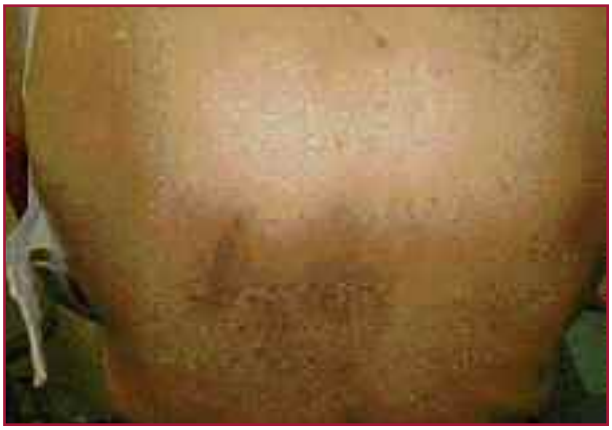
This month – 6 cases:

Case 1

An Itchy Back

This 50-year-old female has had an itchy mid back for eight years. Recently, she was told that the involved area had become darker in colour.



What is your diagnosis?

a. Lichen sclerosis chronicus
b. Macular amyloidosis
c. Lentigo maligna
d. Notalgia paresthetica
e. Lichen planus

Answer

Notalgia paresthetica **(answer d)** refers to a local intense pruitus over the medial and inferior scapular borders. There is usually little to be seen except a well-circumscribed, hyerpigmented, macular change occasionally with excoriations.

There is also little to be seen on a biopsy aside from increased melanophages probably secondary to the chronic scratching at the area.

Macular amyloidosis can have a similar presentation but on biopsy would show an amyloid deposition.

There have been several studies trying to explain the mechanism of chronic itch in this area but it probably represents a sensory neuropathy yet to be determined.

Treatment has included topical and intralesional steroids, topical lidocaine, topical capsaicin products, all of which must be applied frequently to be effective and at that minimally so. Paravertable blocks have also been effective at times.

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

Case 2

Swollen Toes

This 65-year-old lady presented with swollen big toes, which started a year or so ago. She gets recurrent attacks of severe pain in the toes.

What is your diagnosis?

a. Tophaceous gout
b. Rheumatoid arthritis
c. Osteoarthritis
d. Psoriatic arthritis

Answer

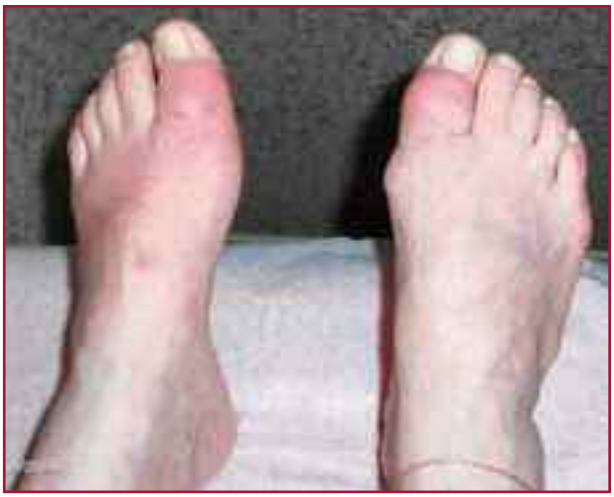
Tophaceous gout **(answer a)** or chronic gout happens after recurrent acute attacks of gout, when urate deposits (tophi) are found in avascular areas (*e.g.*, pinna, tendons, joints and eyes).

Acute attacks of gout are characterized by severe pain, redness and swelling in the affected joint, often the metatarsophalangeal joint of the big toe. Attacks are due to hyperuricemia and the deposition of sodium monourate crystals in joints and may be precipitated by trauma, surgery, starvation, infection and diuretics.

Diagnosis depends on finding urate crystals in tissues and synovial fluid (serum uric acid is not always increased). Synovial fluid microscopy will show negatively birefringent crystal and neutrophils.

X-rays may show only soft-tissue swelling in the early stages. Later, well-defined "punched out" lesions are seen in juxta-articular bone. There is no sclerotic reaction and joint spaces are preserved until late.

Treatment of acute gout is with NSAIDs such as prompt ibuprofen or naproxen 750 mg stat, the 250 mg t.i.d. p.o. If contraindicated (*e.g.*, peptic ulcer), give colchicine 1 mg p.o. initially, then 0.6 mg q.2.h. p.o. until the pain goes or diarrhea and vomiting occurs or 10 mg has been given.



In renal failure, NSAIDs and colchicine are problematic. Steroids can be very effective, but have their own side-effects. Debulking operations are needed for tophaceous gout.

Avoid purine-rich foods (offal, oily fish), obesity and alcohol excess. No ASA should be taken, as it increases serum urate level.

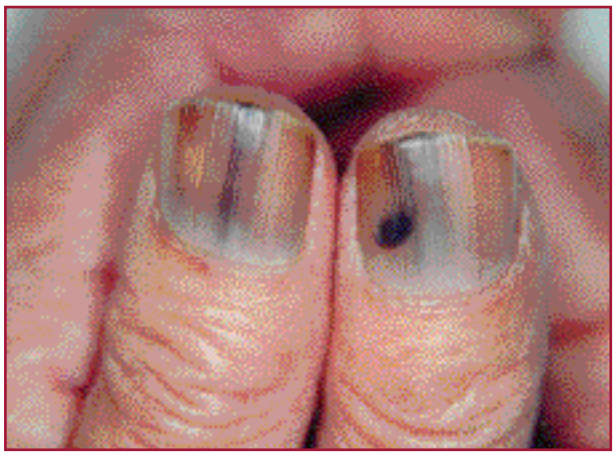
Consider reducing serum urate with long-term allopurinol, but not until three weeks after an attack. Allopurinol 100 mg to 300 mg q.d. p.o., adjusted in the light of serum urate levels (typically 200 mg q.d.; maximum 300 mg t.i.d.). Side-effects are rash, fever, decreased white blood cell count; if troublesome, substitute with a uricosuric drug (*e.g.*, probenecid 0.5 mg b.i.d. p.o.).

Hayder Kubba, MBChB, LMCC, CCFP, FRCS(UK), DFFP, DPD, 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 3

Darkened Thumbnails

A 69-year-old West-Indian female has some concerns about her thumbnails.



What is your diagnosis?

a. Pigmented bands
b. Pigmented bands with subungual hematoma
c. Pigmented bands with melanoma
d. Longitudinal ridging and beading

Answer

Pigmented bands with melanoma or pigmented bands with subungual hematoma if history of trauma **(answers b and c)**.Without history of trauma, a subungual hemorrhage may be hard to tell from a melanoma. A pigmented subungual lesion is more frequently malignant than benign and should therefore be biopsied.

The spontaneous appearance of such a band in a Caucasian person will promptly require biopsy.

Junction nevi can appear in the nail matrix and produce a brown, pigmented band. Brown longitudinal bands are common in black people but rare in Caucasians. A large variety of tumours can occur under the nail but these are rare. A malignant melanoma occasionally arises under the nail plate as it does elsewhere. The growth is usually painless and slow growing and can occur anywhere around or under the nail. The lesion may begin as a pigmented band that increases in width. The combination of a solitary pigmented streak and pigmentation of the posterior nail fold is diagnostic of melanoma (Hutchinson's sign). The spontaneous appearance of such a band in a Caucasian person will promptly require biopsy.

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 4

A Protruding Mass

A five-month-old Chinese infant presents with a mass protruding from the umbilicus. The mass has been noted in the neonatal period soon after the umbilical cord fell off. The mass is soft. It increases in size when the infant cries or strains and is reducible inside the abdomen by external pressure.

What is your diagnosis?

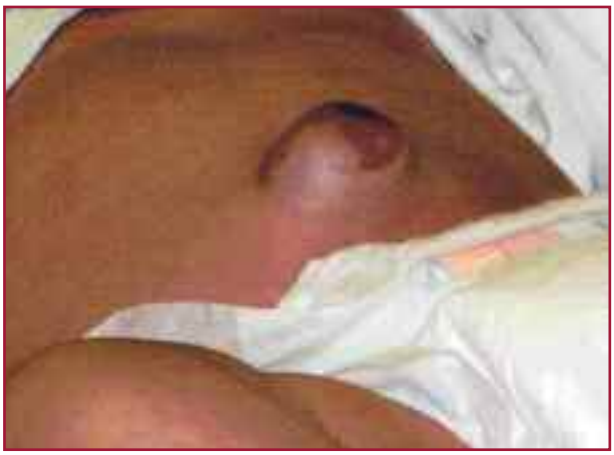
a. Paraumbilical hernia
b. Umbilical granuloma
c. Umbilical cutis
d. Umbilical hernia
e. Patent omphalomesenteric duct

Answer

This is an umbilical hernia **(answer d)** which results from imperfect closure or weakness of the umbilical ring. Classically, an umbilical hernia presents as a soft, skin-covered swelling that protrudes through the fibrous ring at the umbilicus.

The umbilical bulge becomes more apparent during episodes of crying, coughing, or straining and is easily reducible. The content usually consists of a piece of small intestine and sometimes omentum. The condition is most common among Chinese and black infants and is more common in premature than term infants.

Umbilical hernia occurs with increased frequency in patients with Down syndrome, trisomy 13, trisomy 18, congenital hypothyroidism, Beckwith-Wiedemann syndrome and mucopolysaccharidosis.



Most umbilical hernias resolve spontaneously within the first year of life. Rarely, surgery may become necessary if the hernia becomes incarcerated or strangulated, increases in size after the first year of life, or persists for five years. Repair of the hernia at the age of two to three years is advocated by some surgeons if the fascial defect is > 2 cm.

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

Case 5

Depressed Plaque

A 14-year-old female presents to your office with a depressed plaque over the right mid back for three months. It began as a red patch over the area and she thought something she slept on had left a depression over her back. Over the initial few weeks, the lesion became more depressed but is now extending much more slowly.

What is your diagnosis?

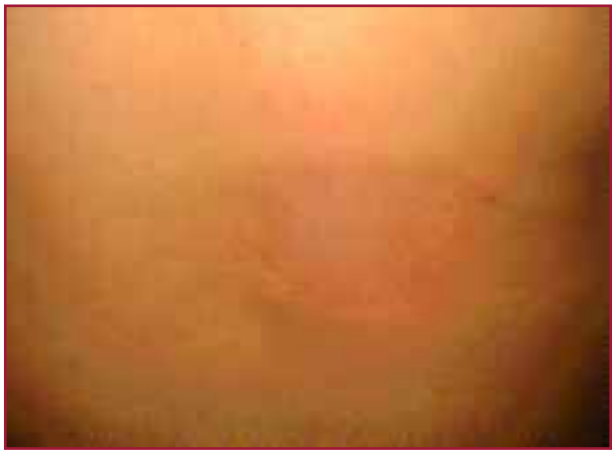
a. Corticosteroid atrophy
b. Atrophoderma of Pasini and Pierini
c. Systemic sclerosis
d. Anetoderma
e. Scleredema

Answer

Atrophoderma of Pasini and Pierini **(answer b)** is a relatively uncommon atrophic disorder of the skin of unknown etiology. Although it can appear at any age, it usually affects patients in their early teens. There is a clear female predominance.

The lesion begins as an asymptomatic patch of atrophy on the trunk, usually over the back. Over the course of weeks, the lesion develops grey to brown pigmentation with slow extension of the atrophic plaque. The edges of the lesion have a characteristic "cliff-edge" border, which helps establish the diagnosis.

The course of atrophoderma is benign and there is no known effective treatment. The disorder remains active for months to years and lesions tend to increase in number and may persist indefinitely. There are no reports of systemic involvement or complications.



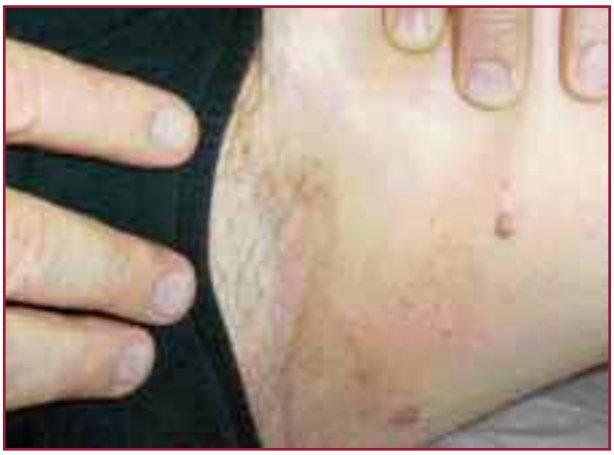
There is no history of topical corticosteroid use in this patient and the sharp drop-off at the borders is not seen with corticosteroid atrophy. Although atrophoderma of Pasini and Pierini is postulated to be a variant of morphea, there is no systemic involvement, distinguishing this from systemic sclerosis. Anetoderma is characterized by small oval lesions of thin, soft, loosely wrinkled, depigmented outpouchings of skin that result from weakening of the connective tissue of the dermis. Scleredema is a rare disorder of diffuse large areas of induration of skin, usually following a streptococcal infection in children.

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

Case 6

Hanging Lumps

This 47-year-old gentleman is quite bothered by these "hanging lumps" as he called them. He wanted to know what they are and whether anything can be done about them.



What is your diagnosis?

a. Dermatofibroma
b. Papilloma
c. Skin tag
d. Seborrheic keratosis
e. Neurofibromas

Answer

Skin tags **(answer c)** are asymptomatic and extremely common. They are small (1 mm to 3 mm), flesh-coloured or brown papules. They are usually pedunculated. Skin tags can occur anywhere on the body, but are particularly common around the neck, in the groin or axillae, or under the breasts in women. They occur more often in people who are obese and tend to run in families.

Skin tags can be confused with seborrheic keratosis, neurofibromas, or nevi. Seborrheic keratosis often have a bumpy surface. Neurofibromas tend to be compressible and larger than skin tags. Nevi frequently are larger than skin tags and more darkly pigmented.

The diagnosis is made on examination. It can be confirmed by shave biopsy.

Skin tags that are asymptomatic are treated mainly for cosmetic reasons. Additional reasons for treating skin tags include colour change, bleeding, itching and interference with clothing. The lesions may be removed by shearing at the base with a scalpel or scissors. They can also be destroyed by light electrodesiccation or cryosurgery.

Skin tags are benign lesions. Like any other skin growth or area of skin, they can rarely be the sight of development of malignancy so change of colour should not be ignored. Any person who has a few skin tags will likely develop more as time progresses.

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