This month – 6 cases:

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Case 1

Blisters on the Soles

This 70-year-old male has had a problem with blisters on his soles since childhood. They are most likely to occur when walking on sand or in hot weather. His sister has a similar problem.

What is your diagnosis?

a. Bullous impetigo
b. Herpes simplex
c. Contact dermatitis
d. Bullous pemphigoid
e. Epidermolysis bullosa simplex

Answer

Epidermolysis bullosa simplex **(answer e)** is a dominantly inherited condition. Typically, blisters occur over areas of friction such as the elbows, knees, hands and soles. Blisters may be noted at birth but especially when the child starts to crawl or walk.

Typically, blisters occur over areas of friction such as the elbows, knees, hands and soles.

Blistering is worse during the hot summer months. There may be associated hyperhidrosis. Scarring does not occur.

Treatment involves patient education to avoid frictional injury. Use of drying agents such as Drysol™ once or twice daily often reduces the severity of blistering.

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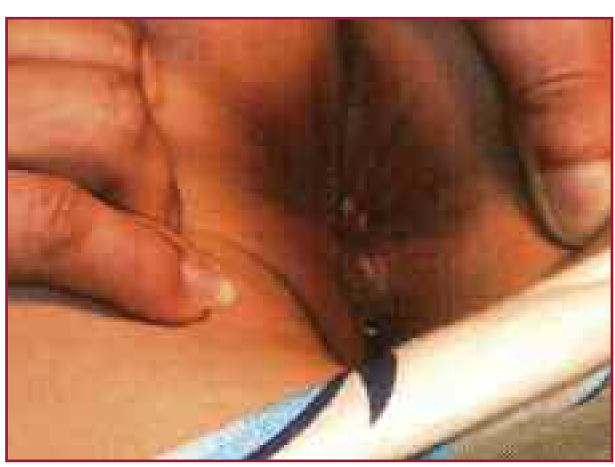
Case 2

Warty Lesions

An 18-month-old boy is noted to have multiple warty lesions in the perianal area. His mother did not have antenatal care. The child was born at term, following a normal spontaneous vaginal delivery.



What is your diagnosis?

a. Condylomata acuminata
b. Infantile perianal pyramidal protrusion
c. Molluscum contagiosum
d. Genital herpes

Answer

Condylomata acuminata **(answer a)** are anogenital warts caused by HPV, notably, types 6, 11, 16 and 18. The majority of cases younger than three-years-of-age are due to vertical transmission of the virus during birth. In the older age group, condylomata acuminata often occur after sexual contact. Non-sexual transmission via intimate contacts is also possible.

The lesions are usually multiple and begin as soft, flesh-coloured, flat or ragged papules. They may coalesce to form velvety plaques, discrete warty papules, or cauliflower-like growths. Condylomata acuminata most commonly occur in the perianal areas. They can also occur on the labia, vulva, scrotum, or penis. Extension of the lesions into the anal canal or vagina is rare in children.

The treatment of condylomata acuminata consists of topical application of podophyllin, podophyllotoxin, or imiquimod. As spontaneous resolution occurs in > 50% of cases within five years of diagnosis, non-intervention is a reasonable initial option. Occurrence of condylomata acuminata in prepubertal children, especially in those over three-years-of-age, should raise questions of child abuse.

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Case 3

A Case of the Bumpy Fingers

A one-year-old female presents to the clinic with discrete, deep-seated, painful ulcers on an erythematous base overlying her ring finger. The lesion was first noticed the previous week after a family reunion and was vesicular at that time. There was a family member with a cold sore.

What is your diagnosis?

a. Bullous impetigo
b. Acropustulosis of infancy
c. Herpetic whitlow
d. Scabies
e. Sucking blister

Answer

Herpetic whitlow **(answer c)** is a unique form of herpes simplex virus (HSV) seen in individuals who have contact with the mouth or genital regions of others with herpetic lesions. The virus is inoculated onto the finger, causing a deep-seated, painful vesicular or bullous eruption with erythema. Resolution usually occurs spontaneously over three weeks time if the condition is left untreated. The diagnosis can be confirmed by viral culture or direct fluorescent antibody testing with the treatment of choice being oral acyclovir (which may help to alleviate pain and allow for more rapid healing).

Bullous impetigo is a superficial skin infection most commonly caused by streptococci, or staphylococci, which presents more frequently as tender, shallow erosions bordered by a remnant of the blister roof or as flaccid, thin-walled bullae.

Acropustulosis of infancy is an idiopathic pustular disorder more commonly located on the palms and soles and begins as pinpoint erythematous papules that enlarge into well-circumscribed discrete pustules.

Scabies is a skin infestation by the mite *Sarcoptes scabiei*. The initial symptom is usually pruritis particularly during the night time with skin findings of papules, nodules, burrows and vesiculopustules typically in the interdigital spaces following.

Sucking blisters are caused by vigorous sucking on the affected area *in utero* and are seen in normal newborns as 0.5 cm to 2 cm oval bullae or erosions on the dorsal aspect of the fingers.

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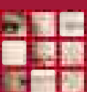


Case 4

A Nasal Lesion

This gentleman presented with this nasal lesion, which he described as skin roughness, which has been present for quite a few years.

What is your diagnosis?

a. Squamous cell carcinoma
b. Rhinophyma
c. Basal cell carcinoma
d. Acne vulgaris

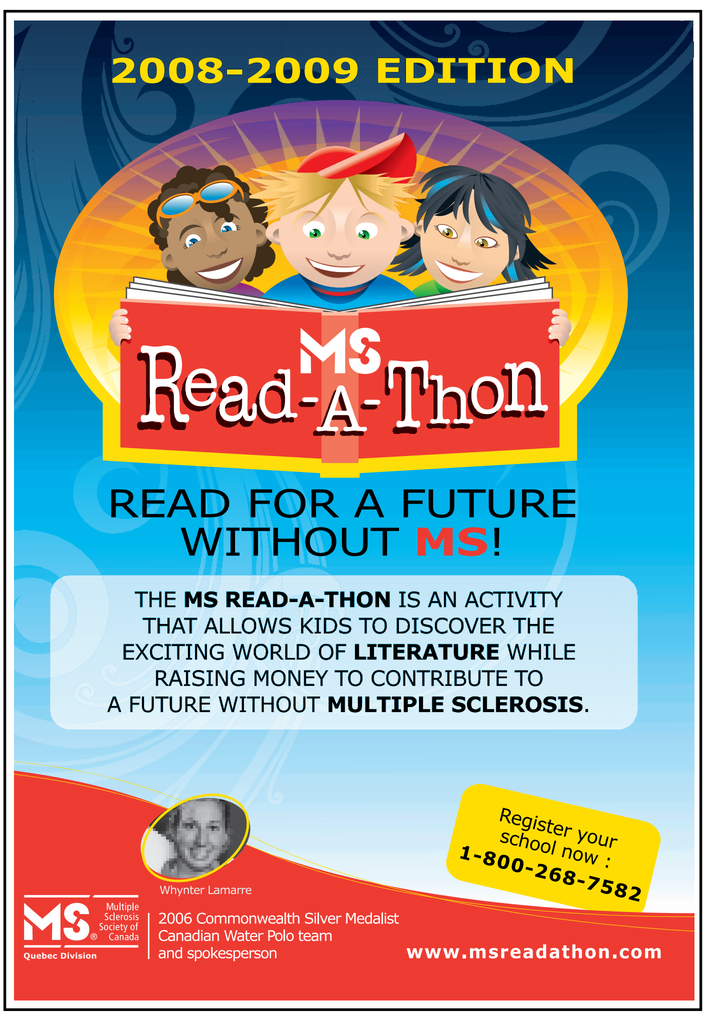
Answer

The cause of rhinophyma **(answer b)** is unknown. It is due to hypertrophied sebaceous glands.

It usually affects men, where there is skin thickening that can cause gross nasal excrescences which may respond to peeling away of the skin.

Blepharitis, conjunctivitis and corneal vascularization can occur.

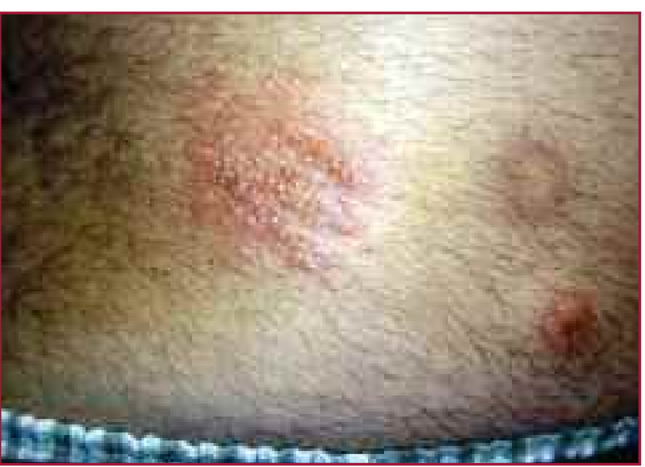
Hayder Kubba, MBChB, LMCC, CCFP, FRCS(UK), DFFP, DPD, graduated from the University of Baghdad, where he initially trained as a Trauma Surgeon. He moved to Britain, where he received his FRCS and worked as an ER Physician before specializing in Family Medicine. He is currently a Family Practitioner in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



Case 5

Weeping Blisters

A 25-year-old male presents with an itchy rash on the right side of his back, consisting of weeping blisters grouped in a linear fashion.



What is your diagnosis?

a. Psoriasis
b. Insect bites
c. Urticaria
d. Contact dermatitis

Answer

Contact dermatitis (poison ivy contact dermatitis) **(answer d)**. In Canada and the US, poison ivy, poison oak and poison sumac produce more cases of allergic contact dermatitis than all other contactants combined. These plants belong to the *Anacardiaceae* family and the genus *Rhus*. This contact occurs from contact with the leaf or internal parts of the stem or root. All parts of the plant contain a potent sensitizing oleoresin called urushiol. The clinical presentation varies with the quantity of oleoresin contacting the skin, individual susceptibility and regional variation in cutaneous reactivity. Small quantities of oleoresin produce only erythema, but large quantities cause intense vesiculation.

The itchy rash characteristic of an allergic reaction to poison ivy, oak, or sumac usually develops within 12 to 48 hours after a sensitized person comes in contact with the urushiol. The time may be as short as four hours or as long as 10 days, depending on one's sensitivity and the extent of the contact. The rash is usually self-limited—it is at its worst after about five days and then gradually improves within a week or two even without treatment.

At first, the skin that has touched the plant or the urushiol becomes red and then bumps and blisters appear. This is usually accompanied by itching and sometimes by swelling. After reaching their peak in several days, the blisters break and the oozing sores begin to crust over and disappear. The rash rarely occurs on the scalp, palms of the hands, or soles of the feet because the outer skin there is very tough and it is difficult for the plant oil to penetrate. Scratching the rash may introduce bacteria into the open sores, causing a secondary bacterial infection. Severe infections may produce symptoms such as abscesses, enlarged glands and fever. Treatment consists of cool, wet compresses in conjunction with topical steroids. If the rash is extensive, a course of systemic steroids is indicated.

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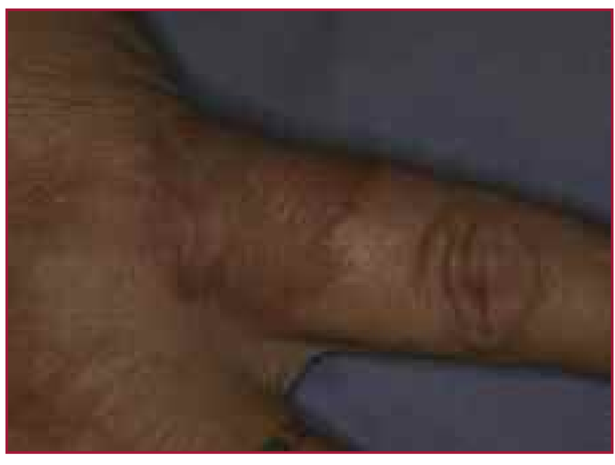
Case 6

A Violaceous Plaque

A 45-year-old diabetic female, with family history of psoriasis, presents with an asymptomatic annular plaque of the right index finger. The lesion had been present for five months, was violaceous, with central depression. No scaling was present.



What is your diagnosis?

a. Tinea corporis
b. Granuloma annulare
c. Sarcoidosis
d. Psoriasis

Answer

Granuloma annulare (GA) **(answer b)** is characterized by an annular, skin-coloured, erythmatous or violaceous plaque with central clearing. It is an inflammatory condition of unknown etiology affecting females twice as often as males. The more common localized form is usually contained to the dorsa of the hands and feet and in 50% of patients only one lesion is present.

In contrast, the generalized form is less common (15% of patients with GA) and consists of ≥ 10 lesions, which may arise as multiple skin-coloured papules on any body site.

GA has been associated with diabetes, however this relationship is not well established. Differential diagnoses of GA include tinea corporis and psoriasis, however the absence of scaling distinguishes it from these conditions. The lesions may resolve spontaneously, often within two years. GA is typically asymptomatic, self-limited and no treatment is required. However, possible treatments for localized GA include topical corticosteroids, cryotherapy, intralesional corticosteroids (*i.e.*, triamcinolone acetonide) and phototherapy.

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