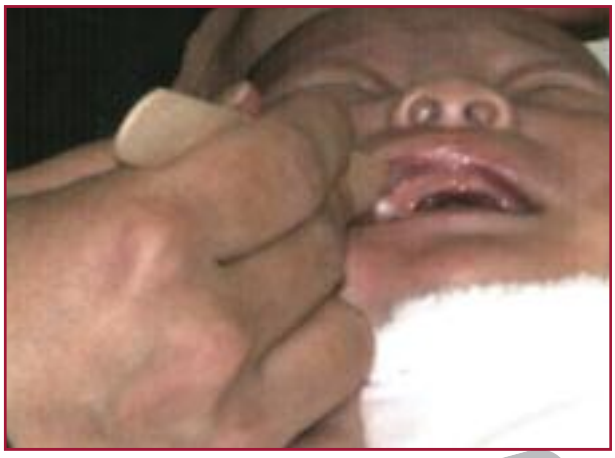
This month – 8 cases:

Case 1

A Whitish Mass

A newborn infant presents with a whitish mass on his upper gum. The infant is breastfed and there is no problem with feeding.



What is your diagnosis?

a. Epstein pearl
b. Neonatal tooth
c. Bohn's nodule
d. Mucocele

Answer

Bohn's nodule **(answer c)** is characterized by a firm, whitish lesion on the buccal and, less commonly, the lingual aspect of the mandibular or maxillary alveolar ridge. The lesion has a rice-like appearance and can be solitary or multiple. It is asymptomatic and does not interfere with feeding.

This condition is often mistaken by parents as an erupting tooth.

Bohn's nodule is often mistaken by parents as an erupting tooth. Once thought of as a mucous gland cyst, recent studies suggest that it is a keratin cyst derived from the dental lamina.

Bohn's nodule tends to shed spontaneously within a few weeks to a few months. No treatment is necessary.

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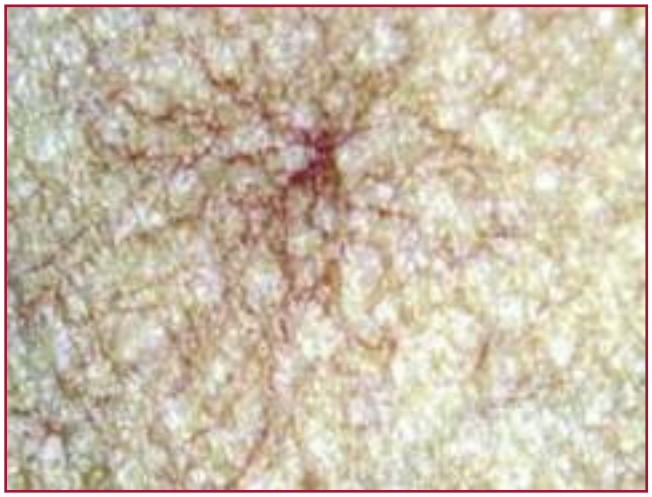
Case 2

Radiating Vessels

A 44-year-old male presents with a few asymptomatic skin lesions on his chest, first noted six months ago. He recently was diagnosed with Hepatitis C. He denies excessive drinking, although he agreed he is sociable. He also has a history of IV drug use about twenty years ago.



What is your diagnosis?

a. Cherry hemangioma
b. Spider angioma
c. Senile angioma
d. Angioma serpiginosum

Answer

Spider angiomas (spider nevus, vascular spider, nevus araneus, arterial spider) **(answer b)** are usually bright red with a small (1 mm), central, red papule surrounded by several distinct radiating vessels. The entire lesion is usually 0.5 cm to 1 cm in diameter. Pressure on the lesion causes it to disappear. Lesions occur most commonly on the face, below the eyes and over the cheekbones. Other common sites include the hands, forearms and ears.

Spider nevi may be benign or indicative of underlying systemic disease. They are seen in 10% to 15% of healthy adults and young children. Most lesions are unrelated to internal disease. Lesions developing during pregnancy or due to OCs usually resolve spontaneously after delivery or on discontinuing the medication. They may also be seen in thyrotoxicosis, patients with rheumatoid arthritis receiving estrogen therapy and women on OCs.

Numerous prominent spider angiomas are one of the strong clinical pointers to severe liver dysfunction in patients with alcoholic liver disease. Spider nevi can be used as one of the most useful parameters for predicting the grade and stage of Hepatitis C with moderate accuracy. Spider nevi also assist in the diagnosis of hepatopulmonary syndrome.

Pregnant women and individuals with liver disease may demonstrate associated palmar erythema. Patients with significant internal disease may exhibit numerous prominent lesions over the trunk and face. Many recent studies have highlighted the importance of spider nevi as a useful sign for the assessment of severity of various hepatic diseases. The spider nevi and thrombocytopenia, with either splenomegaly or hypoalbuminemia, were useful for predicting the presence of hepatic fibrosis in patients with Hepatitis C. Multiple spider angiomata are more frequent in patients with alcoholic cirrhosis and in those with cirrhosis due to Hepatitis C viral infection and alcohol ingestion than in patients with cirrhosis purely due to Hepatitis C virus.

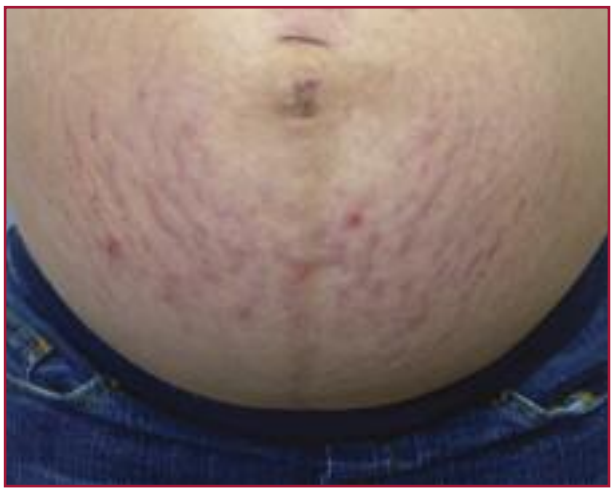
Children do not require any specific treatment, as these lesions are known to fade and resolve spontaneously over time. Electrodesiccation and laser treatments under local anaesthesia are effective therapeutic procedures for facial spider angiomas.

Jerzy K. Pawlak, MD, MSc, PhD, is a General Practitioner, Winnipeg, Manitoba.

Case 3

Pruritic Eruption

This 21-year-old primigravida at 36 weeks gestation was referred with an intensely pruritic eruption present for three weeks. The eruption began in the striae on her abdomen, but slowly started to spread to her lower back and arms.



What is your diagnosis?

a. Prurigo gestationis
b. Pemphigoid gestationis
c. Contact dermatitis
d. Pruritic urticarial papules and plaques of pregnancy
e. Prurigo gravidarum (recurrent cholestasis of pregnancy)

Answer

Pruritic urticarial papules and plaques of pregnancy (PUPPP) **(answer d)** is characterized by tiny (1 mm to 2 mm), erythematous papules, most often occurring in the latter part of the third trimester. It is most commonly seen in primigravidas. It is estimated to occur in approximately 0.33% to 0.76% of all pregnancies. The lesions are extraordinarily itchy, frequently causing the patients difficulty in sleeping at night.

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PUPPP lesions are pruritic papules that frequently begin in striae distensae and then form large plaques centered around the umbilicus. The lesions can progress to involve the buttocks and thighs. Lesions can sometimes occur on the arms, forearms and legs; however, the breasts and face are usually spared. PUPPP usually resolves itself within a few days after delivery and does not tend to recur in subsequent pregnancies.

Treating the lesions twice per day with mid- to high-potency glucocorticoids provides symptomatic relief. New lesions stop forming within a few days and treatment can then be tapered. The eruption often clears spontaneously after delivery.

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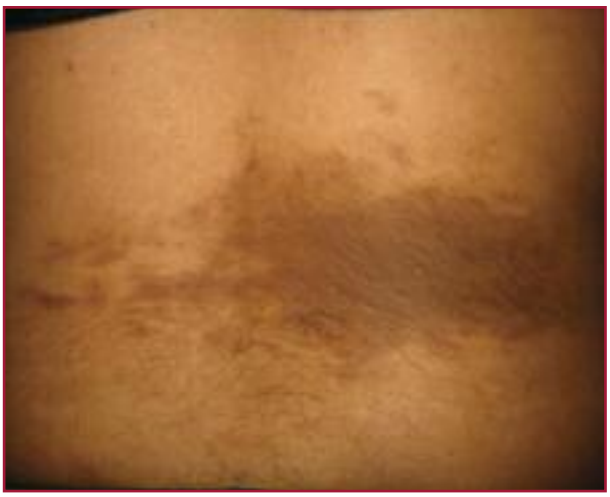
Case 4

A Dark-Brown Patch

A 12-year-old presents to the office with a pigmented, hypertrichotic plaque present since birth. There are no *café-au-lait* spots over the body and the borders of the plaque are feathery. When you stroke the lesion, the hairs seem to become more upright.



What is your diagnosis?

a. Congenital smooth muscle hamartoma
b. Plexiform neurofibroma
c. Congenital melanocytic nevus
d. Becker's nevus
e. Mastocytoma

Answer

A congenital smooth muscle hamartoma **(answer a)** is a benign proliferation of smooth muscles in the reticular dermis that usually presents as a localized hyperpigmented plaque. Rubbing the lesions produces a phenomenon called a "pseudo-Darier's" sign, where the lesion becomes raised with a pebbly surface and transient piloerection. Although congenital, the changes may not be seen until later in life.

A plexiform neurofibroma is on the differential and if unclear, a biopsy needs to be done to rule this out, as this is an early sign of neurofibromatosis type I (NF1). Although neurofibromas in NF1 typically occur later in life, the plexiform neurofibromas may be congenital.

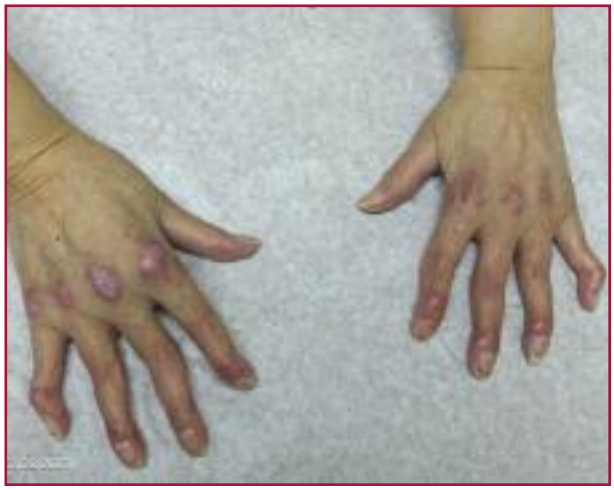
The age of onset, piloerection and feathery borders make a Becker's nevus, mastocytoma and congenital melanocytic nevus less likely.

Joseph M. Lam, MD, is a Pediatrician with two years of Pediatric Dermatology fellowship training. He currently practices in Vancouver, British Columbia.

Case 5

Hand Deformity

This 56-year-old lady just registered with me as her doctor retired. She requested my opinion for her long-standing hand deformity.



What is your diagnosis?

a. Rheumatoid arthritis
b. Osteoarthritis
c. Scleroderma
d. Psoriatic arthritis

Answer

The onset of scleroderma (progressive systemic sclerosis [PSS]) **(answer c)** is insidious. Patients often complain first of Raynaud's phenomenon. The skin in PSS is taut and bound down. It is shiny and may become dyspigmented. The disease may be limited or diffuse. The limited form of PSS is more common and is characterized by slowly progressive hardening of the acral skin, known as sclerodactyly. In diffuse PSS, sclerodactyly is accompanied by widespread involvement of both the skin and the internal organs. Systemic symptoms include fatigue, dysphagia, dyspnea, abnormal bowel function, arthralgias and myalgias. Hypertension may be caused by PSS involving the kidneys.

A variant, known as CREST Syndrome, is characterized by calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly and telangiectasia.

Scleroderma is diagnosed by constellation of findings after the exclusion of other diseases. Once diagnosed, the patient should be assessed for severity of the disease. Laboratory evaluation includes serologic tests for antinuclear antibodies, anticentromere antibody and antitopoisomerase antibody.

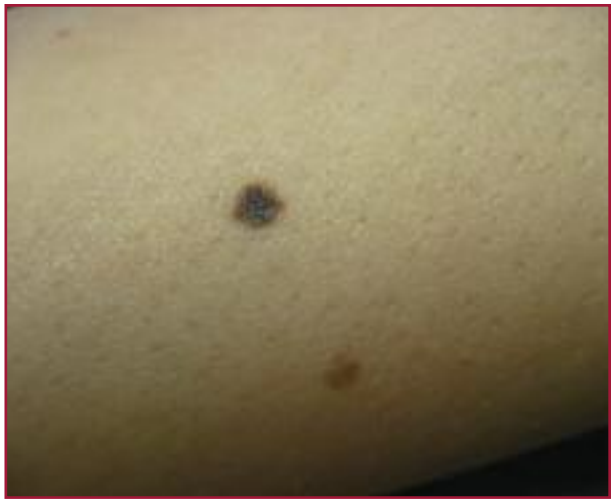
There is no cure for PSS. It is not clear that the process can be arrested or reversed. D-Pencillamine and extracorporeal photopheresis are controversial. Nonspecific therapy is directed at the symptoms and signs, such as calcium channel blockers (nifedipine 30 mg to 60 mg q.d.) or topical nitroglycerin for Raynaud's phenomenon, non-steroidal anti-inflammatories for myalgias and elevation of the head during sleep to prevent aspiration for patients with esophageal dysmotility.

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 6

A Concerning Mole

A 34-year-old female is concerned about a mole on her arm. Her mother recently passed away from melanoma and she now thinks this mole is increasing in size.



What is your diagnosis?

a. Melanoma
b. Benign nevus
c. Pigmented basal cell carcinoma
d. Pigmented actinic keratosis
e. Dysplastic nevus

Answer

A dysplastic nevus **(answer e)** is an acquired melanocytic lesion with controversial definition and criteria, both clinical and histologic. UV radiation is likely an initiator and promoter of the transformation of melanocytes into atypical melanocytes and melanoma. Genetics, along with UV light, determine number and anatomical distribution of nevi. Melanomas can arise *de novo*, as well as from dysplastic nevi. Dysplastic nevi are often:

- Asymmetric,
- have an irregular Border,
- have more than one Colour and
- are larger in Diameter than regular nevi (> 5 mm)

This is referred to as the ABCDs. It is now felt that evolution or changing of a mole is a worrisome sign as well. Dysplastic nevi most commonly develop on the:

- back,
- chest,
- buttocks,
- breasts and
- scalp.

Patients with atypical or dysplastic nevi should be routinely monitored once a year, especially if there is a family history of melanoma. Any lesion changing in size or colour, or developing signs and symptoms, such as bleeding, ulceration, pain or pruritus require immediate assessment and consideration of biopsy.

Benjamin Barankin, MD, FRCPC, is a Dermatologist, practicing in Toronto, Ontario.

Case 7

Erythematous Rash

A 14-month-old boy presents with an erythematous rash in the diaper area. He had otitis media two weeks ago and was treated with amoxicillin for seven days.

What is your diagnosis?

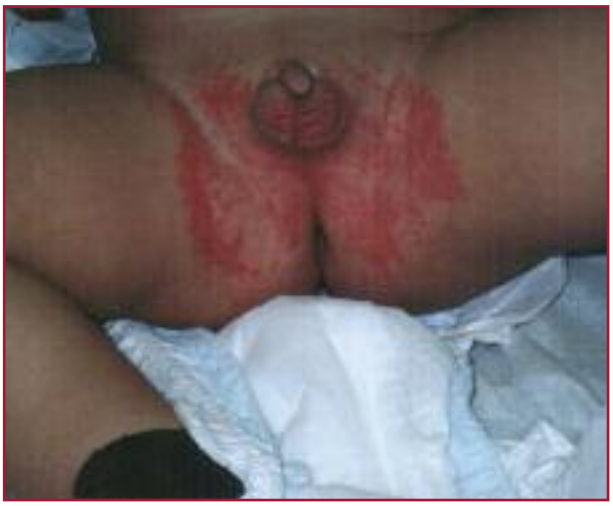
a. Irritant contact dermatitis
b. Candidal diaper dermatitis
c. Allergic contact dermatitis
d. Psoriasis

Answer

Candidal (monilial) diaper dermatitis **(answer b)** is characterized by a beefy red, erythematous rash with a scalloped border and a sharply demarcated margin. The satellite lesions are pathognomonic. Candidal diaper dermatitis is a common sequela of oral or parenteral antibiotic therapy. The condition may be associated with oral thrush.

The condition is characterized by a beefy red, erythematous rash with a scalloped border and a sharply demarcated margin.

The diagnosis is usually clinical and straightforward. If necessary, the diagnosis can be confirmed by microscopic examination of a potassium hydroxide preparation of skin scrapings, which show egg-shaped budding yeasts and hyphae.



Untreated, the rash may spread to the gluteal folds, buttocks and inner thighs. Treatment with a topical anticandidal cream (*e.g.*, nystatin, ketoconazole, miconazole, or clotrimazole) is usually effective. Prompt removal of soiled diapers and aeration of the diaper region are useful adjuncts.

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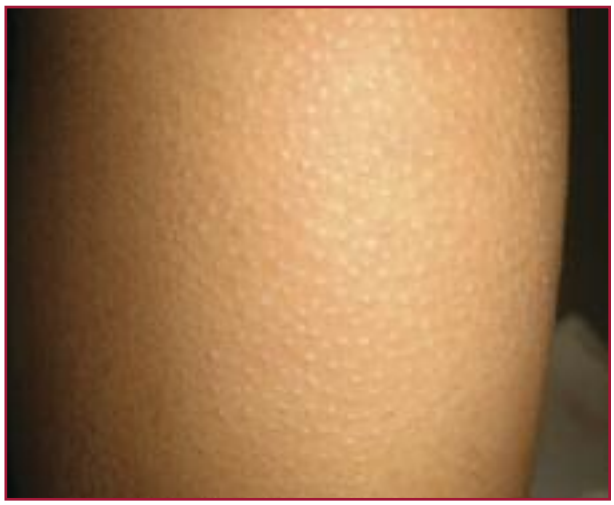
Case 8

Round Plaques

A 10-year-old young boy with a history of dry skin and atopic dermatitis presents with his mother because of round plaques with discrete, flat-topped papules. He is asymptomatic, but is upset because his sister teases him about this.



What is your diagnosis?

a. Lichen spinulosus
b. Atopic dermatitis
c. Tinea corporis
d. Pityriasis alba
e. Mycosis fungoides

Answer

Lichen spinulosus **(answer a)** is an asymptomatic lesion that is commonly seen in patients with dry skin and atopic dermatitis. It presents as round plaques of numerous 1 mm to 2 mm spiny projections that are dry and range from skin-coloured to hypopigmented. The lesions typically respond to topical emmolients and mild topical corticosteroids.

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Lesions of atopic dermatitis are usually very pruritic, unlike lesions of lichen spinulosus. Although tinea may have protean manifestations, it is usually scaly, rather than papular and tends to be pruritic. Pityriasis alba presents as asymptomatic, hypopigmented patches that occasionally have a fine scale.

Mycosis fungoides is a rare disorder and is a form of cutaneous T-cell lymphoma. It generally presents as erythematous, scaly plaques or, in children, as hypopigmented macules and patches. Neither tinea corporis, pityriasis alba or mycosis fungoides present with tiny round collections of fine papules.

cme

Joseph M. Lam, MD, is a Pediatrician with two years of Pediatric Dermatology fellowship training. He currently practices in Vancouver, British Columbia.