apocrine hidrocystomas usually occur as single lesions (or multiple, but this is rare) near the eyelids, while the eccrine variant occurs in single or large numbers on the face and neck.

Eccrine hidrocystomas are small and tense thin-walled cysts, ranging from 1 mm to 6 mm in diameter. The cysts tend to stay asymptomatic and will follow a gradual course until a certain size is reached. They are found predominantly in adult females and are located mostly on the periorbital and malar regions.

Apocrine hidrocystomas arise from the proliferation of apocrine glands and are usually solitary, with a diameter of 3 mm to 15 mm. Apocrine lesions are also found mostly on the head and neck and along the eyelid margin near the inner canthus. Apocrine lesions are less likely than eccrine lesions to occur at periorbital regions; nevertheless, the general distribution of lesions tends to occur in similar locations on the body for apocrine and eccrine hidrocystomas.

Eccrine hidrocystomas are prevalent in adults between 30- and 70-years-of-age. Solitary eccrine hidrocystomas are equally prevalent among males and females; however, the multiple eccrine hidrocystomas are mainly seen in female patients.

Apocrine hidrocystomas affect the same age groups as do eccrine hidrocystomas and rarely occur during childhood or adolescence.

Eccrine hidrocystomas and apocrine hidrocystomas have a very similar presentation and their distinction from other head and neck cyst-like lesions must ultimately be verified on biopsy and by careful examination under the microscope.

The most common approach to the treatment of hidrocystomas is simple needle puncture; however, other treatments such as electrodesiccation, anticholinergic creams, carbon dioxide vaporization and laser treatments have all shown success in treating different types of hidrocystomas.

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Case 5

A Facial Rash

This lady's facial rash appeared two days ago. It was proceeded by pain around the eye.

What is your diagnosis?

a. Acne rosacea
b. Herpes zoster ophthalmicus
c. Acne vulgaris
d. Seborrheic dermatitis

Answer

Herpes zoster ophthalmicus (ophthalmic shingles) (**answer b**). This is zoster of the first (ophthalmic) branch of the trigeminal nerve and accounts for 20% of all shingles cases with only thoracic nerves being more commonly affected (55%).

Pain, tingling or numbness around the eye may precede a blistering rash which is accompanied by much inflammation. In 50% of those with ophthalmic shingles, the eye itself is affected and 40% to 77% have corneal signs and 50% to 56% have iritis.

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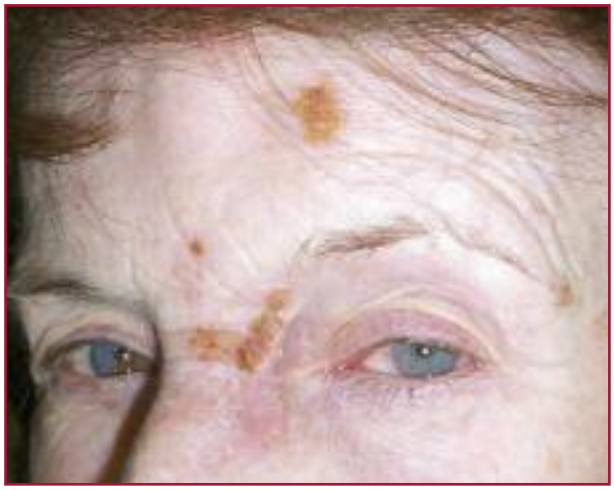
Nose-tip involvement (Hutchison's sign) means involvement of the nasociliary branch of the trigeminal nerve which also supplies the globe and makes it highly likely that the eye will be affected.



A treatment option includes acyclovir. The recommended dosage is 800 mg p.o. five times a day for seven days to:

- reduce viral shedding,
- accelerate healing time and
- reduce incidence of new lesions.

Start treatment within four days of shingles onset. It is advisable for all with ophthalmic shingles to see a specialist within three days to exclude iritis with a slit lamp. Prolonged steroid therapy may be needed.

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