



### This month – 7 cases:

- |                                  |      |                                 |      |
|----------------------------------|------|---------------------------------|------|
| 1. <i>Enlarging Lesion</i>       | p.39 | 5. <i>Skin-Coloured Papules</i> | p.44 |
| 2. <i>Red, Itchy Facial Rash</i> | p.40 | 6. <i>Asymptomatic Lesion</i>   | p.45 |
| 3. <i>Loin Lump</i>              | p.41 | 7. <i>Pearly Lesions</i>        | p.46 |
| 4. <i>Cracked Skin</i>           | p.42 |                                 |      |

## Case 1

# Enlarging Lesion

This 84-year-old gentleman presents with a history of an enlarging lesion on his left upper lip of two years duration. He has had liquid nitrogen treated to it on several occasions without improvement. He has had a history of extensive sun exposure as he spent several years in Italy during the war. On examination, there is a 1.8 cm by 0.4 cm translucent, annular plaque with multiple telangiectasias.

### What is your diagnosis?

- Squamous cell carcinoma
- Nevus
- Seborrheic keratosis
- Basal cell carcinoma

### Answer

Basal cell carcinoma (BCC) (**answer d**) is the most common form of cancer and is a neoplasm resulting from nonkeratinizing cells originating in the basal layer of the epidermis. This type of skin cancer is locally invasive and rarely metastasizes. The most commonly affected areas are those frequently exposed to the sun. Thirty per cent of BCC occur on the nose, but can occur anywhere on the body. Light skinned individuals are also more at risk. Clinical features of BCC have slight variation depending upon the subtype. Typical characteristics include:

- ulceration,
- translucency,



- telangiectasias and
- a rolled border.

Treatment is based on the anatomic location and the histology of the lesion. Management options include standard surgical excision, topical chemotherapy, Mohs micrographic surgery and curettage and desiccation.

Dominique A. Babin-Muise, 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, Professor and Director of Research, Division of Dermatology, Department of Medicine, Dalhousie University, Halifax, Nova Scotia.



Case 2

# Red, Itchy Facial Rash

A 49-year-old male presented with a long history of an itchy, scaly erythematous eruption affecting only the cheeks and sides of his nose and gradually deteriorating over time.

### What is your diagnosis?

- a. Psoriasis
- b. Seborrheic dermatitis
- c. Dermatophytosis

### Answer

Seborrheic dermatitis (**answer b**) is a chronic, scaly inflammatory eruption usually affecting the scalp and face. Sebum production is normal, but the eruption often occurs in the sebaceous gland areas of the scalp, face and chest. No etiological organism has been proven yet. Pyogenic infection is often present. Diet, alcohol and emotions could play some role. Seborrheic dermatitis-like lesions are seen in nutritional deficiencies, like zinc deficiency. The condition is severe in some patients with AIDS. There are four common patterns:

- Scalp and facial involvement
- Petaloid–dry scaly eczema over the presternal area
- Flexural involvement of the axillae, groin and submammary areas by a moist intertrigo often with secondarily colonized by *Candida albicans*
- Pityrosporum folliculitis—an erythematous follicular eruption with papules and pustules over the back



Treatment consists of washing all of the affected areas including the face and chest with antiseborrheic shampoo (containing selenium sulphide or ketoconazole either alone or following the application of 2% sulphur and 2% salicylic acid cream. Facial, truncal and flexural involvement responds to an imidazole or antimicrobial, often combined with 1% hydrocortisone in a cream or ointment base. Recurrences and remissions especially on the scalp are very common and repeated treatment is often necessary.

---

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

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



## Case 3

## Loin Lump

This 69-year-old gentleman asked about the reason for this loin lump, which developed four months after his right nephrectomy that he had three years ago for renal cancer. He was seen two months ago by his oncologist for a routine follow-up visit and had an abdominal CAT scan, which did not reveal any disease recurrence. The mass is painless and fully reducible.

### *What is your diagnosis?*

- Lipoma
- Renal cancer recurrence
- Incisional hernia
- Spigelian hernia

### *Answer*

Incisional hernia (**answer c**) or ventral hernias may occur in the area of any prior surgical incision and can vary in size from very small to very large and complex. They develop as the result of disruption along or adjacent to the area of abdominal wall suturing, often subsequent tension placed on the tissue or other inhibition to adequate healing (infection, poor nutrition, obesity, or metabolic diseases).

These hernias present as a bulge or protrusion at or near the area of the prior incision scar. Virtually any prior abdominal operation can subsequently develop an incisional hernia at the scar area, including those from large abdominal procedures (intestinal surgery, vascular surgery), to small incisions (appendectomy, or laparoscopy). These hernias can occur at any incision, but tend to occur more commonly along a straight line from the breastbone straight down to the pubis and are more complex in these regions. Hernias



in this area have a high rate of recurrence if repaired via a simple suture technique under tension and it is especially advised that these be repaired via a tension free repair method using mesh.

These hernias may develop soon after the original surgery, or at any time thereafter. Incisional hernias gradually increase in size once they develop and become progressively symptomatic. A bulge may not be evident at the hernia site initially and pain may be the only early hernia symptom. These hernias develop in many cases as a result of too much tension placed when closing the abdominal incision, as stated above. Tension creates poor healing, swelling, wound separation and eventual incisional hernia formation.

---

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 4

# Cracked Skin

A 56-year-old male presents with itchy, dry and cracked skin on his shins that developed in midwinter.

### What is your diagnosis?

- a. Xerosis
- b. Nummular eczema
- c. Psoriasis
- d. Eczema craquele
- e. Allergic contact dermatitis

### Answer

Eczema craquele (**answer d**) or asteatotic eczema refers to skin covered with cracks that is typically due to epidermal water loss with resulting fissure formation. This is particularly common in the elderly, in men and during cold winter climates. The main risk factors are:

- low humidity,
- dehydration,
- prolonged hot baths,
- irritants (e.g., soaps) and
- use of diuretics.

*This is particularly common in the elderly, in men and during cold winter climates.*



The most commonly affected area is the legs, though hands and arms can also be involved. Along with fissured and slightly scaly skin, one frequently observes excoriations, erythema and bleeding points from scratching. This is typically a localized form of eczema.

Patients should be advised to minimize long baths, change their soap to a mild skin cleanser, pat dry their skin with a towel rather than rubbing and to use thick moisturizing creams immediately after bathing. In the winter, a humidifier also needs to be turned up. Finally, a mid-potency topical steroid ointment (even better if under occlusion) applied nightly for one to two weeks can be very helpful.

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



Case 5

## *Skin-Coloured Papules*

A four-year-old girl presents with a one-month history of round, slightly elevated, flesh-coloured papules to her arms bilaterally.

### *What is your diagnosis?*

- a. Lichen nitidus
- b. Keratosis pilaris
- c. Lichen planus
- d. Lichen striatus
- e. Molluscum contagiosum

### *Answer*

Lichen nitidus (**answer a**) is an uncommon papular dermatitis, most common in preschool and school-aged children. It is characterized by very small, flat, shiny, skin-coloured papules often in clusters, which may exhibit Koebner phenomenon with lesions forming in areas of trauma.

Lichen planus causes pruritic, small, flat-topped shiny, red-violet papules distributed along the flexor aspects of the body and may also exhibit Koebner phenomenon. It is postulated that lichen nitidus may be associated with or be a variant of lichen planus.

Keratosis pilaris can also be found on the arms, in addition to the cheeks and anterior thighs. It can be distinguished from lichen nitidus as the lesions are usually based around follicles distributed with surrounding erythema and these children often have dry skin.



Lichen striatus is distributed along embryologic lines of development called Blaschko's lines but often occurs unilaterally rather than bilaterally.

Molluscum contagiosum is caused by the poxvirus and produces pearl-like, umbilicated papules.

---

Joseph M. Lam, MD, is a Pediatric Dermatologist practicing in Vancouver, British Columbia.

Melissa Paquette is a Final Year Medical Student at the University of Calgary, Calgary, Alberta.



## Case 6

# Asymptomatic Lesion

This 18-year-old boy has had an asymptomatic lesion of the abdomen, which has increased in size to 3 cm over the past three years.

### *What is your diagnosis?*

- Melanoma
- Congenital nevus
- Lichen aureus
- Cutaneous lupus
- Purpura annularis telangiectodes

### *Answer*

Purpura annularis telangiectodes (**answer e**) are lesions that are annular with central clearings. The variety of colours is secondary to telangiectasias and yellow-brown hemosiderin staining.

Both lichen aureus and purpura annularis telangiectodes (Majocchi's disease) are members of the pigmentary purpura group. They are similar in that they usually occur in adolescence on the lower extremities or trunk. Both show evidence of purpura and hemosiderin staining.

Treatment is generally ineffective and the eruption persists for months to years.

---

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



HELPS PREVENT BONE LOSS AND OSTEOPOROSIS  
With 400 IU Vitamin D

Caltrate PLUS<sup>®</sup>

PAAB<sup>+</sup> Product Monograph available upon request  
Wyeth Consumer Healthcare Inc. Mississauga, ON, Canada L4Z 3M6



Case 7

## Pearly Lesions

A 15-year-old boy presents with multiple pearly lesions on his left arm. His 12-year-old brother has similar lesions on his body.

### What is your diagnosis?

- a. Herpes simplex
- b. Herpes zoster
- c. Molluscum contagiosum
- d. Varicella

### Answer

Molluscum contagiosum (MC) (**answer c**) is caused by a poxvirus of the molluscipox genus in the *Poxviridae* family. The virus is transmitted by close physical contact, autoinoculation and fomites. The virus replicates in the cytoplasm of host epithelial cells. The discrete, smooth, flesh-coloured, dome-shaped papules with central umbilication are pathognomonic of MC. Lesions are usually 1 mm to 5 mm in diameter and the number is usually < 20. Central umbilication can be hard to observe in small lesions.

Although the condition is seen primarily in healthy individuals, those with immunodeficiency, atopic disease and Darier's disease are at increased risk. Immunocompromised individuals often have lesions that are large and profuse. The lesions are often asymptomatic and heal without scarring. Complications are rare and include secondary bacterial infection, chronic conjunctivitis and superficial punctate keratitis. Most lesions resolve spontaneously in six to nine months but may persist for



years. Although some authors suggest benign neglect of the lesions and to await spontaneous resolution, most authors suggest active treatment of lesions for cosmetic reasons and epidemiological concerns.

Active treatments may be mechanical (*e.g.*, curettage, cryotherapy with liquid nitrogen), chemical (*e.g.*, tretinoin, cantharidin, podophyllo-toxin) and immunologic (*e.g.*, imiquimod).

---

Alexander K. C. Leung, MBBS, FRCPC, FRCP (UK and Ire), 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.