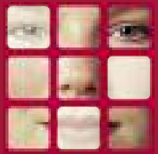


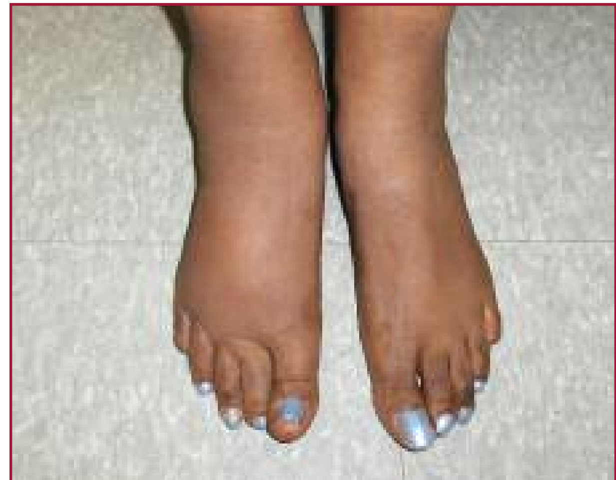
This month – 6 cases:

1. Leg Swelling p.37
2. Flesh-Coloured Papules p.38
3. A Teenage Bald Spot p.39
4. Warty Lesions p.40
5. Excruciating Pain in the Joint p.41
6. A Facial Crust p.42

Case 1

Leg Swelling

This lady presents with left leg swelling that started about three months ago. It started with fever which resolved after a week. Her examination reveals right inguinal lymphadenopathy. She recently came to Canada from Cameroon.



What is your diagnosis?

a. Cellulites
b. Deep venous thrombosis
c. Filariasis
d. Myositis

Answer

Filariasis **(answer c)** is very common. The prevalence is 18 million worldwide. Lymphatic filariasis occur in Asia, Africa and South America and is transmitted by mosquito vectors. Acute infections cause fever and lymphadenitis. Wuchereria bancrofti causes lower limb lymphedema (elephantiasis) and hydroceles. Brugia malaya causes elephantiasis below the elbow/knee. You should have a low index of suspicion for filariasis in immigrants from endemic areas presenting with lymphedema—arrange for a blood film and serology to confirm the diagnosis.

The prevalence of the condition is 18 million worldwide.

Immune hypersensitivity may cause tropical pulmonary eosinophilia (cough, wheeze, lung fibrosis, high eosinophil counts, increased IgE and IgG). It is a major public health problem and has been targeted by the World Health Organization for elimination (*e.g.*, mass treatment with ivermectin and diethylcarbamazine).

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.

Copyright© Not for Sale or Commercial Distribution
Unauthorised use prohibited. Authorised users can download, display, view and print a single copy for personal use

Case 2

Flesh-Coloured Papules

A six-year-old boy presents with numerous smooth, flesh-coloured and slightly pink, flat-topped papules over his forehead for the past six months.

What is your diagnosis?

a. Flat warts (verrucae plana)
b. Facial angiofibroma
c. Early comedonal acne
d. Darier disease
e. Milia

Answer

Flat warts (verrucae plana) **(answer a)** usually occur on the face, neck, arms and legs and present as smooth, flesh-coloured to slightly pink or brown, flat-topped papules measuring 2 mm to 5 mm in diameter. They can vary from a few lesions to several hundred lesions. Contiguous warts may coalesce to form larger, plaque-like lesions. Linear arrangements of the papules in areas of scratching can result from koebnerization (*i.e.*, skin lesions appearing on areas of trauma).

They usually occur on the face, neck, arms and legs and can vary from a few lesions to several hundred lesions.

Facial angiofibromas are firm, discrete papules associated with tuberous sclerosis. They are most often located in the nasolabial folds and on the chin and cheeks. Comedones are seen in acne, which would be unusual in this age group. Darier disease, also known as keratosis follicularis, is an autosomal dominant disorder that commonly manifests as flesh-coloured papules that become covered with a yellow, waxy, scaling crust. Milia are tiny 1 mm to 2 mm pearly white or yellow papules, particularly prominent on the:

- cheeks,
- nose,
- chin and
- forehead.

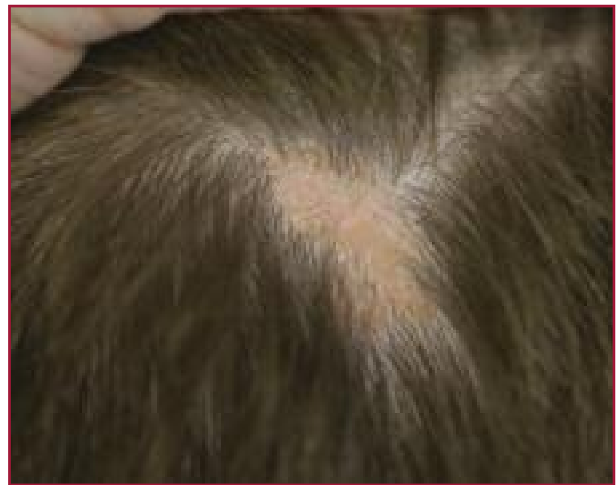
They result from retention of keratin within the dermis.

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

Case 3

A Teenage Bald Spot

A 14-year-old boy presented with an area of congenital baldness. His past medical history was unremarkable. He and his mother had noted that the area had become thickened in the past year.



What is your diagnosis?

a. Congenital melanocytic nevus
b. Aplasia cutis
c. Alopecia associated with birth complication (caput succedaneum)
d. Nevus sebaceous

Answer

Nevus sebaceous **(answer d)** (nevus sebaceous of Jadassohn) are epidermal harmatomas that occur in < 1% of all neonates. They consist of raised, pink, yellow, orange or tan plaques that are hairless. The lesions may be oval or linear and may range in size up to 10 cm or greater. They usually occur on the scalp or on the head and neck region. When occurring on the scalp, the hair is absent and typically presents as a bald patch after birth.

Nevus sebaceous may become prominent after birth and remain unchanged until puberty, when they may become thickened and more elevated. There is a low but potential risk of malignant transformation (likely < 5%) with basal cell carcinoma reported to occur within the lesion. Benign proliferations that can mimic basal cell carcinomas (trichoblastomas) can also occur and may overestimate the rate of basal cell carcinoma occurrence.

Removal is generally not necessary; however, excision would be the primary treatment which can result in an excellent cosmetic result. Changes within these lesions should prompt referral, assessment and possible biopsy of the lesion.

Ashley E. Sutherland, BSc, is a Research Assistant, Division of Dermatology, Department of Medicine, Dalhousie University, Halifax, Nova Scotia.

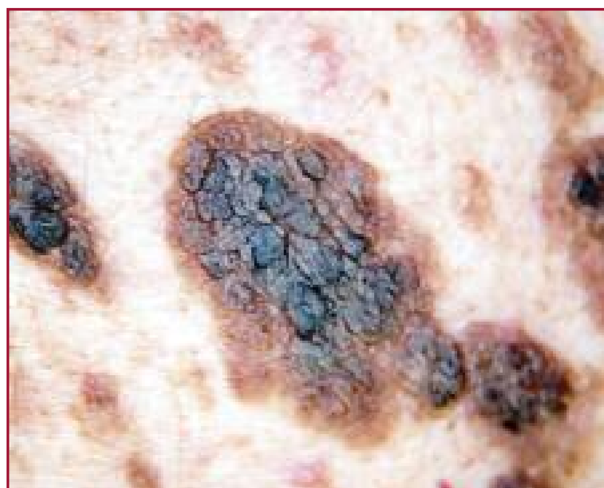
Richard G. B. Langley, MD, FRCPC, is a Dermatologist, Associate Professor and Director of Research, Division of Dermatology, Department of Medicine, Dalhousie University, Halifax, Nova Scotia.

EZETROL® is indicated as adjunctive therapy to diet, when the response to diet and other non-pharmacological measures has been inadequate.
EZETROL®, administered alone or with a statin, is indicated for the reduction of elevated TC, LDL-C, Apo B, and TG and to increase HDL-C in patients with primary hypercholesterolemia.
EZETROL®
ezetimibe
CHOLESTEROL ABSORPTION INHIBITOR
PRODUCT MONOGRAPH AVAILABLE UPON REQUEST
®Registered trademark used under license by Merck Frosst-Schering Pharma, G.P.
MERCK FROSST / Schering
Pharmaceuticals
Merck Frosst-Schering Pharma, G.P.
Kirkland, Quebec H9H 3L1
PAAB
EZT-06-CDN-44200537F-JA

Case 4

Warty Lesions

A 72-year-old retired carpenter presented with a six-year history of a steadily increasing number of warty lesions on his back and chest, occasionally pruritic.



What is your diagnosis?

a. Melanocytic nevus
b. Seborrhoeic keratosis
c. Actinic keratosis
d. Pigmented basal cell carcinoma

Answer

Seborrhoeic keratosis (seborrhoeic wart, basal cell papilloma) **(answer b)**. This is a very common, benign tumour, usually pigmented, consisting of a proliferation of basal keratinocytes. Many seborrhoeic keratosis occur in sun-exposed areas, mostly found on the trunk and face. It is commonly acquired as a familial trait with no potential of malignant changes within the tumours.

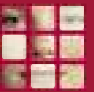
The condition occurs in sun-exposed areas, mostly found on the trunk and face.

A profuse eruption of seborrhoeic keratosis very occasionally has given rise to a malignant melanoma. They are often multiple, affect the elderly and are generally round or oval in shape. They start as small papules, often lightly pigmented or yellow, become darkly pigmented warty nodules 1 cm to 6 cm in diameter. The surface characteristics vary with the age of the lesion and location. The border may be round and smooth or irregular and notched, resembling sometimes malignant melanoma.

Multiple lesions can be adequately dealt with using liquid nitrogen cryotherapy. Thicker seborrhoeic warts are best treated by curettage or shave biopsy, with cautery or hyfrecation. If there is any doubt about diagnosis, excision and histological examination are strongly advised.

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

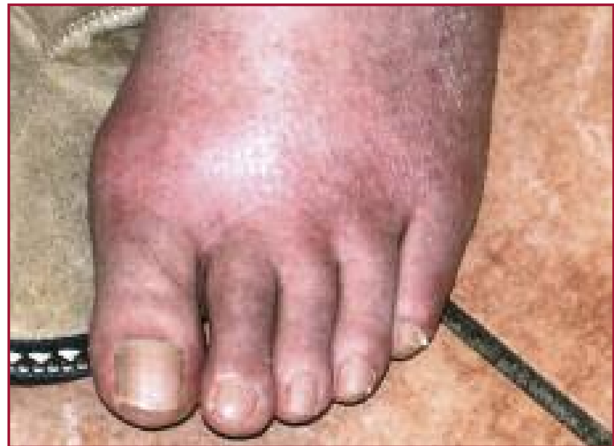
T. J. Kroczak, BSc, is a Third Year Student, University of Manitoba, Winnipeg, Manitoba.



Case 5

Excruciating Pain in the Joint

A 48-year-old man presents with recurrent attacks of excruciating pain in the left first metatarsophalangeal joint for the past year. Other joints are not affected. There is no history of associated fever, urethral discharge, or skin rash. There is no joint deformity.



What is your diagnosis?

a. Reiter's disease
b. Lyme disease
c. Gouty arthritis
d. Rheumatoid arthritis

Answer

Gouty arthritis **(answer c)** is characterized by recurring acute arthritis, usually monoarticular or oligoarticular and later chronic deforming arthritis. The pain is usually excruciating, often accompanied by erythema and edema of the overlying skin. The peak incidence is the fifth decade. The male to female ratio is 9:1.

The condition is associated with increased amounts of urates in the body. The hyperuricemia may be due to overproduction or underexcretion of uric acid, or both. Gouty arthritis may be triggered by trauma, heavy alcohol intake and excessive intake of red meat. The condition may be associated with obesity, impaired glucose tolerance, hypertension, hypertriglyceridemia, myeloproliferative disorders, multiple myeloma, sarcoidosis and medication use (*e.g.*, diuretics, cyclosporine and niacin). If untreated, it may lead to tophi, nephropathy and uric acid nephrolithiasis. Acute gout can be treated with colchicine, indomethacin, or corticosteroids depending on the age of the patient and comorbid conditions.

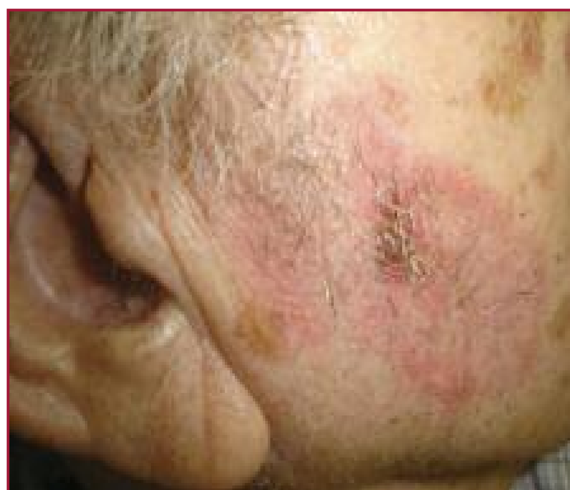
Alexander K. C. Leung, MBBS, FRCPC, FRCP (UK and Irel), is a Clinical Associate Professor of Pediatrics, University of Calgary, Calgary, Alberta.

Alexander G. Leong, MD, is a Medical Staff at the Asian Medical Clinic, an Affiliate with the University of Calgary Medical Clinic, Calgary, Alberta.

Case 6

A Facial Crust

This 70-year-old male has had a crust under his right sideburn area for three months. He has been using an OTC topical antibiotic on the crust with no improvement but an increasingly red eruption of the area.



What is your diagnosis?

a. Tuberculosis cutis
b. Contact dermatitis
c. Cellulitis
d. Infiltrating carcinoma
e. Bowen's disease

Answer

He has developed a contact dermatitis **(answer b)** to the topical antibiotic that he has used. Of the topical OTC antibiotics commonly used, neomycin and bacitracin are the most likely to cause a contact dermatitis. Neomycin is only by prescription in Canada however. Bacitracin may also cause a contact urticaria or even an anaphylactic reaction when applied to large open wounds.

Of the topical OTC antibiotics commonly used, neomycin and bacitracin are the most likely to cause this condition.

The eruption cleared once the topical antibiotic was stopped and a topical steroid applied. The crust proved to be a squamous cell carcinoma.

cme

Stanley Wine, MD, FRCPC, is a Dermatologist in North York, Ontario.